



Government Gazette

REPUBLIC OF SOUTH AFRICA

Vol. 480 Pretoria 1 June 2005 **No. 27629**



AIDS HELPLINE: 0800-0123-22 Prevention is the cure

GENERAL NOTICE ALGEMENE KENNISGEWING

NOTICE 863 OF 2005

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)

1. I, Membathisi Mphumzi Shepherd Mdladlana, Minister of Labour, hereby give notice that, after consultation with the Compensation Board and acting under the powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993), I prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rules applicable thereto, appearing in the Schedule to this notice, with effect from **1 April 2005**.
2. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2005** and **Exclude VAT**.



MEMBATHISI MPHUMZI SHEPHERD MDLADLANA
MINISTER OF LABOUR

GENERAL INFORMATION / EMENE TING**(i) THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER.**

The employee is permitted to choose freely his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc. and no interference with this privilege is permitted as long as it is exercised reasonably and without prejudice to the employee himself or the Compensation Fund. The only exceptions to this rule are those cases where employers, with the Compensation Commissioner's approval, provide their own medical aid facilities in toto, i.e. including hospital, nursing and other services—section 78 of the Act refers.

In terms of section 42 either the Compensation Commissioner or an employer may send the injured employee to another doctor chosen by him (Compensation Commissioner or employer) for a special examination and report. Special fees are payable for this service. This examination and report is usually done only by specialists.

In the event of a change of doctors attending a case, the first doctor in attendance will, except where the case is handed over to a specialist, be regarded as the principal, and payment will normally be made to him. **To avoid disputes, doctors should refrain from treating a case already under treatment without first discussing it with the first doctor.** As a general rule, changes of doctor are not favoured, unless there are sufficient reasons therefore.

If an injured employee is in need of emergency treatment, the doctor should act in the same manner as he would to any patient who needs his urgent help. He should not, however, ask the Compensation Commissioner to authorise such treatment before the claim has been admitted as falling within the scope of the Act.

It should be remembered that an employee seeks medical advice at his own risk. If, therefore, an employee represents to his medical service provider that he is a Compensation for Occupational Injuries and Diseases Act case and yet fails to claim the benefits of the Act, leaving the Compensation Commissioner, or his employer, in ignorance of any possible grounds for a claim, the insurance fund concerned cannot accept any responsibility for any medical expenses incurred if the claim is not reported in the prescribed manner. The Compensation Commissioner can also have reason not to accept the claim lodged against the Fund. In such circumstances the employee would be in the same position as any other member of the public as regards payment of his medical expenses.

The amounts published in the tariff for COIDA for medical services are calculated without VAT. The only exclusion is die "per diem" tariff for Private Hospitals, that includes VAT. The account for services rendered will be assessed and calculated without VAT. If VAT is applicable and a VAT registration number was indicated, it will be calculated and added to the payment without being rounded off

**CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS
FOLLOWS •**

EISE TEENDIE VERGOEDINGSFONDS WORD HANTEER SOOS VOLG:

1. If the claim is accepted as a COIDA claim, reasonable medical expenses will be paid by the Compensation Commissioner • *As die eis teen die Fonds aanvaar word, word redelike mediese koste betaal deur die VergoedingsKommissaris.*
2. If the claim is rejected (repudiated), services will not be paid by the Compensation Commissioner. All parties are informed of this decision, including the service providers. The injured employee will be liable for payment. • *As die eis teen die Fonds afgekeur word (gerepudieer), word dienste nie deur die VergoedingsKommissaris betaal nie. Die betrokke partye word in kennis gestel van die besluit, ingesluit die diensverskaffers. Die beseerde werknemer is dan aanspreeklik vir die rekening.*

If **no** decision can be made due to a lack of information, the outstanding information is requested and upon receipt, the claim will again be adjudicated. Depending on the outcome, the accounts from the service provider, will be handled **as** set out in 1 and 2. Unfortunately, there are claims for which a decision might never be made due to a lack of forthcoming information • *Indien geen besluit geneem kan word nie, weens 'n gebrek aan inligting, word die uitstaande inligting aangevra. Met ontvangs word die eis heroorweeg. Afhangende van die uitslag, word die rekening hanteer soos uiteengesit in nommer 1 en 2. Ongelukkig is daar eise waar 'n besluit nooit geneem kan word nie aangesien die uitstaande inligting nie verskaf word nie*

BILLING PROCEDURE • EIS PROSEDURE:

1. The **first account** for services rendered to the injured employee (INCLUDING the First medical report) must be submitted to the employer who will collate all the documents (from other service providers etc.) and submit them to the Compensation Commissioner • *Die eerste rekening (INSLUITEND die Eerste mediese verslag) vir diens gelewer aan die beseerde werknemer, moet aan die werkgewer gestuur word, wat die eise (van ander diensverskaffers ens.) bymekuar sal sit en dit aanstuur na die Vergoedingskommissaris.*
2. New claims are registered by the Commissioner and the **employer is notified of the claim number** allocated to the claim. Enquiries for claim numbers should be directed to the employer and not to the Commissioner. The employer will be able to give you the claim number for the patient as well as indicate whether the Compensation Commissioner accepted the claim as a COIDA case • *Nuwe eise word geopen deur die Kommissaris en die werkgewer word in kennis gestel van die eisnommer. Navrae vir eisnommers moet aan die werkgewer gerig word en nie aan die Kommissaris nie. Die werkgewer **kan** die eisnommer verskaf en ook aandui of die Kommissaris die eis teen die Fonds aanvaar het of nie*
3. All new accounts are captured on the Commissioners database and a summarized notice is posted weekly to the service provider. This is only an **acknowledgement of receipt** and not a payment or a guarantee there of • *Alle nuwe rekeninge word vasgelê op die Kommissaris se databasis en 'n opsomming van rekeninge ontvang word weekliks aan die diensverskaffer gestuur. Dit is slegs 'n erkenning van ontvangs en nie 'n betaling of waarborg daarvan nie.*
4. If accounts are still outstanding after 60 days following submission and acknowledgement by the Commissioner Service providers should complete an enquiry form, W.CL 20, and submit it ONCE to the Commissioner. **DO NOT SUBMIT DUPLICATE ACCOUNTS WHEN AN ACKNOWLEDGEMENT WAS RECEIVED FOR THE PARTICULAR ACCOUNT** • *Indien die rekening nog uitstaande is na 60 dae na indiening en ontvangserkenning deur die Vergoedingskommissaris, moet die diensverskaffer 'n navraag vorm, W.CL 20 voltooi en EENMALIG indien na die Kommissaris. **MOENIE 'N DUPLIKAAT REKENING INDIEN AS ONTVANGS ERKEN IS VIR DIE BETROKKE REKENING NIE.***
5. If **no acknowledgement** was received and the account is unpaid **60 days after** it was submitted to the employer, a **duplicate account** must be submitted to the Commissioner directly. The account must be accompanied by any supporting documents e.g. PART B of the Employers Report of an Accident (W.CL 2), First (W.CL 4), and Progress/Final (W.CL 5/5F) medical reports • *Indien ontvangs **nie** erken is 60 dae **na** versending aan die werkgewer, moet 'n duplikaatrekening ingedien word by die Vergoedingskommissaris. Die rekening moet vergesel word van ander dokumentasie bv. DEEL B van die Werkgewer se Verslag oor 'n Ongeval (W.CL 2), Eerste (W.CL 4) en Vordering/Finale (W.CL 5/5F) mediese verslae.*
6. If the account is **partially paid** with no reason therefore indicated on the remittance advise, a duplicate account with the unpaid services clearly indicated must be submitted, accompanied

by a WCI 20 form. (*see website for example) • *Indien 'n rekeninggedeeltelik betaal is met geen rede voorsien op die betaaladvies nie, kan 'n duplikaatrekening met die kortbetaling duidelik aangedui, vergesel van 'n WCI20form ingedien word (*sien webblad vir voorbeeld van vorm).*

7. **Information NOT to be reflected** on the account: Details of the employee's medical aid and the practice number of the referring practitioner • *Inligting wat **NIE** aangedui moet word op die rekening nie: Besonderhede van die werknemer se mediese fonds en die verwysende geneesheer se praktyknommer.*
8. Service provider **should not generate** • *Diensverskaffer moenie die volgende genereer:*
 - a. **Multiple accounts** for services rendered on the **same date** i.e. one account for medication and a second account for other services • *Meer as een rekening vir dienste gelewer op dieselfde datum, bv. Medikasie op een rekening en ander dienste op 'n tweede rekening.*
 - b. **Accumulative accounts** but rather submit a separate account for every month • *Aaneenlopende rekeninge: aparte rekeningeper maand word verkies.*
 - c. **Accounts on the old documents (W.CL 4/5/5F) A** *New First Medical Report (W.CL 4) and Progress/Final Report (W.CL 5/5F) forms are available. The old forms combined with the account (W.CL11), were replaced. **Accounts on the old medical reports will not be entertained** • *Rekeninge op die ou voorgeskrewe dokumente van die Vergoedingskommissaris. 'n *Nuwe Eerste mediese verslag (W.CL4) en Vordering/Finale verslag (W.CL5) is beskikbaar. Die vorige vorms gekombineer met die rekening (W.CL11) is vervang. Rekeninge op die ou vorms is nie aanvaarbaar nie.*

* **Examples of the new forms (W.CL 4/5/53) are available on the website
www.labour.gov.za** •

* *Voorbeelde van die nuwe vorms (W.CL 4/5/5F) is beskikbaar op die webblad www.labour.gov.za*

MINIMUM REQUIREMENTS FOR ACCOUNTS RENDERED •
MINIMUM VEREISTES VIR REKENINGE GEHEF

1. **Minimum information** to be indicated on the account submitted to the Commissioner • **Minimum besonderhede** wat aangedui moet word op 'n rekening vir die Vergoedingskommissaris:
 - a. Name of employee **and** ID number • *Naam van werknemer **en** ID nommer.*
 - b. Name of employer and registration number if available. • *Naam van werkgewer en registrasie nommer indien beskikbaar.*
 - c. CC claim number/ alternatively employer's registration number • *CC eisnommer/alternatiewelik die werkgewer se registrasie nommer.*
 - d. DATE OF **ACCIDENT** (not only the service date) • *DATUM VAN **BESERING** (nie slegs die diensdatum nie)*
 - e. Service provider's reference number • *Diensverskaffer se rekening nommer*
 - f. The practice number (In case of address change, BHF must be notified) • *Die praktyknommer (in geval van adresverandering moet dit by BHF verander word)*
 - g. VAT registration number (The Compensation Commissioner will not pay VAT if a VAT registration number is not indicated on the account) • *BTW registrasie nommer (die Kommissaris sal nie BTW betaal as die BTW registrasie nommer nie aangedui word nie)*
 - h. Date of service (Actual service date must be indicated. Invoice date is not acceptable) • *Diensdatum (die werklike diensdatum moet aangedui word. Rekening datum is nie aanvaarbaar)*
 - i. Items according to the official published tariffs • *Items soos aangedui in die amptelik gepubliseerde tariewe.*
 - j. Amount claimed per item and total for account • *Bedrag ge-eis vir item en totaal van rekening.*

2. Please note that **as from 1 January 2004 a certified copy of an employee's identity document will be required** in order to register a claim with the Compensation Fund. If a copy of the identity document is not submitted the claim will not be registered but will be returned to you/the employer to attach a certified copy of the employee's identity document. Furthermore, all supporting documentation sent to this office must reflect the identity number as well. If it is not reflected, the documents will not be processed but will be returned to the sender to add the ID number. • *Neem asseblief kennis dat 'n gesertifiseerde afskrif van van die werknemer se identiteits dokument benodig word vanaf 1 Januarie 2004 om 'neis by die Vergoedingsfonds aan te meld. Indien 'n afskrif van die identiteitsdokument nie aangeheg is nie, sal die eis nie geregistreer word nie en die dokumente sal teruggestuur word aan die werkgewer/uself vir die aanheg van die dokument. Alle ander dokumentasie wat aan die kantoor gestuur word moet die identiteitsnommer aangedui hê. Indien nie aangedui nie, sal die dokumentasie nie verwerk word nie, maar teruggestuur word vir die aanbring van die identiteitsnommer.*

SCALE OF FEES FOR PRIVATE HOSPITALS **(57/58)** (*PERDIEM*TARIFF)
WITH EFFECT FROM 1 APRIL 2005

SCALE OF FEES FOR PSYCHIATRIC HOSPITALS **(55)** (*PERDIEM* TARIFF)
WITH EFFECT FROM 1 APRIL 2005

ACCOMMODATION

The day admission fee shall be charged in respect of all patients admitted as day patients and discharged before 23:00 on the same date.

Ward fees shall be charged at the full day rate if admission takes place before 12:00 and at the half daily rate if admission takes place after 12:00. At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 12:00 and the full daily rate if the discharge takes place after 12:00.

Ward fees to be inclusive of all pharmaceuticals and equipment, which is provided for in accommodation, theatre, emergency room and procedure rooms.

Note: Fees include VAT.

	DESCRIPTION	PRACTICE CODE (57/58) R.c.
1.1	General Wards	
H001	Surgical cases: per day	1434.00
H002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	1434.00
H004	Medical and neurological cases: per day	1434.00
H007	Day admission which includes all patients discharged by 23:00 on date of admission	613.00
		PRACTICE CODE (55) R.c.
H008	General Ward for Psychiatric Hospitals (Inclusive fee : Ward fee, Pharmaceuticals, Occupational Therapy)	1 117.00
12	Private Wards	
H020	Private ward accommodation will be payable at the same rate as for a General Ward: per day	1434.00

	DESCRIPTION	PRACTICE CODE 57/58 R.c.
1.3	Special Care Units Hospitals shall obtain a doctors' report stating the reason for accommodation in an intensive care unit or in high care ward from the attending practitioner, and such report showing the date and time of admission and discharge from the unit shall be forwarded to the Commissioner together with the account. Pre-drafted and standard certificates of authorisation will not be acceptable.	
H201	Intensive Care Unit: per day	9 613.00
H215	High Care Ward: per day	4 962.00
2.	Theatres and Emergency Unit	
2.1	Theatre and Emergency fees to be inclusive of all consumables and equipment. The after hours fee to be included in the normal theatre fee. Emergency fee Rule: Emergency fee - excluding follow-up visits.	
H301	For all consultations including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	344.00
H302	For all consultations which require the use of a procedure room, e.g. for application of plaster, stitching of wounds.	699.00
H303	<u>Follow-up visits:</u> The COID office will imburse hospitals for all materials used during follow-up visits. No consultation or facility fee is chargeable. The account is to be billed as for fee for service.	
H105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit which has been approved by the Board of Healthcare Funders.	2 734.00
2.2	Minor Theatre Fee 4 facility where simple procedures which require limited instrumentation and drapery, minimum nursing input and local maesthetic procedures are carried out. No sophisticated nonitoring is required but resuscitation equipment must be available.	

	DESCRIPTION	PRACTICE CODE 57/58 R.c.
H071	<p>The exact time of admission to and discharge from the minor theatre shall be stated, upon which the minor theatre charge shall be calculated as follows:</p> <p>Charge per minute</p>	41.00
2.3	<p>Major Theatre</p> <p>The exact time of admission to and discharge from the theatre shall be stated, upon which the theatre charge shall be calculated as follows:</p>	
H081	<p>Charge per minute</p>	123.00
5.9	<p>Prosthesis</p> <p><u>Prosthesis Pricing:</u></p> <p>Note: A R886.00 ceiling price per prosthesis is included in the theatre tariff. The combined value of all the components including cement in excess of R886.00 to be charged separately.</p> <p>A prosthesis shall mean a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral part of the device so implanted, and shall be charged as a single unit.</p> <p>Reimbursement to be at the lowest available manufacturer's price (inclusive of VAT).</p>	
H286	<p>Internal Fixators (surgically implanted)</p> <p>Reimbursement to be at the lowest available manufacturer's price include of VAT.</p> <p>Hospitals/unattached operating theatre units shall show the name and reference number of each item. The suppliers invoices, containing the manufacturer's name, should be attached <i>to</i> the account and the components specified on the account should appear on the invoice.</p> <p>External Fixators</p> <p>Reimbursement to be at 33% of the lowest available manufacturer's price include of VAT.</p>	

	DESCRIPTION	PRACTICE CODE 57/51 R.c
	<p>Hospitals/unattached operating theatre units shall show the name and reference number of each item. The suppliers invoices containing the manufacturer's name, should be attached to the account and the components specified on the account should appear on the invoice.</p>	
<p>5.10 H287</p>	<p>Medical artificial items (non-prosthesis)</p> <p>Examples of items included hereunder shall be artificial limbs, wheelchairs, crutches and excretion bags. Copies of invoices shall be supplied to the Commissioner. Reimbursement to be at the lowest available manufacturer's price inclusive of VAT.</p>	
<p>5.11</p>	<p>Further Non-Prosthetic Medical Artificial items: Sheepskins Abdominal Binders Orthopaedic Braces (ankle, knee, wrist, arm) Anti-Embolism Stockings Futuro Supports Corsets Crutches Clavicle Braces Toilet Seat Raisers Walking Aids Walking Sticks Back Supports Elbow/Hand Cradles</p>	
<p>5.11</p>	<p>Serious Burns</p> <p>To be charged at normal fee for service. The following items are applicable and must be accompanied by a written motivation from the treating doctor.</p>	
<p>H289</p>	<p>Serious Burns: Fee for service (Inclusive of all services e.g. accommodation, theatre, etc.) except medication whilst hospitalised.</p>	
<p>H290</p>	<p>Serious Burns: Item for medication used during hospitalisation excluding the TTO's. <i>Note: TTO's to be charged according to item H288</i></p>	
<p>5.12 H288</p>	<p>TTO</p> <p>TTO scripts will be reimbursed by the Commissioner for a period of two (2) weeks. A script that covers a period of more than two (2) weeks must have a doctor's motivation attached.</p>	