DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 3050 OF 2025

PRIVATE HOSPITAL GAZETTE 2025

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

Compensation Fund, Delta Heights Building 167 Thabo Sehume Street, Pretoria 0001
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NOTICE: **DATE:**

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASSES ACT, 1993 (ACT NO.130 OF 1993), AS AMENDED

ANNUAL INCREASE IN MEDICAL TARIFFS FOR MEDICAL SERVICES PROVIDERS.

1. I, Nomakhosazana Meth, Minister of Employment and Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from 1 April 2025.
2. Medical Tariffs will increase by 6% for the financial year 2025/26.
3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2025 and exclude 15% VAT

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Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

POPI ACT COMPLIANCE

In terms of Protection of Personal Information Act, 2013 (POPI Act), the Compensation Fund wants to assure Employees and the Medical Service Providers that all personal information collected is treated as private and confidential. The Compensation Fund has put in place the necessary safeguards and controls to maintain confidentiality, prevent loss, unauthorised access and damage to information by unauthorised parties.

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

1.1. The Compensation Fund requires that any Medical Service Provider, providing medical treatment to patients in terms of the COID Act, must be registered with The Compensation Fund as follows:

1.1.1. Copies of the following documents must be submitted to the nearest Labour Centre

a. A certified identity document of the practitioner

b. Certified valid BHF certificate

c. Recent bank statement with bank stamp or bank letter

d. Proof of practice address not older than 3 months.

e. Submit SARS VAT registration number/ certificate if VAT registered. If this is not provided the Medical Service Provider will be registered as a Non VAT vendor.

f. A power of attorney is required where the MSP has appointed a third party for administration of their COID claims.

1.1.2. A duly completed original Banking Details form (WAC 33) that can be downloaded in PDF from the Department of Employment and Labour Website (www.labour.gov.za).

1.1.3. Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address and Email address. The Fund must be notified in writing of any changes in order to effect necessary changes.

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2. REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

2.1. To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:

2.1.1. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)

2.1.2. Register on the CompEasy application having the following documents to upload:

- A certified copy of identity document (not older than a month from the date of application)
- Certified valid BHF certificate
- Proof of address not older than 3 months

2.2. In the case where a medical service provider wishes to appoint a proxy to interact on the claims processing system the following ADDITIONAL documents must be uploaded:

- An appointment letter for proxy (the template is available online)
- The proxy's certified identity document (not older than a month from the date of application)
- There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

3.1. Third Parties that provide administration services on COID medical invoices on behalf of medical service providers must take note of the following:

3.1.1. A third party transacting with the Fund, must be in a position to obtaining a copies of the original claim documents and medical invoices from medical service providers.

3.1.2. The third party must keep such records in their original state as received from the medical service provider and must furnish the Compensation Commissioner with such documents on request for the purposes of auditing.

3.2. The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information was obtained or relates to a period prior to them contracting to a third party.

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4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

4.1. Medical Service Providers are advised to take note of the following as it pertains to the treatment of patients in relation to the Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

4.1.1. An employee as defined in the COID Act of 1993, is at liberty to choose their preferred medical service provider without interference, as long as it is exercised reasonably and without prejudice to the employee or the Compensation Fund.

4.1.2. The only exception to this rule is in case where an employer, with the approval of the Compensation Fund, provides comprehensive medical aid facilities to its employees, e.g. Hospital, nursing and other medical services — Section 78 of the COID Act refers.

4.1.3. In terms of Section 42 of the COID Act, the Compensation Fund may refer an injured employee to a specialist medical service provider designated by the Director General for a medical examination and report.

4.1.4. In terms of section 76,3(b) of the COID Act, no amount in respect of medical expenses shall be recoverable from the employee.

4.1.5. In the event of a change of a medical service provider attending to a case, the first treating doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal treating doctor.

4.1.6. To avoid disputes regarding the payment for services rendered, medical service providers should refrain from treating an employee already under treatment by another medical practitioner without consulting/informing the principal treating doctor.

4.1.7. Any changes of medical service providers must have sufficient reasons existing for such a change which must be communicated to the Compensation Fund.

4.1.8. According to the National Health Act no 61 of 2003, Section 5, a health care provider may not refuse a person emergency medical treatment. Such a medical service provider should not request the Compensation Fund to authorise such treatment before the claim has been registered and liability for the claim is accepted by the Compensation Fund.

4.1.9. An employee seeks medical advice at their own risk. If such an employee presents themselves to a medical service provider as being entitled to treatment in terms of the COID Act, whilst having failed to inform their employer and/or the Compensation Fund of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for the settlement of medical expenses incurred under such circumstances.

4.1.10. The Compensation Fund may have reasons to repudiate a claim lodged with it, in such circumstances, the employee would be in the same position as any other member of the public regarding payment of their medical expenses.

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5. OVERVIEW OF THE COID CLAIMS PROCESS

5.1. All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:

5.1.1. New claims are registered by the Employers with the Compensation Fund in the prescribed manner. Details of and progress of the claim can be viewed on the online processing system for registered users of the system.

5.1.2. Proof of identity is required in the form of a copy of an Identity document/card, will be required in order for a claim to be registered with the Compensation Fund. In the case of foreign nationals, the proof of identity (passport) must be certified.

5.1.3. All supporting documentation submitted to the Compensation Fund must reflect the identity and claim numbers of the employee.

5.1.4. The allocation of a claim number to a claim after the registration thereof by the Compensation Fund, does not constitute acceptance of liability for a claim. It indicates that the injury on duty has been reported to the Compensation Fund and acknowledged.

5.1.5. When liability for a claim is accepted by the Compensation Fund in terms of the COID Act, reasonable medical expenses, related to the medical condition shall be paid to medical service providers, that treat the employees, in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.

5.1.6. If a claim is repudiated in terms of the COID Act, medical expenses, will not be payable by the Compensation Fund. The employer and the employee will be informed of this decision and the injured employee will be liable for payment of medical costs incurred.

5.1.7. In the event of insufficient claim information being made available to the Compensation Fund, the claim will be rejected until the outstanding information is submitted and liability can be determined.

5.1.8. Manner of payment of medical benefits for Compensation Fund claims, where liability has been accepted (adjudicated) on or after 1 April 2025.

5.1.9. All medical invoices for accepted claims must be submitted, in the prescribed manner within 24 months of the date of acceptance of liability. Medical invoices received after said time frame will be considered as late submission of invoices and may be rejected.

5.1.10. All service providers should be registered on the Compensation Fund claims processing system in order to capture medical invoices and medical reports for medical services rendered.

5.1.11. Medical reports and medical invoices should ONLY be submitted/transmitted for claims that The Compensation Fund has accepted liability for and thus reasonable medical expenses are payable.

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6. BILLING REQUIREMENTS FOR MEDICAL SERVICES PROVIDED TO INJURED/DISEASED EMPLOYEES

6.1. Medical Reports:

In terms of Sec 74(1)(2)(3)(4) and (5) of COID Act, Submission of Medical Report; Medical Service provider are advised to take note of the following:

6.1.1. The first medical report (W. CL 4), completed after the first consultation must confirm the clinical description of the injury/disease. It must also detail any procedure performed and any referrals to other medical service providers where applicable.

6.1.2. All follow up consultations must be completed on a Progress Medical Report (W.CL5). Any operation/procedure performed must be detailed therein and any referrals to other medical service providers where applicable.

6.1.3. A progress medical report is considered to cover a period of 30 days, with the exception where a procedure was performed during that period, then an additional operation report will be required.

6.1.4. Only one medical report is required when multiple procedures are done on the same service date.

6.1.5. When the injury/disease being treated stabilises a Final Medical Report must be completed (W.CL 5F).

6.1.6. Medical Service Providers are required to keep copies of medical reports which should be made available to the Compensation Commissioner when requested.

NB: Hospitals will be required from the 1st April 2025 to provide patient records when submitting medical invoices for services provided.

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7. MINIMUM INFORMATION REQUIREMENTS FOR MEDICAL INVOICES SUBMITTED TO THE COMPENSATION FUND

The following must be indicated on a medical invoice in order to be processed by the Compensation Fund:

1. The allocated Compensation Fund claim number
2. Name and ID number of employee
3. Name and Compensation Fund registration number of Employer, as indicated on the Employers Report of Accident (W.CL 2)
4. DATES:
    a. Date of accident
    b. Date of service (From and to)
5. Medical Service Provider, BHF practice number
6. VAT registration number of Medical Service Provider: VAT will not be applied if a VAT registration number is not supplied on the invoice
7. Tariff Codes:
    a. Tariff code applicable to injury/disease, are as published tariff gazettes.
    b. Amount claimed per code, quantity and the total amount of the invoice.
8. VAT:
    a. The tariff amounts published in the tariff guides exclude VAT.
    b. All invoices for services rendered will be assessed without VAT.
    c. VAT will be applied to VAT registered vendors (MSP's) without being rounded off.
    d. With the exception of the following:
        i. "PER DIEM" tariffs for Private Hospitals that already are VAT inclusive.
        ii. Certain VAT exempted codes in the Private Ambulance tariff structure.
9. All pharmacy or medication invoices must be accompanied by the original script(s)

NB!! All pharmaceuticals will be processed in accordance with Nappi file codes.

10. Where applicable the referral letter from the treating practitioner must accompany the medical service providers' invoice.
11. All medical invoices must be submitted with invoice numbers to prevent system rejections.
12. Duplicate invoices should not be submitted.
13. Compensation Fund does not accept submission of running accounts /statements, but will reject upfront at switch level.

PLEASE NOTE: The Compensation Fund will withhold payments if medical invoices do not comply with minimum submission and billing requirements as published in the Government Gazette

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8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

A switching provider must comply with the following requirements:

1. Register with the Compensation Fund as an employer where applicable in terms of the COID Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with the Fund. This requires that they ensure the following:
    a. Disable Standard FTP because is now obsolete. ...and use latest version and reinforce FTPS protocols and TLS protocols.
    b. Use Strong Encryption and Hashing.
    c. Place Behind a Gateway.
    d. Implement IP Blacklists and Whitelists.
    e. Harden Your FTPS Server.
    f. Utilize Good Account Management.
    g. Use Strong Passwords.
    h. Implement File and Folder Security.
    i. Secure your administrator, and require staff to use multifactor authentication.
3. Submit and complete successful test file after registration before switching the invoices.
4. Verify medical service provider's registration with the Board of Healthcare Funders of South Africa.
5. Submit medical invoices with gazetted COIDA tariffs that are published annually.
6. Comply with medical billing requirements of the Compensation Fund.
7. Single batch submitted must have a maximum of 150 medical invoices.
8. Eliminate duplicate invoices before switching to the Fund.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Only pharmacies should claim from the NAPPI file.

PLEASE NOTE:

Failure to comply with the above requirements will result in deregistration / penalty imposed on the switching house.

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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

*** Mandatory fields**

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
BATCH HEADER				
1	Header identifier = 1	1	Numeric	*
2	Switch internal Medical aid reference number	5	Alpha	
3	Transaction type = M	1	Alpha	
4	Switch administrator number	3	Numeric	
5	Batch number	9	Numeric	*
6	Batch date (CCYYMMDD)	8	Date	*
7	Scheme name	40	Alpha	*
8	Switch internal	1	Numeric	
DETAIL LINES				
1	Transaction identifier = M	1	Alpha	*
2	Batch sequence number	10	Numeric	*
3	Switch transaction number	10	Numeric	*
4	Switch internal	3	Numeric	
5	CF Claim number	20	Alpha	*
6	Employee surname	20	Alpha	*
7	Employee initials	4	Alpha	*
8	Employee Names	20	Alpha	*
9	BHF Practice number	15	Alpha	*
10	Switch ID	3	Numeric	
11	Patient reference number (account number)	11	Alpha	*
12	Type of service	1	Alpha	
13	Service date (CCYYMMDD)	8	Date	*
14	Quantity / Time in minutes	7	Decimal	*
15	Service amount	15	Decimal	*
16	Discount amount	15	Decimal	*
17	Description	30	Alpha	*
18	Tariff	10	Alpha	*
19	Service fee	1	Numeric	
20	Modifier 1	5	Alpha	
21	Modifier 2	5	Alpha	
22	Modifier 3	5	Alpha	
23	Modifier 4	5	Alpha	
24	Invoice Number	10	Alpha	*
25	Practice name	40	Alpha	*
26	Referring doctor's BHF practice number	15	Alpha	
27	Medicine code (NAPPI CODE)	15	Alpha	*
28	Doctor practice number - sReferredTo	30	Numeric	
29	Date of birth / ID number	13	Numeric	*
30	Service Switch transaction number – batch number	20	Alpha	
31	Hospital indicator	1	Alpha	*
32	Authorisation number	21	Alpha	*
33	Resubmission flag	5	Alpha	*
34	Diagnostic codes	64	Alpha	*
35	Treating Doctor BHF practice number	9	Alpha	

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FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
36	Dosage duration (for medicine)	4	Alpha	
37	Tooth numbers		Alpha	*
38	Gender (M, F)	1	Alpha	
39	HPCSA number	15	Alpha	
40	Diagnostic code type	1	Alpha	
41	Tariff code type	1	Alpha	
42	CPT code / CDT code	8	Numeric	
43	Free Text	250	Alpha	
44	Place of service	2	Numeric	*
45	Batch number	10	Numeric	
46	Switch Medical scheme identifier	5	Alpha	
47	Referring Doctor's HPCSA number	15	Alpha	*
48	Tracking number	15	Alpha	
49	Optometry: Reading additions	12	Alpha	
50	Optometry: Lens	34	Alpha	
51	Optometry: Density of tint	6	Alpha	
52	Discipline code	7	Numeric	
53	Employer name	40	Alpha	*
54	Employee number	15	Alpha	*
55	Date of Injury (CCYYMMDD)	8	Date	*
56	IOD reference number	15	Alpha	
57	Single Exit Price (Inclusive of VAT)	15	Numeric	
58	Dispensing Fee	15	Numeric	
59	Service Time	4	Numeric	
60				
61				
62				
63				
64	Treatment Date from (CCYYMMDD)	8	Date	*
65	Treatment Time (HHMM)	4	Numeric	*
66	Treatment Date to (CCYYMMDD)	8	Date	*
67	Treatment Time (HHMM)	4	Numeric	*
68	Surgeon BHF Practice Number	15	Alpha	
69	Anaesthetist BHF Practice Number	15	Alpha	
70	Assistant BHF Practice Number	15	Alpha	
71	Hospital Tariff Type	1	Alpha	
72	Per diem (Y/N)	1	Alpha	
73	Length of stay	5	Numeric	*
74	Free text diagnosis	30	Alpha	
TRAILER				
1	Trailer Identifier = Z	1	Alpha	*
2	Total number of transactions in batch	10	Numeric	*
3	Total amount of detail transactions	15	Decimal	*

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MSPs PAID BY THE COMPENSATION FUND

Discipline Code :	Discipline Description :
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
011	Ambulance Services - Intermediate
012	Dermatology
013	Ambulance Services - Basic
014	General Medical Practice
015	General Medical Practice
016	Obstetrics and Gynecology (Occupational related cases)
017	Pulmonology
018	Specialist Medicine
019	Gastroenterology
020	Neurology
021	Cardiology (Occupational Related Cases)
022	Psychiatry
023	Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopaedic
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Speciality
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiation Oncology
042	Surgery Specialist
044	Cardio Thoracic Surgery
046	Urology
049	Sub-Acute Facilities
052	Pathology
054	General Dental Practice
055	Mental Health Institutions
056	Provincial Hospitals
057	Private Hospitals
058	Private Hospitals
059	Private Rehab Hospital (Acute)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
064	Orthodontics
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists only)

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076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics
078	Blood transfusion services
079	Hospices/Frail Care
082	Speech therapy and Audiology
083	Hearing Aid Acoustician
084	Dietetics
086	Psychology
087	Orthotics & Prosthetics
088	Registered nurses (Wound Care and Nephrology only)
089	Social worker
090	Clinical services : (Wheelchairs and Gases only)
094	Prosthodontic

PRIVATE HOSPITALS PERDIEM TARIFF OF FEES FROM 1 APRIL 2025

Private Hospital Rules

NOTE: Fees include VAT
Submission of running account is not allowed. i:e:
Hospitals are requested to submit a monthly invoices for patients admitted for a prolonged period.
Service dates claimed for should not overlap to the following month.

NB! All invoices should be accompanied by an admission form that reflects the admission date and discharge date where applicable.

Acute Hospital 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 are inclusive of all pharmaceuticals and equipment that are provided in the accommodation, theatre, emergency room and procedure rooms

Drugs, consumables and disposable items used during a procedure or issued to a patient on discharge should be claimed for using the appropriate code.

Day Hospital Admissions

Day admission: Chargeable for all patients admitted and discharged before midnight on the same day irrespective of the time of admission.

Overnight Fee: Applicable to licenced day hospitals only. Charged for cases with complications the maximum of one night.
A medical report from the treating doctor indicating reasons for extended of stay must accompany an invoice.

Special Care Units

Hospitals shall obtain a treating doctor's report stating the reason for accommodation in an intensive care unit or a high care ward. The report must include the date and time of admission and discharge from the unit. The report must be forwarded to the Fund together with the invoice.

Pre-drafted and standard certificates of authorisation will not be acceptable.

Theatres and Emergency Units
Theatre and Emergency fees are inclusive of all consumables and equipment. The after hours fee are included in the normal theatre fee. A copy of the treating doctor's medical report must be submitted, for treatment provided in emergency units for codes H301, H302 and H303. Emergency fee - excludes follow-up visits.
Minor Theatre Fee
This shall refer to : A facility where simple procedures, which require limited instrumentation and drapery, minimum nursing input and local anaesthetic procedures are carried out. No sophisticated monitoring is required but resuscitation equipment must be available. The exact time of admission to and discharge from the minor theatre must be stated.
Major Theatre Fee
This shall refer to : A facility where major procedures are performed under general and local anaesthesia. The exact time of admission to and discharge from the theatre must be stated.
Prosthesis Pricing
A ceiling price of R1 739.32 per prosthesis is included in the theatre tariff. The combined value of all the components including cement in excess of R1739.32 should be charged separately. A prosthesis is 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. Reimbursement will be at the lowest available manufacturer's price (inclusive of VAT). List of items to be reflected in the invoice.

Internal Fixators (surgically implanted)
Reimbursement will be at the lowest available manufacturer's price inclusive of VAT. Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers invoices, each containing the manufacture's name, including the components specified should attached and appear on the medical invoice. List of items to be reflected in the invoice.
External Fixators
Reimbursement will be at 33% of the lowest available manufacturer's price inclusive of VAT. List of items to be reflected in the invoice.
MEDICAL ARTIFICIAL ITEMS (non-prosthesis)
Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers' invoices, each containing the manufacturer's name, including the components specified should be attached and appear on the medical Invoice. List of items to be reflected in the invoice.
Serious Burns (Acute Hospitals PR 57/58)
Billed at normal fee for service. Codes H289 and H290 are applicable and must be accompanied by a medical report from the treating doctor. TTO's should be charged according to code H288. List of items to be reflected in the invoice.
TTO
TTO issued on discharge, and will be reimbursed by the Fund. List of items to be reflected in the invoice.

Acute and Sub-Acute Rehabilitation
Maximum period for a patient stay at Acute rehabilitation (Practice 59) ward is 3 months (12 weeks), then the patient should be discharged or referred to Sub-acute rehabilitation (Practice 49). For all patients transfered from Acute Rehabilitation to Sub-acute Rehabilitation, a referral letter from the treating doctor is required by the Fund. All Sub-acute rehabilitation facilities must have a rehabilitation plan for all patients admitted.
General Ward For Acute Rehabilitation Hospitals
All patients transfered from Acute hospital (Practice 57/58), Acute Rehabilitation (Practice 59) or Sub-acute Rehabilitation (Practice 49), a referral letter is required from the treating doctor. Ward fees shall be charged at the full daily 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 are inclusive of all pharmaceuticals and equipment that are provided in the accommodation and procedure rooms.
Sub - Acute Rehabilitation Hospitals
Admission to the facility should be referred by the treating doctor. Ward fees shall be charged at the full daily 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 are inclusive of all pharmaceuticals and equipment that are provided in the accommodation and procedure rooms.
Frail Care / Paliative / Hospice (Pr 79)
Hospice or similar approved facilities. All patients transfered from Acute hospital, Acute Rehabilitation or Sub-acute Rehabilitation, a referral letter from the treating doctor is required.

TARIFF CODE	DESCRIPTION	ACUTE HOSPITAL (PR 57/58)	DAY HOSPITAL (PR 77)
*	**Can be claimed by a facility**		
-	**Cannot be claimed by a facility**		
1. General Wards			
H001	Surgical cases: per day	**4,624.55**	-
H002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	**4,624.55**	-
H004	Medical and neurological cases: per day	**4,624.55**	-
H007	Day admission which includes all patients discharged by 23:00 on date of admission	**1,901.67**	-
H014	Overnight fee - for complications only (maximum of one night)	-	**1,882.66**
H100	Day admission which includes all patients discharged by 23h00 on date of admission	-	**1,882.66**
1.1 Special Care Units			
H201	Intensive Care Unit: per day	**28,258.11**	-
H215	High Care Ward: per day	**14,582.49**	-
2. Theatres and Emergency Unit			
H301	For all emergencies including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	**1,066.58**	**1055.81**
H302	For all emergencies which require the use of a procedure room, e.g. for application of plaster, stitching of wounds.	**2,163.87**	**2142.24**
H105	Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit.	**8,467.63**	-

3. Follow up visit			
H303	Follow-up visits: The Fund will reimburse 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.	*	-
4. Minor Theatre Fee			
H071	Charge per minute	**128.50**	**128.50**
5. Major Theatre Fee			
H081	Charge per minute	**380.25**	**376.45**
6. Prosthesis			
H286	Internal Fixators (surgically implanted)	*	-
7. Medical Artificial Items (non-prosthesis)			
H287	Examples of items included hereunder shall be artificial limbs, wheelchairs, crutches and excretion bags. Copies of invoices shall be supplied to the Fund. Reimbursement will be at the lowest available manufacturer's price inclusive of VAT. 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	*	*

8. Serious Burns			
H289	Serious Burns: Fee for service (Inclusive of all services e.g. accommodation, theatre, etc.) except medication whilst hospitalised.	*	-
H290	Serious Burns: Item for medication and material used during hospitalisation excluding the TTO's. NB!! List of items used to be reflected in the invoice.	*	-
9. TTO			
H288	Treatment Taken Out issued at discharge	*	*
10. ACUTE REHABILITATION HOSPITALS (PR 59)			
10.1 General Wards			
H010	General Rehabilitation ward per day.	**7,725.48**	-
10.2 TTO			
H288	Treatment Taken Out issued at discharge	*	-
11. SUB-ACUTE REHABILITATION HOSPITALS (PR 49)			
11.1 General Wards			
H020	Sub-Acute Rehabilitation ward per day.	**4,215.63**	-
11.2 TTO			
H288	Treatment Taken Out issued at discharge	*	-
12. PSYCHIATRIC HOSPITAL (PR 55)			
12.1 General Wards			
H008	General Ward for Psychiatric Hospitals.	**3,602.73**	-
12.2 TTO			
H288	Treatment Taken Out issued at discharge	*	-
13. FRAIL CARE / PALLIATIVE / HOSPICE (Pr 79)			
13.1 General Wards			
H950	Frail care/Hospice ward (Daily) (Inclusive fee: ward fee, general care management, Doctors, Nursing staff)	**2,450.97**	-
H955	Home health care, per visit	**585.72**	-
13.2 TTO			
H288	Treatment Taken Out issued at discharge	*	-