GENERAL NOTICE

NOTICE 822 OF *2006*

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 2006**.

2. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2006** and **Exclude VAT.**

M M S MDLADLANA
MINISTER OF LABOUR
19 May 2006

GENERAL INFORMATION / *ALGEMENE INLIGTING*.

(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 total, 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

(i) DIE WERKNEMER EN DIE MEDIESE DIENSVERSKAFFER

Die werknemer het 'n vrye keuse van diensverskaffer bv. Dokter, apteek, fisioterapeut, hospitaal ens. en geen inmenging met hierdie voorreg word toegelaat solank dit redelik en sonder nadeel vir die werknemer self of die Vergoedingsfonds uitgeoefen word nie. Die enigste uitsonderings op hierdie reel is in daardie gevalle waar die werkgewers met die goedkeuring van die Vergoedingskommissaris hul eie geneeskundige dienste in die geheel voorsien, d.i. insluitende hospitaal- verplegings- en ander dienste—artikel 78 van die Wet verwys.

Kragtens die bepalings van artikel 42 mag die Vergoedingskommissaris of die werkgewer na gelang van die geval, 'n beseerde werknemer na 'n ander geneesheer deur hom (Vergoedingskommissaris of werkgewer) aangewys, stuur vir 'n spesiale ondersoek en verslag. Spesiale gelde is betaalbaar vir hierdie dienste. Hierdie ondersoek word uit die aard van die saak feitlik uitsluitlik deur spesialiste gedoen.

In die geval van verandering van geneeshere wat 'n geval behandel, sal die eerste geneesheer wat behandeling toegedien het, behalwe waar die geval aan 'n spesialis oorhandig is, as die lasgewer beskou word en betaling sal normaalweg aan hom gemaak word. **Ten einde geskille te voorkom, moet geneeshere hul daarvan weerhou om 'n geval wat reeds onder behandeling is te behandel sonder om dit eers met die eerste geneesheer te bespreek.** Oor die algemeen word veranderings van geneeshere, tensy voldoende redes daarvoor bestaan, nie aangemoedig nie.

In gevalle waar 'n beseerde werknemer noodbehandeling benodig, moet die geneesheer op dieselfde wyse as teenoor enige pasient wat sy hulp dringend nodig het optree. Hy moet egter nie die Vergoedingskommissaris vra om sulke behandeling goed te keur alvorens aanspreeklikheid vir die eis kragtens die Wet aanvaar is nie. Dit moet in gedagte gehou word dat 'n werknemer geneeskundige behandeling op sy eie risiko soek. As 'n werknemer dus aan 'n geneesheer voorgee dat hy 'n geval is onder die Wet op Vergoeding vir Beroepsbeserings en Siektes en tog versuim om die voordele van die Wet te eis deur die Vergoedingskommissaris of sy werkgewer in die duister te laat van enige moontlike gronde vir 'n eis, kan die betrokke versekeringsfonds geen aanspreeklikheid aanvaar vir geneeskundige onkoste wat aangegaan is nie as die besering nie aangemeld is op die voorgeskrewe wyse nie. Die Vergoedingskommissaris kan ook rede he om nie die eis teen die Fonds te aanvaar nie. Onder sulke omstandighede sou die werknemer in dieselfde posisie verkeer as enige lid van die publiek wat betaling van sy geneeskundige onkoste betref.

Die bedrae gepubliseer in die tarief vir COIDA is BTW uitgesluit. Die enigste uitsondering is die "per diem" tarief vir Privaat Hospitale, wat BTW insluit. Die rekening vir dienste gelewer word aangeslaan en bereken sonder BTW. Indien BTW van toepassing is en 'n BTW registrasie nommer aangedui is, word dit bereken en by die betalingsbedrag gevoeg sonder om afgerond te word.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS •
EISE TEEN DIE 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 Vergoedings Kommissaris 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 uun die werkgewer gestuur **word,** wat die eise (van ander diensverskuflers ens.) bymekaar sal sit en dit aanstuur na die **Vergoedingskomrnissaris.***

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 Kornrnissaris 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 kun die eisnommer verskaf en ook aandui of die Kornmissaris 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 an 'n opsomrning van rekeninge ontvang word weekliks aan die diensverskufler 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 an ontvangserkenning deur die Vergoedingskommissaris, moet die diensverskufler 'n navraag vorm, W.CL 20 voltooi en EENMALIG indien na die Kommissaris. **MOENIE 'N DUPLIKAAT REKENING INDIEN AS ONWANGS 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 **Vergoedingskomrnissaris.** Die rekening moet vergesel word van under dokumentasie bv. DEEL B van die Werkgewer se Verslag **oor** 'n Ongeval (WCL 2), Eerste (W.CL 4) en Vordering/Finale (W.CL 5/5F) mediese veslae.*

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 WCl **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 WCl20 form 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 venvysende geneesheer se praktyknommer.*

8. Service provider **should not generate** e *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 rekeninge per 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 4/5/5F) 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 • *Naanz van werknemer en ID nommer.*
   b. Name of employer and registration number if available. • *Naam van werkgewer en registrasie nommer indien beskikhaur.*
   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 inoet 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 'n eis by die Vergoedingsfondsaan 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.*

COMPENSATION COMMISSIONER

SCALE OF FEES FOR PRIVATE HOSPITALS (57/58) *(PER DIEM* TARIFF) WITH EFFECT FROM 1 APRIL 2006

SCALE OF FEES FOR PSYCHIATRIC HOSPITALS (55) *(PER DIEM* TARIFF) WITH EFFECT FROM 1 APRIL 2006

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	1 491.00
H002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	1 491.00
H004	Medical and neurological cases: per day	1 491.00
H007	Day admission which includes all patients discharged by 23:00 on date of admission	638.00
		PRACTICE CODE (55) R.c.
H008	**General Ward for Psychiatric Hospitals (Inclusive fee**: Ward fee, Pharmaceuticals, Occupational Therapy)	1 162.00
1.2	**Private Wards**	
H020	Private ward accommodation will be payable at the same rate as for a General Ward: per day	1 491.00

	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	**9 998.00**
H215	High Care Ward: per day	**5 160.00**
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.	**358.00**
H302	For all consultations which require the use of a procedure room, e.g. for application of plaster, stitching of wounds.	727.00
H303	Follow-up visits:	
	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.	2 843.00
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.
	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:	
H071	Charge per minute	43.00
23	**Major Theatre**	
	The exact time of admission to and discharge from the theatre shall be stated, upon which the theatre charge shall be calculated as follows:	
H081	Charge per minute	128.00
5.9	**Prosthesis**	
	Prosthesis Pricing:	
	Note: A R922.00 ceiling price per prosthesis is included in the theatre tariff. The combined value of all the components including cement in excess of R922.00 to be charged separately.	
	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.	
	Reimbursement to be at the lowest available manufacturer's price (inclusive of VAT).	
H286	**Internal Fixators (surgicalty implanted)**	
	Reimbursement to be at the lowest available manufacturer's price include of VAT.	
	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.	
	External Fixators	
	Reimbursement to be at **33%** of the lowest available manufacturer's price include of VAT.	

	DESCRIPTION	PRACTICE CODE 57/58 R.c.
	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.	
5.10	**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 Commissioner. Reimbursement to 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	
5.11	**Serious Burns**	
	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.	
H289	Serious Burns: Fee for service (Inclusive **of** all services e.g. accommodation, theatre, etc.) except medication whilst hospitalised.	
H290	Serious Bums: Item for medication used during hospitalisation excluding the TTO's. ***Note:*** *TTO's to be charged according to item H288*	
5.12	**TTO**	
H288	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.	