GENERAL NOTICE

NOTICE 633 OF 2009

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASED 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 2009**.

2. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2009** and **Exclude VAT**.

M M S MDLADLANA
MINISTER OF LABOUR

DATE: 20/03/2009

GENERAL INFORMATION / *ALGEMENE INLIGTING*

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose 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 or to the Compensation Fund. 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 his employees, i.e. including hospital, nursing and other services — section 78 of the Compensation for Occupational Injuries and Diseases Act refers.

In terms of section 42 of the Compensation for Occupational Injuries and Diseases Act the Compensation Fund may refer an injured employee to a specialist medical practitioner of his choice for a medical examination and report. Special fees are payable when this service is requested.

In the event of a change of medical practitioner attending to a case, the first doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal. **To avoid disputes regarding the payment for services rendered, medical practitioners should refrain from treating an employee already under treatment by another doctor without consulting / informing the first doctor.** As a general rule, changes of doctor are not favoured by the Compensation Fund, unless sufficient reasons exist.

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 submitted to and accepted by the Compensation Fund. **Pre-authorisation of treatment is not possible and no medical expense will be approved if liability for the claim has not been accepted by the Compensation Fund.**

An employee seeks medical advice at his own risk. If an employee represented to a medical service provider that he is entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act, and yet failed to inform the Compensation Commissioner or his employer of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for medical expenses incurred. The Compensation Commissioner could also have reasons not to accept a claim lodged against the Compensation Fund. In such circumstances the employee would be in the same position as any other member of the public regarding payment of his medical expenses.

Please note that from 1 January 2004 a certified copy of an employee's identity document will be required in order for a claim to be registered 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 the employer for attachment of a certified copy of the employee's identity document. Furthermore, all supporting documentation submitted to the Compensation Fund must reflect the identity number of the employee. If the identity number is not included such documents can not be processed but will be returned to the sender to add the ID number.

The tariff amounts published in the tariff guides to medical services rendered in terms of the Compensation for Occupational Injuries and Diseases Act do not include VAT. All accounts for services rendered will be assessed without VAT. Only if it is indicated that the service provider is registered as a VAT vendor and a VAT registration number is provided, will VAT be calculated and added to the payment, without being rounded off.

The only exception is the "per diem" tariffs for Private Hospitals that already include VAT.

Please note that there are VAT exempted codes in the private ambulance tariff structure.

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 nie, solank dit redelik en sonder benadeling van die werknemer self of die Vergoedingsfonds uitgeoefen word. Die enigste uitsondering op hierdie reël is in geval waar die werkgewer met die goedkeuring van die Vergoedingskommissaris omvattende geneeskundige dienste aan sy werknemers voorsien, d.i. insluitende hospitaal-, verplegings- en ander dienste — artikel 78 van die Wet op Vergoeding vir Beroepsbeserings en Siektes verwys.*

Kragtens die bepalings van artikel 42 van die Wet op Vergoeding vir Beroepsbeserings en Siektes mag die Vergoedingskommissaris 'n beseerde werknemer na 'n ander geneesheer deur homself aangewys verwys vir 'n mediese ondersoek en verslag. Spesiale fooie is betaalbaar vir hierdie diens wat feitlik uitsluitlik deur spesialiste gelewer word.

In die geval van 'n verandering in geneesheer wat 'n werknemer behandel, sal die eerste geneesheer wat behandeling toegedien het, behalwe waar die werknemer na 'n spesialis verwys is, as die lasgewer beskou word. ***Ten einde geskille rakende die betaling vir dienste gelewer te voorkom, moet geneeshere hul daarvan weerhou om 'n werknemer wat reeds onder behandeling is te behandel sonder om die eerste geneesheer in te lig****. Oor die algemeen word verandering van geneesheer, tensy voldoende redes daarvoor bestaan, nie aangemoedig nie.*

Volgens die Nasionale Gesondheidswet no 61 van 2003 Afdeling 5, mag 'n gesondheidswerker of diensverskaffer nie weier om noodbehandeling te verskaf nie. Die Vergoedingskommissaris kan egter nie sulke behandeling goedkeur alvorens aanspreeklikheid vir die eis kragtens die Wet op Vergoeding vir Beroepsbeserings en Siektes aanvaar is nie. ***Vooraf goedkeuring vir behandeling is nie moontlik nie en geen mediese onkoste sal betaal word as die eis nie deur die Vergoedingsfonds aanvaar word nie.***

Dit moet in gedagte gehou word dat 'n werknemer geneeskundige behandeling op sy eie risiko aanvra. As 'n werknemer dus aan 'n geneesheer voorgee dat hy geregtig is op behandeling in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes en tog versuim om die Vergoedingskommissaris of sy werkgewer in te lig oor enige moontlike gronde vir 'n eis, kan die Vergoedingsfonds geen aanspreeklikheid aanvaar vir geneeskundige onkoste wat aangegaan is nie. Die

Vergoedingskommissaris kan ook rede hê om 'n eis teen die Vergoedingsfonds nie 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.

Neem asseblief kennis dat 'n ***gesertifiseerde afskrif van die werknemer se identiteitsdokument benodig word vanaf 1 Januarie 2004*** *om 'n eis 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 vir die aanheg van die ID dokument. Alle ander dokumentasie wat aan die kantoor gestuur word moet ook die identiteitsnommer aandui. Indien nie aangedui nie, sal die dokumentasie nie verwerk word nie, maar teruggestuur word vir die aanbring van die identiteitsnommer.*

Die bedrae gepubliseer in die handleiding tot tariewe vir dienste gelewer in terme van die Wet op Vergoeding vir Beroepsbeserings en Siektes, sluit BTW uit. Die rekenings vir dienste gelewer word aangeslaan en bereken sonder BTW.

Indien BTW van toepassing is en 'n BTW registrasienommer voorsien is, word BTW bereken en by die betalingsbedrag gevoeg sonder om afgerond te word.

Die enigste uitsondering is die "per diem" tarief vir Privaat Hospitale, wat BTW insluit.

Neem asseblief kennis dat daar tariewe in die kodestruktuur vir privaat ambulanse is waarop BTW nie betaalbaar is nie.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS •
EISE TEEN DIE VERGOEDINGSFONDS WORD AS VOLG GEHANTEER

1. New claims are registered by the Compensation Fund and the **employer is notified of the claim number** allocated to the claim. The allocation of a claim number by the Compensation Fund, does not constitute acceptance of liability for a claim, but means that the injury on duty has been reported to and registered by the Compensation Commissioner. Enquiries regarding claim numbers should be directed to the employer and not to the Compensation Fund. The employer will be in the position to provide the claim number for the employee as well as indicate whether the claim has been accepted by the Compensation Fund • *Nuwe eise word geregistreer deur die Vergoedingsfonds en die **werkgewer word in kennis gestel van die eisnommer**. Navrae aangaande eisnommers moet aan die werkgewer gerig word en nie aan die Vergoedingskommissaris nie. Die werkgewer kan die eisnommer verskaf en ook aandui of die Vergoedingsfonds die eis aanvaar het of nie*

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner • *As 'n eis deur die Vergoedingsfonds **aanvaar** is, sal **redelike mediese koste** betaal word deur die Vergoedingsfonds.*

3. If a claim is **rejected (repudiated)**, accounts for services rendered will not be paid by the Compensation Commissioner. The employer and the employee will be informed of this decision and the injured employee will be liable for payment. • *As 'n eis deur die Vergoedingsfonds afgekeur (**gerepudieer**) word, word rekenings vir dienste gelewer nie deur die Vergoedingsfonds betaal nie. Die betrokke partye insluitend die diensverskaffers word in kennis gestel van die besluit. Die beseerde werknemer is dan aanspreeklik vir betaling van die rekenings.*

4. If **no decision** can be made regarding acceptance of a claim due to inadequate information, the outstanding information will be requested and upon receipt, the claim will again be adjudicated on. Depending on the outcome, the accounts from the service provider will be dealt with as set out in 2 and 3. Please note that there are claims on which a decision might never be taken due to lack of forthcoming information • *Indien **geen besluit** oor die aanvaarding van 'n eis weens 'n gebrek aan inligting geneem kan word nie, sal die uitstaande inligting aangevra word. Met ontvangs van sulke inligting sal die eis heroorweeg word. Afhangende van die uitslag, sal die rekening gehanteer word soos uiteengeset in punte 1 en 2. Ongelukkig bestaan daar eise waaroor 'n besluit nooit geneem kan word nie aangesien die uitstaande inligting nooit verskaf word nie.*

BILLING PROCEDURE • *EISPROSEDURE*

1. The **first account** for services rendered for an injured employee (INCLUDING the First Medical Report) must be submitted to the employer who will collate all the necessary documents and submit them to the Compensation Commissioner • *Die **eerste rekening** (INSLUITEND die Eerste Mediese Verslag) vir dienste gelewer aan 'n beseerde werknemer moet aan die werkgewer gestuur word, wat die nodige dokumentasie sal versamel en dit aan die Vergoedingskommissaris sal voorlê*

2. Subsequent accounts must be submitted or posted to the closest Labour Centre. It is important that all requirements for the submission of accounts, including supporting information, are met • Daaropvolgende rekeninge moet ingedien of gepos word aan die naaste Arbeidsentrum. Dit is belangrik dat al die voorskrifte vir die indien van rekeninge nagekom word, insluitend die voorsiening van stawende dokumentasie

3. If accounts are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za • *Indien rekenings nog uitstaande is na 60 dae vanaf indiening en ontvangserkenning deur die Vergoedingskommissaris, moet die diensverskaffer 'n navraag vorm, W.Cl 20 voltooi en EENMALIG indien by die Arbeidsentrum.* Alle inligting oor Arbeidsentrums is beskikbaar op die webblad www.labour.gov.za

4. If an account has been **partially paid** with no reason indicated on the remittance advice, a duplicate account with the unpaid services clearly marked can be submitted to the Labour Centre, accompanied by a WCl 20 form. (*see website for example of the form). • *Indien 'n rekening **gedeeltelik betaal** is met geen rede voorsien op die betaaladvies nie, kan 'n duplikaatrekening met die wanbetaling duidelik aangedui, vergesel van 'n WCl 20 vorm by die Arbeidsentrum ingedien word (*sien webblad vir 'n voorbeeld van die vorm)*

5. **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*

6. Service providers **should not generate** • *Diensverskaffers **moenie die volgende lewer nie**:*

    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** - submit a separate account for every month • ***Aaneenlopende rekeninge** –lewer 'n aparte rekening vir elke maand*
    c. **Accounts on the old documents** (W.Cl 4 / W.Cl 5/ W.Cl 5F) New *First Medical Report (W.Cl 4) and Progress / Final Medical Report (W.Cl 5 / W.Cl 5F) forms

are available. The use of the old reporting forms combined with an account (W.CL11) has been discontinued. **Accounts on the old medical reports will not be processed** • ***Rekeninge op die ou voorgeskrewe dokumente*** *van die Vergoedingskommissaris. Nuwe *Eerste Mediese Verslag (W.Cl 4) en Vorderings / Finale Mediese Verslag (W.Cl 5) vorms is beskikbaar. Die vorige verslagvorms gekombineer met die rekening (W.CL11) is vervang.* ***Rekeninge op die ou vorms word nie verwerk nie.***

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

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

MINIMUM REQUIREMENTS FOR ACCOUNTS RENDERED • MINIMUM VEREISTES VIR REKENINGE GELEWER

Minimum information to be indicated on accounts submitted to the Compensation Fund • ***Minimum besonderhede*** *wat aangedui moet word op rekeninge gelewer aan die Vergoedingsfonds*

- Name of employee and ID number • *Naam van werknemer en ID nommer*
- Name of employer and registration number if available • *Naam van werkgewer en registrasienommer indien beskikbaar*
- Compensation Fund claim number • *Vergoedingsfonds eisnommer*
- DATE OF ACCIDENT (not only the service date) • *DATUM VAN BESERING (nie slegs die diensdatum nie)*
- Service provider's reference or account number • *Diensverskaffer se verwysing of rekening nommer*
- The practice number (changes of address should be reported to BHF) • *Die praktyknommer (adresveranderings moet by BHF aangemeld word)*
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the account) • *BTW registrasienommer (BTW sal nie betaal word as die BTW registrasienommer nie voorsien word nie)*
- Date of service (the actual service date must be indicated: the invoice date is not acceptable) • *Diensdatum (die werklike diensdatum moet aangedui word: die datum van lewering van die rekening is nie aanvaarbaar nie)*
- Item codes according to the officially published tariff guides • *Item kodes soos aangedui in die amptelik gepubliseerde handleidings tot tariewe*
- Amount claimed per item code and total of account • *Bedrag geëis per itemkode en totaal van rekening.*
- It is important that all requirements for the submission of accounts are met, including supporting information, e.g • *Dit is belangrik dat alle voorskrifte vir die indien van rekeninge insluitend dokumentasie nagekom word bv.*
    - All pharmacy or medication accounts must be accompanied by the original scripts • *Alle apteekrekenings vir medikasie moet vergesel word van die oorspronklike voorskrifte*
    - The referral notes from the treating practitioner must accompany all other medical service providers' accounts. • *Die verwysingsbriewe van die behandelende geneesheer moet rekeninge van ander mediese diensverskaffers vergesel*

COIDA TARIFF SCHEDULE FOR PRIVATE AMBULANCE SERVICES EFFECTIVE FROM 1 APRIL 2009

GENERAL RULES

001 Road ambulances: Long distance claims (items 111, 129 and 141) will be rejected **unless the distance travelled with the patient** is reflected. Long distance charges may not include item codes 102, 125 or 131.

002 No after hours fees may be charged.

003 Road ambulances: Item code 151 (resuscitation) may only be charged for services provided by a second vehicle (either ambulance or response vehicle) and shall be accompanied by a motivation. Disposables and drugs used are included unless specified as additional cost items (see below).

004 A **BLS** (Basic Life Support) practice (Pr. No. starting with 13) may **not** charge for ILS (Intermediate Life Support) or ALS (Advanced Life Support); an **ILS** practice (Pr. No. starting with 11) may **not** charge for ALS. An **ALS** practice (Pr. No. starting with 09) **may charge for all codes**.

005 A second patient is transferred at 50% reduction of the basic call cost.
Rule 005 MUST be quoted if a second patient is transported in any vehicle or aircraft in addition to another patient.

006 Guidelines for information required on each COIDA ambulance account:
Road and air ambulance accounts

- Name and ID number of the employee
- Diagnosis of the employee's condition
- Summary of all equipment used if not covered in the basic tariff
- Name and HPCSA registration number of the care providers
- Name, practice number and HPCSA registration number of the medical doctor
- Response vehicle: details of the vehicle driver and the intervention undertaken on patient
- Place and time of departure and arrival at the destination as well as the exact distance travelled (Air ambulance: exact time travelled from base to scene, scene to hospital and back to base)

Definitions of Ambulance Patient Transfer

Basic Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst the patient is in transit.

Intermediate Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Ambulance Emergency Assistant (AEA), e.g. initiating IV therapy, nebulisation etc. whilst the patient is in transit.

Advanced Life Support - A callout where the patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered paramedic (CCA and NDIP) whilst the patient is in transit.

NOTES

- If a hospital or doctor requires a paramedic to accompany the patient on a transfer in the event of the patient needing ALS / ILS intervention, the doctor requesting the paramedic must write a detailed motivational letter in order for ALS / ILS fees to be charged for the transfer of the patient.

- In order to bill an Advanced Life Support call, a registered Advanced Life Support provider must have examined, treated and monitored the patient whilst in transit to the hospital.

- In order to bill an Intermediate Life Support call, a registered Intermediate Life Support provider must have examined, treated and monitored the patient whilst in transit to the hospital.

- When an ALS provider is in attendance at a callout but does not do any interventions on the patient at an ALS level, the billing should be based on a lesser level, dependent on the care given to the patient. (E.g. if a paramedic sites an IV line or nebulises the patient with a B-agonist which falls within the scope of practice of an AEA, the call is to be billed as an ILS call and not an ALS call.)

- Where the management undertaken by a paramedic or AEA falls within the scope of practice of a BAA the call must be billed at a BLS level.

Please Note

- The amounts reflected in the COIDA Tariff Schedule for each level of care are inclusive of any disposables (except for pacing pads, Heimlich valves, high capacity giving sets, dial-a-flow and intra-osseous needles) and drugs used in the management of the patient, as per the attached nationally approved medication protocols.

- Haemaccel and colloid solution may be charged for separately.

- **An ambulance is regarded by the Compensation Fund as an emergency vehicle that administers emergency care and transport to those employees with acute injuries and only such emergency care and transport will be paid for by the Compensation Fund. A medical emergency is any condition where death or irreparable harm to the patient will result if there are undue delays in receiving appropriate medical treatment.**

- Claims for transfers between hospitals or other service providers must be accompanied by a motivation from the attending doctor who requested such transport. The motivation should clearly state the medical reasons for the transfer. Motivation must also be provided if ILS or ALS is needed and it should be indicated what specific medical assistance is required on route. This is also applicable for air ambulances.

- Authorisation for the transfer of an employee from his home to a service provider, if not in an emergency situation, has to be obtained prior to the transfer. The treating doctor will have to motivate such transport by ambulance, clearly stating the medical reasons why an ambulance is required for such transport and he should also indicate what specific medical assistance is required on route.

- Claims for the transport of a patient discharged home will only be entertained if accompanied by a written motivation from the attending doctor who requested such transport, clearly stating the medical reasons why an ambulance is required for such transport. It should be indicated what specific medical assistance the patient requires on route. If such a request is approved only BLS fees will be payable. Transport of a patient for any other reason than a MEDICAL reason, (e.g. closer to home, do not have own transport) will not be entertained.

RESPONSE VEHICLES

Response vehicles only - Advance Life Support (ALS)

A clear distinction must be drawn between an acute primary response and a booked call.

1. An Acute Primary Response is defined as a response to a call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. If a **response vehicle** is dispatched to the scene of the emergency and the patient is in need of advanced life support and such support is rendered by the ALS Personnel e.g. CCA or National Diploma, the response vehicle service provider shall be entitled to bill item 131 for such service. However, the same or any other ambulance service provider which is then **transporting** the patient shall not be able to levy a bill as the cost of transportation is included in the ALS fee under item 131. Furthermore, the ALS response vehicle personnel must accompany the patient to the hospital to entitle the original response vehicle service provider to bill for the ALS services rendered.

2. In the event of an response vehicle service provider rendering ALS and not having its own ambulance available in which to transport the patient to a medical facility, and makes use of another ambulance service provider, only the bill for the response vehicle service may be levied as the ALS bill under items 131. Since the ALS tariff already includes transportation, the response vehicle service provider is responsible for the bill for the other ambulance service provider, which will be levied at a BLS rate. This ensures that there is **only one bill levied per patient.**

3. Should a response vehicle go to a scene and not render any ALS treatment then a bill may not be levied for the said response vehicle.

4. Notwithstanding 3, item 151 applies to all ALS resuscitation as per the notes in this schedule.

Response vehicle only - Intermediate Life Support (ILS)

A clear definition must be drawn between the acute primary response and a booked call.

1. An Acute Primary Response is defined as a response to a call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. If an ILS **response vehicle** is dispatched to the scene of the emergency and the patient is in need of intermediate life support and such support is rendered by the ILS Personnel e.g. AEA, the response vehicle service provider shall be entitled to bill item 125 for such service. However, the same or any other ambulance service provider which is then **transporting** the patient shall not be able to levy a bill as the cost of transportation is included in the ILS fee under item 125. Furthermore, the ILS response vehicle personnel must accompany the patient to the hospital to entitle the original response vehicle service provider to bill for the ILS services rendered.

2. In the event of an response vehicle service provider rendering ILS and not having its own ambulance available in which to transport the patient to a medical facility, and makes use of another ambulance service provider, only the bill for the response vehicle service may be levied as the ILS bill under item 125. Since the ILS tariff already includes transportation, the response vehicle service provider is responsible for the bill for the other ambulance service provider, which will be levied at a BLS rate. This ensures that there is **only one bill levied per patient**.

3. Should a response vehicle go to a scene and not render any ILS treatment then a bill may not be levied for the said response vehicle.

4. NATIONALLY APPROVED MEDICATION WHICH MAY BE ADMINISTERED BY HPCSA-REGISTERED AMBULANCE PERSONNEL ACCORDING TO HPCSA-APPROVED PROTOCOLS

Registered Basic Ambulance Assistant Qualification

- Oxygen
- Entonox
- Oral Glucose
- Activated charcoal

Registered Ambulance Emergency Assistant Qualification

As above, plus

- Intravenous fluid therapy
- Intravenous dextrose 50%
- B2 stimulant nebuliser inhalant solutions (Hexoprenaline, Fenoterol, Sulbutamol)
- Ipratropium bromide inhalant solution
- Soluble Aspirin

Registered Paramedic Qualification

As above, plus

- Oral Glyceryl Trinitrate
- Clopidegrol
- Endotracheal Adrenaline and Atropine
- Intravenous Adrenaline, Atropine, Calcium, Corticosteroids, Hydrocortisone, Lignocaine, Naloxone, Sodium Bicarbonate 8,5%, Metaclopramide
- Intravenous Diazepam, Flumazenil, Furosemide, Glucagon, Lorazepam, Magnesium, Midazolam, Thiamine, Morphine, Promethazine
- Pacing and synchronised cardioversion

TARIFFS FOR BLS, ILS AND ALS VEHICLES (excluding VAT)

PLEASE NOTE: VAT cannot be added on the following codes: 102, 103, 111, 125, 127, 129, 131, 133 and 141.
VAT will only be paid with confirmation of a VAT registration number on the account.

CODE	DESCRIPTION OF SERVICE	Practice Code 013	011	009
		AMOUNT PAYABLE		
1	**BASIC LIFE SUPPORT** ***(Rule 001: Metropolitan area and long distance codes may not be claimed simultaneously)***			
	Metropolitan area (less than 100 kilometres) *No account may be levied for the distance back to the base in the metropolitan area*			
*102	Up to 60 minutes	1122.55	1122.55	1122.55
*103	Every 15 minutes (or part thereof) thereafter, where specially motivated	280.94	280.94	280.94
	Long distance (more than 100 km)			
*111	Per km **DISTANCE TRAVELLED WITH PATIENT**	13.97	13.97	13.97
112	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	6.27	6.27	6.27
2	**INTERMEDIATE LIFE SUPPORT** ***(Rule 001: metropolitan area and long distance codes may not be claimed simultaneously)***			
	Metropolitan area (less than 100 kilometres) *No account may be billed for the distance back to the base in the metropolitan area*			
*125	Up to 60 minutes	--	1483.57	1483.57
*127	Every 15 minutes (or part thereof) thereafter, where specially motivated		379.17	379.17
	Long distance (more than 100 km)			
*129	Per km **DISTANCE TRAVELLED WITH PATIENT**	--	18.92	18.92
130	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	--	6.27	6.27
	* *VAT Exempted codes*			

CODE	DESCRIPTION OF SERVICE	Practice Code 013 AMOUNT PAYABLE	011 AMOUNT PAYABLE	009 AMOUNT PAYABLE
3.	**ADVANCED LIFE SUPPORT / INTENSIVE CARE UNIT** ***(Rule 001: Metropolitan area and long distance codes may not be claimed simultaneously)***			
	Metropolitan area (less than 100 kilometres) *No account may be billed for the distance back to the base in the metropolitan area*			
*131	Up to 60 minutes	--	--	2354.44
*133	Every 15 minutes (or part thereof) thereafter, where specially motivated	--	--	768.57
	Long distance (more than 100 km)			
*141	Per km **DISTANCE TRAVELLED WITH PATIENT**	--	--	34.10
142	Per km **NON PATIENT CARRYING KILOMETRES** With maximum of 400 km)	--	--	6.27
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**			
151	Resuscitation fee, per incident, for a second vehicle with paramedic and / or other staff (all materials and skills included) **Note:** A resuscitation fee may only be billed for when a second vehicle (response vehicle or ambulance) with staff (including a paramedic) attempt to resuscitate the patient using full ALS interventions. These interventions must include one or more of the following: • Administration of advanced cardiac life support drugs • Cardioversion -synchronised or unsynchronised (defibrillation) • External cardiac pacing • Endotracheal intubation (oral or nasal) with assisted ventilation	--	2622.51	2622.51
153	Doctor per hour **Note:** Where a doctor callout fee is charged the name, HPCSA registration number and BHF practice number of the doctor must appear on the bill. Medical motivation for the callout must be supplied. ** VAT Exempted codes*	--	753.61	753.61

AEROMEDICAL TRANSFERS

ROTOR WING RATES

DEFINITIONS:

1. Helicopter rates are determined according to the aircraft type.
2. Daylight operations are defined from sunrise to sunset (and night operations from sunset to sunrise).
3. If flying time is mostly in night time (as per definition above), then night time operation rates (type C) should be billed.
4. The call out charge includes the basic call cost plus other flying time incurred. Staff and consumables cost can only be charged if a patient were treated.
5. Should a response aircraft respond to a scene (at own risk) and not render any treatment, a bill may not be levied for the said response.
6. Flying time is billed per minute but a minimum of 30 minutes applies to the payment.
7. A second patient is transferred at 50% reduction of the basic call and flight costs, but staff and consumables costs remain billed per patient, only if the aircraft capability allows for multiple patients. Rule 005 must be quoted on the account.
8. Rates are calculated according to time; from throttle open, to throttle closed.
9. Group A – C must fall within the Cat 138 Ops as determined by the Civil Aviation Authority.
10. Hot loads are restricted to 8 minutes ground time and must be indicated and billed for separately with the indicated code (time NOT to be included in actual flying time).
11. **All published tariffs exclude VAT. VAT can be charged on air ambulances if a VAT registration number is supplied.**

AIRCRAFT TYPE A: (typically a single engine aircraft)
HB206L, HB204 / 205, HB407, AS360, EC120, MD600, AS350, A119

AIRCRAFT TYPE B & Ca (DAY OPERATIONS): (typically a twin engine aircraft)
BO105, 206CT, AS355, A109

AIRCRAFT TYPE Cb (NIGHT OPERATIONS): (typically a specially equipped craft for night flying)
HB222, HB212 / 412, AS365, S76, HB427, MD900, BK117, EC135, BO105

AIRCRAFT TYPE D (RESCUE)
H500, HB206B, AS350, AS315, FH1100, EC 130, S316

FIXED WING TARIFFS:

DEFINITIONS:

1. Group A must fall within the Cat 138 Ops as determined by the Civil Aviation Authority.
2. Please note that no fee structure has been provided for Group B, as emergency charters could include any form of aircraft. It would be impossible to specify costs over such a broad range. As these would only be used during emergencies when no Group A aircraft are available, no staff or equipment fee should be charged.
3. **All published tariffs exclude VAT. VAT can be charged on air ambulances only if a VAT registration number is supplied on the account.**

4. Staff and consumables cost can only be charged if a patient were treated.
5. A second patient is transferred at 50% reduction of the basic call and flight cost, but staff and consumables costs remain billed per patient, only if the aircraft capability allows for multiple patients. Rule 005 must be quoted on the account.

GROUP B – EMERGENCY CHARTERS

1. No staff and equipment fee are allowed.
2. Cost will be reviewed per case.
3. Payment of emergency transport will only be allowed if a Group A aircraft is not available within an optimal time period for transportation and stabilisation of the patient.

CODE	DESCRIPTION OF SERVICE	Practice Code 013	011	009
		AMOUNT PAYABLE		
5	**AIR AMBULANCE: ROTORWING**			
	Rotorwing Type A: Transport			
300	Basic call cost	--	--	5373.06
PLUS	**Flying time**			
301	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R 2331.00) applicable	--	--	85.47
302	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	85.47
303	Hot load (per minute) – maximum 8 minutes (R621.60)	--	--	85.47
	Rotorwing Type B and C (day operations): Transport			
310	Basic call cost	--	--	9443.50
PLUS	**Flying time**			
311	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R4023.00) applicable	--	--	147.51
312	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	147.51
313	Hot load (per minute) – maximum 8 minutes (R1072.80)	--	--	147.51
	Rotorwing Type C (night operations): Transport			
315	Basic call cost	--	--	13432.50
PLUS	**Flying time**			
316	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R4023.00) applicable	--	--	147.51

CODE	DESCRIPTION OF SERVICE	Practice Code 013 AMOUNT PAYABLE	011 AMOUNT PAYABLE	009 AMOUNT PAYABLE
317	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	147.51
318	Hot load (per minute) – maximum 8 minutes (R1072.80)	--	--	147.51
	Rotorwing Type A, B and C: Staff and consumables			
320	0 - 30 minutes	--	--	845.68
321	30 - 60 minutes	--	--	1691.36
322	60 - 90 minutes	--	--	2537.04
323	90 minutes or more	--	--	3382.61
	Rotorwing Type D: Transport			
330	Basic call cost	--	--	11332.09
PLUS	**Flying time**			
331	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R4797.00) applicable	--	--	175.89
332	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	175.89
333	Hot load (per minute) – maximum 8 minutes (R1279.20)	--	--	175.89
	OTHER COSTS			
340	Winching (per lift)	--	--	1474.77
6	**AIR AMBULANCE: FIXED WING**			
	Fixed wing Group A (Tariff is composed of flying cost per kilometre and staff and equipment cost per minute).			
	Fixed wing Group A: Aircraft cost			
400	Beechcraft Duke	--	--	21.56
401	Lear 24F	--	--	33.88
402	Lear 35	--	--	33.88
403	Falcon 10	--	--	39.16
404	King Air 200	--	--	31.02
405	Mitsubishi MU2	--	--	33.88
406	Cessna 402	--	--	18.81
407	Beechcraft Baron	--	--	16.28
408	Citation 2	--	--	25.74
409	Pilatus PC12	--	--	25.74

CODE	DESCRIPTION OF SERVICE	Practice Code 013	011	009
		AMOUNT PAYABLE		
	Fixed wing Group A: Staff cost			
420	Doctor – cost per minute spent with the patient Minimum cost for 30 minutes (R1110.00) applicable	--	--	40.70
421	ICU Sister – cost per minute spent with the patient Minimum cost for 30 minutes (R405.00) applicable	--	--	14.85
422	Paramedic – cost per minute spent with the patient Minimum cost for 30 minutes (R405.00) applicable	--	--	14.85
	Fixed wing Group A: Equipment cost			
430	Per patient – cost per minute Minimum cost for 30 minutes (R330.00) applicable	--	--	12.10
	Fixed wing Group B: Emergency charters			
450	Services rendered should be clearly specified with cost included. Each case will be reviewed and assessed on merit.			