DEPARTMENT OF LABOUR

NOTICE 189 OF 2019

AMBULANCE, PRIVATE HOSPITALS AND BLOOD SERVICES 2019

labour

Department:
Labour
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF LABOUR

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, Mildred Nelisiwe Oliphant, Minister of 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 2019**.

2. Medical Tariffs increase for **2019 is 6.4%**

3. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2019** and **Exclude 15% Vat.**

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MN OLIPHANT, MP
MINISTER OF LABOUR

DATE: 05/12/2018

GENERAL INFORMATION

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 designated by the Director General for a medical examination and report. Special fees are payable when this service is requested.

In terms of section 76,3(b) of the Compensation for Occupational Injuries and Diseases Act, no amount in respect of medical expenses shall be recoverable from the employee.

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.

CLAIMS WITH THE COMPENSATION FUND ARE PROCESSED AS FOLLOWS

1. New claims are registered by the Employers and the Compensation Fund and the **employer views the claim number allocated online.** 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

2. If a claim is **accepted** as a COIDA claim, **reasonable medical expenses** will be paid by the Compensation Commissioner.

3. If a claim is **rejected** (**repudiated**), medical expenses 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.

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.

BILLING PROCEDURE

1. All service providers should be registered on the Compensation Fund claims system in order to capture medical reports.

   1.1 Medical reports should always have a clear and detailed clinical description of injury
   1.2 In a case where a procedure is done, an operation report is required
   1.3 Only one medical report is required when multiple procedures are done on the same service date
   1.4 A medical report is required for every invoice submitted covering every date of service.
   1.5 Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.
   1.6 Referrals to another medical service provider should be indicated on the medical report.

2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D.

   2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
   2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.

3. The status of invoices /claims can be viewed on the Compensation Fund claims system. If invoices 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 Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

4. If an invoice has been partially paid with no reason indicated on the remittance advice, an enquiry should be made with the nearest processing labour centre. The service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .

5. Details of the employee's medical aid and the practice number of the referring practitioner must not be included in the invoice.

If a medical service provider claims an amount less than the published tariff amount for a code, the Compensation Fund will only pay the claimed amount and the short fall will not be paid.

6. Service providers should not generate the following:

   a. Multiple invoices for services rendered on the same date i.e. one invoice for medication and a second invoices for other services.

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

MINIMUM REQUIREMENTS FOR ACCOUNTS RENDERED

Minimum information to be indicated on invoices submitted to the Compensation Fund

- Name of employee and ID number
- Name of employer and registration number if available
- Compensation Fund claim number
- DATE OF ACCIDENT (not only the service date)
- Service provider's **invoice number**
- The practice number (changes of address should be reported to BHF)
- VAT registration number (VAT will not be paid if a VAT registration number is not supplied on the account)
- Date of service (the actual service date must be indicated: the invoice date is not acceptable)
- Item codes according to the officially published tariff guides
- Amount claimed per item code and total of account
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
    - All pharmacy or medication accounts must be accompanied by the original scripts
    - The referral letter from the treating practitioner must accompany the medical service providers' invoice.

COIDA TARIFF SCHEDULE FOR PRIVATE AMBULANCE SERVICES EFFECTIVE FROM 1 APRIL 2019

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)
- Details of the trip sheet should be captured in a medical report provided for on the COID system.

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.**

- **Transportation of an employee from his home to a service provider, this includes outpatients between two service providers, if not in an emergency situation, is not payable. In emergency cases such transport should be motivated for and the attending doctor should indicate what specific medical assistance is required on route.**

- **Claims for the transport of a patient discharged home will only be accepted 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

***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	2241.61	2241.61	2241.61
*103	Every 15 minutes (or part thereof) thereafter, where specially motivated	561.07	561.07	561.07
	Long distance (more than 100 km)			
*111	Per km **DISTANCE TRAVELLED WITH PATIENT**	27.93	27.93	27.93
112	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	12.55	12.55	12.55
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	--	2962.42	2962.42
*127	Every 15 minutes (or part thereof) thereafter, where specially motivated		757.22	757.22
	Long distance (more than 100 km)			
*129	Per km **DISTANCE TRAVELLED WITH PATIENT**	--	37.82	37.82
130	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	--	12.55	12.55
	** VAT Exempted codes*			

CODE	DESCRIPTION OF SERVICE	Practice Code 013	011	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	--	--	4701.46
*133	Every 15 minutes (or part thereof) thereafter, where specially motivated	--	--	1534.76
	Long distance (more than 100 km)			
*141	Per km **DISTANCE TRAVELLED WITH PATIENT**	--	--	68.04
142	Per km **NON PATIENT CARRYING KILOMETRES** With maximum of 400 km)	--	--	12.55
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	--		5159.14
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*	--		1482.61

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	--	--	10729.32
PLUS	**Flying time**			
301	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R5889.77) applicable	--	--	170.72
302	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	170.72
303	Hot load (per minute) – maximum 8 minutes (R1570.61)	--	--	170.72
	Rotorwing Type B and C (day operations): Transport			
310	Basic call cost	--	--	18857.41
PLUS	**Flying time**			
311	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R8837.47) applicable	--	--	294.58
312	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	294.58
313	Hot load (per minute) – maximum 8 minutes (R2356.66)	--	--	294.58
	Rotorwing Type C (night operations): Transport			
315	Basic call cost	--	--	26822.74
PLUS	**Flying time**			

CODE	DESCRIPTION OF SERVICE	Practice Code 013	011	009
		AMOUNT PAYABLE		
316	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R8837.47) applicable	--	--	294.58
317	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	294.58
318	Hot load (per minute) – maximum 8 minutes (R2356.66)	--	--	294.58
	Rotorwing Type A, B and C: Staff and consumables			
320	0 - 30 minutes	--	--	1663.67
321	30 - 60 minutes	--	--	3327.31
322	60 - 90 minutes	--	--	4991.14
323	90 minutes or more	--	--	6654.61
	Rotorwing Type D: Transport			
330	Basic call cost	--	--	22628.65
PLUS	**Flying time**			
331	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R10539.36) applicable	--	--	351.31
332	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	351.31
333	Hot load (per minute) – maximum 8 minutes (R2810.50)	--	--	351.31
	OTHER COSTS			
340	Winching (per lift)	--	--	2901.30
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	--	--	58.75
401	Lear 24F	--	--	66.69
402	Lear 35	--	--	66.69
403	Falcon 10	--	--	77.14
404	King Air 200	--	--	61.11
405	Mitsubishi MU2	--	--	66.69
406	Cessna 402	--	--	37.10
407	Beechcraft Baron	--	--	32.04
408	Citation 2	--	--	50.67
409	Pilatus PC12	--	--	50.67

CODE	DESCRIPTION OF SERVICE	Practice Code 013 AMOUNT PAYABLE	011 AMOUNT PAYABLE	009 AMOUNT PAYABLE
	Fixed wing Group A: Staff cost			
420	Doctor – cost per minute spent with the patient Minimum cost for 30 minutes (R2402.51) applicable	--	--	80.08
421	ICU Sister – cost per minute spent with the patient Minimum cost for 30 minutes (R877.63) applicable	--	--	29.25
422	Paramedic – cost per minute spent with the patient Minimum cost for 30 minutes (R877.63) applicable	--	--	29.25
	Fixed wing Group A: Equipment cost			
430	Per patient – cost per minute Minimum cost for 30 minutes (R715.58) applicable	--	--	23.85
	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.			

COMPENSATION FUND

SCALE OF FEES FOR PRIVATE HOSPITALS (57/58) (*PER DIEM* TARIFF) WITH EFFECT FROM 1 APRIL 2019

SCALE OF FEES FOR PSYCHIATRIC AND PRIVATE REHABILITATION HOSPITALS (55/59) (PER DIEM TARIFF) WITH EFFECT FROM 1 APRIL 2019

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.

Note: Fees include VAT

	DESCRIPTION	PRACTICE CODE 57/58
1.1	**General Wards**	
H001	Surgical cases: per day	3433.44
H002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	3433.44
H004	Medical and neurological cases: per day	3433.44
H007	Day admission which includes all patients discharged by 23:00 on date of admission	1469.47
		PRACTICE CODE 55
H008	**General Ward for Psychiatric Hospitals (Inclusive fee**: Ward fee, Pharmaceuticals, Occupational Therapy)	2674.81
1.2	**General ward for Rehabilitation Hospitals**	
H010	General Rehabilitation ward (Inclusive fee: ward fee, general rehabilitaion management (Physiotheraphy, Doctors, Nursing, Occupational Theraphy)	5735.71

	SCALE OF FEES FOR SUB-ACUTE REHABILITATION (49) (*PER DIEM* TARIFF) **General Rules for Rehabilitation Hospitals** 1. Maximum period for a patient stay at acute rehabilitation ward is 3 months (12 weeks), then to be discharged or referred to Subacute rehabilitation (practice 49) 2. All patients transfered from Acute Rehabilitation (practice 59) to Subacute Rehabilitation (practice 49), notification letter is required by the Compensation Fund for proper case management. 3. All practice 49 institutions must have a Rehabilitation plan for all patients admitted. This Rehabilitation plan must be submited to Compensation Fund When requested.	
H020	Sub-Acute Rehabilitation ward (Daily) Professionals are charged separately i.e. Physiotherapy, Rehabilitation Doctors, Nursing, Occupational Therapy, speech Therapist, Clinical Psychologist, social workers)	3433.44

	DESCRIPTION	PRACTICE CODE 57/58
1.3	**Special Care Units** Hospitals shall obtain a doctor's report stating the reason for accommodation in an intensive care unit or a high care ward from the attending medical practitioner, and such report including 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	23015.00
H215	High Care Ward: per day	11876.81
2.	**Theatres and Emergency Unit**	
2.1	**Theatre and Emergency fees are inclusive of all consumables and equipment. The after hours fee are included in the normal theatre fee.**	
	Emergency fee Rule: Emergency fee - excluding follow-up visits.	
H301	For all emergencies including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections.	824.18
H302	For all emergencies which require the use of a procedure room, e.g. for application of plaster, stitching of wounds.	1672.09
H303	Follow-up visits: The Compensation Fund. 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.	6543.18
2.2	**Minor Theatre Fee** 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.	

	DESCRIPTION	PRACTICE CODE 57/58
	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	99.30
2.3	**Major Theatre** The exact time of admission to and discharge from the theatre shall be	
H081	Charge per minute	293.83

5.9	**Prosthesis** Prosthesis Pricing: **Note:** A ceiling price of R1496.93 per prosthesis is included in the theatre tariff. The combined value of all the components including cement in excess of **R**1496.93 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).	
H286	**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 manufacturer's name, should be attached to the account and the components specified on the account should appear on the invoice. **External Fixators** Reimbursement will be at 33% of the lowest available manufacturer's price inclusive of VAT.	
	DESCRIPTION	**PRACTICE CODE 57/58**
	Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers' invoices, each 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 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	

5.11	**Serious Burns** Billed 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 Burns: Item for medication used during hospitalisation excluding the TTO's. ***Note** : TTO's should 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.	

COMPENSATION FUND GUIDE TO FEES FOR BLOOD SERVICES 2019

N.B: The account for blood services must be accompanied by blood requisition form reflecting clinical indications, clinical conditions, number of units required and haemoglobin level.

Item Code	Description	COIDA 2019 Tariffs
10345	Bioplasma FDP - 50ml	380.31
10349	Bioplasma FDP - 200ml	1 074.62
10351	Haemosolvate Factor VIII 300 IU - 10ml	1 093.40
10352	Haemosolvate Factor VIII 500 IU - 10ml	1 769.44
10341	Haemosolvate Factor VIII 500 IU:1000 IU - 2 X 10ml	3 440.05
10390	Haemosolvex Factor IX (500 IU) - 10ml	2 127.19
10300	Albusol 4 % - 200ml	412.71
10311	Ibusol 20 % - 50ml	463.95
10310	Albusol 20 % - 100ml	796.59
10347	Polygam 1g - 50ml	639.59
10343	Polygam 3g - 100ml	1 616.26
10332	Polygam 6g - 200ml	2 782.04
10338	Polygam 12g - 400ml	4 841.52
10321	Intragam 2ml	137.99
10320	Intragam 5ml	267.16
10337	Tetagam IM 500 IU - 1ml	372.04
10335	Tetagam IM 250 IU - 2ml	170.07
10340	Hebagam IM - 2ml	716.21
10346	Rabigam IM - 2ml	719.86
10348	Vazigam IM - 2ml	652.18
10330	Rhesugam IM - 2ml	685.48
	Red Cells	
78040	Red Cell Concentrate	2 326.60
78051	Red Cell Conc. Leucocyte Depleted	3 801.64
78043	Red Cell Conc. Paed. Leucodepleted	2 151.85
	Platelets	
78124	Platelet Conc. Single Donor Apherisis	12 157.20
78125	Platelet Conc. Leucocyte Depleted,Pooled	10 841.62
78127	Platelet Concentrate (Paediatric)	2 959.60
78122	Platelet Concentrate Pooled	9 802.48
	Whole Blood	
78001	Whole Blood	2 576.67
78059	Whole Blood Leucocyte Depleted	4 051.63
78011	Whole Blood Paediatric	2 151.10
	Plasma	
78103	Cryoprecipitate (Fibrinogen Rich)	1 315.03
78174	Frozen Plasma - Cryo Poor Donor	1 501.76
78002	Quarantine FFP Infant	1 547.21
78176	Fresh Frozen Plasma - Donor Retested	1 807.18

Item Code	Description	COIDA 2019 Tariffs
	Diagnostic	
78450	Anti-A Monoclonal 5ml	95.54
78452	Anti-B Monoclonal 5ml	95.54
78454	Anti-A,B Monoclonal 5ml	95.54
78461	Anti-D saline tube &slide monoclonal 5ml	152.32
78467	Anti-D IgM+IgG blend Monoclonal 5ml	159.65
78471	Anti-Human Globulin Polyspecific 5ml	129.04
78478	AB serum 5ml	96.62
78479	Human Complement 2ml	83.40
78482	Lyoph. Bromelin tube & microwell 5ml	78.51
78484	Antibody positive control serum 5ml	84.13
78487	AB serum 20ml	344.96
78488	Group A1 5ml	79.55
78490	Group A2 5ml	79.55
	Phathology Services	
78137	Bone Marrow Typing (Serology)	416.93
4763	Blood DNA Extraction	516.99
4428	HLA High res.Class I/II DNA allele	892.00
4427	HLA low res.Class II PCR/DNA Locus DQB/DRB1	1 140.02
78492	Group B 5ml	79.55
78494	Group O R1R2 5ml	87.16
78496	Group O r 5ml	87.16
78502	Sensitized cells 5ml	106.74
78508	Screen cell set (1 & 2) - 2 X 5ml	210.14
78510	Pooled screen cells - 5ml 60.42	105.39
78516	Panel cell set 9 x 2ml	555.66
78517	Panel cell set 9 x 1ml	277.69
78015	Anti-Human Globulin Polyspecific 15ml	345.83
78018	Group A1 15ml	204.33
78019	Group A2 15ml	204.33
78020	Group B 15ml	204.33
78519	Group O Rh Positive (R1 R2) 15 ml	227.17
78521	Group O r 15ml	227.17
78529	Anti-A Monoclonal 15ml	256.63
78530	Anti-B Monoclonal 15ml	256.63
78531	Anti A,B Monoclonal 15ml	256.63
78536	Screening Cells Pooled	257.28
78522	Group O Screen 1 Cells 15ml	287.85
78523	Group O Screen 2 Cells 15ml	287.85
78524	Panel cell set 9 x 15ml	1 994.97
78525	Sensitized cells 15ml	286.04
78518	Panel cell set 9 x 5 ml	1 404.87
10580	Packaging	87.49
78004	Whole Blood Reagent	1 005.65
78012	Buffy Coats	502.83
	Blood and Administration	
78199	Blood Filters : 1 Units	1 094.33
78200	Blood Filters : 2 Units	2 098.01
78197	Platelet Filter 3 - 6 Unit PL2VAE	2 025.76
78201	Set, Blood and plasma Recipient Set	42.29
78202	Set, Platelet Recipient	84.26

Item Code	Description	COIDA 2019 Tariffs
	Additional Services and Surcharges	
78050	Irradiation Fee	484.60
10210	Transfusion Crossmatch	1 035.29
10333	Type and Screen	450.04
78400	Routine Collection Fee	204.95
78401	Routine Delivery Fee	204.92
78402	Emergency Round Trip	1 394.86
78403	Emergency One Way Fee	976.41
78989	Telephone Consultation 18-0130	288.01
78177	FFP Autologous/Directed Fee	204.14
78049	Directed Donation	249.21
78404	<5 Day Rcc	274.58
78405	<5 Day Whole Blood	196.15
78406	After Hours	523.09
78408	Autologous/Directed WB	257.69
78407	Autologous/Directed RCC	232.63
78409	Blood Return Basis	207.27
78410	Emergency Cross-Match	157.81
78411	Foreign	838.97
78412	HLA Match	1 519.71
78413	Rare Donation	1 786.10
78415	Washed RCC/WB	1 488.36
78414	Offsite Charge	2 097.44
78417	Emergency Blood Surcharge	232.67
	Transplant Services	
78078	HLA low res.ClassI DNA/Locus A/B/C	1 650.28
4424	HLA Specific Allele DNA-PCR	486.46
4603	HLA Specific locus/Antigen	302.97
4604	HLA Class I	583.45
78024	Panel Typing Antibody Class I	2 235.26
78046	T & B Cell Crossmatch	1 430.69
78213	Tissue Rapid HBsAg Screen	344.12
78231	Bone Marrow Engraftment Monitoring	1 515.18
78214	Tissue Rapid HIV Screen	470.17
	Laboratory Services	
4425	CHE Test	141.46
4757	Additional analysis, Mosaicism/ Staining Procedure	804.27
4522	Alpha Feto Protein(AFP): Amnio Fluid	139.36
4755	Karyotyping, amniotic Fluid/Chorionic villus sample/prod of conception	3 101.93
3932	Anti - HIV	158.20
3712	Antibody Identification	94.89
78013	Antibody identification QC	75.65
3709	Antibody Screen/Antiglobulin Test(DAT & IAT)	41.00
3710	Antibody Titration	80.76
4531	HBsAg/Anti-HCV	162.56
4752	Cell Cult. Chorionic Villus Sample	689.31
4750	Cell Culture, blood/cord blood	207.56
4751	Cell Culture, Products of conception/ Amniotic Fluid	516.99
3729	Cold Agglutinins	40.46
3739	Erythrocyte count	25.30
3764	Grouping : A B O Antigen	40.46
3765	Grouping : Rh antigen	40.46
3791	Haematocrit	20.23

Item Code	Description	COIDA 2019 Tariffs
3762	Haemoglobin	20.23
3953	Haemolysin/Test Tube Agglutination	46.57
4430	HIV p24 antigen	280.48
78921	Human Platelet AG Genotyping	2 118.14
78014	Aneuploidy Detection	1 940.90
4754	Karyotyping, Blood/Cord Blood	1 550.96
3785	Leucocyte Count	20.23
78221	Perinatal Cord	202.28
78225	Perinatal Post-Natal Mother	202.28
4117	Protein : Total	38.37
78922	Rapid CMV Screen	210.01
3834	Red Cell Rh Phenotype	111.11
78230	Human Platelet Antibody Screen	3 061.60
	Clinical Services	
78003	Additional Disposal Kit	4 846.49
78054	utologous Serum Eye Drops	4 520.60
78030	Designated Serum Eye Drops	4 520.60
78005	Chronic wound treatment kit	1 770.53
78007	Platelet growth Factor macular hole repair	1 757.70
78008	Platelet growth factor wound treatment	780.35
78006	Topical Haemostatic Agent	2 108.26
78920	Cord Blood Cryopreservation	11 118.25
78090	Medical Examination & Consultation 18-0141	365.60
78204	Red Cell Exchange	8 177.13
78923	Re-Infusion Of Cryo Preserve Stem Cells	846.00
78926	Stem Cell Collection/Leucopherisis	13 804.07
78928	Stem Cell Cryopreservation	11 118.25
78106	Therapeutic Plasma Exchange	8 566.04
78129	Theurapeutic Venesection	89.05
78416	Theurapeutic Exchange (DALI)	15 226.66
78211	hrombocytapherisis	8 258.86
	Miscallaneous	
10298	Stabilised Human Serum 5% 250ml	791.24
10299	Stabilised Human Serum 5% 50ml	151.99
78100	Paternity Investigation - 1 Client	1 636.34
78950	Paternity Investigation - 3 Client	4 909.14
78535	Blood Pack For therapeutic Venesection	280.89
78203	Blood Pack with Anticoagulant	123.35
78206	Blood Pack, No Anticoagulant	168.95

labour
Department:
Labour
REPUBLIC OF SOUTH AFRICA

UMEHLUKO ELECTRONIC INVOICING FILE LAYOUT

Field	Description	Max length	Data Type
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)	10	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
Field	**Description**	**Max length**	**Data Type**
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
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

Field	Description	Max length	Data Type
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

REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

The switching provider must comply with the following requirements:

1. Registration requirements as an employer with the Compensation Fund.
2. Host a secure FTP server to ensure encrypted connectivity with the Fund.
3. Submit and complete a successful test file before switching the invoices.
4 Validate medical service providers' registration with the Health Professional Council of South Africa.
5 Validate medical service providers' registration with the Board of Healthcare Funders of South Africa.
5. Ensure elimination of duplicate medical invoices before switching to the Fund.
6. Invoices submitted to the Compensation Fund must have Gazetted COIDA Tariffs that are published annually and comply with minimum requirements for submission of medical invoices and billing requirements.
7. File must be switched in a gazetted documented file format published annually with COIDA tariffs.
8. Single batch submitted must have a maximum of 100 medical invoices.
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. Medical Service Providers will be subjected to Compensation Fund vetting processes.
12. Provide any information requested by the Fund.
13. The switching provider must sign a service level agreement with the Fund.
14. Third parties must submit power of attorney.

Failure to comply with the above requirements will result in deregistration of the switching house.

MSP's PAID BY THE COMPENSATION FUND	
Discipline Code :	Discipline Description :
4	Chiropractors
9	Ambulance Services - advanced
10	Anesthetists
11	Ambulance Services - Intermediate
12	Dermatology
13	Ambulance Services - Basic
14	General Medical Practice
15	General Medical Practice
16	Obstetrics and Gynecology (work related injuries)
17	Pulmonology
18	Specialist Physician
19	Gastroenterology
20	Neurology
22	Psychiatry
23	Rediation/Medical Oncology
24	Neurosurgery
25	Nuclear Medicine
26	Ophthalmology
28	Orthopedics
30	Otorhinolaryngology
34	Physical Medicine
36	Plastic and Reconstructive Surgery
38	Diagnostic Radiology
39	Radiographers
40	Radiotherapy/Nuclear Medicine/Oncologist
42	Surgery Specialist
44	Cardio Thoracic Surgery
46	Urology
49	Sub-Acute Facilities
52	Pathology
54	General Dental Practice
55	Mental Health Institutions
56	Provincial Hospitals
57	Private Hospitals
58	Private Hospitals
59	Private Rehab Hospital (Acute)
60	Pharmacies
62	Maxillo-facial and Oral Surgery
64	Orthodontics
66	Occupational Therapy
70	Optometrists
72	Physiotherapists
75	Clinical technology (Renal Dialysis only)
76	Unattached operating theatres / Day clinics
77	Approved U O T U / Day clinics
78	Blood transfusion services
82	Speech therapy and Audiology
86	Psychologists
87	Orthotists & Prosthetists

88	Registered nurses
89	Social workers
90	Manufacturers of assisstive devices