DEPARTMENT OF LABOUR

NOTICE 191 OF 2020

RENAL CARE GAZETTE 2020.

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, Thembelani Waltermade Nxesi, Minister of Employment and Labour, hereby give notice that, after consultation with the Compensation Board and acting under powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993), prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rule applicable thereto, appearing in the Schedule, with effect from **1 April 2020**.

2. Medical Tariffs increase for **2020** is **5.6%**

3. The fees appearing in the Schedule are applicable in respect of services rendered on or after **1 April 2020** and **Exclude 15% Vat**.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 17/01/2020

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 invoices 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 invoices and medical reports.

   1.1 Medical reports should always have a clear and detailed clinical description of injury and related ICD 10 Code.
   1.2 In a case where a surgical 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 Referrals to another medical service provider should be indicated on the medical report.
   1.6 Medical reports, referral letters and all necessary documents should be uploaded on the Compensation Fund claims system.

NOTE: 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.

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.
   2.3 Service providers may capture and submit medical invoices directly on the Compensation Fund system online application.

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.CI 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.CI 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.
   b. Cumulative invoices – Submit a separate invoice for every month.

*** 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 INVOICE 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.

COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS

Medical service providers treating COIDA patients must comply with the following requirements before submitting medical invoices to the Compensation Fund:

- Medical Service Providers must register with the Compensation Fund as a Medical Service Provider.
- Medical Service Providers must register with the Compensation Fund as a system user for loading of medical invoices and medical reports.
- Render medical treatment to patients in terms of COIDA Section 76 (3) (b).
- Submit Proof of registration with the Board of Healthcare Funders of South Africa.
- Submit SARS Vat registration number document on registration.
- A certified copy of the MSP's Identity document not older than three months.
- Proof of address not older than three months.
- Submit medical invoices with gazetted COIDA medical tariffs, relevant ICD10 codes and additional medical tariffs specified by the Fund when submitting medical invoices.
- All medical invoices must be submitted with invoice numbers exclude duplicates.
- Submit medical reports and medical invoices through the Compensation Fund Medical service provider application on or before submission/switching of medical invoices.
- Provide medical reports and invoices within a specified time frame on request by the Compensation Fund in terms of Section 74 (1) and (2).
- The name of the switching house that submit invoices on behalf of the medical service provider must be indicated on Medical service provider letterhead. The Fund must be notified in writing when changing from one switching house to another.

All medical service providers will be subjected to the Compensation Fund vetting processes.

The Compensation Fund will reject all invoices that do not comply with billing requirements as published in the Government Gazette.

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 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. 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
35	Emergency Medicine Independent Practice Specialist
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
79	Hospices
82	Speech therapy and Audiology
86	Psychologists
87	Orthotists & Prosthetists

88	Registered nurses
89	Social workers
90	Manufacturers of assisstive devices

Rules for payment of renal care accounts in terms of COIDA

1. In terms of Sec 73 (1) of COIDA, the Compensation Fund shall pay reasonable medical costs incurred by or on behalf of an employee in respect of medical aid necessitated by such accident or disease.
2. The renal condition must be directly related to the nature of injury sustained or complications thereof.
3. Dialysis is always performed in accordance to a dialysis prescription
4. Dialysis prescriptions can be provided by a nephrologist or a medical practitioner with appropriate training in nephrology
5. Haemodialysis provided in a dialysis unit, applies to both outpatients and stabilized in-hospital patients
6. The global fee for haemodialysis (item 1851) requires regular routine visits to the patient during dialysis and covers:
    (a) Dialysis prescription
    (b) Assessment of dialysis adequacy
    (c) Revision of chronic medication
    (d) Counseling
    (e) Consultations for chronic and acute conditions
    (f) Acute medication and prescriptions
7. After a series of treatments prescribed by the nephrologist or a medical practitioner the renal dialysis practitioner should refer the employee back to the treating medical practitioner.
8. If further treatment is still indicated the treating medical practitioner should submit a medical report with clinical indications for further treatment.
9. A monthly medical report should be submitted and should the condition become chronic a medical report explaining such condition must be submitted to the Fund.
10. Codes:
    (a) 75148
    - Chronic haemodialysis for inpatients and outpatients in dialysis unit.
    - Charged once daily

    (b) 75176
    - Continuous ambulatory peritoneal dialysis for inpatients and outpatients in dialysis unit.
    - Charged daily.

    (C) 75177
    - Automated peritoneal dialysis
    - Charged daily.

    (d) 75150
    - Acute haemodialysis inpatient
    - Charged daily.
    - Applies to all acute dialysis including haemodiafiltration, intermittent and continuous modalities.

COMPENSATION FUND GUIDE TO FEES FOR RENAL CARE 2020

CODE	SERVICE DESCRIPTION	2020 TARIFFS
75148	Chronic Haemodialysis (Bicarbonate Dialysate)	2849.47
75176	Global Fee for Continous Ambulatory Peritoneal (CAPD) per 30 day	1011.75
75177	Global Fee for Automated Peritoneal Dialysis (APD), per 30 day period	1404.57
75150	Acute Haemodialysis	5663.47
75151	Treatment procedures for CRRT for up to 6 hours or part thereof	409.90
75152	Treatment procedures for CRRT for up to 12 hours or part thereof	821.58
75154	Treatment procedures for CRRT for up to 12 hours or part thereof	1231.68
75156	Treatment procedures for CRRT for up to 12 hours or part thereof	1641.61

(e) 75151
(f) 75152
(g) 75156

Codes, **75151, 75152** and **75156** for CRRT in hospital patient, to be charged in ICU general ward or high care only.

WOUND CARE

GAZETTE

2020.

Rules for payment of wound care accounts in terms of COIDA

1. In terms of Sec 73 (1) of COIDA, the Compensation Fund shall pay reasonable medical costs incurred by or on behalf of an employee in respect of medical aid necessitated by such accident or disease.
2. Referral letter with clinical indications for wound treatment should be submitted by the referring doctor and medical accounts from wound care practitioners should be accompanied by such motivation.
3. A regular medical report should b submitted to the Fund indicating progress of the wound.
4. The treatment of the wound should be directly related to the nature of injuries sustained by the employee.
5. Wound treatment within four months post operatively must be motivated according to rule 2 otherwise rules G (d) will apply. Rule G (d) of the General Practitioners and specialist Government Gazette stipulates that the fee in respect of a procedure shall include normal aftercare for a period not exceeding four months. If normal aftercare is delegated to any other health professional and not completed by the surgeon it shall be a surgeon's responsibility to arrange for the service to be rendered without extra charge.
6. The Surgeon should refer to the specific procedure code as outlined in the gazette for General Practitioners and specialist for a specific aftercare period.
7. After 10 conservative wound treatments the employee should be referred back to the treating doctor who should write a progress or final medical report. If further wound treatment is indicated the Compensation Fund should be furnished with motivation for further wound care treatment.
8. Wound treatment and cost of materials in the hospital is only payable to the hospital as a per diem tariff.

COMPENSATION FUND GUIDE TO FEES FOR WOUND CARE 2020

CODE	SERVICE DESCRIPTION	2020 TARIFFS
88002	Per 60 minutes. First assessment of the patient and the wound. During this 1 hour assessment, full history of the patient is taken: -Current use of medication, -Patients with other underlying metabolic diseases -HIV positive patients & those taking immunosuppressant drugs -Severely injured patients, ICU, Oncology patients and those with PMB conditions -Patients with infected wounds, swabs or tissue samples to be taken to the laboratory for culture and sensitivity. -need for referral to other appropriate team members, physiotherapists, dieticians, psychologists, occupational therapists is established -Education on healthy lifestyle and good nutrition -Training & education in elevation of injured limbs is also covered. -Patient education on wound healing and nutrition	670.09
88001	Per 30 minutes. This assessment code to be used only with first consultation in healthy patients with minimal factors which may influence healing. All of the above applies, i.e. history, medication, education.	335.04
88041	Per 30 minutes. Wound treatment for complicated wound or potentially complicated wound in patient with underlying metabolic diseases. Patients requiring compression bandaging, sharp debridement, bio mechanical debridement, off loading, will also be billed on this code. Ongoing wound assessment and education with every visit.	352.23
88411	additional time - for additional 15 minutes	94.50
88042	Per 30 minutes. Wound treatment without complications, no sharp debridement, no bio mechanical debridement, no compression therapy or off loading will be billed on this code. Ongoing wound assessment and education with every visit.	189.00

880421	Code for additional time for additional 15 minutes	**94.50**
88040	Per 30 minutes. This code should be used for assessing suture lines in uncomplicated patients. No additional time should be allocated to this code.	**146.04**
88020	Per specimen. This included correct collection of material, swab or tissue, completion of documentation and speedy delivery to laboratory. Ensuring copies of reports to relevant team members are received and acted upon.	**94.50**
88049	Emergency/ Urgent/ unplanned treatment	**189.00**
88046	Per Ankle Brachial Pressure Index (ABPI). Involves testing systolic blood pressure on both arms and both legs with a hand held Doppler. Interpretation of results will determine if patient requires referral to vascular surgeon and if compression bandaging is suitab	**214.77**
88047	Trans cutaneous Oxygen pressure (TcPO2). Measured by a trans cutaneous oxymeter. This measures the oxygen pressure in and around injured tissue, also used in lower limb assessment where arterial incompetence is suspected. Accurate indicator arterial disease and expected would healing.	**481.09**
88301	Cost of material and special medicine used in treatment. Charges fo medicine used in treatment not to exceed the retail Ethical Price Lis	

- Skin closure strips
- Fast setting bandages
- Dressings
- Micropore
- Wound plast
- Orthopaedic wool bandage
- Surgical tape
- Stockinette
- Ribbon Gauze
- Cotton wool
- Crepe bandage
- Elastic adhesive bandage
- Zinc oxide adhesive plaster
- Absorbent gauze and gauze swabs
- Elastoplast
- Cleaning / infusion solution
- Dressing tray
- Ointment
- Gloves
- Face mask
- Protective sheet
- Protective apron

SOCIAL WORKER Psychology GAZETTE 2020.

Rules for payments of Social Worker services and Psychologists in terms of COIDA

From 1 April 2020

1. In terms of SEC 73(1) of COIDA, the Compensation Fund shall pay reasonable medical costs incurred by on behalf of an employee in respect of medical aid necessitated by such accident or disease.
2. The need for the services must be directly related to the nature of injury sustained or complications thereof.
3. The services of a social worker shall be available only on a written referral by a medical practitioner. Medical invoice must be accompanied by a progress report and a referral letter. Without both these reports, payment will not be considered.
4. Code 89205 can be claimed with code 89201.
5. Only 10 sessions are payable (individual and group session together) per claim.
6. Unless timely steps are taken to cancel an appointment, the relevant fee may be charged to the employee.
7. If there is no active therapy for a period of three (3) calendar months, the treatment will be deemed to have terminated. Subsequently services will require a new referral letter and a treatment plan.

PSYCHOLOGISTS

1. Only twelve(12) consultations payable, should further treatment be required, the treating medical practitioner must submit progress report to the Compensation Commissioner indicating a need for further treatment and only a maximum of 6 additional consultations can be approved. Without such a report payment cannot be considered.

TARIFF OF FEES IN RESPECT OF SOCIAL WORKERS SERVICES
EFFECTIVE 1 APRIL 2020

The account for Social workers services must be accompanied by a referral from the treating doctor indicating the condition of the employee and indicating the need for such services

Item Code	Description	COIDA 2020 Tariffs
89201	Social worker consultation,counselling and/or therapy	**590.07**
	Group or Family consultation,counselling and/ or Therapy	
89205	Social worker consultation,counselling and/ or therapy (can be claimed with code 89201)	**182.29**

TARIFF OF FEES IN RESPECT OF PSYCHOLOGISTS SERVICES
EFFECTIVE 1 APRIL 2020

The account for Psychologists must be accompanied by a referral from the treating doctor indicating the condition of the employee and indicating the need for such services

Item Code	Description	COIDA 2020 Tariffs
862975	Assessment, consultation, counselling and/or therapy (indivial). Duration 60 min	1097.05
862976	Assessment, consultation, counselling and/or therapy (indivial). Duration 90 min and ca only be claimed once	1695.49

labour
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REPUBLIC OF SOUTH AFRICA

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) [MANDATORY]	8	Date
65	Treatment Time (HHMM)	4	Numeric
66	Treatment Date to (CCYYMMDD) [MANDATORY]	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