Government Gazette
Staatskoerant

REPUBLIC OF SOUTH AFRICA
REPUBLIEK VAN SUID-AFRIKA

Vol. 492 Pretoria, 30 June / Junie 2006 No. 28963

CONTENTS

GENERAL NOTICE

NOTICE 821 OF 2006

COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993 (ACT NO. 130 OF 1993)

1. I, Membathisi Mphumzi Shepherd Mdladlana, Minister of Labour, hereby give notice that, after consultation with the Compensation Board and acting under the powers vested in me by section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993), I prescribe the scale of "Fees for Medical Aid" payable under section 76, inclusive of the General Rules applicable thereto, appearing in the Schedule to this notice, with effect from **1 April 2006**.

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

M M S MDLADLANA
MINISTER OF LABOUR
19 May 2006

GENERAL INFORMATION / *ALGEMENE INLIGTING.*

(i) THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER.

The employee is permitted to choose freely his own service provider e.g. doctor, pharmacy, physiotherapist, hospital, etc. and no interference with this privilege is permitted as long as it is exercised reasonably and without prejudice to the employee himself or the Compensation Fund. The only exceptions to this rule are those cases where employers, with the Compensation Commissioner's approval, provide their own medical aid facilities in total, i.e. including hospital, nursing and other services—section 78 of the Act refers.

In terms of section 42 either the Compensation Commissioner or an employer may send the injured employee to another doctor chosen by him (Compensation Commissioner or employer) for a special examination and report. Special fees are payable for this service. This examination and report is usually done only by specialists.

In the event of a change of doctors attending a case, the first doctor in attendance will, except where the case is handed over to a specialist, be regarded as the principal, and payment will normally be made to him. **To avoid disputes, doctors should refrain from treating a case already under treatment without first discussing it with the first doctor**. As a general rule, changes of doctor are not favoured, unless there are sufficient reasons therefore.

If an injured employee is in need of emergency treatment, the doctor should act in the same manner as he would to any patient who needs his urgent help. He should not, however, ask the Compensation Commissioner to authorise such treatment before the claim has been admitted as falling within the scope of the Act.

It should be remembered that an employee seeks medical advice at his own risk. If, therefore, an employee represents to his medical service provider that he is a Compensation for Occupational injuries and Diseases Act case and yet fails to claim the benefits of the Act, leaving the Compensation Commissioner, or his employer, in ignorance of any possible grounds for a claim, the insurance fund concerned cannot accept any responsibility for any medical expenses incurred if the claim is not reported in the prescribed manner. The Compensation Commissioner can also have reason not to accept the claim lodged against the Fund. In such circumstances the employee would be in the same position as any other member of the public as regards payment of his medical expenses.

The amounts published in the tariff for COIDA for medical services are calculated without VAT. The only exclusion is die "per diem" tariff for Private Hospitals, that includes VAT The account for services rendered will be assessed and calculated without VAT. If VAT is applicable and a VAT registration number was indicated, it will be calculated and added to the payment without being rounded off

(i) DIE WERKNEMER EN DIE MEDIESE DIENSVERSKAFFER

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

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

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

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

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

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

1. If the claim is **accepted** as a COIDA claim, reasonable medical expenses will be paid by the Compensation Commissioner • *As die eis teen die Fonds **aanvaar** word, word redelike mediese koste betaal deur die Vergoedings Kommissaris.*

2. If the claim is **rejected (repudiated)**, services will not be paid by the Compensation Commissioner. All parties are informed of this decision, including the service providers. The injured employee will be liable for payment. • *As die eis teen die Fonds afgekeur word **(gerepudieer)**, word dienste nie deur die Vergoedings Kommissaris betaal nie. Die betrokke partye word in kennis gestel van die besluit, ingesluit die diensverskaffers. Die beseerde werknemer is dan aanspreeklik vir die rekening.*

If **no decision** can be made due to a lack of information, the outstanding information is requested and upon receipt, the claim will again be adjudicated. Depending on the outcome, the accounts from the service provider, will be handled as set out in 1 and 2. Unfortunately, there are claims for which a decision might never be made due to a lack of forthcoming information • *Indien **geen besluit** geneem kan word nie, weens 'n gebrek aan inligting, word die uitstaande inligting aangevra. Met ontvangs word die eis heroorweeg. Afhangende van die uitslag, word die rekening hanteer soos uiteengesit in nommer 1 en 2. Ongelukkig is daar eise waar 'n besluit nooit geneem kan word nie aangesien die uitstaande inligting nie verskaf word nie*

BILLING PROCEDURE • EIS PROSEDURE:

1. The **first account** for services rendered to the injured employee (INCLUDING the First medical report) must be submitted to the employer who will collate all the documents (from other service providers etc.) and submit them to the Compensation Commissioner • *Die **eerste rekening** (INSLUITEND die Eerste mediese verslag) vir diens gelewer aan die beseerde werknemer, moet aan die werkgewer gestuur word, wat die eise (van ander diensverskaffers ens.) bymekaar sal sit en dit aanstuur na die Vergoedingskommissaris.*

2. New claims are registered by the Commissioner and the **employer is notified of the claim number** allocated to the claim. Enquiries for claim numbers should be directed to the employer and not to the Commissioner. The employer will be able to give you the claim number for the patient as well as indicate whether the Compensation Commissioner accepted the claim as a COIDA case • *Nuwe eise word geopen deur die Kommissaris en die **werkgewer word in kennis gestel van die eisnommer**. Navrae vir eisnommers moet aan die werkgewer gerig word en nie aan die Kommissaris nie. Die werkgewer kan die eisnommer verskaf en ook aandui of die Kommissaris die eis teen die Fonds aanvaar het of nie*

3. All new accounts are captured on the Commissioners database and a summarized notice is posted weekly to the service provider. This is only an **acknowledgement of receipt** and not a payment or a guarantee there of • *Alle nuwe rekeninge word vasgelê op die Kommissaris se databasis an 'n opsomming van rekeninge ontvang word weekliks aan die diensverskaffer gestuur. Dit is slegs 'n **erkenning van ontvangs** en nie 'n betaling of waarborg daarvan nie.*

4. If accounts are still outstanding after 60 days following submission and acknowledgement by the Commissioner Service providers should complete an enquiry form, W.CL 20, and submit it ONCE to the Commissioner. **DO NOT SUBMIT DUPLICATE ACCOUNTS WHEN AN ACKNOWLEDGEMENT WAS RECEIVED FOR THE PARTICULAR ACCOUNT** • *Indien die rekening nog uitstaande is na 60 dae na indiening an ontvangserkenning deur die Vergoedingskommissaris, moet die diensverskaffer 'n navraag vorm, W.CL 20 voltooi en EENMALIG indien na die Kommissaris. **MOENIE 'N DUPLIKAAT REKENING INDIEN AS ONTVANGS ERKEN IS VIR DIE BETROKKE REKENING NIE.***

5. If **no acknowledgement** was received and the account is unpaid **60 days <u>after</u>** it was submitted to the employer, a **duplicate account** must be submitted to the Commissioner directly. The account must be accompanied by any supporting documents e.g. PART B of the Employers Report of an Accident (W.CL 2), First (W.CL 4), and Progress/Final (W.CL 5/5F) medical reports • *Indien **ontvangs nie erken is 60 dae <u>na</u> versending** aan die werkgewer, moet 'n **duplikaatrekening** ingedien word by die Vergoedingskommissaris. Die rekening moet vergesel word van ander dokumentasie bv. DEEL B van die Werkgewer se Verslag oor 'n Ongeval (W.CL 2), Eerste (W.CL 4) en Vordering/Finale (W.CL 5/5F) mediese veslae.*

6. If the account is **partially paid** with no reason therefore indicated on the remittance advise, a duplicate account with the unpaid services clearly indicated must be submitted, accompanied

by a WCl 20 form. (*see website for example) • *Indien 'n rekening* ***gedeeltelik betaal*** *is met geen rede voorsien op die betaaladvies nie, kan 'n duplikaatrekening met die kortbetaling duidelik aangedui, vergesel van 'n WCl20 form ingedien word (*sien webblad vir voorbeeld van vorm).*

7. **Information NOT to be reflected** on the account: Details of the employee's medical aid and the practice number of the referring practitioner • ***Inligting wat NIE aangedui moet word*** *op die rekening nie: Besonderhede van die werknemer se mediese fonds en die verwysende geneesheer se praktyknommer.*

8. Service provider **should not generate** • *Diensverskaffer* ***moenie die volgende genereer:***

   a. **Multiple accounts** for services rendered on the **same date** i.e. one account for medication and a second account for other services • ***Meer as een rekening*** *vir dienste gelewer op* ***dieselfde datum****, bv. Medikasie op een rekening en ander dienste op 'n tweede rekening.*
   b. **Accumulative accounts** but rather submit a separate account for every month • ***Aaneenlopende rekeninge****: aparte rekeninge per maand word verkies.*
   c. **Accounts on the old documents** (W.CL 4/5/5F) A *New First Medical Report (W.CL 4) and Progress/Final Report (W.CL 5/5F) forms are available. The old forms combined with the account (W.CL11), were replaced. **Accounts on the old medical reports will not be entertained** • ***Rekeninge op die ou voorgeskrewe dokumente*** *van die Vergoedingskommissaris. 'n *Nuwe Eerste mediese verslag (W.CL4) en Vordering/Finale verslag (W.CL5) is beskikbaar. Die vorige vorms gekombineer met die rekening (W.CL11) is vervang.* ***Rekeninge op die ou vorms is nie aanvaarbaar nie.***

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

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

MINIMUM REQUIREMENTS FOR ACCOUNTS RENDERED • MINIMUM VEREISTES VIR REKENINGE GEHEF

1. **Minimum information** to be indicated on the account submitted to the Commissioner • ***Minimum besonderhede*** *wat aangedui moet word op 'n rekening vir die Vergoedingskommissaris:*

    a. Name of employee and ID number • *Naam van werknemer en ID nommer.*
    b. Name of employer and registration number if available. • *Naam van werkgewer en registrasie nommer indien beskikbaar.*
    c. CC claim number/ alternatively employer's registration number • *CC eisnommer/alternatiewelik die werkgewer se registrasie nommer.*
    d. DATE OF ACCIDENT (not only the service date) • *DATUM VAN BESERING (nie slegs die diensdatum nie)*
    e. Service provider's reference number • *Diensverskaffer se rekening nommer*
    f. The practice number (In case of address change, BHF must be notified) • *Die praktyknommer (in geval van adresverandering moet dit by BHF verander word)*
    g. VAT registration number (The Compensation Commissioner will not pay VAT if a VAT registration number is not indicated on the account) • *BTW registrasie nommer (die Kommissaris sal nie BTW betaal as die BTW registrasie nommer nie aangedui word nie)*
    h. Date of service (Actual service date must be indicated. Invoice date is not acceptable) • *Diensdatum (die werklike diensdatum moet aangedui word. Rekening datum is nie aanvaarbaar)*
    i. Items according to the official published tariffs • *Items soos aangedui in die amptelik gepubliseerde tariewe.*
    j. Amount claimed per item and total for account • *Bedrag ge-eis vir item en totaal van rekening.*

2. Please note that **as from 1 January 2004** a **certified copy of an employee's identity document will be required** in order to register a claim with the Compensation Fund. If a copy of the identity document is not submitted the claim will not be registered but will be returned to you/the employer to attach a certified copy of the employee's identity document. Furthermore, all supporting documentation sent to this office must reflect the identity number as well. If it is not reflected, the documents will not be processed but will be returned to the sender to add the ID number. • *Neem asseblief kennis dat 'n* ***gesertifiseerde afskrif van van die werknemer se identiteits dokument benodig word vanaf 1 Januarie 2004*** *om 'n eis by die 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/uself vir die aanheg van die dokument. Alle ander dokumentasie wat aan die kantoor gestuur word moet die identiteitsnommer aangedui hê. Indien nie aangedui nie, sal die dokumentasie nie verwerk word nie, maar teruggestuur word vir die aanbring van die identiteitsnommer.*

COIDA TARIFF SCHEDULE FOR PRIVATE AMBULANCE SERVICES EFFECTIVE FROM 1 APRIL 2006

GENERAL RULES

001 Road ambulance: Long distance claims (items 111, 129 and 141) to be rejected **unless distance traveled by 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 ambulance: 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.

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 2nd Patient is transferred at 50% reduction of Basic Call Cost.
Rule 005 MUST be quoted if a second person is transported in any vehicle or aircraft simultaneously.

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

- Diagnosis of patient's condition
- Summary of all equipment used if not covered in the basic tariff
- Name and HPCSA registration number of care providers
- Name, practice number and HPCSA registration number of medical doctor
- Response vehicle: Details of vehicle driver and intervention undertaken on patient
- Place and time of departure and arrival at destination as well as 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 patient assessment, treatment administration, interventions undertaken and subsequent monitoring fall within the scope of practice of a registered Basic Ambulance Assistant whilst patient 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 patient in transit.

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

NOTES:

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

- In order to bill as an advanced life support call, a registered advanced life support provider must have examined, treated and monitored the patient while in transit to hospital.

- In order to bill as an intermediate life support call, a registered intermediate life support provider must have examined, treated and monitored the patient while in transit to hospital.

- Where an ALS provider is in attendance at a callout but does not do any interventions at an ALS level on the patient, the billing will be based on a lower level dependent on the care given to the patient. (e.g. Paramedic sites IV line or nebulises patient with a B agonist - this falls within the practice of an AEA and thus is to be billed as an ILS call 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 at a BLS level.

Please Note:

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

- Haemaccel and colloid solution may be charged separately.

- **Claims for transfers between hospitals must be accompanied by motivation from the attending physician who requested such transport - clearly stating the medical reasons for the transfer. Motivation must be provided if ALS or ILS is needed and what medical assistance is required on route. This is also applicable on air ambulance.**

- **Claims for patient discharges home will only be entertained if accompanied by a written motivation from the attending physician who requested such transport - clearly stating the medical reasons why an ambulance is required for such a transport and what medical assistance the patient requires on route. Only BLS will be payable. Transport of a patient for any other reason than a MEDICAL reason, (e.g. closer to home) will not be entertained.**

DEFINITION: RESPONSE VEHICLES

Response vehicles only - Advance Life Support (ALS)

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

1. The Acute Primary Response is defined as follows: A call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. Should a response vehicle be dispatched to the scene of the emergency and the patient is in need of Advanced Life Support and which is rendered by ALS Personnel e.g. CCA or National Diploma, the respective service shall be entitled to bill on item 131, for such service. However, the service, which is transporting the patient, shall not be able to levy a bill, as the cost of transportation is included in the ALS rate under item 131. Furthermore the ALS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ALS services rendered.

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

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

4. Notwithstanding that, item 151 applies to all ALS resuscitation 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. The Acute Primary Response is defined as follows: A call that is received for medical assistance to an employee injured at work or in a public area e.g. motor vehicle accident. Should an ILS response vehicle be dispatched to the scene of the emergency and the patient is in need of Intermediate Life Support and which is rendered by ILS Personnel e.g. AEA, the respective service shall be entitled to bill on item 125, for such service. However, the service, which is transporting the patient, shall not be able to levy a bill, as the cost of transportation is included in the ILS rate under item 125. Furthermore the ILS response vehicle personnel must accompany the patient to hospital to entitle the service to bill for said ILS services rendered.

2. In the event of a service rendering ILS and not having its own ambulance in which to transport the patient to a medical facility, and makes use of another service, only the bill for the response vehicle may be levied as the ILS bill under item 125. Since the ILS tariff already includes transportation, the response vehicle service is responsible for the bill for the other service provider.

This ensures that there is only one bill levied per patient. Furthermore the response vehicle ILS personnel must accompany the patient to hospital in the ambulance to entitle the service to bill for said ILS services rendered.

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

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

Registered Basic Ambulance Assistant Qualification

- Oxygen
- Entonox
- Oral Glucose

Registered Ambulance Emergency Assistant Qualification

As above, plus

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

Registered Paramedic Qualification

As above, plus

- Oral glyceryl trinitrate, activated charcoal
- Ipratropium bromide inhalant solution
- Endotracheal Adrenaline and Atropine
- Intravenous Adrenaline, Atropine, Calcium, Hydrocortisone, Lignocaine, Naloxone, Sodium bicarbonate, Hetaclopramide
- Intravenous Diazepam, Flumazenil, Furosemide, Hexoprenaline, Midazolam, Nalbuphine, Tramadol and Morphine.
- Pacing and synchronised cardioversion require the permission of the relevant supervising medical officer.

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 VAT registration number on 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 billed for the distance back to the base in the metropolitan area.*			
*102	Up to 60 minutes	963.70	963.70	963.70
*103	Every 15 minutes (or part thereof) thereafter, where specially motivated.	240.80	240.80	240.80
	Long distance (more than 100 km)			
*111	Per km **DISTANCE TRAVELLED BY PATIENT**	10.60	10.60	10.60
112	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	5.40	5.40	5.40
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	--	1284.50	1284.50
*127	Every 15 minutes (or part thereof) thereafter, where specially motivated		320.90	320.90
	Long distance (more than 100 km)			
*129	Per km **DISTANCE TRAVELLED BY PATIENT**	--	15.50	15.50
130	Per km **NON PATIENT CARRYING KILOMETRES** (With maximum of 400 km)	--	5.40	5.40
	* *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	--	--	2038.50
*133	Every 15 minutes (or part thereof) thereafter, where motivated	--	--	665.40
	Long distance (more than 100 km)			
*141	Per km **DISTANCE TRAVELLED BY PATIENT**	--	--	29.50
142	Per km **NON PATIENT CARRYING KILOMETRES** With maximum of 400 km)	--	--	5.40
4	**ADDITIONAL VEHICLE OR STAFF FOR INTERMEDIATE LIFE SUPPORT, ADVANCED LIFE SUPPORT AND INTENSIVE CARE UNIT**			
151	Resuscitation fee, per incident for second vehicle with paramedic and/or other staff (all materials and skills included) **Note :** A resuscitation fee may only be billed when a second vehicle (response car or ambulance) with staff (inclusive of 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	--	2270.60	2270.60
153	Doctor per hour **Note:** Where a doctor callout fee is charged the name and BHF practice number of the doctor must appear on the bill. Medical motivation for callout must be supplied. ** VAT Exempted codes*	--	652.50	652.50

AEROMEDICAL TRANSFERS

ROTOR WING RATES

DEFINITIONS:

1. Helicopter rates are determined according to the aircraft type
2. Day light 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 bill night time operation rates (type C)
4. Call out charge includes Basic Call Cost plus other flying time incurred, Staff and consumables cost can only be charged if a patient has been treated
5. Should a response aircraft go to a scene (at own risk) and not render any treatment then the said craft may not levy a bill.
6. Flying time is billed per minute but a minimum of 30 minutes apply to the payment.
7. A 2nd Patient is transferred at 50% reduction of Basic Call and Flight cost, but Staff and Consumables costs remain per patient. (Only if aircraft capability allows for multiple patients)
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 Civil Aviation.
10. Hot loads restricted to 8 minutes ground time and must be indicated and billed 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 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 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 Civil Aviation.
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 would be advised. The definition of use of these aircraft needs to be narrowed down further to eliminate abuse.

3. **All published tariffs exclude VAT. VAT can be charged on air ambulances only if VAT registration number is supplied on account.**
4. Staff and consumables cost can only be used if patient has been treated.
5. 2nd patient transferred at 50% reduction of Basic Call and Flight Cost, but Staff and consumables costs remain per patient. (only if aircraft capability allows for multiple patients) Rule 005 must be quoted on the account.

GROUP B – EMERGENCY CHARTERS

1. No staff and equipment fee allowed.
2. Cost to be reviewed per case.
3. Only allowed if a Group A aircraft is not available within an optimal time period for transportation and stabilization 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	--	--	4652.00
PLUS	**Flying time**			
301	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R 2220.00) applicable.	--	--	74.00
302	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	74.00
303	Hot load (per minute) – maximum 8 minutes (R592.00)	--	--	74.00
	Rotorwing Type B and C (day operations) : Transport			
310	Basic call cost	--	--	8175.20
PLUS	**Flying time**			
311	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R3831.00) applicable.	--	--	127.70
312	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	127.70
313	Hot load (per minute) – maximum 8 minutes (R1021.60)	--	--	127.70

CODE	DESCRIPTION OF SERVICE	Practice Code 013	011	009
		AMOUNT PAYABLE		
	Rotorwing Type C (night operations) : Transport			
315	Basic call cost	--	--	11629.50
PLUS	**Flying time**			
316	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R3831.00) applicable.	--	--	127.70
317	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	127.70
318	Hot load (per minute) – maximum 8 minutes (R1021.60)	--	--	127.70
	Rotorwing Type A, B and C : Staff and consumables			
320	0 - 30 minutes	--	--	732.20
321	30- 60 minutes	--	--	1464.40
322	60 - 90 minutes	--	--	2196.60
323	90 minutes or more	--	--	2928.70
	Rotorwing Type D : Transport			
330	Basic call cost	--	--	9811.30
PLUS	**Flying time**			
331	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R4569.00) applicable.	--	--	152.30
332	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	152.30
333	Hot load (per minute) – maximum 8 minutes (R1218.40)	--	--	152.30
	OTHER COSTS			
340	Winching (per lift)	--	--	1276.90
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	--	--	18.70
401	Lear 24F	--	--	29.30
402	Lear 35	--	--	29.30
403	Falcon 10	--	--	33.90

CODE	DESCRIPTION OF SERVICE	Practice Code		
		013	011	009
		AMOUNT PAYABLE		
404	King Air 200	--	--	26.90
405	Mitsubishi MU2	--	--	29.30
406	Cessna 402	--	--	16.30
407	Beechcraft Baron	--	--	14.10
408	Citation 2	--	--	22.30
409	Pilatus PC12	--	--	22.30
	Fixed wing Group A : Staff cost			
420	Doctor – cost per minute Minimum cost for 30 minutes (R1056.00) applicable.	--	--	35.20
421	ICU Sister – cost per minute Minimum cost for 30 minutes (R387.00) applicable.	--	--	12.90
422	Paramedic – cost per minute Minimum cost for 30 minutes (R387.00) applicable.	--	--	12.90
	Fixed wing Group A : Equipment cost			
430	Per patient – cost per minute Minimum cost for 30 minutes (R315.00) applicable.	--	--	10.50
	Fixed wing Group B : Emergency charters			
450	Services rendered to be clearly specified with cost included Each case will be reviewed and assessed on merit.			