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DEPARTMENT OF EMPLOYMENT AND LABOUR

NOTICE 3059 OF 2025

AMBULANCE GAZETTE 2025

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Department:
Employment and Labour
REPUBLIC OF SOUTH AFRICA

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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, Nomakhosazana Meth, 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 2025.
2. Medical Tariffs will increase by 6% for the financial year 2025/26.
3. The fees appearing in the Schedule are applicable in respect of services rendered from 1 April 2025 and exclude 15% VAT

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Ms. N Meth, MP

MINISTER OF EMPLOYMENT AND LABOUR

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GENERAL INFORMATION

POPI ACT COMPLIANCE

In terms of Protection of Personal Information Act, 2013 (POPI Act), the Compensation Fund wants to assure Employees and the Medical Service Providers that all personal information collected is treated as private and confidential. The Compensation Fund has put in place the necessary safeguards and controls to maintain confidentiality, prevent loss, unauthorised access and damage to information by unauthorised parties.

1. MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS WITH THE COMPENSATION FUND

1.1. The Compensation Fund requires that any Medical Service Provider, providing medical treatment to patients in terms of the COID Act, must be registered with The Compensation Fund as follows:

1.1.1. Copies of the following documents must be submitted to the nearest Labour Centre

a. A certified identity document of the practitioner

b. Certified valid BHF certificate

c. Recent bank statement with bank stamp or bank letter

d. Proof of practice address not older than 3 months.

e. Submit SARS VAT registration number/ certificate if VAT registered. If this is not provided the Medical Service Provider will be registered as a Non VAT vendor.

f. A power of attorney is required where the MSP has appointed a third party for administration of their COID claims.

1.1.2. A duly completed original Banking Details form (WAC 33) that can be downloaded in PDF from the Department of Employment and Labour Website (www.labour.gov.za).

1.1.3. Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address and Email address. The Fund must be notified in writing of any changes in order to effect necessary changes.

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2. REGISTERING WITH THE COMPENSATION FUND AS AN ONLINE SYSTEM USER FOR MEDICAL SERVICE PROVIDERS

2.1. To register as an online user of the claims processing system, COMPEASY, the following steps must be followed:

2.1.1. Register as an online user with the Department of Employment and Labour website (www.labour.gov.za)

2.1.2. Register on the CompEasy application having the following documents to upload:

- A certified copy of identity document (not older than a month from the date of application)
- Certified valid BHF certificate
- Proof of address not older than 3 months

2.2. In the case where a medical service provider wishes to appoint a proxy to interact on the claims processing system the following ADDITIONAL documents must be uploaded:

- An appointment letter for proxy (the template is available online)
- The proxy's certified identity document (not older than a month from the date of application)
- There are instructions online to guide a user on successfully registering (www.compeasy.gov.za)

3. THIRD PARTIES TRANSACTING ON BEHALF OF MEDICAL SERVICE PROVIDERS

3.1. Third Parties that provide administration services on COID medical invoices on behalf of medical service providers must take note of the following:

3.1.1. A third party transacting with the Fund, must be in a position to obtaining a copies of the original claim documents and medical invoices from medical service providers.

3.1.2. The third party must keep such records in their original state as received from the medical service provider and must furnish the Compensation Commissioner with such documents on request for the purposes of auditing.

3.2. The Fund will not provide or disclose any information related to a medical service provider, represented by a third party, where such information was obtained or relates to a period prior to them contracting to a third party.

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4. THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

4.1. Medical Service Providers are advised to take note of the following as it pertains to the treatment of patients in relation to the Compensation for Occupational Injuries and Diseases Act of 1993 (COID Act):

4.1.1. An employee as defined in the COID Act of 1993, is at liberty to choose their preferred medical service provider without interference, as long as it is exercised reasonably and without prejudice to the employee or the Compensation Fund.

4.1.2. 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 its employees, e.g. Hospital, nursing and other medical services — Section 78 of the COID Act refers.

4.1.3. In terms of Section 42 of the COID Act, the Compensation Fund may refer an injured employee to a specialist medical service provider designated by the Director General for a medical examination and report.

4.1.4. In terms of section 76,3(b) of the COID Act, no amount in respect of medical expenses shall be recoverable from the employee.

4.1.5. In the event of a change of a medical service provider attending to a case, the first treating doctor in attendance will, except where the case is transferred to a specialist, be regarded as the principal treating doctor.

4.1.6. To avoid disputes regarding the payment for services rendered, medical service providers should refrain from treating an employee already under treatment by another medical practitioner without consulting/informing the principal treating doctor.

4.1.7. Any changes of medical service providers must have sufficient reasons existing for such a change which must be communicated to the Compensation Fund.

4.1.8. 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 registered and liability for the claim is accepted by the Compensation Fund.

4.1.9. An employee seeks medical advice at their own risk. If such an employee presents themselves to a medical service provider as being entitled to treatment in terms of the COID Act, whilst having failed to inform their employer and/or the Compensation Fund of any possible grounds for a claim, the Compensation Fund cannot accept responsibility for the settlement of medical expenses incurred under such circumstances.

4.1.10. The Compensation Fund may have reasons to repudiate a claim lodged with it, in such circumstances, the employee would be in the same position as any other member of the public regarding payment of their medical expenses.

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5. OVERVIEW OF THE COID CLAIMS PROCESS

5.1. All claims lodged in the prescribed manner with the Compensation Fund are subjected to the following process:

5.1.1. New claims are registered by the Employers with the Compensation Fund in the prescribed manner. Details of and progress of the claim can be viewed on the online processing system for registered users of the system.

5.1.2. Proof of identity is required in the form of a copy of an Identity document/card, will be required in order for a claim to be registered with the Compensation Fund. In the case of foreign nationals, the proof of identity (passport) must be certified.

5.1.3. All supporting documentation submitted to the Compensation Fund must reflect the identity and claim numbers of the employee.

5.1.4. The allocation of a claim number to a claim after the registration thereof by the Compensation Fund, does not constitute acceptance of liability for a claim. It indicates that the injury on duty has been reported to the Compensation Fund and acknowledged.

5.1.5. When liability for a claim is accepted by the Compensation Fund in terms of the COID Act, reasonable medical expenses, related to the medical condition shall be paid to medical service providers, that treat the employees, in accordance to approved tariffs, billing rules and procedures as published in the medical tariff gazettes of the Compensation Fund.

5.1.6. If a claim is repudiated in terms of the COID Act, medical expenses, will not be payable by the Compensation Fund. The employer and the employee will be informed of this decision and the injured employee will be liable for payment of medical costs incurred.

5.1.7. In the event of insufficient claim information being made available to the Compensation Fund, the claim will be rejected until the outstanding information is submitted and liability can be determined.

5.1.8. Manner of payment of medical benefits for Compensation Fund claims, where liability has been accepted (adjudicated) on or after 1 April 2025.

5.1.9. All medical invoices for accepted claims must be submitted, in the prescribed manner within 24 months of the date of acceptance of liability. Medical invoices received after said time frame will be considered as late submission of invoices and may be rejected.

5.1.10. All service providers should be registered on the Compensation Fund claims processing system in order to capture medical invoices and medical reports for medical services rendered.

5.1.11. Medical reports and medical invoices should ONLY be submitted/transmitted for claims that The Compensation Fund has accepted liability for and thus reasonable medical expenses are payable.

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6. BILLING REQUIREMENTS FOR MEDICAL SERVICES PROVIDED TO INJURED/DISEASED EMPLOYEES

6.1. Medical Reports:

In terms of Sec 74(1)(2)(3)(4) and (5) of COID Act, Submission of Medical Report; Medical Service provider are advised to take note of the following:

6.1.1. The first medical report (W. CL 4), completed after the first consultation must confirm the clinical description of the injury/disease. It must also detail any procedure performed and any referrals to other medical service providers where applicable.

6.1.2. All follow up consultations must be completed on a Progress Medical Report (W.CL5). Any operation/procedure performed must be detailed therein and any referrals to other medical service providers where applicable.

6.1.3. A progress medical report is considered to cover a period of 30 days, with the exception where a procedure was performed during that period, then an additional operation report will be required.

6.1.4. Only one medical report is required when multiple procedures are done on the same service date.

6.1.5. When the injury/disease being treated stabilises a Final Medical Report must be completed (W.CL 5F).

6.1.6. Medical Service Providers are required to keep copies of medical reports which should be made available to the Compensation Commissioner when requested.

NB: Hospitals will be required from the 1st April 2025 to provide patient records when submitting medical invoices for services provided.

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7. MINIMUM INFORMATION REQUIREMENTS FOR MEDICAL INVOICES SUBMITTED TO THE COMPENSATION FUND

The following must be indicated on a medical invoice in order to be processed by the Compensation Fund:

1. The allocated Compensation Fund claim number
2. Name and ID number of employee
3. Name and Compensation Fund registration number of Employer, as indicated on the Employers Report of Accident (W.CL 2)
4. DATES:
    a. Date of accident
    b. Date of service (From and to)
5. Medical Service Provider, BHF practice number
6. VAT registration number of Medical Service Provider: VAT will not be applied if a VAT registration number is not supplied on the invoice
7. Tariff Codes:
    a. Tariff code applicable to injury/disease, are as published tariff gazettes.
    b. Amount claimed per code, quantity and the total amount of the invoice.
8. VAT:
    a. The tariff amounts published in the tariff guides exclude VAT.
    b. All invoices for services rendered will be assessed without VAT.
    c. VAT will be applied to VAT registered vendors (MSP's) without being rounded off.
    d. With the exception of the following:
        i. "PER DIEM" tariffs for Private Hospitals that already are VAT inclusive.
        ii. Certain VAT exempted codes in the Private Ambulance tariff structure.
9. All pharmacy or medication invoices must be accompanied by the original script(s)

NB!! All pharmaceuticals will be processed in accordance with Nappi file codes.

10. Where applicable the referral letter from the treating practitioner must accompany the medical service providers' invoice.
11. All medical invoices must be submitted with invoice numbers to prevent system rejections.
12. Duplicate invoices should not be submitted.
13. Compensation Fund does not accept submission of running accounts /statements, but will reject upfront at switch level.

PLEASE NOTE: The Compensation Fund will withhold payments if medical invoices do not comply with minimum submission and billing requirements as published in the Government Gazette

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8. REQUIREMENTS FOR SWITCHING MEDICAL INVOICES WITH THE COMPENSATION FUND

A switching provider must comply with the following requirements:

1. Register with the Compensation Fund as an employer where applicable in terms of the COID Act 1993
2. Host a secure FTP (or SFTP) server to ensure encrypted connectivity with the Fund. This requires that they ensure the following:
    a. Disable Standard FTP because is now obsolete. ...and use latest version and reinforce FTPS protocols and TLS protocols.
    b. Use Strong Encryption and Hashing.
    c. Place Behind a Gateway.
    d. Implement IP Blacklists and Whitelists.
    e. Harden Your FTPS Server.
    f. Utilize Good Account Management.
    g. Use Strong Passwords.
    h. Implement File and Folder Security.
    i. Secure your administrator, and require staff to use multifactor authentication.
3. Submit and complete successful test file after registration before switching the invoices.
4. Verify medical service provider's registration with the Board of Healthcare Funders of South Africa.
5. Submit medical invoices with gazetted COIDA tariffs that are published annually.
6. Comply with medical billing requirements of the Compensation Fund.
7. Single batch submitted must have a maximum of 150 medical invoices.
8. Eliminate duplicate invoices before switching to the Fund.
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. Only pharmacies should claim from the NAPPI file.

PLEASE NOTE:

Failure to comply with the above requirements will result in deregistration / penalty imposed on the switching house.

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COMPEASY ELECTRONIC INVOICING FILE LAYOUT

*** Mandatory fields**

FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
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)	11	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	*
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	

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FIELD	DESCRIPTION	Max Length	DATA TYPE	MANDATORY
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	*
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	*

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MSPs PAID BY THE COMPENSATION FUND

Discipline Code :	Discipline Description :
004	Chiropractors
009	Ambulance Services - Advanced
010	Anesthesiology
011	Ambulance Services - Intermediate
012	Dermatology
013	Ambulance Services - Basic
014	General Medical Practice
015	General Medical Practice
016	Obstetrics and Gynecology (Occupational related cases)
017	Pulmonology
018	Specialist Medicine
019	Gastroenterology
020	Neurology
021	Cardiology (Occupational Related Cases)
022	Psychiatry
023	Medical Oncology
024	Neurosurgery
025	Nuclear Medicine
026	Ophthalmology
028	Orthopaedic
030	Otorhinolaryngology
034	Physical Medicine
035	Emergency Medicine Independent Practice Speciality
036	Plastic and Reconstructive Surgery
038	Diagnostic Radiology
039	Radiography
040	Radiation Oncology
042	Surgery Specialist
044	Cardio Thoracic Surgery
046	Urology
049	Sub-Acute Facilities
052	Pathology
054	General Dental Practice
055	Mental Health Institutions
056	Provincial Hospitals
057	Private Hospitals
058	Private Hospitals
059	Private Rehab Hospital (Acute)
060	Pharmacy
062	Maxillo-facial and Oral Surgery
064	Orthodontics
066	Occupational Therapy
070	Optometry
072	Physiotherapy
075	Clinical technology (Renal Dialysis and Perfusionists only)

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076	Unattached operating theatres / Day clinics
077	Approved U O T U / Day clinics
078	Blood transfusion services
079	Hospices/Frail Care
082	Speech therapy and Audiology
083	Hearing Aid Acoustician
084	Dietetics
086	Psychology
087	Orthotics & Prosthetics
088	Registered nurses (Wound Care and Nephrology only)
089	Social worker
090	Clinical services : (Wheelchairs and Gases only)
094	Prosthodontic

AMBULANCE TARIFF OF FEES AS FROM 1 APRIL 2025 (PRACTICE TYPE 009, 011, 013)	
General Rules	
Rule	**Rule Description**
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 100,102,103,125,127,131 or 133. Long distance claims (items 112, 130 and 142) to be rejected unless the distance is reflected.
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. (Refer to Section 7: Nationally approved medication)
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. Refer to Aeromedical transfers section 5.
006	**Guidelines for information required on each ambulance invoice:** **Road and air ambulance invoices** · Name and ID number of the employee. · Diagnosis of the employee's condition. · The date on which the service was rendered. · Summary of all equipment used if not covered in the basic tariff. · Summary of medical procedures undertaken on patient and vital signs of patient. · 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. Road Ambulance: exact time travelled from base to scene, scene to hospital). · Details of the trip sheet should be captured in a medical report provided for on the COID system. PLEASE NOTE: VAT cannot be added on the following codes 102,103,111,125,127,129,131,133 and 141.
	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 and/or maintaining 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, it 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.
	DEFINITION: RESPONSE VEHICLES
1.	**Response vehicles only - Advance Life Support (ALS)** **A clear distinction must be drawn between an acute primary response and a booked call.** 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 a 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 item 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.
4.1	**Response vehicle only - Intermediate Life Support (ILS)** **A clear definition must be drawn between the acute primary response and a booked call.** 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.

4.2	In the event of a 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.			
4.3	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.			
	*** 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	**Code Description**	**13**	**11**	**9**
1.	**Basic Life Support**			
	(Rule 001: Metropolitan area and long distance codes may not be claimed simultaneously)			
	Metropolitan area (less than 100 kilometres)			
	No invoice may be billed for the distance back to the base in the metropolitan area			
100	Up to 45 minutes	**2151.48**	**2151.48**	**2151.48**
***102**	Up to 60 minutes	**2900.90**	**2900.90**	**2900.90**
***103**	Every 15 minutes thereafter or part thereof, where specially motivated	**726.09**	**726.09**	**726.09**
	Long distance (more than 100 km)			
***111**	Per km DISTANCE TRAVELLED WITH PATIENT	**36.14**	**36.14**	**36.14**
112	Per km NON PATIENT CARRYING KILOMETRES (With maximum of 400 km)	**16.24**	**16.24**	**16.24**
	* Vat Exempted codes			
2.	**Intermediate Life Support**			
	(Rule 001: metropolitan area and long distance codes may not be claimed simultaneously)			
	Metropolitan area (less than 100 kilometres)			
	No invoice may be billed for the distance back to the base in the metropolitan area			
***125**	Up to 60 minutes	**--**	**3833.71**	**3833.71**
***127**	Every 15 minutes thereafter or part thereof, where specially motivated	**--**	**979.93**	**979.93**
	Long distance (more than 100 km)			
***129**	Per km DISTANCE TRAVELLED WITH PATIENT	**--**	**48.94**	**48.94**
130	Per km NON PATIENT CARRYING KILOMETRES (With maximum of 400 km)	**--**	**16.24**	**16.24**
	* Vat Exempted codes			
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 invoice may be billed for the distance back to the base in the metropolitan area			
***131**	Up to 60 minutes	**--**	**--**	**6084.23**
***133**	Every 15 minutes thereafter or part thereof, where specially motivated	**--**	**--**	**1986.16**
	Long distance (more than 100 km)			
***141**	Per km DISTANCE TRAVELLED WITH PATIENT	**--**	**--**	**88.06**
142	Per km NON PATIENT CARRYING KILOMETRES (With maximum of 400 km)	**--**	**--**	**16.24**
	* Vat Exempted codes			

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)	--	--	**6676.51**
	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. Note applies to both resuscitation by ALS provider and Doctor.			
153	Doctor per hour	--	--	**1918.66**
	Note: Where a doctor callout fee is charged the name, HPCSA registration number and BHF practice number of the doctor must appear on the Invoice. Medical motivation for the callout must be supplied. Note applies to both resuscitation by ALS provider and Doctor.			
5.	**Aeromedical Transfers**			
	Rotorwing Rates (Wings spins to provide aerodynamic lift e.g. helicopter)			
	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 was treated. **5.** Should a response aircraft respond to a scene (at own risk) and not render any treatment, an invoice 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 invoice. **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). **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			
	Air Ambulance : Rotorwing			
Code	**Code Description**	**13**	**11**	**9**
	Rotorwing Type A: Transport			
300	Basic call cost	--	--	**13884.97**
	Plus Flying time	--	--	
301	Cost per minute up to 120 minutes Minimum cost for 30 minutes (R6627.86) applicable	--	--	**220.93**
302	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	**220.93**

303	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R1767.43)	--	--	220.93
	Rotorwing Type B and C (Day Operations): Transport			
310	Basic call cost	--	--	24403.65
	Plus Flying time			
311	Cost per minute up to 120 minutes	--	--	381.22
	Minimum cost for 30 minutes (R11436.69) applicable			
312	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	381.22
313	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R3049.79)	--	--	381.22
	Rotorwing Type B and C (Night Operations): Transport			
315	Basic call cost	--	--	34711.70
	Plus Flying time			
316	Cost per minute up to 120 minutes	--	--	381.22
	Minimum cost for 30 minutes (R11436.69) applicable			
317	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	381.22
318	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R3049.79)	--	--	381.22
	Rotorwing Type A, B and C: Staff and consumables			
320	0 - 30 minutes	--	--	2152.97
321	31 - 60 minutes	--	--	4305.93
322	61 - 90 minutes	--	--	6459.11
323	91 minutes or more	--	--	8611.83
	Rotorwing Type D: Transport			
330	Basic call cost	--	--	29284.06
	Plus Flying time			
331	Cost per minute up to 120 minutes	--	--	454.64
	Minimum cost for 30 minutes (R13639.14) applicable			
332	> 120 minutes Supply motivation for not using a fixed wing ambulance if the time exceeds 120 minutes	--	--	454.64
333	Hot load (A very quick and rushed load into the aircraft usually at the accident scene), (per minute) – maximum 8 minutes (R3637.10)	--	--	454.64
	Other Cost			
340	Winching (per lift)			3754.62
400	Beechcraft Duke	--	--	76.03
401	Lear 24F	--	--	86.31
402	Lear 35	--	--	86.31
403	Falcon 10	--	--	99.83
404	King Air 200	--	--	79.09
405	Mitsubishi MU2	--	--	86.31
406	Cessna 402	--	--	48.01
407	Beechcraft Baron	--	--	41.46

408	Citation 2	--	--	**65.57**
409	Pilatus PC12	--	--	**65.57**
	Fixed wing Group A: Staff cost			
420	Doctor – cost per minute spent with the patient Minimum cost for 30 minutes (R3109.13) applicable	--	--	**103.64**
421	ICU Registered Nurse – cost per minute spent with the patient Minimum cost for 30 minutes (R1135.76) applicable	--	--	**37.86**
422	Paramedic – cost per minute spent with the patient Minimum cost for 30 minutes (R1135.76) applicable	--	--	**37.86**
	Fixed wing Group A: Equipment cost			
430	Per patient – cost per minute Minimum cost for 30 minutes (R926.04) applicable	--	--	**30.87**
	Fixed wing 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.			
450	Services rendered should be clearly specified with cost included. Each case will be reviewed and assessed on merit.			
6.	**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 **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			

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