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GENERAL NOTICES • ALGEMENE KENNISGEWINGS**DEPARTMENT OF EMPLOYMENT AND LABOUR****NOTICE 921 OF 2022****COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES 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 & 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 2022**.
2. Medical Tariffs increase for **2022** is **0%**.
3. The fees appearing in the Schedule are applicable in respect of all services rendered on or after **1 April 2022** and **Exclude 15% Vat**.



MR TW NXESI MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 03/03/2022

Kommunikasie-en-inligtingsteelsel • Diihaeletsano tsa Puso • Tekuchumana laHulumande • EzokuXhumana koMbuso • Dikgokahano tsa Mmuso
Vhudavhizani ha Muvhuso • Dikgokagano tsa Mmuso • Iinkonzo zoNxibelelwano kuRhulumente • Vuhlanganis bya Mfumo • UkuThintanisa koMbuso

Batho Pele - putting people first

GENERAL INFORMATION

THE EMPLOYEE AND THE MEDICAL SERVICE PROVIDER

The employee is permitted to freely choose his/her 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/her own risk. If an employee represented to a medical service provider that he/she 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/her 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 cannot 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 invoices 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 medical invoices and reports.
 - 1.1 Medical reports should always have a clear and detailed clinical description of injury.
 - 1.2 A progress medical report covering a period of 30 days will be required, with an exception where a procedure was performed during that period.
 - 1.3 In a case where a procedure is done, an operation report is required.
 - 1.4 Only one medical report is required when multiple procedures are done on the same service date.
 - 1.5 Service providers are required to keep original documents (i.e medical reports, invoices) and these should be made available to the Compensation Commissioner on request.
 - 1.6 Referrals to another medical service provider should be indicated on the medical report.
2. Medical invoices should be switched to the Compensation Fund using the attached format. - Annexure D.
 - 2.1. Subsequent invoice must be electronically switched. It is important that all requirements for the submission of invoice, including supporting information, are submitted.
 - 2.2. Manual documents for medical refunds should be submitted to the nearest labour centre.
3. The status of invoices /claims can be viewed on the Compensation Fund claims system. If invoices are still outstanding after 60 days following submission, the service provider should complete an enquiry form, W.Cl 20, and submit it ONCE to the Provincial office/Labour Centre. All relevant details regarding Labour Centres are available on the website www.labour.gov.za .
4. If an invoice has been partially paid with no reason indicated on the remittance advice, an enquiry should be made with the nearest processing labour centre. The service provider should complete an enquiry form, W.Cl 20, accompanied by the original invoice with unpaid services clearly indicated, 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.

5.1 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:

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

6.2 Accumulative invoices – submit a separate invoice for every month.

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

MINIMUM REQUIREMENTS FOR INVOICES RENDERED

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

- Compensation Fund claim number
- Name of employee and ID number
- Name of employer and registration number if available
- 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 invoice)
- 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 the invoice
- It is important that all requirements for the submission of invoices are met, including supporting information, e.g:
 - All pharmacy or medication invoices 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.
- Render medical treatment to in terms of COIDA Section 76 (3) (b).
- Submit Proof of registration with the Board of Healthcare Funders of South Africa.
- Submit an applicable dispensing licence on registration as a medical service provider.
- 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 to prevent system rejections. Duplicate invoices should not be submitted.
- Provide medical reports and invoices within a specified time frame on request by the Compensation Fund in terms of Section 74 (1) and (2).
- Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address, Email address. The Fund must be notified in writing of any changes in order to effect necessary changes on the systems.
- The name of the switching house that submit invoices on behalf of the medical service provider. 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 withhold payments if medical invoices do not comply with minimum submission and 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 Health Professional Council of South Africa.
5. Validate medical service providers' registration with the Board of Healthcare Funders of South Africa.
5. Ensure elimination of duplicate medical invoices before switching to the Fund.
6. Invoices submitted to the Compensation Fund must have Gazetted COIDA Tariffs that are published annually and comply with minimum requirements for submission of medical invoices and billing requirements.
7. File must be switched in a gazetted documented file format published annually with COIDA tariffs.
8. Single batch submitted must have a maximum of 100 medical invoices.
9. File name must include a sequential batch number in the file naming convention.
10. File names to include sequential number to determine order of processing.
11. Medical Service Providers will be subjected to Compensation Fund vetting processes.
12. Provide any information requested by the Fund.
13. The switching provider must sign a service level agreement with the Fund.
14. Third parties must submit power of attorney.
15. Only Pharmacies should claim from the Nappi codes file.

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	Radiation/Medical Oncology
24	Neurosurgery
25	Nuclear Medicine
26	Ophthalmology
28	Orthopedics
30	Otorhinolaryngology
34	Physical Medicine
36	Plastic and Reconstructive Surgery
38	Diagnostic Radiology
39	Radiographers
40	Radiotherapy/Nuclear Medicine/Oncologist
42	Surgery Specialist
44	Cardio Thoracic Surgery
46	Urology
49	Sub-Acute Facilities
52	Pathology
54	General Dental Practice
55	Mental Health Institutions
56	Provincial Hospitals
57	Private Hospitals
58	Private Hospitals
59	Private Rehab Hospital (Acute)
60	Pharmacies
62	Maxillo-facial and Oral Surgery
64	Orthodontics
66	Occupational Therapy
70	Optometrists
72	Physiotherapists
75	Clinical technology (Renal Dialysis only)
76	Unattached operating theatres / Day clinics
77	Approved U O T U / Day clinics
78	Blood transfusion services
82	Speech therapy and Audiology
84	Dieticians
86	Psychologists
87	Orthotists & Prosthetists
88	Registered nurses

89	Social workers
90	Manufacturers of assisstive devices

PRIVATE HOSPITALS TARIFF OF FEES FROM 1 APRIL 2022

PRIVATE ACUTE HOSPITALS (57/58) AND PSYCHIATRIC (55) (PER DIEM TARIFF)

ACCOMMODATION

The day admission fee shall be charged in respect of all patients admitted as day patients and discharged before 23:00 on the same date.

Ward fees shall be charged at the full day rate if admission takes place before 12:00 and at the half daily rate if admission takes place after 12:00. At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 12:00 and the full daily rate if the discharge takes place after 12:00.

Ward fees are inclusive of all pharmaceuticals and equipment that are provided in the accommodation, theatre, emergency room and procedure rooms.

Note: Fees include VAT

CODE	DESCRIPTION	RAND
1.	General Wards for Acute Hospitals	PRACTICE CODE 57/58
H001	Surgical cases: per day	3824.04
H002	Thoracic and neurosurgical cases (including laminectomies and spinal fusion): per day	3824.04
H004	Medical and neurological cases: per day	3824.04
H007	Day admission which includes all patients discharged by 23:00 on date of admission	1636.65
H008	General Ward for Psychiatric Hospitals (Inclusive fee: Ward fee, Pharmaceuticals, Occupational Therapy)	PRACTICE CODE 55 2979.11
1.1	Special Care Units	
	Hospitals shall obtain a doctor's report stating the reason for accommodation in an intensive care unit or a high care ward from the attending medical practitioner, and such report including the date and time of admission and discharge from the unit shall be forwarded to the Commissioner together with the account. Pre-drafted and standard certificates of authorisation will not be acceptable.	
H201	Intensive Care Unit: per day	25633.26
H215	High Care Ward: per day	13227.95

2.	Theatres and Emergency Unit	
2.1	Theatre and Emergency fees are inclusive of all consumables and equipment. The after hours fee are included in the normal theatre fee	
H301	Emergency fee Rule: Emergency fee - excluding follow-up For all emergencies including those requiring basic nursing input, e.g. BP measurement, urine testing, application of simple bandages, administration of injections	917.94
H302	For all emergencies which require the use of a procedure room, e.g. for application of plaster. stitching of wounds.	1862.31
H303	<u>Follow-up visits:</u> The Compensation Fund. will reimburse hospitals for all materials used during follow-up visits. No consultation or facility fee is chargeable. The account is to be billed as for fee for service	
H105	Resuscitation fee Resuscitation fee charged only if patient has been resuscitated and intubated in a trauma unit which has been approved by the Board of Healthcare Funders.	7287.56
2.2	Theatre Fees Minor Theatre Fee A facility where simple procedures which require limited instrumentation and drapery, minimum nursing input and local anaesthetic procedures are carried out. No sophisticated monitoring is required but resuscitation equipment must be available. The exact time of admission to and discharge from the minor theatre shall be stated, upon which the minor theatre charge shall be calculated as follows:	
H071	Charge per minute	110.59
2.3	Major Theatre The exact time of admission to and discharge from the theatre shall be stated, upon which the theatre charge shall be calculated as follows:	
H081	Charge per minute	327.26

3.	<p>Prosthesis</p> <p>Prosthesis Pricing:</p> <p>Note: A ceiling price of R1496.93 per prosthesis is included in the theatre tariff. The combined value of all the components including cement in excess of R1496.93 should be charged separately.</p> <p>A prosthesis is a fabricated or artificial substitute for a diseased or missing part of the body, surgically implanted, and shall be deemed to include all components such as pins, rods, screws, plates or similar items, forming an integral part of the device so implanted, and shall be charged as a single unit</p> <p>Reimbursement will be at the lowest available manufacturer's price (inclusive of VAT).</p>
H286	<p>Internal Fixators (surgically implanted)</p> <p>Reimbursement will be at the lowest available manufacturer's price inclusive of VAT.</p> <p>Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers' invoices, each containing the manufacturer's name, should be attached to the account and the components specified on the account should appear on the invoice.</p> <p>External Fixators</p> <p>Reimbursement will be at 33% of the lowest available manufacturer's price inclusive of VAT.</p>
3.1	<p>Medical artificial items (non-prosthesis)</p> <p>Hospitals / unattached operating theatre units shall show the name and reference number of each item. The suppliers' invoices, each containing the manufacturer's name, should be attached to the account and the components specified on the account should appear on the invoice.</p>
H287	<p>Examples of items included hereunder shall be artificial limbs, wheelchairs, crutches and excretion bags. Copies of invoices shall be supplied to the Commissioner. Reimbursement will be at the lowest available manufacturer's price inclusive of VAT.</p> <p>Further Non-Prosthetic Medical Artificial items:</p> <ul style="list-style-type: none"> Sheepskins Abdominal Binders Orthopaedic Braces (ankle, knee, wrist, arm) Anti-Embolism Stockings Futuro Supports Corsets Crutches Clavicle Braces Toilet Seat Raisers Walking Aids Walking Sticks Back Supports Elbow / Hand Cradles
4.	<p>Serious Burns</p>
H289	<p>Billed at normal fee for service. The following items are applicable and must be accompanied by a written motivation from the treating doctor.</p>
H290	<p>Serious Burns: Fee for service (Inclusive of all services e.g. accommodation, theatre, etc.) except medication whilst hospitalised.</p> <p>Serious Burns: Item for medication used during hospitalisation excluding the TTO's.</p> <p>Note: <i>TTO's should be charged according to item H288</i></p>

5.	TTO	
H288	TTO scripts will be reimbursed by the Commissioner for a period of two (2) weeks. A script that covers a period of more than two (2) weeks must have a doctor's motivation attached. Applicable to 49, 55, 57/58, 59 and 79	
	ACUTE (59) AND SUB-ACUTE (49) REHABILITATION (PER DIEM TARIFF)	
1.	General Rules for Rehabilitation Hospitals	
	1. Maximum period for a patient stay at acute rehabilitation ward is 3 months (12 weeks), then to be discharged or referred to Subacute rehabilitation (practice 49)	
	2. All patients transferred from Acute Rehabilitation (practice 59) to Subacute Rehabilitation (practice 49), notification letter is required by the Compensation Fund for proper case management.	
	3. Maximum period for a patient stay at acute rehabilitation ward is 3 months (12 weeks).	
	4. All practice 49 institutions must have a Rehabilitation plan for all patients admitted. This Rehabilitation plan must be submitted to Compensation Fund When requested.	
CODE	DESCRIPTION	RAND
		PRACTICE CODE 59
1.1.	General ward for Rehabilitation Hospitals	
	All patients transferred from, Acute hospital 57/58, Acute Rehabilitation (practice 59) or Subacute Rehabilitation (practice 49), motivation from the treating doctor and approval letter from the Compensation Fund is required for proper case management.	
H010	General Rehabilitation ward (Inclusive fee: ward fee, general rehabilitation management (Physiotherapy, Doctors, Nursing, Occupational Therapy)	6388.22
		PRACTICE CODE
1.2.	General ward for Sub-Acute Rehabilitation Hospitals	49
	Admission to the facility should be motivated for by the treating principal or primary doctor and should be pre authorised.	
	Private sub-acute facilities shall indicate the exact time of admission and discharge on all invoices.	
	a) Ward fees shall be charged at the full daily rate if admission takes place before 11:30 and at the half daily rate if admission takes place after 12:30.	
	b) At discharge, ward fees shall be charged at half the daily rate if the discharge takes place before 11:30 and the full daily rate if the discharge takes place after 12:30.	
	c) Ward fees are inclusive of all pharmaceuticals and equipment that are provided in the accommodation and procedure rooms.	
	This guide caters for services rendered by sub acute facilities only but excludes services by related health care providers like physiotherapy, medical practitioners, occupational therapy, dieticians, speech therapist, clinical psychologist, social workers, etc. Employees of the sub acute facility are not allowed to submit their own individual claim/s.	
H020	Sub-Acute Rehabilitation ward (Daily) Professionals are charged separately i.e. Physiotherapy, Rehabilitation Doctors, Nursing, Occupational Therapy, speech Therapist, Clinical Psychologist, social workers)	3824.04

FRAIL CARE/PALLIATIVE/ HOSPICE(79) (PER DIEM TARIFF)		
General ward for Frail care/Hospice Hospitals General Rules		
1. All patients transferred from, Acute hospital 57/58, Acute Rehabilitation (practice 59) or Subacute Rehabilitation (practice 49), motivation from the treating doctor and approval letter from the Compensation Fund is required for proper case management. It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by the Compensation Fund if the appropriate code is supplied on the invoice.		
CODE	DESCRIPTION	RAND
H950	Frail care/Hospice ward (Daily) (Inclusive fee: ward fee, general care management (Doctors, Nursing staff)	PRACTICE CODE 79 2 109.40
H955	Home health care, per visit	504.10

COMPEASY 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	Member surname	20	Alpha
7	Member initials	4	Alpha
8	Member first name	20	Alpha
9	BHF Practice number	15	Alpha
10	Switch ID	3	Numeric
11	Patient reference number (account number)	10	Alpha
12	Type of service	1	Alpha
13	Service date (CCYYMMDD)	8	Date
14	Quantity / Time in minutes	7	Decimal
15	Service amount	15	Decimal
16	Discount amount	15	Decimal
17	Description	30	Alpha
18	Tariff	10	Alpha
Field	Description	Max length	Data Type
19	Service fee	1	Numeric
20	Modifier 1	5	Alpha
21	Modifier 2	5	Alpha
22	Modifier 3	5	Alpha
23	Modifier 4	5	Alpha
24	Invoice Number	10	Alpha
25	Practice name	40	Alpha
26	Referring doctor's BHF practice number	15	Alpha
27	Medicine code (NAPPI CODE)	15	Alpha
28	Doctor practice number -sReferredTo	30	Numeric
29	Date of birth / ID number	13	Numeric
30	Service Switch transaction number – batch number	20	Alpha

31	Hospital indicator	1	Alpha
32	Authorisation number	21	Alpha
33	Resubmission flag	5	Alpha
34	Diagnostic codes	64	Alpha
35	Treating Doctor BHF practice number	9	Alpha
36	Dosage duration (for medicine)	4	Alpha
37	Tooth numbers		Alpha
38	Gender (M ,F)	1	Alpha
39	HPCSA number	15	Alpha
40	Diagnostic code type	1	Alpha
41	Tariff code type	1	Alpha
42	CPT code / CDT code	8	Numeric
43	Free Text	250	Alpha
44	Place of service	2	Numeric
45	Batch number	10	Numeric
46	Switch Medical scheme identifier	5	Alpha
47	Referring Doctor's HPCSA number	15	Alpha
48	Tracking number	15	Alpha
49	Optometry: Reading additions	12	Alpha
50	Optometry: Lens	34	Alpha
51	Optometry: Density of tint	6	Alpha
52	Discipline code	7	Numeric
53	Employer name	40	Alpha
54	Employee number	15	Alpha

Field	Description	Max length	Data Type
55	Date of Injury (CCYYMMDD)	8	Date
56	IOD reference number	15	Alpha
57	Single Exit Price (Inclusive of VAT)	15	Numeric
58	Dispensing Fee	15	Numeric
59	Service Time	4	Numeric
60			
61			
62			
63			
64	Treatment Date from (CCYYMMDD)	8	Date
65	Treatment Time (HHMM)	4	Numeric
66	Treatment Date to (CCYYMMDD)	8	Date
67	Treatment Time (HHMM)	4	Numeric
68	Surgeon BHF Practice Number	15	Alpha
69	Anaesthetist BHF Practice Number	15	Alpha
70	Assistant BHF Practice Number	15	Alpha
71	Hospital Tariff Type	1	Alpha
72	Per diem (Y/N)	1	Alpha
73	Length of stay	5	Numeric
74	Free text diagnosis	30	Alpha
TRAILER			
1	Trailer Identifier = Z	1	Alpha
2	Total number of transactions in batch	10	Numeric
3	Total amount of detail transactions	15	Decimal

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