DEPARTMENT OF EMPLOYMENT AND LABOUR

NO. R. 4953 **7 June 2024**

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

REGULATIONS ON IRRITANT-INDUCED ASTHMA FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

I, Thembelani Thulas Nxesi, Minister of Employment and Labour, after consultation with the Compensation Board, hereby make the following attached regulations in terms of Section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993) as amended. The proposed regulations are attached as Schedule A.

EFFECTIVE DATE OF REGULATIONS

The regulations will come into effect on the date of publication hereof in the Gazette.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 27/05/2024

SCHEDULE A

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REGULATIONS ON IRRITANT-INDUCED ASTHMA FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

1. DEFINITION OF REGULATION

In these regulations, "the regulations" means the regulations relating to irritant-induced asthma under Compensation for Occupational Injuries and Diseases Act, 1993; and any word or expression to which a meaning has been assigned in the regulations shall have that meaning unless the context otherwise indicates.

TABLE OF CONTENTS:

1. DEFINITIONS

"Bronchodilators" means drugs that cause widening of the bronchi, for example any of those taken by inhalation for the alleviation of asthma.

"Bronchial challenge test" means a lung function test for asthma which is more commonly used in adults than in children. It might be performed if symptoms and

screening spirometry do not clearly or convincingly establish a diagnosis of asthma. During this test, you inhale increasing amounts of methacholine aerosol mist before and after spirometry. The methacholine test is considered positive, meaning asthma is present, if the lung function drops by at least 20%. A bronchodilator is always given at the end of the test to reverse the effects of the methacholine.

"FVC" means forced vital capacity: total volume of air that can be exhaled during a maximal forced effort.

"FEV1/FVC ratio" means the percentage of the FVC expired in one second.

"FEV1" means forced expiratory volume in one second, the volume of air exhaled in the first second under force after a maximal inhalation. Normal values (80%-120%)

"Irritant-induced Asthma" means a disease characterised by variable airflow limitation and/or bronchial hyper responsiveness due to causes and conditions attributable to a particular working environment. This Regulation deals with non-immunological namely Irritant-induced Asthma, resulting from single intense exposure or multiple exposures to known irritant(s) in a previously healthy individual. A claim for Irritant-induced Asthma shall clearly be set out as contemplated in and provided for in section 65 of COIDA

"IgE" means immunoglobulin E (IgE) test which measures the level of IgE, a type of antibody.

"PEFR" means Peak expiratory flow (PEF), also called peak expiratory flow rate (PEFR), and is a person's maximum speed of expiration, as measured with a peak flow meter, a small, hand-held device used to monitor a person's ability to breathe out air.

"Workplace exposure" means exposure or likely exposure to a hazardous substance whilst at work.

2. DIAGNOSIS

(1) Irritant-Induced Asthma shall be made by medical practitioner based on the following:

(a) A lung function tests;
(b) Occupational exposure to a known cause of asthma; and

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(c) A chronological relationship between asthma and the working environment.

Note: If possible, the evidence for the diagnosis of asthma should be documented before commencing treatment.

(d) A characteristic history and physical examinations that suggests asthma.

(2) Physiological evidence of variable airflow limitation. This includes any one or more of the following:

(i) Significant reversibility of FEV_1 post-bronchodilator (>12% and >200ml)
(ii) Excessive variability in twice-daily PEF (>10%) over 2 weeks. Daily PEF variability can be calculated as [(day's highest PEF – day's lowest PEF)/ mean of day's highest and day's lowest PEF]. This variability is summed and averaged over 2 weeks.
(iii) Significant increase in FEV_1 (>12% and >200ml) after 4 weeks of oral steroid anti-inflammatory treatment.
(iv) Positive non-specific bronchial hyperresponsiveness (methacholine or histamine challenge test)

(3) Exclusion of other pulmonary disorders that may explain the symptoms or simulate asthma such as vocal cord dysfunction, hyperventilation syndrome, multiple chemical sensitivity syndrome or COPD.

(4) An occupational exposure preceding the onset of asthmatic symptoms.

(5) An exposure and or physiological evidence of the relationship between asthma and the workplace environment (Diagnosis of Irritant-induced Asthma requires 1 and preferably one or more of 2-5):

(i) Workplace exposure to an irritant agent present as a gas, smoke, fume, vapour or dust. The exposure could be single acute high-level exposure causing acute asthma symptoms within 24 hours, or chronic with low-level exposure causing late onset asthma symptoms.

(ii) Confirmatory diagnosis of irritant-induced asthma can only be determined on lung function tests performed three weeks after removal from exposure.

(iii) An association between symptoms of asthma and work exposure.

(iv) Significant work-related variability (≥20%) in serial PEFR.

(v) Work-related changes in serial testing of non-specific bronchial hyperresponsiveness (e.g. methacholine or histamine challenge test).

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(vi) Positive specific inhalation challenges in the laboratory or workplace challenges.

(7) The Medical officers employed by the Compensation Fund shall determine whether the diagnosis Irritant-induced Asthma was made according to acceptable medical standards.

3. IMPAIRMENT

(1) Assessment of permanent impairment shall be determined one year (but no later than two years) after diagnosis and removal from the exposure or exposure has been reduced, and after maximum medical improvement has been achieved.

(2) The degree of impairment will be evaluated based on lung function tests and the history of medication prescribed to control asthma. Original copies of lung function tests must be submitted to enable the Medical Officers to consider acceptability of the quality of these tests.

(3) A test carried out after the administration of a Bronchodilator must be included.

(4) The impairment class will be determined by the two parameters (post bronchodilator FEV1 and medication requirements), each contributing to the compilation of a class, which determines the permanent disablement of a claimant (whole person impairment).

(5) The evaluation of airflow obstruction will be based on lung function testing in accordance with the Commissioner's Regulation on Irritant-induced asthma.

Table 1: Parameter 1: Postbronchodilator FEV1

Class	FEV1 % Predicted
0	≥80
1	70 – 79
2	60-69
3	50 – 59
4	< 50

* FEV_1 % predicted = measured FEV_1 divided by reference FEV_1 x 100

Table 2: Parameter 2: Minimum Medication Prescribed

CLASS	Medication
0	No medication.
1	Occasional bronchodilator, not daily.

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	OR Occasional or daily short acting bronchodilators + daily low-dose inhaled steroid (≤ 400 micrograms Budesonide or equivalent*).
2	Occasional or daily short acting bronchodilators + daily low dose inhaled steroid (≤400 micrograms Budesonide or equivalent) in addition to any one of the following: – Daily long acting bronchodilator, or – Leukotriene modifier, or – Sustained-release theophylline, or – Occasional (1-3/year) course oral steroid. **OR** Occasional or daily short acting bronchodilators + daily medium dose inhaled steroid (400-800 micrograms of Budesonide or equivalent).
3	Daily short acting bronchodilator +daily medium dose inhaled steroid (400-800 micrograms of Budesonide or equivalent) in addition to any one of the following: – Daily long acting bronchodilator, or – Leukotriene modifiers, or – Sustained-release theophylline, or – Occasional (1-3/year) course oral steroid
4	Daily short acting bronchodilator + daily medium dose inhaled steroid (400-800 micrograms of Budesonide or equivalent) in addition to any one of the following: – Daily long acting muscarinic antagonist (5 micrograms of Tiotropium or equivalent), or – Frequent (>3/year) course oral steroid in addition to any other asthma medication.

* 200 ug Budesonide is equivalent to 250 ug Beclomethasone dipropionate, 100 ug Fluticasone propionate and 80 ug Ciclesonide.

4. COMPENSATION BENEFITS

(1) Payment for temporary disablement shall be made for as long as such disablement continues, but not for a period exceeding 24 months.

(2) Permanent disablement less than or equal to 30%, a lump sum shall be paid terms of the Act and removal from further exposure recommended.

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Note: Determination of permanent disablement shall be done at least three weeks after removal from exposure

5. MEDICAL COSTS

(1) In all accepted cases of Irritant-induced Asthma, medical aid shall be provided for a period of not more than 24 months from the date of diagnosis or longer if further medical costs will reduce the degree of the disablement in the opinion of the Commissioner.
(2) The medical costs shall cover diagnosis of Irritant-induced Asthma and any necessary treatment of asthma provided by any health care provider as well as any costs of chronic medication related to Irritant-induced Asthma treatment.
(3) The Commissioner shall decide on the need for, the nature and sufficiency of medical costs to be supplied.

6. DEATH BENEFITS

Death benefits payable are:

(1) Reasonable burial expenses shall be paid in terms of Burial Expenses Policy; and

(2) Widow's and dependent's pensions shall be payable, where applicable, if the employee dies as a result of irritant-induced asthma.

4. REPORTING

The following documentation should be submitted to the Compensation Fund or the employer individually liable or the licensee concerned:

(a) Employer's Report of an Occupational Disease (W.CL.1)
(b) Notice of an Occupational Disease and Claim for Compensation (W.CL.14)
(c) First Medical Report in respect of an Occupational Disease (W.CL. 22)
(d) For each consultation, a Progress Medical Report (W.CL. 26).
(e) Final Medical Report in respect of an Occupational Disease (W.CL.26) when the employee's condition has reached maximum medical improvement. The most recent lung function tests available, which include pre- and post administration of a bronchodilator, and medication prescribed should be attached to this report.
(f) Exposure History (W.CL. 110) or an appropriate employment history which may include any information that may be helpful to the Commissioner such as Safety Data Sheets, risk assessments or results of environmental hygiene assessments. The suspected workplace agent should be stated if known.
(g) A medical report on the employee's symptom that details the history, establishes a diagnosis of COPD and includes results of lung function tests,

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chest radiographs where appropriate or any other information relevant to the claim.

(h) An affidavit by the employee (W.CL.305) if an employer cannot be traced or the employer fails to timeously submit Employer's report of an Occupational Disease (W.CL.1).

5. CLAIMS PROCESSING

The Commissioner must consider and adjudicate upon the liability of all claims. The Medical Officers employed by the Compensation Fund are responsible for medical assessment of the claim and for the confirmation of the acceptance or rejection of the claim.

MR TW **NXESI, MP**
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 21/05/2024

GOVERNMENT NOTICE

Department of Employment and Labour

No. **2019**

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

REGULATIONS ON WORK AGGRAVATED ASTHMA FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

I, Thembelani Thulas Nxesi, Minister of Employment and Labour, after consultation with the Compensation Board, hereby make the following attached regulations in terms of Section 97 of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993) as amended. The proposed regulations are attached as Schedule A.

EFFECTIVE DATE OF REGULATIONS

The regulations will come into effect on the date of publication hereof in the Gazette.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 27/05/2024

SCHEDULE A

REGULATIONS ON WORK AGGRAVATED ASTHMA FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

1. DEFINITION OF REGULATION

In these regulations, "the regulations" means the regulations relating to work aggravated asthma under Compensation for Occupational Injuries and Diseases Act, 1993; and any word or expression to which a meaning has been assigned in the regulations shall have that meaning unless the context otherwise indicates.

TABLE OF CONTENTS:

1. DEFINITIONS

"Bronchodilators" means drugs that cause widening of the bronchi, for example any of those taken by inhalation for the alleviation of asthma.

"Bronchial challenge test" means a lung function test for asthma which is more commonly used in adults than in children. It might be performed if symptoms and screening spirometry do not clearly or convincingly establish a diagnosis of asthma. During this test, you inhale increasing amounts of methacholine aerosol mist before and

after spirometry. The methacholine test is considered positive, meaning asthma is present, if the lung function drops by at least 20%. A bronchodilator is always given at the end of the test to reverse the effects of the methacholine.

"FEV1" means forced expiratory volume in one second, the volume of air exhaled in the first second under force after a maximal inhalation. Normal values (80%-120%)

"FVC" means forced vital capacity: total volume of air that can be exhaled during a maximal forced effort.
"FEV1/FVC ratio" – The percentage of the FVC expired in one second.

"IgE" means an immunoglobulin E (IgE) test which measures the level of IgE, a type of antibody.

"Methacholine" means an agent that, when inhaled, causes the airways to spasm (contract involuntarily) and narrow if asthma is present.

"PEFR" means the peak expiratory flow (PEF), also called peak expiratory flow rate (PEFR), and is a person's maximum speed of expiration, as measured with a peak flow meter, a small, hand-held device used to monitor a person's ability to breathe out air.

"Skin prick test" means a method for medical diagnosis of allergies that attempts to provoke a small, controlled, allergic response.

"Workplace exposure" means exposure or likely exposure to a hazardous substance whilst at work.

"Work-aggravated Asthma" means a sub-set of work-related Asthma in patients with pre-existing or concurrent Asthma that is worsened, but not caused, by work. The disease is characterised by variable airflow limitation and bronchial hyper responsiveness and/or airway inflammation due to causes and conditions not directly attributable to a particular agent in the working environment.

1. **DIAGNOSIS**

(1) The diagnosis of Work-aggravated Asthma shall be made by medical practitioner based on the following:

(a) Medical history indicating pre-existing Asthma or history of Asthmatic symptoms, prior to the start of employment or exposure to the known aggravating agent.
(b) Presence of work-related exposures preceding and or associated with onset of an Asthmatic attack or the worsening of symptoms.

(c) Presence of work-related factors known to aggravate Asthma symptoms (e.g. cold air, dusty work, chemical or biological irritants, indoor air pollutants, physical strenuous work, second-hand smoke).
(d) Increase in symptoms or medication requirements, or documentation of work-related changes in PEFR or FEV1 after start of employment or occupational exposure.
(e) Presence of reversible airflow obstruction and or non-specific bronchial hyper-responsiveness on pulmonary function testing.

(f) Confirmatory diagnosis of Work aggravated asthma can only be determined on lung function tests performed three weeks after removal from exposure.

(2) The Medical officers employed by the Compensation Fund shall determine whether the diagnosis work aggravated Asthma was made according to acceptable medical standards.

3. IMPAIRMENT

(1) All employees with pre-existing Asthma must have a baseline lung function test before entering workplace that poses a high risk of aggravating asthma. The baseline impairment will be based on lung function tests (FEV1% Predicted) and medication prescribed to control Asthma at the time of employment or before diagnosis of Work-aggravated Asthma.

(2) For purposes of compensation for aggravated asthma assessment of permanent impairment shall be determined one year (but no later than two years) after diagnosis and removal from the exposure or exposure has been reduced, and after maximum medical improvement has been achieved.

(3) The degree of impairment will be evaluated based on lung function tests and the history of medication prescribed to control Asthma.
(4) Original copies of lung function tests performed must be submitted to the Compensation Fund to enable the Medical Officers employed by the Compensation Fund to consider the acceptability of the quality of these tests.
(5) A test carried out after the administration of a bronchodilator must be included.
(6) The impairment class will be determined by the two parameters (post bronchodilator FEV1 and medication requirements), each contributing to the compilation of a class, which determines the permanent disablement of a claimant.

Table 1: Parameter 1: Postbronchodilator FEV1

class	FEV1 % Predicted
0	≥80
1	70 – 79
2	60 – 69
3	50 – 59
4	< 50

Table 2: Parameter 2: Minimum Medication Prescribed

class	Medication
0	No medication.
1	Occasional bronchodilator, not daily. **OR** Occasional or daily short acting bronchodilators + daily low-dose inhaled steroid (≤ 400 micrograms Budesonide or equivalent*).
2	Occasional or daily short acting bronchodilators + daily low dose inhaled steroid (≤400 micrograms Budesonide or equivalent) in addition to any one of the following: – Daily long acting bronchodilator, or – Leukotriene modifier, or – Sustained-release theophylline, or – Occasional (1-3/year) course oral steroid. **OR** Occasional or daily short acting bronchodilators + daily medium dose inhaled steroid (400-800 micrograms of Budesonide or equivalent).
3	Daily short acting bronchodilator +daily medium dose inhaled steroid (400-800 micrograms of Budesonide or equivalent) in addition to any one of the following: – Daily long acting bronchodilator, or – Leukotriene modifiers, or – Sustained-release theophylline, or – Occasional (1-3/year) course oral steroid
4	Daily short acting bronchodilator + daily medium dose inhaled steroid (400-800 micrograms of Budesonide or equivalent) in addition to any
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	one of the following: – Daily long acting muscarinic antagonist (5 micrograms of Tiotropium or equivalent) , or - Frequent (>3/year) course oral steroid in addition to any other Asthma medication.

4. COMPENSATION BENEFITS

The compensation benefits payable according to the Act are:

(1) Payment for temporary total or partial disablement shall be made for as long as such disablement continues, but not for a period exceeding 24 months.

(2) If the employee permanent disablement is assessed at 30%, or less the employee shall be entitled to a lump sum.
(3) If the employee permanent disablement is assessed at higher than 30%, the employee shall be entitled to a monthly pension.
(4) The actual impairment will be determined by subtracting the current impairment from the pre-existing baseline.
(5) If no impairment baseline class is available, it will be assumed that impairment total class was (0) at the time of the diagnosis of work-aggravated Asthma.
(6) Assessment of permanent disablement shall be made when Final Medical Report and lung function test done have been received.

5. MEDICAL COSTS

(1) Medical aid shall be provided Work-aggravated Asthma for a period of not more than 24 months from the date of diagnosis or longer if, in the opinion of the Commissioner, further medical aid will reduce the degree of the disablement.
(2) The medical aid shall cover the costs of the diagnosis of Work-aggravated Asthma and any necessary treatment of Work-aggravated Asthma provided by any health care provider until the condition stabilises.
(3) The Commissioner shall decide on the need for, the nature and sufficiency of medical costs to be supplied.

6. DEATH BENEFITS

Death benefits payable are:

(a) Reasonable burial expenses shall be paid in terms of Burial Expenses Policy; and

(b) Widow's and dependent's pensions shall be payable, where applicable, if the employee dies as a result of work aggravated asthma.

7. REPORTING

An employer must determine baseline impairment score of all employees with pre-existing asthma when entering a workplace that poses a high risk of aggravating asthma.

The following documentation must be submitted to the Compensation Fund or the employer individually liable or the licensee concerned:

(a) Employer's Report of an Occupational Disease (W.CL.1)
(b) Notice of an Occupational Disease and Claim for Compensation (W.CL.14)
(c) First Medical Report in respect of an Occupational Disease (W.CL. 22)
(d) Pre-employment baseline lung function tests
(e) Lung function on the date of reporting of the incident with the current employer
(f) Lung function test performed three weeks after removal from exposure to confirm diagnosis of Work aggravated asthma.
(g) For each consultation, a Progress Medical Report (W.CL. 26).
(h) Final Medical Report in respect of an Occupational Disease (W.CL.26) when the employee's condition has reached maximum medical improvement. The most recent lung function tests available, which include pre- and post administration of a bronchodilator, and medication prescribed should be attached to this report.
(i) Exposure History (W.CL. 110) or an appropriate employment history which may include any information that may be helpful to the Commissioner such as Material Safety Data Sheets, risk assessments or results of environmental hygiene assessments. The suspected aggravating agent should be stated if known.
(j) A medical report on the employee's symptoms that detail the history, establishes a diagnosis of Asthma and includes results of lung function tests, immunological tests, chest radiographs where appropriate or any other information relevant to the claim.

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(k) An affidavit by the employee (W.CL.305) if an employer cannot be traced or the employer fails to timeously submit Employer's report of an Occupational Disease (W.CL.1).

8. CLAIMS PROCESSING

The Commissioner shall consider and adjudicate upon the liability of all claims. The Medical Officers employed by the Compensation Fund are responsible for medical assessment of the claim and for the confirmation of the acceptance or rejection of the claim.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 27/05/2024

GOVERNMENT NOTICE

DEPARTMENT OF EMPLOYMENT AND LABOUR

No. R. **2023**

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

REGULATIONS ON POST-TRAUMATIC STRESS DISORDER FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

I, Thembelani Waltermade Nxesi, Minister of Employment and Labour, after consultation with the Compensation Board, hereby make the following attached regulations for public comment in terms of Section 97 of Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993) as amended. The proposed regulations are attached as Schedule A.

EFFECTIVE DATE OF REGULATIONS

The regulations will come into effect on the date of publication hereof in the Gazette.

MR TW **NXESI, MP**
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 27/05/2024

SCHEDULE A

REGULATIONS ON POST-TRAUMATIC STRESS DISORDER FOR THE COMPENSATION FUND MADE BY THE MINISTER UNDER COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 1993

1. DEFINITION OF REGULATION

In these regulations, "the regulations" means the regulations relating to Post-Traumatic Stress Disorder under Compensation for Occupational Injuries and Diseases Act, 1993; and any word or expression to which a meaning has been assigned in the regulations shall have that meaning unless the context otherwise indicates.

2. PURPOSE OF REGULATIONS

These *Regulations on Post-Traumatic Stress Disorder* seek to clarify the Fund's position on integrated management of employees diagnosed with PTSD within the broader mandate of the Fund. It is developed to regulate and monitor service provision rendered to the Fund's beneficiaries as provided by various stakeholders and medical service providers within the primary and secondary care spheres. It is to be used by all providers as a guiding document when dealing with PTSD in COID beneficiaries from a case management perspective, as well as a tool to guide those who are charged with developing and implementing programmes and policies which seek to promote, prevent and manage occupational hazards, to comply with relevant prescribed legislation. The regulations have taken into account Schedule 2 of the Act to the extent that is not inconsistent with the said Schedule.

TABLE OF CONTENTS:

1. DEFINITIONS

"Causality"	means an association between a given cause and an effect. Causality requires that each of the following criteria is met to a reasonable degree of medical probability: (a) A causal event took place; (b) The person who experienced the event has the condition (injury, impairment or disease); (c)The event could cause the condition; and (d) The event caused or materially contributed to the condition within medical probability.
"Chronology"	means the medico-legal phenomenon that requires that the series of events leading to the event, incident, injury or occupational disease must have a chronological sequence that justifies the link to the cause. In essence, the cause must precede the effect.
"Clinician Administered PTSD Scale (CAPS)"	means a semi-structured interview that is designed to assess the essential features of *Acute Stress Disorder and Post-traumatic Stress Disorder* as defined in the DSM-IV and DSM-V and as edited or revised from time to time. [(American Psychiatric Association, 1994). In addition, the CAPS can also be used to assess the essential features of *Acute Stress Disorder* as currently defined by DSM-IV]. The interview is designed to accommodate different time spans post-trauma as the referent point for diagnosis. Specifically, the CAPS

	affords the clinician flexibility to inquire about symptoms and diagnostic status over the past week, most recent month, and or for lifetime diagnosis.
"Evidence-based Medicine (EBM)"	means the conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients. EBM integrates clinical experience and patient values with the best available research information. It is a movement which aims to increase the use of high quality clinical research in clinical decision-making.
"Independent Medical Examination (IME)"	means an examination for legal, insurance or financial reasons completed by a non-treating physician, who will not be involved in any further treatment or care of the beneficiary beyond the examination. In communicating the reason for an IME being required, the Compensation Fund will ensure that specific reason(s) is(are) clearly discussed with both the beneficiary and their treating physician.
"Managed Healthcare"	means the clinical and financial risk assessment and management of healthcare with a view to facilitating appropriateness and cost-effectiveness of relevant health services within constraints of what is affordable through use of rule-based & clinical management based programmes.
"Man-Job Specifications Traumatic Incident"	means any event that has significant emotional power to overwhelm usual coping methods. It involves any situation or event faced by emergency or public safety personnel that causes a distressing, dramatic or profound change or disruption in their physical and or psychological functioning.
"Maximum Medical Improvement (MMI)"	means a status where patients are as good as they are going to be from the medical and surgical treatment available to them. MMI is reached on a date from which further recovery or deterioration is

	not anticipated, although over time there may be some expected changes.
"Medical Probability"	means the link between the cause and effect which must satisfy the requirements for medical probability, which stipulates that the likelihood that an association between a cause and an effect be greater than 95% for the relationship to be considered probable. Anything below that is medically just "possible".
"Occupational Risk Exposure Profile (OREP)"	means the report that profiles all the hazards that the employee is exposed to, which are inherent to his or her occupation. These hazards are linked to the inherent requirements of the job and the inherent tasks and duties of the job. They include all exposures to physical, chemical, biological, psychological and ergonomic hazards.
"Permanency"	means the condition whereby an impairment or disablement becomes static or well stabilised with or without medical treatment and is not likely to remit in the future despite medical treatment, within medical probability.
"Post-Traumatic Stress Disorder(PTSD)"	means a mental disorder that represents a pathological response to a traumatic event, characterised by symptoms of recurrent and intrusive distressing recollections of the event (e.g. nightmares, a sense of reliving the experience with illusions, hallucinations, or dissociative flashback episodes, intense psychological or physiological distress at exposure to cues that resemble the traumatic event); avoidance of stimuli associated with the trauma (e.g. inability to recall important aspects of the trauma, loss of interest, estrangement from others); and increased arousal (sleep disturbances, irritability, difficulty in concentrating, hypervigilance, and exaggerated startle response). The DSM–V Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion,

avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. It follows exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios in which the employee:

(a) directly experiences, witnesses the traumatic event in person, or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others;

(b) learns that a violent or accidental, traumatic event occurred to a close family member or close friend;

(c) experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related) and the condition causes significant distress or impairment in the employee's social, occupational, or other important areas of functioning; and

(d) the person's response involves intense fear, helplessness, or horror.

"Traumatic Event" means an event that is generally outside the range of usual human experience and would evoke significant symptoms of distress in the majority of people exposed. It is an intensely stressful event during which a person suffers serious harm or the threat of serious harm or death, or witnesses an event during which another person (or persons) is killed, seriously injured, or threatened.

2. DIAGNOSIS OF PTSD

(1) Clinical diagnosis of medical conditions, including PTSD, must be based on approved evidence-based medical guidelines as guided by the medical scientific community as updated from time to time. The ICD-10 diagnosis of PTSD requires that the patient, firstly, have been exposed to a traumatic event, and secondly, suffers from distressing re-experiencing symptoms. For the purpose of this regulations, the diagnosis of PTSD must be made in accordance with the latest applicable version of the Diagnostic & Statistical Manual of Mental Disorders (DSM) for PTSD.

(2) Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The Criterion F concerns duration of symptoms; Criterion G assesses functioning; and, Criterion H clarifies symptoms as not attributable to a substance or co-occurring medical condition.

(3) All suspected Post-Traumatic Stress Disorder cases must be referred to a psychiatrist for assessment and confirmation of diagnosis within three (3) months from the date of the provisional diagnosis or date of accident or traumatic incident. The Medical Officers in the Compensation Fund will determine if the diagnosis was made according to acceptable medical standards.

3. The DSM-V Diagnostic Criteria

(1) The DSM-V Diagnostic Criteria are stipulated below and must be used and met in all cases of suspected PTSD. Full criteria for a diagnosis cannot be met until at least six (6) months after the trauma(s), although onset of symptoms may occur immediately.

Note: The latest edition of the DSM must always be used.

Criterion A: Stressor

A person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, one or more of the following:

(a) Direct exposure;

(b) Witnessing, in person;

(c) Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental;

(d) Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g. first responders, collecting body parts; professionals repeatedly exposed to details of child abuse); and

(e) This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.

Criterion B: Intrusion symptoms

The traumatic event is persistently re-experienced in one or more of the following way(s):

(a) Recurrent, involuntary, and intrusive memories;

(b) Traumatic nightmares;

(c) Dissociative reactions (e.g. flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness;

(d) Intense or prolonged distress after exposure to traumatic reminders; and

(e) Marked physiological reactivity after exposure to trauma-related stimuli.

Criterion C: Avoidance

Persistent effortful avoidance of distressing trauma-related stimuli after the event in one or more of the following:

(a) Trauma-related thoughts or feelings.;

(b) Trauma-related external reminders (e.g. people, places, conversations, activities, objects, or situations);

Criterion D: Negative alterations in cognitions and mood

(a) Negative alterations in cognitions and mood that began or worsened after the traumatic event in two or more of the following:

(i) Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs);

(ii) Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g. "I am bad," "The world is completely dangerous.");

(iii) Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences;

(iv) Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt or shame);

(v) Markedly diminished interest in (pre-traumatic) significant activities;

(vi) Feeling alienated from others (e.g. detachment or estrangement); and

(vii) Constricted affect: persistent inability to experience positive emotions.

Criterion E: Alterations in arousal and reactivity

Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event in two or more of the following:

(a) Irritable or aggressive behaviour;

(b) Self-destructive or reckless behaviour;

(c) Hypervigilance;

(d) Exaggerated startle response;

(e) Problems in concentration; and

(f) Sleep disturbance.

Criterion F: Duration

Persistence of symptoms (in Criteria B, C, D and E) for more than one (1) month.

Criterion G: Functional significance

Significant symptom-related distress or functional impairment (e.g. social, occupational).

Criterion H: Attribution

(a) Disturbance is not due to medication, substance use, or other illness (organic causes).
(b) It must be specified if it is associated with dissociative symptoms.

Additional Considerations

In addition to meeting criteria for diagnosis, individuals may experience high levels of either of the following in reaction to trauma-related stimuli:

a) Depersonalization: experience of being an outside observer of or detached from oneself (e.g. feeling as if "this is not happening to me" or one were in a dream); and
b) Derealisation: experience of unreality, distance, or distortion (e.g., "things are not real").

4. PTSD AS AN OCCUPATIONAL DISEASE

(1) An occupational disease is defined as any disease arising out of and in the course of an employee's employment. A disease would have arisen out of and in the course of employment if it has a broad causal connection to employment and that the employee must have contracted the disease while performing duties that he or she is contractually obliged to perform.

(2) Compensable Post-Traumatic Stress Disorder is regarded as the result of an occupational injury or an occupational disease depending on individual circumstances, in terms of the Compensation for Occupational Injuries and Diseases Act, No.130 of 1993, as amended (COIDA). Therefore, the traumatic event(s) leading to the diagnosis of PTSD must be an accident or a series of accidents as defined in section 1 of the Compensation for Occupational Injuries and Diseases Act, No. 130 of 1993, as amended (COIDA).

(3) A claim for Post-Traumatic Stress Disorder shall not be eligible for benefits under the Act unless:

(a) The employee was exposed to traumatic event(s) arising out of and in the course of employment;

(b) The employment-related trauma was a pertinent factor in the development of the PTSD or played an active role during the development of PTSD; and

(c) Notice of the claim for compensation was made to the employer or the Compensation Commissioner or the employer individually liable or the licensee concerned within one (1) year from date of diagnosis of occupational disease (PTSD).

(4) When delayed-onset PTSD is diagnosed, the claim will be considered if notice of the claim for compensation was made to the employer or Compensation Commissioner within one (1) year of the date of diagnosis.

5. OCCUPATIONS AT RISK OF PTSD

Whether or not people develop PTSD depends on their subjective perception of the traumatic event as well as on the objective facts. Furthermore, those at risk of PTSD include not only those who are directly affected by a horrific event, but also witnesses, perpetrators and those who help PTSD sufferers (vicarious traumatisation). People at risk of PTSD include but not limited to:

(a) Victims of violent crime (e.g. physical and sexual assaults, sexual abuse, bombings, riots etc.);

(b) Members of the armed forces, police services, journalists and prison service, fire service, ambulance and emergency personnel, health care personnel, including those no longer in service;

(c) Victims of war, torture, state-sanctioned violence or terrorism, and refugees;

(d) Survivors of accidents and disasters; and

(e) Women following traumatic childbirth; and individuals diagnosed with a life-threatening illness.

6. EVOLUTIONARY STAGES OF PTSD

Acute Stress Disorder (ASD)

In the first month after trauma, trauma survivors may be diagnosed as having Acute Stress Disorder according to DSM–V, which is characterised by symptoms of PTSD and dissociative symptoms such as depersonalisation, derealisation and emotional numbing. The duration which specifies the disturbance must last at least two days but not more than four weeks, and must occur within four weeks of the traumatic event. The symptoms must resolve within four weeks after the traumatic event, otherwise the diagnosis must be reconsidered.

Acute PTSD

This type of PTSD is characterised by classic symptoms that appear in the first month after the traumatic event, but last for less than three (3) months in duration.

Classic PTSD

Classically, PTSD tends to develop insidiously over a period of three (3) to six (6) months after the initial traumatic event.

Delayed-onset PTSD

(1) The symptoms of Delayed-onset PTSD must surface at least six (6) months or more after the traumatic event(s).

(2) A proper medical and occupational history must be taken to ensure that diagnosis is objectively made. The assessment and treatment of late-onset PTSD must therefore follow the same protocols as the early-onset type.

Persistent or Chronic PTSD

For the condition of PTSD to be regarded as permanent the employee must have received

appropriate treatment for a period of 24 months or an extended period of time as a treating doctor may determine.

7. DIFFERENTIAL DIAGNOSS

(1) The Fund may provide treatment for the aggravation of pre-existing Post-Traumatic Stress Disorder if it is proved that the aggravation is attributable to the employee's work environment.

(2) The medical service provider must ensure that all other potential differential diagnoses or pre-existing disorders are excluded before expressing opinion on PTSD and the work-relatedness of such a condition. The following differential disorders must be excluded before an occupational PTSD can be diagnosed:

(a) Depression (predominance of low mood, lack of energy, loss of interest, suicidal ideation);

(b) Specific phobias (fear and avoidance restricted to certain situations);

(c) Adjustment disorders (less severe stressor, different pattern of symptom);

(d) Enduring personality changes after catastrophic experience (prolonged extreme stressor, different pattern of symptoms);

(e) Dissociative disorders;

(f) Neurological damage due to injuries sustained during the event; and

(g) Psychosis (hallucinations, delusions).

(3) If the report does not indicate or disclose the existence of a relevant pre-existing disorder or a significant comorbid condition, if any, the Compensation Commissoner may not accept such report.

8. MANAGEMENT OF PTSD

Treatment interventions must be evidence-based, scientifically valid and consistent with professional standards.

Early Interventions and Watchful Waiting

(1) The Fund will authorise treatment for acute reaction to traumatic events (Acute Stress Disorder) arising out of and in the course of work.

(2) A follow-up consultation should be arranged within one (1) month of diagnosis of acute stress. A comprehensive report which includes prognostic details must be provided to the Fund after this consultation. A final consultation must be scheduled within two (2) months for the purpose of final medical report.

(3) The treatment and management of Acute Stress Disorder must be finalised within three (3) months of diagnosis and a final medical report must be provided at the end of this period.

(4) All cases of suspected PTSD must have a definitive diagnosis made within the first six (6) months from date of first consultation.

(5) A medical practitioner who diagnoses an occupational PTSD must furnish the Compensation Commissioner or employer with a medical report indicating such diagnosis within three months and thereafter submit further medical reports at intervals set out in the Disease Monitoring and Reporting Table below.

(6) For Acute PTSD the Fund will extend the treatment to six (6) months provided there is justifiable proof of need.

(7) Individuals who at the end of six months do not meet the full criteria for the diagnosis of PTSD must have a differential diagnosis made and a Final Medical Report duly completed and sent to the Fund to finalise the claim.

Immediate Psychological Interventions for PTSD

(1) The treating general practitioner and treating psychiatrist must ensure that employees needing psychological support are identified early and are timeously referred to psychologist for assistance.

(2) The initial consultation with the psychologist will be automatically covered by the Fund, and the psychologist's treatment plan will then be pre-authorised based on a detailed assessment report prior to therapy being provided.

(3) The psychologist and medical practitioner must submit progress medical report to the Fund at the end of the authorised period.

Drug Treatment

(1) Healthcare practitioners must ensure that the treatment provided to patients is included in the list of recommended drugs for PTSD as recommended by the South African Society of Psychiatrists (SASOP) and the South African Society of Psychologists.

(2) PTSD sufferers must be given sufficient information about the nature of these treatments to make an informed choice. Patient preference should be an important determinant of the choice among effective treatments:

(a) Drug treatments for PTSD and change of treatment will only be authorised when prescribed by the treating psychiatrist;
(b) Adjunctive treatment will be approved where there is significant comorbid condition, depression or hyperarousal that significantly impacts on the patient's ability to benefit from the recommended treatment;
(c) This short-term treatment may be initiated by the general practitioner after thoroughly considering all drug interaction implications and where the benefit outweighs the risk;
(d) Subsequent drug modifications should be discussed with the relevant specialist in conjunction with the psychiatrist;
(e) A proof of compliance is required to support a claim of non-response to recommended lines of treatment where clinicians may recommend an item which is off code;
(f) When an employee treated for PTSD has not responded to a drug treatment regime, and the treating psychiatrist considers adding further drugs after the maximum allowable dosages have been reached on the initial recommended drug(s), or the recommended lines of treatments have been exhausted, the Fund may at its own discretion, subject such further treatment plan to a peer review mechanism or refer an employee for further medical examination in terms of section 42;
(g) When an adult sufferer with PTSD has responded to drug treatment, it should be continued for at least 12 – 24 months before gradual withdrawal as recommended by SASOP;

(h) The treating doctor (preferably the general practitioner) must monitor treatment on a monthly basis for the first six (6) months and provide monthly Progress Medical Reports to the Fund in the prescribed manner;

(i) After this period appropriate monitoring must then be done on a lesser frequent basis not exceeding three monthly, where practicable. Six monthly reports from the psychiatrist must be submitted during this period and when maximum medical improvement has been achieved, a Final Medical Report from the treating psychiatrist must be provided;

(j) All PTSD patients requiring treatment beyond twenty-four (24) months will be treated as chronic PTSD by the Fund. The Fund may at its own discretion, and after due processes, consider enrolling any particular employee with PTSD on its chronic treatment programme; and

(k) A Final Medical Report from the psychiatrist indicating the need for continuing treatment on a lifetime basis must be provided to the Fund at the end of twenty-four (24) months.

(3) A detailed follow-up plan with appropriate motivation must also be provided at this point by the psychiatrist.

9. GENERAL RECOMMENDATIONS REGARDING DRUG TREATMENT:

(1) All PTSD sufferers who are prescribed antidepressants or any psychotropic medication should be informed at the time that treatment is initiated, of potential side-effects and discontinuation or withdrawal symptoms as appropriate.

(2) For employees who are back at work, these must be communicated to the employer in the prescribed manner taking into account legal and ethical considerations governing the disclosure of confidential medical information.

(3) Where necessary and medically justifiable, employees doing shift work and safety-critical jobs must be accommodated in alternative placements while on such medications.

(4) For the purpose of subregulation 9.3, the services of an occupational therapist will be required.

10. DEALING WITH COMORBIDITIES IN PTSD

(1) In cases of high co-morbidity of PTSD with generalized physical and mental health problems, the multidisciplinary and interdisciplinary approach must be used.

(2) The treatment plan must be outlined and be in accordance with national credentialing policies and guidelines.

(3) The treating doctor must identify the comorbidities and the multidisciplinary and interdisciplinary teams and apply for authorisation of such treatment.

(4) Healthcare practitioners must clearly document their rationale for opting for such treatment, satisfy themselves that the potential benefits outweigh the known risks and that an informed consent has been duly obtained.

(5) Where beneficiaries are on other chronic medications the Fund will only approve treatment for such chronic conditions during the acute phase and only where the dosage and form of such treatment is different from the usual treatment and where non-treatment of such has a negative impact on the treatment outcome of the PTSD.

11. CASE MANAGEMENT OF PTSD

PTSD case must be managed in accordance with the table below:

Disease Monitoring and Reporting:

Type of Disorder (Evolutionary Stage)	Onset of Symptoms (Months)	Duration of Symptoms (Months)	Frequency of Medical Reports		Timing of Final Medical Report (Months)			
			GP	Psychiatrist	3	6	12	24
Acute Stress Disorder	Immediate	< 3 months	Fortnightly	1 & 3 months				
Acute PTSD	1 – 3 months	1 – 6 months	Monthly	3 and 6				
Classic PTSD	1 – 6 months	6 – 24 months	Monthly	1, then 6 monthly				
Delayed-Onset PTSD	>6 months	6 – 24 months	Monthly	1, then 6 monthly				

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Chronic PTSD	1- 6 months	>24 months	Three monthly	1, then 6 monthly				

12. THE RESPONSIBILITIES OF THE TREATING PSYCHIATRISTS

The responsibilities of the psychiatrists to whom the employee has been referred by the medical practitioner are:

(a) To thoroughly assess the employee as referred to him or her in the prescribed manner and make appropriate diagnosis based on the approved evidence-based medical guidelines as guided by the medical scientific community and updated from time to time. The assessment of PTSD sufferers should be conducted by competent medical practitioners and be comprehensive, including physical, psychological and social needs and a risk assessment;

(b) To device a structured treatment and patient management plan taking into account all relevant personal, social, workplace and environmental circumstances, including the monitoring plan. This plan must include clear roles of key personnel and have measurable and realistic targets;

(c) To institute appropriate treatment taking into account relevant legislation governing the prescription and administration of medicines and related substances. Patient preference should be an important determinant of the choice among effective treatments. PTSD sufferers should be given sufficient information about the nature of these treatments to make an informed choice;

(d) To provide relevant reports on the progress and prognosis of the employee and motivate for the need for continuing treatment, change of treatment or addition of further treatment modalities as appropriate. This will include the motivation for the employee to be consulted by other specialists and for further objective clinical testing; and

(e) To provide expert evidence in medico-legal platforms including during tribunal and court proceedings concerning disputes related to the diagnosis, treatment and management of PTSD.

13. THE RESPONSIBILITIES OF THE PSYCHOLOGISTS

The responsibilities of the psychologists to whom the employee has been referred by the medical practitioner are to:

(a) Thoroughly assess and determine the psychological needs of the patient and devise a structured management plan after appropriate referral from the treating doctor;

(b) Identify the need for social support and advocate the meeting of this need;

(c) Institute appropriate evidence-based treatments and therapies as guided by the medical scientific community and updated from time to time, after approval is obtained from the Fund;

(d) Collaborate with both the general practitioner and the treating psychiatrist to ensure that there is alignment and coordination of care and monitoring of the patient;

(e) Identify the need for appropriate information about the range of emotional responses that may develop and provide practical advice on how to access appropriate services for these problems;

(f) Offer help or advice to the patient or relevant others on how continuing threats related to the traumatic event may be alleviated or removed;

(g) Provide reports to the Fund and treating doctors; and

(h) Provide expert evidence in medico-legal platforms including during tribunal and court proceedings concerning disputes related to the diagnosis, treatment and management of PTSD.

14. THE ROLE OF THE INDEPENDENT MEDICAL EXAMINER

(1) The Independent Medical Examiner must conduct an examination which consists of a review of medical documentation (records), confirmation of relevant medical history and an in-person examination and assessments or objective tests if appropriate.

(2) For the purpose of these regulations, the Fund may refer an employee to any Independent Medical Examiner including but not limited to a Psychiatrist, Occupational Therapist and or a Clinical Psychologist with experience in treating and managing patients with PTSD.

(3) The Independent Medical Examiner is required to use the Clinician Administered PTSD Scale for DSM-V (CAPS 5) to aid him or her in making an objective assessment of the presence and or absence of PTSD, as well as to grade the severity of symptoms thereof if he or she concurs with the diagnosis.

Note: The latest edition of the DSM must always be used.

(4) The scoring of CAPS is given below:

Table 14-10: CAPS - 5 Scoring

CAPS – 5 PTSD Severity	Score
Asymptomatic/ Few Symptoms	0 - 10
Mild PTSD/ Subthreshold	11 - 22
Moderate PTSD / Threshold	23 - 34
Severe PTSD Symptomatology	35 - 46
Extreme PTSD Symptomatology	≥ 47

(5) An employee who claims compensation shall, if and when so required and at the discretion of the Fund, after reasonable notice, submit himself at the time and place mentioned in the notice to an examination by a designated Independent Medical Examiner in accordance with Section 42 of the Act.

(6) The Independent Medical Examiner will have the following roles:

(a) Assess and examine the employee with the diagnosis of PTSD and determine if the diagnosis was appropriately made based on chronology, causality, medical probability, evidence-based medicine and current best practice;

(b) Determine the current appropriate diagnosis if it differs from the treating doctor's, and establish causation of disease or mechanism thereof if appropriate, severity of symptoms, restrictions and limitations;

(c) Assess the appropriateness of treatment proposed or provided based on current best practice and recommended protocols and guidelines for people with PTSD.

(d) Provide treatment recommendations and objective medical findings regarding the person's ability to return to work, and identify any relevant safety considerations.

(e) Formulate opinion and prognosis based on factual findings from the assessment and using current best practice and recommended protocols.

(f) Provide a duly formulated report with recommendation(s) to the Fund on the best course of action.

(g) Provide expert evidence in medico-legal platforms including during tribunal and court proceedings concerning disputes related to the diagnosis, treatment and management of PTSD.

15. PATIENT ASSESSMENT GUIDELINES

(1) For the purpose of:

(a) assessing an employee for diagnoses the medical practiotioners must use the latest edition of DSM;

(b) assessing the need an and extent of treatment medical pratitioners must use the latest edition The Management of PTSD in adults and children in primary and secondary care – 2005 and Treatment Guidelines for Psychiatric Disorders – Volume 19 (3) of 2013;

(c) assessing impairment and disablement for PTSD the Fund will use the latest edition of the "Guides to the Evaluation of Permanent Impairment by the American Medical Association (AMA).

(d) All healthcare professionals must use the material above in the diagnosis, treatment,management and assessment of impairment and disablement of employees suffering from occupational PTSD; and

Two-scales are used by which-impairment due to Post-Traumatic Stress Disorder is rated. Each scale should be measured and the impairment score calculated. The final impairment will be the median (middle) value of the 2 scores.

16. IMPAIRMENT

(1) The calculation of impairment at the time of diagnosis will solely be for the determination of the severity of the disease, the modality and extent of treatment required, and for providing tentative prognostic opinion.

(2) The Fund will use such rating to monitor the impact of treatment and to evaluate the effectiveness thereof in collaboration with medical service providers.

(3) The final impairment calculation will only be determined after the employee has reached Maximum Medical Improvement (MMI).

(4) The Compensation Fund's adjudicating medical panel will determine if MMI has been reached

based on the strength of the available medical reports by the treating psychiatrist and or other independent medical reports.

(5) The Final Medical Report will be required once the panel has adjudicated and concluded that the claimant has reached MMI, for purposes of deciding on impairment.

(6) The Final Medical Report must be based on scientifically-validated healing timeframes as determined by the medical scientific community as updated from time to time. Clinicians shall provide a Final Medical Report when so required by the Fund without any prejudice.

(7) The impairment will be evaluated by the Fund using the latest edition "Guides to the Evaluation of Permanent Impairment" compiled by the American Medical Association (AMA).

(8) Medical service providers must refrain from giving unsolicited opinion on impairment rating or permanent disablement (PD).

(9) The Fund carries the sole responsibility for determining impairment level and permanent disablement due to PTSD.

17. COMPENSATION BENEFITS

The guidelines for benefits payable in terms of the Act are as follows:

(1) Payment for temporary total or partial disablement shall be made for as long as such disablement continues, but not for a period exceeding 24 months from the date of the accident or date of diagnosis. Monthly progress reports must be submitted to the office of the Compensation Commissioner.

(2) This occurs when an employee's condition is such that he or she cannot perform his or her usual duties but is still capable of working at some job during the period of recovery. Employers and medical service providers must collaborate to institute accommodation of the employee in modified duties as a critical element of the treatment plan and return-to-work strategy for such employees. The Compensation Fund must be satisfied that all measures

have been reasonably considered before declaring an employee totally unfit to work on a temporary basis.

(3) Temporary Total Disablement occurs when an employee is totally unable to perform any duty, previous or modified, and is expected to recover with treatment within a foreseeable period. Service providers advising employers on the employee's extent of unfitness and the length of time required for full recovery must take into cognizant that work itself is also curative in nature, so as to guard against inadvertently disadvantaging employees with PTSD.

(4) Periodic payments shall be made for as long as the temporary total disablement is deemed reasonable and shall continue for as long as evidence of continuing disablement is provided. This may not exceed twenty-four (24) months. The Fund may however at any point during this period and at its own discretion declare any such employee permanently impaired. Where such a decision is made by the Fund, the medical service providers providing treatment and other services to the employee will then be required to furnish the Final Medical Report(s) as at that point in time.

(5) Payment of permanent disablement shall be made, where applicable, when a Final Medical Report and or the report from the adjudication panel is received. The Final Medical Report must be submitted when an employee reaches the stage of MMI, whether or not he or she is on treatment. The Fund shall at its own discretion and where deemed necessary solicit such a report which shall be provided without reservation or prejudice.

(6) If total impairment score is zero to three (i.e. permanent disablement less than or equal to 30%), permanent disablement shall be determined and a lump sum shall be paid in terms of the Act.

(7) If total impairment score is more than three (i.e. permanent disablement is higher than 30%), pension shall be paid in terms of the Act.

18. MEDICAL COSTS

(1) Medical costs shall be provided for a period of not more than 24 months from the date of accident, or further 12 months , if in the opinion of the Director-General, further medical costs will reduce

the extent of the disablement that an employee suffers from.

(2) Medical costs covers diagnosis of PTSD by a psychiatrist and any necessary treatment provided by any general practitioner or approved mental health provider, as well as hospitalization and chronic medication when motivated for by the psychiatrist.

(3) The Compensation Commissioner must decide on the need for, the nature and sufficiency of medical costs be provided, inclusive of chronic medication, if applicable.

(4) No treatment shall be automatically accepted by the Fund without prior authorization, except in emergencies. In such cases, service providers must notify the Fund in the prescribed manner within seventy-two (72) hours of such emergency treatment to effect appropriate authorization.

(5) All elective admissions and investigations will require pre-authorisation by the Fund.

19. REPORTING

Any consultation in respect of treatment for PTSD must be reported to the Fund in the prescribed manner as and when it happens. No payments in lieu of any consultation or treatment shall be provided by the Fund without medical reports from practitioners. The following documentation must be submitted to the Compensation Commissioner or the employer individually liable or the licensee concerned:

(a) (W.Cl.2) Employer's Report of an Accident / Occupational Disease

(b) (W.Cl.3) Notice of Accident and Claim for Compensation

(c) An affidavit by the employee (W.CL.305) If an employer cannot be traced or the employer fails to timeously submit Employer's report of an Occupational Disease (W.CL.1)

(d) (W.Cl.4) First Medical Report in respect of an Accident / Occupational Disease / (W.Cl.303) First Psychiatric Report

(e) (W.Cl.5)(P) Progress Medical Reports in respect of an Accident / Occupational Disease / Progress Psychiatric Reports

(f) (W.Cl.5)(F) Final Medical Report in respect of an Accident / Occupational Disease / Final Psychiatric Report

(g) (W.Cl.6) Resumption Report

(h) Detailed psychiatric and or psychological reports within the scope of practice of the therapist and or an occupational therapy report in the prescribed format

(i) Any other relevant reports pertaining to the accident, diagnosis and treatment, where applicable and at the discretion of the CF.

MR TW NXESI, MP
MINISTER OF EMPLOYMENT AND LABOUR
DATE: 27/05/2024