The Council for Medical Schemes

Accreditation Standards for Third Party Administrators of Medical Schemes

Standards and Measurement Criteria

Version 7

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Contents

SECTION 1: INTRODUCTION 2

1. Executive summary 2

2. Accreditation standards formulation methodology and supporting principles 2

2.1 Introduction 2

2.2 Compliance rating 3

2.3 Applying for accreditation 3

SECTION 2: STANDARDS DOCUMENT 5

1. General compliance 5

2. Operational structure 6

3. Member record management 7

4. Contribution management 9

5. Claims management 11

6. Financial management 15

7. Information management and data control 17

8. Broker remuneration management 19

9. Customer services 20

SECTION 1: INTRODUCTION

1. Executive summary

Following the implementation of the Medical Schemes Act, Act no 131, of 1998, an advisory team was appointed around 2002 to develop appropriate administration accreditation standards by identifying and defining the functional elements, associated systems, processes and structures required by administrators in order to deliver effective and efficient administration services to client schemes in compliance with the Act and Regulations.

The document contains version 7 of the standards and criteria that are to be complied with by all accredited administrators and self-administered schemes providing their own administration (as applicable) at all times.

The main difference between Version 6 of the standards published in October 2019 (with effective date from 1 January 2020) and this Version 7 is that one new standard, standard 5.2.1, has been included relating to provider network managment, and the particular standards applicable to entities with limited administrator accreditation (e.g. optometry benefit management organisations) have been indicated with an "♦" next to the standard reference number.

Compliance with the standards, presented in a questionnaire format, is evaluated for each administrator upon initial accreditation by way of an on-site evaluation, and from time to time thereafter as may be required. All standards that are rated as partially or non-compliant on the on-site evaluation findings reports will be included as accreditation conditions (with specified timeframes for compliance) on the accreditation certificate.

2. Accreditation standards formulation methodology and supporting principles

2.1 Introduction

The advisory team developed a draft set of standards that was workshopped with the Council on a number of occasions, resulting in Version 1 of this document, and which contained the standards and their measurable elements (criteria). Versions 2 and 3 were drafted after completion of the evaluation of the 3 pilot project administrator on-site evaluations. Subsequently the standards were revised and updated to reflect new / changed requirements in the medical schemes / administration environment (versions 4 to 7).

The standards encompass the following services provided by administrators:

- General compliance
- Operational structure
- Member record management
- Contribution management
- Claims management
- Financial management
- Information management and data control
- Broker remuneration management
- Customer services

2.2 Compliance rating

Administrators are expected to comply with all the standards in full at all times. Compliance with each standard is evaluated by way of a physical verification of compliance therewith during the on-site evaluation.

The following ratings are applied:

- Compliant (C) means that the standard is complied with in full.
- Partially compliant (PC) means that the standard is not complied with in full but there is positive evidence of / progress towards compliance and the deficiency does not seriously compromise the standard.
- Non-compliant (NC) means that there is no observable evidence of compliance with the standard requirement.
- Not Applicable (NA) means that the standard is not applicable because the organisation does not provide the service at all, or the organisation or department does not provide the service at the particular level the standard is designed to measure.

2.3 Applying for accreditation

1. An organisation that provides administration services to a medical scheme must be accredited in terms of section 58 of the Act, read together with Regulation 17. Entities providing the full range of accredited administration services receive "full" accreditation, whilst entities providing only specific, limited administration services e.g. optometry benefit management services, receive limited accreditation (i.e. the accreditation is limited to the specific services provided).
2. Administrators are obliged to apply for accreditation in writing to the Council for Medical Schemes in the manner determined by the Council. The full set of accreditation standards is available on the Council's website at www.medicalschemes.com.
3. A desk-based analysis is performed on the application form and supporting documentation provided. Additional information is obtained from the applicant where required and the evaluation report is completed.
4. The application evaluation report is submitted to the Council Accreditation Steering Committee for review, after which the report is finalised and submitted to Council for approval.
5. Council may approve the accreditation of the applicant with or without conditions, or refuse accreditation and provide reasons therefor.
6. Once accredited, the Accreditation Unit will make arrangements with the administrator to conduct the on-site evaluation of its compliance with the administrator accreditation standards - for new entities this will usually take place after at least 6 months from date of commencing administration operations.
7. The administrator will be required to complete the Standards Compliance Questionnaire aligned directly to the published accreditation standards and to prepare evidence of compliance therewith.
8. The on-site evaluation of the administrator's compliance with the accreditation standards will be conducted at the administrator's premises at the agreed times, usually for a period of 3 to 6 weeks depending on the size and complexity of the administrator, the systems employed and the schemes administered.
9. Validation of the administrator's compliance with the standards include a review of the evidence and detailed testing of the system functionality.
10. A "close-out" meeting will be held with the administrator on completion of the evaluation, whereby the evaluation team will discuss/confirm the detailed evaluation findings.
11. The administrator is then afforded an opportunity to formally comment on the findings (usually 30 days from receipt of the detailed on-site evaluation findings report).

12. The detailed on-site evaluation findings report is then submitted to the Council Accreditation Steering Committee for review, after which the report is finalised and submitted to Council for approval.
13. The Council may approve amending the accreditation certificate to include the conditions as specified in the detailed on-site evaluation findings report and prescribe timeframes within which the conditions have to be fully complied with.
14. Administrators are required to provide detailed evidence of compliance with the conditions imposed by the due dates. A desk-based analysis of the evidence provided is conducted and a follow-up on-site evaluation may be scheduled to verify compliance. Once all the conditions have been complied with a clear accreditation certificate is issued. Continued non-compliance with the conditions may result in the suspension or withdrawal of the administrator's accreditation.

SECTION 2: STANDARDS DOCUMENT

Introduction

The following sections set out the standards for accreditation as a third-party administrator of Medical Schemes.

♦ - Indicates the standards specifically related to limited accreditation.

1. General compliance

Standard reference	Standard description
1.1 General information in support of the administrator's accreditation is readily available	
♦1.1.1	A copy of the group structure to which the administrator belongs and full details of shareholding in and by the administrator has been provided.
♦1.1.2	Full details, including ID numbers, of the directors of the administrator, its holding company and any other relevant related company have been provided.
♦1.1.3	The administrator has provided a copy of the completed and signed Conflict of Interest Declaration schedule. (Refer to Annexure A of the accreditation application form on the CMS website.)
♦1.1.4	A valid tax clearance certificate has been provided
♦1.1.5	The administrator has in place fidelity and indemnity insurance as prescribed in the Act and Regulations, and appropriate motivation is provided by the administrator for the selected level/value of cover.
1.2 The administration agreements in place are in full compliance with Regulations 18 and 19 to the Act and the accreditation standards requirements.	
♦1.2.1	The administration agreements are signed and clearly identify the administrator and relevant scheme as the contracting parties.
♦1.2.2	The commencement date and duration of the agreement are clearly provided for in the agreement.
♦1.2.3	The agreements confirm the scope and duties of the administrator for each specific scheme.
♦1.2.4	The agreements contain full details of fees payable by the medical scheme, including the basis of determination, reconciliation and payment.
♦1.2.5	Termination arrangements are clearly defined in the agreements, with particular regard to the termination notice period; and the timing, format and cost in respect of the scheme data to be transferred to the scheme or new administrator on termination.
♦1.2.6	Where applicable, the agreements provide for the sub-contracting of administration functions by the administrator to another accredited administrator.
♦1.2.7	The agreements provide that all registers, minute books, records and all other data pertaining to the medical scheme, must at all times remain the sole property of the medical scheme concerned, and that no lien may be held over them by the administrator.
♦1.2.8	The agreements contain details of how confidentiality of scheme data and beneficiary personal information is to be maintained, in line with the legislative / regulatory requirements. (E.g. POPIA, MSA, National Health Act, etc.)

Standard reference	Standard description
♦1.2.9	The agreements confirm that the administrator has in place the required fidelity and indemnity insurance.
♦1.2.10	The agreements contain details on procedures to be followed in instances of breach of contract.
♦1.2.11	Any amendments, including fee adjustments, to the initial agreements are in writing and signed by the parties in terms of Regulation 18(3) of the Act.
♦1.2.12	The service level agreement (SLA) contains details of the service to be provided, the agreed upon service level, the performance measures, and relating penalties/remedies available to the parties in case of non-performance.
1.3 The administrator is financially sound	
♦1.3.1	An auditor has been appointed to examine the accounting records and annual financial statements of the administrator in accordance with International Auditing Standards and in compliance with International Financial Reporting Standards ("IFRS").
♦1.3.2	The financial statements clearly confirm that the administrator's assets exceed its liabilities.
♦1.3.3	The financial statements clearly confirm that the administrator's business is a going concern.

2. Operational structure

Standard reference	Standard description
2.1 General information in support of the administrator's accreditation is readily available	
♦2.1.1	The administrator is able to provide process flow diagrams (high level) of all its current operational functions.
♦2.1.2	The business process flow diagrams clearly illustrate how the operational functions are integrated to ensure the rapid reconciliation and utilisation of data.
♦2.1.3	The administrator is able to provide an up-to-date organogram aligned to its business process flow diagrams, which clearly indicates roles and responsibilities.
2.2 The administrator is able to demonstrate the systems employed and integration thereof	
♦2.2.1	The administrator is able to provide a high-level diagram of the operational, financial and other systems employed, as well as any outsourced services and to demonstrate how integration is achieved.
2.3 Risk assessment	
♦2.3.1	The administrator has a documented risk register that identifies the risks, risk ratings and mitigating controls.
2.4 The administrator has processes and systems in place to detect and prevent irregularities and illegal acts.	
♦2.4.1	The administrator has implemented an effective organisational fraud management policy to ensure irregularities and illegal acts, both internally and externally, are prevented, detected and appropriately responded to. The policy should include at least the following: • Physical and system access controls;

Standard reference	Standard description
	• Internal controls; and • A fraud / whistleblower process.

3. Member record management

Standard reference	Standard description
3.1 The administrator has the ability to fully manage member/employer records to individual member level	
3.1.1	All membership related forms, including member applications, dependant registrations, and member terminations, etc. currently in use are aligned to the registered scheme rules and the Act.
♦3.1.2	The administrator operates a system that maintains individual member records. [Limited accreditation – The administrator should have systems and processes in place to verify membership details and active status of membership.]
3.1.3	All membership related forms should be date-stamped (either physically or by electronic means) and this date should be recorded as the received date on the system.
3.1.4	New members/dependants are registered in a timely manner within the prescripts set by the administration agreement with the medical scheme.
3.1.5	The administrator is able to respond promptly to changes to membership /dependant details and update records on the system to ensure processing of claims against the adjusted benefit or contribution profile, and within the prescripts set by the administration agreement with the medical scheme.
3.1.6	Continuation membership is processed in line with the registered scheme rules.
3.1.7	The member record includes the medical scheme membership number.
3.1.8	The member record includes the full names (as per the member's ID / passport), age and identity numbers of each principal member.
3.1.9	The member record includes the full names (as per the dependant's ID / passport), age and identity numbers of each registered dependant.
3.1.10	The member record includes the member's physical and postal address.
3.1.11	The member record includes the contact details of the member.
3.1.12	The member record includes the date of birth of each member and dependant.
3.1.13	The member record includes the gender of each member and dependant.
3.1.14	The member record includes the race of each beneficiary (where this information has been provided by the beneficiary). (New members / dependants - The information should be requested on the member application forms and it must be made clear that it is to be used for statistical purposes only. The forms should also provide for beneficiaries not to disclose their race if they prefer not to do so.

Standard reference	Standard description
	Existing members / dependants - processes should be put in place to collect the information, provided it is made clear to beneficiaries that the provision of race information is voluntary and will only be used for statistical purposes.)
3.1.15	The member record reflects the relationship between the member and dependants.
♦3.1.16	The member record retains a full history of all transactions for each member family.
3.1.17	The member record reflects a member and dependant's date of admission to and exit from the scheme.
3.1.18	The member record identifies the benefit option pertaining to the member family and changes exercised.
3.1.19	The member record contains details of salary and income bands for each member to allow for contribution calculation, where applicable.
3.1.20	The member record indicates the monthly contributions payable and the method of payment.
3.1.21	The member record contains the name of the medical scheme and period of cover in respect of prior scheme membership.
3.1.22	Where applicable, late joiner penalties indicated on the member record are calculated correctly, and the monthly contributions are adjusted accordingly.
3.1.23	The employer group details include the full name, address and contact details of the employer, where applicable.
3.1.24	Employer group details include subsidiary codes for each employer group / paypoint to identify associated members.
3.1.25	The member's employee number is recorded where applicable.
3.1.26	All membership terminations are processed onto the system promptly in accordance with the service level agreement.
3.2 Waiting periods are applied in line with the registered scheme rules and the Act	
♦3.2.1	The member record indicates general and /or condition specific waiting periods applicable to the member or dependants.
3.2.2	General waiting periods are applied to beneficiaries in line with the scheme's underwriting policy, registered rules and the Act.
3.2.3	Condition specific waiting periods are applied to beneficiaries in line with the scheme's underwriting policy, registered rules and the Act.
3.2.4	Where the application of condition specific waiting periods requires clinical assessment, such cases are referred to an appropriately qualified clinical person for review.
3.3 Compliance with service levels are reported to client schemes monthly	
3.3.1	The administrator provides at least monthly reports to client schemes on its compliance with the membership related service levels in accordance with the Service Level Agreement (SLA) signed with each scheme.
3.4 The administrator has the required systems and ability to maintain and operate an effective membership management system. This system is fully integrated, accurate and is real time compliant.	
♦3.4.1	The individual member record system integrates with all other administration systems in use such as contribution management (including the billing run) and claims management.

Standard reference	Standard description
3.4.2	Audit trails exist for all changes to member records.
3.4.3	The member management system is real time compliant.
3.4.4	The administrator has formal review procedures by senior personnel in place in respect of the processing of the member records prior to the activation of the changes.
3.4.5	The administrator has the ability to supply a certificate stating the period of cover and type of cover to the current or former member and their dependants when required.
3.4.6	The administrator is able to provide relevant Income Tax information in the format required by SARS, including savings refunds and interest on savings, upon request or automatically at the end of the tax year.

4. Contribution management

Standard reference	Standard description
4.1 System parameters and marketing material embodying contribution tables, are developed and maintained and are fully aligned to the registered rules of each scheme under administration.	
4.1.1	Contribution tables per benefit option and related rules are maintained on the system and are fully aligned to the Act and the registered rules of each scheme under administration.
4.1.2	Any changes to the contribution tables on the system must be logged in a detailed audit trail.
4.1.3	A report is generated regularly of all changes made to the contribution tables which is reviewed and signed off by an authorised senior manager to ensure that no unauthorised changes are made.
4.1.4	Marketing material of each scheme under administration is fully aligned with the registered rules (specifically with regards to contributions) if this function is the responsibility of the administrator.
4.1.5	Amendments made to the registered rules that impact on contribution tables are effected timeously onto the system before any further billing runs are generated.
4.1.6	The administrator is able to provide evidence that amendments to the registered rules are submitted to the Office of the Registrar as determined by the Registrar, if this function is the responsibility of the administrator in accordance with the administration agreement.
4.2 Complete and accurate billing runs are generated, and contributions are collected and allocated to individual member level in line with the registered scheme rules.	
4.2.1	The contribution billing system interfaces with the individual membership record to ensure accuracy prior to generating a billing run.
4.2.2	The contribution billing run is generated accurately per payment category, e.g. Persal interface, cash payments, debit order payments, etc.)
4.2.3	Complete and accurate contribution billing schedules, including refund and arrears lists, are provided to members / employer groups timeously.
4.2.4	Contributions are collected within 3 days of becoming due and payable to the medical scheme as provided for in section 26(7) of the Act and in line with the registered scheme rules.

Standard reference	Standard description
4.2.5	The administrator demonstrates that it deposits all medical scheme funds (i.e. cheques and cash received) directly into a bank account opened in the name of the medical scheme within one business day following the date of receipt thereof.
4.2.6	Where medical scheme funds, including contributions, member debt and provider debt, are paid by any electronic means or collected by debit order, such funds are deposited directly into a bank account opened in the name of the medical scheme.
♦4.2.7	The administrator manages and maintains the collection and receipt of contributions to individual member level. [Limited accreditation – Limited to the reconciliation of capitated contributions received to member level.]
4.2.8	The administrator has systems and procedures to advise employer groups / members of discrepancies between billings and contributions received by no later than 30 days after becoming due.
4.2.9	The administrator has systems to correct billing and contribution discrepancies by no later than the end of the month following the month to which the contributions apply. This includes refunding contributions not due to the scheme and ensuring the membership database is updated where appropriate (e.g. for backdated terminations or new member / dependant registrations, etc.)
4.2.10	Audit trails exist for all transactions processed through the contributions system.
4.3 Appropriate and robust credit control measures are implemented in line with the scheme approved credit control policy and registered scheme rules	
4.3.1	The administrator is able to provide a signed copy of the scheme approved detailed credit control policy, which should include at least the following: • Procedures to be followed to collect outstanding contributions or other amounts due to the scheme by members or employer groups; • Procedures to be followed with regards to the suspension or termination of membership in line with the scheme rules w.r.t. contributions or other amounts due; • Procedures to be followed w.r.t. the handing over of debt to collections agencies (where appropriate); and • The policy to be followed w.r.t the provision for or writing off of long outstanding amounts.
4.3.2	The administrator has systems and processes in place to follow up non-payment of contributions or other amounts due to the medical scheme by members or employer groups in line with the scheme approved credit control policy.
4.3.3	Membership is suspended/terminated in terms of the rules of the medical scheme where contributions are outstanding or upon failure to repay debts owing to the scheme.
4.3.4	Reinstatement of membership is performed in accordance with the rules of the medical scheme.
4.3.5	The administrator has the ability to record the reversal of contributions for retrospective terminations correctly.
4.4 Compliance with service levels are reported to client schemes monthly	
4.4.1	The administrator provides at least monthly reports to client schemes on its compliance with the contribution related service levels in accordance with the Service Level Agreement (SLA) signed with each scheme.

5. Claims management

Standard reference	Standard description
5.1 System parameters and marketing material embodying benefit tables, are developed and maintained and are fully aligned to the registered rules of each scheme under administration.	
♦5.1.1	Benefit tables for each benefit option and related rules are maintained on the system and are fully aligned to the Act and the registered rules of each scheme under administration. [Limited accreditation – Limited to the affected benefits in terms of the services provided by the administrator.]
5.1.2	Marketing material of each scheme under administration is fully aligned with the registered rules (specifically with regards to benefits) if this function is the responsibility of the administrator.
♦5.1.3	Any changes to the benefit tables on the system must be logged in a detailed audit trail.
♦5.1.4	A report is generated regularly of all changes made to the benefit tables which is reviewed and signed off by an authorised senior manager to ensure that no unauthorised changes are made.
♦5.1.5	Amendments made to the registered rules that impact on benefit tables are effected timeously onto the system before any claims relating to that specific benefit year are paid.
5.1.6	The administrator is able to provide evidence that amendments to the registered rules are submitted to the Office of the Registrar as determined by the Registrar, if this function is the responsibility of the administrator in accordance with the administration agreement.
5.2 Provider network management arrangements are executed effectively and in the best interest of the scheme beneficiaries.	
♦5.2.1	Where applicable, the administrator has processes in place to effectively demonstrate that provider networks are established and managed in line with the registered scheme rules and in the best interest of the scheme beneficiaries in terms of at least the following: • Transparent and fair selection and appointment of network providers criteria; • Fair and appropriate contractual arrangements between the administrator and network providers; • Dispute resolution processes in terms of disputes between the contracting parties, and/or scheme beneficiaries; and Fair and transparent pricing / tariff considerations
5.3 All claims received are processed and paid in line with the Act and registered scheme rules.	
♦5.3.1	The claims management system is integrated with all other sub-systems to ensure immediate and accurate processing of claims.
♦5.3.2	All claims received by the scheme should be date stamped (either physically or by electronic means) with the applicable date on which the claim was received and ensure that this date is captured as the date received on the system.
♦5.3.3	A process is in place to ensure that all claims received, either physically or by electronic means, have been captured and processed onto the system.
♦5.3.4	The system facilitates the distinction between prescribed minimum benefits and other benefits.

Standard reference	Standard description
♦5.3.5	Where the administrator is unable to confirm the PMB status of claims without additional clinical information, processes and systems are in place to explicitly advise members of such possible PMBs, e.g. by way of an appropriate and detailed message on the member claims statement.
♦5.3.6	All valid non-PMB claims are processed and paid in line with the Act, the registered rules of the medical scheme and individual benefit option profiles.
♦5.3.7	All valid PMB claims are processed and paid in line with the Act, the registered rules of the medical scheme and individual benefit option profiles.
5.3.8	Chronic medicine claims i.r.o. the Chronic Disease List conditions (CDLs) are processed and paid in line with the approved chronic registration programme, registered scheme rules and the Act.
5.3.9	Chronic medicine claims i.r.o. other chronic conditions (non-CDLs) are processed and paid in line with the approved chronic registration programme, registered scheme rules and the Act.
♦5.3.10	The date of service and date of receipt for each claim are recorded on the system.
♦5.3.11	The system automatically generates unique reference numbers for each claim captured.
♦5.3.12	Co-payments or deductibles (where applicable) are correctly calculated and processed in line with the registered benefit rules.
♦5.3.13	Where provided for in the registered scheme rules, co-payments funded by the scheme and then recovered from members are correctly calculated and recorded.
♦5.3.14	Individual beneficiary details per claim are recorded on the system.
♦5.3.15	The date of processing of each claim is recorded on the system.
♦5.3.16	The date of payment of each claim is recorded on the system.
♦5.3.17	The administrator has procedures in place to ensure that the claims management system maintains the most recent diagnostic, procedural, pharmaceutical classification system and other generic tariff codes.
♦5.3.18	Each claim in the system includes the diagnostic, procedural, pharmaceutical classification system or other generic code per line item.
♦5.3.19	Each claim in the system includes the provider name and practice number. (Also include the group practice name and practice number where applicable.)
♦5.3.20	Processes and systems are in place to validate claims to relevant up to date pre-authorisations where applicable.
♦5.3.21	Processes and systems are in place to ensure clinical auditing of relevant claims are appropriate.
♦5.3.22	Processes are in place to enable the reversal of unlawful or overpayment of claims to providers or members (where applicable).
♦5.3.23	Processes and systems are in place to enable the reversal of claims to providers or members (where applicable) i.r.o. retrospective terminations.
5.3.24	The administrator has processes and systems in place to identify and record third party claims (for example Road Accident Fund and compensation for occupational injuries and diseases).
5.3.25	The administrator has processes in place to reconcile and manage third party claims (for example Road Accident Fund and compensation for occupational injuries and diseases) monthly and ensure any reconciling items are cleared timeously.

Standard reference	Standard description
5.3.26	Ex-gratia claims are processed and paid in line with the scheme's ex gratia policy and registered scheme rules.
5.3.27	Appropriate processes are in place to verify the accuracy and completeness of the claims processed. (These would include claims validation controls on the system, quality assurance processes as well as the review of exception reports (e.g. stale claims approved for payment) prior to the payment of the claims.)
5.4 Process and systems are in place to detect and investigate fraudulent acts, fraudulent claims and non-disclosure of material information.	
♦5.4.1	Processes and systems are in place to detect and investigate fraudulent acts, and to implement appropriate action in line with the registered scheme rules and scheme approved fraud, waste and abuse policy.
♦5.4.2	Processes and systems are in place to detect and investigate fraudulent claims, and to implement appropriate action in line with the registered scheme rules and scheme approved fraud, waste and abuse policy.
5.4.3	Processes and systems are in place to detect and investigate potential non-disclosure of material information, and to implement appropriate action in line with the registered scheme rules and scheme approved fraud, waste and abuse policy.
5.5 Claim payments are accurate and valid and are in line with the specific scheme rules and the Act.	
♦5.5.1	The administrator's system is date sensitive and will prevent payment of any benefit after date of suspension/termination, other than benefit entitlements prior to suspension/termination.
♦5.5.2	All valid claims must be paid within 30 days of all information being provided to verify the validity of the claim.
♦5.5.3	The applicant has in place an effective procedure to inform members, within 30 days of receipt of a claim, that such claim is erroneous or unacceptable for payment and to provide reasons therefore (regulation 6(2) of the Act). [Limited accreditation – May be limited to providing appropriate information to the medical scheme or its administrator to enable appropriate communication to the affected member.]
♦5.5.4	The claims management system is able to identify and prevent payment of duplicate claims.
♦5.5.5	The claims management system is able to identify and prevent processing of claims with no membership number.
♦5.5.6	The claims management system is able to identify and prevent processing of stale claims, i.e. claims received after the end of the fourth month following the end of the month of treatment.
♦5.5.7	Stale claims are not paid without an authorised mandate from an authorised officer of the medical scheme concerned.
♦5.5.8	Detailed claim statements are provided to providers after each claims payment run and should indicate at least the following: • Provider name and practice number; • Individual beneficiary details and date of service; • Appropriate ICD10, tariff and/or other diagnostic or procedure codes; • The claimed amounts; • The benefit amounts funded by the scheme in terms of the registered scheme rules; • Amounts payable by members; and

Standard reference	Standard description
	• Comprehensive reason / rejection codes.
♦5.5.9	The administrator has processes and systems in place to ensure that reason / rejection codes applied to claims are comprehensive, specific and appropriate.
♦5.5.10	All discounts received from service providers are allocated to the scheme, and at member level where applicable.
♦5.5.11	Audit trails exist for all transactions processed through the claims management system.
5.6 Medical savings accounts are administered and controlled according to the provisions of the Act and the rules of each medical scheme, with particular regard to the allocation of claims between the risk pool and savings accounts.	
♦5.6.1	The allocation between risk contributions/claims and savings contributions/claims is performed correctly.
5.6.2	The administrator is able to generate at any time a detailed report reflecting each individual member's available savings account balance.
5.6.3	The administrator is able to generate at any time a detailed report reflecting the savings account liability owing to, or the overdrawn savings debtor owing by each member.
♦5.6.4	The claims management system is checked prior to payment to establish that where a claim is made against the savings account there are sufficient funds available in the savings account to pay the claim.
5.6.5	Interest is calculated and allocated to individual member savings accounts on a monthly basis or in accordance with the rules of the scheme.
5.6.6	The system parameters are configured to ensure that no more than 25% of gross contributions (i.e. registered contributions) is allocated to savings accounts.
5.6.7	The administrator demonstrates a procedure to refund the balance of the savings account to the individual member on resignation or death, or to transfer savings balances to another scheme within 6 months of termination date.
5.7 Members receive regular, detailed and accurate claims statements.	
♦5.7.1	Detailed claims statements are provided to affected members after each claims payment run, or at least monthly. [Limited accreditation – May be limited to providing appropriate information timeously to the contracted medical scheme or its administrator to enable timeous distribution of comprehensive member claims statements.]
5.7.2	The detailed claims statement includes the member's name and membership number.
5.7.3	The detailed claims statement indicates to whom the service was provided.
5.7.4	The detailed claims statement provides the name of the service provider.
5.7.5	The detailed claims statement provides the date of service rendered.
5.7.6	The detailed claims statement includes the relevant tariff codes.
5.7.7	The detailed claims statement provides the claimed amounts for the service supplied.
5.7.8	The detailed claims statement provides the amount of benefits funded for the service.

Standard reference	Standard description
5.7.9	The detailed claims statement indicates the amount payable by the member in accordance with the benefit option for that member.
5.7.10	The detailed claims statement includes comprehensive reason / rejection codes per claim line.
5.7.11	The detailed claims statement provides details of the member's available savings balance, or the information is available by telephone or electronic request.
5.7.12	The detailed claims statement provides details of unused/available benefits, or the information is available by telephone or electronic request.
5.8 Compliance with service levels are reported to client schemes monthly	
♦5.8.1	The administrator provides at least monthly reports to client schemes on its compliance with the claims related service levels in accordance with the Service Level Agreement (SLA) signed with each scheme.

6. Financial management

Standard reference	Standard description
6.1 The administrator is able to collect and collate all information required for completion of the statutory returns in the format required by the Council.	
♦6.1.1	The administrator is able to collect and collate financial management information as well as non-financial information to facilitate the compilation of the statutory returns in the required format and within the prescribed time. [Limited accreditation – Limited to the information pertaining to the services rendered by the administrator.]
6.2 The administrator is able to produce, at least monthly, reconciliations between the operating and financial management systems, including but not limited to contributions, claims and savings accounts.	
6.2.1	The administrator has processes and systems in place to ensure that all journal entries are adequately narrated and approved by a senior level official.
6.2.2	Monthly bank account reconciliations between the general ledger, cash book and bank statements are performed and reconciling items are cleared timeously.
6.2.3	The administrator has processes and systems in place to ensure that all electronic claims payments not cleared through the bank account within a month after payment was effected, are reversed back to the relevant provider's creditor account.
6.2.4	The administrator has policies and procedures in place to follow up all unidentified deposits or receipts by the end of the following month to which the contributions or other debt applies.
6.2.5	All unidentified deposits or receipts are recorded in a separately identifiable ledger account along with all known details for further investigation.
6.2.6	Contribution debtors, member debtors and provider debtors' detailed age analyses (at individual member / provider level) are produced monthly and are aged correctly.

Standard reference	Standard description
6.2.7	Monthly contribution debtors account reconciliations between the general ledger and detailed contribution debtors' age analyses (at individual member level) are performed and reconciling items are cleared timeously.
6.2.8	Monthly member debtors account reconciliations between the general ledger and detailed member debtors' age analyses (at individual member level) are performed and reconciling items are cleared timeously.
6.2.9	Monthly provider debtors account reconciliations between the general ledger and detailed provider debtors' age analyses (at individual provider level) are performed and reconciling items are cleared timeously.
6.2.10	Processes and systems are in place to ensure that provisions are raised for any long-outstanding contribution, member, provider and other debt, if not recoverable in line with the scheme approved credit control policy and in line with the applicable International Financial Reporting Standards (IFRS).
6.2.11	Bad debts written off are in line with the scheme approved credit control policy.
6.2.12	Monthly member savings liability account reconciliations between the general ledger and detailed member savings liability listings are performed and reconciling items are cleared timeously.
6.2.13	Monthly broker commission account reconciliations between the general ledger and detailed broker commissions are performed and reconciling items are cleared timeously.
6.2.14	Monthly investment account reconciliations between the general ledger and detailed investment schedules are performed and reconciling items are cleared timeously. (Including the appropriate recording of interest earned / accrued in terms of the scheme's accounting policy.)
♦6.2.15	A valid methodology is used in the calculation of the provision for outstanding claims (IBNR), which takes into account various factors, e.g. claims patterns, member demographics and changes in the nature and average cost of claims, and is supported by appropriate working papers. [Limited accreditation – Where appropriate, e.g. capitation arrangement(s)]
♦6.2.16	The general ledger is updated monthly for the movement on the IBNR as calculated in terms of the methodology.
6.2.17	Administration, managed care and other contracted service provider fees are calculated and paid in terms of applicable agreements.
6.2.18	All monthly reconciled control accounts should be signed off by the responsible person as having completed the task and the financial manager should review all reconciliations monthly.
6.2.19	The administrator is able to produce a monthly balancing trial balance.
6.3 The administrator is able to produce accurate and comprehensive monthly scheme management accounts and annual financial statements in line with current accounting practice.	
6.3.1	Amounts owing by the scheme to members are recorded and reflected in the monthly management accounts and annual financial statements of the scheme separately from amounts owing to the scheme by members.
6.3.2	Contributions owing to the scheme are reflected separately from amounts owing by members in respect of overdrawn savings.
6.3.3	Contributions or other amounts received in advance of due date are reflected as a creditor at period end.

Standard reference	Standard description
6.3.4	The administrator is able to comply with section 37 of the Act with regard to the preparation of annual financial statements for each scheme under administration.
6.3.5	The annual financial statements are prepared in accordance with International Financial Reporting Standards (IFRS).
6.3.6	The annual financial statements fairly present the state of affairs and the business of the scheme and the results thereof and the surplus or deficit for the year.
6.3.7	The applicant provides back-up information for all line items on the income statement.
6.3.8	The applicant provides back-up schedules to validate all major balances on the balance sheet.
6.3.9	The applicant provides accurate and valid monthly management reports in the format required by the Board of Trustees and /or Principal Officer.
6.3.10	The ability exists to produce accurate, valid and complete information per benefit option and on a consolidated basis as required by section 37(4)(d) of the Act.
6.3.11	Where appropriate or prescribed by law, including the SAICA Medical Schemes Accounting Guide, separately discloseable items should be disclosed as such (for example: re-insurance, broker commission, investment schedules of all categories of assets invested, etc).
6.3.12	Audit trails exist for all entries processed through the financial management system.
6.3.13	Items of income and expenditure and assets and liabilities are classified correctly and are not offset against each other (except where allowed for in terms of IFRS and the scheme's accounting policies.)
6.3.14	The administrator is able to provide the schemes with annual budgets with detailed assumptions; and to monitor actual income and expenditure and explain variations thereto on at least a monthly basis.
6.3.15	The administrator maintains and implements comprehensive, written policies and procedures for all accounting functions.
6.4 Compliance with service levels are reported to client schemes monthly	
6.4.1	The administrator provides at least monthly reports to client schemes on its compliance with the financial management related service levels in accordance with the Service Level Agreement (SLA) signed with each scheme.

7. Information management and data control

Standard reference	Standard description
7.1 The administrator is able to maintain the confidentiality, security and integrity of data and information.	
♦7.1.1	Information management policies and procedures are implemented to ensure that the confidentiality of data and information is maintained on the system.

Standard reference	Standard description
♦7.1.2	Information management policies and procedures are implemented to ensure that the confidentiality of data and information is maintained by the staff of the administrator. (This should include staff signing confidentiality agreements.)
♦	Information management policies and procedures are implemented to ensure access to the system is controlled and proper segregation of duties is in place. This should include: • System access control via usernames and passwords; • The granting / updating / termination of access rights when staff terminate employment or transfer to a new position / division; and • System access audit trails.
♦7.1.4	A corporate/enterprise wide Anti-Virus solution is implemented and updated on a regular basis to ensure adequate protection of data against malicious viruses, Trojan, worms, etc.
♦7.1.5	The administrator has processes and systems in place to ensure that only authorised changes or updates to the operational system are implemented.
♦7.1.6	The administrator has implemented effective firewall systems to detect and prevent unauthorised access to the systems, and any risks / weaknesses identified are appropriately addressed.
7.2 Comprehensive back-up, off-site data storage, and disaster recovery and business continuity processes and systems are implemented	
♦7.2.1	Data is successfully and completely backed up daily and stored in a secure and fireproof environment.
♦7.2.2	Backups are stored off the premises of the applicant in a secure and fireproof environment on at least a weekly basis.
♦7.2.3	Comprehensive and up to date disaster recovery and business continuity plans are implemented to ensure complete data recovery and / or business continuity. The comprehensive disaster recovery and business continuity plans should include at least the following: • Define what would be considered a disaster, a significant business interruption, a minor business interruption, etc. • Define critical business functions; • Maximum allowed outage and critical business recovery times; • Clearly define roles and responsibilities; • Risk assessment and business impact analyses per unit / function; • Who can declare a disaster; • Appropriate response to a disaster or significant business interruption; • Specify the primary and alternative / disaster recovery sites; • Communication plan; • Up to date staff and Disaster Recovery Team contact lists; • Emergency evacuation plan and procedures; • ICT disaster recovery plan and procedures; and • Essential equipment / resources list to ensure business continuity. • Etc.
♦7.2.4	The comprehensive disaster recovery and business continuity plans are tested at least annually to ensure that it is fully functional.

Standard reference	Standard description
♦7.2.5	The organisation's data centre / server room is secure and meets best practice guidelines. At least the following should be effectively provided for: • Access is restricted to authorised staff only; • Sufficient air conditioning / cooling systems are implemented; • Sufficient uninterrupted power supply is available; • Sufficient power surge protection is implemented; • Sufficient server continuity infrastructure is in place, e.g. a failover server; • Sufficient flooding prevention / protection measures have been implemented; • Sufficient fire prevention / detection measures have been implemented; • Environmental monitoring measures to monitor for instance temperature and humidity are in place; • All sensors should be remotely monitored on a continuous basis and trigger alerts sent to dedicated staff; and • The room is in a secure location and has no windows.

8. Broker remuneration management

Standard reference	Standard description
8.1 Where required, the administrator appropriately manages the payment of broker commissions in full compliance with the Act and Regulations.	
8.1.1	The administrator produces a fully detailed report of all broker commissions paid that confirms correct payment in terms of the Act. For instance: • Commission is only calculated on contributions received in full; • Commission is calculated at the legislated rate; • VAT is correctly calculated and paid to registered VAT vendors, and • Appropriate adjustments are made (e.g. for backdated terminations).
8.1.2	The administrator has processes and systems in place to ensure that broker remuneration is calculated and paid for member appointed brokers only (or an employer group appointment where applicable), i.e. broker notes or appointment letters are in place. * Should the administrator not have a copy of the required broker appointment note on record, the broker must obtain a current broker appointment confirmation from the member or employer group concerned, and the administrator must keep such appointment on record. ** Should there be a change in the broker appointed by the member, e.g. the member decides to appoint a new broker, or the broker sells his/her business to another broker, or the member is no longer part of an employer group i.t.o. which a broker was appointed, a new broker appointment note must be signed by the

Standard reference	Standard description
	member and kept on record. (A transfer of a member from one broker to another within a brokerage is not considered a change in broker and would not necessitate a new broker appointment note.)
8.1.3	The administrator has processes and systems in place to ensure that the payment of commission is only made in terms of a prior written agreement with the medical scheme.
8.1.4	The administrator has processes and systems in place to verify that commission is calculated and paid to brokers who were accredited during the relevant period.
8.1.5	Detailed broker commission statements at individual member level are produced per broker and per scheme.

9. Customer services

Standard reference	Standard description
9.1 The administrator provides the full range of customer services as specified in the administration and service level agreements of each scheme.	
♦9.1.1	The administrator ensures delivery against all customer services as stipulated in the administration / service level agreement between the medical scheme and administrator. These services might include operating a call centre / information centre on behalf of the scheme.
♦9.1.2	The administrator ensures delivery against all customer services as stipulated in the administration / service level agreement between the medical scheme and administrator. These services might include having processes and systems in place that effectively deal with all enquiries, including telephonic and written enquiries.
♦9.1.3	Enquiries are appropriately categorised (e.g. claims related, or membership entitlement related queries) and records are maintained of all enquiries made per member and the response of the administrator in dealing with them.
♦9.1.4	The administrator ensures delivery against all customer services as stipulated in the administration / service level agreement between the medical scheme and administrator. These services might include maintaining / managing electronic engagement platforms such as scheme websites, scheme mobile applications and social media platforms.
9.2 Compliance with service levels are reported to client schemes monthly	
♦9.2.1	The administrator provides at least monthly reports to client schemes on its compliance with the customer services related service levels in accordance with the Service Level Agreement (SLA) signed with each scheme.