Healthcare Utilisation Annual Statutory Return

Technical Guideline for the preparation of data

Version 10.0

Applicable for the 2020/21 financial years' data submission

January 2022

Enquiries: lion@medicalschemes.co.za

Contents

1. Background

The implementation of the Medical Schemes Act, No. 131 of 1998 needs to be monitored regularly to evaluate its impact on the industry and beneficiaries, and where necessary, to recommend legislative reforms. Good quality data is important to achieve this objective. It is the Principal Officer's responsibility to ensure that the data submitted to the Registrar's office is of good quality. Any deviation from the data specifications published by the Council for Medical Schemes (CMS), including the submission of poor-quality data will result in the Annual Statutory Return being returned to the Principal Officer for correction and re-submission. The non-financial data should be consistently checked for accuracy, completeness, reliability and comparability.

2. Technical Guideline for the preparation of data

2.1. Purpose of this document

This document provides technical guidelines for the preparation of data for submission to medical schemes. The intention of this technical guideline is to provide clear and unambiguous definitions for every item requested in the technical guideline. This data specification does not cover the financial section of the Annual Returns process.

When preparing the data for submission schemes and administrators are urged to stick as closely to the specification and guidelines as possible.

In some cases, judgement will be required, for example in cases where the administration system uses so-called "in-house" tariff codes for certain claim types, or where alternative billing arrangements (not based on tariff codes) are in place. The list of the CMS supplied codes (Tariff / ATC / Procedure / etc.) should be used only as a guideline for identifying utilisation statistics and is not necessarily a complete list of codes used in the industry. Please inform the CMS in case you become aware of any missing codes (excluding "in-house" codes) by sending a list of such codes to lion@medicalschemes.co.za

2.2. Extraction of claims data

Ideally the claims data used to calculate amounts and utilisation statistics should be based on service date. However, the use of service dates would require schemes to wait until April of the following year before the data may be extracted (to allow for claims to be run-off and minimise the impact of IBNR claims).

Comments from the industry indicated that it is not practical for schemes to prepare the submission at such a late date.

In view of the above, the claims extract should be based on payment date. Thus, for the 2020 year, all claims paid from 1 January 2020 to 31 December 2020 should be included. This approach however has some potential pitfalls, including skewed results due to benefit changes from one year to the next, as well as potential double counting as claims are reprocessed.

2.3. References

This technical guideline document should be read in conjunction with the following documents:

[R.1]	Healthcare Utilisation Annual Statutory Return Technical Guideline for the preparation of data Version 9.0
[R.2]	Guidelines for the Identification of Beneficiaries with Risk Factors in Accordance with the Entry and Verification Criteria Version 13.1
[D.1]	ASR Data Specification v9.0 This workbook contains the layout and field type definitions for the data tables.
[D.2]	ASR Valid Codes v9.0 The reference workbook containing tables with valid values for certain key columns specified in [D.1].
[App.1]	ASR Data Specification Appendix A v9.0 The appendix contains relevant codes for the identification of beneficiaries utilising healthcare services.

2.4. How to read the data specification

[D.1] contains the data specification for each table required for submission. The following is an example of a table data specification:

Data Table Number:	A.5				
Data Table Description	Distribution of beneficiaries and benefits paid by province				
Filter:	Number of registered beneficiaries at the end of each month				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	'2018		
Part number is the same as the Data Table Number	Text	Part	A.5		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Beneficiary Type	Text	BeneficiaryType	"Member", "Adult" or "Child"	CdRef 6 BeneficiaryType	BeneficiaryType
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Postal Code	Text	PostalCode	e.g. "1961" for Meyerton	CdRef 18 PostalCodes	Box_Code / Str_Code
Average number of beneficiaries	Decimal(18, 2)	AverageOfBeneficiaries			
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed			
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk			
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings			

The columns in the data specification document must be interpreted as follows:

- **Column Description:** A description of the values that will be contained in this field
- **Data Type:** The type of data contained in this field. This can either be:
- **Integer** (a number such a 0, 1, 2, 3…);
- **Text** (a string of characters such as “ABC”); or
- **Decimal (p,s)** meaning a decimal number with p = precision or the total number of digits that will be stored both to the left or right of the decimal.
- **Column Header:** A field name or column name (if the data is stored in columnar format) that can be safely used in most database systems.
- **Notes:** A note indicating the values that this field should contain.
- **Validate against sheet:** If the values in the field are restricted to a finite set of values then this column refers to the worksheet in [D.2] that contains the list of valid values.
- **Validate column**: Indicates the column in the table referred to in “Validate against sheet” that contains the valid values for this field.

- **The Odata must be used as a standard / reference for all field types, headers and description.**

Fields highlighted in orange indicate fields that contain values. The fields that are not highlighted are "key fields". Where a key field is a text field it will be a coded field. In other words, rather than having free text fields, the values in these fields will be limited to certain codes. For example, ST_PTH rather than the more error prone "Serum Parathyroid Hormone (PTH)".

2.5. Data granularity

Separate copies of every data table must be prepared for *each benefit option* on the scheme. Information on each benefit option should be submitted separately. Efficiency Discounted Options (EDOs) must be reported separately, i.e., they must not be rolled up into the parent options. For example, if the scheme has "*Option X Standard"* and "*Option X with EDO",* then these will be reported separately as "*Option X Standard" and "Option X with EDO"*. Information on beneficiaries must not be reported in more than one option for the same reporting period.

It should also be noted that the key columns are constrained to be unique. In other words, a copy of Table A.5 can only contain exactly one record with the key (2018, "50-54 years", "Member", "Male", "KZN", 2952).

2.6. Definitions for key fields

This section contains a list of valid definitions for key fields or variables that are common across a number of data tables. The specification was designed with the issue of consistency in mind. Therefore, a field with the same name will have the same meaning in any other table where it is used. The names in brackets refer to the "Column Header" for this field.

- **Year of submission (YearOfSubmission):** Year of submission refers to the year for which data is submitted. If data is submitted in 2020 for the 2018 and 2019 financial years, year of submission is 2019.
- **Part:** Part number is the same as the Data Table Number, for example, A.1.
- **Scheme Reference Number (RefNo):** Scheme Reference Number is a unique reference number issued to a scheme on registration (Obtainable for the Odata).
- **Scheme Benefit Option Number (BenefitOptionNumber):** Scheme Benefit Option Number is a unique reference number issued to a scheme's benefit option on registration (Obtainable for the Odata).
- **Financial Year (FinancialYear):** Financial Year refers to the scheme financial year (which always run from 1 January to 31 December). If the row or record contains beneficiary data related to the financial year running from 1 January 2019 to 31 December 2019, then the value for FinancialYear is 2019. If the record contains

claim amounts, then FinancialYear 2019 refers to all claims paid between 1 January 2018 and 31 December 2018 ([D.2] worksheet "CdRef 1 CdRef 1 FinancialYearsAndMonths")

- **Financial Month (FinancialMonth):** ([D.2] worksheet "CdRef 1 CdRef 1 FinancialYearsAndMonths")
- **Year of Birth (YearOfBirth):** Year of birth refers to the year in which an individual was born. For example, if a beneficiary was born on 7 March 1978, then the YearofBirth is 1978.
- **Gender (Gender):** The Gender of a beneficiary can be either "*Male*" or "*Female*" ([D.2] worksheet "CdRef 4 Gender")
- **Age Band (AgeBand):** Parts of the specification document requires that beneficiaries are reported in the ranges contained in [D.2] worksheet "CdRef 3 AgeBands" after calculating the age of the beneficiary. Age is calculated as an integer number using the following definition:
    - **Age = Age as at 1 January of the financial year concerned**
    - For example, in Financial Year 2018 a beneficiary with date of birth 21 March 1984 will have his/her age calculated as:
    - Age = Year (YYYY) of previous birthday as at 1 January 2019 – Year of birth (YYYY)-1
        - = 2019 – 1984-1
        - = 34
- **Postal code (PostalCode):** Postal code indicates the postal or street code area where a beneficiary is resident. Valid postal codes are contained in [D.2] worksheet "CdRef 18 PostalCodes".
    - This may be determined on the basis of:
- **Residential address**, if not available then
- **Private postal code address**, if not available then
- **Business address**, if not available then
- **Employer address (pay-point)**, if not available then
- **Residential address**, if not available then
- **Address of the General Practitioner** where care to the beneficiary was paid for first, if not available then
- **Address of the first provider** where care to principal member or any dependent was paid for, if not available then
- **Other methods** - any method not specified above
- If address is not available, then use code "OTH"
- **Province code (ProvinceCode):** Province code indicate the province where a beneficiary is resident. Schemes must ensure that there is a valid link between ProvinceCode and PostalCode. Data with invalid ProvinceCode and PostalCode will be rejected. See [D.2] worksheet "CdRef 12 Province" for the definition of valid ProvinceCode values.

- **Type of address for beneficiaries (TypeAddress):** The field TypeAddress can take any of the values from 1 to 7 indicating how the scheme is collecting the beneficiary address.

- **Population group (Race):** The population group of a beneficiary can take any of the following categories: "African" or "Coloured" or "Indian/Asian" or "White" or "Unknown". See [D.2] worksheet "CdRef 22 Population Group" for the definition of valid population group values.

2.7. Consistency of Healthcare Utilisation and Financial ASR data

Schemes are advised that it is important to ensure consistency of certain data fields in the two systems, Healthcare Utilisation and Financial ASR. The area of special emphasis includes:

1. Membership – the number of members should be the same on both submissions:

2. Total Benefits – the total benefits paid between the two systems should be consistent:

3. Managed Care benefits – Total expenditure towards managed care on the two systems should also be consistent:

3. Table A.1: Membership at the end of the reporting period

This part contains a report on the number of active beneficiaries as at the end of the financial year, split according to beneficiary type, chronic disease status and year of enrolment in the benefit option.

Data Table Number:	A.1				
Data Table Description	Membership profile at the end of the financial year				
Filter:	All beneficiaries as at the end of the financial (reporting) year.				
Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	A.1		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMon	FinancialYear
Year of Birth	Integer	YearOfBirth	e.g 1947. Must be less than or equal to the ReportingYear		
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Has a CDL Condition	Bit	CDLConditionIndicator	1=Yes 0=No		
Members enrolled for > 12 months	Integer	MembersenrolledforMoreThan12months			
Members joining in the last 12 months	Integer	Membersjoininginthelast12months			
Adults enrolled for > 12 months	Integer	AdultsEnrolledMoreThan12			
Adults joining in the last 12 months	Integer	Adultsjoininginthelast12months			
Childern enrolled for > 12 months	Integer	ChildrenenrolledforGreaterThan12months			
Children joining in the last 12 months	Integer	Childrenjoininginthelast12months			

3.1. Valid Definition

Has a CDL Condition (CDLConditionIndicator):

- If a beneficiary is registered on a chronic disease management programme for any one of the 26 CDL conditions (see [D.2] worksheet "CdRef 2 CDL"), then CDLConditionIndicator is 1, otherwise it is 0.

Year of birth:

- Year of birth refers to the year in which an individual was born. For example, if a beneficiary was born on 7 March 1978, then the YearofBirth is 1978.

Members enrolled for > 12 months (MembersenrolledforMoreThan12months):

- Number of beneficiaries enrolled as Principal members for a period greater than 12 months in terms of the scheme rules.

Members joining in the last 12 months (Membersjoininginthelast12months):

- Number of beneficiaries enrolled as Principal members for a period of 12 months or less in terms of the scheme rules.

Adults enrolled for > 12 months (AdultsEnrolledMoreThan12):

- Number of beneficiaries enrolled as adult dependents for a period greater than 12 months in terms of the scheme rules.

Adults joining in the last 12 months (Adultsjoininginthelast12months):

- Number of beneficiaries enrolled as adult dependents for a period of 12 months or less in terms of the scheme rules.

Children enrolled for > 12 months (ChildrenenrolledforGreaterThan12months):

- Number of beneficiaries enrolled as child dependents for a period greater than 12 months in terms of the scheme rules.

Children joining in the last 12 months (Childrenjoininginthelast12months):

- Number of beneficiaries enrolled as child dependents for a period of 12 months or less in terms of the scheme rules.

3.2. Validation Rules

- Schemes must always ensure that the Year-of-Birth is always less than or equal to the Financial Year.
- The number of beneficiaries reported in Table A.1 must correspond to the number of beneficiaries reported in the Financial ASR for the corresponding period.
- The number of beneficiaries reported in Table A.1 must correspond to the number of beneficiaries reported in the Tables A.2, A.3, A.5 and A7 for the corresponding period.
  1. A1. MembersenrolledforMoreThan12months + A1. Membersjoininginthelast12months = A2. Members **WHERE** (A2. FinancialMonth = 12)
  2. A1. AdultsEnrolledMoreThan12 + A1. Adultsjoininginthelast12months = A2. Adults **WHERE** (A2. FinancialMonth = 12)

3. A1. ChildrenenrolledforGreaterThan12months + A1. Childrenjoininginthelast12months = A2. Children **WHERE** (A2. FinancialMonth = 12)
4. (A1. MembersenrolledforMoreThan12months + A1. Membersjoininginthelast12months + A1. AdultsEnrolledMoreThan12 + A1. Adultsjoininginthelast12months + A1. ChildrenenrolledforGreaterThan12months + A1. Childrenjoininginthelast12months) **≈** A5. AverageOfBeneficiaries
5. (A1. MembersenrolledforMoreThan12months + A1. Membersjoininginthelast12months + A1. AdultsEnrolledMoreThan12 + A1. Adultsjoininginthelast12months + A1. ChildrenenrolledforGreaterThan12months + A1. Childrenjoininginthelast12months) **≈** (A7. NoCDLDisease + A7.ADS + A7.AST + A7.BCE + A7.BMD + A7.CMY + A7.COP + A7.CRF + A7.CSD + A7.DBI + A7.DM1+ A7.DM2 + A7.DYS + A7.EPL + A7.GLC + A7.HAE + A7.HYL + A7.HYP + A7.IBD + A7.IHD + A7.MSS + A7.PAR + A7.RHA + A7.SCZ + A7.SLE + A7.TDH + A7.HIV) **WHERE** (A7. CountPrevalence **=** "Count" **AND** A7.FinancialMonth **=** 12)

3.3. Changes

- None

4. Table A2: Number of registered members and Dependents at the end of each month

The values in this table refer to the number of active beneficiaries *as* at the end of *each month*, split according to "Beneficiary Type" (Members, Adult dependents and Child dependents). The "Persal" field apply to main members only.

Data Table Number:	A.2				
Data Table Description	Number of registered members and Dependents at the end of each month				
Filter:	Number of registered beneficiaries at the end of each month				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	A.2		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Financial Month	Integer	FinancialMonth	e.g. 9 for September	CdRef 1 ReportingYearsAndMonths	Month
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Principal member Population group	Text	Race	"African" or "Coloured" or "Indian/Asian" or "White" or "Unknown"	CdRef 22 Population Group	RaceCode
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Postal Code	Text	PostalCode	e.g. "1961" for Meyerton	CdRef 18 PostalCodes	Box_Code / Str_Code
Please indicate how the scheme is collecting the data for this part	Bit	TypeAddress	e.g. "1" for "Private postal code address"	CdRef 23 Type of address	TypeAddressCode
Principal member is Government employee	Bit	Persal	1=Yes 0=No		
Members	Integer	Members			
Adult Dependents	Integer	Adults			
Child Dependents	Integer	Children			

4.1. Valid Definition

Population group (Race):

- The population group of a beneficiary can take any of the following values: "African" or "Coloured" or "Indian/Asian" or "White" or "Unknown". See [D.2] worksheet "CdRef 22 Population Group" for the definition of valid population group values.

Please indicate how the scheme is collecting the data for this part (TypeAddress):

- The field TypeAddress can take any of the values from 1 to 7 indicating how the scheme is collecting the beneficiary address. See [D.2] worksheet "CdRef 23 Type of address" for code description.

Principal member is Government employee (Persal):

- Principal member is a government employee

Members (Members):

- means a person who has been enrolled or admitted as a member of a medical scheme, or who, in terms of the rules of a medical scheme, is a member of such medical scheme

Adult Dependents (Adults):

- an adult who, under the rules of a medical scheme, is recognised as an adult dependent of a member

Child Dependents (Children):

- dependent child, who, under the rules of a medical scheme, is recognised as a child dependent of a member

4.2. Validation Rules

- The number of beneficiaries reported in Table A.2 must correspond to the number of beneficiaries reported in the Financial ASR for the corresponding period.
- The number of beneficiaries reported in Table A.1 must correspond to the number of beneficiaries reported in the Tables A.1, A.5 and A7 for the corresponding period.
- The “Persal” field apply to main members only, therefore it should be zero for dependents.

4.3. Changes

- None

5. Table A3: Age analysis of member movement for the financial year

This table requires the total number of beneficiaries (i.e. members and dependents where dependents refer to both adult dependents and child dependents collectively) joining and leaving the scheme during the course of a financial year concerned by beneficiary type.

Data Table Number:	A.3				
Data Table Description	Age analysis of member movement for the financial year				
Filter:	All beneficiaries who joined or left the scheme during the course of the year				
Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	A.3		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Number of Members Transferring from Other Schemes	Integer	NumMembTransferringFromOther			
Number of Members not Transferring from Other Schemes	Integer	NumMembNotTransferring			
Number of New Dependents Joining the Scheme	Integer	NumNewDependsJoining			
Number of Members Leaving the Scheme	Integer	NumMembersLeaving			
Number of Dependents Leaving the Scheme	Integer	NumDependsLeaving			

5.1. Valid Definition

Number of members transferring from other schemes: (NumMembTransferringFromOther) -

- The scheme should complete the number of beneficiaries per age band (see [D.2] worksheet CdRef 3 AgeBands) and gender ([D.2] worksheet CdRef 4 Gender) that joined the medical scheme and were previously ***covered*** by any of the registered medical schemes.

Number of members not transferring from other schemes (i.e. where they were not members of a scheme directly prior to joining (NumMembNotTransferring):

- The scheme should complete the number of beneficiaries per age band and gender that joined the medical scheme and were previously not covered by any of the registered medical schemes. A member with a membership gap greater than 90 days must be treated as a "member not transferring from other schemes".

Number of new dependents joining the scheme: (NumNewDependsJoining):

- The scheme should complete the number of dependent beneficiaries that joined the medical scheme, per age band and gender.

Number of members leaving the scheme (NumMembersLeaving):

- The scheme should complete the number of members leaving (membership terminations) the medical scheme, per age band and gender.

Number of dependents leaving the scheme (NumDependsLeaving):

- The scheme should complete the number of dependents leaving (membership terminations) the medical scheme, per age band and gender.

5.2. Validation Rules

- None

5.3. Changes

- None

6. Table A4: Waiting periods, pre-existing condition exclusions and late joiner penalties

This table requires the age distribution of *new* beneficiaries (in other words beneficiaries who joined the scheme during the year) who have had general waiting periods imposed; pre-existing condition exclusions imposed; or late joiner penalties imposed. For each of the categories listed above the table further requires the split between new beneficiaries and transferred beneficiaries similar to Table A.3 M Mov. If more than one waiting period category applied to a member, the beneficiary must be counted in ***all*** valid categories.

Data Table Number:	A.4				
Data Table Description	Waiting periods, pre-existing condition exclusions and late joiner penalties				
Filter:	All beneficiaries who joined or left the scheme during the course of the year				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	A.4		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Number of New Beneficiaries to whom General Waiting Periods were Imposed: New Beneficiaries	Integer	GWP_NewBens			
Number of New Beneficiaries to whom General Waiting Periods were Imposed: Transferred Beneficiaries	Integer	GWP_TransferBens			
Number of New Beneficiaries to whom Pre-existing Condition Exclusions were Imposed: New Beneficiaries	Integer	PreX_NewBens			
Number of New Beneficiaries to whom Pre-existing Condition Exclusions were Imposed: Transferred Beneficiaries	Integer	PreX_TransferBens			
Number of New Beneficiaries to whom Late Joiner Penalties were Imposed: New Beneficiaries	Integer	LJP_NewBens			
Number of New Beneficiaries to whom Late Joiner Penalties were Imposed: Transferred Beneficiaries	Integer	LJP_TransferBens			

6.1. Valid Definition

The scheme should complete the number of beneficiaries, per age band and gender for new beneficiaries for the following fields:

- **Number of New Beneficiaries to whom General Waiting Periods were imposed: New Beneficiaries (GWP_NewBens)**
- **Number of New Beneficiaries to whom General Waiting Periods were imposed: Transferred Beneficiaries (GWP_TransferBens):**

- **Number of New Beneficiaries to whom Pre-existing Condition Exclusions were imposed: New Beneficiaries (PreX_NewBens)**
- **Number of New Beneficiaries to whom Pre-existing Condition Exclusions were imposed: Transferred Beneficiaries (PreX_TransferBens)**
- **Number of New Beneficiaries to whom Late Joiner Penalties were imposed: New Beneficiaries (LJP_NewBens)**
- **Number of New Beneficiaries to whom Late Joiner Penalties were imposed: Transferred Beneficiaries (LJP_TransferBens):**

6.2. Validation Rules

- None

6.3. Changes

- None

7. Table A5: Distribution of beneficiaries and benefits paid by province

In this table data regarding the average number of active beneficiaries *over the reporting financial year* in each group is collected. All active beneficiaries must be counted irrespective of whether they had a claim in any month during the financial year or not.

Data Table Number:	A.5				
Data Table Description	Distribution of beneficiaries and benefits paid by province				
Filter:	Number of registered beneficiaries at the end of each month				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	A.5		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Beneficiary Type	Text	BeneficiaryType	"Member", "Adult" or "Child"	CdRef 6 BeneficiaryType	BeneficiaryType
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Postal Code	Text	PostalCode	e.g. "1961" for Meyerton	CdRef 18 PostalCodes	Box_Code / Str_Code
Average number of beneficiaries	Decimal(18, 2)	AverageOfBeneficiaries	May not be blank		
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank		
Co-payment by member	Decimal(18, 2)	CoPaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank		
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank		

7.1. Valid Definition

Average number of beneficiaries (AverageOfBeneficiaries):

- The average count of beneficiaries in each group during the financial year (based on payment date).

Total amount claimed by provider (TotalAmountClaimed):

- The total amount claimed by the provider (invoice amounts) during the financial year (based on payment date).

Amount paid from risk (AmountPaidFromRisk):

- The total amount paid by the scheme / administrator from risk benefits (benefit amounts excluding payments from medical savings accounts) to the provider during the financial year (based on payment date).

Amount paid from savings (AmountPaidFromSavings):

- The total amount paid by the scheme / administrator from member savings account to the provider during the financial year (based on payment date).

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

7.2. Validation Rules

- The average number of beneficiaries reported in Table A.5 ≈average number of beneficiaries calculated in Table A.2 for the corresponding period.
- Total benefits reported in Part A.5 ≈ Parts B.1 + B.2 + B.3 + B.11+B.12
- The total amount claimed by provider, amount paid from risk and amount paid from savings must represent the schemes experience for the whole year and should not be limited to beneficiaries active in December only.
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

7.3. Changes

- None

8. Table A6: Managed Healthcare Indicators

This table collects data relating to claims limited to a subset of beneficiaries with a specified chronic condition. This table will report the number of utilising beneficiaries using two definitions as set out in table C.5, i.e.
"The data is divided into two measures of prevalence:

- beneficiaries who have had at least one claim for a CDL condition and
- beneficiaries registered for a chronic disease on CDL (not necessarily on a scheme's or subcontracted Disease Management Program)."

The number of utilising beneficiaries for a disease should then be calculated as the total number of unique beneficiaries that meet the criteria for a specified managed care indicator related to that disease at least once during the year. To identify the managed care indicators for the diseases concerned, please refer to [App.1] worksheet "A16 - Managed Care Indicator". This specifies the relevant codes to be used to identify the screening tests for the disease concerned.

Data Table Number:	**A.6**				
Data Table Description	**Managed Healthcare Indicators**				
Filter:	**Prevalence beneficiaries and beneficiaries registered on a chronic disease management programme for identified CDLs (&**				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	A.6		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
In Hospital Indicator	Bit	InHospital	1="Yes" 0="No" 2="Any setting"		
CDL Code	Text	CDL_Code	e.g. "IHD" for Coronary Artery	CdRef2 CDL	CDL_Code
Managed Care Indicator	Text	MHCIndicator	e.g. "MC_HB1" for having been tested for HBC1A at least once during the year	CdRef 5 Managed Care Indicators	MCI_Code
Number of Registered beneficiaries meeting criteria (Managed Care Indicator) at least once during the year	Integer	NumUtilisingRegBens	May not be blank		
Number of all beneficiaries (enrolled and not enrolled) meeting criteria (Managed Care Indicator) at least once during the year	Integer	NumUtilisingPrevBens	May not be blank		

Table A.6 requires that medical schemes report the number of beneficiaries receiving or utilising a managed care intervention in the **out-of-hospital or in-hospital or any setting**. Where the requirement is for at least 2 tests or managed care interventions to be performed for a beneficiary, such tests must occur in the same setting to be counted as **out-of-hospital or in-hospital,** unless the beneficiary received or utilised one managed care intervention out-of-hospital setting and the other in-hospital setting, then assign InHospital Indicator as 2= "Any setting".

At least two (2) HBA1C tests performed for an admitted beneficiary with DM1						
FinancialYear	Gender	AgeBand	InHospital	CDL_Code	MHCIndicator	NumUtilisingBens
2016	Male	25-29	1	"DM1"	HBA1C	**COUNT**
At least two (2) HBA1C tests performed for beneficiary with DM1 out of hospital						
FinancialYear	Gender	AgeBand	InHospital	CDL_Code	MHCIndicator	NumUtilisingBens
2016	Male	25-29	0	"DM1"	HBA1C	**COUNT**
One (1) HBA1C test performed for an admitted beneficiary with DM1 and another One (1) HBA1C out of hospital						
FinancialYear	Gender	AgeBand	InHospital	CDL_Code	MHCIndicator	NumUtilisingBens
2016	Male	25-29	2	"DM1"	HBA1C	**COUNT**
One (1) HBA1C test performed for an admitted beneficiary with DM1						
FinancialYear	Gender	AgeBand	InHospital	CDL_Code	MHCIndicator	NumUtilisingBens
2016	Male	25-29	1	"DM1"	HBA1C	**DO NOT COUNT**
One (1) HBA1C test performed for beneficiary with DM1 out of hospital						
FinancialYear	Gender	AgeBand	InHospital	CDL_Code	MHCIndicator	NumUtilisingBens
2016	Male	25-29	0	"DM1"	HBA1C	**DO NOT COUNT**
At least one (1) GP consultation for a beneficiary with DM2 (admitted)						
FinancialYear	Gender	AgeBand	InHospital	CDL_Code	MHCIndicator	NumUtilisingBens
2016	Male	25-29	1	"DM2"	MC_VGP	**COUNT**
At least one (1) GP consultation for a beneficiary with DM2 (not admitted)						
FinancialYear	Gender	AgeBand	InHospital	CDL_Code	MHCIndicator	NumUtilisingBens
2016	Male	25-29	0	"DM2"	MC_VGP	**COUNT**

If a beneficiary is registered for multiple chronic conditions, then the beneficiary should be counted for each of the conditions specified. It is therefore possible to have multiple records for such beneficiaries.

See [App.1] worksheet "A4 - CDL Condition" for a mapping of ICD-10 codes to CDL conditions.

8.1. Valid Definition

In Hospital Indicator (InHospital)

- If claim occurred in hospital then InHospital is **1**, otherwise it is **0** ([App.1.] worksheet "A32 - InHospital"). Emergency room visits are considered to be in-hospital if they resulted in an admission. Admissions to day clinics are also considered to be in-hospital. For claims *related* to an admission (for example pathology while in hospital) there are three common methods to identify them:

    - The easiest and most accurate method is where all claims are linked to a single case number assigned to the admission on the administration system.
    - The second method is to use the scheme's own In Hospital indicator.
    - The third method is known as the *notional cases* method, which is useful if the above methods are not available. Using this method, claims for the same beneficiary with service dates between the admission date and the discharge date are considered to occur in hospital.

CDL Code: (CDL_Code)

- For each beneficiary that is registered (prevalence) for a specific CDL, the beneficiary may be assigned to the relevant CDL code. For example, *IHD* indicates Coronary Artery Disease. If a beneficiary is registered for multiple chronic conditions, then the beneficiary should be counted for **each** of the conditions specified. It is therefore possible to have multiple records for such beneficiaries. See [App.1] worksheet "A4 - CDL Condition" for a mapping of ICD-10 codes to CDL conditions.

Managed Care Indicator: (MHCIndicator)

- The valid values and valid combinations of CDL_Code and ScreeningTestCode pairs for this field are contained in [D.2] worksheet "CdRef 5 MHC Indicators". It is important to note that this field is used in conjunction with the CDL_Code field. Claims can be categorised based on the Discipline and Tariff Code combinations shown in [App.1.] worksheet "A16 - Managed Care Indicator".

Number of beneficiaries meeting criteria (Managed Care Indicator) at least once during the year: (NumUtilisingPrevBens)

- Number of beneficiaries meeting criteria (Managed Care Indicator) at least once during the year in the **out-of-hospital or in-hospital or any setting.**

Any setting

- Beneficiary receiving or utilising a managed care intervention in either out-of-hospital or in-hospital setting. If beneficiary received or utilised more than one managed care intervention one in out-of-hospital setting and another in-hospital setting, then assign InHospital Indicator as 2= “Any setting”.

Number of beneficiaries registered for chronic disease on the CDL, that meets criteria (Managed Care Indicator) at least once during the year: (NumUtilisingRegBens)

8.2. Validation Rules

- NumUtilisingPrevBens (Table A6) ≤ NoOfBensRegistered (Table C5)
- Number of beneficiaries meeting the managed care criteria (NumUtilisingRegBens) for a CDL condition at least once during the year may not be greater than the number of beneficiaries registered for a relevant CDL. NumUtilisingRegBens(Table A6) ≤ NoOfBensRegistered (Table C5)
- Number of beneficiaries meeting the managed care criteria (NumUtilisingRegBens) for a CDL condition at least once during the year may not be greater than the number of beneficiaries meeting the managed care criteria (NumUtilisingPrevBens) for a CDL condition. NumUtilisingRegBens ≤ NumUtilisingPrevBens
- The **total number** of beneficiaries receiving or utilising a managed care intervention should be **equal** to the **sum** of number of beneficiaries receiving or utilising a managed care intervention in the **out-of-hospital, in-hospital and any setting.**

8.3. Changes

- Valid Definitions and Validation Rules

9. Table A.7: Scheme Risk Measurement data

This table is based on the current Scheme Risk Measurement (SRM) data processes as defined in the "Guidelines for the Identification of Beneficiaries with Risk Factors in Accordance with the Entry and Verification Criteria Version".

A separate table must be provided for each benefit option and for every month of the year. The number of beneficiaries reported for the "Prevalence" table must always be greater or equal to those reported for the "Count" table. The number of beneficiaries without a CDL condition must always be the same for the "Prevalence" and "Count" tables. Schemes must always consider the Q4 data of the previous year when preparing SRM data.

Both "Prevalence" and "Count" data must be submitted for 2019 and 2020 financial years.

Important: Unlike other tables that use CDL codes, the allocation of beneficiaries for the purposes of the SRM table should be based on the *entry and verification criteria* (see [R.2]) rather than prevalence.

A.7				
Scheme Risk Measurement data. (Schemes must always consider quarter 4 data of the previous year when preparing SR				
Beneficiaries at the end of each month.				
Data type	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Integer	YearOfSubmission	2018		
Text	Part	A.7		
Integer	RefNo	can be obtained from Odata		
Integer	BenefitOptionNumber	can be obtained from Odata		
Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Integer	FinancialMonth	e.g. 9 for September	CdRef 1 ReportingYearsAndMonths	Month
Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Integer	CountPrevalence	"Count" or "Prevalence"	CdRef 15 CountPrevalence	CountPrevalence
Integer	NoCDLDisease			
Integer	ADS			
Integer	AST			
Integer	BCE			
Integer	BMD			
Integer	CMY			
Integer	COP			
Integer	CRF			
Integer	CSD			
Integer	DBI			
Integer	DM1			
Integer	DM2			
Integer	DYS			
Integer	EPL			
Integer	GLC			
Integer	HAE			
Integer	HYL			
Integer	HYP			
Integer	IBD			
Integer	IHD			
Integer	MSS			
Integer	PAR			
Integer	RHA			
Integer	SCZ			
Integer	SLE			
Integer	TDH			
Integer	HIV			
Integer	CC2			
Integer	CC3			
Integer	CC4			
Integer	MAT			

9.1. Valid Definition

Valid definitions are contained in the relevant version of the *entry and verification criteria* document (see [R.2]: Guidelines for the Identification of Beneficiaries with Risk Factors in Accordance with the Entry and Verification Criteria)

9.2. Validation Rules

- 'Count' must be ≤ 'Prevalence' for each CDL condition
- (A1.MembersenrolledforMoreThan12months + A1.Membersjoininginthelast12months + A1.AdultsEnrolledMoreThan12 + A1.Adultsjoininginthelast12months + A1.ChildrenenrolledforGreaterThan12months + A1.Childrenjoininginthelast12months) ≈ (A7.NoCDLDisease + A7.ADS + A7.AST + A7.BCE + A7.BMD + A7.CMY + A7.COP + A7.CRF + A7.CSD + A7.DBI + A7.DM1+ A7.DM2 + A7.DYS + A7.EPL + A7.GLC + A7.HAE + A7.HYL + A7.HYP + A7.IBD + A7.IHD + A7.MSS + A7.PAR + A7.RHA + A7.SCZ + A7.SLE + A7.TDH + A7.HIV) WHERE (CountPrevalence = "Count" AND FinancialMonth = 12)
- Differences may be explained by different inclusion criteria in A1 and A7. A beneficiary is counted if he/she is entitled to benefits in respect of that month"), while they are included in A1.
- Multiple chronic condition(CC2,CC3 and CC4) and Maternity(MAT must only be populated for count not prevalence) (If CountPrevalence=Prevalence then CC2,CC3, CC4 and MAT should be equal to zero)

9.3. Changes

- Both "Prevalence" and "Count" data must be submitted for 2019 and 2020 financial years.

10. Table B.1: Analysis of healthcare providers (GP's, Specialists, etc.)

This table should include all non-hospital discipline claims for professional fees charged. Claims for discipline codes 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79 must not be reported in this part. See [D.2] worksheet "CdRef 8 DisciplineCodes" for a list of valid Discipline/Sub discipline code combinations. If a discipline does not have sub disciplines or the sub discipline code is unavailable, then the sub discipline code 0 should be used.

If claim occurred in hospital then InHospital is **1**, otherwise it is **0** ([App.1.] worksheet "A32 - InHospital"). Emergency room visits are considered to be in-hospital if they resulted in an admission. Admissions to day clinics are also considered to be in-hospital. For claims *related* to an admission (for example pathology while in hospital) there are three common methods of identification:

- The easiest and most accurate method is where all claims are linked to a single case number assigned to the admission on the administration system.
- The second method is to use the scheme's own "In-Hospital" indicator.
- The third method is known as the *notional cases* method, which is useful if the above methods are not available. With this method, claims for the same beneficiary with service dates between the admission date and the discharge date are considered to occur in hospital.

Out-of-hospital medicines and consumables claims (e.g. medicine dispensed by a GP) must be reported in Table B.2 to avoid double counting.

Data Table Number:	**B.1**				
Data Table Description	**Analysis of healthcare providers (GP's, Specialists, etc.)**				
Filter:	**All discipline codes excluding** 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.1		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Discipline Code	Integer	DisciplineCode	e.g. 21 for Cardiology	CdRef 8 DisciplineCodes AND	DisciplineCode
Subdiscipline Code	Integer	SubDisciplineCode	e.g 2 for Cardialogy: Paediatrics 0 if discipline has no sub-disciplines or sub-discipline is unknown		SubdisciplineCode
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
In Hospital Indicator	Bit	InHospital	1=Yes 0=No		
No of Beneficiaries visiting at least once a year	Integer	NoOfBeneficiariesAtLeast1Visit	May not be blank	Use 0 when no data available	
Total visits (paid for)	Integer	TotalVisits_Paid_for	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

10.1. Valid Definition

No of Beneficiaries visiting at least once a year: (NoOfBeneficiariesAtLeast1Visit)

- This is calculated as the distinct number of beneficiaries who had at least one claim for the specific service.

Total visits paid for (TotalVisits_Paid_for):

- Refers to all claim lines relating to a specific beneficiary per unique visit to a provider, a single visit is any distinct interaction between a beneficiary and a provider on a service date. The count of distinct visits will give the total number of visits.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims (amounts invoiced by providers) limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication, or consumables, other than specified co-payments

10.2. Validation Rules

- Claims data reported in Table B.1 cannot be duplicated in Parts B.2, B.3, B.11 and B.12.
- Number of beneficiaries visiting at least once per year ≤ Total number registered beneficiaries.
- Number of beneficiaries visiting at least once per year ≠ 0.
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings.
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

10.3. Changes

- Valid Definitions and Validation Rules

11. Table B.2: Utilisation of medicines and consumables

This table should include all out-of-hospital claims for medicines and consumables. Claims for discipline codes 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79 must not be reported in this part. See [D.2] worksheet "CdRef 8 DisciplineCodes" for a list of valid Discipline/Sub discipline code combinations. If a discipline does not have sub disciplines or the sub discipline code is unavailable, then the sub discipline code 0 should be used.

Data Table Number:	B.2				
Data Table Description	Utilisation of medicines & consumables				
Filter:	All out-of-hospital claims for medicines & consumables				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.2		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Discipline Code	Number	DisciplineCode		CdRef 8 DisciplineCodes	DisciplineCode
Subdiscipline Code	Number	SubdisciplineCode		AND IsHospital = 0	SubdisciplineCode
Medicine or consumable	Text	MedsOrConsumable	"Medicine" or "Consumables"	CdRef 9 MedsAndConsInd	MedsOrConsumable
No of Items Dispensed	Number	NoOfItemsDispensed	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

11.1. Valid Definition

The number of items dispensed (NoOfItemsDispensed):

- The number of items dispensed for medicines or consumables is calculated as the number of NAPPI codes that were claimed for out of hospital treatment. This field indicates whether a claim is classified as Medicine or Consumables based on the claim line's NAPPI code value. The schemes shall use the Surgical / Ethical indicator found on the Nappi file to distinguish between Medicine and Consumables (where "Surgical" refers to Consumables and "Ethical" to Medicines).

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims (amounts invoiced by providers) limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme that is not paid from medical savings accounts.

Amount paid from Savings (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid by the scheme from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication, or consumables, other than specified co-payments

11.2. Validation Rules

- Number of items dispensed ≠ 0 OR missing
- Claims data reported in Table B.2 cannot be duplicated in Parts B.1, B.3, B11 and B.12. All fees paid in relation to Managed Care Services must be reported in Table B.12.
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

11.3. Changes

- Valid Definitions and Validation Rules

12. Table B.3: Hospital admissions and expenditure

This table should be completed using data from private and public hospitals (discipline codes 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79). See [D.2] worksheet "CdRef 8 DisciplineCodes" for a list of valid Discipline/Sub discipline code combinations.

A "**day case" (same day inpatient)** is an admission where **Discharge date = Admission date.** An **inpatient** (overnight) admission is an admission where **Discharge date > Admission date.** Schemes are further advised to test the reasonability of the submitted data by calculating **TotalInpatientDays** (Total number of inpatient days / Length of stay) and the Average Length of Stay.

- Total number of inpatient days = date of discharge - date of admission
- Average length of stay = Total number of inpatient days / Total number of admissions

Transfers between hospitals should not be counted as re-admission.

Data Table Number:	B.3
Data Table Description	Hospital admissions and expenditure
Filter:	Hospitals only (discipline codes 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79)

Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.3		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Discipline Code	Number	DisciplineCode	Only hospital claims	CdRef 8 DisciplineCodes AND IsHospital = 1	
Hospital admission as inpatient or day case	Bit	AdmissionType	1="Inpatient" 0="Day case"		
Number of unique beneficiaries admitted	Integer	NoOfBensAdmitted	May not be blank	Use 0 when no data available	
Number of admissions	Integer	NoOfAdmissions	May not be blank	Use 0 when no data available	
Total number of inpatient days	Integer	TotalInpatientDays	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

12.1. Valid Definition

The number of unique beneficiaries admitted (NoOfBensAdmitted):

- This calculation is a count of distinct beneficiaries admitted in hospital for any reason.

Number of admissions (NoOfAdmissions):

- This field counts the number of hospital admissions. Should an admission event extend over two financial years, the year in which the admission was initiated must be used.

Number of inpatient days (TotalInpatientDays):

- Total number of inpatient days = date of discharge - date of admission
- Average length of stay = Total number of inpatient days / Total number of admissions

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid by the scheme from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

12.2. Validation Rules

- Schemes must ensure that the reported number of unique beneficiaries admitted to hospitals is consistent in all instances where such information is reported (Tables B.5, B.6 and B10).
- Number of admissions ≥ The number of unique beneficiaries admitted
- Claims data reported in Table B.2 cannot be duplicated in Parts B.1, B.3, B.11 and B.12.
- TotalAmountClaimed **≥** AmountPaidFromRisk + AmountPaidFromSavings
- TotalAmountClaimed **=**AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

12.3. Changes

- Valid Definitions and Validation Rules

13. Table B.4: Analysis of the total benefits paid in respect of selected principal diagnosis types per ICD-10 codes (ISHTM)

This table should contain data for both public and private hospital admissions related to the International Shortlist for Hospital Morbidity Tabulation (ISHMT) and should therefore include all the discipline codes used in Table B.3. See [D.2] worksheet "CdRef 8 DisciplineCodes" for a list of valid Discipline/Sub discipline code combinations. The International Shortlist for Hospital Morbidity Tabulation (ISHMT) is defined in [D.2] worksheet "CdRef 10 ISHMT" or http://www.who.int/classifications/icd/implementation/morbidity/ishmt/en/.

A "**day case" (same day inpatient)** is an admission where **Discharge date = Admission date.** An **inpatient** (overnight) admission is an admission where **Discharge date > Admission date.** Schemes are further advised to test the reasonability of the submitted data by calculating **TotalInpatientDays** (Total number of inpatient days / Length of stay) and the Average Length of Stay.

- Total number of inpatient days = date of discharge - date of admission
- Average length of stay = Total number of inpatient days / Total number of admissions

Transfers between hospitals should not be counted as re-admission.

Data Table Number:	B.4				
Data Table Description	Analysis of the total benefits paid in respect of selected principal diagnosis types per				
Filter:	~~All hospital claims~~ All claims				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.4		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
International Shortlist for Hospital Morbidity Tabulation (ISHMT) http://apps.who.int/classifications/apps/icd/implementation/hospitaldischarge.htm	Text	ISHMT	e.g."A00-B99" for "Certain infectious and parasitic diseases"	CdRef 10 ISHMT	ICD10_Range
Hospital admission as inpatient or day case	Integer	AdmissionType	0="Day case" 1="Inpatient" 2= "Out-of-hospital"		
Number of unique beneficiaries admitted or treated	Integer	NoOfBensAdmitted_Treated	May not be blank	Use 0 when no data available	
Number of admissions	Integer	NoOfAdmissions	May not be blank	Use 0 when no data available	
Total number of inpatient days	Integer	TotalInpatientDays	May not be blank	If AdmissionType=0 or 2 then use 0.	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CoPaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

13.1. Valid Definition

The number of unique beneficiaries admitted (NoOfBensAdmitted_Treated):

- This calculation is a count of distinct beneficiaries admitted in hospital or treated out of hospital for any relevant ICD-10.

Admission Type

- 0="Day case" 1="Inpatient" 2= "Out-of-hospital"

Number of admissions (NoOfAdmissions):

- This field counts the number of hospital admissions (admission with overnight stay plus same-day admission) for the relevant ISHMT. Should an admission event extend over two financial years, the year in which the admission was initiated must be used.

Number of inpatient days (TotalInpatientDays):

- Total number of inpatient days = date of discharge - date of admission
- Average length of stay = Total number of inpatient days / Total number of admissions

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims (amounts invoiced by providers) limited to the combination of the scheme and member's liability for the relevant ISHMT.

Total amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme that is not paid from medical savings accounts for the relevant ISHMT.

Amount paid from risk (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid by the scheme from medical savings accounts for the relevant ISHMT.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

13.2. Validation Rules

- Number of admissions ≥ the number of unique beneficiaries admitted
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

13.3. Changes

- Valid Definitions and Validation Rules

14. Table B.5: Hospital admissions relating to beneficiaries registered on a CDL disease management programme

This table contains all-cause hospital admissions relating to beneficiaries **registered for a chronic disease on CDL (not necessarily on a scheme's or subcontracted Disease Management Program)**. The valid CDL codes are listed in [D.2] worksheet "CdRef2 CDL".

A "**day case" (same day inpatient)** is an admission where **Discharge date = Admission date.** An **inpatient** (overnight) admission is an admission where **Discharge date > Admission date.** Schemes are further advised to test the reasonability of the submitted data by calculating **TotalInpatientDays** (Total number of inpatient days / Length of stay) and the Average Length of Stay.

- Total number of inpatient days = date of discharge - date of admission
- Average length of stay = Total number of inpatient days / Total number of admissions

Transfers between hospitals should not be counted as re-admission.

Data Table Number:	B.5				
Data Table Description	Hospital admissions relating to beneficiaries with chronic diseases				
Filter:	Registered Beneficiaries on a chronic disease management				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.5		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
CDL Code	Text	CDL_Code	e.g. "IHD" for Coronary Artery Disease	CdRef2 CDL	CDL_Code
Hospital admission as inpatient or day case	Bit	AdmissionType	1="Inpatient" 0="Day case"		
Number of admissions	Integer	NoOfAdmissions	May not be blank	Use 0 when no data available	
Number of unique beneficiaries admitted	Integer	NoOfBensAdmitted	May not be blank	Use 0 when no data available	
Total number of inpatient days	Integer	TotalInpatientDays	May not be blank	Use 0 when no data available	
Total amount claimed	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Total amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Total amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

14.1. Valid Definition

Number of admissions (NoOfAdmissions):

- This field contains the count of **all-cause admissions** relating to beneficiaries registered on a CDL disease management programme for the specified CDL condition.

The number of unique beneficiaries admitted (NoOfBensAdmitted):

- Count of distinct beneficiaries registered on a chronic diseases management program **AND** admitted in hospital for any reason. This count is a subset of the count of **all** beneficiaries registered on a CDL disease management programme (**NoOfBensAdmitted**).

Number of inpatient days (TotalInpatientDays):

- Total number of inpatient days in relation to admissions for beneficiaries registered on a CDL disease management programme for the specified CDL condition **AND** admitted in hospital for any reason.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed in relation to admissions for beneficiaries with a CDL condition is the total amount of claims (amounts invoiced by providers) limited to the combination of the scheme and member's liability for the specified CDL condition.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk in relation to admissions for beneficiaries with a CDL condition is the total amount of relevant healthcare expenditure paid by the scheme, that is not paid from medical savings accounts for the specified CDL condition.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings in relation to admissions for beneficiaries with a CDL condition is the total amount of relevant healthcare expenditure paid by the scheme from medical savings accounts for the specified CDL condition.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication, or consumables, other than specified co-payments

13.2. Validation Rules

- Number of admissions ≥ the number of unique beneficiaries admitted
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

- Schemes shall test the reasonability of the submitted data by calculating the following:
    - Length of stay = date of discharge - date of admission
    - Average length of stay = Length of stay / Total number of admissions

13.3. Changes

- Valid Definitions and Validation Rules

15. Table B.6: Analysis of hospital admission categories

This table is completed for all claims that were incurred while the beneficiary was in hospital by admission categories listed in [D.2] worksheet "CdRef 11 AdmitCats". Claim and benefit amounts should be split according to the type of service provider related to the hospital admission, who was reimbursed, namely: "Hospitals"; "Radiologists and pathologists" (discipline codes 38 and 52); "medical professionals (e.g. specialists)"; and the balance must be allocated to "other service providers".

Data Table Number:	**B.6**
Data Table Description	**Analysis of hospital admission categories**
Filter:	**Hospitals only (discipline codes 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79)**

Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.6		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Admission Category Code	Text	AdmitCategoryCode	e.g. "AC_SUDC" for Surgical	CdRef 11 AdmitCats	AdmitCatCode
Hospital admission as inpatient or day case	Bit	AdmissionType	1="Inpatient" 0="Day case"		
Number of unique beneficiaries admitted	Integer	NoOfBensAdmitted	May not be blank	Use 0 when no data available	
Number of admissions	Integer	NoOfAdmissions	May not be blank	Use 0 when no data available	
Total number of inpatient days	Integer	TotalInpatientDays	May not be blank	Use 0 when no data available	
Discipline Category	Integer	DisciplineCategory	e.g. 0="Hospital" 1="Radiologists"	CdRef 28 Discipline Category	
Amount claimed	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CoPaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	

A "**day case" (same day inpatient)** is an admission where **Discharge date = Admission date.** An **inpatient** (overnight) admission is an admission where **Discharge date > Admission date.** Schemes are further advised to test the reasonability of the submitted data by calculating **TotalInpatientDays** (Total number of inpatient days / Length of stay) and the Average Length of Stay.

- Total number of inpatient days = date of discharge - date of admission
- Average length of stay = Total number of inpatient days / Total number of admissions

Transfers between hospitals should not be counted as re-admission.

When populating the private hospital admission type categories grid, the order in which an admission is assigned to an admission type category is extremely important. There will be instances where the business rules detailed below will result in an admission being assigned to multiple admission type categories. In this instance the category with the higher priority will be used. This will eliminate double-counting of admissions.

The admission type category priorities are specified in [App.1] worksheet "A27 - Admission priority". Certain business rules specified below relate to particular hospital groups. It is therefore necessary to identify which group the admitting hospital belongs to. To assist with this, a list of private hospital practice numbers together with the group they belong to is specified in [App.1] worksheet "A28 - Hospital Group".

Hospitals do change ownership from time to time. In a case where the admission occurred while the hospital belonged to another group the codes that applied at the time of discharge (and billing) should be used.

The specification assumes that a medical scheme is in possession of a hospital authorisation file with at least an admission date, discharge date and primary ICD-10 code for every hospital admission. The admission categories are defined as follows:

Ambulatory

Any private hospital admission that has at least one claim for the discipline and tariff codes shown in [App.1] worksheet "A22 – Ambulatory". Length of stay must not be greater than 0.

Emergency Room

An emergency room admission is classified as:

Any private hospital admission that has at least one claim with a discipline and tariff code that is contained in [App.1] worksheet "A23 – ER" table "Default specific tariff codes".

OR

If the admitting hospital is a member of the Mediclinic group, any admission that has at least one claim with a discipline and tariff code that is contained in [App.1] worksheet "A23 – ER" table "Mediclinic specific tariff codes".

Maternity

A maternity admission is defined as:

Any private hospital admission with a tariff code that is contained in [App1] worksheet "A24 – Maternity" table "Maternity principal ICD-10 codes"

The maternity ICD-10 can be in a secondary position, therefore we should look for a birth outcome in any position.

OR

If the admitting hospital is a member of the Netcare group, any private hospital admission with a tariff code that is contained in [App1] worksheet "A24 – Maternity" table "Netcare specific tariff codes"

OR

If the admitting hospital is a member of the Life Healthcare group, any private hospital admission with a tariff code that is contained in [App1] worksheet "A24 – Maternity" table "Life Healthcare specific tariff codes"

Surgical

A surgical admission is defined as:

Any private hospital admission with a tariff code that is contained in [App1] worksheet "A25 - Surgical" table "Default specific tariff codes"

OR

If the admitting hospital is a member of the Mediclinic group, any private hospital admission with a tariff code that is contained in [App1] worksheet "A25 - Surgical" table "Mediclinic specific tariff codes"

OR

If the admitting hospital is a member of the Netcare group, any private hospital admission with a tariff code that is contained in [App1] worksheet "A25 - Surgical" table "Netcare specific tariff codes"

OR

If the admitting hospital is a member of the Life Healthcare group, any private hospital admission with a tariff code that is contained in [App1] worksheet "A25 - Surgical" table "Life Healthcare specific tariff codes"

NB: Cath lab procedures fall under surgical admissions.

Medical

After allocating admissions to the above categories, the remainder of private hospital admissions must be allocated to the "Medical category.

15.1. Valid Definition

Number of admissions (NoOfAdmissions):

- This field contains the count of **all-cause admissions** for the specified admission category.

The number of unique beneficiaries admitted (NoOfBensAdmitted):

- This calculation is a count of distinct beneficiaries admitted in hospital for any reason for the relevant admission category.

Number of inpatient days (TotalInpatientDays):

- Total number of inpatient days for the relevant admission category.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication, or consumables, other than specified co-payments

15.2. Validation Rules

- Number of admissions ≥ the number of unique beneficiaries admitted
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

- Schemes shall test the reasonability of the submitted data by calculating the following:
  - Length of stay = date of discharge - date of admission
  - Average length of stay = Length of stay / Total number of admissions
  - Admission with overnight stay: Length of stay >0
  - Same-day admissions: Length of stay =0

15.3. Changes

- *Discipline Category* field included
- Valid Definitions and Validation Rules
- CdRef 28 Discipline Category included

16. Table B.7: Total PMB expenditure

This table should be completed based on all claims that have been paid as PMBs. All claims that were flagged or identified as PMBs at the time of payment must be reported irrespective of the scheme rule applied. It is important to note that the ICD-10 codes only serve as a guideline. The scheme must identify the primary, secondary ICD-10 code, and also apply the CMS PMB code of conduct to identify PMB claims. PMBs should not be identified by the principal ICD-10 codes only. According to the ICD-10 coding rules, a PMB condition can be a secondary code. However, if the resource utilisation (services rendered) is supportive of the PMB condition, then that specific claim line (as a subset of the entire claim) may be paid as a PMB. Schemes should also note that the list of codes is revised by the CMS from time to time.

Data Table Number:	**B.7**				
Data Table Description	**Total PMB expenditure**				
Filter:	**All PMB claims both in and out of hospital**				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.7		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
In Hospital Indicator	Bit	InHospital	1=Yes 0=No		
No of unique beneficiaries treated for a PMB condition	Number	NoOfPMBBeneficiaries	May not be blank	Use 0 when no data available	
Amount claimed	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

16.1. Valid Definition

No of unique beneficiaries treated for a PMB condition (NoOfPMBBeneficiaries):

- This calculation is a count of distinct beneficiaries treated for a one or more PMB conditions during the period under review.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed in respect of PMB benefits is the total amount of claims (amounts invoiced by providers) for valid PMB claims limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk in respect of PMB benefits is the total amount of relevant healthcare expenditure for valid PMB claims paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings in respect of PMB benefits is the total amount of relevant healthcare expenditure for valid PMB claims paid by the scheme from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

16.2. Validation Rules

- TotalAmount_Claimed (B.7) ≈ TotalAmount_Claimed (B.8) + TotalAmount_Claimed (B.9)

- AmountPaidFromRisk (B.7) ≈ AmountPaidFromRisk (B.8) + AmountPaidFromRisk (B.9)
- AmountPaidfromSavings (B.7) ≈ AmountPaidfromSavings (B.8) + AmountPaidfromSavings (B.9)
- AmountPaidFromRisk (B.7) ≤ AmountPaidFromRisk (B.1) + AmountPaidFromRisk (B.2) + AmountPaidFromRisk (B.3) + ExG_AmountPaidFromRisk (B.11) + Other_AmountPaidFromRisk (B.11) + MCFeesPaid (B12)
- TotalAmountClaimed (B.7) ≥ AmountPaidFromRisk (B.7) + AmountPaidFromSavings (B.7)
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

16.3. Changes

- Valid Definitions and Validation Rules

17. Table B.8: Total PMB expenditure for CDL conditions

This table should be completed based on all claims that have been paid as PMBs under the CDL definitions. All claims that were flagged or identified as PMBs at the time of payment must be reported, irrespective of the scheme rule applied. The scheme must identify the primary, secondary ICD-10 code, and also apply the CMS PMB code of conduct to identify PMB claims. PMBs should not be identified by the principal ICD-10 codes only. According to the ICD-10 coding rules, a PMB condition can be a secondary code. However, if the resource utilisation (services rendered) is supportive of the PMB condition, then that specific claim line (as a subset of the entire claim) may be paid as a PMB. Schemes should also note that the list of codes is revised by the CMS from time to time.

In cases where a beneficiary suffers from a CDL and a DTP condition that share one or more ICD-10 codes, such beneficiary must be counted for the CDL condition if they are registered in terms of the CDL condition **(not necessarily on a scheme's or subcontracted Disease Management Program)**. If not registered for a CDL condition, the beneficiary must be counted under a DTP condition.

Data Table Number:	**B.8**
Data Table Description	**Total PMB expenditure for CDL conditions**
Filter:	**All PMB claims both in and out of hospital in respect of CDL conditions**

Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.8		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
CDL Code	Text	CDL_Code	e.g. "IHD" for Coronary Artery Disease	CdRef2 CDL	CDL_Code
In Hospital Indicator	Bit	InHospital	1=Yes 0=No		
No of unique beneficiaries treated for a CDL condition	Number	NoOfCDLBeneficiaries	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Total amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

17.1. Valid Definition

No of unique beneficiaries treated for a CDL condition (NoOfCDLBeneficiaries):

- This calculation is a count of distinct beneficiaries treated for a one or more CDL conditions during the period under review.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed in respect of CDL benefits is the total amount of claims (amounts invoiced by providers) for valid CDL claims limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk in respect of CDL benefits is the total amount of relevant healthcare expenditure for valid CDL claims paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings in respect of CDL benefits is the total amount of relevant healthcare expenditure for valid CDL claims paid by the scheme from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

17.2. Validation Rules

- Count of distinct beneficiaries treated for a CDL ≤ number of active beneficiaries registered for the corresponding period.
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

17.3. Changes

- Valid Definitions and Validation Rules

18. Table B.9: Total PMB expenditure for DTP conditions

This table should be completed based on all claims that have been paid as PMBs under the DTP definitions. All claims that were flagged or identified as PMBs at the time of payment must be reported, irrespective of the scheme rule applied. The scheme must identify the primary, secondary ICD-10 code, and also apply the CMS PMB code of conduct to identify PMB claims. PMBs should not be identified by the principal ICD-10 codes only. According to the ICD-10 coding rules, a PMB condition can be a secondary code. However, if the resource utilisation (services rendered) is supportive of the PMB condition, then that specific claim line (as a subset of the entire claim) may be paid as a PMB. Schemes should also note that the list of codes is revised by the CMS from time to time.

In cases where a beneficiary suffers from a CDL and a DTP condition that share one or more ICD-10 codes, such beneficiary must be counted for the CDL condition if they are registered in terms of the CDL condition. If not registered for a CDL condition, the beneficiary must be counted under a DTP condition.

All PMB claims that were not accounted for in Table B.8 should be included in Table B.9 as DTPs.

Schemes must also report the number of unique beneficiaries (**NoOfDTPBeneficiaries**) treated for a DTP condition.

Data Table Number:	B.9
Data Table Description	Total PMB expenditure for DTP conditions
Filter:	All PMB claims both in and out of hospital in respect of DTP conditions

Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.9		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
DTP Code	Text	DTPCode	e.g. "182T" for Abuse or dependence on Psychoactive substance; including alcohol	CdRef 13 DTP	DTPCode
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
In Hospital Indicator	Bit	InHospital	1=Yes 0=No		
No of unique beneficiaries treated for a DTP condition	Number	NoOfDTPBeneficiaries	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Total amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

18.1. Valid Definition

No of unique beneficiaries treated for a DTP condition (NoOfDTPBeneficiaries):

- This calculation is a count of distinct beneficiaries treated for one or more DTP conditions during the period under review.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed in respect of DTP benefits is the total amount of claims (amounts invoiced by providers) for valid DTP claims limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk in respect of DTP benefits is the total amount of relevant healthcare expenditure for valid DTP claims paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings in respect of DTP benefits is the total amount of relevant healthcare expenditure for valid DTP claims paid by the scheme from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

18.2. Validation Rules

- Number of unique beneficiaries treated for a DTP condition < Total number of beneficiaries for the period under review.
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings
- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

18.3. Changes

- Valid Definitions and Validation Rules

19. Table B.10: Reimbursement methods for hospital services

This table should be completed based on all in-hospital claims data and categorised according to the provider reimbursement groupings in [D.2] worksheet "CdRef 14 Hosp Cost Types". Data for hospital cost categories must be reported per discipline codes. Schemes must note that not all hospital cost categories are applicable to all types of facilities / discipline codes.

The following is the list of valid reimbursement groupings for in-hospital based healthcare services:

- **Fee for service:** Hospital is paid a fee for each particular service (ward fees, theatre fees, medicines and consumables) rendered.
- **Global fees:** Any in-hospital managed care arrangements for which global fees reimbursement method for healthcare services are provided.
- **Fixed fee:** Any in-hospital managed care arrangements for which fixed fees reimbursement method for healthcare services are provided.
- **Per Diem fee:** Any in-hospital managed care arrangements for which a per diem rate reimbursement method is used to pay for healthcare services provided.
- **UPFS:** Uniform Patient Fee Schedule (State/provincial hospitals)
- **Other:** Any other in-hospital alternative reimbursement models not provided for in the return.

Data Table Number:	**B.10**				
Data Table Description	**Hospital Cost types**				
Filter	**Hospitals only (discipline codes 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79)**				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.10		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Discipline Code	Integer	DisciplineCode	Hospitals only	CdRef 8 DisciplineCodes AND IsHospital = 1	DisciplineCode
Hospital Cost Type Code	Text	HospCostTypeCode	e.g. "FFS_THEATRE" for fee for service theatre fees	CdRef 14 Hosp Cost Types	HospCostTypeCode
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CopaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

19.1. Valid Definition

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed in respect of reimbursement groupings for in-hospital based healthcare services.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk in respect of reimbursement groupings for in-hospital based healthcare services.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings in respect of reimbursement groupings for in-hospital based healthcare services.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

19.2. Validation Rules

- TotalAmount_Claimed (B.10) ≈ TotalAmount_Claimed (B.3)
- AmountPaidFromRisk (B.10) ≈ AmountPaidFromRisk (B.3)
- AmountPaidfromSavings (B.10) ≈ AmountPaidfromSavings (B.3)
- AmountPaidfromSavings (B.10) ≈ TotalHospPaidFromSavings(B.6)
- TotalAmountClaimed (B.10) ≥ AmountPaidFromRisk (B.10) + AmountPaidFromSavings (B.10)

- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

19.3. Changes

- Valid Definitions and Validation Rules

20. B.11: Other benefits

This table collects data on ex-gratia payments for healthcare services and other benefits that do not fall into any of the categories specified in Tables B.1, B.2, B.3 and B.12 – hence the amounts here should be relatively small. **Claims data reported in Part B.11 must not be duplicated in Parts B.1, B.2, B.3 and B.12.**

Various administration systems handle ex-gratia claims in different ways and this table should be completed accordingly. It is however important to note that ex-gratia claim amounts should not be double counted.

For example, if a claim was partly settled from "normal benefits" with the remainder being paid ex-gratia, then the ex-gratia portion should be shown here with the "normal benefit" amount being show in the relevant area of the submission.

Data Table Number:	**B.11**				
Data Table Description	**Other benefits (benefits that do not fall into any of the categories specified in Tables B.1, B.2, B.3 and B.12)**				
Filter:	**All claims**				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.11		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Ex-gratia payments: Total amount claimed by provider	Decimal(18, 2)	ExG_TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Ex-gratia payments: Amount paid from risk	Decimal(18, 2)	ExG_AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Other benefits: Total amount claimed by provider	Decimal(18, 2)	Other_TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Other benefits: Amount paid from risk	Decimal(18, 2)	Other_AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Other Benefits: Amount paid from savings	Decimal(18, 2)	Other_AmountPaidFromSavings	May not be blank	Use 0 when no data available	
Ex-gratia Co-payment by member	Decimal(18, 2)	ExG_CoPaymentMember	May not be blank	Use 0 when no data available	
Ex-gratia Other payment by member	Decimal(18, 2)	ExG_OtherCoPaymentMember	May not be blank	Use 0 when no data available	
Other Co-payment by member	Decimal(18, 2)	Other_CoPaymentMember	May not be blank	Use 0 when no data available	
Other Other payment by member	Decimal(18, 2)	Other_OtherPaymentMember	May not be blank	Use 0 when no data available	

20.1. Valid Definition

Ex-gratia payments: Total amount claimed by provider (ExG_TotalAmount_Claimed):

- Amount claimed in respect of ex-gratia claims / applications for healthcare services.

Ex-gratia payments: Amount paid from risk (ExG_AmountPaidFromRisk):

- Total amount paid for from risk as ex-gratia for healthcare services at the discretion of the scheme.

Other benefits: Total amount claimed by provider (Other_TotalAmount_Claimed):

- Total amount claimed for any other benefit not provided for in the categories specified in Tables B.1, B.2, B.3 and B.12

Other benefits: Amount paid from risk (Other_AmountPaidFromRisk):

- Total amount paid from risk for any other benefit not provided for in the categories specified in Tables B.1, B.2, B.3 and B.12

Other Benefits: Amount paid from savings (Other_AmountPaidFromSavings):

- Total amount paid from savings for any other benefit not provided for in the categories specified in Tables B.1, B.2, B.3 and B.12

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

20.2. Validation Rules

- Other_TotalAmount_Claimed=AmountPaidFromRisk+AmountPaidFromSavings+CopaymentMember + OtherPaymentMember
- ExG_TotalAmount_Claimed= AmountPaidFromRisk+AmountPaidFromSavings+CopaymentMember + OtherPaymentMember

20.3. Changes

Validation Rules

21. B.12: Accredited Managed Care Services

This table must include all fees paid in relation to accredited managed care services and benefit management services. Schemes should refer to **Circulars 13 of 2014 and 56 of 2015** for the correct classification of managed care and benefit management services.

Data Table Number:	B.12				
Data Table Description	Accreditable Managed Care Services				
Filter:	All claims				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	B.12		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Accreditable Managed Care Services	Text	AMC_Services	e.g. "HBMS_PreAuth" for HBMS: Pre-authorisation services	CdRef 19 Accreditable MC	MCServicesCode
Managed care payment category	Test	MCO_PayCat	1 = "Risk Transfer" 2 = "No risk transfer"	CdRef 21 MCO Category	MCO_Category
Managed Care Organisation	Text	Accreditation_Number	e.g. "0000"	CdRef 20 Accreditable MCO	Accreditation_Number
Managed Care healthcare services premiums/fees paid	Decimal(18, 2)	MCFeesPaid			

21.1. Valid Definition

Accreditable Managed Care Services (AMC_Services):

- The valid categories ([D.2] worksheet "CdRef 19 Accreditable MC") of accredited managed care services and benefit management services are explained in detail in to **Circulars 13 of 2014 and 56 of 2015.**

Managed care payment category (MCO_PayCat):

- Expenditure on accredited managed care services and benefit management services can further be divided into "risk transfer" and "no risk transfer" arrangements.

Managed Care Organisation providing service (Accreditation_Number):

- The Accreditation Number for the Managed Care Organisation providing service is the unique reference number for the MCO and can be obtained from the Odata or [D.2] worksheet "CdRef 20 Accreditable MCO".

Managed Care healthcare services premiums/fees paid (MCFeesPaid):

- Total amount paid for each category of accredited managed care services and benefit management services

21.2. Validation Rules

- Claims data or fees paid reported in Part B.12 must not be duplicated in Parts B.1, B.2, B.3 and B.11.

21.3. Changes

- None

22. Table B.13: Analysis of prices for selected hospital cases

This table collects data on hospital prices for selected "case types" listed in [D.2] worksheet "CdRef 24 Hosp Prices" for all hospital discipline codes used in Table B.3.

Data Table Number:	**B.13**
Data Table Description:	**Analysis prices for hospital services**
Filter:	**All hospital claims**

Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.13		
Scheme Reference Number	Integer	RefNo	can be obtained form Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained form Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Case type	Text	CasetypeNumber	M01, M02, ...S01, S02, 3, ,,.	CdRef 24 Hosp Prices	CasetypeNumber
Typical case	Bit	TypicalCase	0=No 1=Yes	CdRef 25 TypicalCase	pkCaseIndicator
Discipline Code	Number	DisciplineCode	Only hospital claims	CdRef 8 DisciplineCodes AND IsHospital = 1	
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Number of admissions	Integer	NoOfAdmissions	May not be blank	Use 0 when no data available	
Total number of inpatient days	Integer	TotalInpatientDays	May not be blank	Use 0 when no data available	
Discipline Category	Integer	DisciplineCategory	e.g. 0="Hospital" 1="Radiologists"	CdRef 28 Discipline Category	
Amount claimed	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CoPaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	

If for a case of hospitalisation two different procedure codes that qualify for two different surgical case types are reported, then this case should be excluded; or if for a case of hospitalisation one procedure code that qualifies for a case type and one additional operating room procedure code are reported, then this case should be excluded; or if during the same hospitalisation, bilateral hip (knee) replacement surgery replaces both hips (knees) at the same time, then this case should be excluded.

For the purpose of this analysis, length of stay is calculated as the difference between the admission date and the discharge date.

For more details, schemes may refer to ANNEXURE 2 - CASE TYPES DEFINITIONS in Lorenzoni, L. and T. Roubal (2016), "International Comparison of South African Private Hospital Price Levels", OECD Health Working Papers, No. 85, OECD Publishing, Paris. DOI: http://dx.doi.org/10.1787/5jrrxrzn24wl-en

The prices for the case types with case numbers: S18; S19; S20; and S21 must be reported for both overnight and same day admissions, the balance of case types must be reported for the inpatient admissions (overnight).

22.1. Valid Definition

Case type (CasetypeNumber):

Selected case types are listed in [D.2] worksheet "CdRef 24 Hosp Prices"

Typical case (TypicalCase):

- Typical cases are those patients who have undergone a normal and expected course of treatment. Atypical cases are defined as cases for which the "standard" profile of care is not followed because of age, complications, co-morbid diseases, multiple medical conditions and/or injuries, polypharmacy, death, sign-out, or transfer to other facilities. Refer to [D.2] worksheet "CdRef 25 TypicalCase" for more details.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid from medical savings accounts.

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, co-payment for use of non-network provider, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication, or consumables, other than specified co-payments

22.2. Validation Rules

- TotalAmountClaimed =AmountPaidFromRisk + AmountPaidFromSavings + CopaymentMember + OtherPaymentMember

22.3. Changes

- *Discipline Category* field added
- Valid Definitions and Validation Rules
- CdRef 28 Discipline Category included

23. Table B.14: Analysis of the total benefits paid in respect of selected principal diagnosis types per ICD-10 codes (DIS Grouping of National Health Account)

Data Table Number:	B.14				
Data Table Description	Analysis of the total benefits paid in respect of selected principal diagnosis types per				
Filter:	All Claims				

Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	B.14		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Financial Month	Integer	FinancialMonth	e.g. 9 for September	CdRef 1 ReportingYearsAndMonths	Month
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	e.g "GP" for Gauteng	CdRef 12 Province	ProvinceCode
Disease Group	Text	DISGroup	e.g."DIS.1.1"	CdRef 27 DIS	DIS Code
Discipline Code	Number	DisciplineCode		CdRef 8 DisciplineCodes	
Subdiscipline Code	Number	SubdisciplineCode		CdRef 8 DisciplineCodes	
ICD Code Mapping	Text	ICDCode	e.g."D50-D53/D64.9/E00-E02/E40-E46/E50-E64/E90/Z13.2" for "Nutritional deficiencies". These can be separated by a "/" character	CdRef 27 DIS	Mapping to claims data ICD 10 Codes
Hospital admission as inpatient or day case	Integer	AdmissionType	0="Day case" 1="Inpatient" 2= "Out-of-hospital"		
Number of unique beneficiaries admitted or treated	Integer	NoOfBensAdmitted_Treated	May not be blank	Use 0 when no data available	
Number of admissions	Integer	NoOfAdmissions	May not be blank	Use 0 when no data available	
Total number of inpatient days	Integer	TotalInpatientDays	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CoPaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

23.1. Valid Definition

The number of unique beneficiaries admitted (NoOfBensAdmitted_treated):

- This calculation is a count of distinct beneficiaries treated or admitted in hospital for any reason.

Number of admissions (NoOfAdmissions):

- This field counts the number of hospital admissions (admission with overnight stay plus same-day admission) for the relevant DIS Classification (See CdRef 27 DIS). Should an admission event extend over two financial years, the year in which the admission was initiated must be used.

Number of inpatient days (TotalInpatientDays):

- Total number of inpatient days = date of discharge - date of admission
- Average length of stay = Total number of inpatient days / Total number of admissions

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims (amounts invoiced by providers) limited to the combination of the scheme and member's liability for the relevant disease grouping (DIS).

Total amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme that is not paid from medical savings accounts for the relevant disease grouping (DIS).

Amount paid from risk (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid by the scheme from medical savings accounts for the relevant disease grouping (DIS).

Co-payment by member (CopaymentMember):

- All co-payments paid by the beneficiary as specified in the scheme rules such as charges above scheme rates, Non-DSP co-payments, Reference price co-payments, co-payment for procedures, medicines, devices, hospital events and any other predetermined co-payment.

Other payment by member (OtherPaymentMember):

- any amount payable by the member in respect of healthcare services, medication or consumables, other than specified co-payments

23.2. Changes

Included the following fields:

- Financial Month
- Discipline Code
- Subdiscipline Code

24. Table B.15: Analysis of radiology in respect of selected anatomical regions and modality

Data Table Number:	B.15				
Data Table Description	Analysis of radiology in respect of selected anatomical regions and modality				
Filter:					
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2021		
Part number is the same as the Data Table Number	Text	Part	B.15		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Province Code	Text	ProvinceCode	May not be blank	CdRef 12 Province	
Discipline Code	Integer	DisciplineCode	May not be blank	CdRef 8 DisciplineCodes	
Tariff Code	Integer	TariffCode	Capture Tariff code specified in CdRef 29	CdRef 29 Tariff Code	
Admission as inpatient or day case	Integer	AdmissionType	0="Day case" 1="Inpatient" 2= "Out-of-hospital"		
Number of unique beneficiaries utilising health technology service	Integer	NoOfBensUtilisingTech	May not be blank	Use 0 when no data available	
Number of health technology administered	Integer	NumHealthTechAdmin	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Co-payment by member	Decimal(18, 2)	CoPaymentMember	May not be blank	Use 0 when no data available	
Other payment by member	Decimal(18, 2)	OtherPaymentMember	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

24.1. Valid Definition

- All relevant tariff codes are specified in CdRef 29.

24.2. Validation Rules

- None

24.3. Changes

New table

25. Table C.1: Hospital Utilisation Indicators

This table contains hospital utilisation statistics (see [D.2] worksheet "CdRef 7 UtilisationStats"). Note that beneficiary ID refers to the unique ID assigned to an individual beneficiary. This may either be a unique combination of member number and dependent number or some other unique value.

Data Table Number:	C.1				
Data Table Description	Hospital Utilisation Indicators				
Filter:	Hospitals only (discipline codes 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79)				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	C.1		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Discipline Code	Number	DisciplineCode	Only hospitals Must be one of the following: 47, 49, 55, 56, 57, 58, 59, 76, 77 or 79	CdRef 8 DisciplineCodes AND IsHospital = 1	
Statistic Code	Text	StatisticCode	e.g. "Outpatient_NumOfVisits" for Total number of outpatient visits	CdRef 7 UtilisationStats	StatisticCode
Counts	Integer	Counts			

25.1. Valid Definition

Count measures - see [D.2] worksheet "CdRef 7 UtilisationStats"

- **Total number of outpatient visits (Outpatient_NumOfVisits)**
  - A count of visits by beneficiaries who were not hospitalised overnight but who visited a hospital, clinic, or associated facility for diagnosis or treatment.
- **Number of unique beneficiaries visiting facilities on an outpatient basis (Outpatient2_NumOfVisits)**
  - A count of distinct beneficiary ID's who were not hospitalised overnight but who visited a hospital, clinic, or associated facility for diagnosis or treatment.
- **Number of inpatient admissions (Inpatient_NumOfAdmissions)**
  - A count of admissions to a hospital, clinic, or associated facility for diagnosis or treatment that requires at least one overnight stay.
- **Total number of beneficiaries admitted as inpatients (Admissions ≥ 24 hours) (Inpatient_NumUtilisingBens)**

- A count of distinct beneficiary ID's who were admitted to a hospital, clinic, or associated facility for diagnosis or treatment for at least one overnight stay.

- **Number of inpatient days (Admissions ≥ 24 hours) (Inpatient_NumOfInpatientDays)**
  - The use of "inpatient days" is intended to refer to the "number of days a patient is cared for in hospital", i.e. the number of inpatient care days.
  - This is calculated as the sum of the length of stay at all hospital, clinic, or associated facility admissions where:
  - Length of stay = (Discharge Date – Admission Date) calculated in days.
  - For example, if admission date is 2016/1/20 and discharge date is 2016/01/22, then Length of Stay is 2 days.
  - Decimals are not allowed. The number of days will always be an integer.
  - Number of inpatient days is the sum of the length of stay for all hospital, clinic, or associated facility admissions.
- **Number of same-day inpatient admissions (Admissions < 24 hours) (Inpatient2_NumOfAdmissions)**
  - A count of admissions to a hospital, clinic, or associated facility for diagnosis or treatment where the **date of discharge = date of admission.**
- **Total number of beneficiaries admitted as same-day inpatients (Admissions < 24 hours) (Inpatient2_NumUtilisingBens)"**
  - A count distinct beneficiary ID's admitted to a hospital, clinic, or associated facility for diagnosis or treatment where the **date of discharge = date of admission**.
- **Number of beneficiaries admitted for Prescribed Minimum Benefits (PMB_NumOfBens Admitted)**
  - These would be calculated as the number of distinct beneficiary ID's who have been admitted to a hospital, clinic, or associated facility as inpatient (**all inpatient**) where the ICD-10 codes of the admission, combined with the list of ICD codes specified in [App.1] worksheet "A3 - PMB ICD-10" indicate that the admission was a PMB.
  - Schemes normally pre-authorise hospital admissions, and should, at that stage be able to flag an admission as PMB or not.
  - It is important to note that the ICD-10 codes only serve as a guideline. Schemes must identify the primary, secondary ICD-10 code, and also apply the CMS PMB code of conduct to identify PMB claims. The PMB definitions, particularly the DTP definitions, need to be understood and be applied appropriately to the admission data. PMBs should not be identified by the principal ICD-10 codes. According to the ICD-10 coding rules, a PMB condition can be a secondary code. However, if the resource utilisation (services rendered) is supportive of the PMB condition, then that specific claim line (as a subset of the entire

claim) may be paid as a PMB. Schemes should also note that the list of codes is revised by the CMS from time to time.

- All related service provider services rendered must also be considered when establishing whether a condition is a PMB or not. Clinical validation needs to take place against the primary diagnosis of the primary treating doctor and hospital, hospital CCSA code to surgeons RPL code, support services RPL codes to establish if support services are appropriate for the condition, length of stay, level of care validations, and so forth. Schemes should be performing these types of clinical validation as part of their normal claims processes.

- **Number of admissions to ICU (ICU_NumOfAdmissions)**
  - ICU admissions are identified as any hospital admission that has at least one claim associated with a stay in ICU.
  - ICU claims are identified using the discipline and tariff codes specified in [App.1] worksheet "A12 - ICU"
  - Where alternative reimbursement codes that are not included in the lists are used for ICU, schemes should add these claims. Note that [App.1] only serves as a guideline and is not exhaustive.
- **Number of inpatient days in ICU (ICU_NumOfInpatientDays)**
  - Number of inpatient days in ICU is the sum of the length of stay a patient is cared for in a hospital ICU facility.
- **Number of admissions to High Care (HighCare_NumOfAdmissions)**
  - High care admissions are identified as any private hospital admission that has at least one claim associated with a stay in a High Care ward.
  - High Care claims are identified using the discipline and tariff codes specified in [App.1] worksheet "A13 - High Care"
- **Number of inpatient days in High Care (HighCare_NumOfInpatientDays)**
  - Number of inpatient days in High Care is the sum of the length of stay a patient is cared for in a hospital High Care ward.
- **Number of admissions to General Ward (GeneralWard_NumOfAdmissions)**
  - General Ward claims are identified using the discipline and tariff codes specified in [App.1] worksheet "A31 - General Ward"
  - As a control measure schemes can compare the results to the number of inpatient days spent in a General ward, which is calculated as the number of distinct beneficiary ID's who

have been admitted to a private hospital and have had the following criteria met for the hospital admission concerned:

- Length of stay – (High Care inpatient days + ICU inpatient days) > 0

- **Number of inpatient days in General Ward (GeneralWard_NumOfInpatientDays)**
  - Number of inpatient days in General Ward is the sum of the length of stay a patient is cared for in a hospital's General Ward.
- **Number of in-hospital deaths (Deaths_NumOf)**
  - The number of deaths occurring during hospital stay.
  - Some schemes may use ICD-10 coding to record mortality to understand the underlying causes of death. As an interim measure, code R99 can be assigned to members/dependents or beneficiaries who have died. This is a guideline currently used by some stakeholders in the industry.
  - Other schemes use internal coding to record the reason for a beneficiary leaving the scheme (such as resignation or death).
- **Number of repeat admissions within 90 days (RepeatAdmit90Days_NumOf)**
  - Calculated as the number of all-cause hospital admissions that have occurred within 90 days of another hospital admission discharge date.
  - For example, a beneficiary was admitted on 1 January 2018 and discharged on 1 February 2018. The same beneficiary was then admitted on 15 February 2018 and discharged on 25 February 2018. This is counted as one repeat admission. Transfers between hospitals should not be counted as re-admission.

25.2. Validation Rules

- None

25.3. Changes

- None

26. Table C.2: Sustainable Development Goals (SDGs)

This table contains data on Sustainable Development Goals (SDGs) indicators (see [D.2] worksheet "CdRef16 SDGs"). SDG indicators are grouped into the following categories:

- Contraception Coverage
- Cancer Care coverage
- Child Health Coverage
- Eye Care Coverage
- HIV/TB/ Malaria
- Immunisation Coverage
- Malaria Coverage
- Maternal health
- Mental Health Coverage
- Mortality

The codes provided in [App.1] worksheet "A35 SDGs"" must be used only as a guideline, as some may be incomplete or missing altogether. Where a code is not provided, the identification of beneficiaries with SDGs indicators must be based on the scheme's criteria. The CMS will continue to engage with the industry to improve the accuracy of clinical codes used in the completion of the Healthcare Utilisation return.

Data Table Number:	C.2				
Data Table Description	Sustainable Development Goals (SDGs)				
Filter:	All claims				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	C.2		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Maternal Statistic Code	Text	SDGCode	e.g. "MatVisit_After20weeks" for Number of MRI scans administered	CdRef 16 SDGs	SDGsCode
Counts	Integer	Counts			

26.1. Valid Definition

- Detailed indicator definitions are contained in [D.2] worksheet “CdRef16 SDGs”

26.2. Changes

- Reported number of caesarean sections performed reported in Table C2 must correspond to the number of caesarean sections reported in Table B13.

27. Table C.3: Health Technology Utilisation

This table contains data on health technology utilisation (see [D.2] worksheet "CdRef17 TechnologyStats"). Health technology utilisation data includes MRI Scans, CT Scans, PET Scans, Angiograms, Bone density Scans and Renal Dialysis. The codes for the identification of these health technology claims can be found in [App.1] in the following worksheets: (A1 – MRI Scans; A2 – CT Scans; A9 – PET Scans; A10 – Angiograms; A11 – Bone Density Scans; A15 – Renal Dialysis).

The identification of beneficiaries with health technology claims is based on the scheme's criteria, codes are provided as a guideline only.

Data Table Number:	C.3				
Data Table Description	Health Technology Utilisation				
Filter:	All claims				
Column Description	**Data type**	**Column Header**	**Notes**	**Validate against sheet**	**Validate column**
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	C.3		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Financial Month	Integer	FinancialMonth	e.g. 9 for September	CdRef 1 ReportingYearsAndMonths	Month
Technology Statistic Code	Text	TechnologyCode	e.g. "MRI_NumPerformed"	CdRef17 TechnologyStats	TechnologyCode
Counts	Integer	Counts			

27.1. Valid Definition

- Detailed indicator definitions are contained in [App.1] worksheet "A1 – MRI Scans", [App.1] worksheet "A2 – CT Scans", [App.1] worksheet "A9 – PET Scans", [App.1] worksheet "A10 – Angiograms", [App.1] worksheet "A11 – Bone Density Scans", [App.1] worksheet "A15 – Renal Dialysis" and [D.2] worksheet "CdRef17 TechnologyStats"

27.2. Validation Rules

- None

27.3. Changes

- None

28. Table C.4: Provider analysis

This table contains utilisation and expenditure data on the distribution of providers by province, residential code and postal code. Utilisation and expenditure data must be reported for each valid combination of the BHF practice number and HPCSA Number. The HPCSA number field is optional and should be completed only when available. Schemes must also ensure the practice number – discipline code is a valid combination.

Data Table Number:	C.4				
Data Table Description	Provider Analysis				
Filter:	All active providers				
Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2019		
Part number is the same as the Data Table Number	Text	Part	C.4		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	can be obtained from Odata		
Financial Year	Integer	FinancialYear	e.g 2018 for 2018 data	CdRef 1 FinancialYearsAndMonths	FinancialYear
Province Code	Text	ProvinceCode	e.g "MP" for Mpumalanga	CdRef 12 Province	ProvinceCode
Provider Postal Code	Text	PostalCode	e.g. "1961" for Meyerton	CdRef 18 PostalCodes	Box_Code / Str_Code
Longitude	Decimal(12,9)	Longitude	e.g."28.175920" for Eco Park. If Unknown leave blank		
Latitude	Decimal(12,9)	Latitude	e.g. "-25.881480" for Eco Park. If Unknown leave blank		
Gender	Text	Gender	"Female" or "Male"	CdRef 4 Gender	Gender
Provider Population group	Text	Race	"African" or "Coloured" or "Indian/Asian" or "White" or "Unknown"	CdRef 22 Population Group	RaceCode
Discipline Code	Integer	DisciplineCode	e.g. 21 for Cardiology	CdRef 8 DisciplineCodes	DisciplineCode
Practice Type	Integer	PracticeType	1="Facility" 2="Group" 3="Individual Practice" 4="Unknown"	CdRef 26 Provider Type	ProviderTypeCode
Practice Number	Text	PracticeNum	May not be blank	Only valid Practice Number allowed	
HPCSA Number	Text	HPCSANum	Can be blank		
Total visits (paid for)	Integer	TotalVisits_Paid_for	May not be blank	Use 0 when no data available	
No of Beneficiaries visiting at least once a year	Integer	NoOfBeneficiariesAtLeast1Visit	May not be blank	Use 0 when no data available	
Total amount claimed by provider	Decimal(18, 2)	TotalAmount_Claimed	May not be blank	Use 0 when no data available	
Amount paid from risk	Decimal(18, 2)	AmountPaidFromRisk	May not be blank	Use 0 when no data available	
Amount paid from savings	Decimal(18, 2)	AmountPaidFromSavings	May not be blank	Use 0 when no data available	

28.1. Valid Definition

Practice Type (PracticeType):

- This field provides information of medical practice setting, see [D.2] worksheet “CdRef 26 Provider Type” for valid practice types.

Practice Number (PracticeNum):

- A practice number is allocated to all registered healthcare providers providing services to private patients. It is essential in the process of reimbursement of a claim to either a medical scheme member or a service provider in accordance with the requirement of the Medical Schemes Act 131 of 1998.

HPCSA Number (HPCSANum):

- The number is allocated by the Health Professions Council of South in terms of the Health Professions Act 56 of 1974 to health professionals. The HPCSA number field is optional and should be completed only when available. Schemes must also ensure the practice number – discipline code is a valid combination.

Total visits (paid for) (TotalVisits_Paid_for):

- Refers to all claim lines relating to a specific beneficiary per unique visit to a provider, a single visit is any distinct interaction between a beneficiary and a provider on a service date. The count of distinct visits will give the total number of visits.

No of Beneficiaries visiting at least once a year (NoOfBeneficiariesAtLeast1Visit):

- This is calculated as the distinct number of beneficiaries who had at least one claim for the specific service.

Total amount claimed by provider (TotalAmount_Claimed):

- Amount claimed is the total amount of claims (amounts invoiced by providers) limited to the combination of the scheme and member's liability.

Amount paid from risk (AmountPaidFromRisk):

- Amount paid from risk is the total amount of relevant healthcare expenditure paid by the scheme, that is not paid from medical savings accounts.

Amount paid from savings (AmountPaidFromSavings):

- Amount paid from savings is the total amount of relevant healthcare expenditure paid from medical savings accounts.

Longitude:

- geographic coordinate that specifies the east–west position of a point on the Earth's surface, or the surface of a celestial body

Latitude:

- geographic coordinate that specifies the north–south position of a point on the Earth's surface

28.2. Validation Rules

- Valid PCNS number (in terms of the Medical Schemes Act)
- Valid HPCSA number (optional)
- Valid Province code
- Total visits paid for (TotalVisits_Paid_for) ≥ No of Beneficiaries visiting at least once a year
- TotalAmountClaimed ≥ AmountPaidFromRisk + AmountPaidFromSavings
- Practice Number must be 7 digits.

28.3. Changes

- Valid Definitions and Validation Rules

29. Table C.5: CDL Prevalence & registration on a chronic disease program

This table contains prevalence of chronic diseases for beneficiaries with a CDL condition. The data is divided into two measures of prevalence: beneficiaries who have had at least one claim for a CDL condition and beneficiaries registered for a chronic disease on CDL (not necessarily on a scheme's or subcontracted Disease Management Program).

Data Table Number:	**C.5**
Data Table Description	**CDL Prevalence & Registration on a chronic disease program**
Filter:	**Beneficiaries who have had at least one claim for the specified CDL during the**
	Registered Beneficiaries on a chronic disease management programmes

Column Description	Data type	Column Header	Notes	Validate against sheet	Validate column
Year of submission	Integer	YearOfSubmission	2018		
Part number is the same as the Data Table Number	Text	Part	C.5		
Scheme Reference Number	Integer	RefNo	can be obtained from Odata		
Scheme Benefit Option Number	Integer	BenefitOptionNumber	e.g 2018 for 2018 data		
Age Band	Text	AgeBand	e.g. "25-29 years"	CdRef 3 AgeBands	AgeBand
CDL Code	Text	CDL_Code	e.g. "IHD" for Coronary Artery Disease.	CdRef2 CDL	CDL_Code
CoMorbidity	Text	CoMorbidity	e.g. "CHF/AST" for Cardiac Failure and Asthma. These can be separated by a "/" character. May be Blank if no co-morbidity exists	CdRef2 CDL	CDL_Code
Province Code	Text	ProvinceCode	e.g "MP" for Mpumalanga	CdRef 12 Province	ProvinceCode
Total number of Beneficiaries who have had at least one claim for the specified CDL.	Integer	NoOfBens_Prevalence	May not be blank		
Total number of beneficiaries registered on a chronic diseases management program	Integer	NoOfBens_Registered	May not be blank		

Example of C5

Fourty-year-old male with 4 CDL conditions (AST, DM2, HYP and CHF), treated for 3 conditions (DM2, AST, HYP) and only registered on a Disease Management Programme for two conditions (DM2 and HYP).

YearOfSubmission	Part	FinancialYear	Gender	AgeBand	CDL_Code	CoMorbidity	NoOfBens_Prevalence	NoOfBens_Registered
2019	C.5	2019	Male	40-44 years	DM2	AST/CHF/ HYP	1	1
2019	C.5	2019	Male	40-44 years	HYP	AST/CHF/DM2	1	1
2019	C.5	2019	Male	40-44 years	AST	CHF/DM2/HYP	1	0

29.1. Valid Definition

Total number of beneficiaries who have had at least one claim for a CDL condition (NoOfBens_Prevalence):

- The identification of beneficiaries with Chronic Diseases List (CDL) conditions is based on the scheme's criteria. The count of distinct beneficiaries with a CDL condition will include beneficiaries registered, plus those who have had at least one claim for the specified CDL. If a beneficiary has multiple chronic conditions, then the beneficiary should be counted for each of the conditions specified. It is therefore possible to have multiple records for such beneficiaries.

Total number of beneficiaries registered for a chronic disease on the CDL (not necessarily on a scheme's or subcontracted Disease Management Program) (NoOfBensRegistered):

- This field contains the count of all beneficiaries registered for chronic disease on the CDL (not necessarily on a scheme's or subcontracted Disease Management Program, i.e. NoOfBens_Registered) for a specified CDL. If a beneficiary is registered for multiple chronic conditions, then the beneficiary should be counted for each of the conditions specified. It is therefore possible to have multiple records for such beneficiaries.

CDL Code

- CDL Code of the main condition responsible for the patient's need for treatment or investigation

Comorbidity:

- CDL Code of additional conditions that affect patient care or may co-exist with the main condition/primary CDL Code. These can be identified by either the secondary ICD 10 as per a claim or beneficiaries registered on a disease management program or the beneficiary was treated for CDL during the reporting period.

29.2. Validation Rules

- SRM (Scheme Risk Measurement) Entry & Verification (E&V) criteria must not be used to identifying beneficiaries with a CDL condition in Table C.5. DO NOT supply SRM count data, as this will be verified and subsequently rejected. ICD-10 codes should be used to identify the prevalence of these conditions. (NAPPI and other codes should never be used). Valid ICD-10 codes to be used are specified in [App.1] worksheet "A4 - CDL Condition".

29.3. Changes

- None

- end-