CMS Primary Healthcare Package Costing Data Request

(Line level)

September 2026

1 Introduction

This request sets out a specification for membership and claims data that will be required to perform the costing of the proposed Primary Healthcare (PHC) package as part of the Council for Medical Schemes' (CMS) Prescribed Minimum Benefit (PMB) review Costing Committee. This data request is limited to data that should be readily available from an administrator's systems. If any of the requirements are not available or cannot be provided, this can be discussed to determine a suitable dataset.

The data request consists of two components: exposure and costs. Data is required for the period January 2023 to December 2025.

2 Exposure data

The membership table represents a snapshot of all the active members and dependents *each month between January 2023 and December 2025* with the following beneficiary-level information:

- Effective Date (the first day of each month in the specified period)
- Pseudonymised Member Number
- Pseudonymised Dependent Number
- Dependent Type (Main/Adult/Child)
- Date of Birth
- Gender
- Status Code (Active or not)
- Date of Entry
- Date of Withdrawal
- Medical Scheme Code
- Medical Scheme Name
- Benefit Option Code
- Benefit Option Name
- Postal Code
- Region (province)
- Region (city)
- Region (urban/rural)

3 Cost data

Cost data must include claims from service dates in the calendar years 2023, 2024 and 2025, processed to date. Rejected claims must not be included. For claims that have been reversed, the invalid claim and its reversal (with a negative amount) should be included so that the sum of claims still adds up to the correct total.

Only out of hospital data claims data is required.

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3.1. Discipline codes to include

Out-of-hospital data for the following discipline codes is required:

- 14
- 15
- 16
- 32
- 88
- 52
- 38
- 39
- 60
- 70
- 71
- 54
- 93
- 95
- 96

3.2. Out-of-hospital costs

The following fields are required:

- Claim number
- Claim line number

(The above two fields are assumed to be the unique identifier per claim line)

- Pseudonymised Member number
- Pseudonymised Dependant number
- Dependent Type (Main/Adult/Child)
- Benefit option Code
- Benefit option Name
- Service Date (Date of treatment)
- Practice Discipline Code
- RPL Tariff Code / Item code
- RPL Tariff Code Descriptor (especially for in-house Tariff Codes)
- RPL Modifiers
- Quantity / Units
- Nappi 10 Digit Code
- Chronic / Acute Indicator
- CDL Condition
- Surgical/Ethical Indicator
- Primary ICD Code
- Secondary ICD Code
- Other tertiary ICD Codes (these can be separated by a "/" character)
- Benefit Rule Code
- Rule Code Description

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- In / Out of Hospital Flag
- PMB Indicator
- Received Date
- Process Date
- Payment (Settle) Date
- Claimed Amount
- Tariff Amount
- Paid Amount
- Amount paid from Risk
- Amount paid from Savings
- Amount paid by member, if available
- Claim Status (Settled, Reversed, Rejected, etc.)

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