Annual Return Technical Guide

Version 1.4

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1 Introduction

1.1 Purpose of this document

Historically, several of utilisation measures in Statutory Returns were poorly defined and/or open for interpretation. As a result, several inconsistencies exist in the approaches adopted by medical schemes and/or their administrators when these returns are populated.

This document is intended to address this problem by providing a technical specification for Medical Schemes completing the Council for Medical Schemes (CMS) annual return.

The intention of this specification is to provide clear and unambiguous definitions for every item requested in the Statutory Return.

1.2 Definitions, Acronyms and Abbreviations

The following table will define the most significant terms used in this document:

Term	Definition
Beneficiary ID	The unique ID assigned to an individual beneficiary
Service Date	The date as at which a particular service was rendered
Paid Date	The date as at which a particular service was paid for.
Visit	All claim lines relating to a specific beneficiary, on a specific service date to a specific provider would constitute a single visit. For a given beneficiary-provider combination, this specification considers all claim lines occurring on the same service date to relate to the same *visit*.
Beneficiary Type	This refers to the type of beneficiary, and consists of: Principal Members Adult Dependants Child Dependants
Risk amount	Amount paid by the medical scheme, excluding any amounts paid from a Medical Savings Account
Amount charged /claimed	Total amount charged/claimed by healthcare provider
Savings amount	Amounts paid by the medical schemes from a Medical Savings Account on behalf of a member

1.3 References

[R.1] – Proposed CMS Annual Return V1.4 http://www.medicalschemes.com/files/ITAP%20Documents/PropARV1.4.pdf

[R.2] – Guidelines for the Identification of Beneficiaries with Risk Factors in Accordance with the Entry and Verification Criteria Version 7.1 Applicable from 1 January 2013
[http://www.medicalschemes.com/files/ITAP%20Documents/20131121Ver71EVGuidelines.pdf]

[R.3] – PMB Code of Conduct
[http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/CodeOfConduct_20100803.pdf]

[R.4] – Appendix A V1.3 http://www.medicalschemes.com/files/ITAP%20Documents/AppAV1.3.xlsx

2 Completing the CMS Annual Return (Membership)

The sub sections detailed below refer to the document [R.1] and aim to fully define the required metrics.

2.1 Membership at the end of the financial year (PART 2.1)

This section requires the distribution of scheme membership per beneficiary type and per benefit option at the end of the financial year where:

Beneficiaries = Members + Adult Dependants + Child Dependants

Dependant Ratio = (Beneficiaries / Members) - 1

2.2 Number of registered members and dependants at the end of each month (PART 2.2)

This section requires the same data as per section 2.1 but requires the detail on a monthly basis.

2.3 Membership age analysis

2.3.1 Age analysis of beneficiaries as at end of the financial year (PART 2.3.1)

This section requires the distribution of scheme beneficiaries per benefit option, per gender and per age band where:

Age = Age last birthday as at the 1st January

Example: For a beneficiary with birth date 21st March 1984 and financial year end date of 31st December 2014 we have,

Age = Age last birthday as at 1st January 2014

= Year of analysis – Year of birth

= 2013 – 1984

= 29

Where **Year of analysis** is the calendar year for which the data was collected.

2.3.2 Age analysis of members as at end of the financial year (PART 2.3.2)

This section requires the same data as per section 2.3.1 but requires the detail only for each type of beneficiary.

2.4 Member movement

2.4.1 Member movement (PART 2.4.1)

This section requires the total number of beneficiary type's (i.e. members and dependants where dependants refers to both, adult dependants and child dependants collectively) joining and leaving the scheme during the course of the year concerned. Members joining the scheme need to be further categorised between:

- Those not transferring from other schemes
- Those who have transferred from other schemes

2.4.2 Age analysis of member movement for the financial year (PART 2.4.2)

This section requires data similar to section 2.4.1 above but requires the distribution by age band, where age is defined in section 2.3.1.

2.5 Waiting periods (PART 2.5)

This section requires the age distribution of beneficiaries who:

- Have had general waiting periods imposed
- Have had pre-existing condition exclusions imposed
- Have had late joiner penalties imposed

Age is defined as per section 2.3.1. For each of the categories mentioned above it further requires the split between new beneficiaries and transferred beneficiaries similar to section 2.4.1.

2.6 Utilisation (PART 2.6.1)

The utilisation section of the annual return is one which requires detailed attention. In order to avoid any ambiguity in interpretation, the criterion for evaluation for each specific line item is set out below.

Definitions of recurring concepts such as what constitutes a **visit** etc. are specified in section 1.2 of this document.

2.6.1.1 Primary and emergency care services (2.6.1.1)

2.6.1.1.1 Number of beneficiaries visiting GPs at least once a year

Calculated as the number of distinct beneficiary ID's who have had at least one GP visit in the year concerned.

A GP visit is defined as any out of hospital visit to a provider with a discipline code of 14 or 15.

2.6.1.1.2 Total number of visits to GP's

Calculated as the total number of out of hospital visits to providers with a discipline code of 14 or 15.

2.6.1.1.3 Number of beneficiaries visiting dentists at least once a year

Calculated as the number of distinct beneficiary ID's who have had at least one dentist visit in the year concerned.

A dentist visit is defined as any out of hospital visit to a provider with a discipline code of 54.

2.6.1.1.4 Total number of visits to dentists

Calculated as the total number of out of hospital visits to providers with a discipline code of 54.

2.6.1.1.5 Number of beneficiaries visiting private nurses at least once a year

Calculated as the number of distinct beneficiary ID's who have had at least one private nurse visit in the year concerned.

A private nurse visit is defined as any out of hospital visit to a provider with a discipline code of 80.

2.6.1.1.6 Total number of visits to private nurses

Calculated as the total number of out of hospital visits to providers with a discipline code of 80.

2.6.1.1.7 Number of beneficiaries enrolled in primary care networks

Calculated as the distinct count of beneficiary ID's who are members of any benefit options (or efficiency discounted sub-options) which have primary care networks associated with them.

2.6.1.1.8 Number of beneficiaries admitted at Day clinics/ unattached operating theatres (disciplines 76 and 77)

Calculated as the number of distinct beneficiary ID's who have been admitted to a day clinic or unattached operating theatre.

A day clinic or unattached operating theatre admission is defined as an admission in which the discipline code of the admitting facility is either 76 or 77.

2.6.1.1.9 Number of admissions to day clinics/unattached operating theatres (disciplines 76 and 77)

Calculated as the total number of admissions to facilities with a discipline code of 76 or 77

2.6.1.2 Private hospitals – beneficiaries (2.6.1.2)

All the measures in section 2.6.1.2 relate to claims occurring during private hospital admissions. These can be identified as all claims which are related to hospital admissions where the admitting hospital has a discipline code of either 57 or 58.

2.6.1.2.1 Total number of outpatient visits

Calculated as the total number of private hospital admissions where the admission date is the same as the discharge date i.e. hospital admissions with a length of stay of 0 days.

A private hospital admission is defined as a hospital admission in which the discipline code of the admitting hospital is either 57 or 58.

2.6.1.2.2 Number of inpatient admissions

Calculated as the total number of private hospital admissions where the discharge date is strictly greater than the admission date i.e. hospital admissions with a length of stay greater than 0 days.

A private hospital admission is defined as a hospital admission in which the discipline code of the admitting hospital is either 57 or 58.

2.6.1.2.3 Total number of beneficiaries admitted as inpatients

Calculated as the number of distinct beneficiary ID's who have been involved in a private hospital admission where the discharge date is strictly greater than the admission date.

A private hospital admission is defined as a hospital admission in which the discipline code of the admitting hospital is either 57 or 58.

2.6.1.2.4 Number of beneficiaries admitted for Prescribed Minimum Benefits

These would be calculated as the number of distinct beneficiary ID's who have been involved in a private hospital admission where the principal ICD-10 code of the admission is in the list of ICD codes specified in sheet A3 of Appendix A [R.4].

2.6.1.2.5 Number of beneficiaries receiving MRI scans

Calculated as the number of distinct beneficiary ID's who have had settled claims for MRI scans.

MRI scans are identified using the discipline and tariff codes specified in sheet A1 of Appendix A [R.4] [R.4].

2.6.1.2.6 Number of beneficiaries receiving MRI scans repetitions within 28 days

Calculated in the same manner as specified in section 2.6.1.2.5 but limited to distinct beneficiary ID's who have had MRI scan repetitions within 28 days. The 28 day window period must be based on the service date, the definition of which has been specified in section 1.2 above.

2.6.1.2.7 Number of beneficiaries receiving MRI scans repetitions within 3 months

Calculated in the same manner as specified in section 2.6.1.2.5 but limited to distinct beneficiary ID's who have had MRI scan repetitions within 3 months. The 3 month window period must be based on the service date, the definition of which has been specified in section 1.2 above.

2.6.1.2.8 Number of MRI scans administered

Calculated as the total number of settled claims for MRI scans.

MRI scans are identified using the discipline and tariff codes specified in sheet A1 of Appendix A [R.4] [R.4].

2.6.1.2.9 Number of beneficiaries receiving CT scans

Calculated as the number of distinct beneficiary ID's who have had settled claims for CT scans.

CT scans are identified using the discipline and tariff codes specified in sheet A2 of Appendix A [R.4] [R.4].

2.6.1.2.10 Number of CT scans administered

Calculated as the total number of settled claims for CT scans.

CT scans are identified using the discipline and tariff codes specified in sheet A2 of Appendix A [R.4] [R.4].

2.6.1.2.11 Number of births

Calculated as the total number of distinct maternity admissions which have had at least one settled claim for birth related tariff codes.

Birth related tariff codes are specified in sheet A5 of Appendix A [R.4] [R.4].

2.6.1.2.12 Beneficiaries aged 0 who are active for at least 2 months

Calculated as per the age definition in section 2.3.1.

2.6.1.2.13 Number of caesarean sections performed

Calculated as the number of distinct maternity admissions which have had at least one settled caesarean related claim line.

Caesarean related claim lines are identified using the discipline and tariff codes specified in sheet A6 of Appendix A [R.4] [R.4].

2.6.1.2.14 Number of births to women under 15 years

Calculated in a similar manner to section 2.6.1.2.11 but limited to beneficiaries who are aged less than or equal to 15 years, where age is defined as in section 2.3.1.

2.6.1.2.15 Number of births to women between 15 and 19 years

Calculated in a similar manner to section 2.6.1.2.11 but limited to beneficiaries who are aged greater than 15 years and less than or equal to 19 years, where age is defined as in section 2.3.1.

2.6.1.2.16 Number of mammograms paid for

Calculated as the total number of settled claims for mammograms.

Mammograms are identified using the discipline and tariff codes specified in sheet A7 of Appendix A [R.4] [R.4].

2.6.1.2.17 Number of pap smears paid for

Calculated as the total number of settled claims for pap smears.

Pap smears are identified using the discipline and tariff codes specified in sheet A8 of Appendix A [R.4] [R.4].

2.6.1.2.18 Number of deaths

This is one area where industry could enhance existing systems by capturing more accurate and consistent exit codes.

2.6.1.2.19 Number of beneficiaries receiving PET scans

Calculated as the number of distinct beneficiary ID's who have had settled claims for PET scans.

PET scans are identified using the discipline and tariff codes specified in sheet A9 of Appendix A [R.4] [R.4].

2.6.1.2.20 Number of PET scans administered

Calculated as the total number of settled claims for PET scans.

PET scans are identified using the discipline and tariff codes specified in sheet A9 of Appendix A [R.4] [R.4].

2.6.1.2.21 Number of beneficiaries receiving angiograms

Calculated as the number of distinct beneficiary ID's who have had settled claims for angiograms.

Angiograms are identified using the discipline and tariff codes specified in sheet A10 of Appendix A [R.4] [R.4].

2.6.1.2.22 Number of angiograms administered

Calculated as the total number of settled claims for angiograms.

Angiograms are identified using the discipline and tariff codes specified in sheet A10 of Appendix A [R.4] [R.4].

2.6.1.2.23 Number of beneficiaries receiving bone density scans

Calculated as the number of distinct beneficiary ID's who have had settled claims for bone density scans.

Bone density scans are identified using the discipline and tariff codes specified in sheet A11 of Appendix A [R.4].

2.6.1.2.24 Number of bone density scans administered

Calculated as the total number of settled claims for bone density scans.

Bone density scans are identified using the discipline and tariff codes specified in sheet A11 of Appendix A [R.4].

2.6.1.2.25 Number of inpatient days

Calculated as the sum of the length of stay for all private hospital admissions where:

Number of inpatient days = (Discharge Date – Admission Date) measured in days.

For example, if admin date is 2014/1/20 and discharge date is 2014/1/22, then Number of inpatient days is 2 days.

2.6.1.2.26 Number of beneficiaries admitted to ICU

Calculated as the number of distinct beneficiary ID's who have been admitted to a private hospital and have had at least one settled claim associated with the ICU in the private hospital admission concerned.

ICU associated claims are identified using the discipline and tariff codes specified in sheet A12 of Appendix A [R.4].

2.6.1.2.27 Number of inpatient days in ICU

Calculated as the sum of the quantity or units associated with ICU claim lines for private hospital admissions.

ICU claim lines are identified using the discipline and tariff codes specified in sheet A12 of Appendix A [R.4]. It is important to verify that the quantity or units field for these ICU claim lines are in units of days.

2.6.1.2.28 Number of beneficiaries admitted to High Care

Calculated as the number of distinct beneficiary ID's who have been admitted to a private hospital and have had at least one settled claim associated with High Care in the private hospital admission concerned.

High Care associated claims are identified using the discipline and tariff codes specified in sheet A13 of Appendix A [R.4].

2.6.1.2.29 Number of inpatient days in High Care

Calculated as the sum of the quantity or units associated with High Care claim lines for private hospital admissions.

High Care claim lines are identified using the discipline and tariff codes specified in sheet A13 of Appendix A [R.4]. It is important to verify that the quantity or units field for these ICU claim lines are in units of days.

2.6.1.2.30 Number of beneficiaries admitted to General Ward

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 private hospital admission concerned:

Number of inpatient days – (High Care inpatient days + ICU inpatient days) > 0

2.6.1.2.31 Number of inpatient days in General Ward

Calculated for all private hospital admissions as follows:

Number of inpatient days – (Number of inpatient days in High Care + Number of inpatient days in ICU)

Where:

Number of inpatient days is defined in section 2.6.1.2.25

Number of inpatient days in High Care is defined in section 2.6.1.2.29

Number of inpatient days in ICU is defined in section 2.6.1.2.27

2.6.1.2.32 Number of beneficiaries admitted for Renal Dialysis

Calculated as the number of distinct beneficiary ID's who have been admitted to a private hospital and have had at least one settled claim associated with Renal Dialysis in the private hospital admission concerned.

Renal dialysis associated claims are identified using the discipline and tariff codes specified in sheet A15 of Appendix A [R.4].

2.6.1.2.33 Number of beneficiaries enrolled in hospital networks

Calculated as the distinct count of beneficiary ID's who are members of any benefit options (or efficiency discounted sub-options) which have hospital networks associated with them.

2.6.1.2.34 Number of repeat admissions within 90 days

Calculated as the number of private hospital admissions that have occurred within 90 days of another private hospital admission. For example a beneficiary is admitted on 1 January 2014 and discharged on 1 February 2014. The same beneficiary is then admitted on the 15th February 2014 and discharged on the 25th February 2014. This is counted as 1 repeat admission.

2.6.1.2.35 Number of circumcisions in 15 – 49 year old males

Calculated as the total number of settled claims for circumcisions to males between the age of 15 and 49 years, where age is defined as per section 2.3.1.

Circumcisions are identified using the tariff codes specified in sheet A29 of Appendix A [R.4].

2.6.1.3 Public Hospitals – beneficiaries (2.6.1.3)

All the measures in section 2.6.1.3 relate to claims occurring during public hospital admissions. These can be identified as all claims which are related to hospital admissions where the admitting hospital has a discipline code of 55 or 56.

2.6.1.3.1 Total number of outpatient visits

Calculated as the total number of public hospital admissions where the admission date is the same as the discharge date i.e. hospital admissions with a length of stay of 0 days.

A public hospital admission is defined as a hospital admission in which the discipline code of the admitting hospital is 55 or 56.

2.6.1.3.2 Number of inpatient admissions

Calculated as the total number of public hospital admissions where the discharge date is strictly greater than the admission date i.e. hospital admissions with a length of stay greater than 0 days.

A private hospital admission is defined as a hospital admission in which the discipline code of the admitting hospital is 55 or 56.

2.6.2 Private hospital admission type categories

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 sheet A27 of Appendix A [R.4]. Certain business rules specified below relate to a particular hospital group only. 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 are specified in A28 of Appendix A [R.4].

The specification below 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 measures required in this section can be defined as:

Number of admissions – Calculated as the total number of private hospital admissions assigned to the category concerned.

Total number of inpatient days – Calculated as the total length of stay of private hospital admissions assigned to the category concerned where: **Number of inpatient days = Discharge Date – Admit Date**. For example, if a patient is admitted on 2014/1/20 and discharged on 2014/1/22 then the Number of inpatient days is 2 days.

Total hospital amount claimed/paid from risk – Calculated as the total claim/paid from risk amount of hospital claims associated with private hospital admissions assigned to the category concerned.

Hospital claims are those claims which have a discipline in the hospital category in sheet A26 of Appendix A [R.4].

Total radiologist and pathologist amount claimed/paid from risk - Calculated as the total claim/paid from risk amount of radiology and pathology claims associated with private hospital admissions assigned to the category concerned.

Radiology and pathology claims are those claims which have a discipline in the radiology and pathology category in sheet A26 of Appendix A [R.4].

Total professional fees claimed/paid from risk - Calculated as the total claim/paid from risk amount of specialist claims associated with private hospital admissions assigned to the category concerned.

Specialist claims are those claims which have a discipline in the professional category in sheet A26 of Appendix A [R.4].

Total other fees claimed/paid from risk – Calculated as the total claim/paid from risk amount of any other claims associated with private hospital admissions assigned to the category concerned.

The rules used to classify private hospital admissions are as follows. ***These rules are provided in order of priority of assignment.***

2.6.2.1 Ambulatory

Any private hospital admission which has at least one settled claim for the discipline and tariff codes specified in sheet A22 of Appendix A [R.4].

2.6.2.2 Emergency room

Any private hospital admission which has at least one settled claim for the discipline and tariff codes specified in the “Default Tariff Codes” table of sheet A23 in Appendix A [R.4]

OR

If the admitting hospital is a member of the Mediclinic group, any admission which has at least one settled claim for the discipline and tariff codes specified in the “Mediclinic specific tariff codes” table of sheet A23 in Appendix A [R.4].

2.6.2.3 Maternity

Any private hospital admission with a principal ICD-10 code which is specified in the “Maternity principal ICD-10 codes” table of sheet A24 in Appendix A [R.4]

OR

If the admitting hospital is a member of the Netcare group, any admission which has at least one settled claim for the discipline and tariff codes specified in the “Netcare specific tariff codes” table of sheet A24 in Appendix A [R.4]

OR

If the admitting hospital is a member of the Life Healthcare group, any admission which has at least one settled claim for the discipline and tariff codes specified in the “Life Healthcare specific tariff codes” table of sheet A24 in Appendix A [R.4].

2.6.2.4 Maternity - Day case

A maternity – day case is a maternity case where,

Discharge Date = Admission Date

2.6.2.5 Maternity - Inpatient

A maternity – inpatient is a maternity case where,

Discharge Date > Admission Date

2.6.2.6 Surgical

Any private hospital admission which has at least one settled claim for the discipline and tariff codes specified in the “Default Tariff Codes” table of sheet A25 in Appendix A [R.4]

OR

If the admitting hospital is a member of the Mediclinic group, any admission which has at least one settled claim for the discipline and tariff codes specified in the “Mediclinic specific tariff codes” table of sheet A25 in Appendix A [R.4]

OR

If the admitting hospital is a member of the Netcare group, any admission which has at least one settled claim for the discipline and tariff codes specified in the “Netcare specific tariff codes” table of sheet A25 in Appendix A [R.4]

OR

If the admitting hospital is a member of the Life Healthcare group, any admission which has at least one settled claim for the discipline and tariff codes specified in the “Life Healthcare specific tariff codes” table of sheet A25 in Appendix A [R.4].

2.6.2.7 Surgical - Day case

A surgical – day case is a surgical case where,

Discharge Date = Admission Date

2.6.2.8 Surgical - Inpatient

A surgical – inpatient is a surgical case where,

Discharge Date > Admission Date

2.6.2.9 Medical

The remainder of private hospital admissions left after having allocated the above categories will be allocated to the medical category.

2.6.2.10 Medical - Day case

A medical – day case is a medical case where,

Discharge Date = Admission Date

2.6.2.11 Medical - Inpatient

A medical – inpatient is a medical case where,

Discharge Date > Admission Date

2.7 Chronic diseases

2.7.1 Number of beneficiaries with the following chronic diseases: prevalence (PART 2.7.1)

Calculated as the number of distinct beneficiary ID's per benefit option who have been registered for the chronic disease specified. If a beneficiary has multiple chronic conditions then that beneficiary will be counted for each of the conditions specified.

2.7.2 Number of beneficiaries with the following chronic diseases: entry and verification criteria (PART 2.7.2)

For details surrounding this section of the report please refer to SRM Entry and Verification Criteria document [R.2] specified in section 0. Here, as in 2.7.1, if a beneficiary has multiple chronic conditions and meets the entry and verification criteria then the beneficiary will be counted for each of the conditions specified.

2.7.3 Number of screening tests or procedures performed in respect of beneficiaries with the following chronic diseases (PART 2.7.3)

After having identified the beneficiaries with chronic diseases based on the entry and verification criteria as specified in 2.7.2, extract the claims relating to these beneficiaries. The number of screening tests for a disease would then be calculated as the total number of settled claims for the screening tests related to that disease.

In order to identify the screening tests for the diseases concerned, please refer to sheet A16 of Appendix A [R.4]. This specifies the tariff codes to be used to identify the screening tests for the disease concerned.

2.7.4 SRM Grid beneficiary count (Average over the financial year) (PART 2.7.4)

This section is based on the current SRM data submitted by schemes on a monthly basis. The average value for each cell here is calculated as the average value for the respective cell from the monthly SRM data submissions for the financial year.

2.7.5 Private hospital admissions relating to beneficiaries with chronic diseases for current year (PART 2.7.5)

The measures in this section are related to private hospital admissions for beneficiaries who are registered for the chronic disease concerned. For beneficiaries with multiple chronic conditions, the beneficiary will be allocated to the chronic condition with the highest cost as per the evaluation criteria. The measures are defined as: total number of private hospital admissions for beneficiaries registered for the chronic disease concerned.

Number of beneficiaries – Calculated as the total number of distinct beneficiary ID's, registered for the chronic disease concerned who have had a private hospital admission.

Total number of inpatient days - Calculated as the total Number of inpatient days of all admissions relating to the disease concerned where

Number of inpatient days = Discharge Date – Admission Date.

Total amount paid from risk – also referred to as benefit amount relating to the admissions concerned. Excludes amounts paid from medical savings account.

Total amount claimed – Calculated as the claimed amount relating to the admissions concerned.

2.7.6 Beneficiary profile as at end of the financial year

This section provides a profile of the schemes membership as at the end of the financial year concerned. The year of birth, beneficiary type and benefit option dimensions are as per the previous sections. The chronic condition indicator is based on the evaluation and verification criteria as defined in document [R.2]. If the beneficiary is registered for a chronic condition and meets the evaluation criteria as at the end of the financial year then the chronic condition indicator is **yes**, otherwise it is **no**.

2.8 Utilisation of services by medical and dental specialists (PART 2.8)

The measures required in this section are defined as:

Total number of visits to specialists – A visit is defined as per section 1.2

Number of beneficiaries visiting at least once per year - This would be calculated as the number of distinct beneficiary ID's who have had at least one visit to the discipline concerned, where a visit is defined as per section 1.2

The measures are split by discipline code, the details of which are provided in sheet A17 of Appendix A [R.4]. The discipline codes considered in this section belong to the groups Medical Specialists and Dental Specialists.

2.9 Utilisation of services by supplementary and allied health professionals (PART 2.9)

Similar to section 2.8 with the discipline code details provided in sheet A17 of Appendix A [R.4]. The discipline codes considered in this section belong to the groups Supplementary and Allied Health Professionals.

2.10 Utilisation of other benefit services (PART 2.10)

Similar to section 2.8 with the discipline code details provided in sheet A17 of Appendix A [R.4]. The discipline codes considered in this section belong to the group Other Benefits.

2.11 Utilisation of medicines (PART 2.11)

A **single** script in this section is calculated as, all out of hospital medicine claim lines relating a specific beneficiary, on a specific service date to a specific provider.

One exception to this definition is when the claim lines concerned relate to both chronic and non-chronic medication. This will then be counted as **two** scripts. The assumption here is that a provider would not write a **single** script for both chronic and non-chronic medication.

The total number of scripts would then be the sum of these per:

- Pharmacists – providers with discipline code 60
- General practitioners – providers with discipline code 14 or 15
- Medical Specialists – providers with all the discipline codes as specified in section 2.8
- Supplementary and allied health professionals - providers with all the discipline codes as specified in section 2.9
- Other health professionals – the remainder of providers who have dispensed medication

The number of items dispensed is calculated as the number of distinct nappi codes per script, where a script is defined as above. The total number of items dispensed would then be the sum of the number of items for all scripts per:

- Pharmacists – providers with discipline code 60
- General practitioners – providers with discipline code 14 or 15
- Medical Specialists – providers with all the discipline codes as specified in section 2.8
- Supplementary and allied health professionals - providers with all the discipline codes as specified in section 2.9
- Other health professionals – the remainder of providers who have dispensed medication

2.12 Distribution of membership at the end of financial year (PART 2.12)

This section requires the distribution of scheme membership per beneficiary type and per province at the end of the financial year. The amount paid from risk would be all claims relating to beneficiaries and their respective provinces as at financial year end.

2.13 Utilisation of private hospitals by age group and gender (PART 2.13)

This section requires the distribution of private hospital admission measures by age and gender, where age is defined in section 2.3.1. The measures concerned are:

Number of beneficiaries admitted as inpatients - Calculated as the number of distinct beneficiary ID's who have been admitted to a private hospital with a discharge date strictly greater than the admission date.

Number of inpatient admissions – This measure is defined in section 2.6.1.2.2.

Number of inpatient days – This measure is defined in section 2.6.1.2.25.

2.14 Utilisation of public hospitals by age group and gender (PART 2.14)

Calculated in the exact same manner as section 2.13 above but relating to public hospital admissions rather than private hospital admissions.

2.15 Utilisation of hospitals in respect of selected principal diagnosis types per ICD-10 codes

This section requires the distribution of both private and public hospital admission measures by principal diagnosis. The definitions of the measures concerned are the same as in section 2.13.

3 Completing the CMS Annual Return (Financials)

Utilisation measures in this section will be based on paid date (rather than service date) in contrast to section 2.6 which was based on service date. This is required to ensure that these sections can reconcile to paid amounts disclosed in financial sections (that is, exclusive of IBNR).

3.1 Analysis of benefits actually paid during the financial year (PART 3.1)

The measures required in this section are defined as:

Total amount charged by provider – this is commonly known as Claim Amount.

Amount paid from risk – this is commonly known as Benefit Amount. This should not include benefits paid from Medical Savings Accounts.

Amount paid from savings – this is commonly known as Member Savings Amount or Savings Amount.

The business rules below will specify how to identify each line item specified in the return.

3.1.1 General Practitioners

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category General Practitioner of sheet A17 in Appendix A [R.4] then this claim line would contribute to the measures required. It is important to remember to exclude any medicine and consumable claim lines in this section.

3.1.2 Medical Specialists

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Medical Specialists of sheet A17 in Appendix A [R.4] then this claim line would contribute to the measures required. It is important to remember to exclude any medicine and consumable claim lines in this section.

3.1.3 Dentists

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Dentists of sheet A17 in Appendix A [R.4] then this claim line would contribute to the measures required.

3.1.4 Dental Specialists

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Dental Specialists of sheet A17 in Appendix A [R.4] then this claim line would contribute to the measures required.

3.1.5 Supplementary and Allied Health Professionals

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Supplementary and Allied Health Professionals of sheet A17 in Appendix A [R.4] then this claim line

would contribute to the measures required. It is important to remember to exclude any medicine and consumable claim lines in this section.

3.1.6 Hospitals

3.1.6.1 Unattached operating theatres/day clinics

3.1.6.1.1 Ward Fees

The claims are identified by looking at the discipline and tariff codes in sheet A20 of Appendix A [R.4].

3.1.6.1.2 Theatre Fees

These claims are identified by looking at the discipline and tariff codes in sheet A21 of Appendix A [R.4].

3.1.6.1.3 Medicine and consumables (i.e. all other claims)

These claims are the remainder of claims for discipline codes 76 and 77 that have not been allocated in section 3.1.6.1.1 or section 3.1.6.1.2.

3.1.6.2 Private hospitals

3.1.6.2.1 Ward Fees

The claims are identified by looking at the discipline and tariff codes in sheet A18 of Appendix A [R.4].

3.1.6.2.2 Theatre Fees

These claims are identified by looking at the discipline and tariff codes in sheet A19 of Appendix A [R.4].

3.1.6.2.3 Medicine and consumables (i.e. all other claims)

These claims are the remainder of claims for discipline codes 57 and 58 that have not been allocated in section 3.1.6.2.1 or section 3.1.6.2.2

3.1.6.3 Managed care arrangements

This section is calculated based on the type of managed care arrangements a particular scheme has in place.

3.1.6.3.1 Staff model – hospital care

We propose this field be removed. Staff-model HMOs are very uncommon, and where they are prevalent, the concept of a “claimed amount” or “paid amount” becomes illogical because the scheme essentially carries the costs (such as payroll) of delivery of healthcare.

3.1.6.3.2 Fixed fee

Any in-hospital managed care arrangements for which fixed fees or global fees reimbursement method for healthcare services provided.

3.1.6.3.3 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.

3.1.6.3.4 Other

Any in-hospital managed care arrangements which are not provided for in the return

3.1.6.4 Public hospitals

These claims are identified by looking at the discipline code of the provider concerned. Public hospitals have a discipline code of 55 or 56.

3.1.7 Medicine

3.1.7.1 Medicines dispensed by Pharmacists

These claims are identified by looking at the discipline code of the provider concerned. Pharmacists have a discipline code of 60.

3.1.7.2 Medicines dispensed by General Practitioners

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category General Practitioner of sheet A17 in Appendix A [R.4] then this claim line would contribute to the measures required. It is important to remember that in this section it is only medicine and consumable claims that are taken into account (i.e. claim lines which have a nappi code associated with it).

3.1.7.3 Medicines dispensed by Medical Specialists

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Medical Specialists of sheet A17 in Appendix A [R.4] then this claim line would contribute to the measures required. It is important to remember that in this section it is only medicine and consumable claims that are taken into account (i.e. claim lines which have a nappi code associated with it).

3.1.7.4 Medicines dispensed by Supplementary and Allied Health Professionals

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Supplementary and Allied Health Professionals of sheet A17 in Appendix A [R.4] then this claim line would contribute to the measures required. It is important to remember that in this section it is only medicine and consumable claims that are taken into account (i.e. claim lines which have a nappi code associated with it).

3.1.7.5 Medicines dispensed by Other Health Professionals

These are all the remaining claims for medicines and consumables related to discipline codes not belonging to any of the groups defined above.

3.1.8 Ex-gratia-payments

Administrators tend to have different ways to deal with this.

- Some administrators override a the benefit code/rule code with an in-house ex-gratia code for any ex-gratia claims;
- Some administrators would show an entire claim as “ex gratia” whereas others would show only the portion that was paid over and above normal scheme benefits as “ex gratia”

Every administrator is likely to approach this in a unique manner. This is another area where industry could enhance existing systems by capturing more accurate and consistent claim codes.

3.1.9 Other Benefits

Any other benefit not provided for in part 3.1

3.1.10 Managed care arrangements (Out of hospital benefits)

3.1.10.1 Primary care network

Any out-of-hospital healthcare services provided through primary care networks.

3.1.10.2 Other (specify)

Any out-of-hospital managed care arrangements which are not provided for in the return

3.2 Analysis of medical and dental specialists (PART 3.2)

The measures in this section are defined in the same way as those in the previous section (i.e. section 3.1).

The measures are split by discipline code, the details of which are provided in sheet A17 of Appendix A [R.4]. The discipline codes considered in this section belong to the groups Medical Specialists and Dental Specialists.

3.3 Analysis of supplementary and allied health professionals (PART 3.3)

The measures in this section are defined in the same way as those in the previous section (i.e. section 3.1).

The measures are split by discipline code the details of which are provided in sheet A17 of Appendix A [R.4]. The discipline codes considered in this section belong to the groups Supplementary and Allied Health Professionals.

3.4 Analysis of other benefits (PART 3.4)

The measures in this section are defined in the same way as those in the previous section (i.e. section 3.1).

The measures are split by discipline code the details of which are provided in sheet A17 of Appendix A [R.4]. The discipline codes considered in this section belong to the group Other Benefits.

3.5 Analysis of total benefits paid in respect of selected principal diagnosis types per ICD-10 codes (PART 3.5)

The measures required in this section are exactly the same as in section 3.1 of the return. The categories are identified by looking at the principal ICD-10 code of the claim concerned and determining to which ICD chapter it belongs.

3.6 Analysis of out–of–hospital costs (PART 3.6)

The measures required in this section are defined as:

Total amount charged by provider – this is commonly known as Claim Amount.

Amount paid from risk – this is commonly known as Benefit Amount.

Amount paid from savings– this is commonly known as Member Savings Amount or Savings Amount.

The business rules below will specify how to identify each line item specified in the return.

3.6.1 General Practitioners

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category General Practitioner of sheet A17 in Appendix A [R.4] and is paid out of hospital then this claim line would contribute to the measures required. It is important to remember to exclude any medicine and consumable claim lines in this section.

3.6.2 Medical Specialists

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Medical Specialists of sheet A17 in Appendix A [R.4] and is paid out of hospital then this claim line would contribute to the measures required. It is important to remember to exclude any medicine and consumable claim lines in this section.

3.6.3 Dentists

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Dentists of sheet A17 in Appendix A [R.4] and is paid out of hospital then this claim line would contribute to the measures required.

3.6.4 Dental Specialists

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Dental Specialists of sheet A17 in Appendix A [R.4] and is paid out of hospital then this claim line would contribute to the measures required.

3.6.5 Supplementary and Allied Health Professionals

These claims are identified by looking at the discipline code of the provider concerned. If the discipline code of the provider concerned is in the category Supplementary and Allied Health Professionals of sheet A17 in Appendix A [R.4] and is paid out of hospital then this claim line would contribute to the measures required. It is important to remember to exclude any medicine and consumable claim lines in this section.

3.7 Total PMB expenditure paid per age band: in-hospital and out-of-hospital (PART 3.7)

This section can be completed by identifying PMB claims based on a PMB indicator. The other categories required i.e. in hospital / out-of-hospital, gender and age can then be determined using the standard methodology as described above. Schemes are urged to apply the PMB Code of Conduct in the processing and payment of PMB claims [R.3].

3.8 PMB expenditure in-hospital and out-of-hospital: by CDL condition (PART 3.8)

This section can be completed by using the PMB indicator as well as the associated CDL condition for a claim line. Schemes are urged to apply the PMB Code of Conduct in the processing and payment of PMB claims [R.3].

3.9 PMB Expenditure in-hospital and out-of-hospital: by DTP condition (PART 3.9)

This section can be completed by using the PMB indicator as well as the associated DTP condition for a claim line. Schemes are urged to apply the PMB Code of Conduct in the processing and payment of PMB claims [R.3].