



Medical schemes
Administrators
Interested stakeholders

Ref: PMB costing study 2010
Enq: Anton de Villiers
t: 012 431 0579
f:
e: a.devilliers@medicalschemes.com
Date: 16 April 2010

Circular 16 of 2010

PMB costing study 2010: request for data

The Risk Equalisation Fund Technical Advisory Panel (RETAP) meeting held on 19 February 2010 agreed that the cost estimates from the REF Study 2005 are outdated and that it has become necessary to calculate new estimates for current prescribed minimum benefits (PMBs).

Schemes and administrators are requested to provide the Council for Medical Schemes (CMS) with data at a detailed level to be used in this costing exercise. Annexure A below contains the detailed specifications of the data set that is required. Detailed personal information – such as the RSA identification number, name, surname, and address – is not required. Prior to the CMS receiving any data from administrators, Principal Officers are kindly requested to confirm the willingness of their schemes to participate in the exercise and to share their data with the CMS. To protect the confidentiality of the data, the CMS will work with each administrator on the data cleaning and costing process. The CMS will then combine all the data to calculate the estimates for the industry. The industry estimates will be discussed at RETAP before publication.

One of the proposed analytical approaches is to use historical claims and group them into episodes that measure care across inpatient and outpatient settings to account for the entire episode of care related to a given condition. It is not the intention of the CMS to prescribe the grouper for managed care purposes; this analytical tool will only be used for costing the PMB package. The CMS will also apply other techniques to cost the package and the results from utilisation of the various techniques will be compared and feedback given to all participating schemes.

Other interested stakeholders who do not represent schemes or administrators are also invited to contribute data and expertise. A number of administrators, medical schemes, and individuals have already indicated that they would like to participate. Participation is very important to ensure that the estimates reflect the medical scheme population. The CMS invites each entity to nominate before 30 April 2010 a maximum of two people to serve on the PMB Costing Study Technical Committee.

Confidentiality of the data is very important and confidentiality agreements will be entered into where necessary.

C Burton-Durham
ACTING REGISTRAR & CE
COUNCIL FOR MEDICAL SCHEMES

A statutory body established in terms of the
Medical Schemes Act, 1998 (Act 131 of 1998)

Chairperson: Prof. W Pick Acting Registrar & CE: C Burton-Durham



Annexure A

PMB Costing Study 2010

Proposed Data Outline



File Format Specifications

All files submitted should be formatted as standard UTF-8 (**and NOT UNICODE**) text files, complying with the following standards:

1. The first row always contains the names of data columns.
2. Always one line item per row; No single line item of data may contain carriage return or line feed characters.
3. All rows delimited by the carriage return (ASCII 13) + line feed(ASCII 10) character combination.
4. All fields are variable field length, delimited using the pipe character '|' (**ASCII=124**).
5. Text fields are never demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
6. All dates will be 8 characters long, in the format: YYYYMMDD



Beneficiary Data

The membership file should contain the membership data for 2009. **Separate files for each month, or one file with an indicator for the month (extra variable).**

Column Name	Max Length	Type	Description	Mandatory (Y/N)
SchemeBeneficiaryNo	40	Text	The number that uniquely identifies a beneficiary. This field may be never be NULL or empty and the same number must be used to identify a beneficiary in all the files.	Y
SchemeID	10	Numeric	The unique identifier for the scheme that the beneficiary is linked to for this period. This is a numeric field. This is the number that CMS maintains and publishes for all schemes. This field may never be NULL or empty	Y
OptionID	10	Numeric	The unique identifier for the scheme option that the beneficiary is linked to for this period. This is a numeric field. This is the number that CMS maintains and publishes for all schemes. This field may never be NULL or empty	Y
Gender	10	Text	The beneficiary's gender. Accepted values ("Male" / "Female" or "M"/"F") This field may be never be NULL or empty	Y
Age	3	Numeric	The age of the beneficiary at last birthday on 1 January 2009. This field may never be NULL or empty	Y
CoverStartDate	10	Date	The date when the beneficiary becomes eligible for cover. This field may never be NULL or empty	Y
CoverEndDate	10	Date	The date when the beneficiary's cover is not valid any longer. This field may be NULL or empty.	N
IsPaid	1	Text	Indicates if the member fees are fully paid for this period. Accepted values ("Y" / "N") This field may never be NULL or empty. The default will be False.	Y
MembershipStatus	10	Text	Indicate the active status of the beneficiary for this period. Accepted values ("Active" / "Suspended") This field may never be NULL or empty	Y



Claim Line Data

The Claim Line file should contain the claims data for 2009. The data will be filtered on treatment date and it must include all payments with treatment dates in 2009.

Column Name	Max Length	Type	Description	Mandatory (Y/N)
UniqueClaimLineID	50	Text	This field must uniquely identify the record (for the claim Line) in the source system (Client system) for the claim line. This field must never be reused on the source system. This field will be used as the business key in the warehouse and will be used to determine duplicates on the claim line level. This field may never be NULL or empty	Y
SchemeID	10	Numeric	The unique identifier for the scheme that the beneficiary is linked to for this period. This is a numeric field. This is the number that CMS maintains and publishes for all schemes. This field may never be NULL or empty	Y
OptionID	10	Numeric	The unique identifier for the scheme option that the beneficiary is linked to for this period. This is a numeric field. This is the number that CMS maintains and publishes for all schemes. This field may never be NULL or empty	Y
SchemeBeneficiaryNo	40	Text	The number that uniquely identifies a beneficiary. This field may be never be NULL or empty and the same number must be used to identify a beneficiary in all the files.	Y
TreatmentDate	10	Date	The date that the beneficiary has received the treatment/service. This field may never be NULL or empty	Y
TreatmentCode	10	Text	The NHRPL/UPFS/ NAPPI code carried out. This field may never be NULL or empty	Y
TreatmentCodeType	10	Text	The type of code used in the 'TreatmentCode' column. Accepted values ("NHRPL" /"UPFS" /"NAPPI"/"Internal codes"). This field may never be NULL or empty	Y
PaymentDate	10	Date	The date that the claim line was paid. This field may never be NULL or empty	Y
AmountClaimed	10	Real	The amount that was claimed. This field may never be NULL or empty	Y
AmountPaid	10	Real	The amount that was paid. This field may never be NULL or empty	Y
AmountRisk	10	Real	The amount that was paid from the risk benefits. This field may never be NULL or empty	Y
AmountSavings	10	Real	The amount that was paid from the savings account. This field may never be NULL or empty	Y
AmountMember	10	Real	The amount that was paid by the member. This field may never be NULL or empty.	Y
Referring practice no	10	Text	The PCNS number of the doctor who referring the patient.	N
Referring practice type	10	Text	The PCNS type of the doctor who referring the patient.	N
TreatingProviderNo	10	Text	The PCNS number of the doctor who performed the treatment.	Y
TreatingProviderType	10	Text	The PCNS type of the doctor who performed the treatment.	Y
InHospital	3	Text	Indicator if the service was in-hospital or out-hospital. Accepted values ("In" /"Out"). This field may never be NULL or empty.	N
HospitalAdmissionDate	10	Date	The date that the beneficiary was admitted to the hospital. This field may only contain a value if the beneficiary has been admitted to hospital.	N
HospitalDischargeDate	10	Date	The date when the beneficiary was discharged from hospital.	N
Primary ICD10 code	8	Text	Primary ICD10 code on the claim. This field may never be NULL or empty.	Y
Secondary ICD10 1	8	Text	Second ICD10 code on the claim.	N
Secondary ICD10 2	8	Text	Third ICD10 code on the claim.	N
Secondary ICD10 3	8	Text	Forth ICD10 code on the claim.	N
Secondary ICD10 4	8	Text	Fifth ICD10 code on the claim.	N
ATCCCode_1	8	Text	The therapeutic class of the NAPPI where the treatment code type is NAPPI	N
ATCCCode_2	8	Text	The therapeutic class of the NAPPI where the treatment code type is NAPPI	N
ATCCCode_3	8	Text	The therapeutic class of the NAPPI where the treatment code type is NAPPI	N
ATCCCode_4	8	Text	The therapeutic class of the NAPPI where the treatment code type is NAPPI	N
ATCCCode_5	8	Text	The therapeutic class of the NAPPI where the treatment code type is NAPPI	N



ConfinementDate	10	Date	The date on which the beneficiary gave birth. This field may be left blank if the beneficiary was admitted to hospital for the birth thus it is only applicable to births outside of a hospital setting.	N
NatureOfPayment	4	Text	PMBN – PMB not specified CDLP – PMB CDL DTPP – PMB DTP DBS – Discretionary benefit If part of the amount claimed is paid from the risk pool and if there is evidence that it is a PMB, then the NatureofPayment for the claim line must be one of the PMB categories.	Y
NappiCode	9	Text	Nappi Code	N
ChronicCode	3	Text	Authorised chronic CDL (Current list of PMB CDL's: AST, ADS, HYP, etc.)	N
Chronic ICD10 Code	8	Text	The authorised ICD10 code.	N
PMBCode1	6	Text	PMB code for DTP where applicable	N
PMBCode2	6	Text	PMB code for DTP where applicable	N
PMBCode3	6	Text	PMB code for DTP where applicable	N
PMBCode4	6	Text	PMB code for DTP where applicable	N
PMBCode5	6	Text	PMB code for DTP where applicable	N
PMBCode6	6	Text	PMB code for DTP where applicable	N
PMBCode7	6	Text	PMB code for DTP where applicable	N
AuthNo	12	Text	Authorisation number for all types of authorisations	N



Authorisation Data

The authorisation file will be used to verify the diagnosis of the beneficiary as per the REF Entry and Verification Criteria Version and other authorisations part of the PMB package (CDL's and DTP's).

Only active authorisations for 2009 should be included in the file. **One record for each authorisation.**

Column Name	Max Length	Type	Description and Conditions	Mandatory (Y/N)
SchemeBeneficiaryNo	40	Text	The number that uniquely identifies a beneficiary. This field may be never be NULL or empty and the same number must be used to identify a beneficiary in all the files.	Y
DiagnosisDate	10	Date	The date the beneficiary was diagnosed with the condition. This field may never be NULL or empty. If the beneficiary has been diagnosed before 01 January 2006, the diagnosis date may be based on the date of service of the original claim.	Y
DiagnosingProviderNo	50	Text	The PCNS number of the doctor who performed the diagnosis. This field may be NULL or empty if the beneficiary has been diagnosed before 01 January 2006	Y
DiagnosingProviderType	10	Text	The PCNS type of the doctor who performed the diagnosis. Provider type code must adhere to the BHF provider type codes as specified by the CMS. This field may be NULL or empty if the beneficiary has been diagnosed before 01 January 2006	Y
AuthorisationActiveDate	10	Date	The date that the diagnosis authorisation became active. This field may never be NULL or empty	Y
Primary ICD10 code	8	Text	Primary ICD10 code on the claim. This field may never be NULL or empty.	Y
Secondary ICD10 1	8	Text	Second ICD10 code on the claim.	N
Secondary ICD10 2	8	Text	Third ICD10 code on the claim.	N
Secondary ICD10 3	8	Text	Forth ICD10 code on the claim.	N
Secondary ICD10 4	8	Text	Fifth ICD10 code on the claim.	N
Auth	5	Text	Authorised CDL condition (AST, ADS, etc.) or DTP (PMB code: 906A, 341A, etc.)	Y
AuthNo	12	Text	Authorisation number for all types of authorisations.	Y

In-hospital

Authorisation information for each hospital admission for 2009.

Column Name	Max Length	Type	Description and Conditions	Mandatory (Y/N)
AuthNo	10	Text	Authorisation number for hospital authorisations only.	Y
Primary ICD10 code	8	Text	Primary ICD10 code on the claim. This field may never be NULL or empty.	Y
Secondary ICD10 1	8	Text	Second ICD10 code on the claim.	N
Secondary ICD10 2	8	Text	Third ICD10 code on the claim.	N
Secondary ICD10 3	8	Text	Forth ICD10 code on the claim.	N
Secondary ICD10 4	8	Text	Fifth ICD10 code on the claim.	N