South Africa

Medical Schemes Act, 1998

General Regulations, 1999

Government Notice R1262 of 1999

Legislation as at 5 June 2000

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General Regulations, 1999
Contents

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There are multiple commencements

Provisions	Status
ChapterÂ 1 (sectionÂ 1); ChapterÂ 2 (sectionÂ 2â6); ChapterÂ 5 (sectionÂ 15); ChapterÂ 6 (sectionÂ 16â27); ChapterÂ 7 (sectionÂ 28); ChapterÂ 9 (sectionÂ 31â33)	commenced on 1 November 1999.
ChapterÂ 3 (sectionÂ 7â10); ChapterÂ 4 (sectionÂ 11â14); ChapterÂ 8 (sectionÂ 29â30)	commenced on 1 January 2000. *Note: Annexures A and B also come into operation on this date; see section 33*
ChapterÂ 4, sectionÂ 11(6), sectionÂ 12(a), 12(b), 12(c), 12(d); ChapterÂ 7, sectionÂ 28(11)	commenced on 5 June 2000.

[This is the version of this document as it was from 5 June 2000 to 29 June 2000.]

[Amended by General Regulations: Amendment (Government Notice R570 of 2000) on 5 June 2000]

The Minister of Health has, in terms of section 67 of the Medical Schemes Act, 1998 (Act No. 131 of 1998), after consultation with the Council for Medical Schemes, made the regulations in the Schedule.

Chapter 1
Definitions

1. Definitions

In these Regulations any expression defined in the Act bears that meaning and, unless the context otherwise indicates—

"**broker**" means a person as contemplated in section 65 of the Act whose part of regular business or part thereof provides a service or advice in respect of the introduction of prospective members to a medical scheme;

"**child dependant**" means a dependant who is under the age of 21 or older if he or she permitted under the rules of a medical scheme to be a dependant;

"**creditable coverage**" means any period of verifiable medical scheme membership of the applicant or his or her dependant, but excluding membership as a child dependant, terminating two years or more before the date of the latest application for membership;

"**enhanced option**" means any benefit option which offers benefits in respect of scope of treatment and care, location of care or level of amenities available or both in addition to those required under the prescribed minimum benefits package;

"**hospital treatment**" means any treatment which requires:

(a) an overnight stay in hospital or

(b) the use of an operating theatre together with the administration of a general or regional anaesthetic or

(c) the application of other diagnostic or surgical procedures that carry a significant risk of death, and consequently require on-site resuscitation or surgical facilities or both; or

(d) the use of equipment, medication or medical professionals not generally found at a place other than a hospital;

"**late joiner**" means an applicant or the adult dependant of an applicant who, at the date of application for membership, is 35 years of age or older and has not been a member or a dependant of a member of any medical scheme for a period of two years immediately prior to applying for membership;

"**managed health care**" means an arrangement through which utilisation of health care is monitored through the use of mechanisms which are designed to monitor appropriateness, promote efficacy, quality and cost effectiveness of the delivery of relevant health services;

"**practice code number**" means the number allotted to a supplier of a relevant health service as a practice number by an organisation or body approved by the Council;

"**pre-existing sickness condition**" means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made;

"**public hospital system**" means the entire system of hospitals of each provincial government, and includes any necessary transfer to a public hospital outside the province of residence for specialist treatment not available at the province of residence; and

"**the Act**" means the Medical Schemes Act, 1998 (Act No. 131 of 1998).

Chapter 2
Administrative requirements

2. Registration of medical scheme

(1) Every application for registration of a medical scheme must be in writing and signed by the person applying for the registration of the medical scheme and must contain—

(a) the full name under which the proposed medical scheme is to be registered;

(b) the date on which the proposed medical scheme is to come into operation;

(c) the physical and postal addresses of the registered office of the proposed medical scheme;

(d) two copies of the rules of the proposed medical scheme, which must comply with regulation 4(1), and must be duly certified by the applicant as being true copies of the rules which will come into operation on the date of registration of the proposed medical scheme or the date of commencement of the medical scheme, whichever date is applicable;

(e) the full names, physical and postal addresses and *curriculum vitae* of the principal officer and trustees of the proposed medical scheme;

(f) in the case of a restricted membership medical scheme, the name or names of the participating employer(s);

(g) the name and address of the person who will administer the medical scheme;

(h) a copy of the administration agreement, in the case where the proposed medical scheme is to be administered by an administrator;

(i) a copy of any other joint-administration agreement between a medical scheme and any other party;

(j) the guarantees and the guarantee deposit vouchers as the Registrar may require;

(k) a detailed statement of services to be undertaken, directly or indirectly, on behalf of the proposed medical scheme by an administrator, broker and managed care organisation;

(l) a detailed business plan; and

(m) such other information as the Registrar may require.

(2) The application referred to in subregulation (1) must be accompanied by an application and registration fees as prescribed by regulation 31 (a) and (b).

(3) The minimum number of members required for the registration of a medical scheme established after these regulations have come into operation is 6000, and this number must be admitted within a period of three months of registration of the medical scheme.

3. Proof of membership

(1) Every medical scheme must issue to each of its members, written proof of membership containing at least the following particulars—

(a) The name of the medical scheme;

(b) the surname, first name, other initials if any, gender, and identity number of the member and his or her registered dependants;

(c) the membership number;

(d) the date on which the member becomes entitled to benefits from the medical scheme concerned;

(e) if applicable, details of waiting periods in relation to specific conditions;

(f) if applicable, the fact that the rendering of relevant health services is limited to a specific provider of service or a group or category of providers of services; and

(g) if applicable, a reference to the benefit option to which the member is admitted.

(2) A medical scheme must, within 30 days of the termination of membership or at any time at the request of any former member, or dependant, provide that member or dependant with a certificate, stating the period of cover, type of cover and whether or not the person qualified for late joiner status.

(3) A copy of the certificate contemplated in subregulation (2) must be forwarded on request to any medical scheme to which the former member or dependant subsequently applies for membership.

4. Administration of a medical scheme

(1) The rules of a medical scheme which are sent to the Registrar and any amendment thereto must comply with the following requirements:

(a) they must be printed in at least 1,5 spacing and a font of at least 12 on A4 paper of at least 80 grams;

(b) they must be printed on one side of the paper only, with a margin of at least 30 mm on the left side and at least 25 mm at the top and bottom and on the right side;

(c) headings and subheadings must be printed in bold print;

(d) no underlining must be made in the document containing the rules; and

(e) the document referred to in paragraph (d) must at the beginning contain a detailed table of contents of the rules, with references to the relevant page numbers.

(2) A medical scheme that provides more than one benefit option may not in its rules or otherwise, preclude any member from choosing, or deny any member the right to participate in, any benefit option offered by the medical scheme, provided that a member or a dependant shall have the right to participate in only one benefit option at a time.

(3) A medical scheme may in its rules provide that a member may only change to any benefit option at the beginning of the month of January each year, and by giving written notice of at least three months before such change is made.

(4) A medical scheme must not in its rules or in any other manner structure any benefit option in such a manner that creates a preferred dispensation for one or more specific groups of members or to provide for the creation of ring-fenced nett assets by means of such benefit option or to transfer accumulated *pro rata* net assets of such option to another medical scheme.

5. Accounts by suppliers of services

The account or statement contemplated in section 59(1) of the Act must contain the following—

(a) The surname and initials of the member;

(b) the surname, first name and other initials, if any, of the patient;

(c) the name of the medical scheme concerned;

(d) the membership number of the member;

(e) the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;

(f) the relevant diagnostic and such other item code numbers that relate to such relevant health service;

(g) the date on which each relevant health service was rendered;

(h) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine;

(i) where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;

(j) where mention is made in such account or statement of the use of a theatre—

(i) the name and relevant practice number and provider number contemplated in paragraph (e) of the medical practitioner or dentist who performed the operation;

(ii) the name or names and the relevant practice number and provider number contemplated in paragraph (e) of every medical practitioner or dentist who assisted in the performance of the operation; and

(iii) all procedures carried out together with the relevant item, code number contemplated in paragraph (f); and

(k) in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating—

(i) the expected total amount in respect of the treatment;

(ii) the expected duration of the treatment;

(iii) the initial amount payable; and the monthly amount payable.

6. Manner of payment of benefits

(1) A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month—

(a) from the last date of the service rendered as stated on the account, statement or claim; or

(b) during which such account, statement or claim was returned for correction.

(2) If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform the member within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion.

(3) After a member has been informed as referred to in subregulation (2), such member must be afforded an opportunity to correct and resubmit such account or statement before the end of the fourth month following the date from which it was returned for correction.

(4) If an account, statement, or claim is correct or where a corrected account, statement or claim is received, as the case may be, a medical scheme must, in addition to the payment contemplated in section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars—

(a) The name arid the membership number of the member;

(b) the name of the supplier of service;

(c) the final date of service rendered by the supplier of service on the account or statement which is covered by the payment;

(d) the total amount charged for the service concerned; and

(e) the amount of the benefit awarded for such service.

Chapter 3
Contributions and benefits

7. Contributions in respect dependants

A medical scheme may in its rules provide that contributions in respect of a child dependant may be less than those determined in respect of other dependants.

8. Prescribed minimum benefits

(1) From the date of commencement of these regulations, the prescribed minimum benefits that medical schemes must offer in terms of the Act consist of the provision of treatment for all the categories of Diagnosis and Treatment Pairs listed in Annexure A subject to any limitations specified in Annexure A.

(2) Any benefit option that is offered by a medical scheme must reimburse in full, without co-payment or the use of deductibles, the diagnostic, treatment and care costs of the prescribed minimum benefit conditions specified in Annexure A in at least one provider or provider network which must at all times include the public hospital system.

(3) Cover in the public hospital system must include all the costs of diagnosis, treatment and care for the prescribed minimum benefit Diagnosis-Treatment Pairs in Annexure A to a level and entitlement that is not different in terms of quality and intensity to the services provided to publicly funded patients.

(4) Medical schemes may offer enhanced options to their members through additional cover for any specificific entitlements: Provided that diagnosis, treatment and care under the prescribed minimum benefits is provided.

(5) The options referred to in subregulation (4) may include the use of alternative providers or provider networks and could incorporate member co-payments, or enhanced options for other benefits that fair outside of the prescribed minimum benefits or both.

(6) If cover for a prescribed minimum benefit as defined in Annexure A under an enhanced option is exhausted while the patient still requires diagnosis, care or treatment for that prescribed minimum benefit, that patient may be transferred to a lower cost provider or provider network, but the medical scheme must continue to be fully liable for all costs incurred in delivering the prescribed minimum benefit care that is required.

(7) A member or dependant shall not lose his or her entitlement to any prescribed minimum benefit, regardless of any enhanced option they may choose or as a result of any condition associated with that enhanced option.

(8) Medical schemes may employ appropriate interventions aimed at improving the efficiency and effectiveness of health care provision provided that every option offered by a medical scheme must at least provide full cover for prescribed minimum benefits in at least the public hospital system.

(9) These regulations must not be construed to prevent medical schemes from employing techniques such as the designation of preferred providers, requirements for Pre-Authorization and the application of Treatment Protocols: Provided that in the case of Pre-Authorization a medical scheme must not refuse authorization for the delivery in a public hospital of standard treatment for a prescribed minimum benefit as defined in Annexure A.

(10) Every Medical Scheme must make provision in its rules for the reimbursement of the cost of care that is considered to fall within the Prescribed Minimum Benefits prescribed under these Regulations within all the membership options that the medical scheme offers.

(11) Medical schemes must refer to these Regulations in their rules and such reference may not be a full reproduction of these Regulations.

(12) Medical schemes must specify in their rules whether they restrict the provision of the prescribed minimum benefits under specific membership options to a named network of providers.

(13) The Registrar must determine whether a medical scheme's rules are consistent with the provisions of the Act and these Regulations before approving such rules.

(14) Disputes and complaints between a member or a provider and the medical scheme in relation to minimum prescribed benefits must be dealt with in terms of Chapter 10 of the Act.

9. Limits on benefits

A medical scheme may, in respect of the financial year in which a member joins the scheme, reduce the annual benefits with the exception of the prescribed minimum benefits, *pro-rata* to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned.

10. Personal medical savings accounts

(1) A medical scheme must not pay into a members' personal medical savings account an amount that exceeds the equivalent of three contribution months of the total contribution made in respect of the member during the financial year concerned.

(2) The limit on contributions into personal medical savings accounts apply to each individual member of a medical scheme.

(3) Funds deposited in a member's personal medical savings account must not be used to offset contributions.

(4) Credit balances in a member's personal medical savings account shall be transferred to another medical scheme with a personal medical savings account regime when such member changes medical schemes.

(5) Credit balances in a member's personal medical savings account must be taken as a cash benefit, subject to applicable laws, when the member terminates his or her membership of a medical scheme or benefit option without enrolling in another medical scheme or enrolls in another medical scheme without a personal medical savings account provision.

(6) Any balance in a members personal medical savings account shall be excluded from the calculation of the mandatory nett assets of the medical scheme.

(7) Every medical scheme must provide the following to the Registrar with regard to members' personal medical savings accounts—

(a) details of amounts paid into members' personal medical savings accounts;

(b) details on both debit and credit balances in members' personal medical savings accounts;

(c) details on amounts paid to members or their estates on termination through resignation or death;

(d) details on benefits, by category, paid out of members' personal medical savings accounts; and

(e) any other reports that the Council may specify from time to time.

Chapter 4
Waiting periods and premium penalties

11. General waiting periods

(1) A medical scheme may require an applicant to provide the medical scheme with a medical report on any condition present at the time of application for which medical advice, diagnosis, care or treatment was recommended or received within the 12 months period ending on the date on which an application was made by an applicant and his or her dependants.

(2) A medical scheme may impose a general waiting period of up to three months upon a new member and the member's dependant(s) before such member or dependant(s) is entitled to claim any benefits.

(3) A member may choose to make a payment of up to three months to a medical scheme in lieu of the waiting period referred to in subregulation (2).

(4) Subject to subregulation (5), a medical scheme may impose a condition specific waiting period of not more than 12 months on a member or dependent in respect of preexisting sickness condition.

(5) A medical scheme may impose a waiting period of not longer than one month on a person or his or her dependant whose membership of another medical scheme has been terminated because of a change of employment and who has not been a member or a dependant for a continuous period of least two years.

(6) A person contemplated in subregulation (5) shall apply for membership within three months of the change of employment.

[regulation 11 substituted by section 2 of Government Notice R570 of 2000]

12. Pre-existing sickness conditions

No waiting period may be applied—

(a) in respect of any treatment or diagnostic procedure covered within the prescribed minimum benefits;

(b) to a member or dependant who changes from one benefit option to another within the same medical scheme unless the member or dependant is subject to a waiting period on the current option, in which case any remaining period may be applied;

(c) to any person who has been a member of one or more medical schemes for a continuous period of at least 25 months or a dependant of such a member, and who applies for membership within three months of termination of membership of the previous medical scheme; or

(d) on a child dependent born during the period of membership.

[regulation 12 substituted by section 3 of Government Notice R570 of 2000]

13. Premium penalties for persons joining late in life

(1) A medical scheme may apply premium penalties to an applicant or dependant of a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

(2) The premium penalties referred to in subregulation (1) shall not exceed the following bands:

Number of years an applicant was not a member of a medical scheme after age 30	Maximum penalty
5-9 years	1.05 x contribution
10-19 years	1.25 x contribution
20-29 years	1.5 x contribution
30+ years	1.75 x contribution

(3) Any years of creditable coverage which can be demonstrated by the applicant or his or her dependant shall be subtracted from his or her current age in determining the applicable penalty.

(4) Where an applicant or his or her dependant produces evidence of creditable coverage after a late joiner penalty has been imposed, the scheme must recalculate the penalty and apply such revised penalty from the time such evidence is provided.

(5) Late joiner penalties may continue to be applied upon transfer of the member or adult dependant to other medical schemes.

(6) Medical schemes must accept late joiners applying for membership without imposing any of the penalties prescribed in subregulation (1) for a period of 15 months from 1 January 2000 until 31 March 2001 and such applications must be accepted on a first come, first served basis.

[subregulation (6) substituted by section 4 of Government Notice R570 of 2000]

(7) A medical scheme must report annually to the Registrar on the number of late joiners enrolled in each band during the previous year and cumulatively.

14. Conditions for continued membership

(1) If a medical scheme requires that continued membership referred to in section 29(1)(s) and (t) of the Act be subject to a qualifying period of membership in respect of the member, such period shall not exceed five years.

(2) In order to qualify for continued membership contemplated in subregulation (1), contributions may be paid to cover any outstanding period.

(3) Previous membership of any other medical scheme by a member must be taken into account in determining the period referred to in subregulation (1).

Chapter 5
Provision of managed health care

15. Conditions for providing managed health care

(1) If a medical scheme provides benefits to its members by means of a managed health care arrangement with another person, such arrangement—

(a) must be in writing;

(b) must be with a person who has applied to the Council for accreditation; and

(c) must not absolve a medical scheme from its responsibility towards its members if any other party to the arrangement is in default with regard to the provision of any service in terms of such arrangement.

(2) The arrangement contemplated in subregulation (1) must specifically provide that no member or dependant of a member may be held liable by the participating provider for any sums owed by the medical scheme or any other person.

(3) An arrangement between a medical scheme and a provider of a managed health care service must require either party to give at least 90 days prior notice before terminating such arrangement.

(4) A medical scheme shall not enter into any arrangement where a provider of a relevant health service is forbidden in any manner from informing patients of the care they require, including various treatment options, and whether in the provider's view, such care is medically necessary and appropriate.

(5) A medical scheme shall not terminate an arrangement with a provider, nor shall it enter into a arrangement with any other person that provides for termination as a result of—

(a) the provider expressing disagreement with a decision to deny or limit benefits to a member;

(b) the provider assisting the member to seek reconsideration of any such decision; or

(c) a provider discussing with a member any aspect of the member's medical condition, any proposed treatment or treatment alternatives, whether covered by the medical scheme or not;

(6) Where a medical scheme or any other person who provides a managed health care service to a medical scheme proposes to terminate an arrangement with the provider, the notice of termination must include—

(a) the reasons for the proposed termination;

(b) a notice that the provider has a right to request a hearing before an impartial panel appointed by the Council for that purpose;

(c) a period of not less than 30 days within which a provider may request a hearing; and

(d) the date for the hearing which must be within 30 days from the date of receipt of the request for a hearing.

(7) The panel contemplated in subregulation (6)(b) must decide within three days of such hearing, and must communicate the decision to the provider, and the decision may be a reinstatement of the provider, or provisional reinstatement subject to conditions determined by the panel or termination of the arrangement with the provider.

(8) A medical scheme may not use a financial incentive that directly or indirectly compensates a provider for ordering or providing services that are not necessary or appropriate to patients.

(9) Any information pertaining to the diagnosis, treatment or health of any member of a medical scheme or of any dependant of such member must be treated as confidential.

(10) A medical scheme must have access to any treatment records held by the provider and other information pertaining to the diagnosis, treatment and health status of the member in terms of the arrangement, but such information may not be disclosed by the provider to any other person without written consent of the member, unless such disclosure is in terms of any legislation.

(11) A medical scheme may not prohibit, or enter into an arrangement that prohibits the initiation of appropriate intervention by a provider prior to receiving authorization from the medical scheme or any other party, where a person suffers from a condition that requires immediate medical or surgical intervention.

(12) Any decision to deny coverage shall be made by a medical practitioner and after consultation with a medical practitioner treating the patient.

(13) A member may appeal against the decision of the review panel referred to in subregulation (6)(b) to the Council and the Council must hear the appeal as soon as it is practically possible.

Chapter 6
Administrators of medical schemes

16. Compliance with conditions by administrators

In this Chapter—

"internal financial controls" means controls which are established in order to ensure a reasonable safeguarding of assets against unauthorized use or disposition, the maintenance of proper accounting records and the reliability of financial information used within the business of the administrator.

17. Conditions to be complied with by administrators

(1) A person desiring to act as an administrator of a medical scheme must apply to Council for accreditation.

(2) An application for accreditation referred to in subregulation (1) must be in writing and must contain—

(a) the full name and *curriculum vitae* of the person who is the head of the administrator's business;

(b) the home and business addresses and telephone numbers of the person referred to in paragraph (a);

(c) the name of the auditor referred to in regulation 20;

(d) a report prepared by the auditor in the form set out in Annexure C, indicating whether or not the administrator's system of internal financial control is adequate for the size and complexity of the business of the medical scheme or schemes to be administered;

(e) a copy of the proposed administration agreement between the administrator and the medical scheme or schemes concerned; and

(f) such other information or document as the Council may from time to time require.

(3) Accreditation as an administrator is only valid for a period of two years.

18. Agreement in respect of administration

(1) Prior to the commencement of administrative functions with regard to a particular medical scheme, an administrator must enter into a written agreement with the relevant medical scheme in which the terms and conditions of the administration of the medical scheme are recorded.

(2) The agreement referred to in subregulation (1) must provide—

(a) for the scope and duties of the administrator;

(b) that the administrator must, on behalf of the medical scheme, administer the business of a medical scheme in accordance with the Act and as provided for in the rules of the medical scheme;

(c) for the basis on which the administrator is to be remunerated;

(d) for the termination of the agreement at the instance of either party after notice in writing of a period of not less than 90 days and hot more than 180 days; and

(e) that all registers, minute books, records and all other data pertaining to the medical scheme, must at all times remain the sole property of the medical scheme concerned.

(3) Any changes to the agreement referred to in subregulation (1) must be in writing and must be effected by way of an addendum to the existing agreement or a new agreement between the administrator and the medical scheme.

(4) If on the date of coming into operation of this Chapter, an agreement is in force in terms of which an administrator is administering a medical scheme and the existing agreement does not comply with the requirements of this Chapter, such administrator must enter into a new agreement which complies with this Chapter with every medical scheme within six months from the date of coming into operation of this Chapter, unless the medical scheme notifies the Registrar that the interests of the medical scheme are protected in terms of the existing agreement.

19. Termination of administration agreements

(1) If the administration agreement between a medical scheme and an administrator is terminated, such administrator must furnish a report to the Registrar not later than 60 days after such termination, confirming—

(a) that all documents of title relating to assets, the assets register, minute books, members' records and other records and information pertaining to the medical scheme have been delivered to the trustees of the medical scheme or the new administrators, as the case may be;

(b) the date and address of such delivery; and

(c) the name of the trustee or person at the new administrator's business to whom the documents referred to in paragraph (a) have been delivered.

(2) If an administrator is for any reason unable to comply fully or partially with this regulation, the report referred to in subregulation (1) must contain full particulars regarding documentation which has not been delivered, the reasons therefor as well as a plan with the dates on which compliance will take place, to enable the Registrar to approve of such further period as may be determined by him or her.

20. Appointment of auditor

An administrator must appoint an auditor who must examine the accounting records and annual financial statements of the administrator in accordance with the South African auditing standards and satisfy himself or herself that—

(a) the accounting records comply with the requirements of the Act and these regulations; and

(b) that the annual financial statements are in agreement with the accounting records and properly drawn up to fairly present the financial position, changes in equity, results of operations and cash flows of the administrator in accordance with generally accepted accounting practice and in the manner required by the Act and these regulations.

21. Indemnity and fidelity guarantee insurance

An administrator must take out and maintain professional indemnity insurance and fidelity guarantee insurance from and up to such an amount as the administrator, with the concurrence of the Registrar, may determine.

22. Maintenance of financially sound condition

An administrator must at all times maintain his or her business in a financially sound condition by—

(a) having assets which are at least sufficient to meet current liabilities;

(b) providing for liabilities; and

(c) generally conducting the business to ensure that the business is at all times in a position to meet its liabilities.

23. Depositing of medical scheme moneys

An administrator must deposit any medical scheme moneys under administration, not later than the business day following the date of receipt thereof, into a bank account opened in the name of the medical scheme concerned.

24. Safe custody of documents of title

(1) Whenever a document of title relating to assets held by a medical scheme or to be held on behalf of a medical scheme comes into possession of the administrator, the administrator must make adequate arrangements to ensure the continued safety of the assets held in safe custody.

(2) The administrator must mark the document referred to in subregulation (1) in a manner which will render it possible to establish readily that the medical scheme is the owner of such assets, and maintain a register to identify ownership of assets.

25. Annual report

Within four months after the end of the financial year of the administrator, the administrator must furnish the Registrar with—

(a) a report by the auditor of the administrator in the format set out in Annexure C; and

(b) a representation letter from the management of the administrator in the format set out in Annexure D.

26. Furnishing of other information

(1) An administrator must furnish the Registrar with such information concerning the administrator's shareholders, directors, members, partners and senior employees as the Registrar may from time to time require.

(2) If there is a change of owners, directors, members or shareholders and such change has an effect on the control of the administrator in question, the administrator must apply for accreditation in terms of regulation 17(2).

27. Ceasing, dissolution or liquidation of business

(1) If an administrator ceases to conduct business, is dissolved, liquidated or the administrator's accreditation has been withdrawn, the administrator's auditor must furnish a report to the Registrar confirming—

(a) that all documents of title relating to assets, the assets register, minute books, computer records, data and other records pertaining to the medical scheme under administration have been delivered to the trustees of the medical scheme or the new administrators, as the case may be;

(b) the date and address of delivery contemplated in paragraph (a); and

(c) the name of the trustee or other person at the administrator to whom the documents referred to in paragraph (a) have been delivered.

(2) If the auditor is for any reason unable to comply fully or partially with subregulation (1), the report must contain full particulars concerning the documents which have not been delivered, full reasons therefor as well as a plan with the dates on which compliance will take place to enable the Registrar to approve of such further period as may be determined by him or her.

Chapter 7
Conditions to be complied with by brokers

28. Conditions to be complied with by brokers of medical schemes

(1) A medical scheme must not compensate any person in terms of section 65 for acting as a broker unless such person—

(a) has been accredited by the Council to act as a broker or apprentice broker;

(b) has been issued with a certificate by the Council;

(c) is a fit and proper person for purposes of acting as broker or apprentice broker;

(d) enters into a prior written agreement with the medical scheme concerned, and the nature and compensation payable to such person must be fully disclosed in the financial statements of the medical scheme concerned;

(e) discloses to the prospective member the name of the medical scheme concerned and the fact that he or she is acting in terms of an agreement;

(f) discloses to the prospective member the registered contributions for the cover;

(g) discloses to the prospective member the nature of the services rendered by the broker;

(h) provides best advice and acts at all times in good faith towards the member, the prospective member and the medical scheme concerned;

(i) provides documentary proof to the member or prospective member that he or she has obtained accreditation from the Council;

(j) discloses to the member or prospective member the compensation payable to the broker, which shall not be in excess of the maximum amount as determined in terms of subregulation (2);

(k) complies with the minimum level of services provided for in the accreditation requirements;

(l) complies with the recognised educational qualifications contemplated in subregulation (8);

(m) complies with the code of ethics for appropriate behaviour provided for in the accreditation requirements; and

(n) undertakes not to receive any other incentive, reward or compensation from any other source in addition to the disclosed compensation as contemplated in subparagraph (d).

(2) A maximum amount payable in a given year in respect of the performance of services relating to the introduction of a member to a medical scheme by any number of brokers shall not exceed 3% plus value added tax (VAT) of the contributions payable in respect of members introduced by such broker during that year.

(3) Subregulation (2) must not be construed to restrict a medical scheme from applying a sliding fee scale based on the size of the group being introduced provided that the maximum amount in respect of a member introduced as specified in subregulation (2) is not exceeded.

[subregulation (3) substituted by section 5(a) of Government Notice R570 of 2000]

(4) No compensation is payable unless such compensation has been indicated in the rules of the medical scheme concerned.

(5) A medical scheme must not prevent a person from applying for membership of a medical scheme for the reason that that person is not using a broker to apply for such membership.

[subregulation (5) substituted by section 5(b) of Government Notice R570 of 2000]

(6) A person is disqualified from performing broker services if he or she is an unrehabilitated insolvent or has previously received a disqualifying rating as a broker or apprentice.

(7) Any person desiring to be accredited as a broker must apply in writing to the Council and the application must be accompanied by documentary proof of a recognised educational qualification and appropriate experience.

[subregulation (7) substituted by section 5(c) of Government Notice R570 of 2000]

(8) A recognised educational qualification and appropriate experience, for the purposes of this regulation, means—

Grade 12 education; and

a minimum of two years demonstrated experience as broker or apprentice broker in health care business;

(9) Individuals not meeting the qualifications for a broker may apply to the Council for accreditation as apprentice brokers and such applications must be accompanied by documentary proof of—

(a) Grade 12 education;

(b) agreement by a fully accredited broker to supervise the applicant;

(c) current accreditation of the supervising broker; and

(d) enrolment in a course of study sponsored by an organisation recognised by the Council.

[subregulation (9) substituted by section 5(d) of Government Notice R570 of 2000]

(10) Accreditation as a broker may be granted by the Council for two years at a time, to expire at the end of the second year and certification of brokers and apprentice brokers shall be granted on an annual basis and shall expire at the end of each year.

[subregulation (10) substituted by section 5(e) of Government Notice R570 of 2000]

(11) Any person who has paid a broker compensation where there has been a material misrepresentation is entitled to the full return of all the money paid.

[subregulation (11) added by section 5(f) of Government Notice R570 of 2000]

Chapter 8
Accumulated funds and assets

29. Minimum accumulated funds to be maintained by a medical scheme

(1) In this Regulation "accumulated funds" means the nett asset value of the medical scheme, excluding funds set aside for specific purposes and unrealised non-distributable reserves.

(2) Subject to sub-regulations (3) and (4), a medical scheme must at any time maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25%.

(3) A medical scheme must maintain accumulated funds, expressed as percentage of gross annual contributions, of not less than 10% during the first year after these regulations have come into operation, 13,5% during the second year, 17,5% during the third year, and not less than 22% during the fourth year.

(4) A medical scheme that for a period of 30 days fails to comply with subregulations (1) or (3) must notify the Registrar in writing of such failure, and must provide information relating to—

(a) the nature and causes of the failure, and

(b) the course of action being adopted to ensure compliance therewith.

30. Limitation on assets to be held in the Republic

(1) A medical scheme must have assets of the kinds and categories specified in column 1 of Annexure B in the Republic, the aggregate fair value of which, on any day, is not less than the aggregate of—

(a) the aggregate fair value on that day of its liabilities; and

(b) the minimum accumulated funds to be maintained in terms of Regulation 29.

(2) The assets that a medical scheme is required in terms of subregulation (1) to have in the Republic, when expressed as a percentage of the aggregate fair value of the liabilities and the minimum accumulated funds to be maintained in terms of Regulation 29, must not exceed the percentage specified against it in column 2 of Annexure B.

(3) For the purposes of this Regulation, an asset of the kind or category specified in items 1(b), 3(b), 5, 6(b) and 7(b) of Annexure B shall be deemed to be in the Republic.

(4) In this Regulation and Annexure B—

"convertible debenture" means a debenture which is convertible into equity shares of a company;

"fair value" in relation to—

(i) a credit balance, deposit or margin deposit, means the amount thereof;

(ii) property, plant and equipment, means the difference between the cost and the total amount provided or written off for depreciation or reduction in value since the date of acquisition;

(iii) an asset which is listed on a licensed stock exchange, means the selling price at which it was quoted on that stock exchange on the date at which the value is calculated;

(iv) an asset which is a long-term policy, means the amount which would be payable to the policyholder upon the surrender of the policy on the date at which the value is calculated;

(v) an asset referred to as a unit trust, means the price at which the unit would have been repurchased by the unit trust management company on the date at which the value is calculated, and, in the case of a property unit trust, the market value on the date at which the value is calculated, and, if it is listed on a stock exchange, the selling price at which it was quoted on that stock exchange on the date at which the value is calculated;

(vi) a futures contract, means the mark-to-market value, as defined in the rules of SAFEX referred to in section 17 of the Financial Markets Control Act, 1989;

(vii) an option contract, means the price at which it was quoted on a stock exchange on the date at which the value is calculated;

(viii) a derivative not mentioned in paragraph (vi) or (vii), means a price calculated as determined by the Council;

(ix) any other asset or liability, means the price at which the asset could be exchanged, or the liability settled, between knowledgeable, willing parties in an arm's length transaction, as estimated by the medical scheme;

"linked policy" means a long-term policy in relation to which the liabilities of the long-term insurer are linked liabilities as defined in the Long-term Insurance Act, 1998 (Act No. 52 of 1998);

"margin" in relation to a stock exchange, means the margin as defined in regulations issued or approved by the appropriate authority of the state in which the stock exchange is situated or which is required by that stock exchange;

"margin deposit" means a margin with SAFEX and a stock exchange;

“margin with SAFEX" means the margin as defined in the rules of SAFEX referred to in section 17 of the Financial Markets Control Act, 1989 (Act No 55 of 1989;

“property company" means a company—

(a) whose ownership of—

(i) immovable property; or

(ii) all of the shares in the company who's principal business consists of the ownership of immovable property or which exercises control over a company who's principal business consists of the ownership of immovable property; or

(iii) a linked policy, to the extent that the policy benefits thereunder are determined by reference to the value of immovable property,

constitutes in the aggregate, 50 per cent or more of the market value of its assets;

(b) which derives 50 per cent or more of its income, in the aggregate, from—

(i) investments in immovable property; or

(ii) investments in another company which derives 50 per cent or more of its income from investments in immovable property; or

(iii) a linked policy to the extent that the policy benefits thereunder are determined by reference to the value of immovable property; or

(c) which exercises control over a company referred to in paragraphs (a) or (b);

"regulated market” means a market situated, outside the Republic which is characterised by—

(a) regular operation; and

(b) the fact that regulations are issued or approved, by the appropriate authority of the State where the market is situated to determine conditions—

(i) for the operation of and access to the market; and

(ii) to be satisfied by a financial instrument in order for it to be effectively traded in the market;

"SAFEX" means the South African Futures Exchange;

“securities” include bills, bonds, debentures and debenture stock, loan stock, promissory notes, annuities, negotiable certificates of deposit and other financial instruments of whatever nature; and

“shares” include share stock.

(5) In this Regulation and Annexure B an instrument may not be deemed to be a derivative unless—

(a) it is based on an underlying asset of a kind set out in Annexure B or has the equivalent effect to such an instrument; and

(b) in the case of—

(i) an over-the-counter instrument, it is capable of being readily closed out and is entered into with a counter party approved by the Council subject to such conditions as it may determine;

(ii) an instrument referred to in Annexure B, it is listed; or

(iii) any other instrument, it is regularly traded on a licensed stock exchange in the Republic, or on any other financial market in the Republic approved by the Council subject to such conditions as the Council may determine.

(6) For the purposes of calculating the fair value of assets there must be disregarded—

(a) any amount of premium, excluding a premium in respect of a reinsurance policy, which is due and payable;

(b) an amount, excluding a premium in respect of a reinsurance policy, which remains unpaid after the expiry of a period of 12 months from the date on which it became due and payable;

(c) an amount representing administrative, organisational or business extension expenses incurred directly or indirectly in the carrying on of the business of a medical scheme;

(d) an amount representing a liability or a reinsurance contract in terms of which the medical scheme concerned is the policy holder; and

(e) an asset to the extent to which such asset is encumbered.

(7) If the Registrar is satisfied that the value of an asset or liability, when calculated in accordance with subregulations (4), (5) and (6) does not reflect a fair value, he or she may direct the medical scheme to appoint another person, at the cost of the medical scheme, to place a fair value on that asset or liability, or the Registrar may direct the medical scheme to calculate the value in another manner which he or she determines and which will produce a fair value for that asset or liability.

(8) A medical scheme that for a period of 30 days fails to comply with subregulations (1) and (2) must notify the Registrar in writing of such failure, providing information relating to—

(a) the nature and causes of the failure, and

(b) the course of action being adopted to ensure compliance therewith.

Chapter 9
General matters

31. Fees payable

The following fees are payable in respect of the matters as indicated—

(a) An application for registration of a medical scheme: R5000,00;

(b) the registration of a medical scheme: R1000,00;

(c) to change the name of a medical scheme: R500,00;

(d) registration of amendments, rescissions or additions to the rules of a medical scheme in terms of section 31 of the Act, per A4 page or part thereof: R50,00;

(e) inspection of documents in terms of section 41 (3) of the Act, per document: R50,00;

(f) a copy or extract made by the Registrar of or from a document referred to in section 41 (3) of the Act, per A4 page or part thereof: R20,00;

(g) application for approval as an administrator contemplated in section 58(4) of the Act: R10 000,00;

(h) application for accreditation as a broker contemplated in section 65 of the Act: R1000,00;

(i) an appeal contemplated in section 50(3) of the Act: R 2000,00.

(j) An application for accreditation to provide a managed health care service to a medical scheme: R10,000,00

32. Penalties

The penalty for every day which a failure contemplated in section 66(3) of the Act continues, is R1000,00.

33. Commencement of the regulations

These regulations, with the exception of chapters 3, 4 and 8 come into operation on 1 November 1999. Chapters 3, 4, 8, and Annexures A and B come into operation on 1 January 2000.

ME Tshabalala Msimang

Minister of Health

Annexure A

Explanatory Note

The objective of specifying a set of Prescribed Minimum Benefits within these regulations is two-fold:

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.

(ii) To encourage improved efficiency in the allocation of Private and Public health care resources.

The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions. A review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives. In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of:

(i) inconsistencies or flaws in the current regulations;

(ii) the cost-effectiveness of health technologies or interventions;

(iii) consistency with developments in health policy; and

(iv) the impact on medical scheme viability and its affordability to Members.

Prescribed minimum benefits

Categories (Diagnosis and Treatment Pairs) constituting the Prescribed Minimum Benefits Package under Section 29(1)(o) of the Medical Schemes Act (listed by Organ-System chapter)

Brain and nervous system

CODE: 906A

DIAGNOSIS: ACUTE GENERALISED PARALYSIS, INCLUDING POLIO AND GUILLAIN-BARRE

TREATMENT: MEDICAL MANAGEMENT; VENTILATION AND PLASMAPHERESIS

CODE: 341A

DIAGNOSIS: BASAL GANGLIA, EXTRA-PYRAMIDAL DISORDERS; OTHER DYSTONIAS NOS

TREATMENT: INITIAL DIAGNOSIS; INITIATION OF MEDICAL MANAGEMENT

CODE: 950A

DIAGNOSIS: BENIGN AND MALIGNANT BRAIN TUMOURS, TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES RADIATION THERAPY

CODE: 49A

DIAGNOSIS: COMPOUND/DEPRESSED FRACTURES OF SKULL

TREATMENT: CRANIOTOMY/CRANIECTOMY

CODE: 213A

DIAGNOSIS: DIFFICULTY IN BREATHING, EATING, SWALLOWING, BOWEL, OR BLADDER CONTROL DUE TO NON-PROGRESSIVE NEUROLOGICAL (INCLUDING SPINAL) CONDITION OR INJURY

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT; VENTILATION

CODE: 83A

DIAGNOSIS: ENCEPHALOCELE; CONGENITAL HYDROCEPHALUS

TREATMENT: SHUNT; SURGERY

CODE: 902A

DIAGNOSIS: EPILEPSY (STATUS EPILEPTICUS, INITIAL DIAGNOSIS, CANDIDATE FOR NEUROSURGERY)

TREATMENT: MEDICAL MANAGEMENT; VENTILATION; NEUROSURGERY

CODE: 211A

DIAGNOSIS: INTRASPINAL AND INTRACRANIAL ABSCESS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 905A

DIAGNOSIS: MENINGITIS - ACUTE AND SUBACUTE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 513A

DIAGNOSIS: MYASTHENIA GRAVIS; MUSCULAR DYSTROPHY; NEURO-MYOPATHIES NOS

TREATMENT: INITIAL DIAGNOSIS; INITIATION OF MEDICAL MANAGEMENT; THERAPY FOR ACUTE COMPLICATIONS AND EXACERBATIONS

CODE: 510A

DIAGNOSIS: PERIPHERAL NERVE INJURY WITH OPEN WOUND

TREATMENT: NEUROPLASTY

CODE: 940A

DIAGNOSIS: REVERSIBLE CNS ABNORMALITIES DUE TO OTHER SYSTEMIC DISEASE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 1A

DIAGNOSIS: SEVERE/MODERATE HEAD INJURY: HEMATOMA/EDEMA WITH LOSS OF CONSCIOUSNESS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT; VENTILATION

CODE: 84A

DIAGNOSIS: SPINA BIFIDA

TREATMENT: SURGICAL MANAGEMENT

CODE: 941A

DIAGNOSIS: SPINAL CORD COMPRESSION, ISHAEMIA OR DEGENERATIVE DISEASE NOS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 901A

DIAGNOSIS: STROKE - DUE TO HAEMORRHAGE, OR ISCHAEMIA

TREATMENT: MEDICAL MANAGEMENT; SURGERY

CODE: 28A

DIAGNOSIS: SUBARACHNOID AND INTRACRANIAL HEMORRHAGE/HEMATOMA; COMPRESSION OF BRAIN

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 305A

DIAGNOSIS: TETANUS

TREATMENT: MEDICAL MANAGEMENT; VENTILATION

CODE: 265A

DIAGNOSIS: TRANSIENT CEREBRAL ISCHEMIA; LIFE-THREATENING CEREBROVASCULAR CONDITIONS NOS

TREATMENT: EVALUATION; MEDICAL MANAGEMENT; SURGERY

CODE: 109A

DIAGNOSIS: VERTEBRAL DISLOCATIONS/FRACTURES, OPEN OR CLOSED WITH INJURY TO SPINAL CORD

TREATMENT: REPAIR/RECONSTRUCTION; MEDICAL MANAGEMENT; INPATIENT REHABILITATION UP TO 2 MONTHS

CODE: 684A

DIAGNOSIS: VIRAL MENINGITIS, ENCEPHALITIS, MYELITIS AND ENCEPHALOMYELITIS

TREATMENT: MEDICAL MANAGEMENT

Eye

CODE: 47B

DIAGNOSIS: ACUTE ORBITAL CELLULITIS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 394B

DIAGNOSIS: ANGLE-CLOSURE GLAUCOMA

TREATMENT: IRIDECTOMY; LASER SURGERY; MEDICAL AND SURGICAL MANAGEMENT

CODE: 586B

DIAGNOSIS: BELL'S PALSY; EXPOSURE KERATOCONJUNCTIVITIS

TREATMENT: TARSORRHAPHY; MEDICAL AND SURGICAL MANAGEMENT

CODE: 950B

DIAGNOSIS: CANCER OF EYE & ORBIT - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES RADIATION THERAPY

CODE: 901B

DIAGNOSIS: CATARACT; APHAKIA

TREATMENT: EXTRACTION OF CATARACT; LENS IMPLANT

CODE: 911B

DIAGNOSIS: CORNEAL ULCER; SUPERFICIAL INJURY OF EYE AND ADNEXA

TREATMENT: CONJUNCTIVAL FLAP; MEDICAL MANAGEMENT

CODE: 405B

DIAGNOSIS: GLAUCOMA ASSOCIATED WITH DISORDERS OF THE LENS

TREATMENT: SURGICAL MANAGEMENT

CODE: 386B

DIAGNOSIS: HERPES ZOSTER & HERPES SIMPLEX WITH OPHTHALMIC COMPLICATIONS

TREATMENT: MEDICAL MANAGEMENT

CODE: 389B

DIAGNOSIS: HYPHEMA

TREATMENT: REMOVAL OF BLOOD CLOT; OBSERVATION

CODE: 485B

DIAGNOSIS: INFLAMMATION OF LACRIMAL PASSAGES

TREATMENT: INCISION; MEDICAL MANAGEMENT

CODE: 909B

DIAGNOSIS: OPEN WOUND OF EYEBALL AND OTHER EYE STRUCTURES

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 407B

DIAGNOSIS: PRIMARY AND OPEN ANGLE GLAUCOMA WITH FAILED MEDICAL MANAGEMENT

TREATMENT: TRABECULECTOMY; OTHER SURGERY

CODE:419B

DIAGNOSIS: PURULENT ENDOPHTHALMITIS

TREATMENT: VITRECTOMY

CODE: 922B

DIAGNOSIS: RETAINED INTRAOCULAR FOREIGN BODY

TREATMENT: SURGICAL MANAGEMENT

CODE: 904B

DIAGNOSIS: RETINAL DETACHMENT, TEAR AND OTHER RETINAL DISORDERS

TREATMENT: VITRECTOMY; LASER TREATMENT; OTHER SURGERY

CODE: 906B

DIAGNOSIS: RETINAL VASCULAR OCCLUSION; CENTRAL RETINAL VEIN OCCLUSION

TREATMENT: LASER SURGERY

CODE: 409B

DIAGNOSIS: SYMPATHETIC UVEITIS AND DEGENERATIVE DISORDERS AND CONDITIONS OF GLOBE; SIGHT THREATENING THYROID OPTOPATHY

TREATMENT: ENUCLEATION; MEDICAL MANAGEMENT; SURGERY

Ear, nose, mouth and throat

CODE: 33C

DIAGNOSIS: ACUTE AND CHRONIC MASTOIDITIS

TREATMENT: MASTOIDECTOMY; MEDICAL MANAGEMENT

CODE: 482C

DIAGNOSIS: ACUTE OTITIS MEDIA

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, INCLUDING MYRINGOTOMY

CODE: 900C

DIAGNOSIS: ACUTE UPPER AIRWAY OBSTRUCTION, INCLUDING CROUP, EPIGLOTTITIS AND ACUTE LARYNGOTRACHEITIS

TREATMENT: MEDICAL MANAGEMENT; INTUBATION; TRACHEOSTOMY

CODE: 950C

DIAGNOSIS: CANCER OF ORAL CAVITY, PHARYNX, NOSE, EAR, AND LARYNX - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 241C

DIAGNOSIS: CANCRUM ORIS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 38C

DIAGNOSIS: CHOANAL ATRESIA

TREATMENT: REPAIR OF CHOANAL ATRESIA

CODE: 133C

DIAGNOSIS: CHOLESTEATOMA

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 910C

DIAGNOSIS: CHRONIC UPPER AIRWAY OBSTRUCTION, RESULTING IN COR PULMONALE

TREATMENT: SURGICAL AND MEDICAL MANAGEMENT

CODE: 901C

DIAGNOSIS: CLEFT PALATE AND/OR CLEFT LIP WITHOUT AIRWAY OBSTRUCTION

TREATMENT: REPAIR

CODE: 12C

DIAGNOSIS: DEEP OPEN WOUND OF NECK, INCLUDING LARYNX; FRACTURE OF LARYNX OR TRACHEA, OPEN

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT; VENTILATION

CODE: 346C

DIAGNOSIS: EPISTAXIS - NOT RESPONSIVE TO ANTERIOR PACKING

TREATMENT: CAUTERY / REPAIR / CONTROL HEMORRHAGE

CODE: 521C

DIAGNOSIS: FOREIGN BODY IN EAR & NOSE

TREATMENT: REMOVAL OF FOREIGN BODY; AND MEDICAL AND SURGICAL MANAGEMENT

CODE: 29C

DIAGNOSIS: FOREIGN BODY IN PHARYNX, LARYNX, TRACHEA, BRONCHUS & ESOPHAGUS

TREATMENT: REMOVAL OF FOREIGN BODY

CODE: 339C

DIAGNOSIS: FRACTURE OF FACE BONES, ORBIT, JAW; INJURY TO OPTIC AND OTHER CRANIAL NERVES

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 219C

DIAGNOSIS: LEUKOPLAKIA OF ORAL MUCOSA, INCLUDING TONGUE

TREATMENT; INCISION/EXCISION; MEDICAL MANAGEMENT

CODE: 132C

DIAGNOSIS: LIFE-THREATENING DISEASES OF PHARYNX NOS, INCLUDING RETROPHARYNGEAL ABSCESS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 457C

DIAGNOSIS: OPEN WOUND OF EAR-DRUM

TREATMENT: TYMPANOPLASTY; MEDICAL MANAGEMENT

CODE: 240C

DIAGNOSIS: PERITONSILLAR ABSCESS

TREATMENT: INCISION AND DRAINAGE OF ABSCESS; TONSILLECTOMY; MEDICAL MANAGEMENT

CODE: 347C

DIAGNOSIS: SIALOADENITIS; ABSCESS / FISTULA OF SALIVARY GLANDS

TREATMENT: SURGERY

CODE: 543C

DIAGNOSIS: STOMATITIS, CELLULITIS AND ABSCESS OF ORAL SOFT TISSUE; VINCENTS

ANGINA

TREATMENT: INCISION AND DRAINAGE; MEDICAL MANAGEMENT

Respiratory system

CODE: 903D

DIAGNOSIS: BACTERIAL, VIRAL, FUNGAL PNEUMONIA

TREATMENT: MEDICAL MANAGEMENT, VENTILATION

CODE: 158D

DIAGNOSIS: # RESPIRATORY FAILURE, REGARDLESS OF CAUSE

TREATMENT: # MEDICAL MANAGEMENT; OXYGEN; VENTILATION

CODE: 157D

DIAGNOSIS: ACUTE ASTHMATIC ATTACK; PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3

TREATMENT: MEDICAL MANAGEMENT

CODE: 125D

DIAGNOSIS: ADULT RESPIRATORY DISTRESS SYNDROME; INHALATION AND ASPIRATION PNEUMONIAS

TREATMENT: MEDICAL MANAGEMENT; VENTILATION

CODE: 315D

DIAGNOSIS: ATELECTASIS (COLLAPSE OF LUNG)

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT; VENTILATION

CODE: 340D

DIAGNOSIS: BENIGN NEOPLASM OF RESPIRATORY AND INTRATHORACIC ORGANS

TREATMENT: BIOPSY; LOBECTOMY; MEDICAL MANAGEMENT; RADIATION THERAPY

CODE: 950D

DIAGNOSIS: CANCER OF LUNG, BRONCHUS, PLEURA, TRACHEA, MEDIASTINUM & OTHER RESPIRATORY ORGANS-TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 170D

DIAGNOSIS: EMPYEMA AND ABSCESS OF LUNG

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 934D

DIAGNOSIS: FRANK HAEMOPTYISIS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 203D

DIAGNOSIS: HYPOPLASIA AND DYSPLASIA OF LUNG

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 900D

DIAGNOSIS: OPEN FRACTURE OF RIBS AND STERNUM; MULTIPLE RIB FRACTURES; FLAIL CHEST

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, VENTILATION

CODE: 5D

DIAGNOSIS: PNEUMOTHORAX AND HAEMOTHORAX

TREATMENT: TUBE THORACOSTOMY / THORACOTOMY

Heart and vasculature

CODE: 155E

DIAGNOSIS: MYOCARDITIS; CARDIOMYOPATHY; TRANSPOSITION OF GREAT VESSELS; HYPOPLASTIC LEFT HEART SYNDROME

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT; CARDIAC TRANSPLANT

CODE: 108E

DIAGNOSIS: PERICARDITIS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 907E

DIAGNOSIS: ACUTE AND SUBACUTE ISCHEMIC HEART DISEASE, INCLUDING MYOCARDIAL INFARCTION AND UNSTABLE ANGINA

TREATMENT: MEDICAL MANAGEMENT; SURGERY; PERCUTANEOUS PROCEDURES

CODE: 284E

DIAGNOSIS: ACUTE PULMONARY HEART DISEASE AND PULMONARY EMBOLI

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 35E

DIAGNOSIS: ACUTE RHEUMATIC FEVER

TREATMENT: MEDICAL MANAGEMENT

CODE: 908E

DIAGNOSIS: ANEURYSM OF MAJOR ARTERY OF CHEST. ABDOMEN, NECK, -UNRUPTURED OR RUPTURED NOS

TREATMENT: SURGICAL MANAGEMENT

CODE: 26E

DIAGNOSIS: ARTERIAL EMBOLISM/THROMBOSIS: ABDOMINAL AORTA, THORACIC AORTA

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 204E

DIAGNOSIS: CARDIAC FAILURE: ACUTE OR RECENT DETERIORATION OF CHRONIC CARDIAC FAILURE

TREATMENT: MEDICALTREATMENT

CODE: 98E

DIAGNOSIS: COMPLETE, CORRECTED AND OTHER TRANSPOSTION OF GREAT VESSELS

TREATMENT: REPAIR

CODE: 97E

DIAGNOSIS: CORONARY ARTERY ANOMALY

TREATMENT: ANOMALOUS CORONARY ARTERY LIGATION

CODE: 309E

DIAGNOSIS: DISEASES AND DISORDERS OF AORTIC VALVE NOS

TREATMENT: AORTIC VALVE REPLACEMENT

CODE: 210E

DIAGNOSIS: DISEASES OF ENDOCARDIUM; ENDOCARDITIS

TREATMENT: MEDICAL MANAGEMENT

CODE: 314E

DIAGNOSIS: DISEASES OF MITRAL VALVE

TREATMENT: VALVULOPLASTY; VALVE REPLACEMENT; MEDICAL MANAGEMENT

CODE: 902E

DIAGNOSIS: DISORDERS OF ARTERIES: VISCERAL

TREATMENT: BYPASS GRAFT; SURGICAL MANAGEMENT

CODE: 18E

DIAGNOSIS: DISSECTING OR RUPTURED AORTIC ANEURYSM

TREATMENT: SURGICAL MANAGEMENT

CODE: 915E

DIAGNOSIS: GANGRENE; SEVERE ATHEROSCLEROSIS OF ARTERIES OF EXTREMITIES; DIABETES MELLITUS WITH PERIPHERAL CIRCULATORY DISEASE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT INCLUDING AMPUTATION

CODE: 294E

DIAGNOSIS: GIANT CELL ARTERITIS, KAWASAKI DISEASE, HYPERSENSITIVITY ANGIITIS

TREATMENT: MEDICAL MANAGEMENT

CODE: 450E

DIAGNOSIS: HEREDITARY HEMORRHAGIC TELANGIECTASIA

TREATMENT: EXCISION

CODE:901E

DIAGNOSIS: HYPERTENSION - ACUTE LIFE-THREATENING COMPLICATIONS AND MALIGNANT HYPERTENSION; RENAL ARTERY STENOSIS AND OTHER CURABLE HYPERTENSION

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 111E

DIAGNOSIS: INJURY TO MAJOR BLOOD VESSELS - TRUNK, HEAD AND NECK, AND UPPER LIMBS

TREATMENT: REPAIR

CODE: 19E

DIAGNOSIS: INJURY TO MAJOR BLOOD VESSELS OF EXTREMITIES

TREATMENT: LIGATION

CODE; 903E

DIAGNOSIS: LIFE-THREATENING CARDIAC ARRHYTHMIAS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, PACEMAKERS, CARDIOVERSION CODE: 900E

DIAGNOSIS: LIFE-THREATENING COMPLICATIONS OF ELECTIVE CARDIAC AND MAJOR VASCULAR PROCEDURES

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 497E

DIAGNOSIS: MULTIPLE VALVULAR DISEASE

TREATMENT: SURGICAL MANAGEMENT

CODE: 355E

DIAGNOSIS: OTHER ANEURYSM OF ARTERY - PERIPHERAL

TREATMENT: SURGICAL MANAGEMENT

CODE: 905E

DIAGNOSIS: OTHER CORRECTABLE CONGENITAL CARDIAC CONDITIONS

TREATMENT: SURGICAL REPAIR; MEDICAL MANAGEMENT

CODE: 100E

DIAGNOSIS: PATENT DUCTUS ARTERIOSUS; AORTIC PULMONARY FISTULA - PERSISTENT

TREATMENT: LIGATION

CODE: 209E

DIAGNOSIS: PHLEBITIS & THROMBOPHLEBITIS, DEEP

TREATMENT: LIGATION AND DIVISION; MEDICAL MANAGEMENT

CODE: 914E

DIAGNOSIS: RHEUMATIC PERICARDITIS; RHEUMATIC MYOCARDITIS

TREATMENT: MEDICAL MANAGEMENT

CODE: 16E

DIAGNOSIS: RUPTURE OF PAPILLARY MUSCLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 627E

DIAGNOSIS: SHOCK / HYPOTENSION - LIFE THREATENING

TREATMENT: MEDICAL MANAGEMENT; VENTILATION

CODE: 99E

DIAGNOSIS: TETRALOGY OF FALLOT (TOF)

TREATMENT: TOTAL REPAIR TETRALOGY

CODE: 93E

DIAGNOSIS: VENTRICULAR SEPTAL DEFECT - PERSISTENT

TREATMENT: CLOSURE

Gastro-intestinal system

CODE: 920F

DIAGNOSIS: ANAL FISSURE; ANAL FISTULA

TREATMENT: FISSURECTOMY; FISTULECTOMY; MEDICAL MANAGEMENT

CODE: 41F

DIAGNOSIS: ABSCESS OF INTESTINE

TREATMENT: DRAIN ABSCESS; MEDICAL MANAGEMENT

CODE: 489F

DIAGNOSIS: ACQUIRED HYPERTROPHIC PYLORIC STENOSIS AND OTHER DISORDERS OF THE STOMACH AND DUODENUM

TREATMENT: SURGICAL MANAGEMENT

CODE: 254F

DIAGNOSIS: ACUTE DIVERTICULITIS OF COLON

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, INCLUDING COLON RESECTION

CODE: 124F

DIAGNOSIS: ACUTE VASCULAR INSUFFICIENCY OF INTESTINE

TREATMENT: COLECTOMY

CODE: 337F

DIAGNOSIS: AMOEBIASIS; TYPHOID

TREATMENT: MEDICAL MANAGEMENT

CODE: 264F

DIAGNOSIS: ANAL AND RECTAL POLYP

TREATMENT: EXCISION OF POLYP

CODE: 9F

DIAGNOSIS: APPENDICITIS

TREATMENT: APPENDECTOMY

CODE: 952F

DIAGNOSIS: CANCER OF RETROPERITONEUM, PERITONEUM, OMENTUM & MESENTERY - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 950F

DIAGNOSIS: CANCER OF THE GIT INCLUDING OESOPHAGUS, STOMACH, BOWEL, RECTUM, ANUS - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES RADIATION THERAPY

CODE: 95F

DIAGNOSIS: CONGENITAL ANOMALIES OF UPPER ALIMENTARY TRACT - EXCLUDING TONGUE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 214F

DIAGNOSIS: OESOPHAGEAL STRICTURE

TREATMENT: DILATION; SURGERY

CODE: 516F

DIAGNOSIS: ESOPHAGEAL VARICES

TREATMENT: MEDICAL MANAGEMENT; SURGICAL SHUNT; SCLEROTHERAPY

CODE: 902F

DIAGNOSIS: GASTRIC OR INTESTINAL ULCERS WITH HEMORRHAGE OR PERFORATION

TREATMENT: SURGERY; ENDOSCOPIC DIAGNOSIS; MEDICAL MANAGEMENT

CODE: 901F

DIAGNOSIS: GASTROENTERITIS AND COLITIS WITH LIFE-THREATENING HAEMORRHAGE OR DEHYDRATION, REGARDLESS OF CAUSE

TREATMENT: MEDICAL MANAGEMENT

CODE: 6F

DIAGNOSIS: HERNIA WITH OBSTRUCTION AND/OR GANGRENE; UNCOMPLICATED HERNIAS UNDER AGE 18

TREATMENT: REPAIR; BOWEL RESECTION

CODE: 20F

DIAGNOSIS: INTESTINAL OBSTRUCTION WITHOUT MENTION OF HERNIA; SYMPTOMATIC FOREIGN BODY IN STOMACH, INTESTINES, COLON & RECTUM

TREATMENT: EXCISION; SURGERY; MEDICAL MANAGEMENT

CODE: 232F

DIAGNOSIS: PARALYTIC ILEUS

TREATMENT: MEDICAL MANAGEMENT

CODE: 498F

DIAGNOSIS: PERITONEAL ADHESION

TREATMENT: SURGICAL MANAGEMENT

CODE: 3F

DIAGNOSIS: PERITONITIS, REGARDLESS OF CAUSE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 555F

DIAGNOSIS: RECTAL PROLAPSE

TREATMENT: PARTIAL COLECTOMY

CODE: 292F

DIAGNOSIS: REGIONAL ENTERITIS; IDIOPATHIC PROCTOCOLITIS - ACUTE EXACCERBATIONS AND COMPLICATIONS ONLY

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 900F

DIAGNOSIS: RUPURE OF INTRA-ABDOMINAL ORGAN

TREATMENT: REPAIR; SPLENECTOMY; RESECTION

CODE: 507F

DIAGNOSIS: THROMBOSED AND COMPLICATED HEMORRHOIDS

TREATMENT: HEMORRHOIDECTOMY; INCISION

Liver, pancreas and spleen

CODE: 325G

DIAGNOSIS: ACUTE NECROSIS OF LIVER

TREATMENT: MEDICAL MANAGEMENT

CODE: 327G

DIAGNOSIS: ACUTE PANCREATITIS

TREATMENT: MEDICAL MANAGEMENT, AND WHERE APPROPRIATE, SURGICAL MANAGEMENT

CODE: 36G

DIAGNOSIS: BUDD-CHIARI SYNDROME, AND OTHER VENOUS EMBOLISM AND THROMBOSIS

TREATMENT: THROMBECTOMY/LIGATION

CODE:910G

DIAGNOSIS: CALCULUS OF BILE DUCT WITH CHOLECYSTITIS

TREATMENT: MEDICAL MANAGEMENT; CHOLECYSTECTOMY; OTHER OPEN OR CLOSED SURGERY

CODE: 950G

DIAGNOSIS: CANCER OF LIVER, BILIARY SYSTEM AND PANCREAS - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE:255G

DIAGNOSIS: CYST AND PSEUDOCYST OF PANCREAS

TREATMENT: DRAINAGE OF PANCREATIC CYST

CODE: 156G

DIAGNOSIS: DISORDERS OF BILE DUCT

TREATMENT: EXCISION; REPAIR

CODE: 910G

DIAGNOSIS: GALLSTONE WITH CHOLECYSTITIS AND/OR JAUNDICE

TREATMENT: MEDICAL MANAGEMENT; CHOLECYSTECTOMY; OTHER OPEN OR CLOSED SURGERY

CODE: 743G

DIAGNOSIS: HEPATORENAL SYNDROME

TREATMENT: MEDICAL MANAGEMENT

CODE: 27G

DIAGNOSIS: LIVER ABSCESS; PANCREATIC ABSCESS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 911G

DIAGNOSIS: LIVER FAILURE; HEPATIC VASCULAR OBSTRUCTION; INBORN ERRORS OF LIVER METABOLISM; BILIARY ATRESIA

TREATMENT: LIVER TRANSPLANT, OTHER SURGERY MEDICAL MANAGEMENT

CODE: 231G

DIAGNOSIS: PORTAL VEIN THROMBOSIS

TREATMENT: SHUNT

Musculoskeletal system ; Trauma nos

CODE: 353H

DIAGNOSIS: ABSCESS OF BURSA OR TENDON

TREATMENT: INCISION AND DRAINAGE

CODE: 32H

DIAGNOSIS: ACUTE OSTEOMYELITIS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 950H

DIAGNOSIS: CANCER OF BONES - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 206H

DIAGNOSIS: CHRONIC OSTEOMYELITIS

TREATMENT: INCISION & DRAINAGE

CODE: 902H

DIAGNOSIS: CLOSED FRACTURES/DISLOCATIONS OF LIMB BONES / EPIPHYSES - EXCLUDING FINGERS AND TOES

TREATMENT: REDUCTION/RELOCATION

CODE: 85H

DIAGNOSIS: CONGENITAL DISLOCATION OF HIP; COXA VARA & VALGA; CONGENITAL CLUBFOOT

TREATMENT: REPAIR/RECONSTRUCTION

CODE: 147H

DIAGNOSIS: CRUSH INJURIES OF TRUNK, UPPER LIMBS, LOWER LIMB, INCLUDING BLOOD VESSELS

TREATMENT: SURGICAL MANAGEMENT; VENTILATION; ACUTE RENAL DIALYSIS

CODE:491H

DIAGNOSIS: DISLOCATIONS/FRACTURES OF VERTEBRAL COLUMN WITHOUT SPINAL CORD INJURY

TREATMENT: MEDICAL MANAGEMENT; SURGICAL STABILISATION

CODE: 500H

DIAGNOSIS: DISRUPTIONS OF THE ACHILLES / QUADRICEPS TENDONS

TREATMENT: REPAIR

CODE: 178H

DIAGNOSIS: FRACTURE OF HIP

TREATMENT: REDUCTION; HIP REPLACEMENT

CODE; 445H

DIAGNOSIS: INJURY TO INTERNAL ORGANS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 900H

DIAGNOSIS: OPEN FRACTURE/DISLOCATION OF BONES OR JOINTS

TREATMENT: REDUCTION/RELOCATION; MEDICAL AND SURGICAL MANAGEMENT

CODE: 34H

DIAGNOSIS: PYOGENIC ARTHRITIS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 901H

DIAGNOSIS: TRAUMATIC AMPUTATION OF LIMBS, HANDS, FEET, AND DIGITS

TREATMENT: REPLANTATION/AMPUTATION

Skin and breast

CODE: 465J

DIAGNOSIS: ACUTE LYMPHADENITIS

TREATMENT: INCISION AND DRAINAGE; MEDICAL MANAGEMENT

CODE: 900J

DIAGNOSIS: BURNS, GREATER THAN 10% OF BODY SURFACE, OR MORE THAN 5% INVOLVING HEAD, NECK, HANDS, PERINEUM

TREATMENT: DEBRIDEMENT; FREE SKIN GRAFT; MEDICAL MANAGEMENT

CODE: 950J

DIAGNOSIS: CANCER OF BREAST - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 954J

DIAGNOSIS: CANCER OF SKIN, EXCLUDING MALIGNANT MELANOMA - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 952J

DIAGNOSIS: CANCER OF SOFT TISSUE, INCLUDING SARCOMAS AND MALIGNANCIES OF THE ADNEXA-TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 349J

DIAGNOSIS: CELLULITIS AND ABSCESSES WITH RISK OF ORGAN OR LIMB DAMAGE OR SEPTICEMIA IF UNTREATED; NECROTISING FASCIITIS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 901J

DIAGNOSIS: DISSEMINATED BULLOUS SKIN DISEASE, INCLUDING PEMPHIGUS, PEMPHIGOID, EPIDERMOLYSIS BULLOSA, EPIDERMOLYTIC HYPERKERATOSIS

TREATMENT: MEDICAL MANAGEMENT

CODE: 951J

DIAGNOSIS: LETHAL MIDLINE GRANULOMA

TREATMENT: MEDICAL MANAGEMENT, WHICH INCLUDES RADIATION THERAPY

CODE: 953J

DIAGNOSIS: MALIGNANT MELANOMA OF SKIN - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 373J

DIAGNOSIS: NON-SUPERFICIAL OPEN WOUNDS - NON LIFE-THREATENING

TREATMENT: REPAIR

CODE. 356J

DIAGNOSIS: PYODERMA; BODY, DEEP-SEATED FUNGAL INFECTIONS

TREATMENT: MEDICAL MANAGEMENT

CODE: 112J

DIAGNOSIS: TOXIC EPIDERMAL NECROLYSIS AND STAPHYLOCOCCAL SCALDED SKIN SYNDROME; STEVENS-JOHNSON SYNDROME

TREATMENT: MEDICAL MANAGEMENT

Endocrine, metabolic and nutritional

CODE: 331K

DIAGNOSIS: ACUTE THYROIDITIS

TREATMENT: MEDICAL MANAGEMENT

CODE: 951K

DIAGNOSIS: BENIGN AND MALIGNANT TUMOURS OF PITUITARY GLAND WITH/WITHOUT HYPERSECRETION SYNDROMES

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT; RADIATION THERAPY

CODE: 30K

DIAGNOSIS: BENIGN NEOPLASM OF ISLETS OF LANGERHANS

TREATMENT: EXCISION OF TUMOR; MEDICAL MANAGEMENT

CODE: 950K

DIAGNOSIS: CANCER OF ENDOCRINE SYSTEM, EXCLUDING THYROID - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 952K

DIAGNOSIS: CANCER OF THYROID - TREATABLE; CARCINOID SYNDROME

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INLCUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 61K

DIAGNOSIS: CONGENITAL HYPOTHYROIDISM

TREATMENT: MEDICAL MANAGEMENT

CODE: 902K

DIAGNOSIS: DISORDERS OF ADRENAL SECRETION NOS

TREATMENT: MEDICAL MANAGEMENT; ADRENALECTOMY

CODE: 447K

DIAGNOSIS: DISORDERS OF PARATHYROID GLAND; BENIGN NEOPLASM OF PARATHYROID GLAND

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 904K

DIAGNOSIS: HYPER AND HYPOTHYROIDISM WITH LIFE-THREATENING COMPLICATIONS OR REQUIRING SURGERY

TREATMENT: MEDICAL MANAGEMENT; SURGERY

CODE: 31K

DIAGNOSIS: HYPOGLYCEMIC COMA; HYPERGLYCEMIA; DIABETIC KETOACIDOSIS

TREATMENT: MEDICAL MANAGEMENT

CODE: 236K

DIAGNOSIS: IRON DEFICIENCY; VITAMIN AND OTHER NUTRITIONAL DEFICIENCIES - LIFETHREATENING

TREATMENT: MEDICAL MANAGEMENT

CODE: 901K

DIAGNOSIS: LIFE-THREATENING CONGENITAL ABNORMALITIES OF CARBOHYDRATE, LIPID, PROTEIN AND AMINO ACID METABOLISM

TREATMENT: MEDICAL MANAGEMENT

CODE: 903K

DIAGNOSIS: LIFE-THREATENING DISORDERS OF FLUID AND ELECTROLYTE BALANCE, NOS

TREATMENT: MEDICAL MANAGEMENT

Urinary and male genital system

CODE: 354L

DIAGNOSIS: ABSCESS OF PROSTATE

TREATMENT: TURP; DRAIN ABSCESS

CODE: 904L

DIAGNOSIS: ACUTE AND CHRONIC PYELONEPHRITIS; RENAL & PERINEPHRIC ABSCESS

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 903L

DIAGNOSIS: ACUTE GLOMERULONEPHRITIS AND NEPHROTIC SYNDROME

TREATMENT: MEDICAL MANAGEMENT

CODE: 954L

DIAGNOSIS: CANCER OF PENIS AND OTHER MALE GENITAL ORGAN - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 953L

DIAGNOSIS: CANCER OF PROSTATE GLAND - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 950L

DIAGNOSIS: CANCER OF TESTIS - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 952L

DIAGNOSIS: CANCER OF URINARY SYSTEM INCLUDING KIDNEY AND BLADDER - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 906L

DIAGNOSIS: CONGENITAL ANOMALIES OF URINARY SYSTEM - SYMPTOMATIC AND LIFETHREATENING

TREATMENT: NEPHRECTOMY/REPAIR

CODE: 901L

DIAGNOSIS: END STAGE RENAL DISEASE REGARDLESS OF CAUSE

TREATMENT: DIALYSIS & RENAL TRANSPLANT WHERE DEPARTMENT OF HEALTH CRITERIA ARE MET ONLY (SEE CRITERIA PUBLISHED IN GPS 004-9001)

CODE: 900L

DIAGNOSIS: HYPERPLASIA OF THE PROSTATE, WITH ACUTE URINARY RETENTION OR OBSTRUCTIVE RENAL FAILURE

TREATMENT: TRANSURETHRAL RESECTION; MEDICAL MANAGEMENT

CODE: 905L

DIAGNOSIS: OBSTRUCTION OF THE UROGENITAL TRACT, REGARDLESS OF CAUSE

TREATMENT: CATHETERIZATION; SURGERY; ENDOSCOPIC REMOVAL OF OBSTRUCTING AGENT: LITHOTRIPSY

CODE: 436L

DIAGNOSIS: TORSION OF TESTIS

TREATMENT: ORCHIDECTOMY; REPAIR

CODE: 43L

DIAGNOSIS: TRAUMA TO THE URINARY SYSTEM INCLUDING RUPTURED BLADDER

TREATMENT: CYSTORRHAPHY; SUTURE; REPAIR

CODE: 289L

DIAGNOSIS: URETERAL FISTULA (INTESTINAL)

TREATMENT: NEPHROSTOMY

CODE: 359L

DIAGNOSIS: VESICOURETERAL REFLUX

TREATMENT: MEDICAL MANAGEMENT; REPLANTATION

Female reproductive system

CODE: 539M

DIAGNOSIS: ABSCESSES OF BARTHOLIN'S GLAND AND VULVA

TREATMENT: INCISION AND DRAINAGE; MEDICAL MANAGEMENT

CODE: 288M

DIAGNOSIS: ACUTE PELVIC INFLAMMATORY DISEASE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 954M

DIAGNOSIS: CANCER OF CERVIX - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES RADIATION THERAPY

CODE: 952M

DIAGNOSIS: CANCER OF OVARY - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 950M

DIAGNOSIS: CANCER OF UTERUS - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY AND RADIATION THERAPY

CODE: 953M

DIAGNOSIS: CANCER OF VAGINA, VULVA AND OTHER FEMALE GENITAL ORGANS NOS - TREATABLE

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, WHICH INCLUDES RADIATION THERAPY AND CHEMOTHERAPY

CODE: 960M

DIAGNOSIS: CERVICAL AND BREAST CANCER SCREENING

TREATMENT: CERVICAL SMEARS; PERIODIC BREAST EXAMINATION

CODE: 645M

DIAGNOSIS: CONGENITAL ABNORMALITIES OF THE FEMALE GENITALIA

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 266M

DIAGNOSIS: DYSPLASIA OF CERVIX AND CERVICAL CARCINOMA-IN-SITU; CERVICAL CONDYLOMATA

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 53M

DIAGNOSIS: ECTOPIC PREGNANCY

TREATMENT: SURGERY

CODE: 460M

DIAGNOSIS: FISTULA INVOLVING FEMALE GENITAL TRACT

TREATMENT: CLOSURE OF FISTULA

CODE: 951M

DIAGNOSIS: HYDATIDIFORM MOLE; CHORIOCARCINOMA

TREATMENT: D & C; HYSTERECTOMY; CHEMOTHERAPY

CODE: 902M

DIAGNOSIS: INFERTILITY

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 528M

DIAGNOSIS: MENOPAUSAL MANAGEMENT, ANOMALIES OF OVARIES, PRIMARY AND SECONDARY AMENORRHOEA, FEMALE SEX HORMONES ABNORMALITIES NOS, INCLUDING HIRSUTISM.

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT, INCLUDING HORMONE REPLACEMENT THERAPY

CODE: 434M

DIAGNOSIS: NON-INFLAMMATORY DISORDERS AND BENIGN NEOPLASMS OF OVARY, FALLOPIAN TUBES AND UTERUS

TREATMENT: SALPINGECTOMY; OOPHORECTOMY; HYSTERECTOMY; MEDICAL AND SURGICAL MANAGEMENT

CODE: 237M

DIAGNOSIS: SEXUAL ABUSE, INCLUDING RAPE

TREATMENT: MEDICAL MANAGEMENT; PSYCHOTHERAPY

CODE; 903M

DIAGNOSIS: SPONTANEOUS ABORTION

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 435M

DIAGNOSIS: TORSION OF OVARY

TREATMENT: OOPHORECTOMY; OVARIAN CYSTECTOMY

CODE: 530M

DIAGNOSIS: UTERINE PROLAPSE; CYSTOCELE

TREATMENT: SURGICAL REPAIR

CODE: 296M

DIAGNOSIS: VOLUNTARY TERMINATION OF PREGNANCY

TREATMENT: INDUCED ABORTION; MEDICAL AND SURGICAL MANAGEMENT

Pregnancy and childbirth

CODE: 67N

DIAGNOSIS: # LOW BIRTH WEIGHT (UNDER 1000g) WITH RESPIRATORY DIFFICULTIES

TREATMENT: # MEDICAL MANAGEMENT NOT INCLUDING VENTILATION

CODE: 967N

DIAGNOSIS: # LOW BIRTH WEIGHT (UNDER 2500 GRAMS & > 1000g) WITH RESPIRATORY DIFFICULTIES

TREATMENT: MEDICAL MANAGEMENT, INCLUDING VENTILATION; INTENSIVE CARE THERAPY

CODE: 71N

DIAGNOSIS: BIRTH TRAUMA FOR BABY

TREATMENT; MEDICAL MANAGEMENT; SURGERY

CODE: 901N

DIAGNOSIS: CONGENITAL SYSTEMIC INFECTIONS AFFECTING THE NEWBORN

TREATMENT: MEDICAL MANAGEMENT, VENTILATION

CODE: 904N

DIAGNOSIS: HAEMATOLOGICAL DISORDERS OF THE NEWBORN

TREATMENT: MEDICAL MANAGEMENT

CODE: 54N

DIAGNOSIS: NECROTIZING ENTEROCOLITIS IN NEWBORN

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 74N

DIAGNOSIS: NEONATAL AND INFANT GIT ABNORMALITIES AND DISORDERS, INCLUDING MALROTATION AND ATRESIA

TREATMENT: MEDICAL AND SURGICAL MANAGEMENT

CODE: 902N

DIAGNOSIS: NEONATAL ENDOCRINE, METABLIC AND TOXIN-INDUCED CONDITIONS

TREATMENT: MEDICAL MANAGEMENT

CODE: 903N

DIAGNOSIS: NEUROLOGICAL ABNORMALITIES IN THE NEWBORN

TREATMENT: MEDICAL MANAGEMENT

CODE: 52N

DIAGNOSIS: PREGNANCY

TREATMENT: ANTENATAL AND OBSTETRIC CARE NECESSITATING HOSPITALISATION, INCLUDING DELIVERY

CODE: 56N

DIAGNOSIS: RESPIRATORY CONDITIONS OF NEWBORN

TREATMENT: MEDICAL MANAGEMENT; VENTILATION

Haematological, infectious and miscellaneous systemic conditions

CODE: 50S

DIAGNOSIS: SYPHILIS - CONGENITAL, SECONDARY AND TERTIARY

TREATMENT: MEDICAL MANAGEMENT

CODE: 168S

DIAGNOSIS: # HIV-ASSOCIATED DISEASE - FIRST ADMISSION OR SUBSEQUENT ADMISSIONS

TREATMENT: # MEDICAL AND SURGICAL MANAGEMENT FOR OPPORTUNISTIC INFECTIONS / LOCALISED MALIGNANCIES

CODE: 260S

DIAGNOSIS: # IMMINENT DEATH REGARDLESS OF DIAGNOSIS

TREATMENT: # COMFORT CARE; PAIN RELIEF; HYDRATION

CODE: 113S

DIAGNOSIS: ACQUIRED HAEMOLYTIC ANAEMIAS

TREATMENT: MEDICAL MANAGEMENT

CODE: 901S

DIAGNOSIS: ACUTE LEUKAEMIAS, LYMPHOMAS

TREATMENT: MEDICAL MANAGEMENT, WHICH INCLUDES CHEMOTHERAPY, RADIATION THERAPY, BONE MARROW TRANSPLANTATION

CODE: 277S

DIAGNOSIS: ANAEROBIC INFECTIONS - LIFE THREATENING

TREATMENT: MEDICAL MANAGEMENT; HYPERBARIC OXYGEN

CODE: 48S

DIAGNOSIS: ANAPHYLACTIC SHOCK

TREATMENT: MEDICAL MANAGEMENT; VENTILATION

CODE: 900S

DIAGNOSIS: APLASTIC ANEMIA; AGRANULOCYTOSIS; OTHER LIFE-THREATENING HERIDITARY IMMUNE DEFICIENCIES.

TREATMENT: BONE MARROW TRANSPLANTATION; MEDICAL MANAGEMENT

CODE: 197S

DIAGNOSIS: BOTULISM

TREATMENT: MEDICAL MANAGEMENT

CODE: 338S

DIAGNOSIS; CHOLERA; RAT-BITE FEVER

TREATMENT: MEDICAL MANAGEMENT

CODE: 196S

DIAGNOSIS: CHRONIC GRANULOMATOUS DISEASE

TREATMENT: MEDICAL MANAGEMENT, WHICH INCLUDES RADIATION THERAPY

CODE: 916S

DIAGNOSIS: COAGULATION DEFECTS

TREATMENT: MEDICAL MANAGEMENT

CODE: 246S

DIAGNOSIS: CYSTICERCOSIS; OTHER SYSTEMIC CESTODE INFECTION

TREATMENT: MEDICAL MANAGEMENT

CODE: 903S

DIAGNOSIS: DEEP-SEATED (EXCLUDING NAIL INFECTIONS), DISSEMINATED AND SYSTEMIC FUNGAL INFECTIONS

TREATMENT: MEDICAL MANAGEMENT; SURGERY

CODE: 44S

DIAGNOSIS: ERYSIPELAS

TREATMENT: MEDICAL MANAGEMENT

CODE: 179S

DIAGNOSIS: HEREDITARY ANGIOEDEMA; ANGIONEUROTIC ADEMA

TREATMENT: MEDICAL AND SURGICAL THERAPY

CODE: 174S

DIAGNOSIS: HEREDITARY HAEMOLYTIC ANAEMIAS (EG. SICKLE CELL); DYSERYTHROPOIETIC ANEMIA (CONGENITAL)

TREATMENT: MEDICAL MANAGEMENT

CODE: 201S

DIAGNOSIS: HERPETIC ENCEPHALITIS; REYE'S SYNDROME

TREATMENT: MEDICAL MANAGEMENT

CODE: 913S

DIAGNOSIS: IMMUNE COMPROMISE NOS AND ASSOCIATED LIFE-THREATENING INFECTIONS NOS

TREATMENT: MEDICAL MANAGEMENT

CODE' 912S

DIAGNOSIS: LEPROSY AND OTHER SYSTEMIC MYCOBACTERIAL INFECTIONS, EXCLUDING TUBERCULOSIS

TREATMENT: MEDICAL MANAGEMENT

CODE: 336S

DIAGNOSIS: LEPTOSPIROSIS; SPIROCHAETAL INFECTIONS NOS

TREATMENT: MEDICAL MANAGEMENT

CODE: 252S

DIAGNOSIS: LIFE-THREATENING ANAEMIA NOS

TREATMENT: MEDICAL MANAGEMENT; TRANSFUSION

CODE: 908S

DIAGNOSIS: LIFE-THREATENING CONDITIONS DUE TO EXPOSURE TO THE ELEMENTS, INCLUDING HYPO AND HYPERTHERMIA; LIGHTNING STRIKES]

TREATMENT: MEDICAL MANAGEMENT

CODE: 907S

DIAGNOSIS: LIFE-THREATENING RICKETTSIAL AND OTHER ARTHROPOD-BORNE DISEASES

TREATMENT: MEDICAL MANAGEMENT

CODE: 172S

DIAGNOSIS: MALARIA; TRYPANOSOMIASIS; OTHER LIFE-THREATENING PARASITIC DISEASE

TREATMENT: MEDICAL MANAGEMENT

CODE: 904S

DIAGNOSIS: METASTATIC INFECTIONS; SEPTICEMIA

TREATMENT: MEDICAL MANAGEMENT

CODE: 910S

DIAGNOSIS: MULTIPLE MYELOMA AND CHRONIC LEUKAEMIAS

TREATMENT: MEDICAL MANAGEMENT; CHEMOTHERAPY

CODE: 247S

DIAGNOSIS: POISONING BY INGESTION, INJECTION, AND NON-MEDICINAL AGENTS

TREATMENT: MEDICAL MANAGEMENT

CODE: 911S

DIAGNOSIS: SEXUALLY TRANSMITTED DISEASES WITH SYSTEMIC INVOLVEMENT NOT ELSWHERE SPECIFIED

TREATMENT: MEDICAL MANAGEMENT

CODE: 128S

DIAGNOSIS: TETANUS; ANTHRAX; WHIPPLE'S DISEASE

TREATMENT: MEDICAL MANAGEMENT

CODE: 122S

DIAGNOSIS: THALASSEMIA AND OTHER HEMOGLOBINOPATHIES - TREATABLE

TREATMENT: MEDICAL MANAGEMENT; BONE MARROW TRANSPLANT

CODE: 316S

DIAGNOSIS: TOXIC EFFECT OF GASES, FUMES, AND VAPORS

TREATMENT: MEDICAL THERAPY

CODE: 11S

DIAGNOSIS: TUBERCULOSIS

TREATMENT: DIAGNOSIS AND ACUTE MEDICAL MANAGEMENT; SUCCESSFUL TRANSFER TO MAINTENANCE THERAPY IN ACCORDANCE WITH DOH GUIDELINES

CODE: 937S

DIAGNOSIS: TUMOUR OF INTERNAL ORGAN (EXCLUDES SKIN): UNKNOWN WHETHER BENIGN OR MALIGNANT

TREATMENT: BIOPSY

CODE: 15S

DIAGNOSIS: WHOOPING COUGH, DIPTHERIA

TREATMENT: MEDICAL MANAGEMENT

Mental illness

CODE: 182T

DIAGNOSIS: ABUSE OR DEPENDENCE ON PSYCHOACTIVE SUBSTANCE

TREATMENT: HOSPITAL-BASED MANAGEMENT UP TO 3 WEEKS/YEAR

CODE: 910T

DIAGNOSIS: ACUTE DELUSIONAL MOOD, ANXIETY, PERSONALITY, PERCEPTION DISORDERS AND ORGANIC MENTAL DISORDER CAUSED BY DRUGS;

TREATMENT: HOSPITAL-BASED MANAGEMENT UP TO 3 DAYS

CODE: 901T

DIAGNOSIS: ACUTE STRESS DISORDER ACCOMPANIED BY RECENT SIGNIFICANT TRAUMA, INCLUDING PHYSICAL OR SEXUAL ABUSE

TREATMENT: HOSPITAL ADMISSION FOR MEDICAL/PSYCHOTHERAPY UP TO 3 DAYS; COUNSELLING

CODE: 910T

DIAGNOSIS: ALCOHOL WITHDRAWAL DELIRIUM; ALCOHOL INTOXICATION DELIRIUM

TREATMENT: HOSPITAL BASED MANAGEMENT UP TO 3 DAYS LEADING TO REHABILITATION

CODE: 908T

DIAGNOSIS: ANOREXIA NERVOSA AND BULIMIA NERVOSA

TREATMENT: HOSPITAL-BASED MANAGEMENT UP TO 3 WEEKS/YEAR

CODE: 903T

DIAGNOSIS: ATTEMPTED SUICIDE, IRRESPECTIVE OF CAUSE

TREATMENT: HOSPITAL-BASED MANAGEMENT UP TO 3 DAYS

CODE: 184T

DIAGNOSIS: BRIEF REACTIVE PSYCHOSIS

TREATMENT: HOSPITAL-BASED MANAGEMENT UP TO 3 WEEKS/YEAR

CODE: 910T

DIAGNOSIS: DELIRIUM: AMPHETAMINE, COCAINE, OR OTHER PSYCHOACTIVE SUBSTANCE

TREATMENT: HOSPITAL-BASED MANAGEMENT UP TO 3 DAYS

CODE: 902T

DIAGNOSIS: MAJOR AFFECTIVE DISORDERS, INCLUDING UNIPOLAR AND BIPOLAR DEPRESSION

TREATMENT: HOSPITAL-BASED MEDICAL MANAGEMENT UP TO 3 WEEKS/YEAR; ELECTRO CONVULSIVE THERAPY

CODE: 907T

DIAGNOSIS: SCHIZOPHRENIC AND PARANOID DELUSIONAL DISORDERS

TREATMENT: HOSPITAL-BASED MEDICAL MANAGEMENT UP TO 3 WEEKS/YEAR

CODE: 909T

DIAGNOSIS: TREATABLE DEMENTIA

TREATMENT: ADMISSION FOR INITIAL DIAGNOSIS; MANAGEMENT OF ACUTE PSYCHOTIC SYMPTOMS - UP TO 1 WEEK

Explanatory notes and definitions to Annexure A

1) Interventions shall be deemed hospital-based where they require:

- An overnight stay in hospital.

or

- The use of an operating theatre together with the administration of a general or regional anaesthetic.

or

- The application of other diagnostic or surgical procedures that carry a significant risk of death, and consequently require on-site resuscitation and/or surgical facilities.

or

- The use of equipment, medications or medical professionals not generally found outside of hospitals.

2) Where the treatment component of a category in Annexure A is stated in general terms (i.e. “medical management” or "surgical management", it should be interpreted as referring to prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition. Where significant differences exist between Public and Private sector practices, the interpretation of the Prescribed Minimum Benefits should follow the predominant Public Hospital practice, as outlined in the relevant provincial or national public hospital clinical protocols, where these exist. Where clinical protocols do not exist, disputes should be settled by consultation with provincial health authorities to ascertain prevailing practice. The following interventions shall however be excluded from the generic medical / surgical management categories unless otherwise specified:

   i) Tumour chemotherapy

   ii) Tumour radiotherapy

   iii) Bone marrow transplantation / rescue

   iv) Mechanical ventilation

   v) Hyperbaric oxygen therapy

   vi) Organ transplantation

   vii) Treatments, drugs or devices not yet registered by the relevant authority in the Republic of South Africa

3) “Treatable" cancers. In general, solid organ malignant tumours (excluding lymphomas) will be regarded as treatable where:

   i) they involve only the organ of origin, and have not spread to adjacent organs

   ii) there is no evidence of distant metastatic spread

   iii) they have not, by means of compression, infarction, or other means, brought about irreversible and irreparable damage to the organ within which they originated (for example brain stem compression caused by a cerebral tumour) or another vital organ

   iv) or, if points i. to iii. do not apply, there is a well demonstrated five year survival rate of greater than 10% for the given therapy for the condition concerned

4) **Tumour chemotherapy with or without bone marrow transplantation and other indications for bone marrow transplantation**

   These are included in the prescribed minimum benefits package only where Annexure A explicitly mentions such interventions. Management may include a first full course of chemotherapy (including, if indicated, induction, consolidation and myeloablative components). Where specified in terms of Annexure A, this may be followed by bone marrow transplantation/rescue, according to tumour type and prevailing practice. The following conditions would also apply to the bone marrow transplantation component of the prescribed minimum benefits:

   i) the patient should be under 60 years of age

   ii) allogeneic bone marrow transplantation should only be considered where there is an HLA matched family donor

   iii) the patient should not have relapsed after a previous full course of chemotherapy

   iv) (points i. and ii. shall also apply to bone marrow transplantation for non-malignant diseases)

5) **Solid organ transplants**

The prescribed minimum benefits Annexure includes solid organ transplants (liver, kidney and heart) only where these are provided by Public hospitals in accordance with Public sector protocols and subject to public sector waiting lists.

6) In certain cases, specified categories shall take precedence over others present. Such “overriding" categories are preceded by the sign "#" in their descriptions within Annexure A. For Example, where someone is suffering from pneumonia and HIV, because the HIV category (168S) is an overriding category, the entitlements guaranteed by the 'pneumonia' category (903D) are overridden.

7) **Hospital treatment where the diagnosis is uncertain and/or admission for diagnostic purposes**

Urgent admission may be required where a diagnosis has not yet been made. Certain categories of prescribed minimum benefits are described in terms of presenting symptoms, rather than diagnosis, and in these cases, inclusion within the prescribed minimum benefits may be assumed without a definitive diagnosis. In other cases, clinical evidence should be regarded as sufficient where this suggests the existence of a diagnosis that is included within the package. Medical schemes may, however, require confirmatory evidence of this diagnosis within a reasonable period of time, and where they consistently encounter difficulties with particular providers or provider networks, such problems should be brought to the attention of the Council for Medical Schemes for resolution.

8) NOS - not otherwise specified

Annexure B

Limitation on assets to be held in the Republic

Item		Categories or kinds of assets	Maximum percentage of aggregate fair value of total assets of scheme
1.	(a) Inside the Republic—		
	Deposits and balances in current and savings accounts with a bank or a mutual bank, including negotiable deposits, and money market instruments in terms of which such a bank or mutual bank is liable. Paid-up shares of a mutual bank, or deposits and savings accounts with the Post Office savings bank, as well as margin deposits with SAFEX:		100%
	Per bank		20%
	Per mutual bank		20%
	Post Office Savings Bank		20%
	SAFEX		5%
	Territories outside the Republic		15%
	Deposits and balances in current and savings accounts with a bank including negotiable deposits and money market instruments in terms of which such a bank is liable		2.5%
Krugerrands			
1.	Bills, bonds and securities issued or guaranteed by and loans to or guaranteed by—		
	(a) Inside the Republic—		
		(i) A local authority authorised by law to levy rates upon immovable property	100%
		—per local authority	20%

		(ii) Development Boards established under the Black communities Development Act, 1984 (Act No. 4 of 1984)	20%
		(iii) Rand Water Board	20%
		(iv) Eskom	20%
		(v) Land and Agricultural Bank of South Africa	20%
		(vi) Local Authorities Loans Fund Board	20%
		(vii) SA Transport Services	20%
	(a) Territories outside the Republic—		
	the foreign Government concerned		15%
1.	Bills, bonds and securities issued by and loans to an institution in the Republic, which bills, bonds, securities and loans the Council approved in terms of section 19(1)(h) of the Act before the deletion of that section by section 8(a) of the Act No. 53 of 1989, and also bills, bonds and securities issued by and loans to an institution in the Republic, which institution the Council likewise approved before such deletion		100%
	—per institution		20%
2.	Bills, bonds and securities issued by the government of or by a local authority in a territory other than the Republic, which territory the Council approved in terms of section 19(1)(I) of the Act before the deletion of that section by section 8(a) of Act No. 53 of 1989, and also bills, bonds and securities issued by an institution in such an approved territory, which institution the Council likewise approved before such deletion		100%
	—per authority		20%
3.	immovable property and claims secured by mortgage bonds thereon. Units in unit trust schemes in property shares and shares in, loans to and debentures, both convertible and non-convertible, of property companies		20%
	(a) inside the Republic		20%

	—per single property, property company or property development project			5%
	(b) territories outside the Republic			10%
	—per single property, property company or property development project			5%
1.	Preference and ordinary shares in companies excluding shares in property companies. ertible debentures, whether voluntarily or compulsorily convertible and units in equity unit trust mes which objective is to invest their assets mainly in shares			75%
	These investments are subject to the following limitations:			
	(a) inside the Republic			75%
		(i) Unlisted shares, unlisted convertible debentures and shares and convertible debentures listed in the Development Capital sector of the Johannesburg Stock Exchange		5%
		(ii) Shares and convertible debentures listed on the Johannesburg Stock Exchange other than the Development Capital sector		75%
			(a) Per one company with a market capitalisation of R2 000 million or less	10%
			(b) per one company with a market capitalisation of more than R2 000 million	15%
	(a) territories outside the Republic—			
	Preference and ordinary shares in companies, convertible debentures, whether voluntarily or compulsorily convertible			15%
		(i) unlisted shares and unlisted convertible debentures		2.5%
		(ii) shares and convertible debentures listed on any recognised foreign exchange		

			(a) per one company with a market capitalisation of R2 000 million or less	15%
			(b) per one company with a market capitalisation of more than R2 000 million	10%
1.	Listed and unlisted debentures, units in a unit trust scheme with the objective to invest e generating securities and inside the Republic any secured claims against an insurance any in terms of a long-term policy of insurance			10%
1.	Computer equipment, furniture and other office equipment, as well as motor vehicles, ct to the following limitation:			
		(a) Computer equipment		5% (10% by exemption)
		(b) Other equipment, as well as motor vehicles		2,5% (5% by exemption)

(b)Annexure C

Report of the independent auditors of _____ (name of administrator) to the Registrar of Medical Schemes in compliance with Regulation 25 under the Medical Schemes Act, 1998

1. We have reviewed the [proposed] system of internal financial control of _____ (name of administrator)/ [that _____ (name of administrator) intends to Implement from _____].

2. The [implementation and] maintenance of an adequate system of internal financial control [are] is the responsibility of the directors/partners/sole proprietor. Our responsibility is to report on whether or not, based on our review, anything has come to our attention that would indicate that the [proposed] system of internal financial control is not adequate for the size and complexity of the business of the medical scheme or medical schemes [to be] administered.

3. **Scope**

   We conducted our review in accordance with the statement of South African Auditing Standards applicable to review engagements. This standard requires that we plan and perform the review to obtain moderate assurance with regard to the [proposed] system of internal financial control. A review is limited primarily to inquiries of personnel of the administrator, inspection of evidence and observation of, and enquiry about, the operation of the internal control procedures for a small number of transactions. [A review is limited primarily to inquiries of personnel of the administrator about the proposed operation of the system of internal financial control and inspection of related evidence.]

4. **Inherent limitations**

Because of the inherent limitations of a system of internal financial control, including concealment through collusion or forgery, it is possible that errors and irregularities may occur and not be detected.

A review is not designed to detect all weaknesses in the system of internal financial control as it is not performed continuously throughout the period and the tests performed are on a sample basis. [A review is not designed to detect all weaknesses in the proposed system of internal financial control.]

[As the proposed system of internal financial control has not yet been implemented, we do not provide any assurance as to whether or not the system will operate adequately.]

5. Any projections of the evaluation of the system of internal financial control to future periods is subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with them may deteriorate.

6. Also, a review does not provide all the evidence that would be required in an audit, thus the level of assurance provided is less than given in an audit We have not performed an audit and, accordingly, we do not express an audit opinion.

7. **(b) Review opinion**

Based on our review, nothing of significance has come to our attention that causes us to believe that the [proposed] system of internal financial control is not adequate for the size and complexity of the business of the medical scheme or schemes [to be] administered.

Name _____

Registered Accountants and Auditors _____

Chartered Accountants (SA) _____

Date _____

Address _____

Note: In the case of a new administrator, i.e. where the system of internal financial control has not yet been implemented by the administrator, the text in the square brackets should be included in the report.

Report of the independent auditors of _____ (name of administrator) to the Registrar of Medical Schemes in compliance with Regulation 25 under the Medical Schemes Act, 1998

A. Annual financial statements

1. We have audited the attached annual financial statements of _____ (name of administrator) ("the administrator") set out on pages _____ to _____ for the year ended _____ The annual financial statements are the responsibility of the directors/partners/sole proprietor. Our responsibility is to express an opinion on these financial statements based on our audit.

2. **Scope**

We conducted our audit in accordance with statements of south african auditing Standards. Those standards require that we plan and perform the audit to obtain reasonable assurance that the annual financial statements are free of material misstatement. An audit includes:

2.1 examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements;

2.2 assessing the accounting principles used and significant estimates made by management; and

2.3 evaluating the overall financial statement presentation.

We believe that our audit provides a reasonable basis for our opinion.

3. **Audit opinion**

In our opinion the annual financial statements fairly present, in all material respects, the financial position of the administrator at _____ and the results of its operations and cash flows for the year then ended in accordance with generally accepted accounting practice and in the manner required by the Companies Act, 1973 (include where appropriate).

B. Consideration of the system of internal financial controls

4. in planning and performing the above-mentioned audit, we considered the system of internal financial control of the administrator in order to determine our audit procedures for the purpose of expressing our audit opinion on the annual financial statements, not to provide assurance on the system of the internal financial control.

5. The directors/partners/sole proprietor of _____ (name of the administrator) are/is responsible for establishing and maintaining an effective system of internal financial control. In fulfilling this responsibility, estimates and judgements by the directors/partners/sole proprietor are required to assess the expected benefits and related costs of internal financial control policies and procedures. Two of the objectives of a system of internal financial control are to provide the directors/partners/sole proprietor with reasonable, but not absolute, assurance that assets are safeguarded against loss from unauthorised use or disposition and that transactions are executed in accordance with their/his/her authorisation and recorded properly to permit preparation of annual financial statements in conformity with generally accepted accounting practice.

6. Because of the inherent limitations of a system of internal financial control, it is possible that errors or irregularities may occur and not be detected. Furthermore, any projection of the evaluation of a system of internal financial control to future periods is subject to the risk that the procedures may become inadequate because of changes in circumstances, or that the degree of compliance with them may deteriorate.

7. Our consideration of the system of internal financial control would not necessarily disclose all matters in the system that might be material weaknesses. A material weakness is a condition in which the design or operation of the specific internal financial control does not reduce to a relatively low level the risk that errors or irregularities in amounts that would be material in relation to the annual financial statements being audited, may occur and not be detected within a timely period by employees in the normal performance of their assigned functions.

8. However, based on our consideration of the system of internal financial control for purposes of our audit, nothing of significance has come to our attention that causes us to believe that the financial record keeping and the system of internal financial control are not adequate for the size and complexity of the business the administrator is presently conducting. All changes to the system of internal financial control that came to our attention during the course of our audit have been recorded in writing.

9. This report is intended solely for the use of the Registrar of Medical Schemes and is not to be distributed to other parties.

Name _____

Registered Accountants and Auditors _____

Chartered Accountants (SA) _____

Date _____

Address _____

Note: In the case of a sole proprietor, reference to "administrator" should be read as reference to the administration business of the sole proprietor.

Annexure D (For completion on letterhead of Administrator)

Management representation letter to the Registrar of Medical Schemes in compliance with Regulation 25 under the Medical Schemes Act, 1998

This representation letter is provided in connection with the financial statements of _____ (name of the administrator) for the year ended _____ (date) to enable the Registrar to evaluate whether or not _____ (name of the administrator) has complied with the Medical Schemes Act and related regulations.

We confirm, to the best of our knowledge and belief, the following representations:

1. We had _____ (quantity) registered funds under our administration at the year-end.
2. The fidelity guarantee and professional indemnity insurance cover is adequate to cover the risks of losses due to fraud, dishonesty and negligence.
3. We deposited the moneys of the medical schemes under our administration in the bank accounts of the schemes on no later than the business day following the receipt of the schemes' moneys.
4. No changes in ownership, directors, members or shareholders having the effect of a *de facto* change of control took place during the year ended _____ (date), without the approval of the Registrar.
5. Administration agreements entered into with medical schemes during the year ended _____ are in writing and conform to regulation 18.
6. The following administration agreements were terminated during the year ended _____ (date) and in respect of them, regulation 19 have been complied with:
7. For the year ended _____, we have maintained a register of documents of title in our safe custody as contemplated in regulation 24. Furthermore, all these assets are held in the names of the respective medical schemes.
8. We conducted the business in terms of the Act, the regulations, the agreements with medical schemes and the rules of these medical schemes.
9. The administration business is maintained in a financially sound condition as contemplated in regulation 22.
10. The system of internal control is adequate for the size and complexity of the business.

11. We believe that the business will continue in operational existence for the foreseeable future.

_____

Managing Director

_____

Financial Director