PATIENT ADMINISTRATION AND REVENUE MANAGEMENT POLICY

DEVELOPING CHIEF DIRECTORATE: BUDGET AND REVENUE MANAGEMENT

APPROVAL DATE:

REVIEW DATE:

HOD'S FOREWORD

The collection of fees for services rendered to patients is critical for the continued provision of health care services. In this regard, Section 38 (1) (a) (i) and Section 38 (1) (c) (i) of the Public Finance Management Act (PFMA), Act No. of 1999, as amended, state, "the Accounting Officer:

i. Must ensure that the department has and maintains effective, efficient and transparent systems of financial, risk management and internal control

ii. Must take effective and appropriate steps to collect all money due to the department"

Patient fees are a key source of revenue for the Department. The Patient Administration and Revenue Management Policy provides guidelines for the accurate classification of patients and proper case management, to ensure the correct billing of patients who receive services from public health institutions in Gauteng. On the other hand, Section 27 (1)(a) of the Constitution of the Republic of South Africa, No. 108 of 1996, states, "everyone has the right to have access to health care services, including reproductive health care". The Department has a Constitutional obligation to safeguard the right to access health care services for all people who require health care from public health establishment in Gauteng Province, irrespective of their nationality. The accurate classification of patients will therefore ensure that patient fees are collected from those who can afford to pay for health care services and the provision of free health care services to persons who are eligible for such free health care services, as enshrined in Section 4 (3) (a) of the National Health Act, No 61 of 2003, as amended.

South Africa is a host to various categories of migrants, who have come into the country for different reasons. The public health system is affected by migration, as it has an obligation to ensure access health care services to everyone. The right to access health care services, as espoused in Section 27 (1) (a) of the Constitution, extends to those who have migrated into the country for various reasons. To this end, the Policy provides for all pregnant and lactating women and children below the age of six, who are not members or beneficiaries of medical aid schemes, to receive free health care services. This includes pregnant and lactating women and children below the age of six, who are not members or beneficiaries of medical aid schemes, who have not come to South Africa for the specific purpose of obtaining health care, irrespective of nationality and documentation status.

Mr. LA. Malotana
Acting Head of Department
Date: 2023/10/18

DEFINITIONS OF TERMS & ACRONYMS

I. Definition of terms

Admit	means the admittance of a person to or at a hospital and includes the re-admittance of such a person;
Admitting officer	means an official employed by the hospital, working in admissions or wards. He or she deals with patient administration work.
Applicant	means a person applying, or on whose behalf an application is made, for admission;
Asset	means the total value of the fixed and movable property
Dependent	means every — (a) Person who is dependent upon someone for maintenance or support by reason of marriage. The person may be a wife or husband (b) Biological child who is a minor under the age of 21 years who is in the care of a breadwinner;
Department:	Gauteng Department of Health
Debt	means an amount owed to the department.
Doubtful debt	is a debt that is due to the department, but which might not be recoverable.
Donor	means a person who voluntarily reports at a hospital for the donation of an organ, blood, milk or tissue, and is admitted for such purposes, or a person who died in hospital and whose family has given permission for the donation of an organ or organs or tissue for the purpose of a transplant.
Exempted patient	means a person who receives services free of charge for a specific condition due to an illness and circumstance;
Family unit	means a household consisting of a breadwinner with one or more dependents;
Foreign Patient	means a person from outside the borders of the Republic of South Africa including foreign tourists or an employee of a foreign company visiting the RSA but excluding Refugees and Asylum seekers with valid documents who must be classified by means test.
H1	Individuals with an income less than R70 000 per annum and households with an income less than R 100 000 per annum.

H1(F)	Refugees and Asylum seekers with valid documents with an individual income less than R70 000 per annum or household with an income less than R 100 000 per annum.
H2	Individuals with an income less than R250 000 per annum and households with an income less than R 350 000 per annum.
H2(F)	Refugees and Asylum seekers with valid documents with an individual income less than R250 000 per annum or household with an income less than R 350 000 per annum.
H3	Individuals with an income greater than or equal to R250 000 per annum and households with an income greater than or equal to R 350 000 per annum.
H3(F)	Refugees and Asylum seekers with valid documents with an individual income greater than or equal to R350 000 per annum or household with an income greater than or equal to R 350 000 per annum.
Hospital patient	means a person who is treated at a hospital by a health care professional/worker who is in the service of such hospital at an inclusive tariff;
7Income	in relation to a person, means the total income on admission, before deduction of any contribution to a pension fund, medical aid or fund, any premium on an insurance policy, any charge in respect of boarding and lodging, or of any other amount whatsoever not being expenditure incurred or to be incurred in the earning of such income which the person receives or anticipates receiving by way of derived from salary, wage, bonus ,commission, pension, interest, maintenance, dividend rent, the carrying on of farming operations or any trade business, profession, or occupation, any other assets or any other way from any other source whatsoever;
Individual	means a responsible person without dependents;
Irrecoverable debt	is debt that is due but is not expected to be collected.
Lodger	means a person who is admitted on the written authority of the Chief Executive Officer or Officer acting on his behalf, by reason of the fact that in the opinion of a health care professional/worker, his presence is necessary for the recovery of a patient in or at such hospital;
Member of a medical Scheme	means any person who has been enrolled or admitted as and still is a member of the scheme or who in terms of the Medical Scheme Act or rules of the Scheme is a member of the Scheme.

Medical scheme	Any Medical Scheme as defined in the Medical Scheme Act 131 of 1998
Month	means the period extending from the first day to the last day, both days included, in any one of the 12 months of the calendar year;
Patient companion/ Border	means any person either a family member or an acquaintance of a patient who accompanies that patient without any reason to a hospital and requires accommodation without any reason for caring and security to a hospital because he has no other refuge;
Non-South African resident	means a person from outside the borders of the Republic of South Africa visiting RSA.
Private hospital patient	means an externally funded patient who has been classified as a private patient at a hospital but is treated by a health care professional/worker who is in the service of such hospital (PH);
Private patient	means a person who is treated in or at a hospital by a healthcare professional/worker who is not in the service of such hospital (P)
Relative	means a member of a family of a patient who with the written authorization of the Chief Executive Officer, or officer acting on his behalf, is admitted for examination in order to assist in the diagnosis of the condition of such patient;
Resident baby	a newborn baby of a mother who is still a maternity patient in the hospital;
Resident child	means an infant who does not receive medical treatment or nursing care, but who is cared for and fed by its mother who is a patient in the hospital;
Responsible person	means a person who is not a dependent, whether he has dependents or not;
Revenue	is the gross inflow of economic benefits or service potential during the reporting period when those inflows result in an increase in net assets.
UPFS	means Uniform Patient Fee Schedule, a billing mechanism that is used in Public Hospitals;

II. Acronyms used

CEO	Chief Executive Officer
CFO	Chief Financial Officer
COIDA	Compensation for Occupational Injuries and Diseases Act
BAS	Basic Accounting System
GDOH	Gauteng Department of Health
HIS	Health Information System
LOS	Length of Stay
ICD 10	International Classification of Diseases and Related Health Problems (10th revision)
DoJCD	Department of Justice and Constitutional Development
PFMA	Public Financial Management Act
PH(F)	Private Hospital Foreigner
SAP	System Application Products
SAPS	South African Police Services
DOD	Department of Defense
DCS	Department of Correctional Services
PRASA	Passenger Rail Agency of South Africa
TPH	Transvaal Provincial Hospital
UPFS	Uniform Patient Fee Schedule

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1. INTRODUCTION

The Gauteng Department of Health is mandated to provide health care services to every member of the community without discriminating on the basis of colour, creed or affordability. This policy provides guidance on how patients shall be classified prior to being registered and admitted at public health institutions in Gauteng. It further provides guidelines on the implementation of case management services at public health institutions.
In terms of the Public Finance Management Act (PFMA), 1999 (as amended by Act No.29 of 1999), the Accounting Officer: -

iii. Must ensure that the department has and maintains effective, efficient, and transparent systems of financial, risk management and internal control {section 38(1)(a)(i)}

iv. Is responsible for the effective, efficient, economical, and transparent use of resources of the department {section 38(1)(b)}

v. Must take effective and appropriate steps to collect all money due to the department {section 38(1)(c)(i)}

The accurate classification of patients and proper case management form the basic tenets of revenue collection. The Gauteng Department of Health (GDOH) has the responsibility to collect all monies due to the Department for services rendered. It is imperative that the Department puts processes and procedures in place to ensure efficient and effective identification, collection, recording, reconciliation and safeguarding of revenue.

2. POLICY OBJECTIVES

The objectives of the policy are:

a) To streamline the revenue management process within all GDOH institutions;
b) To ensure compliance with the regulatory framework governing revenue management
c) To ensure a transparent process for the identification, recording and reporting of revenue within all GDoH institutions
To provide guidance on the management of departmental debts and writing off of irrecoverable debt

3. SCOPE OF THE POLICY

The policy applies to:All officials of the Gauteng Department of Health at Central Office, Central Hospitals, Tertiary Hospitals, District Hospitals, Regional Hospital, District Offices and Primary Health Care Facilities, Forensic Medical Services Facilities, EMS Bases, Nursing Colleges, Staff Residences and Laundries, who are responsible for patient administration, case management and revenue management.

4. PROBLEM STATEMENT

In a matter between Section 27 and Others vs MEC for the Gauteng Department of Health and Others, Case No 19304-22, the Deputy Judge President in the High Court, Gauteng Division, declared the Gauteng Regulations, published in General Notice 1426 in Provincial Gazette 414 of 24 November 2021 ("the Gauteng Regulations") invalid, to the extent that they require pregnant and lactating women and children under the age of six, who are not members or beneficiaries of a medical aid scheme, to undergo a classification and fees assessment in circumstances where they have a right to free health care service.

As a result, the Gauteng Department of Health was ordered to amend, by 16 October 2023, the Policy Implementation Guidelines on Patient Administration and Revenue Management, 2020 as published in Gauteng Department of Health Circular 27 of 2020 ("the 2020 Policy') to expressly provide for all pregnant and lactating women, and children below the age of six, who are not members or beneficiaries of medical aid schemes and who have not come to South Africa for the specific purpose of obtaining health care, are entitled to free health services at any public health establishment, irrespective of nationality and documentation status.

The Department has amended the Policy Implementation Guidelines on Patient Administration and Revenue Management, 2020, which shall hereinafter be referred to as the "Patient Administration and Revenue Management Policy", to provide for all pregnant and lactating women and children below the age of six, who are not members or beneficiaries of medical aid schemes and who have not come to South Africa for the specific purpose of obtaining health care, to receive free health care services at any public health facilities in Gauteng Province, irrespective of nationality and documentation status.

5. LEGISLATIVE FRAMEWORK

The policy is informed by the prescripts listed below:

a) Public Finance Management Act, 1999 (Act No. 1 of 1999)
b) Treasury Regulations, March 2005
c) National Treasury Departmental Guide Managing Departmental Debt 2013

d) Department of Health, Gauteng Administration Procedure Manual

e) Prescription Act, 1969 (Act No. 68 of 1969)

f) Road Accident Fund Act (Act No. 56 of 1996)

g) Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993)

h) Medical Scheme Act no 1 31 of 1998

i) National Health Act 61 of 2003

j) Constitution of the Republic of South Africa, Act No 106 of 1996

k) Promotion of Access to Information Act No. 2 of 2000.

l) Uniform Patient Fee Schedule (UPFS) and User guide

m) Hospital Ordinance Act 14 of 1958.

n) Immigration Amendment Act (Act 13 of 2011)

o) Refugees Amendment Act (Act 33 of 2008)

p) Mental Health Care Act (Act 17 of 2002)

q) The Magistrates Courts Act, 1944 (Act 32 of 1944)

r) Protection of Personal Information (POPI) Bill 09 of 2009

s) Promotion of Access to Information Act (PAIA) Act 2 of 2000

t) Consumer Protection Act 68 of 2008

u) Child Protection Act 38 of 2005 (amended 2007)

v) Pharmacy Act 53 of 1974 (amendment 1 of 2000)

w) Nursing Act 33 of 2005

x) Health Professions Act 5 of 1974 (amendment 29 of 2007)

y) Case Management Standards of Practice (CMASA 2011)

z) Quality in Health care for South Africa 2007

aa) National ICD-IO coding standards circular no.3 of 2012

bb) National Core Standards for Health Establishments in South Africa (NDOH 2011)

6. CONSULTATION

The stakeholders listed below were consulted on the policy:

a) Chief Executive Officers
b) Patient Administration, Case Management and Revenue Management officials at institutions

c) Policy Coordination Unit
d) Executive Management Technical Committee (EMC Tech) in the Gauteng Department of Health

7. POLICY IMPLEMENTATION

7.1. Patient Classification

a) Every person who consults or is admitted for treatment at a public health hospital shall be classified according to the following categories:
   i. Full paying patients
   ii. Subsidized patients
   iii. Patients receiving free services
   iv. Exempted patients
b) Every patient shall be classified according to his or her income status (means test) for financial classification
c) All patient visits shall be linked to the appropriate billing group and tariff category (case classification).
d) If the income of a patient cannot be determined, such a patient shall be provisionally classified as per paragraph 7.8 of this policy
e) A dependent shall be classified based on the classification of the person upon whom he or she is dependent.
f) Every patient shall on registration be informed verbally or in writing of his/her classification category and fees payable
g) As stipulated in Section 25 (14) & (15) of National Health Act No.61 of 2003, all patients or users must give consent to disclose information for billing purposes either on the Registration/Admission form or the printed version from billing system.

7.2. Explanation of Classification Categories

7.2.1. Full Paying Patients

a) This category of patients includes externally funded patients (see Appendix A), those being treated by their private practitioners, Folateng Patients and non-South African citizens excluding Refugees and Asylum seekers with valid documents. These patients

are liable for the full UPFS fees as listed in Provincial Gazette Extraordinary for Tariffs revision.

7.2.2. Subsidized patients

a) In terms of Section 41 (1) of the National Health Act No .61 of 2003, the Minister and the relevant MEC may prescribe procedures and criteria for admission to and referral from a health establishment.
b) Subsidized patients are categorized based on their ability to pay for health services according to the three categories, namely: H1, H2 and H3.
c) These patients are classified according to a means test and they also include civil pensioners, refugees and asylum seekers with valid documents.

7.2.3. Free Patients (H0)

a) Patients in this category receive all services free of charge and are known as H zero (H0)
b) This category comprises of recipients of social pension or grants and the formally unemployed.
c) Patients must provide proof of the type of pension, social grant they receive, or a letter from the Department of Labour as proof that they are recipients of the Unemployment Insurance Fund, in order to be classified as H0.
d) If found to be on medical aid, the patient will forfeit the H0 status and be liable to pay for services rendered to him or her by the health facility.

7.2.4. Exempted Patients (HG)

a) In terms of section 4 and section 41 (1) of the National Health Act no.61 of 2003, the Minister of Health, after consultation with the Minister of Finance and the relevant Members of Executive Councils, may prescribe conditions subject to which categories of persons are eligible for free health services at public health establishments. See detailed list in Table 1: Explanation of the Classification of patients for the determination of fees.
b) *All pregnant, lactating women and children below the age of six, who are not beneficiaries of medical aid schemes and who have not come to South Africa for the specific purpose of obtaining health care, are entitled to free health care services, irrespective of nationality and documentation status policy.*
c) Exempted Patients will receive free health care services only when these conditions are confirmed and will be exempted from paying prescribed fees irrespective of any additional diagnosis, their income or normal classification. A full list of patients qualifying for these statutory based circumstances is provided in Table 1.

7.3. Documents required for Patient Registration and Classification

a) Every person presenting himself/herself at the hospital shall provide the following documents to an Admitting Officer before he/she is registered or admitted, for the purpose of determining a classification and tariff category:

i. Proof of identification: Identity Document, Passport, Birth Certificate, Refugee Permit, Asylum Seeker Permit, Permanent Residency Permit
ii. Medical aid card
iii. Appointment card
iv. Pay slip/salary advice
v. Proof of address (residential or postal address)

Documentation from other Organs of State and/or other Provinces

7.4. Declaration OF Income/Assets GPF 4 (Annexure B)

a) All patients who have no proof of income shall fill the Declaration of Income form GPF4 (Annexure B).
b) The form shall assist the Admitting Officer to determine the classification category for the patient.
c) The Admitting Officer shall add all values and determine the classification according to the means test.

7.5. Registration or Admission Form GPF 3 (Annexure A)

a) All patients shall be registered on the GPF 3 form or Health Information Systems (HIS) before any consultation and/or admission at a hospital.
b) The GPF 3 form shall be completed by the patient or the Admitting Officer
c) In case of a computerized system, the patient shall be registered by the Admitting Officer.
d) The GPF 3 form shall only be used when the computerized registration/admissions system is offline.
e) It is the responsibility of the Admitting Officer to ensure that information on the GPF 3 or HIS is completely captured.
f) In terms of section 14 of the National Health Act No.61 of 2003, all information concerning a user, including information relating to his or her health status, treatment or admission in a health establishment, is confidential and no person may disclose any information unless the user consents to that disclosure in writing.
g) The Admitting Officer shall sign the GPF 3 form and ensure that the patient also appends his/her signature on both the manual form and printed version from the HIS. This means patient shall be giving consent to the health institution to use his/her medical information for billing purposes.
h) All forms shall be checked daily and randomly by the supervisors in charge of the registration and admission processes to ensure accuracy and completeness. The

supervisors shall append their signatures on all **randomly** checked forms and keep records for audit purposes.

i) The GPF 3 form shall be completed legibly, completely and accurately.

7.6. Out-Patients

a) An outpatient shall be classified at his or her first visit to a hospital and such classification shall remain in force for a period of twelve (12) months and thereafter he/she shall be classified anew.
b) After twelve (12) months, an outpatient shall re-submit his/ her supporting documents and be reassessed
c) Patients whose medical aid has been terminated or exhausted, shall notify the Admitting Officer on their next visit, with supporting documents, and shall be classified accordingly. The reclassification shall remain for 12 months. The reassessment of patients applies to patients who receive free and subsidized services.
d) Patient classification shall remain for a period of 12 months. However, if the patient is externally funded, e.g. RAF, COIDA, etc., the patient shall be classified according to the status available and applicable during the patient's visit to the hospital.

7.7. In- Patient

a) An in- patient shall be classified every time he or she is admitted at the hospital and such classification shall remain applicable until the patient is discharged.
b) The above requirement shall not apply to a person:

i. Who is an in-patient on the day that precedes the implementation of the revised tariffs; or
ii. Whose admission and classification as an in-patient had been approved before the implementation of the revised tariffs for the period ending on the date upon which he/ she is discharged from the hospital concerned.

7.8. Provisional Classification of Patients

a) In case of emergency or outpatient hospital visit, whereby the information required is not readily available to determine the classification and tariff category of the patient, provisional classification shall apply.
b) Provisional Classification shall apply to the following categories of patients:

i. Unconscious patients
ii. Minor children who are not brought by their parents to the hospital.

iii. The above shall be classified as Provisional H1
iv. The cases referred to in (i) and (ii) above when admitted, shall be classified provisionally as H3.

c) All patients shall be informed of their provisional classification and be requested to furnish the required information as soon as possible. If the required information is furnished, the patient shall be correctly classified, but will remain liable to pay for the incurred medical costs from the provisional classification.
d) If the required information is not furnished; the provisional classification shall remain, and the patient shall be liable for the cost incurred.
e) In case of non-emergency cases whereby the information required is not readily available to determine the classification and tariff category of the patient, such patient shall be admitted and classified as follows:

i. The patient with no documentation but is employed, shall be classified provisionally as H3 on admission.
ii. Ward Clerks shall ensure that all provisionally classified patients are followed up regularly to provide the required documentation before being discharged.
iii. If the required information is not furnished, the patient shall be liable to pay the incurred medical costs, unless all the required documentation is provided.
iv. Patients who declared that they are unemployed on the GPF4 during the OPD visit, shall retain the OPD classification on admission.
v. All Provisionally Classified patients shall be informed of their provisional classification and the costs that will be incurred.

7.9. Erroneous Classification of Patients

a) An erroneous classification arises when a patient is incorrectly classified as a result of any false, incorrect or misleading declaration, information or document having been made available or furnished, or as a result of any error or any incorrect application or interpretation of a policy or for any other acceptable reason.
b) Whenever it is discovered that a patient has been erroneously classified as a result of any of the reasons mentioned above, such a patient shall be classified afresh in the correct category with effect from the date of such erroneous classification.
c) An erroneous classification shall not be confused with a reclassification. A classification which is corrected as a result of error is not a reclassification, but a correction of a wrong classification.
d) The correction of an erroneous classification shall be approved by a senior official designated by the Chief Executive Officer for this purpose. The following are examples of erroneous classifications:

i. A patient claiming that he or she has been injured on duty and is therefore entitled to treatment in terms of the Compensation for Occupational Injuries and Diseases Act No 130 of 1993 and is accordingly classified as a private patient in category (PH) COIDA and his or her claim is later rejected by the employer or Compensation Commissioner.

In such a case, the patient was erroneously classified and shall therefore be classified anew with effect from the date of the erroneous classification.

ii. A patient furnishes incorrect information regarding his or her income intentionally and is classified accordingly. Later the correct amount of his or her income is determined, by whichever means or from whichever source. The patient shall be classified anew according to his or her correct income with effect from the date of the erroneous classification. Such classification may remain the same or may be in a lower or higher category.

A patient is erroneously classified as a result of an error or an incorrect application or interpretation of a policy by the Admitting Officer. In such a case, the erroneous classification shall be corrected with effect from the date of such erroneous classification.

7.10. Reclassification of Patients

a) A request to change the patient's current classification to a lower classification category may be made by or on behalf of the patient on the following grounds:

i. If a patient is liable for considerable costs of treatment or the anticipated costs of treatment being received will entail excessive financial burden. Reclassification does not apply to patients attending Folateng Wards and patients treated by their own private practitioners.

ii. If a patient whose medical benefits are exhausted in terms of the medical scheme rules whereby it has been proven by the doctor or case manager that the patient is not being treated for any Prescribed Minimum Benefit (PMB) condition.

iii. A request for a reclassification shall be made on an application form for reclassification. The application form (see Appendix "E") shall be fully completed in all respects to enable the Chief Executive Officer or his or her delegate to make an informed decision.

b) If a request for a reclassification is based on the grounds of financial burden:

i. Documentary evidence indicating the financial burden or status shall be furnished, and copies of bank statements, clothing accounts, loan and credit cards accounts, school fees statements and any other related accounts attached to the relevant application form and kept for audit purposes.

ii. The CEO or his or her delegate shall verify the anticipated costs indicated on the application form.

c) The reclassification of an applicant or patient is considered solely on the information furnished. If a reclassification is granted, the applicant or patient shall be reclassified to a lower category based on affordability.

d) In the case where the patient has already paid an amount in advance, no refund shall be made and reclassification shall take effect upon expiry of the period in respect of which such payment was made.
e) The reclassification of an applicant or patient shall remain in force for a period of 12 months except:

i. For an out-patient or in-patient who is a member of a medical scheme, whose benefits are renewed before the expiry of the period of 12 months, in which case the reclassification shall lapse on the day immediately preceding the day on which his or her benefits are renewed.
ii. If there is any change in circumstances which gave rise to the reclassification before the expiry of the 12 months period i.e. when the regulations relating to the classification and tariffs are amended.

f) A request may be made to the CEO by or on behalf of an applicant or patient. An applicant or patient can apply for reclassification on the following grounds:

i. When considerable costs for treatment already incurred or anticipated, does not qualify for reclassification, and his or her present classification will probably entail excessive financial hardship; or
ii. If he or she became liable for considerable costs for treatment in respect of any disease, injury, or other physical or mental condition during the period of 12 months immediately preceding the date of such request.

g) A request for reclassification must be made in the application form (TPH13)
h) A written request for reclassification or for further reclassification for any sound reason, other than those already advanced in his or her original request, may be submitted to the Chief Executive Officer. If the Chief Executive Officer or his or her delegate considers that a reclassification or further reclassification is justified, he or she shall classify the applicant or patient to a lower category as he or she may consider reasonable in the circumstances, with effect from the date upon which he or she received such request.

7.11. Downtime - Manual Billing Template

a) The manual billing template shall be utilised whenever the HIS is down.
b) The template shall be utilised to raise claims for all categories of classifications excluding H0, HG and PG.

7.12. Case Management Process

The Assistant Director: Case Management at the institutional level shall ensure the following standards are applied and adhered to in all public hospitals:

a) Case Managers shall conduct a comprehensive assessment of the patient's health and psycho-social needs and develop a case management plan with the patient, family or caregiver.
b) Plan with both the patient, family, doctor and the funder in order to maximize the health care outcome.
c) Facilitate communication and coordination between members of the healthcare team and the patient in decision making processes.
d) Identify and select customers who can benefit the most from case management services in a hospital setting.
e) Support the clinicians and other members of the health care team in the planning of caregiving.
f) Educate the patient, family/caregiver and members of the health care team about treatment options and insurance benefits so that timely and informed decision can be made regarding the correct course of action to take.
g) Empower the patient to make proper decisions in order to maximise desired outcomes.
h) Encourage the appropriate use of health care services and maintain cost effectiveness on each case handled.
i) Advocate for the needs of the patient, hospital and the funder in order to promote positive cost-effective outcomes.
j) Ensure identification and reporting of suspected abuse, neglect or any mistreatment of patients.
k) Provide specialised skills such as positive relationship building, effective verbal and written communication, critical analysis, ability to plan and organise effectively.
l) Provide knowledge such as funding sources, health care services, human behaviour, health care delivery system and clinical standards in order to execute case management.
m) Promote smooth transition of care when the patient is discharged from one setting to the other.
n) Provide monthly reports to Head Office on the utilization per funder, ICD 10 coding average billed amounts, total amount claimed, rejected claims, average length of stay and compliance status on Administration and Billing workflow processes for the hospital.

7.13. Case Management Criteria

a) Case management shall apply to patients receiving care and treatment at the public hospitals in Gauteng provided they are:

i. Valid and Confirmed Medical Scheme patients.
ii. Subsidized patients with long hospital stay or require expensive medical treatment.
iii. Foreign Patients Classified as PH (F).
iv. Externally Funded Cases: RAF, SAPS, COID, DCS, PRASA, SANDF, DOJ and Cross boarder.

7.14. Responsibilities of a Case Manager in Patient Administration/Wards and Service Points

a) Supervision and support of Confirmations Unit by ensuring that all externally funded patients are confirmed and validated by the responsible Administration Clerk.
b) Assessment and screening of patients requiring case management services.
c) Ensure complete and accurate management of externally funded patients' medical reports.
d) Provide support to Billing Clerks on ICD 10 coding and completion of charge sheet.
e) Conduct file audits to ensure the correct patient classification and services rendered are captured.
f) Provide treatment quotations where required.
g) Promote data integrity.
h) Ensure confidentiality and security of patients' information.
i) Contact Medical Schemes and Funders for authorization purposes.
j) Provide the primary and secondary ICD 10 codes to medical schemes.
k) Determine the health benefits and benefit options.
l) Determine available costs benefits for services allocated to the patient.
m) Identify Prescribed Minimum Benefits (PMB), update patient file and manage the process with funders.
n) Provide clinical updates to funders.
o) Conduct ward rounds to ensure compliance to length of stay where authorisation was granted.
p) Identify financial and clinical risks and discuss with the relevant members of the health care team.
q) Train health care professionals on the usage of charge sheet and identification of billable services.
r) Ensure workflow processes are in place for theatre and ICU for the identification of all high cost consumables used i.e. Prosthetic items, implants etc.
s) Conduct file audits to ensure that all the patients' particulars are updated by Ward Clerks and report findings to the relevant officials.
t) Update funders on:

i. Patient's health condition and relevant ICD 10 codes.
ii. Length of stay and level of care.
iii. Laboratory tests.
iv. Procedures and services provided (Theatre, imaging, allied health consultations etc.)
v. Motivation/reasons for high cost treatments in consultation with the relevant health care professional.
vi. Oncology treatment care plans in consultation with the relevant clinicians.

u) Ensure records are kept for evidence purposes with regards to:

i. Pre-authorization, updates and feedback from funders.
ii. ICD 10 and UPFS training records and attendance registers.
iii. Monthly utilization and LOS reports to monitor trends.
iv. Policies and standards of practice.

7.15. Responsibilities of the Case Manager in Billing Departments

a) Conduct patients file audits to ensure that all billable services are included.

b) Ensure compliance to ICD 10 coding and completeness on all finalised invoices.

c) Provide support on ICD 10 and procedure coding.

d) Provide ongoing in-service education and support to staff on case management activities i.e. Charge sheet, ICD 10 coding, procedure coding etc.

e) Ensure initial orientation for all newly appointed staff on roles and responsibilities of case management.

7.16. Role of the Case Manager in the Discharge Planning Process

a) Ensure patients advocacy, care coordination and health education to patients and family.
b) Assist with the coordination of discharge process i.e. step-down facility, home care nursing with other members of health care team.
c) Encourage patient's compliance to treatment.
d) Promote smooth transition of care during patient discharge or transfers to other settings i.e. step-down facilities.
e) Ensure correct record keeping.

7.17. Revenue Management Process Flow

7.17.1. Cash Management

7.17.1.1. Cashiers

a) Main Cashiers and Sub Cashiers shall be responsible for the collection of all money due to the Department and shall be appointed in writing by the Chief Executive Officer or Finance Manager. (See attached Administrative Procedure Manual (APM) Appendix "F").

b) Main Cashiers and Sub Cashiers shall sign a "confidentiality clause" for the non-disclosure of patient information.

c) Main Cashiers and Sub Cashiers shall report to Revenue Finance Manager.

7.17.1.2. Segregation of Duties

a) Main Cashiers shall not register patients.

b) Cashiers shall collect cash from patients.

c) In cases where resources are limited, Registration Clerks shall be delegated to collect cash per day/night shift.

7.18. Handling of Cash Collection and Credit Visits on the System: Processes to be Followed When Issuing Receipts by Sub Cashiers

7.18.1. Issuing of Receipts for Patients Paying Cash before Treatment

a) The registration of a patient visit shall be done on the patient administration system.

b) A visit invoice shall be printed out and be handed over to the patient.

c) A patient shall be informed to make a payment to a Sub-Cashier.

d) The Sub-Cashier shall issue a receipt in duplicate against the visit invoice.

e) The receipt shall be given to the patient and a copy filed in the patient's file.

f) Patients that are unable to settle the invoices immediately shall be handled as follows:

i. The patient shall be directed to the Sub-cashier who shall make the patient sign a credit agreement.

ii. On subsequent visits, the patient shall be referred to the Credit Control Section for payment arrangements.

7.18.2. Issuing of Receipts to Patients Paying an Account/Outstanding Visit

a) The Sub-Cashier/Main Cashier shall issue a receipt in duplicate against the outstanding visit invoice.

b) The receipt shall be given to the patient and a copy filed in the patient's file.

c) The Sub Cashiers shall collect cash for patient fees after hours from 16:00 p.m until 07:00

a.m the next day. Any revenue collected other than patient fees, shall be recorded using a TAS Receipt book (TPH 60) i.e., fines, telephone accounts, etc.

7.18.3. Sub Cashiers Day End Processes

a) A shift shall be closed by the Supervisor.

b) The Sub-Cashiers shall not have access to view the "Day End Cash/Card Collection Report".

c) A Day End Cash/Card Collection Report shall be printed by the Supervisor.

d) A Day End Cash/Card Collection Report shall be reconciled against the cash/card collected. This process shall be done in the presence of three officials, namely, (the Sub Cashier, Supervisor and a witness.

e) The Cash/Card Control Form shall be completed by the Sub Cashier and be signed by both the Sub Cashier and Supervisor.

f) A Day End Cash/Card Collection Report, Cash/Card Control Form and cash collected for the day shall be handed over to the Main Cashier by the Sub Cashier accompanied by a Security Officer or an escort, preferably a Security Officer.

7.19. Processes to Be Followed When Issuing Receipts by Main Cashier

7.19.1. Issuing of Receipts for Cash Handed Over by Sub Cashiers.

a) The Main Cashier shall print the "Day End Consolidated Summary Report" of cash/card collected by the Sub Cashiers.

b) The summary report shall be reconciled against the cash/card handed over by the Sub Cashiers. This process shall be done in the presence of two officials, namely, the Main Cashier and Supervisor.

c) The Main Cashier shall issue a receipt in duplicate from the Electronic Receipting System, as per the Sub Cashier's collection.

d) One copy shall be attached to the Sub-Cashier's cash up summary and the other copy shall be filed with the final banking.

7.19.2. Issuing of Receipts for Cash Collected from Other Revenue Sources

a) The Main Cashier shall issue a receipt in duplicate for a product sold/service rendered.

b) One receipt shall be given to the payee, the other receipt shall be filed, and a copy given to the service point.

7.19.3. Issuing of Receipts for Cash Against an Outstanding Account

a) The correct debtor account shall be recalled on the system.

b) A receipt shall be issued in duplicate against the debtor account.

c) One receipt shall be given to the payee and the other receipt filed.

7.19.4. Daily Banking of All Monies Collected

a) The Supervisor shall print a summary report of all cash/card collected by the Main Cashier.

b) The total daily collection shall be reconciled with a summary report to ensure that the money correlates.

c) A deposit slip shall be printed from the SAP e-Receipting System.

d) The money shall be deposited into the "Bulk Deposit Acceptor" (BDA) known as Smart Box.

e) A copy of the deposit slip from the Smart Box shall be attached to SAP e-Receipting deposit slip.

f) Cash collection slips fade after some time; copies must be made to avoid fading.

g) All transactions shall be recorded on the TPH 45A (Revenue Register) and balanced at the end of the month.

h) The SAP e-Receipting System Summary Reports shall be pasted on the TPH 45A.

7.20. Handling of Cash Collection & Credit Visits Manually

7.20.1. Processes to be Followed When Issuing Receipts by Sub Cashiers.

7.20.1.1. Issuing of a Receipt to a Patient Paying Cash Before Treatment

a) The registration of a patient visit shall be done on the visit register (TPH 31).

b) A patient shall be informed to make a payment to a Sub Cashier.

c) The Sub Cashier shall issue a TPH 208 receipt in duplicate against the visit.

d) The original must be given to the patient.

e) A stub must be attached to the patient file.

f) Copy remains in the book.

g) TPH 208 book copy must be handed over to the Main Cashier at the close of every shift.

h) Patients that are unable to settle the visits immediately must be handled as follows:

i. The TPH 201 account must be issued and be handed to a patient by the Sub Cashier.

ii. The patient must sign the manual credit agreement.

7.20.1.2. Issuing of a Receipt for Patients Paying an Account/Outstanding Visit

a) The Sub Cashier must issue a TPH 208 receipt in duplicate against the outstanding visit.

b) The original receipt shall be given to the patient and a stub attached to the patient's file and a copy shall remain in the book.

c) The TPH 208 book shall be handed over to the Main Cashier at the close of every shift.

7.20.1.3. Sub Cashiers Day End Processes

a) The Supervisor shall close all manual books utilized for the shift by summarizing and signing the last receipts.

b) The TPH 208 book shall be reconciled against the cash collected. This process shall be done in the presence of three officials, namely, the Sub Cashier, Supervisor and Witness.

c) The Cash Control Form shall be completed by a Sub Cashier and be signed by both the Sub Cashier and Supervisor.

d) The TPH 208 book, Cash Control Form and cash collected for the day shall be handed over to the Main Cashier by the Sub Cashier and escorted by the Security Officer/Escort.

7.20.2. Processes to be Followed When Issuing Receipts by The Main Cashier

7.20.2.1. Issuing of Receipts for Cash Handed Over by the Sub Cashiers

a) A copy of the TPH208 book shall be reconciled against the cash handed over by the Sub Cashiers. This process shall be done in the presence of two officials, namely, the Main Cashier and Supervisor.

b) The Main Cashier shall issue a Z1512 receipt in triplicate per Sub Cashier's collection.

c) One copy shall be attached to a Sub Cashiers manual collection.

d) One copy shall be sent to the Gauteng Department of Health, Directorate: Revenue Management for updating on BAS.

e) One copy shall remain in the TPH208 book.

7.20.3. Issuing of Receipts for Cash Collected from Other Revenue Sources

The Main Cashier shall issue a Z1512 receipt in triplicate for a product sold/service rendered whereby:

a) The original shall be given to a payee.

b) One copy shall be sent to the Gauteng Department of Health, Directorate: Revenue Management for updating on BAS.

c) One copy shall remain in the TPH208 book.

d) A photocopy of the Z1512 receipt shall be made to the service point.

7.21. Daily Banking of All Monies Collected

a) A deposit slip shall be printed from the SAP E-Receipting System.

b) The money shall be deposited into the "Bulk Deposit Acceptor" (BDA) known as Smart Box.

c) A copy of the deposit slip from the Smart Box shall be attached to SAP-e-Receipting deposit slip.

d) Cash collection slips fade after some time; copies must be made to avoid fading.

e) All transactions shall be recorded on the TPH 45A (Revenue Register) and balanced at the end of the month.

f) The SAP E-Receipting System Summary Reports shall be pasted on the TPH 45A.

g) All transactions shall be recorded on the TPH 45A (Revenue Register) and balanced at the end of the month.

7.22. Updating of the System After Downtime

a) Manual transactions including patient registration shall only be updated on the Billing system and NOT on the Electronic Receipting System, as soon as the system is back online.

b) Manual transactions shall always be banked separately using the Manual Bank Deposit Slip.

7.23. Billing of Patient Accounts H1, H2, H3, Private & Externally Funded Patients

a) Accounts Officers shall obtain a discharge list daily from the Health Information System.

b) The files of the patients that appear on the discharge list shall be collected from the Pharmacy/Records Management Section.

c) The Patient Administration Section shall ensure that the correct referral documents are enclosed in the patient file e.g. SAP 70 for SAPS, G111 for DCS and a referral letter.

d) All services rendered shall be billed and an account shall automatically be raised.

e) The Revenue Management Section shall ensure that all services are billed on invoices.

f) In cases where additional services must be added on a "**closed auto billed case**", Annexure G shall not be completed as this is not an erroneous adjustment and the case number will remain the same.

g) The Revenue Management shall ensure that the Buy Outs/Consumables are included in the invoice.

h) Debtors' bills shall be finalized within thirty (30) days of in-patient discharge/out-patient treatment.

i) The debtors shall be billed upon discharge and the bill shall immediately be sent to the debtor by post.

j) A claim submission spreadsheet shall be prepared for all accounts sent to the relevant funders and the following information shall be listed:

i. Service date.

ii. Patient name.

iii. Amount.

iv. Bill number.

v. Reference number.

k) Invoices shall immediately be sent to the relevant funder/self-paying patient.

l) A copy of the claim submission spreadsheet shall accompany the accounts to be submitted to the funders.

m) The funder shall sign & stamp the claim submission spreadsheet as an acknowledgement of receipt.

n) The Accounts Department shall compile a spreadsheet of all bills posted to external funders.

7.24. BAS Payments Allocation

7.24.1. Allocation of Receipts by Revenue Management Officials

7.24.1.1. Electronic Funds Transfers

a) A BAS Patient Fee Accounts Charged Report must be requested weekly.

b) Remittances must be obtained on time to be matched with the BAS report.

c) The BAS General Journal numbers shall be used as references when allocations are made on the billing system.

d) Payments shall be allocated to the specific debtor's account that the funder is paying for.

e) Any excess payments shall be recorded on the billing system.

f) Remittances shall only be allocated when they appear on the BAS Patient Fee Accounts Charged report.

g) Remittances may be obtained online via the medical schemes websites.

h) The South African Police Services/Correctional Services remittances may be obtained by email.

i) All remittances shall be filed daily with the claim submission spreadsheet and BAS report.

7.24.1.2. Direct Deposit and Internet Transfers

a) A BAS Patient Fee Accounts Charged Report must be requested weekly.

b) Deposits and Internet transfers with correct references shall only be allocated when they reflect on BAS in the Billing System.

c) The BAS General Journal numbers shall be used as references when allocating on the Billing Systems.

d) Debtors presenting deposit slips or proof of transfers directly to the Accounts Office, shall be confirmed on BAS prior to being allocated on the debtor's account.

e) Any excess payments shall be recorded on the billing system.

f) All deposit slips/proof of internet transfers shall be filed daily with the BAS report.

7.25. Debtor's Refunds

The revenue management officials are responsible for the processing of refunds.

7.25.1. Same Day Refunds Before Banking

a) A patient file shall be checked if treatment has not been rendered.

b) The debtor shall present the receipt as proof of payment.

c) The supervisor shall authorise the refund.

d) The receipt and invoice/visit shall immediately be cancelled on the system.

e) Hard copies of the receipts shall be cancelled by writing the word "cancelled" across. The hard copies shall also be signed by the supervisor.

f) The cash refund shall be done from the daily collection.

g) The debtor shall acknowledge the receipt of the cash refund by signing refund control register.

7.25.2. Refunds after Banking (amounts less than R 2000)

a) A patient file shall be checked if the treatment has not been rendered.

b) The debtor shall present the receipt as proof of payment.

c) The amount shall be verified on the BAS system before any refund can be processed.

d) A permission to withdraw the money from the provincial revenue account shall be sought from the authorised official (See attached APM Part V: 12.0).

e) The supervisor shall authorize the refund.

f) In cases where a service was billed but not rendered and payment was received, the following shall take place:

i. The Visit Invoice shall be cancelled if it is within the accounting month.
ii. A Credit Adjustment (Reversal of Visit) if it is after the accounting month.
iii. A debit note shall be processed on the Billing system to clear the credit (if necessary).
iv. The cash refund shall be done from the petty cash by completing the petty cash voucher.

v. Ensure that the allocations of the petty cash vouchers match the allocations on the payment on BAS.
vi. The debtor shall acknowledge the receipt of the cash refund by signing the Refund Form and the patient shall present an identity document.

7.25.3. Refunds After Banking (amounts greater than R 2000)

a) The debtor shall present a receipt as proof of payment and an identity document.

b) The amount shall be verified on the BAS item before any refund can be processed.

c) A permission to withdraw the money from the provincial revenue account shall be requested (ref. to APM Part V:12.0).

d) The supervisor shall authorize the refund.

e) In cases where a service was billed but not rendered and the payment was received, the following shall be adhered to:

i. The Visit Invoice shall be cancelled if it is within the accounting month.
ii. A Credit Adjustment (Reversal of Visit) if it is after the accounting month.
iii. A debit note shall be processed on the Billing system to clear the credit (if necessary).
iv. The debtor shall register with Central Supplier Database (CSD) and provide the registration number for further processing by the Accounts Payable Department.
v. A Payment Advice Form shall be completed as a request to have the money refunded directly to the debtor's account.
vi. Ensure that the allocations on the Payment Advice Form match the allocations of the receipts on BAS.

f) The following supporting documents must always be attached:

i. Debtor's account statement.
ii. BAS Report where the credit appears.
iii. Permission to withdraw from the Provincial Revenue Account Form.
iv. A refund register shall be used to record all refunds made to patients.

7.26. Patients Fees deposits

7.26.1. Deposits for patients without Patient Numbers

a) A quotation shall be issued to the patient/funder.

b) The patient/funder shall be informed to quote the Hospital's Practice Number as a reference when making the deposit.

c) The patient shall provide the institution with proof of payment.

d) The institution shall send a copy of proof of payment to the Gauteng Treasury and/or the Revenue Management Directorate at the Central Office.

e) The funds shall be allocated to Patient Fees: Accounts Charged.

f) The transaction shall be reported as a reconciling item on the reconciliations since it can only be cleared from the Patient Account post treatment.

g) The Patient Account must immediately be cleared once the Bill has been raised.

7.26.2. Deposits for patients with Patient Numbers

a) A quotation shall be issued to the patient/funder.

b) The patient/funder shall be informed to quote the Hospital's Practice Number & Patient Number as a reference when making a deposit.

c) The patient shall provide the institution with proof of payment.

d) The institution shall send a copy of proof of payment to the Revenue Management Directorate at Central Office and the Gauteng Provincial Treasury.

e) The funds shall be allocated to Patient Fees: Accounts Charged.

f) The transaction shall be allocated to the Patient Account on the Billing System regardless of the bill not being raised.

g) The Patient Account shall immediately be cleared once the bill has been raised.

7.26.3. Adjustments

a) Annexure "G" shall be compiled indicating the reasons for any adjustments.

b) Annexure "G" shall be approved by the Supervisor.

c) The incorrect bill shall be adjusted by means of a credit note.

d) The new bill for the correct amount shall be raised.

e) The new bill/account shall be issued to the debtor for notification purposes.

f) Adjustments shall be done under the following circumstances:

i. Erroneous classifications and incorrect levies e.g.: Incorrect procedure, medication billed, etc.

ii. Annexure "G", Incorrect and New Correct Bill must be kept in the financial file of the debtor.

7.27. Face Value Books

The following face value books shall be used at the institutions:

a) Manual billing template

b) TPH 201

c) TPH 208

d) Z1512

e) TAS Book (TPH60)

7.27.1. TPH 201 Account

a) TPH 201 account shall be used at hospitals where the registration and admission sections are not computerized, or the system is offline.

b) TPH 201 account shall be issued to an in/out- patient who has not paid an applicable fee before or at the commencement of treatment and is classified as H1, H2, H3, PF & P(S) i.e. self-funded patients.

7.27.2. TPH 208 Receipt

a) TPH 208 account shall be used at hospitals where the registration and admission sections are not computerized, or the system is offline.

b) TPH 208 receipt shall be issued to an in/out patient who paid an applicable fee before or at the commencement of treatment and is classified as H1, H2, H3, PF & P(S) i.e. self-funded patients.

7.27.3. Z1512 Receipt

a) Z1512 receipt shall be used at hospitals/institutions by the Main Cashier where the office/section is not computerized, or the system is offline.

7.27.4. Control of Face Value Books

The following procedures shall be followed in handling the face value books:

a) The face value books issued to Counter Clerks or authorized persons shall be locked in a safe when not in use.

b) The Supervisor or a responsible person designated by the Supervisor in writing, shall at least once a week, conduct an inspection on all face-value books to ensure that the amount on hand is correct, money which should have been banked has not been withheld and that the instructions regarding the receipts, custody and disposal of State money has been carried out.

c) All books shall be recorded in a sequence manner prior to distribution and after use.

d) The Supervisor shall make an official sign for the book before it is issued.

The Supervisor shall check that all pages used are accounted for and correctly issued in a sequence when books are returned to him/her.

7.28. Revenue Reconciliations

7.28.1. Why Is Reconciliation Important?

a) It ensures that the money being paid in/out of an account correlates with the actual money received/paid. This is done by making sure the balances correlate at the end of an accounting period.

b) It enables the Department to know that the amount of revenue reported by the institutions is consistent with the amount of cash shown on the BAS records.

c) It also allows the institutions to uncover any possible discrepancies such as:

i. Incorrect allocations.
ii. Unallocated transactions on either one of the two systems.
iii. Cheques that have been declared unpaid by the bank.
iv. Refunds that have not been implemented on the other systems.
v. Incorrect debits on transactions that have been previously credited.

7.28.2. Types of Reconciliations to be Performed Monthly

a) Reconciliation on cash collected at the institutions amongst bank account, SAP E-RECEIPTING and BAS.

b) Reconciliation on patient fees between BAS and the Patient Billing System.

c) Reconciliation for Parking between the Persal System and BAS.

d) Reconciliation for Staff Accommodation between the Persal system and BAS.

e) Reconciliation for rentals received from Vendors.

7.28.3. Signatories

a) The compiler must sign the reconciliations.

b) The checker (supervisor) must verify the correctness of the reconciliation and sign.

c) The Head of Finance must sign off the reconciliation.

7.28.4. Review of Reconciliations

a) All revenue reconciliations will be reviewed quarterly by Head Office.

7.29. Monthly Revenue Report (In Year Monitoring Report)

7.29.1. Revenue projections [PFMA Section 40 (4) (a)(b)]

a) The Head of the institution must, each year before the beginning of a new financial year, provide the Department with a breakdown of the projections per month in a prescribed format. The factors that shall be considered when projecting revenue include:

i. Historical collection trends
ii. Effects of once-off revenue amounts
iii. Changes in demand for the output or service rendered
iv. Changes in applicable tariffs
v. The identification of potential new revenue sources and
vi. Collection efficiency, that is, the cost of collection relative to the amount collected

b) The Head of the institution must within the prescribed date of the month submit:

i. Information on the revenue collected for the month
ii. A projection of expected revenue collection for the remainder of the financial year; and
iii. Where necessary, an explanation of any material variances and a summary of the steps to be taken to ensure that the revenue remains within budget.

7.30. Debt Management

7.30.1. Categories of Patient Debtors

7.30.1.1. Self-Funded

a) Individuals owing R500 or less (H1, H2, H3, PF & P(S).)

b) Individuals owing more than R500 (H1, H2, H3, PF & P(S).

7.30.1.2. Externally Funded

a) Government Departments such as the Department of Correctional Services (DCS), South African Police Services (SAPS), and Department of Justice and Constitutional development (DoJCD) etc.,

b) Public Entities such as Road Accident Fund (RAF), Compensation Fund, and Passenger Rail Agency of South Africa (PRASA) etc.

c) Other countries such as Swaziland, Botswana etc.

d) Other Provinces such as North West Province, Limpopo Province and Mpumalanga Province etc.

e) Registered Medical Schemes such as Discovery, Government Employees Medical Scheme (GEMS), etc

f) Medical Insurance and Societies.

7.31. Referral of Debt to the Collecting Agencies Appointed by the Department

a) As part of the revenue enhancement initiatives, the Department shall appoint service providers that will be responsible for the following:

i. Road Accident Claims in terms of RAF Act, 56 of 1996
ii. Compensation for Occupational Injuries and Diseases claims in terms of COIDA Act,130 of 1993
iii. Self-paying patient's debt collection
iv. Patient identification, verification and tracing system
v. Medical aid claims submission via Electronic Data Interchange.

7.32. Follow Up on Outstanding Debts (APM Part III Par. 3.0)

7.32.1. Self-Funded

7.32.1.1. Individuals Owing R500 or Less (H1, H2, H3, PF & P(S)) (APM PART III PAR. 3.1.1-3.1.2.3)

a) No telephone calls or written communication shall be made or sent to these debtors as it is uneconomical.

b) Debtors shall be verbally reminded of their debt on subsequent visits to the hospital.

c) The debts shall be written off if not settled within 90 days from the date of treatment.

d) Only accounts that are irrecoverable shall be written off.

e) An attempt shall be made to recover debts from debtors whose accounts have been written off.

f) Payments shall be recorded on the Billing System and BAS as Bad Debts Recovered.

7.32.1.2. Individuals Owing More than R500 (H1, H2, H3, PF & P(S)) (APM PART III PAR. 3.1.3-3.1.2.3)

a) An accurate record shall be kept of all enquiries made and the result obtained. This record will be of great value if the debtor cannot be traced, and the debt has to be written off.

b) The account shall be sent to the debtor, thirty days after the patient has been discharged.

c) If the debtor does not respond to an account rendered to him/her, a reminder shall be sent to him or her not later than the end of month following the month in which the account was first rendered.

d) If necessary, a final reminder shall be sent a month later.

e) In addition to the above-mentioned steps, telephone calls shall be made to remind the debtor.

f) If at any stage during the follow-up procedure it is established that the debtor's circumstances have changed since the debt originated, the case shall be dealt with in the following manner:

7.32.1.2.1. Debtor Insolvent or Died

a) Establish the name of the Executor and submit the debtor's account for settlement.

b) If the name of the Executor cannot be established, the local Magistrate's Office or the Master of the High Court may be approached. The full particulars of the debtor, such as his/her full names, identity number, and date of birth and if applicable, date of death shall be furnished.

7.32.1.2.2. When in Doubt State Attorney Must be Consulted

a) If a debtor cannot be traced for any reason (e.g. change of address or employer, false or incorrect information), effort shall be made to determine his/her whereabouts.

b) His/her correct particulars may possibly be obtained through the Patient Information Verification System

c) Officials shall always confirm the contact details of the debtor, for example:

i. Confirm if the address the debtor provided is still valid
ii. Request alternative telephone numbers
iii. Verify if debtor is still employed at the address, he/she provided
iv. Confirm the identity number.

d) If the account is not settled or if a satisfactory arrangement for settlement is not made within 14 days of the date of the final reminder, the procedures prescribed hereunder shall be followed:

i. A Letter of Demand (Annexure "A" APM PART 3 attached) shall be sent to the debtor
ii. If the debtor does not respond to the letter of demand by the due date indicated in the letter, the recoverability of the debt shall be considered in terms Treasury Regulation 11.4 (Writing off of debts owing to the state).
iii. If it is determined that the debt is irrecoverable or should not be recovered, the case shall be dealt with in terms of paragraph 3.6 of APM PART III (Writing off of patient debts)
iv. If it is determined that the debt is recoverable, it shall be recovered through a legal process. It is recommended that only debts above R 1000 shall be referred to the State Attorney
v. Officials responsible for the recovery of patient debts shall acquaint themselves with procedures relating to summonses (APM PART III PAR 3.2.1 to 3.22).
vi. The procedures for issuing summons are outlined in the APM PART III PAR 3.27 to PAR 3.2.12.3. If the debtor settles the debt, legal costs shall also be recovered from him/her.

e) If the debtor settles the debt, legal costs shall also be recovered from him/her

f) If the debtor makes an offer to pay the debt by instalments the following procedures shall be followed:

i. A debtor shall complete in writing the "Admission of Liability and Undertaking to Pay Debt by Instalments" or otherwise, in terms of section 57(1) of the Magistrates' Courts act, 1994 (act 32 of 1994) form. See Annexure C APM PART III par. 3.2.1.51
ii. The procedures to be followed are outlined in APM PART III PAR 32.15 to PAR 3.2.15.5

g) If the debtor claims that he/she is unable to pay the debt, he/she shall submit evidence to substantiate his/her claim (e.g., statement of assets, income and expenditure), and if there is reason to doubt the recoverability of the debt, the case shall be considered for writing off in terms of Treasury Regulation 11.4

h) If the debtor consents to judgment for the amount of the debt and costs claimed in the summons, the steps to be followed are outlined in the APM PART III PAR 3.2.17 to PAR 3.2.17.2

i) If the debtor gives notice of his/her intention to defend the action, the case shall immediately be referred to the State Attorney, together with copies of all relevant documents, refer to the APM PART III PAR 3.218.

j) If the debtor does not respond to a summons within the period proclaimed in the summons, a written request [Form No. 5] in duplicate, together with the original summons and the return of service, shall be lodged with the Clerk of the Court for judgment by default against the debtor for the amount claimed in the summons, and costs. (refer to the APM PART III PAR 32.19).

7.32.1.3. Recovery of Patient Debts by Means of Legal Action by the State Attorney

a) When referring cases to the State Attorney, the following information must be furnished (APM PART III PAR 3.3):

i. Full particulars of the debt and the debtor
ii. Steps already taken to recover the debt
iii. The debtor's full residential address
iv. The name and address of his or her employer
v. If the debtor is a woman, her marital status shall be given and, if applicable, the names of her husband and whether they are married in or out of community of property
vi. Any movable property (e.g., furniture, motor vehicles) or immovable property owned by the debtor of which the hospital is aware.

7.32.1.4. Legal Costs (APM PART III PAR 3.4)

a) Legal costs arising from the issuing of a summons by a hospital, such as revenue stamps and sheriff fees, shall be paid by the hospital.

b) Revenue stamps shall be purchased out of petty cash.

c) The sheriff's account shall be accompanied by a return indicating the manner in which the summons had been dealt with.

d) Legal costs incurred by the State Attorney in respect of cases referred to him/her for legal action, shall be reimbursed by the hospital.

7.32.2. External Funders

a) Government Departments such as the Department of Correctional Services (DCS), South African Police Services (SAPS), and Department of Justice and Constitutional Development (DoJCD) etc. are considered external funders.

b) The Road Accident Fund (RAF), Compensation Fund, and Passenger Rail Agency of South Africa (PRASA) etc. are regarded as external funders.

c) Other countries such as Swaziland, Botswana etc, are regarded as external funders.

d) Other Provinces such as North West Province, Limpopo Province and Mpumalanga Province etc, are also regarded as external funders

e) All external funders shall be contacted by means of telephone and written communication if necessary, to recover outstanding amount.

f) Meetings may subsequently be arranged by the Director: Revenue Management to negotiate the payments of outstanding accounts.

7.32.3. Registered Medical Schemes, Insurances and Societies

a) Follow up in this case shall be done on rejected claims.

b) Rejection reports from Medical Schemes, Insurance and Societies shall be acquired and be corrected and resubmitted to the Medical Scheme, Insurance and Societies.

c) If the Medical Scheme, Insurance and Society do not fully settle the account for any reason, the member shall be responsible for the payment of the outstanding amount.

d) The Tracing/Debt Management Section shall make the necessary follow-up to recover the

outstanding amount.

7.32.4. Irrecoverable of Debt

a) Treasury Regulation Section 11.4 issued in terms of Section (76) (i) (e) and 76 (4) (a) of the PFMA, empowers the Accounting Officer to write off debt owed to the state under the following conditions:

i. If the debt amounting to R500 or less for Self-Paying Patients (H1, H2, H3 and Private) is not settled within 90 days from the date of treatment shall be written off.
ii. Recovery of the debt would be uneconomical.
iii. Cases where there is lack of information to pursue the debtor.
iv. Debtor is untraceable (where the debtor cannot be located in spite of all reasonable efforts to locate him/her);
v. Cannot be substantiated by evidence.
vi. Recovery would cause undue hardship to the debtor or his or her dependants.
vii. RAF cases submitted after the prescribed period.
viii. Debts are legally without merit.
ix. Costs of debt recovery actions which may exceed the anticipated recovery amounts.

x. Any other statutory requirements exist to terminate debt recovery actions.
xi. The Debtor is insolvent or sequestrated.
xii. Debts that are 3 years and older are regarded as prescribed (Irrecoverable). Any account that is 3 years or older and has not been followed up within that period, according to the Prescription Act, has prescribed.
xiii. Returned accounts by the State Attorney are deemed due to irrecoverable and
xiv. Other reasons as stated in the Adjustment and Writing Off of Irrecoverable Debt Amendment 1 of Circular Minute 48 of 2012 **(Appendix G).**

7.32.5. Delegations for Write Offs

a) The Accounting Officer has delegated the power for the writing off of debt with amount limits per individual case to the following post incumbents in accordance with Gauteng Department of Health Financial Delegations, 2018 **(APPENDIX H):**

i. Up to R5000.00 Chief Administration Clerk/Administration officer
ii. Up to RI0 000.00 Senior Admin Officer
iii. Up to R20 000.00 Assistant Director
iv. Up to R30 000.00 Deputy Director
v. Up to R40 000.00 Director
vi. Up to R60 000.00 Chief Director
vii. Up to RI00 000.00 Chief Finance Officer
viii. R 100 000.00 and above Head of Department

7.32.6. Writing Off Debts

a) A debt write-off memo must be compiled. The memo must consist of the following headings:

(i) **Purpose:** requesting permission from a delegated authority and indicating amount to be written off .
(ii) **Background:** A brief description of the debtor, date of origin and the amount owed and indicating whether the debtor has been referred to debt collecting agencies.
(iii) **Discussion/Motivation:** A clear indication of the reason why the debt should be written off measured against the conditions that are applicable for a write off.
(iv) **Financial Implications:** A clear indication of the amount to be written off.
(v) **Recommendation:** a recommendation to write off irrecoverable debt in accordance with this policy must be made.
(vi) The compiler shall sign the memo and submit it for **approval** at the appropriate level in terms of the financial delegations.

b) Write offs can only be processed after the approval of the memo.

c) The list of proposed accounts to be written off shall be attached to the memo.

d) Officials shall consider write off only if it can be proven that all attempts to recover the money has been exhausted.

e) In cases where an account cannot be settled, it shall be written off and the correspondence from the State Attorney shall be attached to the submission of the write off as a supporting document.

7.32.7. Interest Payable on Debts to the State [Section 80 Of The PFMA]

The National Treasury issued Government Notices No. 2269 of 8 July 2022 in terms of Public Finance Management Act, 1999: Different Categories Of Debt For Interest Rate Applicable to Debts Owing To State.

In terms of section 80(2) of the Public Finance Management Act, 1999 (Act No.1 of 1999 –"the Act"), the Minister of Finance repealed Government Notices Nos. 469 of 23 June 2017 and 499 of 18 May 2018 and determine that for debt which is payable into a Revenue Fund and owed by a person to an institution to which the Act applies and which—

(a) results from the employment relationship between the person and a department or constitutional institution, no interest shall be payable at the rate determined in terms of section 80(1)(b) of the Act, except that such interest shall be payable for-

(i) wrongly granted remuneration as provided for in the prescripts applicable to the department or constitutional institution, where—

(aa) the person has left the employ of the department or constitutional institution; or

(bb) the monetary advantage resulted from the person's fraudulent action;

(ii) loss or damage resulting from wilful or grossly negligent act of an employee or former employee of the institution; or

(iii) breach of contract or any delictual claim relating to the contractual relationship between the person and the institution; or

(b) is a debt other than a debt resulting from the employment relationship between the person and the institution, referred to paragraph (a), the interest shall be payable at the rate determined in terms of section 80(1)(b) of the Act, except that no such interest shall be payable for—

(i) a health service by a public health establishment provided to the person who is a patient classified as H1, H2 or H3 by the Minister of Health;

(ii) an overpayment made to the person for a social or unemployment benefit;

(iii) a health service funded or partly funded—

(aa) in terms of the Compensation for Occupational Injuries and Diseases Act, 1993 (Act No. 130 of 1993);

(bb) in terms of the Road Accident Fund Act, 1996 (Act No. 56 of 1996);

(cc) by a medical scheme registered in terms of the Medical Schemes Act, 1998 (Act No. 131 of 1998);

(iv) any fee for a patient treated by his or her own private practitioner in a public health establishment; or

(v) a health service by a public health establishment provided to a foreigner as defined in section 1 of the Immigration Act, 2002 (Act No. 13 of 2002).

7.33. Roles and Responsibilities

The Patient Administration, Case Management and Revenue Management officials at the institutions shall ensure that appropriate control measures relating to revenue management are implemented. The following are some of the responsibilities relating to revenue management:

7.33.1. Responsibilities of the CEO

a) Ensure that all patients are correctly classified and billed timeously.

b) Ensure that monthly reconciliations are performed.

c) Ensure that Debt management processes are followed.

d) Ensure that there is proper cash management system and processes.

e) Ensure compliance with financial prescripts.

7.33.2. Responsibilities of Patient Administration, Case Management and Revenue Management Officials

a) Ensure the completeness and correctness of patient details during registration, admission, discharge and billing through patient verification, fully completed registration forms, proof of identification, proof of address, proof of income, referral documents, medical reports, completed charge sheet, comprehensive claim and tracing reports.

b) Ensure that all patients are billed for services rendered and all patients are registered.

c) Use the patient verification system to verify patient information on admission.

d) Ensure that the GPF 4 & 5 forms are fully completed and signed by the Admitting Officer.

e) Ensure that the signatures of both the patient and Admitting Officer are on the registration/admission form.

f) Ensure that the confirmation of medical aid patients is done during admission/ registration.

g) Ensure that the Patient Administration, Case Management, Revenue Management Supervisor and Manager verify the patient's classification regularly for accuracy.

h) Ensure the correct charging for all goods sold and services rendered according to current tariff guidelines.

i) Ensure that the Patient Administration, Case Management and Revenue officials record all revenue due from the sale of goods and rendering of services.

j) Ensure the segregation of duties between:

i. Patient Administration official for registration and admission of patients.
ii. Revenue Management official (Sub-Cashier) for collection and recording of cash
iii. Revenue Management Official (Main Cashier) for recording, collection and cash deposits
iv. The Revenue Management Supervisor for reconciliations of cash collected and deposited.

k) Ensure the Main Cashier deposits the slip from Bulk Deposit and files it once the deposit transaction is complete.

l) Ensure reconciliation of collection systems and revenue collected to deposit books used by collecting agencies is carried out.

m) Ensure the identification and allocation of all receipts.

n) Ensure the implementation of effective debt management processes.

o) Ensure the collection of all money due to the institution.

p) Ensure there are internal verification processes for recording cash receipts.

q) Ensure reconciliations of monies collected and manually receipted have been captured on the relevant system.

r) Ensure reconciliations of BAS/Persal/ accommodation and parking are carried out, and

s) Ensure reports on revenue collected from Vendors that are renting or leasing facilities at institutions are carried out.

7.34. Resource Requirements

A Health Information System is required. Computers and Printers will be required at institutions. Additional human resource capacity will be required for the Patient Administration, Case Management, Billing and Tracing Units.

7.35. Training Plan

Training shall commence within three months after the approval of the policy to ensure efficient and consistent application throughout the Department. Training shall be provided by the Revenue Management officials at Central Office as follows:

TYPE OF TRAINING	REGION	TIMELINE
Cash and Debt Management	Tshwane District Johannesburg District West rand/ Ekurhuleni District Sedibeng District	Every Quarter
Patient Administration, Case Management and UPFS	Tshwane District Johannesburg District West rand/ Ekurhuleni District Sedibeng District	Every Quarter

8. POLICY MONITORING

8.1. Policy Outputs

Output	Performance Indicators	Timelines
Improved Patient Classification	Correct classification of patients and maximisation of revenue collection	31 March each financial year
Timeous Billing	Minimization of late submission of claims and improved revenue collection	31 March each financial year
Debt management	Reduction of debt book	31 March each financial year
Case Management	Reduction of rejections	31 March each financial year
Reconciliations	Accurate monthly reconciliations.	

8.2. Monitoring Mechanism

The Revenue Management Directorate at Central Office shall be responsible for monitoring the implementation of the policy. The policy implementation will be monitored through the compliance assessment processes of the Revenue Management, Internal Control and Risk Management Directorates. Oversight visits to the institutions will be undertaken by the Revenue Management Officials at Central Office to monitor compliance with the policy.

Revenue reports will be submitted in accordance with the reporting requirements in terms of section 32 of the Public Finance Management Act, 1999 and Treasury Regulations Part 4,7.2.1. Finance Reviews and Revenue Forums will also be held quarterly to measure the performance of institutions.

8.3. Compliance

Ongoing training on the policy will be provided to improve compliance. Non-compliance letters will be issued to institutions that are not adhering to the policy, alerting them of areas of non-compliance, so that remedial action can be taken.

9. REVIEW

This policy shall be reviewed every three (3) years or earlier when there is a need. The review process shall commence six months before the policy is due for review .

10.APPROVAL

FOR OFFICE USE ONLY	
THE KEY STAKEHOLDERS CONSULTATION	
Policy written by: The developing Branch or Chief Directorate acknowledges and accepts the policy	
Signature..................................	Date..16/10/2023
Comment...	
Technical support provided by CD: Policy, Planning, Research and HIEM Assurance that technical support was given, and Policy Development, Review and Approval Guidelines followed	
Signature..................................	Date 16.10.23....................
Comments...	
APPROVAL OF POLICY	
Approved/Not Approved/Approved with Amendments The HOD approves operational policies	
Head of Department: Health Signature..................................	Date..2023/10/18
Comments:	

11. REFERENCES

1. Public Finance Management Act, 1999 (Act No.1 of 1999)

2. National Treasury Regulations

3. National Health Act No.61 of 2003

4. Medical Schemes Act, 1998 (Act No. 131 of 1998)

5. Compensation for Occupational Injuries and Diseases Act No 130 of 1993

6. Administrative Procedure Manual Part III & V of 2020

7. Gauteng Department of Health: Amendment 1 of circular minute 48 of 2012: Adjustment and writing off of irrecoverable debt

8. Gauteng Department of Health Financial Delegations, 2018

9.Immigration Act No. 13 of 2002

12.ANNEXURES

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J	**Manual Billing Template**	**J1-J6**

APPENDIX A

Table 1: Explanation of the Classification of patients for the determination of fees

CLASSIFICATION	GROUP	DESCRIPTION	CLASSIFICATION	
			Patient treated by Health care professional/worker on duty	Patient treated by Private Health care professional/worker
1. Full Paying Patients	Externally Funded **Patient whose health services are funded or partly funded**	1. All patients visiting Gauteng institutions who were involved in a Road Accident should be classified as Private patients: The Road Accident Fund Act, 1996 (Act No 56 of 1996)	PH (RAF)	
		All patients involved in Train Accidents National Railway Safety Regulator (Act No 16 of 2002).	PH (PRASA)	
		A medical scheme registered in terms of the Medical Schemes Act, 1998 (Act No 131 of 1998).	PH (M)	P (M)
		The Compensation for Occupational Injuries and Diseases Act, 1993 (Act No 130 of 1993),	PH (COI)	
		Patients treated on the account of another province (cross border)	PH (CRB)	
		Patients treated on the account of another state department: a) Department of Defense Force patients	PH (DOD)	

CLASSIFICATION	GROUP	DESCRIPTION	CLASSIFICATION	
			Patient treated by Health care professional/worker on duty	Patient treated by Private Health care professional/worker
		Any person who, in terms of the provisions of the Defense Act No 44 of 1957 is entitled to treatment in a hospital at the expense of the State.		
		b) South African Police Service (SAPS)	PH (SAPS)	
		c) Department of Justice and Constitutional Development (DoJCD)	PH (DOJ)	
		(d) Department of Correctional service (DCS)	PH (DCS)	
	Patient treated by a private practitioner	2. Any patient treated by his or her own private practitioner in a public health care facility will be liable to pay the full facility fee component for services rendered by the private practitioner at the facility and the full UPFS fee for any other service received by the patient. These patients are classified as Private Self-Funded :P (S)		P (S)
	Non-South African citizens	3. All Non-South African citizens are classified as Full Paying Patients excluding Refugees and asylum seekers .	PH (F)	P (F)

CLASSIFICATION	GROUP	DESCRIPTION	CLASSIFICATION	
			Patient treated by Health care professional/worker on duty	Patient treated by Private Health care professional/worker
		These patients are classified as Private Hospital Foreign patients: PH (F) or P (F) if they opt to be treated by their own health care professional/workers		
2. Subsidized Patients	Means Test apply for (a) Individuals with Income R0 R70 000 per annum (b)Household with Income I R0 – R100000 per annum	4. Receive a percentage of subsidization from the full Uniform Patient Fee Schedule on selected tariff as per Provincial Gazette.	H1	P (S)
	(c) Individuals with Income R70 001 – R250 000 per annum. (d) Household with Income more than R100 000 to R350 000 per annum	5. Receive a percentage of subsidization from the full Uniform Patient Fee Schedule on selected tariff categories.	H2	P (S)
	(e) Individuals with Income greater or	6. Receive a percentage of subsidization from the full Uniform Patient Fee Schedule.	H3	P (S)

CLASSIFICATION	GROUP	DESCRIPTION	CLASSIFICATION	
			Patient treated by Health care professional/worker on duty	Patient treated by Private Health care professional/worker
	equal to R250 000per annum (f) Household equal to or greater than R350 000 - per annum	Not all Tariffs are charged at a discounted rate.		
3. Free Service	**Social pensioners**	7. Recipients of the following types of pension/grants are classified as social pensioners and receive all services free of charge: • Old age pensioners • Child support grant • Veteran's pension • Care dependency grant • Pension for the blind • Family allowance • Maintenance grant • Disability grant • Single- care grant – • (Persons with mental disorders in need of care discharged from hospitals for the mentally ill but has not been decertified.)	H0	P(S)

CLASSIFICATION	GROUP	DESCRIPTION	CLASSIFICATION	
			Patient treated by Health care professional/worker on duty	Patient treated by Private Health care professional/worker
		Should the social pensioners also belong to a medical scheme, they will be regarded as full paying patients. Civil Pensioners are classified according to their income under subsidized patient category. Those that belong to a medical scheme, they are regarded as full paying patients		
	Formally unemployed	8. Persons supported by the Unemployment Insurance Fund (UIF). Proof of unemployment must be produced.	H0	P (S)
	Deceased unknown patient	9. An unknown, Unconscious patient who had been provisionally classified, who dies in hospital, and whom no particulars are known or obtainable must be reclassified as an H0	H0	
4. Exempted patients	Pregnant women	10. NOTICE 657 OF 1994, 1 July 1994 As from 1 June 1994, free health services must be provided to :	HG	P (S)

CLASSIFICATION	GROUP	DESCRIPTION	CLASSIFICATION	
			Patient treated by Health care professional/worker on duty	Patient treated by Private Health care professional/worker
		(a) pregnant and lactating women for the period commencing from the time the pregnancy is diagnosed to 42 days after the pregnancy has terminated, or if a complication has developed as result of the pregnancy, until the patient has been cured or the conditions as result of the complication has stabilized; (b) children under the age of six years; (c) Refugees and asylum seekers who incidentally develop a health problem whilst in South Africa. (d) Patients on ARV who do not belong to any funder NB:**Free health services included the rendering of all available health services to the persons mentioned in above, including the rendering of free health services to pregnant women for conditions that are not related to the pregnancy*. **The following persons are excluded from the free health services: (i) Persons and their dependents who are members of a medical scheme.		