GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

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TO: **DEPUTY DIRECTOR GENERALS, CHIEF DIRECTORS, DIRECTORS, CHIEF EXECUTIVE OFFICERS, EMERGENCY MEDICAL SERVICES, DEANS OF ORAL AND DENTAL HOSPITALS, PHARMACY MANAGERS AND CENTRAL OFFICE LINE FUNCTIONS**

CIRCULAR NO: 27 OF 2020

SUBJECT: POLICY IMPLEMENTATION GUIDELINES ON PATIENT ADMINISTRATION AND REVENUE MANAGEMENT

1. In accordance with Treasury Regulations Part. 4(7.2), issued in terms of the Public Finance Management Act, 1999. The Accounting Officer of an Institution must manage revenue efficiently and effectively by developing and implementing the appropriate processes that provide for the identification, collection, recording, reconciliation and safeguarding of information about revenue.

2. In line with the above regulations and other legislations for revenue, Revenue Management under Chief Directorate: Budget and Revenue Management has compiled a Policy Implementation Guidelines on Patient Administration and Revenue Management to guide Institutions in managing revenue efficiently and effectively.

3. The Policy Implementation Guidelines on Patient Administration and Revenue Management including attachments are implementable effective from 1 April 2020.

4. Institutions are advised to comply with the Policy Implementation Guidelines on Patient Administration and Revenue Management.

5. The contents of this circular should be brought to the attention of all relevant officials.

.....
PROF M. LUKHELE
HEAD OF DEPARTMENT: HEALTH
DATE: 10/05/2020

DEPT OF HEALTH
PRIVATE BAG X085
MARSHALLTOWN
12 MAY 2020
REGISTRY
DEPT OF HEALTH

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

POLICY IMPLEMENTATION GUIDELINES ON PATIENT ADMINISTRATION AND REVENUE MANAGEMENT

APPROVAL DATE:

REVIEW DATE:

CHIEF DIRECTORATE: BUDGET AND REVENUE MANAGEMENT

REF NO: GDL

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 implementation guideline provides guidance on how a patient shall be classified prior to being registered and admitted at a public health institution in Gauteng and also provides guidelines in the implementation of case management services. All patients shall be registered electronically or manually where full details are to be obtained from the patient or his/her escort. The information shall be used for the sole purpose of rendering health care services and related activities. Officials of the department shall have access to patient information while executing their duties but the information cannot be used for any other purpose. Patient confidentiality is key (primary) and shall be maintained at all times by those that have access to that information.

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

In terms of the Public Finance Management Act (PFMA), 1999 (as amended by Act No.29 of 1999), the Accounting Officer: -

i. 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)}
ii. Is responsible for the effective, efficient, economical and transparent use of resources of the department {section 38(1)(b)}
iii. Must take effective and appropriate steps to collect all money due to the department {section 38(1)(c)(i)}

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3. DEFINITIONS OF TERMS & ACRONYMS

3.1. 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 with valid documents.
H1	Individuals with an income less than R70 000 per annum and households 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
H3	Individuals with an income greater than or equal to R350 000 per annum and households 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;
Income	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 a 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 Republic **resident**	means a person from outside the borders of the of South Africa visiting the RSA.
Private hospital patient	means a person 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 health care professional/worker who is not in the service of such hospital (P)
Relative	means a member of 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 new born 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;

3.2. Acronyms used

CEO	Chief Executive Officer
CFO	Chief Financial Officer
COID	Compensation for Occupational Injuries and Diseases
BAS	Basic Accounting System
GDOH	Gauteng Department of Health
HIS	Health Information System
LOS	Length of Stay
PHCOID	Private Hospital Compensation for Occupational Injuries
ICD10	International Classification of Diseases and Related Health Problems (10th revision)
DOJ	Department of Justice
PFMA	Public Financial Management Act
PH (F)	Private Hospital Foreigner
SAP	System Application Products
SAPS	South African Police Services
TPH	Transvaal Provincial Hospital
UPFS	Uniform Patient Fee Schedule

4. BACKGROUND

4.1. Problem statement

There is lack of uniformity and standardization of practice at hospitals/institutions in the management and implementation of revenue processes as well as non-compliance to departmental prescripts. Lack of uniformity affects audit outcomes and leads to loss of revenue. The non-compliance is due to poor management and lack of skills transfer by institutional managers.

5. PURPOSE OF POLICY GUIDELINES

5.1 The purpose of this policy is to:

i. Provide uniformity in the application of all revenue management procedures and processes within the Department.

ii. simplify the implementation of policies,

iii. Assign responsibilities and prescribe procedures regarding Revenue Management within the Gauteng Department of Health.

iv. Provide necessary support and guidelines to be followed in the identification, generation, collection, recording, and reconciliation and safeguarding of information on revenue within the department.

v. Provide and strengthen internal controls within the revenue management process.

vi. Ensure achievement of clean audits for revenue.

6. CONSULTATION PROCESS BY POLICY DEVELOPMENT TEAM

Policy Profile			
Policy Reference:			
Version:	1		
Author:	Revenue Management Directorate		
Executive sponsor:	Chief Director Budget and Revenue Management		
Target audience:	All Gauteng Department of Health staff		
Date issued:	March 2020		
Review date:	March 2025		
Consultation			
Key individuals and committees consulted during drafting	Chief Executive Officers	Date	16 March 2020
	Patient Administration, Case Management and Revenue Management officials at institutions	Date	24,26,28 February 2020
	Other stakeholders: Policy Development Unit	Date	January and February 2020
	Senior Management in the Gauteng Department of Health **(EMC)**	Date	16 March 2020
	Organised labour	Date	Consultation do be done at the Multilateral Meeting
Approval			
Approval Committee:			
Date:			
Ratification			
Ratification Committee:	Executive Management Committee		
Date:			

7. SCOPE OF THE POLICY GUIDELINES

7.1 This policy is applicable to:

i. All officials in the Gauteng Department of Health (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.

ii. The officials are expected to adhere to the revenue management policy guidelines.

8. POLICY GUIDELINES DIRECTION

8.1. Objectives of the policy guideline

i. To streamline the revenue management process within all GDOH institutions in every financial year.

ii. To ensure compliance with regulatory framework with regard to Revenue Management.

iii. To ensure a transparent process in the identification, recording and reporting of revenue within all GDOH institutions.

iv. To provide guidance on the management of departmental debt; and to guide officials in the process of writing off any irrecoverable debt.

8.2. Legislative Framework

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

ii. Treasury Regulations, March 2005

iii. National Treasury Departmental Guide Managing Departmental Debt ,2013

iv. Department of Health, Gauteng Administration Procedure Manual

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

vi. Road Accident Fund Act (Act No. 56 of 1996)
vii. Compensation for Occupational Injuries and Diseases Act, 1993 (Act No.130 of 1993
viii. Medical Scheme Act no 131 of 1998
ix. National Health Act 61 of 2003
x. Constitution of the Republic of South Africa,1996
xi. Promotion of Access to Information Act No. 2 of 2000.
xii. Uniform Patient Fee Schedule (UPFS) and User guide
xiii. Hospital Ordinance 14 of 1958.
xiv. Immigration Amendment Act (Act 13 of 2011)
xv. Refugees Amendment Act (Act 33 of 2008)
xvi. Mental Health Care Act (Act 17 of 2002)
xvii. The Magistrates Courts Act, 1944 (Act 32 OF 1944)
xviii. Protection of Personal Information (POPI) Bill 09 of 2009 –
xix. Promotion of Access to Information Act (PAIA) Act 2 of 2000
xx. Consumer Protection Act 68 of 2008
xxi. Child Protection Act 38 of 2005 (amended 2007)
xxii. Pharmacy Act 53 of 1974 (amended 1 of 2000)
xxiii. Nursing Act 33 of 2005
xxiv. Health Professions Act 5 of 1974 (amended 29 of 2007)
xxv. Case Management Standards of Practice (CMASA 2011)
xxvi. Quality in Health care for South Africa 2007
xxvii. National ICD-10 coding standards circular no.3 of 2012
xxviii. National Core Standards for Health Establishments in South Africa (NDoH 2011)

9. ANALYSIS OF POLICY ISSUES

9.1. Description of current services levels and policy issues

Currently, there is lack of uniformity and non-compliance with the prescribed revenue management processes at the public health institutions in Gauteng. The processes that are not currently adhered to are: incorrect Patient Classification, timeous billing, debt management processes not followed, reconciliations not performed and claims rejections. The policy guidelines will therefore streamline revenue management processes in the Department.

9.2. How will this guideline address the policy gaps and issues

This policy guideline will provide standardisation in executing revenue processes as per departmental prescripts through clarification of roles and responsibilities of officials, simplifying the procedures for patient classification and billing.

10. GUILDELINES IMPLEMENTATION PLAN AND STRATEGY

10.1. Identify outputs, performance measures and timelines

Revenue Reports to be submitted in accordance to the reporting requirements in terms of section 32 of the Public Finance Management Act, 1999 and Treasury Regulations Part 4, 7.2.1. The Finance Reviews and Revenue Forums are held quarterly to measure performance of institutions. The circular indicating the timeline for reporting is issued annually.

Output	Performance Managers	Timelines
Patient Classification	Correct classification and maximisation of revenue collection	31 March each financial year
Timeous Billing	Minimise late submission and Improve revenue	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 reconciliations	31 March each financial year

10.2. Roles and responsibilities for implementation of the guidelines.

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: -

10.2.1. Role of the CEO

i. Ensure that all patients are correctly classified and billed timeously.
ii. Ensure that monthly reconciliations are performed.
iii. Ensure that Debt management processes are followed.
iv. Ensure that there is proper cash management system and process.
v. Ensure compliance with financial prescripts.

10.2.2. Roles of Patient Administration, Case Management and Revenue Management Officials

i. Ensure 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.

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

iii. Use the patient verification system to verify patient information on admission.

iv. Ensure the GPF 4 & 5 forms are fully completed and verified by the supervisor.

v. Ensure signatures of both the patient and Admitting officer are on the registration/admission form.

vi. Ensure confirmation of medical aid patients done during admission/ registration.

vii. Ensure Patient Administration, Case Management, Revenue Management Supervisor and Manager verify patient's classification regularly for accuracy.

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

ix. Ensure Patient Administration, Case Manager and Revenue officials shall record all revenue due from the sale of goods and rendering of services.

x. Ensure Segregation of duties between:

a. Patient administration official for registering and admission of patients.

b. Revenue Management official (Sub-Cashier) for collection and recording of cash.

c. Revenue Management Official (Main Cashier) for recording, collection and cash deposits.

d. The Revenue Management supervisor for reconciliations of cash collected and deposited;

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

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

xiii. Ensure the identification and allocation of all receipts.

xiv. Ensure the implementation of effective debt management processes –

xv. Ensure the collection of all money due to the institution.

xvi. Ensure there are internal verification processes for recording cash receipts.

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

xviii. Ensure reconciliations of BAS/ Persal / Accommodation and Parking are carried out ***and***

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

10.3. Financial and Human Resource and Service implications of the Policy Guidelines

The Health Information System is required. Computers and Printers will be required at institutions. Additional capacity will be required for patient administration, case management, billing and tracing units.

10.4. Training Plan after Policy Guideline approval

Training on the policy shall commence within three months after the approval of the policy guidelines in consultation with the **Chief Directorate: HRD&EWP,** to ensure efficient and consistent application of the policy guidelines throughout the Department. Training shall be provided by the Revenue Management officials at Central Office. Training shall be provided in the following regions:

TYPE OF TRAINING	REGION	TIMELINE
Cash and Debt Management	Tshwane Region Johannesburg Region West rand/ Ekurhuleni Region	Every Quarter
Patient Administration	Tshwane Region Johannesburg Region West rand/ Ekurhuleni Region	Every Quarter

11. MONITORING OF POLICY GUIDELINES IMPLEMENTATION

11.1. Who is responsible for the monitoring this policy guidelines?

The Patient Administration, Case Management, and Revenue Management officials at the institutions shall be responsible for the monitoring of this policy guidelines.

11.2. How will this policy guidelines implemented be monitored?

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 by the Revenue Management Officials at Central Office, Revenue Management monthly checklist and submission of monthly reports.

11.3. What are the steps to be taken to ensure compliance to guidelines?

Non- compliance letters shall be issued to institutions that are not adhering to the guidelines. Monthly Revenue oversight meetings shall be held with institutions. Newly appointed officials shall be trained on the guidelines.

12. PATIENT CLASSIFICATION

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

Every patient shall be classified according to his or her income status and placed in an appropriate classification and tariff category. If the income of a patient cannot be determined, such a patient shall be provisionally classified (see section 12.7. of this document).

The classification of a dependent shall be determined by the classification of the person upon whom he or she is dependent, except in the case of an exempted patient where a dependent shall also be exempted.

Every patient shall on registration be informed verbally or in writing of his/her classification category and fees payable.

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.

12.1. Explanation of Classification Categories

i. Full Paying Patients

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

ii. **Subsidized patients**

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. Subsidized patients are categorized based on their ability to pay for health services according to the three categories, namely: H1, H2 and H3. These patients are classified according to a means test and they also include Refugees with valid documents.

iii. **.Free Patients (H0)**

Patients in this category receive all services free of charge and are known as H zero (H0). This category comprises of recipients of social pension or grants and the formally unemployed. 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 unemployment insurance in order to be classified as H0. If found to be on Medical Aid, the patient will forfeit the H0 status and therefore liable to pay for services rendered to him or her by a health facility.

iv **Exempted Patients (HG)**

In terms of section 4 of the National Health Act no.61 of 2003, The Minister of Health, after consultation with the Minister of Finance and; section 41(1) relevant Member of Executive Councils, may prescribe conditions subject to which categories of persons are eligible for free health services at public health establishments.

The following are exempted categories:

a. Pregnant and lactating women.
b. Children below the age of six years.
c. See detailed list on the Table in this document.

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.

12.2. Documents required for Patient Registration and Classification

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)
vi. Documentation from other Organs of State

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

i. All patients who have no proof of income shall fill the Declaration of Income form GPF4 (Annexure B).
ii. The form shall assist the Admitting Officer to determine the classification category the patient should be put in.
iii. The Admitting Officer shall add all values and determine the classification according to the means test.

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

i. All patients shall be registered on the GPF 3 form or Health Information Systems (HIS) before any consultation or admission at a hospital.
ii. The GPF 3 form shall be completed by the patient or the Admitting Officer and/or
iii. In cases of a computerized system, only the Admitting Officer shall complete the form.
iv. The GPF 3 form shall only be used when the computerized registration/admissions system is offline.

v. Information required on the Registration, Admission Form or Billing system shall be furnished by patients during consultation and/or admission.

vi. It is the responsibility of the Admitting Officer to ensure that information on the GPF 3 or HIS is completely captured.

vii. 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.

viii. 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 the patients shall be giving consent that the health institution may use his/her medical information for billing purposes.

ix. 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.

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

12.5. OUT PATIENTS

i. 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.

ii. After twelve (12) months, an outpatient shall re-submit his/ her supporting documents and be reassessed

iii. 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 re-classification shall remain for 12 months. The reassessment of patients applies to patients who receive free and subsidized services.

iv. 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 current visit at a hospital.

12.6. IN- PATIENT

12.6.1 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.

12.6.2 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.

12.7. PROVISIONAL CLASSIFICATION OF PATIENTS

12.7.1. In the 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. 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 (a) and (b) above **when admitted** shall be classified provisionally as H3.

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.

v If the required information is not furnished; the provisional classification shall remain and the patient shall be liable for the cost incurred.

12.7.2. In the 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 are 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 that declared that they are unemployed on the GPF4 during the OPD visit, shall retain the OPD classification on admission

12.7.3. All Provisional Classified patients shall be informed of their Provisional classification and the costs that will be incurred.

12.8. ERRONEOUS CLASSIFICATION OF PATIENTS

12.8.1. An erroneous classification arises when a patient is incorrectly

i. 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 the policy or for any other acceptable reason.

12.8.2. 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.

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 is a correction of a wrong classification.

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 claim 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 PHCOI 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.

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

12.9. RECLASSIFICATION OF PATIENTS

12.9.1. 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.

12.9.2. 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

12.9.3. If a request for a reclassification is based on the grounds of financial burden:

a) 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.

b) The CEO or his or her delegate shall verify the anticipated costs indicated in the application form.

12.9.4. 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.

12.9.5. 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.

12.9.6. 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.

12.9.7. 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.

12.9.8. A request for reclassification must be made in the application form (TPH13)

12.9.9. 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.

13. CASE MANAGEMENT PROCESS

13.1. The Assistant Director, Case Management, at the institutional level shall ensure the following standards are applied and adhered to in Central, Tertiary, Regional and District hospitals:

i. 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.
ii. Plan with both the patient, family, doctor and the funder in order to maximize the health care outcome
iii. Facilitate communication and coordination between members of the healthcare team and the patient in decision making process
iv. Identify and select customers who can benefit the most from case management services in a hospital setting
v. Support the clinicians and other members of the health care team in the planning of caregiving
vi. Educate the patient, family/caregiver and members of the health care team about treatment options, insurance benefits so that timely and informed decision can be made regarding the correct course of action to take
vii. Empower the patient to make proper decisions in order to maximise desired outcomes
viii. Encourage the appropriate use of health care services and maintain cost effectiveness on each case handled
ix. Advocate for the needs of the patient, hospital and the funder in order to promote positive cost effective outcomes
x. Ensure identification and reporting of suspected abuse, neglect or any mistreatment of patients
xi. Provide specialized skills such as positive relationship building, effective verbal and written communication, critical analysis, ability to plan and organise effectively.
xii. Provide knowledge such as funding sources, health care services, human behaviour, health care delivery system, clinical standards in order to execute case management.
xiii. Promote smooth transition of care when the patient is discharged from one setting to the other.
xiv. Provide monthly reports to Head Office on 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 work flow processes for the hospital.

13.2. CASE MANAGEMENT CRITERIA

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. Road Accident Fund Cases
v. Other Externally Funded cases like SAPS, COID, Correctional Services, DOJ, etc.

13.3. RESPONSIBILITIES OF A CASE MANAGER IN PATIENT ADMINISTRATION/WARDS AND SERVICE POINTS.

13.3.1. Supervision and support of the Medical Schemes Confirmations Unit by ensuring that all patients classified as P (M) are confirmed and validated by the Administration Clerk responsible.
13.3.2. Assessment and screening of patients requiring case management services.
13.3.3. Management of first reports on injury on duty cases.
13.3.4. Provide support to coders on ICD 10 coding.
13.3.5. Conduct random file audits to ensure the correct patient classification is performed.
13.3.6. Provide treatment quotations where required.
13.3.7. Promote data integrity.
13.3.8. Ensure confidentiality and security of patients' information
13.3.9. Contact Medical Schemes and Funders for authorization purposes
    i. Provide the primary and secondary ICD 10 codes to medical schemes.
    ii. Determine health benefits and benefit options.
    iii. Determine available benefit costs for services allocated to the patient.
    iv. Identify Prescribed Minimum Benefits (PMB), update patient file accordingly and manage the process with funders.
13.3.10. Provide clinical updates to funders.

13.3.11. Conduct ward rounds to ensure compliance to length of stay where authorization was granted.

13.3.12. Identify financial and clinical risks and discuss with the relevant members of the health care team.

13.3.13. Train health care professionals on usage of charge sheet and identification of billable services

13.3.14. Ensure work flow processes are in place for theatre and ICU Units for the identification of all high cost consumables used i.e. Prosthetic items, implants etc.

13.3.15. Conduct random file audits to ensure that all the patients' particulars are updated by Ward Clerks and report findings to the relevant officials

13.3.16. 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.

13.3.17. 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.

13.4. RESPONSIBILITIES OF THE CASE MANAGER IN BILLING DEPARTMENTS

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

13.4.2. Ensure compliance to ICD 10 coding and completeness on all finalized invoices.

13.4.3. Provide support on ICD 10 and procedure coding.

13.5. TRAINING

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

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

13.6. ROLE OF THE CASE MANAGER IN THE DISCHARGE PLANNING PROCESS

13.6.1. Ensure patients advocacy, care coordination and health education to patients and family

13.6.2. Assist with the coordination of discharge process i.e. step down facility, home care nursing with other members of health care team

13.6.3. Encourage patient's compliance to treatment

13.6.4. Promote smooth transition of care during patient discharge or transfers to other settings i.e. step-down facilities

13.6.5. Ensure correct record keeping

14. REVENUE MANAGEMENT PROCESS FLOW

14.1. CASH MANAGEMENT

14.1.1. CASHIERS

i. 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 Manager. (See attached Administrative Procedure Manual (APM) Appendix "F").
ii. Main Cashiers and Sub Cashiers shall sign a "confidentiality clause" for the non- disclosure of patient information.
iii. Main Cashiers and Sub Cashiers shall report to Revenue Finance Manager.

14.1.2. Segregation of Duties

i. Sub Cashiers and Main Cashiers shall not register patients
ii. Only Cashiers should collect cash from patients

14.2. HANDLING OF CASH COLLECTION AND CREDIT VISITS ON THE SYSTEM

14.2.1. PROCESSES TO BE FOLLOWED WHEN ISSUING RECEIPTS BY SUB CASHIERS.

14.2.1.1. Issuing of receipts for patients paying cash before treatment

i. The registration of a patient visit shall be done on the patient administration system.
ii. A visit invoice shall be printed out and be handed over to the patient.
iii. A patient shall be informed to make a payment to a Sub-Cashier

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

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

vi. Patients that are unable to settle the invoices immediately shall be handled as follows:

- The patient shall be directed to the Sub-cashier who shall make the patient sign a credit agreement.
- On subsequent visits, the patient shall be referred to the Credit Control Section for payment arrangement.

14.2.1.2. Issuing of receipts to patients paying an account / outstanding visit.

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

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

iii. The Sub Cashiers shall collect cash for patient fees after hours from 16:00 pm until 07:00 am the next day. Any revenue collected other than patient fees, shall be recorded using a TAS Receipt book. i.e. fines, telephone accounts, etc.

14.2.1.3. Sub Cashiers Day End Processes.

i. A shift shall be closed by the Supervisor.

Ii. A day end cash collection report shall be printed by the supervisor.

iii. A day end cash collection report shall be reconciled against cash collected. This process shall be done in the presence of three officials, namely: the Sub Cashier, Supervisor and a witness).

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

v. A day end cash collection report, Cash Control Form and cash collected for the day shall be handed over to the Main Cashier by ???accompanied by a Security Officer or an escort (preferably a Security Officer).

14.3. PROCESSES TO BE FOLLOWED WHEN ISSUING RECEIPTS BY MAIN CASHIER

14.3.1. Issuing of receipts for cash handed over by Sub Cashiers.

i. The Main Cashier shall print the "Day End Consolidated Summary Report" of cash collected by the Sub Cashiers.

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

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

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

14.3.2. Issuing of receipts for cash collected from Other Revenue Sources

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

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

14.3.3. Issuing of receipts for cash against an outstanding account

i. The correct debtor account shall be recalled on the system.
ii. A receipt shall be issued in duplicate against the debtor account.
iii. One receipt shall be given to the payee and the other receipt filed

14.3.4. Daily banking of all monies collected

i. The Supervisor shall print a summary report of all cash collected by the Main Cashier.
ii. The total daily collection shall be reconciled with a summary report to ensure that the money correlates.
iii. A deposit slip shall be printed from the SAP E-Receipting System.
iv. The money shall be placed in a sealed bag together with the deposit slip .
v. The bag shall be handed over to the cash collection company.
vi. The Main cashier shall ensure that the cash collection company acknowledges receipt of the money by issuing a cash collection slip which shall be signed by both parties.
vii. A copy of the collection slip shall be attached to the deposit slip.
viii. Cash collection slips fade after some time; copies must be made to avoid fading.
ix. A stamped deposit slip shall be returned by the cash collecting company within three working days and filed by the Main Cashier.
x. All transactions shall be recorded on the TPH 45A (Revenue Register) and balanced at the end of the month.
xi SAP E-Receipting System Summary Reports shall be pasted on the TPH 45A.

14.4. HANDLING OF CASH COLLECTION & CREDIT VISITS MANUALLY

14.4.1. PROCESSES TO BE FOLLOWED WHEN ISSUING RECEIPTS BY SUB CASHIERS.

14.4.1.1. Issuing of a receipt to a patient paying cash before treatment

i. The registration of a patient visit shall be done on the visit register (TPH 31).
ii. A patient shall be informed to make a payment to a Sub Cashier.
iii. The Sub Cashier shall issue a TPH 208 receipt in duplicate against the visit
iv. The original must be given to a patient.
v. A stub must be attached to the patient file.
vi. Copy remains in the book.
vii. TPH 208 book copy must be handed over to the Main Cashier at the close of every shift.
viii. Patients that are unable to settle the visits immediately must be handled as follows:

a. TPH 201 account must be issued and be handed to a patient by the Sub Cashier.
b. Patient must sign the manual credit agreement.

14.4.1.2. Issuing of a receipts for patients paying an account/outstanding visit.

i. The Sub Cashier must issue a TPH 208 receipt in duplicate against the outstanding visit.
ii. 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.
iii. TPH 208 book shall be handed over to the Main Cashier at the close of every shift.

14.4.1.3. Sub Cashiers Day End Processes.

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

ii. 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

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

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

14.5. PROCESSES TO BE FOLLOWED WHEN ISSUING RECEIPTS BY THE MAIN CASHIER

14.5.1. Issuing of receipts for cash handed over by the Sub Cashiers

i. 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.

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

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

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

v. One copy shall remain in the TPH208 book.

14.5.2. 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:

i. The original shall be given to a payee.
ii. One copy shall be sent to the Gauteng Department of Health, Directorate: Revenue Management for updating on BAS.
iii. One copy shall remain in the TPH208 book

v. A photo copy of the Z1512 receipt shall be made to the service point.

14.5.3. Daily banking of all monies collected.

i. The total daily collection shall be reconciled with the Z1512 Book to ensure that the money correlates.
ii. A deposit slip shall be completed.
iii. The money shall be placed in a bag together with the deposit slip and sealed.
iv. The bag shall be handed over to the cash collecting company.
v. The Main Cashier shall ensure that the cash collecting company acknowledges receipt of the money by issuing a cash collection slip which shall be signed by both parties.
vi. The Main Cashier shall ensure that the cash collecting company acknowledges the collection in writing.
vii. A stamped deposit slip shall be returned the following day and filed by the Main Cashier.
viii. All transactions shall be recorded on the TPH 45A (Revenue Register) and balanced at the end of the month.

14.5.4. Updating of the System subsequent to it being on line:

i. 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.

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

14.6. BILLING OF PATIENT ACCOUNTS H1, H2, H3, PRIVATE & EXTERNALLY FUNDED PATIENTS

i. Accounts Officers shall obtain a discharge list on a daily basis from the Health Information System;

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

iii. Patient administration shall ensure that the correct referral documents are enclosed in the patient file e.g. SAP70 for SAPS, G111 for DCS and a referral letter.

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

v Revenue management shall ensure that the under charges are provided on Invoice.

vi Revenue management shall ensure that the Buy Outs/Consumables are included in the Invoice.

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

viii The debtors shall be billed upon discharge and the bill shall immediately be sent to the Debtor by post.

ix. A claim submission spreadsheet shall be prepared for all accounts sent to the relevant Funders and the following information shall be listed:

a. Service date.

b. Patient name.

c. Amount.

d. Bill number.

e. Reference number.

x. Invoices shall immediately be sent to the relevant funder/self paying patient.

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

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

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

14.7. BAS PAYMENTS ALLOCATION

14.7.1. Allocation of receipts by Revenue Management officials

a. Electronic Funds Transfers

i. Request a BAS Patient Fee Accounts Charged report on a weekly basis.

ii. They shall ensure that remittances are obtained on time to be matched with the BAS report.

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

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

v. Any excess of payments shall be recorded on the billing system.

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

vii. Remittances may be obtained online via the medical schemes websites.

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

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

a. Direct Deposit and Internet transfers

i. Request a BAS Patient Fee Accounts Charged report on a weekly .basis

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

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

iv. 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.

v. Any excess of payments shall be recorded on the billing system.

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

14.8. DEBTOR'S REFUNDS

The revenue management officials are responsible for the processing of refunds

14.8.1. Same day Refunds before Banking

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

ii. The debtor shall present the receipt as proof of payment.

iii. The supervisor shall authorise the refund.

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

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

vi. The cash refund shall be done from the daily collection.

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

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

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

ii. The debtor shall present the receipt as proof of payment.

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

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

v. The supervisor shall authorize the refund.

vi. In cases where a service was billed but not rendered and payment was not received, the following shall take place

a. The Visit Invoice shall be cancelled if it is within the accounting month.

b. Credit Adjustment (Reversal of Visit) if it is after the accounting month.

c. A debit note shall be processed on the Billing system to clear the credit (if necessary).

d. The cash refund shall be done from the petty cash by completing the petty cash voucher.

vii. Ensure that the allocations of the petty cash vouchers matches the allocations of the payment on BAS

viii. The debtor shall acknowledge the receipt of the cash refund by signing

ix the Refund Form and the patient shall present an identity document.

14.8.3. Refunds after Banking (amounts greater than R 2000)

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

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

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

iv. The supervisor shall authorize the refund.

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

a. The Visit Invoice shall be cancelled if it is within the accounting month.

b. Credit Adjustment (Reversal of Visit) if it is after the accounting month.

c. debit note shall be processed on the Billing system to clear the credit (if necessary).

d. The debtor shall complete the BAS Entity Maintenance Form .for BAS registration

e. A Payment Advice Form shall be completed as a request to have the money refunded directly to the debtor's account.

f. Ensure that the allocations on the Payment Advice Form match the allocations of the receipts on BAS

vi. The following supporting document must at all times be attached:

a. Debtor's account statement.
b. BAS Report where the credit appears.
c. Permission to withdraw from the Provincial Revenue Account Form.
d. A refund register shall be used to record all refunds made to patients

14.8.4 Patients Fees deposits

14.8.4.1. Deposits for patients without Patient Numbers

i. A quotation shall be issued to the patient/funder.
ii. The patient/funder shall be informed to quote the Hospital's Practice Number as reference when making the deposit.
iii. The patient shall provide the institution with proof of payment.
iv. The institution shall send a copy of proof of payment to the Gauteng Treasury and/or the Revenue Management Directorate at the Central Office.
v. The funds shall be allocated to Patient Fees: Accounts Charged.
vi. The transaction shall be reported as a reconciling item on the Reconciliations since it can only be cleared from the Patient Account post treatment.
vii. The Patient Account must immediately be cleared once the Bill has been raised.

14.8.4.2 Deposits for patients with Patient Numbers

i. A quotation shall be issued to the patient/funder.
ii. The patient/funder shall be informed to quote the Hospital's Practice Number & Patient Number as a reference when making a deposit.

iii. The patient shall provide the institution with proof of payment.

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

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

vi. The transaction shall be allocated to the Patient Account on the Billing System regardless of the Bill not being raised.

vii. The Patient Account shall immediately be cleared once the Bill has been raised.

14.8.4.3. Adjustments

i. The Annexure "G" shall be compiled indicating the reasons for any adjustments. (See attached APM PART III PAR 3.9.1 ANNEXURE G)

ii. The Annexure "G" shall be approved by the Supervisor.

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

iv. The new bill for the correct amount shall be raised.

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

vi. Adjustments shall be done under the following circumstances:

a. Erroneous classifications. incorrect levies e.g.: Incorrect procedure/medication billed.

b. Annexure "G", incorrect and new correct bill must be kept in the financial file of the debtor.

14.9. FACE VALUE BOOKS

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

i. Manual billing template

ii. TPH 201

iii. TPH 208

iv. Z1512

14.9.1. Manual billing template

i. Manual billing template shall be used at hospitals whenever the HIS is not operative.

ii. Manual billing template shall be rendered after treatment of a patient who is classified as H1.

iii. Manual billing template shall be rendered after treatment of a patient who is classified as H2.

iv. Manual billing template shall be rendered after treatment patient and out-patient who is classified as P and PH.

14.9.2. TPH 201 Account

i. TPH 201 account shall be used at hospitals where the admission section is not computerized or the system is off line.

ii. TPH 201 account shall be rendered to an in- patient who has not paid an applicable fee before or at the commencement of treatment and is classified as H1.

iii. TPH 201 account shall be rendered to an out- patient who has not paid an applicable fee before or at commencement of treatment and is classified as H1 and H2 excluding P and PH.

14.9.3. TPH 208 Receipt

i. TPH 208 receipt shall be used at hospitals where the admission section is not computerized or the system is off line.

14.9.4. Z1512 Receipt

i. Z1512 receipt shall be used at hospitals/institutions by the Main Cashier where the office /section is not computerized or the system is off line.

14.10. CONTROL OF FACE VALUE BOOKS

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

i. The face value books issued to Counter Clerks or authorized persons shall be locked in a safe when not in use.
ii. 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.
iii. All books shall be recorded in a sequence manner prior to distribution and after use.
iv. The Supervisor shall make an official sign for the book before it is issued.
v. The Supervisor shall check that all pages used are accounted for and correctly issued in a sequence when books are returned to him/her.

14.11. REVENUE RECONCILIATIONS

14.11.1 WHY IS RECONCILIATION IMPORTANT?

i. 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 a particular accounting period.

ii. 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.

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

a. Incorrect allocations.
b. Unallocated transactions on either one of the two systems.
c. Cheques that have been declared unpaid by the bank.
d. Refunds that have not been implemented on the other systems.
e. Incorrect debits on transactions that have been previously credited.

14.11.2 TYPES OF RECONCILIATIONS TO BE PERFORMED MONTHLY

i. Reconciliation on cash collected at the institutions amongst bank account, SAP E-RECEIPTING and BAS.
ii. Reconciliation on patient fees between BAS and the Patient Billing System.
iii. Reconciliation for Parking between the Persal System and BAS.
iv. Reconciliation for Staff Accommodation between the Persal system and BAS.
v. Reconciliation for rentals received from Vendors.

14.12. MONTHLY REVENUE REPORT (IN YEAR MONITORING REPORT)

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

The Head of the institution must, each year before the beginning of a 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.

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.

14.13. DEBT MANAGEMENT

14.13.1. CATEGORIES OF PATIENT DEBTORS

i. **Self-Funded**
   a. Individuals owing below R500 (H1, H2, H3 & Private.)
   b. Individuals owing above R500 (H1, H2, H3 & Private).

ii. **Externally Funded**

a. Government Departments such as Department of Correctional Services (DCS), South African Police Services (SAPS), and Department of Justice (DOJ) 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 Medical Schemes such as Discovery, Government Employees Medical Scheme (GEMS) etc.

14.13.2. REFERRAL OF DEBT TO THE COLLECTING AGENCIES APPOINTED BY THE DEPARTMENT

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, 1993.
iii. Self-paying patient's debt collection.
iv. Patient identification, verification and tracing system.
v. Medical aid claims submission via Electronic Data Interchange.

14.13.3. FOLLOW UP ON OUTSTANDING DEBTS (APM PART III PAR. 3.0)

14.13.3.1. Self-Funded

i. **Individuals owing below R500 (H1, H2, H3 & Private). (APM PART III PAR. 3.1.1- 3.1.2.3)**

a. No telephone calls or written communication 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.

ii **Individuals owing above R500 (H1, H2, H3 & Private) (APM PART III PAR. 3.1.3-3.1.2.3)**

a. The account shall be sent to the debtor, thirty days after the patient has been discharged.
b. 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.
c. If necessary, a final reminder shall be sent a month later.
d. In addition to the above-mentioned steps, telephone calls shall be made to remind the debtor.
e. 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:

iii **Debtor Insolvent or Died**

a. Establish the name of 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 in this regard. 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.

iv **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 Patient Information Verification System

c. 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.

d. Officials shall at all times 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 ID number.

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