DEPARTMENT OF LABOUR

NOTICE 354 OF 2019

NOTICE TO COMPENSATION FUND MEDICAL SERVICE PROVIDERS

COMPULSORY INVOICING REQUIREMENT IN MEDICAL CLAIMS

The Compensation Fund is in the process of implementing the new claims management system. The system will go live on the 30th September 2019. This letter is to advise all medical service providers of upcoming changes that will be implemented on the system go live date. In the past and currently the Fund's systems have been accepting invoices as well as running accounts on medical claims. This has resulted in submission of duplicate invoices that clog the systems resulting in delays regarding timeous finalising of medical invoices.

With the implementation of the new claims management system and in an effort to improve service delivery the Compensation Fund will no longer be accepting running accounts or statement of accounts from 1 October 2019. The Fund will only accept medical invoices and statements of accounts that are resubmitted will not be accepted but will be rejected as duplicate invoices.

All medical service Providers are requested to note the requirement and compliance to the unique invoice number for each and every medical invoice that is submitted to facilitate the process of submission and processing of all medical invoices within specified time frames. Please note that running accounts/statements will not be received by the Compensation Fund systems but will be rejected upfront at the switch as duplicates. The Fund will not be liable for medical invoices that have been rejected for non compliance. The new SAP system will have a functionality to accept and process genuine short paid medical invoices.

As part of improved service delivery and efficiency the Compensation Fund will be implementing ICD-10 and tariff coding rules that need to be adhered to when submitting medical invoices. This will be implemented in a phased approach. For implementation on 30 September 2019, the following will apply:

a) ICD-10

ICD-10 validations will apply as per the national ICD-10 phase 3 and phase 4.1 requirements as per attachment. Note that these phases were implemented on 01 July 2014 and entail the following:

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- Valid and ICD-10 codes as the SA ICD-10 Master Industry Table
- Maximum level of specificity: ICD-10 codes to be valid at the correct 3rd, 4th or 5th character level.
- Valid ICD-10 primary codes, codes not valid as primary will be rejected
- Comply with the dagger and asterisk rule
- Comply with the sequelae coding rules
- Age edits for ICD-10 codes that have age requirements
- Gender edits
- All injury and poisoning codes must be accompanied by external cause codes

b) Tariff Codes and Modifiers

- Valid tariff codes and modifiers
- Discipline type indicators where relevant
- Valid primary codes
- Codes not allowed
- Tariff and modifier age edits
- Tariff and modifier gender edits
- Modifiers allowed per tariff code
- Utilisation rules such as maximum number of items that can be billed per day, per patient, per treatment, per annum, etc.

Please ensure that you are familiar with the above to avoid unnecessary claim rejections. The date and the requirements for the next phase will be communicated in due course.

COMPENSATION FUND MEDICAL SERVICE PROVIDERS REGISTRATION REQUIREMENTS

Medical service providers treating COIDA patients in terms of Section 73 & 74 of COIDA must comply with the following requirements before submitting medical Reports and invoices to the Compensation Fund:

- Medical Service Providers must register with the Compensation Fund as a Medical Service Provider.
- Submit Proof of registration with the Board of Healthcare Funders of South Africa.
- Submit an applicable dispensing licence on registration as a medical service provider.
- Submit SARS Vat registration number document on registration.
- A certified copy of the MSP's Identity document not older than three months.
- Proof of address not older than three months.
- Submit the following additional information on the Medical Service Provider letterhead, Cell phone number, Business contact number, Postal address, Email address. The Fund must be notified in writing of any changes in order to effect necessary changes on the systems.

All medical service providers will be subjected to the Compensation Fund vetting processes.

The Compensation Fund will withhold payments if medical invoices do not comply with minimum submission and billing requirements as published in the Government Gazette.

Extract from COIDA regarding sections 73 and 74 as mentioned above

Medical expenses

73. (1) The Director-General or the employer individually liable or mutual association concerned, as the case may be, shall for a period of not more than two years from the date of an accident or the commencement of a disease referred to in section 65(1) pay the reasonable cost incurred by or on behalf of an employee in respect of medical aid necessitated by such accident or disease.

(2) If, in the opinion of the Director-General, further medical aid in addition to that referred to in subsection (1) will reduce the disablement from which the employee is suffering, he may pay the cost incurred in respect of such further aid or direct the employer individually liable or the mutual association concerned, as the case may be, to pay it.

Submission of medical report

74. (1) A medical practitioner or chiropractor shall within 14 days after having for the first time examined an employee injured in an accident or within 14 days after having diagnosed an occupational disease in an employee, furnish a medical report to the employer concerned in the prescribed manner: Provided that where the employee was at the time of the diagnosis of an occupational disease not employed, the medical report shall be furnished in the prescribed manner to the commissioner.

(2) If the commissioner or the employer individually liable or mutual association concerned, as the case may be, requires further medical reports regarding an employee, the medical practitioner or chiropractor who has treated or is treating the employee shall upon request furnish the desired reports in the manner and at the time and intervals specified or prescribed.

(3) If a medical practitioner or chiropractor fails to furnish a medical report as required in subsection (1) or (2) or in the opinion of the commissioner or the employer individually liable or mutual association concerned, as the case may be, fails to complete it in a satisfactory manner, such party may defer the payment of the cost of the medical aid concerned until the report has been furnished or completed in a satisfactory manner,

and no action for the recovery of the said cost shall be instituted before the report has been so furnished or completed.

(4) No remuneration shall be payable to a medical practitioner or chiropractor for the completion and furnishing of a report referred to in subsection (1) or (2).

(5) A medical practitioner or chiropractor shall at the request of an employee or the dependant of an employee furnish such employee or dependant with a copy of the report referred to in subsection (1).