CMS Council for Medical Schemes

CMScript

Member of a medical scheme?
Know your guaranteed benefits!

Issue 6 of 2014

As a member of a medical scheme you would in recent years have noticed a range of codes shown on your doctor's accounts and also on the statements of your medical scheme. You may well find these codes confusing and may be wondering why they have become a fixture on your accounts. In this CMScript we hope to shed some light on the codes that have become such an integral part of the modern medical schemes environment.

The coding and funding of medical scheme claims

Regulations to the Medical Schemes Act 131 of 1998

Regulation 5 of the Medical Schemes Act 131 of 1998 is focused on accounts that are submitted to medical schemes by suppliers of services. In terms of these regulations accounts must contain very specific information. This information is listed as:

The account or statement as outlined in section 59 (1) of the Act must contain the following:

a) *the surname and initials of the member;*
b) *the surname, first name and other initials, if any, of the patient;*
c) *the name of the medical scheme concerned;*
d) *the membership number of the member;*
e) *the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;*
f) the relevant diagnostic and such other item code numbers that relate to such relevant health service*; (emphasis added)*
g) *the date on which each relevant health service was rendered;*
h) *the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine;*
i) *where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;*
j) *where mention is made in such account or statement of the use of a theatre—*
    i. *the name and relevant practice number and provider number contemplated in paragraph (e) of the medical practitioner or dentist who performed the operation;*
    ii. *the name or names and the relevant practice number and provider number contemplated in paragraph (e) of every medical practitioner or dentist who assisted in the performance of the operation; and*
    iii. *all procedures carried out together with the relevant item code number contemplated in paragraph (f); and*
k) *in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating—*
    i. *the expected total amount in respect of the treatment;*
    ii. *the expected duration of the treatment;*
    iii. *the initial amount payable; and the monthly amount payable*

As per Regulation 5 (f), all accounts that are sent to a medical scheme must contain the diagnostic code and item or procedure codes for the services provided.

2

Diagnostic Coding

What is the diagnostic code?

ICD-10 codes are an example of the types of codes that appear on healthcare provider accounts. The codes are used to inform medical schemes about the conditions their members were treated for so that claims can be settled correctly.

ICD-10 stands for International Classification of Diseases and Related Health Problems (10th revision). It is a coding system developed by the World Health Organization (WHO) that translates the written description of medical and health information into standard codes, e.g. J03.9 is the ICD-10 code for acute tonsillitis (unspecified) while G40.9 is the ICD-10 code for epilepsy (unspecified).

The purpose of ICD-10 coding is to convert diagnoses of diseases and other health-related problems from descriptions into a code.

Why do we use ICD-10 codes?

The use of ICD-10 codes ensures that health information is stored and communicated in a predictable, consistent and reproducible manner. It furthermore enables medical schemes and other healthcare entities to store, retrieve and analyse information. Using codes instead of words to describe the diagnosis also provides a level of protection in terms of the disclosure of personal health-related information. As part of the protection of your health information, the description of the diagnosis may not be indicated on the account/claim.

When joining a medical scheme you will choose and pay for the particular benefit option that best suits your personal requirements. This benefit option offers a basket of services that often has limits when it comes to the payment of certain healthcare services.

Because ICD-10 codes provide accurate information on the condition you have been diagnosed with, the use of ICD-10 codes assists medical schemes in determining what benefits you are entitled to and how these benefits can be paid.

This becomes particularly important if you have a prescribed minimum benefit (PMB) condition, as these can only be identified with the use of the correct ICD-10 codes. If for example, the incorrect ICD-10 codes are provided, your PMB-related services might be paid from the wrong benefit such as from your medical savings account. Should your day-to-day hospital benefit limits be exhausted your care may not be funded.

Procedure/Item Coding

What is a procedure/item code?

A procedure/item code is used to notify medical schemes exactly what service was provided to a medical scheme member so that claims can be settled timeously and correctly. The purpose of a procedure or item code is specifically to convert descriptions of services into a code format. Each individual health discipline such as medical practitioners (doctors), dentists, physiotherapists etc. has its own unique set of codes which describes the specific services.

For example, should you visit your general practitioner, the consultation will be shown using code 0190. This means that you are a new/established patient of the doctor and that you had a consultation of average duration and/or complexity.

Which procedure/item codes are used in South Africa?

Unlike the diagnostic coding system, there is no national standard for procedure/item codes in South Africa. At the moment three different coding systems are in existence.

The coding system used in the public (state) sector is known as the Uniform Patient Fee Schedule (UPFS).

The coding systems that are used in the private sector are:

- Reference Price List (RPL) – these codes are used by all healthcare providers
- Complete Current Procedural Terminology (CPT®) for South Africa (CCSA) – these codes are mostly used by hospitals

Why do we use procedure/item codes?

As with diagnostic coding, the use of the procedure/item codes ensures that health information is stored and communicated in a predictable, consistent and reproducible manner. It enables medical schemes and other healthcare entities to store, retrieve and analyse information.

You may also have received a list of services that are typically rendered by your medical scheme. This specifically provides you with a range of services that you are entitled to for each specific condition. These lists or baskets of care usually outline the discipline or provider type that is able to render the service alongside the procedure/item code for the service and the number of payable services. To make it easier for you as a member the scheme may also include the description of the procedure or item.

Example:

Discipline	Procedure/Item Description	Procedure/Item Code	Quantity that will be paid
General Practitioner	Consultation	0190/0191/0192	4
Pathology	LDL cholesterol	4026	2
Pathology	Cholesterol total	4027	2
Pathology	HDL cholesterol	4028	2
Pathology	Glucose: Quantitative	4057	2

Funding of accounts/claims

Medical schemes use the procedure/item codes to determine if the service that was provided is included in your specific benefits. The ICD-10 code assists in this process as the medical scheme uses this to determine if the condition or disease that you have is included in the specific scheme benefits.

We already indicated that PMB conditions are identified by the correct ICD-10 codes. It is therefore critical that the medical scheme receives the ICD-10 codes in order to determine if the account or claim must be paid and from which benefit the payment should be made. In South Africa medical schemes must reject an account or claim if there is no ICD-10 code on each line of the claim for all providers except hospitals who report the codes in the header level of the claim.

As a member of a medical scheme, it is your responsibility to check your account and make sure that the diagnostic codes and procedure and item codes are provided. In order to manage and protect your medical funds you should also ensure that the services that were charged by the healthcare provider were actually provided.

PMBs

Prescribed minimum benefits (PMBs) are defined by law. They are the minimum level of diagnosis,treatment, and care that your medical scheme must cover – and it must pay for your PMB condition/s from its risk pool and in full. There are medical interventions available over and above those prescribed for PMB conditions but your scheme may choose not to pay for them. A designated service provider (DSP) is a healthcare provider (e.g. doctor, pharmacist, hospital) that is your medical scheme's first choice when you need treatment or care for a PMB condition. You can use a non-DSP voluntarily or involuntarily but be aware that when you choose to use a non-DSP, you may have to pay a portion of the bill as a co-payment. PMBs include 270 serious health conditions, any emergency condition, and 25 chronic diseases; they can be found on our website by accessing the link provided (www.medicalschemes.com/medical_schemes_pmb/index.htm).

The Communications Unit would like to thank Ronelle Smit for assisting with this edition of CMScript.

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