Code of Conduct in respect of Prescribed Minimum Benefits (PMBs)

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Document	**:**	**PMB Code of Conduct**
Section	**:**	**2017 Version**
Manual	**:**	**CMS Office of the Strategist**

1. BACKGROUND

The Prescribed Minimum Benefits (PMBs) are a set of minimum benefits that must be provided to every beneficiary of a medical scheme on any benefit option as provided for in the Medical Schemes Act, No. 131 of 1998 as well as the Regulations to the Act. These benefits must be funded in full subject to Regulation 8(2).

In terms of Annexure A to the Regulation "the objective of specifying a set of Prescribed Minimum Benefits within these regulation is two-fold:

i) To avoid incidents where individuals lose their medial scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.
ii) To encourage improved efficiency in the allocation of Private and Public healthcare resources."

During 2009 to 2010 the Council for Medical Schemes (CMS), the Minister of Health and stakeholder representatives identified a need to embark on a collaborative process to find solutions to the problems associated with the provisions and funding of PMBs. Subsequently, a representative task team was established to draft the PMB Code of Conduct which was completed and published in June 2010. The task team consisted of members from the CMS and other organs of state; medical schemes and administrators; healthcare providers; as well as members of medical schemes and consumers.

The process of reviewing and updating the PMB Code of Conduct was commenced in March 2017 in line with the terms of reference of the new representative task team, attached hereto as "Annexure 1".

2. SCOPE AND PURPOSE OF THE CODE OF CONDUCT

2.1 Scope

The scope of the PMB Code of Conduct is limited to the current legislative framework and does not include the PMB Review process even though the inputs made in this forum may be considered by the PMB Review task team.

2.2 Purpose

The purpose of the Code of Conduct is to protect the interests of beneficiaries of medical schemes regarding their entitlements and access to PMBs, by ensuring that legislative requirements are practically achieved; as well as to protect the long-term sustainability of medical schemes. It further seeks to update and improve the 2010 version of the Code of Conduct.

3 DEFINITIONS AND ABBREVIATIONS

Definitions regarding the PMB Code of Conduct are taken out of the Medical Schemes Act and where no definitions are provided the provisions of the Interpretation Act applies.

3.1 **"CMS"** means the Council for Medical Schemes;

3.2 **"CoC"** means Code of Conduct

3.3 **"Designated Service Provider"** means a healthcare provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions (Regulation 7);

3.4 **"NDoH"** means the National Department of Health;

3.5 **"Emergency medical condition"** means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy (Regulation 7);

3.6 **"Health practitioner"** means any person, including a student, registered with the Health Professions Council in a profession registerable in terms of the Health Professions Act 56 of 1974;

3.7 **"HPA"** means the Health Professions Act, No. 56 of 1974;

3.8 **"MSA"** means the Medical Schemes Act, No. 131 of 1998;

3.9 **"Payment in full"** means payment of the amount on the provider or supplier's invoice (Kara v GEMS as confirmed in the Genesis v Joubert Supreme Court of Appeal judgment);

3.10 **"Prescribed"** means prescribed by regulation (section 1 of the MSA);

3.11 **"Prescribed minimum benefits'** means the benefits contemplated in section 29(1)(o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of -

(a) the Diagnosis and Treatment Pairs listed in Annexure A, subject to any limitations specified in Annexure A; and
(b) any emergency medical condition (Regulation 7);

3.12 **"Prescribed minimum benefit condition"** means a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition (Regulation 7);

3.13 **"Registrar"** means the Registrar of Medical Schemes appointed in terms of section 18 of the Medical Schemes Act, No. 131 of 1998.

3.14 **"Relevant health service"** means any healthcare treatment of any person by a person registered in terms of any law, which treatment has as its object -

(a) the physical or mental examination of that person;

(b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;

(c) the giving of advice in relation to any such defect, illness or deficiency;

(d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;

(e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or

(f) nursing or midwifery;

and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy (section 1 of the MSA);

3.15 **"Treating provider"** means any person registered in a profession by the Health Professions Council of South Africa as a **health practitioner** or a **medical practitioner"** (section 1 of the HPA)

3.16 "**Unprofessional conduct**" means improper or disgraceful or dishonourable our unworthy conduct or conduct which, when regard is had to the profession of a person who is registered in terms of the Health Professions Act, is improper or disgraceful or dishonourable or unworthy.

4 LEGAL FRAMEWORK

Relevant legislative provisions include but are not limited to:

4.1	Medical Schemes Act 138 of 2008	
a)	Section 29(1)(o)	The rules of a medical scheme shall provide for the scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed.
b)	Section 29(1)(p)	The rules of a medical scheme shall not place a limitation to the re-imbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient.
c)	Section 29A(1)	Waiting periods may only be imposed in respect of PMB conditions if the applicant was not a beneficiary of a medial scheme for a period of at least 90 days preceding the date of application.
d)	Regulation 8	(1) Subject to the provisions of this Regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions. (2) Subject to section 29(1)(p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that - (a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and (b) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider. (3) For the purposes of sub regulation (2)(b), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if -

		(a) the service was not available from the designated service provider or would not be provided without unreasonable delay; (b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or (c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence. (4) Subject to sub regulations (5) and (6) and to section 29(1)(p) of the Act, these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of healthcare provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies. (5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member. (6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a healthcare provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.
e)	Regulation 15	15D Standards for managed healthcare- (d) The scheme must ensure that qualified healthcare professionals administer the managed care programmes and oversee funding decisions, and that the appropriateness of such decisions are evaluated periodically by clinical peers. (e) Healthcare providers, any beneficiary of the relevant medical scheme or any member of the public must be provided, on demand, with a document setting out- i) A clear and comprehensive description of the managed healthcare programmes and procedures; ii) The procedures and timing limitations for appeal against utilisation review decisions; and

		iii) Any limitations on rights or entitlement of beneficiaries, including but not limited to restrictions on coverage if disease states, protocol requirements and formulary inclusions or exclusions. 15E(1)(c) When a medical scheme contracts with a participating healthcare provider such a provider may not be forbidden in any manner from informing patients of the care they require, inkling various treatment options, and whether in the healthcare provider's view, such care is consistent with medical necessity and medical appropriateness. 15H. Protocols. — If managed healthcare entails the use of a protocol — (a) such protocol must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; (b) the medical scheme and the managed healthcare organisation must provide such protocol to healthcare providers, beneficiaries and members of the public, upon request; and (c) provision must be made for appropriate exceptions where a protocol has been ineffective or causes or would cause harm to a beneficiary, without penalty to that beneficiary. 15I. Formularies — If managed healthcare entails the use of a formulary or restricted list of drugs — (a) such formulary or restricted list must be developed on the basis of evidence-based medicine, taking into account considerations of cost effectiveness and affordability; (b) the medical scheme and the managed healthcare organisation must provide such formulary or restricted list to healthcare providers, beneficiaries and members of the public, upon request; and; (c) provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary.
4.2.	National Health Act, No. 61 of 2003	
a)	Section 6	User to have full knowledge (1) Every healthcare provider must inform a user (patient/member) of -

		(a) the user's health status except in the circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interest of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks, costs and consequences generally associated with each option; and (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.

5 CODE OF CONDUCT

5.1 Drafting of the code of conduct

The CoC has been drafted in consultation with industry representatives who were appointed to the task team. The details of the CoC contains the rights and responsibilities of the affected parties, which are members, providers and medical schemes. When a medical scheme outsources some of its functions to an accredited administrator or managed healthcare organisation, the scheme shall ensure that these entities also abide by the CoC as it equally applies to them. The details are annexed hereto as "Annexure 2".

5.2 Amendments to the Code of Conduct

a) The CoC is a living document and may need to be updated from time to time.
b) Any amendments to this document or the Annexures will only have effect after the notice of intention to do so has been published on the CMS' website and provision has been made for public comments.
c) Once the public comments have been received the CoC with the amendments and the public comments must be approved by the Council.
d) The final and updated version of the CoC shall then be published on the CMS' website and stakeholders will be informed accordingly.

6 CODE OF CONDUCT

A. COMMUNICATION

1. The Council for Medical Schemes published Communication Guidelines for Medical Schemes in July 2014. The guidelines cover all identified aspects of information members should be provided with i.e.:

   i. The role of the Council for Medical Schemes
   ii. The role and functioning of medical schemes
   iii. The role and function of administrators of a medical scheme
   iv. Dispute processes at both scheme and Council level; and access to benefits
   v. Standardised terminology to be used in the industry
   vi. Communication of managed care tools such as changes in formularies, pre-authorisation, etc. to members in writing each time there is a change to their formulary or protocol
   vii. The language of communication, accessibility to older members, the distribution of documents, and the role of brokers in such communication.

   Medical schemes, administrators and managed care entities are advised to follow these guidelines to ensure members understand their rights and responsibilities.

2. Whilst recognising that it is not possible, practical or helpful to provide members with all information relating to the coverage of every possible diagnosis at point of entry onto the scheme; pertinent information specific to the member's cover must be made available when joining a scheme. This information must be updated and communicated at the beginning of each year or whenever changes are made that directly affect member benefits.

3. Communication in respect of benefits must be clear, in plain language and must be readily available.

4. Managed care principles e.g. pre-authorisation, Designated Service Provider (DSP) arrangements, formularies and protocols, must be communicated to members and providers. These should be communicated to members on joining the medical scheme and each time there is a change to their formulary or protocol in writing.

5. The location and contact details of DSPs must be easily accessible to members. Members who do not have access to the internet must be informed of their DSPs on registration of chronic diseases and during authorisation calls, followed by written confirmation. DSPs information on medical scheme websites should be available on the home page and clearly marked.

6. The medical scheme must ensure that the member is informed of the applicable process and procedure if services or beds within the DSPs are not available at the time of request. The obligations rest with the medical scheme to ensure that the member is assisted in obtaining services from an alternative service provider and that such assistance should be timeously done and with due regard to the member's clinical needs.

7. Members must be informed of their responsibility to obtain the details with regards to the PMB level of care, basket of care and medicine formulary, including the responsibility of providing such information to their treating provider. The onus is then on providers to provide patients and schemes with the relevant information where treatment beyond the standards specified in the benefit definitions is required.

8. The process to lodge a "clinical appeal" to the medical scheme's dispute committee must be specified and provided to members when joining a scheme and should be added to the annual benefit guide.

9. On resignation from a medical scheme, the scheme must provide the member with a certificate of membership which must at least include information regarding the duration of membership, and chronic conditions for which a member is registered, and for which treatment is covered, as well as any relevant underwriting information.

A. APPLICATION OF MANAGED CARE INTERVENTIONS

PMBs are not restricted to hospital-based management, but include appropriate delivery of relevant and appropriate care on an outpatient basis, or in a setting other than a hospital.

i. Designated Service Providers (DSP)

In keeping with Regulation 8(3) a member will be deemed to have involuntarily obtained a service from a provider other than a DSP, as stated below:

- The hospital is a contracted DSP but no DSP specialist in the specific clinical field is available in this DSP hospital, no co-payment may be imposed.
- The healthcare provider is a DSP but does not work in any contracted DSP hospital, no co-payment may be imposed.
- Emergency rooms at a DSP hospital mostly operate as a General Practitioner practice. Members are not aware of this and as such no co-payment may be imposed if a member obtain emergency treatment at such practice.

ii. Medicine formularies

In keeping with Regulation 15D(e):

"(e) healthcare providers, any beneficiary of the relevant medical scheme or any member of the public are provided on demand with a document setting out —

(i) a clear and comprehensive description of the managed healthcare programmes and procedures; and

(ii) the procedures and timing limitations for appeal against utilisation review decisions adversely affecting the rights or entitlements of a beneficiary; and

(iii) any limitations on rights or entitlements of beneficiaries, including but not limited to restrictions on coverage of disease states; protocol requirements and formulary inclusions or exclusions."

- Medical schemes should provide specific formulary lists to members according to their specific conditions when they join the scheme and whenever changes are made that directly affect member benefits. Such information may be communicated to the specific members and not the entire membership population.
- Medical schemes that implement a medicine formulary may not penalise the member twice in stipulating specific medicines only and then implementing the "maximum medical aid price (MMAP)". Medicines specified on a formulary must be funded in full.
- Medical schemes should further take regard of Regulation 15I(c) in developing formularies and funding of appropriate substitution of drugs.

iii. Discharge reports

In keeping with section 10(1) and (3) of the National Health Act No. 61 of 2003:

(1) A healthcare provider must provide a user with a discharge report at the time of the discharge of the user from a health establishment containing such information as may be prescribed.

(3) A discharge report provided to a user may be verbal in the case of an outpatient but must be in writing in the case of an inpatient.

The medical scheme may request that the member provide such discharge report to the medical scheme where the information is required in determining funding of benefits.

iv. Determination of a "reasonable" co-payment

The CMS will consider the level of co-payments which it deems reasonable. The undesirable business practice relating to penalty co-payments project is being finalised and will address this issue.

v. Implementation of Regulations 15H(c) and 15I(c)

There are medical grounds and clinical settings whereby protocols, formularies or benefit definitions may not constitute appropriate care for a given member for a PMB diagnosis. Medical schemes must have a pre-defined process that will allow members and / or their healthcare professionals to apply for treatment beyond that which is available in the protocols, formularies, or prescribed algorithms, where this is clinically appropriate.

The manner whereby members get access to a clinical appeals process must be communicated and easily accessible, and must not be constructed as a barrier to access to alternative treatment interventions under these exceptional circumstances. The process of reviewing standard benefits, under these exceptional circumstances, must ensure that members and providers are treated fairly and consistently.

Alternative treatment should only qualify as a PMB entitlement where the standard protocols, formularies, and prescribed algorithms have been tried and demonstrated to be ineffective, causes or is likely to cause, adverse reaction in beneficiaries.

The onus is on healthcare providers to supply medical schemes with relevant clinical information to assist in the decision-making in these exceptional cases.

Where alternative treatment is deemed appropriate and meets the criteria for PMB entitlement, payment must be from the risk benefit, and may not be paid from medical savings accounts or other benefits. In the case of alternative treatment that is not considered PMB level of care the medical scheme must fund the claims up to the amount that would have been paid for stipulated PMB level of care.

B. IDENTIFICATION OF PMBs AND DEFINING PMB LEVEL OF CARE

The CMS published a PMB coded list in 2013 to assist stakeholders with the identification of possible PMB conditions. The PMB coded list is not a legislated document and must only be used as a basic guideline. It may not be used as the legal interpretation of PMB conditions.

i. Valid PMB cases

In isolation, The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) codes alone are seldom adequate to correctly identify PMB benefits since the PMB regulations define PMB benefits as a diagnosis with specified severity, in relation to specified treatment. Medical schemes must capture all submitted ICD-10 codes as many of these may trigger a potential PMB benefit, including codes not present on the current PMB code list developed by the CMS as a basic guideline.

Additional information required for the identification of PMB claims include but is not limited to:

a. The setting (e.g. hospital or not)
b. The nature and severity of the condition or injury
c. The procedure or treatment
d. The drugs used
e. Co-morbidities
f. The age and gender of the patient
g. Pathology or radiology results
h. Response to previous therapy

i. The hospital discharge summary

ICD-10 codes must be submitted in accordance with the rules and guidelines developed by the former ICD-10 Ministerial Task Team. The onus is on healthcare providers to ensure that personnel dealing with clinical codes are adequately trained to improve the quality of ICD 10 coding.

The onus is on both "diagnosing" and "non-diagnosing" providers to submit accurate and specific ICD-10 codes on claims to facilitate the identification of PMB benefits. Non-diagnosing providers who cannot provide an ICD-10 code may not be penalised if the non-specific Z-codes are used on accounts especially where a referral code was not provided.

ii. Pre-registration, application, and authorisation for PMBs

Considering that many PMB claims cannot be correctly identified as PMBs based on the ICD-10, procedure or medicine codes, a pre-registration, application or authorisation process may be requested by medical schemes. Such pre-registration, application or authorisation process must not place an unnecessary burden on, and must be readily accessible to patients and providers.

Registration for PMBs is applicable to benefits which require a once-off registration such as CDLs, the chronic elements of DTPs (such as post-transplant care) and pregnancy. Registration must not require re-application for benefits in cases where conditions are of a chronic nature and treatment interventions are not likely to change.

Registration of PMBs must be a once-off process and should not require annual renewal.

Members may be requested to provide clinical updates if there are changes to their medical treatment, to ensure correct payment decisions regarding the new treatment. The clinical updates are necessary to determine entry and exit criteria on specific treatments.

Where pre-registrations are neither possible nor practical such as DTPs without chronic elements. Authorisation for hospitalisation and specialised investigations may however be required. This requirement must be clearly specified in the medical scheme rules and benefit guides.

Members may not be expected to obtain authorisation / registration for each clinical service provided as part of medical treatment, whilst such member is admitted to hospital.

In the case of emergencies, medical schemes may not deny benefits because authorisation was not obtained prior to the diagnosis, treatment or care intervention. Authorisation may be provided within 48 hours or on the first working day. In cases where the member cannot obtain authorisation due to his/her clinical condition and does not have any family member who can contact the medical scheme for authorisation, hospital authorisation must be accepted as sufficient.

Medical schemes may not deny funding of PMBs in cases where members do not comply with chronic treatment or do not want to be part of a disease management programme.

Schemes must capture authorisation information in an electronic extractable format and must keep the original information (hard copies, electronic image files, voice recordings, etc.) for at least three years.

Medical scheme claims-processing systems must automatically pay valid PMB claims where clinical information to verify that the condition is indeed a PMB is not required.

Medical schemes must reimburse healthcare providers for writing clinical motivations where such motivation is requested by the medical scheme or managed care company.

iii. Chronic elements of DTPs

The CMS will provide a list of all chronic conditions / elements of the DTPs to the industry. Funding of chronic treatment for these conditions are included in the PMBs and only managed care principles may be applied during adjudication of claims.

iv. PMB level of care

In relation to the desired public sector levels of care;

i) The technology, medicine or service considered in funding of PMBs must be available in the public sector after it was purchased through a tender or a special motivation (buy-out process) and not because of research, sponsored clinical trial or compassionate-use programmes.
ii) The prevailing / standard care in state sector facilities is as available in at least 3 public sector hospitals across 3 different provinces. Only in highly specialised cases such as limb salvaging where the public sector resources are available in only one or two specific tertiary institutions can treatment be considered PMB level of care.
iii) Where regulatory authorities exist and where healthcare interventions are regulated, the healthcare intervention must be registered with the appropriate regulatory body e.g. the South African Health Products Regulatory Authority (SAHPRA) based on the Medicines Control Council (MCC), as of 1 April 2018), South African Bureau of Standards (SABS), etc. Experimental interventions should therefore not be included in the benefit definitions.

It is important to note that not all PMB level of care should be benchmarked against public sector healthcare provision. Where the private sector provides more efficient and clinical best practice care, specifically cost-effective and affordable interventions, such level of care should be recognised as PMB level of care.

Where available and applicable, health economic evaluations must be used to support funding decisions for treatment interventions as PMB level of care is required to be cost-effective. Such evaluations must be done on the specific treatments impact for the specific benefit option. At the reasonable discretion of the scheme, such evaluations must be made available to relevant individuals or parties on request.

In consideration of the managed care principles, access to and the availability of particular health interventions to an individual must also be weighed against the interest of the collective membership, therefore affordability for the scheme is an important consideration.

v. Diagnostic and Procedure Coding

The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) is the only valid diagnostic coding system as it is the National Standard in South Africa.

All claims must contain an ICD-10 code in accordance with the rules and guidelines developed by the former ICD-10 Ministerial Task Team.

The National Reference Price List 2006 is the only legal procedure coding system in South Africa.

All claims must be submitted with the relevant procedure code per claim line. In cases where there is no specific procedure code for the treatment provided, claims must be submitted on comparable services (NRPL – Rule C).

"Comparable services:

A service may be rendered that is not listed in this edition of the coding structure. The fee that may be charged in respect of the rendering of a service not listed in this coding structure shall be based on the fee in respect of a comparable service. For these procedure(s) / service(s), item 6999: Unlisted procedure or service code, should be used. Please contact the SA Medical Association (SAMA) Private Practice Unit via e-mail on coding@samedical.org to obtain a comparable code for the unlisted procedure / service which will be based on the fee for a comparable service in the coding structure. When item 6999 is used to indicate that an unlisted service was rendered, the use of the item must be supported by a special report. This report must include information regarding the following:

(1) An adequate definition or description of the nature, extent and need for the procedure / service or "medical necessity";

(2) In which respect is this service unusual or different in technique, compared to available procedures / services listed in the coding structure? Information regarding the nature and extent of the procedure / service, time and effort, special / dedicated equipment needed to provide this service, must be included in the report;

(3) Is this procedure / service medically appropriate under the circumstances? Explain why another procedure / service listed in the coding structure will not be appropriate in this case;

(4) A description of the complexity of the symptoms and concurrent problems must be supplied;

(5) Final diagnosis supported by the appropriate ICD-10 code(s);

(6) Pertinent physical findings (size, location and number of lesions if applicable);

(7) Mention any other diagnostic or therapeutic procedure(s) / service(s) provided at the same session;

(8) Any further diagnostic or therapeutic procedure(s)/service(s) to be provided in the follow-up period; and

(9) Description of the follow-up care needed.

Please note: *This comparable service code may not be used for a period longer than six months for a particular procedure / service after which time an application has to be made for the addition of a specific code for this procedure"*

vi. Approach when a possible PMB diagnosis is made but not yet confirmed

The diagnosis and management of a condition leading to a definitive diagnosis and confirmation of a medical condition as a PMB shall fall under the ambit of PMB benefits.

Where a medical emergency is provisionally diagnosed, and is not confirmed by additional medical evidence, the scheme will be held liable to cover costs of clinically appropriate investigations and treatment as PMB benefits up to the stage where a PMB condition has been excluded. Attention is drawn to Explanatory Note 7 to Annexure A in the Regulations, whereby schemes may request confirmatory evidence from providers and whereby schemes must inform the CMS, where problems in this respect are experienced.

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

In instances where a provisional diagnosis of a PMB condition is not confirmed and a Non-PMB condition is confirmed, and where such a change in diagnosis results in a scheme

withdrawing authorisation for diagnosis, treatment, or care interventions, it is incumbent on the scheme to immediately notify the member and the relevant providers of such withdrawal, and how the treatment will be covered.

C. PAYMENT FOR PMBs

Schemes must capture all submitted ICD-10 codes and where a valid PMB ICD10 code is submitted, this must act as a trigger for potential payment from the PMB benefit.

Medical scheme claims-processing systems must, where applicable, automatically pay valid PMB claims from risk pools (not medical savings accounts), based on the availability of valid clinical codes and pre-authorisation, which in turn is subject to benefit definitions.

- In keeping with Regulation 10(6) – *"(6) The funds in a member's medical savings account shall not be used to pay for the costs of a prescribed minimum benefit"*

i. Payment of PMB claims after these were initially not considered a PMB

In instances where:

(a) claims could not be identified as valid PMB claims based on clinical codes alone, and

(b) where neither the additional clinical information considered in B i (page 12),

nor

(c) registration or authorisation information is indicative of the fact that the claim constitutes a PMB benefit, then

the claim may be rejected as a PMB benefit or funded from another benefit. In such an instance, the member may raise a clinical dispute up to three years after the claim has been rejected or paid from another benefit.

D. ADMINISTRATIVE MATTERS

Final claims data submitted to the CMS must clearly specify each claim line as PMB or Non-PMB.

Emergency claims must be paid automatically where they can be clearly identified.

Medical schemes must provide for:

a. A simple process designed to allow the medical scheme to obtain relevant clinical information on which to evaluate whether a claim is indeed a PMB.
b. Well documented clinical criteria to facilitate effective adjudication, which should be available to providers and members via various communication channels (written, telephonic, website).
c. Authorisations for these should be processed within 7 days once full information required to make the adjudication has been made available to the scheme.

d. It should be noted that "full information" may sometimes include the decision of an external panel. Once the external panel has made a recommendation, the scheme must process the authorisation within 7 days. External panels should decide within 7 days after receiving the request and clinical information.
e. Schemes should ensure that staff managing such authorisation requests and claims queries, are adequately trained subject-matter experts who can promptly and effectively respond to and assist members and providers with these enquiries. Clinical updates by hospital case managers have been noted to be done after discharge. This practice places members in a very difficult position specifically with regards to the length of stay. As such medical scheme case manager must ensure that updates are provided timeously and prior to discharge or extended length of stay.

ii. Disputes in respect of PMB benefits

Disputes that arise over the validity of claims against the entry criteria must be dealt with by a query and escalation processes (including a clinical appeals process) over and above the standard authorisation process.

Query and escalation staff should be readily available to assist promptly.

Clinical criteria must be documented and available to providers and members via various communication channels (written, telephonic, website). Telephone conversations must be recorded.

In situations where a member (who has a valid PMB diagnosis) voluntarily makes treatment choices in excess of the medical scheme's defined baskets or outside of the DSPs, schemes are permitted to impose a reasonable co-payment. This penalty is required to give sufficient incentive for providers to join DSP networks and the co-payments may not be paid from medical savings accounts.

7 OVERSIGHT AUTHORITY

Implementation	CMS
Compliance	Compliance will be monitored through regulatory interventions which include the adjudication of complaints, onsite evaluations of regulated entities and inspections into the affairs of medical schemes.
Monitoring and evaluation	CMS: Office of the Strategist
Development and / or review	Representative task team
Interpretation and advice	CMS Legal Services and Clinical Units

8 RELATED DOCUMENTS

Model Rules www.medicalschemes.com
Communication Guidelines www.medicalschemes.com
Consumer Protection Act

9 CONTROL SHEET

	Responsibility	Signature	Date
Compiled by:	Office of the Registrar in consultation with industry		
Approved by:	Chairperson of Council for Medical Schemes		

10 REVISION HISTORY

Version	Revision Date	Issue Date
One	Not applicable – new document	June 2010
Two	24 March 2017	29 March 2017
Third	18 August 2017	