



June 2009

Diagnosing PMBs

You and your doctor cannot be certain that the condition is a prescribed minimum benefit (PMB) unless it is tested and proven to be one. In this issue of CMScript we break down PMBs by taking a closer look at one of the three components of the package for providing PMBs: their diagnosis. Nevertheless, it should never be forgotten that PMBs cover the diagnosis, treatment, and care costs of a defined set of conditions.

In addition to specifying that any emergency medical condition must be covered by a medical scheme, the Medical Schemes Act (Act 131 of 1998) defines PMB conditions through the inclusion of a list of appropriate diagnosis methods and the associated required management of these conditions. In some instances screening itself is a PMB, for instance screening for cervical and breast cancer.

Apart from emergency conditions, PMBs are diagnosis-driven. This means that most conditions cannot be declared a PMB unless they are tested and proven to be so.

According to the National Institute of Health and Merriam Webster dictionaries, diagnosis is the art of determining the nature of a disease or condition from its signs and symptoms by conducting physical examination, various tests (radiology and pathology), and the like.

If and when a conducted diagnosis leads to the conclusion that a condition is a PMB, only then can a condition be classified as a PMB and a member is entitled to PMBs regardless of the medical scheme option to which s/he belongs. The medical scheme must pay in full for all relevant consultations and appropriate tests that have yielded the positive PMB diagnosis from its risk pool and not the member's medical savings account. However, if consultations and diagnostic tests established that a member was not suffering from a PMB condition, then the scheme has to provide cover only in terms of its normal benefits and available limits.

Remember! PMBs are concerned about the diagnosis; it does not matter how you got the condition. Complications arising from conditions that are non-PMBs might be a PMB condition if the complication itself is listed under the PMB conditions. There are conditions that are excluded from cover, such as cosmetic surgery and examinations for insurance purposes, but if a member contracts septicaemia after cosmetic surgery, for example, then the scheme has to provide cover for septicaemia because it is a PMB condition. Septicaemia (a PMB condition) arising from cosmetic surgery (a non-PMB condition) has to be covered in full by a scheme at its designated service provider (DSP).

PMBs are concerned about the diagnosis; it does not matter how you got the condition.

Remember too that in most cases you will know that you have a PMB condition only after the diagnostic tests have been completed. This means that your scheme must cover the consultation(s) and investigation(s) (e.g. radiology and pathology) retrospectively. If your scheme initially paid for these from your savings account, you have to request it to reverse the costs to the risk pool, since PMB-related services may never be paid from savings accounts. If your funds were depleted and you had to pay for them yourself, the scheme must once again be notified and reimburse you accordingly.

Unlike an already identified PMB condition where your scheme may subject you to the use of designated service providers (DSPs) for your PMB-related services (further tests, treatment and care), screening tests that are yet to determine a diagnosis can be done either at any healthcare provider or at a network provider as determined by your benefit option. These providers could be radiology and pathology practices, doctors, pharmacists, hospitals as well as the public health sector. If the diagnosis yields PMB-positive results, your scheme must pay the service provider in full without co-payment.

All PMBs are identifiable by the ICD-10 (International Classification of Diseases 10th Revision) codes. ICD-10 codes facilitate the easy identification of PMBs by service providers and funders while at the same time promoting confidentiality of your health information. It is important to ensure that diagnosis information provided is correct to guarantee that benefits are paid out from the correct benefit pool.

Remember!

PMBs are guaranteed benefits which your medical scheme has to cover, regardless of the benefit option you have chosen to join. In terms of the Medical Schemes Act, PMBs cover the costs related to the diagnosis, treatment, and care of:

- any emergency medical condition;
- a limited set of ±270 medical conditions (called the Diagnosis and Treatment Pairs or DTPs, listed in the Act); and
- the 25 Chronic Diseases List (CDL) conditions.

Keep in mind that there are chronic diseases that are not part of the CDL but that fall under the ±270 conditions of the PMBs. The full list of PMB conditions is available on our website www.medicalschemes.com.

Note:

Explanatory note 7 to the PMB definitions does, however, make the following provision:

“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 PMBs are described in terms of presenting symptoms rather than diagnosis, and in these cases, inclusion within the PMBs 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.”

support@medicalschemes.com

Tel: 012 431-0500 / 0861 123 267 Fax: 012 430-7644

Mail: Private Bag X34, Hatfield, 0028

Pictures: courtesy of www.flickr.com & Microsoft Clip Art