

CMScript



COUNCIL FOR MEDICAL SCHEMES

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The secret's in the code

ID number. Bank account number. PIN. Alarm code. Computer access code. Numbers and codes are everywhere we turn. When it comes to your medical aid claims, however, few numbers are as important as ICD10 codes.

Patrick was diagnosed with high blood cholesterol (hyperlipidaemia) by his GP a few months ago. Understanding the rules of his medical scheme, Patrick completed the necessary chronic medicine application forms. His GP completed his section on the form and supplied a copy of the lipogram pathology report that was used to make the diagnosis. The scheme was satisfied that Patrick met all the criteria and he was registered for chronic benefits. Patrick's GP advised him to obtain the treatments standards and list of medicines covered from his scheme. The doctor prescribed medication that appeared on the scheme's formulary, i.e. the list of drugs fully covered by the scheme, and Patrick started with his treatment.

During the course of this process, Patrick learned that high cholesterol is a Prescribed Minimum Benefits (PMB) condition. This, he was told, means that his medical scheme has to provide full cover for his treatments and medication regardless of his chronic benefits limits for the year. The conditions attached to this are that he uses the drugs listed in the scheme's formulary, adheres to the scheme's treatment standards and, where necessary, goes to the scheme's Designated Service Providers for treatment and medication.

The scheme's treatment standards specify that Patrick may undergo one lipogram pathology test per year to monitor the effectiveness of his treatment. After a couple of months, his doctor duly sends him for a test, but he then receives an account from the pathology laboratory indicating that the scheme had failed to settle the account. When Patrick contacts his scheme, he is told that the diagnosis code (ICD 10 code) on the account does not correspond to his diagnosis. This means that the scheme cannot reimburse the laboratory as PMB related service and that Patrick has to reimburse it himself, since he has exhausted his day-to-day pathology benefits.

"Fortunately, I was informed about ICD10 codes and I knew where to start to address the problem", says Patrick. He went to his doctor and discovered that the GP did not provide the correct diagnosis code on the pathology referral note. The laboratory, therefore, could not put the correct code on the account. "The solution was as simple as asking my GP to get the right code and send it to the laboratory. The lab then resubmitted its account to the scheme and it was settled as a PMB related expense."

The ins and outs of ICD10 codes

ICD 10 codes appear on healthcare provider accounts and are used to inform medical schemes of the conditions for which members sought healthcare services 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 Organisation (WHO), that translates the written description of medical and health information into standard codes, e.g. J03.9 is an ICD 10 code for acute tonsillitis and G41.0 denotes epilepsy (unspecified).

When you join a medical scheme, you choose and pay for a particular benefit option. This benefit option contains a basket of services that often has limits on the health services that will be paid for. Because ICD 10 codes provide accurate information on the condition you have been diagnosed with, the codes help the medical scheme to determine what benefits you are entitled to and how these benefits could be paid.

This becomes very important if you have a PMB condition, as these can only be identified by the correct ICD 10 codes. Therefore, if the incorrect ICD 10 codes are provided, your PMB-related services might be paid from the wrong benefit (e.g. medical savings account) or it might not be paid at all if your day-to-day or hospital benefits limits have been exhausted.

ICD 10 codes must also be provided on medicine prescriptions and referral notes to other healthcare providers (e.g. pathologists and radiologists) *continued*

What to ask your medical scheme about your chronic condition:

- Is my illness a PMB condition?
- Who are the DSPs for my condition listed in your rules?
- What are the treatment standards (protocols) for my condition according to your rules?
- Which medicines are on your formularies list?
- Are there any other requirements I need to be aware of, e.g. joining a managed care programme?
- What do I need to ask or tell my doctor (e.g. ICD 10 codes) to ensure full PMB benefits?

The Council can help

PMBs can be a rather complicated subject and your medical scheme might not be able to answer all your questions.

Do not despair. The Council for Medical Schemes (CMS) was established to supervise medical schemes in South Africa. In this role, its first priority is to protect the rights of consumers and to ensure that they are treated fairly.

Therefore, if you have a problem with your medical scheme, contact them in any of the following ways:

Tel: 012 431-0500 / 0861 123 267

Fax: 012 430-7644

E-mail: support@medicalschemes.com

Mail: Private Bag X34, Hatfield, 0028

who are not all able to make a diagnosis. Therefore, they require the diagnosis information from your referring doctor so that their claim to your medical scheme can also be paid out of the correct pool of money.

Important note: Medical schemes are obliged by law to treat information about members' conditions with the utmost confidentiality. They are not allowed to disclose even ICD-10 codes to any other party, including employers or family members.

PMB chronic conditions: a quick reference guide

- The Medical Schemes Act lists 25 chronic conditions that are covered by the PMB provisions.
- Medical schemes have to cover the diagnosis, treatment and medication associated with the care of the listed chronic conditions.
- Schemes may decide which chronic drugs they cover and which not, as long as it is in line with the minimum treatment standards published in the Government Gazette. If you choose not to use a formulary drug, you will be liable for a co-payment. The co-payment calculation has to be published in your scheme's rules and may not come out of your savings account.
- Your scheme may require you to join a managed care programme for your condition. Even if they don't, it still is a good idea to do so. Not only do you receive assistance with managing your disease, but you also learn from other people in the same boat and receive invaluable moral support.
- Designated Service Providers (DSPs) are healthcare providers (doctors, pharmacists, hospitals, clinics, etc.) that are a medical scheme's first choice when its members need diagnosis, treatment or care for a PMB condition. The DSPs have to be stated in the scheme's rules and the scheme has to ensure that it is easy for beneficiaries to get to the DSPs and that they can provide the necessary service. State hospitals can be DSPs, but are not necessarily.