



**PRESCRIBED MINIMUM BENEFIT SUMMARY JANUARY 2010**

**WHAT ARE PMB'S?**

Prescribed Minimum Benefits (PMB) is a set of defined benefits to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide people with continuous care to improve their health and well-being and to make healthcare more affordable.

PMBs are a feature of the Medical Schemes Act, in terms of which medical schemes have to cover the costs related to the diagnosis, treatment and care of:

1. Any emergency condition
2. A limited set of 270 medical conditions
3. 26 chronic conditions

When deciding whether a condition is a PMB, the doctor should only look at the symptoms and not at any other factors, such as how the injury or condition was contracted. This approach is called diagnosis-based. Once the diagnosis has been made, the appropriate treatment and care is decided upon as well as where the patient should receive the treatment (at a hospital, as an outpatient or at a doctor's rooms).

• **ANY EMERGENCY CONDITION:**

- An emergency medical condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death.

In an emergency it is not always possible to diagnose the condition before admitting the patient for treatment. However, if doctors suspect that the patient suffers from a condition that is covered by PMBs, the medical scheme has to approve treatment. Schemes may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

• **LIMITED SET OF 270 MEDICAL CONDITION – DIAGNOSIS AND TREATMENT PAIRS:**

- The Regulations to the Medical Schemes Act in Annexure A provide a long list of conditions identified as Prescribed Minimum Benefits. The list is in the form of Diagnosis and Treatment Pairs (DTPs)
- A DTP links a specific diagnosis to a treatment and therefore broadly indicates how each of the approximately 270 PMB conditions should be treated. The treatment and care of PMB conditions should be based on healthcare that has proven to work best, taking affordability into consideration. Should there be a disagreement about the treatment of a specific case, the standards (also called practice and protocols) in force in the public sector will be applied.

The treatment and care of some of the conditions included in the DTP may include chronic medicine, e.g. HIV-infection and menopausal management. In these cases, the public sector protocols will also apply to the chronic medication.

Here is an example of a DTP as it appears in the Medical Schemes Act:

Code	Diagnosis	Treatment
109A	Vertebral dislocations/fractures, open or closed with injury to spinal cord	Repair/reconstruction; medical management; inpatient rehabilitation up to two months

The 270 conditions that qualify for PMB cover are diagnosis-specific and include a range of ailments that can be divided into 15 broad categories:

PMB Category	Example
Brain and nervous system	Stroke
Eye	Glaucoma
Ear, nose, mouth and throat	Cancer of oral cavity, pharynx, nose, ear, and larynx
Respiratory system	Pneumonia
Heart and vasculature (blood vessels)	Heart attacks
Gastro-intestinal system	Appendicitis
Liver, pancreas and spleen	Gallstones with cholecystitis
Musculoskeletal system (muscles and bones); Trauma NOS	Fracture of the hip
Skin and breast	Treatable breast cancer
Endocrine, metabolic and nutritional	Disorders of the parathyroid gland
Urinary and male genital system	End-stage kidney disease
Female reproductive system	Cancer of the cervix, ovaries and uterus
Pregnancy and childbirth	Antenatal and obstetric care requiring hospitalisation, including delivery
Haematological, infectious and miscellaneous systemic conditions	HIV/Aids and TB
Mental illness	Shizophrenia
Chronic conditions	Asthma, diabetes, epilepsy, hypothyroidism, schizophrenia, glaucoma, hypertension

**No exclusions**

Medical schemes often have a list of conditions – such as cosmetic surgery – for which they will not pay, or circumstances – such as travel costs and examinations for insurance purposes – under which a member has no cover. These are called exclusions. Exclusions, however, do not apply to PMBs. If you contract septicaemia after cosmetic surgery, for example, your scheme has to provide healthcare cover for the septicaemia part because septicaemia is a PMB. (Cosmetic surgery remains an exclusion.) PMBs are concerned about the diagnosis; it doesn't matter how you got the condition.

- **26 CHRONIC CONDITIONS:**

- The Chronic Disease List (CDL) specifies medication and treatment for the 26 chronic conditions that are covered in this section of the PMBs:

Addison's Disease	Dysrhythmias
Asthma	Epilepsy
Bipolar Mood Disorder	Glaucoma
Bronchiectasis	Haemophilia
Cardiac Failure	Hyperlipidaemia
Cardiomyopathy	Hypertension
Chronic Obstructive Pulmonary Disorder	Hypothyroidism
Chronic Renal Disease	Multiple sclerosis
Coronary Artery Disease	Parkinson's Disease
Crohn's Disease	Rheumatoid arthritis
Diabetes Insipidus	Schizophrenia
Diabetes Mellitus types 1 & 2	Systemic Lupus Erythematosus
Dysrhythmias	Ulcerative Colitis

To manage risk and ensure appropriate standards of healthcare, so-called treatment algorithms were developed for the CDL conditions.

The algorithms, which have been published in the Government Gazette, can be regarded as benchmarks, or minimum standards, for treatment. This means that the treatment your medical

scheme must provide for may not be inferior to the algorithms.

To view the CDL algorithms please click on this link:

If you have one of the 26 listed chronic diseases, your medical scheme not only has to cover medication, but also doctors' consultations and tests related to your condition. The scheme may make use of protocols, formularies (lists of specified medicines) and Designated Service Providers (DSPs) to manage this benefit.

### **THE OBJECTIVES OF PMB'S**

There are two main reasons why PMBs were created:

1. To ensure that medical scheme beneficiaries have continuous healthcare. This means that even if a member's benefits for a year have run out, the medical scheme has to pay for the treatment of PMB conditions.
2. To ensure that healthcare is paid for by the correct parties. Medical scheme members with PMB conditions are entitled to the specified treatments and these have to be covered by their medical scheme, even if the patients were treated at a state hospital.

But there are other valid reasons too:

To provide minimum healthcare to everybody who needs it, regardless of their age, state of health or the medical scheme cover option they belong to. PMBs have a part to play in ensuring that medical schemes remain financially healthy. When beneficiaries receive good care on an ongoing basis, their general wellness improves, resulting in fewer serious conditions that are expensive to treat. To protect the interests of medical scheme beneficiaries by ensuring, for instance, that schemes first cover essential treatments before setting funds aside for discretionary services.

### **WHY DESIGNATED SERVICE PROVIDERS ARE IMPORTANT**

A Designated Service Provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc) that is a medical scheme's first choice when its members need diagnosis, treatment or care for a PMB condition.

If you choose not to use the DSP selected by your scheme, you may have to pay a portion of the bill as a co-payment. This could either be a percentage co-payment or the difference between the DSP's tariff and that charged by the provider you went to.

Medical schemes have to ensure that it is easy for beneficiaries to get to the DSPs. If there is no DSP within reasonable distance of your work or home, then you can visit any provider and the scheme is obliged to pay.

When you suffer an emergency condition, or are involved in an accident, you may go to the nearest healthcare facility for treatment, even if it is not a DSP. Your scheme will have to cover the costs.

Schemes also have to ensure that the DSPs of their choice can deliver the services needed and without members having to wait unreasonably long. Where a DSP is unable to accommodate or treat a member, the medical scheme remains liable for all the costs of treating the PMB condition at a non-DSP.

The State's healthcare facilities can be, but are not necessarily, DSPs. Before they can be listed as such, schemes have to make sure that their beneficiaries can get to the facilities and that the required treatment, medication and care are available and accessible.

Treatment at DSPs can be handled in two ways:

1. Schemes can insist that you go to a DSP as soon as your condition is diagnosed, in which case they cover the costs from the start. Treatment at a DSP will be covered in full by the medical scheme under the PMB conditions when delivered according to scheme protocols and formularies.
2. If your benefit option allows for this, the doctor of your choice can treat you. If you choose to use a provider of your choice for these services, the scheme may apply a co-payment, as registered in their rules

### **THE IMPORTANCE OF ICD-10 CODES**

One of the types of codes that appear on healthcare provider accounts is known as ICD-10 codes. These codes are used to inform medical schemes about what 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 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 (unspecified) and **G40.9** 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, these 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 (such as from your 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) 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.

#### **THE RESPONSIBILITIES OF MEDICAL SCHEME BENEFICIARIES**

PMBs are very good news for medical scheme beneficiaries and give them considerable rights as far as healthcare is concerned. However, as a consumer you also have certain responsibilities to ensure that PMBs work as well for you as they should.

First and foremost, educate yourself about your medical scheme's rules, the listed medication and treatments (formularies) for your specific condition, as well as who the Designated Service Providers (DSPs) are.

Obtain as much information as possible about your condition and the medication and treatments for it. If there is a generic drug available, do your own research to find out whether there are any differences between it and the branded drug.

Don't bypass the system: if you must use a GP to refer you to a specialist, then do so. Make use of your medical scheme's DSPs as far as possible. Stick with your scheme's listed drug for your medication unless it is proven to be ineffective.

Be a good consumer: ask questions and follow the complaints process if you are not treated fairly. Make sure your doctor submits a complete account to the medical scheme. It is especially important that the correct ICD-10 code is reflected.

Follow up and check that your account is submitted within four months and paid within 30 days after the claim was received (accounts older than four months are not paid by medical schemes).

#### **THE RESPONSIBILITIES OF MEDICAL SCHEMES**

Among other objectives, PMBs want to achieve appropriate healthcare, resulting in lower costs associated with complications and hospitalisation. When beneficiaries are properly taken care of and their illnesses managed, the need for expensive hospitalisation decreases.

Medical schemes have a critical role to play in making PMBs work.

Schemes have to educate their beneficiaries about PMBs and the benefits that are included in them.

Schemes must inform their beneficiaries of their DSPs and keep them updated should any changes occur. Schemes should empower their beneficiaries with information on matters such as the intricacies of rules and the formularies for specific conditions.

Medical schemes have to guarantee and ensure reasonable access and availability of DSPs.

The public sector cannot be designated as a DSP without the medical scheme ensuring that the necessary service will be available.

#### **THE RESPONSIBILITIES OF HEALTHCARE PROVIDERS**

Doctors do not usually have a direct contractual relationship with medical schemes. They merely submit their accounts and if the medical scheme does not pay, for whatever reason, the doctor turns to the beneficiary for the amount due. This does not mean that PMBs are not important to healthcare providers nor that they don't have a role to play in its successful functioning.

Doctors should familiarise themselves with ICD-10 codes and how they correspond with PMB codes. If you use the correct ICD-10 code your account will definitely be paid as PMBs enjoy guaranteed medical aid cover.

Consider on which option your patients are and what can realistically be covered before recommending a drug or treatment.

Alert patients to the fact that their condition is a PMB and encourage them to engage their medical scheme on the matter.

Keep proper clinical records of patients so that when a formulary drug or protocol is not effective, or causes adverse side effects, you can justify your alternative recommendation.

Do not abuse PMBs. The result will be an unsustainable private healthcare system with unaffordable contribution increases. Abuse could compel government to consider alternative payment options in the private healthcare sector.

Allow your practice to be listed as a DSP.

The "payment in full" concept is there to ensure accessibility of healthcare services for medical scheme beneficiaries if the DSP is not available; it is not a reimbursement model.

### **CMS HELP**

PMBs can be a rather complicated subject and your medical scheme might not be able to answer all your questions. Sometimes, your medical scheme may be reluctant to provide you with the cover you are entitled to for a PMB condition and you need someone to champion your cause.

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 us in any of the following ways:

Tel: 012 432 0500 / 0861 123 267

Fax: 012 430 7644

E-mail: support@medicalschemes.com

Mail: Private Bag X34, Hatfield, 0028

### **FREQUENTLY ASKED QUESTIONS**

#### **FROM BENEFICIARIES:**

##### **Is my medical scheme obliged by law to provide cover for certain medical conditions?**

Yes, these are known as Prescribed Minimum Benefits (PMBs). They were introduced into the Medical Schemes Act to ensure that beneficiaries of medical schemes would not run out of benefits for certain conditions and find themselves forced to go to State hospitals for treatment. These PMBs cover a wide range of ±270 conditions, such as meningitis, various cancers, menopausal management, cardiac treatment and many others, including medical emergencies. However, take note that certain limitations could apply, such as the use of a DSP and specified treatment standards.

PMB diagnosis, treatment and care are not limited to hospitals. Treatment can be received wherever it is most appropriate, including a clinic, outpatient setting or even at home. Always check your benefits with your medical scheme and make sure you have the scheme's rules at your disposal.

##### **Is it true that schemes now also have to provide chronic medication?**

Yes, the list of PMBs includes 26 common chronic diseases in the Chronic Disease List (CDL) and other chronic conditions within the ±270 DTP section. Medical schemes have to provide cover for the diagnosis, treatment and care of these diseases. However, you should remember that a medical scheme does not have to pay for diagnostic tests that establish that you are not suffering from a PMB condition.

The treatment algorithms (guidelines for appropriate treatment) for each of the CDL chronic conditions have been published in the Government Gazette while the chronic diseases in the DTP section are guided by the public sector protocols. This assures you of good quality treatment and reassures your medical scheme that it will not have to pay for unnecessary treatment. Your doctor should know and understand most of the guidelines so that he or she can help you get the treatment you need for any of these conditions without incurring costs that your scheme does not cover.

##### **Why are some chronic illnesses covered and some not?**

The diseases that have been chosen are the most common, they are life threatening, and are those for which cost-effective treatment would sustain and improve the quality of the member's life.

##### **Does my scheme need to do anything to ensure that the Designated Service Provider can treat me?**

The Council for Medical Schemes has been advising medical schemes to enter into contracts with any DSP they choose, especially State hospitals, to ensure that these providers can supply the necessary services. Many State hospitals have set up separate wards to serve beneficiaries whose treatment and hospital stay is paid for by their medical scheme and to whom the hospital can then afford to provide better service. Other schemes have made arrangements with private hospital and certain retail pharmacies to treat their beneficiaries.

**Can I be refused cover for the chronic conditions if I do not get authorisation or have certain tests?**

Yes, medical schemes can make a benefit conditional on you obtaining pre-authorisation or joining a benefit management programme. These programmes are aimed at educating members about the nature of their disease and equipping them to manage it in a way that keeps them as healthy as possible. For example, many schemes offer treatment through groups that manage diseases such as diabetes, and are equipped to give the medication and monitor that disease.

**Can my scheme insist that it will only fund treatment that follows the appropriate protocol?**

Yes. The minimum medicines for treatment of all PMB conditions have been published in the Government Gazette, and are known as treatment algorithms (benchmarks for treatment). Your scheme may decide for which medicines it will pay for each chronic condition, but the treatment may not be below the standards published in the treatment protocols. If your scheme's cover conforms to that standard and you and your doctor decide that you should rather use different medication, then you may have to pay a co-payment towards the cost of that medicine. Your medical scheme must, however, pay for the treatment if your doctor can prove that the standard medication is ineffective or detrimental to your condition.

Your medical scheme may develop protocols to manage the use of benefits. Such protocols would specify, for example, types of tests, investigations and number of consultations. Members who might need more frequent or extra services than provided for in the protocols, can appeal to their scheme for these to be covered. The scheme's appeal process might include a motivation from the treating doctor that explains the clinical reasons for the additional services.

**Can my scheme refuse to cover my medication if I need, or want, a brand other than that which the scheme says it will pay for?**

Yes, the medical scheme may refuse to cover a part of the expenses. Your scheme may draw up what is known as a formulary – a list of safe and effective medicines that can be prescribed to treat certain conditions. The scheme may state in its rules that it will only cover your medication in full if your doctor prescribes a drug on that formulary. Generally speaking, schemes expect their members to stick to the formulary medication.

Often the medicines on the list will be generics – copies of the original brandname drug – that are less expensive but equally effective. If you want to use a brandname medicine that is not on the list, your medical scheme may foot only part of the bill and you will have to pay either the difference between the price of the medication you use and the one on the formulary, or a percentage co-payment as registered in the scheme rules.

If you suffer from specific side-effects from drugs on the formulary, or if substituting a drug on the formulary with one you are currently taking affects your health detrimentally, you can put your case to your medical scheme and ask the scheme to pay for your medicine. You can also appeal to the scheme if the formulary drug is ineffective and does not have the desired effect. If your treating doctor can provide the necessary proof and the scheme agrees that you suffer from side-effects, or that the drug is ineffective, then the scheme must give you an alternative and pay for it in full.

**Can my scheme make me pay for a PMB from my savings account?**

No, the regulations state that schemes cannot use your medical savings account to pay for PMBs.

**Can my scheme make me pay a co-payment or levy on a PMB?**

No, your scheme cannot charge you a co-payment or levy on a PMB if you follow the scheme formulary and protocol. However, if your scheme appoints a DSP and you voluntarily use a different provider, your scheme may charge you the difference between the actual cost and what it would have paid if you had used the DSP or the percentage co-payment as registered in the scheme rules.

**Can schemes still set a chronic medicine limit?**

Yes, your scheme can set a limit for your chronic medicine benefit. Any chronic medication you claim for will then reduce that limit, regardless of whether or not it is one of the PMB chronic conditions. However, if you exhaust your chronic medicine limit, your scheme will have to continue paying for any chronic medication you obtain from its DSP for a PMB condition.

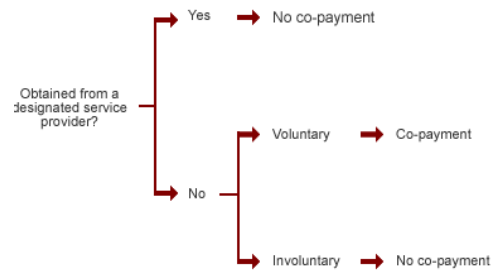
**FROM MEDICAL SCHEMES:**

**When do co-payments apply to PMBs?**

Co-payments can only be levied when members voluntarily choose not to go to a DSP for a specific service, and/or when beneficiaries voluntarily decide not to use protocol or formulary medication or treatments.

Co-payments have to be specified in the medical scheme rules and may never be 100% of the cost of

the service or medication. Schemes are also not allowed to recover co-payments from beneficiaries' savings accounts.



**FROM HEALTHCARE PROVIDERS:**

**Can medical schemes prescribe protocols and formularies?**

Schemes can most certainly prescribe treatment protocols in terms of PMBs to improve their risk management. However, should medical schemes make use of formularies, these must be developed on the basis of evidence-based medicine, taking cost-effectiveness and affordability into account while also being on par with the gazetted algorithms for chronic diseases and the public sector protocols for the DTP

**Is there a process to follow when the formulary is not effective for a specific patient?**

An appeals process is in place for a medical scheme member to request his or her scheme to carry the costs for treatment outside the scheme's formulary. It is very important that complete medical records are submitted in support of the request. As the treating doctor, it is your responsibility to record the patient's reaction to the formulary treatment, including all efforts that were made to determine correct dosages and/or other possible contributing factors.

**If the PMB codes do not always correspond with the ICD-10 codes, what do I do to ensure a correct account?**

The Council for Medical Schemes has compiled a guideline on how to reconcile the two sets of codes. However, whenever there are differences between the ICD-10 codes and PMB codes, the latter takes precedence. This guideline is available on the CMS website [www.medicalschemes.com](http://www.medicalschemes.com) under the Regulatory Info menu as "Prescribed minimum benefit ICD-10 coding".

Please note the above information has been obtained from the CMS website.



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