Note: Prescribed Minimum Benefits

Introduction

The note is prepared to provide an overview of the application of the legal principles regarding Prescribed Minimum Benefits.

Statutory Provisions

Regulation 7 provides the following definitions for Prescribed Minimum Benefits and Prescribed Minimum Benefit Conditions:

'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.

'prescribed minimum benefit condition' *means a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition.*

Prescribed Minimum Benefits are governed by Regulation 8 and 15 of the General Regulations to the Medical Schemes Act. For ease of reference, we provide the wording to Regulation 8 below:

Regulation 8. Prescribed Minimum Benefits

(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 subregulation (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 subregulations (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 health care 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 health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.*

Designated Service Providers

In terms of the Medical Scheme Act and Regulations, medical schemes are obliged to appoint Designated Service Providers for the diagnosis, treatment and care of prescribed minimum conditions on behalf of their members. This takes the form of a contractual relationship between the scheme and the practitioner in which, amongst others, the practitioner agrees to render these services at a specified reimbursement rate. The practitioner also undertakes to adhere to the scheme's treatment protocols and formularies.

It is important to note that many preferred provider /network contracts contain a provision that the participating practitioner is also appointed as a Designated Service Provider.

Voluntary and Involuntary Use of a DSP

Whether or not the patient receives treatment a DSP or a Non-DSP does not negate the scheme' obligation to pay for the services rendered. The distinction comes in at which rate the medical scheme is obliged to pay. In short, where the patient voluntarily makes use of the services of a Non-DSP, the scheme is only obliged to reimburse at scheme rate (not what the Non-DSP charges). If, however, the patient makes use of the services of a non-DSP on an involuntary basis (for example an emergency situation, or where there are no DSPs within a reasonable proximity) then the scheme is obliged to reimburse the service provider "in full" – at the rate at which the service provider usually charges for the services rendered.

Emergencies

An emergency medical condition is defined in Regulation 7 as a 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.

Therefore any planned procedures would not meet the test of "suddenness" or unexpectedness contained in the definition. Planned procedures would not, therefore constitute an "emergency' as contemplated in the PMB regulations, but may, nevertheless still be reimbursed as a PMB if the condition being treated is on the list of PMBs.

Proximity

Regulation at 8(3)(c) does not stipulate a specific distance, but rather uses the term "reasonable proximity" in relation to the beneficiary's place of residence or business. We therefore hold the view that the imposition by medical schemes of a distance to determine this proximity (for example 50 km) is neither provided for, nor permitted, in terms of the legislation. The reasonable proximity of a Designated Service Provider would therefore need to be assessed on a case-by case basis taking into account the individual circumstances of the medical scheme member and location and availability of appropriate Designated Service Providers in order to confirm that the patient obtained services from a non-DSP on an involuntary basis.

Where a beneficiary has involuntarily obtained the services of a Non-DSP in an instance where there are no other DSPs within a reasonable proximity to the beneficiary's place of residence or business, it would be unreasonable and unjustifiable regard that beneficiary's continued use of the non-DSP service provider as voluntary.

Level of Care

The 2017 PMB Code of Conduct has not been implemented yet. This Code of Conduct contains detailed provisions on the level of care in respect of treatment for PMBs.

PMB level of care may not be less than the prevailing / standard level of care that is available in the public sector.

Currently the Clinical Review Committee of the Council for Medical Schemes accept treatment as PMB level of care if said treatment is available in 3 hospitals in **2** different provinces. Highly specialized treatment is accepted as PMB level of care even if it is only available in 1 or 2 public hospitals, due to the available resources in the public sector.

In Hospital and Out of Hospital

PMB Regulations make no distinction between "in hospital" and "out of hospital" diagnosis, treatment and care of PMB conditions. In other words, a patient does not need to be in hospital for their condition to be regarded as a PMB. The determining factor is whether or not the condition suffered by the patient is a PMB condition.

The only implied exception to this is where we are dealing with an emergency condition. Where a patient is admitted for an emergency condition, and subsequently is discharged from hospital, the "emergency" nature of the condition no longer exists and therefore, unless that particular condition is a listed PMB condition, it cannot be reimbursed as such.

Therefore, provided the "out patient" is receiving treatment for a PMB condition – it makes no difference whether the patient is in or out of hospital and the client should be reimbursed in full, provided all other requirements of Regulation 8 are met.

Partial Payment

The wording of Regulation 8 to the Medical Schemes Act is clear. Where a scheme member receives treatment for a Prescribed Minimum Benefit condition on an involuntary basis from a non- Designated Service Provider, the account submitted must be paid **in full**. Section 59(2) of the Medical Schemes Act, which requires the scheme to make payment within 30 days of submission of the account. The Medical Schemes Act and Regulations do not allow or make provision for the practice of partial payment of submitted claims in respect of PMB services obtained involuntarily from Non-DSP practitioners. The mere fact that the PMB is initially reimbursed at scheme rate indicates an acceptance and acknowledgement that the services were, in fact rendered in respect of a PMB condition.

Treatment Algorithms

The Regulations clearly define the treatment for each PMB condition -although these treatment pairings may be outdated in some instances. There has been ongoing work done by the CMS to updated the treatment protocols, but very little meaningful progress has been made in this regard.

Of importance to note is the definition of prescribed minimum benefits which confine PMBs to the provision, treatment and care costs of the diagnosis and treatment pairs listed I Annexure A (to the Regulations). And any emergency medical condition. It can be inferred that the treatment and care for emergency conditions are not "prescribed", but the treatment of non-emergency and listed PMB conditions is confined to the "prescribed" treatment contained in the list (in order to qualify for "payment in full").

A deviation from the treatment prescribed will result in the possibility of a co-payment payable by the member, as the scheme would not be obliged to "pay in full" (unless they agree otherwise).

With regard to the capacity of medical schemes to implement measures to minimize their risk relating to PMB conditions, Regulation 8(4) and (5) allow them to do so. For your ease of reference, I provide these regulations below:

(4) Subject to subregulations (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 health care 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.

These regulations place an onus on the medical scheme member to obtain the requisite pre-authorisation if required by their particular medical scheme. Similarly, as per regulation 8(5), a co-payment may be levied on the scheme member if they knowingly opt for a drug that does not appear on the scheme's formulary.

Where the practitioner is a DSP, they would contractually be bound to adhere to treatment protocols and formularies. Where the practitioner is not a DSP, there is no such contractual obligation, but there is a legislative one. However, in the case of involuntary use of a DSP (which I have previously dealt with at length), there is still the obligation on the scheme member to ensure that they obtain authorisation and adhere to all requirements their scheme may have in respect of PMB conditions. Similarly, the Non-DSP must adhere to the PMB diagnostic and treatment pairs in order to receive payment in full.

Simply put, the involuntary use of the DSP in terms of Regulation 8(2)(b) and (3) will prevent "co-payments" for the involuntary nature of obtaining the services of this DSP. This "exemption" does not extend to a deviation, without authorisation from the medical scheme from their particular requirements relating to pre-authorisation, treatment protocols and formularies (as the case may be).

Billing for Consultative Services | Guidelines for the Addition of Code 0147

Code 0147 read as follows:

0147	For an unscheduled emergency consultation/visit AWAY from the doctor's home or rooms, all hours: ADD only to the consultation/visit items 0190-0192, items 0173-0175, items 0161-0164 or items 0166-0169, as appropriate. Note: Only one of items 0145, 0146 or items 0147 may be charged and not combinations thereof

We note a significant number of claims from certain surgical practices who are billing code 0147 as an add-on to code for ***elective*** surgical procedures that are covered as part of the Prescribed Minimum Benefits (PMB). It is inappropriate to add code 0147 to any claim for elective surgical procedures, irrespective of whether the condition is covered under PMB legislation or not.

In addition, in accordance with the industry standards, code 0147 cannot be billed ***routinely*** together with a first hospital consultation (code 0173-0175). In the case of a of "bona fide" emergency scenario, the addition of code 0147 is indeed appropriate, and it is imperative that the relevant ICD 10 code for the emergency medical condition is also included at the claims line level for both code 0173 and code 0147 e.g., acute myocardial infarction (ICD 10 code I21.9). However, in the clinical scenario where the acute admission was not directly related to an additional emergency, then the addition of code 0147 is inappropriate.

It is important to ensure that the correct billing codes & code combinations are used at all times. Erroneous billing will ultimately result in medical schemes investigating claims and clawing back money already paid to you. It is not a defence to state that the medical schemes have paid claims containing incorrect codes in the past. Incorrect use of codes and code combinations, falls into the category of "fraud, waste and abuse" in the view of medical schemes. Xpedient is always here to assist you where possible, however as the claiming practitioner, you are ultimately responsible for the correctness of accounts submitted to medical schemes.

Conclusion

We trust that the above is of assistance.

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