Pick n Pay

Medical scheme

Understanding Prescribed Minimum Benefits (PMBs)

The following extracts from the Council for Medical Schemes' (CMS) website will assist you in understanding Prescribed Minimum Benefits (PMBs). For more information on PMBs, please visit the CMS website at www.medicalschemes.com.

What are PMBs?

Prescribed Minimum Benefits (PMBs) are a set of limited conditions which medical schemes are legally required to cover. This is 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 wellbeing, and to make healthcare more affordable.

Which conditions are covered?

According to the Medical Schemes Act, medical schemes have to cover the costs related to the diagnosis, treatment and care of the following:

- any emergency medical condition
- a limited set of 270 medical conditions called Diagnosis and Treatment Pairs (DTPs)
- 26 chronic conditions that make up the Chronic Disease List (CDL).

The decision on whether a condition is a PMB should be diagnosis-based. This means that your doctor should only look at your symptoms and not at any other factors e.g., how the injury or condition was contracted. Once the diagnosis has been made, the appropriate treatment and care is decided on, as well as where the patient should receive the treatment (i.e. at a hospital as an outpatient, or in a doctor's rooms).

What are emergency conditions?

An emergency medical condition means the sudden 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 your doctor suspects that you suffer from a condition that is covered by PMBs, your medical scheme has to approve treatment. Medical schemes may request that the diagnosis be confirmed with supporting evidence within a reasonable period of time.

What are DTPs?

Diagnosis and Treatment Pairs (DTPs) are a limited set of ±270 medical conditions that qualify for PMB cover. 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) used in the public sector will be applied. Treatment and care for some of the conditions included in the DTPs may include chronic medication for HIV infection and menopausal management. In these cases, the public sector protocols will also apply to the chronic medication.

Which conditions make up the Chronic Disease List?

The Chronic Disease List (CDL) specifies medication and treatment for the following 26 chronic conditions:

- Addison's disease
- Asthma
- Bipolar mood disorder
- Bronchiectasis
- Cardiac failure
- Cardiomyopathy disease
- Chronic obstructive pulmonary disease (COPD)
- Chronic renal disease
- Coronary artery disease
- Crohn's disease
- Diabetes insipidus
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Dysrhythmias
- Epilepsy
- Glaucoma
- Haemophilia
- Hyperlipidaemia (high cholesterol)
- Hypertension (high blood pressure)
- Hypothyroidism
- Multiple sclerosis
- Parkinson's disease
- Rheumatoid arthritis
- Schizophrenia
- Systemic lupus erythematosus
- 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 may not be inferior to the algorithms. If you have one of the 26 listed chronic conditions, your medical scheme not only has to cover medication, but also doctors' consultations and tests related to your condition(s). Your medical scheme may use protocols, formularies (lists of specified medication) and Designated Service Providers (DSPs) to manage this benefit.

Note:

For most medical schemes, these benefits are subject to pre-authorisation, the application of clinical protocols and treatment care plans. This means that you **MUST** apply for these benefits, or you may lose your entitlement to them. Certain benefits are also only covered in full if you use the DSP (contracted provider) nominated by your medical scheme (refer to your benefit schedule for details). Where sub-limits are specified for chronic medication, these are first used to pay for all chronic medication (including PMBs), and thereafter continued benefits are only provided for PMBs.

As a medical scheme member, what are my responsibilities with regard to PMBs?

- You need to obtain as much information as possible about your condition(s) and the medication and treatments for it. If generic medication is available, find out whether there are any differences between it and the branded, original drug.
- If you need a general practitioner (GP) to refer you to a specialist, then do so. Use your medical scheme's DSPs as far as possible.
- Stick with your medical scheme's medication formulary for your medication, unless it is proven to be ineffective.
- Make sure that your doctor submits a complete account to your medical scheme. It is especially important that the correct diagnosis codes (ICD-10 codes) are reflected. Follow up and check that your account is submitted within four months and paid within 30 days after the claim was received, as accounts older than four months are not paid by medical schemes.

Q&As on PMBs

1. **Is it true that medical schemes must provide chronic medication?**

   Yes, the list of PMBs includes 26 common chronic conditions in the Chronic Disease List (CDL) and other (±270) chronic conditions within the Diagnosis and Treatment Pairs (DTP) list. Medical schemes have to provide cover for the diagnosis, treatment and care of these conditions. However, you should remember that your 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 conditions on the DTP list 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 the treatment you need for any of these conditions without incurring costs that your medical scheme does not cover.

2. **Does my medical scheme need to do anything to ensure that the DSP can treat me?**

   The Council for Medical Schemes (CMS) 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. Other medical schemes have made arrangements with private hospitals and certain retail pharmacies to treat their beneficiaries.

Q&As on PMBs (continued)

3. **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 condition(s) and equipping them to manage it in a way that keeps them as healthy as possible. For example, many medical schemes offer treatment through groups that manage specific conditions such as diabetes, and are also equipped to administer medication and monitor your condition(s).

4. **Can my medical scheme insist that it will only fund treatment that follows the appropriate protocols?**

   Yes. The minimum medications for treatment of all PMB conditions have been published in the Government Gazette and are known as treatment algorithms (benchmarks for treatment). Your medical scheme may decide which medication it will cover for each chronic condition, but the treatment may not be below the standards published in the treatment protocols. 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.

5. **Can my medical scheme refuse to cover my medication if I need, or want, a brand other than that what my medical scheme will pay for?**

   Yes, your medical scheme may refuse to cover a portion of the expenses. Your medical scheme may draw up what is known as a formulary, i.e. a list of safe and effective medication that can be prescribed to treat certain conditions. Your medical scheme may state in its rules that it will only cover your medication in full if your doctor prescribes a drug that is listed on that formulary. Medical schemes generally expect their members to stick to the formulary medication. If you suffer from specific side effects to drugs on the formulary, or if substituting a drug on the formulary with one you are currently taking is detrimental to your health, you may ask your medical scheme to pay for your medication. Your treating doctor will need to provide the necessary proof and submit a clinical motivation why you may not substitute your medication. If your medical scheme advisor agrees with the doctor's motivation and it complies with treatment protocols, then your medical scheme may agree to cover you for an alternative.

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

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

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

   No, your medical scheme cannot charge you a co-payment or levy on a PMB if you follow their formulary and protocols. However, if your medical scheme appoints a Designated Service Provider (DSP) and you voluntarily use a different provider, you will be subject to a co-payment (calculated as the difference between the actual cost and what it would have cost if you had used the DSP).

8. **Can my medical scheme still set a chronic medication limit?**

   Yes, your medical scheme can set a limit on your chronic medication benefit. Any chronic medication you claim for will then reduce that limit, regardless of whether it is one of the PMB chronic conditions. However, if you exhaust your chronic medication limit, your medical scheme will have to continue paying for any chronic medication you obtain from its DSP for a PMB condition.

9. **Am I covered for PMBs if I have chosen a basic hospital plan with my medical scheme?**

   Yes, all benefit options, regardless of contribution levels, must cover PMBs in- and out-of-hospital, including the 26 chronic conditions.

Source: Council for Medical Schemes