



CMScript

*Member of a medical scheme?
Know your guaranteed benefits!*

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The Council for Medical Schemes' Clinical Unit receives numerous enquiries on the short payment of accounts related to conditions that are not included in the Prescribed Minimum Benefit (PMB) regulations or has limited PMB cover.

Introduction

In this Script, the three conditions that relate to the majority of enquiries will be discussed. The article will further provide information on how you as a member can manage your financial risk and ensure that out-of-pocket payments are as minimal as possible. The article will however not discuss the reasons why the conditions were not included or limited in the PMBs, defend or criticise the current regulations.

Conditions/illnesses queried most often

Osteoarthritis

Osteoarthritis is the most common joint disease. The condition is however not included in the PMB regulations.

Osteoarthritis occurs when the protective cartilage on the ends of your bones wears down over time. Other risk factors of the condition include older age, gender, obesity, joint injuries and trauma, work related repetitive stress on the joint, genetics / inherited tendency, bone deformities and other conditions such as gout or diabetes mellitus.

Although osteoarthritis can damage any joint in your body, the disorder most commonly affects joints in your hands, knees, hips and spine. Treatment of the disease usually focus on decreasing pain and increasing movement of the joint. Medication is often used as pain treatment but when the cartilage is completely worn out and you have bone rubbing against bone, joint replacement surgery may be considered.

Most of the enquiries received at the CMS relate to the surgical intervention and specifically joint replacements. Medical schemes often have strict limits on joint replacement surgery or even exclude funding for joint replacements unless the condition is a PMB.

Joint replacement surgery entails that the affected joint is replaced by an internal prosthesis (artificial joint) to improve function of the joint. The cost of the actual surgery will include the hospitalisation, the orthopaedic surgeon, assistant to the surgeon, the anaesthetist, the joint prosthesis, physiotherapy and



medication for pain and antibiotics when necessary (in-hospital and to take home). The surgery can be very expensive and result in large co-payments (payment from your own pocket). Co-payments can be from any of the accounts mentioned. The following suggestions may assist you to know what your plan covers, potential co-payment and financial preparedness for your surgery. Make sure exactly what benefits, if any, your specific medical scheme benefit option pay towards joint replacement surgery: Ask your surgeon for the procedure codes and cost for each code. Make sure that the code for the specific prosthesis is also provided to you.

- Contact your medical scheme and ask what the medical scheme tariff for each of these codes are (medical scheme tariff is the price that the scheme will pay for the specific code).
- Discuss the medical scheme tariff with your surgeon and negotiate the price that you will pay.
- Your surgeon must obtain your written consent for

each of the charges before you have the surgery.

- Try to use a scheme designated provider. The scheme may appoint a surgeon, hospital and anaesthetists as designated service providers. These providers usually have agreements with the schemes for non-PMB's as well.
- Ask your scheme to provide you with a designated service provider for the prosthesis if possible.
- Determine if there is a shortfall and make plans how this will be funded.
- As most of the joint replacement surgeries are not an emergency, try to obtain codes from other providers. Your GP or scheme may recommend other surgeons.

The above mentioned information will assist you in calculating how much you will need to pay out of your own pocket.

Hernias

Hernias are caused by a combination of pressure and an opening or weakness of the muscle or fascia (sheet of connective tissue covering or binding together body structures). The pressure pushes an organ or tissue through the opening or weak spot. Sometimes the muscle weakness is present at birth; more often, it occurs later in life.

The most common types of hernias are inguinal (inner groin), incisional (resulting from a cut/incision/operation), femoral (outer groin), umbilical (belly button), and hiatus (upper stomach).

Anything that causes an increase in pressure in the abdomen can cause a hernia, including:

- Lifting heavy objects without stabilising the abdominal muscles
- Diarrhea or constipation
- Persistent coughing or sneezing
- In addition, obesity, poor nutrition, and smoking can all weaken muscles and make hernias more likely.

If left untreated, a hernia may grow larger and become more painful. A portion of your intestine could become trapped, or "incarcerated," in the abdominal wall. This can obstruct your bowel, causing severe pain, nausea, and constipation. If the trapped section of intestine cannot receive enough blood flow, "strangulation" occurs. This can cause the intestinal tissue to become infected or die (gangrene) and is a life threatening medical emergency.

The treatment of a hernia is determined by the size and the severity of the symptoms that you experience. Small hernias can be treated with dietary changes and medication but larger hernias may need surgical repair.

Hernias are included in the PMB regulations only when:

- You are younger than 18 years
- It is complicated with obstruction and/or gangrene
- Hernia surgery entails that the hole in the abdominal wall is closed. The most common treatment is to patch the hole with surgical mesh. The cost of the actual surgery will in-

clude the hospitalisation, general surgeon and his assistant, the anaesthetist and the surgical mesh (an internal prosthesis). The surgery can be very expensive and result in large co-payments (payment from your own pocket).

If your condition does not qualify as a PMB the following suggestions may assist you to know what your co-payments will be and help to keep these at a minimum:

- Ask your surgeon for the procedure codes and cost for each code. Make sure that the code for the specific prosthesis is also provided to you.
- Contact your medical scheme and ask what the medical scheme tariff for each of these codes are (medical scheme tariff is the price that the scheme will pay for the specific code).
- Discuss the medical scheme tariff with your surgeon and negotiate the price that you will pay.
- Your surgeon must obtain your written consent for each of the charges before you have the surgery.
- Try to use a scheme designated provider. The scheme may appoint a surgeon, hospital and anaesthetists as designated service providers. These providers usually have agreements with the schemes for non-PMB's as well.
- Ask your scheme to provide you with a designated service provider for the prosthesis if possible.
- Determine if there is a shortfall and make plans how this will be funded.

The above mentioned information will assist you in calculating how much you will need to pay out of your own pocket.

If your hernia however qualifies for PMB cover the medical scheme should fund the surgery as such. However the Medical Schemes Act allow for certain limits. The medical scheme may:

- Require you to use a designated service provider. If you voluntarily use a non-designated service the medical scheme may implement a co-payment as specified in the scheme rules.
- Fund the mesh (internal prosthesis) in full provided that it is the same type of mesh that would have been used in the public/state sector.
- Fund the mesh from your annual internal prosthesis limit first. If the annual limit is not sufficient the remainder of the cost should be funded from the risk pool.

As the above may cause co-payments it is suggested that you:

- Contact your medical scheme and ask who the designated service provider is.
- Ask your surgeon for the codes that will be charged. This will include the procedure codes and the mesh (internal prosthesis) that will be used.
- Contact your medical scheme and ask whether the specific type of mesh will be funded in full. If not make sure that you know what part of the cost will be for your own pocket.
- Ask your scheme to provide you with a designated service provider for the prosthesis.
- Determine if there is a shortfall and make plans how this will be funded.



Sleep apnoea

Sleep apnoea is a potentially serious sleep disorder in which breathing repeatedly stops and starts. You may have sleep apnoea if you snore loudly and you feel tired even after a full night's sleep.

There are two main types of sleep apnoea:

- Obstructive sleep apnoea, the more common form that occurs when throat muscles relax
- Central sleep apnoea, which occurs when your brain doesn't send proper signals to the muscles that control breathing

Mild cases of sleep apnoea are usually treated with lifestyle changes such as losing weight and smoking cessation. More severe cases however may require the use of continuous positive airway pressure (CPAP) machines during sleep.

Continuous positive airway pressure (CPAP) involves wearing a pressurised mask over your nose while you sleep. The mask is attached to a small pump that forces air through your airway to keep it from collapsing. CPAP may eliminate snoring and prevent sleep apnoea.

The enquiries and complaints received by the CMS are usually that the medical schemes reject funding of the CPAP machine or that only a small amount of money is available.

Sleep apnoea is only included in the PMB regulations if you also suffer from cor pulmonale.

Cor Pulmonale is failure of the right side of the heart (right ventricle failure). It is caused by long-term high blood pressure in the arteries of the lung and right ventricle of the heart.

The medical scheme may therefore request clinical evidence that confirms the diagnosis of cor pulmonale before benefits for the CPAP machine are provided. If there is no clinical evidence

that you do not suffer from cor pulmonale, the medical scheme is not legally obliged to pay the sleep studies and CPAP machine as they do not qualify as PMB level of care.

If you are diagnosed with sleep apnoea but do not suffer from Cor Pulmonale, it is suggested that you:

- Contact your medical scheme and ask who the designated service provider is (if any).
- Ask your doctor for the code of the CPAP machine that you should use.
- Contact your medical scheme and ask what benefits are available on your specific benefit option for the CPAP machine prescribed by the doctor.
- Check if your scheme has a designated service provider for CPAP machines.
- Where possible ask the provider to assist you with obtaining codes from several companies. It should be noted that your doctor may have preferences based on your clinical condition. In this instance you as a member will not have sufficient evidence to shop around for better quotations.

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PMBs

Prescribed minimum benefits (PMBs) are defined by law. They are the minimum level of diagnosis, treatment, and care that your medical scheme must cover – and it must pay for your PMB condition/s from its risk pool and in full. There are medical interventions available over and above those prescribed for PMB conditions but your scheme may choose not to pay for them. A designated service provider (DSP) is a healthcare provider (e.g. doctor, pharmacist, hospital) that is your medical scheme's first choice when you need treatment or care for a PMB condition. You can use a non-DSP voluntarily or involuntarily but be aware that when you choose to use a non-DSP, you may have to pay a portion of the bill as a co-payment. PMBs include 270 serious health conditions, any emergency condition, and 25 chronic diseases; they can be found on our website by accessing the link provided (www.medicalschemes.com/medical_schemes_pmb/index.htm).

The Communications Unit would like to thank
Ronelle Smit for assisting with this edition of CMScript
information@medicalschemes.com

Hotline: 0861 123 267
Fax: 012 430 7644

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