A QUADPARA ASSOCIATION OF SOUTH AFRICA PUBLICATION

Reimbursement Toolkit

“Navigating your way in successfully dealing with medical schemes”

Reimbursement pathway for Health and Wellness

QuadPara
Association of South Africa (QASA)

WWW.QASA.CO.ZA

QASA vision

All South African Quadriplegics and Paraplegics will live their lives to their full potential.

Content

Foreword

It is with great pride and enthusiasm that the Quadpara Association of South Africa (QASA) presents this *Reimbursement Toolkit*, a valuable and practical guide for understanding and accessing the best healthcare services for managing the bladder of spinal cord-afflicted patients in South Africa.

This toolkit incorporates essential bladder management guidelines published in the South African Medical Journal (S Afr Med J 2019;2(part 2):195-202. DOI:10.7196/SAMJ.2019.v109i3b.13690) in March 2019, encompassing the best practices in bladder management.

The importance of this toolkit cannot be overstated, as it provides crucial information on the reimbursement pathway and necessary templates for rightful reimbursement. Its continued demand for distribution is a testament to the invaluable content it offers.

QASA extends its heartfelt gratitude to all those who contributed to the gathering of information for this publication. The collaboration with the Southern African Spinal Cord Association (SASCA) and the joint efforts of the Clinical Advisory Panel (CAP), academics, clinicians, and consumers of health services have been instrumental in shaping the toolkit's vision, promoting full participation, and striving to enhance the lives of those affected by spinal cord injuries.

As an organisation, we remain confident that our involvement in this publication will contribute to the long-term objective of establishing comprehensive bladder management guidelines in South Africa, aligning with global best practices to improve the quality of life for individuals with a neurogenic bladder following spinal cord injuries.

To ensure the relevance and up-to-date nature of the information, we continuously update this booklet, incorporating innovations, emerging trends, and new insights to inform and empower our members. Through this process, healthcare practitioners can better understand changes and provide lasting support to individuals with spinal injuries through the dissemination of this booklet.

In conclusion, we hope that this *Reimbursement Toolkit* continues to serve as a valuable source of support for those in need of essential information, empowering individuals, and enhancing the healthcare landscape for the betterment of all.

Richard Barron
General Manager
QASA

Contact us

031 767 0352
info@qasa.co.za
www.qasa.co.za

Follow us

@QuadParaSA
Quadpara Association
@quadpara
@Quadpara

Background and use of this guide

This self-help booklet is intended to guide those with spinal cord injuries and/or afflictions on how to navigate through the often complex reimbursement processes that you will encounter when making claims for the healthcare products and services you need.

We use the example of claiming for benefits for intermittent catheters in bladder management. The same principles apply for any reimbursement pathway and process requirements, including assistive devices and medicines.

The process is described in four logical and consecutive steps, each represented by its own flow diagram with an explanation for each of them. These are:

1. Doctor, nurse, clinic or hospital visit;
2. Application for reimbursement by funder (for example, medical scheme, Road Accident Fund or Compensation Fund);
3. Handling responses from funders; and
4. Using complaints and appeals mechanisms.

Each step has a set of activities to ensure that you collect and use the correct information. An explanation of the principles and concepts are provided where relevant in the "Explainers" section found on page 18 of this guide.

Relevant templates (Form 1 and Form 2) are provided. Further guidance is provided in appendices on:

- How you should write a good and complete motivation (Appendix 1a).
- What you can say and/or do when you receive specific reasons for decline of your motivation for benefits (Appendix 2).
- A checklist for gathering information as required for reimbursement (Appendix 3).

References are made to different concepts that may be of a technical nature. Explanations of these can be found in the "Explainers" section found on page 18.

This will help you prove that you have followed the process and gathered all relevant information should you need to complain or appeal a decision made.

Disclaimer:

This guide is designed to be used as a reference only with regards to the reimbursement process and may NOT be re-produced and/or distributed in any form. The information herein is subject to change when new information becomes available and changes to the respective processes are made (please refer to the QASA website for updates).

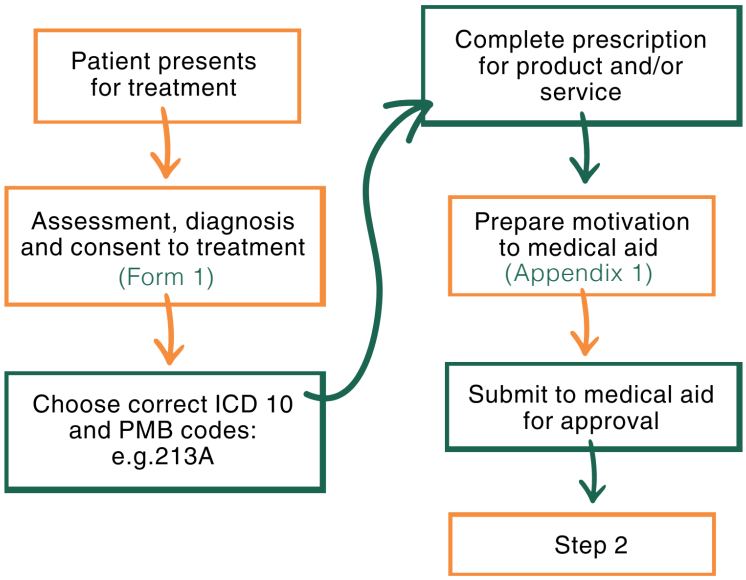
It still remains the responsibility of the hospital/doctor and/or patient to establish what services are covered by their respective medical funds according to benefits/cover purchased. This information is provided for information only and does not represent any statement, promise or guarantee by QASA and/or SASCA concerning levels of reimbursement or charges.

Typical Reimbursement Pathway

for healthcare services, medicines and devices (e.g. single-use hydrophillic catheters)

Step One

Doctor, nurse or hospital visit



Your reimbursement journey begins with your healthcare professional (for example, a doctor or nurse) regardless of whether you are presenting for treatment for the first time (initial injury), or for a subsequent visit as part of follow up, or if the need arises.

During this visit, your healthcare professional must confirm your diagnosis and use the correct International Classification of Diseases (ICD10) code. They must prescribe the most appropriate treatments (product and/or services) to manage your condition.

Note that there may be more than one ICD10 code for your health, and it is important that all the codes are added, specifically those that are Prescribed Minimum Benefit (PMB) in medical schemes.

During the visit, the healthcare professional will examine you, ask questions (assessment) and make a diagnosis. The healthcare professional should discuss your health, the diagnosis and all treatment alternatives with you. You have to agree to a treatment path, this agreement is called “consent to treatment”.

Reference:

Explainers: The consent to treatment/care form template.

Form 1: Requirements for “informed consent” form.

This is an important step for reimbursement of health services as it makes clear why you need a specific treatment, product or other intervention (e.g. hospital admission). Although it is not required by law to have consent in writing, written consent helps in the reimbursement process.

Your healthcare professional should discuss with you the treatment options. For example, what are the various ways of bladder management; what are the available products; and what are the benefits, risks and costs of each. Bladder infections, for example, is a common risk of not using intermittent catheters.

The product and management of any complications may have cost implications. Then, your healthcare professional must provide you with clear instructions.

As we stated above, your healthcare professional's diagnosis must be accompanied with the correct ICD10 Codes. These Codes also identify whether a health condition falls within a PMB.

Note that non-PMBs can be part of medical scheme benefits. Always check with your medical scheme. If they do fund a non-PMB condition, such funding must still be scientific and medically defensible.

Reference:
Explainers: Prescribed Minimum Benefit (PMB)

One of the biggest problems with getting medical aids to pay out PMB benefits is the use of incorrect codes. It is vital that the doctor chooses and includes the correct PMB and ICD10 codes in their motivation letter.

As an example, The PMB code according to the Council for Medical Schemes for spinal/neurological patients with eating, breathing, swallowing, bowel and bladder problems is PMB 213A.

The ICD10 codes relating to the condition (whether paraplegic/quadriplegic) are from G81.0 to G82.5. The ICD10 codes relating to the bladder condition are from N31.0 to N31.9.

References:
Relevant Diagnosis Codes within PMB 213A

This table may be used as a guideline, but the doctor will have access to a complete list of all relevant codes.

The only exception where a PMB is not reimbursed is when the member is new to a medical scheme and was not a member of another scheme before.

Exclusion of funding for a limited period may then be applied. If you move from one medical scheme to another within three months, no exclusions should apply for any PMB.

Please seek assistance if you are unsure about whether the scheme is permitted to impose these so-called "waiting periods".

PMBs should not affect your savings and are paid out of the common risk pool, as

a risk benefit. This also applies to another medical expense that is a PMB, for example care or appliances.

These must be covered "in full" even over and above limits the scheme may set. All PMB care must be funded in full. PMB funds can, therefore, not be "exhausted" or a co-payment levied.

This of course applies only when the specific care or product is the only care or product for you and would prevent harm.

References:
Explainers: Co-payments.

Explainers: Designated Service Providers (DSPs).

Once the assessment and diagnosis have been completed, and you have consented to a specific treatment, the healthcare professional must complete the relevant form for reimbursement as a PMB. This is commonly called a "motivation".

If you are newly diagnosed with a PMB, some schemes require that the PMB condition be registered.

Please remember that these forms and letters must include the correct ICD10 and PMB codes.

This motivation form must make it clear why you require a particular type of treatment, medicine and/or device; how often and so on.

You, as the patient, must also understand "why" you need the specific treatment or product, and why other or some options are not appropriate for you. For example, if you previously had bladder infections due to the type of catheter you used.

References:
Appendix 1a: Key questions for a motivation.

Appendix 1b: Checklist for writing a motivation.

Explainers: Differences between a PMB Limit and a Chronic Medication Limit.

A prescription for all products and services (including product so-called "NAPPI Codes") MUST accompany the motivation. Either you, the practice or health facility submits this to the funder.

Note that as your condition is permanent, only a single application/motivation to the medical scheme for reimbursement is required.

Schemes should not require annual applications for funding for permanent conditions where it is not necessary and where the patient's condition does not change.

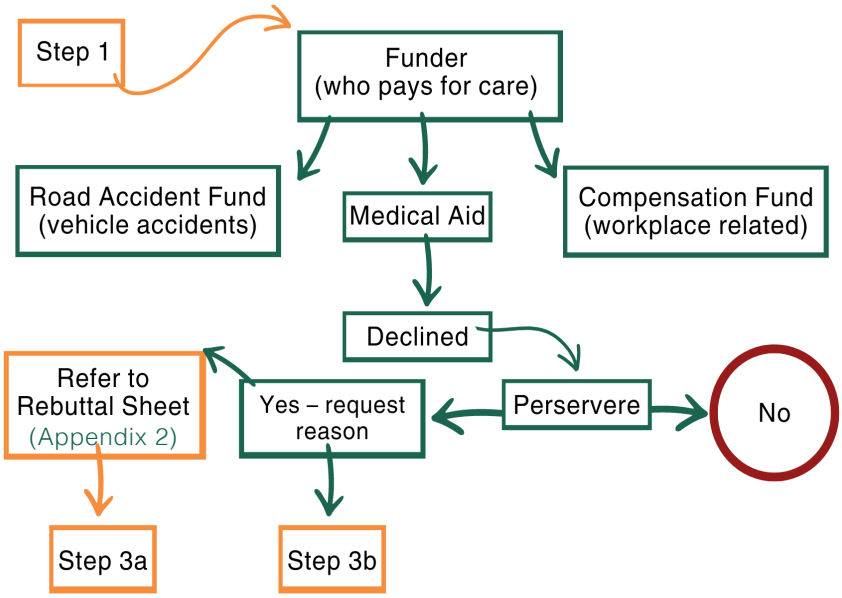
References:
Explainers: Completing a Prescription

Explainers: NAPPI Code

Step Two

Application for reimbursement by funder

(medical scheme, Road Accident Fund, Compensation Fund)



The above process diagram lists different types of funders, but continues to describe the typical process for reimbursement within the medical scheme environment. The process for claims from the Compensation Fund, for workplace injuries and disease, and the Road Accident Fund (RAF) may differ, but the principles apply in all cases:

- What is appropriate for your specific health needs, and
- What is scientifically defensible ("evidence-based medicine").

The motivation for reimbursement, which should use the above principles of appropriateness and evidence-based medicine, is submitted by you, the practice or health facility, to your medical scheme. If the motivation and/or claim is rejected/ declined, you are entitled to request the reasons for the rejection. This will help you take the matter to the next step. Reasons provided for any decline may include, for example, "no benefits"; "state level of care"; "limits/caps exceeded"; or "scheme exclusion".

Please refer to the "Rebuttal sheet" (page 13), which is a list of anticipated reasons for declines and the suggested responses and rebuttals.

If there is any suggestion to pay a portion and/or funding out of savings accounts, note that this is not allowed for PMB conditions. If the reason for decline is not provided, you may use any of the arguments on the rebuttal sheet to challenge the rejection.

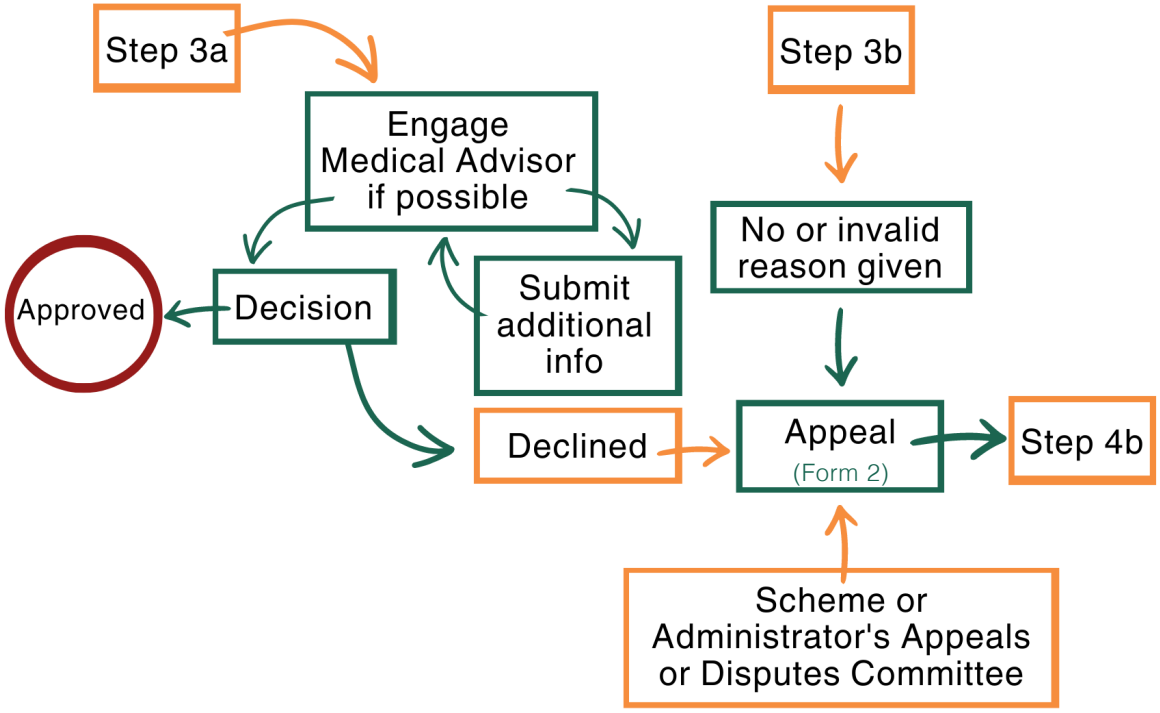
References:

Appendix 1a: Key questions for a motivation.

Appendix 2: Rebuttal sheet.

Step Three

Handling responses from funders



If the claim is rejected again, your doctor or other healthcare professional should speak with the relevant Medical Advisor for the scheme (Step 3a).

This allows the healthcare professional treating you to explain exactly why you need the specific treatment or product. The scheme's medical advisor may request further information from your healthcare professional.

If your claim is declined after relevant medical advisor has spoken with your healthcare provider, and there is no valid reason (Step 3b), then move on to the medical scheme appeal process.

This internal medical scheme process can be started by using the letter template provided on page 11. This is sent to the Scheme or scheme Administrator Appeals Committee who will have to follow a disputes resolution process.

Most scheme decline letters include the details of this appeals process. If not, please contact the scheme's general number and ask for the e-mail address to which appeals within the scheme is to be sent.

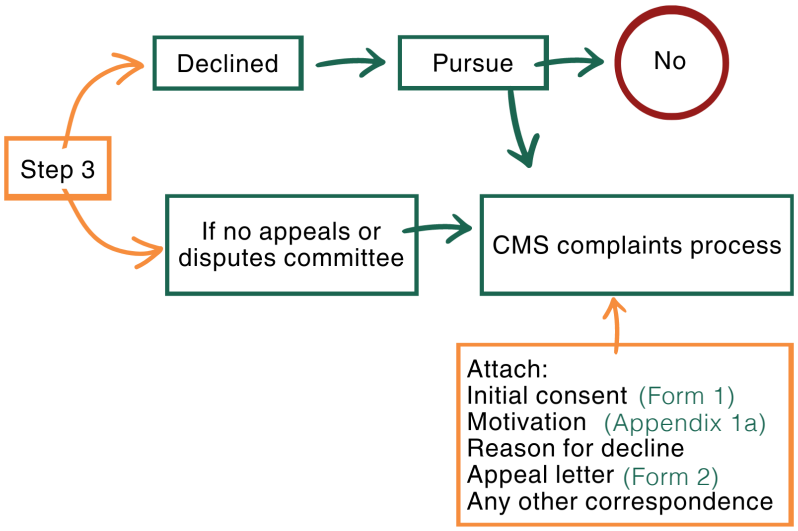
If there is no such process, proceed to a Council for Medical Schemes (CMS) complaint (Step 4).

References:

Form 2: Appeal against medical scheme decision letter template.

Step Four

Using complaints and appeals mechanisms



If your internal scheme appeal letter is still unsuccessful and your request declined (from Step 3); and/or if there is no appeals or disputes committee within the scheme and you still cannot find any resolution to your motivation for reimbursement, your next port of call is the Council for Medical Schemes (CMS). Any medical scheme member or dependent who is aggrieved with the scheme's decision can submit a complaint to the CMS. The Council has the power to instruct a scheme to fund a treatment or product in full. The complaints procedure and relevant forms can be found the on CMS website: **www.medicalschemes.co.za**.

The complaint should be accompanied by all documentation including the initial consent to treatment and care form (Form 1), the motivation form (Appendix 1a), the scheme rules referred to, the decline letter, any other correspondence with the scheme, the appeal committee letter, if applicable (Form 2) and all reasons for decline at each stage of the process.

Tip: Name the Annexures to clearly indicate what the document contains. Refer to the Annexures in your complaint sequentially. For example, in your letter you may write:

I have been diagnosed with … This means that I have a neurogenic bladder. The PMB and ICD10 codes are … (See Annexure "A").

Name the file Annexure "A" as follows: "AnnexureA_DoctorMotivationLetter20230630".

If you battle to attach the various supporting documents to the CMS online complaints portal, the complaint and supporting documents can be e-mail to complaints@medicalschemes.co.za

Your medical scheme must be kept updated of changes in your health status and your health needs. For this, all doctors, pharmacists, etc., involved in your treatment and care must at all times have correct (and if needed, updated) ICD10 codes, updated motivations, new prescriptions, etc.

A checklist is available for the member to ensure as much information is included when claiming for reimbursement and that the process is thoroughly followed.

References:
Appendix 3: Reimbursement Checklist.

Form 1 Requirements for "informed consent" form

1. Healthcare professional practice details, including their professional number and practice code number.

2. Patient details, including their medical scheme details (specifically whether the patient is the main member or dependent), and the pateint's demographic details.

3. Information on the patient's health:
   - Health status of the patient (how "well'" the patient is and/or specific challenges experienced, for example, bladder infections);
   - Diagnosis / diagnoses;
   - ICD10 Code(s), indicating as well inter-related codes; and
   - PMB Code(s), indicating as well where a specific health situation is as a result of a PMB.

4. Patient declaration that:

In order to make an informed decision on the appropriateness of treatment, the patient must also declare that they have been informed of the following:

- The treatment options. For example, with a neurogenic bladder, the patient should be informed about what the bladder management options are, and the various products associated with the options.
- The benefits of the various treatment options and products on the market.
- The risks associated with the options and products, including the risk of not being optimally treated, for example if work circumstances makes sterilisation of products difficult, and the risk of complications, such as infections.

5. The patient must then be informed of the cost, which may include the cost of complications, should their chosen treatment and/or product not be reimbursed, or should they chose a product that comes with such risks.

6. The patient must then agree to their chosen treatment option and products.

Form 2 Appeal against medical scheme decision letter template

On the next page, a letter template can be found that can assist with structuring your appeal against a medical scheme decision. Simply complete the sections indicated with brackets [], include any supporting documents and submit.

Letterhead (or patient / patient family member)

By e-mail (date)

Dear Principal Officer / Medical Advisor

RE: INTERNAL APPEAL AGAINST / DISPUTE OF DECISION TO DECLINE BENEFITS

Patient initials and surname:
Patient medical scheme nr:

You have declined the motivation for [list specific treatment or product], as submitted to you on [date]. The decline, which has been communicated to us telephonically [or: "in a letter/e-mail dated …"] stipulated that [paraphrase what the decline stated].

As the treatment / product is used in relation to the treatment and care of a PMB, in this case _____ [list], your attention is drawn to regulation 8. It requires that the diagnosis, treatment, and care costs of a PMB condition, which has to be funded "in full and without co-pay".

A co-payment may only be imposed if the patient would have been appropriately treated on an alternative product. This is not the case with this patient, and the experience is [please elaborate on what impact has been on patient].

The law requires protocols and formularies to be based on evidence-based medicine. We are not clear as to what exactly in evidence-based medicine justifies the specific decline. Please, in your reply, provide us with copies of the evidence that underpins the rule, policy and/or protocol on which this decision is based.

We look forward to hearing from you on this matter within the next ____ days. As this is an urgent matter, due to the nature of the wound, any delay could seriously prejudice the patient.

I attach the following documents to assist in this matter [delete what is not applicable and add additional information if previously supplied]:
(a) Patient consent to treatment
(b) Healthcare professional motivation
(c) Clinical information [attach e.g. hospital admissions, other medicines / products prescribed, pathology test results, etc.]
(d) Clinical guidelines / treatment guidelines relating to [insert]
(e) …

Should I / the patient suffer any harm resulting from your refusal to fund this treatment, or a subsequent switch in treatment, liability will pass unto the scheme, as the cause of such harm.

_____

Patient signature or patient authorised representative signature

Appendix 1a

Key questions for a motivation

Here are key questions for your doctor to precede a motivation to a medical scheme.

1. What does my condition mean? Are there aspects of my health to consider, such as previous hospital visits, my other treatments, or my job or home life?

2. What will this treatment and/or product take from me? What do I need to do on a daily basis?

3. What will happen if I choose the treatment or products that my scheme will definitely fund?

4. Why are the scheme-recommended treatment(s) or product(s) not appropriate for me? Why will I not be okay on them?

5. Why do you recommend the specific products or types of products? Why is it appropriate for me?

6. Will I still be okay on alternative products?

7. What could happen if I am not on the recommended treatment or product?

Appendix 1b

Checklist for writing a motivation

1. Patient Information
   - Name, address and contact number/s;
   - Medical scheme and option/plan;
   - Medical scheme number;
   - Whether patient is main member or beneficiary; and
   - Date of service.

2. Medical Practitioners Information:
   - Name of treating doctor;
   - Practice number; and
   - Practice address and contact number/s (if not on letterhead).

3. Assessment and Diagnosis:
   - Patient medical history; and
   - Indicate all relevant codes clearly for the prescribed minimum benefit (PMB) condition, or related conditions, including:
     - Primary Diagnosis (ICD10 Code);
     - Secondary Diagnosis (ICD10 Code); and
     - PMB Code and description.

4. Treatment (service; medicines; consumables; assistive devices etc)
   - Describe the specific condition where it can be concluded that, in terms of clinical research (evidence) and data, the prescribed treatment and/or products are required?
   - Describe symptoms, test results etc listed, that logically show why the specific treatment is required?
   - Describe in detail other conditions and/or consequences (adverse events) that may be caused by failure to treat with the proposed treatment.
   - Indicate clearly if scheme-

recommended products were used before, and if it did not work (treatment failure).
- Indicated if harm has been suffered, or could be suffered, if the recommended treatment is not followed, and why this would be the case (e.g. urinary tract infections previously).
- Important: Attach or insert references to treatment protocols or guidelines, scientific research, medical articles, consensus statements, etc.

5. Service provider
   - Why a DSP (if applicable/imposed) would not be suitable, e.g. DSP is not available, does not render the required services, is too far from patient's home or work or immediate care was / is required.

6. Patient and doctor signature/s

Appendix 2 Rebuttal sheet

What to say when motivation is declined

What scheme says	What you say	Legal basis for your view
The product is not on our formulary / list	How was your list compiled? What evidence have you used to get to the list, and to compare products? I require this product, and not one of the products on your list, because [other products have previously not worked, have caused me adverse events (rashes, irritation, etc.) or harm (hospitalisation because of an infection, etc.)].	Regulation 15 of the Medical Scheme Regulations of 1999 Regulation 15H
The product is too expensive / there is a cheaper alternative	The law requires schemes to evaluate cost-effectiveness, not whether a product is expensive or cheap. The benefit in the longer run, compared to the cost, including the cost of managing complications, must be considered.	Regulation 15G and 15H
The products are all basically the same	How did you evaluate that? Remember that not all patients tolerate all products in the same manner, and not all patients' needs are the same.	Regulation 15, 15I and 15H
You must upgrade to a higher option to get access to more / better benefits	All options must cover treatment and care for the PMBs in full. One is always entitled to appropriate care, irrespective of the option or plan.	Regulation 8

What scheme says	What you say	Legal basis for your view
Your appliance benefit is exhausted	All PMB benefits must be funded in full, i.e. one cannot run out of benefits for the treatment and care of one's PMB condition.	Regulation 8, regulation 15G
The same product works for all patients	The clinical needs and clinical experience of patients with different circumstances differ. The definition of evidence-based medicine recognises "individual clinical experience". It cannot be assumed that all products and all patients are the same.	Regulation 15
Please provide us with a quotation	I will gladly do so. However, remember that the cost alone is not the relevant factor, what is appropriate for the specific patient, is and what is "cost-effective".	Regulation 15, 15H
That product is not available in the state sector	I did not buy medical scheme cover to get state care. Where in the scheme's information does it say I could only get what is available in the public sector? The reasons why products are not available in the state sector is different to why medical schemes should or should not fund.	Consumer Protection Act
This is paid from savings	PMBs must be paid from the common risk pool.	Regulation 8
We can only provide x number of products per month	How did you determine that that number is adequate care for a person like me? The law states that what must be provided must be substantiated with what literature, clinical experience and research shows as appropriate. If you force me to re-use single-use items, and I get an infection, I would suffer harm and the law states that schemes must make exceptions to their general rules if there could be harm.	Regulation 15 Regulation 15H
It's in the rules, and we must always abide by the rules	No, the CMS has made it clear that the rules must comply with the law. How do your rules comply with PMB regulations, evidence-based medicine and/or clinical appropriateness?	CMS Annual report 2011/12

Appendix 3 Reimbursement Checklist

Here is the information you will need at various stages of the process of reimbursement. Your right to information and choice is underpinned by the Consumber Protection Act (CPA) and the National Health Act (NHA).

1. When talking to your doctor about your condition and giving consent for treatment:
   - ☑ Has he/she described your condition to you clearly?
   - ☑ Has he/she described all available treatment and care alternatives/ option available and:
     - Their risks;
     - Their benefits; and
     - Their costs.
   - ☑ Have you indicated when you did not understand, and asked for clarification?
   - ☑ Do you know what your responsibilities would be with the various options, i.e. has the doctor also explained what you would have to do in relation to your care, e.g. when using certain appliances?
   - ☑ Have you signed a consent form that refers to the above having taken place?

2. If your diagnosis is defined as a Prescribed Minimum Benefit (PMB):
   - ☑ Have you been given all relevant ICD 10 (diagnosis code) pertaining to your diagnosis and any other conditions you may have that are relevant for your treatment? Have you been given the PMB code in which the above codes fall?
   - ☑ Do you understand that for PMB conditions or related conditions your medical scheme must fund in full?
   - ☑ If you do not have reasonable access to a Designated Service Provider (DSP) and/or you are not okay (i.e. do not respond/get better) with a formulary product, that you are entitled to an appropriate alternative without co-payment.

3. When preparing a motivation for authorisation by your scheme, to be submitted as is required by the scheme or its administrator:
   - ☑ The PMB condition, or condition caused by a PMB condition, must be indicated clearly. Conditions that flow from, or complications associated with PMBs, are also PMBs and must also be funded in full.
   - ☑ Is your specific condition described as such where it can be concluded that, in terms of clinical research (evidence) and data, you need to be on the specific treatment and/or products as prescribed?
   - ☑ Are your symptoms, test results, etc. listed in a way that logically shows why you need that particular treatment?
   - ☑ Are other conditions and/or consequences (adverse events) that may be caused by failure to treat with the proposed treatment described in detail?
   - ☑ And/or if you have tried scheme-recommended products before, and it did not work for you (treatment failure) and is that clearly

indicated, with proof, if available (such as hospital admissions or medicines prescribed to address the treatment failure)?
- ☑ Or is it indicated that you have suffered harm or could suffer harm if the recommended treatment is not followed, and why this would be the case (e.g. urinary tract infections previously).

Note:
If benefits are conditional on the schemes imposing anything covered in points 5, 6 and/or 7, please refer to those corresponding checklists under each point.

4. If your authorisation is declined, you or your doctor may escalate the enquiry with the following:
   - ☑ Were you given the reasons for the decline?
   - ☑ Did you respond to these reasons using the rebuttal sheet?
   - ☑ If still declined did your doctor escalate this to the medical advisor, if possible?
   - ☑ Was any further information requested by the medical advisor and provided?
   - ☑ If still declined, did you escalate to schemes appeals committee, if they have one?
   - ☑ If no answer or decline, are you and your doctor prepared to escalate a complaint to the Council for Medical Schemes (CMS)?

Note:
Refer to point 8 for the CMS complaints process.

5. Should your scheme refer you to a designated service provider (DSP) for the prescribed treatment:
   - ☑ Is your DSP too far from work and/or home? Although there is no fixed distance in the law, if it becomes difficult to reach the DSP, it is a good indicator that it is too far from you.
   - ☑ Is your DSP not available (i.e. cannot get an appointment, the right type of staff is not in that DSP and/or the right products/appliances is not available in that DSP)?
   - ☑ Do you require treatment immediately, e.g. you should not wait to have an infection treated?

Note:
If one or all of the above exist, or if a DSP does not exist at all, then your scheme is obliged to pay in full without any co-payments. Alternatively, you are always free to visit your provider of choice. If you choose not to use a DSP when none of these conditions exist, you will be required to co-pay. The scheme can, however, not refuse to pay at all.

6. Should your scheme only provide benefits for products (medicines and devices/appliances) that are on a formulary (list of approved medicines/medical devices):
   - ☑ Have these products been included using evidence-based medicine and can the scheme substantiate how they have set what is included (e.g. types of catheters), and how many times you can access the benefit (e.g. number of catheters)?
   - ☑ Have they performed a cost

effectiveness analysis to prove that the products on their list indeed provide better effect/result at the same or a lower price?
- ✓ Have these products been selected based on price only?

Note:
Should you choose to use a product that is not on formulary and you would have been okay on the formulary product, then you may be required to co-pay. If you do not respond to treatment/s, or experience harm or side-effects using these formulary products you are entitled to an appropriate alternative without co-payment.

7. Should your scheme only provide benefits for treatments based on a managed care clinical protocol/policy:
   - ✓ Has this policy been developed using science, i.e. evidence-based medicine, including consultation with local specialty healthcare professional groups, international and local guidelines and can they substantiate this?
   - ✓ Have they performed a cost effectiveness analysis to prove that the policy indeed provides better effect/result at the same or a lower price?
   - ✓ Can your scheme provide a full copy of such a policy?

Note:
Managed care is about rules-based programmes that include a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of, health care services, procedures or settings, on the basis of which appropriate managed health care interventions are made.

8. When using the Council for Medical Schemes (CMS) complaints process:
   - ✓ Are you and your healthcare professional prepared to fight this?
   - ✓ Can you collate all previous correspondence by yourself and your doctor with the scheme?
   - ✓ Do you know which rights you can rely on to fight your case (including the aspects mentioned elsewhere in this document)?
   - ✓ If another person or entity, such as a patient support group or a lawyer supports you, have you provided them with consent, which authorises them to take the matter on, on your behalf?

Note:
There are three levels of complaints at the CMS. A first complaint is sent to complaints@medicalschemes.co.za, which is then sent to the scheme for its response. Thereafter, the CMS Adjudication Officers make a ruling. If one is not satisfied with the outcome at that level, one has 90 days within which one can lodge an appeal to the Appeals Committee of the CMS. A positive ruling at that level will assist in helping other patients, as the Appeals Committee rulings are published on the CMS website. If one is still not satisfied with such a ruling, one has two months to appeal to the Final Appeal Board, that is chaired by a judge.

Appendix 4 Legal references

Medical Schemes Act 131 1998
National Health Act 61 2003
Consumer Protection Act 68 2008
Health Professions Act 56 1974 (regulations and ethical rules) Nursing Act 33 2005 (regulations and ethical rules) Competition Act 89 1998
Protection of Private Information Act 4 of 2013

Appendix 5 Explainers

THE CONSENT TO TREATMENT/CARE FORM TEMPLATE

A "consent-to-treatment" or "care" form is a useful and necessary document that outlines the diagnosis and all treatment alternatives, risks, benefits, and costs to the beneficiary. This is the starting point, and information should be accurate. Make sure that you, as the patient, understand why the doctor recommends certain treatments, and not others. This should include a full assessment and diagnosis of the prevailing condition, e.g. neurogenic bladder. All treatment options should be described to you and, after discussion with the patient, a prescribed treatment/ care plan should be provided, with recommended medicines, devices and follow-up interventions.

PRESCRIBED MINIMUM BENEFIT (PMB)

The first important thing to understand is the definition of Prescribed Minimum Benefits (PMBs) as contained in the Medical Schemes Act, which requires that medical schemes provide full funding for all defined PMB conditions (within certain boundaries). This funding may NOT be taken from a member's medical savings account and may not be withdrawn. These are paid out of risk. PMBs cover three categories of diagnoses, treatment and care:

- Emergency care.
- Chronic conditions of which there are 25 defined conditions. These are generally well understood and well defined by the various schemes and include conditions such as high blood pressure or heart failure.
- Diagnostic Treatment Pairs (DTP) which cover 270 medical conditions. These are generally less well understood by the public and the medical profession when advising patients, and as a result schemes have not always applied these correctly.

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 in specific circumstances and taking into account a patient's specific needs and experiences.

Should there be a disagreement about the treatment of a specific case, evidence

must be provided regarding the appropriate manner to treat a specific PMB. These are found in academic articles, research papers and treatment guidelines or protocols. There is for example a DTP that relates to quadriplegia and paraplegia.

213A – Diagnosis: Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non- progressive neurological (including spinal) condition or injury. **Treatment**: Medical and surgical management; ventilation.
The ICD-10 code relating to specific condition (required when motivating PMB funding and subsequent claims) for example G82.4 – spastic quadriplegia – must be given by the doctor and reflected on all invoices that are to be submitted for reimbursement. The G82 codes cover paraplegia and quadriplegia.

Medical and surgical management must be funded by the medical scheme, including:

- Bladder management – catheters, leg bags, bed bags, catheter trays for changing catheters, annual (or more) blood tests to check kidney function, pathology tests in the case of urinary tract infections (UTIs), and necessary consultations with a urologist/doctor.
- Bowel management: laxatives, suppositories, latex gloves, KY jelly etc.

Relevant Diagnosis Codes within PMB 213A

213A	Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non-progressive neurological (including spinal) condition or injury	Medical and surgical management; ventilation	G81.0	Flaccid hemiplegia
			G81.1	Spastic hemiplegia
			G81.9	Hemiplegia, unspecified
			G82.0	Flaccid paraplegia
			G82.1	Spastic paraplegia
			G82.2	Paraplegia, unspecified
			G82.3	Flaccid tetraplegia*
			G82.4	Spastic tetraplegia*
			G82.5	Tetraplegia*, unspecified
			N31.0	Uninhibited neuropathic bladder, not elsewhere classified
			N31.1	Reflex neuropathic bladder, not elsewhere classified
			N31.2	Flaccid neuropathic bladder, not elsewhere classified
			N31.8	Another neuromuscular dysfunction of bladder
			N31.9	Neuromuscular dysfunction of bladder, unspecified

Note: International Classification of Diseases and Related Health Problems (10th revision) is a coding system developed by the World Health Organization (WHO) that translates the written description of medical and health information into standard codes. The term "tetraplegia" is a technical term and should be read as "quadriplegia" – a term that people with spinal cord injuries/afflictions are more familiar with and most commonly used.

DIFFERENCES BETWEEN A PMB LIMIT AND A CHRONIC MEDICATION LIMIT

Medical aids cover certain monthly medications for certain chronic conditions under a "chronic medication benefit". It does not affect savings.

However, there may be a limit per year and once the limit is exceeded, the patient may have to self-fund, pay out of savings or be referred to a state hospital for medicine. This is, however, not always true as we explain below.

For PMB conditions, medications (such as laxatives, various bladder medications, etc.) will be deducted from the chronic limit. But, because it is a PMB, once the limit is exhausted, the medical scheme must still continue paying from risk.

If these medicines fall under a chronic limit only and have NOT been linked to the PMB profile, it will require self-pay once the chronic limit is exhausted.

The doctor needs to specify in the motivation letter that these are PMB medicines (e.g. PMB213A) and that they are to be linked to a PMB profile under the chronic limit (e.g. medicines such as laxatives, suppositories, etc).

Other monthly items (excluding medicines) needed to manage bowel and/ bladder conditions would be applied for as PMB (e.g. urostomy bags, leg bags, catheters, bed bags, gloves, linen savers, KY gel).

NAPPI CODE

Each item ("product") when invoiced to the medical aid needs a NAPPI code. This stands for National Pharmaceutical Product Price Index and is required by law to allow medical aid schemes to pay for it.

The code is a unique product code and your doctor needs to make sure they are using the correct code on your script. For example, a leg bag may have 100 different NAPPI codes depending on size, manufacturer, and so on.

It is pointless if the doctor sends a script for NAPPI code 33333, but your pharmacy invoices it as NAPPI code 44444.

The best way to ensure that you don't go backwards and forwards between doctor, pharmacist and medical aid is to get all facts correct before the script and claim are sent to the medical aid.

COMPLETING A PRESCRIPTION

Together with any motivation letter, the doctor needs to provide a script for ongoing items needed for bowel and bladder management.

1. Check with the medical aid what information they require on the script.

2. The script should say "repeat 6 months" or repeat "12 months". Some medical aids require a new script every six months and some just once a year. The Medicines Act also limits the number if repeats. Please ask your doctor if you are not sure about the repeats you can get. If a patient has difficulty accessing the doctor for more frequent prescriptions, this should be addressed with the scheme.

3. The script needs to include how many of each item are required per month and the correct NAPPI Code provided for each item (very important).

4. Some medical aids may also require the cost of each item on script as well as the brand.

5. The practice number of the pharmacist/ hospital pharmacy where these items are being sourced from needs to be provide on the prescription.

6. The doctor must also include the PMB code 213A or any other relevant code on top of script and it must include relevant ICD10 codes that apply to the PMB condition.

Reference:
Appendix 1a: Key questions for a motivation

CO-PAYMENTS

Sometimes you may be okay on the treatments or products that your scheme recommends. This means that the scheme recommendations are appropriate for you, but you know, and your healthcare professional have informed you, that there are better, and perhaps more convenient solutions.

In these cases, where you would have been appropriately treatment with the scheme-recommended options, the scheme can lawfully levy a co-payment on you.

They then would not fund the treatment or product in full. The co-payment must however be "reasonable", i.e. close to the real difference in price of what the scheme would have funded, and the cost of your chosen treatment or product.

If you are, or will NOT be okay on the scheme recommended treatments or products, the scheme cannot force you to go unto such treatments or use such products. They also cannot levy a co-payment. This means they must fund the product or treatment in full.

DESIGNATED SERVICE PROVIDER (DSP)

Medical schemes may select Designated Service Providers (DSPs) and require of members to use the services at those DSPs. If one does not obtain the services at the DSPs, the scheme may also levy a co-payment.

The law however provides for circumstances where the scheme may not levy a co-payment if you go to a non-DSP. These circumstances are:

- Where the DSP is too far from your house or work, such as where you would need to travel a long time to get to the DSP.
- Where the DSP is not rendering the services you need. For example, if a state hospital is the DSP, but they do not have intermittent catheters or nurses who are able to provide you with the support you need.
- Where your condition requires immediate attention, such as where you have an infection and must be admitted to a hospital, and there is no DSP hospital or hospital bed available to treat you.

Acknowledgements

Contributors

ELSABÉ KLINCK

Elsabé Klinck specialises in health law, policy and other services to health sector and other role-players.

Elsabé holds the following degrees: B. Juris (UFS 1991), LL.B (UFS 1993), B.A. Hons (German) (cum laude) (UFS 1999) and a BA in Applied Psychology for Professional contexts (UNISA 2008). She has worked in the health sector since 2001, first at the SA Medical Association as legal advisor, and then at the Foundation for Professional Development as Director of Research, Compliance and Consulting. She also experience at a pharmaceutical trade association.

Elsabé started her career in 1994 in the Department of Constitutional Law at the Free State University, where she advanced to the position of senior lecturer within eight years. From 2008-2010 she worked as a consultant at a prominent healthcare consultancy.

Elsabé has published and spoken widely on topics relating to constitutional law, human rights, health law, ethics and social security. She is co-author of, among others, the books *Employment Equity Law* and *International Human Rights Standards,* and has published chapters in *Social Security Law*. She has undertaken research for, among others, the Taylor Committee of Enquiry into Social Security and the SA Business Coalition on HIV and Aids.

elsabe@elsabeklinckassociates.co.za
www.elsabeklinckassociates. co.za

MARK BRAND

Mark specialises in strategy and market access for health technologies and other services to numerous role players in the health sector.

Mark holds Diplomas in Engineering (Electronics), Marketing Management (IMM), Masters in Business Administration (WITS), MBA - Strategy (Hull University - UK) and Certificate in Health Technology Assessment – HTA. (USB). Mark has worked in the health sector since 1984. His career has evolved from defence system engineering, clinical engineering and into commerce in the health sector, holding various leadership positions in sales, marketing, new business development and market access responsible for introducing diverse and complex health technologies.

Most of his experience was gained during a 15 year tenure with Johnson and Johnson that established this business as market leader in the markets served. Mark founded BrandTech Healthcare Technology Consulting in 2006, which specialises in health technology strategy, business development and market access services across the industry. Mark has built extensive and unique experience converging business and market access and a network that aims to benefit existing and potential clients. Mark is actively involved in the industry, as a member of the South African Medical Devices Association (SAMED) and Market Access.

marketaccess@brandtechconsulting.co.za
www.brandtechconsulting.co.za

2nd Fold

AUTONOMIC DYSREFLEXIA
(Medical Emergency Card)

QuadPara Association of South Africa (QASA)

Autonomic Dysreflexia (AD) results from a sudden rise in blood pressure in an individual with a spinal cord injury (SCI), with a neurological level of T6 or above.

The cause of AD is a pain stimulus below the level of injury, resulting in an unopposed sympathetic system discharge. Raising the blood pressure 20-40mm Hg systolic above the person's normal baseline blood pressure, may trigger the symptoms of AD.

Symptoms of Autonomic Dysreflexia

- Increased blood pressure • Severe headache
- Flushing & sweating above the level of the SCI
- Bradycardia • Anxiety • Cardiac irregularities
- Bronchospasm or respiratory distress • Goose bumps on skin above the level of the SCI

If left untreated, this condition can result in seizure, retinal hemorrhage, stroke or in extreme cases, death.

If any symptoms of AD appear, ensure the following:

- Keep the person in a 90° upright position.
- Check there is free urinary drainage.
- Check for distended bowel.
- Check for ingrowing toenails and skin sores.
- Assess for other possible noxious stimuli.
- Hypertension should be treated medically if it persists with prescribed Nifedipine.

Card Holder's Medical Information

Name: . . . . . .

Baseline Blood Pressure: . . . . . .

Level of Injury: . . . . . .

Emergency Contact: . . . . . .

Relationship: . . . . . .

Phone Number: . . . . . .

0860ROLLING

1st Fold

1st Fold

2nd Fold

Ever thought about what happens to the plastic breadtag?

Did you know **350kgs** of breadtags = **2** standard **wheelchairs**

Start collecting & join this project.

Contact QASA on 031 767 0348 or projectcoordinator@qasa.co.za

Breadtags for wheelchairs

QuadPara Association of South Africa (QASA)

Seen someone abusing a wheelchair demarcated parking bay?

Please take a photo & ensure the vehicle registration plate is clear & wheelchair parking sign is visible

WhatsApp it to 073 853 9675

Please include location, date & time.

Read the ROLLING INSPIRATION magazine

FOR FREE

Scan the QR Code with your smartphone and read or download our latest magazine for free.