Motivating for a Better Quality of Life

“Navigating your way in successfully dealing with medical schemes”

Reimbursement pathway for Health and Wellness
The QuadPara Association of South Africa’s (QASA) Vision:
All South African Quadriplegics and Paraplegics will live their lives to their full potential.
QASA CEO Forward

The QuadPara Association of South Africa (QASA) is very proud to be able to publish and distribute a toolkit which will allow the opportunity for everybody to understand the reimbursement pathway to ensure better health and well-being.

Too often, the members of medical aids, especially our vulnerable people, do not understand the process and the opportunities that exist within the rules of the medical aid/insurer to claim rightful benefits. This publication gives you an understanding of the reimbursement pathway and the templates that you would might require should these be necessary for your rightful reimbursement.

We are grateful for the cooperation and collaboration in the gathering of information for this publication and we know that this will be a very useful tool to ensure successful reimbursement from YOUR medical insurance cover.

QASA publishes to inform and develop the capacity of our members.

We are proud of our partnership with the South Africa Spinal Cord Association of South Africa (SASCA) who assist us in knowledge development.

This publication will be updated when necessary and we are always open to suggestions of how to develop and re-develop the information we gather and distribute.

See our www for a download of this publication and follow us on fb.

Ari Seirlis
Background and Use of this Guideline

This self-help booklet is intended to guide those with spinal cord injuries and/or afflictions on how to navigate your way through the often complex reimbursement processes that you will encounter when making claims for benefits from your funder. Although the guide refers for the most part to the reimbursement process for SCI and the neurogenic bladder the same generic principles may be applied for any reimbursement pathway and process requirements. The typical process is described in four logical steps (steps 1, 2, 3 and 4), both in the form of a flow diagram (Reimbursement Process: Your typical pathway through the system) as well as an explanation of each part (Bladder Management: Rights to services and consumables (drugs and devices)).

Each part has a typical set of activities that you will, in consultation with, and under the care and with guidance from your doctor (or any other relevant service provider), have to undergo, ensuring that you collect and use the correct information that you require for achieving reimbursement. Explanation of principles and concepts are provided where relevant and necessary in shaded text boxes.

Relevant templates (Forms 1, 2 and 3 - ie how to write relevant letters etc) are provided for yours and your doctors use should there be need to formally write to relevant parties if and when necessary. Further guidance is provided in relevant appendices on how you should write a good and complete motivation (Appendix 1), what you can say and/or do when you receive specific reasons for decline of your motivation for benefits (Appendix 2) as well a checklist for gathering information as required for reimbursement (Appendix 3), ensuring that you have followed the process as thoroughly as possible to maximise your chances of getting your benefits paid, and more importantly, proving that you have followed the process and gathered all relevant information should you need to escalate your motivation and/or complaint to the highest level.

Disclaimer: This guide is designed to be used as a reference only with regards the reimbursement process and may not be re-produced and/or distributed in any form. The information herein, however, is subject to change when new information becomes available and changes to the respective process will be made (please refer to 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.

www.qasa.co.za
Bladder Management: Rights to services and consumables (drugs and devices)

Submitting Claims to Medical Schemes for Reimbursement of Spinal and Neurogenic Bladder Conditions

**Step 1:**
A newly injured patient will pass through the Acute and Rehabilitation phases of care with most, if not all, claims for services rendered covered by their funder (i.e., medical scheme, Compensation Commission and/or RAF). After assessment, consent to the appropriate treatment will be attained (Form 1: Consent to Treatment / Care Form or Informed Consent letter template) from the patient after appropriate counselling.

This means that the patient must be provided by the medical practitioner with all the treatment and care options generally available, and be informed of the benefits, risks and costs of each. S/he must also be provided with clear instructions.

The treating doctor will make a diagnosis that will determine whether the subsequent medical aid claims will be covered. If the diagnosis (and ICD 10 code which signifies the specific condition and its circumstances) falls into a PMB DTP then you should proceed with the claim.

**The consent to treatment / care form explained:**
A useful and necessary form that documents the diagnosis and all treatment alternatives, risks, benefits and costs to the beneficiary. To give a greater chance of success should this need to be escalated through a complaints/appeals process, this is the starting point and information should be accurate. This should include a full assessment and diagnosis of the prevailing condition eg bladder management. Based on this options should be provided and, after discussion with the patient, a prescribed treatment/care plan should be provided, with recommended medicines, devices and follow up interventions.

One of the biggest problems in getting medical aids to pay out of a PMB risk pool is incorrect codes. It is vital that the doctor includes the correct PMB and ICD10 codes in his/her motivation letter. 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/tetraplegic) are from G81.0 to G82.5. The ICD10 codes relating to the bladder condition are from N31.0 to N31.9.

The table below may be used as a guideline but the doctor will have a full reference to all ICD 10 codes and PMB codes and the list should not been seen as exhaustive.

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

1 It must be noted that it is proposed that the Road Accident Fund in future also work like a medical scheme, i.e. the same criteria for reimbursement would apply, viz. benefit limits, motivations and pre-authorisation, etc.
Prescribed Minimum Benefits (PMB) explained:

The first important thing to understand is the definition of a Prescribed Minimum Benefit (PMB) as contained in the Medical Schemes Act. The Act 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. PMB’s cover 3 categories of diagnoses, treatment and care:

1. Emergency care.
2. 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.
3. 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 tetraplegia – 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. This includes:

- Bladder management – catheters, leg bags, bed bags, catheter trays for changing catheters, annual (or more, if required) blood tests to check kidney function, pathology tests in the case of urinary tract infections (UTI’s), and necessary consultations with a urologist/doctor.
- Bowel management: laxatives, suppositories, latex gloves, KY jelly etc.
The only times there may be exclusions are when the member is new to a medical scheme and a three month exclusion is applied. PMB’s do not affect your savings and are paid out of risk. Claims may be paid out of an Appliance limit or other risk or day to day benefit as long as it does not come out of savings. Most importantly, if a patient medically needs care, appliances, etc over and above those limits, s/he are entitled to it as all PMB care must be funded “in full”. PMB funds can therefore not be “exhausted” and it should be funded from a common risk pool shared by all the scheme’s beneficiaries.

Depending on the medical scheme, these items may only be available from a state hospital or designated service provider (DSP) for these items. Some schemes will not impose this and PMB items will be made available at a pharmacy. Some may allow access from a pharmacist up to a certain limit, but then require that the rest are accessed from a state hospital or DSP for the rest of the year.

In certain circumstances appointing the state sector as a DSP, or having a DSP, could have implications for patients. The DSP or state facility may be too far from the patient’s home or work, or it may not have the specific products available that the patient require, or the necessary nursing staff or doctors to properly assess and prescribe the correct products for the patient. Access may also be required immediately (i.e. the patient cannot wait). In these circumstances the law says that the patient is entitled to go to a non-DSP for the treatment and care (i.e. access to the products) s/he requires, and the scheme may NOT levy a co-payment. The law also provides the option where a person can voluntarily go to a non-DSP, and may then be required to make a co-payment. Many patients prefer this option. The scheme may then, however, not refuse to pay at all.

Once the assessment and diagnosis is confirmed by the doctor, to then claim for benefits the scheme will have a special request form for funding of PMB’s – the doctor must complete the application form along with a motivation form (Appendix 1: Checklist for writing a good and complete motivation) with all relevant ICD and PMB codes. This motivation form must make it clear why the particular patient requires a particular type of care and products, the frequency thereof, etc.

A prescription of all supplies with NAPPI Codes MUST accompany the motivation. This is then submitted to the funder.

**NAPPI Code explained:**

*Each item 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 s/he is using the correct code on your script (a leg bag may have 100 different NAPPI codes depending on size, manufacturer, etc). 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 get all facts correct before the script and claim is sent to the medical aid.*
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.

**Completing a Prescription explained:**

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 6 months and some just once a year. 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 with relevant ICD10 codes that apply to the PMB condition.
Step 2:

The motivation for benefits is submitted in completed form to the respective funder. In the event of this claim being rejected, should you wish to pursue it then you are fully entitled to request reasons for the rejection if not given, and using any rebuttals i.e. arguments to counter the possible reasons for the rejection (Appendix 2: Rebuttal Sheet: what to say/do when a motivation is declined) you can ask for a review of the initial decline. The rebuttal sheet is a list of anticipated reasons for rejections to the motivations and provides suggested responses and rebuttal as based on the rights of doctors and patients. If there is an offer/suggestion to part pay and/or funding out of savings accounts, note that this is not allowed for PMB conditions.

Step 3:

If the claim is rejected again, the doctor should speak with the relevant Medical Advisor, if possible, and submit any further information where requested. If this is still unsuccessful declare it a dispute and formally appeal (Form 2: Appeal against medical scheme decision letter template) to the Scheme Administrator Appeals Committee who will have to follow a disputes resolution process.

Step 4:

If there is no scheme committee, or if time is of the essence or if this appeal is unsuccessful, send a complaint to the Council for Medical Schemes (CMS). The form and complaints process is on their website (Form 3: CMS Complaints form). The complaint should be accompanied by all documentation including the initial consent to treatment and care form (Form 1), motivation form (Appendix 1), the scheme rules referred to, the decline letter and any correspondence with the scheme, the appeal committee letter, if applicable (Form 2) and all reasons for decline at each stage of the process.

If at this point the medical aid concedes and pays the claim, the process has been successful; if not, ask for a CMS ruling by lodging a complaint at the CMS at complaints@medicalschemes.com or fax 012 431 0608.

For an efficient claiming process, the onus is on the doctor and patient to ensure the medical aid is kept updated of changes and that all doctors, pharmacists, etc. involved in the treatment cycles have correct ICD10 codes on the respective account profile.

A checklist (Appendix 3: Reimbursement Checklist: information you will need at various stages of the process) is available for the member to ensure as much information is included when claiming for reimbursement and that the process is thoroughly followed.
Reimbursement Process: Your typical pathway through the system
Form 1: Consent to treatment/care or Informed consent letter template

The practice of Dr(s) ....

Patient name: 

Medical scheme: 

Next of kin / mandated person: 

(Note: this person consents if patient is unable to consent)

If patient is not Principal Member, 

name of Principal Member: 

Patient identity number: 

Patient age: 

(Note: patients 12 years or older can consent to medical treatment)

Treating medical practitioner: Dr 

ICD10 Code: 

The above-mentioned patient / his or her mandated representative / next of kin hereby declares:

(please delete what is not applicable)

Treatment options

1. The doctor has discussed with me the available treatment options for my condition.

2. The doctor has also discussed with me the benefits and risks associated with the treatment options.

3. I declare that I understand the various options, benefits and risks as outlined by the doctor and therefore hereby provide informed consent for the use of the prescribed therapy, which includes relevant drugs, consumables and/or equipment, if applicable, as part of the treatment for the condition. I hereby agree to the treatment, which includes the risks associated thereto: ________ (initial)

Treatment costs

4. I have also been informed of- and understand the costs associated with the various treatment options, which include reference to associated costs and/or possible downstream costs associated with the available treatment options.

5. I understand that the treatment of my condition entails the consultation fees of the doctor, the costs of the prescribed treatment (which includes drugs, consumables and/or equipment, if applicable), as well as costs associated with hospital care and/or home nursing care (if applicable) and hereby provide my informed consent to the costs associated with the treatment.

6. I have noted the consultation fees of the medical practitioner and hereby agree to such fees being charged.
7. I acknowledge that the fees and treatment costs, including the cost of the prescribed therapy and consumables actually incurred may differ from those reimbursed by my medical scheme, and I agree that I am liable for any shortfall in such instances.

8. I hereby consent to- and acknowledge the disclosure of my healthcare- and personal information for the following purposes only, and only to the extent necessary and/or as is required by legislation:
   a. To my medical scheme and medical motivations all information required by the scheme to evaluate reimbursement.
   b. To the Road Accident Fund and/or Compensation Commission in cases of motor-vehicle accidents and/or workplace injuries or diseases.
   c. To referring- and/or other healthcare professionals (pharmacists, other doctors, nursing staff, etc.) involved in my care who need the information in my interest.
   d. To persons who I mandate to receive information on my healthcare, or, who, under law, can receive such information and consent on my behalf to treatment, if I am unable to do so.
   e. [Add other: e.g. research done, data sharing and selling, etc. if applicable]

For all other disclosures the practice will require your written consent. This practice is contractually obliged to ensure that all your information is kept in confidence and according to the standards set by the Protection of Personal Information Act, 2013.

9. I acknowledge that, although pre-authorisation has been obtained or will be obtained for the treatment, there is no guarantee that my scheme will reimburse treatment. I understand that I have a right to address such non-payment at my scheme and if I am not satisfied, at the Council for Medical Schemes:
   Email: Complaints@medicalschemes.com  Fax Complaints: (012) 431-0608

Patient Responsibilities

10. I have been informed of the care required in relation to the treatment. I understand that, should I not adhere to the advice and instructions or the doctor and/or nursing staff, I cannot hold the practice, its staff and/or the manufacturers of any product or consumable liable for any harm that may flow from not following the said advice or instructions.

Signed in ___________________________ on this _ day of ___________________________ 20__.

____________________________________  ______________________________________
Signature: Patient / Patient mandated person / kin  Signature: Witness  next of kin

Designation of mandate person or next of kin (if applicable)

Should the patient not be able to consent, his/her nominee or otherwise his/her spouse / partner, adult child or parent may consent on their behalf.

____________________________________  ______________________________________
Signature: Doctor / Delegate  Signature: Witness
Form 2: Appeal against medical scheme decision letter template

Letterhead (or patient / patient family member)

By fax / by email

(date)

Dear Principal Officer / Medical Advisor

APPEAL AGAINST DECISION TO DECLINE BENEFITS

Patient initials and surname:
Patient medical scheme nr:

You have declined the motivation for (list specific benefit), as submitted on (date). The decline, which has been communicated to us telephonically (or in a letter /email dated ....) stipulated that [paraphrase what decline says / said]

As the 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 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.

Should the patient suffer any harm as a result of 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 authorized representative signature
APPLICATION FORM:
COMPLAINT LODGED

[IN TERMS OF SECTION 47(1) OF THE MEDICAL SCHEMES ACT 131 OF 1998]

I, the undersigned,

[full names]

of [full address]

[Member No.]

[Tel. Number]

[Fax Number]

[E-mail]

IF ACTING ON BEHALF OF MEMBER:

[full names & membership number of the member]

I, the undersigned,

[full names]

of [full address]
DO HEREBY LAY A COMPLAINT AGAINST: [Fill in where applicable]

MEDICAL SCHEME: ........................................................................................................

ADMINISTRATOR: ........................................................................................................

BROKER: [full name & accreditation number, if known] ................................................................

BROKERAGE: [full name & accreditation number, if known] .....................................................

MANAGED CARE ORGANIZATION: ..................................................................................

........................................................................................................................................

ON THE GROUNDS THAT:

a) They have acted improperly by ......................................................................................

........................................................................................................................................

b) Acted/ failed to act in contravention of the Act by .........................................................

........................................................................................................................................

I FURNISH HEREWITH A FULL [YET SUCCINCT] DESCRIPTION OF THE DETAILS OF THE

CONDUCT COMPLAINED OF AS FOLLOWS:

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[Attach any supporting documentation that may support your complaint].

__________________________________________
COMPLAINANT

__________________________________________
Date
Appendix 1: Checklist for writing a good and complete motivation

How to create a good motivation form: Checklist

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

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

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

4. **Treatment Protocol** (service; drugs; 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).

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 a motivation is declined

### Rebuttal tool for patients

<table>
<thead>
<tr>
<th>What scheme says</th>
<th>What you say</th>
<th>Legal basis for your view</th>
</tr>
</thead>
<tbody>
<tr>
<td>The product is not on our formulary / list</td>
<td>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.).]</td>
<td>Regulation 15 of the Medical Scheme Regulations of 1999 Regulation 15H</td>
</tr>
<tr>
<td>The product is too expensive / there is a cheaper alternative</td>
<td>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, must be considered.</td>
<td>Regulation 15G and 15H</td>
</tr>
<tr>
<td>The products are all basically the same</td>
<td>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.</td>
<td>Regulation 15, 15I and 15H</td>
</tr>
<tr>
<td>You must upgrade to a higher option to get access to more / better benefits</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>Your appliance benefit is exhausted</td>
<td>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</td>
<td>Regulation 8, regulation 15G</td>
</tr>
<tr>
<td>The same product works for all patients</td>
<td>The clinical needs and clinical experience of patients with different circumstances differ. The definition of evidence-based medicine recognize &quot;individual clinical experience&quot;, it cannot be assumed that all products and all patients are the same.</td>
<td>Regulation 15</td>
</tr>
<tr>
<td>Please provide us with a quotation</td>
<td>I will gladly do so. However, remember that the cost alone is not the relevant factor, what is appropriate for the specific patient, is.</td>
<td>Regulation 15, 15H</td>
</tr>
<tr>
<td>That product is not available in the state sector</td>
<td>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.</td>
<td>Consumer Protection Act</td>
</tr>
<tr>
<td>This is paid from savings</td>
<td>PMBs must be paid from the common risk pool.</td>
<td>Regulation 8</td>
</tr>
<tr>
<td>We can only provide x number of products per month</td>
<td>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.</td>
<td>Regulation 15 Regulation 15H</td>
</tr>
<tr>
<td>It's in the rules, and we must always abide by the rules</td>
<td>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</td>
<td>CMS Annual report 2011/12</td>
</tr>
</tbody>
</table>
Appendix 3: Reimbursement Checklist: information you will need at various stages of the process

**Reimbursement Checklist**

*Your right to information and choice is underpinned by the Consumer 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, 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?
   - Have you been given the PMB code in which the above codes fall?
   - Do you understand that for PMB conditions or a condition caused by a PMB condition your medical scheme must fund in full?
   - If however, you do not have reasonable access to a DSP and/or you are not ok (i.e. do not respond/get better) with a formulary product, that you are entitled to an appropriate alternative without co-pay.

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.
   - 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, that logically show 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) is that clearly indicated?
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-pay. Alternatively, you are always free to visit your provider of choice and 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 ok 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-pay.

7. **Should your scheme only provide benefits for treatments based on a managed care clinical protocol/policy:**

   - Has this policy been developed using evidence-based medicine, including consultation with local speciality groups, international and local guidelines and can they substantiate this?
   - Have they performed a cost effectiveness analysis to prove that the policy indeed provide 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 doctor 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)?

**NOTE:** There are three levels of complaints at the CMS – a first complaint that goes to complaints@medicalschemes.com, in which the complaint is sent to the scheme for its response, after which one of the CMS Adjudication Officers make a ruling. If one is not satisfied with the outcome at that level, one has 30 days within which one can lodge an appeal to the Appeal Committee of the CMS. A positive ruling at that level will assist in helping other patients, as the Appeal Committee rulings are published on the CMS website. If one is still not satisfied with such a ruling, one has 2 months to appeal to the Final Appeal Board, that is chaired by a retired 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
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Mark specialises in Strategy and Market Access and other services to all sectors of the healthcare. Founded on an engineering background with qualifications in engineering (NTD Electronics – W. Cape Technicon 1982)), Marketing Management (IMM - 1998), Business Management (MAP I & II WITS GSBA – 1994), MBA Strategic Marketing (Hull University – 2000) and Health Technology Assessment (USB 2007), Marks experience spans 30 years in health care, formally employed by both local medical technology distribution and multinational companies, established the first dedicated Health Economics and Reimbursement Unit in 2002 for a medical device company in South Africa; Mark has 8 years of consulting experience to organisations on strategic marketing and health technology assessment. Mark is a member of the Pool of Experts for OSEC, the competence centre for Swiss foreign trade promotion. Experience includes developing business strategies and health technology related value propositions for clients across the sector. Mark is actively involved in the industry, previously a board member of the South African Medical Devices Association (SAMED), current member of the SAMED Market Access (HTA) Portfolio Committee, board member for the International Society for Pharmaco-economics and Outcomes research (ISPOR), leading initiatives aimed at improving patient access to innovative health care. Mark conducts training seminars on market access, and is part of faculty lecturing at the University of Stellenbosch Certificate in HTA.

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- Increased Blood Pressure.
- Severe Headache.
- Flushing & Sweating above the level of 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.

Card Holder’s Medical Information

Name: 
Baseline Blood Pressure: 
Level of Injury: 
Emergency Contact: 
Relationship: 
Phone Number: 

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