PG GROUP MEDICAL SCHEME

NEWSLETTER

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Dear Member

Spring has finally arrived and with it a reminder to not only spring clean your home but also your finances. To help you, the Scheme provides some insight into what co-payments are and how to reduce them. We also provide information about home oxygen and clarify the rules for dental confirmation of benefits and pre-authorisation.

The Scheme welcomes any suggestions that you may have on articles or member benefits you would like to see published in future newsletters. Please send your suggestions to the Scheme Manager, Eugene Eakduth, by fax to 0861 647 775 or by email to eugene.eakduth@momentum.co.za.

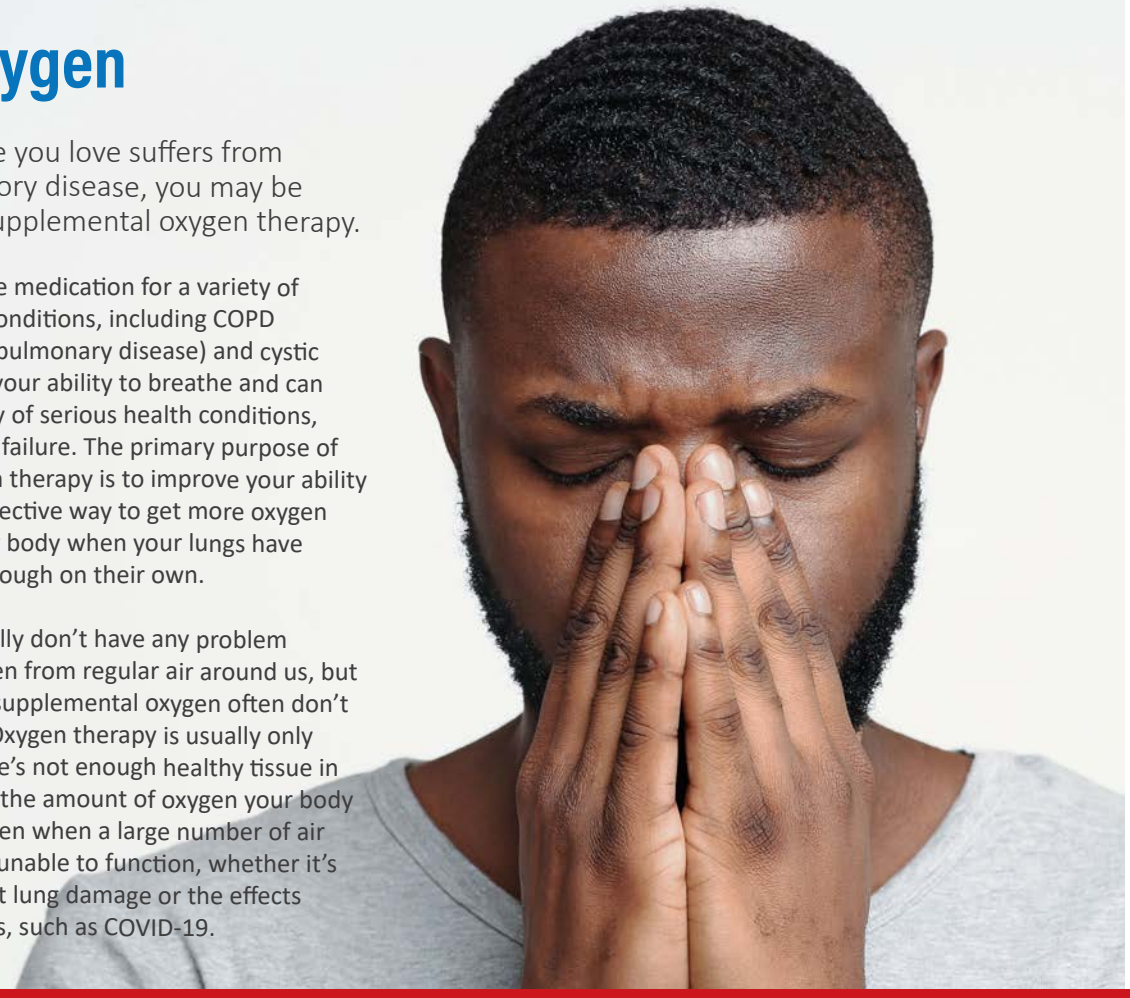
Yours in good health.

Home oxygen

If you or someone you love suffers from a chronic respiratory disease, you may be required to use supplemental oxygen therapy.

Oxygen is an effective medication for a variety of chronic respiratory conditions, including COPD (chronic obstructive pulmonary disease) and cystic fibrosis. It improves your ability to breathe and can also prevent a variety of serious health conditions, including respiratory failure. The primary purpose of supplemental oxygen therapy is to improve your ability to breathe. It's an effective way to get more oxygen flowing through your body when your lungs have trouble absorbing enough on their own.

Healthy lungs generally don't have any problem getting enough oxygen from regular air around us, but people who require supplemental oxygen often don't have healthy lungs. Oxygen therapy is usually only necessary when there's not enough healthy tissue in your lungs to absorb the amount of oxygen your body needs. This can happen when a large number of air sacs in the lungs are unable to function, whether it's caused by permanent lung damage or the effects of a temporary illness, such as COVID-19.



When this happens, providing extra, oxygen-rich air allows the remaining, functioning lung tissue to absorb more oxygen than it would from the air.

Doctors prescribe oxygen therapy for health disorders such as:

- COPD
- pulmonary fibrosis
- cystic fibrosis
- severe asthma
- sleep apnoea
- COVID-19.

An oxygen concentrator is an electrical device that uses sieve-bed technology (filters that remove nitrogen from the air) to extract oxygen from the surrounding air. The oxygen is then delivered to the patient using a plastic tube connected to a nasal cannula or facemask. Oxygen concentrators operate on electricity – it is therefore critical that they are always supplied with a back-up cylinder to ensure uninterrupted oxygen supply, even during a power failure.

The process to obtain authorisation for supplementary oxygen is simple, but requires clinical information.

Your attending doctor must send through a prescription with the ICD-10 diagnosis code, the patient's blood gas report and a motivation to an oxygen supplier such as Ecomed Medical (Pty) Ltd, VitalAire South Africa or Oxygen at Home, to name a few.

The oxygen provider will then forward the doctor's documents, together with a monthly quotation for a home oxygen concentrator, to the managed care team of PG Group Medical Scheme. If you are in hospital, it is best that the doctor initiate this process a day or two prior to your discharge from hospital so you have an oxygen concentrator available upon your discharge.

The concentrator and cylinder will be reimbursed at the Scheme rate per month. Due to high costs, portable concentrators are not paid for by the Scheme.

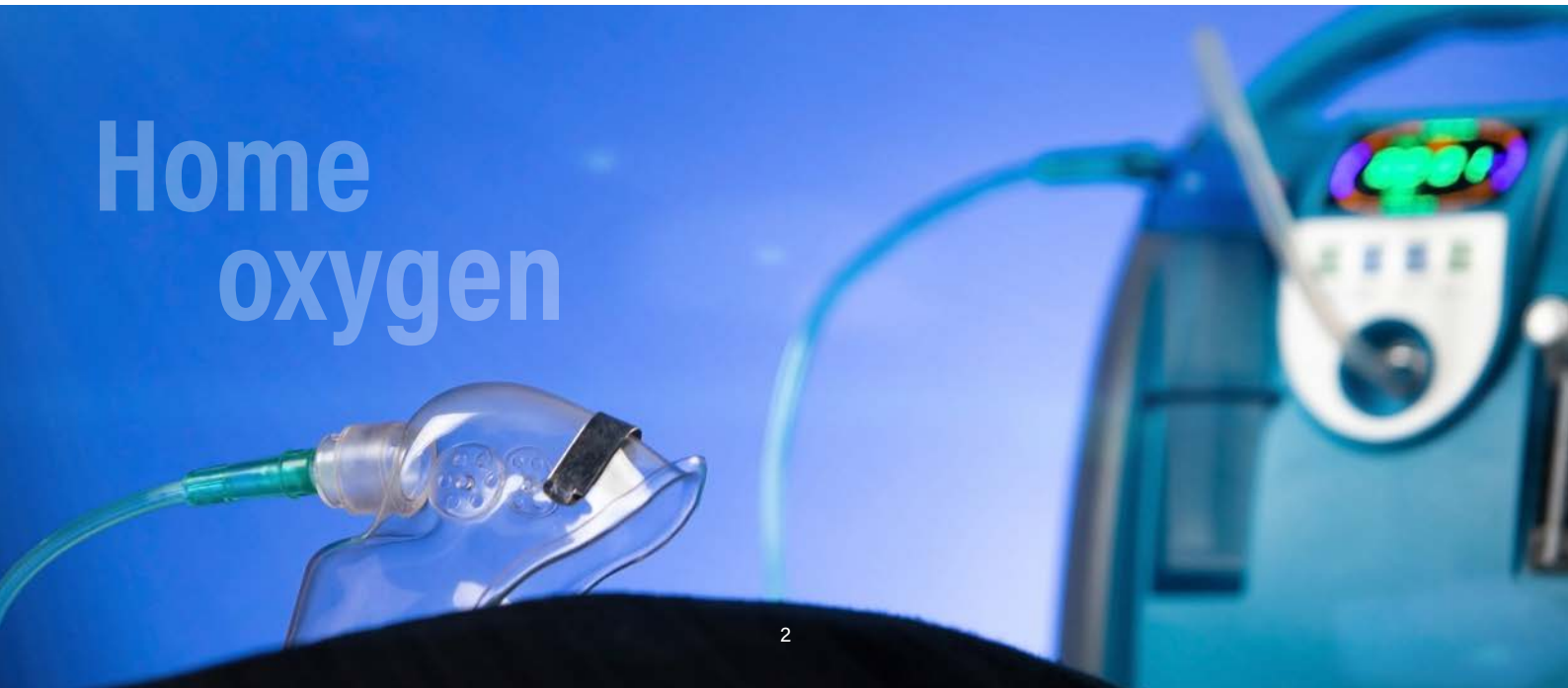
Once the authorisation is in place, you, as well as the oxygen provider, will be notified. The oxygen provider will provide the Scheme with quarterly updates about whether the patient is, for example, using the oxygen properly, if he or she is smoking or perhaps not doing any physical activity to improve his or her health status.

COVID-19 positive members requiring home oxygen

In such cases the same requirements apply as mentioned above, but authorisations are limited to a two-month period. Should a patient require home oxygen beyond the two-month period, a clinical motivation will be required.

If, after two months of use, home oxygen is no longer required, the home oxygen provider will collect the equipment from the patient and, after a stringent decontamination process, release it to another patient in need.

Home oxygen is paid from the external appliances benefit, which is limited to R6 520 per family per year.



WHAT ARE **CO-PAYMENTS**?

Most patients dread hearing the words 'the doctor charges private instead of medical scheme rates' upon entering a medical practitioner's rooms. But the reality is that more medical professionals are charging private (and in some cases exorbitant) fees that are above what your medical scheme pays. This means having to fork out money from your own pocket to pay the service provider and claiming back the shortfall amount from your medical scheme only to be reimbursed a portion of what you have paid. This shortfall amount is called a co-payment.

Medical schemes in South Africa pay claims according to the National Health Reference Price List (NHRPL), as determined by the Department of Health, based on submissions by the Council of Medical Schemes (CMS) and professional medical associations.

Some doctors feel that these rates are too low and therefore charge private rates. Professional medical organisations like the South African Medical Association (SAMA) provide guidelines to doctors as to the rates that they should charge, but it is still the doctor's decision to choose the rate. They can charge more or less as they see fit.

Medical schemes are not obliged to pay doctors the rate that they demand, but patients have to if they wish to use the services of the doctor in question, causing instances where some doctors may charge rates that seem unaffordable to some patients. The patient who cannot afford these rates has the choice to seek medical care elsewhere. The Scheme believes that while you can't make your responsibility for paying these costs disappear, you can probably reduce your burden if you know the right questions to ask.

Every procedure that is performed by a healthcare provider has a diagnostic or ICD-10 and procedure code related to the amount charged for the treatment. This code is indicated on the claim that is submitted to the medical scheme to process in line with NHRPL guidelines and protocols and, based on the outcome, could result in only part of the full claim being paid.

The issue with coding is that the average medical scheme member has no idea what the codes mean or exactly what the doctor should be charging. Therefore, the first step in fee negotiations with your doctor is to understand what your medical scheme will pay for the planned treatment and use this as a basis to negotiate the exact fee your doctor will charge. Begin by asking your doctor for a quote or itemised account in writing to submit to the Scheme.

Some doctors are open to negotiating fees, while others are not, but if you don't ask, you will never know. The quote or itemised account will indicate any upfront charges, which will enable you to plan your finances and not be left with a shortfall. When asking for a quote or itemised account, make sure you ask the doctor to indicate all fees associated with the procedure, rather than just the surgical costs, e.g. the cost of the anaesthesiologist, radiologist, laboratory tests, etc., as specialised fees can be charged over and above medical scheme rates. Another important point to remember is to be aware of your available benefits. The next time you visit your doctor or surgeon, remember this valuable piece of advice: many healthcare providers will negotiate on price only when you enquire upfront and don't usually offer reduced fees if people don't make enquiries.

While following this advice may seem tedious, do not be deterred, as it is worthwhile and can save you a lot in out-of-pocket medical expenses.

Here are **common medical terms** to help you understand what is being charged on doctors' accounts.

- The **Maximum Medical Aid Price (MMAP) i**s the maximum price that medical schemes will pay for generic chronic medication.
  The MMAP applies on all options for chronic medication.
- The **Single Exit Price (SEP)** is the regulated maximum price that can be charged for a product or medication.
- A **dispensing fee** is an additional fee that pharmacies or healthcare providers may charge when they dispense medication. The fee depends on the price of the medication that is dispensed.
- **ICD-10 codes** are diagnosis codes that describe the conditions that you are being treated for.
- **Tariffs codes** indicate the type of treatment or service provided by a healthcare provider and the associated cost. Each of these codes has an amount attached to it, which determines the rate at which any healthcare provider will be paid.
- **Current procedural terminology (CPT)** is a set of codes, descriptions and guidelines intended to describe procedures and services performed by physicians and other healthcare providers. Each procedure or service is identified by a five-digit code.
- **National Pharmaceutical Product Index (NAPPI)** codes are identifier codes for surgical or medical products and medication.
- **Scheme reimbursement rate (SRR)** is the the rate of payment that the Scheme considers to be affordable for its members and may be lower or higher than the rate your medical practitioner charges.
- **Formulary reference pricing** or a **medicine formulary** is a list of medication that consists of both generic and original, brand-name medication items that will be paid for by a medical scheme.

Sources:
https://www.medicalaide.co.za/are-private-rates-charged-by-doctors-unethical/
https://www.businessessentials.co.za/2019/06/18/smart-ways-to-negotiate-your-medical-bills/

Managing out-of-pocket expenses

Fortunately there are steps that you can take to plan and save, which can help you reduce out-of-pocket medical expenses and prepare yourself financially.

Always use network providers

Medical schemes negotiate preferential rates with network providers. This means that if you use a doctor or pharmacy contracted to the network, you will not be charged more than the rate agreed with the Scheme. This preserves the funds in your medical savings account and also helps you to avoid co-payments, deductibles and additional out-of-pocket expenses. Members who use these providers for healthcare services, such as the Preferred Provider Network (PPN) for optical services, Netcare 911 for ambulance services and DENIS for dental services, are charged preferred rates for specific services. If you are not happy with the rates a specific practice is charging, simply shop around for another provider that will charge you better rates.

Register all chronic diseases

If you use chronic medication to treat a chronic condition such as diabetes, hypertension (high blood pressure) or hypothyroidism, you could qualify for chronic medication benefits. This means that the Scheme pays for the medication from your chronic medication benefit and not your Medical Savings Account (MSA). You must, however, register your condition as a chronic condition and have it approved, because otherwise the costs will be paid from your MSA.

Use formulary medication

The Scheme uses a list of medication they cover called formularies. Using these formularies for chronic medication and day-to-day medication needs can help preserve your MSA balance. Another way to avoid co-payments and out-of-pocket expenses is to ensure that your doctor treats you with medication listed on your Scheme's formulary. You can contact the Scheme's customer care centre on 0860 005 037 and request to be put through to the Medicine Risk Management department for a list of medication that is on the formulary for your specific condition, so that you can choose cheaper generic medication with little or no co-payments.

Early detection screening tests and vaccination

The Scheme's wellness benefits and managed care programmes offer early detection of serious medical conditions through screening tests and are intended to help you stay as healthy as possible. Regular, scheduled visits and tests allow your doctor to identify any medical problems before they can become serious. Some of the screening tests include those for blood glucose, cholesterol, blood pressure, body mass index (BMI), HIV, bone density and breast cancer. Pneumococcal and flu vaccines can be administrated at your nearest Clicks or Dis-Chem pharmacy or other clinics, while certain preventative tests may require you to schedule regular check-ups with your doctor. The preventative tests will not have an impact on your day-to-day benefits and are covered by the Scheme.

Managed care programmes

You will be required to register certain medical conditions, such as HIV, cancer and pregnancy, on the Scheme's managed care programmes to receive prescribed minimum benefit (PMB) cover and management of your condition. The Scheme pays PMB claims based on diagnostic or ICD-10 codes, so you need to know what the code is that relates to your condition and ensure that it appears on every claim. When you are sent for tests, scans or any other treatment for a PMB condition, try to ensure that the doctor who treats you indicates the correct codes for the tests, scans or treatment on your claim before submitting it to the Scheme. The Scheme identifies and pays claims automatically based on the diagnostic codes on your accounts and an incorrect diagnostic or ICD-10 code could result in your claim being rejected or paid from an incorrect benefit, such as your MSA. If you have successfully registered your chronic condition, most claims for chronic medication and related treatment will be paid automatically from the correct benefit, provided your doctor used the correct code for the condition on your accounts.

Sources:
Health24
https://www.news24.com/health24/Medical-schemes/General-info/How-to-save-for-medical-emergencies-20140526
https://www.iol.co.za/personal-finance/get-your-pmb-claims-paid-1054405

Confirmation of dental benefits and pre-authorisation: **WHAT YOU NEED TO KNOW!**

Confirmation of benefits

Did you know that there are limits to the number of times you can make use of certain dental benefits within a specified period? For instance, if a claim for treatment has been paid, the benefit applicable to the treatment might only be available again after a specified period. One example is claims for scaling and polishing (code 8159) that are covered only once in six months; i.e. the treatment dates should be 180 days (six months) or more apart.

These types of protocols and limitations are in place to ensure that your benefits are available for clinically appropriate treatment when you need it the most.

Before any treatment starts, please ensure that the dental practice contacts DENIS on 0860 104 939 to confirm if benefits are available for the treatment codes applicable to the planned treatment. Keep in mind that if the practice is not part of the DENIS dental network, they might charge above the PG Group Medical Scheme dental tariff. The DENIS service consultant will provide a quotation so that you know exactly what amounts are covered by the Scheme and what amounts are payable by you.

Dental authorisations

The claims for certain dental procedures* will only be considered for payment if authorisation is obtained before the treatment is received. If your dentist plans a dental procedure that is subject to authorisation, you or the practice can contact DENIS on 0860 104 939 or via email at **pgenq@denis.co.za**.

Each type of procedure has its own set of requirements for authorisation. To ensure that there is no unnecessary delay in the authorisation process, kindly visit the DENIS website at **www.denis.co.za** to find out if you have all the required information available.

Feedback will be provided to you telephonically or on an authorisation letter within five working days.

*Pre-authorisation is required for the following dental procedures/treatment

Dentures
Plastic dentures
Partial metal (chrome cobalt) frame dentures

Specialised dentistry
Crowns and bridges
Implants
Orthodontics
Periodontics

Moderate or deep sedation in the dental rooms
Benefit limited to extensive dental treatment

Hospitalisation/General anaesthetic
Benefit available for children under the age of five years for extensive dental treatment and for the removal of impacted teeth

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