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Member of a medical scheme? Know your guaranteed benefits!

Coding and Funding of Claims

Coding in healthcare is a simple, standardised system for recording and sharing information about medical conditions, treatments, and services. Instead of long medical terms, this system uses short codes that are universally recognised and specific to different diseases and treatments. Accurate coding helps the healthcare industry bill, process and pay claims, track health trends, and improve patient care. It also helps maintain proper health records and makes the administration process smoother. Coders must stay updated on the latest rules and changes to keep systems running correctly.

The clinical information furnished in this article is intended for information purposes only and professional medical advice must be sought in all instances where you believe that you may be suffering from a medical condition. The Council for Medical Schemes is not liable for any prejudice in the event of any person choosing to act or rely solely on any information published in CMScript without having sought the necessary professional medical advice. The Communications Unit would like to thank the Clinical Unit for assisting with this edition of CMScript.

Types of coding systems used in South Africa

1. **International Classification of Diseases (ICD)** were developed by the World Health Organization (WHO). ICD codes are used to describe the patient's signs and symptoms, and diagnosis or reason for seeing a healthcare provider. They contain both letters and numbers that healthcare providers and medical schemes use to communicate about the health issue being treated. These codes also help medical schemes to decide how a condition should be covered or funded. They enable the consistent recording, analysis, interpretation, and comparison of health information about illnesses and causes of death. The 10th ICD (ICD-10) version is currently used in the country. An example of an ICD-10 code is "*J45.9*" which refers to "*Asthma, unspecified*".

2. **National Reference Price List (NRPL)** coding is used to inform medical schemes about the services that were provided to a member so that claims can be settled correctly. The purpose of the procedure/item codes is to convert the description of services into specific codes. Various healthcare disciplines, such as doctors, nurses, and physiotherapists, have their own unique set of codes that describe the specific services they can charge. An example of a four-digit NRPL tariff code is "*1101*", which refers to "*Tonsillectomy (dissection of the tonsils)*", usually performed by an Ear, Nose and Throat (ENT) Specialist.

3. **Current Procedural Terminology (CPT®)** codes were developed by the American Medical Association (AMA) to describe medical, surgical, and diagnostic services. These five-digit codes help medical professionals and medical schemes clearly communicate about the treatments or services the patients receive. The South African Medical Association (SAMA) publishes an annual version of the Complete CPT® for South Africa (CCSA) codes. An example of a CCSA code is "*99199*", which is used for "*unlisted special services, procedures, or reports*".

4. **Uniform Patient Fee Schedule (UPFS)** codes are used in the public sector to standardise payment rates for various medical services and procedures. An example of a UPFS code is "*2511*", which refers to "*Outpatient Consultation – General medical practitioner*".

5. **National Pharmaceutical Product Interface (NAPPI)** codes are used to identify pharmaceutical products, including medicines and medical devices. These codes have nine digits. The first six digits of a NAPPI code identify the product/medicine, and the last three digits indicate the pack size. For example, a NAPPI code for "*Corsodyl mint mouthwash (0,2%)*" is "*808377*". These codes are essential for the billing and dispensing of medications.

Legislation guiding the payment of healthcare accounts or claims

Regulation 5 of the Medical Schemes Act (131 of 1998) specifies that the account or statement contemplated in section 59 (1) of the Act must contain the following -

a. The surname and initials of the member;
b. the surname, first name and other initials, if any, of the patient;
c. the name of the medical scheme concerned;
d. the membership number of the member;
e. the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;
f. the relevant diagnostic and such other item code numbers that relate to such relevant health service;
g. the date on which each relevant health service was rendered;
h. the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine;
i. where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;
j. where mention is made in such account or statement of the use of a theatre—
   (i) the name and relevant practice number and provider number contemplated in paragraph (e) of the medical practitioner or dentist who performed the operation;
   (ii) the name or names and the relevant practice number and provider number contemplated in paragraph (e) of every medical practitioner or dentist who assisted in the performance of the operation; and
   (iii) all procedures carried out together with the relevant item code number contemplated in paragraph (f); and
k. in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a treatment plan indicating—
   (i) the expected total amount in respect of the treatment;
   (ii) the expected duration of the treatment;
   (iii) the initial amount payable; and the monthly amount payable.

It is, therefore, important for the coder to be aware of the information required by the medical schemes in terms of the legislation to consider a claim valid for funding purposes.

Medical claims process

Funding of accounts/claims

Medical schemes rely on specific ICD-10 codes to identify conditions or diseases that qualify as Prescribed Minimum Benefits (PMBs). If a condition is not a PMB, it will be funded based on the medical scheme rules. It is worth noting that medical schemes may not pay claims without an ICD-10 code from the treating healthcare provider. It is, therefore, critical that the medical schemes are provided with the correct ICD-10 codes to determine how the accounts or claims should be paid.

It is also important for healthcare providers to submit claims with the correct procedure codes for the treatments or services that were rendered. Additionally, healthcare providers and members of medical schemes have a responsibility to ensure that the correct codes are provided when claims are submitted to the medical schemes.

What affects the funding of claims?

Designated Service Providers (DSPs): Medical schemes often have agreements with specific healthcare providers known as Designated Service Providers (DSPs). Choosing non-DSPs may result in out-of-pocket costs due to penalties applied for using them.

Benefit Limits and Exclusions: Each medical scheme has specific limits on certain benefits and may exclude some treatments or services altogether. Understanding these limits is important to avoid unexpected expenses.

Pre-authorisation Requirements: Some procedures and treatments require pre-authorisation from the medical scheme. Failing to obtain this can lead to claims being denied.

PMBs: Understanding PMBs can help members ensure that they receive the necessary care without additional costs.

Medical Scheme Rules and Policies: Each medical scheme has its own set of rules and policies that govern how claims are processed and paid. Members are encouraged to familiarise themselves with these to help understand what is covered and how to claim.

Contribution Levels: The amount the members contribute to a medical scheme can affect the level of coverage they receive. Higher contributions often mean better benefits and lower out-of-pocket costs.

The CMS has published downloadable consumer education material to help you better understand key factors affecting your medical scheme claims and benefits. Click here to access them.

References

1. Council for Medical Schemes, 2024. Why do we have PMBs? [online] Available at: https://www.medicalschemes.co.za/resources/pmb/#:~:text=Why%20do%20we%20have%20PMBs%3F&text=To%20ensure%20that%20healthcare%20is,treated%20at%20a%20state%20hospital [Accessed 8 October 2024].
2. Republic of South Africa (1998) Medical Schemes Act, No. 131 of 1998. Available at: https://www.gov.za/sites/default/files/gcis_document/201409/a131-98.pdf [Accessed: 10 October 2024].

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