

Code of Conduct in respect of PMB benefits

31 July 2010

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Background and purpose

Subsequent to the release of Circulars 37 of 2009, 7 of 2010, and 9 of 2010 and meetings held with the Minister of Health and stakeholder representatives on the funding of prescribed minimum benefits (PMBs), the Department of Health with the assistance of the Council for Medical schemes and the Health Professions Council of South Africa, held a workshop with affected parties on 11 May 2010 in the Eastrand.

Parties to this process have agreed that it is in the best interest of the medical scheme members to proceed with a collaborative process whereby solutions to PMB related problems could be found, which has led to the establishment of a representative task team.

Working under tight time pressure, this code of conduct was prepared by the task team during June and July 2010. The task team consisted of four members each from four different groupings, made up by representatives from organs of state, medical schemes and administrators, health care providers, and members of medical schemes and consumers. The secretariat function was performed by the CMS (see Annexure C (page 16) for more details).

The immediate objective was to develop a code of conduct whereby PMBs could be offered to members of medical schemes in compliance with current legislation. Secondly, the task team will continue to exist in order to advise the Department of Health and CMS on possible amendments to the PMB regulations.

The task team had meetings on 25 May 2010, 4 June 2010 and 21 June 2010, during which the terms of reference for the task team were finalised and the draft framework for a code of conduct was established. Smaller group meetings were subsequently held on 9, 14 and 23 July 2010, during which further drafts of the code was developed. The fourth draft was discussed by the full task team on 30 July 2010, at which point sufficient consensus was reached to ask the secretariat to make minor changes to draft version 4.01 of the code for sign-off by electronic mail on Monday 2 July 2010.

The main document includes the areas where consensus was reached, and is reflected in Parts I to Part VI in the document. Future work emanating from the process is listed in Annexure A (Page 14), while the areas on which consensus was not reached are identified in Annexure B (Page 15). Annexure C (page 16) lists the task team members and Annexure D (page 17) contains the declaration which was made per electronic mail by the task team members.

Part I: The accessibility of information on access to PMB benefits, including the use of designated service providers (DSPs), requirements on marketing information, and desired educational efforts by stakeholders in respect of the PMBs

1. Whilst recognising that it is not possible, practical or helpful to provide members¹ with all information relating to the coverage of every possible diagnosis at point of entry onto the scheme; pertinent information (see paragraphs 3 and 4 below) must be made available when joining a scheme. This information must be updated and communicated at the beginning of each year or whenever changes are made that directly affect member benefits.
2. Communication in respect of benefits must be clear, in plain language and must be readily available.
3. CMS will lead a participative process to develop communication guidelines, which will, among other, stipulate the minimum level, format, and medium of communication required to communicate from schemes to members and providers. The purpose of the envisaged guidelines is to clarify the obligation on schemes, and to inform members on PMBs. During this process:
 - a. Consideration must be given to the minimum required frequency and timing of communication on PMB matters to ensure that members make informed choices on scheme and option selection.
 - b. The guidelines must consider at least the following matters:
 - i. The role of the Council for Medical Schemes,
 - ii. The functioning of medical schemes,
 - iii. The function of administrators of a medical scheme,
 - iv. The functions of the scheme's Principal Officer (PO) and Board of Trustees (BOT),
 - v. Dispute resolution at both scheme and Council level,
 - vi. Access to benefits,
 - vii. This process must strive to standardise terms such as block benefits, day to day benefits, major medical benefits, thresholds, savings accounts, self-payment gaps, and others, across all options within a medical scheme and within the medical schemes' industry in general,
 - viii. The manner in which managed care tools (pre-authorisation, DSP arrangements, formularies and protocols) are applied must be communicated to members and providers,
 - ix. The language of communication, accessibility to older members, the distribution of documents, and the role of brokers in such communication.

¹ The term "member" refers to main or principal members of a medical scheme, but may include "beneficiaries", which may be interchangeable with "patient", throughout this document.

4. Until the guideline considered in paragraph 3 above is in place, schemes must ensure the following information is available to all members:
 - a. The process by which members can apply or register² for PMB coverage must be made available to providers and members (see Part V, paragraphs 7, to 9, page 10),
 - b. The outcome of the application or registration process mentioned in paragraph 4 a above must be communicated members,
 - c. The location and contact details of DSPs,
 - d. The way in which claims will be covered if the member does not make use of the DSPs or baskets of care,
 - e. The applicable process and procedure to be followed if there are no available services or beds within the DSP at the time of request, and where such clinical services should be obtained by the member. Furthermore, the obligations of the scheme to ensure that the member is facilitated in obtaining those services from an alternative service provider and that such facilitation should be timeously done and with due regard to the member's clinical needs,
 - f. The process to make a "clinical appeal" as referred to in paragraph 4c.i), (In part III, page 6),
 - g. On resigning from a medical scheme, the scheme must provide the member with a certificate of membership which must at least include information regarding:
 - i) duration of membership, and
 - ii) chronic conditions for which a member is registered for and for which treatment is covered, and
 - iii) any relevant underwriting information.
5. Any information provided to members may not differ from the registered scheme rules however the broad principles of managed care (where applicable) must be communicated to members.
6. The above information should be available via:
 - a. The medical scheme website
 - b. The call-centre when requested
 - c. The benefit brochures in summarised format (which should indicate to members how they can access the detailed information when required)
 - d. Written format which can be sent to members on request
7. Given all of the above, it should be recognised that members have an obligation to familiarise themselves with the ways in which to navigate the Prescribed Minimum Benefits

² Registration for PMB benefits are applicable to benefits which require once-off registration such as CDLs, the chronic elements of DTPs (such as post-transplantation care) and pregnancy. Registration must prevent re-application for benefits in cases where conditions are of a chronic nature or where treatment interventions are spread over a longer period. Application for benefits typically needs to be done after the event for benefits which may not always be identified correctly on the basis of diagnosis and procedure codes alone.

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of their medical scheme. Members however, have the right to seek clarity in this regard, and may contact their medical scheme at any given time for an explanation of their benefits.

8. On request, call centre performance information (such as average waiting times, dropped call rates etc.) must be available to members.

Part II: Proposed solutions to problems relating to the “*payment in full*” provisions in regulation 8

1. The task team did not reach consensus on proposed solutions to address the problems related to the “payment in full provisions” in Regulation 8. More work will be done in this area (see Annexure B (Page 15)).

Part III: Establishing clarity and certainty of the benefits prescribed in Annexure A (including the explanatory notes) to the regulations,

The prescribed level of care for PMB conditions

1. Where appropriate, PMBs are not restricted to hospital-based management, but include appropriate delivery of relevant and appropriate care on an outpatient basis, or in a setting other than a hospital.

Development of benefit definitions

2. The CMS will coordinate a process whereby benefit definitions are developed to improve the clarity of the entitlement that members have, and the liabilities that schemes face, in respect of the PMB provisions in the Act and regulations.
3. The CMS coordinated process will take place in consultation and in collaboration with the DoH, funders, providers, academic sector, colleges, and other relevant regulatory bodies.
4. Benefit definitions³ must consider the level of appropriate clinical practice as desired in the public sector, supported by well researched evidence based clinical protocols, formularies or treatment guidelines, which are based on repeatable procedures that have demonstrated significantly improved clinical outcomes, and which have been tested on large numbers of people and for which there exists a high level of agreement among academic health professionals.
 - a. General supportive measures in relation to PMBs, including but not limited to pain management or rehabilitative services, must be included in the benefit definitions.
 - b. The chronic elements of care included in the DTPs⁴ must be included in the benefit definitions⁵.
 - c. By its nature, benefit definitions must at least meet the needs of a typical patient, but may make provision for newly diagnosed patients or patients whose diseases are not adequately controlled.
 - i) Schemes must therefore have procedurally fair clinical appeals processes in place, in consideration of Part IV of this code of conduct.

³ Benefit definitions constitute clear, comprehensive descriptions of the benefits which, in terms of the provisions of the PMB regulations, must be available for specific prescribed minimum benefit conditions. These descriptions should contain condition-specific standardised entry and verification criteria, stipulate defined baskets of services, care, and goods associated with such a benefit. Benefit definitions may include formularies, and for the provision of any specific benefit, specify the setting and level of care (*including primary care*) that are most appropriate for the treatment of the relevant prescribed medical condition.

⁴ Note that full consensus was not reached on the chronic elements of DTPs (see Annexure B, heading 3, page 15).

⁵ Note that, similarly, management of acute elements and complications of conditions included in the CDLs or their medical management are considered part of the PMBs.

- ii) Should the clinical appeals process not lead to acceptable resolution, the CMS may request that schemes demonstrate that dispute resolution processes are accessible to members and providers.
 - iii) The onus is on providers to provide patients and schemes with the relevant information where treatment beyond the standards specified in the benefit definitions is required.
 - d. In relation to the reference to the desired public sector levels of care;
 - i) The technology, medicine or service considered in the benefit definition must be available in the public sector after it was purchased through a tender or buy-out process (state funded), and not as a consequence of research, sponsored treatment trial, or compassionate-use programmes, and
 - ii) Where regulatory authorities exist and where healthcare interventions are regulated, the healthcare intervention must be registered with the appropriate regulatory body e.g. MCC, SABS, etc. Experimental interventions should therefore not be included in the benefit definitions.
 - e. Where available and applicable, health economic evaluations must be used to support funding decisions for treatment interventions. At the reasonable discretion of the scheme, such evaluations must be made available to relevant individuals or parties on request.
 - f. In consideration of the principles alluded to in paragraph 4 (page 5), access to and the availability of particular health interventions to an individual must be weighed against the interest of the membership as a collective, thus affordability for the scheme is an important consideration.
5. Until these CMS coordinated benefit definitions are developed, the onus is on schemes to provide benefits that meet the requirements set in paragraph 4 above, and these benefit definitions must be made available to interested parties on request, at the scheme's reasonable discretion, subject to its intellectual property policy.

The approach when a presumptive PMB diagnosis is made but not yet confirmed

- 6. The diagnosis and management of a condition leading to a definitive diagnosis and confirmation of a medical condition as a PMB shall fall under the ambit of PMB benefits.
- 7. Where a medical emergency is provisionally diagnosed, and is not confirmed by additional medical evidence, the scheme will be held liable to cover costs as PMB benefits up to the stage where a PMB condition has been excluded. Attention is drawn to explanatory note 7 to Annexure A in the regulations, whereby schemes may request confirmatory evidence from providers and whereby schemes must inform the Council for Medical Schemes, where problems in this respect are experienced.
- 8. In instances where a provisional diagnosis of a PMB condition is not confirmed and a NON-PMB condition is confirmed, and where such a change in diagnosis results in a scheme withdrawing authorisation for diagnosis, treatment, or care interventions, it is incumbent on

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the scheme to immediately notify the member and the relevant providers of such withdrawal, and how the treatment will be covered. The onus then rests on the provider to ensure that the member continues with the healthcare intervention with the full knowledge that the costs will be covered by the scheme in accordance to its benefit schedules for non-PMB conditions.

Part IV: The accessibility of alternative interventions, where prescribed interventions, scheme protocols or formularies are not adequate, or may cause harm to individuals, as prescribed by regulations 15H and 15I

1. There are medical grounds and clinical settings whereby protocols, formularies or benefit definitions may not constitute appropriate care for a given individual for a PMB diagnosis. Medical schemes must have a pre-defined process that will allow members and / or their healthcare professionals to apply for treatment beyond that which is available in the protocols, formularies, or prescribed algorithms, where this is medically necessary.
2. The manner whereby members get access to a clinical appeals process must be communicated and easily accessible, and must not be constructed as a barrier to access to alternative treatment interventions under these exceptional circumstances. The process of reviewing standard benefits, under these exceptional circumstances, must ensure that members and providers are treated fairly and consistently.
3. Alternative treatment should only qualify as a PMB entitlement where the standard protocols, formularies, and prescribed algorithms have been tried and demonstrated to be ineffective, causes or is likely to cause, adverse reaction in beneficiaries.
4. Being mindful of the fact that regulations 15H and 15I deal with patients where the standard protocols, formularies, and prescribed algorithms are not appropriate for specific individuals, alternative treatment interventions in these instances must be based on the same principles as those applicable to the development of benefit definitions in the first place (see Part III, paragraph 4, page 5).
5. The onus is on healthcare providers to supply schemes with relevant clinical information to aid decision-making in these exceptional cases.
6. Where alternative treatment is deemed appropriate and meets the criteria for PMB entitlement, payment must be from the risk benefit, and may not be paid from medical savings accounts or other benefits.

Part V: Conduct required to accurately identify PMB conditions

Valid PMB claims

1. In isolation, ICD10 codes alone are seldom adequate to correctly identify PMB benefits since the PMB regulations define PMB benefits as a diagnosis with specified severity, in relation to specified treatment, and
2. Payment as a PMB benefit (from the risk pool and not medical savings accounts or other benefits), is subject to the application of managed care interventions (formularies, DSPs, evidence based medicine and by implication, benefit definitions as considered in paragraph 4 [Part III, page 5]), and the use of DSPs.

Additional information required for the identification of PMB claims

3. Schemes must capture all submitted ICD10 codes as many of these may trigger a potential PMB benefit, including some codes not present on the current PMB code list developed by the CMS⁶ as a guide. Where appropriate, additional clinical information must be used to verify if a claim qualifies as a PMB benefit. This additional information includes but is not limited to:
 - a. The setting (e.g. hospital or not)
 - b. The nature and severity of the condition or injury
 - c. The procedure or treatment
 - d. The drugs used
 - e. Co-morbidities
 - f. The age and gender of the patient
 - g. Pathology or radiology results
 - h. Response to previous therapy
 - i. The hospital discharge summary
4. In principle, the onus is on the treating physician to provide a discharge summary that could be used as additional information to assist in identifying PMB claims. The exact modus operandus of this new requirement must be considered by a CMS-lead consultative process (see Annexure A, page 14).
5. ICD 10 codes must be submitted in accordance with the National ICD 10 Task Team rules and guidelines. The onus is on providers to ensure that personnel dealing with clinical codes are adequately trained to improve the quality of ICD 10 coding.

⁶ This is particularly true for medical emergencies.

6. The onus is on both “diagnosing” and “non-diagnosing” providers to submit accurate and specific ICD 10 codes on claims to facilitate the identification of PMB benefits⁷, and to provide the information considered in paragraph 3 above.

Pre-registration, application, and authorisation for PMB benefits

7. Considering that many PMB claims cannot be correctly identified as PMB benefits based on ICD10, procedure or medicine codes, a pre-registration, application or authorisation process may be required by schemes. Such pre-registration, application or authorisation process must not place an unnecessary burden on, and must be readily accessible to patients and providers (see Part I, paragraph 4a, page 2).
8. Registration for PMB benefits are applicable to benefits which require once-off registration such as CDLs, the chronic elements of DTPs (such as post-transplantation care) and pregnancy. Registration must prevent re-application for benefits in cases where conditions are of a chronic nature or where treatment interventions are spread over a longer period.
9. Where pre-registrations and authorisations are neither possible nor practical, (as with certain DT PMBs such as Otitis Media) schemes may establish an application process.
10. Pre-registration or pre-authorisation are appropriate and practical for CDLs and the chronic elements of DTPs where treatment interventions are done regularly. Similarly, pre-registration or authorisation is required for elective basis interventions.
11. In the case of emergencies, schemes may not deny benefits because authorisation (or registration) was not obtained prior to the diagnosis, treatment or care intervention.
12. Schemes must capture authorisation information in an electronic extractable format and must keep the original information (hard copies, electronic image files, voice recordings, etc.) for at least three years.

Processing of PMB claims

13. Schemes must capture all submitted ICD10 codes and where a valid PMB ICD10 code is submitted, this must act as a trigger for potential payment from the PMB benefit, as required in paragraph 14 below.
14. Medical scheme claims-processing systems must, where applicable, automatically pay valid PMB claims from risk pools (not medical savings accounts or other benefits), based on the availability of valid clinical codes and pre-authorisation or registration information, which in turn is subject to benefit definitions (see paragraph 4, Part III, page 5).

⁷ The practise whereby “non-diagnosing” providers (including radiologists, pathologists, pharmacists and allied health professionals) submit non-specific Z-codes, is not condoned. The diagnosis provided from the requesting provider must be submitted to the scheme.

Payment of PMB claims after these were initially not considered to be a PMB benefit

15. In instances where:

- a. claims could not be identified as valid PMB claims based on clinical codes alone, and
- b. where neither the additional information considered in paragraph 3 above (page 9), nor
- c. pre-registration, application or authorisation information is indicative of the fact that the claim constitutes a PMB benefit, then

the claim may be rejected as a PMB benefit or funded from another benefit. In such an instance, the member may raise a clinical dispute up to three years after the claim has been rejected or paid from another benefit.

Part VI: Administrative processes

Pre-registration, pre-authorisation, and application for PMB benefits

1. As a general principle, it is recognised that most PMB entitlements cannot accurately be identified through the information provided by the claim alone. Treatment interventions for CDL conditions, the chronic element of DTPs, and other conditions where treatment and care interventions are spread over a prolonged period, may require a pre-registration process.
2. After such a pre-registration, payment must be automatic in accordance as a PMB entitlement from the risk pool and not medical savings accounts or other benefits (see Part V, paragraphs 7 to 12 on page 10).
3. Schemes may make provision for the pre-authorisation of PMB benefits.
4. Diagnosis, treatment and care cost for conditions where pre-registration or pre-authorisation is neither practical nor applicable, may be subject to an application process (see Part V, paragraphs 7 to 12 on page 10).
5. Emergency claims must be paid automatically where they can be clearly identified.
6. Given the above, schemes must provide for:
 - a. A simple process designed to allow the Scheme to elicit relevant clinical information on which to evaluate whether a particular claim is indeed a PMB.
 - b. Well documented clinical criteria to facilitate effective adjudication, which should be available to providers and members via various communication channels (written, telephonic, website) on a by-request basis (see Part III, paragraph 4, page 5).
 - c. Authorisations for these requests should be processed within 7 days once full information required to make the adjudication has been made available to the scheme.
 - d. It should be noted that “full information” may sometimes include the decision of an external panel. Once the external panel has made a recommendation, the scheme must process the authorisation within 7 days.
 - e. Schemes should ensure that staff managing such registration, application or authorisation requests and claims queries, are adequately trained subject-matter experts who can promptly and effectively respond to and assist members and providers with these enquiries.
 - f. The communication of all relevant information as required in paragraphs 3 and 4 in Part I (page 1).

Disputes in respect of PMB benefits

7. Disputes that arise over the validity of claims against the entry criteria must be dealt with by a query and escalation processes (including a clinical appeals process) over and above the standard authorisation process (PMB escalations, disputes, CMS complaints, and appeals - see Part III, paragraph 4c, page 5).
8. Query and escalation staff should be readily available to assist promptly
9. Clinical criteria must be documented and available to providers and members via various communication channels (written, telephonic, website)

Payment of co-payments and deductibles from medical savings accounts in respect of PMB benefits

10. In situations where a member (who has a valid PMB diagnosis) voluntarily makes treatment choices in excess of scheme's defined baskets or outside of the DSPs, schemes are permitted to impose a reasonable co-payment⁸. This penalty is required to give sufficient incentive for providers to join DSP networks and the co-payments may not be paid from medical savings accounts.
11. To qualify for an exemption from the prohibition of co-payments or other deductibles from medical savings accounts considered in paragraph 10 above, schemes must apply to the CMS for section 8 (h) exemption from the requirements set in Regulation 10.

⁸ The CMS will communicate the quantum of a "reasonable" co payment to task team members (See Annexure A, heading 5, page 14).

Annexure A: Work emanating from the PMB task team process

1. Development of benefit definitions

- The CMS must lead a participative process whereby benefit definitions, as considered in Part III (see page 5) are developed.

2. Development of communication guidelines

- The CMS must lead a participative process whereby communication guidelines, as considered in Part I (see page 1) are developed.

3. Development of a process for the submission of discharge summaries

- The CMS must lead a consultative process whereby agreement between stakeholders could be reached on whereby the attending physician's discharge summary could be submitted to the scheme along with the hospital bill. PHISC may be engaged with to assist in the standardisation of the electronic format for the submission of such discharge summaries.

4. Interaction with the National ICD10 task team

- The CMS must interact with the National ICD10 task team to consider options whereby training on ICD10 coding could be made more accessible to providers.

5. Determination of a "reasonable" co-payment

- The CMS will consider the level of copayments which it deems reasonable and communicate with the task team in this respect.

6. Co-payments from medical savings accounts

- The CMS will consider solutions and engage with the Department of Health in respect of the use of savings accounts for voluntary co-payments by members for benefits in excess of the respective scheme PMB benefits.

Annexure B: Areas where consensus was not reached through the PMB task team process

1. Proposed solutions to problems relating to the “payment in full” provisions in regulation 8

- Consensus was not reached on any of the alternatives discussed around the “payment in full” requirements stated in regulation 8.
- The CMS representative indicated that further consultation with the CMS will be undertaken in this respect but reiterated that the CMS has resolved that further postponement beyond 30 July 2010 to reach consensus could not be given. On various occasions, organ of state representatives indicated to the task team that the MSA gives no discretion to the CMS on whether the “payment in full” provisions must be enforced or not.
- The task team nevertheless requested the CMS to consider that it might be in the best interest of members to avoid any punitive action in respect of the “payment in full” provisions, and instead focus on the full implementation and adherence to the code of conduct, to monitor the situation, and to assist in addressing the uncertainty in respect of tariffs subsequent to the high court ruling in respect of the RPL.

2. Tariffs

- The Registrar will study the impact of the 28 July 2010 high court ruling in respect of the RPL and revert to the task team on potential options that could be jointly considered.

3. Chronic elements of DTPs

- Note that full consensus could not be reached by all scheme and administrator representatives on whether DTPs have chronic elements or not

4. Level of care

- Note that representatives from consumer groups and beneficiaries of medical schemes argued that the level of care in the benefit definitions should not refer to the level of care in the public sector as the desired standard for PMBs.

Annexure C: PMB Task team members

1. Organs of state

Secretariat (Provided by the Council for Medical Schemes):

Stephen Mmatli

Nkuli Mlaba

Council for Medical Schemes

Boshoff Steenekamp

Department of Health

Moremi Nkosi

The Health Professions Council of SA

Bheki Mbhele (Chairperson)

Viraj Ramdas

2. Medical schemes and administrators

Jonathan Broomberg

Neil Nair

Bettina Taylor

Rajesh Patel

3. Healthcare providers

Medical specialists and general practitioners

Chris Archer

Adri Kok

Marmol Stolz

Hospital groups

Mark Bishop

4. Consumer groups and beneficiaries of medical schemes

Fanie du Toit

Madelein du Toit

Samantha Galliet

Noeline de Goede

Annexure D: Declaration by PMB Task team members

Members of the PMB task declared that the content of this document is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached.

(Individual task team members have made this declaration by electronic mail.)

31 July 2010

From: Jonathan Broomberg [JonathanB@discovery.co.za]
Sent: 01 August 2010 08:02 PM
To: Boshoff Steenekamp
Cc: Rajesh Patel (rpatel@bhfglobal.com); Bettina Taylor (bettinat@medscheme.co.za); Neil Nair (neiln@samwumed.org)
Subject: Declaration

Dear Boshoff

I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached.

Dr Jonathan Broomberg
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Discovery Health

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From: Neil Nair [neiln@samwumed.org]
Sent: 03 August 2010 07:47 AM
To: Boshoff Steenekamp; Nkuli Mlaba
Subject: RE: Please respond by Monday 2 August!

Dear Boshoff and Nkuli,

"I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached."

Regards,

Neil Nair
SAMWUMED
PA: Edith Andersen
e-mail: editha@samwumed.org
Tel: 021 697 9004
Fax: 021 696 3060
web: www.samwumed.org

From: Bettina Taylor [bettinat@medscheme.co.za]
Sent: 02 August 2010 03:26 PM
To: Boshoff Steenekamp
Subject: RE: Please respond by Monday 2 August!

Dear Boshoff

"I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached."

regards

Bettina

From: Rajesh Patel [rpatel@bhfglobal.com]
Sent: 02 August 2010 10:59 AM
To: Boshoff Steenekamp
Subject: FW: Please respond by Monday 2 August!
Attachments: 10 07 31 Final COC for approval.docx

Hi Boshoff

"I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached."

Please note the one comment on point 3, Annexure B. I've added on to fully reflect the unresolved item...

Kind regards,
Rajesh

Rajesh Patel
Head: Benefit & Risk
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Dr Patel added the following comment on the COC document (cf. heading 3, page 15 in Annexure B):

3. Chronic elements of DTPs

- Note that full consensus could not be reached by all scheme and administrator representatives on whether DTPs have chronic and or outpatient elements or not

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From: Marmol Stoltz [drmmstoltz@icon.co.za]
Sent: 02 August 2010 02:38 PM
To: Boshoff Steenekamp; JonathanB@discovery.co.za; chrisarcher@wol.co.za; jakok@mweb.co.za; bettinat@medscheme.co.za; Bheki; nkfsa@mweb.co.za; msu@multiplesclerosis.co.za; Mark.Bishop@netcare.co.za; Moremi Nkosi; NkosiMo@health.gov.za; neiln@samwumed.org; Nkuli Mlaba; nationaldirector.no@epilepsy.org.za; rpatel@bhfglobal.com; samantha@encourage.co.za; Stephen Mmatli; virajr@hpcsa.co.za
Subject: RE: Please respond by Monday 2 August!

Dear DR Steenekamp

"I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached."

Dr MM Stoltz

From: Chris Archer [chrisarcher@wol.co.za]
Sent: 03 August 2010 12:02 PM
To: Boshoff Steenekamp
Subject: RE: Please respond by Monday 2 August!

Dear Boshoff,

My apologies for the delay in responding to your request. I declare that this document is an accurate reflection of the debates held by members of the task team and that areas where consensus could not be reached is reflected in the document.

Kind regards

Chris Archer

From: Mark Bishop [Mark.Bishop@netcare.co.za]
Sent: 02 August 2010 12:02 PM
To: Boshoff Steenekamp; Jonathan Broomberg; Chris Archer; Adri Kok (jakok@mweb.co.za); Bettina Taylor (bettinat@medscheme.co.za); Bheki; Fanie du Toit (nkfsa@mweb.co.za); Madelein du Toit (msu@multiplesclerosis.co.za); Marmol Stoltz (drmmstoltz@icon.co.za); Moremi Nkosi; Moremi Nkosi (NkosiMo@health.gov.za); Neil Nair (neiln@samwumed.org); Nkuli Mlaba; Noeline De Goede; Rajesh Patel (rpatel@bhfglobal.com); Samantha Galliet; Stephen Mmatli; Viraj Ramdas
Subject: RE: Please respond by Monday 2 August!

Dear Boshoff

I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached.

I wish again to point out for the record, that my agreement that the document is an accurate representation of the workgroups efforts, is not agreement on behalf of any party; who I may be construed as representing; as final agreement and support of the COC.

Regards

Mark

**CODE OF CONDUCT IN RESPECT OF PMB BENEFITS
31 JULY 2010**

From: Samantha Galliet [samantha@encourage.co.za]
Sent: 02 August 2010 01:48 PM
To: Boshoff Steenekamp; 'Jonathan Broomberg'; 'Chris Archer'; 'Adri Kok'; 'Bettina Taylor'; Bheki; 'Fanie du Toit'; 'Madelein du Toit'; 'Mark Bishop'; 'Marmol Stoltz'; Moremi Nkosi; 'Moremi Nkosi'; 'Neil Nair'; Nkuli Mlaba; 'Noeline De Goede'; 'Rajesh Patel'; Stephen Mmatli; 'Viraj Ramdas'
Subject: RE: Please respond by Monday 2 August!

"I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached."

Warm regards

Samantha Galliet

Mobile: +27 83 629 1024
Fax: 0866 848 187
Email: samantha@campaign4cancer.co.za
Website: www.campaign4cancer.co.za

From: msu [msu@multiplesclerosis.co.za]
Sent: 02 August 2010 04:15 PM
To: 'Marmol Stoltz'; Boshoff Steenekamp; JonathanB@discovery.co.za; chrisarcher@wol.co.za; jakok@mweb.co.za; bettinat@medscheme.co.za; Bheki; nkfsa@mweb.co.za; Mark.Bishop@netcare.co.za; Moremi Nkosi; NkosiMo@health.gov.za; neiln@samwumed.org; Nkuli Mlaba; nationaldirector.no@epilepsy.org.za; rpatel@bhfglobal.com; samantha@encourage.co.za; Stephen Mmatli; virajr@hpcsa.co.za
Subject: RE: Please respond by Monday 2 August!

Dear Boshoff

It seems as if my e-mail has not received you? Thus, here it is again:

"I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached."

Madelein du Toit

(Chairperson)

Hope is putting faith to work when doubting would be easier (Anon)



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Melville 2109

CODE OF CONDUCT IN RESPECT OF PMB BENEFITS
31 JULY 2010

Subsequent to the final document, the following comments was received from consumer groups and beneficiaries of medical schemes representatives:

Dear Boshoff

I have read through the document again and there are only the following that I would like to suggest:

On page 2: Part 1, point 4 (b) there is a word missing: " communicated to members. "

The next point is on page 5: Part 3, point 3 where there is no reference to the consumer groups or disease-specific groups (NGOs) being part of this process.

I would also like to ask that the wording of Annexure B point 4 be changed to read: **"Note that the consumer representatives argued that the level of care in the benefit definitions should not be set at the level of care in the public sector since the MSA is clearly making reference to level of care to be evidence based."**

Lastly in Part 1, point 3 (b)(ix) the reference to "older people" can be confusing and should maybe rather read something like "people that don't have access to information through normal channels".

Kind regards

From: Noeline de Goede [nationaldirector.no@epilepsy.org.za]
Sent: 02 August 2010 02:34 PM
To: 'Samantha Galliet'; Boshoff Steenekamp; 'Jonathan Broomberg'; 'Chris Archer'; 'Adri Kok'; 'Bettina Taylor'; Bheki; 'Fanie du Toit'; 'Madelein du Toit'; 'Mark Bishop'; 'Marmol Stolz'; Moremi Nkosi; 'Moremi Nkosi'; 'Neil Nair'; Nkuli Mlaba; 'Rajesh Patel'; Stephen Mmatli; 'Viraj Ramdas'
Subject: RE: Please respond by Monday 2 August!

Dear Boshoff

I was represented in the meetings by the other beneficiary representatives and thus agree with them as follows:

"I declare that the content of this document "10 07 31 Final COC for approval.docx" is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached."

Kind regards,



Noeline de Goede

National Director

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**CODE OF CONDUCT IN RESPECT OF PMB BENEFITS
31 JULY 2010**

From: Viraj Ramdas [VirajR@hpcsa.co.za]
Sent: 02 August 2010 03:58 PM
To: Boshoff Steenekamp; Nkuli Mlaba
Subject: FW: Please respond by Monday 2 August!

Dear Boshoff

I have received confirmation from the Acting Registrar and Advocate Boikanyo to respond as follows:

“I declare that the content of this document “10 07 31 Final COC for approval.docx” is an accurate reflection of the outcome of the debates held by the task team, and that the document reflects areas where consensus has not been reached.”

Regards,

Mr Viraj Ramdas

Legal Advisor

Legal Department

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