Discovery
Health Medical Scheme

GUIDE TO TRANSPLANT CLAIMS SUBMISSION PROCESS

DISCOVERY HEALTH MEDICAL SCHEME
2022

Overview

This document explains how Discovery Health Medical Scheme pays for pre-transplant investigations, the transplant procedure and post-transplant care, where approved as a Prescribed Minimum Benefit (PMB).

About some of the terms we use in this document

There may be some terms we refer to in the document that you may not be familiar with. Here are the meanings of these terms.

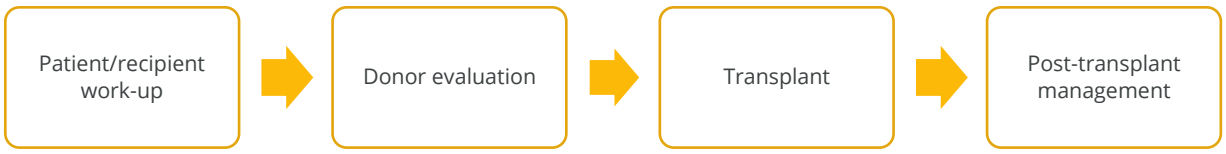
TERMINOLOGY	DESCRIPTION
Above Threshold Benefit (ATB)	**Available on the Executive, Comprehensive and Priority plans** Once the day-to-day claims you have sent to us add up to the Annual Threshold, we pay the rest of your day-to-day claims from the Above Threshold Benefit (ATB), at the Discovery Health Rate (DHR) or a portion of it. The Executive and Comprehensive plans have an unlimited ATB, and the Priority plans have a limited ATB.
Day-to-day benefits	These are the available funds allocated to the Medical Savings Account (MSA) and Above Threshold Benefit (ATB). Depending on the plan you choose, you may have cover for a defined set of day-to-day benefits. The level of day-to-day benefits depends on the plan you choose.
Discovery Health Rate (DHR)	This is a rate we pay for healthcare services from hospitals, pharmacies, healthcare professionals and other providers of relevant health services.
Emergency medical condition	An emergency medical condition, also referred to as an emergency, is the sudden and, at the time unexpected onset of a health condition that requires immediate medical and surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's life in serious jeopardy. An emergency does not necessarily require a hospital admission. We may ask you for additional information to confirm the emergency.
ICD-10 code	A clinical code that describes diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).
Medical Savings Account (MS)	**Available on the Executive, Comprehensive, Priority and Saver plans** The Medical Savings Account (MSA) is an amount that is allocated to you at the beginning of each year or when you join the Scheme. You pay this amount back in equal portions as part of your monthly contribution. We pay your day-to-day medical expenses such as GP and specialist consultations, acute medicine, radiology and pathology from the available funds allocated to your MSA. Any unused funds will carry over to the next year. Should you leave the Scheme or change your plan partway through the year and have used more of the funds than what you have contributed, you will need to pay the difference to us.
Prescribed Minimum Benefits (PMBs)	In terms of the Medical Schemes Act of 1998 (Act No. 131 of 1998) and its Regulations, all medical schemes have to cover the costs related to the diagnosis, treatment and care of: • An emergency medical condition • A defined list of 271 diagnoses • A defined list of 27 chronic conditions. To access Prescribed Minimum Benefits (PMBs), there are rules defined by the Council for Medical Schemes (CMS) that apply: • Your medical condition must qualify for cover and be part of the defined list of Prescribed Minimum Benefit (PMB) conditions • The treatment needed must match the treatments in the defined basket of benefits

- You must use designated service providers (DSPs) in our network. This does not apply in emergencies. However even in these cases, where appropriate and according to the rules of the Scheme, you may be transferred to a hospital or other service providers in our network, once your condition has stabilised. If you do not use a DSP we will pay up to 80% of the Discovery Health Rate (DHR). You will be responsible for the difference between what we pay and the actual cost of your treatment.

If your treatment doesn't meet the above criteria, we will pay according to your plan benefits.

Understanding how the transplant claims process works

For simplicity, we have identified four definite steps that must take place for a transplant, as shown in the diagram below:



The information below describes each step in the claims process. The process to have the patient or transplant recipient's accounts paid is different to the process for the donor accounts. We explain these two processes separately.

Patient or transplant recipient work-up

Discovery Health Medical Scheme will pay for the appropriate, approved work-up costs which include amongst other costs consultations, procedures, investigations like blood tests, x-rays and medicines for you, the transplant recipient.

Getting work-up accounts paid as a Prescribed Minimum Benefit (PMB)

- To ensure claims are funded correctly as Prescribed Minimum Benefits (PMBs), it is important that all healthcare providers submit claims with the approved ICD-10 diagnosed codes
- Claims may be submitted by email to claims@discovery.co.za
- Proof of payment must be submitted if these claims have been paid for upfront, if done prior to your preauthorisation.

If we initially paid your transplant work up accounts from the day-to-day benefits (which sometimes occur if incurred prior to your transplant preauthorisation), we will pay the amounts back into the day-to-day benefits retrospectively and pay the healthcare professionals at the agreed rates. If you paid the accounts upfront, we will refund you once proof of payment is received with the claim at the agreed rates.

Donor work-up

Paying the accounts

- Once a suitable or compatible donor is found, and where appropriate, the transplant coordinator will send us the donor's full name and ID number. We will pay for the procurement of the organ and the necessary tests done before the donor's surgery to harvest the organ. This includes x-rays, electrocardiogram (ECG) and blood tests, which will be paid retrospectively once the transplant surgery has been done
- Discovery Health Medical Scheme will only approve and pay for one donor work-up per transplant
- The donor does not have to be a member of the Discovery Health Medical Scheme. We will approve and pay these accounts through an Ex-gratia exception process outside of the normal claims process
- In the event that the donor later becomes unsuitable, a letter of motivation is required from the treating doctor stating the reason the donor is no longer suitable. The treating doctor also needs to explain the reason the newly selected donor is more suitable. A clinical panel will review the letter of motivation and will notify you of the outcome of the review.

Getting the donor accounts to us so we can pay them from the appropriate benefit

- Make sure the accounts are clearly marked as "Donor account approved as ex gratia"
- Ensure that the donor's full name and ID number reflects on the account
- Please email the accounts to EXGRATIA_APPROVED_CLAIMS@discovery.co.za for payment of the accounts.

The transplant

The hospitalisation costs for the transplant surgery is paid from your Hospital Benefit

We will pay for the transplant procedure in-hospital from the Hospital Benefit. You can call us on 0860 99 88 77 for authorisation and we will explain the details of cover at the same time.

Post-transplant management

Certain treatment needed after the transplant surgery may also qualify for payment as a Prescribed Minimum Benefit (PMB)

After the transplant surgery, treatment is required as part of ongoing management of the condition. The condition being treated may be a Prescribed Minimum Benefit (PMB) and the treatment may be part of the basket of care for that PMB. This may include tests or investigations, chronic medicine and consultations.

Consultations, tests or investigations

You must notify us that the transplant surgery has taken place by emailing PMB_APP_FORMS@discovery.co.za. We will then activate the post-transplant benefit. Making sure that the post-surgery treatment is covered as a Prescribed Minimum Benefit (PMB)

Chronic medicine

Funding for chronic medicine is not automatic. You need to apply for funding for chronic medicine. A Chronic Illness Benefit (CIB) application form must be completed and sent back to us by email at CIB_APP_FORMS@discovery.co.za and we will approve the request subject to certain criteria being met. If you are already registered on the Chronic Illness Benefit (CIB) for this condition, we need a copy of the new prescription for the medicine required.

Where to get application forms

Up to date forms are always available on www.discovery.co.za under Medical Aid > Manage your health plan > Find important documents and certificates.

If we do not approve funding, you may ask us to review the funding decision by submitting additional clinical information

.

Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66
Go to www.discovery.co.za to Get Help or ask a question on WhatsApp. Save this number 0860 756 756 on your phone and say "Hi" to start chatting with us 24/7.
PO Box 784262, Sandton, 2146. 1 Discovery Place, Sandton, 2196.

Complaints process

Discovery Health Medical Scheme is committed to providing you with the highest standard of service and your feedback is important to us. The following channels are available for your complaints and we encourage you to follow the process:

1 STEP 1 – TO TAKE YOUR QUERY FURTHER:

If you have already contacted the Discovery Health Medical Scheme and feel that your query has still not been resolved, please complete our online complaints form on www.discovery.co.za. We would also love to hear from you if we have exceeded your expectations.

2 STEP 2 – TO CONTACT THE PRINCIPAL OFFICER:

If you are still not satisfied with the resolution of your complaint after following the process in Step 1 you are able to escalate your complaint to the Principal Officer of the Discovery Health Medical Scheme. You may lodge a query or complaint with Discovery Health Medical Scheme by completing the online form on www.discovery.co.za or by emailing principalofficer@discovery.co.za.

3 STEP 3 – TO LODGE A DISPUTE:

If you have received a final decision from Discovery Health Medical Scheme and want to challenge it, you may lodge a formal dispute. You can find more information of the Scheme's dispute process on the website.

4 STEP 4 – TO CONTACT THE COUNCIL FOR MEDICAL SCHEMES:

Discovery Health Medical Scheme is regulated by the Council for Medical Schemes. You may contact the Council at any stage of the complaints process, but we encourage you to first follow the steps above to resolve your complaint before contacting the Council. Contact details for the Council for Medical Schemes: Council for Medical Schemes Complaints Unit, Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion 0157 | complaints@medicalschemes.co.za | 0861 123 267 | www.medicalschemes.co.za