gems
Government Employees Medical Scheme

2024 ORTHOTISTS & PROSTHETISTS PROVIDER GUIDE

This guide provides more information on **how GEMS covers medical appliances and prosthetics**

DISCOVER THE BRILLIANCE OF GEMS

Introduction

GEMS has designed its prosthetics and medical appliances benefit in such a way as to ensure that all beneficiaries have access to cost-effective, quality medical devices, appliances, orthotics and prosthetics and associated professional services irrespective of their benefit option.

This guide provides more information on how medical appliances and prosthetics are covered as well as the processes to be followed to ensure that claims are covered without unnecessary co-payments by GEMS members.

Access the Provider portal at hcp.gems.gov.za and download the GEMS Provider App from Google Play or the App Store, or use the QR code.

GET IT ON Google Play

Download on the App Store

Please ensure that all your practice information, including contact details, are updated with the BHF so that you are able to receive the OTP during registration.

What's **new in 2024**

GEMS has applied an annual adjustment to all benefits across all GEMS options. In line with this change, the sub-limits for certain categories have been updated as follows:

- Foot orthotics: R5 893
- Orthotic shoes, foot/shoe/ankle inserts and levelers: R1 684
- Crutches: R670
- Wheelchairs: R7 377
- Compression stockings: R558 per pair
- Pulse Oximeter: R446
- Knee and back braces: R3 345 per brace

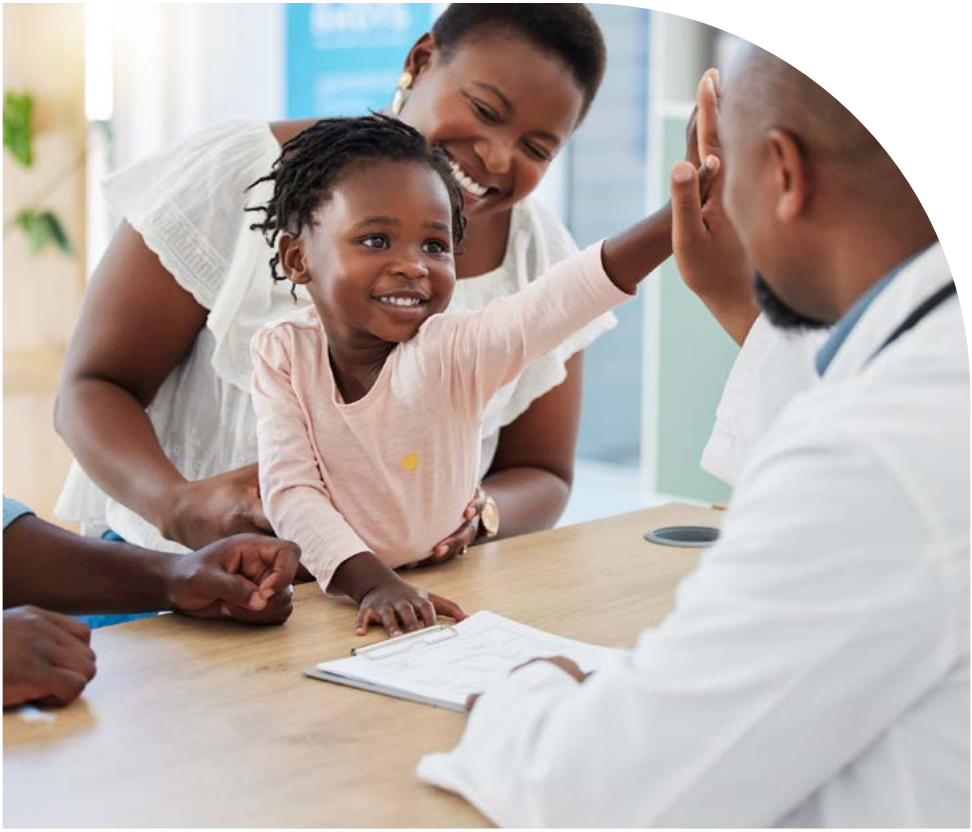
GEMS Medical **Appliance Benefit**

Two broad categories of medical appliances

The devices and appliances that are covered by GEMS are divided into two broad categories: those for which no pre-authorisation is required, and those for which pre-authorisation must be obtained and which are subject to managed care protocols.

Pre-approved list of medical appliances – no pre-authorisation required

When prescribing an appliance for GEMS patients, service providers can choose from a wide variety of medical appliances without any need for pre-authorisation from GEMS. The medical appliance list can be viewed by clicking **here**.



Medical appliances that require pre-authorisation

If the required appliance is not on the pre-approved list, it means that it will have to be pre-authorised and is subject to managed care protocols. The reason for this is that GEMS intends to assist members to avoid unforeseen co-payments, specifically where benefit sub-limits apply.

The following are some of the categories of appliances that require pre-authorisation by GEMS:

- Blood pressure monitors
- Braces (knee and back)
- Breast prostheses and mastectomy bras
- Commodes
- Nebulisers
- Orthotic shoes
- Oxygen concentrators
- Prosthetics & components
- Sleep apnea devices
- Specialised beds
- Specialist compression stockings
- Suction units
- Wheelchairs, accessories and repairs

Benefits for certain appliances and devices are made available over longer cycles than a single benefit year, and the table below provides additional detail on this.

Appliance Category	Quantity Limit	Frequency / cycle	Eligibility
CPAP	One (1)	36 months	Per beneficiary
Hearing Aid	One (1) Unilateral/ One (1) pair of Bilateral	36 months	Per beneficiary
Knee braces	One (1)	Per annum	Per beneficiary
Wheelchair	One (1)	24 months	Per beneficiary
Back braces	One (1)	Per annum	Per beneficiary
Oximeters	One (1)	Per annum	Per family
Compression Stockings	Three (3) pairs	Per annum	Per beneficiary

How to obtain pre-authorisation for medical appliances

Providers should request authorisation by sending an email to **enquiries@gems.gov.za** and include the following:

- **A prescription or letter with clinical information; and**
- **A quotation from a registered provider (a provider with a practice number) that includes a description of the device or appliance, the NAPPI code, the quantity requested, and the price.**

Prescribed Minimum Benefits (PMB)

- **GEMS funds PMB requests in line with PMB legislation.**
- **PMBs will pay from the available benefit limits first and then from risk. PMBs are not payable from savings.**
- **In terms of the Scheme Rules, GEMS may obtain a competitive quotation which could necessitate the need for an additional assessment by the second provider.**
- **Quotations received are reviewed in line with criteria depending on the appliance requested, and taking cost-effectiveness into account. If approved, an authorisation will be created and communicated to the member and provider.**

IMPORTANT

- **Please ensure that the membership number appears on all the relevant documents and in the subject line of the email (if applicable).**
- **Always obtain pre-authorisation before making custom prostheses.**

How appliances are covered by GEMS

Cover is dependent on the Scheme option, and it is important to remember that managed care protocols may apply. In addition, the medical and surgical appliance benefit is a shared benefit for both in-hospital and out-of-hospital prostheses and appliances.

Benefits available for medical and surgical appliances and prostheses:

OPTION	PROSTHESIS BENEFIT LIMIT	APPLIANCES SUBLIMIT
Tanzanite One	R35 590	R8 376
Beryl	R41 896	R13 964
Ruby	R53 663	R20 938
Emerald Value	R53 663	R20 938
Emerald	R53 663	R20 938
Onyx	R72 489	R24 234

Please read more about the cover for appliances in the Scheme Rules **here**.

Ex-gratia process

Ex-gratia funding is a concession exercised at the sole discretion of the Ex-Gratia Committee, and not a benefit to which members are entitled. Please remember that all submissions are assessed on merit, and this does not guarantee any previous funding decision will be reversed.

In clinically and financially appropriate cases, members or providers may apply to GEMS for ex-gratia consideration should the applicable benefit be depleted or insufficient.

Providers may request application forms by calling 0860 00 4367 or emailing enquiries@gems.gov.za. In addition, members can request an application form at any of the GEMS walk-in centres. Ex-Gratia Committee meetings are held at least every 8 weeks.

How to facilitate claims payment

Verification of benefits

- First verify membership details and confirm the identity of the patient.
- Always ensure that available benefit codes and tariff values are verified with the Scheme. The Scheme will not be held responsible for payment of services excluded in terms of either the Scheme Rules or managed care protocols. Members will be liable for claims incurred for benefits not included in the benefit schedule.
- Benefit confirmation via pre-authorisation is required if the appliance is not included on the appliance **list**.

Information required on claims

- **Main member details such as membership number, option, name and contact details;**
- **Patient details, including date of birth, name and/or identity number;**
- **Provider details, including a valid Board of Healthcare Funders practice number, name and contact details;**
- **Diagnosis and summary of services rendered and items dispensed to the patient;**
- **Relevant tariff codes, ICD10 codes and NAPPI codes; and**
- **Associated costs.**

Please note that clinical information and codes should reflect corresponding service dates, and details of codes used. If these details are incomplete, the claim will be rejected.

Coding of prosthetics and appliances

Please note that GEMS makes exclusive use of NAPPI coding for prosthetics and appliances. All claims and authorisation requests should include the correct NAPPI codes to avoid any delay in the finalisation of your request.

Practitioners should request manufacturers to register with MediKredit if they have not already done so. Where products do not yet have an allocated NAPPI code, the claim will be rejected until a valid NAPPI code has been provided. This includes multi-component surgical products such as kits, packs and trays. Suppliers can also update product information, or discontinue product listings with MediKredit.

More information on the registration process and application forms can be found on the MediKredit website: https://www.medikredit.co.za/products-and-services/nappi/nappi-forms/. Alternatively, an email can be sent to productfile.nappi@medikredit.co.za, or contact made via telephone on 011 770 6000.

Additional information to consider

Annual review of the benefit design

GEMS has a well-established process through which all funding guidelines, member benefits and provider remuneration is fully reviewed on an annual basis. This includes changes made to benefits and sub-limits, funding cycles and the funding of new technology. Input from many stakeholders is considered and GEMS welcomes suggestions from representative societies and providers alike. Input must be sent to **ProductDevelopment@gems.gov.za.** All submissions must be received by the end of the first quarter of each year and will then be considered as part of the overall project.

Chronic Back and Neck Rehabilitation programme

In cases where orthoses or prostheses for spinal pathology are clinically indicated or being considered, please remember that GEMS has an established Chronic Back and Neck Rehabilitation (CBNR) Programme that could be explored as a complementary option for treatment.

This programme provides GEMS beneficiaries with appropriate treatment to manage their chronic back and neck pain. Positive outcomes of this non-surgical programme include improved flexibility, restoring functionality, reducing pain and a decrease or delay in the need for surgery, which leads to a more productive life. The focus of the CBNR programme is on back and neck rehabilitation with the major components being controlled exercises, biopsychosocial support and pain education. The FP located at some centres is the coordinator of spinal care and he/she is supported by a multidisciplinary team (including a physiotherapist and/or biokineticist and/or occupational therapist). Clinical measurements are taken and recorded and these are used to re-evaluate the progress of treatment over time. The cost of the programme is paid from a separate CBNR benefit so there is no financial impact on day-to-day benefits or savings. Should your GEMS patient require a referral to a CBNR network facility, kindly send an email to **enquiries@gems.gov.za**.

What is **Fraud, Waste & Abuse?**

GEMS has a responsibility to protect beneficiaries' benefits from irregular claims submissions. The unfortunate reality is that some service providers deliberately or unintentionally submit irregular claims to the Scheme that are either false (claims submitted for services not rendered) or claims that are excessive and not medically necessary.

Fraud, Waste and Abuse (FWA) is recognised as a major challenge for healthcare systems, globally and in South Africa. Fraud, waste and abuse can be defined as follows:

Fraud

Fraud refers to intentional deception by misrepresentation or by supplying false information with the knowledge that the deception could lead to payment or other benefit where no entitlement to such would otherwise exist. These acts may be committed either for one's own benefit or for the benefit of a third party.

Waste

Waste refers to the extra costs incurred when healthcare services are unnecessarily overused, or when bills for services are prepared incorrectly. Unlike fraud, waste is usually caused by mistake rather than illegal or intentionally wrongful actions.

Abuse

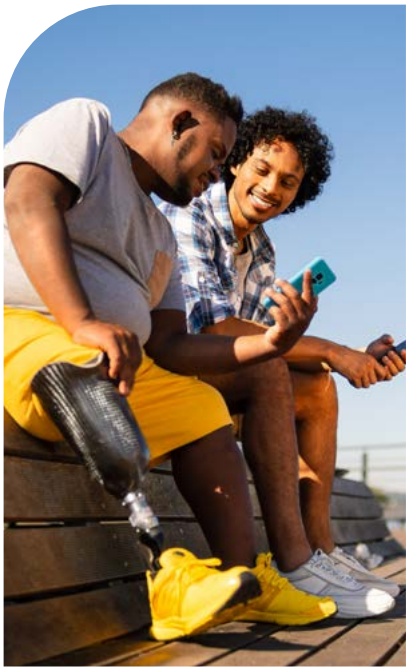
Abuse occurs when practices are inconsistent with sound fiscal, business or medical practice, and such inconsistencies result in an unnecessary cost to a medical scheme, or in reimbursement for services that are not medically necessary.

The primary difference between fraud, waste, and abuse is **intention.**

GEMS has a zero tolerance approach to FWA and has a dedicated Claims Risk Management Unit and whistle-blower hotline to identify irregular claiming behaviour. It is your responsibility as a provider to ensure that all claims submitted on behalf of the member are valid. The misuse of membership details to submit irregular claims may result in remedial actions being taken which may include reporting the unethical behaviour to the Regulatory bodies, civil and criminal action.

GEMS claims overview

- The Audi Alteram Partem (let the other side be heard) Principle is applied. This allows providers the opportunity to respond to or give an explanation related to findings of potentially irregular claims.
- Letters specifying anomalies identified in a specific practice are drafted and forwarded to providers. Providers are then given 7 to 14 days to respond to the requests noted in the letters. The time given depends on the nature and complexity of the requests. These requests may be simple, such as the confirmation of practice details, locums or number of GEMS members treated. Alternatively, information that is more detailed may be required. Detailed requests may include requests for the explanation of use of certain codes or even evidence of services rendered.
- GEMS may arrange engagements with a provider at their request and/or when the provider's responses to the anomaly findings are not clear enough to conclude an audit
- GEMS will then compile a report containing responses and evidence supplied by providers. The report is then presented and discussed at a forum at which decisions are made on remedial actions and/or recovery of irregular claims.
- GEMS supports the regulatory body's processes and unprofessional conduct is always reported to them.



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