

Best Practice Guidelines for health funds

How to interpret and apply the pre-existing ailment rule

Table of contents

Summary - overarching principles to best practice application of the PEA rule	3
Introduction	4
Key points – Pre-existing ailments	6
Fund PEA advertising and marketing material	7
Customer service officers and call centre staff – what to tell consumers	9
Customer service officers and call centre staff – what to send to consumers	12
Claim staff guidelines	14
Guide for health fund medical practitioner	15
Sign and symptom – definitions for fund medical practitioners	16
Guide for Interface between hospitals and health funds	19
Emergency admissions	21
Guide for informing members of PEA assessment	22
Case studies to explain how the PEA rule is applied	23
Steering Committee membership	Attachment A
Medical Certificate regarding Pre-existing Ailments	Attachment B
PEA Assessment Form	Attachment C
Statement of Reason	Attachment D

Summary - overarching principles to best practice application of the PEA rule

These best practice guidelines for health funds have been designed to provide consistency in approach with respect to the administration and application of the pre-existing ailment (PEA) rule.

The success of the pre-existing ailment rule relies on the adoption by health funds of the following over-arching principles:

1. Commitment to apply and administer the pre-existing ailment rule in accordance with these best practice guidelines.
2. Act in good faith and work cooperatively with hospitals, medical practitioners and fund members to provide members with a PEA assessment prior to admission in all circumstances possible.
3. Commitment, where it is not already the case, to provide a comprehensive web-based or other telecommunications benefit eligibility confirmation system to ALL hospitals (public/private/agreement/non agreement). The eligibility confirmation system should have the capacity to confirm at least the following basic membership details 24 hours per day, 7 day per week:

Member name	Date joined current hospital table
Patient name	Excess payable
Patient date of birth	Co-payments payable
Financial status of membership	Excluded treatments
Current hospital table	Restricted benefits treatments

This information will enable the treating hospital to identify members who are at risk of PEA and other waiting periods and/or excluded treatments.

4. Commitment, where relevant, to negotiate with hospitals to include in agreements, an acceptable cost sharing arrangement to cover emergency (unplanned) admissions where it is not possible for the hospital to confirm with the fund the above basic membership details prior to the admission.
5. In most cases, pre-existing ailment assessments and confirmation of benefit entitlements will be clear-cut. These guidelines will be most useful in ensuring fairness where cases are less clear. Remember, usually all parties will be acting in good faith.
6. Health funds are reminded that they have the discretion to grant benefits in individual cases where the pre-existing ailment rule could be applied. For example in circumstances where it may be appropriate to give the member the benefit of the doubt, or for any other reason as determined by the fund.

Introduction

The need for best practice guidelines

An independent review of the pre-existing ailment rule found that the health funds were applying the rule inconsistently, creating uncertainty and potential unfairness for consumers. The review committee recommended that best practice guidelines be developed to address these issues.

Guidelines for health funds

The guidelines set out the responsibilities for health funds from the very beginning (advertising and marketing) through to the PEA assessment and the advice that should be provided to a member once the assessment has been finalised.

The information has been broken into the following segments so that health fund staff can easily identify PEA best practice as it applies to their particular job.

1. Guide to PEA advertising and marketing material;
2. Guide for customer service officers and call centre staff;
3. Guide for claims staff;
4. Guide for medical practitioners appointed by the fund
 - what is a sign
 - what is a symptom;
5. Guide for interface between hospitals and health funds
 - planned admissions
 - emergency admissions;
6. Guide for informing members of PEA assessment.

Who developed these best practice guidelines?

Representatives from health funds, medical practitioners, private hospitals, the Office of the Private Health Insurance Ombudsman, consumer representative organisations and the Department of Health and Aged Care developed these guidelines. A full list of committee members is at ***Attachment A***.

The committee has developed similar PEA best practice guidelines for hospitals and medical practitioners.

The committee has also written a brochure explaining the rule for consumers.

Introduction, continued

Why do we have a pre-existing ailment rule?

People choose to take out private hospital insurance for many different reasons. If there was not a pre-existing ailment waiting period people could take out hospital cover or upgrade to comprehensive cover only when they know or suspect that they might need hospital treatment and immediately make an expensive hospital claim. If these new members then left the fund or downgraded to a low premium table, their hospital costs would have to be paid for by the long-term members who remain on these hospital tables. This would not be fair.

Remember, new members who do have pre-existing ailments can still seek treatment for these conditions in a public hospital under Medicare.

What is the formal definition of a pre-existing ailment?

The National Health Act defines a pre-existing ailment as:

an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the organisation (the health fund), existed at any time during the 6 months prior to the member beginning contributions to the organisation for hospital cover or upgrading to a higher level of cover.

The law also specifies that, in forming an opinion about a pre-existing ailment, the medical practitioner appointed by the health fund must consider any information that was provided by the medical practitioner who treated the ailment, illness or condition.

Key points – Pre-existing ailments

1. This legislated definition of pre-existing ailments only applies to hospital tables. Some funds do apply similar rules to their ancillary cover;
2. It is the medical practitioner appointed by the health fund who decides if an ailment, illness or condition is pre-existing. They must also consider any information regarding signs and symptoms provided by the treating medical practitioner(s);
3. Whether or not a member has a pre-existing ailment must always be assessed from that person's individual circumstance. It is not allowable to say that certain conditions are always pre-existing;
4. The medical practitioner appointed by the health fund must be satisfied that there is a direct link between the ailment, illness or condition that requires hospital treatment and the signs and symptoms that existed in the 6 month period prior to the member joining or upgrading hospital cover;
5. It is not necessary for the ailment, illness or condition, to have been diagnosed in the 6 month period – only that signs or symptoms were, or would have been, evident;
6. These signs and symptoms should have been reasonably apparent to either the member, or a reasonable general practitioner had the member been examined in this 6 month period;
7. The waiting period for pre-existing ailments cannot exceed 12 months from date of joining or upgrading hospital tables.

Fund PEA advertising and marketing material

Best practice requires the following explanation of the pre-existing ailment rule to be included in health fund brochures.

Explanation of the PEA rule

PEA waiting period

Health funds can apply a special waiting period to new members of hospital tables who have pre-existing ailments. This waiting period also applies to existing members who have recently upgraded their level of hospital cover.

If the ailment, illness or condition is considered pre-existing:

- new members must wait 12 months for any hospital benefits;
- members transferring/upgrading to a higher hospital table must wait 12 months to get the higher hospital benefits. Existing members with at least 12 months membership in total across their old and new cover, are entitled to the lower benefits on their old cover.

What is a pre-existing ailment?

A pre-existing ailment is one where signs or symptoms of your ailment, illness or condition, in the opinion of a medical practitioner appointed by the health fund (not your own doctor), existed at any time during the six months preceding the day on which you purchased your hospital insurance or upgraded to a higher level of hospital cover.

The only person authorised to decide that an ailment is pre-existing is the medical practitioner appointed by us (the health fund). The fund medical practitioner must, however, consider any information regarding signs and symptoms provided by your treating medical practitioner(s).

Additional explanation

Health funds have discretion to include some, or all, of the following additional information on the pre-existing ailment rule in their promotional material.

The pre-existing ailment rule still applies even if your ailment, illness or condition was not diagnosed prior to joining the hospital table.

The only test is whether or not, in the 6 months prior to joining your current hospital table signs and symptoms:

- were evident to you; or
- would have been evident to a reasonable general practitioner if a general practitioner had been consulted.

Fund PEA advertising and marketing material, continued

Additional explanation (continued)

When to contact the health fund

If you have less than 12 months membership on your current hospital table, make sure you contact us *before* you are admitted to hospital and find out whether the pre-existing ailment waiting period applies to you.

We need about 5 working days to make the pre-existing ailment assessment, subject to the timely receipt of information from your treating medical practitioner(s).

Make sure you allow for this timeframe when you agree to a hospital admission date.

If you proceed with the admission without confirming benefit entitlements and we (the health fund) subsequently determine your condition to be pre-existing, you will be required to pay all outstanding hospital charges and medical charges not covered by Medicare.

Emergency admissions

In an emergency, we may not have time to determine if you are affected by the pre-existing ailment rule before your admission. Consequently if you have less than 12 months membership on your current hospital table you might have to pay for some or all of the hospital and medical charges if:

- you are admitted to hospital and you choose to be treated as a private patient; and
- we later determine that your condition was pre-existing.

What must be explained if funds offer 'no waiting period' promotion

Fund marketing campaigns that offer to waive waiting periods *must* clearly indicate whether or not the PEA waiting period is also waived.

Funds must write to the member (not rely on a general brochure) and advise the waiting periods that have been waived under the marketing campaign and those that still apply.

Customer service officers and call centre staff – what to tell consumers

Notification of admission

When a member contacts the fund to advise:

- a planned admission; and
- contact is made in business hours

health fund customer service officers and call centre staff should follow these steps:

Clarify basic membership details with the member

Check the fund's records and/or with the member to confirm the following membership details:

- member name;
 - patient name (if different to member);
 - patient date of birth;
 - patient covered by membership;
 - member financial;
 - length of time on current hospital table;
 - planned date of admission;
 - name and address of treating hospital (if known);
 - name and address of admitting doctor;
 - anticipated procedure(s) and/or reason for admission;
 - check for exclusions and restricted benefits.
-

PEA does not apply – more than 12 months membership

Members that have more than 12 months membership on their current hospital table are not affected by the PEA rule.

Provide these members with full confirmation of their benefit entitlements in particular exclusions and restricted benefits and follow up with written confirmation as soon as possible.

PEA assessment required - less than 12 months membership

If the member has less than 12 months membership on their current hospital table, advise them that the pre-existing ailment waiting period might apply and the fund will need to assess their case.

Advise that if the condition is determined to be pre-existing:

- new members must wait twelve months from the date of joining for benefits for that condition;
 - transferring/upgrading members must wait 12 months from the date of transferring/upgrading, for higher benefits for that condition, under the new level of cover.
-

Explain what a pre-existing ailment is

Explain that a pre-existing ailment is:

‘an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the health fund (not your own doctor), would have existed at any time during the 6 months prior to taking out hospital insurance or upgrading to a higher level of hospital cover.’

Customer service officers and call centre staff – what to tell consumers, continued

**Explain:
What is a sign?
What is a symptom?**

Advise the only test for a pre-existing ailment is whether or not, in the 6 months prior to joining their current hospital table signs or symptoms:

- were evident to them; or
- would have been evident to a reasonable general practitioner if a general practitioner had been consulted.

This means that the pre-existing ailment rule could still apply if the illness had not been formally diagnosed prior to taking out hospital cover.

Emphasise that the fund medical practitioner makes the decision

Emphasise to the member that the person who decides if a condition is pre-existing is the medical practitioner appointed by the health fund.

Explain the member's treating doctor(s) does not decide whether the condition is pre-existing – but they will be asked for an opinion about the member's signs and symptoms.

Advise member to confirm PEA prior to hospitalisation

Advise the member that:

- The fund will commence the PEA assessment process immediately.
- The fund will send to the member/patient a copy of the PEA consumer brochure and some PEA medical certificates that the patient needs to sign and take to their treating medical practitioner(s) for completion.
- The health fund will need up to 5 working days to complete the assessment. This timeframe assumes the treating medical practitioner(s) are able to complete the PEA medical certificates and quickly return them to the fund.
- If they proceed with the admission without confirming benefit entitlements, and the fund subsequently determines the condition is pre-existing, the member will be required to pay all out-of-pocket hospital charges and medical charges not covered by Medicare.
- If the member has at least 12 months membership in total across their old and new hospital cover they are entitled to the benefits that are payable on their old hospital cover.
- Do not offer any opinion about whether or not the condition may be pre-existing.

Customer service officers and call centre staff – what to tell consumers, continued

Further advice to member if late notification

(admission is in less than 5 days)

If the fund is notified less than 5 days before a planned admission, the fund must warn the member that:

- due to late notification, the fund may not have enough time to confirm if the condition is pre-existing prior to the admission;
- every reasonable effort will be made to carry out the pre-existing ailment assessment as quickly as possible.

Advise member of other options

Advise the member to consult their doctor and discuss alternative options in case the health fund cannot finalise the PEA determination prior to admission.

Advise the member that if they wish to proceed with the admission and pay personally for the treatment they should obtain a written estimate of costs from the treating hospital and medical practitioner(s).

Document the inquiry and the verbal advice provided

Always document, preferably on the member's electronic member file, the details of the PEA inquiry and the verbal advice provided.

Customer service officers and call centre staff – what to send to consumers

Fund business decision that benefits payable – no PEA assessment required

Fund makes a business decision to pay benefits to a member with less than 12 months membership without questioning if the condition is pre-existing. No PEA assessment required.

Fund writes to member to confirm:

- benefits are payable under their current hospital table;
- details of patient payments that may arise due to policy excess, copayments, exclusions, restricted benefits including exceptional drugs (if relevant) and out of pocket costs associated with choice of hospital and/or medical gap fees.

Fund business decision - PEA assessment IS required

Send to the member on the same day the fund is notified of the planned hospital admission, a letter explaining:

- the member has less than 12 months membership on their current hospital table and a pre-existing ailment assessment is required;
- the detail of the anticipated treatment, the treating hospital and the planned date of admission;
- that the medical practitioner appointed by the health fund makes the PEA assessment (not the treating medical practitioner(s));
- the fund will need up to 5 working days to make the pre-existing ailment assessment, providing the treating medical practitioners quickly return the completed PEA medical certificates to the fund;
- that if pre-existing ailment assessment is not finalised prior to admission and the condition is subsequently found to be pre-existing - fund benefits for this treatment under their current hospital table will NOT be payable.

PEA Medical certificates

Attach two PEA medical certificates (*Attachment B*).

Explain the member/patient must sign the consent section on both certificates and take one to the general practitioner and the other to the specialist for completion.

Explain that the treating medical practitioners should return the completed certificates to the health fund as soon as possible.

Consumer brochure

Enclose a copy of the PEA consumer brochure and invite the member to call the health fund for more information, if needed.

Customer service officers and call centre staff – what to send to consumers, continued

Include confirmation of membership details

The letter should also confirm all other membership details including, if relevant:

- financial status of membership;
- length of membership on current hospital table;
- clarification of whether anticipated treatment is excluded;
- restricted benefits and estimated financial consequences if treatment is provided in the hospital the member has indicated;
- other restrictions that apply such as exceptional drugs;
- co-payments and/or excesses payable;
- the level of benefit for this condition payable under a former hospital table;
- other waiting periods;
- whether the fund has an agreement with the hospital and/or medical practitioners and the financial implications for the member.

Advise the hospital in writing that a PEA assessment is required

Immediately advise the hospital (if known) in writing, or electronically, that the member has less than 12 months membership and a PEA assessment is required.

Further information about what to write to the hospitals is contained in the section titled “Guide for Interface between health fund and hospital”.

Claim staff guidelines

Health fund receives claim after hospitalisation

A member could lodge a claim for hospital benefits after the hospitalisation has been completed.

If the fund does not immediately approve the claim because the membership history and details of the condition indicate a pre-existing ailment assessment is required, give the member the opportunity to discontinue the claim before proceeding to a full PEA assessment.

Write to the member

Write to the member advising that:

- the member should note the explanation of the pre-existing ailment rule and definitions of sign and symptom in the consumer brochure;
- the member has less than 12 months membership on their current hospital table, therefore the pre-existing ailment rule may apply;
- enclose a copy of the PEA consumer brochure and PEA medical certificates;
- if the member decides to discontinue the claim after reading the explanation of the PEA rule, they should advise the fund;
- if the member decides to pursue the claim they should sign the PEA medical certificates and take them to their treating medical practitioner(s) for completion and then return the certificates directly to the fund;
- the fund will notify the member of the assessment after it has been finalised;
- if the condition is assessed to be pre-existing the member will not be eligible for benefits under their current hospital table. The member will be required to pay all associated out of pocket hospital charges and medical charges not covered by Medicare;
- members with at least 12 months membership in total across their old and new cover will be entitled to the lower benefits on their old hospital cover.

Member decides to proceed with PEA assessment

Where fund receives completed PEA medical certificates, and the claim is still not payable, send the PEA medical certificates to the fund medical practitioner to be assessed.

Guide for health fund medical practitioner

Authority to make PEA assessments	The medical practitioner appointed by the health fund has the authority to make PEA assessments.
Check member/patient details	<p>For each assessment, confirm the following details:</p> <ul style="list-style-type: none">• date the member joined the current hospital table;• date of known or expected admission; and• procedure(s) and/or reason for admission (procedure MBS numbers and/or ICD10 codes). <p>Obtain the PEA medical certificates, completed by the patient's treating general practitioner and specialist(s) and further evidence as required.</p> <p>Obtain a copy of the hospital benefits claim if the hospital admission has already occurred.</p>
Assess evidence of sign and symptom	<p>Assess the evidence of signs and symptoms noted by the treating medical practitioner(s) in the PEA medical certificate and in other evidence obtained.</p> <p>Make the assessment strictly in accordance with the definitions of sign and symptom outlined in these best practice guidelines.</p>
Complete PEA assessment certificate	Use the PEA assessment form at Attachment C to make a clear determination of whether or not the ailment is pre-existing. Where necessary, refer to supporting evidence.
Advise nominated officer of fund	Send the completed PEA assessment form to the health fund chief executive officer, or other nominated officer, as quickly as possible.

Sign and symptom – definitions for fund medical practitioners

Signs and symptoms in 6 month test period

The test for applying the pre-existing ailment rule rests entirely on whether there were signs and symptoms of the ailment, illness or condition in the 6 months before the member joined or upgraded hospital cover.

All PEA assessments should be based on the definitions of sign and symptom outlined below.

The descriptions of sign and symptom were developed cooperatively by the industry committee that produced these best practice guidelines. It included representatives from health funds, hospitals, medical practitioners, consumer representatives, the Private Health Insurance Ombudsman and the Department of Health and Aged Care.

Definition of “sign”

A ‘sign’ is something that relates to the ailment, illness or condition now causing hospitalisation which was present during the six months before commencing or upgrading hospital insurance and:

- (a) was objectively apparent to the fund member; **or**
- (b) was apparent to the attending medical practitioner on examination of the fund member; **or**
- (c) would have been apparent to a reasonable general practitioner on performing the relevant *physical* examination of the fund member *if* the member had been examined.

What is considered to be a sign if a person had NOT been to see a general practitioner?

Where a person had **not** been to see a general practitioner in the six month test period prior to joining or upgrading hospital insurance, the only signs that can be considered are those that:

- are directly related to the ailment illness or condition that requires hospital treatment in the first twelve months of membership of the current hospital table; **and**
- would have been either externally visible and therefore objectively apparent to the fund member such as a visible lump, rectal bleeding, skin lesions; or
- would have been apparent to a reasonable *general practitioner* on performing a relevant *physical* examination if the member had been examined. In these circumstances “sign” does **not** extend to evidence of an ailment, illness or condition that could only have been detected through exhaustive examination such as surgery, laboratory tests, imaging investigations, colonoscopy, ultrasound or angiogram.

Sign and symptom – definitions for fund medical practitioners, continued

What is considered to be a sign if a person had been to see a medical practitioner?

Where a fund member *had* been to see a general practitioner and/or referred onto other medical practitioners for further tests and advice in the six month test period prior to joining or upgrading hospital insurance, the signs that can be considered are those that:

- are directly related to the ailment illness or condition that requires hospital treatment in the first twelve months of membership of the current hospital table; **and**
- were identified through any or all of the medical tests and examinations carried out by the treating practitioners *at the time* including exhaustive examinations and laboratory tests etc.

It is not, however, appropriate for health funds to apply the PEA rule by arguing that in hindsight, once the diagnosis is known, a sign that was not identified would have been apparent if, at the time, the treating practitioner had carried out a certain medical test.

Definition of “symptom”

A ‘symptom’ is something that relates to the ailment, illness or condition now causing hospitalisation which was subjectively manifest to the fund member during the six months before commencing or upgrading hospital insurance. This includes situations where:

- (a) the symptom was recorded by the treating medical practitioner but the ailment, illness or condition was not diagnosed; or
- (b) the ailment, illness or condition has been actually diagnosed; or
- (c) the ailment, illness or condition has been actually diagnosed, treated and in remission.

What symptom means in practice

A symptom is the person’s knowledge of an ailment, illness or condition because it has been diagnosed, or if there has not been a diagnosis, the person knows that something is wrong because of pain, discomfort or irregularities.

For example, a person would be considered to have a symptom if:

- a person had been diagnosed and treated for ailment, illness or condition at *some time* in the past; and
- this same illness remained present during the six months prior to joining the hospital table.

A symptom would still apply even if there were no objective signs of the same illness in the test period prior to joining.

Sign and symptom – definitions for fund medical practitioners, continued

What a symptom does not mean in practice

In contrast, a person would *not* be considered to have a symptom if:

- a person had been diagnosed and treated for a particular ailment, illness or condition at some time in the past; and
- at the time the ailment, illness or condition had been resolved or was declared by the treating medical practitioner to be cured.

The previous diagnosis and treatment would not be considered to constitute a “symptom” as long as there were no new signs or symptoms of this same ailment, illness or condition in the six months prior to joining or upgrading hospital insurance.

Risk factors

Risk factors and family history are not to be considered either a sign or a symptom for the purposes of the pre-existing ailment rule.

Psychiatric illnesses

Psychiatric illnesses must be assessed for PEA in the same manner as all other illnesses.

Not all psychiatric illnesses are related or ongoing. Evidence of a psychiatric illness or episode in the past does not in itself constitute symptoms of the same or another psychiatric illness some time later.

All PEA assessments for psychiatric hospital treatment should be made in consultation with the treating psychiatrist.

Case studies

Some case studies are included as examples of how the PEA rule can be applied. These are in Appendix I.

Guide for Interface between hospitals and health funds

Immediately advise treating hospital of possible PEA

As soon as the fund is notified of a planned admission, immediately provide the treating hospital with documented advice that:

- fund member has less than 12 months membership on current hospital table and a PEA assessment is required;
- advise the hospital that the fund will need up to 5 working days to make the PEA assessment, subject to the timely receipt of the information from the treating medical practitioner(s);
- fund will send the member/patient the PEA medical certificates for signature and completion by treating medical practitioner(s);
- fund will advise the hospital in writing of the assessment outcome as soon as it is finalised.

Request confirmation from hospital

Request the hospital to provide written or electronic confirmation of:

- member name;
- membership number (if known);
- patient name (if different to member);
- patient date of birth;
- anticipated procedure(s) and/or reason for admission (procedure MBS numbers and/or ICD10 codes);
- date of admission;
- anticipated length of stay.

Confirm with hospital all other membership details

Provide hospital with same day written or electronic confirmation of all other membership details and benefit entitlements specified below (where relevant):

- membership number;
- member name;
- patient name (if different to member);
- patient date of birth;
- financial status of membership;
- length of membership on current hospital table and any applicable waiting periods;
- treatments excluded;
- treatments only eligible for restricted benefits;
- copayment and/or excesses;
- any other restrictions that apply such as exceptional drugs.

Explain that confirmation of benefit entitlements is based on written advice received from the hospital regarding the condition and the anticipated hospital treatment required.

Guide for interface between hospitals and health funds, continued

Further advice to hospital if late notification and PEA assessment required

(less than 5 days notice)

Alert the hospital that due to late notification the fund may not be possible to confirm PEA prior to admission.

Advise that every reasonable effort will be made to carry out the PEA assessment prior to admission.

If patient proceeds with the admission before PEA assessment is finalised and the condition is subsequently determined to be pre-existing, health fund benefits under the current hospital table will NOT be payable.

Emergency admissions

Emergency admission in business hours	Funds are likely to receive notification of an emergency admission from the treating hospital. If the notification is received by the fund during business hours, the process to confirm PEA is the same as that outlined for planned admissions, but under tighter timeframes.
Emergency admission outside of business hours	Health funds are not expected to confirm PEA outside of business hours. Funds are, however, expected to have systems in place to confirm basic membership details specified on page 3 of these guidelines, including length of membership on current hospital table. This will enable the treating hospital to identify members who are at risk of PEA and other waiting periods and/or excluded treatments.
Do PEA assessment immediately next working day	Commence any assessment of PEA for emergency admissions immediately the next working day and provide the member and the hospital with written or electronic verification of the PEA assessment as quickly as possible and no later than the same day the assessment is finalised.

Guide for informing members of PEA assessment

If the condition is NOT pre-existing	<p>Write to the member on the same day the PEA assessment is finalised and confirm:</p> <ul style="list-style-type: none">• that the PEA assessment is finalised and condition is <i>not</i> considered to be pre-existing;• the member is eligible for benefits under their current hospital table;• details of patient payments that may arise due to policy excess, copayments, exclusions, restricted benefits including exceptional drugs, and out of pocket costs associated with choice of hospital and/or medical gap fees.
If the condition IS pre-existing	<hr/> <p>Send to the member, on the same day the PEA assessment is finalised, a statement of reason (<i>Attachment D</i>).</p> <p>Also include written advice on the following:</p> <ul style="list-style-type: none">• the level of benefits that are payable, if the member has accrued 12 months membership in total across their old and new hospital cover;• the name of a contact officer in the fund to discuss the PEA assessment if the member requires further clarification. <p>If the patient has not yet been admitted to hospital, advise them to contact their treating medical practitioner(s) immediately to discuss other options for treatment.</p> <p>Advise the member that if they wish to proceed with the admission and personally pay the costs of hospital treatment and medical gap costs they should ask the hospital and treating medical practitioner(s) for a written estimate of the costs.</p>
Call member to advise of PEA assessment outcome	<hr/> <p>Call the member to advise of the PEA assessment outcome if it is unlikely that written confirmation will reach the member prior to the planned admission date. Follow up with written advice.</p>
Advise the treating hospital	<hr/> <p>Immediately (no later than the same day the assessment is finalised) write to the treating hospital (fax/email/electronic) and confirm if PEA applies. Specify the benefits that are payable if any.</p>

Case studies to explain how the PEA rule is applied

Case study 1

A member presents to their doctor with pr bleeding in the six months prior to joining or upgrading hospital insurance and is diagnosed with colon cancer, by a specialist after joining the fund.

The pre-existing ailment rule *does apply* because in the six month test period prior to joining the hospital table:

- (a) there was a sign, in this case the bleeding, that is directly related to the colon cancer, and which was objectively apparent to the member and the medical practitioner.

Case study 2

A member undertakes a routine mammogram six months after joining or upgrading hospital insurance because she is in the target age group, not because she or her doctor had noticed signs or symptoms. The mammogram reveals a small lump which would not have been detectable without mammography and which is subsequently found to be malignant.

The pre-existing ailment rule *does not apply* because in the six month test period prior to joining the hospital table:

- (a) there was no symptom (something subjectively manifest to the patient); and
- (b) there was no sign directly related to the subsequent breast cancer that would have been identified by a reasonable general practitioner on a relevant physical examination if the member had been examined. The lump could only be detected by mammography but there were no other signs or symptoms which would have prompted a reasonable general practitioner to order a mammography.

Case study 3

A member joined a hospital table and suffered a heart attack three months later. In this case study there were no symptoms of the heart condition and consequently the member had not seen a medical practitioner in the six month test period prior to joining the table.

The pre-existing ailment rule *does not apply* because in the six month test period prior to joining the hospital table:

- (a) there were no symptoms subjectively apparent to the member; and
- (b) there was no sign objectively apparent to the member.

Case study 4

A person had not been to see a general practitioner in the six month test period prior to joining or upgrading hospital cover, but sought to claim for hospital treatment associated with breast reduction within the first twelve months of membership.

The pre-existing ailment rule *does apply* because in the six month test period prior to joining the hospital table:

- (a) there was a symptom of the ailment, illness or condition. The member would have known she wanted a breast reduction;
- (b) a sign of the ailment, illness or condition would have been objectively apparent to a reasonable general practitioner following a relevant physical examination of the member if the member had been examined.

Case study 5

A member was diagnosed and treated for prostate cancer two years ago. There were no signs or symptoms of the prostate cancer in the six-month test period prior to joining or upgrading hospital insurance. Three months after he joined the hospital table, he presented to his medical practitioner with cough and bloodstained sputum. This was investigated and the member required hospital treatment for cancer of the lung.

The pre-existing ailment rule *does not apply* to the hospital treatment required for lung cancer because in the six month test period prior to joining the hospital table:

- (a) there was no symptom of the lung cancer;
- (b) there was no sign of the lung cancer that was objectively apparent to the member; or
- (c) there was no sign of the lung cancer that would have been apparent to a reasonable general practitioner following a relevant physical examination of the member if the member had been examined.

Case study 6

A member presented to his doctor with back pain that developed three months after joining or upgrading hospital insurance. He had not had any symptoms like this at any time in the past. However, he had had a radical prostatectomy for cancer of the prostate nine months prior to joining the hospital table. Although it was thought that the surgery had successfully removed the cancer, he had been advised to see his doctor for regular follow up tests as it was possible that the cancer could return. X-ray and pathology tests showed that he now had a secondary cancer in his vertebrae which was causing his back pain and required hospital treatment.

The pre-existing ailment rule *does apply* because in the six month test period prior to joining the hospital table there was a symptom – the condition was in remission. The former condition had not been declared cured, it was being monitored and it is the same condition that now requires hospital treatment.

Steering Committee Membership

Dr Geoff Dreher	Australian Regional Health Group Limited
Mr Russell Schneider	Australian Health Insurance Association
Mr Michael Bassingthwaighte	Health Insurance Restricted Membership Association of Australia
Mr Norman Branson	Private Health Insurance Ombudsman
Ms Samantha Gavel	Office of the Private Health Insurance Ombudsman
Mr Roger Gimblett	Office of the Private Health Insurance Ombudsman
Ms Joan Lipscombe	Australian Consumers' Association
Mr Matthew Blackmore	Consumers' Health Forum
Dr Christopher Baggoley	Committee of Presidents of Medical Colleges
Dr John North	Royal Australian College of General Practitioners
Mr Michael Roff	Australian Private Hospital Association
Ms Rosemary Townsend	Australian Private Hospital Association
Mr Denis Hogg	Epworth Hospital, Victoria
Dr Bert Boffa	AXA Australia Health
Mr Dale Brooker	Medibank Private
Dr Gavin Frost	Medical Benefits Fund of Australia (MBF)
Mr Alan Kinkade	Hospital Contributions Fund of Australia (HCF)
Ms Chris Harrington	Commonwealth Department of Health and Aged Care
Ms Leonie Hull	Commonwealth Department of Health and Aged Care

Health fund
logo/name**MEDICAL PRACTITIONER
CERTIFICATE**Health fund
address

Regarding

'Pre-existing Ailments'

Under the National Health Act 1953, a pre-existing ailment is an ailment, illness or condition, the signs and/or symptoms of which in the opinion of a medical practitioner appointed by the health fund, existed at any time during the six months preceding the day on which the contributor (patient) began contributions to their current hospital table.

This form requests information from you about signs and/or symptoms associated with the condition/s requiring hospital treatment. The medical practitioner appointed by the health fund will use the information to make an informed PEA assessment and allow the health fund to determine the level of health insurance benefits to which the patient is entitled. The health fund may disclose the information to the patient as part of the evidence considered in this matter. The patient may disclose the information to the Private Health Insurance Ombudsman in the event of a complaint arising from this matter.

CONSENT by patient for disclosure of information by doctor to health fund

The information collected on this form only relates to the condition/s requiring hospitalisation at this time. The information will be used only for the purpose of determining whether the condition/s requiring hospitalisation is/are pre-existing.

I consent to the disclosure of my medical information relating to the condition/s requiring hospital treatment to (name of health fund). I also give consent for any other medical practitioner(s) who has/have seen me regarding the condition/s to give medical information to the health fund.

Signature:.....

Name:.....Date:...../...../.....

Address:.....State:.....Postcode:.....

Phone: (.....)Date of Birth:...../...../..... Fund Member No:.....

CERTIFICATION by Medical Practitioner

- 1) **DATE of HOSPITAL Admission** (or proposed Admission)/...../..... to/...../.....
- 2) a) **PRINCIPAL CONDITION** (reason for hospitalisation)
- b) **Nature of Operation** (if any)
- c) **Associated Conditions** (if any)
- 3) **DATE of patient's FIRST attendance for this illness**/...../.....
- 4) **SIGNS or SYMPTOMS of the condition** (i.e in 2a. above) when first seen:
 - a) **consisted of**.....
 - b) **had commenced on**,/...../.....,
 - c) **had been present for**,days/weeks/.....months/.....years.
- 5) **Are you the patient's usual General Practitioner?** **YES / NO** (Please Circle)
 If **YES** - Did you refer the patient to a specialist? **YES / NO** (Please Circle)
 If **YES** - to whom?
Date of Referral/...../..... **Name of Specialist:**
- Address of Specialist****Phone:** ().....
- 6) **Are you a Specialist by whom the patient was treated ?** **YES / NO** (Please Circle)
 If **YES:** By whom was the patient referred to you?
Date of Referral/...../..... **Name of referring Practitioner:**
- Address of Practitioner**.....**Phone:** ().....

Signature:..... Name: Dr.

Address.....State.....

Postcode.....Phone: ()Date:/...../.....

(Date)

Attachment C

To CEO of Health Fund

Dear (CEO of Health Fund),

Attention: (Health Fund Claims Manager)**(Name and address of Subscriber/patient)***(HealthFund)* Member No., who commenced coverage on the current hospital table on .../.../....**'Pre-existing Ailment' Rule Assessment****Date of request:**

I refer to your request dated/.../... regarding the above.

Source of information:

- I have noted the Certificate provided by Dr..... regarding *(name of Subscriber)*.
- I have also:-
spoken with Dr., General Practitioner/Specialist who cares for the above.
and/or I have also spoken with *(name of subscriber)*.
and/or I have perused the medical records concerned.
and/or etc..

Description and opinion of condition:*(Name of subscriber)* presented to Dr.....on .../.../.../ with *(symptoms/signs)* which had been present for etc.*(This paragraph should contain a description of the symptoms and signs relating to the condition resulting in or leading to the need for hospitalisation. It should include a medical opinion/explanation of why the symptoms/signs are those which led to the need for hospitalisation).***Comment:***(if the opinion of the fund practitioner and the treating medical practitioner differ regarding signs and/or symptoms, for each point of difference the fund practitioner must justify with appropriate references why the opinion of the treating medical practitioner should be disregarded.)***Conclusion:**As the symptoms and signs of the condition leading to the admission/ proposed admission of *(Subscriber's name)* to hospital for *(name of condition/operation)* were/ were not present during the six months before taking out insurance with *(name of Health Fund)* on *(date of commencement of hospital insurance with Health Fund)* then in my opinion his/her condition *is/ is not* classed as Pre-existing.

(Signed)(Name of Medical Officer appointed by Health Fund)

PEA - Statement of Reason

Dear (health fund member)

I am writing to you about your admission to (hospital) for (procedure/reason for admission) on (date of admission).

A doctor appointed by (health fund name) has determined that the condition requiring this hospitalisation is a pre-existing ailment, because signs and symptoms of the condition existed in the six month period before you joined your current hospital table.

In making this decision, the health fund doctor has considered the information supplied by your treating doctor(s) about the condition, the signs and symptoms and when they were first evident.

A copy of the information provided by your treating doctor(s) is at **Attachment A**.
A copy of the health fund doctor's pre-existing ailment assessment is at **Attachment B**.
A copy of a consumer brochure that explains the pre-existing ailment rule is at **Attachment C**.

In view of this decision, (the health fund) cannot pay the benefits provided on your current hospital table in respect of this hospitalisation.

If the member has not yet been admitted to hospital (Select option 1 or 2)

Option 1 – they are a new member and no benefits are payable

This means, if you proceed with your admission and you elect to be treated privately, you will be responsible for paying the full cost of your hospitalisation and any medical fees not covered by Medicare.

If you do not wish to pay personally for private treatment, you should contact your treating doctor to discuss other treatment options. For example, you might want to be admitted to a public hospital and treated as a Medicare patient, or you might prefer to defer your treatment, if this is clinically appropriate, until you are eligible for hospital benefits. For your information you will have served 12 months membership on your current hospital table on (insert date xx/xx/xx).

Option 2 – they have at least 12 months membership in total across their old and new cover, and are entitled to the lower benefits on their old cover.

However, as you have already served the waiting periods on your previous hospital table, you are entitled to the benefits provided on your previous lower table. I have attached a statement of the health fund benefits that will be payable to you if you decide to proceed with your admission as a private patient. *(Advise the member if they are likely to face significant out of pocket costs due to restricted benefits or other limitations).*

If the member has already been admitted and treatment has been received (select option 3 or 4)

Option 3 – they are a new member and no benefits are payable

This means, you are responsible for paying the full cost of your hospitalisation and any medical fees not covered by Medicare.

Option 4 – they have at least 12 months membership in total across their old and new cover, and are entitled to the lower benefits on their old cover.

However, as you have already served the waiting periods on your previous hospital table, you are entitled to the benefits provided on your previous lower table. I have attached a statement of the health fund benefits that will be payable to you.

(continue with the following paragraphs after inserting appropriate options above)

If you would like to discuss this decision at all, please do not hesitate to contact (nominated person within the health fund) on (telephone number).

If, after reading all the information provided by (the fund) and discussing your case with us, you believe the decision is not appropriate, you can contact the Office of the Private Health Insurance Ombudsman to lodge a complaint. The telephone number for the Ombudsman's Complaints Hotline is 1800 640 695, or you may wish to lodge a complaint via the Internet at www.phio.org.au/lodgecomplaint.php.

Yours sincerely