10 November 2021

RULINGS ISSUED BY THE OFFICE OF THE REGISTRAR

The CMS hereby publishes summaries of rulings recently issued by the Complaints Adjudication Unit in respect of complaints lodged against regulated entities, in terms of Section 47 of the Medical Schemes Act.

These rulings are published solely for information purposes and may not be taken to be precedent setting in any way. Decisions articulated in these rulings may still be appealed in terms of Section 48 of the Medical Schemes Act. The CMS reserves the right to modify or remove any information published herein, without prior notice.

The contents of these rulings do not constitute legal or medical advice and may not be taken out of context. The findings and any opinions expressed in these rulings are based on the specific facts of each complaint, the evidence submitted, and applicable legal provisions.

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Identifiable personal information of the complainants and any associated individuals have been redacted for their protection.

E KLINCK & ASSOCIATES obo Dr K **THE COMPLAINANT**

and

MEDSCHEME HOLDINGS (PTY) LTD **THE RESPONDENT**

The complainant in this complaint is Dr K, a practicing healthcare professional. The complaint was lodged against Medscheme Holdings Pty (Ltd) ("Medscheme"), an administrator accredited in terms of Regulation 17 to the Medical Schemes Act, 131 of 1998.

The complaint arose following a decision by Medscheme to withhold claim payments which were allegedly owed to the Complainant's practice for services rendered to members of respective medical schemes administered by Medscheme. On the facts submitted with this complaint, Medscheme alleged that the Complainant's hospital admission rates and costs per event were higher than that of his peers and had on that basis, requested him to provide patient records for verification / audit. The Complainant asserted that he was unable to obtain consent from all the patients he had treated and only submitted the records for which he was able to obtain patient consent.

In its response to the complaint, Medscheme submitted that the Complainant was identified on its Internal Fraud Management System as a high claimer. This was reportedly based on an assessment of his claims and angiogram rates which were alleged to be substantially higher than that of his peers.

Medscheme confirmed that a verification of service letter was sent to the Complainant in which various documentation were requested to complete the audit process. The requested documentation included patient files, coupled with the relevant qualification certificates for purposes of conducting the audit on the practice. Medscheme indicated that it conducted numerous audits and found that the Complainant received R47.96 million in payments to his practice over a three-year period and that the high rate of these payments were attributed to erroneous billing and the *"blatant exploitation"* of Prescribed Minimum

benefits (PMB's).As a result, Medscheme sought to recover some of the claim payments which were alleged to have been irregularly claimed.

Medscheme denied the allegation that the amount it had quantified for recovery was not substantiated and further argued that a claim-to-claim review would be impractical due to the large volume of data which must be audited. The amount claimed for recovery from the Complainant was therefore based on statistical sampling.

The issue which arose for adjudication was whether Medscheme had complied with the Medical Schemes Act, the Regulations, and other related laws in its decision to claw back money from the Complainant's practice for alleged irregular billing. The office of the Registrar had to determine whether Medscheme had followed a fair and lawful process. The following legislative prescripts were considered:

- Section 59(3) of the Medical Schemes Act
- Rules 8.2.3 and 9.1.2.2 of the Guidelines for Good Practice in the Health Care Professions: Confidentiality-Protecting and Providing Information, published by the Health Professions Council of South Africa.

Section 59 of the Act bears relevance in this case as it provides the framework for payment of claims to a healthcare provider for services rendered to medical scheme beneficiaries. The section also provides in subsection 3, for instances where medical schemes or its administrators (acting on behalf of medical schemes) may recover any amounts which have already been paid in good faith to a member or healthcare provider, if it is determined that such a member of healthcare provider was not entitled to those payments.

Section 57 of the Medical Schemes Act imposes several statutory obligations for medical schemes and those acting on behalf of medical schemes to exercise care and implement appropriate controls to protect the funds entrusted on them by medical scheme members and look after the interests of members. To this end, where claim payments have been made in good faith and it is later established that recipients of such payments were not entitled thereto, medical schemes have a fiduciary duty to recover such payments.

The facts in this matter reflect that Medscheme had on numerous occasions, communicated to the Complainant, its reasons for initiating the claims audit. It also appeared from the evidence submitted that Medscheme had proceeded to request further information for verification purposes, however, some of its

questions remain unanswered. By failing to cooperate with the claim's verification process, the Complainant missed an opportunity to provide his own evidence that he was entitled to payments received and/or refute Medscheme's audit findings.

The Complainant's contention was that he was unable to obtain patient consent before providing Medscheme with the requested information. The National Health Act permits disclosure of patient information where it is for a legitimate purpose and within the practitioner's scope and duties. The HPCSA Guidelines further provides practitioners direction with regards to how to carefully balance the obligation to disclose patient information and protecting their right to privacy. In particular Rule 9.1.2.2 states that disclosure for administrative or audit purposes are unlikely to breach the ethical rules of the HPCSA. Thus, Medscheme as an administrator acting on behalf of the medical schemes it administers, is entitled to be furnished with the information required for legitimate administration purposes such as claim auditing and verification of services rendered as well as payment of members' claims.

As regards the amount claimed by Medscheme from the Complainant, the office of the Registrar found did not accept Medscheme's contention that it was entitled to recover an amount based on statistical sampling. The Registrar found that there was no evidence to confirm that the amount claimed was an accurate sum total of the amount paid in respect of irregular claims. In our view, the implication of section 59(3) is that there must be certainty in respect of the claims which are being recouped. In other words, there must be specific claim(s) which a medical scheme or administrator has paid in good faith but later determined that the provider or member was not entitled thereto. In the instance where a Medical Scheme alleges that a section 59(3) deduction is warranted against a provider, for incorrect, inappropriate and/or unethical billing, such allegations must be substantiated and tested before the appropriate authority. The authority to make a determination in respect of alleged unethical or unjustified billing vests in the HPCSA.

In so far as the Complainant's billing practice and/or misconduct is concerned, the Office of the Registrar is not in a position to adjudicate on the conduct of the healthcare provider, and this is an issue that should be directed to the HPCSA. In conclusion, the Complainant was directed to provide the required patient information to Medscheme in order for accurate claim auditing to take place. On the other hand, Medscheme was directed to substantiate, with adequate detail, the claims it wishes to recover from the Complainant.