BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES
(SECTION 48 APPEAL)

REFERENCE No: CMS 82368

In the matter between

Bonitas medical scheme	**Appellant**
	And
R obo S	**Respondent**

Date of Appeal Hearing:
3 June 2024

RULING AND REASONS

THE PARTIES

1. The Appellant is Bonitas Medical Scheme (the "Appellant" or the "Scheme"), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the "MSA").

2. The Respondent is Mr R (the "Respondent"), a service provider to the dependent member of the Bonitas Medical Scheme, Mr S.

3. This is an appeal under section 48(1) of the MSA, providing that –

   "(1) Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council."

INTRODUCTION

1. The Appeals Committee heard the Appeal on 3rd June 2024, *via* audio and video conferencing.
2. Ms D, legal advisor at Medscheme, the administrator of the Scheme, appeared for the Appellant. She was assisted by the coding specialist at the administrator, Ms M.
3. Mr R appeared for the Respondent. The member, Mr S, was not present. Ms D, from the service provider’s billing company was also present.
4. The Appellant lodged an appeal against the Registrar’s ruling based on the 11th of July 2023, which emanated from the initial complaint from the Cardiovascular Perfusionist, for the Scheme to fund in full the costs of the tariff codes 75085 and 75013, he billed.
5. The Registrar's in his ruling rejected the Scheme's funding decision.
6. The Appellant, the Scheme, submitted their Section 48 Appeal on the 21st August 2023.

BACKGROUND

7. Mr S is a dependent member of the Bonitas Medical Scheme and is on the Primary Select Option.
8. The member required open heart surgery due to his chronic conditions.
9. He was admitted to the Krugersdorp Private Hospital on the 18th October 2021 for heart failure for a prolonged period until the 24th November 2021, during which he required a CABG procedure, which was done on the 28th October 2021.
10. This procedure required an intra-aortic balloon pump (IABP), which required the services of a Cardio-Vascular Clinical Technologist / Cardiac Perfusionist, Mr R, in addition to a multidisciplinary team consisting of the cardio thoracic surgeon, anaethetist and other healthcare workers.

11. On 5 November 2021 the Fund received an account for service dated 28 October 2021 from Mr R for R 29 284.50 and paid R 27 677.30 on 11 November 2021.

12. On the 17th March 2023, a section 47 complaint was registered by the Respondent, after repeated engagement and applications (in 2022) did not resolve the matter. The Respondent stated that the claim submitted is a PMB claim as per ICD10 codes I25.0, I10, Z115.5, I20.0, I21.1 and that the Scheme has not paid for the following codes: 75085 x 4.

13. The Scheme responded on the 18th April 2023 stating that the tariff code 75085 for each additional 30 minutes for R401.80 that was charged four times, were all rejected by the Scheme for the reason: "Mutually exclusive procedures claimed together" and billed concurrently with add on code 75013.

14. The Clinical Review Committee (CRC), after receiving the referral from the Registrar, found that the member's condition is a PMB, and found that:

    a) "Tariff code 75085 - Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time and tariff code 75013 - Continued operation of extra-corporeal equipment during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time may be charged together as there is no rule in the NRPL 2006 that indicate these codes as mutually exclusive. In this case the clinical technologist (perfusionist) indicated that code 75085 was charged for the time spent before the surgery started and then again for the time spent after the surgery ended. There is sufficient evidence that the perfusionist is required to transport the patient to and from theatre and settling the member in the ICU. The claim in this case should be funded in full as PMB level of care."

15. The Registrar ruled on 11th July 2023 that the Respondent was entitled to charge tariff code 75085 in addition to tariff code 75013.

16. The Registrar found that the Scheme is liable for the funding of tariff code 75085 in addition to tariff code 75013 and thus for R1607.20.

17. The Bonitas medical scheme has now appealed this decision of the Registrar in terms of section 48 Appeal submitted on the 21st August 2023.

DISCUSSION AND LEGAL FRAMEWORK

APPELLANTS SUBMISSION

18. Ms D, for the Appellant, informed that the service provider had misinterpreted the coding guidelines and shall provide reasons in their submission why the Scheme interpretation of the billing codes is correct.
19. The Appellant accepted that the member's condition is a PMB condition, and that treatment required is in terms of the guiding code of conduct for a PMB level of care.
20. From the Scheme information, billing codes cannot be used simultaneously or concurrently when applied to the same treatment provider and that the codes submitted were mutually exclusive.
21. The coding specialist at the administrator, Ms M, continued the submission, stating that the Add-on code 75085 was allocated 10.0 relative value units (RVUs) and was rejected when billed with add-on code 75013, which was allocated 20,3 RVUs. The rejection is based on the following:
    a. Both codes represent services that were billed from 06:41 to 13:25 and have run concurrently at increments of 30 minutes.
    b. Although one code was for 5,5 hours and the other for 2 hours. Based on the times allocated for both codes to the claim and applying national and international coding guidelines, for correct coding interpretation, it will be correct to bill and pay the code allocated the most RVUs only. The same principle applies to other medical disciplines as stated in the bundle of documents.
22. In South Africa, the National Reference Price List (NRPL) was last updated in 2006 and citing the CMS Circular 66 of 2021, Schemes are allowed to use updated codes that shall benefit patient care from an evidence based and cost effectiveness perspective.
23. As per the bundle of documents from the Appellant, the CPT[4] guidelines are the reference point for how service providers need to bill and time-based billing is not unique to cardiac perfusionists but apply to various other disciplines.
    a. Further coding principles are applied to the South African context, and it is not correct of the Respondent to claim that the coding principles are only based on foreign guidelines.
    b. These guidelines whilst originating in the USA, have migrated and is applied globally.

24. Ms M further informed that she has met with Mr R on several occasions where he represented the association of service providers, Perfmed, and where the scheme had to engage with his association and the other association, SACTA, on the billing issue.

25. She informed that the Scheme had requested Mr R to correct the billing but both he and his billing company had not.
    a. It was further submitted that the Respondent had not provided adequate clinical records to substantiate the bills received by the Scheme
    b. The Appellant reiterated that the CPT[4] and coding guidelines apply to various other professions as well, citing examples for haemodialysis, psychiatry, social workers and time based coding needs to follow rigorous guidelines so as not to be abused

26. In ending their submission, the Scheme stated that it was obliged in terms of the MSA to fund appropriately and that the regulation was in place to prevent open ended financial liabilities including for PMB conditions, and irrespective of the quantum of the bill, service providers in terms of their scope of service from the Health Professions Council (HPCSA) are required to code and bill properly and ethically.
    a. The Appellant concluded that the Scheme cannot just change the billing and coding principles to suit one discipline and that the Registrar, and the Respondent did not interpret the billing guidelines appropriately as there are clear principles in place when it comes to time-based billing.
    b. The Scheme has correctly funded the bills from the service provider and further engaged with the service provider to amend their bill.
    c. The Scheme would like the Registrar's ruling overturned.

RESPONDENTS SUBMISSION

27. Mr R, for the Respondent, commenced his submission by stating that he had been in private practice for 23 years and also served as the vice chairperson of Perfmed, which is an association representing about 80% of the cardiac perfusionists in private practice.

28. The Respondent felt that the Scheme is misleading the committee with their interpretation of the coding guidelines, and it is common sense to use time-based codes, which in this case

for managing the IABP of the patient from the ICU to the theatre (75085), the 75013 code whilst in theatre, and then the 75085 code from theatre to the ICU.

a. Therefore, these codes are not being used concurrently but have been applied in a practical, clinical setting.
b. He submitted that his billing codes being used simultaneously was common practice and that there is no rule in the NHRPL guidelines to state that these billing codes must be mutually exclusive.
c. Cardiac perfusionists work regularly in the multidisciplinary team setting and hence the letters of motivations to support this team approach to such surgery.

29. Ms D, representing the practice's billing company, informed that they have an amended bill, but this was not submitted in the bundle of documents.

30. Mr R in reflecting on his engagements with the Scheme/ Medscheme Administrator with his Perfmed hat on, was applying an American based billing standard to the South African context

a. He confirmed that his organization had assisted the administrator separately in their section 59 forensic investigations
b. He is not here to defraud the Scheme in any manner but to argue for the appropriate compensation according to his associations billing guidelines which are based for the South African healthcare context.
c. He, therefore, questions the Scheme's understanding of the billing guidelines.

31. Mr R concluded that the Appellant has not properly adjudicated his practice billing and common sense should prevail in the billing for accompanying and monitoring the IABP from the ICU to theatre (06h30 to 07h39, code 75085), in theatre (07h30 to 14h30, code 75013) and from theatre to the ICU (14h12 to 15h12, code 75085).

32. For the reasons set out above, and in his heads of argument, it is submitted that this Appeal Committee find in favour of the Respondent and uphold the decision of the Registrar.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

33. The relationship between the member and the scheme is governed by the terms of the contract ('*the scheme rules*') that the member concluded with the Bonitas Medical Scheme.
34. The Contract in turn is governed by the Medical Schemes Act 131 of 1998 and the regulations (as amended) contained in the Act; and wherein there are managed care and service provider contractual obligations and arrangements.
35. The NHRPL Guidelines of 2006
36. The 2009 ICD 10 Coding guidelines
37. The CMS, Circular 66 of 2021

ANALYSIS AND FINDINGS

38. The Appeals Committee considered the papers filed in this Appeal; the further submissions the parties made; the relevant provisions of the MSA; and the rules of the Scheme.

39. It is common cause that-
    a) Mr S is dependent member of the Bonitas medical scheme.
    b) The service provider, Mr R, is a registered cardiac perfusionist under the HPCSA and is in private practice.
    c) The dispute is about the interpretation of the billing codes used by the service provider.
    d) The service provider also serves in a leadership capacity for his association of cardiac perfusionists, which is involved with the administrator, in discussions around coding and guidelines.

40. From the evidence provided, there is no dispute that the treated condition is a PMB condition.
    a) The Appeal Committee is of the view that the Respondent had abided the rules of the Scheme in terms of Regulation 8 of the MSA, which sets out rules for the

scheme to pay for the diagnosis and treatment of a PMB benefit condition.

a. Regulation 8(1)[1] must be paid in full.

b. Regulation 8(2) [2](a) read with 8(2)(b) allows for schemes to charge a co-payment, if the member uses a non-DSP under voluntary circumstances; and which is not applicable in this case

c. The Appeal Committee is further of the view that the Appellant's case does not meet the criteria for Regulation 8(3)[3], which is the basis for payment in full and preventing the Scheme from imposing a co-payment when a PMB Condition is being treated by a non-DSP, and where a member has involuntarily obtained the service of a non-DSP and is not applicable in this case.

41. It is further not in dispute that the cardiac perfusionist is allowed to operate the intra-aortic balloon pump and is responsible for the supervision before, during and after theatre
    a. The committee noted the letters of motivation from the other medical professionals and recognizes that open heart surgery is a complex operation and requires the attendance of a multidisciplinary team.
    b. The committee agrees with the scope of practice assertions from the Respondent in alignment with the guidelines from the HPCSA

42. Considering that this is case about the billing query on the member's account, the Appeal committee expressed its viewpoint, that matters between the association of cardiac perfusionists, and the administrator cannot be brought into this case.
43. The committee believes that the discourse around the NHRPL whilst dated to 2006 is beyond its purview.
44. The 2009 ICD 10 Coding guidelines as referenced by both parties has its applicability in the service provider's submitted bill.

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[1] 8(1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions

[2] Regulation 8(2) provides:
Subject to section 29(1)(p) of the Act, the rules of a medical scheme, in respect of any benefit option, provide that-
(a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical Scheme if those services are obtained from a designated service provider in respect of that condition; and
(b) a co-payment or deductible, the quantum of which is specified in the rule of the medical Scheme, may be imposed on a member if that member or his or her dependent obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member of the service was involuntarily obtained from a provider other than a designated service provider."

[3] *) Regulation 8(3) reads as follows*
For the purposes of subregulation (2) (b), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if—
(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;
(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider;
(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence."

45. The committee is of the view that the entitlement for the PMB condition lies in the Diagnosis and Treatment Pair (DTP) and that the matter is specifically therefore turns on the correct usage of the billing of codes 75013 and 75085 in the bill and their interpretation in the case of the member of the scheme.
46. For ease of reference, the bill[4] is contained below:

47. In reviewing the above-mentioned bill, the time period of 07h39 to 14h12 was put forward for both billing codes in dispute, 75013 and 75085.

48. The scheme response to the coding dispute[5] is contained below for reference:

" On 5 November 2021 the Fund received an account for service date 28 October 2021 from Mr R (Cardio-Vascular Clinical Technologist) for R 29 284.50 and paid R 27 677.30 on 11 November 2021. Tariff code 75085 - Each additional 30 minutes for R401.80 was charged four times which were all rejected for the reason: "Mutually exclusive procedures claimed together."
4. Add-on code 75085 allocated 10.0 RVUs was rejected when billed with add-on code 75013 allocated 20,3 RVUs. The rejection is based on the following:
• Both codes represent services that were billed from 06:41 to 13:25 and have run concurrently at increments of 30 minutes.
• Although one code was for 5,5 hours and the other for 2 hours. Based on the time/s allocated for both codes to the claim and applying national and international coding guidelines, when applying correct coding, it will be correct to bill and pay the code allocated the most RVUs only. The same principle applies to all medical disciplines as stated in the attached Medicare National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP).
5. Mr R is using the unofficial coding guidelines that have been compiled by his own association. Medscheme does not recognise this coding schema for the following reasons:
• They only apply to a select few that are members of Perfmed.
• The official coding schema used by the medical aid industry and endorsed by CMS is the 2006 RPL for clinical technologists and has not changed since its inception."

49. The Appellant has stated that it requested the service provider on several occasions to amend his bill and whilst the service provider's billing company's representative informed that the bill has been amended, this evidence was not contained in the bundle.

50. Given the Appellant's submission that the interpretation of coding practice should be universal, evidence based and applicable to the South African context, the committee

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[4] Per paginated pages (pp) p 6 to 8 of the appeal bundle

[5] Per paginated page 22 of bundle of documents

agrees that the Scheme's interpretation of the associated RUVs is correct and therefore the service provider's contention that the interpretation is based on international guidelines and not the South African guidelines, is incorrect.

51. The committee, whilst reviewing the memo from the administrator of the scheme, that there shall no longer be a policy to pay for a 2nd cardiac perfusionist, recognizes that the Respondent is the sole professional in this case and that the memo does not pertain to the adjudication of this matter.

52. The committee agrees with the coding specialist from the Scheme, in that time-based apportionment, supporting clinical records and the exacting RUVs per the established codes does serve as a fair guide to the cardiac perfusionists and as such prevents duplication of billing and allows for professionals to bill for their actual time spent.
    a. In effect the codes for the time period before and after theatre should have been clearly demarcated with the supporting code 75085.
    b. The time period in theatre and from the combined ICU bill, the relevant code 75013 unbundled and billed by the service provider
    c. These codes therefore cannot just run concurrently
    d. The billing of the codes together can create challenges of distortion and inaccuracy of data.

53. The committee is further in alignment with the position set out by the Scheme[6] as follows:

[6] Per paginated pages 73 & 74 of bundle of documents

28. What must be considered is the billing practices prescribed to providers and the clinical coding guidelines that allow for the Scheme to function optimally in a financially feasible manner.

29. The approved HPCSA scope of practice for clinical technology: Point 7 herein outlines the scope of practice is specific to data capturing for interventional procedure (record keeping) which supports Medscheme's position that the cardiac perfusionist should supply a time for code 75085 ((*Each additional 30 minutes or part thereof, provided that such part comprises 50% or more of the time (for operation of an intra-aortic balloon pump)*. Annexure A

30. The CPT (Current Procedural Terminology) code set specifies billing for intra-aortic balloon pump (IABP) in a South African environment by Cardiothoracic Surgeons and Anaesthetists and hospitals (ICU nurses) specifically RPL.

31. Wherein it is clear that cardiothoracic procedures involve a multi-disciplinary team which include amongst others; Cardiothoracic surgeons (X 3), anaesthetist and assistant, a cardiac perfusionist, a theatre nurse with skills to manage IABP care. Annexure B

32. Once patient is transferred to cardiothoracic ICU, theatre nurses with skills to manage the patient with an IABP will take over. Furthermore, the IABP management by Cardiothoracic surgeons or the anaesthetist will occur. Only one of these providers will bill for the IABP management, once the patient arrives in the ICU, the function is taken over by ICU staff whose costs are bundled into the ICU per day fee. Annexure B

33. In terms of the international guidelines on billing for time: *(Continued operation of extra-corporeal* equipment *during surgery for a time in excess of one hour in 30 minute increments or part thereof provided that such part comprises 50% or more of the time)*. Annexure C

54. The committee takes cognizance of the point about standardized coding practices and is of the view that the Registrar erred in his ruling by not unpacking the billing codes to the proper time period apportionment and allowing for concurrent billing

55. The committee whilst noting that the amount in question of R1607.20 is a small amount, supports the view that allowing for coding practice not adhering to proper standards and guidelines can result in exploitation and can lead to financial detriment of members of Schemes.

56. The Appeal Committee, for the reasons above, accepts the logic that correct time period billing, accuracy, supporting clinical evidence and billing within the scope of any service provider practice or discipline, needs to be adhered to.

FINDING

57. The discussions, ongoing negotiations on billing guidelines between the administrator and service provider's association is not before this committee and nor is this in the merit of the Appeal case.
58. The Scheme is correct in its interpretation of the billing codes and has provided ample evidence of the practice application across the cardiac perfusionist and other disciplines.
59. The service provider was provided ample opportunity to amend the bill accordingly.
60. The Appeal Committee agrees that the relationship between a Scheme and its member is contractual. The terms of the contract between the member and the Scheme consist of the Scheme Rules, the Medical Schemes Act and its Regulations.
61. Section 32[7] of the MSA stipulates that the Appellant is bound by the Rules of a medical scheme.

ORDER

62. The Appeals Committee upholds the Appeal and dismisses the Registrar's decision of 11th July 2023.

DATED AT CAPE TOWN ON THIS 8 July 2024

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Dr S Naidoo

For: The Appeal Committee (Chairperson)

WITH –

Ms P Beck

Dr K Chetty

Dr T Mabeba

Ms M Ramagaga

Dr X Ngobese

CONCURRING, IT SO BE RULED

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[7] Section 32. The binding force of rules.—The rules of a medical scheme and any amendment thereof shall be binding on the medical Scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.