THE COUNCIL FOR MEDICAL SCHEMES (CMS)

INQUIRY UNDER SECTION 59 OF THE MEDICAL SCHEMES ACT

HELD AT

BLOCK A, ECO GLADES 2, OFFICE PARK, CENTURION

21 AUGUST 2019

DAY 7

PROCEEDINGS HELD ON 21 AUGUST 2019

ADV NGCUKAITOBI: Good morning everyone, we are continuing the Section 59 enquiry. This morning we have a submission from Elsabe Klinck and Associate, who is present on behalf of the four of you, who will be talking?

MS ELSABE KLINCK: I will be talking and they will supplement on particular matters because all of us deal with different matters.

ADV NGCUKAITOBI: Alright, so I should take the oath of each and every one of you because what you will say will go into evidence. Alright. What is your name?

MS ELSABE KLINCK: Elsabe Klinck.

ADV NGCUKAITOBI: Okay. Can I take your oath – are you happy to take the oath or ...?

MS ELSABE KLINCK: Yes.

ADV NGCUKAITOBI: Alright. So will you say after me, I, and your name.

MS ELSABE KLINCK: I, Maria Elizabeth Klinck.

ADV NGCUKAITOBI: Hereby swear.

MS ELSABE KLINCK: Hereby swear.

ADV NGCUKAITOBI: That the evidence I will give shall be the truth.

MS ELSABE KLINCK: Shall be the truth.

ADV NGCUKAITOBI: The whole truth.

MS ELSABE KLINCK: The whole truth.

ADV NGCUKAITOBI: Nothing else but the truth.

MS ELSABE KLINCK: And nothing else but the truth.

ADV NGCUKAITOBI: Please raise your right hand and say so help me God.

MS ELSABE KLINCK: So help me God.

ADV NGCUKAITOBI: Thank you, and who else will be talking.

PATRICIA MATSEKE: I will be speaking as well.

ADV NGCUKAITOBI: Your name is?

PATRICIA MATSEKE: Patricia Matseke.

ADV NGCUKAITOBI: Patricia Matseke?

PATRICIA MATSEKE: Yes.

ADV NGCUKAITOBI: Alright, so Ms Matseke, will you take the oath?

PATRICIA MATSEKE: Yes, I am happy to take the oath.

ADV NGCUKAITOBI: Then say after me. I, and your name.

PATRICIA MATSEKE: I, Mataka Patricia Matseke.

ADV NGCUKAITOBI: Hereby swear.

PATRICIA MATSEKE: Hereby swear.

ADV NGCUKAITOBI: That the evidence I will give.

PATRICIA MATSEKE: That the evidence I will give.

ADV NGCUKAITOBI: Shall be the truth.

PATRICIA MATSEKE: Shall be the truth.

ADV NGCUKAITOBI: The whole truth.

PATRICIA MATSEKE: The whole truth.

ADV NGCUKAITOBI: Nothing else but the truth.

PATRICIA MATSEKE: And nothing else but the truth.

ADV NGCUKAITOBI: Please raise your right hand and say so help me God.

PATRICIA MATSEKE: So help me God.

ADV NGCUKAITOBI: Thank you, and would those two ladies also be talking? Alright. And what is your name?

YVONNE NAIDOO: Yvonne Naidoo.

ADV NGCUKAITOBI: Okay, so Ms Naidoo, will you take the oath as well?

YVONNE NAIDOO: Yes, I will.

ADV NGCUKAITOBI: Alright so say after me. I, and your name.

YVONNE NAIDOO: I, Yvonne Charmaine Naidoo.

ADV NGCUKAITOBI: I hereby swear.

YVONNE NAIDOO: I hereby swear.

ADV NGCUKAITOBI: That the evidence I will give.

YVONNE NAIDOO: That the evidence I will give.

ADV NGCUKAITOBI: Shall be the truth.

YVONNE NAIDOO: Shall be the truth.

ADV NGCUKAITOBI: The whole truth.

YVONNE NAIDOO: The whole truth.

ADV NGCUKAITOBI: Nothing else but the truth.

YVONNE NAIDOO: And nothing else but the truth.

ADV NGCUKAITOBI: Please raise your right hand and say so help me God.

YVONNE NAIDOO: So help me God.

ADV NGCUKAITOBI: Thank you, and what is your name Ma'am?

EBBIE IHEANYI: My name is Ebbie Iheanyi.

ADV NGCUKAITOBI: How do you spell your surname?

EBBIE IHEANYI: I-h-e-a-n-y-i.

ADV NGCUKAITOBI: I-h-e-a-n-y-i. Iheanyi.

EBBIE IHEANYI: Yes sir.

ADV NGCUKAITOBI: Alright. So Ms Iheanyi will you also take the oath?

EBBIE IHEANYI: Yes I will.

ADV NGCUKAITOBI: So please say after me. I, and your full name.

EBBIE IHEANYI: I, Ebbie Iheanyi.

ADV NGCUKAITOBI: Hereby swear.

EBBIE IHEANYI: Hereby swear.

ADV NGCUKAITOBI: That the evidence I shall give.

EBBIE IHEANYI: That the evidence I shall give.

ADV NGCUKAITOBI: Shall be the truth.

EBBIE IHEANYI: Shall be the truth.

ADV NGCUKAITOBI: The whole truth.

EBBIE IHEANYI: The whole truth.

ADV NGCUKAITOBI: And nothing else but the truth.

EBBIE IHEANYI: And nothing else but the truth.

ADV NGCUKAITOBI: Please raise your right hand and say so help me God.

EBBIE IHEANYI: So help me God.

ADV NGCUKAITOBI: Thank you. So, we will go into the first, Ms Klinck, will you be the first?

MS ELSABE KLINCK: Yes, as we go along I will refer to ...(indistinct), apologies – Chairperson, I will do the presentation and as we go along

where there is specific examples or a statement that we make, I will revert to my colleagues and they will chip in at that stage.

ADV NGCUKAITOBI: Yes, I see that you have a PowerPoint.

MS ELSABE KLINCK: Yes indeed.

ADV NGCUKAITOBI: So carry on and just take us through.

MS ELSABE KLINCK: Okay. So just what we will talk about first is an introduction about us and then also a bit about our perceptions in terms of discrimination and potential discrimination and where I think I recorded healthcare professional approaches versus forensic approaches are also where worlds collide, because it is quite a collision sometimes. Then I also want to just share our attempts to clarify the application of the law and what that has caused and then we will go into a bit of the details in terms of our concerns around procedural issues, substantive issues, confidentialities and then the acknowledgement of debts or settlement agreements that are signed in the end or the matter ending, in some cases it is not resolved but it ends. Okay, so about us, we are consultants, we all have legal backgrounds, there are six professionals, two of us have additional qualifications in the health sector, one a pharmacist and another one a nursing professional. Which for the rest of us, they are not here today because one is in Free State and Cape Town, but they are very useful for us because they help us understand some of the specific technical details. So we then – we normally get involved, my career in the health sector started at the South African Medical Association about 19 years ago, so we have people approach us because they know us and they know us through our healthcare professional

society involvement. We have got a lot of societies as our clients who we help navigate health policy and health law environment, and that is how many people get referred to us. We also get referrals from malpractice insurance entities or malpractice cover entities who never support or do not render the support as part of the malpractice insurance that they provide and then these people are referred to us. We have a number of word of mouth clients, so we often find that if there is one physiotherapist will talk to another person and say you need help, you cannot do this on your own and *ja* that is how we deal with this. Or just through – we do a lot of CPD presentations to healthcare professionals and so on, then people get to know of us and that. So we cannot say that our client base would be a statistical representative because people come to us or they do not come to us or we get a referral or we do not get a referral. So, our clients are from all groups, so we have dietician clients, he have got general practitioners, specialists, occupational therapists, clinical technologists that are all very specific because they qualify only in their subgroup like perfusionists, that operate the heart-lung machines and so on. So we have got a wide variety of clients who face these investigations but we can say that there is a pattern to it and I think that is what we want to show today to you. Then we also see smaller facilities, so step downs, rehab facilities, also alcohol and drug rehab facilities, and then smaller doctor owned hospitals. And they often then come to us through the healthcare professionals that is associated with them, or that may own the facilities. Then we have professionals from all regions that come to us and then also from all racial groups. There are in

certain of the groups, and I think it is a function of the various – h =ow transformed a particular profession in the health sector is, that you will find more black clients or fewer black clients, so *ja,* this is what we then experience. I do think, and it is hard for us to make pronouncements on it, but I do think people do not always understand the potential for indirect discrimination. So what we have experienced, so I can mention two examples, if you do an investigation and you want an appointment book, you assume that where that practitioner practice people make appointments, and we know that that is not necessarily true. So I think there could be discrepancies depending on where somebody practice and the profile of that particular area. And then certain medicals schemes are only in certain areas, so if we talk about Lonmin, we know we talk about the whole Marikana type of are, so you cannot – it will have a particular profile as a result of where those practitioners are, so and the way in which people practice may differ in response to their various – *ja,* their – what – how you practice in certain areas is not necessarily the same. We also recognise that there could be perceptional bias in how people relate to each other so that the – that we may be tainted by our perception of people. So there may be a perception relating to KZN doctors. There may be a perception relating to people in the Free State or whatever, but, but I think we have to be – as South Africans we constantly aware of that that our perceptions our on colour, how we perceive others and then also how we treat them. And then culture and religion also plays a role. People are brought up to – for example, nod, it may not mean that they agree, it might just mean I hear you, but they will nod because they are

taught that you have to do this, or they are taught if somebody is in a hierarchical relationship to you cannot object, whereas in either cultures people say, you know, you can go all out, you can shout at each other. Whereas it is not acceptable, I think in that we can all learn in terms of how to make that better.

ADV NGCUKAITOBI: Just tell me is there a perception that the – relating to Kwazulu-Natal doctors in your experience?

MS ELSABE KLINCK: It seems so, so ...(intervenes).

ADV NGCUKAITOBI: Just elaborate on that, when you say, you know, that we get more specifics.

MS ELSABE KLINCK: It is so – we have been told by people in – so healthcare professional groupings even, that in Kwazulu-Natal, you know, they battle with the billing processes and people would exploit billing processes. So but it is – we do not have hard evidence but it does seem that there may be a perception in relation to certain areas and that certain areas maybe more problematic than other, or people would say that these people are not registered for VAT, they should be registered for VAT, so but there is – I do not have any hard evidence, it is what people say.

ADV KELLY WILLIAMS: Can I perhaps ask, who says it?

MS ELSABE KLINCK: So we have had that from people that sell billing software, and then there are perceptions that certain professions condone for example code unbundling. So code unbundling is where you try to heap more than one billing code on top of another in order to get a better

income. And that was also investigated by the health market enquiry that there are instances of ...(intervenes).

ADV KELLY WILLIAMS: So who are the people who sell the billing software that say this?

MS ELSABE KLINCK: There is many of the billing companies, I – we can provide you with a list of some of the prominent billing companies. Because I do think it is also relevant because some of them sell their services to healthcare professionals on the promise that they will optimise their income, and for us that is often a red flag. In many of the cases we see that the intermediary that actually does the billing, that there could be issues there in terms of ICD10 coding, saying to somebody to change the code, the diagnostic code form this to that, you can increase that. *Ja,* but we can provide you with a list of billing companies in cases that we were involved. In one of them that Pat was involved with the billing company confessed and said that they were – that they did make the mistake, but nonetheless, the healthcare professional was then reported to the HPCSA and as we sit here today they are still scrapped form the roll although the intermediary entity said it was their mistake. Okay so then the – I think one of the big things is the differences in approaches between lawyers and healthcare professionals. So lawyers are often in a fighting mode, you know, we will say, we will immediately say denial ...(intervenes).

ADV KELLY WILLIAMS: Sorry Mrs Klinck, can I just interrupt again, could I just take you back to the previous slide, I did not realise you were moving on.

MS ELSABE KLINCK: Of course, yes.

ADV KELLY WILLIAMS: I just want to ask you from your experience, we hear you in relation to your comments on this indirect discrimination and lack of awareness in diversity. But what I am interested to hear your reflections on, is assume we understand, broadly speaking how the FWA process works from a scheme administrator's perspective, and there were points at which the scheme administrators would interact with healthcare professionals. Where exactly do you see this – these – let us say diversity issues playing out in that process?

MS ELSABE KLINCK: So I think in the meetings between the professionals and forensic people, during on-site visits that sometimes happens unannounced, so and I – but I am not sure to what extent, so what we have also seen is waves of investigation where in a certain area, and we have had an area, Yvonne, I think that you have dealt with those cases in Marikana. Where there was a number of doctors that were targeted straight after each other, so it then does seem – so what – whether that is prompted by race or just somebody caving and signing an AOD or whether it is about somebody – a potential perception on a – because Yvonne's cases were all around probes. So it seems that the probes were all sent into a particular area, so that I think is the point where we experience that.

ADV KELLY WILLIAMS: Are you going to be addressing us on the method of work of the probes?

MS ELSABE KLINCK: Yes, definitely, definitely.

ADV NGCUKAITOBI: Can you just – just to follow up on my colleague, Ms Williams' question on how does this perception manifest. So take the example you have given about the perception which you say exists around KZN doctors, so what is the perception about the KZN doctors, that they are likely to be prone to fraud and corruption?

MS ELSABE KLINCK: The perception is that they may be more generous with coding and claiming from medical schemes. And for me that in itself does not proves anything. It may be because there is a high incidence of diabetes there, we have had cases where a cardiologist runs an emergency practice, so of course they will see – and they are covering a whole bunch of hospitals, so of course they will see a disproportionate number of suspected heart attacks, so that is the thing that may prompt the investigation. But to me that does not necessarily prove fraud or corruption. I must also say the cases that we have seen in our business, and perhaps people just do not come to us if they have committed that, fraud and theft cases are the absolute minimum. Every now and again you see something or even if a lawyer looks at it, they say it is impossible that everybody can have lower back pain this practice. You know, it is kind of self-evident. And if they do you know, they are few and far between, but it may also be because of who we are that we do not get them. But we will say to people you know what, you have done wrong and you have to pay back the money and that is it, you know, you say sorry and you do the right thing. But we do not see – we often see cases that could be misconduct or where there is coding disputes and so on, but that is the absolute bulk of our matters.

ADV KELLY WILLIAMS: And will you be providing us with the number of matters that fall into this category that you investigate, Section 59 that you persisted with?

MS ELSABE KLINCK: Yes, we can draw that figures for you, we can. We have not done it for today but we can draw that for you.

ADV KELLY WILLIAMS: I am interested to know who in particular comes to seek your assistance and how that racial profile looks.

MS ELSABE KLINCK: Okay, yes, we can do that, we can do that. Chair, can I continue?

ADV NGCUKAITOBI: You may proceed, *ja.*

MS ELSABE KLINCK: Okay so this is just where the worlds collide, where it is – when the healthcare professionals contact us they are in an absolute flat spin, they are totally thrown, and what sometimes or in a lot of times happen is they immediately think they have done something wrong. They say perhaps my records is not okay, or it is – and I think all my colleagues can also attest to that, is that it is a totally different reaction to how lawyers would react and we sometimes have to say to them just be careful, because you could be conceding to stuff that you should not be conceding to. Things that do not make the threshold of misconduct or something that causes the scheme loss, but they will say I am so sorry, and I think it is those two things that sometimes collide, and afterwards, we have a heap of cases where people have signed acknowledgment of debts and then they have regrets and they come to us and we ask them why did you do it? And they felt so under pressure and so – and nobody's business I think in this country is perfect, I think if you

go into our records you will also find stuff that is perhaps not perfect, but they are different, I think that is why they are healthcare professionals. They are in a totally different space than us as lawyers are in. And I do think we have to consider that because I see it too frequently where people afterwards say, and I say but you know, they say I violated this ethical rule. I say but you know it is not an ethical rule, so why did you not look and they say I was not sure and perhaps I was wrong. So I think that is for me, plays a big role in the way, and this is why we have advocated for a much more consistent predictable process because currently it is so hard, we have to prepare people for the absolute worst. We have to say to them that you know, even before this process is concluded, all payments to your practice may be suspended. You know, we have to say that to them because we will be dishonest if we do not, and you know, so we – it is *ja,* it is a totally different approach. So that brings us then then our attempts so far. So we have got - me as the managing director of the business, every now and again we get staff members that...(intervenes).

ADV KELLY WILLIAMS: When the healthcare professionals contact you are they already placed on indirect payment?

MS ELSABE KLINCK: In many cases yes.

ADV KELLY WILLIAMS: In many cases, not all?

MS ELSABE KLINCK: Yes. Yes. In many cases, not all of them, *ja.*

ADV NGCUKAITOBI: May I just follow this question from my colleague. You see, what we have heard so far is that there are two ways in which this suspension of payments or placing people on indirect payments are

two practices followed by schemes, so we had a testimony yesterday that what Discovery typically does is that they will give you notice that you are under investigation, and only if you refuse to co-operate will they put you on direct payment.

MS ELSABE KLINCK: Yes, *ja.*

ADV NGCUKAITOBI: But that is not the same thing that is followed by others schemes who suspend you immediately and then investigate you.

MS ELSABE KLINCK: *Ja.*

ADV NGCUKAITOBI: What is your experience in that?

MS ELSABE KLINCK: It is similar but you may get cases where if the – so there is sometimes – there is a process of a letter and correspondence and so on. If this process does not play out and the forensic units feels they – at any stage payment can be suspended. So we have had that where you are still in a process of engaging, and some of the cases are complex, I mean, some of them if you deal with rehab, physical rehab and alcohol and drug rehab, it is – in my view it is complex cases, mental healthcare is also and it is emotional and it is because it involves sensitive information around people and it gets complex if it is healthcare professionals who work in ICU for example, because then we try go get the ICU chart that is held by the hospital and there is in that process, in any stage, from all the forensic units, you could find a suspension of payment. And that puts tremendous hardship on practices who do not have the cash flow to sustain that, or who do not have – in-****** some cases they are able to claim from the patients but that is not in all areas, that works very well in Sandton, but that does not work in the south of

Johannesburg, because people do not have the cash, they cannot pay the healthcare provider. So, in terms of when suspensions take place, it can be at any stage, and then the worst is blacklisting, that means not, neither the patient, nor the provider is being paid and in those cases people just sign because you cannot afford – and you also cannot afford to be – that the message goes out that...(intervenes).

ADV NGCUKAITOBI: I mean what we understand so far on the evidence is that from a doctor's perspective it makes no difference if you are put on direct payment or blacklisted, because the patient typically takes the money and goes to shop with it, rather than paying the doctor.

MS ELSABE KLINCK: Yes, *ja.* So the blacklisting, neither party gets paid. So the patient can claim from the scheme but the scheme says your provider is blacklisted by us and we will not pay you because you should not have gone to that person. And obviously I think that is a severe limitation to people's rights so we have not had a whole bunch of those, but we have had cases of those – instances of those. And it is a very effective way where – to get somebody to concede, *ja.* Okay, thank you very much Chair. The – our attempts so far – so what I was saying is this is not – I personally, I do not like to do this work, I find it extremely negative, I would rather work on things where we kind of change health systems and you change the way in which people do and you help them develop nice policy statements, that is nice work, but this really not, this is really negative work. And every now and again, we fact that our staff are – it has a toll on them as well, so – and at one such stage in December 2013 with one of our previous employees, who have now

emigrated, she said to me we have to go and speak to the CMS about this, because it cannot continue like this. And we – it as a great meeting and we thought we were aligned and the CMS were aligned with us on our interpretation of Section 59(3) and its interaction with, in particular Regulation 6. However, since then we have had very, varying rulings from the CMS, because if a matter gets to a point where people – and our clients do not have money to take cases to court, that is a given, so the CMS becomes their recourse. But we have had such a mixed bag of rulings, both at the complaints level and then at the appeals level at the CMS, it is very hard, you cannot discern a consistent application and interpretation of the law. In some cases, for example, the ruling will say we have to refer the matter to the HPCSA, they must come back to us but you can still suspend payment to the practitioner in the meantime. Other cases say no, you cannot just suspend to the practitioner, and we have got a collection of cases that we are involved with, that we can also make available to you, but I guess the CMS would be the right place to get all the Section 59 cases. So it has been very hard, and I have always felt that anybody – the principal of equal protection and benefit of the law must apply, so a body must have a way in which it says we apply our law, it cannot be totally *ad hoc*. And that has also hampered this because there is no way that you can predict how the case will turn out. We have also tried with some of our professional society clients to get an agreement with funders to say if you do forensics with OT's for example, occupational therapists, we will do this and that and that and we will agree that this is the process. And unfortunately none of those have

borne fruit, because I thought that would be a much more constructive way, let us have an agreement and let us know where the society fits into this and so on. And then the last ...(intervenes).

ADV KELLY WILLIAMS: Sorry, may I just ask a question about the CMS's cases, two things is it correct that the CHM does not effectively have a doctrine of precedent?

MS ELSABE KLINCK: Yes that is how we understand it and it is – it leads to, in my view, application of the law that then is inconsistent, and I think it is not in line with the country's constitution.

ADV KELLY WILLIAMS: Okay. And the second question is, one of the other submissions has indicated that the CMS is not publishing, I think appeal board and appeal committee decisions, is that also correct?

MS ELSABE KLINCK: That is correct, up until 2017 they always published the appeal committee rulings, which was great because it gave you a good idea and also it had – I think it lowered the burden because people know the CMS would look at it, the appeal committee would look at it in a particular way, and it has not been published. It is not clear to us why it has not been published. We have – you can get those rulings through a prior application, but it is a schlepp. So Ebbie does a lot of our other CMS cases with patient rights and so on, and where patients do not get benefits. And that is always useful to, for example, say how they evaluated access to an expensive biological drug or whatever. And – but we – you can get it if you do a prior application and it is no longer published and I do think that also makes I difficult. And the appeals

committee rulings, the appeals committee people are good. Really, the rulings are well thought through, so *ja*.

ADV KELLY WILLIAMS: And is there compliance with the rulings, and if not, does the CMS enforce its rulings?

MS ELSABE KLINCK: *Ja,* we – there is nowadays not, it was always in the past and we are taking the matter now to court on that. So...(intervenes).

ADV KELLY WILLIAMS: On trying to enforce the ruling?

MS ELSABE KLINCK: To enforce an appeals committee ruling.

ADV NGCUKAITOBI: No, I think you should still give us some detail, who is not complying with CMS rulings?

MS ELSABE KLINCK: Okay, so this is the cases that we are dealing with are not forensic cases, those are patient rights cases, or patient access to benefit cases. Since beginning of this year, so we always understood, in all the years, I have been in the health sector now for 19 years, the others here, Ebbie has worked with medical schemes and so on for over nine years, so it was always understood that a Section 48 appeal is enforced, and that you could approach the CMS and they have got an enforcement unit who would then enforce the ruling. That is from about February, we had a rare disease case that was all over the media. First the medical scheme and then when we approached the CMS the initially said yes, we will enforce, and then later on say, no we will not enforce because the matter is under appeal to the final appeal board. We said but we have always known because of the different wording in the two Sections of the Medical Schemes Act that you enforce – because you

protect the patient's rights in the meantime whilst an appeal is ongoing and since that particular case that was publicised a lot, the other part there – I mean, it is public record, was GEMS. There is also been three cases against Discovery Health and initially the funders indicated that they will approach the courts for a declarator on it but then said no, you know, they will just refuse to implement and the CMS will refuse to implement and if we want an implementation we must approach the courts.

ADV TEMBEKA NGCUKAITOBI: So it is the funders that are refusing to implement?

MS ELSABE KLINCK: Yes, but the CMS is also not enforcing, the CMS is always enforced. So you could always contact – so the legal unit people will always tell you contact this person, they will make sure that the ruling is enforced. So we have always had that and we used to – that is how the process worked. Is it now obviously – I think there might have been a policy change in the CMS on that.

ADV ADILA HASSIM: How would the CMS ensure that there is enforcement of their rulings because we heard that their hands are tied.

MS ELSABE KLINCK: Oogh, you would need to ask them how they always enforced. I do not know what they – if they used – it was part heard, so you have a ruling, I would assume – I am assuming now. You would have a ruling that says this is how you comply with the – with – you have not complied with the Act and therefore you must comply with the Act and because the CMS has a mandate to ensure compliance with the Act, they could potentially threaten a scheme with suspension or,

you know, the normal powers that they have, if there is a scheme that would not adhere to the Act because you get registered under the Act and part of it is that you will comply with the Act. So that is what I would assume. But I am not sure, you would probably need to ask them.

ADV TEMBEKA NGCUKAITOBI: But, I mean I suppose in fairness, you see at the first stage once there is an appeal, the Act itself says that the decision is suspended. The problem is the second stage.

MS YVONNE NAIDOO: Yes, exactly.

ADV TEMBEKA NGCUKAITOBI: *Ja,* and then because that – there is no provision in the Act.

MS ELSABE KLINCK: Exactly, exactly. *Ja.* And this is why – we always had an interpretation of it and everybody was *ad idem* in the past, even people who worked at medical schemes was in agreement but that then changed beginning of this year.

ADV KERRY WILLIAMS: And last question from my side on this slide. So – and you say in the slide CMS has apparently put on hold Section 59 rulings due to the work of this committee. Are you saying that even – you *cannot* even complain to the registrar in relation to Section 59 breaches at the moment?

MS ELSABE KLINCK: Yes, so we have a couple of cases and we can give you the details of those, that is in process and if we follow up regularly – because you want an outcome for your clients. And we were told that whilst the committee is investigating this they will not process anything or advance anything in terms any pending Section 59 thing to

which we objected because I do not believe that is correct but be that as it may, you know, that is what we were told. We have not escalated that to Craig's office which would probably be the next step, but *ja.* Okay, our next bit is the procedural issues and I think our – in summary what we believe is that the principles of administrative justice should apply to these processes, if not PAJA, which I think is maybe a stretch in terms of legal interpretation but it is common law admin justice principles and there we differ from our colleagues, at some of the forensic units who believe it should not apply at all. So one of the key things for us is the inconsistency in timelines and the whole unpredictability of the process. Sometimes our clients get letters and it says you have respond within seven days. Sometimes it says you have to respond within 21 days but there is no correlation as to why in certain matters – one of 21 days response deals with the single potential fraud committed by a patient. One of our seven days ones is 60 files that need to be provided. So there does not seem to be any consistency in the process and any predictability of that. Then this is our biggest problem, is we really battle to assist our clients in preparing for a written response and/or a face-to-face meeting. In many cases the information is scant and we *cannot* – because we would like to – we normally sit with our clients in lengthy prep meetings and we want to understand what is going on in their practices and we work with their societies as well. Are there billing issues? Is this person misunderstanding the coding system or whatever? But you need information in order to prep that. So what sometimes happens is, is

we think something may go into a particular direction or we think there may be a concern and we work on that but it is – but I revert to both Yvonne and Ebby to give us some more information on their experiences.

ADV TEMBEKA NGCUKAITOBI: Thank you.

MS EBBY IHEANYI: Thank you, Elsabe, thank you, Chair. So with regards to information that is required or adequate information that is required. In order for a client or a healthcare professional to be able to provide the information or the answers that the scheme is looking for, they adequately need to know what the question is. But usually you will find with the scheme there is no adequate question of what the situation is. For example, you get an email from – this particular one was from Discovery that says your practice appears to be an outlier in certain instances, please provide why. So there is information that they have, they have done a comparative analysis or something behind but they do not give the particular healthcare professional what exactly it is that they are looking for and you will find that in most instances – I think Chair was referring earlier to the issue that – at a certain point payment is suspended but you will find that there is also no consistencies as to when payment is suspended. You will find in certain instances the moment you respond to an email there is a suspension that happens. In certain instances prior to even being heard, prior to a meeting between healthcare professional and the forensic unit suspension of payment is made. So there is ...(intervenes).

ADV KERRY WILLIAMS: Ms Iheanyi, sorry to interrupt. May I ask you just to take us back to that letter? Alright. You read it quite fast, could you read the full letter, just so we understand your complaint in relation to it?

MS EBBY IHEANYI: Alright, so I will read one of the first letters and I will read the second letter. So it says:

> "Enquiry into your practice. Discovery Health is committed to supporting a robust and efficient private healthcare system and strives to achieve world-class administration of claim reimbursement in support of the world-class medical care that healthcare professionals provide our members we have a responsibility to the members of the scheme we administer to ensure the reimbursement of claims aligned to both legislative and accepted industry requirements. To support our commitment we regularly conduct enquiries into alleged concerns relating to claims received."
>
> So it says:
>
> "Your practice appears to be an outlier in certain regards. As part of the claims review we recently completed an enquiry on your practice and observed the following concerns:
>
> Your practice has an outlier profile with regards to the following:
>
> 1. High time codes when compared to your peers. High costs per claim compared with your peers outlier on risk exposure to in-house medical schemes.

Please send us information.

Please provide us with information for the members of the attached list, annexure A, so that we can verify the claims submitted by your practice.

We are not prescriptive on which information to supply us for verification of the claims of your practice as long as such information enables us to verify the claims which your practice submitted and received for.

The information might be any or all of the following.

Copies or relevant extracts of your clinical notes to verify that a consultation occurred and the time for which such consultation lasted. It will be satisfactory for you to redact or exclude aspects of these notes if you are of the opinion that these aspects are not known to us and its disclosure would compromise the confidentiality of the patient concerns.

Timesheets and/or an appointment diary.

Please send me the requested information within 14 days of receipt of this letter.

In the interim all our rights are reserved including the right to take any measures and deemed necessary to minimise the risk for the schemes we administer until this matter has been finalised."

ADV KERRY WILLIAMS: Thank you very much and – go ahead?

MS EBBY IHEANYI: So the challenge is when you have read this letter and the information required, the subsequent meeting that followed,

they immediately informed the service provider that you have been billing incorrectly. One, we have suspended your payments. Secondly, what they required, what information was required from this entire process, is that the scheme indicated that there were particular procedure codes that were not supposed to be billed as she was billing. So they needed, one, an immediate explanation as to why those claims were billed like that which was not in the document that initially sent. They immediately advised that the claim would – amounts owed to the scheme would be in the range of approximately about 280 000 that she needed to pay back, but there is nothing of that sort in the email that we receive or even what the outcome of the audit is and specific quotes that are relating to – so it is difficult to prepare for a meeting that you are given fuzzy information on.

ADV KERRY WILLIAMS: And who is the letter addressed to because the schemes – of course we want an opportunity to respond to some of this, so just needs to be said for the record.

MS EBBY IHEANYI: That is the redacted part of my – it is addressed to healthcare professionals.

MS ELSABE KLINCK: Apologies, Chair, for jumping in. We can provide the case reference number. Our clients – clients have literally begged us to not name their names. People are scared and in particular if they have – the bulk of their practices are dependent on certain medical schemes, they are scared. So ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Let me just expand on this. You see, you are not first one to say that doctors are scared of schemes. I think

we have had this many, many times. Why are doctors scared of schemes?

MS ELSABE KLINCK: Because of the payment system, so if people get claim on a weekly basis and you get a pay run from the patients of that scheme that comes on a weekly basis, if that suddenly gets cut off, it is problematic. So and it is not only doctors, it is also occupational therapists and physiotherapists, various professionals. So the direct payment system do make them vulnerable. Many of them are also in negotiations with schemes in other contacts, so they would for example be negotiating a global fee agreement or they would be negotiating on a managed care contract and so on and they are scared that whatever they do in one setting will affect the success of the negotiations that they may be in a different setting. So rightly or wrongly so, but that is the perception. We find, for example, in cardiology because cardiologists do health insurance investigations as well as medical scheme things and they are worried that if they – if I do not – if I am not compliant on the medical scheme stuff side perhaps the insurance side will also no longer reimburse my – the medicals that I am doing for the insurance side of that business. So I think it is a complex range of reasons but perhaps the bulk one has potential for being flagged again. We have seen that – we have lots of repeat clients. So when it is – sorry – why – but people are scared that they will face – and people who face a first and a second and sometimes a third audit, are really worried that they are being flagged in a negative way and that there will be further audits and because they experience so negative, it is – I

cannot tell you how catastrophic they experience it. We have got a box of tissues in our office for our forensic because people – they get totally thrown by this. So, *ja.*

ADV TEMBEKA NGCUKAITOBI: I have noted three, so the first is what – retaliation by schemes. The second is the negative impact on commercial negotiations and the third is the ramifications on the insurance payments. Alright, thank you. Your colleague was still in her stride.

MS EBBY IHEANYI: Thank you, Chair. I think additionally for – particularly the letter that I just read now ...(intervenes).

ADV ADILA HASSIM: Sorry, Ms Iheanyi, if I just – I just want to go back one step on the insurance ramifications, as my colleague puts it. How – why would – what is the connection between the scheme and the insurers because you talk about long term insurers, I would imagine.

MS ELSABE KLINCK: Yes, *ja, ja.* So a lot of the – in the umbrella of some of the bodies where you have a medical scheme administrator there is also life insurer and so on and it is in particular in those cases where certain professionals do work for – you also find it with occupational therapists and so on that may be doing assessments for the insurance part of the business and they believe that causing ructions in the group would have an implication in another legal entity within that group.

ADV TEMBEKA NGCUKAITOBI: Thank you will you please proceed?

MS EBBY IHEANYI: Thank you, Chair. I think in addition for this particular practice that I just read a letter for, the fear was 95% of her

business comes from schemes, either Discovery or schemes that are administered by Discovery. So anything goes wrong there, 95% of her practice has gone. So it is a real and a genuine fear. So in addition to that, I think I just wanted to add a particular affidavit that I got from one of the healthcare professionals that was being investigated. I am not sure if I should read all of it or the relevant portion of it where she articulates to say that:

"I was threatened with unfair suspension of claims."

So if you do not play the game then the idea is you are going to be having a unilateral suspension of claims from the medical schemes which you have no choice over. So that is the challenges you have with particular medical schemes. Thank you, Chair.

ADV TEMBEKA NGCUKAITOBI: Thank you, who else is still to – oh, Ms Naidoo.

MS YVONNE NAIDOO: Thank you, Chair. I actually have a letter that we can also present to you where this scheme wrote to the healthcare professional saying that seeing that we *cannot* reach an agreement on the matter, that they would then suspend and engage the other medical schemes that they are administering to also suspend future funding to the practice and then with regards to the letters, what makes it difficult for us as well to assist healthcare professionals when we attend these meetings is that these letters are never – they never give sufficient information as to if you are referring to a particular billing code that was incorrectly billed by the healthcare professional, which one are you specifically referring to as the scheme and when we engage and we

write to the scheme then all of a sudden extra codes are then also added which was not originally what the enquiry was when they approach, when they conducted the enquiry with the healthcare professional or where in cases where they send probes as well, the letters – the initial initiation letter never specifies what – how the – what the position of the enquiry was that was conducted by the scheme and it just indicates that they want to have an open discussion with the healthcare professional regarding sick notes that were issued, for example, but when you attend the meeting, the meeting immediately goes into interrogation where the healthcare professional is requested to provide information on a spreadsheet that is been pulled three years back and the healthcare professional is requested then to respond as to on which day they issued false sick notes and they need to quantify to the scheme what the loss of the scheme is as a result of the – through your record that is pulled at that meeting. So, *ja.*

ADV KERRY WILLIAMS: Just to understand. I am concerned about how the letters, I assume you intend to up, are going to be hand-up and read into the record.

MS YVONNE NAIDOO: Yes, yes.

ADV KERRY WILLIAMS: What are you intentions in relation to that? Would you like to explain the context and read the relevant portions into the record?

MS YVONNE NAIDOO: Okay, so I can read one of my examples. This one pertaining specifically to the probes that are sent to the healthcare professional. It says:

"Dear Mr so and so, we would like to meet with you about the enquiry into your practice.

Discovery Health is committed to supporting a robust and efficient private healthcare system and strives to achieve world-class administration of claims reimbursed in support of the world-class medical care that healthcare professionals provide our members.

We have a responsibility to our medical scheme members to ensure the reimbursement of claims aligns to both legislative and accepted industry requirements.

To support our commitment we regularly conduct enquiries into alleged concerns relating to claims received. As part of this claim review process we recently completed an enquiry on your practice and have observed the following points of concern:

Issuing of sick notes without any medical reason. We would like to present you with the outcome of this enquiry. We would appreciate the opportunity to meet with you at your offices based at 1…"

And the address.

"…to present you with the outcome of the enquiry. Please call Mr so and so within seven days after you receive the letter for the scheduled meeting."

So in this very particular case by the time the client received this letter his claims were already suspended and when we attended the meeting it was one of the first questions that I asked, if there was a

suspension on the claim of the client and – because the client was not informed but he could pick up from claims that he submitted that he was not getting paid and it was at the meeting that was disclosed that the client was already under suspension even though we had not had an opportunity to meet yet to get the outcome of the enquiry.

ADV TEMBEKA NGCUKAITOBI: And presumably was not informed that they were suspended?

MS YVONNE NAIDOO: *Ja,* the client was not informed, we had no record in writing. Just when I asked in the meeting if there was a suspension because client had indicated to me prior the meeting that he had submitted now for a couple of weeks since the letter was sent to him and there was no payment from Discovery and it was at the meeting that it was said that yes, he was suspended even though he was never informed of the suspension.

ADV TEMBEKA NGCUKAITOBI: Alright. So what is the – you said you are going to read a letter which was something to do with the probes.

MS YVONNE NAIDOO: *Ja.*

ADV TEMBEKA NGCUKAITOBI: And so far there is nothing there about probes.

MS YVONNE NAIDOO: Exactly my point. So when we attended the meeting, it was at the meeting that video footage was then presented and there it showed several days of probes that were sent in, who physically took video footage of the doctor r and requesting basically - I do not know if I can say, it is as if they were luring the doctor to kind of give them sick notes but – and also some probes that presented

themselves as elderly sick people who were not on – who did not have medical aid and then they would request that the younger probe that is sitting next to the elderly lady would then request the doctor to please consult with her and give her medication because she is sick and then take the claim from the one that is actually a member. So it is only at the meeting that this is now presented and then the healthcare professional's faced with the evidence, they show him the evidence. In many of the instances in the case that I have conducted with the probes it was locum doctors as well and then at that meeting the healthcare professional is advised to then respond to the allegations and to explain and even though they do not – from the three year claims that they pull, they would only maybe present two probes. But then they would expect the healthcare professional to then quantify loss in terms of the entire three-year period.

ADV TEMBEKA NGCUKAITOBI: To come back to this letter, I mean, so you go with your client to an enquiry. There they show him a video of the several occasions where they send what they call probes to his practice.

MS YVONNE NAIDOO: Yes.

ADV TEMBEKA NGCUKAITOBI: Which scheme is this?

MS YVONNE NAIDOO: It is Discovery Health.

ADV TEMBEKA NGCUKAITOBI: And then what became of that case? I mean, the evidence been hearing is, you know, the use of these probes is problematic at various levels. The one level at which it is problematic is that the probes will entice a doctor to commit fraud and

then the scheme will use that evidence to say to the doctor you have committed fraud but it is the fraud committed because the probe was there in the first place.

MS YVONNE NAIDOO: Yes.

ADV TEMBEKA NGCUKAITOBI: So what is your actual evidence on this, what is your experience.

MS YVONNE NAIDOO: Okay, my experience is exactly that. When the probe enters the premises of the practice it is normally also on days where the practice is very full, so it would be on days like Mondays and you can just see generally on the video footage that the doctor's overwhelmed on that particular day. The person seems to be very trained when they walk into the session, they make small talk with the doctor, kind of lure him in a trust situation and befriend the doctor and it is at that point that they would then say to the doctor they do not feel like going to work, it is Monday, they do not feel like going to work and then they would ask the doctor to please give a letter and that they have medical aid, for example. So this is what the feeling is and then you can see that the medical health professional is completely caught off guard, he has no idea that he is being – that there is video footage running and then he would now present the patient with the sick note. In the other cases it was where they came with – there were two probes and the one was posed as an elderly lady and she was the daughter of the younger probe and she complained of being very sick and that she cannot go to the clinic because there is a queue and she needs the doctor to really help her and things are tough, you know, in the area,

that kind of thing, and then the other probe would then say to the doctor can you please then just assist my mom because she is not feeling well and she does not have medical aid and then you can just claim from my medical aid. So this is footage that was presented and it is also footage where the investigating officer says that he sent in that particular person to test the doctor and this is then what happened. And then with the cases as well is, in all three of these cases that I conducted, the scheme could not quantify loss. If they could quantify loss it was only based on the probes that they sent in but they could not quantify loss in terms of the three year records that they normally pull and they would then send in – they would send correspondence to the doctor or the healthcare professional to tell them that they need to go and look at their three year record that was pulled from the claims that they submitted to the scheme and they need to quantify the scheme's loss and if this is not done then they cannot guarantee what they need to do with that information because it contravenes the ethical rules of the HPCSA.

ADV ADILA HASSIM: What exactly do you mean by the three-year record? Is it that record of all of the claims that have been submitted to that scheme by that healthcare professional?

MS YVONNE NAIDOO: Yes, so that is generally the pattern that is followed and we have picked it up ...(intervenes).

ADV ADILA HASSIM: And to show what from that? The records meaning what, what are the records?

MS YVONNE NAIDOO: So it differs from each healthcare professional

but generally they pull out the record to show what the scheme has paid the doctor within the three year period and then they would say - in these meetings they would say well, if you want us to go away, we have paid 1.5 million so there we are showing you that we have paying you 1.5 million, if you give us 10% of that, then we can resolve the matter even though they do not provide any evidence to show that they have suffered that loss. So this is the general – normally when we go to these meetings there is always a three year record that they pull and I assume this is for prescription reasons so that they can still claim within that period or – but that is our assumption.

ADV TEMBEKA NGCUKAITOBI: So you go to this meeting where the video is played, what would the scheme say is the legal basis for sending a trap to a doctor's practice?

MS YVONNE NAIDOO: Okay, so they always say that they got a tip-off and when we request information about the tip-off it is never provided to us, they tell us then to do formal application for information and so in all ...(intervenes).

ADV KERRY WILLIAMS: Ms Naidoo, can I just ask just to be of assistance, can you – is this what happened in this case in relation to this letter?

MS YVONNE NAIDOO: Yes.

ADV KERRY WILLIAMS: So you asked for information in relation to the tip-off?

MS YVONNE NAIDOO: Yes.

ADV KERRY WILLIAMS: And information - they refused to provide

information?

MS YVONNE NAIDOO: *Ja,* no information was provided as to who the tip-off was but in the record of proceedings the investigating officer normally starts – that is the opening statement that he makes that a tip-off was received and as a result of this tip-off he then sent in a probe and the tip-off was that doctors got the habit of issuing sick notes without medical reason.

ADV KERRY WILLIAMS: So just so I am understanding this correctly. So the provider in this meeting gets a letter which does not indicate that a probe or a trap was sent in.

MS YVONNE NAIDOO: Yes.

ADV KERRY WILLIAMS: You go in with the provider, you have no knowledge of this either. You are told that the trap was sent or the probe was sent as a result of a tip-off and you have – are not subsequently then or subsequently given information in relation to that whistle blower or that tip-off.

MS YVONNE NAIDOO: Yes.

ADV TEMBEKA NGCUKAITOBI: Now just tell me, these traps or probes, what do they get from the schemes? Would be a pretty risky business to put your life through this, especially the case you have outlined of a daughter and their mother, both of them serving as probes, what is the incentive to do this?

MS YVONNE NAIDOO: We do not know because we have never – I have asked in meetings but we have never – in passing by at some point in one of the meetings I was told that – by the investigating

official that the probes are actually – they work for Discovery but I was never – we have never had any solid evidence of that or we do not know what the incentive is but what is very evident is when you look at the video footage, the probe is there to do exactly what they are instructed to do and they – it is as if they are trained, very well-trained to kind of source the information, they know just how to get – to meet the ends – at the – so it seems that they are trained to do this type of work but how do they are incentivised, we do not know.

ADV ADILA HASSIM: So and just to be clear, in the case of the mother and the daughter, the mother pretended to be ill?

MS YVONNE NAIDOO: Yes and the reason why we know this is at the meeting they present- the meeting comes off like a proper interrogation in terms of criminal law. So they come with forensic bags and they had the medication that was actually given to the mother who was sick. And they have the medical certificate and everything in forensic bags which they place on the table and then they will tell the healthcare professional, so here is the evidence and then they would present a video. And I did ask in the meeting so – and the medication is still sealed as well which is why I think that they also they allude you to that the medication is still sealed, it was new so therefore you gave this medication, this person did not need it or whatever. But in that specific video the elderly lady, she does come off as someone who is genuinely ill, she says she is sick but in the other videos where there is only one probe, those probes would say that they are not sick and they just want the letter because they *do not* want to go to work. But for

that one she did come off and say that she is ill and then they asked the doctor for help.

ADV ADILA HASSIM: In the case of the sick note, that separate scenario, when they asked for the records for the past three years it is not in relation to the sick note so it is not how many sick notes have you provided over the last three years, it is all claims.

MS YVONNE NAIDOO: *Ja,* so what they do is they use it as a blackmail kind of tactic because they pull out the three year record and then they will say even though they only presenting you with evidence of two probes that they have sent in within this month but then they pulling out three year claims. And then what they will say is they will say to the doctor, you either go back review and you tell us how much times you have issued sick notes without a medical condition and you quantify that amount of the loss that we suffered as a scheme. If you choose not to do so, then we will take the entire three year record that we have here and then we going to conduct a full enquiry into your practice relating to everything and then we will quantify and amount.

So it is like the doctor needs to choose is he going to pay the 10% of the 1.5 million or is he willing to take the risk to have a full audit conducted in his practice irrespective of what was genuinely initiated which was the issue of sick notes. So after a period is no longer an issue of sick notes, then it becomes full claims completely.

ADV ADILA HASSIM: And have that doctor issued false sick notes in any other – for any other *ja,* any other patient?

MS YVONNE NAIDOO: *Ja.* So one of the … (intervenes).

ADV ADILA HASSIM: Or was it just this probe?

MS YVONNE NAIDOO: For one of the doctors that I had his was very hard headed on this and he insisted that he did not and we went through his claims together and he could not find record of – and this was specifically because it was also the locum in one of the cases that actually issued the sick notes. And the doctor had only started practicing in February this year but Discovery still wanted the doctor to give them an offer to make the matter – to resolve the matter even though they could not provide any other evidence that sick notes were issued either by the doctor or by the locum in other day other than the day that they sent the probe and we are still busy with that case.

ADV TEMBEKA NGCUKAITOBI: I suppose there could be – you know, so you go to a doctor, they give you a sick note. They should not give you a sick note so they are acting in breach of the professional rules but that is not bearing on whether or not a scheme have suffered any financial loss.

But in order to quote unquote make the matter go away, you must give them money. So the exchange is you give us money and we will not report you. It is not as if there is a financial *quid pro quo* as it were, it is just that the scheme says, I will not report you for misconduct if you give me money. I mean that is the scenario you are presenting.

MS YVONNE NAIDOO: Yes it is.

ADV KERRY WILLIAMS: A follow up from the question from the Chair. Is it correct that if a doctor sees a patient who claims to be sick that the doctor then charges for a consultation rather than for the issuing of

a sick note? You do not charge for the issuing of a sick note I assume ...(intervenes).

MS YVONNE NAIDOO: Yes.

ADV KERRY WILLIAMS: You charge for a consultation.

MS YVONNE NAIDOO: Yes.

ADV KERRY WILLIAMS: So a consultation would have taken place?

MS YVONNE NAIDOO: So the argument from them is, the mere fact that they have the video footage and within the footage the doctor does not – there is no consultation for example, the doctor does not touch the patient or engage on why you are sick or what is – the interchange between the doctor and the patient is that I am not sick and I do not want to go to work so can you please give me a sick note. And doctor would then concede because obviously he is now presented with this evidence and he sees that this happened and he is willing then to reimburse the fund and with regards to that loss. But what happens they use this information to then exploit more out of the doctor so that is when it gets ...(intervenes).

ADV KERRY WILLIAMS: So on this second issue, could you just explain to us in relation to the case you are talking about in question, what was ultimately – what happened, what was agreed in terms of paying back the scheme for anything of the like?

MS YVONNE NAIDOO: Okay in one of the matters the healthcare professional that was assisting is – he was very old and extremely scared about the outcome even though we had given him alternatives like writing a ...(intervenes).

ADV KERRY WILLIAMS: Is this in relation to the letter you read out?

MS YVONNE NAIDOO: No, do you want me to only talk to this letter?

ADV KERRY WILLIAMS: If you would not mind.

MS YVONNE NAIDOO: Okay. So with this current matter we still in process, Discovery is still – they sending – we have sent them an acknowledgement of debt based only on the amounts that was claimed with the probe that was sent out to the locum because with this doctor pertaining to this letter it was they only had evidence of the locum who was appointed at the time and not the actual doctor. So we have sent out an acknowledgement of debt for him to reimburse the fund in terms of what they have proven with regards to those consultation fees that were claimed. However they have subsequently come back to say that they do not accept it and that the investigating officer is of the opinion that what he is presenting in the acknowledgement of debt does not quantify the loss in terms of the three year period that they had pulled out in the meeting. And that is currently where we are with this particular case.

ADV ADILA HASSIM: The difference in amounts between the quantified loss in relation to the evidence of the probes … (intervenes).

MS YVONNE NAIDOO: Yeah so that is the … (intervenes).

ADV ADILA HASSIM: And then the percentage?

MS YVONNE NAIDOO: That is the catchy part about the nature of how they conduct the specific cases where they call out probes, they *do not* give quantification. They rather let the doctor quantify, they present the doctor with the evidence and then they say, you must go back and

you must give us an amount to make this go away basically. So they will tell the doctor, you quantify and then you send us an offer and then refer to this as a commercial agreement. And then they will say, but we conducting commercial agreement so we negotiating. So ...(intervenes).

ADV ADILA HASSIM: So the doctor would be able to quantify what claim he put in for that false consultation that he did?

MS YVONNE NAIDOO: Yes.

ADV ADILA HASSIM: And so he could offer to reimburse for that ...(intervenes).

MS YVONNE NAIDOO: Yes.

ADV ADILA HASSIM: False claim.

MS YVONNE NAIDOO: But they do not accept it which is what we have done.

ADV ADILA HASSIM: And in other what is the difference in amount between the offer by the doctor to reimburse for the false claim versus what scheme is asking for?

MS YVONNE NAIDOO: Okay. So what they do is they do not ask for a particular amount, they just push doctor to keep making an offer. So if doctor makes an offer that is too small, then they will say to the doctor, we are willing to accept 5% on top of that. So there is not – we cannot differentiate an amount because there was not even an amount to begin with and it is only depending on that given day what percentage they are willing to accept of the offer that the doctor brings forward.

ADV TEMBEKA NGCUKAITOBI: Thank you. We still in the slide on

how *Audi alteram partem*.

MS ELSABE KLINCK: Thank you Chair. I think we have spoken on this information. Often what we discover and was not disclosed during the initial letter or even during a meeting is that in some cases there is a disgruntled employee. In one of the cases we had the employee – two billing employees were actually fired and then blew the whistle towards the funder and say that this – the very stuff over which they were fired, they were then – they were blowing the whistle on towards the doctor and I dealt with part of it and Pat is dealing because there is now a follow up forensic investigation by another funder on exactly the same matter so and he has been reported to the HPCSA. So and I do think any person who gets evidence from a disgruntled ex-employee or a practice shareholder and so on, one should be circumspect in that evidence that gets presented. So *ja,* the whole thing of when you do get a spreadsheet, we have had instances where we then get into the meeting and we realise but the spreadsheet is incomplete. The moment if you get the complete information, so you have a big aha moment and say, but hang on this now explains the issue. So and then the moving target bits, we have had a client that provided 20 files and then after she provided the 20 files, there is another 60 files and you just never know when this is going to stop. So this is actually also, I think this is one of Pat's cases on we are doing a meeting, the person said that, yes we see you are talking but remember you owe us still – I do not know, it was 200 or 300 000 rand more. And Pat insisted and said, but how did you calculated that, where did that come from? But perhaps Pat can

elaborate on that.

MS PATRICIA MATSEKE: Thank you Chair. I just want to speak a little bit or add on a little bit on the issues of probes. I did have one other case it was my only case where probes were used. And what the doctor said to me was, I have never done this before but this person was so forceful and so adamant, it was very difficult for me to even refuse. I do not do this as part of my practice but this person was so adamant. And it is almost the same scenario where someone who is younger who has medical cover, comes in with an elder …(intervenes).

ADV TEMBEKA NGCUKAITOBI: I am happy for you to explain this, perhaps just back to Ms Naidoo's, the one thing I noted I wanted to ask you is how did this scheme get the camera inside the doctor's practice in order to capture that video?

MS YVONNE NAIDOO: Okay. So the probe comes in with a cell phone and she videos. She would then, if doctor's sitting there, she would play with the phone and video doctor while he does that and herself as well maybe under the table so that you can see and hear her talking clearly and then video him as well as if she is just having a conversation with him about the soccer that happened now in the past week or so. And then in all of this she is busy taking video footage.

ADV TEMBEKA NGCUKAITOBI: Was that part of the discussion in that meeting that the trap also came with a camera and secretly recorded the exchange?

MS YVONNE NAIDOO: Yes. So this is only disclosed at the meeting and then they actually they ask you if you want to view the footage,

they ask the doctor, would you like to view the footage that we have? And then that is when they would then play the footage on the laptop and it would be a full video footage of the probe entering the practice, what the reception looks like, into the consultation room and doctor jotting down a sick note or a script and then also what happens when you come out of the practice, what does the receptionist do in terms of filing or the receptionist fold up the – would fold up the sick note for the patient into an envelope. All of that is recorded but very strategically so because to know one who is being recorded is it obvious that video footage has been taken.

ADV TEMBEKA NGCUKAITOBI: Sorry. Thank you.

MS PATRICIA MATSEKE: Thank you Chair. I just wanted to say also that in the case that I handled, there did not appear to have been a video footage in fact we were told at the meeting that there was affidavit by supposedly that probe. But what I wanted to place on record is that what the doctor felt like, in fact she immediately – when we went into the meeting and the same scenario where there were forensic bags with the medications that she issued and scripts that she had issued was brought in. And we were told then that there were probes that were sent into the practice, she said, I know I can actually give you the specific date because she could remember that day that she was forced to actually write a script or do something that is obviously unethical. So she could remember that experience because it was something that never really happened.

ADV ADILA HASSIM: How was she forced?

MS PATRICIA MATSEKE: What she said is that person was so forceful in terms of, she insisted that the doctor must actually give her a script, she was very ...(intervenes).

ADV ADILA HASSIM: Without a consultation?

MS PATRICIA MATSEKE: Yeah, without the medical cover without the cover so she was presenting her mother who does not have cover to be so that they could claim under her own cover – her own medical aid. So she was – the doctor actually could remember that instance because she never experienced that before. And she could give specific dates to say, I remember this day this is exactly what happened because I was put under such an uncomfortable position and I can tell you exactly what happened then. Without even have the video or whatever and in this case there was no video. So I just wanted to add on that. What I wanted to speak about actually I have a case that I am handling currently with Discovery *Audi alteram partem* and in our interpretation is that where you have an issue with the doctor's claims or anything of that matter, we insist that please can you provide us with information of what your initial audit has found. And in this case it is also an issue of the doctor being called an outlier without providing any more details. What happened in this matter is that the doctor was told in a letter that, we have done preliminary investigations we found that you are an outlier. That is simply how the letter goes and they have asked for a almost 75, I think there was about 69 patients that he is supposed to disclose including an appointment the scheme requested copies of clinical notes, appointment diary and validation of time spent with the

members. The doctor is a psychiatrist. And simply put they said, as part of their claims review they recently completed an enquiry on your practice and have observed the following points of concern. Your practice has an outlier profile with regards to the following; outlier on risk exposure to the in-house scheme. So basically in our experience because we have seen a few cases where once you go to the meeting and Discovery or the other medical schemes will disclose what they deem as an outlier and what caused them to actually categorise you in that practice in that manner that would say things like you are consultations are longer than your peers or you are working hours are longer than your peers. In this case we have not actually been invited to a meeting and subsequent to this initial letter being received there was a withhold on the doctor to an amount of R970 000. The doctor was resistant in providing the information that they required because there is no detail in terms of what it is that they are looking for or why they are looking for that information. So he felt as if that there is a sort of a fishing expedition going on by this scheme and secondly he is a psychiatrist and he is position is that, my clients are quite vulnerable and for me to actually go to them and ask for consent. So there is various issues in play with this matter. The issue of fact that there is no detail in terms of what has been found in the preliminary enquiry or what led the scheme to believe that he is an outlier so that he can positively respond to that. So he does not have that information. And secondly, he went back to the scheme and said, this is the profile of my clients and for me to pull out 70 files, I would need to get consent for

that. So we are actually also arguing on the issue of whether consent is something that patient needs to provide in instances of audit for the doctor to be able to provide those records to the medical scheme. So that is one of the issues that we were dealing with. But on the issue of *Audi alteram partem* where we said to the scheme, listen you have not given us enough information for us to be able to respond towards. You have not even given us a meeting so that we can so that we can discuss what you have found in your enquiry. What has come back from Discovery when we raised this issued of being heard, we were in fact told in – there were other various letters that were sent to us, correspondence between the two us and Discovery but we were quoted a case by a Discovery employee who to summarise the position that Discovery holds with the issue of hearing the other parties position was that because they are not exercising public power therefore the *Audi alteram partem* is not applicable to this particular case meaning that they can actually take that decision. Before this letter was sent a few months, actually I think it was around April, when the doctor gave them the position and asked for more information, they decided that then the doctor has failed to verify his claims and therefore they are going to do a negative cost adjustment meaning that they have actually logged back the R970 000. Between the first letter and now the doctor has not had a meeting with Discovery or there has not been more information regarding what has been found in the initial enquiry by Discovery.

ADV ADILA HASSIM: What was the race of the doctor in all of these examples?

MS PATRICIA MATSEKE: The doctor in this case is black.

ADV ADILA HASSIM: And in all of these other examples that you have presented?

MS YVONNE NAIDOO: My doctors were all black.

ADV KERRY WILLIAMS: Ms Matseke, on this example that you are explaining in relation to the psychiatrist and his or her – his interaction with Discovery.

MS PATRICIA MATSEKE: Yes.

ADV KERRY WILLIAMS: What exactly did you on the psychiatrist behalf or the psychiatrist himself ask from Discovery as in what exactly is the additional information that is required in order to make the allegations all answerable?

MS PATRICIA MATSEKE: I unfortunately do not have the correspondence here but in general when we receive this type of correspondence where it is almost a blank or a blanket, we would ask for specifics with regards to, why do you say that he is an outlier? Can you provide us with claims, claim dates and patients so that we can actually see exactly what it is that you are referring to and respond specifically to those cases because in this instance 70 files will stop him from practising for a month for him to be able to pull those out to be fair. So those are the specifics that we ask for, what claims are you referring to, is this a billing issue, which patient are you referring to, what claims date are you referring to in this matter. Can you provide us with a report of your preliminary enquiry so that we can see exactly what the findings are and be able to respond? But that has not

happened in this case and they what Discovery come back to say is that, they do not regard our position that the psychiatrist or the doctor in this matter has been heard. They say that they have been engaged with him for the past few months and by engagement what they mean is that them being adamant or insisting on records and that is what they regard as engagement and for us that is not sufficient because they have not opened up or even given him an opportunity to respond to anything because there was nothing really in our opinion to respond to.

ADV KERRY WILLIAMS: Just going into the detail of this issue of what is required in order to enable the provider to respond adequately. That is really where the source of my question comes from. Perhaps you can give us your views on this but if Discovery were to supply the data which underlined their finding that the doctor is an outlier, would that be enough?

MS PATRICIA MATSEKE: So in cases where they are referring to outlier, in most instances they would be referring to his claims patterns being more than his peers in the specific region or the number of patients that he is seeing is more than what his peers in that region sees. So we actually did respond sort of trying to feel around what it is that they referring to. So the doctor did go and explain to them that, I work from this hour in the morning up until this hour. So it would be progressive for them to actually supply specifics to say, is this because I have more patients or I am seeing more patients than peers because then I can explain that or are you saying that the amount of claims that you are seeing in my practice versus my peers is more then I can

explain that. But there is not really that type of information that the doctor can respond to. So if we did receive that type of feedback or specifics, we would be able to go back and say, doc how many hours do you work a day and what causes you to work – there was a response that we tried to put forward to say, when I am in my practice I see about 10 to 15 patients a day and then after that I go to the hospital and I consult there and I see about 10 patients. And that would more or less try to give the schemes an idea of why they would say he is an outlier but there could be other factors that caused them to say that he is an outlier that we may not be responding to and hence they insist that he needs to supply patients records. So it is not really clear.

ADV TEMBEKA NGCUKAITOBI: So did you supply the patient records that Discovery asked for?

MS PATRICIA MATSEKE: No, the doctor does not want to supply patient records because he feels that the scheme is not providing enough evidence first. And then secondly, that they are not being upfront in terms of what their preliminary report or enquiry has found so that he can respond to specifics.

ADV TEMBEKA NGCUKAITOBI: What is the problem in supplying the records?

MS PATRICIA MATSEKE: He feels that he deserves to get more detail in terms of what the findings were so that he can respond to that.

ADV TEMBEKA NGCUKAITOBI: But I mean why does he need detail? He knows what the scheme wants he must just give them what they want.

MS PATRICIA MATSEKE: I suppose I cannot answer for him but the issue of the matter is that we have seen in many instances in some instances we are the ones that are saying, please provide us with more details because we need to be able to respond to something. But in this instance and sometimes we do encourage our clients to actually supply the patient records after they received consent because we want to help progress that matter. But in this case he insists that he does not want to – he is not answerable to Discovery. If they have found something that they need to actually call him to book with, they have to be specific. If they have to call the HPCSA they can do that, but they need to be upfront in terms of what it is that they looking for in those patient files because they simply called him an outlier.

ADV TEMBEKA NGCUKAITOBI: You see because what we have been hearing here is that some schemes, it is Discovery that was mentioned, they will ask you for information and you will refuse to provide which seems to be your case.

MS PATRICIA MATSEKE: Yes.

ADV TEMBEKA NGCUKAITOBI: And then they will suspend and put the patient on – the doctor on direct payment.

MS PATRICIA MATSEKE: *Ja.* So that is exactly what they have done in this case.

ADV TEMBEKA NGCUKAITOBI: So you say even that – the unfairness is that they request for information was unreasonable because it seems that if you are doing an investigation, you ask for information you do not get it. On one reading of that it seems reasonable to then suspend

pending the provision of information.

MS PATRICIA MATSEKE: I suppose that is one way of looking at it.

MS ELSABE KLINCK: Chair, can I jump in? We have – so if we get consent, so this is how we approach it because even on the incorrect reading of Regulation 15J, that is the reliance of providing the record from the side of the forensic people. Well, we never get consent. So they will say 20 and we will get 16 patients consent and it is particularly that is a psychiatrist, we find it is particularly sensitive in psychiatry in mental health also with mental health occupational therapist, either the patient is not compos mentis, they cannot consent or the patient is so embarrassed because they may now be a controlled schizophrenic and they do not want – there may be all kinds of things in the files that people do not want disclosed. So where we find that it is really easy in surgical disciplines, people had a hip replacement and so on, nothing contentious there. We dealt with a few cases beginning of the year with orthopaedic surgeons, nothing contentious, patients agreed, doctor provided his notes that he take during the procedure by a recording and then no problem. But I do think it requires a more nuance approach and I do think the blanket nature of giving a patient file with everything in it, I am not sure that that withstands constitutional scrutiny in terms of the over broadness of it. And we have – it is really hard to get the psychiatrist and the OT's working in mental health to disclose the files or to even get the patient's consent because it is much more sensitive than perhaps in other fields.

ADV TEMBEKA NGCUKAITOBI: Do they not say, see we had this

evidence, do they not say that they patient have given the consent in advance to the scheme. So they *do not* understand why you as the doctor are refusing to supply the information.

MS ELSABE KLINCK: *Ja.* So when I – in healthcare in my 19 years when I started working at the Medical Association years back that was one of the things that were absolutely in terms of ethics is that you cannot have a blanket consent with health records, it needs to be really specific and a blanket consent is not a proper consent. So that is what we were – that is the ethical approach to thus and I think it is also a constitutional approach to say, you cannot go fishing for things. And some people are more concerned than others as to what could jump out in a file because people do share things with their healthcare providers that are not necessarily directly related to perhaps the subject matter of the investigation. So we unable you will see we have a slide on the confidentiality. We unable to supply the principle of severability that is in the Access to Information Act where you would redact the stuff that is not relevant to the matter at hand and because we do not know what people are actually looking for, you cannot redact things from those files.

ADV ADILA HASSIM: I just want to take you back to the engagement we were having previously, Ms Matseke. It is quite important to understand, if not from the psychiatrist's position, but perhaps from Elsabe Klinck & Associates' position, what information you believe schemes or the administrator should be providing in order to enable doctor to properly respond? In other words, to allow a procedurally far

process.

MS PATRICIA MATSEKE: Yes.

ADV ADILA HASSIM: So perhaps you can just revisited that because... And if you do not have an answer now, you can give it to us later. But the scheme's position, I would imagine, would be that those letter which flag you as an outlier should be information enough to respond to or should be enough information. And I am just interested in your response to that.

MS PATRICIA MATSEKE: Thank you. So our response to this is that there could be more detail that is supplied. And as I have said, they could even list, you know, certain factors that play into them, having determined that he is an outlier. For instance, he could – they could simply say that: "We see that you have seen more patients." And as you have heard. Yvonne read out where her client was regarded as an outlier, but they actually gave a little more detail. I do not know if it is Yvonne or Ebbie. But they gave a little bit more detail, in saying that: "You are seeing more patients in general than your peers or you are working more hours than the people around, in the same profile as you, in that same area." And that would, being an outlier, would then give him a position or an opportunity for him to respond to those specific issues and where they are requesting ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Does not your client really her complaint or his complaint really boil down to this? You cannot use the outlier at all. If you are saying that claim X is wrong, then tell me that claim X is wrong.

MS PATRICIA MATSEKE: Hence, the initial response. We would have written to Discovery which I do not have here. Would have been for them to explain what they mean when they say an outlier and then secondly, to provide specific errors that they may have identified in those parts that they have requested, so he can respond to those specific issues. Instead of giving the whole entire files which is 70 of them.

ADV ADILA HASSIM: So your position is that given the date which underlines the view that someone is an outlier is not enough? They must give specifics in relation to actual patient consultations or what the particular issues are *visa via* particular consult etcetera.

MS PATRICIA MATSEKE: Yes.

ADV ADILA HASSIM: It cannot be the underlining data that is disclosed. That does not give the doctor enough to respond to.

MS PATRICIA MATSEKE: Do you want to respond?

UNIDENTIFIED SPEAKER: (Indistinct).

MS PATRICIA MATSEKE: H'm?

UNIDENTIFIED SPEAKER: (Indistinct).

ADV TEMBEKA NGCUKAITOBI: Will you answer this question? I mean, this is important to understand what is the degree of information that you are concerned with.

MS PATRICIA MATSEKE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Because we have heard this idea of identifying someone as an outlier. That it is creating problems and that people must be more specific.

MS ELSABE KLINCK: Yes, so this also goes to the burden of proof and how do you prove a loss. And I think in order to properly respond, you need to be able, I love the old days. In the beginning we used to get these full spreadsheets and I really liked that because then you could – you could actually see. It will tell you this code. 0006 for the physios is proper and you sort it on Excel and you get it and you can, you can ask the client to work through it and you can actually check. And they can say: "*Ja,* this was a true emergency. That was one was not an emergency." And one could respond to that. That methodology seems to have changed to requesting patient files that makes it much more murky because you do not know what is in the file and what could be in the file. What we try to do is we try to anticipate what the question would be by knowing our client and asking them a lot of uncomfortable questions. And then we may build the table, where we say, let us say it is an OT Group Section. We will say: "Do you have the patient's T's and C's? Do you have the patient's consent? Did the patient attend the session? Signed in?" Nowadays they want you to sign out. "Did you make a note on that patient's record after the...?" So we try to package the file in terms of what could potentially be the issues. But that is not ideal because you could miss something. So one would want to know. Is the problem that your – of your eight patients in this group section? We had claims from nine patients and you cannot prove that the ninth one was there. Or we have – we have seen they were double claiming. There were two psychologists in the session and there should only be one. That one can respond to. But to

say if that manifests. So you have got two psychologists in the sessions. Then your claims will be spiking because you will be claiming double what somebody else might have claimed. So but just saying you are claiming double does not help. Then we still do not drawn down to what exactly the allegations or the problems are. So I think one would want more detail and just a responsiveness in terms of – and also what prompted it. Something must have prompted it. You know. So, yes, we evaluated code 0006 and that was the outcome of it. We think it is being claimed too frequently because you actually do not have an emergency practice. We see you are not often in hospital. So how can you – you know. That type of explanation would help tremendously.

ADV ADILA HASSIM: Sorry. One of the examples that was provided was a description that the doctor is an outlier because of high time codes in relation to peers. What does that mean to you, the high time codes and how does one respond to the allegation that you or whatever. First, explain to me high time codes. The meaning of that.

MS PATRICIA MATSEKE: What I have experienced with one of the psychologists is that their codes are time based. And they will vary from fifteen minutes to an hour. And I am going to assume what they mean when they say high time codes that that person is actually frequently or mostly claiming the one would the highest time or the both time code that is applicable to their practice. So I would suppose that is what they are talking about, where out of ten patients nine patients you would have actually seen them for an hour and that would be – that

is actually common where that is used as something to flag an outlier by the schemes to say that: "You are charging or you are billing more high time codes than other people or your entire practice, as is, 90% of your bills is actually this one code which is an hour which the highest time that you can give."...(intervenes).

ADV ADILA HASSIM: So there are different codes for different time increments?

MS PATRICIA MATSEKE: Yes, yes. But as I have said. In this case, there is not an inkling of, you know, what is that they have found that can help us to respond to things like that. Is it a code that you are talking about? Is it too many patients? In some instances, they would say that there is only 24-hours in a day and then out of this 24-hours you have actually within – including other medical schemes – you have actually billed a total of 18-hours and we do not think that is reasonable. So we can respond to thing like that. To say: "Actually, I have a busy practice and that is why I am actually working 18-hours and I can – people at the hospital that I see, patients, that they can tell you I started working at 5 o'clock and at my practice they will tell you my last patient will leave at 8 o'clock. Which would quantify or give an idea that I am actually working an 18-hour day." So we are unable to respond. And the other risk that we see in also providing a blanket patient file is that it actually – it does become a fishing expedition because then the scope of the audit is actually now expanded to where we do not even know when it will end because they may find other things that – and if it is a practice where they can actually push and

keep asking further things without the matter coming to an end. So that actually helps us to try and actually draw down a scope of, you know, what the audit is about and respond to that. If there is other findings then we can actually deal with that, but to also protect the doctor and his practice because these things can be very interruptive to one's business and to go – it may go on for a very long time.

ADV TEMBEKA NGCUKAITOBI: All right. Let us finish the slides.

MS ELSABE KLINCK: Okay. So, we can also provide you with – we will provide you with all the supporting information and so on afterwards. Sometimes it seems that Section 59 is interpreted as authorising a reversed *onus* provision and in particular – and this is what Yvonne eluded to. Where you get confronted and that is often as the result of the probes where: "You tell us how much you owe us, doctor." And then there is a bit of a guess work then to kind of – and if people do not want confrontation, they invariable want to make some offer, but there is actually no factual or legal basis behind that. But there are two really difficult situations here. One relates to what proof would you require from us then. And this is – I eluded to that. For example: "Do you want a sign-in and a sign-out when the patient started? Particularly with the time based codes. Some of these time based codes are really bizarre. It says up to 52-minutes. And you know they want you to show they saw a patient for 52- and not 53-minutes because from 53-minutes you can charge higher and so. So they want sign-in and sign-out. But there is not rule in law or in the HPCSA Guidelines that says patients must sign in and sign out. So and

they do not do – doctors do not do like us, you know. We start – we say you have started to consult with the client at three minutes past 12 and you ended at 12 minutes past six, you know. They do not do that. And then you – it is really then hard to dispose of that onus because in certain cases, for example, they will say but the notes are too brief. Okay. So, you know, how much detail do you want our clients to provide? And we often say that to the forensic people. I say – we will say – we will write to the big bosses there and say: "We need to advise our clients. You have done a particular type of claw back. How must we advise our clients? How do you want these records to be done? So that we are in compliance with whatever you want." And part of the thing on the notes, in particular, is the fact that the regulations under the National Health Act on how a record must look, has never been made. So we kind of – people work on the HPCSA booklet on record keeping and for certain groups, if it is not an HPCSA – even that is not detailed in terms of what you must do. And then these coding systems. I will not go into that because we are not much of experts but you also need to know if it is a code. What coding system is being used to evaluate that you have coded incorrectly? And there it is also sometimes a moving target. So are you using the SAMA Codes? Are you using the old RPL? Are you using the NHRPL? What are you using? Because they have different description of what that code means. And some of them in the past it might have said up to 15-minutes. It now says 15-minutes. So if you did not see the patient for the full 15-minutes, you cannot claim. Whereas, if it said up to 15-

minutes you can claim anything from 1-minute to 15-minutes. So the coding issues – and I really believe strongly that because the coding systems are in a mess. And nobody is sure. And some funders have their own codes and they block certain codes and people create codes and society creates new codes as new technology comes to bear, you need a code to say this is – if I use this machine here, I need to charge that code and people develop that. And because there is no standardisation on us, it is really hard to anticipate which coding. We recently have seen that people would say in OT cases, for example, that they apply the OT Guide on coding. And then it is great because then we know what they are working from. In psychology it is a disaster because there is no necessarily coherent thing. So, *ja.* But I think there may be other people that are more qualified to talk about this. It is also sometimes a problem between the hospital codes and the providers codes. They do not necessarily talk to each other. So the doctor will say that the patient is in ICU but there is no ICU code for the hospital. The high care and the ICU codes are the same, for example. Then it looks as if there is a discrepancy between how the patient was admitted by the hospital versus how the patient – the doctor's coding. So there are heaps of coding thing that I really think – codes should be – if somebody exploits a code and commits fraud, by all means. But coding discrepancies and coding uncertainties, should be, in my view, not trigger forensic investigations, if there is uncertainty around these codes. And this is why it is important for us if we deal with these matters that we know what coding system is being

used. And that people are told: "You can no longer use this particular codes. We, the funder, decided it is not part of our benefits." And we often asked that and say: "Did you tell people that this is no longer something that you pay for?" And then by all means. And then we can use our systems and let everybody know to please not use that code because that scheme will not reimburse it. But you need to know that upfront. It cannot be done in retrospect. And probes, I think, we have exhausted. I have also got a few probe cases that I have handled that we could share with you. But – and one of them – there were six probes. The doctor has a brilliant receptionist and she actually caught the people out. She just did not let them through because when she saw two people where the one is on the other one's medical scheme, she just said the doctor does not do this. But out of – it was on allowing them in but they caught them out on two of the six. And I went to see his practice because I wanted to know where the errors came in with medication. And he is really an elderly man and he was – the errors were always in multiples of ten and that looked funny to me. And it is just again the software. The software that he used, when he wanted to say ten tables he actually typed in there on the computer – he dropped down ten and it was actually ten packs. But he then just – so, *ja.* But in this case we also do not know then how many probes are sent in until you are successful. H'm, *ja a*nd then the surprised visits to facilities. And then they throw the healthcare professionals, we have had that in dialyses units for example where they then say but you – where is your emergency trolley? And everybody is flustered now.

Should we have an emergency trolley. We are not sure if we should have one. And I do not think that is the duty of – that is the office of the health standards compliance or, you know. I am not sure that that is correct. And then unfortunately we have had three cases where the forensic investigations followed on other disputes between – and this why – what you are asking on why are doctors fearful or the healthcare professionals fearful is because they see these things. They see somebody had a dispute with the funder or a group of doctors had a dispute with the funder and then suddenly they are being targeted with forensics. So we have got two such cases. Not recent cases. And then we have got one case where that originated through a family member of a forensic investigator and she actually investigated the case. So, *ja* and that is what makes people think that there could be victimisation or repercussions. If you are fighting somewhere you could face a forensic inquiry as a result of that. Then we are – we have a number of cases where – we have spoken about the actions taken prior to completion of the particular case but there are also the cases where people have to make an undertaking to the funder that they will now never use this code again or they will issue a fake sick certificate ever again. And we are not sure what happens with these confessions that you now have to sign to kind of say that you have given an undertaking. We had an OT case where the OT had to undertake, she always now makes her patients sign in and sign out. And they do that because they want the matter to go away. And then we have cases where somebody cleared the forensic investigation a couple of years back and now an

investigation on exactly the same codes but now suddenly it is a problem. And every time we then present this, but hang on, three years ago you said it was fine. How is that it is no longer fine? And then I have spoken about the repeat cases that we have had and also Pat now has a case where the first audit was kind of not completed and there is already now a second audit that is been undertaken. So, *ja* and I think this relates to this procedural thing. There is never – there is not a clear starting and end point of – for these matters.

MS PATRICIA MATSEKE: Can I just jump in?

MS ELSABE KLINCK: (No audible answer).

MS PATRICIA MATSEKE: In this case where there is two audits back-to-back. The medical schemes were making use of one forensic unit. I think it is a third party that they were using. And, I mean, our client complied with everything that they wanted. We went to various meetings. We have submitted patient records. We sat there and explained how their practice works and thereafter when we concluded, we were now talking about issues of what the findings out of the entire process were. And there were three findings in total where we actually managed to explain or at least give reasons why two out of the three existed. And then we conceded where there were errors and made an offer to pay where the fund has made losses. And then there was a third finding that we did not agree with and we have asked the scheme to provide us proof of that finding. For instance, to say, in these two particular cases there were patients that there were claims that were lodged where patients were not consulted with. I think that

was the finding in that case. To say that there were claims that were rendered where patients were not seen. And that where we actually, you know, sort of got a stalemate where they could not prove to us that in this case there is a claim but you did not provide us with the records. So what happened is that when we pushed for a response from the medical schemes to say that we have actually made an offer of this amount of money because we did concede where we were wrong but now you are still insisting that you want more money. On what basis are we now going to have to pay the 200 000? I think it was relating to the previous slide. So at that point, the matter sort of fizzled out because we never got a response. Either to say this is us supporting our 200 000 claim that we want to get from you. Or to say that we agree. We are closing the matter. It is never closed. While we were still pushing for a response, we received a letter from MedScheme who is the administrator and they put themselves out to now still being investigating the same practitioner and requested files. Our first response was that we have just been audited on the same medical scheme by a forensic unit. Now you are starting this afresh. What happened to the previous audit where we have done all the work? And what we have simply been told is that we have told this other forensic unit you need to, you know, close the matter. So basically all the work that has been done is being ignored and then we starting a new audit. So for us that actually is an unfair process, you know, that has been taken upon our client. And we are still sort of trying to find out, you know, how and why this is happening and what happens to all the work

that has been done in the previous audit? We are still waiting for responses on that.

MS ELSABE KLINCK: Thank you, Chair. So I think in terms of who makes these decisions on these things, there is also vagueness. We do not know – we know the investigators. And we can now say if somebody says to me that I have received a letter from a specific – from MedScheme or from Discovery and it is signed by that person, we know our forensic investigation. You know. So we know and they all know us. But we actually are not sure who makes the ultimate decision. So, you know, is it because – I think from their perspective, the ideal is to after that meeting get the signed AOD or get the thing wrapped up but I am always wondering who makes that final decision, to say – so schemes will tell us they have a mandate from the trustees to do this. But it does seem that there is a bit of a – between the investigator and who actually makes the decision that the investigation leads to a logical decision to claw back. It seems a bit murky in terms of that. And that would be great if that is clarified because then one also knows that we are dealing with an investigator and not the decision maker and a finding will put to a decision maker. But that is not always clear.

ADV ADILA HASSIM: What are the qualifications of the forensic investigators? Are they medically trained?

MS ELSABE KLINCK: No, I understand they – I think they have got this – they must actually say to you. But at the bottom of their thing it says they are certified forensic investigators and so on. So I am not

sure what that qualification is. *Ja,* but that is - *ja.* We tried to insist on having a clinical person in meetings because it does help if there is a clinician who can say that if you are a psychiatrist and you see mostly schizophrenic patients, this is how it goes. Or we had an issue with paediatric OT's a couple of years back. We only, once we got the society and other paediatric OT's involved that everybody realised but, hang on, with Pete's OT's, if you see really small kids, you actually need to see the parents as well. And they have got a specific code and their billing looks different to adults going to an OT. And if we had that right from the start that was really a whole sad scenario because there were two people who lost their practices as a result of claw backs that happened before we and OTASA actually got involved. But often you can explain why something looks different. So in Pete's OT's and mental health OT's, for example, things looked different. In different types of physiotherapy practices things look different. And that is why it is very useful is there is a clinician in that meeting who understands that field. With the allies' what people call the allies' physios and so on, it may be easier to get somebody there with specialist. It gets really difficult. Because you do not necessarily have – schemes do not employ specialists. And this is why you will see that one of our slides is about the importance of peer review. That you actually have a formalised mechanism where that person's peers can say, hang on, if you are a – if you also had an issue with a prem baby, neonatology unit. You need to be able to say – somebody needs to understand. What does it mean, this whole thing and prem babies. And why do they

need a paediatric pulmonologist? Because their lungs are not properly, whatever. I think it is really, really important. Because coding is – and billing must give effect to professional activities and that, I often – I \ mean, I am – we do – there were so many cases. But I feel so uncomfortable within the coding space and stuff because, you know, it is complex.

MS ADILA HASSIM: So just to summarise what you said. The decision making, there are two issues with the decision making. One is the conflation of the roles of the investigator and the judicator. The second is the qualification of the decision maker to be able to assist the correctness or not of the doctors or the – whatever you want to call it – let say the doctor. Of the doctor's behaviour or coding.

MS ELSABE KLINCK: *Ja,* exactly.

ADV KERRY WILLIAMS: May I ask a question on that point then going back to your written submission? In your written submission you say – and it is under a heading called The Desktop Analyses by Scheme Analysists. And you say:

> "We have been told and formally during forensic matter meetings with funders that the analysists have to find a certain number of cases per week, as part of their employment key performance indicators."

Perhaps you can expand on that just what underlines that and also to just clarify if you see a distinction between an analyst and an investigator?

MS ELSABE KLINCK: Yes. So in terms of the analysists. There are

people that will present you – they are the fundi's with the Excel spreadsheets and things. They can draw things and can compare profiles and do all of that. I am not sure how all of their qualifications are and I am not sure if it is consistent amongst the various forensic units. You need to ask them that. The people with the qualification will normally say at the bottom of their emails that they are a qualified or registered forensic investigator with some qualification thing. So I am not sure what the difference is between that. That particular statement, we were told – because from time to time, you know, you can defend a case and our clients do not have to pay anything. And then one of the cases – a staff member said to us: "Ag, forgive this person. Because we pressurise them to see how many of that particular professions they can catch out in a week's time." So they pour over the data to try to find us. So, I would much rather that people get incentivised for finding fraud. For finding wrongdoing and not just have you – if you are put through the system 20 people. I am not sure. You need to ask them. But is what we have been told to kind of – it was one of those cases where at the end you think: "Okay, we have wasted a whole lot of time. This never should have happened." And that was the response.

ADV ADILA HASSIM: What medical scheme administrator was this?

MS ELSABE KLINCK: Discovery.

ADV NGCUKAITOBI: Thank you, will you continue to the substance abuse?

MS ELSABE KLINCK: Okay, a lot of it we have addressed so I think we could go quite fast through that. So, the two legal basis in our view for clawbacks, so offsetting losses to the scheme, would be Section 59(3)(a) and (b), what warrants it, because incomplete notes of the healthcare provider does not prove any loss to the scheme. We have now had, recently had a case where they said *ja,* but the provider knows that they should not scratch stuff out in a chemical record, they must initial or date it or we saw there were notes in pencil. And for me that does not rise to what we would want to say is a Section 59. So, I think getting clarity as to what type of transgressions, for lack of a better word, would rise to Section 59(3) clawbacks by schemes, is important, *ja.* Then this is our thing on the peer review and I think where we are in agreement in terms of understanding what happened in a particular practice and why a particular practice has a particular profile. We have had investigations against paediatric neurologists, and you have a totally different practice than a normal paediatrician and a normal neurologist, and they do Botox and things for reasons that relate to their specific field, so they will look different and this is why it is important to them for another paediatric neurologist to say, this is how this should be evaluated. We also believe that people who are not – the ethical rule 21 says you have to be experience in a particular field to make a pronouncement on it. And you cannot, as a general practitioner or as a physiotherapist for example make a pronouncement on paediatric neurology, because you would not have that experience. Then, the use or I sometimes think of the abuse of the HPCSA policies, this really, this is a big threat for healthcare

professionals, so to say to somebody you have violated the HPCSA ethical rules and we could report you, is a big sword that hang over people's heads. But apart from the fact that it may not relate to loss to the scheme, many of these complaints, it is also an issue sometimes where the rules are misinterpreted or abused. So people will refer to the HPCSA business practice policy and say but you are not allowed to employ this person or ...(intervenes).

ADV KELLY WILLIAMS: Who would say that, the forensic investigator?

MS ELSABE KLINCK: Yes, *ja.* And there is more, this is why we ask people to not go there unrepresented. Because if we sit with the repercussions of a signed AOD, and you get the recordings and you hear what was said, and unfortunately healthcare professionals are sometimes ignorant about what the details of the ethical rules are. So one guy felt under tremendous pressure because he married his clin-tech. And I said you cannot marry our clin-tech and they did. And that was the whole thing, your, this professional and you should not be marrying this person and it is a misconstruction of the specific rule in the HPSCA rules. But because, they just want to treat patients or whatever, they often do not know. And when the horse has bolted it is really hard to then roll that back. So we have got a number of examples of what you think has been. Yes, and if you have an HPSCA investigation against you, it drags on for a long time, so you have got a sword hanging over your head for a long time. It does affect your malpractice premiums because now you have had a complaint against you. So it has got all kinds of – so it is actually,

in terms of making people scared, it is a very effective way of making them scared. So I am rushing a bit.

ADV KELLY WILLIAMS: Sure, *ja,* just – at some point before you close you are going to tell us how race factors in your cases and what pattern you have discovered?

MS ELSABE KLINCK: Okay. Alright, so what we will do is we can also provide you with a breakdown of our cases in terms of race, so the cases that we have spoken about here are majority black cases, of black persons but we also have large cases that we have not mentioned here, so physio for example are predominantly, physio cases are above 80% white people but then there is also specific codes that we know are being targeted and I think one needs to look at the healthcare professionals, how does the physio demographic look currently in South Africa? With psychiatrists we have got way more black people because I think it is also, it is a profession where, if you look at a psychiatry conference, I do not have all the data, but it looks as if it is much more transformed than for example other professions. But *ja,* I think that data *ja,* some people may have better data on that than use. Because we, whoever approaches us we help, *ja.*

ADV NGCUKAITOBI: What you might help us with – I suppose is to look at the totality of your clientele, and split that along racial lines.

MS ELSABE KLINCK: Okay.

ADV NGCUKAITOBI: If you have got 18 people that you have seen in the last two years.

MS ELSABE KLINCK: Okay.

ADV NGCUKAITOBI: And 20% of those investigators have been black or white, that would be helpful.

MS ELSABE KLINCK: *Ja.*

ADV NGCUKAITOBI: But I think there is also something helpful in what you are saying that we must also look at a particular occupation because that might also tell us something about whether the targeting is racially based or whether it is code specific.

MS ELSABE KLINCK: *Ja.*

ADV NGCUKAITOBI: *Ja.*

MS ELSABE KLINCK: *Ja. Ja,* we have also seen it is sometimes code, because if there was a successful clawback from one, you know, we can get a lot of money form a lot of other people as well, so *ja.* And then there is issues with practice structures, RWOP's, remunerated work outside of public service they will say give us your RWOP's agreement, did you do have an RWOP thing, you could not claim so much money because you have to work in the public sector for five hours and how is it possible that you then claimed another eight hours of work? So, *ja,* those have also been kind of interferences with how practices are organised. There is nothing wrong if you have got an RWOP's agreement, to actually also work in the private sector and I do not think it is the medical scheme's business to now challenge the RWOP, we have had cases where people then said you know the minister says RWOP's is a bad thing you know, it is bad for the public sector because the doctors will run away to do their private work. But I do not think, it is neither here or there in my view. That is politics and if the government has a problem with RWOP's

they need to act on RWOP's. And then there is also incorrect application of laws on products and professionals, so what can a nurse do, what can she not do, should – and it is contradictory sometimes, they say no but the nurse should have done it and billed for it because it would have been cheaper. In other cases they say no, the nurse must not do it. And if it is says supervision it means the doctor must sit there and check the nurse. I mean I know it is not necessarily how supervision works, so that is the one thing and then on the Medicines Act and the medical scheme and the medical devices that come in there, that people will say you need a licence and then you do not need a licence. And the person is so sometimes smaller business will be totally rattled, oh flip perhaps I do need a licence, I just do not know about it, and that then gets used, so the clawback does not happen on that that seems to be a thing, it is like the guy who married his clin-tech, it is, that is not, But it seems to be raised in the meeting as something that creates a lever on, you have done something wrong somewhere and you know, *ja.* So the clawback then is not on that, but it is raised during the meetings. And then, there is definitely inconsistency between what we see in a broader scheme policy and what forensic units would do. So the two examples we have there is with managed care. So, MedScheme for example has a system where if you are in a managed care agreement, your notes, the patient notes goes to the funder and it will say what happened to this patient, got physio, doctor saw him, blah, blah, blah. It is all in that system. And for three years there was no problem with that and then there is a forensic investigation and somebody says but why did the nurse mobilise the

patient and not the physio, why did the physio and not the nurse? But there is a managed care agreement between the parties but it was never, and it seems to be a disconnect between this managed care agreement where they get told you are doing a great job, and the forensics that start unpacking that and say hang on, you should not have done that. We have seen the same with global themes and alternative reimbursement methods, where on the one hand schemes are very in favour of it. But if we have a forensic thing suddenly they dig into the SLA's between the parties and they say what is in there, you only paid this person this, you should have only claimed, you should therefore claimed less from us and it just makes no sense that on the one hand you will have this bigger scheme policy and on the other hand your forensic unit would exactly undermine that policy. *Ja.* Then, the confidentiality, I think we have spoken about that, that is a big issue. And what muddied the waters is the differences in statements that were issued by the HPCSA in the past and then there was one blog issued and then there was another one issued to kind of correct it. And the middle one said you know, you have to basically provide the patient files to the forensic people, whereas the previous one and the one after that said you still need the patients' consent. That regulation 15J is about managed care arrangements, we do not believe that you can apply it if there is not a managed care arrangement. That whole Chapter 5 of the medical scheme regulations where this appear, is about managed care. So and it is because managed care is defined as the clinical and financial management. That is why the entities would both have access to the clinical records, because that is

what it is. You need to check is this person not only financially but also clinically correctly managed, but I do not believe that gives authority to get the patient files and get all patient files under Section 59. And then the last bit is just on the AOD's and the settlement agreements. This phase of this whole thing can go away if you just sign, we have heard often. And we – this is why we also say to people do not go and then sign. You can sign if you think you must sign, just do not sign there at the meeting, you know, take a cool-off and *ja.* And so we have a number of AOD regrets, Ebbie had to fly yesterday to Durban to deal with one of those cases where somebody afterwards said actually I should not have signed and I do not think that I have done anything wrong. So we try to manage it but it is hard to manage them because the person has signed. And we have examples of some of these documents that we can give to you. What is also sometimes a battle, so some of the independent forensic units that get contracted in after the meeting, they will give you a CD with the recording, which is great because then everybody is on the same page. But with – in some cases you actually have to do a prior application to get a copy of the recording and then you are in for another 30 days waiting and then we fight as to whether we have to sit there in the offices and take down at, or whether we can actually get it on a disk or on a that, so it can easily add to this whole drawn out thing. And you will see in one of the examples that we will give you, the clawback is based, it says in the notes there because your profile is above the national average, we are clawing back to bring you in line back to the national average. Which is just mathematically, we have an average

because there is people above and below the average. If we bring everybody above the average, we are creating a new average that is lower. So I battle to understand why that could justify a clawback. *Ja,* and then...(intervenes).

ADV NGCUKAITOBI: So tell me, this point, I mean – I am not sure if I understand the profile being higher than the national average because some evidence says they would target a specific geographic area, and then yesterday we heard actually, no, what is the norm is the national average as opposed to a specific geographic area. And so, often, because they use the national average, it will throw out someone working in a small town.

MS ELSABE KLINCK: *Ja.*

ADV NGCUKAITOBI: I think Vryburg was the example used yesterday, or Vryheid, I cannot remember which. But what is your experience on what they said it the norm against which they will then charge you practice to be an outlier?

MS ELSABE KLINCK: So, we have had cases of national average, and we have had cases of that says your peers, so saying that similar people with a similar type of practice would look similarly. We have also had cases because there is a different agreement between a professional society and the scheme where they would have agreed parameters and then they will say based on that and in those cases it is sometimes just median and not average. So, but I cannot see any consistency, but for me it is important, the context is very relevant, the Vryburg practice will look different to – and the same with the Bloem practices will look

different there. KZN practices with high diabetes incidents will look different for a specialist physician than somebody in another area of the country. And this is why I do not think, you cannot statistically prove loss and harm in these cases. Because it is, *ja,* I just do not think that is the correct way.

ADV NGCUKAITOBI: Just something else, your presentation says, I mean it is records, what we have also had here that the scheme say 53% of all investigations are triggered by whistle-blowers, anonymous whistle-blowers, but you say that is not consistent with your practice and your experience?

MS ELSABE KLINCK: Not in our business no. It may be elsewhere but not in our business. It is the absolute minimum of cases where you actually see, where there is actually a whistle-blower and where you see there is a patient who – and we have had cases where they put it up for you and you see this patient is totally *deurmekaar* as to who is the doctor and who is the OT for example, they cannot you know – but it is not our experience. Maybe elsewhere but *ja.*

ADV KELLY WILLIAMS: Ms Klinck on this clawback, and I understand your evidence to be that, the clawback is the quantum of the clawback is sometimes determined on bringing the practitioner back on the profile of the national average, is that right? Which schemes or administrators are doing this or using this as a mechanism or a reason to justify the quantum of the clawback?

MS ELSABE KLINCK: I am under correction, I know Discovery, I know that one the specific one comes from Discovery, but I do not know if you

guys have had MedScheme or MMI cases on that. *Ja,* so Yvonne confirms it, she has had it with other administrators as well, with MedScheme. I know the one MMI case that we have had with the paediatric neonatologists, working with prem babies that was an MMI case, also related to why their specific practice looked different to other practitioner, so I am not sure how pervasive it is but we then have individual cases where it happens across administrators.

ADV KELLY WILLIAMS: I just want on this quote, will you provide us the national average profile based on the national average, will you provide us with that specific letter?

MS ELSABE KLINCK: *Ja,* it is here.

ADV NGCUKAITOBI: That 30% I understand is not all schemes, that comes from Discovery specifically? Where they say that 53% of their investigations come from anonymous whistle-blowers? What is your experience about where Discovery's investigations come from?

MS ELSABE KLINCK: So up until recently before the file story where people ask for files it was desktop audits, and specific audits was with codes that has been analysed, and it does seem – we have really seen them in waves, so then Pat has had a whole wave of dieticians, so it seems if they found something in dieticians, hospital based dieticians in particular, then they will go out and they will look at what is happening with other hospital based dieticians. So it does seem as if one may trigger all and what we also see, the physio's the same, and then if we see clin-techs the same. So it does seem like something, whatever prompts the initial one, we do not always know but we do see them in

waves. So clinical technologists in dialysis, perfusionists, a couple of years back was a big thing, so one persons' investigation leading a positive result to me seems like it leads to people then saying hang on, we can, there is more that we can get from this.

MS PATRICIA MATSEKE: Can I just add, from what we have seen, I think it might be one of the slides that we are going to address, but what we have also seen is that on the increase now is where one scheme actually does the audit, immediately thereafter another scheme might follow. So whatever might have triggered a Discovery audit, might be a reason why MedScheme also decides to audit a practice, what type of information may be enhanced or not between the two, but what we have seen in a couple of instances is that once one audit is done by one medical scheme, another medical scheme would follow on the same practice with an audit. So it could be that one trigger on one medical scheme would actually be used as a trigger on another.

MS ELSABE KLINCK: So we now warn our clients and say if you have had Discovery you will get MedScheme shortly thereafter, if you have had MedScheme you will get Discovery because we have got many that are now twinned, *ja.* And then, we have spoken about this actually, what happens if you do not cooperate or there is no agreement. So there is simply then a clawback and the justification provided by the schemes is that it is to protect us against this risk that this person may pose for us, so *ja,* there is a number of examples that we can also provide you with the underlying information then, on that. So I do not know, Pat, Ebbie and Yvonne if you want to say something about these last bits?

PATRICIA MATSEKE: Can I maybe just address this last bullet point, I do have an example of a case here and I think what we have experiences is that our clients would say that you know, the scheme would have said to them you know if Elsabe Klinck and Associates were not involved, this matter would have taken two days and we would not be here for weeks. But because we try to challenge or at least support our clients so that you know, there is some sort of fairness, what would happen or what we realise happens when they are not represented or supported is that they would come in the one day they would receive a letter and the next day there would be an AOD signed without really any sort of information or even whether the agreement is signed based on something that is credible or evidence that have been you know, found against them. So our involvement I suppose maybe the frustration with the schemes is that we challenge things that we think should be challenged in order to protect the client and that may cause the matter to take a week or two which is something that the scheme would not desire. But our experience in this specific case where there is a clin-tech that has been providing services and obviously they have a registered nurse in the facility and that registered nurse provides dialysis. We are sort of having a discussion between ourselves and Discovery specifically on whether or not that registered nurse is entitled, whether the clin-tech should be billing on the registered nurses' code in a dialysis practice. And once the discussion was finalised and we have sent our position to Discovery, what Discovery in a few sentences said to us, we agree with everything that you are saying but this matter has been dragging on for too long, and now we are

just going to clawback. So there is that type of position where it is taking too long and we should settle although the issues are not finalised. But we would want it to be settled at some point without getting to any clarity or agreement. And therefore we have that power to say you know, we have decided that is has taken too long and we are going to clawback on this patient. However they did not proceed with you know, the clawback in that case.

ADV KELLY WILLIAMS: In the time that this back and forth was going on, there was no suspension or indirect payment?

PATRICIA MATSEKE: There was suspension.

ADV KELLY WILLIAMS: There was?

PATRICIA MATSEKE: Yes. *Ja.*

EBBIE IHEANYI: Right, I think there is also some, in conclusion to look at being an outlier per se is not a problem but you would find that the narrative or the jargon that is used by the scheme to say you are an outlier, the moment we find the word outlier, we now know there is a problem. But being an outlier per se should not be a problem but looking at the healthcare professionals can practically bill, there is a guideline, but they bill somewhere within the range. So the other challenge that we have as well , with schemes that you are having now is to say sometimes you have a forensic investigation meeting, but you – in that meeting, I think some of them are recorded by the schemes. In that particular meeting you will find that, which could be wrong, it could be a feeling, but you will find that when you have the particular one that I had last time you had white counterpart who has had a forensic audit before, we bring

out that there has been a forensic in 2016, now you are forensic auditing in 2019. You need to go back to the 2016 and then the 2019 and probably relook at – you had an opportunity to discuss certain issues and you did not. We had exactly the same thing yesterday in KZN, where you have now a black counterpart who is now saying now hold on, I had an audit in 2016, but the idea is, before they even perused they say the outcome will still be the same. So it feels sometimes that in as much as the documents, the papers, you kind of feel in certain instances to say there is a propensity to say this one by virtue of profiling tells the truth, this one by virtue of profiling does not tell the truth. So the quantum of proof or what they need to provide at the table is humongous and that kind of subtly comes in as you are having the actual forensic investigations, then you find forensic teams that are not transformed in themselves.

ADV NGCUKAITOBI: The example that you went to Durban for yesterday where the investigators told your client, it does not matter, the outcome will still be the same, that is a black doctor, what is the name of the scheme?

EBBIE IHEANYI: Discovery. So you find that in as much as you want them to at least go and review the 2016 audit in order to come up to say, probably we will not – we will disregard that for certain reasons, before we even leave the forensic investigations, someone says the investigations outcome will still be the same. So inasmuch as it is not said or it is not articulated on paper, there is certain feelings that you now see this physiotherapist is now an outlier and they are asking the physiotherapist to say but no, the referral notes and the entire hospital

has got the same referral system, but they are asked to say that in addition to the doctors having a referral file in the hospital file, you still need to either take a photo or you still need to make a copy of that particular and have it in your records. So it feels like there is an administrative burden on this small practice and it comes across to say if not for race, what else? Thank you chair.

ADV NGCUKAITOBI: Thank you, Ms Klinck will this be all or will you still have more?

MS ELSABE KLINCK: No, this is it. Thank you very much for bearing with us.

ADV NGCUKAITOBI: Thank you. It remains of me then to thank you, Ms Klinck and your team, you have really helped the work of this panel and we may be sending further enquiries on further information especially on some of the underlying evidence that you were presenting, but that will be done via our secretariat. Thank you, the inquiry is then adjourned until 13:00.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Good afternoon we are continuing the Section 59 Investigation this afternoon, we will be hearing from HealthMan. Will you please introduce yourselves gentlemen?

MR CASPER VENTER: Okay, good afternoon to all. If I can introduce ourselves, it is on the slide there. My names is Casper Venter. I am the managing director of the business and been involved for many years. Mardi Roos, heads up our investigations but she is not

available today, so I will be taking it. Then on my left-hand side we have got Mr Peet Kotze. Peet does most of our data analytic work, he is an accountant by trade. Then on the left we have got Mr Julian Botha who is our internal legal adviser, so should anything come up on the legal aspects, you know, which we are actually not dealing with in our presentation but was in our written submission. He will answer that. And on our right we have got Mrs Brenda Gous who is our coding expert, having spent 30 years in coding at MediHelp so we are going to deal a bit with coding, so if there is any specific issues that you might have, she may be able to respond better.

ADV TEMBEKA NGCUKAITOBI: Thank you. So who will be talking?

MR CASPER VENTER: I will do the original presentation – the full presentation and theirs might be limited to one question that I do not have the answer.

ADV TEMBEKA NGCUKAITOBI: Alright, so maybe let us take your oath then. So you are Mr Venter?

MR CASPER VENTER: That's correct.

ADV TEMBEKA NGCUKAITOBI: Will you – are you happy to take the oath?

MR CASPER VENTER: Yes.

ADV TEMBEKA NGCUKAITOBI: Alright, so you just say after me, I and your full name.

MR CASPER VENTER: I, Casper Venter.

ADV TEMBEKA NGCUKAITOBI: Hereby swear.

MR CASPER VENTER: Hereby swear.

ADV TEMBEKA NGCUKAITOBI: That the evidence I am about to give.

MR CASPER VENTER: That the evidence I am about to give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth, the whole truth and nothing else but the truth.

MR CASPER VENTER: Shall be the truth, whole truth and nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: Raise your hide hand and say so help me God.

MR CASPER VENTER: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. Thank you, so you can continue then.

MR CASPER VENTER: Okay, so if I just look at the agenda, the items we would like to cover today is a bit of a background to HealthMan that we spoke about yesterday and the societies and how they all fit into each other because this is very much a combined effort between everybody. I would like to deal a bit with the HealthMan experience in doing a forensic support. Why do the investigations take place? What is the investigation review process? Problems experienced, data analysis which was alluded to yesterday as well. Then a very important part for us is coding. You know, that is – we would like to deal with that and we have pushed it to the end. And then our view on the way forward how we can make things work. If I look at SAPPF, SAPPF is a multiple – has multiple members across many societies and that is a brief summary of them. If we look at the governance structures of SAPPF itself, it has a board of directors with

Dr Archer as the CEO, a surgical division, a consulting division and each one of them nominates four or five directors to the board and then on the support side, we have various other disciplines that participate. So all in all we have about 7 000 members in SAPPF. SAPPF on its own basically deals with regulatory issues and do not get involved in any day-to-day issues. So it is all regulatory issues that is dealt with and if one looks at the disciplines you will see that both on the surgical and consulting side it is very complete list of disciplines and those would be the disciplines that have access to us if they should have any forensic issues, you know, those members are entitled to come to HealthMan for assistance. And what I thought, just to show you how a specific discipline – and this is generic across most of the disciplines work, you have a society at the top, you have a public sector component, a private sector component and then various sub-specialties and as Dr Kok said yesterday, it is in the area of the sub-specialities where there is often confusion or especially in the profiling area because those people are not identified. This is specifically a gynaecology, the society at the top that has about 700 members and then there are management groups, so the differentiation between management groups and the societies is the society looks after ethics and CPD and training and the management group looks after the commercial aspects dealing with the medical schemes, looking after coding, member queries and so on. They would subcontract that work to HealthMan and HealthMan on its side then consults to SAPPF on whatever matters comes up and then each of these groups have a

variety of consultants that they use in various aspects and I am not going to go through each of those. So the gynae focus, for instance, for the past two years is on better obstetrics, the new focus will be on better gynaecology, so a lot of quality stuff coming out of that. Just from the HealthMan's side, just so that we understand, we have been around since 1996, we are a private healthcare consultancy company. Important, we have no external shareholders and we do not consult to medical schemes, administrators or hospitals, so our total consulting base is private practitioners, you know, we only work on the one side being the practitioner side. The directors, myself, Ernst Ackermann, who is in Cape Town office, an attorney, Mardi, that I have alluded to and then Peet that is sitting next to me, 55 support staff and then offices Jo'burg and Cape Town and similar to the SAPPF sort of footprint is the HealthMan footprint of the various societies that we represent and I think important at this stage, we represent a group, a discipline, a society, we do not have individual members. So if you look at our profile, we would have 26 clients and we report to their board of directors and their board of directors gives us in terms of a service level agreement certain tasks to perform and forensics being one of them. So if we – look, I am not going to go through any of other services but on the forensics side and the legal support. Okay, we support our clients in the forensic reviews against them by medical schemes, administrators and then the HPCSA. I must add that the HPSCA ones are very far and few, probably every five years or so, not many of those that comes up. And then we participate in various fraud

management units being the BHF. So one of our staff members sits on the fraud management unit of BHF. I previously did as well. And then the people that we interact with really are the four major administrators, Discovery, Metropolitan and MedScheme and then GEMS is always seen as business unit by themselves. We do get the occasional enquiry coming or – not enquiry coming to us but that we have to deal with and that would be Kabeka and then occasionally a firm of attorneys somewhere that is been tasked to look at a specific matter. So just to talk a bit about our experience in forensic reviews. You know, so first of all I would like to give you a historic perspective of what has happened over the years. Now one has got to look at it that I am talking about a process of eight years and things have evolved so if I look at the initial experience with forensic reviews, it was very confrontational and there was no trust between the various parties, always confrontation, a lot of agro. In those, our view is definitely that the – and if I talk about doctors it is generic practitioners because we work with other disciplines as well, physiotherapy, OT's and so on. The practitioners really felt threatened and many just signed acknowledgement of debts and I think it was their lives got to carry on, you have got to take the position – if a doctor, if he is got a forensic review, he feels very embarrassed about it, you know, because it is called the forensic review. So that is – just signed a lot of it prior to our involvement. Doctors are embarrassed, so the early day investigators were in my view not very experienced, they do not come out the field that the understand the healthcare and invariably they

might not have had forensic experience, you know, it is a skilled area to work in. Our view, a lot of bullying tactics initially, e.g. the meetings were recorded, sound and visual recordings were done of the investigations and initially doctors were not always informed, you know, that it is recorded or it is been visually recorded as well. But the process has matured now, I think things are going a lot better and I think from our side, as an organisation, we have good relationships with all of the units. The Metropolitan one is very new, so not a lot has come from that but a longstanding with Discovery and MedScheme and even with GEMS, you know, carrying out these reviews. So if one looks at an overview of all the investigations that were done in the past, probably five, six years, you know, one's got to look at it. So if one looks at the provincial mix of it, one would expect Gauteng to be at the top, so Gauteng 139 and I have given you the sort of mix, the race profile across those – across Gauteng. The second highest number is KZN. So you will see in KZN – and that is because of the doctor population there, we have had 54 investigations, Indian practitioners. The Free State 32, the Western Cape 32. I think size-wise the Free State is a bit high in relation to the population that it has there, North West 14, Mpumalanga 10, unknown where we just do not know where the people are, 3 – ag, 5. Limpopo, Northern Cape and then sundries. So in total over this period we have been involved in 320 investigations against practitioners of all disciplines and I will refer you to the various disciplines that we have looked at and then you will see the totals obviously at the bottom of it, so 95 black practitioners, 97 Indian

practitioners, 122 white practitioners, coloured only 4. The coloured ones is of course also difficult because we have to base it on the surname, that is not always easy to understand and allocate it. And the unknown is where we really just do not know. You know, we have not met the people, they are not on our database and - you know, but nonetheless we have recorded it. Now dissimilar to a ...(intervenes).

ADV KERRY WILLIAMS: May I interrupt, Mr Venter, and just ask a question?

MR CASPER VENTER: Sure.

ADV KERRY WILLIAMS: Where – what is the total population of your clientele – I suppose what I am trying to ask is where – who comes to you to assist with investigations and what are the demographics of that group just so that we can make sense of this table?

MR CASPER VENTER: *Ja,* at this stage with the time that we had available and sort of only realising yesterday what is of interest, you know, we have not done that per discipline, of course, and you will see the disciplines. So for the psyches that presenting on the 29th, we have done it, and you will get that, I am going to show you that and with the physicians that was – yesterday it was done because I presented by themselves. We will provide it to the Commission, if that is what you want but we will have to get each society's - just their consent.

ADV KERRY WILLIAMS: Please, thank you.

MR CASPER VENTER: Which they will give.

ADV ADILA HASSIM: Thank you. Thanks and can you tell us over

what period these investigations are done?

MR CASPER VENTER: Look, this would be probably about a six year period, so about 50 a year. At this stage it seems to be escalating a bit, and so we are getting one every second day at least. So that is a six year period.

ADV TEMBEKA NGCUKAITOBI: I want to just ask a couple of things about these figures. What is the baseline number that you are working from? I mean, the total is 320, of what?

MR CASPER VENTER: No, 320 and in some of the detail you will see – so it is 320 investigations.

ADV TEMBEKA NGCUKAITOBI: Yes, but of what is the potential pool that could be investigated?

MR CASPER VENTER: That would probably 3 000. We will have to get that demographics for you, we have not extracted that.

ADV TEMBEKA NGCUKAITOBI: 3 000.

MR CASPER VENTER: At least 3 000 specialists.

ADV TEMBEKA NGCUKAITOBI: Specialists, yes.

MR CASPER VENTER: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Now out of that 3 000 specialists, what is the racial breakdown?

MR CASPER VENTER: No, once again that we will have to pull, we do not – we have not done and as you would have heard yesterday with Dr Kok we *do not* actually record it, so when we did the physician one for yesterday we actually sorted the surnames, you know, because it is not on the application forms, so no society has it as a requirement and

we do not have it but you can guess from surnames, more or less, it is a 90% accuracy. So that can be done.

ADV TEMBEKA NGCUKAITOBI: Thank you.

MR CASPER VENTER: Okay, if we look at the investigations, the 320 per the various administrators/medical schemes, you will see that the most has come from Discovery Health. I have been at it the longest as well and you will see the racial mix on that, you know, being 36 black, 58 Indian and 81 white. That makes up the 179. The MedScheme one – and then also remember that these are members that come to us voluntary, you know, they do not have to come to us but if they come to us voluntary, we will assist them as part of our mandate with the society and it does not cost them any money, you know, so it is a worthwhile service but it is a voluntary one and, you know, when the process start – and I will talk a bit about the processes, they have got to give us a mandate and in the mandate we will specifically tell them what we are going to do. Okay, so MedScheme 72, GEMS on its own, 46, Metropolitan a lot less, 10. They have got a new unit, it constantly changes but one can probably add the 46 GEMS to them because the GEMS forensic unit works in Metropolitan. Then Medihelp – the other schemes, not a lot, you know? And it is, I guess, a reality that the smaller schemes that is self-administered or smaller administrators just do not have the skills or the capacity to deal with these investigations. So that is the mix per administrator scheme. Okay, if we look at our distribution per discipline. So we have the psychiatrist right at the top, 119 and I am going to show you some of their details a bit later. You

will also hear about them in a lot more detail on the 29th when Dr Talatala is going to lead some evidence on that. The GMG is gynaecology, 46. The reason it is high is it is probably the largest surgical group, they have got pretty much over 600 members, you know, so that is the CPF, it is clinical psychologists, you can lump them with the psychiatrist to a certain extent because it is a time-based discipline. General surgeons, 24, the physicians, yesterday, the 22, ENT surgeons 19, GP's 13. We do not have a big client base in the general practitioners, it is sort of 280 clients and it is been quite limited, the ones that we have had to attend to. Then paediatricians, ophthalmology, very few ophthalmologists, neurologists, 8, but there is probably only 80 in the country. SIII is audiology, we have had a few of those but not a lot, it is limited. Radiographers, ATSA is dieticians, the Neurosurgeon Society, a small number, urology, dermatology, one ocularist, one occupational therapist which was from Bloem. The plastic surgeon is an unknown because we have only dealt with this survey in the – ag, request in the last week, it is a new client of ours from the 1 July and we do not have their database yet and then only one optometrist who was from Nelspruit. So that is sort of the mix and you will find that the tendency is that time-based disciplines are the subject of most of the investigations because the other ones is a bit more complicated because coding is a lot more complicated than the other disciplines but a time discipline is quite straightforward, you are selling minutes, you know, it is an easy one to actually pursue. FCPSA, I have purely kept in here to keep our documents complete but

we have dealt with it so we *do not* have to go back to it today. Psychiatry, this is where we spend most of our time. So you will see our investigations – I have started with the demographics of our psychiatry group, so it is 284 psychiatrists and it is split 64 black, 147 white and this is in the management group and not the society, so the society would have 500 members but only people of their management group has access to us and our services. So that is the membership split and I guess important in all of these cases the management groups and the societies, they are all voluntary, you know, it is a voluntary, so – and we can never get stats, how many people are not members of the societies because it is not available at BHF for the PCNS and it is not available at the HPCSA either. So that is our membership on that one and it is sort of a membership like that that we can give you on other disciplines if you require specific – perhaps the big one, the gynaecologist, but not – you know, the small ones where it is only been three or four, it is not really going to add a lot of value. Okay, so if we look at the split in the psychiatry investigations, most were in Gauteng, 26 in KZN and then the rest, the split as well you can see there is 45 black practitioners, 40 Indian practitioners and 34 white practitioners. If one looks at this slide, similar to the FCPSA one yesterday, so it has the number of investigations and then the number of members investigated. So if you look at let us say the black practitioners, 23 practitioners with 45 investigations and you will see it is all over. So in the psychiatry field except in the coloured one, there are multiple investigations against the practitioners, you know, and in

some of them it is not multiple investigations but quite a few repeat investigations, you know, a practitioner was investigated five years back and now he comes back for another investigation for pretty much the same thing, you know, same type of errors, coding errors, time-based and so on. So the psychiatry is probably 90% time-based is the issue, you know, that we have to deal with.

ADV KERRY WILLIAMS: Just to take you back, sorry, to that slide, if you are still on it. *Ja, ja.* So there does seem something odd about this because it does look like – if you look at the bottom row, that black and Indian psychiatrists are disproportionately investigated.

MR CASPER VENTER: Or this is a – you know, this is how it comes in.

ADV KERRY WILLIAMS: *Ja.*

MR CASPER VENTER: You know, just remember, on this, everybody. So if you do a time-based investigation you look at all 400 psychiatrists, you know, it is quite easy because you purely add up the codes, you add up the minutes, so everybody will be reviewed in one go and you know what tends to happen, the way - a lot of the investigation goes in cycles so you would do it three years back and you would do it another three years later but – and there is a lot easier to review everybody and then you extract the ones where the time is excessive and this is the result of that. You know, so it is purely – it is a numbers game.

ADV TEMBEKA NGCUKAITOBI: I just want to follow this because, you see, the member demographics has to be compared with the investigation demographics. Now on the white side the member

demographics is 147 and the investigation demographics is 34. Now if you look at the Indian demographics on the members' side, it is 66 and 40 investigations and that is an astonishingly high number and the same thing with the – black means African, I presume? That Is 64 people and you compare that with the demographic of investigation, it is 45.

MR CASPER VENTER: 45 investigations, yes, *ja.*

ADV TEMBEKA NGCUKAITOBI: Investigations, *ja,* but this has a population of only 64.

MR CASPER VENTER: *Ja,* but you have to look at ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: It has to be higher than ...(intervenes).

MR CASPER VENTER: Practitioners is 23.

ADV TEMBEKA NGCUKAITOBI: Yes.

MR CASPER VENTER: But the investigations, as I said, it is multiple.

ADV TEMBEKA NGCUKAITOBI: Yes. No, it could be multiple in this. But, I mean, the baseline figure there is 64 in total and 45 in total on the investigation side.

MR CASPER VENTER: So as an example – sorry ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: *Ja,* no, I mean that means there would have been 45 investigations as against a population of 64.

MR CASPER VENTER: 45 – *ja.*

ADV TEMBEKA NGCUKAITOBI: *Ja,* 45 against ...(intervenes).

MR CASPER VENTER: So 64 members went through 45

investigations, yes.

ADV TEMBEKA NGCUKAITOBI: Ja and the same with the Indians. It ISs 40 members went – sorry, 66 – out of 66, 40 went through investigations, there could have been multiple investigations per person.

MR CASPER VENTER: Yes, that is correct.

ADV TEMBEKA NGCUKAITOBI: And then you look at the last number, it is 147 and only 34 have been taken to investigations on the one side.

MR CASPER VENTER: *Ja,* you must remember that is the result of the data analytics, you understand? If the data analytics comes up positive then that is so. You know, it is a numbers game, you do not know it in advance but just to get back to that 45 investigation, there is one practitioner has been investigated five times, you know, and the bulk of these actually come out of GEMS, you know, and that is a GEMS profile, unfortunately. So we pick it up as a number, numbers game.

ADV ADILA HASSIM: Sure, we are just trying to make sense of the numbers and what the numbers are showing.

MR CASPER VENTER: *Ja.*

ADV ADILA HASSIM: Then if we did not use that figure because there are multiple investigations and if we just looked at the next row, which is the number of members that are investigated ...(intervenes)

MR CASPER VENTER: Yes.

ADV ADILA HASSIM: It tells a similar story.

MR CASPER VENTER: Yes.

ADV ADILA HASSIM: 23 out of 60 all black, 25 of 147 white.

MR CASPER VENTER: *Ja,* those are the facts.

ADV KERRY WILLIAMS: So you say it is just a product of the data. Please just explain to us how you put this together then because I am trying to understand, the bottom row says:

"Percentage of individual members investigated per race."

Right? So I understand that is the total – that is the results effectively of all the preceding slides.

MR CASPER VENTER: Yes.

ADV KERRY WILLIAMS: So you can see 35.9% of black practitioners are being investigated, 37.9% of Indian and 17% white, okay? But that is investigated. Are you saying this is not investigation, this is just what the flagging system produces?

MR CASPER VENTER: No, no, this is investigations.

ADV KERRY WILLIAMS: It is investigation?

MR CASPER VENTER: *Ja, ja,* formal investigations.

ADV KERRY WILLIAMS: Okay, good. So why are you saying it is just a product of the data analytics.

MR CASPER VENTER: Because on what initiates the process is a set of data, so it would run – and I *do not* know how the Discovery analysis works or the MedScheme data and so on but one assumes, you know, it is data analytics, you are pushing all the practices and it would be 100% review of practices, there is formulas that adds up the codes and time and it produces a result for investigation and they would obviously also look at – I mean, if someone is 10% out of the norm, no. If

someone is 50% out of the norm, yes. So in this case, just remember in – so psychiatry, I would guess 90% of their work goes through three codes. So it is a consultation and then a short psychotherapy, a longer psychotherapy and an hour's psychotherapy. So if you have 20 patients per day having a 2975 long term – a long psychotherapy does not add up because you cannot. Those are the numbers. You know, so it is – this is an easier one than a surgical discipline because it is minutes that shows your variance.

ADV TEMBEKA NGCUKAITOBI: Thank you.

ADV ADILA HASSIM: There is something that is – would you agree that there is – the outcome is racially biased.

MR CASPER VENTER: No, it is not biased because you work on the input. On the outcome ...(intervenes).

ADV ADILA HASSIM: *Ja,* outcome shows that there are more investigations (indistinct – microphone not on) black than white.

MR CASPER VENTER: There is more investigations but it might be that the profiles indicated these practitioners for investigation and it indicated less in the white provider side to be investigated. Just remember it is a number.

ADV ADILA HASSIM: No, no, it is a numbers matter.

MR CASPER VENTER: *Ja,* but the results of that is – but that is what your analytics indicates. Cannot get away from that.

ADV TEMBEKA NGCUKAITOBI: Yes, I think you should continue.

ADV KERRY WILLIAMS: Yes.

ADV TEMBEKA NGCUKAITOBI: We are now on the slide with the

percentages, correct? Oh no, sorry, on the slide.

MR CASPER VENTER: So we are now going to look a bit at the – why the forensic reviews take place and should you old enough to know this investigator, you know, should have put him onto forensics. Okay, the one that we debated quite long yesterday is if you deviate from the norm or average of your peers. Now as was said yesterday, it is undefined, you know, it is – you are told that you are outside the norm but you never know what the norm is or the average is and that is a criticism of the process and even we do not get access to that data either, so you have to look at practitioner on its own. So what we are now trying to do as a follow-up or counter to that is to get our own data and say well, is that in fact true so we did a test run for the psychiatry with claims data where some of them was indicated to be outside the average, the norm or the peers and the data that we received independently indicated it is not so. You know, so that is a process that is a bit that initiated that a bit difficult and Dr Kok did say, you know, especially when you get into the sub-specialties, well, what is the norm? In the gynaecology there is about eight sub-specialties, you know, in the paediatrics there is – so there is a lot sub-specialties. In the psychiatry not really. So this is – and I do say allegedly not rendered but claimed for because one does not know that up to the stage that one actually do it and what would happen is the forensic investigator would send a list to the doctor or practitioner and say the following patients say they did not see you. You know? So that leads to an investigation. The level of acuity, so quite a bit of debate about

the level of care that you receive and, you know, whether it is in the high care ward or whether it is in ICU. So what happens is the hospital bills at that level of care and the doctor bills at another level of care, you know, and there is a dispute. Okay, there is a dispute, so we are going to investigate. Can I perhaps just backtrack and Peet can correct me. In the psychiatry, I think 55% of our investigations, 55% in the number came to a zero. You know, there is no – nothing, so it was closed off, the files, no recoupment you know, so there is a high percentage that actually – so even the numbers are high, you know, a lot of them ends up with doctor, you are okay, you know, so – and that is by consensus with the investigator. So it is a bit of unnecessary then, but nonetheless, just want to – I forgot that one.

ADV KERRY WILLIAMS: That just suggest there is something wrong with this – the data, the data that is putting out these numbers.

MR CASPER VENTER: No, the data is that the investigations were carried out, it is either acknowledgment debt or the file is closed.

ADV KERRY WILLIAMS: Could you repeat that?

MR CASPER VENTER: So the investigation started, that is the investigation, we have done our reviews, the scheme has done their reviews, we either agree or disagree, there is acknowledgment of debt signed or the scheme agrees that it is not a valid investigation and the file can be closed. Also not guilty, if that is easier.

ADV TEMBEKA NGCUKAITOBI: I think *ja,* we accept that.

MR CASPER VENTER: Okay. So then ... (intervenes).

ADV TEMBEKA NGCUKAITOBI: So it is 55% comes back with 0?

MR CASPER VENTER: *Ja,* in that also 122 cases in psychiatry so it is … (intervenes).

ADV TEMBEKA NGCUKAITOBI: So I just want to understand that 50, if we are looking at … (intervenes).

MR CASPER VENTER: That's correct, yeah.

ADV TEMBEKA NGCUKAITOBI: Your figures just to make sure we understand. So it is out of those flagged for investigation. That would be the two other slides?

MR CASPER VENTER: *Ja* and that is in the report that will be presented on the 29th. So a high percentage of those investigations were settled without any sanctions or repayments.

ADV TEMBEKA NGCUKAITOBI: Yes.

ADV ADILA HASSIM: With an acknowledgement of debt? Sorry.

MR CASPER VENTER: No without.

ADV ADILA HASSIM: Without?

MR CASPER VENTER: *Ja.* 45% ended up in an acknowledgement of debt.

ADV TEMBEKA NGCUKAITOBI: *Ja.*

MR CASPER VENTER: Or something else.

ADV TEMBEKA NGCUKAITOBI: It's out of what that 55%? Just to make sure I understand.

MR CASPER VENTER: Of the investigations.

ADV TEMBEKA NGCUKAITOBI: Of your slides, which ones?

MR CASPER VENTER: 122.

ADV TEMBEKA NGCUKAITOBI: 122.

MR CASPER VENTER: Or 120.

ADV TEMBEKA NGCUKAITOBI: Or the 120, so that is the slide at page 7.

MR CASPER VENTER: Well, let us quickly have a look at the page. *Ja,* that is the total number of investigations is 120.

ADV TEMBEKA NGCUKAITOBI: Yes. So 55% of that would be?

MR CASPER VENTER: 55% of them ... (intervenes)

ADV TEMBEKA NGCUKAITOBI: Zero.

MR CASPER VENTER: Were solved.

ADV TEMBEKA NGCUKAITOBI: And then the rest will be a sanction of some sort?

MR CASPER VENTER: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Alright.

ADV KERRY WILLIAMS: Could you also provide us with racial demographics of those that are found not guilty? This approximate 60 something, I think that will be helpful.

MR CASPER VENTER: I am not sure if we have all of that because occasionally we leave it up to the scheme and the provider but we can have a look prior to the 29th.

ADV TEMBEKA NGCUKAITOBI: Okay. Now just to make sure I understand this, so we have got the 55% that is been forgiven, we have got the 45% that has a sanction of some sort.

MR CASPER VENTER: *Ja.* No, that 50, oh sorry – 55 not forgiven but its assumptions were wrong.

ADV TEMBEKA NGCUKAITOBI: Yes but the investigations was wrong,

it has found nothing.

MR CASPER VENTER: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Yes and then the 45 … (intervenes).

MR CASPER VENTER: And it can be say- sorry if I interrupt.

ADV TEMBEKA NGCUKAITOBI: *Ja* it is fine.

MR CASPER VENTER: It can be- you do not want to hear it, the number is going again. We had as an example two weeks back where the investigation started off, doctor there is a day that you actually spent 49 hours with patients. So when we looked at the date and know it was compiled and correct and it ended up at 8 hours. Can I say it is going to be closed? Okay, if I can perhaps give you that answer. I got to put on specs again. Okay in 35 cases anomalies were found and the doctor had to refund, so that 34 to 28%. And then in 66 audit cases, so 55% of the cases no anomalies were found and the medical schemes accepted the feedback and explanation that gives you the 55. And then 13 cases the doctor referred their audits to lawyers and we did not carry on further and I must add that is the wrong thing to do is to take it to attorneys. That is with respect to the legal profession because they come at it from a non healthcare … (intervenes).

ADV TEMBEKA NGCUKAITOBI: *Ja* well, as long as you are talking about attorneys that is fine.

MR CASPER VENTER: *Ja.* I would not go to advocates

ADV TEMBEKA NGCUKAITOBI: I understand it.

MR CASPER VENTER: And then 7% were still in progress – ag 705.8% so the data is available but we have not put the racial part to that.

ADV TEMBEKA NGCUKAITOBI: Alright. Just on something else on these numbers. So everyone gets investigated and what we know what the schemes do is either they will put you in direct payment at the commencement of the investigation or in the middle of the investigation or at the conclusion of the investigation, one never knows. So out of this 55% that has been found not guilty, in other words there was no basis for the investigation to begin with. Do you know how many were suspended during the investigation?

MR CASPER VENTER: We will have to look at that we *do not* have that statistic. And it depends- so if I take the Discovery Health environment whilst the investigation is ongoing, they not suspend you. So it carries on until we have it. Unfortunately in the MedScheme initially when investigation started, payment was suspended until it is concluded. But in the Discovery one they do not suspend except if you now take 9 months to come back with an answer, of course, then that will happen or if it is an obvious fraudulent transaction. But the ones that we deal with is not suspended.

ADV TEMBEKA NGCUKAITOBI: Alright. Thank you.

MR CASPER VENTER: Okay, we are back to our friend. Okay so if you deviate – so the level of acuity does lead to problems and you know what happens there is that the schemes would also say that doctors put patients unnecessary into ICU. Your ICD-10 does not indicate it but it is a reality because they are concerned that often the level on nursing is not adequate and it is risky especially with the neonate babies, they end up 100% in ICU. But that is sort of a problem

that we generally can solve. Then I put the next one in red because I guess this is 80 or 90% of our work is alleged coding irregularities and we have heard Dr Unben Pillay make comments about coding and I am sure other people have made coding but we will tell you the other side of coding and why it happens. So the reasons for it and I am going to- we are having a session on coding. Its combination of code is incorrect so you will use two or three codes in a combination and it is not appropriate, you not allowed to use it correct. Up-coding or unbundling, so the unbundling would be let us say a new replacement an you try and eight – add eight or nine codes to it so that is the unbundling. The up-coding is to go to a higher level of code so if you see the patient for 40 minutes, you charge the 60 minute code, that would be the up-coding just take it to a higher level so the up-coding and the unbundling two different issues. In the surgical environment unbundling is very complex and very few people understand it hence we bring the coding experts on to it. And then the incorrect application of certain codes, there is a big dispute between the medical side and the funders for example about what is an emergency. So if you run a casualty unit and a person stops at the casualty unit, is it an emergency or not? And as far as the doctors are concerned you come to casualty because you have got an emergency. So what the investigators would say, well if I look at the ICD-10 it did not end up in an emergency but it is the perception. I go to a casualty because I really feel frot you know sick and what do you do if you have got a child, you take the person to the casualty. There is a lot of debate

about that and that is specifically was our GP one which was a casualty unit of 20 odd doctors and it only runs as a casualty unit. But so interpretation is often an issue. Patient complaints, patients do complain about services were not rendered or they were overcharged. Now forensics does not really work with overcharging except when it gets to certain consumables and devices, hearing aids and so on. But services not rendered, the doctor did not see me and that obviously has to be followed up. It is not always the case because the patient might have been in ICU. It might have been that it is a doctor that is on duty for the weekend and the doctor sees all the patients especially in psychiatry you would back-up and you will not always know but that does happen and one deals with it. Total time spent per day, very relevant to time based disciplines, it can be GP, psychiatrist, clinical psychologist, that is purely times based type of disciplines. I am sure one might find it to a certain extent in physiotherapy as well but we *do not* deal with much physiotherapy. Fraudulent behaviour including collusion with patients, we see that a lot in the press. You get a service but you actually did not get a service and you split money. Those fortunately do not end up with us, a doctor that is involved in those would not come to us that is – and then the consistent use of longer time based codes and group codes, we see multiple patients in the psychiatry area you will see a group therapy of patients and it can be 12 patients in a go so often what the schemes do then is they add all 12 patients codes, tie them together and you end up with 49 hours. So it is a bit of a contentious one. Doubts about the scope of practice,

how investigators will tell the good doctor and we heard Dr Kok yesterday, we going to investigate you because you not allowed to do an echo or for a Gynae on why are you doing ultrasounds. Well, all Gynaes do ultrasounds but we have had investigation on gynaecologist doing ultrasounds saying it is outside the scope of practice and that invariably leads to and I talk about fishing expeditions a bit later, please send us your qualification, please send us a letter from your professor that you are adequately trained to do that. Well, if you are registered you are probably adequately trained and especially if you have been in practice for 20 or 30 years. So scope of practice not often but it does happen. So what triggers these and the first one is the administrator data analytical review, that is what triggers it but they do also have other type of reviews. So you will do clinical audits as well so it is not only a data analytical, they will do clinical audits as well. Hotlines, whistle-blowers, typical large administrators do have that. Then rule based detection software and internal controls, so that is where you look at clinical aspects. Internal forensic often innocent errors can trigger- so you have made an error and that then leads to full investigation of your practice and Mr Kotze and I have seen that when we look at the capturing of data. You capture a 6 instead of a 9, it leads up in a total different code. Outside your scope of practice, then they look at your whole practice. Those finger errors happen in coding quite frequently as well. Then routine audits, so they would a routine audit so one typically finds that investigators would decide let us go and have a look for the next 6 months at Ophthalmology. Let us

see what do we see, what trends do we see in ophthalmology or not or psychiatry or they would pick on a specific code. So our problematic codes would be 1046 and 1047 which has debatable definitions to it. So they will draw everything with 1046 or 1047 code and look at it all the application of rules. That is also rules and we will speak a bit about the rules in the coding session. Then we back to the deviation from the normal profiles compared to peers. They will give you an easy one in psychiatry we had one that probably took us 6 months to solve in the end where a specific psychiatrist only had one hour consultations, that is it. They said, well if we look at your peers they have got 20 minute, 40 minute, 60 minute but this is the way the practice works. This specific practitioner does not hospitalise patients but does psychotherapy in rooms. But now you different form your peers and it was a long, it was really a battle to solve it but we did and there was no repayment on that. In combination of codes, there is wrong combination of codes and you will see coding is quite complex and then the high normal utilisation of specific codes. These are all sort of analytical one, they would pick a code and see how many times have you used it, how many times has another practitioner use it so we have got a the specific one now for instance where I think it is a general surgeon that purely specialises in pain management so his codes does not look like the rest. That's his only thing that he does its pain management. But of course, you do not know that when you look at the numbers. You actually have to get the partition on board but then he has already received or she a letter of investigation. So I think what

one should do is and it is not now a recommendation is that you should differentiate coding reviews from forensic investigations. Coding reviews are less threatening and coding reviews will always happen. So I would personally split it and then involve of course people with extensive coding knowledge. So if I look at what is the HealthMan forensic review process ... (intervenes).

ADV TEMBEKA NGCUKAITOBI: Can you just tell me ... (intervenes).

MR CASPER VENTER: Sure.

ADV TEMBEKA NGCUKAITOBI: On the slide about what triggers an investigation. The Discovery report says that 53% of their forensic investigations start off as an anonymous whistle-blower.

MR CASPER VENTER: I cannot confirm that or not, it sounds high for me.

ADV TEMBEKA NGCUKAITOBI: Because you say that actually the highest is the internal ... (intervenes).

MR CASPER VENTER: Coding.

ADV TEMBEKA NGCUKAITOBI: Analytical reviews by the schemes themselves.

MR CASPER VENTER: *Ja* that is what I would assume but I am not- I cannot tell you what discovery or MedScheme does.

ADV TEMBEKA NGCUKAITOBI: *Ja.*

MR CASPER VENTER: So the whistle-blower does not sound right for me, it does not. And if you think about it, whistle-blowers would be very much I would guess where it is a fraudulent type of thing that is happening but it does not sound right. Okay. So from our side we

would receive a complaint from a member. We would request the mandate so we *do not* the work if the doctor has not agreed that we do the work and in order to do the work, we need full cooperation from the practitioner otherwise it drags on for months. We had investigations so we have really tightened up on this because we do not want to spend 9 months on an investigation. So it is quite difficult. Explain the process to the client, what we are going to do. We inform the investigating parties. So we would ask the practitioner to inform the scheme or administrator that they have appointed HealthMan and their society to do the investigation. We would then communicate with the investigation officer and or the department doing it. We try and determine as much as possible information and stuff upfront. If it is coding related and as I have said most of ours is coding, we would request an expert coding opinion. Now that coding opinion can be ours internally. We will always go back to the society as well and ask them their view on the appropriate to use other coding and then there are a few people out in the market that we use as expert opinions so we do get good view on that and we talk to the specific administrator schemes coding experts as well. But I must add I do not think you have more than 10 experts in this country that really understands coding, it is I think even some of the larger administrators have either one or two or nothing so it is a difficult one. So we will compare that expert opinion with the findings that we have had, we will validate investigating party calculations. So that is when we get to the data analytics and we will deal with that in a separate side. So we will do all the work in

separately and then compare our findings with the schemes and that is where we pick up anomalies. We will communicate the outcome to our client. We will meet with the client and then discuss the findings. Now when we meet with the client ... (intervenes).

ADV KERRY WILLIAMS: Mr Venter, sorry to interrupt. Can I just you a question about the coding and the expertise in relation to coding? Much of the evidence we have heard so far suggest that there is not any certainty around coding and if there is an expert you would think an expert would be able to give a certain view. But it is beginning to sound like to me that a lot of this is negotiated and is it there many pragmatic outcomes in relation to the coding. Would that be fair comment?

MR CASPER VENTER: No, I do not think that is fair comment that there is no certainty. It creates a lot of issues but there are rules applicable to coding, coding has been around for a long time, it is published, it is discussed, there are training workshops and so on. The dilemma that you have is that there is no formal training for a doctor in the academic part then you do your houseman ship or you become a registrar to specialise and right up to the day that you open private practice you have received no training.

ADV KERRY WILLIAMS: Perhaps ... (intervenes).

MR CASPER VENTER: And then you ask your colleagues and your colleagues have been doing it wrong for 10 years.

ADV KERRY WILLIAMS: Perhaps it is a starting point. If a young doctor or anyone in fact looking for the correct code starts his or her

search, what code do they turn to?

MR CASPER VENTER: What code?

ADV KERRY WILLIAMS: Yes, what is the documents name which gives the certainty?

MR CASPER VENTER: Okay, this is the starting point so this is the current 2019 Medical Doctors Coding Manual compiled by SAMA and reviewed by Specialists Societies, it is been around since I have been in the industry and it is updated probably every second year. So it is around and you can see it is quite a big one. If you go to the groups that we work with and I did send those documents to you on Friday. We produce specific booklets for each of the disciplines so a young doctor gets hold of this book and has a look at it and if all else fails phones.

ADV KERRY WILLIAMS: And do the schemes accept across the board that that SAMA Coding Manual is the correct manual to have reference to?

MR CASPER VENTER: *Ja,* when we get to the coding section you will see there is a lot of resistance from the schemes now, we will deal with that a bit later. A lot of conflict in that area but if one thinks about it coding is about clinical practice and coding is in the domain of the profession it is not in the domain of a medical scheme and even in the SAMA one, they did it from each of the specialists societies. And the process as always, if you want to change a code, update a code, we actually refer to a CPD being the American system, so we cannot change a code in South Africa, if that equivalent code does not exist in the CPD system which is the most comprehensive coding system

probably in the world.

ADV KERRY WILLIAMS: So is you submission we should accept that the SAMA Manual is the correct one and that is what brings certainty to coding in this environment.

MR CASPER VENTER: Yes it is the correct - I know it is the one that is in use. It is approved, there is a process to approve it. Does it have certain and I will speak about that a bit later as well. There are codes that should be changed. There are codes that should be reviewed. But it is the most current version and I will repeat it later but I will say it now as well. Many schemes default to 2006 RPL which is totally inappropriate and it cannot be used but many forensic reviews actually default to 2006 and say well 2006 this is what it said and that is 13 years later. So we are slowly convincing the schemes so Discovery to a large extent will follow this. We progressing very well with Medscheme but if I look at historic events that is happened, it was not accepted. But this is the bible.

ADV TEMBEKA NGCUKAITOBI: That is what I wanted to just explore in relation to what you are saying to my colleague. You are saying that as far as you are concerned there is a bible, it is called the SAMA code of ... (intervenes).

MR CASPER VENTER: Sorry, can you just repeat that?

ADV TEMBEKA NGCUKAITOBI: I mean as far as you are concerned there is coding bible.

MR CASPER VENTER: *Ja.*

ADV TEMBEKA NGCUKAITOBI: It is produced by SAMA, it is updated

every two years.

MR CASPER VENTER: *Ja,* two three years but it can occasionally be one – so it did have a break and I will get to that when the competition commission interfered in 2004 that led to a little bit of a break in the update but it has been updated regularly. And then the health market enquiry sort of also leads to a bit of a gap in updating but it is updated. But it is only updated if a specific specialist society requests it. So if you have a society that does not, it might be 10 years out of date but on balance it is the reference point to start on.

ADV TEMBEKA NGCUKAITOBI: Yes. Now we have a problem because on the evidence we have heard, the schemes do not accept that.

MR CASPER VENTER: Well, it does not mean they are correct if the schemes do not accept it. And I will go as far to say the schemes either *do not* accept it when it suits them, so I will make that bland statement. I have been through many of these investigations. When something does not suit them, you do not accept it but on balance we do not have problems at this stage at the acceptance of the coding and of the specialist discipline … (intervenes).

ADV TEMBEKA NGCUKAITOBI: Yes. Now the consequence …(intervenes)

MR CASPER VENTER: And to say that they do not accept it I think is not correct.

ADV TEMBEKA NGCUKAITOBI: Yes.

MR CASPER VENTER: It is not the truth.

ADV TEMBEKA NGCUKAITOBI: Now what those schemes will say they

do not accept the SAMA code. So you say they revert back to the 2006 reference pricing.

MR CASPER VENTER: *Ja.*

ADV TEMBEKA NGCUKAITOBI: But which is no longer applicable.

MR CASPER VENTER: It is no longer applicable and if I can just take it one step further in the 2010 court case on the NHRPL the 2007 to 2009 NHRPL were set aside by the High Court. 2006 is just a different version of it but the application to court was to set aside the specific versions that the department of health dealt with. So hence the 2006 which was produced still by the council for medical schemes but then also take into account that that 2006 is purely a version of the SAMA 2004. So if they accept the 2006 well then by implication you actually accept the SAMA 2004, a similar book which was then called a doctor's billing manual and that same manual 2004 is updated to 2006/9/12/15/18/19.

ADV TEMBEKA NGCUKAITOBI: Now the consequence of these schemes reverting to 2006 and from your perspective the SAMA 2019 coding book should be used. Is that the schemes have the power to approve the payment and they will not approve the payment if you do not dance according to their tune.

MR CASPER VENTER: If it is not according to their choice.

ADV TEMBEKA NGCUKAITOBI: Yes.

MR CASPER VENTER: Then yes, and that would be specifically certain things in psychiatry the coding and the coding descriptive have changed so the coding descriptive now is a lot more definitive, that

suits them so they will use it. In another case in another code that has been changed is not acceptable and we go back to 2006 and it might be a procedure that is no longer done. So if you look at coding currently there is a lot of procedures that is not being done at all and yet the scheme would accept that code because it is in the 2006. So it is an issue but there is a solution as well. So talk about coding. Sorry, belabouring coding but that does create a lot of the issues. Okay so just to get back … (intervenes).

ADV ADILA HASSIM: But it does not mean – sorry to interrupt you on the question again.

MR CASPER VENTER: No sure.

ADV ADILA HASSIM: And I know we are going to get to it. It does not mean that the use of one code over the other is an indication of misconduct by the doctor.

MR CASPER VENTER: No, in fact I would rather say using the old one is misconduct but it is the only way you going to get paid. Just to give an example, we have just recently done updated the gynaecology coding and what they have done is they have removed all those old things that doctors just do not do. They just do not do it in clinical practice but the codes are still there in the old version, now it is gone. But it is still in a lot of the administrators billing systems so if you look at the information that schemes send out December and January and we do get thorough copies of it as well. It still reverse to NHRPL it just means how outdated it is so and the NHRPL does not exist even but that is the reference.

ADV TEMBEKA NGCUKAITOBI: Now is there any consolidated piece of paper that a doctor will go into that say if you want to claim from Discovery that you can log on to a document and see what codes they want whether those codes mirror the 2006 reference pricing or whether they mirror the 2019 SAMA coding book.

MR CASPER VENTER: So each of the schemes do publish every year a list of codes and tariffs and so on but it is all electronically so it is available but if you do a procedure it does not necessary would say if you do a knee replacement, these are the codes that you should use for Discovery or MedScheme or so on, it should be consistent. What we try and do if you go into our own website, we can and publish the codes and tariffs for Discovery, for MedScheme, for Bankmed or not MedScheme – Bonitas, Fedhealth. So doctors – our members can go there and say well this is the relevant code, that is the tariff that I am allowed to charge, this is my contract. So there are things available yes. So it is not darkness but it is the different views on coding.

ADV TEMBEKA NGCUKAITOBI: Yes but I mean would you also agree that yes there is the problem of the different views but there is also the problem of the inconsistency by the schemes when it comes to which codes would be approved.

MR CASPER VENTER: *Ja,* I would agree with that.

ADV KERRY WILLIAMS: So there is some uncertainty?

MR CASPER VENTER: *Ja* but there should not be because it is a definitive matter, there is a code, there is a- and we will go through the … (intervenes).

ADV KERRY WILLIAMS: We do know your point that it should not be.

MR CASPER VENTER: *Ja.*

ADV KERRY WILLIAMS: *Ja.*

MR CASPER VENTER: Okay and then we present ultimately to the client, tell the investigator the outcome. So when we do a final discussion we will always have senior member out of that discipline that sits in so that there is no doubt about the outcome and the reasoning and the incorrect coding and then I guess especially in the surgical disciplines as to afterward especially if a doctor was wrong is to amend to that doctor and have meetings and discussions. So each of our conferences we do run coding workshops which Ms Gous presents and Mardie is present a coding expert from the discipline would be to try and teach the doctors how to code but it is not a nice thing to attend, it is quite boring, admin people attend to it and that is not correct, the coding is the doctors responsible. So if you look at the … (intervenes).

ADV ADILA HASSIM: Sorry, before you move up the slide, can you just tell us how long this entire process takes to come to the end point of negotiations.

MR CASPER VENTER: Well I did one last week which took four days. So that is an easy one because the scheme's assertions on that one was wrong from the beginning and I think that is why I call this is a fishing expedition. It was nonsense and the answers would lead to no conclusion but some of them- we like to do it in 30 days 30 to 60 but some of them 6 months, some of them just – I mean we have got two

investigations now and I do not want to mention schemes but this is a specific GEMS one where the investigator has not come back to us in a year on the issues. It is not so and we have taken it up with them now and with Metropolitan but so some can take more than a year and for the practitioner it is a year of misery because I am under investigation.

ADV ADILA HASSIM: Is the practice now in indirect payment in that time?

MR CASPER VENTER: No, well in GEMS would invariably pay all practices direct but they have investigation they would stop payment. But they only have contracts DSP type of contracts, now I am sure you have heard enough about DSP's as well, is they only have DSP contracts with about five disciplines now. And the GEMS environment they rolled it out about two per year because it is complex the contracts. And there of course I can divert back to the schemes and ourselves and the doctors. Is we try and where there is a formal contract that it is a contractual term that the scheme will adhere to the latest available coding principles even if they battle to sign it. You know, it is – because that is logic. How can you enter into a contract if you do not know in terms of what you will be paid? I mean, that is – so, if I would to get back to a 2006 NHRPL. It does not exist even. Where does a doctor go and find a practitioner in 2006? Now the disciplines that are extremely exposed are all the Allied Groups. The Allied Groups have not been able to update their coding. Schemes just ignore it. So they exposed fraud. Fortunately from the SAMA and the doctors and specialist and so on. Then a lot stronger than the Allied

Groupings to actually do so. So that is still a bit of a nightmare. Okay, so if we look at the type of analyses. We basically have two general types. You know, one is the time based code practitioners. So when we have a forensic query with a time based practitioner, we analyse a 100% of the claims data because it is the only way you can actually get to the total minutes that has been spent. And occasionally that investigation will take longer and it is a lot of line items to analyse. Then we have the other disciplines. Consulting and surgical. We end up with multiple queries on that. And there you tend to focus on the specific issue that is being raised. So if a specific code is been raised or combination, we only do that and it is very infrequently that you will look at those practices a 100% of their claims data because it is very specific issues that have been identified by the investigator but it still takes a fair bit of time and then trying to combine it, making sure the service date combination and all of those things are correct. So it is two very different ones. And then, of course, you also have issues with, as I have mentioned, devices, consumables, lenses and stuff like that which comes up. So if I look at a specific type of queries and I do not want to bore you with technical details. These are just type of issues that come up on a regular basis. So you have codes, rules and modifiers in the coding books. So a rule is specific. It talks about post-operative care. If you had an operation the doctor cannot charge any visits in the next 30-days. That is the rule. You know, so everything is for free. But, of course, then occasionally patients have complications and complications are not covered by the specific rule.

So we do have a fare type of queries in this regard. Now if the complications arises, it will have a separate ICD-10 code. So we get a lot of these. But I am not going to go through everything that we do because it is not just to indicate what happens. So a Rule L, for instance, would say – that deals with – if you do your patient's first visit at the same day you do the operation, you can charge for the visit. The next rule actually then goes onto to say. If you see the patient per day and you do the operation on Monday, you cannot charge another patient's visit. But things do change. You might have to. You know. So these are the type of issues that comes up. This is a more clinical one. And I will get to it later as well. Code 0129 adds units and tariffs. If you see a patient for more than 60-minutes. Now the problem is that you then have to charge it a combination of 0193 or 0175. Doctors do not record the 0193. They will either record the 0910 or the 0911 because medical schemes do not pay for 0193, 4 and 2 in any case. You know. So that is really an area which I am going to refer to later, where I think the schemes are erring to a large extent. All of them. There is not one that actually attends to it and this leads to a lot of queries. So, you know, the solution of course is that we have to have more detailed patient records on which we record that we have actually spent more time with the patient. This is a typically unbundling one which is very clinical. So I am not going to go through it. But these are the types of things that comes up with a combination codes, unbundling and so on and one needs to apply it but this is not something that a straight forensic investigator can do, you know. So

they need their internal coding experts and if the scheme itself does not have an external coding expert that is really of value, you know, it is always going to lead to a discipline and there is a whole host of these that happens. But once again, it gets back to coding. You know. So they do happen. When we start to look at data, these are the full fields that we have to look at data. And I have asked for a copy of this document to be provided to the panel. It is just one with a lot of columns which you do not actually even have to look at but it is an example. So with this specific doctor it ended up with 119 pages of data that had to be analysed. Now the normal practitioner in this position has no means actually to do the work and many schemes do not do it correctly, in any case. You know. So it is very difficult if it is a complexed review and you have to look at three years' data for a practitioner to respond to it or have any means to respond to it. And that is where, with respect, I said keep the attorney's out of it because they are not going to do it. They are going to find a legal argument to try and get out of it. But that, with respect, all they say is that they ai have very good friends with attorney. So, you know. So one should not say that in any case. But, nonetheless. So data analytics where it supplied by us or by your schemes. Quite difficult. I think especially in our dealings with Discovery Health, we now agree on data analytics. In a forensic review. But it took a few years to get there. But it is good in that and we share the data and so on. But only relating to the practitioner. I think if we get to the GEMS and the Metropolitan, their analytics at this level, will be non-existent, with respect to them.

ADV ADILA HASSIM: Is this the data that Discovery – that you and Discovery have agreed?

MR CASPER VENTER: *Ja,* this data that we then get from Discovery. They send it to us in Excel and this keeps Peet or Mr Kotze busy. And this can take a few days to do. It will be literally – it can be four or 5 000 line items. So if you send that to a practitioner and in fact you send it in pdf. What are they going to do with it? Throw it away and hope the problems goes away. So it is quite complex. So the data and analytics are really part of the process. In the time base we collected from the practice it is a lot easier. We try and agree with the practice data as well. Unfortunately, doctors do not always know or practitioners how their practice administration system works and it is a bit of a battle. So we will try and get the total date. We will try to compare it to other schemes and so on, as well. So it does work. Well, it takes a lot of time to clean it up. There are a lot of duplications. So in our initial reviews of scheme data a lot of duplications, you know, the same claimed twice, more than once. You know, that is working. And Peet – Mr Kotze has built models that we can identify duplications and incorrect codes. So it works quite well. So calculate the average hours. So the next item is – was contentious when we started. So if you have for example a 20- to 40-minute consultation with a specific code. What do you take? You know. So what the scheme originally did, they would take the maximum. So that of course will give you a higher number of hours and so on. So we have now agreed that when you do analyses like this, you must use the minimum. You must use the

min and the maximum and come to a compromise. The min being the compromise. Some of those administrators still battle to work with the min and they tend to use the maximum. And that is a good example of a doctor that works 49-hours. It is a typical example of where the data was wrong and it was in fact an 8-hour and not a 49-hour day. So we calculate the time. We compare it to the time billed for the practice versus what are available days. What are the days that you typically work? Now, of course, you do get doctors that are workaholics like advocates. You know, they work long hours every day and they work on Saturdays. You do get doctors that work 255-days a year and they work 12-hours a day. And there are some of those doctors. And you have heard from Dr Kock yesterday. She could at any time have fifty patients in ward to look after. Long days. The same with the psychiatrist. Time per day and analyses. We do it per code and then we have a look at the group sessions. You know, what is the impact of groups sessions. You cannot multiply it by twelve. You have got to take – divide it by the number of patients in those specific sessions. We also look at the unique patient scene. How many patients did this specific practice see. We look at the combination rule and look at the total annual sort of number of hours and minutes and so on. Now one of the issues raised and we did not specifically put in our reports. This is fact that the review are three years retrospective. Now that is quite harsh. So there is no current system that has a prospective review. So if you have rules placed system which most schemes do, it will pick certain clinical stuff up front but if you use a valid code system. It says

it is a valid code. It exists. So they pay for it and then when they do a retrospective review three years back, you have got a problem. So, I think in principle the three year retrospective is wrong. You know, at the most the current year and one year. Three years, I think, is quite harsh. A doctor carries on for three years without knowing something is wrong. And as you said what happens with a new doctor that is now three years down the line? It will basically be quite destructive on the system. So it follows a lot of processes. So we can see in order to get to an answer, at the end of the day, we go through a lot of processes in order to come to a finding that we discuss with the doctor. Other disciplines a lot more difficult. So you have the rules to look at. You have to look at the unbundling of codes. The 014, 5 and 8. And then multiple providers billing for the same service. So that occasionally happens that you have two doctors seeing a patient and they are both billed for the work done. Or you have, for an example, sleep studies being done and the technologist bills for putting up the equipment and the doctor bills for it. So that has got to be unravelled. Wrong NAPPI codes. The NAPPI system, in our view, is a bit of a waste of time but schemes do follow. The pricing in it is wrong. And you would often be investigated for the pricing on that. And that used code 0201. Currently happening a lot with the hearing aid industry and we have told them that it is not going to work. Questionable mark-up on materials. There is not regulation that say you cannot mark-up, let us say a hearing aid or an interocular lens. There is no regulations on it. And yet you would be reviewed for – perceived too high mark-up. You

know. Which is very difficult. So that especially in the audiology. Yes, there are some practitioners that abuse it totally. But there is a norm that you can use. But the NAPPI pricing is wrong. Then we deal a lot with the modifiers and so on. On this one, as I have said, often some of the reviews are fishing experience. And you all know what a fishing experience is. The judges do not like that and if you sort of actually do not know what to ask so you will ask useless question. So, Adri Kock yesterday was, you know, send us all your registration certificates. So we sent everything from Cambridge to South Africa. But how is that relevant to a forensic investigation? It does not make sense. Another one that comes through is send us your mal-practice insurance cover. It has got nothing to do with the forensic investigation. One we had two weeks back is: "Please send us confirmation that you have actually paid your suppliers of stuff." Why is that relevant? So if you have not paid, then what? It is the suppliers problem. And in this specific instance, it was that the supplier were already confirmed that they were paid. But they said that they wanted to see the payment. It takes it nowhere. So these fishing type of things. I can name another one that happened with a gynaecologist affair: "When last was your equipment maintained? Send us the last invoice when maintenance was done." You know, please. You know that are different issues. It is not – but, nonetheless. That is fishing and they did not catch anything.

ADV TEMBEKA NGCUKAITOBI: Can you just tell us? On your statistics and maybe you can note it for later. How many complaints are related to coding?

MR CASPER VENTER: 80%.

ADV TEMBEKA NGCUKAITOBI: 80%?

MR CASPER VENTER: *Ja,* 80 to 90%. *Ja,* it almost – *ja,* it is in fact 90% plus. So – because we do not deal with the ones where services not rendered. It does not come to us. So for the rest it would coding and interpretation. So, in fact, you can make it a 100%. Our typical problems are the medical scheme administrators make the rules regarding the investigations. I guess it is their right to do so. It is their business. They determine who should be investigated. And it might come out various ways but it is – I have to respond to that. They carry out the investigations themselves. It is not that it is every contracted to an expert in a specific field. They apply their own methodology. So, you know, I think what one should try and do. There should be a standard way of doing the work. A standard flow of processes. The way you deal with the analytics. The timing that you do with it. Everybody must not do their own thing. It makes our lives a misery and the practitioners as well. The initial letter to the practitioner can be very intimidating with unreasonable demands. And that still implies. Doctor, here is the list of things that we want. Please send it to us within seven days or please send it to us within in fourteen days. No, that is unreasonable. When that ends up with us, we will contact the scheme and we will adequate time to resolve that. But that initial letter I think should be a bit more accommodating.

ADV ADILA HASSIM: And are you then able to get that data from the practitioner?

MR CASPER VENTER: *Ja.* The letter?

ADV ADILA HASSIM: No. The information that the letter is requesting.

MR CASPER VENTER: *Ja,* we have got to get from the practitioner but occasionally it would be – let us say we will not and that is another debate – I guess we want 60 patient files.

ADV ADILA HASSIM: Yes.

MR CASPER VENTER: And now for a doctor to extract that 60 patient files is time consuming. They are busy. They also have to go through the files to see what in the contents. Invariable some of those clinical data will be in the hospital files. And the hospitals are not always that keen. So, you know, that is not appropriate. But our personal investigations once we interact with either MedScheme or Discovery, we will have enough time to do the work.

ADV ADILA HASSIM: And confidential information of the patient.

MR CASPER VENTER: *Ja,* you know, that is not one that I can answer you. But there is a lot of resistance to it and our recommendations, it is really something that the HPCSA and the CMS must come up with definite guidelines or recommendations on that. In a lot of instances it is not that critical but I think when you deal, let us say, with mental health, that is very confidential what is in there. And that cannot be shared. No, I guess the – if it went to a doctor then it is fine. But it does not go to a doctor. If it goes to – and even invariable some of it, *ja.* If you want a neuro-surgeon's file, it should go to a neurosurgeon. But the confidentiality is a issue. I do not have the answer on that.

ADV TEMBEKA NGCUKAITOBI: And it is the forensic investigator that then assesses what you provide?

MR CASPER VENTER: I would assume so. You know, whether they ask their own medical staff to look at it. Possibly. In our work – in the MedScheme environment, we always have a doctor that works with us on everything.

ADV ADILA HASSIM: Do you bring in the doctor or is it the scheme's?

MR CASPER VENTER: No, it is the schemes doctor. But just remember. In all of our cases we will bring in one of our doctors as well and in this case, the MedScheme doctor will sit our doctor and they will go through it and come to an agreement. That works a lot quicker. You get rid of the useless stuff very quickly. Okay, so the clinical data. *Ja,* that is difficult and I guess, once the new POPI Act is in place even more difficult. Occasionally some of those initial...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Is there not another problem with this access to clinical data? Because, you see. Some schemes will suspend or put in direct payment because of non-cooperation and one of the grounds of non-cooperation is failure to submit clinical information. And one hand the practitioner says: "I cannot give it to you because I am bound by doctor patient privilege."

MR CASPER VENTER: I agree with you.

ADV TEMBEKA NGCUKAITOBI: And how...? I mean, you say...(intervenes).

MR CASPER VENTER: It is problematic but we seldom get into those.

You know, what we would have is we would – a doctor would collect the files and we will jointly go to the scheme and request for a medical advisor and go through it. But I do not think we have had cases where looking at the clinical notes have actually resulted in much, you know, so – if it is a time based. Yes, you can have a look at it. I saw the patient 10- or 30-minutes or so on. But let us say if it is a surgery. Who is going to unravel that? No one. The only thing that you can see out of the file is that the doctor saw the patient but there are other ways to verify that. You can look at diary. You can look at billings. You can look at a whole host of stuff. But it is contentious and one needs definitive answers on what should happen and what should the process be. Should there be something more independent. Okay, then the other problem which we have already...(intervenes).

MR JULIAN BOTHA: I am sorry to interject. Perhaps if I can assist in regard to the legislature of clinical information by practitioners to medical schemes. Medical schemes quite often rely on a blanket of consent contained in their membership contract with the medical scheme member and state that is the reason they are entitled and have consent, proper consent, to view the records. The HPCSA has actually also recently pronounced on the matter, stating that it is in order. And I am sorry. I cannot get network connection. But it is in order for practitioners to make this information available to medical schemes. So the practitioner is bound by their statutory counsel.

ADV ADILA HASSIM: So the HPCSA has said that in those circumstances where blanket consent has been given the doctors must

make the patient information available?

MR JULIAN BOTHA: *Ja.* We will source the actual documents. I would do so now. I will make it available, if you do so require.

ADV TEMBEKA NGCUKAITOBI: When did they say that?

MR JULIAN BOTHA: It was earlier this year, if I am not mistaken. Earlier this year or late last year. I am speaking under correction now.

ADV TEMBEKA NGCUKAITOBI: I mean, this is odd. Because we have had individual practitioners here who told us that this presents a dilemma for them. They have told this last month. And we had the HPCSA here to give evidence and no one spoke about this blanket consent. Everybody has proceeded until now on the assumption that in supplying this information is a violation of the National Health Act. Anyway. Whenever you find it, if you could send it to the secretariat here?

MR JULIAN BOTHA: I will do so, Chair.

MR CASPER VENTER: Okay, and then of course the last one there is, you know, especially in the early days and even occasionally now, payment has been suspended without due process being followed. You know. So which is of course quite unfair on a practitioner. Okay, then schemes can take a protracted period to progress with the investigations. I have already eluded to the GEMS one which is now already a year later and nothing has happened.

MS KERRY WILLIAMS: Mr Venter, can I just interrupt you there? It seems the appropriate moment to do so. I just want to take you to your submission on page 4, paragraph 5. I mean, it is part of your

recommendations and it goes to this question of what the medical scheme or administration – what information should the medical scheme or administrator be providing to the provider in order to be able to properly answer any allegations that are made against the provider in relation to fraud, waste and abuse? And in your submission you suggests three things. I mean, I am just going to read it out because I do not expect you to turn to it immediately.

MR CASPER VENTER: Sure.

MS KERRY WILLIAMS: So you say:

> "To ensure that all parties clearly understand the investigation and allegations, it will be requested that the scheme administrator forensic entity provides us with a detailed account of the investigation, the codes investigated and the alleged irregularities."
>
> And then you say:
>
> "Sufficient details in writing relating to practice profiles and possible anomalies."
>
> And the third is:
>
> "Disclosure of all evidence, including data, patient testimonials obtained in writing and not merely by hearsay, as well as exact details of the issues that the scheme has with the healthcare provider."

So, I wanted you just get you to confirm that, that that is what you believe should be provided and explain some of the detail. Because are we are grabbling with what is the provider entitled to know

in order to be able to meaningfully answer any allegations. And we had some debate about this in the morning and you have suggest so far, that being provided with the data is one of the components, but I want to understand more about this.

MR CASPER VENTER: Yes, I definitely do think so. If you take the – and I just looked at the letter earlier today again, where it sorts of says we have done the calculation and you owe us 600 000. That is it. You know, based on. But there is no data. So you need – if you want 600 000 from a practitioner I want each and every line item that compromises that 600 000. Each on the errors that were made, the quantification thereof. Because on the practice's side, ultimately, you would have to allocate it against a patient's account. So, you know, if there is just a blanket deduction. How do you ever get your accounting system in line? You cannot. The further one that we have not even mentioned here. How to handle you VAT? It has a VAT implication. How do you handle your tax? If they receive a query, suddenly your profile differs which hopefully they are going to do again. Is, how do you substantiate that? You know. Okay, tell us. What exactly makes it up. So I do not think you can reclaim anything without the detailed account pin line item of everything that you want. You know. All the data. All the assumptions. So, I will give you a fare example of this morning's one that we have read. It sort of reads:

> "We have calculated that on average your practice works 12-hours a day. That is too much. We only going to allow 4-hours per day across our schemes."

How do you get to that thumb suck? You cannot do that. So definitely any recovery, quantification has to be per line item. You cannot do without that. The other is. We have investigated a sample. Let us have 16 that we found ten errors. Therefore, we extent or extrapolate that over your total claims based and we are going to recover a million. It is also wrong. You cannot use a sample. If you want to quantify an error, you have to look at each and every item unfortunately. It is the only fair way. You cannot make a generalisation. No.

ADV TEMBEKA NGCUKAITOBI: I suppose from the perspective of the scheme, I mean, they, firstly are processing large volumes. I think someone spoke about 35 000 claims submitted each year.

ADV ADILA HASSIM: Each day.

ADV TEMBEKA NGCUKAITOBI: Or each day, rather. And they have to use an average, a model in order to – because it is just impractical. And then that is the one argument put forward. And the other argument is. It is actually in the interest of the members that we must have an expedited system of recoveries.

MR CASPER VENTER: Yes, you must – sorry.

ADV TEMBEKA NGCUKAITOBI: And so why they need to pick up a sample, the average and they give you a percentage.

MR CASPER VENTER: *Ja,* well. My answer to that. It is the wrong way to do it. Second one is. You process a large volumes of transactions per day. That is what you get paid for to do. You know, so do not complain about it, if that is what your job is to do. To

extrapolate and recover is not the appropriate way to do it. And we – in the work that we now do, we do not follow that approach. It has got to be per line item and we want to come to the right answer. And you can just think when you go to court and you put someone in jail because you have now average data. You know. He does not commit one murder. It is likely that it might have been twenty or thirty. Or a speeding fine. You cannot average. If you want to recover and find someone guilty about a transgression, it has to be factual. You know. It cannot be different.

ADV ADILA HASSIM: Sorry. Can I just ask Mr Botha question?

MR JULIAN BOTHA: Sure.

ADV ADILA HASSIM: On the guideline – the change to the guideline that you have referred to. Does that not apply in the context of managed healthcare. That HPCSA Guideline.

MR JULIAN BOTHA: It does. But if my recollection serves correctly. It was also used with regards to forensic investigations. I am trying to source the information now. It was done by the guys of Regulation 15J. Guys. It is an unfair word, but on...(intervenes).

ADV ADILA HASSIM: But Regulation 15 deals with managed healthcare. So it would not cover this private practice of a sole practitioner or even a group practice that is not a managed care organisation. In that situation, it would not be permissible then for the doctor to provide the clinical information. Is that a correct understanding?

MR JULIAN BOTHA: I am sorry. Could you just rephrase that? I am

not sure if I...(intervenes).

ADV ADILA HASSIM: So if the guideline that you are referring to, the recent one, is based on Regulation 15J and Regulation 15J talks about managed care organisations, it would mean that it is only practitioners that work in that context that would be required to provide the patient information to the funder.

MR JULIAN BOTHA: Yes.

ADV TEMBEKA NGCUKAITOBI: But I mean, if I can take you to your submission. At page 5. At paragraph 32 under Written consent regarding clinical notes. This is what you say here. So I just want to understand that we get you right:

> "Regulation 15J to C states that it is subject to the provision of other legislation. Therefore, it is subject to Section 14 of the National Health Act..."
>
> That is what I was trying to put to you there.
>
> "This means that, notwithstanding the wording of the regulation, a practitioner must seek his or her patient's consent before disclosing that information to a medical aid scheme. Our submission is that the recent pronouncements by the HPCSA in this regard is mistaken and that the plain and unambiguous wording of the regulation means that proper written consent must be obtained from the patient prior to disclosure of the information for purposes of forensic investigations."
>
> So it seems that it certainly in the written submission, you

disagree with the pronouncements. What you are proposing instead is that each time a scheme wants information for forensic purposes, it should ask for specific consent? It cannot rely on prior consent that was given to the scheme generally.

MR JULIAN BOTHA: Yes, that is correct. It is for that specific particular purpose.

ADV NGCUKAITOBI: So then why are we concerned with what the HPCSA said when you say they are mistaken anyway?

MR JULIAN BOTHA: (No audible answer).

ADV NGCUKAITOBI: Anyway, let us continue Mr Venter.

MR CASPER VENTER: I think we have covered most of the items on this because you have asked the questions already about further concerns on the investigation process. We spoke about data sharing and data analysis yesterday and I think that remains a stumbling block, you know if you do not have let us say in a specific discipline full data analysis it is very difficult to indicate whether you are outside the norm or you do not compare to your peers, you know. So we do get the data on the practitioner that is being investigated, but that is sort of stuck in the middle a bit, we do not know where it fits in the total spectrum. Now that is the one thing I guess that in general in the industry, in the healthcare industry that data is not made available in any meaningful really and especially the GEMS people do not share any level of data, so at least what we get out of the Discovery Health's environment, we get aggregate claims data that we use every year so we do see a lot of trends in that how man practitioners claim certain codes, what the total values are. So

that is made available a year in arrears so we can check against that, but in other environments we just do not get any data, so data will remain a sticky point. Coding, as you have already heard the coding is a contentious issue, it leads to about 100% of our forensic reviews. I am going to tell you a bit about the history of coding just so that you understand it, and you know, I will try and be brief, if that is possible from an accountant. So prior to 2004 I think it was a happy world and everybody spoke to each other, BHF and the SAMA was able to meet with each other and discuss things. So the medical profession determined the codes and descriptors but they continued to do so. The HPCSA calculated an ethical tariff that was discontinued in 2008. Now that on its own does create a dilemma because it was always used as the benchmark for overcharging, there is no benchmark for overcharging at this stage so if you charged six times more, so what, you know, there is no benchmark, it does not happen. Prior to 2004 there was the annual negotiations between BHF and SAMA and coding structures and tariffs, so you know, it was a happy world, and in 2004 the competition commission intervened in stating that these processes are collusive, they fined how SAMA and BHF and consent orders to SAMA that it will not happen again. The result of course is that there is no benchmarks, no codes at that stage, no tariffs, you know, so it did leave a bit of a void. The MHRPL was created by the CMS for two years and that actually worked will because the CMS at that stage did sit down with the disciplines and discuss it, you know, and we took certain disciplines and looked at them specifically in those years. That is when psychiatry worked quite well and that is why psychiatry have

clear based consultations. Department of Health assumed responsibility between 2006-2009 and that led to the court case in 2010. The applicants in that case was SAPPAF, HASA, ER24 and Netcare911, and it was heard in Pretoria, and it was set aside. However SAMA continues with the publishing of the medical doctors' coding manual as I said earlier. HPCSA tried a process in 2012 and 2013 to determine ethical tariffs and publish, it was a dismal failure. It actually never got off the ground even, you know, we attended those meetings but in fact, the chairman of that committee told us let us meet next Saturday and we will sort out the coding and tariffs. Now that was a bit optimistic, you know, it was not going to happen. SAMA kept on publishing as I have said, SAMA and SAPPAF have a memorandum of understanding with each other going forward on coding because it does not help you to have two organisations going in different ways. If you do not cooperate on the coding and you do not agree on the contents of this manual, processes are in place with Discovery for updates, so that is working quite well, we work quite well with their coding expert and Mrs Gous spends a lot of time with them when we do changes so that there is consensus, you know, so if schemes say they do not follow it, it is not the truth. There is lots of consensus on lots of changes and it is happening. MedScheme has come to the party and that is now as well, we are sitting with their coding expert on a regular basis to update their systems. I have shown you the specific specialist guidelines, these publications, this is really worthwhile and this is even better than the big bible because it is discipline specific. It is very difficult to unravel this big book and find your stuff so this is an

applicable to the discipline and extremely easy to update and there is no cost really involved in it, so that works quite well. What we did propose at SAPPAF is the establishment of an independent coding authority, we have discussed that with Department of Health, but it has not gone any further, we have discussed it with the HPCSA, it has not gone anywhere, it is in the HMI report of course, but is not the HMI that thought about it, it comes from our submission and at least it looks that they read it you know, which is quite pleasing. And it was in their final report as well, they talk about the independent regulator. Unfortunately I think Doctor Pillay indicated to us he is just going to file that recommendation, it is going to be too difficult to do it, we will just see where that goes. So we have already established certain entities, it has been registered with CIPC, SA Classification of Healthcare Interventions, which is a multi-stakeholder organisation and a non-profit company that one can work from. So the main coding systems, RCD, CPT and the medical doctors coding manual, there is nothing outside that you know, and the CPT, SAMA holds the licence, it is updated annually a year in arrear with the US systems so that is in place. Then I thought this would be interesting for you because it indicates that the coding world is not that difficult. You know, to resolve, so I have looked at the total claims base of data that we have received, so 25 codes comprise 50% of all claims. So I am talking about the doctor environment, not pathology, radiology, the specialists, the surgeons, the general practitioners. So, sort out that 25. How difficult is that. 100 is 74%, 200 is 85%, 300 is 90%, 463 is 95%. So if you sort out 463 codes and the combinations thereof you cover 95% of

the claims, so do that well. And be in agreement between the funders, the doctors, investigators about those issues and then you can see the difference on that is, it is 1300 codes only makes up 5%, you know, that is not the major issue you know, you have got to attend to the ones at the top. Consoles 25%, modifiers 7%, procedures and equipment 63%, that is just aggregating it. And just of interest, these are the top 12 codes that you can focus on, this is published every year by the Council for Medical Schemes, so basic consult at the top, your hospital visits, and then your various surgical procedures and if you the split that into procedures, you will see. And that is why there is such a lot of emphasis on the psychiatrists with a lot of pressure from the medical schemes, it is the highest charged procedure codes, psychotherapy, so it is even higher than caesareans or cataracts. So once again, if you have problems, these are the top 12 codes that drive the medical industry to a large extent. Focus on these items, it is not that difficult, so what we have done in the processes, okay so let us identify the top 300 codes per discipline, making up and fix it. You know, so we have already fixed about a third of those and come to an agreement with the scheme as to what we have done. So, the gynaecology, 30 codes that has got to be fixed, it has been done, Discovery has agreed to it, SAMA has agreed to it and we are busy with MedScheme on that. And so you can work through each of the disciplines and fix what is broken or fix what is unclear in your mind. This is to indicate another area where forensics do come up, so I have taken the global obstetric fee, the vaginal delivery, the correct relative value units that should be used in the system is 462

with the exception of Polmed, all the other schemes divert to 282, which coming back to your earlier, is 2006. Now what has happened in between, insurance cost has rocketed for a gynaecologist to R1 100 000.00, you have got to recover it, you recover it out of your obstetric fee. This number was come up by inside actuaries so we are happy with the number. This is where we base a time based issue, let us say psychotherapy. So the code reads 21240, schemes, now where do you fit it in, you know, do you fit it in at 21 or 30 or ...(indistinct), it leads to a confusion so that one we are busy re-writing. This is a specific Discovery group issue, so the accepted unites for 0019 is 15 units, Discovery across the schemes pay 10. So the doctors are of course not happy and that leads to you doing other things, you know and perhaps we should go and recover this, you know, also send a letter and say in seven days, please pay. It is being a bit fastidious but nonetheless. Okay, then the consultation, I want you to understand that there is no medical schemein South Africa that pays medical doctors for the full time that they spend on patients. So if you spend an hour with a patient, except psychiatry because we fixed that in 2004, if you spend an hour with a paediatrician, you will be paid 26 minutes. So if you have a paediatric neurologist that there is a dozen in the country, you are not going to be paid and that is all that you do. So, you are not getting paid for it, you get paid at 50%. Then they use a variety of time so I have put the correct time, that is how it is published, and it has been like that for many years. The schemes pay, let us say for a 15 minute consult, across the various disciplines, they will pay either 15 minutes, 17 minutes, 18 minutes of 26.

So the 15 is GP's, the 17 is ENT, neurologists and so on, the 18 is the gynae, the 26 is a neurosurgeon, paediatricians and so on. But then they pay that exact same combination for 30 minutes, 45 minutes, and 60 minutes and they do not budge on it, so if he was an advocate and he chose an hour I am only going to pay you for half an hour and you are not going to be happy. Now the doctors are not happy that attorneys of course, charge per minute, you know, that is even worse. But nonetheless, that is a major area of contention as you have seen on the previous slide, this makes up about 25% of the total healthcare claims on which the doctors are not being compensated, so that will remain an issue, so the way forward I think we have got to get to some consensus, going to be rough road but we need consensus. So our recommendations, all parties to agree to a fair and transparent process that is uniform across the industry. We do not want one process at the one administrator, another one at another one, you do it in different ways, that should include you know, the withheld, recovery and so on. And there should be a standard terms of reference which we drew up may years back but no one wanted to agree to it, continued to pay the practitioner whilst the investigation is in process, the NDCM, the doctors coding manual should be the reference for all coding disputes. Because if you have a dispute and you do not have a reference point, what do you use, you know you should have a book, like the Companies Act. If you have a dispute you go to the Companies Act, you know, dispute it. Coding disputes not resolved should be referred to external experts, we already do so, that is independent and can be made up of the various

disciplines. We have spoken just now CMS, HPCSA to clarify access to patient records and you know, we will get the documents to you. Legal advice where the data can be shared across disciplines, you know, can Discovery and MedScheme share data on a doctor or not, you know, I do not know what the legal position on that would be, but it does happen, you know, I do not think it is fair, but nonetheless. Our advise to the practitioners, never ever tackle this without representatives, you know, but that is the doctors' or the practitioners' choice. If you do want to do it alone you are in the deep end. Disputes not resolved, I do not think, I think in our recommendation we might have said the total independent directorate, I think that is not going to work, but for disputes you need an ombudsman. I do not think we can ever have a central body doing all the investigations, that is the scheme's prerogative, to do it, it is their claim, it is their money, it is their patient. But if you do not resolve a dispute there must be some mediation mechanism to try and resolve it. Repeat offenders, and we do have repeat offenders, should be referred to the HPCSA for sanctioning, you know, that will have an effect. Unfortunately, and I am being critical, there is the HPCSA process takes years. You know, I am still battling with 10 year old disputes, you know, it is not an easily done and that is why the schemes will not refer to the HPCSA because nothing should happen and then the fraudster should be dealt with within the law. Okay, and then the sharing of the data we have already spoken about and the only way to resolve it is to actually work together, you know we must not work in our own little silo's you know, the schemes, the doctors, the investigators should work together and try and

resolve the issues. Thank you.

ADV NGCUKAITOBI: Thank you, your colleagues are still here, I wonder if they want to add anything or will you decide if you think there is something they should add?

MR CASPER VENTER: I do not think so, I think we have dealt with all the issues, it was purely if you were going to ask me a quick question then I will claim innocence and I will refer it to the panel.

ADV NGCUKAITOBI: No, that is fine, thank you very much. Alright, thank you very much then to you and Mr Venter and to your team for the presentation. We will be sending you further questions, if you could, if you do not mind sending them to our secretariat.

MR CASPER VENTER: *Ja,* of course, we will do so, thank you very much.

ADV NGCUKAITOBI: Thank you, we will adjourn then for say ten minutes, so we will resume at 15:10.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Thank you, we are continuing with Section 59 Investigation, the – we are now going to get a presentation from the South Africa Medical and Dental Practitioners. Is it gentlemen? Yes. Who is going to be talking? Alright, only one person will be talking? Alright, so I need to take the oath and perhaps you should all introduce yourselves starting from there until here.

DR DAN THOKOANE: My name is Dan Thokoane, I am a practicing ...(indistinct) practitioner in the township of Zamdela, Sasolburg.

ADV TEMBEKA NGCUKAITOBI: Thank you.

DR JOE MAELANE: I am Dr Joe Maelane, the Chairperson of South Africa Medical and Dental Practitioners.

ADV TEMBEKA NGCUKAITOBI: Thank you. Maenane?

DR JOE MAELANE: Maelane, it appears there, under Maelane.

ADV TEMBEKA NGCUKAITOBI: Alright, thank you.

DR SAMSONG TSHABANGU: I am Dr Samsong Tshabangu I am a GP in Soweto and I am an executive of SAMDP.

ADV TEMBEKA NGCUKAITOBI: Thank you, Dr Tshabangu.

DR NKATEKO MUNISI: I am Dr Nkateko Munisi, I am a GP in the far East Rand in Nigel, I am also an executive for the SAMDP.

ADV TEMBEKA NGCUKAITOBI: Thank you, Dr Munisi.

DR T S L SIZANI: Dr T S L Sizani, a practicing dentist in Mamelodi.

ADV TEMBEKA NGCUKAITOBI: Sizani?

DR T S L SIZANI: Sizani.

ADV TEMBEKA NGCUKAITOBI: Sizani, okay. Thank you, Dr Sizani. Alright, so I would need to take the oath then of the person who will be talking and that is you, Dr Munisi?

DR NKATEKO MUNISI: Yes, it will be me but, Chair, I would suggest that the other colleagues take the oath as well. Part of our presentation is that they will all at some stage contribute.

ADV TEMBEKA NGCUKAITOBI: Alright, let us do that. Shall we start here with Dr Sizani, I will lead and say after me, I and your names?

DR T S L SIZANI: I ...(indistinct) Sizani.

ADV TEMBEKA NGCUKAITOBI: Swear that.

DR T S L SIZANI: Swear that.

ADV TEMBEKA NGCUKAITOBI: The evidence that I shall give.

DR T S L SIZANI: The evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR T S L SIZANI: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR T S L SIZANI: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

DR T S L SIZANI: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: If so raise your right hand and say so help me God.

DR T S L SIZANI: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you and then Dr Munisi. Say after me, I and your name.

DR NKATEKO DAVID MUNISI: I Nkateko David Munisi.

ADV TEMBEKA NGCUKAITOBI: Swear that.

DR NKATEKO DAVID MUNISI: Swear that.

ADV TEMBEKA NGCUKAITOBI: The evidence that I shall give.

DR NKATEKO DAVID MUNISI: The evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR NKATEKO DAVID MUNISI: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR NKATEKO DAVID MUNISI: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

DR NKATEKO DAVID MUNISI: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: If so raise your right hand and say so help me God.

DR NKATEKO DAVID MUNISI: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you, Dr Tshabangu, can you say after me, I and your names?

DR SAMSONG TSHABANGU: I Samsong Tshabangu.

ADV TEMBEKA NGCUKAITOBI: Swear that.

DR SAMSONG TSHABANGU: Swear that.

ADV TEMBEKA NGCUKAITOBI: The evidence that I shall give.

DR SAMSONG TSHABANGU: The evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR SAMSONG TSHABANGU: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR SAMSONG TSHABANGU: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

DR SAMSONG TSHABANGU: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: If so raise your right hand and say so help me God.

DR SAMSONG TSHABANGU: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. Dr Maelane can you then also say after me, I and your names?

DR JOE MAELANE: I Dr Joe Maelane.

ADV TEMBEKA NGCUKAITOBI: Hereby swear that.

DR JOE MAELANE: Hereby swear that.

ADV TEMBEKA NGCUKAITOBI: The evidence that I shall give.

DR JOE MAELANE: The evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR JOE MAELANE: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR JOE MAELANE: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

DR JOE MAELANE: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: If so raise your right hand and say so help me God.

DR JOE MAELANE: So help me God

ADV TEMBEKA NGCUKAITOBI: Thank you, Doctor. Is it Mr or Dr?

DR DAN THOKOANE: Doctor.

ADV TEMBEKA NGCUKAITOBI: Alright, sorry, I would just ask say after me, I and your names?

DR MANDESA DANIEL THOKOANE: I Mandesa Daniel Thokoane.

ADV TEMBEKA NGCUKAITOBI: Hereby swear.

DR MANDESA DANIEL THOKOANE: Hereby swear.

ADV TEMBEKA NGCUKAITOBI: That the evidence that I shall give.

DR MANDESA DANIEL THOKOANE: That the evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR MANDESA DANIEL THOKOANE: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR MANDESA DANIEL THOKOANE: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing else but the truth.

DR MANDESA DANIEL THOKOANE: And nothing else but the truth.

ADV TEMBEKA NGCUKAITOBI: If so raise your right hand and say so help me God.

DR MANDESA DANIEL THOKOANE: So help me God

ADV TEMBEKA NGCUKAITOBI: Thank you. Dr Munisi?

DR NKATEKO MUNISI: Thank you, Chair. As we begin, I will just take you through the first page. We just outlined our presentation, we will ask Dr Maelane to do an introduction and then I will take you through the body of our presentation. This will then be followed just before we conclude by evidence to be presented by Dr Thokoane who is one of the SAMDP members affected by the application of Section 59. We also have in our presentation – a presentation from Dr Motlanthe which we would want to place on record. He was supposed to join us but he runs a busy practice in Katlehong and the locum doctor that was supposed to relieve him was not feeling well this morning, so he is not able to be with us. If it is so allowed we can give just a summarised version of his presentation. It is there in our pack for the record.

ADV TEMBEKA NGCUKAITOBI: Thank you.

DR NKATEKO MUNISI: Dr Maelane.

DR JOE MAELANE: Thank you, thank you, Dr Munisi and I want to thank the CMS for affording us the opportunity to come and present verbally. We are the South African Medical and Dental Practitioners Association. I thank you. As evidenced by the delegates today, our association really as presented here, I will just one minute present that we are a national association of medical and dental colleagues and we

cover our members who come from the all the nine provinces. We also have members in the academia, even in the government structures and our members we service mainly previously disadvantaged areas like townships, rural areas and informal settlements. SAMDP is a known brand in the medical and dental industry in all other stakeholders. We – this is a declaration that we – the majority of our members, were are dispensing medicines officially. I will really stop here as I said that our background information is contained in our presentation document.

ADV TEMBEKA NGCUKAITOBI: Thank you, Doctor.

DR NKATEKO MUNISI: Thank you, Chair, I just want to add to that introduction and indicate that the formation of SAMDP in 1989, that is when levies were starting to be – were introduced by medical schemes so as doctors servicing the disadvantaged population, who literally could not afford the initial levies of about 4 cents that were introduced in 1989, that is really the genesis of this organisation. The next big matter that the organisation had to deal with was when general sales tax, this was before the advent of VAT, when general sales tax was introduced to medicines, SAMDP was instrumental in challenging the introduction of general sales tax. We are also one of the founder organisations where SAMDP, NUMDA and MASA were amalgamated to form SAMA but because of the uniqueness of the profile of the patients serviced by SAMDP doctors, despite us actively participating within the SAMA structures, we felt it necessary to keep SAMDP alive. To that extent, a number of the chairpersons including Dr Khosi Letlape comes from SAMDP. Dr Gwen Ramogopa, just to mention some of the

members who come from this organisation. I will proceed to item 2 which is essentially the profile of SAMDP members. Currently in our books we have got about 1 663 members, only two of those members are white. The rest are black which includes African, Indian and Coloured. These members practice mainly in previously disadvantaged areas which includes townships, rural areas and in the majority, we service black patients. As a result of this, the significant majority are dispensing practices, exactly because most of the townships do not have pharmaceutical services. The significance of raising the dispensing aspect will later be illustrated as an added risk where Section 59 is open to misapplication and eventual abuse of our practitioners. The demographics and profile of patients that we service, as already alluded to, they are in the majority black and largely due to their socioeconomic status these members are of the lower – usually of the lower options of the medical schemes with limited benefits generally and usually tied up with one or other designated service provider and we are of the view that is part of – or the root of the problem at hand, out of pocket payment by the members that we service is a difficulty, they are largely dependent on the benefits afforded to them by the plan of the medical scheme that they would have subscribed for. As far as the allegations of racial discrimination by medical schemes, as SAMDP, we are unable to conclusively comment on the issue of racial profiling by medical schemes since our membership profile is almost entirely black, thus data exposure is almost exclusively related to the black healthcare professionals. Also

taking into the cognisance the fact that only 9.9% of blacks are members of medical aids compared to about 72.9% of the white counterparts but we wish to state on record that as SAMDP we are against any form of racial profiling. I will move on to cover some of the issues raised in relation to Section 59 by practitioners that we represent. 5.1.1 would be the first complaint which relates to entrapments where probes are sent to the practice to entice a doctor to commit a crime, like asking for medical certificate and asking for favours. We are of the view that this does tamper with the doctor/patient relationship. The next one relates to the withholding of payment. This practice does affect doctors, it affects the cash flow of the practice, it has even led to practitioners losing their practices, assets and even some taking their lives due to the distress associated with payments being withheld. The third matter refers to payment of patients rather than the doctor. In instances where the scheme pays the patient instead of the doctor, this has led to the patients using the money for other matters and largely not paying for the services that have been rendered by the doctor. Most of them we say literally considers this a bonus as and when it happens. As we have already indicated that the patients that we largely service literally live at the border of the economic status. We further quote the Sechaba judgment which relates to Section 59, paragraph 2, where direct payment to doctors rather than paying of members where the judge summed in his judgment in this manner, I quote:

"When a member utilises medical services and arranges for

provider to submit a claim to the scheme they are authorising the scheme to pay the doctor directly and not the member."

The fourth complaint relates to the coercing of doctors to sign acknowledgement of debt. Doctors who are accused of fraud are frequently coerced to sign acknowledgement of debt to a medical scheme by withholding of payment or paying patients directly. This, as already indicated – or this move affects his cash flow. This acknowledgement of debt in a sense becomes a repayment planning of amounts allegedly defrauded from the medical aid. The amounts computed in these acknowledgement of debt we contend are largely thumb suck. The doctor is intimidated by the process, is ill-equipped to represent himself and to challenge or test the validity of the allegations in most of the cases and is threatened by adverse publicity and being reported either to the regulator, the HPCSA or SAPS should he resist to signing the acknowledgement of debt. In the next item we wish to raise some matters of contention. The first one is that medical schemes apply Section 59 of the Medical Schemes Act wrongly to their own benefit and to the disadvantage of doctors and their patients. Firstly, they leverage Section 59 to ensure that service providers signed the DSP arrangements with the medical scheme that they administer. Patients are then channelled to these DSP's. If a patient visits a non-DSP doctor, some schemes would either pay the patient directly or others would pay the doctor a lower fee. In other instances, patients are then forced to make a co-payment. Secondly, they leverage the Section 59 to conduct forensic investigations on service providers. Our

submission is that our arguments raised in the above matter have specific reference to Regulations 5 and 6 of Section 59 and the Medical Schemes Act, Act 131 of 1998. As far as Section 59(1) read together with Regulation 5 of the Medical Schemes Act which prescribes in detail how a service provider shall render an account to the medical scheme member and his medical aid. Section 59(2) read together with Regulation 6 of the Medical Schemes Act prescribes in detail how a medical scheme shall pay any benefit owing to a supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the scheme. Our submission is that Section 59 and Regulation 5 and 6 of the Medical Schemes Act affords a medical scheme and medical scheme members sufficient protection to ensure that an account rendered by the supplier of service is correct and acceptable for payment within a period of up to 90 days. This, we contend, should even be much more easier for those that are designated service providers who have been accredited and contracted by the medical schemes administrator to provide such services. These accredited service providers pertain – these practices are accredited pertaining to meeting the requirements and such requirements would include the electronic submission of claims and adherence to the prescribed rules of those schemes. But then we now are going to cover how we feel despite all of the protection that we have just covered as protection for the scheme and the scheme's member, there are misapplications. The first misapplication is where Section 59 prescribes in detail how accounts should be rendered, checked for

correctness and acceptability and paid for. The forensic units set their own requirements and can start questioning going back sometimes up to four years where both the member of the medical scheme – whereas these accounts were checked for, before they were paid. We are of the view that going back four years when the Medical Schemes Act dictates a maximum of 90 days is totally unacceptable and no basis exists for doing this and is extremely detrimental and prejudicial to our members. The second misapplication is that the forensic units use desk top audits to collate statistical data that is extremely blunt and totally removed at times from clinical grounds or medical practice profiling where at times it is not even a contact with a patient. They further do not provide proof of any theft, fraud, negligence or misconduct. The next misapplication is where the administrator would then take action without what we would have considered as a full investigation and one of the initial applications is where payment is then withheld from the practitioner and they then quote Section 59, clause 3, out of context, we contend, to give the impression that an injustice has been perpetrated by the practitioner. That misapplication is further compounded by the computation of the amount that is to be recouped which we are of the view is largely arbitrary. The amounts recouped are never for the benefit of the patients, they are largely shared by the fraud units, forensic units and administrators. As SAMDP, we have participated in a number of the cases as a mediator on behalf – or at the invitation of our members. Where we have been involved, SAMDP would be invited by the members and between 2004 and this year we

have accompanied plus minus 50 SAMDP members to these hearings. The frequency would be between two and three of such hearings but at this stage I just need to say to the Commission that this is not reflective of the totality of the members of SAMDP that have been invited but most of the practitioners are solo practitioners who would largely either by not wanting the embarrassment of such matters to be shared with colleagues would then represent themselves. So the two or three practices that we represent a year, we are of the view is not – does not cover the totality of practices that have had to go through the process. Where we have been invited by the practitioner, we would accompany the member to the hearing and the types of transgressions would differ between the GP's and the dentists. Examples of transaction – or transgressions for the general practitioners would include, as detailed in 8.2:

1. Claiming for ethical or originator medication whereas generic medication have been dispensed.
2. Over-servicing or even claiming for patients not seen.
3. Practicing without the necessary permission to do RWOP's, remunerative work outside of government work. For dentists these would include ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Just explain how would the item 8.2.3 impact on a scheme?

DR NKATEKO MUNISI: Because you have – part of the computation that gets presented by the scheme is that you, Dr Munisi, you are employed by government from 08:00 to 16:00 and to that extent you are

supposed to have not been at the practice, one. But secondly, if you are to do any remunerative work, you need to have had permission from your employer, being the State. To answer your question directly, my view is that it would – would not necessarily directly impact on the scheme, the fact that your practice continues to operate. The person that can be aggrieved or the entity that could be aggrieved would be the taxpayer or the State if you then leave your place of work to go and do your private work. But other than that, it should not have any impact necessarily on the scheme.

ADV TEMBEKA NGCUKAITOBI: But I mean how would this happen – so you submit a claim on the basis that you saw a patient between three and four and maybe you should have done it because you should have been in a State hospital, but the fact is that you were not and you saw a patient and you are claiming for the payment. So what would the scheme do? They have to settle the claim because it is a valid claim. The mere fact that you committed misconduct in relation to your state employer, how would that actually apply in practice?

DR NKATEKO MUNISI: So essentially it is one of the complaints that are presented. In fact, this matter Chair will be quite illustrated when Dr Dan Thokoane presents because he is amongst the things that he is accused of doing is that he has seen patients without having the necessary RWOP's. But we content that whether you do have the RWOP's or not, as far as the scheme is concerned, if the patient has been seen ordinarily it should not have any impact. But the aggrieved party in that transgression would largely be the tax payer not the

medical scheme. Examples of transgressions as far as dentist are concerned the first one is inflation of invoices particularly where the work or the preparation for instance of dentures was done by a dental lab, tooth extraction claimed for when not actually done. Once – and now we go back to the process which we have been party to at those hearing. Once the medical aid or administrator has presented the details of the matter at hand, we would then as SAMDP usually request that the administrator recuse themselves so that we can privately confer with a practitioner. And the discussions that we would have with a colleague are used to get more information from the colleague where applicable – and where applicable would have a peer to peer engagement with a practitioner. This might but is not limited to at times we have to highlight the errors which might have been committed by the colleague. We then also start preparing for a plea of leniency together and advised by the colleague and where the colleague indicates to us that they have committed errors as in some of those errors include where they have dispensed generic medication and claimed for ethical's which are usually much more expensive than the generic ones. We would then advise the colleague that we need to prepare an offer or be ready that the discussion would include talking about an offer to settle the matter. The process is then concluded by all parties discussing and at the end if wrongdoing is found around the colleague and a settlement has been arrived at which the colleague would then sign the acknowledgement of debt and settle the matter. Where there is no transgressions by the colleague, there would be no

such acknowledgment of debt signed. With all of the challenges and problems with Section 59, we wish to make proposals as SAMDP on how dome of the matters should be concluded or how Section 59 can be amended to be accommodative and as a win-win for both the practitioners and the schemes. Noting as per Section 59 and the Medical Aid Act which dictates a 90 day as a period in which practitioners can submit and query patient accounts. We wish to propose that a similar period of 90 days should be applicable to medical aids for the finalisation of any queried accounts. And this aspect we wish that it could be regulated or even legislated so that you do not then get surprises with matters being queried sometimes going back three to four years. Secondly, we propose that standards relating to coding claims process and the treatment guidelines should be agreed upon to enable a mutually understandable audit process and gets where disputed.

ADV TEMBEKA NGCUKAITOBI: I do not know if you were here when we listened to the previous presentation. But Mr Venter told us that as far as coding is concerned the SAMA guidelines on coding published in 2019 should be the reference point. What is your view on that?

DR NKATEKO MUNISI: We would very much be in favour of that as a point of departure because with the findings from the competitions commissioner which ended the round table discussion of pricing and coding, that is part of where some of the matters or the problems emanated from. So we are fully supportive of such guidelines.

ADV TEMBEKA NGCUKAITOBI: Is it also your experience that there is

inconsistency in the coding by the schemes?

DR NKATEKO MUNISI: Completely and Chair same patient presenting to you with an abscess, a boy, for one scheme the way in which you are supposed to charge for it is completely different from the other scheme. It does pose a very grey area and a very difficult area to be navigated by a solo practitioner. I am sure it does pose similar challenges for even bigger practices. We further propose that no audit process should be completed without the engagement of patients and practitioners. To that extent had no primitive measures such as withholding of payments should be implemented until the process is completed and ratified preferably by an independent panel.

ADV TEMBEKA NGCUKAITOBI: Well you see the problem is that the schemes are saying, look we suspect there is wrongdoing. We do not know fully whether there is or is not. Here is information, please help us. Doctors on the other hand refuse to supply the information sighting the doctor patient confidentiality. Then the schemes are saying their risk is too high to the rest of the members to continue allowing the doctor that potentially is fraudulent and so in order to mitigate the risk, we do not terminate the relationship but we pay the patient directly. The process you are now designing here is not going to be conducive to that risk mitigation strategy that the schemes are claiming.

DR NKATEKO MUNISI: Chair, that is why part of one what we suggesting is that the patients need to be involved which immediately takes care of the confidentiality matters because either a patient or a patient nominated representative would be part of or party to that

process. We have also proposed that these matters need to be settled ideally within that 90 day period not coming back three years later which has got its own many challenges as indicated by what we have presented.

ADV TEMBEKA NGCUKAITOBI: What happens then if it has not been resolved in that 90 day period? Are you saying that the money that has been lost to the scheme should simply never be recovered?

DR NKATEKO MUNISI: If there is fraud, we one as SAMDP do not support any fraud.

ADV TEMBEKA NGCUKAITOBI: Yes.

DR NKATEKO MUNISI: Secondly, if there is fraud we are of the view that the legal processes should take its course.

ADV TEMBEKA NGCUKAITOBI: What should they do? They should issue a summons and go to court.

DR NKATEKO MUNISI: Absolutely and also possibly report such colleagues because fraud would not be within the prescript of the ethical guidelines from the HPCSA. So that extent such a colleague should then be subject as well if fraud is proved to the prescripts of the HPCSA regulator.

ADV TEMBEKA NGCUKAITOBI: And that even poses even a more greater risk to the members of the scheme. I mean if each and every claim as long as you do not identify it within that 90 days in the context to where 35 000 are processed every day. And every time you must go to court and try and recover whatever you can. I mean that does not sound to me to be terribly practical.

DR NKATEKO MUNISI: You want to come in

DR SAMSONG TSHABANGU: Yeah. If I may come in, Chair?

ADV TEMBEKA NGCUKAITOBI: Mm.

DR SAMSONG TSHABANGU: I think it goes to proper coding and a great coding so that when a claim is adjudicated right up front, by the time it is paid 90% of the work is done but this is a proper claiming and so on and so on. Should you pick up that there is something wrong with that claim, surely it *cannot* take four years for you to realise that there was some claim that was paid four years ago that is erroneous. Secondly the issue of aggregating so called claims in itself it is wrong because basically it means that you agree that a little crime is fine, it is only when a million has been lost that you want to do something about it. I think somewhere along the line we lose the basic thing that we are dealing with treatment to a patient and we are concentrating too much on the money side without saying that has the patient been treated, has he been treated properly? Now if you come after four years and I have not treated the patient properly, it actually means nothing for the patient at that time. And this is an underlying problem with third-party payment because on the one hand you have got the clinical management of the patient on the other hand you have got financial management of the patient. And then of course then you have got fraud units which ex-policemen men who are have got no interest in the patient at all. And if you are going to mine a lot of data and try to create something out of it, firstly it does not help the patient at that time. Secondly, in terms of proper treatment of the patient, we are not

using that in a proactive manner to say, how do we treat patients better? How do you make sure that the patient's rand goes far enough? I mean for instance the patient's benefits might have run out in that particular time because of the alleged fraud and he did not get treatment or something happened to him. Three years thereafter that is of no use to the patient whether you recover the money or not and lastly I am sure I mean banking situations handles far more bigger volumes of transactions. We should have robust systems enough but be able to adjudicate claims properly. Not so much from a financial aspect only but from whether the patient has had that treatment, has had proper treatment and so on. After all this is what the whole industry is premised on payment for treating patients.

ADV TEMBEKA NGCUKAITOBI: I mean what is also unclear to me about this is although they ask for this data, the three year data. It's unclear what they do with it because in practice the way they recover is simply by averaging on a particular proven set of claims. So it looks like this request for information is in any event unrelated to the recovery. So you just wonder then why is a doctor terrorised with a request for information which bears no relationship to the actual claim that the scheme is going to use anyway. Anyway I was just testing the practicality of your – the suggestions you put in 9.3. I mean the idea of going through an independent party each time to proof one claim, it does not sound to be too practical. But I get your with it that if we have robust systems up front, that would minimise the necessity to recover after the fact.

DR TIEHO SIZANI: Chair?

ADV TEMBEKA NGCUKAITOBI: Yes, you decide.

DR TIEHO SIZANI: I just want to mention a point that you touched on earlier on in terms of the codes and referred to code of SAMA

ADV TEMBEKA NGCUKAITOBI: Yes.

DR TIEHO SIZANI: And as a dentist let me also say for the dentist who also rely on the codes from SADA and that is point number one. But in terms of interpretation of these codes it is sometimes form the medical aid side coupled with that what you would call protocol. And those protocols by in large some times are not consistent across the medical aid – they would like to call themselves industry. The other thing is the question of options and as SAMDP most of our members are serving in areas where members of the schemes would be of the lower options and lower option, the more stringent are your protocols and that is an inconsistency that we find very problematic. The last thing that I would like to mention especially with dentist and dental practices, is the whole notion of authorisation where in there is always an element sometimes of a lab fee and it can be very expensive. You then get an authorisation that says on this they can go on and do with the procedure only to be told later on that the authorisation that give in fact, is the writer that says, the authorisation cannot be regarded as making sure or meaning that for sure your payment will be done or you will be paid for what you have done. So that from the practitioner's point of view is always a problem.

ADV KERRY WILLIAMS: May I just pick up on your submissions in

relation to the coding for dentists. So we also heard earlier and previously that the Allied Health Professionals do not obviously have codes which are published by SAMA because it is a different set of professionals. So I understand also that SADA publishes dental codes and you would not have any resort to the codes in the SAMA manual.

DR TIEHO SIZANI: (No audible answer).

ADV KERRY WILLIAMS: You would not - dentists do not have any resort to codes in the SAMA manual? I am just getting you to confirm that.

DR TIEHO SIZANI: No not SAMA it is SADA.

ADV KERRY WILLIAMS: Yes correct. I understand you have to resort to the SADA manual.

DR TIEHO SIZANI: Yes as a dentist.

ADV KERRY WILLIAMS: Now is there a 2019 SADA manual.

DR TIEHO SIZANI: 2019, I think the last time it was - I am not sure it is not revised every year but they would rely on the latest version.

ADV KERRY WILLIAMS: And is there in terms of your membership, is there anyone else who falls let us say outside the SAMA bucket? So you have got dentist who fall outside of it, Allied Health Professionals fall outside it. Is there any other professional that we have not heard from who ... (intervenes)?

ADV TEMBEKA NGCUKAITOBI: I think the question was whether the SADA manual has any relationship to the SAMA manual?

DR TIEHO SIZANI: No, let me clear that one because SAMA would be for many medical codes and SADA would be for dental codes but it is a

speciality that is sort of process over to the medical codes which is the maxillofacial and oral surgeons because some of the codes are not covered under SADA they then rely on specific the most people as you would imagine deal with head and neck and they would then rely on maybe ENT codes that would be found within the medical from SAMA.

ADV TEMBEKA NGCUKAITOBI: Thank you. You wanted to add something doctor?

DR JOE MAELANE: Yes, thank you Chair. I am just coming back to the 90 days dispute. The three month is sufficient really and when you are presenting, I could not just imagine in my head why could the problem exceeded that and going wherever because in most of the cases I represent the association and as it is presented, we just go there. The forensic investigator presents and our member presents, we are sitting on the fence, very neutral. And after the presentation it will be clear whether the practitioner has wronged the scheme or not. Then after the presentation that is where the scheme will go out and then we get the truth and then we settle the problem. So it cannot like that. Three months it is sufficient. Thank you.

ADV TEMBEKA NGCUKAITOBI: Thank you.

DR NKATEKO MUNISI: Thank you. We further propose that any panel dealing with or investigating panel dealing with the medical fraternity should not only comprise of legal counsel but should be enriched by the presence of healthcare practitioners and civil society representatives of patients. SAMDP further recommend that all users should have a unique patient identifier and common health information system or a

system that is able to aggregate the medical data so that it can then be easily accessible to the providers because one of the areas which the SAMDP members or any practitioner that finds themselves being holding for an enquiry is the lack of data. The repositories of data are essentially the schemes and the data that they have usually they are not at liberty to share with you. Data that would cover how they have arrived at the amounts that you are said or you are requested to repay. We also recommend that the funds that are recouped in the majority should be placed back in the pool of medical benefits for the patients and that this particular matter should be regulated by law. At this point Chair, we will pause and request that we move on to a presentation by Dr Dan Thokoane who as we have indicated is an effected doctor. It is his presentation is on the last part of the pack. Once he has detained his matter and we find it will put a good perspective to the matters that we have able to have an effected doctor being with us. Once he is gone through his presentation I will give a very summarised presentation from the matter relating to Dr Solly Nonhlanhla Dr Thokoane.

DR DAN THOKOANE: Thank you. Thank you Chair, as earlier said, my name is Dan Thokoane. I am practicing in the township of Zamdela in the Free State and I have been practicing there since 2003. On the 24th of May this year, I received a correspondence from a MedScheme. The title of that correspondence was, Verification of Claim Details. In that correspondence MedScheme alleged that I am state employed. As I said, the last time I was employed by government was in 2002. So in

2003 I have been working independently as a practitioner duly so under the law so MedScheme put it to me that as matter of fact I am employed by the state. Secondly, the claims that are submitted through my practice were higher for member living in a province other than where I am practicing.

ADV TEMBEKA NGCUKAITOBI: Dr Thokoane, I am trying to find this letter that you received.

DR DAN THOKOANE: Okay.

ADV TEMBEKA NGCUKAITOBI: Because we have the letter of the 7th of June.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: And the ... (intervenes).

DR DAN THOKOANE: 24th .

DR NKATEKO MUNISI: Four pages from the back of the pack. Our sincere ... (intervenes).

ADV TEMBEKA NGCUKAITOBI: Yes, I have got here.

DR NKATEKO MUNISI: *Ja.* Our sincere apologies that that last part is not numbered.

ADV TEMBEKA NGCUKAITOBI: Yes. Well I mean nothing is numbered here but yeah, this is fine, we have got it. Annexure 8 document 4.

DR DAN THOKOANE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Thank you.

DR DAN THOKOANE: Thank you Chair. The claims that I submitted through my practice were higher for clients living in a province other the where I work. They were asserting that I am working somewhere

else and not in the Free State whereas I am working somewhere else, the clients that I am seeing are predominantly coming from Free State which is not true. They also said that I have a high volume of claims submitted for Sunday and therefore requested that as result of this, I must give them records of a number of my patients for the period May 2017 to 2019. That I should also provide them with the proof of permission by the Government to do work outside of State employment and that the 3rd thing I must submit was the tax invoices of medicines that I dispensed for a period that was not specified. MedScheme further said that they could do this because they were empowered by the law to do so, they quoted ... (intervenes).

ADV TEMBEKA NGCUKAITOBI: Is this letter only one page because we only have one page here?

DR DAN THOKOANE: One page?

ADV TEMBEKA NGCUKAITOBI: Well, we have the first page. Alright sorry, my colleague has found it. It is after Annexure B not Annexure D.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: Oh yes, I think this is probably it. Yes, I think this is where it is. Alright, carry on we found it.

DR DAN THOKOANE: Okay. And therefore the law that they quoted was Regulation 15(2)(c) of the Medical Schemes Act that it actually empowered them to access records of patients who were in the managed healthcare kind of arrangement. And they were quoting that as the basis for which they wanted records of patients that is

stipulated. I wrote back – okay. The second document – the second letter that I received from them, was the letter that was sent on the 7th of June.

ADV TEMBEKA NGCUKAITOBI: Yes?

DR DAN THOKOANE: The letter of the 7th of June pretty much repeated what was suggested earlier on that I am still employed. That I see more patients from a different province from where I am practicing and that I have a large volume of patients seen on Sundays and therefore I needed to provide, you know, a list of records of patients that I have seen for the period 2017 to 2019. Invoices for undisclosed period, as well as proof of permission. But this one came also with that – over this period I have literally defrauded MedScheme in the sum of almost 3 500 000. You know. That I also needed to make arrangements to pay. You know. They have given me three options on how to pay them. I wrote them to find out what they were basing their allegations on. They send me a piece of paper that is written Employment Gov which is not headed. Which is not titled. Which is not official. It is part of their package.

ADV ADILA HASSIM: So, Dr Thokoane. In the letter, in the table that amounts to about 3 500 000. On the left-hand side, are those the schemes, those abbreviations?

DR DAN THOKOANE: Those are the schemes that they say I had seen members who are living in a different province for a period that they wanted proof that these clients were seen and that was solely based on the fact that, according to them, I am practicing elsewhere and

therefore my practicing elsewhere constitutes fraud. So those are the schemes.

MS KERRY WILLIAMS: And just to clarify that. The amount of R 3.475 million. Did you know at the time how that was calculated?

DR DAN THOKOANE: There was no explanation on how that figure was arrived at. They simply said that for a period of three years, I have seen clients outside of my area of my practice. Even though it was not true. I mean, I am working where the clients are. You know. They decided to put me somewhere else. And therefore, by being somewhere else, where they knew, I owe them R3 500 000. So I wrote to MedScheme to request that they give me the basis for their allegations and they gave me an email with an untitled document. It is Annexure D. That document extends to the back page of that Annexure D. It clearly says that I am currently employed by government. That my postal address as appearing here which in actual fact is my residential address. They say that was my postal address. My residential address is where I am practising actually. They took my practice address and put it as residential address and the practice address they could not provide me.

ADV ADILA HASSIM: But is the postal and residential addresses not in different provinces?

DR DAN THOKOANE: I stay in Joburg South but I practice in Sasolburg. And this address can never be confused because on a yearly basis, from as far back I started practicing, we registered with the council. We registered with our board of our funders. We

registered with the Department of Health. The information they are mis-quoting, it is information that if they checked with those institutions, they will find it to have been the same historically. So they took that information and which is available with those institutions and messed it around. Decided to put me where I stay as my practice. When that property is registered as a business property, you know. It has been registered at the Deed's Office that this property is where I am staying.

ADV ADILA HASSIM: Are you saying the only thing that is incorrect in this – on this table is that the residential address and postal address is swopped around.

DR DAN THOKOANE: They not only swopped those around, they also say that I am employed with government which is not so. My postal address is not this one. This my residential address. I do not post from my house. I have a postal address which is not here and they have it. They brought the postal address. They put my house as the postal address and they took my practice address and said that is my residential address. And on the basis of that, they concluded that I am seeing patients that I am not supposed to be seeing and I owe them R3 500 000.

ADV TEMBEKA NGCUKAITOBI: They suspended you at the time of the July or the June letter?

DR DAN THOKOANE: *Ja,* they suspended my payments. In fact, they started taking money for claims that I have been sending. They have been ...(intervenes).

ADV ADILA HASSIM: They have suspended you on the 24th of May?

DR DAN THOKOANE: In May they wrote the initial letter. In June, that is when they started suspending my payments.

ADV TEMBEKA NGCUKAITOBI: Yes, the 7th of June.

DR DAN THOKOANE: Yes. They started suspending my...(intervenes).

ADV TEMBEKA NGCUKAITOBI: That is where they say that... Anyway. Your point is that prior to the conclusion of the investigation, you were put on direct payment?

DR DAN THOKOANE: No, there no direct payments. They simply stopped paying me.

ADV TEMBEKA NGCUKAITOBI: Because it says here in the 7th of June letter:

"Please note that during the period of recovery, your practice shall not be entitled to recover any payments for members from the aforementioned schemes."

So this is a backlisting?

DR DAN THOKOANE: They literally blacklisted me, *ja.*

ADV ADILA HASSIM: So they did put you on suspension first and then they blacklisted you?

DR DAN THOKOANE: They - firstly, they...(intervenes).

ADV ADILA HASSIM: Can you look at the 24 May letter, please? The second page. Do you see it?

DR DAN THOKOANE: Give me a minute. It is the Annexure A, Document 4. That is what we were looking for earlier and got to the second page. It is the third paragraph from the bottom. The 24 May –

the one that you have here, I am looking for the end of that ...(intervenes).

ADV ADILA HASSIM: You are looking for the ...(intervenes)?

DR DAN THOKOANE: (No audible answer).

ADV ADILA HASSIM: The 24 May. The one that was marked Annexure A, Document 4. The one that you had initially referred us to.

DR DAN THOKOANE: *Ja,* but it is not complete here. There is a second part to it.

ADV ADILA HASSIM: Yes.

DR DAN THOKOANE: Yes, that is what you want? You want the second part?

ADV ADILA HASSIM: I have got it, because I have found it another part of the pack.

DR DAN THOKOANE: Yes.

ADV ADILA HASSIM: So I think it is earlier on in the pack.

DR DAN THOKOANE: *Ja.*

ADV TEMBEKA NGCUKAITOBI: It was found after Annexure B.

ADV ADILA HASSIM: Yes.

DR DAN THOKOANE: Okay. Yes, that is the one. That is the one. This is the one I am talking about. Yes, that is the one.

ADV ADILA HASSIM: Okay. So can you see the third paragraph from the bottom?

DR DAN THOKOANE: Where they are saying that the abovementioned schemes – is that the one you are talking about?

ADV ADILA HASSIM: No. I do not know what we are looking at now.

I am looking at the second page of the 24th of May letter.

DR DAN THOKOANE: Yes?

ADV ADILA HASSIM: Where it says:

"Please be further advised that due to provisional findings, payments to your practice has been suspended until finalisation of this audit. It is our intention to finalise this audit within thirty days or less, subject however, to your full and timely cooperation."

DR DAN THOKOANE: This was the later one. This is the June letter.

ADV TEMBEKA NGCUKAITOBI: No, it is not the June letter. The 7th of June letter, that is the one we looked at earlier. That is when they blacklisted you.

ADV ADILA HASSIM: Yes.

DR DAN THOKOANE: The 7th of June...(intervenes).

ADV TEMBEKA NGCUKAITOBI: The earlier letter now.

DR DAN THOKOANE: The 7th of June letter, that is where they were saying that they want to verify.

ADV ADILA HASSIM: I am not asking you about ...(intervenes).

DR DAN THOKOANE: (Indistinct) 24th of May letter. That are the two documents that I have given you now. Yes, yes. Where it says:

"Please be further advised that due to provisional findings, payments to your practice has been suspended until finalisation of this audit."

ADV ADILA HASSIM: That is right.

DR DAN THOKOANE: Yes, yes.

ADV ADILA HASSIM: So on the 24th of May they say payments to your practice have been suspended. So interpret that to mean that you were

put on indirect payment and that within – and that this would last for thirty days because it was their intention to finalise the audit within thirty days with your cooperation.

DR DAN THOKOANE: *Ja.*

ADV ADILA HASSIM: So is that correct that you were put on indirect payment?

DR DAN THOKOANE: No, there were no indirect payments. They actually stopped paying me completely.

ADV ADILA HASSIM: From 24th May?

DR DAN THOKOANE: Yes. The time that they have actually started paying me indirectly was after I had complaint. After I had complaint – I have written letters to them and quoting the Council of Medical Scheme's decision on relevant cases that are similar to mine and the law. They then decided to say that they are going to pay me indirectly. Which they also still limited.

ADV ADILA HASSIM: Okay, but according to this letter. They say you are indirect payment but then not even two weeks later, they say: Look, basically, you are blacklisted.

DR DAN THOKOANE: *Ja.* What happened is that they wrote to say that they want to verify and then later on they wrote to say that I owe them 3 500 000. Thereabout. And they will not be paying my claims anymore. Which they did. They never paid. I continued to see patients. I continued to dispense medicine. Continued to submit my claims. That is what had happened. So from the second letter which has the figure that is when they stopped paying me completely. Now I

wrote to request them to provide me with the basis of their allegations and then this is the document. The small page. That they sent through.

ADV TEMBEKA NGCUKAITOBI: *Ja,* it looks like what happened is that on the 31st of July, they wrote to you again, where they said:

"Due to us not presumable being able to validate the services you claimed to have rendered, the schemes have loaded a recovery and offset from your current claims."

And then they said:

"We stopped the recovery at around R 270 000,00 and allowed future claims to paid members until the audit is being completed."

So it looks like on the sequence that what they did is that in May they told you that they were going to put you on direct payment. In June they actually blacklisted you.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: In July they put you back on indirect payments.

DR DAN THOKOANE: Yes, yes. That is the sequence.

ADV ADILA HASSIM: They resumed payment, indirect payment?

DR DAN THOKOANE: Indirect payment.

ADV ADILA HASSIM: And they recovered R 270 000,00?

DR DAN THOKOANE: They held that R 270 000,00 after I had complained and I requested them to give me reasons for claiming that I was owing them three-and-half-million rand. They did not come back to explain themselves. They wrote to say that they have taken a decision

to rescind my suspension and they are going to pay me but they are going to pay me indirectly. The 3 500 00 had been kept at R 270 000,00 that they had taken from my - in fact, that was a by the way.

ADV ADILA HASSIM: But where is the R 270 000,00 come from? How did they get to that figure that they withheld?

DR DAN THOKOANE: From June they started taking my money. They stopped paying me. And all the money they had taken from June had amount to R 270 000,00 by the time they wrote that letter on the 31st. And in fact that letter was a by the way because they wrote earlier to say that they would be suspending their decision not to pay me. And when...(intervenes).

ADV TEMBEKA NGCUKAITOBI: That is the on the 18th of July?

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: It says:

"I would like, in the meantime, to inform you doctor that the suspension of your account will be lifted. However, we will allow future claims to members until the audit has been completed."

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: All right. I mean, we get the sequence of how this happened. The first threat to suspend and then a blacklisting and then back to reinstate you etcetera.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: So, let us get to the substance of complaints that you have. I mean, the one is that they incorrectly

understood your address to be Johannesburg when in fact it was Sasolburg and they confused them with the residential and business addresses. Now we get that.

DR DAN THOKOANE: The crux of the issue here is that audits are done in a manner that is not structured. They have no basis. It is an audit that comes as a result of allegations that are baseless. It is easy to prove whether somebody is working for the state or not. All of us who work for the state until then, have a personal number that is linked to your ID. You walk to any government department and they will tell you the activity of that personal number until a certain period. Secondly, it is also easy to find out whether somebody is practicing from a different address. When we, for example, register for dispensing, a special certificate gets issued with a specified address. I cannot use that dispense medicine elsewhere. It must be on the premises where it is issued because they come and make sure that the premises comply. So these allegations that upon which allegations, further allegations, are made of owing money is a basis that I think should be hammered out as to how do medical aids get it wrong. How does one trust the process that is based on lies? In the first place. How does one give documents with the hope that they will be interpreted correctly if what medical aids have is deliberately warped up? So the issue that I think we have with the medical schemes with MedScheme in particular is that, whereas we do not mind to have audits running because we are a regulated industry, those must be based on a set of values. If you keep money on a basis of lies, you are

not improving service. You destroy lives. What is worse is that even after it was said that there will be indirect payments.. I sit here with an affidavit of a patient who had been told on more than three occasions that the money had gone into their account and no such money could be found and that patient made me an affidavit yesterday, you know. To say that your money is said to have gone into account. I have gone to my account many times and there is no such money. You know. So the indirect payment also affects clients in a very negative way. So in as much there is an agreement that audits ought to be done, they ought to be done in a proper way. In a way that inspires confidence. That doctors are not being victimised here. And I have strong suspicion that the manner in which these audits are being done is primarily the reason why the focus of medical aids is where it is. In townships where they know that people might actually not have the capacity to go through the law or even afford legal representation. So there is reason why, you know, we have today a commission, finding out whether there is a bias, you know, in how audits are being done. They are done primarily because there is no prove in how they conduct it.

ADV TEMBEKA NGCUKAITOBI: Can you just tell us one thing? I am not sure if I understand in this narrative. The R 270 000,00 that had been withheld on the 18th of July when they decided to place you back on indirect payment. Have you repaid that money or is it still with MedScheme?

DR DAN THOKOANE: It is still with MedScheme.

ADV TEMBEKA NGCUKAITOBI: All right. Now then the amount that

they have calculated that R 3.5 million. What is the connection between that amount and the allegations? As I understand, the allegations against you are that you claim to be employed by the state. Sorry, you claim not to work for the state, but in fact, you are employed by the state.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: The second one is the confusion around your business versus residential address.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: And there was no complaint specifically that the claims themselves are either fraudulent or incorrect cause or excessive time?

DR DAN THOKOANE: No, nothing like that.

ADV TEMBEKA NGCUKAITOBI: And so the amount of repayment of R 3.5 million. Was that ever made clear to you what the basis is for the ...(intervenes)?

DR DAN THOKOANE: No, never. I wrote to request that be made. It was never. In fact, that is when they decided that they will suspend my blacklisting, after I had written to them to say that: "What is the basis of your R 3.5 million?" You know.

ADV TEMBEKA NGCUKAITOBI: And now, I mean, the recovery stopped because they were deducting the money directly. And now what is the status? As far as they are concerned you owe the money. As far as you are concerned there is a statement. You do not owe them anything.

DR DAN THOKOANE: There cannot be any possibility of me owing them the money, unless there was a process to determine. If firstly, is money owed? Secondly, how much of that money is owed? You cannot in this country suggests that somebody owes you money because you suspect they are working for the state. That you owe them money because they are suspecting that you are practicing at a different address to what you know. It cannot be.

ADV ADILA HASSIM: Is the 19th of July the last time they wrote to you?

DR DAN THOKOANE: They wrote, I think...(intervenes).

ADV ADILA HASSIM: Was there anything that might be missing?

DR DAN THOKOANE: (No audible answer).

ADV ADILA HASSIM: Oh, *ja.* The 31st.

DR DAN THOKOANE: The 31st I think was the last.

ADV ADILA HASSIM: So, the 31st was the last?

DR DAN THOKOANE: *Ja,* the 31st was. Yes, the 31st was.

ADV ADILA HASSIM: So they are waiting for that information and then they will reimburse you?

DR DAN THOKOANE: They are waiting for information on my tax invoices from medicines that I purchased without saying what period and what legal basis they have. Secondly, they are waiting for information on patients which is I said to them that I could only provide them with those patient files. Upon each and every one of those patients giving me permission to do so.

ADV TEMBEKA NGCUKAITOBI: I mean, that is the thing I was trying

to understand. Is that, they are complaining about an address and they are also complaining about you being employed by the state.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: So why are they asking for information about patients?

MS KERRY WILLIAMS: Does that have to do with the allegation around seeing patients on Sunday?

DR DAN THOKOANE: It had nothing to do with that. All they are saying is that I am seeing more patients on Sunday than on other days of the week.

MS KERRY WILLIAMS: We are just trying to understand why they are requesting your patient files and it is just not clear to us.

DR DAN THOKOANE: It is not clear because what they are saying is that I work for myself – I mean, I work for the state. I am working at a different address and that I am seeing more patients on Sunday. Therefore, they want the files. So it is not clear how you link the allegations with the patient files.

ADV TEMBEKA NGCUKAITOBI: All right. Anyway, as you said. The last time they wrote to you was on the 31st of July.

DR DAN THOKOANE: Yes.

ADV ADILA HASSIM: And that MedScheme might be a better place to explain why they asked for patient files.

DR DAN THOKOANE: Yes.

ADV TEMBEKA NGCUKAITOBI: And that from your perspective, they are not relevant to the complaints?

DR DAN THOKOANE: Definitely.

ADV TEMBEKA NGCUKAITOBI: All right. Anything else?

ADV ADILA HASSIM: But they also have not told you why they are requesting your invoices for medicines that you purchased?

DR DAN THOKOANE: They have stipulated a number of, you know, medical formulas and say that they want invoices without saying why.

ADV TEMBEKA NGCUKAITOBI: All right. Do you have anything else to add?

DR DAN THOKOANE: No, nothing. Thank you.

ADV TEMBEKA NGCUKAITOBI: All right. So we have got this slide issue. Because you have given us the statement by Dr S Motlanthe. So I do not what you want to do with that statement which is – it is actually not a statement by him. It is just an extract of a statement from him which is included in your submission.

DR NKATEKO MUNISI: Yes, Chair. As indicted in the beginning. Dr S Motlanthe was supposed to have been with us.

ADV TEMBEKA NGCUKAITOBI: Yes.

DR NKATEKO MUNISI: But due to circumstances beyond his control he was not able to join us. So we would like to submit it as part of our submission to the Commission. But then at your advice, Chair. Whether should he have it as a sworn affidavit or is it acceptable as is? He does have a matter which he detailed. It is a matter between himself and Discovery Health. He has complained to CMS. Did not get any help. He then went through to complain to the Minister of Health and currently is in the process because he has not have the matter

resolved and is suspended from direct payment by Discovery Health and to that extent, he is now seeking legal assistance on the matter.

ADV TEMBEKA NGCUKAITOBI: Look, the problem is that it is not even a statement. You know. It is not even signed by him. Let alone the fact that he has not deposed to it in an affidavit form. It is extracts from something else he wrote which is then inserted into your statement. So, I mean, we need him, at the very least, to give us a sworn statement or a signed statement.

DR NKATEKO MUNISI: Okay.

ADV TEMBEKA NGCUKAITOBI: It is ...(intervenes).

DR NKATEKO MUNISI: We will arrange that and forward it to the secretariat.

ADV TEMBEKA NGCUKAITOBI: *Ja,* it is hearsay now. Anyway, it does not matter. If you want to, you can just tell us briefly about his case, you can do that but we need the actual evidence from him.

DR NKATEKO MUNISI: Okay, we will forward that to the Commission. The summary of the matter is that Dr S Motlanthe on the 17th of October 2018, he received a letter from Mr Roots at Discovery Health. The letter demanded that he hand over pharmaceutical invoices for the past three years for the purpose of validating certain claims. He then, on the 18th, called the writer to find out whether there were any unethical or fraudulent activities from his side. He was then assured that there is no unethical or fraudulent activity detected against his parties. This was just a routine audit to all practices. The letter demanded summary or copies of certain medicine invoices for the past

three years. He does run a busy practice in Kagiso where he sees between 40 and 50 patients a day. He then got the services of someone to help him to compile those invoices. He indicated to them that 14 days was too short because of the volume of invoices that were needed. He requested at least three months to prepare those invoices. He then did compile invoices. He says: "I went through over t10 000 invoices and made up about 8 000 copies for them of invoices." But the impasse then happens when once he had prepared the files or the copies of those invoices, he then indicated to Discovery that he had done the 8 000 copies and the costs of him indicated that what it had cost to prepare those invoices and requested them to pay for that information before he submits the information. Then Discovery refused to pay for the invoices and they gave him seven days within which if he has not submitted that information to them, they would then stop direct payment to him. In fact, he says, "to date they have withheld about two-hundred..." No. "They withheld the 25 000 due to my practice." And he then complained, indicating that it is proper that they pay for the copies that he had made for them. When they stopped direct payment to his practice, he proceeded to complain to CMS. The CMS made Discovery Health aware of the complaints. Discovery wrote back to CMS and told them "that I am talking nonsense." I am quoting from the letter. But he then had a meeting with Dr Kabane(?) at CMS who ...(intervenes).

ADV NGCUKAITOBI: You have read that part.

DR NKATEKO MUNISI: Essentially after having gone through all of this processes, the current stats is that his matter, he remains suspended by Discovery from direct payment and it is, his practice opens until about nine at night and it is having a negative impact on the patients who pay him for the service and then claim from Discovery. We will request him for a sworn affidavit which will be an, or a signed letter.

ADV NGCUKAITOBI: And the underlying documents, the correspondence...(intervenes).

DR NKATEKO MUNISI: The correspondence that relates to this matter. We also chair wish to state and further apologise for the documents relating to Dr Dan Thokoane's matter, we will also forward properly numbered documents just for the record.

ADV NGCUKAITOBI: Now if the documents are complete we will get our secretary to help us with the numbering.

DR NKATEKO MUNISI: Okay.

ADV NGCUKAITOBI: We do not want to place further documents unless there are outstanding documents you are going to send through.

DR NKATEKO MUNISI: And in conclusion, or as we conclude chair, we content that healthcare providers generate data that is used by medical schemes against them without the providers having access to the same data and how they are profiled. In addition our members are likely solo practitioners who use different service providers to submit their claims. This is part of the reason why SMDP does not necessarily have any aggregated data and would not be able to say whether there is a

difference in the way the different race groups are treated. As far as data...(intervenes).

ADV NGCUKAITOBI: The evidence of Dr Motlante is that he enquired from his white colleagues who told him that they are not experiencing the same treatment from Discovery.

DR NKATEKO MUNISI: Absolutely.

ADV NGCUKAITOBI: And it is not, what is your experience on that?

DR NKATEKO MUNISI: *Ja,* as indicated right at the beginning you know, as far as SMDP members, the two white doctors that are members of SMDP have not had any problems but we are of the view that their data is so limited, our members are black, we do not have data which would, or on the basis of which we can say there is racial discrimination as far as the adjudication of claims is concerned. We further wish, as we conclude, wish to say that it is important that as data is captured that the racial demographics of the patients should be indicated. Our view is that this would help from the public health perspective, it is important to understand the disease patterns, the frequencies of occurrences, and together with the best treatment options, as per racial group. So to that extent we are of the view that it is necessary for schemes to aggregate data and have and one of the parameters, the racial profile or the race of the member. The SMDP cannot conclusively state that racial profiling is used by schemes and administrators given the background...(intervenes).

ADV NGCUKAITOBI: There are apparently two types of data, the one data that we are talking about is the data of patients.

DR NKATEKO MUNISI: Yes.

ADV NGCUKAITOBI: We have not focused on that on whether or not there is available data, whether schemes have it. What the schemes say is the data they do not have is the debtor of practitioners because they do not register them, they only register them by practice number, I mean is that the data you say should be available and if so, what is the purpose of keeping that data?

DR NKATEKO MUNISI: Just noting the demographics of the different populations that we treat. We have said our practitioners treat largely black patients, low economic status, it would be valuable information, if aggregated, even for the benefits of researchers and pharmaceutical companies as to one. There is practitioners who are black treating black patients, what type of medication are they using? What profile of illnesses, ailments are they treating? Just for the broad healthcare of the nation, I think that data would be valuable. Lastly SMDP agrees that Section 59 has loopholes that can be exploited by schemes and administrators. We stand firm in stating our position against racial profiling and the misuse of Section 59 against service providers. Thank you chair, I do not know whether my colleagues would like to say any closing remarks?

ADV NGCUKAITOBI: Thank you, then, in that event, it remains of me to thank the South African Medical and Dental Practitioners, to thank Doctor Maelane, the chair, and his team for coming. And also for the research that you prepared and that you presented with us. We will obviously be writing correspondence to you asking for further documentation, what we obviously need immediately is just the sworn affidavit of the member that

we can take into consideration. So the matter then, the hearing is postponed to Friday, commencing at 10:00, on Friday we will be having among others, Mr Wim Trengove who will be giving us a legal interpretation of what racial profiling means. Thank you.

INQUIRY ADJOURNS TO 23 AUGUST 2019

TRANSCRIBERS CERTIFICATE FOR

THE COUNCIL FOR MEDICAL SCHEMES (CMS) INQUIRY UNDER

SECTION 59 OF THE MEDICAL SCHEMES ACT

HELD AT

BLOCK A, ECO GLADES 2, OFFICE PARK, CENTURION

DATE HELD	: 2019-08-21
DAY:	: 07
TRANSCRIBERS	: D BONTHUYS; V FAASEN; B DODD; Y KLIEM

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