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

27 SEPTEMBER 2019

DAY 12

PROCEEDINGS HELD ON 27 SEPTEMBER 2019

ADV TEMBEKA NGCUKAITOBI: Good morning this is a continuation of the Section 59 Inquiry. Today we will be hearing the evidence of Dr Ntumba Kalanda. I see Mr Kalanda you are by yourself alright. Do you have an objection to taking the oath?

DR NTUMBA KALANDA: No I don't.

ADV TEMBEKA NGCUKAITOBI: You don't alright so I will administer your oath and before your evidence. So will you say after me, I and your names?

DR NTUMBA KALANDA: I, Ntumba Wa Bodika Kalanda.

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

DR NTUMBA KALANDA: Swear that the evidence that I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR NTUMBA KALANDA: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR NTUMBA KALANDA: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing but the truth.

DR NTUMBA KALANDA: And nothing but the truth.

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

DR NTUMBA KALANDA: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. So Dr Kalanda I don't know if you have been watching these proceedings but we received your representations, we've also received the response from the scheme. So

you can take it we are fairly familiar with your version and the scheme's version. So we would like you to just take us through your complaint as you see it and what aspects you want to emphasise that will be entirely up to you but maybe you can start by introducing yourself and your practice and what you do and what your patient base looks like and what the relationship with the scheme is?

DR NTUMBA KALANDA: Firstly I greet all of you, I thank you for the opportunity that is given to me. I am Dr Ntumba Wa Bodika Kalanda I am a radiologist – specialist radiologist working in private practice in Polokwane Limpopo. I'm the owner of my practice, this is the first black owned radiology practice in the province. My work consists of ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: The first or the only?

DR NTUMBA KALANDA: The first and the other one came I think two, three years after me.

ADV TEMBEKA NGCUKAITOBI: I see.

DR NTUMBA KALANDA: So we are two now. My work consists of – I work on referral base. My patients – all my patients are referred by other physician when they want some radiological investigation such as a CT scan, ultrasounds, x-rays etcetera. Patient should come with a request form and in the request form the physician states the reason, his clinical findings and what investigation especially he want me to perform on his patient. We take the patient through the process and we send him to my team of radiographer to take the pictures and myself also we perform all the investigation together. After collecting all the data I sit and read the

images and read the findings and produce a report for the referring physician which will be handed over to the patient or to the referring physician.

When this process is completed the patient usually their come with a medical aid then we first confirm the benefits with the medical aids and then we introduce our claim with the medical aid in connection with the examination that was done. And from there we expect our payments and the patient goes to his referring physician, when they have some query they contact me we talk and we discuss about the case. So this is the situation ...(intervenes).

ADV KERRY WILLIAMS: Dr Kalanda just to interrupt for a second, by way of introduction can I, you've got a bundle in front of you is that right?

DR NTUMBA KALANDA: Yes I have two bundles.

ADV KERRY WILLIAMS: Is it one of our bundles that are paginated?

DR NTUMBA KALANDA: Your bundle is here.

ADV KERRY WILLIAMS: Great, would you mind turning to page 765?

DR NTUMBA KALANDA: Yes?

ADV KERRY WILLIAMS: Is that the licence for your radiological equipment in your practice?

DR NTUMBA KALANDA: Yes this is the licence for my radiological equipment.

ADV KERRY WILLIAMS: Just by way of introduction could you explain then what equipment you have in your practice with reference to the licence so we know what procedures I suppose or not procedures, what radiological tasks you perform?

DR NTUMBA KALANDA: I have a CT scan machine, I have an x-ray for general x-ray and I do a thyroscopy, I do ultrasounds, I do mammography yes those are the mains.

ADV KERRY WILLIAMS: So do those four machines listed in that licence correspond with those four tasks?

DR NTUMBA KALANDA: Yes, *ja.*

ADV KERRY WILLIAMS: Okay thank you.

DR NTUMBA KALANDA: Can I continue?

ADV TEMBEKA NGCUKAITOBI: Yes please.

DR NTUMBA KALANDA: Okay so there is a document that I e-mailed this morning on my complaint, I introduced a complaint against Medscheme and Bonitas and I think that the way they're treating me is probably due to racial profiling that is why I introduced my complaint.

ADV KERRY WILLIAMS: Dr Kalanda can I ask you to address your complaint in relation to both of them separately and I also see in the bundle that there's correspondence from POLMED, do you have issues with POLMED?

DR NTUMBA KALANDA: Yes, Medscheme covers POLMED, POLMED comes under Medscheme and Bonitas also they are on Medscheme so I think it's Medscheme what I think is the one who's managing those medical schemes. So it started in August 25 – 25 August 2016 I think the document is not with you I'll just e-mail it now. I receive a demand of verification of services from Medscheme it was sent by the Medscheme Forensic Fraud Waste and Abuse Management Analyst.

They were asking me to provide them with my registration

certificate, it was in 2016 now, to provide them with radiology radiography reports and to provide them with letters from referral doctors with clinical information. Why they were asking it because they said that they have identified some irregularities, this was in 2016. Then I took my phone I called the person who sent me the e-mail and I ask her why are you asking me all this and what irregularity have you found, are you doing it because I'm not a white person. She said, she thought she said no look Doctor I just advise you to send us the document that are requested and then you take this thing out of your way. I followed her advice then I sent her the documents in 2016. Then after sending her the documents I didn't hear from them and I thought that it was closed and they didn't find any irregularities.

Now in May 2018 I think two years later, 8 May 2018 I receive a ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Sorry Dr Kalanda I mean I don't have the 2016 documents here?

DR NTUMBA KALANDA: *Ja* I can give it to you.

ADV TEMBEKA NGCUKAITOBI: So I don't know if you gave them to as part of your complaints?

DR NTUMBA KALANDA: I just e-mailed it but I can give it to you. *Ja* I've e-mailed this to you just, not long ago. So now in 8 May 2018, I receive an invite letter from Forensic Services and they were inviting me to – because they have been mandated by Bonitas when they were pursuing preliminary investigation they have uncovered certain discrepancy in account which I have submitted to their clients. So before

making recommendation to their clients they were asking to – they were proposing a meeting so that I can go to their office with or without a legal representative.

ADV KERRY WILLIAMS: Dr Kalanda won't you mind just telling us which page in the bundle this 8th May 2018 letter is?

DR NTUMBA KALANDA: On the bundle - *ja*, page 743. Wait is it the same letter?

ADV KERRY WILLIAMS: That is the letter from the Forensic Investigators representing ... (intervenes).

DR NTUMBA KALANDA: Because you see I just received your bundle now so I haven't, I have my own bundle so it doesn't follow the same chronology. I'm trying to see if I can find it. Okay page 757 ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: The document at 757.

ADV KERRY WILLIAMS: Thank you.

DR NTUMBA KALANDA: Yes so after receiving these documents I sent a reply to the investigator asking him which case – which specific case he was referring to ...(intervenes).

ADV KERRY WILLIAMS: Dr Kalanda sorry now that I'm looking at the letter it's on a Bonitas letterhead.

DR NTUMBA KALANDA: Bonitas letterhead ja this one is a Bonitas but there's an item with an e-mail, an invite letter from – let me check it quickly ...

ADV KERRY WILLIAMS: And further it is signed by Dawie Supra who is a director and it says Qhubeka Forensic Services duly mandated by Bonitas

medical scheme.

DR NTUMBA KALANDA: *Ja* because it – *ja* it was an invite letter, can I continue?

ADV KERRY WILLIAMS: I'm just trying to understand who the letter is from, is it from Bonitas, Qhubeka Forensic Services or Medscheme?

DR NTUMBA KALANDA: I received an invite letter from Qhubeka Forensic Services and this letter from Bonitas was in an attachment. So the letter from Qhubeka said:

> "Please find attached letter on behalf of our clients Bonitas Medical Aid for your urgent attention. Kindly contact Christo ..."
>
> They give the number:
>
> "... within 40 days from date of receipt hereof to arrange a suitable date for the requested meeting."

So this is the cover and then the attachment was the Bonitas letter. On my reply I said:

> "Good day, I have received your e-mail and I thank you. Would you please and kindly identify for me which account you are referring to."

ADV KERRY WILLIAMS: Dr Kalanda, apologies for doing this but where in the bundle is your e-mail reply?

DR NTUMBA KALANDA: In the bundle.

ADV TEMBEKA NGCUKAITOBI: Alright you know what Dr Kalanda let's ...(intervenes).

DR NTUMBA KALANDA: Because this bundle ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: No, no wait, wait, wait ...(intervenes).

DR NTUMBA KALANDA: I have my own bundle which ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Wait, wait, wait let me finish, let me finish. What we must do we must adjourn and take 15 minutes there is a problem because your documentation is inconsistent with what the secretariat has given to us and so we are struggling to follow the sequence of your evidence. So we are going to give you 10 minutes to speak to the members of the secretariat to make sure that when you are referring us to a document it can be traced to the documents we have in front of us.

DR NTUMBA KALANDA: Okay.

ADV TEMBEKA NGCUKAITOBI: Do you have anything to say?

DR NTUMBA KALANDA: No I will try to see those documents and put them according to the same chronology with my documents so that I can follow.

ADV TEMBEKA NGCUKAITOBI: No, no I agree, I want to give you 10 minutes to do that, are you happy with that?

DR NTUMBA KALANDA: *Ja* I'll try *ja*.

ADV TEMBEKA NGCUKAITOBI: Alright thank you we're adjourned for 10 minutes.

INQUIRY ADJOURNS

INQUIRY RESUMES

ADV TEMBEKA NGCUKAITOBI: Alright. We have adjourned the evidence of Dr Kalanda to later in the day when the issues with the documentations have been sorted out. So we will interpose Dr Magan in

the interim. Sir, do you have an objection to taking the oath or?

DR AVESH JUGADISH MAGAN: I have no objection.

ADV TEMBEKA NGCUKAITOBI: No objection. Alright, thank you. So will you then say after me, I and your full names?

DR AVESH JUGADISH MAGAN: I Avesh Jugadish Magan.

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

DR AVESH JUGADISH MAGAN: Swear that the evidence I shall give.

ADV TEMBEKA NGCUKAITOBI: Shall be the truth.

DR AVESH JUGADISH MAGAN: Shall be the truth.

ADV TEMBEKA NGCUKAITOBI: The whole truth.

DR AVESH JUGADISH MAGAN: The whole truth.

ADV TEMBEKA NGCUKAITOBI: And nothing but the truth.

DR AVESH JUGADISH MAGAN: And nothing but the truth.

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

DR AVESH JUGADISH MAGAN: So help me God.

ADV TEMBEKA NGCUKAITOBI: Thank you. So Dr Magan, we have received your complaint and a response from Discovery. So you can take it that we are familiar with the essential facts of the matter but you can take us through the situation as you see it. If you have any responses to give to what Discovery has said, also give us those responses.

DR AVESH JUGADISH MAGAN: Just before I proceed, I would just like to find out, have you received any response on Medscheme?

ADV TEMBEKA NGCUKAITOBI: Was it not given to – because the

response of Discovery should have been given to you.

DR AVESH JUGADISH MAGAN: I have the response on Discovery. I'm just enquiring about the response on Medscheme. My complaints were twofold, one against Discovery and then the second against Medscheme.

ADV TEMBEKA NGCUKAITOBI: Alright, we will have a look at the – whether or not it was delivered but I can't tell you now. But let's use the time Dr Magan for now.

DR AVESH JUGADISH MAGAN: Right. With regards to the response from Discovery I have here …(intervenes).

ADV KERRY WILLIAMS: Dr Magan, perhaps you can just start by …(intervenes).

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: Introducing yourself and explaining a bit about your practice.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: I think that's always an appropriate place to start. So we understand how you work and how you work with the schemes and then perhaps go onto …(intervenes).

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: Onto the specific scheme responses.

DR AVESH JUGADISH MAGAN: Thanks very much for this opportunity. I'm a specialist orthopaedic surgeon and my practice at the time of the audits was situated in Umtata in the former Transkei. At the time I had two practices at Life Queenstown Private Hospital in the former Ciskei and Life St Marys Private at in former Transkei based in Umtata.

So I had two practices concurrently in both Queenstown Umtata, 240 kilometres apart. Historically I was the first South African board certified orthopaedic surgeon to start practicing my speciality of orthopaedic surgery in the former Transkei and the former Ciskei, both in Life healthcare institutes and I began my practice in 2012.

The nature of the practice is that it obviously has a large – very large catchment area that starts from Kokstad on KZN border and it terminates in East London in the Eastern Cape. So we looking at around a 400 to 500 kilometre radius and far interior as Aliwal North going towards the Maloti Mountains so a fairly large part of the Eastern Cape being the only – at the time, the only South African orthopaedic surgeon in a vast territory. So that is the nature of the practice.

The practice was based on the fact that being the only orthopaedic surgeon I did have attended to emergencies and elect to work and that most times the emergencies would supersede the elect to work. The realm of pathologies were a vast and because of the nature of the territory there's huge amount of interposition of socioeconomic factors taking place interwoven with pathology and it hence made practice very very challenging in an area of absolute need.

ADV TEMBEKA NGCUKAITOBI: Yes, thank you. You can just take us through – thanks for that description, in relation to the genesis of the complaint.

DR AVESH JUGADISH MAGAN: Okay. So the complaints actually started I on – with regards to Discovery per se 17th of April 2018, I received a letter from Discovery requesting the copies of clinical notes

and patient information, theatre notes etcetera. I am sure you've perused those requests. And so at the time I request – I've got legal – I sought legal advice from an MPS representative, advocate Janse van Vuuren, Altus van Vuuren who accompanied me to a meeting at Discovery's head offices on the 10th of May.

It was a meeting that took place and the people that were – I think advocate Altus van Rensburg did submit his – he did submit his Affidavit as well.

ADV KERRY WILLIAMS: Dr Magan, in our bundle or the documents that you've provided the panel with, the correspondence begins at the 4th of February 2019, page 851 of the bundle. You now referring to 17th of April 2018, where is that in the bundle of documents that you provided us with as part of your complaint.

DR AVESH JUGADISH MAGAN: Sorry, which page did you mention on?

ADV KERRY WILLIAMS: So the complaints we are aware of, the first letter from Discovery.

DR AVESH JUGADISH MAGAN: H'mm.

ADV KERRY WILLIAMS: Is at 851.

DR AVESH JUGADISH MAGAN: 851 alright. Alright, that is correct, *ja.*

ADV KERRY WILLIAMS: And just to orientate you in the bundle. Then at 918 is your recent correspondence to the panel on the 4th of September 2019.

DR AVESH JUGADISH MAGAN: That's correct, *ja.*

ADV KERRY WILLIAMS: Okay. And there's a number of other pages which it's hard to follow the chronology but then now at 941 is

Discovery's response. And I can see a bit of orientation in the bundle.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: Just be aware that's all we have in front of us and that is all we've read.

DR AVESH JUGADISH MAGAN: Okay. Thanks. I've perused the documents that Discovery had – well, basically Discovery's response to our letters of complaint. You'd obviously want my interpretation of that or my thoughts on that.

ADV TEMBEKA NGCUKAITOBI: Now you see, what would help is if you just take us through step by step.

DR AVESH JUGADISH MAGAN: Alright.

ADV TEMBEKA NGCUKAITOBI: Don't start at the end, start at the beginning. You know what your experience was in dealing with Discovery and what the impact of their response was and you can also do the same thing in relation to Medscheme.

DR AVESH JUGADISH MAGAN: Okay alright, so I'm not going to follow this so can I just speak?

ADV TEMBEKA NGCUKAITOBI: Yes please.

DR AVESH JUGADISH MAGAN: Sure. My experience with the Discovery was that they initially had suspended my account upon starting the audit and they'd given me strict guidelines into terms of when I could hand through the documents. And my legal advice at the time said – wanted us to have a meeting with Discovery and so Discovery had agreed.

At the panel, the person that I was liaising was, was Dr Nash Pillay and we had gone to Discovery's offices and to have a meeting

regarding various things that we thought was not correct.

ADV KERRY WILLIAMS: Dr Magan.

DR AVESH JUGADISH MAGAN: Yes.

ADV KERRY WILLIAMS: What year are we in?

DR AVESH JUGADISH MAGAN: We in 2018.

ADV KERRY WILLIAMS: Okay, so this is after you received this letter in 2018, not 2019?

DR AVESH JUGADISH MAGAN: No, absolutely 2018.

ADV KERRY WILLIAMS: Okay.

ADV ADILA HASSIM: And the meeting was on 10 May 2018?

DR AVESH JUGADISH MAGAN: 2018, that's correct.

ADV ADILA HASSIM: With Discovery?

DR AVESH JUGADISH MAGAN: With Discovery.

ADV ADILA HASSIM: In Sandton.

DR AVESH JUGADISH MAGAN: In Sandton.

ADV ADILA HASSIM: And with whom did you meet?

DR AVESH JUGADISH MAGAN: I met with Dr Nash Pillay. I've met with the Head of Forensics, it's detailed the people that were present at that meeting, it's in the bundle. And a Clinical Coding Specialist was present, my attorney which was advocate Altus Janse van Rensburg and myself.

ADV ADILA HASSIM: Continue.

DR AVESH JUGADISH MAGAN: Okay.

ADV KERRY WILLIAMS: So may I ask, is it correct that all these documents that you are referring to are in Discovery's Affidavit, not in the documents you provided us with?

DR AVESH JUGADISH MAGAN: No, I did provide it as well. It was emailed through to the Investigative Panel.

ADV KERRY WILLIAMS: It certainly is not in our bundle. It's now in the Discovery Affidavits but it's not in the bundle of documents that we received from you unless there's been an administrative mistake.

ADV TEMBEKA NGCUKAITOBI: Not your administrative mistake so carry on.

DR AVESH JUGADISH MAGAN: Alright. If I may, there's certain issues that I would like to discuss. I mean I would like to make use of this opportunity and to discuss the points that or to succinctly go through the points that I would like you to hear in person from that meeting.

So I've perused the response from Discovery and there's lots of information that was not in that response from Discovery that I would like to be given the platform to discuss. That was ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: This is your platforms so?

DR AVESH JUGADISH MAGAN: Alright.

ADV TEMBEKA NGCUKAITOBI: Go through it, *ja.*

DR AVESH JUGADISH MAGAN: Thanks very much for that advocate. The issues that we've had with Discovery and these are many so I'll take it from the very first thing. Yes, we are aware of the legalities or the interpretation of Section 59 regarding the confidentiality of patients, the contents of patients' clinical notes, theatre notes, hospital notes etcetera. And both the advocates representing me and the advocate representing Discovery at the time agree to not to agree regarding the different interpretations of that. Where Discovery were quite vehement to that any

member gives their right to have that information disclosed upon request. advocate van Rensburg was in complete disagreement of that. That was the first thing.

We then agreed to – I'd come through with a bunch of patient files, I had about 30 patient files at the time. It's important to note that we'd only discussed two patients file at that particular meeting before our time had run out or two hours had run out. So what was discussed at that meeting was firstly the concept of outliers which I was told that I was at the time and I did discuss upon them the nature of the practice, that it was not a usual practice, it was a practices that was – I had two concurrent practices 240 kilometres apart covering a vast are of the country. Then pathologies that were present was certainly that of the were pathognomonic of patients that was – were obviously with socioeconomic neglect and were very challenged. I had most of my patients were immunocompromised, not necessarily from HIV but immunocompromised.

So from that perspective we didn't final – honed down on the fact that we haven't established who the peers were. Discovery kept referencing my practice to peers and to this date, I don't know who they are. I'm not sure where they get that information from, who are they cross-referencing the pathologies that I did treat at the time, which practices, to this date we had not been furnished with that details or information.

With regards to the pathologies or the codes that were discussed and this was my biggest bone of contention, if you mind the pun is that

Discovery had a nurse in present who called herself a Coding Specialist. And my question was in our round-table discussion is what is a coding specialist? I up to now I have no idea what that is.

It took me 17 years of post matric training and qualifications in tertiary and board exams to get to practice what I do to appreciate the pathology that I treat and hence a full appreciation of the codes that I'm allowed to use in treating the pathology. Yet, I'm made to sit at a table with an ex nurse with possibly a three-year qualification to discuss pathology or operations of extreme sophistication. So I find that – I found it extremely unfair. I'm hesitant to use the word unlawful but I find it extremely unfair that there were no peer review taking place at this particular meeting.

I had hoped that being a peer in the sense of another orthopaedic surgeon in full time private practice who is – who at the time do see patients or who have inherit pathologies that I was treating at the time. But the only "peers" was available was a general practitioner who admittedly had not seen the operation that we going to discuss, were not involved or assisted in the surgery that we going to discuss, and a nurse who called herself a coding specialist.

So I found that very unfair to having to discuss details and having to motivate certain procedures were done why the use of codes that we use to people who has never been involved in such complex surgeries or operations, so I found that to be extremely unfair.

ADV TEMBEKA NGCUKAITOBI: Just tell me the – I'm trying to follow the – there is a document at page 918 which is dated the 4th of September.

DR AVESH JUGADISH MAGAN: Alright.

ADV TEMBEKA NGCUKAITOBI: That seems to come from an attorney.

DR AVESH JUGADISH MAGAN: No, this 918 is my documentation, it's my Affidavit.

ADV TEMBEKA NGCUKAITOBI: Now that contains the minutes or the notes of what transpired at the meeting with Discovery.

DR AVESH JUGADISH MAGAN: That's correct. That was my summary.

ADV TEMBEKA NGCUKAITOBI: On the 10th of May.

DR AVESH JUGADISH MAGAN: 10th of May, that's correct.

ADV TEMBEKA NGCUKAITOBI: Was that ever given to Discovery? Did they ever confirm that those in date were the – I mean item number one of that meeting, the one you've just spoken about says that Discovery admitted that they didn't have case managers in rural areas …(intervenes).

DR AVESH JUGADISH MAGAN: *Ja.*

ADV TEMBEKA NGCUKAITOBI: That verify management of patients claims and authenticity of admissions, treatment plans …(intervenes).

DR AVESH JUGADISH MAGAN: Well, that well I'm sure will be at the minutes with Discovery. That meeting was held and it's also documented in at my attorney that was present at the time.

ADV TEMBEKA NGCUKAITOBI: And then …(intervenes).

DR AVESH JUGADISH MAGAN: So we had this meeting with Discovery and they had agreed to have a follow up meeting which they didn't. All we received was the amount that needed to be clawed back, that was the only communication that we had from Discovery at the time. There are

lots of things that we – that's why I'm in response to this – in my response to Discovery's response of the documents that was recently submitted, there's lots of information there that was not present in the response recently that Discovery had sent through to the Investigative Panel. Hence I'm using this platform now to discuss those intricacies that was discussed at that meeting that are not present in Discovery's response.

ADV TEMBEKA NGCUKAITOBI: No, its fine I'll come back to that.

DR AVESH JUGADISH MAGAN: Okay.

ADV TEMBEKA NGCUKAITOBI: And the second item is they admitted that they don't have software in place to refute a claim within the 30 days …(intervenes).

DR AVESH JUGADISH MAGAN: Absolutely. So the coding specialist, she was a nurse at the time and a very approachable lady and she admitted that in accordance to Section 30 where a scheme has got 30 days to query a claim or to refute a claim or an invoice, they didn't have the software or even up to now, don't have the software to pick up anomalies in invoices, to have it questioned within the 30 day format as governed by Section 30.

So she agreed to that that they don't have the software at the time. So there's lots of things that were discussed at that round-table in Discovery that the lawyer who wrote the response didn't mentioned and turns out uses platform to go over that information that was absolutely pertinent to what we are today not present in his response.

ADV ADILA HASSIM: Is it not though that – okay, that might be the case

that there isn't the software to pick up an anomaly within 30 days.

DR AVESH JUGADISH MAGAN: Alright.

ADV ADILA HASSIM: The response to that may be that it's in given the number of claims that are processed on a daily basis by the schemes – by Discovery. Let's just take Discovery. It's impossible to be able to detect an anomaly within the tight timeframe that the Act requires the scheme to make payment which is why they are entitled under Section 59 to claim back amounts that they show have not been- you've been paid to which you were not entitled, right.

So that's really the area we are in, it's not the 30 days, it's once the scheme has identified that there's been a payment that's been made to which the practitioner is not entitled to be able to recover that amount.

DR AVESH JUGADISH MAGAN: Okay, I'm glad you brought that point up. With all due respect it is the duty of the funder to pick up such anomalies early enough to have engage with a doctor like myself to say, we have noticed that certain codes are incompatible because remember who chooses the codes?

A medical funder cannot be prescriptive as to what codes ought to be compatible for a particular ICD-10 code, it is the clinician such as myself who deals with a patient, who understands the pathology and then chooses judiciously as to which code he can or cannot use.

Now if Discovery or any funder for that time thinks that this particular code should not be compatible, then it is the onus of the medical funder to engage the doctor early on at the quickest possible time to say these codes cannot be used, these are the reasons why they

not compatible.

I was subjected to a five-year retrospective analysis and I think it's terribly unfair for a young surgeon, age 35, in an area that is challenged to be all alone to go through a process, seeing challenging patients, submit claims where my college of orthopaedic surgeons did not guide us as to what codes we can use. It's up to me to my discretion and interpretation as to which codes are applicable to the pathologies being addressed. It is the funders obviously choice as to whether these codes are acceptable for funding but surely that must occur quickly, it must take- if you say 30 days well, perhaps 60 days then perhaps 90 days.

Five-year retrospective analysis of those codes is terribly unfair because by then who's entitled to correct a billing behaviour who is meant to say these are the required codes, who's duty is that? Is it the Health Professionals Counsel, is it the South African Orthopaedic Association's duty to tell a young surgeon, doctor, these are the prescriptive codes or the suggested codes that we can be used. Whose duty is that advocates would mind enlightening me?

ADV KERRY WILLIAMS: Dr Magan.

DR AVESH JUGADISH MAGAN: Yes.

ADV KERRY WILLIAMS: Can I ask you a question? You might have to look at your bundle just to follow my question. But as my colleague has pointed out at page 920 of the bundle, that's your submission.

DR AVESH JUGADISH MAGAN: That's correct, that is my submission.

ADV KERRY WILLIAMS: There is this record of the – well, your concern, that the use of clinical codes ought to be peer reviewed by an

orthopaedic surgeon in private practice.

DR AVESH JUGADISH MAGAN: Absolutely.

ADV KERRY WILLIAMS: So that's your position. Discovery or I shouldn't say Discovery rather the National Health Association has also given evidence on this and they suggested that wasn't possible in this type of speciality to have this type of peer review because there aren't enough orthopaedic surgeons to do so.

DR AVESH JUGADISH MAGAN: I totally disagree with that.

ADV KERRY WILLIAMS: I can hear that so then if I can take you to 975 of the bundle. Now this is the minutes of the meeting that went from – it's the minute of the meeting that took place on the 10th of May 2018 as well and now this is Discovery's minutes.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: So if you hold your finger on 920 you've got a description of ...(intervenes).

DR AVESH JUGADISH MAGAN: Sorry, page 920, I've ...(intervenes).

ADV KERRY WILLIAMS: 920 is yours.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: And 974.

DR AVESH JUGADISH MAGAN: 974.

ADV KERRY WILLIAMS: Is Discovery's.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: So if you turn over to 975.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: Under the heading that says, decisions taken.

I'll read it verbatim, it says,

> "15 cases reviewed (those are 15 of your cases were reviewed) with all our information (that's Discovery's information) to be forwarded to Dr Magan to provide additional clinical information should he wish to do so where after information will be forwarded to the Orthopaedic Society for an opinion."

DR AVESH JUGADISH MAGAN: Well, this is the first time I'm seeing this advocate. I received no such communication from Discovery neither did my advocate. Neither did my advocate receive such information. You can contact him to verify that. We, that means advocate Janse van Rensburg and myself have received no such evidence of this communication from Discovery, we will oblige to do so.

ADV KERRY WILLIAMS: Can I ask, is it a correct recordal of the decisions taken in the meeting?

DR AVESH JUGADISH MAGAN: No such – this decision making by Discovery was certainly not discussed with us at our round-table discussion neither was it put in writing and neither do we have advocate van Rensburg's ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Is that the document at 974?

DR AVESH JUGADISH MAGAN: 975 advocate.

ADV TEMBEKA NGCUKAITOBI: 975 but go to 976.

DR AVESH JUGADISH MAGAN: Alright.

ADV TEMBEKA NGCUKAITOBI: And at the bottom there, item 10, confirmation of the record. And then the undersigned part is therein

that's the provider which presumably is yourself and that's Discovery, both of you seemed to have signed the ...(intervenes).

DR AVESH JUGADISH MAGAN: Yes but I'm not sure if it's contemporaneous enough because this writing in handwriting, I've never seen it before. How do we verify whether it's contemporaneous?

ADV ADILA HASSIM: Dr Magan.

DR AVESH JUGADISH MAGAN: *Ja.*

ADV ADILA HASSIM: Is that your signature on page 976?

DR AVESH JUGADISH MAGAN: It is my signature.

ADV TEMBEKA NGCUKAITOBI: So then how can you say that you didn't ...(intervenes).

DR AVESH JUGADISH MAGAN: No but I can certainly have not seen this communication from Discovery because I will gladly have met with South African Orthopaedics Association.

ADV ADILA HASSIM: So you've seen this document?

DR AVESH JUGADISH MAGAN: I've seen those document on 976.

ADV ADILA HASSIM: You've seen this handwriting on page 975?

DR AVESH JUGADISH MAGAN: No, I've not seen the handwriting on 975, I've – this is my signature on 976. I have not and I swear under oath, I have not seen this writing on 975.

ADV ADILA HASSIM: Did you initial page 975?

DR AVESH JUGADISH MAGAN: I don't see my signature there.

ADV TEMBEKA NGCUKAITOBI: On 974 is initials, 975 is initials, 976 is signed and all of that is under oath.

DR AVESH JUGADISH MAGAN: H'mm.

ADV TEMBEKA NGCUKAITOBI: Anyway.

DR AVESH JUGADISH MAGAN: But I will have gladly compiled if I had seen this or neither would mu advocates have mentioned this.

ADV ADILA HASSIM: The issue with the codes.

DR AVESH JUGADISH MAGAN: Alright.

ADV ADILA HASSIM: Is so you know we've heard quite a lot on the codes at the beginning of our investigation and the complexities.

DR AVESH JUGADISH MAGAN: Alright.

ADV ADILA HASSIM: And the different manuals – the different coding manuals and so on but what appears to be the case here is that whether it's a result of the coding – well, it appears to be as a result of the coding, your – the cost of your claims was significantly higher than the norm. In some cases more than – in some cases almost 300% higher than the norm.

DR AVESH JUGADISH MAGAN: For these patients mentioned notwithstanding the thousands of patients that have not been mentioned. So ...(intervenes).

ADV ADILA HASSIM: Okay, but do you agree that it was ...(intervenes).

DR AVESH JUGADISH MAGAN: I agree.

ADV ADILA HASSIM: I mean that's not just ...(intervenes).

DR AVESH JUGADISH MAGAN: I agree advocates that in these particular individual patients due to the complexity of the pathology, it's certainly high than it would in my own practice if I had to compare the other thousand patients ...(intervenes).

ADV ADILA HASSIM: You're saying it was the high claim in that case

was justified because of the complexity of the case?

DR AVESH JUGADISH MAGAN: For this particular – if we take each patient individually and look at it individually, these are complex pathologies. If you are to compare myself with reason that if you look at my coding, my ability to practice or my ability to code over a period – over a graph of 5 000 of my own patients, you would find that on patients where they have mild pathology, the coding is within the norm or even below the norm.

Yet, for patients with complex pathology, it's certainly going to be higher. So if you look at the ability to use coding, we only – we are looking at a small sample size. I am looking at a 10 000 patient file of 10 000 patients or even particularly if you look at Discovery, there's hundreds of patients. We have to look at it in perspective of over all patients being billed. Patients would have got pathology.

ADV ADILA HASSIM: H'mm.

DR AVESH JUGADISH MAGAN: We have to treat each pathology individually, each patient individually and that's where I have the biggest issue here. You cannot look at pathologies as coding, then extrapolates codes use over a period of 10 years and compare that as a percentage over a national average, that's terribly unfair.

Each human being is unique, each pathology is unique, no gunshot wound is the same to any individual. It cannot be the same. That is why each patient has to be peer reviewed individually, not being grouped as a percentage over a period of six cases, what is the cost between that.

It's okay if you doing a desktop audit sitting in a beautiful building in Gauteng, yet, I am dealing with patients far far away in a rural area with massive amounts of pathology. Hence my question advocate, where were the Discovery case managers? So my colleagues in Johannesburg, Pretoria, Durban and Cape Town are blessed to have Discovery case managers walk into the wards, greet the patients tell them who they are and assist in working together symbiotically so that for the best interest of the patient as Discovery puts it.

Yet, why was I not privileged to have a case manager? These five patients or 20 patients have complex pathology, long patient stay. Where was the Discovery manager at the time?

ADV ADILA HASSIM: These were surgeries so there would need to be pre-authorisation from the scheme.

DR AVESH JUGADISH MAGAN: No, it had to be – these were patients admitted via emergency departments. So they're come into hospital, my offices don't pre-authorise. It is the case managers employed by the institute who then have to liaise with case managers from the medical schemes to update on codes. Now who are the case manager? Are they nurses, are they doctors or are they specialists? 99% of the time, case managers are nurses who do not communicate with doctors at all.

My question is, if Discovery had seen these were high paying cost or high cost to the scheme, was it not their duty to sent the case manager out whilst the patient was there to then have an engage with me and say, doctor, why are you doing three operations on this particular gunshot? What is the need, can we look at that wound? As my

colleagues do in the bigger cities, case managers come in when the wound is exposed, they get to see the tendons there, they get to see the bones that are fractured, they get to see the immunocompromise of the patient, the weak emaciated resuscitated state of the patient. And yet, it's easy for them to update to the scheme here at head office exactly the pathologies being determined.

Why must I in an area of need not have the privileged of a case manager from Discovery coming to say, Dr Magan, can we engage with you regarding your complex patients, your patients who have no access to running water, no access to electricity, yet they are medically ensured. 60% of our country has no access to these amenities, yet a lot of them are medically ensured. Most of my patients who lived in Umtata in the former Ciskei, are medically ensured but still to this date have no access to an inside toilet, running water or ablution facility that you and I enjoy. It is the same neglect that the medical aids do not send the medical advisor to the hospital or to my practice to help each other. Here I am and alone, a young surgeon in a difficult area that – and area that's challenged, yet no help from Discovery. No guidance from the various organisation, yet I'm in a young 35-year-old has to make informed decisions as to the best interest of my patient.

That the scheme suddenly forgets these are their members that they have the best interest in but they don't care to send a representative to see what's best for the patient.

ADV ADILA HASSIM: So you said that there were two patient files that you managed to get through in the meeting with Discovery?

DR AVESH JUGADISH MAGAN: No *ja,* out of 30 we only managed to discuss two of those.

ADV ADILA HASSIM: You managed to get two?

DR AVESH JUGADISH MAGAN: That's correct.

ADV ADILA HASSIM: Alright.

DR AVESH JUGADISH MAGAN: In those two hours.

ADV ADILA HASSIM: And what was the outcome of the review of the two patient files?

DR AVESH JUGADISH MAGAN: We were in total disagreement. We agreed on certain things. What we agreed on that yes, Discovery had failed to send a case manager out and if I were to quote Discovery, we are still working on sending case managers to areas of need or remote areas or rural areas. To this date it has still not taken place.

ADV ADILA HASSIM: But you know – sorry, Dr Magan, just I hear you and I hear your frustration. My question is what was the outcome of those two patient reviews?

DR AVESH JUGADISH MAGAN: Dear advocates, I'm saying that the outcome was that we have not concluded any finality regarding resolution of those patients. We only discussed two. We agreed to take this matter further. We had presented what we had to present. Discovery was meant to come back to us regarding an amicable solution.

All we got was the amount that needed to be clawed back. That was all the communication that I have received. So we had not received a finalisation or an amicable solution to the contents being discussed at that particular meeting.

ADV ADILA HASSIM: Was there any solution?

DR AVESH JUGADISH MAGAN: No solution.

ADV KERRY WILLIAMS: There was – was there ...(intervenes).

DR AVESH JUGADISH MAGAN: No solution apart from the respondents had got in writing via email that a certain percentage had to be clawed back and you've got that in writing why?

ADV KERRY WILLIAMS: And that's what you agreed to pay back?

DR AVESH JUGADISH MAGAN: Well, I had no choice – well, we're still going to get to the matter. I mean, I subsequently left the region due to – we'll discuss that in detail but I subsequently left. I was forced to leave the region that I was passionate about, I trained there, I worked there, I served the community there, I was forced to leave due to the duress that I had suffered.

Currently, I'm not sure where my patients are, I still receive phone calls asking me to return to provide the service and during this time, as noted in my affidavits, patients were indebted to the service that they received, they were grateful for the outcomes of the surgeries and I still maintain a relationship with my patients. I have no relationship with medical schemes, I have relationships with my patients.

ADV ADILA HASSIM: One of the reasons for your – you say justifies the high cost of your claims was the complexity of the cases.

DR AVESH JUGADISH MAGAN: For those individual cases.

ADV ADILA HASSIM: For those individual cases.

DR AVESH JUGADISH MAGAN: Yes, with those cases mentioned.

ADV ADILA HASSIM: And that was complicated for example by your patients being HIV positive and ...(intervenes).

DR AVESH JUGADISH MAGAN: No, no, no, that was misinterpreted, I said immunocompromised. HIV is one cause of immunocompromised, one form of immunocompromised. There's lots of others.

ADV ADILA HASSIM: So were you able to show in respect of those patients that they were immunocompromised even if it wasn't as a result of HIV?

DR AVESH JUGADISH MAGAN: Absolutely and those are clinical information, I had mention at a meeting to the doctors present that as a surgeon, by looking and handling delicate tissue you know that a patient is immunocompromised by looking at the quality of the bone, the quality of the blood, the quality of the (indistinct) fluid, quality of tendon structure, these are clinical things. Remember, not all patients agree to voluntary counselling and testing. Not all patients.

Remember, we're dealing with a very sensitive rural community where it is still up to this date very taboo and not many patients would agree for VCT but, as a clinician, I have a right to manage my patient holistically to the best of my ability. Even patients will now tell me doctor, I don't want to be tested but you manage me symptomatically or clinically and so these are clinical findings, Doctor – I mean, advocate, these are clinical findings.

ADV ADILA HASSIM: Sure and so – and are they contained in the clinical notes?

DR AVESH JUGADISH MAGAN: Absolutely.

ADV ADILA HASSIM: So you – and you provided the clinical notes?

DR AVESH JUGADISH MAGAN: Absolutely.

ADV KERRY WILLIAMS: So you – and you provided the clinical notes?

DR AVESH JUGADISH MAGAN: The clinical notes are all present. In my surgical notes that I have in those files we had 30 files present, we only got through 20 – or only got to two. What's most important here, advocate, we just said that the most important factor here is the patient, the member. No one spoke to the member. When you do an audit, I think it's pertinent in my professional capacity, as a specialist orthopaedic surgeon, if you are doing and audit and the audit contains patients, human beings, please contact them, talk to them, manage them, see here they're living.

Go to their houses, look at the pathology, look at the conditions, the clinical – we're dealing with people, human beings here, not files in an office, not things on a shelf, human beings with emotions.

ADV ADILA HASSIM: But you did not provide the clinical notes to discovery in order to – for them to verify ...(intervenes).

DR AVESH JUGADISH MAGAN: We had agreed that there are – we agreed that they were allowed to ask generic questions on clinical aspects but I had the files in present, on the table, all 30 of them at the time, we only got through two of them. I had them ready, they were there at the time. They were there, they were all available.

ADV ADILA HASSIM: So how do you propose – I mean, it's necessary for Discovery to be able to enquire and investigate cases where

...(intervenes).

DR AVESH JUGADISH MAGAN: Absolutely.

ADV ADILA HASSIM: Before they take any action they need to check ...(intervenes).

DR AVESH JUGADISH MAGAN: I think the manner in ...(intervenes).

ADV ADILA HASSIM: How are they supposed to establish ...(intervenes).

DR AVESH JUGADISH MAGAN: Right.

ADV ADILA HASSIM: Whether the claim is ...(intervenes).

DR AVESH JUGADISH MAGAN: Thank you very much.

ADV ADILA HASSIM: To submit the claim or not.

DR AVESH JUGADISH MAGAN: Thank you very much for asking that wonderful question. This is how it's supposed to be. And this is what takes place in other parts of the country. A patient gets admitted to a hospital. There is a case manager that's present or can either be sent through to verify the justification of a patient being admitted.

So if the patient comes from a doctor's rooms, authorisation is requested, a case manager can verify yes, this patient has got a fracture, yes, this patient has got an extra report containing the pathology present and when the patient goes to theatre there is a comparison between the hospital files and the surgeon's files that a particular pathology has been attended in conjunction with the case manager from the funder being present in the hospital at the time and that is the norm in the country. That's the way it is.

And in that way you can be sure that no patient gets operated

without particular pathology. Remember, as I've mentioned in my affidavit ...(intervenes).

ADV KERRY WILLIAMS: Dr Magan, must that case manager be an orthopaedic surgeon?

DR AVESH JUGADISH MAGAN: The case manager – not necessarily, the case manager can be anybody. If the scheme deems it right that the case manager needs to be an orthopaedic surgeon, that's up to the scheme. But this is how it's currently taking place in the country and this is what ...(intervenes).

ADV KERRY WILLIAMS: So why is not appropriate for the scheme then to use GP's to give views on coding in relation to orthopaedic surgery?

DR AVESH JUGADISH MAGAN: It's because we – if we're discussing the use of coding for a particular type of surgery, how would a GP be involved in discussion ...(intervenes).

ADV KERRY WILLIAMS: Coding seems much more innocuous than given some kind of clinical decision as a case manager.

DR AVESH JUGADISH MAGAN: The case manager is not there to give a clinical decision, the case manager has to verify that the patient is indeed there ...(intervenes).

ADV KERRY WILLIAMS: Verification involves a clinical judgment. It does seem like a rather unusual proposal you're making to suggest medical schemes ...(intervenes).

DR AVESH JUGADISH MAGAN: No, no, please don't misquote me, I didn't say that. I said at the – if you do an audit and you're discussing complex pathology it's best to be peer reviewed and this was

vehemently echoed by the presence of the South African Medical Association as well, that if you're dealing with specialists and you're discussing intricate matters that are surgically inclined, it has to be peer reviewed.

ADV KERRY WILLIAMS: Let me perhaps explain my question here. I certainly read if you go – if you could turn to 975 of the bundle again and this minutes of the meeting that took place, I certainly read Discovery as offering you an olive branch in this meeting by offering that you submit your clinical information and then they offer to refer it to the Orthopaedic Society.

DR AVESH JUGADISH MAGAN: Well, just to reiterate, I never received this communication. If I had at the time or was it – or ...(intervenes).

ADV KERRY WILLIAMS: We have heard that, thank you.

DR AVESH JUGADISH MAGAN: Or even if they had presented to me at the round table I would have certainly accepted that because I have – in my own accordance, I have engaged with the presence of the South African Orthopaedic Association and at the – remember, I'm a member of various committees of the South African Orthopaedic Association.

ADV TEMBEKA NGCUKAITOBI: Dr Magan, let me just on this topic, I put to you something I don't understand. So in that note that you prepared which is at page 920.

DR AVESH JUGADISH MAGAN: Right?

ADV TEMBEKA NGCUKAITOBI: So there were three items that you put there, so there's the case manager issue, the software issue and then on this particular issue about whether a GP suffices or a specialist is

necessary, it's item 3.

DR AVESH JUGADISH MAGAN: Right.

ADV TEMBEKA NGCUKAITOBI: Where you say the general practitioner Dr Pillay tasked to interpret the use of codes for surgical events had no knowledge of the nuances of the type of surgery performed. Now if we start there, you say that they have no knowledge of the nuances of the type of surgery performed.

DR AVESH JUGADISH MAGAN: Right.

ADV TEMBEKA NGCUKAITOBI: Now isn't that why at page 975 because at that meeting it's agreed that there is a concern about Dr Pillay?

DR AVESH JUGADISH MAGAN: Right?

ADV TEMBEKA NGCUKAITOBI: Isn't that why at page 975 they then offer you a specialist?

DR AVESH JUGADISH MAGAN: Absolutely. And I wish I had been – I wish I that I was given that at the time. On the 10th of May if that had been suggested I would have gladly accepted that. I would have gladly accepted to sit with a peer an discuss it to the absolute detail. Gladly. It was certainly not offered and I'm sure my legal representatives at the time will be bear testimony to that as well.

ADV TEMBEKA NGCUKAITOBI: I mean, I should probably just put this to you because the note at 975, there are two possibilities. If you deny – you accept the signature at 975 and you deny the initials at 975 then you are alleging that Discovery has forged this document.

DR AVESH JUGADISH MAGAN: I'm saying that it's the first time that

I'm seeing this. I'm not alleging that they forged the document.

ADV TEMBEKA NGCUKAITOBI: No, it is impossible that you are seeing it for the first time because you signed it on the 10th of May. It's impossible that you could have signed 976 without the previous two documents. You would have been signing just a piece of paper with no meaning because what you signed at 975 is a confirmation of the record and the record is 974 and 975.

So what I'm putting to you is that it's very unlikely that this document was manufactured and there could be a fair accusation that you are lying to this Commission.

DR AVESH JUGADISH MAGAN: No, I've sworn under oath that the information that I've now been presented it's certainly the truth. I don't ever remember reading this information because my requests from the word go was to have it peer reviewed. It was certainly my request. Had this been given to us at the time my legal advocate would have certainly encouraged me to do so but I mean we can certainly – if you look at his affidavit, he doesn't mention that as well. If you look at advocate Altus van Rensburg, he also in his affidavit did not mention that an opportunity was given to us for me to present this to the South African Orthopaedic Association.

ADV TEMBEKA NGCUKAITOBI: I'm looking for the affidavit from your advocate. What page is it?

DR AVESH JUGADISH MAGAN: I think it's 914.

ADV TEMBEKA NGCUKAITOBI: 914.

DR AVESH JUGADISH MAGAN: Sorry, 913 and 914.

ADV TEMBEKA NGCUKAITOBI: 913.

DR AVESH JUGADISH MAGAN: 914 and 915. So 913 to 915 and 916 as well and 917. So from 913 to 917.

ADV TEMBEKA NGCUKAITOBI: No, I want the affidavit from Altus Janse van Rensburg, I don't – this is just an email. I want the affidavit where you say that even your legal representative confirms that you were not given the opportunity to refer this to an orthopaedic surgeon which is the evidence you gave earlier.

DR AVESH JUGADISH MAGAN: You know, unfortunately, I mean, I - whatever that he has provided I've emailed through to the Investigative Panel.

ADV TEMBEKA NGCUKAITOBI: No ...(intervenes).

DR AVESH JUGADISH MAGAN: I can still obtain that affidavit from him.

ADV TEMBEKA NGCUKAITOBI: No, Dr Magan, I asked – you said in your evidence that even your lawyer has confirmed that you were never given a chance. The problem is that there is inconsistent evidence on the record with what you have said. We have to get to the bottom of this issue.

DR AVESH JUGADISH MAGAN: Right.

ADV TEMBEKA NGCUKAITOBI: You told me when I asked you the question that even your lawyer confirms on affidavit that you were never given a chance to refer this to an orthopaedic surgeon. I asked you where's the affidavit? You've referred me to an email. Now I ask you for the affidavit, you're telling me that the affidavit is not here, you

will get it.

DR AVESH JUGADISH MAGAN: I'm sorry, I may have used the word – I apologise for that, I may have used the word affidavit incorrectly, it's the correspondence, that ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Alright, show me where in that letter then does it say you were not given a chance to refer this to an orthopaedic surgeon?

DR AVESH JUGADISH MAGAN: No, I don't think he's mentioned that but I mean – but in our discussions with my legal team and myself, we – you know, we've not received any communication from Discovery apart from the letter to claw back.

ADV ADILA HASSIM: One of the other issues with the codes – sorry, we hear you, you say you didn't get that, you – one of the issues with the codes was also claiming for assistant fees when no assistant was present in this – during the surgery. What's your response to that?

DR AVESH JUGADISH MAGAN: *Ja,* we discussed this at the meeting in Discovery and in my records, my theatre notes, the assistant surgeon was present. Now I'm not sure why the hospital – remember, the hospital that we're in, 60 to 80% of nurses are volunteers, are not permanent staff. I cannot be – I cannot under oath mention why it was not documented at the time. I have no reason why.

ADV ADILA HASSIM: So you're saying that your theatre notes record an assistant as being present?

DR AVESH JUGADISH MAGAN: Absolutely.

ADV ADILA HASSIM: But the hospital's notes don't?

DR AVESH JUGADISH MAGAN: Don't.

ADV ADILA HASSIM: And that yours is correct and theirs is not?

DR AVESH JUGADISH MAGAN: I can't answer, I can only have what I have documented at the time, that the assistant surgeon was present. I understand that but it's – there's lots of issues to be discussed, I mean that's – I mean that's one little – that's one aspect.

ADV TEMBEKA NGCUKAITOBI: Yes, I think you should take us through the aspects you wanted to discuss with us then whatever is of concern to you and then ...(intervenes).

DR AVESH JUGADISH MAGAN: Okay. So my concern was – well, that's discovery, my concern was with Medscheme and if you look at the correspondence – I won't use the word affidavit again – if you look at the correspondence from my attorneys, our meeting of the 10th of May, the same day that we had our meeting with discovery, with Medscheme was completely different. They were not willing to be – they were not willing to be – they were not cooperative and not willing to have a round table discussion with regards to the use of codes, the type of pathologies that were present in those particular patient files.

Now if you look at Medscheme on the other hand, they based their findings on five patient files and they've managed to deduce that my billing is 70% higher than peers for the use of those particular codes based on looking at five patient files and my question is that is it reasonable to base a billing practice or billing rhythm on just five patient files where at our disposal we have hundreds and hundreds of patients who were subjected to surgical procedures which show in

contrast that there's certainly not more than 70% of the national norm. It's similar to what we discussed previously that you have to look at patients ...(intervenes).

ADV KERRY WILLIAMS: Dr Magan, can I just interrupt you, sorry?

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: Can you turn to 879 of the bundle please? As I understand, this is a document you provided us with.

DR AVESH JUGADISH MAGAN: That's correct.

ADV KERRY WILLIAMS: Can you explain it to us please?

DR AVESH JUGADISH MAGAN: So these are the – this is Medscheme's analysis of the five patient files that was – that they chose to – they've chosen these files from their random audit and these are the findings of five patients' files.

ADV KERRY WILLIAMS: Where does it say it's – the analysis comes from five patient files?

DR AVESH JUGADISH MAGAN: It says there on page 880, analysis of five patient files confirmed the irregularities in billings seen.

ADV TEMBEKA NGCUKAITOBI: I think the names of the patients are at 883 if I'm correct. No, probably 884.

DR AVESH JUGADISH MAGAN: 884, yes.

ADV TEMBEKA NGCUKAITOBI: And that's where it says patient file analysis.

DR AVESH JUGADISH MAGAN: That's correct.

ADV KERRY WILLIAMS: Let me just understand this. I'm sure Medscheme will tell us if this analysis was done on five patient files.

DR AVESH JUGADISH MAGAN: This is from Medscheme, by the way, this is their documents.

ADV KERRY WILLIAMS: Yes, no, I understand that.

DR AVESH JUGADISH MAGAN: *Ja.*

ADV KERRY WILLIAMS: But the sentence says:

> "Analysis of five patient files confirmed the irregularities."

DR AVESH JUGADISH MAGAN: Yes. So it's confirmed the irregularities in billings seen. They don't stipulate seen over 1 000 patients or 500 patients, you know? I got patients files that show that there's no such irregularities. They're – in my affidavit that I submitted previously, I stated that they have cherry picked five patient files which should ...(intervenes)

ADV TEMBEKA NGCUKAITOBI: Yes. No, that is the point of interest. So if you go to the patient files that they have cherry picked.

DR AVESH JUGADISH MAGAN: Yes.

ADV TEMBEKA NGCUKAITOBI: And let us forget about the fact that they've cherry picked but let's look at whether they are right in what they say. I mean, if you look at patient number 4, I mean, this thing stopped me:

> "Gunshot firearm, five surgical procedures, R178 000 paid to our surgery billed at R88 000."
>
> I mean, how do you possibly justify that?

DR AVESH JUGADISH MAGAN: Well, you know, I don't determine the rand value per code. These codes had their particular rand value.

When I perform an operation, the codes that the – the anatomical structures that have been operated are formulated with a code. The codes are then sent through to a billing bureau. It's the billing bureau that then processes the data and sends the codes off to the medical funder.

ADV KERRY WILLIAMS: I think we must be clear about what this report says because I'm not sure I'm understanding your evidence. Is it clear to you that the report makes use of Medscheme's data not just your five patient files to come to the view that you exhibit costs 30% higher and specialist fees 70% higher than your peer group? They're not just using the five patient files, they're using their claims data generally, including yours. Is that clear to you?

DR AVESH JUGADISH MAGAN: That's clear to me but it's not all the codes that I've used. I mean, if you look at orthopaedic surgery ...(intervenes).

ADV KERRY WILLIAMS: Before we go on, I just want to be fair to Medscheme in relation to what your evidence is. So is your complaint, why you're complaining about them having cherry picked five patient files because their answer is that they are checking whether their broader analysis is correct by looking at five patient files.

DR AVESH JUGADISH MAGAN: My question is that out of a 1 000 patients we could easily have picked 200 patients where I have below the national averages for my peers. Who the peers, I'm not sure? Why not discuss that?

ADV ADILA HASSIM: Okay, but for these five, if we just look at this –

again, like my colleague said, regardless of whether they cherry picked, in respect of these five, it cost the scheme R841 000 for the five patients, that that seems like a lot. But you're saying that that is not a lot because it was just the cost of seeing those five patients was 841 000.

DR AVESH JUGADISH MAGAN: Look, I agree it does seem like a lot but if you look at it on the grand scheme of things, out of a 1 000 patients ...(intervenes).

ADV ADILA HASSIM: No. No, no, don't go to the grand scheme and 1 000 patients. Are you saying that the 841 is justified in respect of these five patients when you go back and look at that file and the notes and the surgery that was performed? So, you see, the codes ...(intervenes).

DR AVESH JUGADISH MAGAN: That's correct.

ADV ADILA HASSIM: And how you use the codes will inform your claim, right? And they are saying that the way you've used the codes have resulted in an inflated claim. Inflated by 70%. That's what they are saying.

DR AVESH JUGADISH MAGAN: And how did they determine by 70%? Would you kindly ...(intervenes).

ADV ADILA HASSIM: By looking at these five patient files.

DR AVESH JUGADISH MAGAN: 70% in reference to what?

ADV ADILA HASSIM: In reference to your peers or in reference to what ...(intervenes).

DR AVESH JUGADISH MAGAN: And who may they be?

ADV ADILA HASSIM: Well, I'm not answering the questions here, you're answering the questions.

DR AVESH JUGADISH MAGAN: No, no, no, I just want ...(intervenes).

ADV ADILA HASSIM: I want you to explain ...(intervenes).

DR AVESH JUGADISH MAGAN: I just want to understand what you're asking me here.

ADV ADILA HASSIM: No. I'm asking you whether you are in agreement or not that 841 000 is the legitimate and appropriate amount to have charged for seeing those five patients.

DR AVESH JUGADISH MAGAN: Having looked at the pathologies at the time, I was not aware what they amount to. I basically used the codes that I had done. When I am submitting codes I don't have a reference to a rand or cent value. It's only the billing bureau who has got the privilege to see what each code costs. At the time when I perform an operation ...(intervenes).

ADV ADILA HASSIM: So you don't know what the rand value of the codes are. When you submit a claim there isn't a rand value on your claim?

DR AVESH JUGADISH MAGAN: No. No, no, no, when I – I don't submit claims, I submit codes to a billing bureau. The billing bureau then submits the codes to the funder. So at the time when I'm performing the operations, I'm not aware what the rand values of what I'm performing, I have no idea. It's impossible to know with the hundreds of codes that are available what the rand and cent values for each particular code. All I'm in control of is performing the operation

and knowing what I've done within that operation.

So if retrospectively when I do get the figure and the amount being – yes, yes, I agree it does look exorbitant, yes, I agree it's a lot of money but that's certainly up for discussion. I was not given the opportunity to discuss that.

ADV TEMBEKA NGCUKAITOBI: Look, I mean, Dr Magan, you know, I don't understand why you say you don't know why Medscheme were saying these things because in the letter to you, they told you why, so this all, you know, is contained at 883 and 884 and they went into detail, it's one of the fewer cases where they go into this extent of the detail. So they tell you:

> "Code 0303, 128 units was charged 125 times."
>
> And then it goes on:
>
> "The code 0593 was the highest income earner for this practice accounting for 23% of the revenue alone whereas it is on average 6.6% of the peer groups. 2.72 million of the total 11.6 million and in this period."
>
> It goes on:
>
> "Other code issues include billing 0173/4/5 on admission to hospital despite the procedure being an elective booked case where the patient was seen in the rooms. Use of code 0129, nationally this code is used in 2% of office visits, but Dr Magan bills this at 55.6% of office consults. R128 000 was paid which at least 90% is in question. Billing individual fracture codes as

well 0465 for the same fracture."

They even tell you what the comparators. Firstly they've told you the usage of the code and they've told you in reference to what. 884 they do the same thing.

> "Using this tool, Dr Magan rates as category 3 highest costs with a specialist cost 90% higher than expected for similar cases. The higher cost is due to excessive use of codes and incorrect rates in many codes, is an overall event cost 30% higher than expected. The admission rates are 29% higher and the use of pathology testing is 72% higher which could be affected by the demographics of the practice, rural location, higher commodity risk, use of ICU at high care is significantly lower and length of stays are on par with the peer group."

And then they give you the patients. After that they say:

> "What these patients are showing is an astonishing figure of R841 000."

Which they say is erroneously billed. Then they say:

> "Due to the substantial extent of overcharging it was deemed necessary to request a further 25 files to confirm the initial trend."

So it's not as if they just acted randomly. They gave you the specific facts, they gave exactly what the inconsistencies with the code is and they gave you the comparator that you are complaining about

and then they said we are using this to illustrate patterns, we want 25 extra files to look into what you are doing. So I don't follow exactly what you say they did wrong.

DR AVESH JUGADISH MAGAN: advocate, no, they chose 25 files. I mean, if you're going to do an assessment of ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Dr Magan, we can't have this. You see, you first complained about having chosen five files. Now I'm showing you that even that is wrong because what they were looking for is actually 25, a bigger sample. Now you are also complaining about 25. So essentially you should have been left alone.

DR AVESH JUGADISH MAGAN: No, I mean, if their intention is to claw back, if their intention is to show that I'm an outlier, you're obviously going to choose the patients' files to verify what the intentions are. If my intention is to say that I'm an ethical biller based on a large cohort, I can produce 300 files that will prove otherwise.

The question is, is it reasonable or not reasonable to say that my billing pattern is irregular or not? Is it reasonable if I produce 500 files to show that the pattern is regular? Does that make me an irregular biller compared to 25 files that they have chosen that will show complex pathology? You see, the ...(intervenes).

ADV ADILA HASSIM: *Ja,* but you see – but the thing is that's not correct because they do – as I understand it, but if I'm getting it wrong, please correct me.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: There are different methods they used here.

One was looking at the five patient files.

DR AVESH JUGADISH MAGAN: Right.

ADV KERRY WILLIAMS: And they said this is exorbitantly more than a norm but let's look at more files and so they request another 25. But as far as the codes go, it's not limited to five, it's a greater number. They look at the codes used over a period of time and they say to you that for code, example, 465, this is what – you know, how often it's used by your peers versus you, percentage difference is 31 – 312% difference. So but what I'm trying to say is that the codes that they are looking at here are not specific patient files, but codes that you over a period of time and I think the period of time is January 2015 to December 2017. So it's over a two-year period.

DR AVESH JUGADISH MAGAN: Right.

ADV KERRY WILLIAMS: So it's not a small sample, in other words.

DR AVESH JUGADISH MAGAN: advocate with all due respect, they've chosen a few codes. Within the realm of orthopaedics there's hundreds of codes that we use in day to day practice, hundred so codes. If you look at highest cost to the scheme which is spinal fusion, total joint replacement, those are the biggest costs for any orthopaedic costs to any particular scheme. What are my costs – what are the use of my codes to my peers? Why was that never discussed?

Now I can tell you that when I choose a particular code it is based on an individual's pathology. Now out of the 300 or 400 patients that I perform arthroscopic knee surgery on, on patients that are immunocompromised, morbidly obese, uncontrolled diabetics, I choose

to use procedures that are safe that will benefit the patient. Why haven't I used codes that are the highest paying codes such as a total knee replacement? What are my use of total knee replacement codes? What are my use of posterior spinal fusion codes, which are the highest paying codes? I do what relevant to the patient, so ...(intervenes).

ADV KERRY WILLIAMS: No, no, sorry, I think I get the drift, I get the response.

DR AVESH JUGADISH MAGAN: So I've got 200 codes that I use. Why choose the codes that will show – that will be flagged across the national norm that the peers are using? Why not compare highest paying codes to my peers, to those peers in question. It was never mentioned. These codes are meant to justify their means, their audits.

ADV KERRY WILLIAMS: I get what your response is.

DR AVESH JUGADISH MAGAN: I am saying that I've got 500 files that will show conservative practice, conservative patient treatment and according to my peers will be far less than the national norm. What happens to those codes? What happens to those patients, the 600, 700, 1 000 patients that are far below the national norms? What happens to those? Why don't Medscheme put those codes in their analysis?

ADV ADILA HASSIM: Sorry I have taken you off your ...(intervenes).

DR AVESH JUGADISH MAGAN: No.

ADV ADILA HASSIM: Your ...(intervenes).

DR AVESH JUGADISH MAGAN: Yes, ...(intervenes).

ADV ADILA HASSIM: If you can just then get back to what ...(intervenes).

DR AVESH JUGADISH MAGAN: Before we conclude... (intervenes).

ADV ADILA HASSIM: Your concerns were.

DR AVESH JUGADISH MAGAN: There is an important matter that I wanted to discuss today. That is unfortunately my legal correspondents did allude to I but omitted to submit in my affidavit. And that is the meeting on the 1st of November 2017 with GEMS medical aid. Now, even though you may not have the details of this.

ADV TEMBEKA NGCUKAITOBI: Sorry, Dr Magan, are you finished with Medscheme and Discovery?

DR AVESH JUGADISH MAGAN: No, no, no, I have not finished yet but I think it is pertinent to discuss – just to add reference to what advocate Hassim is asking me regarding the use of these codes.

ADV TEMBEKA NGCUKAITOBI: Alright.

DR AVESH JUGADISH MAGAN: Now, remember in my practice there is ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Just conclude then your submissions on Medscheme.

DR AVESH JUGADISH MAGAN: Okay.

ADV TEMBEKA NGCUKAITOBI: And then you can move on to GEMS.

DR AVESH JUGADISH MAGAN: Alright, is there anything more ...(intervenes).

ADV KERRY WILLIAMS: And Dr Magan also please be aware that we heard evidence on coding in your speciality previously, so we do know some of this.

DR AVESH JUGADISH MAGAN: Thank you very much. I want to move on to the meeting with GEMS medical aid. Remember, in my practice, advocate Hassim, 60% to 70% of our practice is GEMS medical aid. Okay? Discovery and Medscheme form a small 20%- 25% of the patients I had attended in the 7 years based in the rural Transkei – in the rural Ciskei. GEMS were a vast majority 70% of my patients. Now , if you look at the meeting I had on the 1st of November with 2017 GEMS, the reason for having that meeting was to discuss my outlier status. Okay? The meeting on the 1st of November 2017 was attended by – in attendance was advocate Janse van Rensburg and members of GEMS panel, was also attended by Dr Gregg with Dr Pratt who is Medscheme's general practitioner who was in attendance at the meeting they had on the 5th of May.

At that meeting with GEMS medical aid we discussed the same issues we are discussing now advocate. We discussed the geographical distribution of my patients; we discussed the socio-economic challenges of my patients. Why is it that GEMS with the same medical advisor gave the practice a clean bill of health? Approved of what I was doing, thanked me for the service that I was providing to an area of need, yet the same medical advisor in a smaller medical scheme takes the complete contrasting stance? The matter – the meeting with GEMS was amicably concluded. They understood that my conservative means to practise was

well appreciated. They noticed that I saved the scheme lots of money and was happy with the way I practise. They showed in their graphs in most circumstances I was far less than the national norms. Yet for the codes that Medscheme choose to highlight I am 70% higher for patients of similar pathology, in a similar socio-economic geographical area.

So, if you look at the details of GEMS outcome, of their meeting, that should be held in contrast to Medscheme's meetings which was completely different. Medscheme was hostile, uncooperative and not willing to listen to me. Their *modus operandi* was that of to be punitive, to suspend my account and to this date I have not stopped seeing Medscheme patients. I still see them yet I do not bill for those operations, neither do the schemes reimburse their members. Currently no one gets paid for those particular operations. I have been doing hundreds of operations without being reimbursed, neither did the members get reimbursed by Medscheme. And that is currently to practice.

ADV TEMBEKA NGCUKAITOBI: I do not remember reading the GEMS correspondence.

DR AVESH JUGADISH MAGAN: I did not submit it. That is why I mentioned in my opening line that I omitted to submit that correspondence but I can certainly retrieve that and have that emailed through to you.

ADV ADILA HASSIM: Please do so.

ADV KERRY WILLIAMS: Dr Magan, sorry, what is your evidence in relation to GEMS that they had no issues at all?

DR AVESH JUGADISH MAGAN: That GEMS perfectly understood the reasons for me being an outlier. It shows that in use of coding that there was a vast amount of codes that I fell below the national norm.

ADV KERRY WILLIAMS: An outlier in relation to what? They understood that you were ...(intervenes).

DR AVESH JUGADISH MAGAN: In terms ...(intervenes).

ADV KERRY WILLIAMS: In relation to the coding?

DR AVESH JUGADISH MAGAN: No, in terms of the number of operations performed, that – of the pathologies being identified and the codes relating to those pathologies.

ADV KERRY WILLIAMS: So, did GEMS have any issues with your billing?

DR AVESH JUGADISH MAGAN: Absolutely not. Absolutely not.

ADV KERRY WILLIAMS: Mr Magan can I then take you to page 913 please? This is the letter from your lawyer to yourself.

DR AVESH JUGADISH MAGAN: Alright.

ADV KERRY WILLIAMS: Turn over to the next page at 914 and if you could read the third paragraph down?

DR AVESH JUGADISH MAGAN: "They undertook to revert to us to specific issues"

ADV KERRY WILLIAMS: The third paragraph down beginning with the word, 'According to GEMS'

DR AVESH JUGADISH MAGAN: Sorry, on page 914?

ADV KERRY WILLIAMS: Correct.

DR AVESH JUGADISH MAGAN: "According to GEMS there were not any issues with the patient outcomes, only with the billing."

So, to highlight that, they were enquiring on the type of codes used and the type of billing but after my explanation they were happy with the explanation offered and the doctor present at the time was Dr Pratt who did not raise any objections. Yet he is the same doctor that represents Medscheme, that was present a Medscheme's meeting.

ADV TEMBEKA NGCUKAITOBI: So, it is actually not true that GEMS had no issues with your billing.

DR AVESH JUGADISH MAGAN: They – I would not say issues, they had raised concern that is why they wanted a meeting in person to allow me a chance to discuss …(intervenes).

ADV TEMBEKA NGCUKAITOBI: Alright, I think you should wrap up because we interposed you in the place of another witness. But I do not want to pressure you, if there are important things you want to raise, feel free.

DR AVESH JUGADISH MAGAN: The important things I would like to raise is that currently, I never had a contract signed with Medscheme or Discovery, I was not a contracted member. The only relationship I have is with my patients. Currently it has been two years in the standing that my account with Medscheme has been suspended yet the impact on my practice is such that I have not failed in my duty to offer emergent and semi-emergent care to my patients. Irrespective of the type of funding

that they had, either on the basis of coming to my rooms or via casualty or the hospital.

So, to date, Medscheme chooses not to pay the member and neither do they choose to pay me. Upon asking members to contact their medical aid as for them to – upon giving them the codes of services rendered, they were told that they have to pay the specialist up front in cash first or pay the specialist, show the proof of payment and then go back to the funder to get reimbursed. And I think in conjunction with or in reference to my legal advisor, this is certainly unlawful where a paying member has to pay for an operation or service, then go back to a funder to be reimbursed.

My understanding is that as an indirect payment method you either pay the specialist in good faith, or you pay the member. In this particular case, or in my case, my patients or members are not being paid, neither am I being paid for services rendering for the last two, two and a half years now. So I still fulfil my duties of providing care to my patients. My patients are greatly indebted to the work that I have done. The Health Professions Council will verify that they have not received any complaints from patients or from any other body for that matter regarding the work that I have been doing for the last seven years.

My question is that, if I choose an indirect method with Medscheme, and that is purely by choice as a proprietor of my own business, surely that they ought to pay their members? Why should members be subjected to paying a specialist up front before they are reimbursed by a funder? And I have been told that is simply unlawful. So

currently we have got over two years of complex , semi-complex elective operations performed with Medscheme that have not been funded, neither have the members been refunded, neither have I been refunded or funded for those particular patients.

ADV TEMBEKA NGCUKAITOBI: How much are they withholding for the services rendered?

DR AVESH JUGADISH MAGAN: I am aware – I am not ofay of the amount but my billing bureau or will certainly note those figures. I am not aware; it is accumulated over period of two years now. I am not aware of it. Even though that the codes – I have no control on which codes that the Medscheme will choose to pay or choose not to pay but I have not made my patients liable for the services that I have rendered. I have not put pressure on them to pay me. I have simply asked them to contact their medical aid and deemed that they should be refunded for services that have been rendered to them.

I have also made mention to my patients that if they feel that I am not deserving of that particular money, then so be it. Then so be it. But I have not raised any objection from not a single member for the thousands of patients that I have treated that were not satisfied for the service I have rendered. So, that is the question that I would like to use this platform is that if Medscheme chooses an indirect form of payment which they have chosen in the last correspondence to me, why are they not paying their members? I do not mind that they do not pay me and they have reason to do that, we can agree to disagree but pay their members.

The second thing that I would like to make mention is that the – currently the use of coding, and whenever we engage with Medscheme or Discovery, would always revert us back to, 'please inform your association, please get your association to guide you with the coding'. And currently, as an orthopaedic surgeon board certified in this country, there is no platform to guide surgeons on coding. It does not exist in this country. That means it is left to the discretion of the attending doctor on the use of coding. It is left to an open platform with the funders, with your regulatory bodies and the service providers to engage in meaningful discussion on the type of codes to be used.

If after year one of practice, if an association or regulatory body had told me, 'Dr Magan, if you are fixing a femur, these are the acceptable codes' surely I would comply? If someone tells me, 'Dr Magan, these are the codes you are allowed to bill, if anything more, please ask your members to be liable for the payments.' Surely I would do that? But there is not any current platform in this country that guides surgeons, that regulates surgeons on the type of coding used. The only thing that is used to guide a surgeon is the pathology being identified, is the type of operation that is being performed. And I can tell you by and analysing my peers that are surgeons in private practice throughout the country, that transcends all racial groups, my choice of coding is no different from their choice of coding. The only difference is the volume of patients being operated by me in an outlying area versus a surgeon who is working in Pretoria, Johannesburg who has ten other orthopaedic

surgeons under one roof. I happen to be the only orthopaedic surgeon in a 500 kilometre radius.

ADV TEMBEKA NGCUKAITOBI: No, we are appreciative of that. I presume that marks the end of your presentation and testimony?

DR AVESH JUGADISH MAGAN: My final statement and request is an open platform is to discuss if there are billing errors been done in the past, why not have an open, I am happy to sit at any open forum to discuss that. If there are errors being done, be guided as what needs to be guided because I am still a young surgeon. I am still supplying an area of need. I am only 42 years old. God willing there will be another 20 years of practice in this country where I would choose to run my practice ethically and run my practice governed by the latest regularities. But certainly, to be engaged in regulatory bodies that are meaningful and non-prejudiced. In my experience I have not had the privilege of sitting in a round table discussion without prejudice. They have all been prejudiced.

The things that I would like to be discussed is that the monies that have been clawed back, if you are being incentivised or your income is based on commission, on money that is clawed back, surely your *modus operandi* is to claw back as much money as possible? Up to this date I have been investigated by a nurse or GPO lawyer but no one has investigated their earnings. Where are their bank accounts? I get to be scrutinised how much I earn per minute as a specialist surgeon. Who gets to scrutinise their earnings as an ex-nurse, a self-proclaimed Forensic Investigator, a self-proclaimed Coding Specialist? Where are

their bank accounts? How much have they earned? How much have they been incentivised to claw back? How much have they been incentivised to call it fraud, waste and abuse? When you group fraud, waste and abuse together I think it is terribly unfair.

If you say I am committing fraud, I have every patient, a human being that has been brought to an operating table. No fictitious patients were ever manufactured. No unnecessary operations were performed. Here we are contesting the use of coding. Whether that contributes to fraud and waste, I do not know. If that defines fraud, then I am yet to be corrected. When it regards waste and abuse, how does that constitute abuse? Abuse by who? Abuse by a funder who chooses to cherry pick codes. Who chooses to claw back money? What is the incentive for doing that? How does that impact on the rising cost of submissions from our people on a year to year basis?

If you claim to have R15 billion in reserve every year why don't our members benefit from that? People in rural areas, people that we serve, people that we have relationship with. Our funders choose carefully not to come to areas of neglect, not to come to areas of need but to sit in offices such as these and to make decisions, hard decisions some of them, on people working on the ground providing our best to areas of need. I served a population of 4 million people that no South African chose to go before, with daily water cuts, daily electricity cuts. To serve people. I started at the University of the Transkei. The advocate knows what it is like to be at that university. It is a difficult area to work in. Yet I have subjected to harsh amounts of criticism, harsh

analysis, for patients, work done to people who are greatly indebted to the work that I provided.

All I ask for is a platform to be fairly assessed, a platform to be guided, a platform to assist each other going forward to the future.

ADV TEMBEKA NGCUKAITOBI: Thank you.

DR AVESH JUGADISH MAGAN: Thank you very much.

ADV TEMBEKA NGCUKAITOBI: I have no doubt that people who are aware of that have listened to what you are saying and people who can help will take that into account. Thank you. If there are further questions, especially the GEMS correspondence that you spoke about, if you could please send that to the ...(intervenes).

DR AVESH JUGADISH MAGAN: I certainly will do that.

ADV TEMBEKA NGCUKAITOBI: Yes, to the CMS. Thank you. I think we should not adjourn; we should just carry on to the next witness. Will you just exchange the seating arrangement? Dr Kalanda, will you come to the front please?

DR NTUMBA KALANDA: Yes.

ADV TEMBEKA NGCUKAITOBI: Dr Kalanda we are reinstating your evidence, we had interposed Dr Magan so you can commence pretty much where you left it before the adjournment.

DR NTUMBA KALANDA: Okay I was at page 15.

ADV KERRY WILLIAMS: Dr Kalanda can you please put your mic on when you speak thanks.

DR NTUMBA KALANDA: Okay I was saying that I was at page 15, invite letter.

ADV TEMBEKA NGCUKAITOBI: Yes.

DR NTUMBA KALANDA: Yes I received an invitation from the Qhubeka Forensic Services and the attachment was asking me that for – no I think they've – okay *ja,* it was on 8 May in 2018 so they were asking me to go to their offices because they've uncovered certain discrepancies in my accounts and they wanted to talk to me about that. In my reply I was asking them to forward me the accounts so that I can prepare for that meeting. While I was waiting for the reply then the reply came back on the 7 June and they were saying that:

> "We are mandated by Bonitas Medical Fund to conduct that analysis and auditing. This is for audit purposes to ensure that Bonitas members are satisfied with the services you have rendered them."

So it's completely different stories from the previous one where they were talking about my accounts and:

> "The auditors have chosen a random radiologist in the area and your profile was one of them."

Then I start questioning myself what type of profile.

> "We hereby request for your patient files on the attached sample list to enable us to complete our analysis."

So it was from a forensic and criminal investigation. Then because of those discrepancy I just decline and I told them that I was not available for that and that they could select another radiologist in the area to conduct their study. After that on 4 June I receive a radiology profile from POLMED, they were profiling my practice.

After reading the document I realised that they were saying that I was claiming more than my peers so I don't know which peer they compare me with and they were false allegation inside the documents. They were claiming that they pay me R111,00 for MRI which I don't have an MRI in my practice so I never claimed for MRI. R2 969,00 for angiography, I don't have an angiography so I just stopped there and considered that the document was cooked, they were looking for something and when I look at the documents the heading on the last pages it's empty and on the heading they set up for your top magnetic resonance image your practice claim more than peer, so they have prepared already just to fill up. If I had an MRI they were just going to fill up that I claim maybe 100% more than my peer.

ADV KERRY WILLIAMS: Dr Kalanda sorry what page are you on now?

DR NTUMBA KALANDA: On the radiology profile, the last page 37. It's just an empty shot it's just ready to be filled with numbers and tables.

ADV KERRY WILLIAMS: And can you explain your interpretation of that?

DR NTUMBA KALANDA: My interpretation on that is in my letter, I said that:

> "I have received your e-mail and I don't agree with its content. It must be clear and understood that I'm not POLMED Medical Scheme employee …"

ADV KERRY WILLIAMS: What page are you reading from?

DR NTUMBA KALANDA: 24:

> "... and my radiology practice is not working for POLMED Medical Scheme. As far as I am concerned I don't have

any contractual issue with you. We never agreed on table of tariff on how I must charge. My practice has never introduced a claimed for MRI."

This one I just deal now.

"And even the total amounts of my practice claim to POLMED Medical Scheme for year 2018 does not correspond with the amount in your profiling. And my practice performs radiological investigation only on referred patient when there is indication."

So this is what in summary what I was telling them it was on 4 June 2019. Then we go to page 38 I receive a letter on 10 June 2019 from Medscheme, it was Medscheme and Bonitas telling me that:

"A routine verification visit in order to verify service rendered by your practice has been conducted on 5 June.

It is unfortunate that ..."

What's happened is that I was in my office and my receptionist called me and tell me that there are five people here, I think four or five people, they want to see you. Then I went to see them, they said no they told me that they are from Medscheme they want to see my equipments. I was surprised because I didn't have any appointment with them and they didn't even provide me with any document to prove that they are from Medscheme.

I told them look I don't have a problem but I'll give you one condition, this one I didn't write in the letter, all the white practices here go and see their equipment and then when you come back from there you

come to me I'll phone them and find out if you went to see their equipment and then I'll show you my equipment these are my conditions. They left and they went to another black practice to check for equipment because the colleague phoned me and asked me did you receive a visit I say yes they came but I didn't show them my equipment.

So after that I received this letter that:

"...as a result of that the payment to your practice has been suspended and a full audit has become necessary to verify your claims."

Then on page 41 I'm giving them my reply telling them what I've told you now that I received four individuals and I refused to give them access to my equipments and despite the fact that they are suspending my payments I'll continue to see my patients as usual and I will send my claim to them and wait for payment within 30 days. If not I'll ask the patient to come and settle and the difficult case will be handed over to debt collector and I'm asking them if it's what they want for their members.

I receive a reply on 14 June they wish to advise me that a direct payment to my practice is terminated, it's page 46 and it will be effective from 18 June 2019 and stating that all accounts for your service must be settled by the patient and then submitted by our member so they will pay back, they will refund the members.

ADV KERRY WILLIAMS: Dr Kalanda referring to that letter from Medscheme ...(intervenes).

DR NTUMBA KALANDA: Page 46.

ADV KERRY WILLIAMS: 46, what do you know about their review of your claiming patterns and profile?

DR NTUMBA KALANDA: Oh we are going there.

ADV KERRY WILLIAMS: We're going there, great.

DR NTUMBA KALANDA: This is before we get there.

ADV KERRY WILLIAMS: But at this stage what you know ...(intervenes).

DR NTUMBA KALANDA: This stage they were not review yet.

ADV KERRY WILLIAMS: Okay at this stage you know nothing?

DR NTUMBA KALANDA: No nothing, no there's no review pattern you see first 2016 they said that there are irregularities they send me the audits, I reply, I ask the lady is it, why are you doing this, she say okay give us your document, then I give and nothing, no irregularities. 2009 – I think 2018 if I can remember again irregularities, I ask them which irregularities no it's not irregularity we just want to do an audit to check if our members are satisfied. So I understood that irregularity for them is a generic word. Whenever they want to access somewhere they say okay I've got some irregularity but when you ask them which irregularity they don't have anything. So they must access your file to dig up and find something.

So I'm at 40 – I think page 46 they say that they will no longer pay me and they will pay patients. On my reply I tell them:

> "I have received your letter. I feel like I am bullied and racially profiled by your medical scheme. In my eyes your decision to suspend payment to my practice does not seem based on valid reason."

Because they didn't give me a valid reason that they are suspending my payments and I dispute it and I told them:

"I am available to discuss and try to settle any means understanding."

Page 48 they acknowledge receipt of my letter and say that they will come back to me. They came back to me and we had a telephone conversation. During that telephone conversation I think after that then they decide to do an audit. Because I'm complying I don't have anything to hide I say okay I don't have a problem you can do your audits. So they were saying in page 50:

"The audit will start from January 2017 up to 10 June 2019 verification of services."

So they were giving me a list of patients for which they wanted a file. They wanted to have a clear list of equipment including licences but I gave them licences – my licence in 2016, they want it again. They want a list of all employees employed in my practice including their practice numbers. I provided them with information page 53. Then 15 August 2019 after the audits that's when they start with their problems. So following the audit they have said that they have found some irregularities especially with unbundling of ultrasound codes.

Because of those irregularities there is a certain amount that I should pay back to them, page 59 and if I don't pay them, they give me an option, repayment agreement by way of an agreed payment arrangement over a fixed period, settlement by means of a deposit of the entire amount owed; three by means of direct deduction from future current valid claims

submitted by my practice. If I don't agree they reserve the right to report me to credit bureau for blacklisting.

In fact what are they saying? When I do ultrasounds I have a request for ultrasound from the referring physician. The referring physician wants an ultrasound of abdomen and pelvis. The abdomen starts here and ends here and the pelvis starts here below. Then I examine the abdomen and pelvis then I claim the abdomen and pelvis. But the medical aids has made a provision where they have bind those two codes the abdomen and pelvis they have bind it into one to make it cheaper for them. It become abdomen including pelvis. So this is the code that they want me to use. So because I have not used that codes all the extra they have now tried to calculate from the audit that they have done all the difference amounts I owe them and if I don't pay they will blacklist me.

ADV TEMBEKA NGCUKAITOBI: Why do you believe that your method of coding which separates the two, why do you believe that is the accurate method versus the scheme that says the two should be bundled?

DR NTUMBA KALANDA: I'm doing what the referring physician asked me to do. I don't know how to explain it. You go to a shop, to a car dealer you want a bakkie and a sedan and the guy give you a double cab I don't know, he said no it's cheaper to have a double cab but you want a bakkie and a sedan. So the referring physician I've given them all the request form and my reports for the audits and the referring physician is requesting the ultrasound of abdomen and ultrasound of pelvis. So they must talk to the referring physician tell him please refer according to the

code that we want, don't request like that.

ADV TEMBEKA NGCUKAITOBI: Sorry Doctor I think we are at cross-purposes because what I'm trying to explore is whether there is an inconsistency between the job that must be done from a clinician's point of view and the function of the scheme which is reimbursement because you are saying that from a medical point of view you have to separate them clinically. The scheme says for purposes of billing they must be combined, that is what I'm trying to explore with you and you're saying that the real problem is that the schemes do not care about what we must do from a clinician's point of view?

DR NTUMBA KALANDA: This combining is just for money purpose; the scheme wants to save money. The main issue is that the scheme want to save money, that's the main issue.

ADV KERRY WILLIAMS: And the dilemma is the scheme will argue you want to make money.

DR NTUMBA KALANDA: I'm in business. I'm serving the people but not only I want to make money I'm the one who decide what I will do, there are people who are walking free from my practice, I look at him I say this one I'm doing for free. It's not irregular. This one I just tell my staff please don't claim for that guy just let him go. It's my decision, it's not the medical scheme decision so it doesn't become irregular for that. Because actually they want to impose on me which I don't accept.

So in 61 I'm telling them that I'm accountable for all codes that I've used, all claim and all ...(intervenes).

ADV KERRY WILLIAMS: Dr Kalanda sorry can I just read; the scheme

has given a response as you know to your complaint ...(intervenes).

DR NTUMBA KALANDA: Ja I'm going to there, I'm just ...(intervenes).

ADV KERRY WILLIAMS: Will you take us ...(intervenes).

DR NTUMBA KALANDA: Do you want us to go straight to it?

ADV KERRY WILLIAMS: No, no it relates to the same point so I don't want, I'm not asking you to jump around your chronology is fantastic. Are you aware of the e-mail that the scheme – Medscheme has put up from Dr Richard Tuft the ...(intervenes)?

DR NTUMBA KALANDA: I'm aware of it.

ADV KERRY WILLIAMS: Okay so you'll come to that?

DR NTUMBA KALANDA: *Ja.*

ADV KERRY WILLIAMS: Thank you.

DR NTUMBA KALANDA: I'm aware of it. So now I'm telling them that I'm not owing them money if they want to take me to credit bureau they can go ahead but I will sue them for loss and damage. But at the end I'm telling them look I'm available to discuss and harmonise with you of any change you wish for the future of our relation. So I'm making myself available to talk to them, to negotiate, to see where we can meet and how we can move forward.

ADV KERRY WILLIAMS: Before you carry on I just need to ask one other question about this letter from Medscheme to yourself when they suggest the amounts that you should pay back. So at page 58, and we obviously have to test if Medscheme is being fair, they say to you:

> "Patient records requested were received and a number of billing irregularities were identified."

At that time what, did you know what these billing irregularities were?

DR NTUMBA KALANDA: That's the problem with Medscheme they use the term irregularity you know this is the only irregularity that they came with is that one the unbundling of codes. Except for that they didn't come with something else.

ADV KERRY WILLIAMS: And do you know how that amount of R170 281,00 was calculated?

DR NTUMBA KALANDA: That's what I was explaining before, they took all the claim that I've done for abdomen and pelvis they make it as whole abdomen including pelvis and the difference amounts is what they are saying that, they are claiming that I owe them.

ADV KERRY WILLIAMS: Okay I thought that amount was the 169 below so that's why I – because that relates to the abdomen and pelvis issue so that's why I'm asking about the R170 000,00.

DR NTUMBA KALANDA: I didn't really – what I'm doing here I'm not going into detail into the amount I'm just going into the principle first. I will look at the amount later, I'm going on the principle is there any irregularity or not, that's the principle I'm working on because the amounts – I'm not looking at the amount. I'm looking first is there irregularity because I'm telling them there is no irregularity in what I've done so have nothing to claim from me that's where we are fighting now.

ADV KERRY WILLIAMS: Go ahead.

DR NTUMBA KALANDA: And I give them my e-mail and my phone number so that we can talk and discuss but if they go on – carry on with

credit bureau I don't have a problem with that, I'll take them to task. Then because of that I've shown them that I'm willing to negotiate, I'm willing to talk to them but they're not showing any willingness then I introduce my complaint to the medical scheme. In that complaint I was talking about the bullying tactic, the letter of invitation from criminal investigator, the radiology profile, cooking of documents, sending unidentified people in my practice just to want to check, why are they doing that because of my profile, unlawful suspension of payment to my practice because they didn't give me a valid reason when they have suspended.

This unbundling of codes problem came only after the audits imposition of tariff code to use and attempt to extort money from my practice. So that was my complaint for and my expectation that I was asking them to stop bullying me and to cancel the unlawful suspension of payments and to stop cooking documents and to contact me or my practice directly and immediately if they identify any specific billing anomaly or error and they must be specific about it in order to provide me with the opportunity to verify allegation and give an appropriate response, page 70, and to stop any attempt to extort money from me.

Then we've had another telephone conversation after that because I told them that I was available. Page 71 they informed me that there was some missing – from the previous audits, there was some documents that they didn't receive and I asked them to forward me the list and I give them again that information. So they receive all the information they needed for the audits and page 73 they come with

something else. They continue with this irregular ultrasound code billing but this time they are not threatening to take me to credit bureau they say that they will just collect money from the money that they owe me.

Page 74 the last paragraph:

> "Please be advised that the quantification for irregular billing will be recovered by means of direct deduction from future current valid claims submitted by your practice."

Then after that I replied to them because they have been in breach of their own letter first because they were suspending my payment on 18 June but in fact they have stopped paying before 18 June, page 76 then I provided them with a list of patients for whom I didn't receive payment before 18 June because according to their letter they say we will suspend your payment effective from 18 June. So they were in breach of their own letter. Secondly they were in breach of the Section 59 of Medical Scheme which gives them 30 days to pay claims after receiving, to pay a provider or a member after receiving claims irrespective of what.

And I also stop, I tell them that I will no longer talk to them and I will wait for the – I informed them that I have lodged a complaint against them and that I'm no longer available for discussion. So that's where we are with them.

So with regard to page 84 no, no what you are referring to about – *ja* page 86 first I think I've given you a document page 87.

> "Practices are reminded that as in the past it is their prerogative to determine their own billing rates."

After reading this letter on 86, I've contact the Radiology Society to ask them if they can give me a guideline on how we should claim. While I was here I receive some reply, I tried to - went to go through it but it was not talking about the issue at hand that is one and I don't know what the medical aids ask the Radiology Society I don't' know if there are correspondences I have only this answer. But he is saying the underlying principle of the coding structure is that wherever possible.

Then it means that it's a discretion of the radiologist who doing – the person who's doing the investigation. So on my side I think there is no irregularity on my billing. They are just trying to force my hand to admit that there's an irregularity.

I told them that there's no irregularity and for that I'm not owing them any money. So we are at that stage. And they didn't pay even some members didn't receive money from them – some of their members.

ADV TEMBEKA NGCUKAITOBI: I mean I don't think that the case made by Medscheme is that you've done anything dishonest. I think there is a problem about unbundling.

DR NTUMBA KALANDA: *Ja.*

ADV TEMBEKA NGCUKAITOBI: That is the main complaint they have against you now.

DR NTUMBA KALANDA: H'mm.

ADV TEMBEKA NGCUKAITOBI: Now someone needs to set the rules about the bundling or unbundling of codes. You've given us this document from the Radiological Society of South Africa which on the face of it seems to say it's your prerogative to decide your code.

But the scheme set its codes which you are aware of and you've signed and you've agreed to them. Why don't you comply with them?

DR NTUMBA KALANDA: I didn't sign anything with the scheme. My customer are – I mean my patients, those are the person I'm dealing with. The scheme is with his patients and me, I'm with my patients. So I'm claiming because the patient tells me, look this is my medical aid.

But I didn't sign anything with the scheme. I don't have any contractual obligation with a scheme and I'm not working for the scheme.

ADV TEMBEKA NGCUKAITOBI: I'm saying why don't you just comply with what the scheme says, what's the problem?

DR NTUMBA KALANDA: Because I'm not working for them, I'm not their employee and you know I think I've shown them that I'm willing to talk to them. What does it mean? They can come and negotiate with me and tell me, look doctor, we would like it to be done this way. It costing us, we need to save some money for our shareholders. Can you please help us in that way? But they don't do that, they just coming to force me. I cannot accept that.

ADV TEMBEKA NGCUKAITOBI: And I mean a part of the problem of course is that this is all retrospective.

DR NTUMBA KALANDA: *Ja.*

ADV TEMBEKA NGCUKAITOBI: And there doesn't seem to have been any notice before that you couldn't unbundle.

DR NTUMBA KALANDA: No, I'm doing – they have, if you because – what I want to say, the case the specific cases that they have selected are the cases from oncologists, those are patients with cancer and cancer

it spreads all over the body.

That is why, that specific oncologists is requesting abdomen and pelvis because he knows even – he knows that cancer in the brain, you can see something down there. So it's a general check-up. So there are cases where I use the unbundle codes but it's up to me, it's not up to the medical aid. It's up to me.

ADV TEMBEKA NGCUKAITOBI: Just to make sure that I understand that. I mean is there anything clinically that would be wrong if you used the codes that the scheme suggest you use, in other words, the bundled code?

DR NTUMBA KALANDA: There is nothing really clinically that will – no, nothing clinically but the amount of work, the work and time.

ADV ADILA HASSIM: Isn't it less work if you doing a pelvic and abdomen scan at the same time than if you were doing them separately?

DR NTUMBA KALANDA: No, it will be same work but more time.

ADV ADILA HASSIM: If you doing it ...(intervenes).

DR NTUMBA KALANDA: More time like ...(intervenes).

ADV ADILA HASSIM: In one go ...(intervenes).

DR NTUMBA KALANDA: Like I do the abdomen, the patient goes out then come back for a pelvis.

ADV ADILA HASSIM: It would take more time to do a separate pelvic scan and a separate abdomen scan, right. Than it would to do both on one patient in one go?

DR NTUMBA KALANDA: You know as I'm telling you, this patient is an oncology patient which mean is a patient with cancer. There are many

small details that we are looking at unlike someone who come, look I have pain. So the attention, the energy is different.

ADV ADILA HASSIM: But in general.

DR NTUMBA KALANDA: H'mm.

ADV ADILA HASSIM: If you were to do a pelvic scan separate from an abdomen scan.

DR NTUMBA KALANDA: H'mm.

ADV ADILA HASSIM: That would take a bit more work and time than if you were doing them together on the same patient.

DR NTUMBA KALANDA: On the same patient together it will not take – it depend on experience. Me it takes me around 15 minutes, 15 to 20 minutes for abdomen and pelvis. I don't understand the ...(intervenes).

ADV ADILA HASSIM: My point is that it would be because it is less – you would use a simple word. Just it takes less time, it's less complicated. It's not two separate patients or one patient that are seen on two different days and two different scans.

DR NTUMBA KALANDA: H'mm.

ADV ADILA HASSIM: And that it is appropriate to use a bundled code.

DR NTUMBA KALANDA: No because ...(intervenes).

ADV ADILA HASSIM: Because if you use the unbundled code, you suggesting that there are two separate scans are being done which cost more.

DR NTUMBA KALANDA: *Ja.* You see they have selected a specific cases for their audits. And those specific cases are patients with cancer and patient with cancer even a cancer of the breast, it can spread in

different organs so we are staging. So I have to check small details and not miss them. That is why ...(intervenes).

ADV TEMBEKA NGCUKAITOBI: Now that's what I'm trying to test ...(intervenes).

DR NTUMBA KALANDA: This, me I'm also charging for this energy that I am – it's a lot of energy.

ADV TEMBEKA NGCUKAITOBI: Yes. You see what I ...(intervenes).

DR NTUMBA KALANDA: It's not like someone who come with, look I have a pain. You don't use the same attention.

ADV TEMBEKA NGCUKAITOBI: Yes. I mean what I was trying to ...(intervenes).

DR NTUMBA KALANDA: What I want to say, the work is not the same. It's not the same work depending on the clinically indication.

ADV TEMBEKA NGCUKAITOBI: Yes. Now that's – earlier I was asking you if your testimony to be understood is that the bone of contention between you and the scheme that you say, you have to do it your way because that is a clinical judgement.

DR NTUMBA KALANDA: H'mm.

ADV TEMBEKA NGCUKAITOBI: Which is in the interest of the patient?

DR NTUMBA KALANDA: H'mm.

ADV TEMBEKA NGCUKAITOBI: In other words, you must unbundle the two procedures.

DR NTUMBA KALANDA: *Ja.*

ADV TEMBEKA NGCUKAITOBI: From a clinical point of view.

DR NTUMBA KALANDA: *Ja.*

ADV TEMBEKA NGCUKAITOBI: Then you said, no, no, no you don't have to do it from a – there's nothing clinical about what you are doing. It's just a choice.

DR NTUMBA KALANDA: H'mm. I don't get it.

ADV TEMBEKA NGCUKAITOBI: What I mean, you could have chosen to do it the way the scheme wants, you just don't want to.

DR NTUMBA KALANDA: I'm doing it, it doesn't mean that in my practice I don't charge the unbundle one, I do it. I use that code but the specific patients that they used for that study are patient with unbundled codes and those patients clinically those are patient with cancer.

So it requires from me more energy to check unlike the other one which I'm – their using the unbundled which like you have some healthy patients, just some pains. The indication is not the same. Then I from the energy that I am spending and the time I'm selecting this code because also this is what the physician requested. The physician requested me to do an abdomen ultrasound and pelvis ultrasound. So I'm giving him what he asked me to do.

ADV TEMBEKA NGCUKAITOBI: Now show me where you told the scheme those two explanations you've given.

DR NTUMBA KALANDA: H'mm.

ADV TEMBEKA NGCUKAITOBI: That firstly these are oncology patients and secondly it was an instruction from the physician.

DR NTUMBA KALANDA: H'mm. *Ja,* more – I didn't tell them that these are oncology patient because I just realise it when I was doing the – collecting the data for them. I realise oh but these are the oncology

patient that they are requesting because oncology patient are the most expensive.

When the doctor for oncology request a CT scan, he doesn't want – he request sometime from the head till there. Those are the most expensive so they selected the most expensive investigation because it's costing them and they say let's verify. But these are patient – most of them, all of them those are oncology patients that they have verified. So if they have selected all the patient, they will see that I'm also using the unbundled codes. But the point here is that there is no irregularity.

ADV KERRY WILLIAMS: Can I ask a question about these codes?

DR NTUMBA KALANDA: *Ja.*

ADV KERRY WILLIAMS: Do each of the codes so the 43200, 41200, 40210. Do they each have dissociated time?

DR NTUMBA KALANDA: *Ja* because they have a limitation. If for example I say ultrasound of the abdomen, then I limit here. I examined this area.

ADV KERRY WILLIAMS: Does the code have like psychologists, is there a time, does it take you 10 minutes, does it take you 5?

DR NTUMBA KALANDA: No, there's no time. The time depends on each one with his experience. There's no – the timeframe for your investigation, someone can take one hour where someone can take 10 minutes and someone can – so it depends on the individual but *ja.*

ADV TEMBEKA NGCUKAITOBI: Thank you, do you have anything else to add?

DR NTUMBA KALANDA: No, I don't have anything else to add.

ADV TEMBEKA NGCUKAITOBI: Alright. Well, thank you then for your time and for coming.

DR NTUMBA KALANDA: Thanks a lot.

ADV TEMBEKA NGCUKAITOBI: If there are further questions, they will be sent to you in writing.

DR NTUMBA KALANDA: Okay thanks a lot.

ADV TEMBEKA NGCUKAITOBI: The Inquiry is adjourned until further notice.

INQUIRY ADJOURNS *SINE DIE*

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

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