SECTION 59 INVESTIGATION

Submission by Advocate Hasina Cassim

Introduction

- Qualifications
- Experience in healthcare sector

This submission

- Personal capacity
- Based on collective experience spanning various schemes/administrators and various healthcare provider disciplines
- Objective and subjective assessment

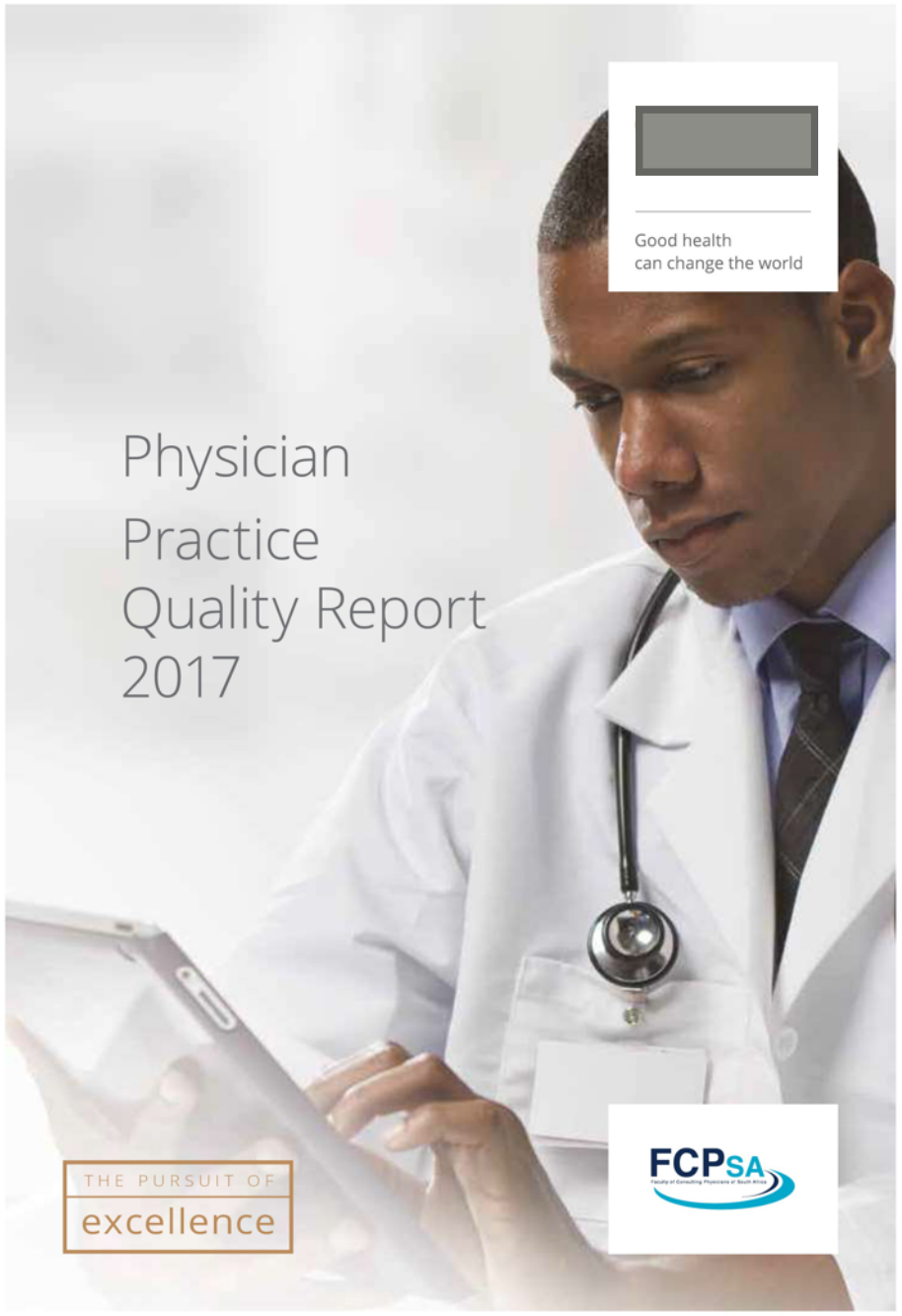
Demographics of professionals represented

Gender	Male – 47%	Female – 53%
Racial mix	White – 13.3%	Black – 86.67%

discipline	
Specialists	27% (mainly consulting disciplines)
General practitioners	20%
Allied healthcare professionals	46%
Pharmacists	7%

Types of ”investigations” conducted by schemes

- Forensic investigations
  - *Based on billing codes, cost per event*
  - *Purportedly initiated by “tip-offs”*
  - *Previous investigations (flagged practices)*
  - *? Probes*
  - *By discipline*
  - *Time-based billing practices*
- Risk-management investigations
  - *Almost exclusively consulting disciplines*
  - *Outcomes-based (admission rates, total costs, number of visits per beneficiary)*
  - *Risk adjusted*
  - *Cost per admission (all costs attributed to primary admitting doctor)*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Authority to perform investigations

- Scheme must operate in accordance with the Act (MSA) and the Scheme's rules.
- Scheme rules
  - *Rule 12.5.4 of the Scheme Rules which states that the* [redacted] *board is "to maintain a fraud management policy and implement the sanctions contained therein from time to time, which may include the recovery of losses by the scheme".*
  - *Rule 12, is in respect of the* ***members*** *of the scheme and more specifically "SUSPENSION AND TERMINATION OF* ***MEMBERSHIP****" (own emphasis)*
- Contract between scheme and administrator/managed healthcare organisation/FU

Systemic issues which ”distort” investigations

- Co-payments
- Deductibles
- ”savings accounts”
- Scheme rules (exclusions e.g. out-patient diagnostics)
- Non-payment for tele-medicine and tele-consulations, reports, PMB motivations

Procedural issues with investigations

- Asymmetry of power and resources
- Conflation of fraud, abuse and waste (“billing irregularities”)
- Timelines - unreasonable and inconsistent
- Conduct at hearings
  - *Inquisitorial (despite being characterized as a “mediation”)*
  - *Intimidating (”smile – you’re on camera”)*
- Asked to sign “record of proceedings” without an opportunity for proper review
- Informed about “tip-off” without details of same
- Consent (non-specific)

Investigations are substantively unfair

- Letter is vague and lacks detail
- Provider categorized as an “outlier” without proper explanation or elaboration on how analysis was conducted
- No risk-adjustment or outcome measurement
- Asked to produce a limited sample of patient files, but investigation includes all patients from all schemes administered by administrator
- Type of information requested exceeds scheme’s mandate (purchase invoices, diaries)
- “blanket consent” and refusal to indemnify provider
- Sharing and requesting information from competitor schemes/administrators

Substantive unfairness (continued)

- Extrapolation exercise (consideration of Section 59 and regulations 6?)
- Coercion in signing AOD
- Automatic suspension if no resolution at conclusion of meeting
- Make-up of forensic team – subconscious biases
- Non-disclosure of “experts”

Issues with coding

- Time-based and procedure-based
- Lack of ownership
- Consultation
- Unit value must be justifiable and sustainable
- Units allocated in accordance with the complexity of a procedure
- Examples of misalignment
  - *Cardiology*
  - *Psychiatry*
  - *Orthopaedics*

Section 59 and Regulations 5 and 6

- In regard to the Medical Schemes Act, it is important to have regard to sections 26 and 59, read with Regulation 6:
- "59 Charges by suppliers of service –

  1) A supplier of a service who has rendered any service to a beneficiary in terms of which an account has been rendered, shall, notwithstanding the provisions of any other law, furnish to the member concerned an account or statement reflecting such particulars as may be prescribed;

  2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

  3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of –

  a) Any amount which has been paid bona fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled; or

  b) Any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme, deduct such amount from any benefit payable to such member or supplier of health service."

Regulations 5 and 6

- Regulation 5 of the MSA regulates the detail that is required from suppliers of services to ensure that a member's benefits can be determined and payments made.
- Regulation 6 of the MSA deals with payments of claims in respect of benefits and includes:
- Regulation 6(2) which specifically states that:

  *"If a Medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it **must** inform both the member and the relevant healthcare provider **within 30 days** after receipt of such an account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion".*

- Regulation 6(4) which states that:

  *"If a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of subregulation (2) or fails to provide an opportunity for correction and resubmission in terms of subregulation (3**), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute**."*

- Regulation 6 recognises and caters for the huge administrative burden of claims and payment administration – and importantly imposes statutory timeframes within which certain steps must be taken. See specifically 6(2), (3) and (4).
- Regulation 6(2) requires medical schemes to raise any challenge to an account, statement or claim within 30 days and state the reasons.
- If a medical scheme fails to act within the aforesaid 30-day period, then in terms of Regulation 6(4) the onus shifts to the medical scheme.
- The Act through the stipulations in Section 59 and Regulations 5 and 6 make it patently clear that a claim for a service by a member or a healthcare service provider, must be honoured where:
  - *The member is a valid beneficiary of the scheme*
  - *The service falls within the definition of the benefits that a member is eligible for*
  - *The claim has been submitted in accordance with the prescripts of the Act*

- Funders have adopted a blanket approach and have failed to meet the obligations created in terms of Regulation 6(2), which state that a dispute must be declared and that in order to not fulfil its obligations that arise in terms of the MSA in respect of honouring a claim, that it must prove that each and every claim that forms part of the dispute is either erroneous or unacceptable.
- Where a medical scheme opts to “claw-back” sums paid, it must do so within the prescripts of Section 59(3). Section 59(3)(a) applies only to claims which a medical scheme has paid bona fide, but which payment it has subsequently determined the member or the service provider was not entitled to.
- In the instance of Section 59(3)(b), the test is that a medical scheme must have suffered loss as a result of theft, fraud, negligence or any misconduct. The Funders in cases of so-called billing irregularities, have failed to make a case for any of the above allegations.

Conclusion and recommendations

- Fraud (as defined in law) is inexcusable (0-tolerance)
- Waste and abuse must be dealt with in a systematic manner
- Investigations and sanctions must be undertaken in accordance with legal prescripts (in substance and procedure)
  - *Justice – (fairness, consistency, certainty)*
  - *Independence in adjudication*
  - *Unbiased adjudication*
  - *Audi alterem partum (representation)*
- Proof - the fundamentals of evidence, must be invoked
  - *Proper investigation (entrapment?)*
  - *Factual proof*
- Conciliation, mediation and arbitration (independent and objective)

The relationships of trust must be re-kindled

Patient-provider

Provider-funder

Regulator/s - stakeholders