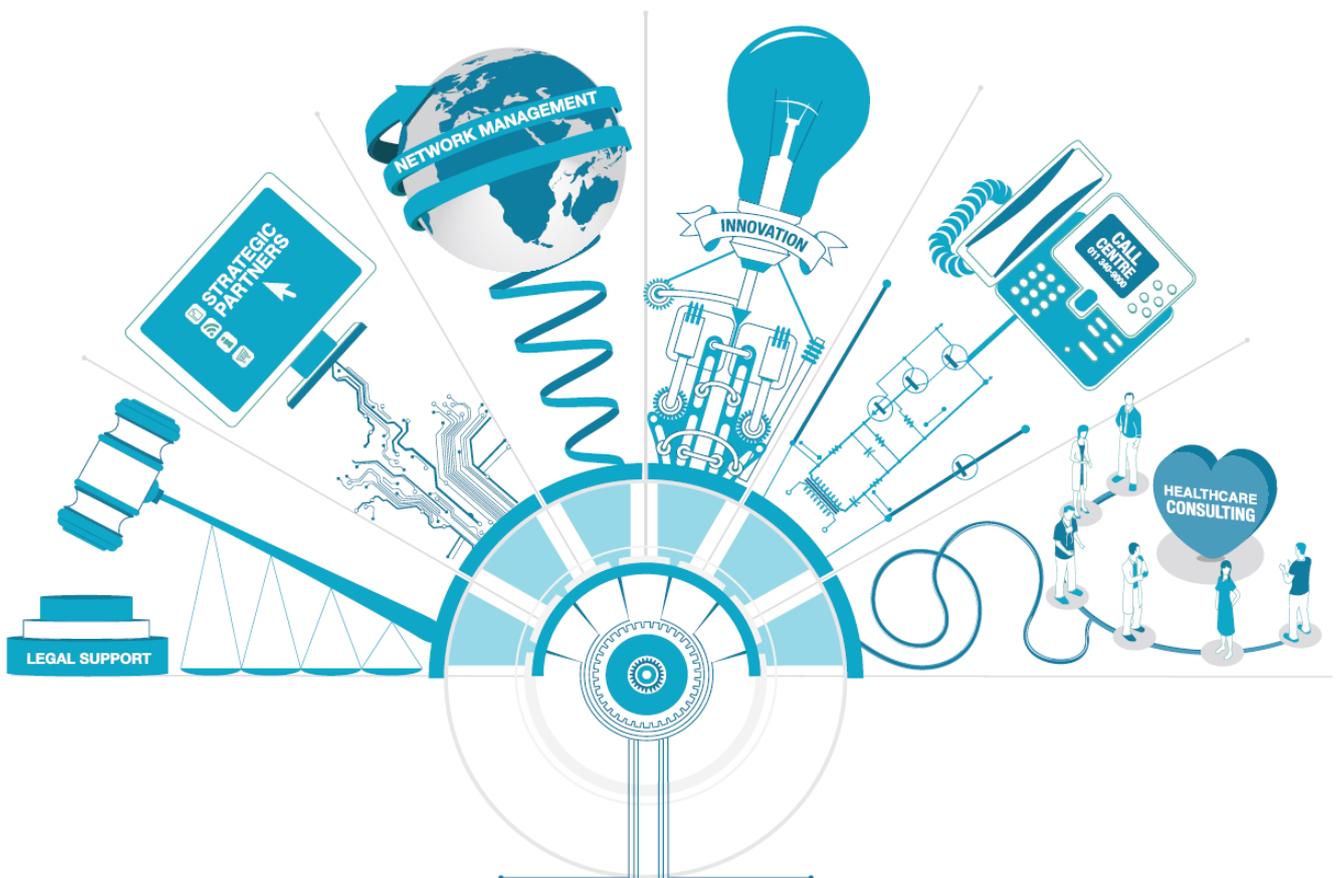


New Year Newsletter 2016



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INTRODUCTION

The management and staff at HealthMan wish all our clients, their staff, and recipients of our newsletter a prosperous, memorable and stress-free 2016.

This time last year our radar was clearly trained on issues like the Competition Commission's Inquiry into private health care, amendments to the National Health Act related to Certificates of Need defining regional distributions of working practitioners and renewed challenges to Prescribed Minimum Benefits legislation. As in the past these and other issues, despite targeted and well-informed challenges, tend to get swept under the rug – never really going away but hiding out of sight until they are dusted off and brought to light again.

2015 saw the results of a Ministerial Task Team investigation into the Health Practitioners Council of SA, revealing what many have felt in their frustrated dealings with Council – that it has become increasingly dysfunctional and inappropriate for the sector it purportedly regulates. Regulation 8 pertaining to payment in full for PMBs again came under court scrutiny and seems, for now, to have been upheld. Lastly, but certainly not least, the long-awaited White Paper on National Health Insurance surfaced quietly amid a December week shadowed in outrage and consternation over foolhardy and unilateral Presidential decisions. Maybe the idea was to steamroll its unworkable proposals through under the authority of a new Minister. Yet, with the quick re-appointment of the very Finance Minister – Pravin Gordhan – who dismissed the burdensome project when it was pitched in 2011, it will be interesting to see what, if any, provisions are made for the NHI scheme in next month's budget.

The regulatory framework serving as the basis for all future relations between practitioners, medical schemes and the public health service has not sprung any new surprises at the South African Private Sector. The flashpoints remain relevant and will occupy us all for many years. What has not changed is HealthMan's dedication to keeping our clients informed and protected when the public sphere seeks to infringe on their domain.

The Competition Commission's Inquiry is still underway. We will provide updates regarding this and remind you below of new timelines relevant to the foregoing process. Regarding medical scheme news, you will find your 2016 designated payment arrangement updates outlined below for your convenience, along with scheme rate increase for the upcoming year, news of amalgamations, benefit option changes and general changes.

We trust our 2016 Annual New Years' Newsletter finds you healthy, rested, and confident to meet a new year full of challenges and opportunities.

The HealthMan Team

11 January 2016

1. REGULATORY NEWS

1.1. Competition Commission Market Inquiry into Private Healthcare

The sheer volume of written submissions to the Competition Tribunal undertaking the Competition Commission's (CC) Inquiry into Private Healthcare costs and the "extent of the inquiry" itself has delayed publication of a provisional report into the Commission's findings, which was expected by November 2015. Instead, on October 16, an amended Terms of Reference (ToR) for the completion of the market inquiry was published, along with a revised administrative timetable on its website.

[\(http://www.compcom.co.za/healthcare-inquiry/\)](http://www.compcom.co.za/healthcare-inquiry/).

The CC has an opportunity to make recommendations which can assist the State in bringing quality and affordable healthcare to all South Africans. In terms of the amendment, the final Inquiry report will be completed by 15 December 2016. This says the CC "may include recommendations", which is unsurprisingly non-committal. The scope of the Inquiry remains unchanged. The CC added that the Inquiry was in its "information assessment and analytical phases." Information requests related to the submissions and responses received, were sent to over 160 stakeholders in the private healthcare sector, allowing the team apparently "to conduct detailed inquiries into the potential healthcare access and competition concerns highlighted".

This pushes the process out by another year. Of immediate interest is that Public hearings (to clarify aspects raised in the written submissions and for which requests to participate must have already been made) are scheduled to kick off on 1 April 2016. These should run until 31 May 2016. The Commission subsequently re-opened applications to the oral hearings.

The first stage of the hearings will take place between 1st and 12th February 2016, dates dedicated to consumers' responses to issues raised in the ToR. There will be five further stages of hearings between the end of February and the end of May 2016. The specific topics to be covered in each of these stages are of some relevance to doctors, medical specialists and allied practitioners. For example: the third stage of the hearings will explore whether competition exists amongst healthcare practitioners and the effectiveness of this competition; the fifth stage will explore competition that exists amongst healthcare practitioners and private hospitals. The intention is for the CC panel to present its analysis and presumably give stakeholders an opportunity to respond, correcting in these interim stages any misconceptions or crucial omissions.

Legal counsel has advised some of HealthMan's clients who have made written submissions and intend to be present at the hearings to, at least, keep a watching brief at all the 6 stages of the hearing; request to make further oral submissions during the period 9 to 12 May 2016 (this will be after the general hearings on whether there is effective competition amongst healthcare practitioners and after the Commission has presented its analysis of this issue).

1.2. The Health Professions Council of South Africa (HPCSA) - A Case of Multi-System Failure CD

In March 2015 Health Minister Motsoaledi launched a ministerial task team (MTT) to investigate the troubled HPCSA – a failed merger of the historic Medical and Dental Council with bodies regulating a number of other non-specialist health, emergency, and rehabilitative health services. To determine if complaints against it were founded, the MTT focussed on the Council's performance in terms of its core functions, namely: "(1) registration of health professionals, (2) examination and recognition of foreign qualifications of practitioners, (3) professional conduct enquiries, (4) approval of programmes in training schools, and (5) continued professional development." Managerial functions were scrutinised in light of previous findings of tender fraud and procurement irregularities in the areas of IT, HR and overall Risk Management.

In September the MTT's findings presented in a report entitled 'A Case of Multi-System Failure' was handed to the Minister. It corroborated what former employees of the Council and aggrieved members have felt for years: that "the HPCSA is in a state of multi-system organisational dysfunction which is

resulting in the failure of the organisation to deliver effectively and efficiently on its primary objects and functions in terms of the Health Professions Act.”

The MTT furthermore discovered:

- Administrative irregularities, mismanagement and poor governance in procurement processes for IT systems.
- Unfitness of incumbents in senior leadership roles, recommending dismissal and disciplining of the Council’s CEO, COO and Legal Services General Manager.
- The HPCSA has severe structural defects that contribute to its dysfunction: “Conflicts of interest”, “institutional problems in relation to skills mix”, a “fail[ure] to provide leadership and guidance to the health professions”.

While an interim executive management team composed of people with medical training and experience in turning around failing organisations as well as future regulatory amendments were proposed to fix the failed system, it has been announced that Council is now wasting resources with an internal investigation of its own. It has disregarded the MTT’s recommendations as “advices or proposals and therefore not binding”.

1.3. The Independent Coding Authority: South African Classification of Healthcare Interventions (SACHI)

Funder, specialist and regulatory stakeholders assembled for the first joint *SAPPF/SAMA Industry Coding Workshop* in almost two years in Midrand on 26 June 2015. The purpose, pressing and crucial, was to discuss how SAMA and SAPPF should examine industry requests for accommodating new codes and evolving medical reality in the clinical coding universe. The meeting was not a forum to discuss tariffs or fees. SAPPF CEO Dr Chris Archer said that these must be for another not-yet-established body (potentially under the auspices of the NDoH).

Most of the work has already been done to attain a uniform language that accurately describes medical, surgical and diagnostic services and thereby serves as an effective means for reliable national private and public sector communication amongst all healthcare professionals, patients, funders and administrators. What is missing are the governance bodies and management processes to keep it accurate, updated and apolitical; preventing unilateral determinations by funders of what constitutes scope of practice; simplifying complexity, which leads unknowledgeable practitioners to “up-code and code-farm” and protecting patients from undue co-payments.

On the agenda then were: the importance of proposed changes to SAMA codes for 2016, a reiteration of the need for tiered consultations (which SAMA proposed in 2004) and for an Independent Coding Authority and proposals on how the Medical Coding Governance Process can and should proceed going forward despite the regulatory distractions posed by the CC Market Inquiry and resurrected Regulation 8 Challenge.

Collective fee negotiations came to a halt in 2003/4 with the Competition Commission’s ruling that such practice was collusive and tantamount to price-fixing. The troublesome component that falls afoul of the competition act is not codes, descriptors or RVUs, but the Rand Value attached to them which converts codes into tariffs. CC representatives were in attendance, essentially to acquaint themselves as part of their ongoing inquiry into the South African Private Healthcare market with the unintended legacy of their forerunners’ decision.

Dr Eugene Allers summarised the current dilemma in the coding structure as the inability to account for new technology and techniques, the lack of an authoritative source reference (including a Reference Price List) for codes and queries, or a means to determine outdated Relative Value Units (RVUs). All OECD states with a private sector use RVUs, Dr Archer reminded listeners. When one considers that 54,000 practitioners nationwide are responsible for submitting approximately 74,000,000 claims to schemes annually, the integrity of our coding system is critical.

It was proposed that responsibility for Coding and updating and maintaining the RVUs attached to it must lie with the medical profession, as it is a clinical and scientific activity demanding professional expertise. Suggestions from doctors, specialist societies, medical schemes, administrators, managed care organisations and those who deal regularly with health care information are the only way to ensure that Coding reflects current practice, according to Dr Allers. All of the codes on the Scheme Payment Schedules must be open for public comment. Most importantly, the logic underpinning them must allow for schedules that are unique, anatomical, hierarchical and expandable.

A discipline-by-discipline breakdown shows that the most work will come in the specialties of Neurosurgery and Orthopaedics (69 Codes) and General Surgery (52 Codes). Neurosurgery hasn't been revised since the 1990s, with the consequence that two decades of advances have rendered codes in the Doctors' Billing Manual such that they bear little relevance to what Neurosurgeons perform procedurally. It makes it difficult to police practitioners and revisionary lag has meant that some specialists will fight against change because they stand to lose out. Expanded definitions and modifier rules would prevent unbundling, cut out redundancies and generate efficiencies of scale that would streamline preauthorisation with Funders.

Twenty years ago the industry was in the same position as it is now. Why reinvent the wheel? CPT4 rules were recommended after researching international peer markets, but at the time, RCFs (Rand Conversion Factors) complicated interdisciplinary relativities. A universal RCF would entrench inequalities between Consulting and Surgical disciplines, and was resisted by those who stood to lose out. The proposal at the time was to have an alternative RCF, initially, that would be adjusted gradually to fully reflect fair interdisciplinary relativities. Currently, in the absence of the adjustable and regularly adjusted RCF, both systems are being used and abused.

Against criticisms that code changes lead to price-creep, Dr Franco Colin succinctly noted that coding is just a framework. Individual practices and specific disciplines then need to work with funders. Against the accusation that specialist-group-led changes to schedules is "specialist-centric", it was countered that benefit design is "funder-centric". Evidently, what is needed is the kind of countervailing negotiation framework that used to exist, overseen and regulated by an independent impartial regulator. Who or what that is, or could be, is the subject of future discussions.

There is work to be done in the interim. A draft document for agreeing to *Guidelines and Principles for Establishing and Maintaining an Effective Medical Coding System in SA* has been completed. It now lies with stakeholders to decide on a budget to fund the necessary work ahead of us. Despite signs of initial co-operative intent, the Board of the South African Medical Association subsequently discussed the deliberations of the above meeting and informed SAPPF of its decision not to be party to the SACHI effort.

SAPPF has nevertheless taken the lead and a draft Memorandum of Incorporation for the SACHI concept has been tabled. SACHI's objects, as defined in the working MOI, shall be as follows:

- to be an independent, multi-stakeholder non-profit organisation, free of any political or other interference;
- to assist with and manage processes related to the implementation of the Codes by health care practitioners in Southern Africa;
- to recommend revisions, updates or modifications to SAMA, SADA, SAPPF and other healthcare professional societies in respect of the codes, descriptors, rules and guidelines in the Codes;
- to collect and analyse Coding Data;
- to develop RVUs to be assigned to new or revised Codes, to ensure the fair and accurate valuation for all healthcare providers and allied discipline service providers in Southern Africa;
- to set and regulate SACHI membership fees for all participating medical associations and disciplines;
- the Company shall promote and carry out public benefit activities, as envisioned in the Ninth Schedule to the Income Tax Act, in the Republic of South Africa."

1.4. Genesis v. The Minister of Health - Prescribed Minimum Benefits

Back in 2011, Judge Cynthia Pretorius of the Gauteng North High Court ruled against the Board of Healthcare Funders (BHF) in its attempt to reinterpret “pay in full” under Regulation 8 of the Medical Schemes Act (MSA) to mean ‘full scheme rate’ in regard to PMBs. The ruling upheld the interpretation implied in the MSA, and advocated by the CMS and others, that pay in full should mean *at the invoiced amount* (the cost of providing the service) and NOT *at Scheme Rate*. The BHF, after two further unsuccessful appeals, announced that it was disappointed that their case was not evaluated on its merits, but was dismissed on a legal technicality – the legal standing of the applicants (BHF and SAMWUMED) to bring the matter to court.

In December 2014, news broke that SAMWUMED, and Genesis (a medium-sized open scheme) were again threatening court action – this time against Min. Motsoaledi, if he did not amend the legislation they called “beyond-the-law, irrational and unconstitutional”. Genesis Medical Scheme alone brought proceedings against the Minister, who neither supported nor opposed the proceeding.

Numerous parties vociferously opposed to the main application, however, applied for leave to intervene, since the only respondent – the Minister - opted to abide by the court’s ultimate decision. In addition to SAPPF and SAPPF’s former chairperson, Dr Franco Colin, the other applicants included Mediclinic, HASA, and individual societies and associations with an interest to oppose. Except for the CMS and its Registrar (admitted as respondents by agreement with Genesis), Genesis opposed all other applicants’ leave to intervene.

Justice Blignault of the Western Cape High Court in his judgement of 29 July 2015 held that it was in the interests of justice to admit the intervening parties, particularly in light of the fact that the Minister of Health is not defending the review application and that the intervening parties will be able to lead relevant and helpful evidence to assist the Court.

He also ordered Genesis to pay the other applicants’ legal costs, reasoning that the intervening parties have a “real, direct and substantial interest” in the case. In particular, he held that healthcare providers would be prejudicially affected if the review application is successful, as their existing right to full reimbursement from medical schemes for the treatment of PMB conditions would be removed and medical schemes would be able to determine, without regulation, the rate at which health care providers are reimbursed for the treatment of these conditions in the private sector. He also held that Genesis’s arguments against the intervention – that the intervening parties only have a financial interest in the matter and are only entitled to intervene if they are required as a matter of law to be joined in the review application – “did not hold water”.

Genesis’s counsel, Clyde and Co, was instructed to appeal Justice Blignault’s judgment. They lost in an appeal to the Constitutional Court, who ordered that its application be dismissed “as it lacks prospects of success”. It then appealed to a Full Bench of the Cape High Court. Not being bound by a decision of the full court, Blignault in November again dismissed its leave to appeal with costs. One of his reasons was a pragmatic one: “The proposed appeal will unduly delay the determination of the main application and cause the wastage of scarce resources as a result of the costs to be incurred by the parties.”

It was hoped that after losing its initial High-Court application, a Constitutional Court Appeal and its Cape High-Court Appeal, Genesis would let the matter drop. In December though, instead of proceeding with their main application and setting a date to have the court review the merits of Regulation 8, Genesis announced it was appealing to the Supreme Court of Appeal (SCA).

HealthMan will keep its clients informed of the success or failure of this appeal and the proceedings if they make it to a hearing.

1.5. Department of Health Reforms

1.5.1. Proposed amendments to Regulations 5 and 8 of the Medical Schemes Act (1998)

Deputy DG for health regulation and compliance management, Dr Anban Pillay, says that in meeting after meeting, medical schemes express their abiding concern over regulation 8 to the DoH. The phrase 'blank cheque' is repeatedly used in relation to private healthcare practitioners. Any decision by the DoH to prevent schemes from proceeding with court action would require the publication of draft amendments for public comment.

As the figure with the authority to make regulations in terms of the Medical Schemes Act 131 of 1998, Minister Motsoaledi nonetheless does not oppose or support the main application by Genesis Medical Scheme to have Regulation 8 reviewed and set aside.

In the middle of July, he nevertheless published draft amendments to regulations under the MSA aimed at limiting medical schemes' liability to pay for the benefits they have to cover in full - PMBs. They will be able to reimburse at scheme rates (arbitrary levels based on the 2006 NHRPL, published by the CMS as a stopgap measure while government got its act together drafting procedural regulations for the formulation of future lists based on practice-cost data).

The changes proposed to regulation 8 this time would effectively cap reimbursement at 2006 NHRPL plus inflation. Schemes still use these rates and codes to devise plan benefits and negotiate designated service provider arrangements. There is no official alternative. The data proving how out of balance they are with the scope and cost of 2015 medical practice are disputed by bureaucrats, who don't like the numbers.

Pillay conceded that the CMS, doctors and hospitals had not been consulted, styling the draft regulatory amendment as "the health department's attempt to solve the problem". The proposed amendments do say medical schemes will be able to negotiate higher tariffs with healthcare providers to protect members from co-payments. But if they are not legally obliged to, why would they? The BHF roused schemes to fight tooth and nail to lend support to the Minister, insisting also that "patients would not face co-payments". Of course such rhetoric isn't accompanied by any policy documents or analyses of the medical schemes industry, which is quite healthy and sustainable at present. Acknowledging that "patients might face co-payments", Pillay himself contradicts the BHF's Humphrey Zokufa, going on to replace blind optimism with a *caveat emptor* – advising members to familiarise themselves with their medical schemes' rules".

Schemes routinely reject claims for full payment of PMBs, a distinctly illegal practice under current conditions – one attested to by the volume of complaints to this effect dealt with by the overburdened Council for Medical Schemes. The serial defaulters in paying PMBs are Momentum Health, SAMWUMED, Genesis and Cape Medical Plan, all the while sitting on reserves far above the prescribed level.

If this unilateral problem-solving attempt goes unchallenged, the essential aim of the prescribed minimum benefits – to protect medical scheme members from financial hardship and possible bankruptcy – is turned on its head. Luckily though, the industry is small and key role players who have been involved in every project related to price regulation in the past decade (Reference Price Lists, Regulation 8 Issue, Pricing Committee, Ethical Tariff Norm Determination and Competition Commission Enquiry), role players who understand the debate and the implications of various alternatives, are standing up for consumers and healthcare practitioners.

The legal view is that it is difficult to predict what might happen with the proposed amendments to Regulations 5 and 8. Rumour has it that the proposed amendments are not yet finalised. Rumour also has it that they are being finalised speedily. The working assumption is that the proposed amendments will be finalised during the course of 2016 and if they are finalised in their current

form (or similar), then it will be necessary to assess whether there is a constitutional or an administrative law basis on which the regulations could be judicially reviewed and set aside by court.

Assessing them from this angle saves the expense of launching any court proceedings – although having to challenge them in their finalised form in court, as with the RPL in the past, is not without the realm of possibility.

1.5.2. White Paper on National Health Insurance (NHI)

On 11 December 2015, the Minister of Health published the long-awaited 90-odd page White Paper on National Health Insurance (NHI), in addition to the Terms of Reference for six Work Streams to provide technical support in the final implementation of the scheme that, it is hoped, will take 15 years to bring into being. The work streams' tasks will be to prepare for the establishment of the NHI Fund; prepare the purchaser-provider split and accreditation of providers; to design NHI Health Care Service Benefits; define the role of medical schemes under NHI; complete a Policy paper for public release and strengthening of the District Health System.

NHI is a health financing system designed to provide access to quality, affordable health care services for all South Africans based on their health needs, through pooling of funds and risks. NHI will “necessitate a massive reorganisation of the current health care system, both public and private”.

In essence, it is an unaffordable undertaking to be financed via a payroll levy on the middle class, rendering medical schemes largely obsolete and contracting private doctors and specialists at rates the state will determine.

The White Paper on NHI was supposed to have been issued during July 2012. After 4 years, one would have expected the major shortcomings of 2011's Green Paper on the project to have been resolved or thought through, taking previous criticisms and suggestions on board and that some Treasury-approved financial modelling accompany it in order to lend credence to the economically unrealistic assumptions underpinning the scheme. Responsibility for the latter belongs to the National Treasury, whose Chief Director for health and social development, Mark Blecher, acknowledged in 2013 that the Treasury's discussion document was a year and a half late, but was “nearly ready”.

“There is no evidence in the White Paper of Treasury's assessment of the costs; there's just a projection based on 2010 prices,” said the DA's health spokesman, Wilmot James, who panned the paper's estimations as a “thumb suck”. Indeed, the true costs will be opaque because the package of benefits patients will receive for free at the point of delivery has yet to be defined – a criticism raised in 2011.

In 2011, Pravin Gordhan maintained that thoroughgoing reforms like NHI cannot be financed with increased borrowing, or through increased taxation, especially since it is very unlikely that economic growth will be above 3% every year until 2025, as envisioned in the Green Paper. With Gordhan back at the helm of the Finance Ministry after December's ill-considered dismissal of Minister Nhlanhla Nene, it remains to be seen if his previous (and still valid) reservations will be reiterated in his first budget for 2016.

Our regular newsletters - HealthView and Private Practice Review - and presentations at CPD meetings will keep you up to date on all these matters. We will also, from time to time, be issuing Special Reports on matters of importance.

2. MEDICAL SCHEME & DESIGNATED SERVICE PROVIDER & SPECIALIST PAYMENT ARRANGEMENTS

In the absence of any guidance as to what tariffs to apply in 2016, Schemes must continue to set their tariffs independently. The reality is that Administrators are setting tariffs on behalf of the Schemes they administer. This holds true for Discovery, Medscheme and Metropolitan Health Risk Management.

If one then compares various Scheme Rates it is also obvious that Schemes do not differ much from each other. Such action by Administrators is tantamount to a unilateral determination of a national Benchmark Tariff - an administrative procedure that should be investigated by the CC.

Detailed tariff lists are available on most Scheme web sites and/or are available to all Practitioners and members on request. Problematically, however, few Schemes and Administrators have the capacity or insight into coding structures. Scheme tariffs still blindly make use of the illegal published RPL and annual tariff increases still apply to the structure inherent to the long-discredited NHRPL 2006, which does not contain all the recent changes to codes, descriptors, rules and modifiers approved by SAMA, SAPPF and other Associations from 2006 to 2016.

The general increases in tariffs for 2016 for major schemes vary between 5% (Multiple Schemes) and 7.9% (Ingwe Medical Scheme). Details of Scheme increases are set out in Annexure A.

A summary of increases for 2016, per Administrator and selected Schemes, is set out below:

- Discovery Health - 5.0%
- Momentum Health - 5.0%
- Bonitas – 5.2%
- Medscheme – 5.2% to 6.0%
- Metropolitan Health 5.4% to 6.1%
- GEMS – 5.0%
- Profmed - 6.0%
- Liberty Health Medical Scheme – 6.0%
- Medshield - 6.0%
- Medihelp - 6.0%
- Bestmed - 6.6%
- Polmed – 6.0%

2.1. Bankmed Specialist Network

From 1 January 2016 Bankmed will be administered by Discovery Health (Pty) Ltd.

Members on the **Bankmed Core Saver Plan, Traditional Plan, Comprehensive Plan and Plus Plan**, will be able to access specialist services from the Bankmed Specialist Network.

Bankmed has partnered with Netcare as the anchor partner in the hospital network for the Bankmed **PMB, Basic and Traditional Plans**. For the *PMB* and *Basic* plans, there is a core sub groups of specialists that Bankmed would like to encourage to join the network. These include the following:

- *Gynaecologists*
- *Physicians*
- *Paediatricians*
- *ENT Surgeons*
- *Surgeons*

No *balance billing*, administration fees, levies or any other additional charges can be applied to a claim. For **Core Saver and Traditional Plans**, payment is subject to a GP-to-specialist benefit authorisation process. If you need more information or would like to join the Bankmed Specialist Network, please call 0860 44 55 66 or email healthpartnerinfo@discovery.co.za.

If you would like to join the Bankmed Specialist Network and or Bankmed Specialist Entry Network, please call us on 0860 44 55 66 or email us at healthpartnerinfo@discovery.co.za.

Bankmed Plans	In-Hospital	Out-of-Hospital
Basic and PMB plans	110%	110%
Core Saver	135%	150%
Traditional	135%	150%
Comprehensive	135%	150%
Plus	200%	215%

(Rates expressed as a % of the Scheme Rate)

Discovery Health Tariffs and Payment Arrangements

For 2016, Discovery will be increasing all the Discovery Health Rates by 5%. All Direct Payment Arrangement multipliers continue to apply to these increases (Refer to Annexure A for list of schemes)

Discovery Health Rate	% of 2016 DH Rate
Premier Rate – Essential, Coastal, Classic & Smart Plan	
• Premier Rate A (In-Hospital)	137%
• Premier Rate A (Out-of-Hospital)	162%
• Premier Rate B (Both In- and Out-of-hospital)	147%
<i>(Specialists on Premier Rate A, Premier Rate B & Custom Direct Payment Arrangements agree NOT to balance bill members)</i>	
Essential and Coastal Plans	100%
<i>(Specialists have the option to balance bill)</i>	
Classic Plans and Smart Plan	
• Classic Plans (In-Hospital)	217%
<i>(No Balance Billing above 217% of the DH Rate)</i>	
• Classic Plans (Out-of-Hospital)	100%
<i>(Specialists have the option to balance bill)</i>	
Discovery Health Rate	% of 2016 DH Rate
Executive Plan	300%
<i>(No Balance Billing above 217% of the DH Rate)</i>	
Custom Direct Payment Arrangement	
• N Option Basic (Naspers Medical Fund) (Both In- and Out-of-hospital)	130%
KeyCare Specialist Arrangement	
• LA KeyPlus, Quantum KeyPlus, Remedi Standard Option and WitsMed Network Option	110%
<i>(Specialists taking part in the KeyCare specialist network agree not to balance bill all KeyCare members on participating schemes or to charge co-payments, levies or other administrative fees. This is to protect low-income members against out-of-pocket costs.)</i>	

Specialists should also take note that collaboration between the specialist management groups and Discovery Health over the last few years has resulted in the following **Shared Value Initiatives**:

- **Physicians Quality Network for members of the Faculty of Consulting Physicians of SA (FCPSA)**
 - Appropriate admissions via casualty – Casualty evaluation code CAS18
 - Hospital Discharge Management summary – Hospital Discharge Management code HDM1
 - Resulting in actual enhanced income in 2015

- **Paediatric Governance Project for members of the Paediatric Management Group**
 - Additional remuneration on consultations for Asthma and Epilepsy
 - In excess of R150 million additional payments have been made to participating paediatricians since the start of this initiative.
 - Collaborative support for complex ICU admissions
 - Enhanced remuneration for neonatal episode management
- **Surgicom Project for members of Surgicom**
 - Seamless pre-authorisation with benefit approval for a list of surgical cases
 - Hospital Discharge Management summary on HealthID – reimbursed at R455*
 - Reviewing of patients’ health records on HealthID
- **Obstetrics Sustainability Project for members of SASOG and GMG**
 - Discovery HomeCare Postnatal home care nursing service
 - This initiative will enhance the quality of care while increasing reimbursement to the obstetrician
- **Day Surgery**
 - Participating surgeons and anaesthesiologists are receiving significant enhancements to their remuneration when they perform appropriate procedures in day surgery settings. The table below indicates the surgical rates:

Surgeon DPA Arrangement	Member Plan Type	Acute Hospital Rate*	Day Surgery Rate* #
Classic Direct	Classic	217%	230%
	Essential/Coastal	100%	200%
Premier A	Essential/Coastal/Classic	137%	167%
Premier B	Essential/Coastal/Classic	147%	177%
Executive	Executive	300%	

* Expressed as a % of the Discovery Health Rate

No balance billing in excess of these rates

2.2. GEMS Rate for 2016 and Specialist Payment Arrangements

GEMS tariffs for all options will be increased as follows for 2016:

- Specialist Network Providers:
 - Paediatric Network – 5%
 - Obstetrics and Gynaecology Network – 5%
- Non-Network Healthcare Providers where there is a GEMS Network – 5%
- Non-Network Healthcare Providers where there is no GEMS Network – 5%
- All General Practitioner (GP) Tariffs for Network and Non-Network – 5.5%

The scheme’s operational structure and environment consist of outsourced service provisioning through a number of contracted service providers. Services are rendered both directly and indirectly to the scheme’s beneficiaries with interactive support being largely provided via the GEMS service provider network (SPN).

During the course of 2015, GEMS undertook an extensive review of its service structure and operational provisioning. Based on the outcome of this review the scheme took a decision to revise its Clearing House provision by separating the Pharmaceutical Benefit Management (PBM) and the Radiology and Pathology Services into two services with effect 1 January 2016.

GEMS Specialist Paediatric Network and Obstetricians & Gynaecologists Network (expressed as a % of the GEMS Scheme Rate):

GEMS Specialist Paediatric Network		
GEMS Option Name	In-Hospital	Out-of-Hospital
Sapphire	100%	100%
Beryl	100%	100%
Onyx	130%	130%
Emerald	130%	130%
Ruby	130%	130%

GEMS Specialist Obstetricians & Gynaecologists Network		
GEMS Option Name	In-Hospital	Out-of-Hospital
Sapphire	130%	130%
Beryl	130%	130%
Onyx	130%	130%
Emerald	130%	130%
Ruby	130%	130%

The Medical Schemes Act (MSA) on the Claims Process:

The Medical Schemes Act stipulates the following with regard to claim submissions and payments in Chapter 2 of the MSA, dealing with Administrative requirements:

- A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependent of such member is entitled, **limit, exclude, retain or withhold**, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month:
 - from the last date of the service rendered as stated on the account, statement or claim; or
 - During which such account, statement or claim was returned for correction.
- 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 health care provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion.
- After the member and the relevant health care provider have been informed as referred to in sub regulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of 60 days following the date from which it was returned for correction.
- 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 a sub regulation (2) or fails to provide an opportunity for correction and resubmission in terms of sub regulation (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.

The Stale Claims Process:

1. Claims submitted to GEMS after the last day of the 4th month will be rejected with a stale claims message on the claims statement.
2. The member or provider is then required to provide GEMS with proof that the claim was submitted within the 4 month period. If proof cannot be provided then the claim cannot be considered for payment.
3. Where a claim was erroneous or not acceptable for payment (which will be communicated via the claims statement) and the member/provider did not resubmit the correct claim within 60 days then the claim cannot be considered for payment.

4. Claims queried will be assessed against the above rules and will be subjected to an approval process in line with the Medical Schemes Act and the Scheme rules.

GEMS PMB claims processing rules:

1. GEMS payment in respect of PMBs

GEMS processes PMB claims in accordance with PMB regulations and the GEMS registered Scheme rules.

2. PMB regulations:

In order for a procedure to be considered for payment as a PMB and funded at cost as per the regulations, the following criteria must be met:

- The diagnosis must be a PMB condition, as defined in the Regulations of the Medical Schemes Act.
 - The diagnosis must thus be:
 - A condition which is included in one of the “Diagnostic and Treatment Pairs” (DTPs) or be on the list of 25 chronic diseases (with their associated ICD-10 codes), described in Annexure A of the Regulations.
- OR**
- An emergency medical condition
- The DTPs are described in broad terms and the CMS maintains a list of ICD-10 diagnostic codes which cross-walk to the DTPs. This serves as a guide to whether the condition is PMB or not.
 - It is important to note that diagnostic codes alone do not identify PMB claims. The diagnostic code alone may furthermore not suffice in determining potential PMB eligibility. For some diseases, the severity of the illness may be a critical determinant of potential PMB entitlement (e.g. cancer of breast – treatable). For this reason further clinical evaluation may be necessary prior to deciding on the former.
 - The treatment / service provided must be PMB level of care, as defined in the Regulations of the Medical Schemes Act.
 - Level of care is determined by prevailing State practice, unless specified otherwise, and for the listed chronic diseases it is determined by the published therapeutic algorithms.
 - Certain treatments may be excluded unless specifically listed (e.g. chemo- and radiotherapy, bone marrow transplantation, hyperbaric oxygen therapy, mechanical ventilation, organ transplantation, treatments, drugs or devices not yet registered by the relevant authority in the Republic of South Africa). For infertility, a more detailed explanation of what is included under the broad term of ‘medical and surgical management’ is provided.
 - The treatment/service must be provided by the DSP (the state for in-hospital PMBs) as set out in Annexure G of the Scheme rules (except in the case of an emergency).
 - Except for emergencies, if the member chooses not to use of the DSP, as stated in Annexure G of the Scheme rules, and
 - The DSP is not available within a reasonable distance, and/or
 - The PMB service required is not available at the DSP, and/or
 - The waiting period for the service at the DSP is deemed unreasonable,
 - Then the member should obtain pre-authorisation stating the above reasons prior to the provision of services.
 - If pre-authorisation is not obtained, then the service is deemed to constitute voluntary use of the non DSP and the claim will be funded at Scheme rate.
 - If the service provided is an emergency as defined in the regulations, it is deemed to constitute involuntary use of a non DSP and the claim to be funded in full.

- All members and providers are informed in writing at pre-authorisation level that for in-hospital PMBs the State is the DSP for GEMS.
- Should a member or provider query the payment of a PMB claim, MHRS will review the DSP accessibility (distance to DSP, waiting period at the DSP, availability of services) on a case-by-case basis and medical advisory input, if required, is sought regarding waiting periods and the reasonability thereof.
- Providers will be funded at cost in cases of emergency, as well as any cases where the member made use of the non-DSP involuntarily.

Annexure G of the GEMS Scheme rules:

Annexure G, Point 2:

- The service provider(s) designated by the Scheme for the delivery of Prescribed Minimum Benefits (PMB) to its beneficiaries are:

PMB Services	Sapphire	Beryl	Ruby	Emerald	Onyx
In Hospital	State and GEMS Specialist Network	State and GEMS Specialist Network	State and GEMS Specialist Network	State and GEMS Specialist Network	State and GEMS Specialist Network
Out-of-Hospital	State, SB GP Network, GEMS Specialist Network	State, SB GP Network, GEMS Specialist Network	REO GP Network, GEMS Specialist Network	REO GP Network, GEMS Specialist Network	REO GP Network, GEMS Specialist Network

Annexure G, Point 4:

- Prescribed Minimum Benefits voluntarily obtained from other providers.
- If a beneficiary voluntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit condition from a provider other than a DSP, the benefit payable in respect of such service shall be the Scheme Rate where a DSP exists.
- Where a DSP does not exist, the benefit payable in respect of such service shall be 100% of the cost.

Annexure G Point 5:

- Prescribed Minimum Benefits involuntarily obtained from other providers.
 - a. If a beneficiary involuntarily obtains diagnosis, treatment and care in respect of a Prescribed Minimum Benefit Condition from a provider other than a DSP, the medical scheme will pay 100% of the cost in relation to those Prescribed Minimum Benefit Conditions
 - b. For the purposes of paragraph a. above, a Beneficiary will be deemed to have involuntarily obtained a service from a provider, other than a DSP, if
 - i. the service is not available from the DSP or would not be provided without unreasonable delay;
 - ii. immediate medical or surgical treatment for a Prescribed Minimum Benefit Condition was required under circumstances or at locations which reasonably precluded the Beneficiary from obtaining such treatment from a DSP; or
 - iii. there was no DSP within reasonable proximity to the Beneficiary's ordinary place of business or personal residence.
 - c. Except in the case of an emergency medical condition, a Member shall notify the Scheme prior to involuntarily obtaining a service from a provider other than a DSP in terms of this paragraph, to enable the Scheme to confirm that the circumstances contemplated in paragraph b. above are applicable.
 - d. If a Member fails to notify the Scheme in accordance with paragraph 4.c. above, the benefit payable in respect of such services shall be the Scheme Rate.

2.3. Medscheme Specialist Payment Arrangements Rate for 2016

The Medscheme Specialist Payment Arrangement will continue for both Bonitas and Fedhealth.

It is important that the specialist should have a Specialist Referral Number for the following schemes:

- Bonitas (BonCap, Standard and Primary options)
- Fedhealth (all options)
- Sasolmed
- MBMED

How a GP should obtain a specialist referral number in 6 easy steps:

1. Contact our call centre on 086 111 2666 to obtain a Specialist Referral Number and follow the easy guided steps.
2. Make an appointment for the patient/member to see a Specialist.
3. The Family Practitioner has the option of requesting a Specialist Referral Number which can be authorized for a period of six months.
4. The Family Practitioner must give a Specialist Referral Note with the following details:
 - a. The name of the specialist to whom the patient/member was referred.
 - b. The specialist appointment details, including date, time and address.
 - c. Clinical details and reason for referral.
5. It is important that the patient/member makes sure the Specialist Referral Note accompanies them when going to see the Specialist.
6. Remember: The claims may not be paid without this number.
7. In the case of an emergency, a Specialist Referral Number must be obtained by the member from the Family Practitioner within 72 hours after seeing a Specialist.

2.3.1. Bonitas Specialist Participating Scheme Rates 2016

Bonitas has increased the base remuneration rate by 5.2% for 2016 and the table below illustrates the various Bonitas plans and tariffs as a percentage of the Bonitas scheme rate for 2016. Bonitas has introduced two new options for 2016:

- Standard Select (similar to the Standard option and limited to the use of a Family Practitioner, Specialist, Hospital and a Pharmacy Network) and
- BonFit (similar to the BonSave option and limited to a network of Hospitals).

Bonitas recognises the importance of care coordination and therefore encourages members to obtain a referral from their family practitioner prior to a specialist visit.

- The Specialist will be reimbursed according to the following tariff structure:

Option Name	In-Hospital	Out-of-Hospital
Standard	130%	130%
Primary	130%	130%
Standard Select	130%	130%
BonSave	150%	130%
BonFit	130%	130%
BonEssential	130%	130%
BonClassic	130%	130%
<i>Rates are illustrated as a percentage of the Bonitas scheme rate.</i>		

- The above tariffs are applicable to all Specialist practice types identified by the Scheme except oncologists, clinical haematologists, pathologists, radiologists, anaesthetists and maxilla-facial surgeons.

- The tariffs for BonComprehensive and BonCap will remain in place for participating and non-participating specialists in 2016, and are excluded from the agreement above.

Option Name	In-Hospital	Out-of-Hospital
BonComprehensive	300%	100%
BonCap	100%	100%
<i>Rates are illustrated as a percentage of the Bonitas scheme rate.</i>		

2.3.2. Fedhealth Specialist Participating Scheme Rates 2016

Specialists will be reimbursed according to the following tariff structure of scheme rate:

Option Name	Percentage of scheme tariff for both In- and Out-of-Hospital services
Ultimax	300%
Ultima 200	165%
Maxima Plus	210%
Maxima Exec	210%
Maxima Standard	165%
Maxima Standard Elect	165%
Maxima Saver	165%
Maxima Basis	165%
Maxima Core	165%
Maxima EntrySaver	100%
Maxima EntryZone	100%
Blue Door Plus	100%

Take note that the Maxima EntrySaver, Maxima EntryZone and Maxima Standard Elect options may only be admitted to a Network Hospital.

Details regarding the Medscheme Provider Networks, participating rates for 2016 and a list of the Network Hospitals can be found on the Medscheme website on www.medscheme.com.

The above tariffs are applicable to all Specialist practice types identified by the Scheme and the Scheme rate has increased by 5.5% for 2016.

2.4. Metropolitan Health Risk Management Specialist Arrangements

In the absence of a formal price guideline in the industry, individualised scheme rates have been provided in the table below and are effective as of 1 January 2016. The table below provides the specific detail per scheme:

Scheme Name	2016 Rate Increase
BP Medical Aid Society	6.00%
Engen Medical Benefit Fund	6.00%
Fishing Industry Medical Scheme	6.00%
Golden Arrow Employees Medical Benefit Fund	6.00%
Imperial Medical Scheme	6.10%
Medipos Medical Scheme	6.00%
Metropolitan Medical Scheme	6.00%
Moto Health Care	6.00%
PG Group Medical Scheme	5.50%
Pick and Pay Medical Scheme	6.00%
SAB Medical Aid Society	6.00%

Scheme Name	2016 Rate Increase
Transmed Medical Fund	5.50%
Wooltru Healthcare Fund	5.40%

PLEASE NOTE: These are the general 2016 scheme tariff increases and are independent of negotiated reimbursement rates.

The benefit options and reimbursement rates per participating scheme are as follows:

Imperialmed options (Limited Efficiency Network PMB's)	Pricing	In-hospital claims	Out-of-hospital claims
Budget Plan	Low cost	Current Specialist Billing Rate	Normal Scheme benefits – Network not applicable
Health Plan	Middle-income plan	Current Specialist Billing Rate	Normal Scheme benefits – Network not applicable

SAB Medical Aid Scheme (Std Network)	% of Scheme rate paid on In-Hospital claims	% of Scheme rate paid on Out-of-Hospital claims
Essential	120%	120%
Comprehensive	160%	160%

BP Medical Aid Society (Limited Efficiency Network)	In-Hospital Claims	Out-of-Hospital Claims
All members	150% of Scheme Rate (PMB and Non-PMB Claims)	120% of Scheme Rate (PMB and Non-PMB Claims)

Transmed (Limited Efficiency Network)	In-Hospital Claims	Out-of-Hospital Claims
Private Network Plan	120% of Scheme Rate (PMB and Non-PMB Claims)	120% of Scheme Rate (PMB and Non-PMB Claims)

2.5. Momentum Health Medical Scheme Rate for 2016

Momentum Health will be increasing their 2016 scheme rate by 5.0%. This will be applicable to all providers (except for those with specific negotiated or agreed rates in place), effective from 1 January 2016.

Momentum Health Tariff Schedules and Benefit guides for 2016 are available for your reference at: www.provider.momentum.co.za.

Momentum Health pays specialist claims directly to participating specialists subject to the practice agreeing to bill the following rates per option/option groups

Momentum Health Options and Specialist Arrangement
High Income Plan (Summit) ○ 200% of Scheme rate for in-hospital claims and 215% for out-of-hospital claims.
Middle Income Plans (Custom, Incentive & Extender) ○ 137% of Scheme rate for in-hospital claims and 154% of scheme rate for out-of-hospital claims.
Low-income plans (Ingwe & Access) ○ 100% of scheme rate for all claims.

Comments:

1. Approximately 85% of Momentum Health members are on the middle-income plans.
2. If you wish to participate in any of Momentum's specialist arrangements, please email: specialistpartner@momentum.co.za
3. Specialists should take note of tariff codes which are not to be billed in conjunction.
4. Dispensed medicines and consumable products used as part of in-room procedures will be reimbursed as follows:
 - All dispensed medicines (including unscheduled) are priced according to the SEP/List Cost Price + 30% to a maximum of R23.40 per item.
 - All unscheduled consumable products (0201) used during procedures are priced according to List Cost Price + 31% mark-up.
 - All scheduled consumable products (schedule 0 to 8) used during procedures are priced according to SEP + 30% to a maximum of R23.40 per item.
5. Network Hospitals
 - Ingwe Option members who choose Ingwe Active Primary Care Providers have access to any hospital. Members who choose Ingwe Primary Providers can choose either Ingwe Network hospitals or State hospitals.
 - Access Option members have cover for hospitalisation at Access Hospital network.
 - Custom, Incentive and Extender Option members can choose either any hospital or Associated Hospital network.

2.6. Netcare Clinical Partners

The Netcare scheme rate has increased by 5.5% for 2016. The contracted Netcare Clinical Partners Specialist Rate is set at 150% of the Netcare scheme Rate. This rate is applicable to employees of the Netcare Group making up close to 40 000 beneficiaries. Information on the Netcare Clinical Partners Network is available on the website, www.netcaremedicalscheme.co.za or from Jalna le Roux at jalna.leroux@netcare.co.za.

2.7. Liberty Medical Scheme Specialist Network

Liberty Medical Scheme contracted ONECARE Health to establish and manage a Specialist Designated Service Provider (DSP) Network for its beneficiaries. As far as we understand this agreement is at scheme rate with no enhanced reimbursement. This is a DSP fee agreement with the scheme, for the treatment of their members' PMB and Non-PMB conditions, in- and out- of hospital. The Liberty Memorandum of Understanding (MOU) sets out (amongst other points) the fees that the specialist agrees to, as well as the fact that you will not charge their members any co-payments. Should your practice at any point in time decide that you no longer wish to see these members, you need only inform them and the scheme of your decision in writing, giving 30 days' notice of your withdrawal from the network.

2.8. Important Changes at Medical Schemes

2.8.1. Schemes no longer administered by Metropolitan

2.8.1.1. POLMED

From 1 January 2016, Medscheme will take on the role of both administrator and managed care provider to the South African Police Service Medical Scheme, POLMED. The movement of POLMED administration from Metropolitan Health to Medscheme should not affect the payment of claims nor the Network arrangement between the Scheme and Service providers.

Medscheme will provide pre-authorisations for services rendered from 1 January 2016. All claims submissions and transactions for 2016 will be processed by Medscheme. Contact polmed@medscheme.co.za.

All hospital claims, transactions and claims queries up to 31 December 2015, will be processed by Metropolitan Health until midnight on 29 April 2016. For all specialist network-related queries for 2015, send an email to networks@metropolitanmhg.co.za. From 30 April 2016, claims queries for services rendered between 1 January 2014 and 31 December 2015 must be addressed to Medscheme.

For the time being, all GPs and Specialist will remain contracted and contracts will remain in place at the same contracted rate as 2015. There is a 6% increase for 2016. Medscheme will be sending a new Specialist contract for signing to the Specialists Network due to fact that the previous specialist agreement was signed between MHG (on behalf of the scheme) and the specialist. The new contract will be between POLMED and the Specialist.

For all GP and Specialist network-related queries and/or to join the network, send an email to providernetwork@polmed.co.za.

2.8.1.2. BANKMED

Bankmed will be administered by Discovery Health (Pty) Ltd from 1 January 2016.

Claims with a service date up to 31 December 2015 should be submitted to the previous administrator – Metropolitan Health. Providers will have 5 months in which to submit and finalise claims with a service date until 31 December 2015. There will be no payment for any claims received after this 5 month period.

Claims with a service date from 1 January 2016 should be submitted to Discovery Health.

3. COMPARATIVE SPECIALIST CONSULTATION TARIFFS 2016

		GEMS Scheme Tariffs	Discovery Premier A
0190	Surgical	R 317.60	R 579.30
0190	Consulting	R 485.70	R 832.00
0191	Surgical	R 317.60	R 579.30
0191	Consulting	R 485.70	R 832.00
0192	Surgical	R 317.60	R 579.30
0192	Consulting	R 485.70	R 832.00
0161	Psychiatry Consulting	R 342.90	R 847.40
0162	Psychiatry Consulting	R 628.60	R 847.40
0163	Psychiatry Consulting	R 914.20	R 847.40
0164	Psychiatry Consulting	R 1 199.90	R 847.40

Note: As there is no RPL, we have listed GEMS and Discovery Health tariffs for comparative purposes and guidance. O&G tariffs are R18.880 higher for Scheme tariffs in the various categories (no differentiation for Discovery). Neither the GEMS nor Discovery Health differentiate between Tiered Consultations. There is also no justification for the three differential sets of tariffs between specialist groups, other than a “historical accident”.

Also note that Neurosurgery consulting tariffs for GEMS and Discovery are at the consulting group levels. Both Discovery Health and GEMS apply irrational and discriminatory policies in setting consultation tariffs. This applies equally to all other Schemes and Administrators.

In order to track the impact of tiered consultations, we again urge all practices to charge time-based consultations appropriately, even though schemes do not pay accordingly.

4. SUMMARISED RAND CONVERSION FACTORS (RCFs) - SCHEME RATES 2016

	DISCOVERY 2016	GEMS 2016	BONITAS 2016	PROFMED 2016	MEDIHELP 2016
Specialist Consultative Services	R 18.686	R 19.175	R 18.880	R 19.503	R 19.538
GP Consultative Services	R 18.686	R 18.260	R 21.170	R 21.865	R 19.538
Consultative Services (Paediatrics & Paediatric Cardiology)	R 18.686	R 19.175	R 18.880	R 19.503	R 19.538
Psychiatry	R 22.71	R 22.860	R 22.510	R 23.260	R 23.302
Clinical Procedures	R 11.563	R 11.860	R 11.640	R 12.078	R 12.099
Anaesthesiologists	R 87.327	R 74.500	R 73.450	R 75.806	R 75.942
Ultrasound	R 11.023	R 11.321	R 11.140	R 11.513	R 11.534

5. HPCSA & TARIFFS

The HPCSA has given no indication what tariffs they will apply in any disciplinary hearing. The current tariffs used by the HPCSA are of no value and can for all intents and purposes be ignored. However, we strongly advise all practitioners, where practical, to inform their patients upfront what they will be charged, and whether co-payments are likely. Please contact the HealthMan offices if you receive notification that complaints of overcharging have been made against your practice to the HPCSA.

6. MALPRACTICE INSURANCE

The malpractice insurance rate increases continue to exceed inflationary adjustments. We continue to provide Practitioners with alternative cover through our arrangements with Aon South Africa. These rates are in general well below that of MPS and can be structured in various levels of cover. This product now has in excess of 2500 members. Further group discounts are available for ENT Surgeons and other management Groups. This arrangement is not available for Obstetrics & Gynaecology or for Spinal Surgery.

The 2016 MPS premium for Obstetrics vary between R650 000 and R1 300 000.

For further details email Casper Venter at casper@healthman.co.za.

7. IMPORTANT REMINDER REGARDING RUN-OFF COVER

“It is critically important that we are notified immediately of any incidents which may lead to a claim or any actual claims. It is a condition of your cover that timeous notification of such is made to Insurers and they are especially strict on this,” Carol-Lee Axford of AON emphasises.

Some examples of ‘possible’ claims to be reported as soon as you (the Insured) become aware of them:

1. Any notification from a patient whether verbal or written indicating that they are unhappy with treatment received;
2. Receipt of correspondence from attorneys requesting copies of treatment records in respect of any of your patients;
3. Indications from any medical aid that they are investigating your accounts;
4. Allegations of any criminal conduct in the conduct of your profession, including allegations of sexual harassment etc.;
5. Complaint that is lodged against you at the HPCSA. Please do not submit your response to the HPCSA prior to consulting with us as you may unwittingly prejudice your defense.”

Note that all potential matters brought to the insurer's attention during the period covered by the policy will be picked up by the Insurer, even if the policy is cancelled or even when the 3 years run-off cover period is reached. Run-off cover period allows the Insured (or in the event of the Insured's death, the Executor of the Insured's Estate) to report any claims that may come to their attention after the policy has ceased (through Retirement, Death, or the cessation of practicing as a Registered Healthcare Practitioner for reasons **other** than those enumerated below) for an additional period of thirty six (36) months (the Additional Reporting Period) to identify circumstances in connection with work performed during the currency of the Policy that may give rise to a claim for indemnity in terms of this Policy and provided that the Additional Reporting Period:

- i. is not granted should the Insured's license or right to practice have been revoked, suspended or surrendered or should any prior breach of this Policy;
- ii. shall not apply to circumstances that may give rise to a claim advised to Insurers after the commencement date of run-off cover period;
- iii. is subject otherwise to all the terms, Exclusions and Conditions of this Policy;
- iv. shall notwithstanding the stated thirty six (36) months period, terminate immediately at the commencement date thereof should insurance be obtained by the Insured replacing in whole or in part the insurance afforded by this Policy

8. FORENSIC REVIEWS

HealthMan and the various management groups/societies continue to assist members faced with forensic audits or HPCSA complaints regarding billing and the use, possible misuse, or interpretation of various billing codes, rules and modifiers. Typically a scheme will demand a refund of all monies that they believe have been erroneously paid and this may be back-dated by several years. HPCSA is currently imposing huge "admission of guilt" fines for suspected transgressors whom the Committee of Preliminary Enquiry believes are guilty of "misdemeanors" with regard to billing codes.

We urge doctors to familiarize themselves once again with the various procedure codes, descriptors, rules and modifiers. Recent cases have focused on presumed incorrect billing for post-operative consultations (Rule G); pre-operative consultations on the day of surgery (Rule M); unscheduled emergency and after hour codes 0145–0148; modifier 0011 for emergency procedures; ICU billing codes 1204–1210, etc.

In ICU it is very important to note that doctors **MUST** clarify with colleagues who the primary physician is, who will charge for ventilation, and who will charge for IV nutrition. Not infrequently both physician and surgeon charge for one or more of these codes, and when the accounts are reviewed by the medical scheme it becomes necessary for money to be refunded.

Doctors are once again advised to consult with their management group/association and HealthMan directly, rather than to attempt to deal with such enquiries single handedly.

9. PCNS RENEWAL FEE

At this stage, BHF continues to administer the Practice Code Numbering System (PCNS). The PCNS annual renewal fee for 2016 has increased by 6%. The fee is R241.68 (Incl. VAT) and will be due by 31 March 2016. Kindly ensure that your contact information is up to date. For further information contact the PCNS Client Services on 0861 30 20 10 or email clientservices@bhfglobal.com.

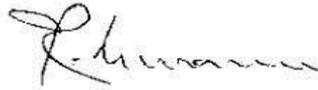
10. GENERAL DISCLAIMER

The information disclosed above is based on publically-available healthcare industry information which we believe would be of assistance to you. HealthMan is not responsible for any losses incurred by a practitioner relying on the above information. Where any doubt exists regarding the eligibility of members, availability of benefits, etc. we recommend that the practitioner makes direct enquiries with the relevant medical schemes.

Regards



Casper Venter
Director HealthMan



Ernst Ackermann
Director HealthMan



Mardi Roos
Director HealthMan

11 January 2016

ANNEXURE A - Medical Scheme Rates - 2016

SCHEMES ADMINISTERED BY MEDSCHEME

Scheme Name	2016 Rate Increase
AECI Medical Aid Society	6.00%
Barloworld Medical Aid	5.30%
Bonitas Medical Fund	5.20%
Fedhealth	5.50%
Glencore Medical Scheme	6.00%
Horizon Medical Scheme	6.00%
MBMed Medical Aid Fund	5.30%
Nedgroup Medical Aid Scheme	6.10%
Old Mutual Staff Medical Aid Fund	6.00%
Parmed Medical Aid Scheme	5.30%
SABC Medical Scheme	5.30%
Sasolmed Medical Aid Scheme	5.20%

POLMED: From 1 January 2016, Medscheme will take on the role of both administrator and managed care provider to the South African Police Service Medical Scheme, POLMED.

SCHEMES ADMINISTERED BY METROPOLITAN

Scheme Name	2016 Rate Increase
BP Medical Aid Society	6.00%
Engen Medical Benefit Fund	6.00%
Fishing Industry Medical Scheme	6.00%
Golden Arrow Employees Medical Benefit Fund	6.00%
Imperial Medical Scheme	6.10%
Medipos Medical Scheme	6.00%
Metropolitan Medical Scheme	6.00%
Moto Health Care	6.00%
PG Group Medical Scheme	5.50%
Pick and Pay Medical Scheme	6.00%
SAB Medical Aid Society	6.00%
Transmed Medical Fund	5.50%
Wooltru Healthcare Fund	5.40%

CLOSED MEDICAL SCHEMES ADMINISTERED BY DISCOVERY HEALTH, PARTICIPATING IN DIRECT PAYMENT ARRANGEMENTS FOR 2016

Scheme Name	Premier Rate Payment Arrangement	Classic Direct Payment Arrangement	Custom Direct Payment Arrangement	KeyCare Specialist Arrangement
Anglo Medical Scheme	No	No	No	No
Anglovaal Group Medical Scheme	Yes	No	No	No
BMW Employees Medical Aid Society	Yes	No	No	No
LA Active	Yes	No	No	No
LA Comprehensive	Yes	No	No	No
LA Core	Yes	No	No	No
LA Focus	Yes	No	No	No
LA KeyPlus	Yes	No	No	No
Lonmin Medical Scheme	No	No	No	No
Malcore Medical Aid:				
- Plan A	Yes	No	No	No
- Plan B	Yes	No	No	No
- Plan C	Yes	No	No	No
MMED Option of the Naspers Medical Fund	Yes	No	No	No
Naspers Medical Fund N Option Plus	Yes	No	No	No
Naspers Medical Fund N Option Basic	No	No	Yes	No
Quantum Essential Comprehensive	Yes	No	No	No
Quantum Essential Saver	Yes	No	No	No
Quantum KeyPlus	No	No	No	Yes
Remedi Comprehensive Option	Yes	Yes	No	No
Remedi Classic Option	Yes	Yes	No	No
Remedi Standard Option	No	No	No	Yes
Retail Essential	Yes	No	No	No
Retail Essential Plus	Yes	No	No	No
TFG Medical Aid Scheme Plan A	Yes	No	No	No
TFG Medical Aid Scheme Plan B	Yes	No	No	No
Tsogo Classic Comprehensive	Yes	No	No	No
Tsogo Classic Saver	Yes	No	No	No
UKZN Medical Scheme	Yes	No	No	No
Wits Medical Scheme	Yes	No	No	No
Wits Medical Scheme Network Option	No	No	No	Yes

Consultation codes limited to 0190 – 0192 and 0161 – 0164

Scheme Name	Reimbursement Rate for 2016						
	Premier Rate A (IH)	Premier Rate A (OH)	Premier Rate B (IN & OH)	Classic Direct (IH)	Classic Direct (OH)	Custom Direct (IH & OH)	KeyCare Specialist (IH & OH)
Anglovaal Group Medical Scheme	137%	162%	147%				
BMW Employees Medical Aid Society	137%	162%	147%				
LA Active	137%	162%	147%				
LA Comprehensive	137%	162%	147%				
LA Core	137%	162%	147%				
LA Focus	137%	162%	147%				
LA KeyPlus	137%	162%	147%				
Malcore Medical Aid							
- Plan A	137%	162%	147%				
- Plan B	137%	162%	147%				
- Plan C	137%	162%	147%				
MMED Option of the Naspers Medical Fund	137%	162%	147%				
Naspers Medical Fund N Option Plus	137%	162%	147%				
Naspers Medical Fund N Option Basic						130%	
Quantum Essential Comprehensive	137%	162%	147%				
Quantum Essential Saver	137%	162%	147%				
Quantum KeyPlus							110%
Remedi Comprehensive Option	137%	162%	147%	217%	100%		
Remedi Classic Option	137%	162%	147%	217%	100%		
Remedi Standard Option							110%
Retail Essential	137%	162%	147%				
Retail Essential Plus	137%	162%	147%				
TFG Medical Aid Scheme Plan A	137%	162%	147%				
TFG Medical Aid Scheme Plan B	137%	162%	147%				
Tsogo Classic Comprehensive	137%	162%	147%				
Tsogo Classic Saver	137%	162%	147%				
UKZN Medical Scheme	137%	162%	147%				
Wits Medical Scheme	137%	162%	147%				

ALL OTHER SCHEMES

Scheme Name	2016 Rate Increase
AECI	6.00%
BARLOWORLD	5.30%
BCIMA	6.00%
Bestmed	5.00%
BONITAS	5.20%
BPSA	6.00%
Camaf	5.83%
Cape Medical Plan	6.10%
Commed	6.00%
Compcare	6.00%
De Beers	6.00%
Discovery Health Medical Scheme	5.00%
Engen	6.00%
Fedhealth	5.50%
Fishmed	6.00%
Furnmed	5.00%
GEMS	5.00%
Genesis	5.50%
Glencore	5.50%
Golden Arrow	6.00%
Grintek	6.00%
Harmony Health Services	5.83%
Horizon	6.00%
Hosmed	6.00%
Impala Medical Services	5.83%
Imperialmed	6.10%
Ingwe	7.90%
International Monetary Fund	5.83%
Keyhealth	6.00%
Liberty Health	6.00%
MASSMART	6.00%
MB MED	5.30%
Medihelp	6.00%
Medimed	5.00%
Medipos	6.00%
Medshield	6.00%
Metropolitan Medical Scheme	6.00%
Midmed	6.00%
Momentum (MMSA)	5.00%
Moto Health Care	6.00%
Namibia Health Plan	5.83%
Nammed	5.83%
NBCRFI Wellness Fund	5.83%
Nedgroup	6.10%
Nestle	5.83%

Scheme Name	2016 Rate Increase
Netcare	5.50%
Nimas	5.83%
Nufaswa	5.83%
Old Mutual Staff	6.00%
Opmed	5.83%
Parmed	5.30%
Pg Bison	6.00%
PG Group Medical Scheme	5.50%
Pick n Pay	6.00%
Platinum Health	5.83%
Polmed	6.00%
Primecure	5.50%
Profmed	6.00%
Prosperity	5.83%
Rand Mutual	6.40%
Rand Water	6.00%
Resolution Health	6.00%
RU Med	5.00%
SABC	5.30%
SABMAS (SA Breweries)	6.00%
Samwumed	5.83%
Sasolmed	5.20%
Sedmed	5.83%
Selfmed	7.50%
Sibanye Gold Ltd	5.83%
Sisonke Health	5.00%
Sizwe	5.83%
Spectramed	5.00%
Spes Bona	5.83%
Suremed	5.00%
Swazimed SA	5.83%
Swazimed Swazi	5.83%
Thebemed	6.00%
Tiger Brands	6.00%
Topmed	6.00%
Transmed	5.50%
Umvuzo Health	7.50%
UNDP	5.83%
UNICEF	5.83%
Universal Health Plan	6.00%
UNOPS	5.83%
UNV	5.83%
WCMA (Witbank Coalfields)	5.60%
Wooltru	5.40%
Yebomed	5.60%

