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Surgicom News

Discovery Health Responds to Surgicom regarding Breast Care

In December we reported that surgeons caring for Discovery Key-Care members were in an invidious position though the scheme's refusal to fund any form of breast biopsy unless the result indicates the presence of a breast malignancy. Several meetings, considerable correspondence and the support of the Breast Interest Group, BIGOSA has resulted in a complete reversal of Discovery's original position.

1 **Out of hospital:** DH will now fund breast biopsy (Fine Needle Aspiration and Core Biopsy) from the specialist benefit subject to the specialist limit, including related pathology. This will apply to surgeons and radiologists.
2 **In hospital:** DH states that they do appreciate the fact that a limited number of cases will require an excision biopsy to confirm diagnosis. They will review these requests on a case-by-case basis, based on supporting clinical risk factors. If criteria are met, funding will be approved from the hospital benefit at a KeyCare network hospital.

VABB (Vacuum Assisted Breast Biopsy) remains an exclusion on KeyCare plans as does surgery for benign breast disease (subject to the consideration set out above).

These developments attest to the effectiveness of your professional organisation. Our problem is that currently all surgeons benefit from Surgicom's initiatives rather than only our paid-up members. We are actively pursuing initiatives that will benefit Surgicom members but not be accessible to non-members.

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SURGICOM OFFICE
www.surgicom.co.za
Unit 16, Northcliff Office Park 203
Beyers Naude Drive Northcliff, 2115

Registration No. 1997/001593/07
VAT Reg No: 4700163670
PO Box 2127, Cresta, 2118

Tel: 011 340 9000
Fax: 011 782 0270
email: surgicom@healthman.co.za

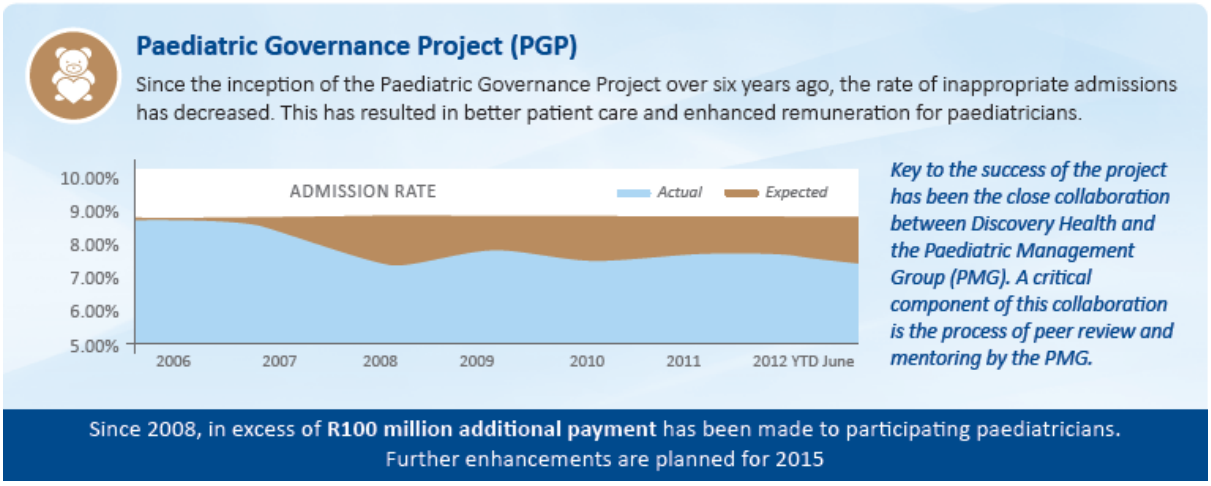
www.surgicom.co.za
www.sappf.co.za
www.healthman.co.za

SOON SURGICOM MEMBERS MAY HAVE THE OPPORTUNITY OF EARNING MORE WHEN THEY SEE DISCOVERY PATIENTS

Surgicom has made progress exploring a possible governance project with Discovery Health along the lines of the very successful project that the Paediatric Management Group has been involved with for many years. Surgicom members who participate by sharing data and complying with norms, guidelines and peer-review stand to earn a substantially higher fee from Discovery Health, allowing exception management rather than micro-management of every event. This would reduce the need for pre-authorisation and lower Discovery's management costs to enable them to pay more to participating surgeons. A sub-committee of Surgicom including Philip Matley, Andre Reddy and John Strachan are engaging with Ryan Noach, Maurice Goodman, Darren Sweiden and Roshini Moodley Naidoo of Discovery Health to examine a possible structure. Only Surgicom members will be eligible for participation in this scheme.

WHY IS SURGICOM COPYING THE PAEDIATRIC MODEL?

The PMG / Discovery Health governance project began in 2006 and has seen membership and participation increasing ever since. Paediatricians outside of the PMG are not able to participate. Participation implies a willingness to be subjected to peer review. The focus has been hospital admission rates for certain conditions and during this time Discovery has been able to provide a 50% increase in the fee for neonatal care and a substantial increase in remuneration for repeat hospital visits and emergency care. Paediatricians are audited with regard to certain outcomes and parameters but the assessment is carefully risk-adjusted depending on practice profile etc. Outliers are identified statistically and the top 40 outliers become the focus of attention. A letter of concern is sent to participants who are considered outliers and further intervention may be called for if they remain in this group. A small number may be asked to meet with DH and the PMG. Participation and remuneration is independent of any direct payment agreement with Discovery Health.



After nearly 10 years it seems clear that Discovery Health has saved money and been able to pay an additional R100 million to participating paediatricians with no compromise in clinical care. Surgicom anticipates that practicing general surgeons will benefit considerably when the Surgicom / Discovery Health project begins. Surgeons who are not members of Surgicom will not be able to participate.

OWNERSHIP AND USE OF RADIOLOGY & ULTRASOUND EQUIPMENT BY SURGEONS

On 5 December 2014, HPCSA published the new guidelines governing the ownership and use of X-Ray and ultrasound equipment by medical practitioners. These devices may be owned by any individual or legal entity but the owner is ultimately responsible for the safety of both personnel and the patient. Where licensing of such equipment is required, this must be done according to the legal prescripts and additional guidelines laid down by the relevant bodies and/or agencies acting on behalf of the Department of Health. Any individual, being a currently registered member of the Medical and Dental Professions Board, the Professional Board of Radiography and Clinical Technology or the Professional Board of Dental Therapy and Oral Hygiene of the Health Professions Council of South Africa, with specific training, and suitable credentialing in radiation safety and related matters may operate such equipment. Any individual currently registered with the Medical and Dental Professions Board or the Professional Board for Dental Therapy and Oral Hygiene and who is adequately educated, trained and sufficiently experienced to interpret and record the findings may interpret and report on these images. Both written or electrically generated reports as well as the images must be stored for a minimum of 6 years.

The HPCSA guidelines further state that "To qualify as appropriately credentialed, the individual practitioner must have successfully completed a training programme approved and accredited by the Board for registration purposes" as well as being able to demonstrate experience with the investigation and attest to having performed a "minimum number of interventions annually to remain proficient". "Short courses" alone are not deemed to be adequate.

There are a number of issues that will need to be challenged through on-going engagement with HPCSA but surgeons now have the responsibility of addressing issues regarding training, credentialing and accreditation. ASSA and Surgicom believe that the College of Surgeons is the body that must provide this. The President of ASSA, Bob Baigrie has written to the President of the College, Martin Veller to request that the College take on this responsibility. The matter is tabled for further discussion at the next meeting of the Federation of South African Surgeons (FOSAS) on 16 May 2015.

MALPRACTICE INSURANCE 2015

Surgeons in 2015 will have to once again cope with a sharp increase in premiums for satisfactory cover from the Medical Protection Society. Various alternatives do exist in the market place which are considerably less expensive but are associated with possible limitations. The offer from Impact Brokers is detailed on the Surgicom Website. Members need to carefully weigh up the pros and cons of switching to a more affordable provider.

ENGAGEMENT WITH ASSA AND FOSAS ON A SINGLE MEMBERSHIP FEE

The Surgicom board believes that every ASSA member that is in private practice should automatically be a member of Surgicom and pay the monthly fee. This is the model that has worked very well for O&G, Ophthalmology and ENT. Ultimately we would like to see this incorporated into a single invoice managed through FOSAS but at this stage the challenge is for Surgicom to offer so much to general surgeons that membership is irresistible. The Discovery Governance Project may well facilitate this together with an increased awareness of the advantages that Surgicom members enjoy.

Surgicom Fees 2015

A 6% membership fee increase will take effect 1 May 2015 for the new financial year. The new Surgicom membership fees will be R610 per month for members in full-time private practice and R245 per month for those in limited private practice.

COMPLIMENTARY MEMBERSHIP FOR NEW SURGEONS AND PRACTICE MANAGEMENT COURSES

Surgicom now offers complimentary membership and practice management support to all new surgeons for 12 months following their commencement of private practice. We have engaged with The South African Association of Surgeons in Training (SASSIT) to explore closer communication and are planning regional workshops for registrars on how to run a private practice. The course material is currently being developed by Dean Lutrin and was presented to the Surgicom Board on 13 February 2015 to considerable acclaim.

PMB's

A comprehensive database of schemes that pay PMB claims higher than scheme rates and directly to the provider is now accessible on the secure section of the Surgicom Website. This is not accessible to non-members.

GAP COVER POLICIES

Surgicom's database of GAP Cover schemes has been published on the secure section of the website. Knowledge of these schemes should enable surgeons to bill more effectively as most of these schemes will pay for 300% or more. It is important to be aware of rules, limitations and exclusions before reassuring a patient that their policy will cover all the costs. These are detailed on the website. As the number of such schemes is rapidly increasing the data base will be regularly updated.

FORENSIC REVIEWS

Surgicom continues 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 believe are guilty of "misdemeanors" with regard to billing codes. We urge members to familiarize themselves once again with these various codes, rules and modifiers. Recent cases have focused on presumed incorrect billing for post-operative consultations (Rule G), pre-operative consultations of the day of elective surgery (Rule M) and inappropriate additional use of code 1819 for "laparotomy" in addition to defined intra -abdominal procedures. Members are once again advised to consult with Surgicom directly rather than attempt to deal with such enquiries single handedly.

WHAT IS HAPPENING AT THE COMPETITIONS COMMISSION TRIBUNAL?

Thus far 68 submissions have been received, totaling some 15,000 pages. Participants now have until March 5 to respond to allegations, claims and data with responses which are "Precise, succinct and supported". There has been no discussion of contents of submissions, only themes at this stage, especially healthcare inflation. The finalised timetable for public hearings, site visits and provisional findings should be published in April 2015.

ASSISTANCE WITH PMBS, CMS COMPLAINTS AND REVIEWS

One of the services provided by Surgicom is unlimited access to the helpline desk for assistance with queries regarding PMB claims, complaints to the Council for Medical Schemes and a large range of other matters.

THE GP AS "GATEKEEPER"

From 1 January 2015 all GEMS beneficiaries are required to consult their treating network family practitioner prior to consulting a specialist. In order for specialist claims to be reimbursed, all Sapphire and Beryl members must obtain a referral number before making an appointment to see a specialist. The referring family practitioner practice number must reflect on all GEMS claims for Sapphire, Beryl, Ruby, Emerald and Onyx options. Fedhealth members must also visit their family practitioner prior to seeing a specialist from 1 March 2015. These schemes are convinced that using the general practitioner as "gatekeeper" will save on unnecessary visits to specialists and better control down-stream costs. We anticipate several other schemes following suit.

In a number of interactions with Medscheme who administer GEMS and Fedhealth, members of Surgicom and several of the other specialist groups have pointed out some of the disadvantages to patients, specialists and schemes of this policy and have insisted that a list of exceptions be recognised beyond the current exceptions of patients younger than 6 months and pregnant patients requiring obstetric care. There are a number of scenarios that may benefit from general exemption
such as referral on by one Specialist to another Specialist(s), scheduled follow up by surgeon, e.g. 6 or 12 monthly, follow up of hospitalisation and surgery, scheduled oncology follow-up, scheduled endoscopic surveillance examinations and PMBs where our understanding is that schemes may not stipulate at what level a PMB condition is managed; the client may legally proceed directly to any provider that can offer the services as contemplated in the Act. It is clear that considerable negotiation with schemes will still be needed on this issue. Surgicom board members are doing this on behalf of all surgeons.

MEDIHELP CPT PROJECT

Nearly half of all Surgicom members continue to benefit from the Medhelp CPT project with considerably enhanced remuneration for certain procedures when the claims are correctly coded in CPT. This is particularly true for out of hospital endoscopy and for surgical gastroenterology. SAMA's position is that CPT is the most suitable path to follow with respect to future coding methods. Most of the codes in the SAMA book have been harmonised to unit values of comparative procedures in CPT. New codes are introduced based on CPT relativities. Most hospitals currently code in CPT to serve their accounts. Recently Surgicom sent a revised "Guide to CPT Coding" to all members. This is accessible from the Surgicom Website. Members who wish to know more about the project or need assistance should contact the Surgicom/HealthMan helpline.

THE SURGICOM CODING GUIDELINE BOOK

There is a great deal of confusion and inconsistency with regard to billing practice and the correct use of the SAMA billing code, rules and modifiers. Whereas some surgeons may have disadvantaged themselves by not comprehensively billing for services that they are entitled to bill for, it is likely that the real problem is misuse of these codes. The majority of forensic matters considered by Surgicom relate to complaints against a member regarding billing codes. Surgicom is currently producing a guidebook for members under the editorship of Jan Mook and this should be available later in 2015.

SURGICAL 'PROFILING'

Funders are currently engaged in profiling specialists with regard to their outcomes and the costs that they generate. Surgicom has teamed up with Barry Childs of Insight Actuarial Services who have access to a great deal of this data. It will soon be possible to provide each Surgicom member with a summary of their profile versus other surgeons in respect of costs generated, theatre times, hospital and ICU stays and readmission rates. This data will be strictly confidential and will not be shared with any third parties without the consent of the member. We are currently gathering data to compare the overall performance of Surgicom members versus surgeons who are not members of Surgicom.

PHILIP MATLEY
CHAIRMAN: SURGICOM
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