PRIVATE PRACTICE CORNER

South African Private Practice Forum (SAPPF) http://www.sappf.co.za

The SAPPF was established to protect the private sector in what has become an extremely hostile and volatile healthcare environment, to strive for and ensure appropriate and realistic pricing for private professional services and to facilitate reform.

Many societies (e.g. ASSA-Surgicom) have enjoined their members en bloc, but SAGES is a multi-facetted society. Specialists are encouraged to join SAPPF individually – see their Website for details.

The first challenge for SAPPF was to take over the functions of an ailing SAMA Specialist Private Practice Committee (SPPC). Funding and the formal relationship with SAMA are still being brokered.

Dissatisfaction with the Reference Price List (RPL) process resulted in SAPPF launching a legal challenge against the Department of Health (DoH). An intense, complex and costly legal process ensued, but SAPPF has won the day! DoH did not oppose the Application and agreed to withdraw the 2009 RPL. The door is now open to structured negotiations — but with a tight deadline.

This has been an expensive route to go, but the first round is proof that the decision made by the various Associations/Societies, including SAGES, was indeed correct and that the DoH was at fault in its publication of the 2009 RPL and by not complying with its own Regulations.

One of the important results is that HPCSA will have to back down on its highly publicised, but erroneous views of ‘‘ethical’’ tariffs.

There is thus no legal RPL.
A specialist may charge what the individual deems appropriate to their practice
USE R25 PER MINUTE AS AN AVERAGE, AUDITED AND REFERENCED PRICE

Practice cost studies RPL 2010

SAPPF and SAMA made submissions for 2010.

A benefit of the OSD negotiations and increased State salaries is that the reference salary used to calculate the practice costs will also increase in line with that of senior State officials.

Upper GI endoscopy and colonoscopy are procedures that attract a lot of attention as cost drivers and due to their potential for abuse.

Further studies of gastroenterology practice costs, office endoscopy standards, costs of special equipment and renegotiation of formulae used by DoH are underway to ensure that endoscopic and allied practice is appropriately remunerated.

PMBs demystified

Prescribed Minimum Benefits (PMBs) are guaranteed benefits which a medical scheme has to cover. In terms of the Medical Schemes Act, PMBs cover the costs related to the diagnosis, treatment (in-patient and out-patient), and care of:

- any emergency medical condition;
- a limited set of ±270 medical conditions (called the Diagnosis and Treatment Pairs or DTPs, listed in the Act); and
- the 25 Chronic Diseases List (CDL) conditions.

The full list of PMB conditions is available on the Council for Medical Schemes (CMS) website http://www.medicalschemes.com/

Only when a diagnosis leads to the conclusion that a condition is a PMB, can a condition be classified as a PMB. A member is entitled to PMBs regardless of the medical scheme option. The medical scheme must pay in full for all relevant consultations and appropriate special investigations that have yielded the positive PMB diagnosis from its risk pool and not

the member's medical savings account. If the scheme initially paid for these from savings account, the member should request the Scheme to reverse the costs to the risk pool, since PMB-related services may never be paid from savings accounts. If funds were depleted and the client paid "out of pocket", the scheme must reimburse the client.

If consultations and diagnostic tests established that a member was not suffering from a PMB condition, then the scheme has to provide cover only in terms of its normal benefits and available limits.

Complications arising from conditions that are non-PMBs might be a PMB condition if the complication itself is listed under the PMB conditions. There are conditions that are excluded from cover, such as cosmetic surgery and examinations for insurance purposes, but if a member contracts septicaemia after bariatric or cosmetic surgery, the scheme has to provide cover in full for a complication that is a PMB condition.

Note: "Hospital treatment where the diagnosis is uncertain and/or admission for diagnostic purposes. Urgent admission may be required where a diagnosis has not yet been made. Certain categories of PMBs are described in terms of presenting symptoms rather than diagnosis, and in these cases, inclusion within the PMBs may be assumed without a definitive diagnosis. In other cases, clinical evidence should be regarded as sufficient where this suggests the existence of a diagnosis that is included within the package. Medical schemes may, however, require confirmatory evidence of the diagnosis within a reasonable period of time."

Unlike an already identified PMB condition where the scheme may stipulate the use of designated service providers (DSPs) for PMB-related services (further tests, treatment, and care), screening tests that are yet to determine a diagnosis can be done either at any healthcare provider or at a network provider as determined by the benefit option. These providers could be radiology and pathology practices, doctors, pharmacists, hospitals as well as the public health sector. If the diagnosis yields PMB-positive results, the scheme must pay the service provider in full without co-payment.

ICD-10 codes facilitate the easy identification of PMBs by service providers and funders while at the same time promoting confidentiality of health information. It is important to ensure that diagnosis information provided is correct to guarantee that benefits are paid out from the correct benefit pool.

PMBs are under review to expand the list of conditions covered considerably and to align the Regulations with the NHI reformation.

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