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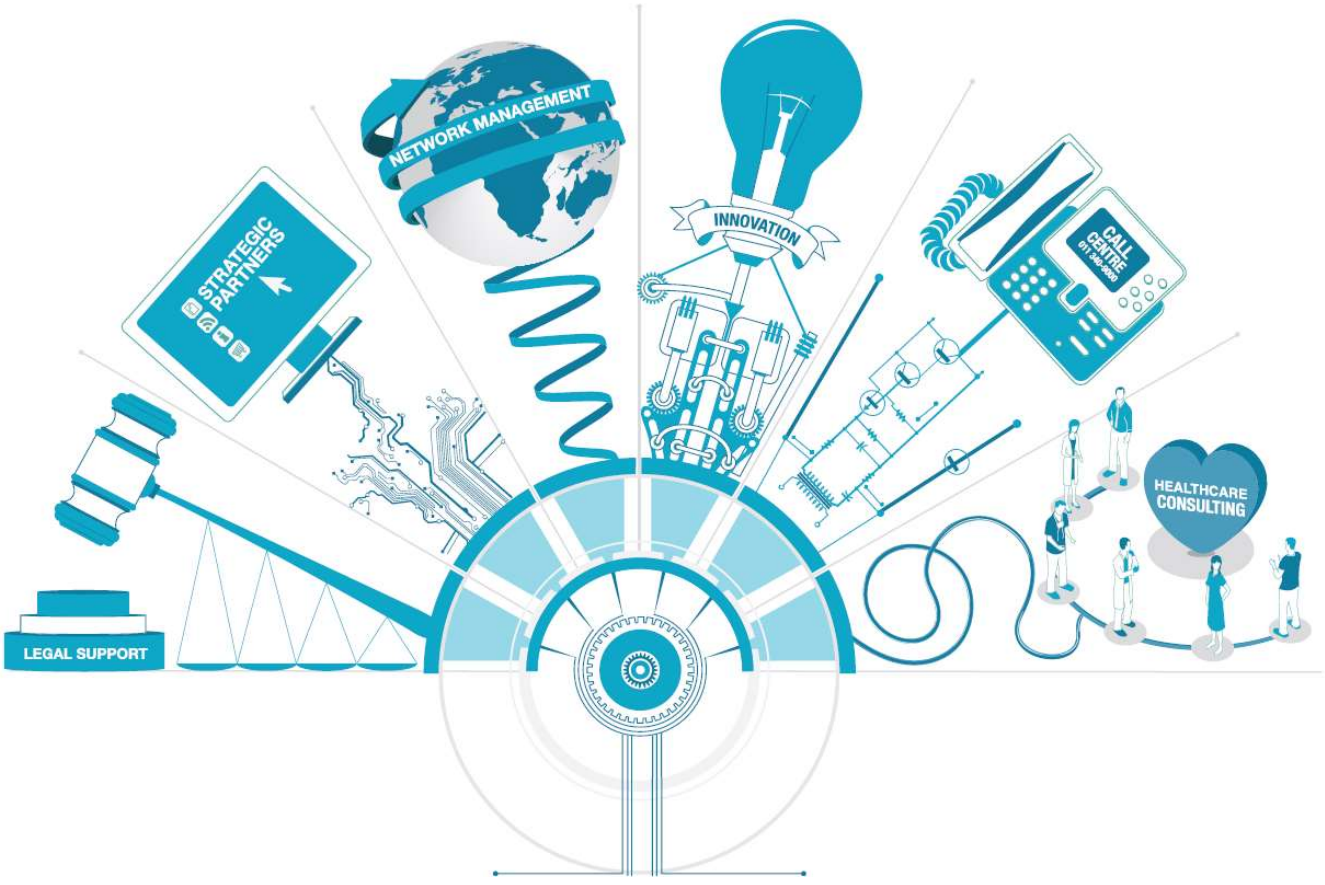
Private Practice Review January2017

Regulatory Review, Tariffs, DSPs, DPAs and Governance Projects



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1. INTRODUCTION

The management and staff at HealthMan wish all our clients, their support staff, and other recipients of our newsletter a prosperous, memorable and stress-free 2017.

2017 will, no doubt, prove to be an interesting and busy year in the healthcare industry. The long awaited Health Market Inquiry Report by the Competition Commission will be published in December 2017 and a lot of work still needs to be done before its finalisation. HealthMan will keep practitioners informed on the progress and will advise individual societies and management groups of their potential required involvement in the processes. SAPPF will also be intricately involved in submitting responses to the various reports during the year and will make an oral submission during the May/June public hearings.

A number of the HPCSA Ministerial Task Team recommendations will be actioned in 2017 and there is bound to be some important changes in the HPCSA, of which HealthMan will keep clients apprised. The hope is that the dysfunctional nature of the organisation will be changed for the better by these proposed changes.

Public awareness of the proposed NHI was raised immensely in 2016, with lots of analysis of the system and its components, based on the limited information supplied in the NHI White Paper that was published in December 2015. This year will most probably have the publication of a second NHI White Paper, which will hopefully address the shortcomings in information on how the NHI will work, the costs involved and how it will be financed. Indications from the submissions on financing of the NHI to the Davis Tax Commission in 2016 was largely that the NHI is not affordable to South Africa in its current format. Financing of the funding shortfalls by the very narrow South African tax base would be an impossibility in our current low growth and high unemployment scenario. The debate around alternative ways to achieve Universal Healthcare in South Africa has been gaining momentum and going forward, the hope is for a more affordable and better structured health system than the NHI proposal.

The long overdue review of PMBs by the Council for Medical Schemes in 2017 is bound to lead to many late nights for all the participants in the process. A concerning development is the indication that the PMBs will be aligned to the NHI policy, which has a totally different role envisioned for medical schemes in healthcare funding. One can only hope that sanity will prevail and that the current healthcare challenges will be weighted more heavily in the review than a policy shift that will be implemented many years down the line. Practitioner management groups and societies are encouraged to actively participate in this important review process, which will affect all providers.

Regarding medical schemes, there are ongoing challenges with fraud, abuse and waste, with various investigations regarding this conducted by medical schemes, administrators and their different agents. HealthMan does not condone fraud, waste and abuse and encourages practitioners to bill ethically and to raise coding related queries with the relevant management groups and societies, if any uncertainty exists regarding the interpretation of codes. HealthMan is always available to assist with investigations by schemes.

You will find 2017 designated payment arrangement updates outlined in this newsletter for your convenience, along with scheme rate increase for the upcoming year, news of amalgamations, benefit option changes and general changes. Do take note of these changes, as especially the implementation of Hospital Networks by many schemes can have a large impact on admitting practitioners.

We trust our 2017 Annual New Years' Newsletter finds you healthy, rested, and confident to meet a new year full of challenges and opportunities.

The HealthMan Team

9 January 2017

2. REGULATORY NEWS

2.1 Competition Commission Market Inquiry into Private Healthcare

The Health Market Inquiry (HMI) is currently still ongoing and did not publish a final report on 15 December 2016, as originally planned. The sheer volume of submissions and expansive scope of the inquiry necessitated an extension of the Inquiry into 2017.

The Competition Commission published a revised timetable on 1 December 2016, which indicates that the inquiry will carry on in 2017 with the publication of the final report to be on 15 December 2017. Reports on various aspects will be published on an ongoing basis for public commentary during the year. A summary of their Healthcare Consumer Survey was published in November 2016 while reports on Descriptive Statistics for Medical schemes and an attribution analysis of Medical scheme data were published in December 2016.

Some other important publication dates for HealthMan clients in 2017 are as follows:

28 February 2017	Analytical Report of Prescribed Minimum Benefits
28 February 2017	Report on Supplier induced demand in private healthcare
1 March 2017	HMI Facilities Analysis report
1 March 2017	HMI Practitioner Analysis Report
1 March 2017	HMI Funder Analysis Report
15 March 2017	Profitability Analysis on Private Healthcare Funders
15 March 2017	Profitability Analysis on Private Healthcare Facilities
1 September 2017	Provisional Findings Report and Conditional Recommendations
15 December 2017	HMI Final Report and Recommendations

There will be a 30 day period for public comments after every report.

A further period of public hearings will take place during May and June 2017, with preparations and identification of subject matter for these further hearings taking place in April 2017.

HealthMan clients are encouraged to apprise themselves of the contents of all the HMI reports up to March 2017 and then consider whether any commentary on the contents is required or whether a presentation at the Public Hearings would be necessary to address any findings in these initial reports. All reports and the programme for public hearings will be published on (**http://www.compcom.co.za/healthcare-inquiry/**).

2.2 The Council for Medical Schemes Prescribed Minimum Benefits Review

On 2 December 2016, the Council for Medical Schemes (CMS) published circular 83 of 2016, which announced a review of Prescribed Minimum Benefits (PMBs). A review of PMBs has not happened since 2010 and is supposed to happen every two years, in terms of the Medical Schemes Act (131 of 1998). PMBs are subject to review, to address issues relating to:

1. Inconsistencies or flaws in current regulations;
2. The cost effectiveness of health technologies or interventions;
3. Consistency with developments in the health policy;
4. The impact on medical scheme viability and its affordability on members.

The previous review, in 2010, was apparently not approved by the Department of Health, citing the "hospicentric posture as an issue of concern". The official response from the Department of Health has never been made public and remains unconfirmed. The White Paper on National Health Insurance is quoted by the CMS as a motivation for the proposed current review of PMBs. With medical schemes only offering supplementary services under the NHI, it is difficult to see why the current PMB review needs to consider the NHI, which is still 10 years away from implementation. PMBs are supposed to be reviewed every 2 years and there should thus be a further four reviews before NHI is implemented. The guiding principles outlined in the CMS release also do not correlate with consideration of the NHI. The quoted guiding principles for review are as follows:

- The Current Health Situation of the Country
- The Needs of the Country
- Internationally agreed instruments
- Clinical and Cost effectiveness of interventions

- Efficiency
- Affordability of Interventions

Table 1 shows the proposed construct of the PMB Package, which takes into consideration the alignment of the Private sector package with that of the public sector.

Table 1: Proposed PMB Construct

Primary Healthcare Package	Hospital Level Package
Preventative Services	Inpatient Education Services
Maternal and Neonatal Services	Maternal and Neonatal Services
Child Health Services	Child Health Services
Mental Health Services	Mental Health Services
Diagnostic: Laboratory Services	Diagnostic: Laboratory Services
Diagnostic: Imaging Services	Diagnostic: Imaging Services
Pharmaceutical Services	Pharmaceutical Services
Emergency Medical Services	Emergency Medical Services
Palliative Services	Palliative Services

Input on the proposed packages will be solicited from different stakeholders during the period November 2016 to January 2017. There will then be a PMB workshop on the review project in February 2017. Multidisciplinary committee meetings to interrogate the submissions and to propose recommendations will take place between March 2017 and August 2017. The closing date for submission of proposals and applications for inclusion on the review committee is 27 January 2017. Send to pmbreview@medicalschemes.com. Contact your Society or Management Group for information on their submission strategies.

SAPPF has requested a 90 day extension for submissions, as the CMS has not engaged with stakeholders up to present.

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

SAPPF is continuing with work on finalising the SACHI Memorandum of Incorporation (MOI) and 2017 will prove to be a year filled with hard work in getting industry traction for this important initiative.

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 Procedural 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 Relative Value Units (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.

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

The Genesis v Minister of Health issue regarding PMB payment has finally been laid to rest in 2016. Genesis has agreed to drop the matter and not to pursue the proposed changes to Regulation 8 dealing with PMBs any further. The merits of the case never made it to court, as Genesis spent inordinate amounts of time and energy appealing the inclusion of SAPPF as respondents in the High Court, the Supreme Court of Appeal and the Constitutional Court, appeals that were lost on every occasion. There was also an additional Court Case before the Constitutional Court in 2016, in which Genesis was ordered to pay for PMB conditions in full, at the invoiced

rate. This finding made it unlikely that the other case would succeed and Genesis subsequently dropped any further action.

2.5 HPCSA

2.5.1 Unbundling of the Boards from the HPCSA

The Ministerial Task Team Report (MTT) on the HPCSA, commissioned by the Minister of Health, Dr Aaron Motsoaledi in October 2015, made the following recommendations:

1. To explore the fitness of the three senior officials within the council, namely; the Registrar/Chief Executive Officer, the Chief Operations Officer (COO) and the Head of the Legal Department. This also incorporated the disciplinary proceedings that would be considered in view of the conduct of the three senior officials in respect to the MTT report.
2. The formation of an interim management team.
3. Acting on the KPMG forensic report around the acquisition of the oracle system.
4. The recommendation for proper orientation of newly elected Board members and Council members.
5. The unbundling of the Medical and Dental Board being separate from other structures within council.

Following the MTT recommendation around unbundling, the HPCSA Professional Boards have embarked on a process where all twelve (12) Boards representing thirty (30) professions will deliberate the issue. The Boards will then engage the relevant stakeholders with respect to their professions. Thereafter, the HPCSA Council will discuss the reports from the different Boards and pave a way forward. The issue of unbundling relates to what is the best regulatory model that the country should follow and the HPCSA anticipates that there will be a need for an open summit for the sharing of ideas with all those stakeholders and all those with vested interests in which health regulatory model the country should adopt.

There are advantages and disadvantages regarding unbundling from the HPCSA, however, the body would like to reassure the professions that currently, each Board has authority and autonomy on professional matters that pertain to the healthcare professionals registered by that Board. Should there be a need for a regulation to be amended, the Board would ensure that the Council adopts the regulation which will then be open for public comment by the Minister of Health. The public will then be afforded the opportunity to provide their inputs. Only once the comments have been analysed, will the final regulations be promulgated by the Minister.

2.5.2 Pre-authorisation is the patient's responsibility

The majority of medical schemes require their members to obtain authorisation before receiving services from healthcare practitioners registered under the Health Professions Act.

While acting in the best interest of their patients, some practitioners offer to assist them with obtaining authorisation from their medical schemes for services to be rendered. Unfortunately, this has left members of medical schemes with the impression that it is the healthcare practitioner's responsibility to obtain permission from their medical schemes.

The HPCSA has received numerous complaints against practitioners emanating from this misconception and as a result, some patients have experienced financial losses.

Patients who are members of the medical schemes are advised as follows:

- Healthcare practitioners have no relationship with the patient's medical scheme except that which is provided for in managed healthcare arrangements;
- The responsibility for obtaining authorisation for treatment or services to be rendered lies with the member of the medical scheme after receiving prescribed information from the patient's treating practitioner;
- Patients are also reminded that it is their responsibility to ensure that the authorisation obtained from their medical scheme covers the scope of their treatment and services to be rendered;
- Patients should communicate with the practitioner concerned, especially when there are any limitations to the authorisation given.

2.6 Department Of Health Reforms

2.6.1 National Health Insurance (NHI)

The proposed National Health Insurance has not progressed much further in 2016, following the release of the White Paper on 11 December 2015. The indications during the year was that the Department of Health, through the six workstreams, is finalising a second version of the White Paper, which was due for publication towards the end of 2016. This publication has not happened, despite indications to the contrary during the year. The NHI workstreams and National Treasury were busy finalising a costing model for the NHI, based on a basket of care which is still currently being finalised.

The Davis Tax Commission requested submissions on NHI funding during October 2016, which would be used to compile a contributing report towards the finalisation of the NHI White Paper. SAPPF and various other organisations submitted commentary on the Funding of the NHI and oral submissions were made on 2 November 2016. The general consensus in the submissions on NHI funding was that the NHI is unaffordable in the current economic climate of low growth and high unemployment. The small South African tax base is also unlikely to be able to afford additional taxes to fund NHI. Various organisations looked at alternative funding methods for the NHI, but none were able to provide sufficient income to cover the shortfall on the current NHI cost estimates. The current estimates were also questioned and the indication is that the NHI would already be more expensive than the estimated R256 billion figure in the White Paper. The SAPPF urged the tax commission and the government to rather look at alternative scenarios to achieve universal health coverage in South Africa, as the NHI is unlikely to achieve this outcome.

In November 2016, the Democratic Alliance Launched an alternative proposal for Universal Healthcare called "*Our Health Plan*". The focus is on a more efficient use of current infrastructure and better management in the current health system to improve access to quality healthcare for all. There was extensive reporting in the press of NHI related issues during 2016, raising public awareness of the project and the concerns raised by various parties regarding its viability. Many of the concerns remain unaddressed. Two vital issues raised in the National Development Plan, namely the lack of quality in the public sector and the high costs in the private sector, both remain unresolved. Indications during 2016 were that both these issues were actually getting progressively worse and no progress seems to have been made on either.

The next draft of the NHI White Paper will have to clarify many of the questions raised following the original White Paper release, if there is to be any chance of successful implementation of the NHI in 2025.

Our regular newsletters - HealthView and Private Practice Review - and presentations at CPD meetings will keep you up to date on all these and other matters of importance.

3. OTHER NEWS

3.1 Medical Malpractice Crisis

There is currently a looming crisis regarding Medical Malpractice costs for the Obstetric community. Obstetricians are faced with Malpractice Insurance premiums of R850 000 for 2017. This is causing many practitioners to consider abandoning Obstetrics and only practicing as Gynaecologists. SAGOG and GMG are currently investigating other avenues to try and reduce the burden placed on them by excessive premiums. They have met with the Minister of Health, Dr Aaron Motsoaledi, to discuss their concerns. The Minister admitted that rising malpractice claims are a big concern in government facilities, with current liabilities in the public sector amounting to approximately R48 billion. Alternative Insurance models and insurers are also currently being investigated by SASOG/GMG, while programmes such as BetterObs are being implemented to reduce the frequency of claims in the Private Sector.

4. MEDICAL SCHEME INCREASES, DESIGNATED SERVICE PROVIDER & SPECIALIST PAYMENT ARRANGEMENTS

In the absence of any guidance as to what tariffs to apply in 2017, Schemes continue to set their tariffs independently. The likelihood is, however, that Administrators are setting tariffs on behalf of the Schemes they administer. This is more apparent for Discovery Health, while schemes administered by Medscheme and Metropolitan Health Risk Management show a larger variation in increases for 2017.

Detailed tariff lists are available on most Scheme web sites and/or are available to all Practitioners and members on request. Problematically, however, is that few Schemes and Administrators have the capacity or insight into coding structures. Scheme tariffs still blindly make use of the published Reference Price Lists 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 5.0% (Multiple Schemes) and 7.0% (Medshield). The highest increases in the industry are for Golden Arrow Medical Scheme and Horizon Medical Scheme, offering 7.1% increases. Details of Scheme increases are set out in Annexure A.

A summary of increases for 2017, per Administrator and selected Schemes, is set out below:

- Discovery Health – 5.5%*
- Momentum Health –5.7%
- Bonitas – 5.2%
- Fedhealth – 5.4%
- Metropolitan Health 6.0%
- GEMS – 5.0%
- Profmed – 5.0%
- Keyhealth – 6.2%
- Medshield – 7.0%
- Medihelp –6.2%
- Bestmed –5.0%
- Polmed – 6.0%

The increase for Direct Payment Arrangements (DPAs). Non-DPAs have different rates of increases and in the case of Discovery is 0% for consultations.

4.1 DISCOVERY HEALTH ADMINISTERED SCHEMES

4.1.1 Bankmed

For 2017, Bankmed will be increasing the Bankmed Specialist Rates by 5.5% for Network Providers, 5.5% for Procedures at Non-Network Providers and 3% for Consults at Non-Network Providers.

Hospital Networks

Members on Essential, Basic and Traditional Plans are confined to the use of a DSP Hospital Network. Mediclinic Hospitals are largely excluded from this network, with the exception of Mediclinic Hospitals in Lephalale, Thabazimbi, Tzaneen, Secunda, Barberton, Ermelo, Kimberley, Upington, Oudshoorn, Hermanus, Paarl and George. The complete list of Network Hospitals for these plans can be downloaded at Essential and Basic Plan Hospital Network and Traditional Plan Hospital Network.

Procedures in Doctor's Rooms

According to Bankmed, the following procedures can, in most cases, be safely performed in a Doctor's rooms, without the need for a hospital admission. Only exceptional cases will be authorised for hospital admission. Doctor's rooms procedures will be covered from the available benefits as specified under 'General practitioners (GPs): Procedures in rooms' and 'Specialists: Procedures in rooms'. The list of procedures is as follows:

Cone Biopsy	Drainage of superficial abscess
Cauterisation of Warts	Superficial foreign body removal
Coposcopy	Gastroscopy
Nasal Cauterisation	Sigmoidoscopy
Meibomain cyst excision	Breast Biopsy
Circumcision	

See Rooms Procedures Link for a complete SAMA code list of the relevant procedures.

DSP Network

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 or Bankmed Specialist Entry Network, please call 0860 44 55 66 or email healthpartnerinfo@discovery.co.za.

Bankmed Specialist Network	In-Hospital	Out-of-Hospital
Bankmed Specialist Network Entry Plan, Essential, Basic Plans	110%	110%
Bankmed Specialist Network Traditional, Saver & Comprehensive	135%	150%
Bankmed Specialist Network Plus Plan	200%	215%
All rates expressed as a % of the Scheme Rate		

4.1.2 Discovery Health Medical Scheme

For 2017, Discovery will be increasing the Discovery Health Specialist Rates by 5.5% for Providers with Direct Payment Arrangement (DPA), 5.5% for Procedures at Non-DPA Providers and 0% for Consults at Non-DPA Providers.

Tariffs for **procedures will increase at 5.5%** with gastroenterological scopes increasing at a variable rate depending on the setting of care. The rates for a defined list of **GI scopes** performed **in hospital** will increase at **3%**, in **day facilities** at **6%** and when performed **in the doctors rooms** at **8%.**

Discovery Health Rate	% of 2017 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%
(Specialists on Premier Rate A, Premier Rate B & Custom Direct Payment Arrangements agree NOT to balance bill members)	
Essential and Coastal Plans	100%
(Specialists have the option to balance bill)	
Classic Plans and Smart Plan	
• Classic Plans (In-Hospital)	217%
(No Balance Billing above 217% of the DH Rate)	
• Classic Plans (Out-of-Hospital)	100%
(Specialists have the option to balance bill)	
Discovery Health Rate	**% of 2017 DH Rate**
Executive Plan	300%
(No Balance Billing above 300% of the DH Rate)	
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%
(Specialists taking part in the KeyCare specialist network agree not to balance bill 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.)	

- Specialists can choose between the Premier Rate Arrangement and the Classic Direct Payment Arrangement for Discovery Health Medical Scheme (on all plans except KeyCare) and schemes administered by Discovery Health.
- Claims reimbursement will be made in accordance with the billing guidelines and plan benefits of the participating medical schemes
- Specialists can **ALSO** join the Custom Direct Payment Arrangement **AND** the KeyCare Specialist Arrangement.
- **The details of scheme participation in the payment arrangements for 2017 are provided in Annexure A.**

Day Surgery Rates

The day-surgery benefit applies to all procedures performed in a day-surgery facility. This benefit excludes **ophthalmology**, **maxillo-facial and oral surgery**, **dentistry**, **GIT endoscopies**, consultations and procedures typically performed in the doctor's rooms. Minor procedures that are typically performed in the doctor's rooms are not covered through the day-surgery benefit unless explicitly approved for funding.

Direct Payment Arrangement	Health Plan Type	Acute Hospital Rate	Day Surgery Rate
Classic Direct Rate	Classic	217%	230%
	Essential or Coastal	100%	200%
Premier Rate A	Essential, Coastal or Classic	137%	167%
Premier Rate B	Essential, Coastal or Classic	147%	177%
Executive	Executive	300%	300%

No Balance billing allowed above Day Surgery Rates

Criteria for participation in this benefit

1. You have to be part of a Discovery Health direct payment arrangement
2. You may not bill patients the balance of the account.

How to access the enhanced direct payment arrangement rates for procedures performed in a day surgery Facility:

- Follow the normal benefit preauthorisation process by calling 0860 44 55 66. You can also apply electronically by accessing www.discovery.co.za and navigating to 'Your hospital admission'.
- Submit your claim with the enhanced rate together with the place-of-service indicator (below) on your claim to access the enhanced direct payment arrangement rate:
  24 - Day clinic or hospital

Discovery Governance Projects

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)

Casualty evaluation code CAS18

Plan Types	Classic Direct	Premier A	Premier B	Keycare	Custom Direct
Executive and Classic Plans	R2 378.60	R1 501.70	R1 611.30	-	-
All Other Plans	R1 096.10	R1 501.70	R1 611.30	R1 205.80	R1 425.00

Criteria for accessing this benefit

- Participate in the peer review/mentoring processes involving the exchange of clinical/administrative information (including profiles) to jointly promote an efficient and high-quality healthcare system
- Be a member of the Faculty of Consulting Physicians of South Africa (FCPSA) – Discovery Health reserves the right to verify your membership of the FCPSA
- Participate in one of Discovery Health's direct payment arrangements
- Use code 'CAS18' to bill for the casualty evaluation fee, note that no other consultation codes can be billed in conjunction with CAS18.

Hospital Discharge Management code HDM1

From **1 January 2017** you can submit discharge summaries through HealthID using the app and the website. In 2017, Discovery will no longer accept discharge summaries sent by email.

Plan Types	Classic Direct	Premier A	Premier B	Keycare	Custom Direct
Executive and Classic Plans	R919.20	R580.40	R622.70	-	-
All Other Plans	R427.00	R580.40	R622.70	R465.90	R550.70

Criteria for accessing this benefit

- Be the principal doctor for the admission event
- Participate in the peer review/mentoring processes involving the exchange of clinical/administrative information (including profiles) to jointly promote an efficient and high-quality healthcare system
- Be a member of the FCPSA – Discovery Health reserves the right to verify your membership of the FCPSA
- Participate in one of the Discovery Health direct payment arrangements
- Use code 'HDM1' instead of code '0109' to bill the hospital discharge management fee with the discharge visit.

The Physician Quality Network applies to all the schemes administered by Discovery Health (Pty) Ltd, excluding:

- Anglo Medical Scheme
- Bankmed Medical Scheme
- Glencore Medical Scheme
- Netcare Medical Scheme

Paediatric Governance Project for members of the Paediatric Management Group

Benefits for 2017

Existing Paediatric Governance Project benefits:

- All doctors participating in the Paediatric Governance Project qualify for an annual tariff increase of 5.5% on consultations. The Paediatric Governance Project rate tables are available on the HP Zone at www.discovery.co.za
- Participating doctors in the Paediatric Governance Project who demonstrate an admission rate efficiency at or better than the risk-adjusted benchmark will have access to an additional code 0177 at a rate of R310. This is for the completion of an electronic discharge summary on HealthID mobile or web-based application platforms. This is only available for Discovery Health Medical Scheme plans (KeyCare plans included). **Eligible doctors will be notified of their access to this benefit**.
- The most efficient doctors participating in the Paediatric Governance Project qualify for a 10% annual tariff increase for consultations for 2017. **Eligible doctors will be notified of their access to this higher tariff.**

Enhancements to the submission process for the Asthma and Epilepsy Benefit

The Quality Consultation report template is now available on HealthID mobile and web-based application platforms. From 1 January 2017, paper reports sent via email will no longer be accepted. Completion of the Quality Consultation report will be remunerated at R132 per consultation, per condition, per year for asthma and epilepsy only. Please use the unique code – PGPQC as a separate line item on your claim**.**

Discovery Health reimbursement on Paediatric Governance Project 2017							
	DH Rate 2017	Premier Rate A	Premier Rate B	Classic Direct Rate*	Executive Plan Rate	KeyCare Specialist Rate	Custom Specialist Rate
In-hospital consultation code		137%	147%	217%	300%	110%	130%
0111 (DPA rates)	R317.70	R435.30	R467.00	R689.40	R953.10	R349.50	R413.00
0111 (Paediatric Governance Project)	R443.30	R607.40	R651.70	R961.90	R1 329.90	R 487.60	R576.30
0149 (Paediatric Governance Project)	R 128.40	R175.90	R188.70	R278.60	R385.20	R141.30	R166.90

*Rate for medical scheme members on Classic plans. For medical scheme members on other plans, reimbursement is at the project rate with an option to balance bill the patient if you choose to do so.

ICU Consulting Codes and Tariffs

Consultation code	Brief description	DH Rate (Non-network/ DPA)	Governance Project/DPA Rate	Premier Rate A - 137%	Premier Rate B - 147%	Classic Direct Rate* - 217%	KeyCare Specialist
1204	Intensive Care Category 1	R346.70	R365.80	R501.10	R537.70	R793.80	R402.40
0019	Modifier		R182.90	R250.55	R268.85	R396.90	R201.20
Total (1204 + modifier)			**R548.70**	**R751.65**	**R806.55**	**R1 190.70**	**R603.60**
1205	Intensive Care Category 2 first day	R1 156.30	R1 219.90	R1 671.30	R1 793.30	R2 647.20	R1 341.90
0019	Modifier		R609.95	R835.65	R896.65	R1 323.60	R670.95
Total (1205 + modifier)			**R1 829.85**	**R2 506.95**	**R2 689.95**	**R3 970.80**	**R2 012.85**
1206	Intensive Care Category 2 subsequent days	R578.10	R609.90	R835.60	R896.60	R1 323.50	R670.90
0019	Modifier		R304.95	R417.80	R448.30	R661.75	R335.45
Total (1206 + modifier)			**R914.85**	**R1 253.40**	**R1 344.90**	**R1 985.25**	**R1 006.35**
1207	Intensive Care Category 2 weeks+	R346.70	R365.80	R501.10	R537.70	R793.80	R402.40
0019	Modifier		R182.90	R250.55	R268.85	R396.90	R201.20
Total (1207 + modifier)			**R548.70**	**R751.65**	**R806.55**	**R1 190.70**	**R603.60**
1208	Intensive Care Category 3 Primary doctor	R1 584.20	R1 671.30	R2 289.70	R2 456.80	R3 626.70	R1 838.40
0019	Modifier		R835.65	R1 144.85	R1 228.40	R1 813.35	R919.20
Total (1208 + modifier)			**R2 506.95**	**R3 434.55**	**R3 685.20**	**R5 440.05**	**R2 757.60**
1209	Intensive Care Category 3 Other doctors	R670.60	R707.50	R969.30	R1 040.00	R1 535.30	R778.30
0019	Modifier		R353.75	R484.65	R520.00	R767.65	R389.15
Total (1209 + modifier)			**R1 061.25**	**R1 453.95**	**R1 560.00**	**R2 302.95**	**R1 167.45**
1210	Intensive Care Category 3 subsequent days	R578.10	R609.90	R835.60	R896.60	R1 323.50	R670.90
0019	Modifier		R304.95	R417.80	R448.30	R661.75	R335.45
Total (1210 + modifier)			**R914.85**	**R1 253.40**	**R1 344.90**	**R1 985.25**	**R1 006.35**

*Rate for medical scheme members on Classic plans. For medical scheme members on other plans, reimbursement is at the project rate with an option to balance bill the patient if you choose to do so.

Efficient Providers' Rewards - Paediatrics

Practices who are listed amongst the most cost efficient practices for the current review period will be eligible for a **10%** annual increase in consultations for 2017. ***Eligibility for this reward will be communicated to the individual qualifying practices.***

Practices demonstrating an admission rate better than the risk-adjusted benchmark, are eligible to bill an **additional code 0177 at a fixed fee rate of R310 from 1 February 2017,** for completion of the electronic discharge summary on the mobile or desktop version of HealthID. This is only available for Discovery Health

Medical Scheme plans (KeyCare plans included). ***Eligibility for this reward will be communicated to the individual qualifying practices.***

Surgicom Governance Project for Members of Surgicom

Participating surgeons in the Surgicom Governance project, are reminded of their agreement to adhere to the following:

1. The principles and objectives of the initiative.
2. Applying Surgicom-endorsed care pathways, guidelines and protocols which will be released from time to time.
3. Integrating HealthID into daily interaction with patients and implementing Surgicom discharge planning guidelines, including the submission of a discharge summary via HealthID for Discovery Health Medical Scheme and any future participating medical schemes.
4. Billing code 0177 for the submission of a discharge summary where the surgeon is the admitting doctor.
5. Participating in the Surgicom mentoring process, which involves the exchange of clinical and administrative information towards jointly promoting efficient and high-quality care.

   Please note:

   - This project applies initially to Discovery Health Medical Scheme only. Other schemes administered by Discovery Health that would like to participate in this agreement will be automatically included, subject to approval of the relevant scheme's Board of Trustees. We will communicate with you if this happens. Subject to these terms and conditions, all other scheme rules will still apply.
   - The processes and benefits making up the project will apply for the duration of the agreement or until notification of termination is received by either party.

Initiative fee increase

As of 1 January 2017, the participating admitting doctor will receive a fee of R400.00 for the submission of the discharge summary for each patient using the Discovery electronic platform HealthID.

Please contact Discovery Health at mhealthpartners@discovery.co.za or the Surgicom website http://surgicom.co.za/ for more information and details of this initiative.

4.1.3 Glencore

Glencore Medical Scheme is being administered by Discovery Health, since 1 July 2016. They are no longer with Medscheme.

4.1.4 Netcare Medical Scheme

From 1 January 2017, Discovery Health will be the administrator of the Netcare Medical Scheme.

2017 Tariffs and DSP Arrangements

The current Netcare Medical Scheme (NMS) tariff has been increased by 6% with effect from 1 January 2017. The Netcare Clinical Partners (CP) Network re-imbursement rate for 2017 will remain at 50% above the NMS tariff. Note that the enhanced re-imbursement rate only applies to those specialists who are part of the Clinical Partners Netcare Specialist Network. Non-network specialists will continue to be paid at the NMS rate. NMS will continue to work on a Designated Service Provider (DSP) register. It is important for DSPs to comply with the negotiated Netcare CP Network rates for all conditions/treatments, including PMBs.

- Claims with a service date up to 31 December 2016 must be sent to the previous administrator – PrimeMed, as was previously the case.
- From 1 January 2017, all Netcare Medical Scheme member claims must be submitted to Discovery Health using the existing submission channels or by e-mailing claims@netcaremedicalscheme.co.za.

Discovery Health will transfer all approved hospital admissions of Netcare Medical Scheme members for 2017 to its administration database.

You are welcome to contact Clinical Partners at any time should you have any questions, concerns or are in need of a personal update regarding the Clinical Partners network on mhealthpartnerinfo@discovery.co.za.

4.2 MEDSCHEME ADMINISTERED SCHEMES

The scheme increases for Medscheme administered schemes are shown in the table below:

Scheme Name	2017 Rate Increase
AECI Medical Aid Society	6.3%
Barloworld Medical Aid	6.0%
Bonitas Medical Fund	5.2%
Fedhealth	5.4%
Horizon Medical Scheme	7.1%
MBMed Medical Aid Fund	6.0%
Nedgroup Medical Aid Scheme	6.0%
Old Mutual Staff Medical Aid Fund	5.8%
Parmed Medical Aid Scheme	5.3%
Polmed	6.0%
SABC Medical Scheme	6.0%
Sasolmed Medical Aid Scheme	6.0%

Specialist Referral Number

It is important to obtain a Specialist Referral number for **Bonitas** (BonCap, Standard, Standard Select and Primary options), **Fedhealth** (all options), **Sasolmed**, **MBMED** and **Medshield (**Mediphila option). Claims may not be paid without this number. However, some specialist referrals do not require a Specialist Referral Number.

There are six easy steps for the Family Practitioner to follow to obtain a Specialist Referral Number (SRN):

1. Contact Medscheme's 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 doctor's note to the patient with the following details:
   – The name of the Specialist to whom the patient/member was referred;
   – The Specialist appointment details, including date, time and address;
   – 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.
   Remember: The claims may not be paid without this number.
6. 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.

Specialists that DO require a Specialist Referral Number:

- Cardiologist
- Paediatric Cardiologist
- Dermatologist
- Gastroenterologist
- General Surgeon
- Gynaecologist
- Neuro Surgeon
- Neurologist
- Orthopaedic Surgeon
- Otorhinolarynologists (ENT)
- Paediatrician
- Physician
- Plastic and Reconstructive Surgeon
- Psychiatrist
- Pulmonologist

- Rheumatologist
- Urologist

A patient/member DOES NOT need a Specialist Referral Number (SRN) for…

- the **first** visit to a gynaecologist, however, for all subsequent visits thereafter, a SRN will be required
- a child that is below the age of two (2) and needs to see a Paediatrician [for Sasolmed below the age of one (1)]
- Gynaecologist visits during pregnancy.

4.2.1 Bonitas

Bonitas will be increasing the base remuneration rate by 5.2% for 2017.

Several changes occurred in Bonitas during 2016. Amongst other things, Bonitas announced their amalgamation with LMS (formerly Liberty Medical Scheme).The amalgamation of Bonitas and LMS follows an increasing trend within the current healthcare industry to create a stronger and more sustainable medical scheme. Below is a summary of changes that Bonitas will be making to their products, benefits and contributions for 2017.

Three new options will be introduced in 2017. A savings option, BonComplete and two hospital plans: Hospital Plus and Hospital Standard.

Hospital Network

The **Standard Select, BonFit** and **BonCap** options have **specific hospital networks** and co-payments are applied when members choose not to use the hospitals on these networks.

Members on the other options, namely BonComprehensive, BonClassic, BonComplete, BonSave, Standard, Primary, Hospital Plus, Hospital Standard and BonEssential have access to all private hospitals countrywide. However, due to ample choice of high quality facilities, **a 30% co-payment will apply to the following hospitals**:

- Rosepark Hospital
- Bedford Gardens Private Hospital
- Brenthurst Clinic
- Carstenhof Clinic
- Flora Clinic
- Genesis Clinic (Saxonwold)
- Wilgeheuwel Private Hospital
- Eugene Marais Hospital
- Faerie Glen Hospital
- Little Company of Mary Hospital
- Wilgers Hospital
- Hilton Life Private Hospital
- Kingsbury Hospital
- Vincent Pallotti Hospital

By using a hospital from the preferred group, and avoiding the hospitals on this list, Bonitas members will be able to avoid co-payments.

To help limit future contribution increases as far as possible, certain changes will be implemented during the course of 2017. Members will be advised prior to the implementation of these changes, which include:

- Preferred supplier networks for appliances, hearing aids, internal and external prostheses.
- Designated service providers for substance abuse and mental health admissions.

Specialist Network

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:

Plan Name	In-Hospital	Out-of-Hospital
BonClassic	130%	130%
Hospital Plus	130%	130%
Standard	130%	130%
BonComplete	130%	130%
Standard Select	130%	130%
BonSave	150%	130%
Primary	130%	130%
BonFit	130%	130%
Hospital Standard	130%	130%
BonEssential	130%	130%
Rates are illustrated as a percentage of the Bonitas scheme rate.		

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 are excluded from this agreement and are covered as per the option benefit and illustrated as a percentage of the scheme rate in the table below:

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

4.2.2 Fedhealth

The 2017 Scheme increase for Fedhealth is 5.4%.

Specialist Payment Arrangements

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%
Maxima Plus	210%
Maxima Exec	210%
Maxima Advanced	165%
Maxima Standard	165%
Maxima Standard Elect	165%
Maxima Saver	165%
Maxima Saver^{GRID}	165%
Maxima Basis	165%
Maxima Basis^{GRID}	165%
Maxima Core	165%
Maxima Core^{GRID}	165%
Maxima EntrySaver	100%
Maxima EntryZone	100%
Blue Door Plus	100%
Rates are illustrated as a percentage of the Fedhealth scheme rate.	

Information on the new EDO

The Efficiency Discounted Option (EDO) is a sub-option which contains the same level of benefits as the main option at a discounted contribution. To this end, medical services must be obtained from the Networks.

Members will voluntarily choose this option with the understanding that they are choosing a network restricted option including a hospital network.

These options will be known as the 'GRID' range EDO options:

- Maxima Basis^{GRID}
- Maxima Core^{GRID}

- Maxima Saver[GRID]

Some of the Fedhealth Medical Scheme options are subject to their own hospital networks and grouped as follows:
1) Blue Door Plus
2) Maxima StandardElect
3) Maxima EntryZone, Maxima EntrySaver, Maxima Core[GRID], Maxima Basis[GRID] and Maxima Saver[GRID]

A list of the Fedhealth Network Hospitals can be found on the Medscheme website at www.medscheme.com

Ultima 200 has undergone a name change and is now called the Maxima Advanced option. The membership numbers will remain the same.

4.2.3 Polmed

Polmed introduced an increase of 6.0% with effect 1 January 2017.

Polmed tariffs for Network specialists

The tariffs for Network specialists covered as per the option benefit and illustrated as a percentage of the Scheme rate are indicated in the table below. Take note that tariffs are applicable to both POLMED plans, namely ***Aquarium*** and ***Marine***.

Specialist participation	In-hospital	Out-of-hospital
Network specialists	120%	135%
Non-Network specialists	100%	100%
Rates are illustrated as a percentage of the Polmed scheme rate.		

4.3 METROPOLITAN/MOMENTUM HEALTH ADMINISTERED SCHEMES

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 2017:

Scheme Name	2017 Rate Increase
BP Medical Aid Society	6.0%
Engen Medical Benefit Fund	6.0%
Fishing Industry Medical Scheme	6.0%
GEMS	5.0%
Golden Arrow Employees Medical Benefit Fund	7.1%
Imperial Medical Scheme	6.0%
Medipos Medical Scheme	6.0%
Metropolitan Medical Scheme	5.7%
Momentum Health	5.7%
Moto Health Care	5.7%
PG Group Medical Scheme	6.0%
Pick and Pay Medical Scheme	6.2%
SAB Medical Aid Society	6.5%
Transmed Medical Fund	6.0%
Wooltru Healthcare Fund	6.2%

4.3.1 Government Employees Medical Scheme (GEMS)

GEMS tariffs for all options will be increased as follows for 2017:
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%

The new GEMS Efficiency Discount Option (EDO), the Emerald Value Option (EVO)

- Comes into effect from 1 January 2017, subject to approval by the Council for Medical Schemes.

- Is an alternative to the current Emerald plan, with a similar benefit structure which offers members value at a more affordable premium.
- A network driven plan and includes a list of network hospitals where cover is provided in full, subject to member benefits and Scheme rules
- Unless in emergencies or other special circumstances (e.g. lack of access), consultation with a Specialist without referral from a nominated FP or admission to a non-network hospital will attract a co-payment from the member
- Full lists of participating network hospitals and Providers available on the GEMS website
- Rates and tariff increases for both FPs and Specialists are unaffected by this option

Paediatrician, Physician and Psychiatry Networks

Should you wish to participate in these networks you will also receive an additional 30% for the Ruby, Emerald Value and Emerald Onyx options as illustrated in the table below:

GEMSOptions	Participating tariff rates for in- and out-of-hospital	Non-participating tariff rates for in- and out-of-hospital
Sapphire	100%	100%
Beryl	100%	100%
Ruby	130%	100%
Emerald	130%	100%
Emerald Value	130%	100%
Onyx	130%	100%
Rates are illustrated as a percentage of the GEMS scheme rate.		

Specialist networks ensure GEMS members have access to Specialist care without incurring a co-payment for prescribed minimum benefits (PMBs) and non-PMBs. A participating Specialist is also the designated service provider (DSP) for PMBs.

The Family Practitioner plays an important role in ensuring appropriate coordination of patient care. It is therefore important to ensure that your GEMS patient has received a specialist referral authorisation from their nominated Family Practitioner prior to their specialist visit in order for your claim to be paid in full.

Obstetrics and Gynaecology Network

Gynaecologists will receive a CPI related tariff increase of 5% for 2017. Should you wish to participate in the network you will also receive an additional 30% for all GEMS options as illustrated in the table below:

GEMSOptions	Participating tariff rates for in- and out-of-hospital	Non-participating tariff rates for in- and out-of-hospital
Sapphire	130%	100%
Beryl	130%	100%
Ruby	130%	100%
Emerald	130%	100%
Emerald Value	130%	100%
Onyx	130%	100%
Rates are illustrated as a percentage of the GEMS scheme rate.		

In recognition of the increase in medical malpractice insurance fees, GEMS will also reimburse participating Specialists an additional **enhanced fee** for the two (2) delivery codes listed below:

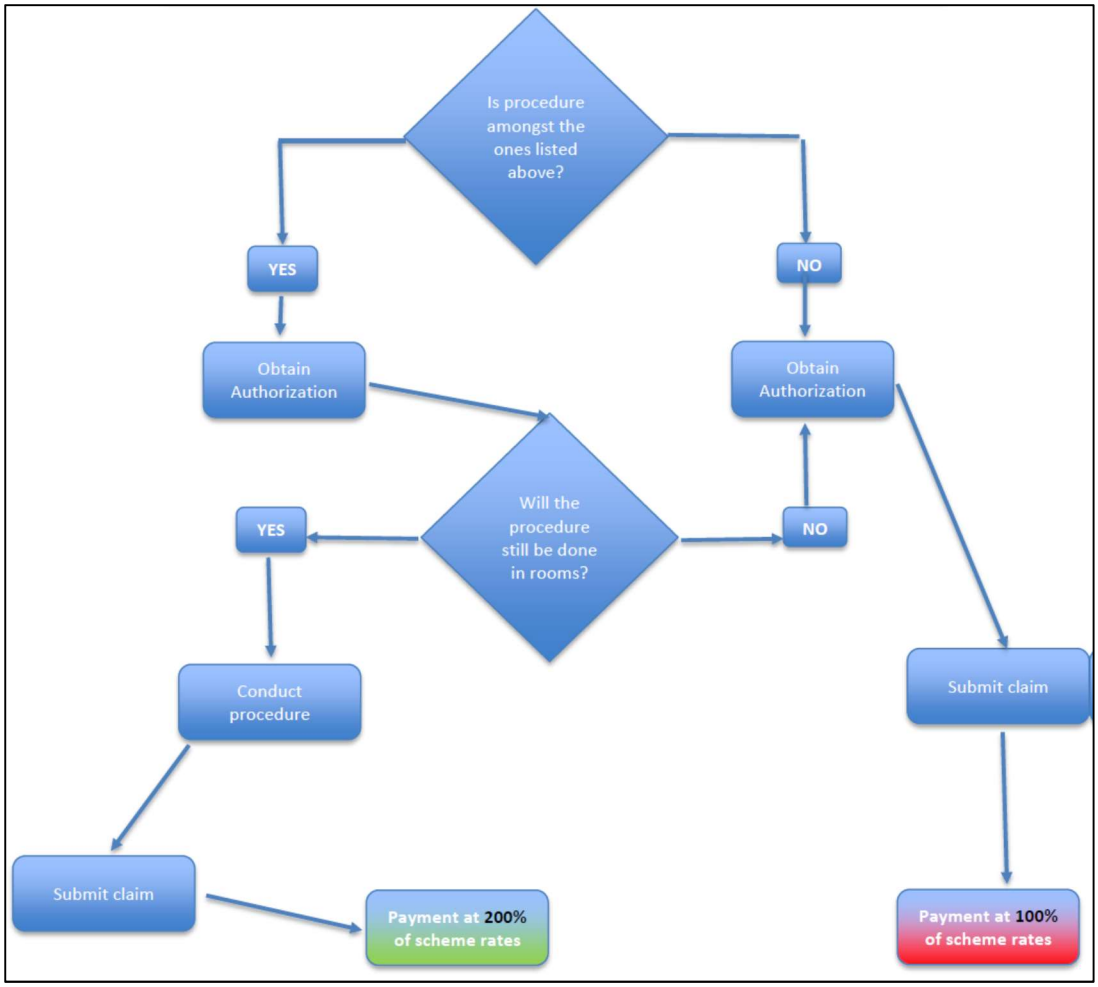
Codes	Description	Participating	Not participating
2614	Global Obstetric Care: All-inclusive fee that includes all modes of vaginal delivery (excluding Caesarean Section) and obstetric care from the commencement of labour until after the post-partum visit (4 weeks)	**R5 868.70**	**R4 090.30**
2615	Global Obstetric Care: All-inclusive fee for Caesarean Section and obstetric care from the commencement of labour until after the post-partum visit (4 weeks)		

GEMS In-Rooms Procedures

GEMS Recommended "in-rooms" procedures:

Procedure	Procedure Code
1. Gastrointestinal tract (oesophagus and stomach) - gastroscopy	1587
2. Gastrointestinal tract (intestines) – colonoscopy	1653
3. Gastrointestinal tract (intestines) – sigmoidoscopy	1676
4. Gastrointestinal tract (intestines) –proctoscopy	1681
5. Testis and epididymis - vasectomy	2207
6. Integumentary system – excision of nail bed (without bone involvement)	0244
7. Nose and sinuses – flexible nasopharyngolaryngoscopy	1018

Flowchart for In-Rooms Procedures



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:

GEMS payment in respect of PMBs

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

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 26 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/Value	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

* SB – Sapphire Beryl Network, REO – Ruby, Emerald , Onyx 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.

4.3.2 Momentum Health Medical Scheme

Momentum Health will be increasing their 2017 scheme rate by 5.7%. This will be applicable to all providers (except for those with specific negotiated or agreed rates in place), effective from 1 January 2017. Momentum Health Tariff Schedules and Benefit guides for 2017 are available for your reference at: Momentum Provider Page.

Hospital Networks

- *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.

See Provider Choice Lists for information on the various hospitals on the networks.

Provider Networks

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. (Member Co-Payment now R100 as opposed to 10% of the account)

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.

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

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)

4.4 OTHER SCHEMES

4.4.1 SAMWUMED

Medscheme and Aid for Aids to provide additional managed care services to SAMWUMED effective 01 January 2017.

Medscheme and Aid for Aids (AfA) have been appointed as the managed care service providers for Chronic Medicine Management and HIV Disease Management for SAMWUMED effective **01 January 2017**. These services will be in addition to the current Hospital and Oncology Benefit Management services provided by Medscheme.

4.4.2 Bestmed

The scheme increase for Bestmed is 5.0% for 2017. There are variations on this increase for network members, as shown below:

	Non Network	Network
Specialists	5% on all codes applicable to the specific discipline	7.5% on all codes applicable to the specific discipline
All disciplines where there is no network	Scheme tariff: 5% on all codes	

As of 1 January 2017, Bestmed will be the administrator for Pulse1 and Pulse2 claims. All claims processed before 1 January 2017 will still be finalised by CareCross and ONECARE administration.

4.4.3 Keyhealth

Keyhealth Network providers will be reimbursed at 150% of scheme rate on all options, for both in- and out-of-Hospital services for PMB and non PMB conditions.

5. COMPARATIVE SPECIALIST CONSULTATION TARIFFS 2017

		GEMS Scheme Tariffs	Discovery Premier A
0190	Surgical	R333.50	R611.20
0190	Consulting	R499.50	R877.70
0191	Surgical	R333.50	R611.20
0191	Consulting	R499.50	R877.70
0192	Surgical	R333.50	R611.20
0192	Consulting	R499.50	R877.70
0161	Psychiatry Consulting	R360.00	R894.10
0162	Psychiatry Consulting	R660.00	R894.10
0163	Psychiatry Consulting	R959.90	R894.10
0164	Psychiatry Consulting	R1259.90	R894.10

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.

5.1 SUMMARISED RAND CONVERSION FACTORS (RCFs) - SCHEME RATES 2017

	DISCOVERY 2017	GEMS 2017	BONITAS 2017	PROFMED 2017	MEDIHELP 2017
Specialist Consultative Services	19.70	19.70	20.01	20.478	20.749
GP Consultative Services	27.10	27.10	22.44	22.958	23.262
Consultative Services *(Paediatrics & Paediatric Cardiology)*	19.70	19.70	20.01	20.478	20.749
Psychiatry	19.70	24.00	23.86	24.423	24.747
Clinical Procedures	12.19	12.19	12.33	12.682	12.849
Anaesthesiologists	92.13	78.20	77.85	79.596	80.650
Ultrasound	11.629	11.877	11.80	12.089	12.249

6. HPCSA & TARIFFS

The HPCSA has still not published an updated ethical tariff list since 2005. There is thus no indication which tariffs they will apply in the case of a complaint for overcharging. However, HPCSA ethical regulations require the provider to inform their patients upfront what they will be charged, and whether co-payments are likely. The HPCSA will enforce this regulation in the case of any complaints against a provider. Please contact the HealthMan offices if you receive notification that complaints of overcharging have been made against your practice to the HPCSA.

7. 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 2017 MPS premium for Obstetrics vary between R850 000 and R1 300 000.

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

7.1 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.

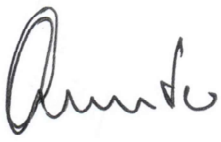
9. PCNS RENEWAL FEE

At this stage, BHF continues to administer the Practice Code Numbering System (PCNS). The PCNS annual renewal fee for 2017 has increased by 7.6%. The fee is R260.00 (Incl. VAT) and will be due by 31 March 2017. 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.

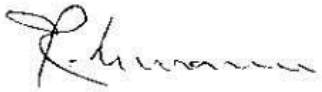
10. GENERAL DISCLAIMER

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

9 January 2017

ANNEXURE A - Medical Scheme Rates - 2017

SCHEMES ADMINISTERED BY DISCOVERY HEALTH

Scheme Name	2017 Rate Increase
Anglo Medical Scheme	6.0%
Anglovaal Group Medical Scheme	5.5%
Bankmed	5.5%*
BMW Employees Medical Aid Society	5.5%
Discovery Medical Scheme	5.5%*
Glencore Medical Scheme	5.5%
LA Health	5.5%
Lonmin Medical Scheme	5.5%
Malcor Medical Aid	5.5%
MMED Option of the Naspers Medical Fund	5.5%
Naspers Medical Fund	5.5%
Netcare Medical Scheme	6.0%
Quantum Medical Scheme	5.5%
Remedi Health	5.5%
Retail Medical Scheme	5.5%
TFG Medical Aid Scheme	5.5%
Tsogo Medical Scheme	5.5%
UKZN Medical Scheme	5.5%
Wits Medical Scheme	5.5%

* - Non Network Provider Consult increases differ from general increase rate

CLOSED MEDICAL SCHEMES ADMINISTERED BY DISCOVERY HEALTH, PARTICIPATING IN DIRECT PAYMENT ARRANGEMENTS FOR 2017

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
Bankmed	No	No	No	No
BMW Employees Medical Aid Society	Yes	No	No	No
Glencore Medical Scheme	No	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	No	No	No	Yes
Lonmin Medical Scheme	No	No	No	No
Malcor Medical Aid:				
- Plan A	No	No	No	No
- Plan B	No	No	No	No
- Plan C	No	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

Scheme Name	Reimbursement Rate for 2017						
	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	2017 Rate Increase
AECI	6.3%
Anglovaal Medical Scheme	6.0%
BARLOWORLD	6.0%
Bankmed	5.5%*
BCIMA	6.0%
Bestmed	5.0%
BONITAS	5.2%*
BPSA	6.0%
Camaf	5.97%#
Cape Medical Plan	5.97%#
Commed	5.97%#
Compcare	6.0%
De Beers	5.97%#
Discovery Health Medical Scheme	5.5%*
Engen	6.0%
Fedhealth	5.4%
Fishmed	6.0%
Furnmed	5.97%#
GEMS	5.0%
Genesis	4.7%
Glencore	5.5%
Golden Arrow	7.1%
Grintek	6.0%
Harmony Health Services	5.97%#
Horizon	7.1%
Hosmed	6.0%
Impala Medical Services	5.97%#
Imperialmed	6.0%
Ingwe	5.97%#
International Monetary Fund	5.97%#
Keyhealth	6.2%
Malcor	5.5%
MASSMART	6.5%
MB MED	6.0%
Medihelp	6.2%
Medimed	5.97%#
Medipos	6.0%
Medshield	7.0%
Metropolitan Medical Scheme	6.0%
Midmed	5.97%#
Momentum (MMSA)	5.7%
Moto Health Care	5.7%
Namibia Health Plan	5.97%#
Nammed	5.97%#
NBCRFLI Wellness Fund	5.97%#
Nedgroup	6.0%
Nestle	5.97%#
Netcare	6.0%
Nufaswa	5.97%#
Old Mutual Staff	5.8%
Opmed	5.97%#
Parmed	5.3%
PG Bison	5.97%#
PG Group Medical Scheme	6.0%
Pick n Pay	6.2%

Scheme Name	2017 Rate Increase
Platinum Health	5.97%#
Polmed	6.0%
Primecure	5.97%#
Profmed	5.0%
Prosperity	5.97%#
Rand Mutual	5.97%#
Rand Water	5.97%#
Resolution Health	5.97%#
RU Med	5.97%#
SABC	6.0%
SABMAS (SA Breweries)	6.5%
Samwumed	6.0%
Sasolmed	6.0%
Sedmed	5.97%#
Selfmed	5.97%#
Sibanye Gold ltd	5.97%#
Sisonke Health	5.97%#
Sizwe	5.97%#
Spectramed	5.97%#
Spes Bona	5.97%#
Suremed	5.97%#
Swazimed SA	5.97%#
Swazimed Swazi	5.97%#
Thebemed	6.0%
Tiger Brands	6.0%
Topmed	5.97%#
Transmed	6.0%
Umvuzo Health	6.0%
UNDP	5.97%#
UNICEF	5.97%#
Universal Health Plan	5.97%#
UNOPS	5.97%#
UNV	5.97%#
WCMAS (Witbank Coalfields)	5.97%#
Wooltru	6.2%
Yebomed	5.97%#
* - Different Rates for Network and Non-Network	
# - Where scheme increases are not available, a weighted average of 5.97% was utilised	