View in web browser

NEWSLETTER

DECEMBER 2021

Dear Members

Please find below the December 2021 Newsletter:

1. BOOSTER VACCINES FOR HCPs
2. PROGRESS WITH GLOBAL FEES INISIATIVE
3. REVIEW OF DISCOVERY HEALTH FORENSIC PROCESSES
4. DOES CPT4 HAVE A FUTURE IN SA
5. CODING ISSUES
6. CMS Circular 66 of 22 November 2021
7. PAEDIATRIC SURGERY
8. BSI DEEP HEALTH OUTCOME MEASUREMENT INISIATIVE
9. COIDA – URGENT ACTION NEEDED TO OPPOSE THE NEW REGULATIONS
10. SAPPF MATTERS:
    a. HPCSA & Employment of Doctors
    b. Certificate of Need
    c. HPCSA Fees 2022

SURGICOM PRIVATE PRACTICE WEEKEND 2022 - SAVE THE DATE!
SEASONS GREETINGS

1. Booster Vaccines for HCPs

The Sisonke 2 booster programme for healthcare workers began on 10 November 2021. The ENSEMBLE 2 trial evaluated a booster Ad26.COV2 (J&J) dose given at least two months after the first dose in 31 300 participants in more than nine countries. An Ad26.COV2.S dose administered two months after the primary Ad26.COV2.S dose was shown to substantially increase protection, especially against symptomatic and severe/critical disease, including when caused by SARS-CoV-2 variants of concern. Vaccine efficacy against symptomatic disease was 94% in the US and 75% globally. At a global level vaccine efficacy was 100% against severe disease and critical disease. In this study, two doses were safe, and the usual vaccine side effects (‘reactogenicity’) were reduced following the second dose. The American FDA has recommended a second dose of the Janssen® (J&J) vaccine in anyone over 18 years of age.

Based on this information, and to bolster the immune response of HCWs ahead of a predicted fourth wave, the SAMRC, NDOH, SAHPRA and J&J have together provided early access to Janssen® (J&J) vaccine booster doses for all HCPs who received a first dose of this vaccine as part of the Sisonke study. Access is in the context of a Phase 3B study and results will be used to guide future decisions regarding boosters.

SAMA in an open letter to the Minister of Health has requested that HCWs be permitted to make a choice of COVID-19 booster vaccine because of evidence that a booster in the form of a mRNA vaccine such as those produced by Pfizer is potentially more effective than the second dose of a more traditional vector-based vaccine such as that produced by J&J. The three small studies referred to have demonstrated better antibody and cell-mediated immune responses using a heterologous approach.

Deputy director-general of the NDOH, Nicholas Crisp has responded stating that the addition of such a choice would delay the roll-out of the booster programme by six weeks. There are still some unanswered questions regarding the *clinical* efficacy and safety profile of a mRNA booster following a primary vaccination with the J&J vaccine and the Pfizer vaccine is not yet registered with SAHPRA for this indication. Crisp indicated that trials with mRNA vaccines might follow.

HCWs must now decide whether to wait for a possible mRNA booster vaccine at some undetermined point in time or immediately avail themselves of the opportunity presented by Sisonke 2 given that a fourth wave is predicted in South Africa as early as mid-December 2021.

2. Progress with Global Fees Initiative

Surgicom continues to meet regularly with Discovery Health to develop a global fee strategy for certain general surgical procedures. We are together working on laparoscopic cholecystectomy and groin hernia repair as the likely first candidate procedures and are determining pathways of care and definitions for uncomplicated and complicated cases. 98% of DH cholecystectomies are performed laparoscopically but as many as 40% of these may not fit into our current global fee model because they are emergencies, develop complications, require high care or are performed as part of an oncology procedure. Approximately 40% of groin hernias are repaired laparoscopically but for 50% of these there is already a fixed hospital fee in place. Costing models are complex requiring considerable actuarial input and we need to determine whether a suggested “kit” of instruments and disposables will cover the vast majority of cases.

We will have to aim for most laparoscopic hernia patients being discharged on the day of surgery (only 33% are currently) and most uncomplicated laparoscopic cholecystectomy patients being discharged after a single night in hospital (42% at present). Negotiating the arthroplasty global fee initiative took 3 years but we are aiming to launch this at the beginning of 2023, or earlier if no benefit design change is required (which makes the regulatory process through the Council for Medical Schemes easier). We will report further progress in each Surgicom newsletter.

3. Review of Discovery Health Forensic Processes

Following several complaints, the interim findings of the Section 59 inquiry and at least one high court action, Discovery Health has initiated an extensive external review of its forensic processes. Simon Strachan, CEO of SAPPF and myself have been participating in this with weekly meetings under the chairmanship of Dr Ntuthuko Bhengu (previously of the Health Market Inquiry) and facilitated by attorney Charles Nupen. Also participating are the Radiological Society of South Africa, SAMA, SASA, The South African Society of Physiotherapy and the United Forum of Family Practitioners (UFFP). This group which has been named the Health Practitioners Reference Group aims to deliver a report with substantial recommendations before 31 December 2021 so that changes can be made at the beginning of the 2022 benefit year.

The final publication of the CMS report on the section 59 inquiry may have an impact on the outcome but this is unlikely to happen before 31 December. We are challenging Discovery Health to institute processes that will identify faulty coding and billing at an early stage (within a month or two) to move away from 3-year reviews and claw-backs. We are challenging their sampling and extrapolation methodology and the manner in which they approach health care professionals. We are emphasising the role of professional societies and the importance of peer review and will insist on early triggering of a satisfactory dispute resolution process recognising *nemo judex in causa sua* – Discovery cannot be permitted to be the sole judge in its own cause. We have emphasised that this process needs to extend way beyond the nuts and bolts of forensic processes to deal with coding itself and in particular, the scheme’s reluctance to embrace new codes and their tendency to revert to 2006 whenever it suits them. This is a crucial issue and now we have an opportunity to tackle it head-on.

4. Does CPT4 Have a Future in SA?

The CPT4 coding system has sound, proven & tested international methodology with clear, well-defined descriptions as well as clear guidelines and rules to govern the structure. This counteracts unbundling, facilitates teamwork and provides for more reasonable inter-disciplinary relativities. Although healthcare practitioners use the SAMA 4-digit codes, hospitals use CPT4. All motivations for new codes or changes to the relative value units require a crosswalk to the relevant CPT4 codes. For many years the American Medical Association has allowed SAMA to act as the licensing entity in South Africa through CCSA (Complete CPT4 for South Africa).

Unfortunately, the AMA has recently changed its licensing policy. CPT4 will no longer be licensed by any entity within RSA but only the AAPC in the USA. We can continue to use CPT4 codes via CCSA, but private hospital groups will need to pay a licensing fee per bed and schemes will have to pay a licensing fee per beneficiary. This will add millions to the costs of private healthcare and be unaffordable in this country. SAPPF is currently undertaking a review of the 350 most commonly billed codes with cross-walks to CPT4 and Surgicom has been extensively using the system for new code development. PHISC, the Private Healthcare Information Standards Committee has therefore suggested that a new coding system will have to be developed but this will take several years and may negatively impact our current efforts to change the codes for general surgery.

5. Coding Issues

In conjunction with VASSA, Surgicom in 2021 undertook an extensive review of the current vascular codes examining the potential impact of a possible migration to CPT4 codes. It is clear that without a significant change to the Rand Conversion Factor (RCF), surgeons performing endovascular procedures would be financially disadvantaged by such a migration. We are certainly not permitted to “cherry pick” codes. Any change would have embrace all codes. We continue to focus on new codes, particularly for procedures where surgeons must currently use equivalent codes (6999-Rule C) but the chief stumbling block is the refusal of most schemes to accept these codes. Many schemes will not accept codes introduced since the publication of the 2006 NRPL. We are currently engaging with both Discovery and Medscheme to resolve this impasse as further code development without the buy-in of the major schemes is of very limited value.

6. CMS Circular 66 of 22 November 2021

Just when we are engaging with schemes to have a large number of codes recognized and reimbursed, the Council for Medical Schemes has further muddied the waters with Circular 66 in which they assert that the 2006 RPL is the last legal procedure coding system for South Africa and remains the basis for the CMS adjudicating complaints and claims. The circular notes that several disciplines have developed new codes but warns that these cannot negatively affect members or beneficiaries of schemes. This puts us back by 15 years as the 2006 codes do not reflect healthcare as currently practiced. CMS offers no solution in terms of a mechanism or legal framework to enable any updating of this schedule. Could this be a political move to give the National Department of Health complete control of the coding structures ahead of its intended introduction of NHI?

SAPPF and SAMA met on 24 November 2021 and discussed a joint response. We will call for a high-level multi-stakeholder meeting during the first quarter of 2022 to address the coding impasse and try to provide a mechanism to update the current codes, recognise codes that have been introduced since 2007 and allow the introduction of further codes. This engagement will have to include the leaders of healthcare provider groups, schemes, CMS and HPCSA and well as NDOH.

CMS Circular 66 of 2021 attached.

7. Paediatric Surgery

Fifteen Paediatric Surgeons have recently joined Surgicom. We have engaged with BHF to arrange a unique PCNS number (114) to consistently identify this specialty and have started dealing with the schemes who have tended to view paediatric surgeons as no different to general surgeons in spite of the fact that paediatric surgery was registered as its own specialty in 2007. Paediatric surgery coding needs a lot of attention. A number of new codes have been introduced since 2011 but schemes have once again tended not to recognize these.

8. Surgicom / BSI Deep Health Outcome Measurement Initiative

Outcomes data is becoming more and more important and is increasingly driving funder decisions. Real outcomes cannot be provided by medical scheme claims alone. Clinical outcomes data can only be provided by clinicians. Surgicom is exploring the possibility of creating a database to which members can contribute their clinical and outcomes data. Such a data base would be enormously powerful in negotiations with funders and hospitals, both for the individual surgeon and surgeons as a group.

We are launching a pilot project in conjunction with BSI Deep Health, a partnership between surgeons and software developers who have developed a clinical notes system that is able to track surgical outcomes. The initial aim is to enrol 25 surgeons. Once the initial group have accumulated sufficient data, funding will be sought to make this sustainable for all Surgicom members. The system provides for the capture of key data without imposing an extra administrative burden on surgeons. The value of the data accumulated will increase with time. Projects like Health ID have emphasised how determined schemes are to access better clinical data. With the emergence of value-based care, it is clinical outcome data that will drive alternative reimbursement models, but this data must be generated by and owned by clinicians.

Members who are interested in this project or would like to participate in a zoom meeting looking at it in more detail, should contact Dr Thinus Smit at 082 323 9495 or at thinus@prosurgholdings.com.

9. COIDA – Urgent Action Needed to Oppose the New Regulations

On 19 October 2021, the Compensation Fund gazetted regulations for public comment. These proposed regulations will only allow Compensation Fund payments to be made directly into the accounts of medical service providers. It is well recognised that, without the services of third party administrators or pre-funders, it often takes the Compensation Fund over 2 years to pay IOD claims. Frequently these claims are not paid at all.

SAMA, in collaboration with workers, employers and a range of affected parties, will be opposing these regulations. Medical service providers have until 17 December 2021 to submit comments. Surgicom has provided a submission on behalf of general surgeons but individual surgeons are encouraged to comment as well. Comments should be directed via email to commentsAVS@labour.gov.za by Friday, 17 December 2021.

10. SAPPF Matters

Surgicom’s membership of SAPPF enables us to impact on issues of national importance and issues that involve the wider medical community. Some of the current issues include:

a. HPCSA & Employment of Doctors

HPCSA has in recent times allowed limited employment by private hospitals of various healthcare practitioners including radiographers, occupational therapists and medical practitioners. There is a growing concern regarding the potential corporatisation of private healthcare. At a meeting between HPCSA and various stakeholders on 19 October 2021, most groups expressed their disapproval of direct employment of doctors by private hospitals. SAPPF will be conducting a survey among doctors in order to prepare a position statement on the subject. The rather limited Econex survey on doctor employment by private hospitals commissioned by SAPPF in 2017 indicated that more than 50% of respondents thought that doctors should have the *option* of working for a private hospital and about 40% indicated that they would choose this option for themselves if the conditions were favourable. There are risks of loss of clinical autonomy and the potential for abuse when specialists are employed by hospitals but specialists working for hospital groups is a model that seems to work well in several private health systems in other countries.

b. Certificate of Need

This is back in the spotlight: “The controversial draft regulations bear little relation to the empowering sections in the National Health Act of 2003, to the Health Market Inquiry (HMI) recommendations, or the existing legal frameworks – not least the Office of Health Services Compliance (OHSC) – and as such should be totally withdrawn and redrafted after proper consultation with all relevant health service and associated providers” says attorney Elsabe Klinck. Trade union, Solidarity has embarked on a legal action requiring the President to provide an unequivocal assurance that sections 36-40 of the National Health Act of 2003 will not be brought into operation, failing which the constitutionality of this section will be challenged in court. SAPPF has signed an affidavit in support of this action.

c. HPCSA fees 2022

The draft budget for the 2022 financial year was presented during the Medical and Dental Professions Board (MDB) stakeholders meeting on 19 October 2021. This draft budget suggested that another sizeable increase in membership fees was likely for medical and dental professionals in 2022. The budget, amongst other things, highlighted increases in running costs, the need to pay for external legal counsel as well as a suggested 17% salary increase for HPCSA employees. The general feeling at the meeting was that another annual increase in fees was not acceptable and that there was a need to examine the functioning of the HPCSA to ensure better efficiencies and streamlining of costs. SAPPF has requested to be invited to all meetings both at MDB level and at Council level where the 2022 budget and fees will be discussed. We have indicated that we will not accept a fee increase for 2022 without this level of consultation and participation.

PRIVATE PRACTICE WEEKEND 2022
3 – 5 JUNE 2022
@
Blaauwberg Beach Hotel, Blouberg
Cape Town, Western Cape

SAVE THE DATE!

A face-to-face Private Practice Business Weekend will take place at the Blaauwberg Beach Hotel, Western Cape on Saturday, 4 & Sunday, 5 June 2021. Please save this date. The programme will be finalized in the new year.
Event Organiser: Joey Swart / 083 279 5920 / events@healthman.co.za

SEASON’S GREETINGS

2021 has been a very demanding year for all of us. The Board of Surgicom and the team at HealthMan wish all our members and their families the very best of the holiday season. May you enjoy quality family time and a well-deserved break.

Kind regards

Philip Matley
Chairman: Surgicom

Dr PJ Matley (Chairman), Dr ADR Reddy (Vice Chairman)
Dr B Dube, Dr N Harran, Dr T Lowan, Prof SS Pillay, Dr SN Raidoo, Prof JM Ramos, Dr T Smit,
Dr P Taylor, Dr MD Wellsted, Prof P Goldberg (ASSA Representative), Dr SP Grobler (Consultant)

Wishing you Happy Holidays
and a New Year filled with
prosperity and success!

©123Greetings.com