Medical Aid Audits and Investigations. What now?

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You've been contacted by the forensic unit of a medical aid. They are raising queries pertaining to some of the claims that you have submitted and they want to meet with you. What now?

The first thing that you need to do is to notify us in writing. It is a condition of your medical malpractice insurance policy that you notify the Insurers (notifying us in writing will suffice) as soon as you become aware of any circumstances that could lead to a claim or an HPCSA complaint against you.

At this stage, while you are required to notify us, the cover under your policy has not yet been triggered as there is no threat of a claim or of an HPCSA complaint being made against you. Insurers will therefore not become involved or be in a position to assist you.

Previously when we have notified the insurers of requests made to our insured members to attend meetings requested by medical aids to discuss their accounts, insurers advice has always been that the member should co-operate and go along and answer the questions as honestly as possible and to advise us immediately in the event that they are subsequently accused of fraud or reported to the HPCSA.

We have subsequently obtained an opinion from Elsabe Klinck Consulting and she has offered the following guidelines:

1. Never sign any document indicating that you accept responsibility, owe the scheme money or that you have wrongly (whether intentionally or unintentionally) used the wrong codes or billed the scheme wrongly. Remember that, in doing so, you may be admitting to fraud (which is a crime), or to having acted unprofessionally (billing the wrong codes). Only sign after your attorney has helped you redraft any portion thereof that could make you liable for criminal or unprofessional sanction.

2. Do not meet with scheme representatives without having a strong person there to support you. It may be an experienced accountant, or, preferably, a lawyer. Disclose everything to that person, so that they can advise you on the best possible way to deal with the meeting.

3. If, in a meeting, you feel pressurized, ask for time out, consider what you have been asked and if you are not sure, rather say that you will respond to the question in writing at a later stage.

4. Make clear that any meeting is being attended on a strictly "without prejudice" basis. This means that, whatever you say in that meeting cannot be used against you in any subsequent legal proceedings. Nonetheless, ensure that proper minutes are kept of what was said during the meeting, so as to prevent disputes later on as to what was said or agreed to. If the scheme keeps the minutes, it is important to ask for a copy of the draft minutes and to make corrections of those or indicate where one differs from the scheme's version of events. If you or another person that accompanies you takes minutes, send the draft to the scheme for their confirmation of agreement that the minutes accurately record the discussion at the meeting.

5. PRIOR to any meeting or prior to responding to any letter, ask the meeting organisers or drafters of the letter for -
   (a) an agenda (in the case of a meeting);
   (b) a list of questions, concerns and queries the scheme has (do not accept general descriptions on "discrepancies" or "practice profiles as compared to …" etc.);
   (c) all evidence the scheme has, including examples of accounts and patient interactions they might have had (schemes sometimes contact patients to ask whether they received certain treatments or not, etc.). You are entitled to this information under the Promotion of Access to Information Act to protect your right to be presumed innocent and your right to fair administrative action.

6. Make it clear that, prior to the matter being finalized, the scheme cannot take any action, as the principles of administrative justice necessitate adherence to the principle of 'audi alteram partem' ("hear the other side") BEFORE any decision is taken to, for example, reverse monies or to recover monies from your practice.

7. Seek advice from your Society or Association on the correct use of billing codes and/or treatment modalities. A consensus statement by your society or association on this could assist in ensuring proof of correct billing.

You should also be aware of the following before you attend any meetings that you might be requested to attend:

The Medical Schemes Act and regulations

1. The scheme should have informed you within 30 days after receiving the account that they believe the account is wrong or unacceptable and they must state the reasons for believing that. Regulation 6 prescribes the whole process, which ends with requiring of the scheme TO PROVE IN FACT that the account was wrong or unacceptable:

    1.1. "*(2) 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*."

    1.2. "*(3) After the member and the relevant health care provider have been informed as referred to in subregulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned for correction*."

    1.3. "*(4) 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 subregulation (2) or fails to provide an opportunity for correction and resubmission in terms of subregulation (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.*"

2. Section 59 governs the off-setting of amounts ONLY in cases of fraud, theft, negligence or misconduct. In order to preserve the principle of presumption of innocence, such offsetting can ONLY take place in cases of PROVEN fraud, theft, etc. The relevant provisions in section 59 read as follows:

    2.1. "*(2) A medical scheme shall, in the case where an account has been rendered, subject to the provisions of this Act and the rules of the medical scheme concerned, pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.*" This means that payment should take place within 30 days or, if not, must be accompanied by the scheme informing the provider why they believe the account was wrong or unacceptable (ito reg 6).

    2.2. "*(3) Notwithstanding anything to the contrary contained in any other law a medical scheme may, in the case of—*

        (a) any amount which has been paid bone fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or

(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme,

deduct such amount from any benefit payable to such a member or supplier of health service." This allows the deduction to take place, but it must be proven, and interpreted in line with principles of administrative justice and the country's Constitution (presumption of innocence), and only SUCH proven amounts may be offset. However, as the words "member OR supplier" appears in section 59, the conclusion is that, where payments had been made to a member, the offset has to take place from the MEMBER and not from the supplier, and vice versa.

3. Section 59(2) allows the scheme to pay either the member or the supplier. In cases where accounts are placed in dispute, schemes may decide to pay members directly, and suppliers of services may find it had to reclaim such amounts from members (their patients). It is highly recommended that practice agreements (signed by patients) between yourself and your patients make it clear that:
   3.1. The member / patient remains personally liable for all amounts relating to all services rendered by the staff of the practice;
   3.2. This liability is based on the consent of the patient to be treated by the practice, and that the costs, or a cost estimate was provided to the patient, and that s/he has agreed to such costs [NOTE: written proof should be kept of the agreement and the cost discussions];
   3.3. This liability is based on the full costs of the treatment provided, and is independent from the rules of the scheme to pay in full, in part or not at all;
   3.4. Legal action may be taken in accordance with the provisions of the National Credit Act relating to incidental credit, i.e. 20 business days after a final notice of the outstanding amount has been sent; and after the patient has not paid after a further 10 business days after receiving the notice.

Case law on section 59 and related matters

1. There have been a number of court cases where healthcare providers (suppliers) took section 59-matters to court. In a case between *Tshwane Pharmacy and GEMS* (North-Gauteng High Court, case no 28532/11), the pharmacy was informed that due to "questionable claim submissions", claims were paid to members of the scheme (so-called "indirect payment"). As the pharmacy could not prove that there was an agreement by the scheme to pay them directly, the pharmacy lost the case. The matter of the questionable claims were not raised or addressed in this case.

2. In a 2005 case, the Supreme Court of Appeal (*Medscheme v Bhamjee*) ruled in a matter where a doctor did indeed sign two agreements confirming his indebtedness to the medical schemes. Due to the decision by one of the schemes to pay the members, the practice of the doctor

collapsed. The doctor challenged the validity of the two agreements as having being signed under duress. In the High Court the doctor won the case, and Medscheme appealed against that ruling. This matter started with Dr Bhamjee's practice profile being "substantially higher" than the average cost of comparable practices. The Court distinguished between "hard bargaining" and economic duress. The Court also considered information obtained from a former associate of Dr Bhamjee who alleged that he submitted false and inflated claims to schemes, and, although retracted, the scheme found that he had seen as many as 172 patients on a day. In the end it was found that Dr Bhamjee had no right to be paid directly by the scheme, but also that the agreements between Medscheme and Dr Bhamjee were not lawful, as they were not confirmed by the schemes Medscheme administered.

3. If you do not believe that you owe schemes any money, and that you have billed correctly and honestly, you should not sign agreements in which you acknowledge that you owe schemes money.

Acknowledgement and thanks go to Elsabe Klinck of Elsabe Klinck Consulting CC who prepared the opinion on which my article is based.

Should you wish to contact Elsabe Klinck, you can e-mail her on elsabe@ekconsulting.co.za or phone her on Mobile: +27 (0)71 607 2752.

Please remember to notify us immediately in the event that you receive a letter from any Medical Scheme requesting that you meet with them to discuss your accounts.

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Cover for professionals

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