FINANCIAL CLAWBACKS AND THE TRUTH ABOUT S59

In the past number of years, a tendency of bullying medical practitioners by medical schemes have become prevalent.

I use the word bullying because this type of conduct is by definition correct:

“seek to harm, intimidate, or coerce (someone perceived as vulnerable)”

In an industry where medical practitioners rely on the income from medical schemes, the medical practitioner has become vulnerable to financial manipulation and prescripts determined by large corporate companies.

Many professional bodies including those of the surgeons, podiatrists and the physiotherapists even the HPCSA and CMS have been approached with complaints about the conduct of medical schemes.

It is imperative to inform medical practitioners of these current improper practices, to warn them, and equip them to defend these complaints and the ways in which they are approached by the medical schemes.

Medical schemes approach medical practitioners with unconfirmed and baseless allegations, where among other they are probing certain codes or the use of therapy and treatment by medical practitioners.

The scheme questions, declines or prescribes treatment and treatment plans to the medical practitioners without any medical knowledge.

They blatantly aver that the medical practitioner has provided unnecessary treatment, abused a particular code or incorrectly applied a particular code.

The Scheme have themselves, and without a reference to any medical specialists decided on the suitability of the therapy and treatment offered by someone like a physician and the treatment plan that the practitioner would choose to follow, they then further question the use of certain codes and the charging of fees.

The medical practitioner is then bombarded with allegations and threats from the medical scheme and in many instances an unreasonably short period of time in which they are required to disprove the allegations and submit documentation.

With the medical scheme's aggressive and imperious attitude, the practitioner is under enormous pressure to reach settlements with the medical scheme because threats are issued that debt comparison or an off-set will take place against the amounts the scheme claim are due to them and subsequently future payment to the practice will be withheld.

Due to the fact that a large number of medical schemes are administered by a few larger schemes, the occurrence in this regard seems to stretch across a large number of medical schemes.

At this stage it is larger medical schemes who have once again embarked on a process already addressed in 2017 by the Health Professions Council of South Africa along with several professional bodies who condemned this practice which they considered to be prohibited.

In 2017/2018 there were lengthy meetings, where several cases were investigated and worked through by the Insurance Law Faculty of the University of Pretoria under the guidance of Prof. Birgite Kuscke, and were found by the professional bodies and the HPCSA to be irregular and medical funds were required to stop this practice.

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The medical scheme usually conducts the audit going back 3 years, should the medical practitioner question their methods and the period of audit, the medical scheme then threatens to go back 5 years as they claim to have that right.

This is a blatant untruth as debt prescribes after 3 years and there would be no legal basis for that threat.

Regardless of what the provisions of the prescription Act state, Regulation 6(2) and Regulation 6(3) of the Medical Schemes Act, states that,

A fund has 30 days to pay the practitioner. This means it has 30 days to verify the claim before payment is due.** Where the fund so challenges the validity of a claim, it must give written notice thereof to the patient and the practitioner. This is, for purposes of issues on prescription.

Reg 6(3) the practitioner has 60 days from date of notification to amend the claim, to resubmit a claim, address the issue with the patient, to respond to the fund on its concerns, etc. etc. This means the right to *audi alteram partem* is hereby respected.

It must occur before a claim may be disputed (which I interpret to mean formally proceed therewith). The fund does not comply in its processing of claims with Reg 6 - It states it cannot as it does not have the resources to check all claims. My question is when did your capacity indemnify you from compliance with the law??

In this manner it deprives the practitioner (and the patient whose benefits are at issue) the right to information, and the right to *audi alteram partem*.

The dispute after the time periods in Regulation 6 have expired

Once, after the 30 + 60 days - a dispute continues to exist (see Reg 6 (4)) then section 59 (3) on the right to set-off, may be invoked **ONLY IF** in compliance with Reg 6(4) the fund proves that:

Sec59(3)(a)- payment was made bona fide by a fund, that was not due to the health service provider***sec 59 (3)(b) that the loss was sustained by the fund due to theft or fraud (in my opinion, as confirmed by the HPCSA and by the Professional Board for Physiotherapy, Podiatry and Biokinetics (7 December 2017) if found guilty thereof in a court of law); negligence or any misconduct this means found liable/guilty by either the HPCSA under the concomitant professional Board) or of course by a court of law or other.

It is clear in my opinion that the fund may not merely allege that there was negligence misconduct theft or fraud based only on their algorithms, their own conclusions without providing some form of proof thereof, and then directly invoke section 59(3).

This would be a form of abusive self-help not intended by the legislator if one interprets the words used in S59, and its application that clearly only can be followed once Reg 6 has been followed.

I'll get int burden of proof a little later.

The medical scheme insists in their meeting or letter to receive the immediate clinical notes of the patients from the practitioner.

Without the patient's express notice.

Refusal to deliver these clinical notes starts the threats and we are aware of medical practitioners who have signed settlement agreements out of sheer fear and ignorance.

Once you disclose these clinical notes, the medical scheme alleges wrongful practice, these allegations are made without any medical basis by a forensic analyst using a computer algorithm.

An amount is allocated based on the so-called investigation and the wrongful practice alleged by the medical scheme.

Each patient must be evaluated individually as every patient is subjectively different, there is no one-size-fits-all in medicine. For each patient there must be a peer review board in order to determine if there was in fact grounds for the allegations made against the medical practitioners.

Parties and obligations

The patient is contractually bound to the practitioner for delivery of services and owes a reciprocal duty of payment. The patient is a member of a fund. The latter may pay the practitioner on *behalf of* the patient. If not, the patient remains liable to pay the practitioner.

In some instances, a claim is pre-authorized, meaning that the fund had an opportunity to evaluate the services to be performed and the benefits to cover the concomitant claims, and by consenting to pay, literally accept the duty to pay – I propose it as an express mostly written acknowledge of debt and undertaking to pay at least a tacit guarantee to make payment.

Some practitioners have contracts with one or more funds that stipulate the way the obligation between the parties are administered. Practitioners who have no such contract(s) with fund(s) are not contractually or otherwise bound to the fund(s) – and thus a *lacuna* in law exists regarding direct claims by the fund against the practitioner.

It is for this purpose that the Act has introduced section 59 – to bridge this gap to allow and facilitate a direct *enrichment* claim by the fund against the practitioner by ways of set-off <u>ONLY once a practitioner is guilty of the conduct mentioned specifically in sec 59(3).</u>

Contractual obligation between Scheme and Service provider

Some practitioners have express agreements with specific medical schemes that will regulate their relationship.

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With reference to the 4 requirements of off set of a debt, we firstly look at the relationships between parties involved,

The patient has a contract with a medical practitioner for the provision of medical services, and thus, the patient has a payment obligation to the medical practitioner and that contract is exclusively between those 2 parties.

The medical aid has its own contract with its own members (the patients) and the medical aid can now be asked to pay on behalf of the patient to the practice but at no time does it create a legal obligation between the medical aid and the practice.

The medical aid and the practice have no contract with each other unless negotiated and agreed and thus no off set of debt may take place.

Private medical information can only be disclosed with the express informed consent of a patient given to the medical practice or the medical practitioner that this information may be disclosed.

It is a huge concern that the provisions of POPIA are ignored by the medical schemes and the patient's right to privacy and more so the medical practitioner's right to privacy is being infringed on.

Medical practitioners under the pressure, and lack of knowledge and understanding of the POPIA have indeed disclosed the clinical notes to the medical schemes.

Medical schemes are authorized in a contract with their members or patients to act on behalf of their patients in certain circumstances and to request information. this is a general clause that exists in the pro forma contract of the scheme.

The general clause is not brought to the patient's attention and it is only accepted that it is an overarching consent that they may obtain any information of their patients from any practitioner.

This is not the case because it is about very personal clinical notes and not just finances. The contract between the medical scheme and their client relates to financial assistance and not clinical evaluation.

The express consent, which is informed consent, must be obtained from the patient. Which means that the medical scheme must tell the patient why they need that specific personal medical information and that they do still have the patient's consent to obtain the information.

The clause that medical schemes have in the contract with the patient (members) expressly states that the patient may at any time withdraw his consent or refuse to release information.

It is precisely for this reason that we tell the medical practitioner that the patient must give a new current valid informed consent for this clinical information to be disclosed should the patient feel that it is necessary for his medical fund to know this information.

Patients could take the medical scheme to court if they put pressure on a medical practitioner to provide them with clinical notes, if the patient would not give consent.

Of course, it is actually the patient who has to complain about the fact that he was charged too much or the fees were too high.

It is the patient who can bring complaints against a practitioner not a medical aid.

Usually the patient is not contacted, the patient does not know that there is an investigation into certain codes from which he benefited, and treatment that he did receive.

The funds claimed back by the medical scheme on behalf of the patient is not paid to the patient's benefit but pooled in the medical scheme to promote business development. – The patient remains liable for the outstanding account.

The forensic analyst receives a financial incentive based on the money he can recover for the medical scheme and the patient is not notified at all of the process, nor does the patient benefit in any way whatsoever, in fact the patient is financially prejudiced.

The rounded amounts that are being claimed by the medical schemes proves that individual patient merit is not considered. The medical practitioner is the professional and the qualified person to decide on a treatment plan for a patient and the medical scheme cannot prescribe the treatment.

Medical schemes cannot question the professional discretion and competence of the medical practitioner.

Should the medical scheme insist on prescribing treatment for a patient, it should accept, in writing, the associated liability as well.

The English word used for what is currently happening here is “Claw back” i.e. to grab back with your claws at amounts that were payable in the past with threats of debt settlement of unliquidated debts which the schemes alleged they are entitled to claim.

These are fees that the medical scheme purports they have a right to claim back, however, they cannot. They want to apply debt settlement or “off-set” against claims that are due and outstanding to the practitioner.

The threat of this off set has a serious impact on the medical practitioner and could effectively financially ruin a small practice, thus, the medical scheme “softens the blow” by offering an acknowledgment of debt to assist the medical practitioner – this is fruit from the poison tree!!!! DO NOT SIGN AN AOD!!!

Burden of proof

The medical schemes cannot discipline or prosecute health practitioners for unprofessional conduct but may report practitioners to the HPCSA for unprofessional conduct or report any criminal offence to the South African Police Service (SAPS).

Section 34 of the Prevention and Combating of Corrupt Activities Act, 2004 (Act no 12 of 2004) requires that anyone in position of authority or an entity (medical schemes, HPCSA, etc.) that suspects or has knowledge that a practitioner has been involved in fraudulent activity that involves an amount of R100 000 or more to report such knowledge or suspicion to the South African Police Service.

Failure of such a person or entity to comply with this provision of the law constitutes an offence under the Act mentioned above.- ***

Application, interpretation and burden of proof

As I interpret it to be a statutory right of set-off, it must still, however, comply with all the ordinary requirements for set-off (which we know are in most cases challenging – the *conditio indebiti* for example).

At the least it must be proven by the fund that the debt is in fact due, that debts are liquidated *yet* not that it is between the same parties in the same capacities. As the latter is not the case here, the Act in section 59 bridges that gap and allows an exception, in my opinion, only to this requirement.

Reg 6(4) to the Act places the burden of proof upon the fund once a *dispute exists* that a claim is irregular. Some form of judgement/acknowledgement of debt/confirmation/ finding of the fact that the alleged debt is due and payable is required in the absence of any other indication of an obligation that the debt is due and payable (such as contract). AOD!!!

Sett off Debts

In terms of Section 59(2) of the Medical Schemes Act, the scheme should pay a claim either to the member or practitioner within 30 days of receiving the claim. According to Regulation 6 of the Medical Schemes Act Regulations, if a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both 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 and the member or health practitioner has sixty days to correct and resubmit such an account or statement.

Where the medical scheme has failed to either notify the member or health care provider within 30 days that an account/ statement/ claim erroneous or unacceptable for payment**, OR fails to provide an opportunity for correction and resubmission**, the **medical schemes bears the onus of proving that such account/ statement/ claim is in fact erroneous or unacceptable for payment when there is a dispute**. Practitioners are advised to report medical schemes who unlawfully withhold claims due to them to the Council for Medical Schemes.***

Debt off set may only be done under very specific circumstances;

1. The obligations must be mutual – both parties must be indebted to each other in the same capacity.
2. The debt must be of the same kind.
3. The debts must be due and enforceable; and
4. Both debts must be liquidated.

X owes Z an amount of R 50 000
On the other hand, Z owes X an amount of R 40 000
Automatically in law, only the balance remains outstanding:
X only owes Z the amount of R 10 000

AOD

The threats in order to obtain an acknowledgement of debt is considered duress.

Prescription

The fund denies that it is subject to the normal rules of prescription. Their reasoning is that as the Act in sec 59 does not limit its right to set-off by reference to a specific prescription period, that none so applies. This is of course irrational reasoning, as all debts fall within the scope Prescription Act unless specifically excluded (which these claims are not), and thus the normal time for prescription remains is 3 years.

As to the starting date of prescription: The Prescription act sec 12(10 and 12 (3) states expressly that once a creditor is aware of a debt or should by exercising reasonable care have become aware thereof, prescription starts running. This, in my mind, is the term of 30 days as per Reg 6(2), during which the creditor (fund) *has the opportunity to become aware* of the irregularity and take necessary action if, after term of 60 days in Reg 6(3) has expired and the dispute continues to exist. I cannot see that in most cases any date thereafter – unless in the event of an extraordinary occurrence – should serve as the starting date for prescription.

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Unless the fund has a miraculous success in proving *vetustas** , my opinion is that they remain subject to a normal 3-year prescription period. *"*When any state of things had endured so long a time that its origin dated back to a period to which the memory of man did not extend, there was a legal presumption that such origin had been legitimate and parties were dispensed from furnishing proof that it was so…*The nature and quality of proof to be adduced by the parties, it is unnecessary to consider".

An acknowledgment of debt by practitioner is course an interruption of prescription and new term of 3 years starts running.

A practice in Pretoria told the medical fund to give a list of all the patients with whom there was a real problem, in order to get a specialized opinion before any claims may be made in respect of the allegation that too much money is being paid to the practice or that the practice charges irregular fees.

The medical fund brought thousands of member numbers to the meeting, relating to every patient who has ever been seen by a very large practice with multiple medical practitioners most of whom have been referred patients, the practice cannot contact everyone and ask for express permission, it was a malicious action on the part of the medical aid to thwart the attempt of such a situation.

You cannot claim money until you have a firm and secure claim.

Section 59 of the Medical Schemes Act states as follows:

Recovery of benefits paid bona fide to a practitioner who was not entitled to receive such benefits

Section 59(3) of the Medical Schemes Act empowers the medical scheme to recover any amount which has been paid bona fide to which **a practitioner is not entitled to** or **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.

Thus, the provisions of S59 (3) cannot be invoked and the threat thereof will not succeed under these circumstances.

THAT YOU!