

LEGAL OPINION

QUESTION : Can a medical scheme pay an account that does not have a valid practice code number?

Introduction

The Registrar of Medical Schemes has issued a Circular 35 in relation to practice code numbers the core of which reads as follows:

“In essence the opinion states that the situation is basically the same regardless of whether a healthcare practitioner never applied for a practice code number or did previously apply but the practice number was rendered inactive by the BHF owing to non payment of the renewal fees. In either case, the opinion states that:

The relevant practitioner would not be entitled to receive payment from a medical scheme; but

Subject to the rules of the medical scheme, the member would nevertheless be entitled to claim benefits from the medical scheme in relation to health services rendered by the practitioner.”

The “opinion” referred to in the Circular is that of senior counsel.

The Law

Reference to the practice code number is to be found in regulations 1 and 5 of the Regulations to the Medical Schemes Act.

In terms of regulation 1, 'practice code number' means the number allotted to a supplier of a relevant health service as a practice number by an organisation or body approved by the Council.

In terms of Regulation 5 the account or statement contemplated in section 59(1) of the Act must contain the following:

- (a) The surname and initials of the member;
- (b) the surname, first name and other initials, if any, of the patient;
- (c) the name of the medical scheme concerned;
- (d) the membership number of the member;
- (e) the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service;
- (f) the relevant diagnostic and such other item code numbers that relate to such relevant health service;
- (g) the date on which each relevant health service was rendered;

- (h) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine
- (i) where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;
- (j) where mention is made in such account or statement of the use of a theatre-
 - (i) the name and relevant practice number and provider number contemplated in paragraph (e) of the medical practitioner or dentist who performed the operation;
 - (ii) the name or names and the relevant practice number and provider number contemplated in paragraph (e) of every medical practitioner or dentist who assisted in the performance of the operation; and
 - (iii) all procedures carried out together with the relevant item code number contemplated in paragraph (f);..

The section of the Act in terms of which these regulations are made is section 59 which states that –

- (1) A supplier of a service who has rendered any service to a beneficiary in terms of which an account has been rendered, shall, notwithstanding the provisions of any other law, furnish to the member concerned an account or statement reflecting such particulars as may be prescribed.
- (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.

Of relevance to the current analysis are the provisions of section 66 of the Act to which state that

- (1) Any person who-
 - (a) contravenes any provision of this Act or fails to comply therewith;

.....

Shall...be guilty of an offence, and liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and imprisonment.

In terms of section 1 of the Medical Schemes Act, the phrase “this Act” includes the regulations.

Section 32 of the Medical Schemes Act states that “the rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.”

In terms of section 57(4)(h) of the Act the trustees of a medical scheme are obliged to “ensure that the rules, operation and administration of the medical scheme comply with the provisions of this Act and all other applicable laws”.

Regulation 6(2) stipulates that 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.

Regulation 6(3) states that 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 sixty days following the date from which it was returned for correction.

Other Relevant Material

The Model Rules issued by the Council for Medical Schemes as a guideline for schemes to follow in drawing up their own rules state at rule 15.1 state:

“Every claim submitted to the Scheme in respect of the rendering of a relevant health service as contemplated in these Rules must be accompanied by an account or statement as prescribed.”

The rules of many medical schemes are likely to incorporate this principle in one form or another given that it appears in the Model Rules. Medcor, for instance, states in its rules states in rule 14.1 that :

“Every claim in respect of which an account is rendered for the rendering of a health care service as contemplated in these rules shall be submitted as a detailed account, or statement which shall comply with the provisions of the Act and the Regulations and shall at least contain the following particulars:

.....

14.1.5 The practice code number, group practice number and individual provider registration number issued by the Registering Authorities if applicable, of the supplier of service and in the case of a group practice, the name of the practitioner who provided the service...

Therefore in this scheme’s rules, the requirement of a practice code number is stated twice – once in terms of Rule 14.1 obliquely with reference to the Act and regulations and the second time expressly in terms of rule 14.1.5.

In the Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act, 1974, made by the Health Professions Council of South Africa Rule 4(1)states that a practitioner “shall print or have printed on letterheads account forms and electronic stationery pertaining only to such practitioner’s-

- (a) name;
- (b) profession;
- (c) registered category;
- (d) specialty or subspecialty or field of professional practice;
- (e) registered qualifications or other academic qualifications or honorary degrees in abbreviated form;
- (f) registration number;
- (g) addresses (including e-mail address);
- (h) telephone and fax numbers;
- (i) practice or consultation hours;
- (j) practice code number; and
- (k) dispensing licence number (if any).”

In the National Health Reference Price List for service by social workers, psychologists, and physiotherapists, it is stated that every account shall contain the following particulars

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- The name and practice code number of the referring practitioner (if applicable)
- The name of the member;
- The name of the patient;
- The name of the medical scheme;
- The membership number of the member;
- The practice code number and name of practitioner
- The nature and cost of the treatment
- The date on which the service was rendered
- The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.

Conclusions

A medical scheme may not pay an account that has an invalid or not practice number reflected thereon because:

1. The practice code number is required by the Act and regulations to be on the account- in other words this is a legal requirement. The board of trustees is legally required to ensure that the rules, operation and administration of the medical scheme comply with the provisions of this Act and all other applicable laws. If the account does not reflect a valid practice code number then it is not compliant with the Act and the regulations. If it is not compliant with the Act and the regulations then payment of the account is not in accordance with the Act. This is a breach of the statutory requirement that a medical scheme operates in compliance with the Act (which by definition includes the regulations). The Board of Trustees would therefore be acting in breach of their duty in terms of section 57(4)(h) of the Act in allowing such an account to be paid, irrespective of whether the member or the provider submits it and irrespective of whether the member or the provider is paid.
2. It is a requirement of the rules of most (if not all) medical schemes that in order for a claim (medical account) to be paid it must contain the legally prescribed particulars. In terms of section 32 of the Act, the rules of a medical scheme are

binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming. This means that the scheme rules are binding on the medical practitioner submitting a claim directly to the scheme for payment as well as a member who has paid the practitioner and is subsequently submitting a claim for payment. The medical practitioner's claim is "derived from" the claim of the member. The rules are also, incidentally binding on the scheme. If a scheme pays an account without a valid practice code number it is not only acting in violation of its rules it is also acting in violation of section 32 of the Act in that it is flouting its rules contrary to this section.

3. In terms of section 66 of the Act it is a criminal offence to violate a provision of the Act. It is therefore technically speaking an offence for a scheme to pay a claim without a practice code number. It must be borne in mind that a violation of the Regulations also constitutes an offence in terms of this section because the phrase "the Act" by definition includes the regulations.

The correct procedure for a scheme to follow when a scheme receives a claim without a valid practice code number is contained in regulation 6 of the regulations under the Medical Schemes Act. When the scheme receives a claim without a valid practice code number 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. It must provide an opportunity for the account to be corrected or the fault to be remedied and then resubmitted for payment.

It is unethical for a medical practitioner not to submit a valid practice code number on an account by virtue of the ethical rules published by the Health Professions Council of South Africa which render it mandatory to print the practice code number of the health professional concerned on the statement of account. A provider who prints an invalid practice code number on the account is acting in contravention of the ethical rules and could be disciplined by the HPCSA in consequence thereof.

Interpretation of Circular 35

A close reading of Circular 35 indicates that the Circular is supportive of the legal position described under the heading "Conclusions" above.

The Circular states that "subject to the rules of the medical scheme, the member would nevertheless be entitled to claim benefits from the medical scheme in relation to health services rendered by the practitioner".

This is because the rules of a medical scheme cannot be inconsistent with the Act and regulations and cannot override them. The Act itself cannot be overridden by a Circular issued by the Registrar of Medical Schemes either and so must be interpreted within the legislative framework of the Act. What the circular is saying in effect is that provided that the provisions of the Act are satisfied, and the scheme rules permit a claim by the member, a member can claim benefits. However as has been pointed out, the scheme Rules must comply with the Act which requires the submission of a valid practice code number and in all likelihood the scheme rules themselves contain a provision to this effect.

Therefore in practical terms, the effect of the Circular is that a medical scheme may not pay a claim without a valid practice code number either to the member or to the provider. The provider is bound by the scheme rules, as is the member and the scheme itself.

The Circular does not say that a medical scheme must pay a claim in the absence of a valid practice code number. It says that where the rules allow such a claim, it may be made by the member. Since the rules cannot allow such a claim as this would be contrary to the Act, a medical scheme cannot entertain such a claim but must follow the procedure set out in regulation 6 of the regulations under the Act.

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