



OVER R50 MILLION RETRIEVED

By the end of last year, the Council for Medical Schemes retrieved more than R50 million in membership fees which had either been fraudulently spent or invested in illegal reinsurance contracts.

Following the Registrar of the Council, Patrick Masobe's investigation into the increased spending on reinsurance over the past years, members of Medicovert 2000 received R38 million from MunichRe and could receive a similar amount from CologneRe. When Medicovert was placed under curatorship last year the Council found that 'potentially inappropriate contracts involving reinsurance, managed health care and administration' had been entered into.

HanoverRe paid R5 million to members of KwaZulu-Natal Medical Scheme, which was placed under curatorship in 1999 and MunichRe repaid R15 million to Omnihealth members. Omnihealth illegally entered into a reinsurance agreement by neglecting to submit their proposed reinsurance contracts to the Registrar for approval before implementing them, as required by the Medical Schemes Act.

PRACTICE MANAGEMENT

SETTING UP A PRACTICE

By Jules and Tana Rivalland

For any newly qualified doctor, setting up a practice is an incredibly challenging and time-consuming task. This is particularly so in today's complicated and technologically diverse practice environment.

Locating premises

Firstly, one needs to analyse the area and number of operating GPs in relation to population, as well as the number of cash versus medical aid patients. One can then decide whether this location would suit your requirements.

Locating premises in your area of choice can also be complicated. Perhaps choose a central venue that is easy to find and has a continuous flow of passing traffic, such as close to a housing development, train station, taxi rank or shopping centre. Also ensure that you consider access to running water, electricity and telephone lines and security during selection.

Financial aspects

The financial aspect of starting any business is always daunting - be prepared for the usual start-up costs as well as the numerous small hidden expenses such as stationery. If you choose to dispense, you will need more capital to equip your surgery with the necessary medication. Ensure that you talk to other GPs and numerous pharmaceutical companies in order to get the best possible prices.

Administration

The administrative aspect of starting a practice is extremely complicated. Prior to becoming an operating GP, you must ensure that you pay registration fees to the Board of Healthcare Funders (BHF) in order to get a practice number. If you have chosen to become a dispensing doctor, then you will also need to pay registration fees to the Health Professions Council to obtain a Dispensing Registration Certificate.

If you are in an area that generates much business from medical aid patients, you will have to register with each medical aid, providing them with your practice number and banking details prior to submission of any claims. Most medical aids generate payment via Electronic Fund Transfer and require copies of your Identity Book and cancelled cheques. Although you can continue to receive cheques via post, it is faster and safer to receive funds via EFT and some medical aids will not pay via any other method.

Claims submissions

Once the above areas have been covered, it is imperative that you decide the method of claims submissions. There are still many GPs who submit hand-written paper claims. However, an option that allows for electronic submission results in quicker payment turnaround. There are numerous choices when selecting electronic submissions:

Accounts from your surgery

Hiring your own staff and purchasing IT enables you to run your accounts from your premises. The advantages are that you can benefit from electronic submissions while still keeping your fingers on the pulse of your business. However, the biggest disadvantages are that it is costly at the beginning and time-consuming to gather the necessary information and skills. There are basically two options:

1. Purchasing software operated solely by your staff involves:
 - keeping up to date on all medical aid changes (e.g. address changes, submission formats, administrative changes);
 - keeping abreast of price changes (e.g. ethical, MMAP, MPL and MEL price lists, discounts and levies);
 - inputting, submitting and reconciling claims, as well as posting claims that are not electronically submitted.
2. Entering into a software deal whereby electronic claims are administered by the vendor. This option enables you to benefit from quick payment turnaround without the hassle of dealing with medical aid format changes, price changes and co-ordination of claims submissions. However, you must still input claims, submit claims that are not electronically accepted and reconcile claims.

Using a bureau

Outsourcing the majority of the practice's administration to



professionals lowers costs and saves time. However, the disadvantage is that you rely on someone else to control your cash flow. There are basically two options:

1. Using a bureau service that stores all the necessary information means that you do not have to handle the day-to-day submissions, and your staff will only handle claims reconciliation and balancing of accounts.
2. A complete bureau service handles all electronic and paper claims and reconciles accounts. This takes care of all administrative aspects of your practice and allows you to concentrate solely on patients.

Both of the above options must be carefully considered. Choose a company that has been in business for a reasonable period, has extensive experience and does not base their fees on a percentage of turnover (which can result in fraudulent claims being submitted to increase monthly figures). As a bureau does not have daily access to patient files, surgery staff must provide sufficient information to reduce rejections and delays as much as possible.

Although the health care profession is forever changing, it is also never-ending - be prepared for a bumpy start, but with the correct choices, you are sure to make valuable contributions to this rainbow nation.

Jules and Tana Rivalland are directors of Rivalland Computing in the Western Cape, which specialises in medical claims administration, including price-lists, reconciliations and the follow-up of unpaid claims. Their website is at www.rivalland.co.za.

LEGISLATION

SUMMARISED HIGHLIGHTS OF THE LATEST AMENDMENTS TO THE REGULATIONS OF THE MEDICAL SCHEMES ACT: PART II

By Elsabé Klink

The amending regulations to the Medical Schemes Act of 1998 (as amended) were published on 4 November 2002 in the *Government Gazette* and came into on 1 January. All persons or groups entering into managed care agreements from 1 January 2004 will have to be accredited by the Council for Medical Schemes.

This is the second part of the serialisation of the amendments in the SAMJ. SAMA has warned doctors to be vigilant and ensure that schemes adhere to the provisions, especially as far as accounts, managed care agreements, protocols and formularies are concerned.

Regulation 9: Limits on benefits (9a and b added)

Regulations 9A and B deal with the non-accumulation of unexpected benefits (not savings account benefits) and the reduced contributions for child dependants respectively.

Regulation 10: Savings accounts (changed)

Ascheme may not pay more than 25% of the total gross yearly contribution of a member into a savings account. The member may not use the savings account to offset contributions, but the scheme may use the savings account to offset debt to the scheme upon the termination of membership. Credit balances must be taken as a cash benefit, subject to taxation laws upon termination and enrolling in a scheme with no savings account option or if the member does not enroll in another scheme.

Savings accounts benefits may not be used to pay PMB costs! Schemes have to provide the Registrar with details concerning its savings accounts.

Regulation 11 and 13: Definitions for waiting periods and late-joiner penalties (changed)

'Creditable coverage' is defined in view of regulations pertaining to late joiners. A member has had 'creditable coverage' when they were a member or dependant of a scheme; a member or a dependant of an entity exempted from the provisions of the scheme (e.g. another type of health care cover); a uniformed employee of the SANDF or a member of the Permanent Force Contribution Fund. This definition, together with the provisions of subregulation 6a, may alleviate the plight of persons who were insured in, for example, another country under a different system such as NHI. These persons will thus not be penalised when coming into a South African medical scheme. This may also imply that alternative social security arrangements such as stokvels and hospital plans may count as creditable coverage. Subregulation 6 requires a sworn affidavit on the relevant periods s/he was a member or dependant of a medical scheme or 'other relevant entity'.

'Late joiner' is defined as an applicant or adult dependant who is 35+ years of age. It excludes persons who had cover from a date preceding 1 April 2001 without a break of more than three consecutive months since that date. A formula is given in the regulations in terms of which late-joiner penalties are described. The maximum penalties have been lowered.

Regulation 12: Medical Reports (changed)

If a medical report is required of an applicant in terms of section 29a of the Act, the scheme shall pay to the applicant or provider the costs of the tests and examinations required for the compilation of the report.

Regulation 14: Continued membership (scrapped)

Regulation 15: Managed health care (changed *in toto*. Managed care accreditation only applicable from 1 January 2004)