

**IN THE APPEAL COMMITTEE OF THE COUNCIL FOR
MEDICAL SCHEMES**

Case Number: CMS 15666

In the matter between:

KY

Appellant

and

GOVERNMENT EMPLOYEES MEDICAL SCHEME Respondent

RULING

[1] The issue in this appeal is whether the Appellant is entitled to charge for what is known in the healthcare industry as a “modifier code 0019” in the amount of R7 040.00. The Appellant, a paediatrician, maintains on the basis of an amended description of “Modifier code 0019” in the 2007 version of the South African Medical Association Doctors’ Billing Manual (“the SAMA DBM”),

that the Respondent is liable pursuant to regulation 8(1) to the Medical Schemes Act, 131 of 1998 (“the MSA”), to settle his account in full without requiring the member to contribute towards its settlement, or limiting the account to the scheme’s own tariff schedule.

- [2] The amendment of the 2007 SAMA DBM comes in the form of the introduction of a paragraph (b) to the description of the modifier to include ICU care for neonates. In other words, in addition to surgical procedure on neonates, service providers can now (in terms of the new 2007 SAMA DBM) also charge for ICU care for neonates under this modifier. The 2006 National Health Reference Price List (“the NHRPL”), however, only recognises surgery on neonates as a service for which a charge can be levied under this modifier. So does the tariff schedule of the Health Professions Council of South Africa (“the HPCSA”). The scheme in this case uses the 2006 NHRPL as its tariff schedule.
- [3] The scheme refuses to pay for the services the Appellant says he performed under the modifier code 0019. It says the Appellant’s charge is for “neonatal ICU care” while the modifier under which he claims is for “surgery on neonates”. The Appellant did not

perform any surgical procedure, says the scheme, and so is not entitled to payment under this modifier. The registrar, in his ruling of 17 September 2007, agrees with the scheme.

- [4] The Appellant maintains that he is so entitled because the tariff schedule on which he relies (the 2007 SAMA DBM) allows him to charge for neonatal ICU care under this modifier. He points also to a provision in the 2006 NHRPL (the scheme's tariff schedule) for the proposition that service providers are free to determine their own fee structures without reference to the scheme's tariff schedule.

The provision reads:

“The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements, which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.”

- [5] On a plain and literal reading of this provision of the 2006 NHRPL, which the scheme has adopted as its tariff schedule, there can be no doubting that the Appellant is correct in his submission. Such a literal reading, however, gives rise to an irresolvable conundrum because the very same 2006 NHRPL says doctors may charge under the modifier code 0019 only for surgical procedure on neonates, not neonatal ICU care.
- [6] It seems to me the answer must lie in the Legislature's intention in introducing prescribed minimum benefit ("PMB") provisions into the MSA. Both parties are agreed that neonatal ICU care is a PMB condition.
- [7] A PMB condition is defined in regulation 7 to the MSA as "*a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition*". Among the conditions listed in annexure A to the regulations is low birth weight of less than 1 000 grams with respiratory difficulties (code 67N) for which the recommended treatment is "*medical management, not including ventilation*", and "respiratory conditions of newborn" (code 56N) for which medical management including ventilation is recommended. But what

makes the condition of the twin babies a PMB condition in this case is that theirs was an emergency medical condition.

- [8] Where payment for a PMB condition is at issue, the interpretation of regulation 8 is triggered. The relevant parts of the regulation read as follows:

- “(1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must *pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.*
- (2) Subject to section 29(1)(p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that –
- (a) the diagnosis, treatment and care costs of a prescribed minimum benefit will only be *paid in full by the medical scheme* if those services are obtained from a designated service provider in respect of that condition;
- (b) ...”

(Emphasis supplied)

- [9] The question that arises is what does “*pay in full*” or “*paid in full*” mean in the context of the MSA? The Appellant maintains that regulation 8 requires that the scheme pays his account in full without reference to the limit prescribed by its own tariff. In this regard, he refers to the provision of the 2006 NHRPL cited earlier

to the effect that service providers are free to determine their own fee structures.

[10] In my view, the phrase “*pay in full*” or “*paid in full*” in regulation 8 cannot mean that for which the Appellant contends because that would make nonsense of the Legislature’s clear intention in introducing PMB provisions into the MSA. The purpose behind the introduction of PMB provisions in the MSA was clearly to make healthcare services affordable. To that end, medical aid scheme members are expressly exempt from paying for any emergency medical conditions and for the diagnosis, treatment and care costs of those conditions listed in the regulations (including respiratory difficulties of newborns) out of their own pockets. The medical aid scheme must pay for these from the members’ premiums.

[11] That this exemption is limited in respect of those PMB healthcare services obtained voluntarily from designated service providers with whom the medical aid scheme would have negotiated favourable rates on behalf of its members is a clear indication that the Legislature’s intention is to encourage the keeping of healthcare service costs down (regulation 8(2)(a)). This intention also becomes demonstrably clear from the fact that an out-of-

pocket contribution may be imposed on a member who voluntarily obtains such services from a service provider with whom his medical aid scheme has not negotiated a favourable rate (regulation 8(2)(b)). Only where a member obtains PMB healthcare services from a non-designated service provider involuntarily would the exemption from out-of-pocket contribution remain in place (regulation 8(2)(b)). This could arise in a number of ways. One could be an emergency situation. Another could be where there is no designated service provider facility in the area in which the member happens to be at the time PMB healthcare services are required.

- [12] With this clear intention in mind, the Legislature could not at the same time have intended to nullify the policy framework so carefully crafted to keep healthcare service costs down, by quirkily permitting healthcare service providers to charge whatever fee they please in terms of their own tariff schedule and without regard to the Scheme's tariff for PMBs. The Legislature is presumed to be consistent with itself (see *Principal Immigration Officer v Bhula* 1931 AD 323 at 345).

- [13] This carefully crafted policy framework begins with the Constitution. Section 27 of the Constitution not only provides for the right of access to healthcare (s 27(1)); it also obliges the State to take reasonable legislative measures to ensure the realisation of that right (s 27(2)). That legislative measure has come in the form of a number of Acts of Parliament, among which is the MSA.
- [14] Section 29(1)(q) of the MSA obliges medical aid schemes to make provision in their rules for the payment of any benefits according to “*a scale, a tariff or recommended guide*” or specific prescribed directives. The scale, tariff, recommended guide or prescribed directives of GEMS are contained in the 2006 NHRPL. They say modifier code 0019 will be funded by the scheme only where a surgical procedure is performed on a neonate at 2006 NHRPL+4.9%.
- [15] The Registrar’s express concern in circular 32 of 2006 dated July 2006 as regards service providers construing the provision in regulation 8 for the full payment of PMB costs as a “blank cheque” was a concern giving expression to the Legislature’s intention in introducing PMB provisions into the MSA, namely, to keep healthcare service costs down. It was a warning against abuse of

these provisions. In my view, an interpretation of regulation 8 that says service providers are free to charge in excess of medical aid scheme rates for PMBs, and that schemes have an obligation to pay those accounts in full, can only have the very effect of a “blank cheque” against which the Registrar warned in July 2006. The Appellant’s submission, with reference to the 2006 NHRPL, that he is free to determine his own fee structure without reference to the scheme’s tariff schedule is demonstrative of this.

- [16] In any event, even assuming that the meaning of “*pay in full*” or “*paid in full*” in regulation 8 clearly and unambiguously connotes full payment (in the sense of paying an account as presented) without limit based on the scheme’s tariff schedule, the absurdity to which such a literal interpretation would give rise is such that the only reasonable conclusion can only be that the Legislature could not reasonably have intended it. As Schutz JA pointed out in a unanimous judgment of the Supreme Court of Appeal in *Poswa v Member of the Executive Council for Economic Affairs, Environment and Tourism, Eastern Cape* 2001 (3) SA 582 (SCA) at paragraph [10], “*the literal meaning of an Act (in the sense of strict literalism) is not always the true one*”. Where that literal meaning would result in “*absurdity so glaring that it could never*

have been intended by the Legislature” (per Innes CJ in *Venter v R* 1907 TS 910 at 914), or in “*absurdity, inconsistency, hardship or anomaly which from a consideration of the enactment as a whole a court of law is satisfied the Legislature could not have intended”* (per Stratford JA in *Bhyat v Commissioner for Immigration* 1932 AD 125 at 129), then a court is justified in departing from the clear and unambiguous meaning of the section (see also *Hanekom v Builders Market Klerksdorp (Pty) Ltd and Others* 2007 (3) SA 95 (SCA) at paragraph [7]).

- [17] In any event, the SAMA DBM (to the extent that it conflicts with the scheme’s tariff or recommended guidelines that were determined in order to give effect to a legislative requirement in section 29(1)(q) as regards procedures that can be charged for under the modifier code 0019) and the 2006 NHRPL (to the extent that it purports to licence service providers to charge in excess of the scheme’s tariff) cannot validly derogate from the Legislature’s clear intention in introducing PMB provisions into the MSA. In the circumstances, the only reasonable conclusion must be that the Legislature could not, in regulation 8, have intended that healthcare service providers determine their own tariff schedule above that of medical aid schemes.

[18] The Appellant says if this appeal should fail, then the member would be liable to pay for the modifier code 0019. I do not agree. On a proper interpretation of regulation 8, a member is not liable to make any out-of-pocket payment for PMB services, unless she voluntarily obtained those services from a non designated service provider in circumstances where she could have done so from a designated service provider. It was not argued before the appeal panel that the Appellant is a non designated service provider from whom the member voluntarily obtained PMB services in the circumstances described.

[19] In the result, the appeal cannot succeed.

VUYANI NGALWANA for Appeal Committee

For the Appellant: KY
For the Respondent: Mr D Gerald (Bowman Gilfillan)

Date of hearing: 06 December 2007
Date of Ruling: 14 December 2007