PRIVATE PRACTICE 101

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INTRODUCTION

South Africa has a dual healthcare system that operates in both the state and private sectors. The state sector is funded by taxation revenue via the national and provincial health budgets whereas the private sector is funded via the individual, often via a third party medical insurance provider. Within the state sector there is a natural progression from medical school to internship to community service. Following this one has the option to progress through registrar training in order to specialize in a specific discipline. This requires training for a specified time, successful completion of examinations and completing a Masters of Medicine (MMed). Once these have been successfully negotiated one can register as a specialist with the Health Professions Counsel of South Africa (HPCSA). At this point one has the opportunity to pursue a career in state or move to the private sector. A 2011 study of South African doctors found that 58% of specialists choose to practice in the private sector compared to 42% in the state sector\(^1\). Given this statistic it is clear that knowledge of the functioning of the private sector is important.

While the functioning of the state sector is well known to all medical professionals by virtue of the fact that junior years must be completed in this sector, specialists are often ill prepared for the transition to private practice. This may be attributed to the necessity that on entering private practice one can no longer operate solely as a clinician and manager, but must become familiar with the principles of running a business. Unfortunately we have minimal or no formal business management training, as part of our specialist training and thus the transition to the private sector can be daunting. This booklet and presentation aims to broadly outline considerations for entering the private sector as an anaesthetic specialist and the some of the considerations of opening a private practice.

REGISTRATIONS

Following completion of the required examinations, MMed, and registrar time, specialists must register with various bodies prior to commencing work in the private sector. Some of these registrations are a legal requirement, while others are optional. Below, these organisations are discussed and, in the interests of practicality, the current requirements for registration are detailed.

Health Professions Council of South Africa (HPCSA)

The HPCSA is a familiar counsel to all health professionals in South Africa as registration is a prerequisite to practice both publically and privately. The HPCSA describes its mandate as, ‘promoting the health of the population, determining standards of professional education and training, and setting and maintaining excellent standards of ethical and professional practice’\(^2\).

As such, the HPCSA functions as a body that ensures registration of professionals as well as any further qualifications they obtain, for example a fellowship of the college of anaesthetists of South Africa (FCA). Fundamentally, the HPCSA exists to protect the public on issues pertaining to healthcare and thus become involved where issues of unethical practice or malpractice are reported to them\(^2\). Importantly, these issues may not relate solely to clinical issues but extend to issues such as consent and billing practices. These issues are explored in further detail later on.

Another function of the HPCSA is to ensure continuing professional development (CPD). The reason for this requirement is to promote on going knowledge acquisition and is a compulsory task to maintain registration. Broadly, it necessitates obtaining 30 ‘Continuing Education Units (CEU’s)’, 5 of which must be ethics related’ per 12 months. Each point obtained is valid for 24 months and practically this equates to accruing 60 points in the first 2 years and then ‘topping...
up’ points as they expire. Periodically the HPCSA may choose to audit a practitioner to ensure compliance upon which certificates proving completion of CPD accredited activities must be provided³.

A useful resource to assist in keeping ones CPD portfolio up to date is www.cpdexpress.co.za. This site offers HPCSA accredited courses and one can submit certificates to the HPCSA directly⁴.

Finally, the current forms required for registration as a specialist with the HPCSA are included for reference (See appendix). The relevant forms are; Form 19 (application for registration of an additional qualification), Form 21 (application for registration as specialist/subspecialist) and Form 57 (certificate relating to training in specialties including completion of research component). These forms are all available on the HPCSA website and require signatures from the Colleges of Medicine of South Africa (CMSA), academic head, research supervisor, medical superintendent and medical school⁵.

**Board of Healthcare Funders of Southern Africa (BHF)**

The BHF is a less familiar board to practitioners operating in the state sector but registration is key in the private sector. The primary function of the BHF is to represent companies providing healthcare funding, or more colloquially ‘medical aids’. They describe their aim as, ‘to ensure the sustainability of the healthcare sector by enabling medical schemes, managecare organisations and administrators to provide accessible, affordable, quality healthcare to their medical scheme members’⁶.

The relevance to the private practitioner is that the BHF provides the link between the medical insurance provider and themselves. Registration is a requirement for the payment of funds from the insurer to the practitioner. This is facilitated by the practice code numbering system (PCNS), the process whereby a practitioner obtains a practice number. This number is required by the medical aid to identify the healthcare provider and process a claim. A single practice number is sufficient for a practice with multiple individual practitioners but a personal practice number is required if working independent of a practice⁷.

Registration is online at www.bhfglobal.com where the following required forms can be found; details of commissioner of oaths, practice details, signed declaration and banking details. Required documents include certified copies of ID, marriage certificate, proof of HPCSA registration as a specialist and proof of current HPCSA fees payment. These documents must be delivered to the BHF office⁸.

**Medical malpractice insurance**

Medical malpractice insurance is not compulsory but is highly recommended not only for practice in the private sector, but the state sector as well. Broadly, malpractice insurance provides cover for legal liability as a consequence of alleged or actual medical or professional malpractice. This includes costs of legal representation and any claims awarded against you.

Many insurance companies provide medical malpractice insurance and a responsible approach to selecting a provider would be coverage offered, services provided and premiums required. Certain companies exist solely for medical malpractice insurance, the largest of which globally is the Medical Protection Society (MPS). Services include; clinical negligence claims, investigations, disciplinary procedures and preparing for inquests⁹.
Importantly, as the companies provide financial cover if a practitioner is found liable for malpractice, it is in their interest to defend you legally. It is therefore advisable to contact your malpractice provider as early as possible when potential issues arise, as they will provide you with advice on how best to proceed from the outset of a potential claim against you.

South African Society of Anaesthesiologists (SASA)

SASA is a professional body that represents the interests of anaesthesiologists in South Africa. They describe themselves as ‘a member association, not for gain, that is dedicated to the furtherance of the discipline of anaesthesia at both an academic and a clinical level. SASA has been in existence since 1943 and is devoted to the welfare of its members’. It is a society which exclusively acts in the interests of its members and the profession at a policy making level10.

The society is made up of five ‘business units’, each with a different focus. Importantly, there is a Private Practice Business Unit (PPBU) that specifically aims to enhance recognition of anaesthesia in the private sector. It has previously benchmarked private practice costs, which increased remuneration in private practice. The PPBU is responsible for publishing the coding and ethical billing manuals that allow for easier billing and predictability for patients and medical aids11.

SASA’s South African Journal of Anaesthesia and Analgesia (SAJAA) provides a forum to publish research and gain CPD points. Importantly, it is also publishes guidelines and set practices as suggested by its Regulation Business Unit. This is a critical resource for guidance on clinical decision-making11.

Finally, the ‘Wellness in Anaesthesia Support Group’ provides a space to ‘mentor and support’ colleagues. This is of particular importance in the private sector where members can feel isolated11.

SASA membership advice can be accessed at www.sasaweb.com10.
UNDERSTANDING MEDICAL AIDS

Major role players in the private healthcare sector in South Africa are the medical aids and an understanding of their role in the industry is critical to forming a successful practice. Medical aids provide insurance for their members should they require medical services. All medical schemes in South Africa fall under the Council for Medical Schemes, which acts as a proxy for the Department of Health. In general, individuals pay a monthly premium to a medical scheme of their choice and in return receive a degree of financial coverage for medical care based on how comprehensive the policy they have bought. Accordingly, the more comprehensive the coverage of a scheme, the higher the premium required. There are many companies offering medical insurance and each of these companies has multiple packages with varying degrees of coverage. Examples of this are basic plans which cover only hospital admissions all the way to plans offering full coverage for both inpatient and outpatient services.

Given the varying degrees of cover explained above, it is logical that patients will often access a service beyond what they are covered for. This creates a shortfall where the individual must finance the difference between what the medical aid contributes to an account and the total cost of the service. This is often referred to as a co-payment. It is important to note that regardless of any medical aid cover, the individual who accessed the private health system is financially, and legally, responsible for settling the account.

Unfortunately, patients accessing private medical care are often unaware of the coverage provided by their medical aid and this can lead to conflict between patients, healthcare providers and medical aids. Much of this confusion is based on the term ‘medical aid rates’ and this explained further below.

In addition to the discrepancy between fees charged and cover provided, there are many other aspects to medical aids that need to be understood by both healthcare providers and their patients. These include prescribed minimum benefits (PMB’s), designated service providers (DSP’s) and, more recently, event based billing. These areas are discussed below.

Medical aid rates and who sets them?

The term ‘medical aid rate’ is a misnomer as there is currently no centralised or regulated rate for healthcare services in the private sector. The term is historical and an understanding of how medical aids have developed over time is required. Prior to 2004 the BHF published an annual ‘pricelist’ for medical services. Importantly, this list was formulated in consultation with the South African Medical Association (SAMA) and thus healthcare providers had input into these rates. The HPCSA published a parallel list, until 2008, which was known as the ‘ethical medical tariffs’ and this served to provide a norm against which to compare complaints of overcharging. In 2004 the Council for Medical Schemes established the National Health Reference Price List (NHRPL). Critically, this list was made without negotiation and acted only as a guideline. In July 2010 the NHRPL was discontinued and since then there has been no uniform guideline in South Africa. Instead, each medical aid sets its own Medical Scheme Rate (MSR).

Where ‘medical aid rates’ were previously determined with input from providers, the MSR’s are entirely based on each medical schemes own determination. Interestingly, different tiers within a single medical aid may each have their own MSR, meaning higher tier products offer higher MSR’s, or more comprehensive cover. It is also important to understand that MSR’s are calculated based on risk where numbers of claims in previous years are extrapolated to predict number of claims in the future. This is then offset against the available funds, based on members’ contributions, and a rate is determined. This is obviously completely discordant from the actual service provided or its value from the perspective of the provider.
It is clear that there is a bias for the medical aids to set their MSR at a lower level than what a healthcare provider may determine to be reasonable for their services. Further compounding this situation is the fact that MSR’s have not kept up with inflation. This has created a situation where fees charged by service providers are significantly different to MSR’s.

Ultimately, in the absence of any regulation, healthcare providers are free to charge whatever they feel their service is worth. It is important that the billing practices are communicated to patients ahead of time, where possible, with an explanation that fees charged may be significantly in excess of the coverage of the patients medical aid. This is discussed in more detail below\textsuperscript{13}.

Prescribed minimum benefits (PMB’s)

The Medical Schemes Act of 1998 includes the definition and scope of prescribed minimum benefits while the council of medical schemes further explains its objectives. Broadly, these are specified medical conditions and treatments that the medical scheme is obliged to pay the full cost invoiced, irrespective of the benefits level that a member is on. The objective of this is that medical schemes must pay for these services regardless of whether a members benefits have been exhausted or if they have been treated in a state hospital. Also, more generally, it exists to ensure that a minimum of healthcare coverage for all members regardless of age, health or financial status. There are three categories under the PMB umbrella; emergency medical conditions, a limited set of 270 medical conditions, and 25 chronic conditions\textsuperscript{16}.

Emergency medical conditions are further defined by the council of medical schemes as ‘the sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. If the treatment is not available, the emergency could result in weakened bodily functions, serious and lasting damage to organs, limbs or other body parts, or even death’\textsuperscript{16}. It is logical that such a condition is managed rapidly and issues related to payment are considered thereafter. The medical scheme may ask for supporting documentation and the final diagnosis before making payment, but are obliged to pay the full amount invoiced by the healthcare practitioner, regardless of the MSR, for services rendered where such a situation exists.

The second group of PMB’s are the specified 270 medical conditions (subdivided into 15 categories, e.g. ENT, GIT etc.) and these are further defined as Diagnosis and Treatment Pairs (DTP’s), where a specified treatment is listed for each condition. These treatments are based on best practice and any deviation in treatment will need to be motivated. Should an agreement still not be reached then the standards or protocols from the public sector should be applied\textsuperscript{16}.

The final group includes 25 chronic diseases and specifies medication and treatment for each. As these are chronic medical issues they are less relevant to the anaesthetist in private practice.

A few important issues arise from PMB’s and the manner in which the healthcare provider, the patient and the medical aids interact. As mentioned above, medical schemes are obliged to pay the full amount for emergency situations and the listed conditions and as such it is important for all three role players to be aware of what constitutes a PMB. It is crucial for the provider to use the correct International Classification of Diseases and Related Health Problems (10\textsuperscript{th} revision), commonly known as the ICD-10 code. This code must appear on all documentation to ensure the diagnosis and treatment is recognised as a PMB. It is also important for the patient to be made aware that a condition is a PMB and they should not be expected to make any co-payments\textsuperscript{16}.
For the healthcare provider, it is a benefit to bill a condition as a PMB as the medical aid is then obliged to pay the full amount, however, it is important that the system is not abused. Common mechanisms of abuse would be to manipulate a diagnosis that is not a PMB but to record it as a similar condition that is a PMB or to charge a higher rate when a condition is recognised as a PMB. Such abuse is unethical and would make the provisions of PMB’s unsustainable. It would also open the practitioner up to legal liability.

**Designated service providers (DSP’s)**

Another aspect of private healthcare, medical schemes and PMB’s is the concept of Designated Service Providers (DSP’s). The definition and purpose of DSP’s is again stipulated in the Medical Schemes Act of 1998 and is particularly important in the context of PMB’s. A DSP is a healthcare provider selected by a medical aid as the preferential provider for its members for the management of PMB’s.

Where a treatment is not an emergency, the medical scheme can insist that a PMB service is provided by a DSP and if this is not done then the medical aid may only pay a portion of the account. Even in the context of an emergency, once stabilised, the medical aid can insist that a DSP takes over management of the patient.

The benefit to the medical scheme is that a pre-negotiated rate will be agreed on with a DSP and this is likely to be lower than the rate charged by a non-DSP. In theory, a DSP should be thoroughly reviewed by the medical scheme to ensure that they are able to supply the prescribed service at an acceptable level. Benefits to the healthcare provider are that they will receive referrals based on their appointment as a DSP and payment is guaranteed by the medical scheme. However, it is likely that the medical scheme will require a reduction in fee in order to appoint them. It may also cause conflict with colleagues providing a similar service, as patients will choose the provider based on their status as a DSP rather than on patient preference. Finally, the patient benefits by having their PMB attended to at a discounted rate by the DSP with the guarantee of the claim being paid in full. Again, it may cause conflict between the member and their scheme if they have a preference for a non-DSP in the context of a PMB.

**Event based billing**

A more recent concept in private practice is that of event based billing. The general principle is that a fixed fee is charged for a given procedure, regardless of the specifics of the anaesthetic provided. Practically, this means that an ‘all-inclusive’ quote can be given to the patient or medical scheme for a given procedure. Event based billing can present in various forms including ‘event based fee’, ‘global or fixed fee’, and ‘bundled fee or service’. These are explained further below. There are subtle differences in each and it is important for the anaesthetist to understand how each product is structured. It is worth noting that both SASA and the HPCSA currently view this as an acceptable billing practice.

‘Event based fee’ is a predetermined fee associated with a specific clinical event and a specific professional service, i.e. a fixed amount is charged by the anaesthetist to provide the anaesthetic service for specified surgical procedure, e.g. anaesthesia for a total knee replacement. This fee is independent of any modifiers or specific procedures performed, and is agreed upon prior to the procedure being performed. Practically, this means that the same predetermined fee is charged to an ASA 1 patient receiving a spinal and PCA, as to an ASA 3 receiving a complex general anaesthetic and peripheral nerve block. Importantly, this fee exists as a contract between the patient and the anaesthetist, although it may be negotiated with a medical aid. Critically, this fee is for a specific provider, in this case the anaesthetist, and does not require a third party to decide how to distribute payment. SASA and the HPCSA currently view this as an acceptable billing practice.
‘Bundled fee or service’ differs in that it is a predetermined fee for a specified clinical event for ALL professional services provided, i.e. a fixed amount is charged for a specified procedure that must then be distributed between all service providers. Practically, the fee is generally paid to the team leader (usually the surgeon) who then decides how to distribute the fee between themselves, the anaesthetist and any auxiliary healthcare providers. A variation on this structure is that it can include hospitalisation. In this case the fee is paid to the hospital, which must then distribute the fee to itself and the various providers. It is clear that such a structure introduces the potential for conflict in deciding how fees are distributed. It also introduces the possibility of certain providers agreeing to a lower percentage of the fee and thus being used and this may not be in the best interest of the patient. SASA and the HPCSA deem this form of billing ‘undesirable’ in view the potential ethical infringements described above.13

‘Global fee or fixed fee’ is defined similarly to bundled fee, above, by the SASA private practice guidelines. The major difference in definition is that global fees is the term used when applied to a larger system or more comprehensive coverage than a specific procedure. An example of this would be a total fee paid to an institution, possibly monthly, to manage all the healthcare needs of a patient. Again, this would then require the institution to determine how to disperse payment to individual service providers. Once again, SASA and the HPCSA deem this practice ‘undesirable’ at present.13

Event based billing is a contentious issue and is likely to continue to evolve in the near future within the South African private healthcare sector. SASA is actively engaged in this process and it is advisable to review their stance on the issue prior to entering any agreements with patients, medical aids or other health providers. The major issues to consider are fair financial compensation for all parties and the avoidance of under servicing patients, which may be incentivised in a bundled payment structure.13
BUSINESS SERVICES REQUIRED

As mentioned above, the fundamental change for a specialist moving from the state sector to the private sector is the fact that one must now act as a business owner. Starting a business is a complex process that requires expert knowledge of several areas that may be unfamiliar to healthcare practitioners. It is highly advisable to consult with individuals who understand the fundamentals of running a business and outsourcing certain functions to third parties. While there are many companies who offer assistance regarding the opening and management of private medical practices, this discussion will focus on specific aspects that one must consider.

Accounting services

A key function of any business is financial management. At a simplistic level this involves the costs of running a practice versus the income generated by the practice. It is critical that a suitable margin of profitability is maintained to make a practice financially viable. While this may seem straightforward it is both time consuming and becomes more and more complex as a practice grows. Accounting services cover many aspects of business management and outsourcing this part of the business is a relevant consideration. The two most important functions that an accounting service provides are managing income and expenses and ensuring tax compliance.18

Bookkeeping involves the reconciling of all accounts billed and all payments received as well as all other practice related expenses, e.g. salaries, office rental, etc. A comprehensive accounting solution will ensure that all accounts are received by patients and keep track of which are settled and which remain overdue. A process will then proceed to follow up on overdue accounts. An accounting service may also manage the manner in which payments are received, e.g. point-of-sale card machines or an online payment platform. Accounting services will be able to offer software to assist with individual patient billing that is integrated with the broader account management of the practice. These solutions save time, allow for tracking of individual accounts, and broad management of the practice income and expenses.18

The second major function of an accounting service is the management of both practice and individual tax. State practitioners are used to the ‘pay as you earn’ (PAYE) mechanism of tax payment. This is convenient as tax is deducted on a month-to-month basis by the employer and paid to the South African Revenue Service (SARS). However, when opening a private practice all income is received by the practice and a calculation must be made on when and how much taxes to pay. This is a complex process that is based on many factors, including; registration of business, projected earnings, tax deductible expenses, etc. Tax is both a legal issue where one is obliged to correctly calculate one’s obligation but also a business issue where insightful ‘tax optimisation’ strategies can significantly reduce one’s obligations legally.18 This is again a complex issue that requires expert knowledge to maximise the benefit to the practice.

Finally, an accounting service will be able to prepare or audit annual financial statements, prepare and file tax returns and, as a practice becomes more financially successful, assist with managing financial investments to maximise profitability.18 For this multitude of reasons it is highly advisable to seek assistance from accountants or accounting firms with knowledge of medical practices.
Legal services

Where an accountant manages the financial wellbeing of a company, an attorney manages legal issues involved with starting and managing a company. While there are several reasons a company may require legal assistance, the two main aspects for medical practices are drawing up various legal contracts and debt collection.

Private medical practices may have many instances where they enter into agreements or contracts with other parties. For example, SASA recommends signing a contract between the anaesthetic provider and the person responsible for settling the account and they specifically advise getting legal assistance when designing this contract\textsuperscript{13}. This is discussed further below. In addition to contracts with patients, as a practice grows, auxiliary staff will be hired to assist with practice management, and this requires employment contracts. A practice may be involved in the purchase of assets or property and this involves contracts or conveyance documents. As a practice grows and employs more specialists, contracts regarding shareholding and business ownership are required\textsuperscript{19}. These are all complex issues requiring outsourcing of legal assistance.

Debt collection is a difficult aspect of private medical practice. Medicine is a grudge expense and poor public understanding of medical aids obligations and their own financial obligations compound this. Where an accounting firm may keep track of outstanding accounts, debt collection ultimately becomes a legal issue where letters of demand and even litigation may be required\textsuperscript{19}.

Litigation for medical malpractice is another area where legal services may be required, however, as discussed above, it is best to obtain coverage from a malpractice insurer, as they are experts in this field.

Given the varied requirement of potential legal services, it is advisable to seek out attorneys or law firms who specialise in medical practice legal requirements.

Human resources services

A final service that may be required as a practice grows is that of human resources management. Larger practices require a number of supporting staff in addition the specialists forming the practice. The supporting staff includes administrative staff, bookkeepers or accountants and practice managers. It is vital that you, as the owner of the practice, are a compliant employer. Practically this involves employment contracts, performance reviews, and dispute resolution, etc\textsuperscript{20}. These, again, are complex issues and require input from experts to ensure they are handled correctly.
PATIENT COMMUNICATION

Patient communication is a vital component of any patient-doctor interaction. When one enters the private sector this communication must extend beyond the familiar clinical exchange to include aspects such as billing policy and contractual agreements between the patient and the specialist. SASA guidelines suggest communication is made at least 24 hours prior to elective procedures to allow time for the patient to understand their anaesthetic procedure and their financial responsibility for the service. The SASA private practice and coding guidelines 2019 suggest 4 specific areas of communication; general anaesthetic information, informed consent, billing policy and a contract between provider and patient. The guidelines give examples of each, provided below, with the suggestion that each provider tailors the documents to their specific practice.13

The exchange of information between the provider and the patient may take multiple forms but options are an information pamphlet at the surgeons office that can be given to the patient on booking an elective procedure, phone call, text message, e-mail or an informative website. Some practices use e-mail or text messages that return a read receipt when accessed by the recipient as a means to prove that reasonable effort has been made to fully inform patients, in light of above, prior to the day of surgery.

It is advisable that all such documents are prepared prior to commencing work in the private sector. SASA further advises that all of these documents are created with legal advice to ensure legal adequacy.13

General anaesthetic information

Patients who are unfamiliar with anaesthetics may have very little insight into the role of an anaesthetist. Providing a generalised explanation of our role in the perioperative setting may help to inform them and allow an understanding of the critical role of a competent anaesthetist during their surgical procedure. It is difficult to determine how much information to supply but a general approach might include a definition of anaesthesia, types of anaesthetics (e.g. general, neuroaxial, regional etc.), general risks, pre-operative guidance (e.g. fasting guidelines, current medication, etc.), post operative expectations (e.g. pain, nausea, recovery from anaesthesia effects, etc.) and guidance on how to contact the anaesthetist pre-operatively with any concerns. This information could be tailored to specific procedures or the practice preference of the provider. SASA provides an example their guidelines (see figure 1) and attaches it to the informed consent document. A further resource is the Royal College of Anaesthetists who have many examples of patient information leaflets, accessible at https://www.rcoa.ac.uk/patientinfo.21

Informed consent

Informed consent is a critical part of any treatment or procedure that a patient undergoes. The ethical principles underlying informed consent are a topic on their own but must be thoroughly understood by any practitioner involved in taking consent or developing a document to record it. The HPCSA has multiple ‘guidelines for good practice’ and booklet 4 – ‘Seeking patients’ informed consent: The ethical considerations’ was published in September 2016. This document is the best reference in the South African context.22

SASA guidelines state that informed consent must be obtained prior to any anaesthetic service provision. It further states that consent is only valid for the specific procedure consented for and may be withdrawn at any time prior to the procedure starting. It is the responsibility of the anaesthetist to discuss concerns, options, risks and possible complications for the specific procedure and factors relating to the specific patient concerned. Having completed the process
of obtaining consent, it should be documented on a consent form designed specifically for the anaesthetic procedure. As mentioned above, SASA provides an example an informed consent form combined with an information form (see figure 1)\textsuperscript{13}.

**Billing policy**

A fundamental change when working in the private sector is the need to create a bill when a service is provided. The technicalities of billing are discussed thoroughly below but a key process, prior to commencing work in the private sector, is to decide on a general billing policy. In its broadest sense this is deciding the rates you will charge for the services you provide. This is generally discussed as a rate relative to MSR (discussed above). For example you may choose to charge the base MSR, i.e. ‘100% medical aid rate’. Charging this rate will mean that medical aids are more likely to pay the entire bill and patients will not have to make co-payments. However, you may choose to charge 3 times the MSR, i.e. ‘300% medical aid rate’. This will mean you bill more for each service delivered but the medical aids will not pay the entire amount and patients will need to pay the shortfall. It is clearly important that patients understand this prior to undergoing their procedure.

The decision on what rates to charge is complex and multiple factors need to be considered. From a purely business perspective the socio-economic status of the area of practice should be examined when deciding on appropriate rates, i.e. a low income area will unlikely be able to afford higher than medical aid rates, whereas a high income area will. Similarly, the costs of running the practice (external services, office space, travel costs, etc.) need to be considered to decide what income needs to be generated to make the practice profitable\textsuperscript{13}. Such considerations are complex if one is inexperienced in the business field and consultation with professionals with such expertise is advisable.

Having decided on the general rate that your private practice will charge it is important to bill consistently based on this billing policy. The billing policy should be easily available to the patient prior to the provision of any services. It remains at the discretion of the provider to offer discounts in certain situations, for example pensioners, and it is unethical to change the quality of care based on any discount awarded\textsuperscript{13}.

SASA guidelines suggest the following are the minimum requirements of a billing policy (see figure 2)\textsuperscript{13};

1. Coding authority used to code bill
2. Method of determining professional tariffs
3. The standard tariff of the practice, ideally as compared with the MSR
4. Statement indicating that the account is the responsibility of the ‘guarantor’ and not the medical aid
5. Statement that medical aids may not pay for all codes (with a list of common examples, e.g. cosmetic surgery). The guarantor is responsible in this case.
6. A dispute resolution process with contact information for parties involved

Finally, SASA explicitly says that members should determine their standard tariff based on the criteria mentioned above and does not make any suggestion of what this tariff should be\textsuperscript{13}.
Contract

The final document suggested is a contract between the anaesthetist and the person responsible for the paying the bill. This contract may include a cost estimate for the service to be provided but it is important to understand that this is not a quote and is subject to change based on how the procedure unfolds. For example, if the procedure takes twice as long as anticipated for surgical reasons then the cost will increase.

SASA guidelines suggest the following are the minimum requirements of a contract (see figure 2)\textsuperscript{13}:

1. Patient or guarantor is ultimately responsible for payment of the account
2. All information provided is correct
3. Statement that terms of contract and billing policy have been read and understood
4. Full name, surname and signature of guarantor
5. Date and place where contract signed
6. Initial and surname of service provider
7. Consent from patient to share relevant clinical information with other healthcare providers, guarantors or medical aids
Figure 1 – SASA general information and informed consent exemplar
# BILLING POLICY

## A. Coding
1. The Practice determines the costs associated with the provision of anaesthetic services by using the coding rules as determined by the South African Society of Anaesthesiologists (SASA) and the South African Medical Association (SAMA).
2. A specific Medical Aid may not recognize the validity of any or all the codes as used by the Practice.
3. The Practice will assume that the rules and guidelines as determined by SASA and SAMA as the correct and ethical interpretation.

## B. Fee Determination
1. The Practice’s anaesthetic fee is determined by the anaesthesiologist based on training, expertise, experience and practice costs and do not relate to any medical scheme rate. (Commission of Commission ruling 2006). The rates used to determine the fee will be adjusted for each patient, irrespective of circumstance or medical aid membership as required by the Consumer Protection Act.
2. The cost of an anaesthetic is dependent on time and procedure complexity. As it is impossible to predict how long a procedure will take, this makes estimating the cost of an anaesthetic extremely difficult. The cost estimate table below is therefore based on the average time taken for a procedure and assume the procedure is of average complexity.

<table>
<thead>
<tr>
<th>Procedure Units</th>
<th>Estimated Time</th>
<th>Practice Average Anaesthetic Fee</th>
<th>Approximate “100%” scheme rate</th>
<th>100% rate shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic anaesthetic less than 30 min</td>
<td>30 min</td>
<td>R 0 000.00</td>
<td>R 1 150.00</td>
<td>-R 0 000.00</td>
</tr>
<tr>
<td>Basic anaesthetic 30 to 60 mins</td>
<td>60 min</td>
<td>R 0 000.00</td>
<td>R 1 505.00</td>
<td>-R 0 000.00</td>
</tr>
<tr>
<td>Basic anaesthetic 60 to 90 min</td>
<td>90 min</td>
<td>R 0 000.00</td>
<td>R 2 030.00</td>
<td>-R 0 000.00</td>
</tr>
<tr>
<td>Basic anaesthetic 90 min to 2 hrs</td>
<td>2 hours</td>
<td>R 0 000.00</td>
<td>R 2 265.00</td>
<td>-R 0 000.00</td>
</tr>
<tr>
<td>Every additional 15 mins (after 2 hrs)</td>
<td>per 15 min</td>
<td>R 0 000.00</td>
<td>R 270.00</td>
<td>-R 0 000.00</td>
</tr>
</tbody>
</table>

3. Cost estimates above DO NOT include additional costs for ICU, pain control techniques, ultrasound, blood pressure control, procedures performed by the anaesthetist, pandiatrics, fractures and emergency surgery or cases not booked on routine lists.
4. If the procedure takes longer than the estimated time it will increase according to the duration of the procedure.
5. If your BMI (body mass index) is greater than 35 kg/m² you will be charged an additional 50% of the anaesthetic fee. To calculate BMI = weight(kg)/height(m) x height(m)
6. Explanations of the codes on the account can be obtained from the South African Medical Association (www.sama.org.za), your medical scheme or the South African Society of Anaesthesiologists (www.sasa.org).
7. Your medical aid will reimburse you for your anaesthetic account at a rate based on the plan you have selected and the rules of your medical aid fund. This can vary from 30% of the Practice Fee (most “100%” plans) to 100% of the Practice Fee. The total amount may not be covered by your medical aid. You will be responsible for the shortfall.
8. The anaesthetist is not a designated service provider (DSP) of any medical insurance company, this pre excludes minimum benefit (PMB) conditions may not be covered by your medical insurance.

## C. Account Administration
1. The administration of an account remains the responsibility of the patient and/or guarantor.
2. In cases where a funders’s administration is substandard or payments from the funders are paid directly to the patient, the Practice will NOT submit the account to the funders but directly to the patient/guarantor.
3. The Practice may only accept payment from the patient and/or the patient’s guarantor and/or a medical funders registered as such with the Council of Medical Schemes. The Practice does not accept any direct payment from another doctor, hospital, insurance company or any other entity that acts on behalf of funders or the patient, nor handle any account administration on these accounts on behalf of the patient.

## D. Terms of Payment
1. The patient and/or guarantor and/or employer (IOO cases) remains responsible for the full amount of the account.
2. Terms of payment is strictly 30 (thirty) days after service delivery.
3. After the 30-day period has expired, the account will be handed to a lawyer for debt recovery.

## E. Medical Aid payments and Motivations
The Practice will NOT supply motivations to Medical Aids and/or Hospitals for the use of any medication and/or procedures and/or equipment that may be required during the course of the anaesthetic.
- Examples of medication and/or procedures and/or equipment where the Medical Aid may refuse payment are require motivation include (list not complete):
  - Gastroscopy/Colonoscopy/Radial/Coastic/Sterilization procedures
  - Blood (Sugar/meds)
  - Desmedetdomine (Precaud)
  - Emergency medication (noradrenaline/protamine/both oride idi/nomol/e/both(dina 1000)
  - IV/DOS (Regional oxygen saturation monitoring)
  - Use of Ultrasound (Code 8123)
  - Pain Control Device (Code: 8123)
  - Codes 001,001,001,003,002,003,004,005,004,044,046,015,078,001,052

## COST ESTIMATE
If you require a more detailed cost estimate for the procedure you may contact the practice offices or send an email to the mymailaddress.co.za.

## CONTRACT WITH THE ANAESTHESIOLOGIST
1. I understand that the anaesthetic account is separate from the hospital and surgery accounts.
2. I accept responsibility for the full amount of the anaesthetic account.
3. I understand that all EFT payments must be accompanied by the correct reference number, and that the anaesthesiologists will not be held responsible for any costs associated with payments that could not be allocated due to incorrect reference numbers.
4. I declare that the anaesthetic account will not form part of any administrative order that exists on the guarantor’s name.
5. I declare that all personal information supplied by me is true and correct. (Domicilium citatur and executandis)
6. I accept responsibility for all legal and tracing costs that may be incurred due to non-payment according to attorney and client scales.
7. I declare that, in the case that I am not the guarantor, I have the permission of the guarantor to sign this contract.
8. I declare that I have read and understood the complete contents of this document and that I accept all terms and conditions as specified under the “BILLING POLICY”.

Signed by: ________________________________
Date: ____________
Signature: ________________________________

PLEASE SEE REVERSE
UNDERSTANDING CODING

As mentioned above, understanding how to use various coding systems is a crucial part of documenting anaesthetic services provided and allows for consistent billing practices as well as facilitates communication with medical aids. It is important for any healthcare practitioner to be familiar with the coding systems relevant to their discipline. While these systems may seem complex at first, they are in fact intended to simplify the manner that both a diagnosis and treatment is reported.

South Africa uses the International Classification of Diseases and Related Health Problems (10th revision), commonly known as the ICD-10 code to record a medical diagnosis. This coding system is used in both the public and private sector. The ICD-10 code is developed by the World Health Organization (WHO) and it converts a written diagnosis, or a description of a disease, into a standard code. In the context of anaesthetic private practice, the surgeon generally supplies the ICD-10 code as they make the initial diagnosis requiring a surgical procedure. It is important to maintain consistency between disciplines when documenting this code, as medical aids may not pay an account where different codes are supplied. An example of an ICD-10 code is K35.80, which denotes ‘unspecified acute appendicitis’. ICD-10 coding manuals are easily available online and should be fully understood and easily accessible prior to commencing work in the private sector.

Where the ICD-10 coding system is used to report a diagnosis, the reporting of an anaesthetic service uses the South African Medical Association (SAMA) Medical Doctors’ Coding Manual. This is generally referred to as the electronic Medical Doctors’ Coding Manual (eMDCM) and is available for purchase from the SAMA website. SASA refers to this coding system and it is extensively explained in the SASA private practice and coding guidelines 2019. This system uses a four-digit number attached to a predetermined number of units to report various aspects of an anaesthetic service. For example, the code 0151 denotes a pre-operative risk assessment and it is assigned 16 units. For the purposes of this document, I have attempted to outline the basics of this coding system as a means of introduction. It is advisable to study the SASA guidelines and have a thorough knowledge of how this coding system works prior to commencing anaesthetic services in the private sector.

Anaesthetic coding basics

When reporting an anaesthetic service, the anaesthetist will use the eMDCM coding system to record the various aspects involved when giving an anaesthetic. These are divided into four broad categories;

1. Consultation units
2. Anaesthetic units
3. Clinical units
4. Ultrasound units

The consultation category refers to preoperative assessment of a patient. In most cases this is a simple pre-operative review shortly prior to surgery, but can be a complex anaesthetic clinic review with multiple investigations performed or reviewed. There are different codes depending on the nature and complexity of the consultation.

The anaesthetic category is the most complex of the four as it must first code for the actual procedure for which an anaesthetic is required, then any modifiers that added to the complexity of the case, and finally the anaesthetic time must be factored in. Each procedure has its own code and associated unit value with more complex procedures carrying a higher unit value. For
example, a cystoscopy may have a weighting of 3 units but an adrenalectomy for phaeochromocytoma has a weighting of 15 units. This accounts for the higher risk associated with more complex procedures\textsuperscript{13}.

Having coded for the relevant procedure, modifiers are added in as appropriate. A modifier is any aspect of the anaesthetic that adds to the complexity and risk of the anaesthetic and procedure. There are multiple modifiers coded for but broadly include anaesthetic technique, age, physical status and musculoskeletal procedures. To add to the confusion, some of these modifiers carry a unit value of their own, while others add a 50\% increase of units of anaesthetic time\textsuperscript{13}.

The final aspect of the anaesthetic category is the inclusion of anaesthetic time. This time starts when the anaesthetist prepares the patient for the anaesthetic and ends when they are no longer personally needed to manage the patient. For elective surgery, 2 anaesthetic units are added for each 15-minute interval for the first hour and then 3 units for each 15-minute interval thereafter\textsuperscript{13}.

The third broad category is the clinical category and this reflects any ‘non-standard’ procedures performed by the anaesthetist. Standard procedures include peripheral access, fluid administration, standard monitoring, routine airway management, etc. Examples of non-standard procedures are central venous access, arterial lines, nerve blocks, one lung ventilation, etc. Each of these non-standard procedures has a specific code and unit value\textsuperscript{13}.

The final category is the ultrasound category and this is simply added if an ultrasound is used to assist any procedures. Again, there are codes and unit values depending on what procedure the ultrasound was used for\textsuperscript{13}.

The simplest way to understand this system is to use an example. I have adapted this example from the SASA guidelines.

A healthy, young patient presents for open reduction and internal fixation of a forearm fracture. The procedure is booked on an elective slate. The patient is seen in the pre-op area and a decision to perform a general anaesthetic with an ultrasound guided brachial plexus block is made. The anaesthetic time is 49 minutes.

The first category to include is the uncomplicated pre-operative consultation, along with the associated code and unit value.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Pre-op risk assessment</td>
<td>0151</td>
<td>16</td>
</tr>
</tbody>
</table>

The anaesthetic category is then included which shows the procedure, the modifier and the anaesthetic time.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Pre-op risk assessment</td>
<td>0151</td>
<td>16</td>
</tr>
<tr>
<td>Anaesthetic</td>
<td>Fracture: Radius or ulna</td>
<td>0391</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal modifier</td>
<td>5441</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Anaesthetic time x 49 minutes</td>
<td>0023</td>
<td>8</td>
</tr>
</tbody>
</table>
Then the clinical category is added to include the block.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Pre-op risk assessment</td>
<td>0151</td>
<td>16</td>
</tr>
<tr>
<td>Anaesthetic</td>
<td>Fracture: Radius or ulna</td>
<td>0391</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal modifier</td>
<td>5441</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Anaesthetic time x 49 minutes</td>
<td>0023</td>
<td>8</td>
</tr>
<tr>
<td>Clinical</td>
<td>Peripheral nerve block</td>
<td>2802</td>
<td>25</td>
</tr>
</tbody>
</table>

Finally, the ultrasound category is included to show that an ultrasound-guided block was done.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Pre-op risk assessment</td>
<td>0151</td>
<td>16</td>
</tr>
<tr>
<td>Anaesthetic</td>
<td>Fracture: Radius or ulna</td>
<td>0391</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal modifier</td>
<td>5441</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Anaesthetic time x 49 minutes</td>
<td>0023</td>
<td>8</td>
</tr>
<tr>
<td>Clinical</td>
<td>Peripheral nerve block</td>
<td>2802</td>
<td>25</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Ultrasound soft tissue</td>
<td>5103</td>
<td>50</td>
</tr>
</tbody>
</table>

This example serves to illustrate how an anaesthetic is described using the eMDCM codes and the associated unit values. In this example there is a total of 16 consultation units, 12 anaesthetic units (The sum of units for procedure, modifier and time), 25 clinical units and 50 ultrasound units.

**Rand Conversion Factor (RCF)**

Having understood the method of recording the anaesthetic using the coding system, the final step is understanding how to convert the total unit values to a monetary value. This is done by applying a rand conversion factor (RCF) to each of the four broad categories described above. This means that each of the four categories is assigned a ‘per unit’ rand value that is then multiplied by the total number of units for the procedure. There are a few important concepts to understand when applying the RCF and ultimately generating an account for the procedure.

The first concept to recognise is that each of the four categories carries its own RCF. This means that the consultation category will have a specific RCF (RCF1), the anaesthetic category will have a different RCF (RCF2), the clinical category will have a third RCF (RCF3), and finally the ultrasound category will have a different RCF (RCF4).

Practically, if we examine our example from above, we can calculate the total rand value of the account by substituting the 4 RCF’s that the hypothetical practice in question is using. So, if;

- RCF1 = R66
- RCF2 = R290
- RCF3 = R38
- RCF4 = R36
Then the account generated will be as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Code</th>
<th>Units</th>
<th>RCF calculation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>Pre-op risk assessment</td>
<td>0151</td>
<td>16</td>
<td>16 x R66 (RCF1)</td>
<td>R1056</td>
</tr>
<tr>
<td>Anaesthetic</td>
<td>Fracture: Radius or ulna</td>
<td>0391</td>
<td>3</td>
<td>3 x R290 (RCF2)</td>
<td>R870</td>
</tr>
<tr>
<td></td>
<td>Musculoskeletal modifier</td>
<td>5441</td>
<td>1</td>
<td>1 x R290 (RCF2)</td>
<td>R290</td>
</tr>
<tr>
<td></td>
<td>Anaesthetic time x 49 minutes</td>
<td>0023</td>
<td>8</td>
<td>8 x R290 (RCF2)</td>
<td>R2320</td>
</tr>
<tr>
<td>Clinical</td>
<td>Peripheral nerve block</td>
<td>2802</td>
<td>25</td>
<td>25 x R38 (RCF3)</td>
<td>R950</td>
</tr>
<tr>
<td>Ultrasound</td>
<td>Ultrasound soft tissue</td>
<td>5103</td>
<td>50</td>
<td>50 x R36 (RCF4)</td>
<td>R1800</td>
</tr>
<tr>
<td><strong>Total fee:</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>R7286</strong></td>
<td></td>
</tr>
</tbody>
</table>

The second important concept is to understand how one decides on the actual rand values to assign to each of the 4 RCF’s described above. This requires knowledge of the general MSR that the medical aids applies to each of these categories. As discussed above, there is no defined ‘medical aid rate’ and each of the medical aids determine their own rates, similarly, each medical aid will determine their own RCF’s and apply them to any anaesthetic bill. It is important to note that the eMDCM code and unit value is consistent between the practitioner and all medical schemes and thus it is the RCF that determines whether the MSR is charged, or by what factor the practitioner is charging relative to the MSR.

To utilise our example again, if a medical scheme has quoted their RCF’s as:

- RCF1 = R33
- RCF2 = R145
- RCF3 = R19
- RCF4 = R18

Then the account total in our example will be calculated as R3643. This is because each of the medical scheme RCF’s is 50% that of the hypothetical practice. In this example the practice should report its billing practice as 200% of the MSR.
CONCLUSION

Opening a private practice is both a daunting and exciting prospect for many anaesthetists. Unfortunately, while we may be experts in medicine, we often have very little exposure to the complexities of opening and managing a business. In addition to issues around general business management, there are also important issues to consider specific to the practice of private medicine in South Africa.

The objective of this booklet and presentation is to shed some light on the many factors that an anaesthetist should consider before embarking on a move from the public to private sector. While it is impossible to pre-empt every potential challenge, the aim has been to provide practical, broad advice. Private practice medicine offers the prospect of an entirely new education and challenge and remains a viable career path for anaesthetic specialists in South Africa.
APPENDIX

1. HPCSA Form 19 (application for registration of an additional qualification)
2. HPCSA Form 21 (application for registration as specialist/subspecialist)
3. HPCSA Form 57 (certificate relating to training in specialties including completion of research component)
**APPLICATION FOR REGISTRATION OF AN ADDITIONAL QUALIFICATION**

**IN MEDICINE, MEDICAL SCIENCE, DENTISTRY, DENTAL THERAPY, ORAL HYGIENE OR EMERGENCY CARE**

**Form 19**

*NB: AN INCOMPLETE FORM WILL DELAY REGISTRATION*

Please PRINT and return the ORIGINAL FORM to: The Registrar, PO Box 205, Pretoria 0001
553 Madiba Street, Arcadia, Pretoria 0083

<table>
<thead>
<tr>
<th><strong>A. PERSONAL PARTICULARS</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HPCSA Registration Number:</td>
<td></td>
</tr>
<tr>
<td>I, (Dr, Mr, Mrs, Miss)</td>
<td>Surname:</td>
</tr>
<tr>
<td>Maiden name (if applicable):</td>
<td>Identity No.:</td>
</tr>
<tr>
<td>First names:</td>
<td></td>
</tr>
<tr>
<td>Postal address:</td>
<td></td>
</tr>
<tr>
<td>Residential address:</td>
<td></td>
</tr>
<tr>
<td>Tel (H):</td>
<td></td>
</tr>
<tr>
<td>Cell:</td>
<td>Fax:</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

*Marital Status: Divorced Married Single Gender: Male Female*

*Race: Asian African Coloured White Country of origin:*

*VERIFIED DATE CAPTURED DATE VERIFIED DATE*

hereby apply to register the additional qualification and declare that I am the person referred to in the attached certificate or qualification referred to below.

I also declare that I have never been convicted of any criminal offence or been debarred from practice by reason of unprofessional conduct in any country and that, to the best of my knowledge and belief, no proceedings involving or likely to involve a charge of offence or misconduct is pending against me in any country at present.

**SIGNATURE:** ___________________________ Date: ____________

**B. THE FOLLOWING IS SUBMITTED IN SUPPORT OF MY APPLICATION:**

1. Registration fee of R216.00. A copy of the proof of payment must be attached to the application.
2. A certified copy of my identity document or birth certificate.
3. A copy of my marriage certificate (should you wish to register in your married surname).
4. My original degree/diploma certificate (a copy will only be accepted if certified by an attorney in his/her capacity as Notary Public and bearing the official stamp.) Copies certified by a Commissioner of Oaths will not be accepted.

**OR**

5. Section C duly completed.

**C. TO BE COMPLETED BY THE UNIVERSITY/UNIVERSITY OF TECHNOLOGY/COLLEGE**

*NB: ALTERATIONS TO THIS SECTION WILL NOT BE ACCEPTED*

Name of University/University of Technology/College: ____________________________

It is hereby certified that ____________________________ complied with all the requirements for the Degree/Diploma/Certificate ____________________________ of this institution on ________ (day) ________ (month) ________ (year) and that this qualification will be conferred/issued at a graduation ceremony on ________ (day) ________ (month) ________ (year).

I consider him/her to be a competent and fit person to practice as a ____________________________

**WE RECOMMEND him/her for registration**

**SIGNATURE: RECTOR/DEAN/OPERATIONAL HEAD**

**SIGNATURE: REGISTRAR/PRINCIPAL**

**ORIGINAL OFFICIAL DATE STAMP OF INSTITUTION**

*Please complete for statistical purposes.*

**NB: Please note that the Council, in the normal course of its duties, reserves the right to divulge information in your personal file to other parties.**

GA/01/2014
**APPLICATION FOR REGISTRATION**

**SPECIALIST/SUB-SPECIALIST**

Form 21

**NON-COMPLIANT APPLICATION WILL BE REJECTED AND SENT BACK TO YOU**

Please PRINT and return the ORIGINAL FORM to:

The Registrar, PO Box 205, Pretoria 0001 by registered mail for ease of tracking mail

533 Madiba Street, Arcadia, Pretoria 0083

1. The application form must be completed IN DETAIL and CORRECTLY. Information regarding experience must be provided in CHRONOLOGICAL order.
   - For registration as a **specialist**, in the case of dentists information since qualifying as a dentist/for medical practitioners since commencement with internship.
   - For registration as a **sub-specialist**, information since registration as a specialist.

2. Attach documentary evidence in respect of **experience** and **posts** held and provide the **exact** post held and time spent in each post (beginning and end dates must be clearly indicated).

3. Additional information pertaining to your application, to which you wish to draw attention, should be provided in a separate document.

4. In order to register as a specialist, you will have to register an acceptable specialist qualification as an additional qualification against your name. (Form 19 duly completed as well as additional qualification registration fee of R319.00)

5. Only duly completed applications, which include the registration fee of R4229.00 and the fee for registration of the additional qualification, if applicable.

* Please complete for statistical purposes.

**NB:** Please note that the Council, in the normal course of its duties, reserves the right to divulge information in your personal file to other parties.

**PERSONAL PARTICULARS**

HPCSA Registration Number: .......................................................... .......................................................... ..........................................................

Surname: .......................................................................................................................... ..........................................................

First names: .......................................................................................................................... ..........................................................

Identity Number: .................................................................................................................. ..........................................................

Postal address: .......................................................................................................................... ..........................................................

.......................................................................................................................... Postal code: ..........................................................

Tel (H): .......................................................................................................................... (W): ..........................................................

Cell: .......................................................................................................................... Fax: ..........................................................

Email: ..........................................................................................................................

*Marital Status: [ ] Divorced [ ] Married [ ] Single [ ] *Gender: [ ] Male [ ] Female


I declare that I have never been convicted of any criminal offence or been debarred from practice by reason of unprofessional conduct in any country and that, to the best of my knowledge and belief, no proceedings involving or likely to involve a charge of offence or misconduct is pending against me in any country at present.

**SIGNATURE:** .......................................................... Date: .......................................................... 20

**NAME OF SPECIALITY/SUB-SPECIALITY FOR REGISTRATION IN REGISTER:**

**QUALIFICATIONS ALREADY REGISTERED WITH THE BOARD:**

**ANY OTHER MEDICAL/DENTAL QUALIFICATIONS HELD:**

**PLEASE INDICATE REGISTRATION WITH OTHER MEDICAL/DENTAL COUNCIL:**

Date of registration: .......................................................... and registration status: ..........................................................

SEE PAGE 2 FOR EXPERIENCE IN CHRONOLOGICAL ORDER (See 1. above).

**NB:** Please note that the Council, in the normal course of its duties, reserves the right to divulge information in your personal file to other parties.

Updated/April 2018
**NAME OF PRACTITIONER:** ………………………………………………………… **ETHICS CLEARANCE NUMBER** ……………………………………. (Attach a copy of ethics clearance certificate)

**COMPLETION OF REGISTRAR TRAINING TIME AND RESEARCH COMPONENT (THESIS / DISSERTATION / RESEARCH ASSIGNMENT)**

<table>
<thead>
<tr>
<th>Post held as Registrar</th>
<th>Board approved registrar post number</th>
<th>Academic Department</th>
<th>Period spent in each Academic Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Certified correct we, the undersigned, declare that post(s) listed against ……………………………………. are accredited registrar post(s). The performance and progress of the said Registrar was satisfactory / unsatisfactory. (If unsatisfactory, please state reasons in separate submission.)

We the undersigned certify that the candidate has submitted a research component that complies with the HPCSA requirements and this has been signed off by the research supervisor(s). This research component has not contributed towards obtaining any other degree, including, but not limited to another MMed or MPhil degree.

Signed: ………………………………………………... Signed: ………………………………………………... Signed: ………………………………………………...

**Head of Academic Department**

**Supervisor of research project**

**Medical Superintendent of teaching/satellite hospital/department/facility**

**Dean: Faculty/School of Medicine/Health Sciences of University**

Date: ……………………………………………... Date: ……………………………………………... Date: ……………………………………………...
REFERENCES

2. https://www.hpcsa.co.za/About
3. https://www.hpcsa.co.za/CPD
5. https://www.hpcsa.co.za/registrations/ApplicationForms
7. https://pcns.bhfglobal.com
11. https://www.sasaweb.com/ContentDetails/ContentDetails/?ContentId=10&SubMenuType=1
17. http://www.medicalschemes.com/medical_schemes_pmb/designated_service_providers.htm
21. https://www.rcoa.ac.uk/patientinfo
23. https://www.samedical.org/products/readMore/1