SADA

The South African Dental Association (SADA) NPC

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MANAGED CARE CONTRACTS

What to Consider

Updated September 2026

THE MANAGED-CARE CONTRACT LIFECYCLE



Ongoing amendments / renewed cycles — each change agreed in writing

DISCLAIMER

This guide is intended to help dental practitioners to engage with managed-care contracts commercially and professionally. It is provided for general information and guidance only. It is not intended to constitute legal advice and should not be relied upon as a substitute for obtaining independent legal advice. Dental practitioners should seek professional legal advice regarding the interpretation, application, or implications of any specific managed-care contract or contractual terms.

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1. Introduction

SADA receives regular enquiries from members about managed-care contracts offered by medical schemes and managed care organisations (MCOs). Some practitioners prefer not to participate in third-party funding arrangements, while others consider network participation commercially important because of their patient base.

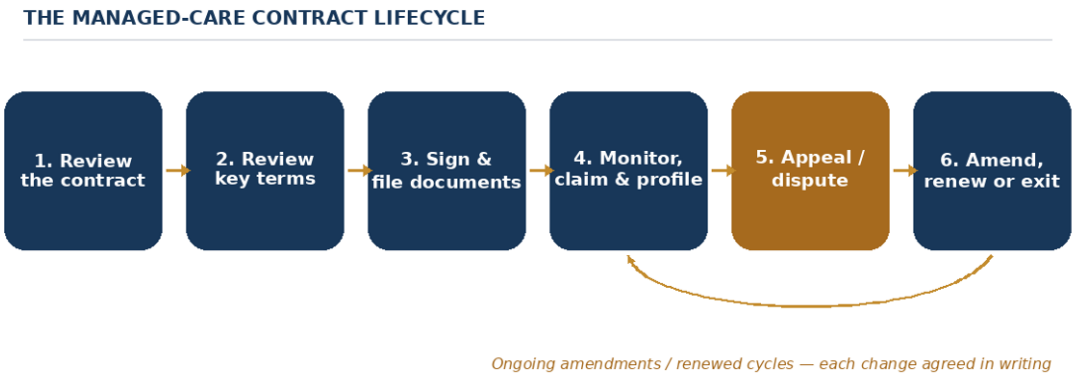
There is no single answer appropriate for every contract. The commercial value, obligations, restrictions, reimbursement levels, administrative burden and exit rights must be assessed against the wording of each particular contract. At the same time, individual practitioners may have limited bargaining power when faced with standardised or non-negotiable network arrangements. Recurring concerns affecting practitioners collectively may therefore require engagement at an industry or regulatory level rather than being treated solely as individual contractual issues.

> *A practitioner should not assume that a contract signed several years ago has expired. Many agreements continue until formally terminated and may incorporate later amendments, tariffs, protocols or manuals.*

This guide therefore addresses not only whether a dentist should sign, but also what a dentist can do after signing: review the agreement, protect professional independence, maximise legitimate reimbursement, challenge inappropriate decisions and exercise contractual termination rights.

While managed-care arrangements can provide important access to patients and predictable funding arrangements, SADA recognises that practitioners may face challenges wherein contractual requirements, reimbursement arrangements, administrative burdens or utilisation-management processes place disproportionate pressure on individual practices. SADA's approach is therefore to support participation in managed care where it operates fairly and transparently, while advocating for arrangements that respect professional independence, support appropriate patient care and are commercially sustainable for dental practices.

This guide is intended for dental practitioners and practices, including practice owners, associates and practitioners working within group or corporate practice structures, recognising that contractual responsibilities and professional accountability may differ depending on the practice structure.



2. What is managed care?

Managed health care is a system of clinical and financial risk assessment and management intended to facilitate appropriate and cost-effective health services within affordability through rules-based and clinical programmes.

Managed care may involve utilisation review, clinical protocols, formularies, pre-authorisation, preferred-provider or designated-provider networks, reimbursement arrangements, profiling, case management and other mechanisms that influence how benefits are funded.

Managed care may be performed by a medical scheme itself or through an accredited MCO. Chapter 5 of the Regulations made under the Medical Schemes Act regulates managed health care arrangements, including the prerequisites for managed-care arrangements, accreditation of managed-care organisations, standards for managed health care, provider arrangements, capitation and related requirements.

3. Do I have to sign a managed-care contract?

There is no general obligation requiring a dental practitioner to sign any network, preferred-provider contract, offered by a scheme or MCO. A practitioner may decide not to participate, subject to any existing contractual obligations already undertaken.

Before declining or accepting participation, consider the effect on patient volumes, referral patterns, practice profitability, administrative workload and the practice's ability to replace the relevant revenue.

When assessing participation in a network, practitioners should also consider the broader effect of the arrangement on patient access and continuity of care, including where relevant the position of rural or underserved communities, the viability of smaller practices and the ability of younger or newly established practitioners to participate sustainably. These considerations do not determine whether a practitioner should accept a particular contract but may be relevant when assessing the wider impact of network design and managed-care arrangements on the profession and patients.

> *Do not assume that refusing a new contract allows you to ignore an existing contract. First establish whether an existing agreement remains in force and what its termination provisions require.*

SADA's position on fair managed-care arrangements

SADA supports managed-care arrangements that are transparent, fairly contracted and consistent with applicable legal, ethical and professional requirements. In particular, practitioners should be able to understand the following:

- the services and products to which the agreement applies;
- the applicable reimbursement and how it may be changed;
- authorisation and utilisation-management requirements; audit, recovery and dispute processes;
- the circumstances in which participation may be suspended or terminated; and
- the practitioner's ability to exercise independent clinical judgement.

Where contractual arrangements create significant uncertainty, disproportionate administrative or financial burdens, or interfere with professional independence, practitioners should consider raising these concerns with the scheme or MCO and, where appropriate, seek advice or assistance from SADA.

4. Minimum fair-contracting principles

SADA supports transparent, fair, clinically appropriate and commercially sustainable managed-care arrangements. The following are the minimum principles for fair contracting:

1. Clinical independence — the arrangement should respect the practitioner's professional independence and clinical judgement.
2. Transparent reimbursement — tariffs, reimbursement methodologies and any conditions affecting payment should be clear and accessible.
3. Reasonable notice — practitioners should receive reasonable notice of material changes to tariffs, administrative requirements or other contractual terms.
4. Clear authorisation requirements — pre-authorisation and utilisation-management requirements, including applicable response times and review processes, should be clearly stated.
5. Proportionate audits — audit, investigation and recovery processes should be appropriately defined, proportionate and subject to fair procedural safeguards.
6. Fair appeal rights — practitioners should have a meaningful opportunity to challenge disputed funding, claims, profiling or audit decisions.
7. Data minimisation — requests for patient or practice information should be limited to information that is lawfully required and reasonably necessary for the stated purpose.
8. Clear termination and exit rights — the contract should clearly state how participation may be terminated, the applicable notice requirements and the treatment of outstanding claims and obligations after termination.
9. Clear dispute mechanisms — disputes should have defined escalation routes, responsible decision-makers and reasonable timeframes.
10. Written contractual certainty — material amendments and variations should be capable of being identified, recorded and retained with the contractual documentation.

Where contractual arrangements create significant uncertainty, disproportionate administrative or financial burdens, or concerns regarding professional independence, practitioners should consider raising these concerns with the scheme or MCO and, where appropriate, seek advice or assistance from SADA.

5. Professional independence and clinical judgement

Managed-care contracts can impose contractual obligations concerning funding, tariffs, authorisation, documentation and utilisation management, but they do not give a scheme or MCO an unrestricted right to dictate a dental practitioner’s clinical judgement.

The HPCSA's current Business Practice Policy states that practitioners may participate in managed-care models provided they do not violate applicable law or ethical rules, must act in patients' best interests, and must maintain professional independence. It also states that practitioners should not enter contracts that affect their clinical independence or judgement.

Clinical protocols and review criteria used in managed care should be scientifically developed. Where a dentist's treatment recommendation differs from what the scheme or MCO is willing to fund, the dentist should explain the clinically appropriate options to the patient in writing so that the patient can make an informed decision.

A funding decision is not necessarily the same as a clinical decision. A scheme or MCO may assess whether a service qualifies for funding under the scheme rules, protocol or contract. That does not automatically entitle it to direct the dental practitioner to provide clinically inappropriate treatment.

> *The responsibility for determining the clinically appropriate treatment for a patient rests with the dental practitioner. Where the treatment authorised or funded by an MCO does not, in the practitioner's professional clinical judgment, adequately meet the patient's clinical needs, the practitioner should inform the patient of the available treatment options and the implications of the funding limitation. The practitioner should not provide treatment that is clinically inappropriate or that does not meet the patient's clinical needs merely because it is the treatment funded by the MCO.*

6. Before signing — complete contract review

Obtain and review the complete contractual package, including:

- the provider agreement and all schedules and annexures;
- the current fee/tariff schedule and annual tariff methodology;
- clinical protocols, utilisation criteria, formularies and pre-authorisation rules;
- billing and coding requirements;
- network/DSP/product lists;
- profiling and audit policies;
- fraud, waste and abuse (FWA) policies and investigation procedures;
- payment, clawback, deduction and set-off provisions;
- amendment and unilateral-change provisions;
- termination, renewal and notice provisions; and
- dispute-resolution and appeal procedures.
- Other rules such as minimum standard hours of operation by the practice.

> *If a document is incorporated by reference, obtain and retain a copy with the contract. Record the applicable version/date. Do not rely solely on a website version without establishing which version formed part of the agreement.*

7. Tariffs, profitability and product selection

Do not assess a contract by looking only at the nominal tariff. Calculate the total cost of participation, including staff time, authorisation administration, rejected claims, coding requirements, audits, reporting, consumables, payment delays and the opportunity cost of chair time.

Use a practice profitability simulator, such as the SADA DCalc™, to determine whether reimbursement produces an acceptable margin and return on investment. High patient volume at inadequate reimbursement can reduce rather than increase profitability.

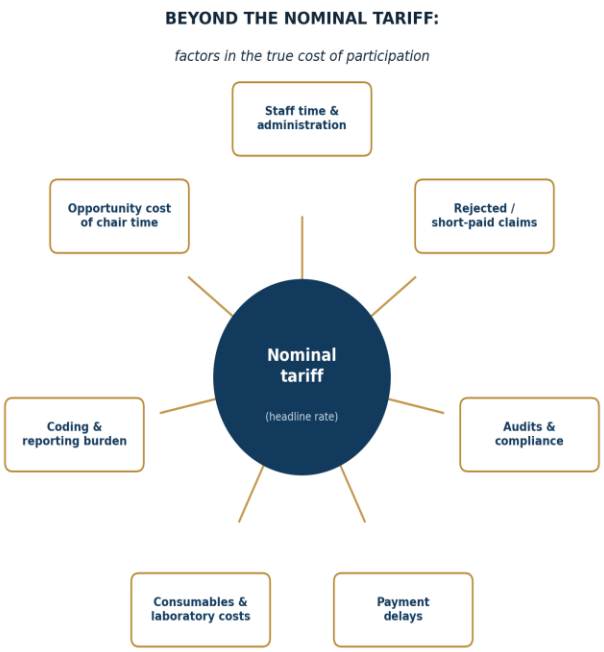


Figure 2 — the headline tariff is only the starting point; each surrounding factor can materially reduce real margin.

Determine whether different products have different reimbursement levels and whether the contract permits product-by-product participation.

> *Before signing, also determine whether the contract prohibits co-payments, balance billing or direct patient billing. Never assume that a service may be billed to the patient merely because the scheme does not fund it; the contract and applicable law/rules must be checked.*

8. How to exit or terminate a contract

Does a dental practitioner have a legal right to terminate a managed-care contract with a medical scheme or managed-care organisation, and what notice and other requirements apply to that termination under the Medical Schemes Act and its Regulations? The answer depends on the specific agreement. Review:

- termination without cause and required notice period;
- termination for breach and a reasonable opportunity to remedy such breach;
- termination following tariff changes;
- termination of one product versus all products;
- automatic renewal provisions;
- clear notice periods and how notice must be given;

- post-termination obligations;
- claims submitted before termination;
- clawbacks or deductions after termination;
- confidentiality and records obligations; and
- any restrictions on re-entry into the network.

> *Do not simply stop accepting patients, stop submitting claims or begin charging outside the contract without first checking the agreement. That could itself amount to breach.*

If an MCO proposes termination or materially restricts participation, ask for the contractual and factual basis in writing and use the applicable appeal or dispute mechanism. Where the issue has material financial or professional consequences, obtain legal advice before signing an acknowledgement, admission, settlement or amendment.

For managed-care agreements contemplated by Regulation 15A, Regulation 15J generally requires at least 90 days' notice of termination, subject to specified exceptions. In addition, Regulation 15E provides protection against termination merely because a participating provider disagrees with a decision to deny or limit benefits or assists a beneficiary in seeking reconsideration of such a decision.

While Regulation 15J provides for a 90-day notice period, practices should also check the specific managed-care agreement they have signed with the relevant medical scheme or managed-care organisation. In practice, contractual termination provisions may provide for shorter notice periods in certain circumstances, and agreements may also allow for immediate termination where specified circumstances or breaches arise. The terms of the particular agreement should therefore be checked rather than relying on the 90-day period alone.

9. Tariff changes

Never assume that a new tariff is automatically accepted simply because it appears in a circular or on a website. Check the contract.

- effective date of the new tariff;
- required notice period;
- whether acceptance is deemed if no objection is made;
- whether the practitioner may terminate if the new tariff is unacceptable;
- whether different products have different tariffs; and
- whether the MCO may change tariffs unilaterally.

> *Calendar the notice deadline. Missing a contractual deadline may result in continued participation on the revised tariff.*

10. Contract amendments — agreed in writing

Amendment provisions deserve the same scrutiny as tariff clauses and are closely related to them. Any amendment to the agreement should be assessed against the contract's amendment and variation provisions. Where the contract requires mutual written agreement, the amendment should be formally agreed and recorded in writing. Where the contract permits unilateral amendments or deemed acceptance following notice, the practitioner should assess

whether the contractual procedure and notice requirements have been complied with and whether any right to object or terminate exists.

A dental practitioner should not treat an email circular, a website notice, a manual update or any other unilateral communication as a binding variation of the contract, unless the contract's own amendment clause expressly permits that method and the practitioner has not exercised any available right to object or terminate within the stipulated period.

Before accepting a proposed amendment, confirm the following:

- how the proposed change is communicated, and by whom it must be approved;
- whether the practitioner's affirmative written agreement is required, or whether the contract allows continued participation to be treated as deemed acceptance;
- the effective date of the proposed change and the notice period given;
- whether the practitioner retains a right to reject the amendment and terminate the contract (or the affected product) instead; and
- whether the amendment is signed, countersigned, or otherwise formally recorded by both parties.

> *As a matter of practice, keep a signed or otherwise clearly documented copy of every amendment together with the original contract, and treat verbal or informal assurances about changed terms as provisional until confirmed in writing by both parties.*

11. Pre-authorisation and utilisation management

Managed-care programmes may use pre-authorisation and utilisation review to determine whether services qualify for funding. These processes should operate according to scientifically developed protocols and clinical review criteria.

The dental practitioner should distinguish between the clinical decision about what treatment the patient requires and the funding decision about what the scheme is obliged to pay under its rules, benefits and managed-care programme.

The HPCSA Business Practices Policy provides that pre-authorisation procedures should be conducted according to scientifically developed protocols and should include peer-to-peer communication before any denial of benefits. It further provides that an appeals process should be available to providers who disagree with a medical scheme or managed-care organisation’s decision.

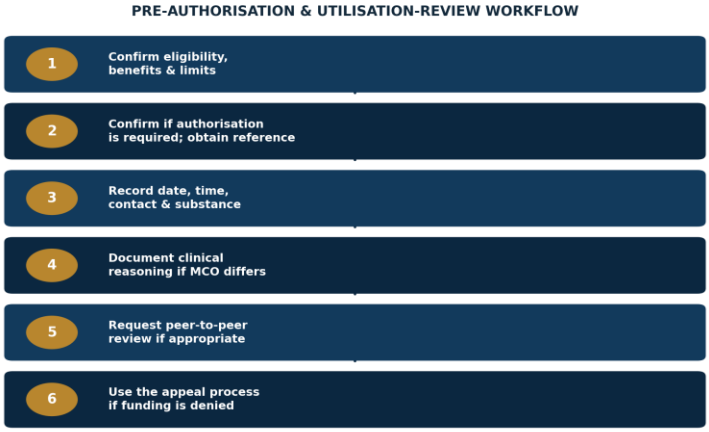


Figure 3 — recommended pre-authorisation and utilisation-review workflow.

12. Legitimately maximising claims and payments

The objective should be to ensure that the practice receives all reimbursement properly due under the applicable contract, scheme rules and tariff. Claims must reflect services actually rendered and clinically justified.

- use the correct procedure and diagnostic codes;
- ensure the clinical record supports the service billed;
- obtain and retain authorisation/reference numbers;
- submit complete claims promptly;
- check provider, practice, member and dependant details;
- reconcile remittance advice against the original claim;
- identify rejected, short-paid, reversed and unpaid claims systematically;
- request the specific contractual, scheme-rule or protocol basis for a rejection;
- correct administrative errors and resubmit where appropriate;
- use peer-to-peer review for clinically disputed decisions;
- use the contractual appeal/dispute process within the deadline;
- keep a record of unpaid claims and follow up on outstanding payments.;
- monitor tariff and product changes;
- keep evidence of written authorisations and communications; and
- review recurring rejection patterns to identify training or billing-system problems.

> *A dentist should not sign an acknowledgement of debt, settlement, admission of liability or repayment agreement simply to close an audit or FWA matter without understanding the legal and financial consequences.*

13. Claims, payment and rejections

The managed-care accreditation framework contains requirements relating to claims processes, valid claims, reasons for rejected or unacceptable claims and payment administration. The Medical Schemes Regulations also contain rules concerning claims and notification of erroneous or unacceptable accounts.

Where a claim is rejected or short-paid, ask for the precise reason and the rule, tariff, protocol or contract provision relied upon. Do not accept a generic response if the underlying provision can be identified.

Keep a complete audit trail: claim number, submission date, amount claimed, amount paid, reason for rejection/short payment, authorisation, correspondence, appeal date and outcome.

14. Appeals and disputes

The managed-care framework contemplates appeal mechanisms for utilisation-review decisions. The HPCSA policy also supports an appeals process for providers who disagree with scheme/MCO decisions.

Use the internal appeal process where required but diarise every deadline.

The practitioner may escalate the matter to the Council for Medical Schemes (CMS) where the nature of the dispute falls within the CMS's jurisdiction; otherwise, the practitioner should follow the dispute-resolution mechanism contained in the provider agreement. Distinguish between a contractual dispute with an MCO, a benefit dispute affecting a scheme member and conduct that may warrant regulatory intervention.

> *For every dispute, prepare an evidence pack containing the contract, applicable tariff, claim details, authorisation, clinical motivation where relevant, remittance advice and correspondence. Ensure all patient information is redacted.*

15. Profiling

Profiling can be used to monitor provider utilisation and patterns. The HPCSA policy states that profiling is acceptable if transparent and scientific and that practitioners should be able to query their personal profiles and understand the criteria used.

- request the profile/data on which an adverse conclusion is based;
- request the methodology or criteria used;
- identify inaccurate data and request correction;
- provide legitimate case-mix explanations; and
- request peer review where appropriate.

16. Audits, FWA investigations and clawbacks

Contracts commonly permit audits and recovery of amounts said to have been incorrectly paid. These provisions should be read carefully.

1. Ask for the scope of the investigation and claims under review.
2. Ask which contractual, scheme-rule, coding or clinical requirement is allegedly not satisfied.
3. Preserve all relevant records and correspondence.
4. Do not alter or recreate clinical records retrospectively.
5. Provide a factual response supported by the contemporaneous record.
6. Challenge incorrect factual assumptions or inappropriate comparisons.
7. Check whether deductions, set-off or clawbacks are contractually permitted and whether the required procedure was followed.
8. Check whether the clawback is still legally enforceable, as claims may prescribe after a certain period. If the clawback is older than the applicable prescription period, this should be raised and challenged. The Prescription Act 68 of 1969 generally provides a three-year prescription period for debts, subject to the applicable provisions and circumstances.
9. Do not sign an acknowledgement of debt or admission merely because it is presented as an administrative form.

An audit right should be exercised within the scope and procedure permitted by the agreement and applicable law; a contractual audit clause should not be treated as an unlimited entitlement to access all practice or patient information.

> *Where potential liability is material, obtain independent legal advice before making admissions or agreeing repayment terms.*

17. Confidentiality, records and patient information

Patient information remains confidential. Third-party access must comply with applicable confidentiality, consent and data-protection requirements.

Patient consent is not necessarily required for every request from a medical scheme or managed-care organisation, provided that the disclosure has a lawful basis and is limited to the information reasonably necessary for the specific purpose. Practitioners should not disclose more patient information than is necessary for that purpose and should obtain the patient's consent where required by law or where there is no other lawful basis for the disclosure.

For example, a practice may provide information reasonably required for claims, pre-authorisation or clinical review, such as treatment codes, diagnosis, relevant clinical notes or radiographs. It should not automatically provide the patient's entire clinical file if the information requested is sufficient for the purpose.

Where there is no applicable lawful basis for the disclosure, the patient's consent should be obtained. If unsure, the practice should ask the scheme to specify the purpose and basis for its request before releasing the information.

18. Designated service providers and PMBs

Dentists may be offered contracts that appoint them as designated service providers for Prescribed Minimum Benefits (PMBs). These arrangements should be assessed separately from ordinary network participation.

PMB funding is governed by the Medical Schemes Act, Regulations and the registered rules of the particular scheme. Schemes may use protocols, formularies and pre-authorisation mechanisms within the statutory framework.

Dentists may be offered contracts appointing them as Designated Service Providers (DSPs) for Prescribed Minimum Benefits (PMBs). These arrangements should be assessed separately from ordinary network participation.

A PMB diagnosis does not mean that every treatment, procedure or code associated with that diagnosis automatically becomes a PMB benefit. PMB legislation provides for a minimum level of care for specified diagnosis-and-treatment pairs (DTPs). The treatment must be clinically appropriate for the particular PMB condition and fall within the applicable PMB level of care.

In determining the PMB level of care, practitioners should consider:

- the applicable Diagnosis and Treatment Pair (DTP) in the Medical Schemes Act Regulations;
- any applicable CMS treatment protocols, formularies or benefit definitions;
- whether the proposed treatment is clinically appropriate for the patient's condition;
- the level of care and treatment ordinarily available in the public sector, where this is relevant to determining the PMB level of care; and
- the scheme's applicable rules and managed-care requirements, including pre-authorisation where applicable.

The existence of a PMB diagnosis therefore does not give a practitioner unrestricted discretion to code or charge treatment as PMB. A practitioner should not assume that because a condition is a PMB, every treatment that could potentially be used to treat that condition must be funded as a PMB.

Where a practitioner believes that the applicable PMB protocol or minimum treatment option is clinically inappropriate for a particular patient, the practitioner should document the clinical reasons and use the applicable exception, motivation, peer-review or appeal process. The practitioner should also ensure that the appropriate PMB ICD-10 code is recorded on the claim, where applicable, to assist in identifying the condition as a Prescribed Minimum Benefit (PMB) claim and facilitate its correct processing by the medical scheme. CMS guidance recognises that an evidence-based alternative may be appropriate in exceptional circumstances, including where the stipulated protocol is ineffective or presents a risk of an adverse event.

19. Capitation and risk-sharing

Capitation involves a fixed pre-negotiated payment for specified benefits and transfers a defined degree of financial risk. It differs fundamentally from ordinary fee-for-service reimbursement.

Before entering a capitation arrangement, determine:

- services included;
- patients covered;
- duration;
- financial risk transferred;
- assumptions underlying the capitation rate;
- treatment of high-cost and exceptional cases;
- quality and utilisation measures;
- risk of under-servicing;
- audit/reporting requirements; and
- termination or renegotiation rights.

20. Choice of products and networks

Some MCOs require participation in all products offered to a scheme's members. Others permit product-by-product participation.

Ask whether you may select individual plans/products, whether new products are automatically added, whether new tariffs apply automatically, whether future products can be declined without terminating existing participation, and whether termination of one product terminates all products.

21. Dispute-resolution clauses

A dispute clause should provide a practical route to resolution rather than an indefinite series of internal escalations. Determine:

- who receives the dispute;
- response timeframes;

- who conducts peer review;
- whether the decision-maker is independent;
- whether urgent disputes can be escalated;
- mediation/arbitration requirements;
- allocation of legal/arbitration costs;
- governing law and jurisdiction; and
- whether contractual remedies remain available after internal processes.

23. Practice checklist — before signing

Complete contract and annexures obtained.	☐	Amendment/unilateral-change provisions understood.	☐
Incorporated documents obtained and version-dated.	☐	Amendment/variation mechanism understood, including whether amendments require mutual written agreement, notice and/or deemed acceptance.	☐
Tariffs for every participating product understood.	☐	Termination and renewal provisions understood.	☐
Cost and expected margin calculated.	☐	Important notice dates diarised.	☐
Pre-authorisation requirements understood.	☐	Product-by-product termination rights checked.	☐
Appeals and peer-review procedures understood.	☐	Patient/practice impact considered.	☐
Audit, FWA, clawback and deduction provisions understood.	☐	Professional independence protected.	☐
Profiling methodology and challenge process understood.	☐	Legal advice obtained on material or unusual risks.	☐

24. Practice checklist — rejected or short-paid claim

Obtain remittance advice.	☐	Request clarification if unclear.	☐
Identify exact rejection/short-payment reason.	☐	Correct administrative errors and resubmit where appropriate.	☐

Check contract and tariff.	☐	Request peer-to-peer review for clinical disputes.	☐
Check scheme rules and protocol.	☐	Lodge an appeal within the deadline.	☐
Check clinical record and coding.	☐	Determine whether the dispute falls within CMS jurisdiction and identify the appropriate contractual or regulatory escalation route.	☐
Check pre-authorisation.	☐	Retain complete evidence trail.	☐

25. Practice checklist — considering exit

Locate signed contract and amendments.	☐	Confirm handling of outstanding claims.	☐
Confirm whether contract remains in force.	☐	Confirm clawback/deduction provisions.	☐
Check termination clause and notice period.	☐	Consider patient communication and continuity of care.	☐
Check tariff-change termination rights.	☐	Obtain legal advice where breach is possible.	☐
Check whether termination affects one or all products.	☐	Give notice exactly as required and retain proof.	☐
Identify post-termination obligations.	☐		☐

26. Key questions for every contract

1. Is the contract commercially viable?
2. Which products and patients does it cover?
3. What exactly am I agreeing to provide?
4. What tariff applies and how can it change?
5. Which services require pre-authorisation?
6. What happens if the scheme/MCO disagrees with my clinical recommendation?
7. Is peer-to-peer review available?
8. How do I appeal a funding or claims decision?
9. Can the MCO audit me and recover amounts retrospectively?

10. Can it deduct disputed amounts from future payments?
11. Can it pay patients directly?
12. Can it suspend me while investigating?
13. How is profiling conducted and challenged?
14. Can the contract be amended unilaterally, or must amendments be agreed in writing by both parties?
15. How can I terminate?
16. Can I terminate individual products?
17. What happens to outstanding claims after termination?
18. Does the agreement preserve my professional independence and ability to give patients appropriate information?

27. What dental practitioners should not do

- Do not provide clinically inappropriate treatment because a contract makes it cheaper.
- Do not submit inaccurate codes.
- Do not unbundle or duplicate claims to increase reimbursement.
- Do not conceal clinical information to obtain authorisation.
- Do not ignore an old contract.
- Do not assume a website tariff changes the contract without checking the amendment mechanism.
- Do not treat a unilateral notice as a binding amendment unless the contract's amendment clause allows it and no further written agreement is required.
- Do not sign an acknowledgement of debt or settlement without understanding it.
- Do not retrospectively alter clinical records.
- Do not allow commercial incentives to override professional obligations.

28. SADA's practical approach

SADA's role is not limited to assisting individual practitioners with the interpretation and management of managed-care arrangements. SADA also seeks to promote a managed-care environment that is fair, transparent, clinically appropriate and commercially sustainable for dental practices, while recognising the legitimate role that managed care can play in supporting patient access and appropriate funding.

SADA supports constructive engagement with medical schemes, managed-care organisations, the Council for Medical Schemes (CMS), regulators and other relevant stakeholders on systemic issues affecting dental practitioners and patients. These may include contractual transparency, reimbursement and tariff processes, administrative requirements, utilisation management, authorisation processes, audit and recovery practices, dispute mechanisms, continuity of care and other recurring concerns affecting the sustainability and accessibility of dental services.

Members are encouraged to provide SADA with relevant, appropriately anonymised information about recurring contractual, reimbursement, administrative or managed-care concerns. Such information may assist SADA in identifying systemic issues and developing an evidence-based understanding of issues affecting the profession.

SADA advocacy commitment

Where recurring concerns are identified, SADA will, within its mandate and subject to appropriate legal and competition-law safeguards:

- promote fair contracting, transparent processes and clinically appropriate funding decisions;
- collect and consider appropriately anonymised evidence of recurring member concerns;
- engage medical schemes, managed-care organisations, the CMS and other relevant stakeholders constructively on systemic issues affecting patient access and the sustainability of dental practices; and
- provide members with education, practical guidance and tools to assist them in assessing managed-care contracts, managing claims and understanding available contractual, professional and regulatory processes.

SADA's advocacy does not extend to prescribing or coordinating commercial terms between practitioners. In particular, SADA does not recommend or coordinate tariffs, require or encourage practitioners collectively to accept or reject particular tariffs or networks, or facilitate the exchange of competitively sensitive information between practitioners.

Practitioners remain responsible for making their own independent commercial decisions. Any collective engagement by SADA will be conducted within applicable competition law and other legal requirements and should be appropriately structured and legally reviewed where necessary.

Where a dispute is highly fact-specific, financially material or potentially contentious, members should obtain independent legal advice. SADA guidance is not a substitute for legal advice on the interpretation or enforcement of a particular contract.

29. Key legal and regulatory references

Reference	Relevance
Medical Schemes Act 131 of 1998 and Regulations	Particularly Regulation 15 and related managed-care provisions.
HPCSA Business Practice Policy (March 2025)	Managed care, contracts, clinical guidelines, utilisation management, pre-authorisation and profiling.
Council for Medical Schemes managed-care standards	Managed-care accreditation standards and managed-care agreement guidance.
Registered rules of the relevant medical scheme	Governs PMB funding and scheme-specific benefit rules.

> *The legal position should always be checked against the legislation, regulations, current HPCSA policies and the particular scheme/MCO contract in force at the relevant time.*

30. Conclusion

Managed-care participation is both a commercial and professional decision. A dentist should not sign simply because a contract promises additional patients and should not reject participation without considering the financial and patient consequences.

Managing a managed-care contract does not end when the contract is signed. Dentists should actively monitor their contracts, tariffs, authorisations, claims, profiles and audits; use negotiation and appeal mechanisms; document clinical decisions; and exercise contractual exit rights where appropriate.

The objective is to protect professional independence, provide appropriate patient care and ensure that the practice receives all reimbursement to which it is legitimately entitled.

Where recurring concerns arise across managed-care arrangements, practitioners should not necessarily regard these as matters that must be resolved individually. Where recurring concerns arise across managed-care arrangements, practitioners should not necessarily regard these as matters that must be resolved individually. SADA may use appropriately anonymised member experience and evidence to identify systemic issues and engage constructively with schemes, MCOs, the CMS, regulators and other relevant stakeholders to promote fair contracting, transparent processes, appropriate clinical governance, patient access and sustainable participation by dental practitioners.

DISCLAIMER

This document is general guidance for SADA members and is not legal advice. Legislation, regulations, scheme rules, contracts and HPCSA policies may change. A dental practitioner should obtain advice on the specific wording and circumstances of a contract before signing, terminating, admitting liability or settling a material dispute.