4 April 2022

RULINGS ISSUED BY THE OFFICE OF THE REGISTRAR

The CMS hereby publishes summaries of rulings recently issued by the Complaints Adjudication Unit in respect of complaints lodged against regulated entities, in terms of Section 47 of the Medical Schemes Act.

These rulings are published solely for information purposes and may not be taken to be precedent setting in any way. Decisions articulated in these rulings may still be appealed in terms of Section 48 of the Medical Schemes Act. The CMS reserves the right to modify or remove any information published herein, without prior notice.

The contents of these rulings do not constitute legal or medical advice and may not be taken out of context. The findings and any opinions expressed in these rulings are based on the specific facts of each complaint, the evidence submitted, and applicable legal provisions.

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Identifiable personal information of the complainants and any associated individuals have been redacted for their protection.

V v South African Police Service Medical Scheme (Polmed)

Voluntary use of non-DSP(Regulation 8(2))

This complaint was lodged by a member of POLMED, following the short payment of claims in respect of treatment rendered to his dependant. The complainant explained that the dependant experienced extreme pain over a number of days and when oral medication did not assist in relieving the paid, attempts were made to consult a Specialist.

The first Specialist contacted could not accommodate the dependant and referred her to another Specialist, who managed to consult with her the next day. The dependant underwent a pelvic ultrasound which revealed the source of pain as a large mass on her left ovary. The dependant was subsequently referred back to the first Specialist, who recommended hospital admission and a surgical procedure.

It was confirmed by the Complainant that the dependant had consulted with the first Specialist previously and that he was aware that this Specialist was not a Designated Service Provider (DSP). Nevertheless, the Complainant argued that the dependant's pain was too severe for them to try and find a DSP. He therefore maintained that the Scheme must be compelled to fund the accounts in full, as it was an emergency PMB admission.

In its response to the complaint, the Scheme upheld its funding decision and indicated that it had conducted a PMB review on the claims and maintained that the claims were correctly paid at the scheme rates, due to voluntary use of a non-DSP. The Scheme's decision was based on Regulation 8(2), which states that:

> (2) Subject to section 29 (1) (*p*) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that—
>
> (*a*) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and
>
> (*b*) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

After studying the contents of the complaint as well as a response from the Scheme, the matter was referred to the CMS's Clinical Review Committee (CRC) for a clinical opinion on whether or not the dependant's diagnosis qualified as an emergency medical condition. Having reviewed the clinical reports, the CRC advised that since the dependant started experiencing pain over a number of days which was managed with pain medication and subsequently consulted and was booked for admission a few days later, the condition did not fulfil the criteria for emergency medical condition as defined in Regulation 7. Furthermore, the evidence revealed that the dependant was not precluded from obtaining treatment from a DSP, nor was there any attempt to enquire from the Scheme about the nearest DSPs.

It was ultimately found that the dependant had voluntarily made use of a non-DSP, for a non-emergency admission, in circumstances which did not preclude the use of a DSP. The Registrar found that under these circumstances, the Scheme could not compel to fund the outstanding account shortfall as the claims were processed in line with Regulation 8(2).