BEFORE THE APPEALS COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES

***via* Microsoft teams video and audio conferencing**

CMS 78787

In the matter between:

T on behalf of B	Appellant
and	
Discovery Health Medical Scheme	Respondent

APPEALS COMMITTEE HEARING PANEL

Ms D Terblanche - Chairperson

Dr T Mabeba – Member

Mr M Maimane – Member

DATE OF HEARING: 21 June 2023

DATE OF RULING: 26 October 2023

RULING AND REASONS

THE PARTIES

1. The Appellant is Mr T (the "Complainant") of Claims Hound (a division of Empress Holdings (Pty) Ltd. on behalf of Ms B (the "Appellant" or "B"), the latter a member Discovery Health Medical Scheme in terms of an mandate to act on the member's behalf.

2. The Respondent is the Discovery Health Medical Scheme (the "Respondent" or "Discovery" or the "Scheme"), a medical scheme registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the "Act" or the "MSA").

3. The Appeals Committee heard the appeal on 21 June 2023 *via* Microsoft teams video and audio conferencing.

4. Mr T appeared at the appeal hearing on behalf of the member, B (the "Member").

5. Ms M appeared on behalf of DHMS, accompanied by Dr R, Ms D and Ms P.

THE APPEAL

6. This is an Appeal in terms of Section 48 of the MSA against the ruling the Registrar of Medical Schemes (the "Registrar") handed down on 11 October 2022.

7. The Appellant is not appealing the claims decisions, but the Scheme's conduct in the process of administering the claims.

8. Section 48(1) provides that -

> *"Any person who may be aggrieved by any decision relating to the settlement of a complaint or dispute appeal against such decision to the Council."*

THE APPELLANT'S SUBMISSIONS

9. The Appellant lodged complaints on behalf of the member against the Scheme, on 7 January 2022, the detail of which ran into some 181 pages of the paginated bundle.

10. For ease of reference the Appeals Committee requested the Appellant to list all the complaints, as according to the Appellant the Registrar did not forward all the

complaints to the Scheme for comments, and the Registrar consequently did not rule on all the complaints.

11. According to the Appellant there are two sets of complaints relating to claims' payments, namely –

    11.1. One, the claim of Dr L (Referred to below as Issue 1):

        11.1.1. In respect of this claim the Appellant agreed that the Scheme paid the claim.
        11.1.2. There is no issue on appeal regarding payment.
        11.1.3. What the Appellant complained about is the Scheme's treatment of the member.

    11.2. Two, the claims in respect of the Pathcare diagnostic tests (Referred to below as Issue 2):

        11.2.1. The Registrar decided this claim in favour of the Scheme.
        11.2.2. The Appellant decided not to appeal the Registrar's ruling because the Appellant does not have the CRC opinion.

12. Over and above the complaints the Registrar ruled on, the Appellant listed the below complaints as part and parcel of the complaints the complainant made to the Registrar, namely -

    12.1. That Discovery Health Medical Scheme and the Administrators are indistinguishable from each other.
    12.2. The Scheme paid for the member's PMB claims from the member's medical savings account ("MSA"). The Registrar did not order the Scheme to pay interests on the funds the Scheme disbursed from the members' MSA for PMBs, and subsequently refunded.

12.3. Because the Scheme neglects to include ICD10 or Nappi codes on statements to members, it is difficult for members to reconcile their statements against the service providers' invoices.

12.4. The Scheme does not set out Reason codes (prescribed information) in full.

12.5. The Scheme burdens members by requiring members to complete forms contrary to the Code of Conduct (CoC).

12.6. The Scheme places an additional burden on health care service providers (HCSP) and members to compensate their HCSP (related to issue 1).

12.7. The Scheme institutes rules that are not in the best interests of members. The administrative requirement that members must apply for out-of-hospital PMB authorizations does not fall within the four corners of the Act or the Regulations.

12.8. The Scheme did not state that completion of forms is a requisite to qualify for out of hospital PMB (relates to Rules issue).

12.9. The Scheme does not honour its definition of appointed DSPs. Dr L was not paid in full (related to issue 1).

12.10. The Scheme did not pay a DSPs in full for an PMB, though Dr L was eventually paid (related to issue 1).

12.11. The Scheme burdens members with requirements they do not require their own DSPs to comply with. Members have to complete forms which DSPs could have completed (related to issue 1).

12.12. The Scheme does not recognize PMBs until they decide a specific condition is a PMB in terms of Code of Conduct specific way to deal with it and the scheme does not (related to issue 1).

12.13. The Scheme did not pay for a PMB within the allotted time. Dr L was not paid within 30 days (related to issue 1).

12.14. The Scheme is selective regarding the treatment codes they pay for (Issue 1)

12.15. Payment arrangements with service providers is problematic, the Scheme paid service provider after Ms. B paid the service provider (related to issue 2).

12.16. The Scheme did not credit the member's MSA with interest after the Scheme incorrectly paid a claim from the member's MSA (related to issue 1).

12.17. The Scheme refunded the member's MSA without paying interests on the amounts taken from the member's MSA (related to issue 2).

12.18. The Scheme made only certain (some) information available to the Registrar.

12.19. The Scheme disregards the prescripts of the Code of Conduct (no details) – come back.

12.20. The Scheme, by not making information available, makes it difficult for members.

13. According to the Appellant the Register did not invite the Scheme's comments, nor ruled on them.

14. The Appellant requested the Appeals Committee to refer the complaints the Registrar did not rule on back to the Registrar, *alternatively* that the Appeals Committee '*slaps the Scheme on the wrist'* for the Scheme purported unacceptable behaviour.

THE RESPONDENT SUBMISSIONS

15. It is unclear what recourse the Appellant seeks.

16. The Appellant makes sweeping statements not substantiated by fact

17. The issue between the Scheme and its Administrator does not prejudice members.

18. The Appellant complains that the Scheme does not recognize PMBs until they decide a condition is a PMB. In this regard the Scheme submitted that it is within its rights to ask for clinical information to confirm a PMB.

19. The PMBs paid from MSA was dealt with in the Registrar's ruling the Appellant is not appealing.

20. If a member has insufficient information the member is at liberty to ask for more information.

21. It is inherent in administration of a Scheme for information requests for information to be made available. The Scheme does not understand how the member expects the administration of the Scheme without information being provided, on the basis that providing such information is burdensome to members. There is nothing unreasonable to expect information from members when required, same as for providers. Due diligence dictates and have to account to all its members only payments that are due are to be made.

22. The complaint that the Scheme rules are not in the best interests of members is too broad and vague, and consequently the Scheme finds it impossible to respond to the complaint.

23. The member might be confusing the completion of forms to qualify for PMBs with registration for chronic benefits. There is no need to complete a form for a PMB entitlement.

24. The Scheme does not know and cannot respond to the that the Scheme *"Does no honour definition of DSP"*.

25. Regarding the members claim that she be paid interests on the funds that was expended from her MSA, the Scheme submitted that the Appeals Committee cannot entertain such a claim- it is not a civil court, and payment of interests is not provided for in the MSA. Interests is not a cost the member incurred. The MSA provides for defrayal of costs by members.; this is not the forum.

26. In a nutshell DHMS submitted that –

    26.1. What had to be paid had been paid.

26.2. Regarding referring the matter back to the Registrar, there are no grounds for the matter to be referred back to the Registrar.

26.3. The Code of conduct is a Guiding not Binding document. Stakeholders must aspire to act within the parameters of the Code of Conduct. The Code of Conduct is not mandatory *per se.* If they don't follow the Code of Conduct, but does not contravene the MSA, there is no contravention.

DISCUSSION AND FINDINGS

27. Ms B (the "Appellant" or "B") mandated the Appellant, Mr T (the "Complainant") of Claims Hound (a division of Empress Holdings (Pty) Ltd. to act on her behalf *"…to engage and or negotiate with the Respondent Scheme and / or medical service provider regarding unpaid and / or incorrectly paid medical scheme benefits in order to correct the claims"* (Clause 6, page 40 of the paginated 'Mandate to Act on Client's Behalf').

28. The Appellant submitted that he is not appealing the Registrar's ruling regarding the "*unpaid and / or incorrectly paid medical scheme benefits"* pertaining to Dr L and the Pathcare claims, but the twenty (20) complaints the Appellant placed before this Appeals Committee the Appellant claims the Registrar did not rule on.

29. It is clear from section 48(1) read with section 48(2) of the MSA provides that appeals may be brought to Council regarding " *… any <u>decision</u> relating to the settlement of a complaint or dispute.."* (Emphasis added) and that the "*… operation of any decision which is the subject of an appeal under subsection (1) shall be suspended."*

30. It is not for this Appeals Committee to deliberate and make findings in appeal on matters the Appellant alleged the Registrar did not place before the Scheme and consequently did not make decisions.

31. It appears from the record that the Registrar advised the Scheme that "*The Complainant is aggrieved with the scheme funding decision for non-payments of PMB related account and payments of PMB related account from MSA."* The other matters do not appear from the advice to the Scheme for comments..

32. The redress the Appellant seeks on these complaints are not for the "*unpaid and / or incorrectly paid medical scheme benefits"*, save for arguably the payment of interest on funds the Scheme initially paid to Dr L from the member's Medical Savings Account (MSA). What the Appellant wants is for the complaints to be referred back to the Registrar or if this Appeals Committee entertains the complaints and find in his favour "*to slap the Scheme on the wrist*". We will deal with this aspect in detail later in this ruling.

33. The only matter on appeal before the Appeals Committee pertains to the treatment of the member by the Scheme / conduct of the Scheme towards the member during the administration of the Dr L claim/s. The issues around the L claim seem to relate to L's DSP status, the member's PMB entitlement, the requirement surrounding funding the PMB entitlement, and the member's interests claim on funds disbursed from the member's MSA.

34. All these matters on a balance of probabilities appear necessary for the Scheme to exercise due diligence in ensuring that it only pays claims and amounts that are legitimately due and payable in terms of the member's benefits.

FINDINGS

35. The Appeals Committee finds that the complaints the Appellant submitted the Registrar did not investigate and decided are not ripe to serve before the Appeals Committee under section 48 of the MSA.

36. The Appeals Committee further finds that the Appellant has not placed evidence on the balance of probabilities that the Scheme miss-treated the member during the process of administering the 'L claim'. (See paragraph 11.1.3 above)

ORDER

37. The Appeal is dismissed.

Dated at Centurion on the 25th day of October 2023.

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D Terblanche

Chairperson of the Appeals Committee Panel

Dr T Mabeba (Member), and Mr M Maimane (Member) concurring it is so ordered.