**BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES (SECTION 48 APPEAL)**

**HELD VIA MICROSOFT TEAMS VIDEO AND AUDIO-CONFERENCING TECHNOLOGY.**

(Instituted in terms of the Medical Schemes Act No 131 of 1998)

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| **In the matter between** | **Ref number: CMS 84105** |
| **Ms. H** | **Appellant** |
| **And** | |
| **Bestmed Medical Scheme** | **Respondent** |

**Panel:** Dr K. Chetty; Dr X. Ngobese; Ms P. Beck; Dr S Naidoo.

**Date of hearing:** 2nd December 2024.

**Date of ruling:** 21 January 2025.

## RULING AND REASONS

### THE PARTIES

1. The Appellant is Ms H (The “Appellant” or “Member”), a Member of Bestmed Medical Scheme.
2. The Appellant was represented by Mr. H, her father who is also a legal consultant from Lawsolve.
3. The Respondent is Bestmed Medical Scheme (The “Respondent or the “Scheme”), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the “MSA” or “Act”).
4. Ms K, Legal Advisor for Bestmed appeared for the Respondent.
5. Mr V, complaints specialist for Bestmed was also present.

### BACKGROUND

6. The Appellant, Ms H is a Member of the Bestmed Medical Scheme.
7. Ms H was born with a severe unilateral cleft lip and palate which is a Prescribed Minimum Benefit (PMB) condition.
8. The Appellant was referred at birth to Prof B, a leading specialist in the field of cleft lip and palates. The repair of her deformity has been over a period of 25 years and Prof B has always been her treating specialist.
9. The Appellant stated that all these operations were paid for in full by Discovery and Bonitas medical schemes, of which she was a member prior to joining Bestmed.
10. The Appellant stated that she received pre-authorisation approval from Bestmed.
11. The Appellant stated that when she enquired she was informed that the treating provider is not a Designated Service Provider (DSP).
12. The Scheme stated that it was informed for the first time that the Appellant is under the care of Prof B when the claim was received from him in respect of a consultation with the Appellant in May 2022.

13. The Scheme stated that in 2023 the Appellant was informed that she needs to make use of a DSP to ensure that her claim is paid in full and that Prof B is a non-DSP.
14. The Scheme stated that the short payment of the amount of R25 062.18 was due to the co-payment imposed by the Scheme for the use of a non-network specialist.

## THE REGISTRAR'S RULING

15. The Registrar's Ruling was issued on 4th June 2024.
16. The Registrar ruled that in the absence of evidence to the contrary, the Registrar finds that the Complainant's circumstances do not accord with any of the ones outlined in Regulation 8(3) and for that reason, her use of non-DSP cannot be said to be involuntary. In the absence of evidence of involuntary use of a non-DSP, there is no lawful reason to compel the respondent to fund the full cost of the claim. It is therefore our ruling that the Respondent has correctly applied Regulation 8(2) in this case and funded the claim at scheme rates due to the voluntary use of non-DSPs.
17. The Member is now appealing this decision in terms of Section 48 Appeal.

## APPLICATION TYPE AND RELIEF SOUGHT

18. This is an appeal under section 48(1) of the Medical Schemes Act (the "MSA or the Act").[1] This section provides that:
    a. *"(1) Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council".*
19. The Appeals Committee heard the appeal on 2nd December 2024 via an audio and video conferencing link.

[1] Medical Schemes Act 131 of 1998 as amended by Act 55 of 2001; Section 48(1); Proc 13/GG 19725/19990129

## RELEVANT STATUTORY AND REGULATORY PROVISIONS

20. The relationship between the Scheme and the Member is governed by the terms of the contract ("the Schemes rules") the Scheme concluded with Member. The contract in turn is governed by the "MSA" and the regulations (as amended) made in terms of the Act.
21. This is a wide appeal. The Appeals Committee may consider the matter afresh and is not restricted to the record of proceedings that were before the Registrar.
22. The burden of proof rests on the Appellant who must prove on a balance of probabilities that the appeal should succeed.

## THE ISSUE IN DISPUTE

23. The issue in dispute is whether the Scheme was correct to not fund the account for services rendered in full on the basis that it constitutes voluntary use of a non-DSP.

## APPELLANTS SUBMISSION

24. The Appellant Ms. H joined Bestmed on 1st January 2015 and is currently registered on the Beat 3 Network benefit plan.
25. The Appellant was born with a severe unilateral cleft lip and palate which is a Prescribed Minimum Benefit (PMB) condition. She was referred at birth to Professor B, a leading specialist in the field of cleft lip and palates and Head of the Facial Cleft Deformity clinic at the University of Pretoria at the time.
26. The repair of her deformity has been over a period of 25 years and Prof B has always been her treating specialist.
27. The Appellant stated that all these operations were paid for in full by Discovery and Bonitas medical schemes, of which she was a member prior to joining Bestmed.
28. The Appellant stated that she initially received pre-authorisation approval from Bestmed on 18th July 2023, in which Bestmed had pre-authorised the operation and hospitalisation, but indicated a co-payment of R13 078.

29. The Appellant stated that she queried this authorisation on the same day and pointed out that Prof B had performed all her operations since birth and that did not make sense to utilise another surgeon.

30. The Appellant stated that in response to this email she received a pre-authorisation approval from Bestmed on 24th July 2023. She stated that in the section "financial information about your authorization" and "deductible/co-payment" a personal liability of R2 500 was listed and next to "Approved Amount" personal liability of R0.00 is indicated.

31. Based on this the Appellant deduced that no co-payment was required from her and that she would not be liable for any amount above scheme tariffs.

32. The Appellant stated that on 2nd September 2023 she received an email from Bestmed that advised her that the co-payment of R2 500 for hospital fees had been waived due to the length of the hospital stay having been updated.

33. On or about 14th September 2023 it came to the Appellant's attention that only a portion of Prof B's account had been paid. The scheme paid R10 208.32 from a bill of R35 270.50 leaving a short payment of R25 062.18.

34. The Appellant stated that when she enquired she was informed that the treating provider is not a Designated Service Provider (DSP). The Appellant is disputing whether this was a voluntary choice, as she said that all her prior operations were performed out of necessity by Prof B and there are no other service providers with the necessary prior information and intimate knowledge of her case to perform the operation.

35. The Appellant stated that "*in this scenario my choice of DSP cannot be seen as voluntary, as the lack of alternative options, my particular medical history (including that Professor B performed all 10 of my previous operations and the risk of the operation), gave me no choice but to use the services of Prof B again. My use of Professor B as a non-DSP in this case was therefore not voluntary, even if DSP's on Bestmed's networks were available to perform the same procedures (which in any event is not admitted)….. In real and practical terms, taking my medical history and use of only Professor B in the past into account, there was no other surgeon DSP or otherwise, who realistically could or should have performed the operation on me. I had no choice but to use him and it was therefore not voluntary use. In any event in terms of Bestmed schemes rules it has the discretion to approve the use of a non-DSP in certain circumstances*

*and if his or her fees exceed the schemes rate the full amount of the fees must be paid by the scheme.*[2]

36. The Appellant stated that the Scheme has a duty to give clear and comprehensive information about their available healthcare providers within their network.
37. The Appellant requests that the Registrar's ruling is dismissed and that a comprehensive review of the disputed claim and payment in full of Professor B's statement, in the amount of R25 462.18.

**RESPONDENTS SUBMISSION**

38. The Appellant Ms H has been a member of Bestmed since 2nd June 2022 on the Beat 3 Network.
39. The Respondent stated that when the Appellant applied for membership she did so voluntarily, to change from her previous medical schemes to Bestmed. In addition, her signature on the application form confirms that she fully acknowledges, understands, and agrees to (amongst others) abide by the scheme rules, the limitations contained in her chosen Beat 3 network option, and the possible co-payments for voluntary use of a non-DSP.
40. The Scheme submits that it was informed for the first time that the Appellant is under the care of Professor B when the claim was received from him in respect of a consultation with the Appellant on 30th May 2022.
41. The Respondent stated that on the 20th June 2023 the Appellant applied to have consultations and future bi-annual consultations funded from Prof B for code 8901.
42. The Respondent stated that on 17th July 2023 the scheme informed the Appellant that she needs to make use of a DSP to ensure that it is paid in full. In the same correspondence the appellant was also informed that if she voluntarily chooses to use a non-DSP network provider, the claim will only be paid up to the scheme tariff and that she will be liable for the difference.

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43. On 17 July 2023 the Appellant requested pre-authorisation for PMB funding for reconstruction of her cleft nose deformity to be performed by Professor B for tariff codes 8962, 9268 and 8966.

44. On 18th July 2023, the Scheme informed the Appellant in a pre-authorisation pending letter that Professor B is the non-DSP and that she would be liable for any amount exceeding the applicable scheme tariff. On the same letter the scheme also stipulated that a co-payment of R13 078 is applicable for certain procedures as per the 2023 Beat range benefit options. This co-payment was included in the Scheme's correspondence of 18 July 2023, as at the time there was no facility noted for the procedure.

45. The Respondent stated that the Appellant submitted correspondence to the scheme on 18th July where the co-payment was queried and mention was made that Prof B had been attending to all her operations since birth.

46. The Respondent stated that the Appellant contacted the scheme on 21st July 2023 to inquire about the co-payment of R13 078. The Bestmed case manager telephonically advised her that this amount was because there was no hospital which was noted at the time, and also advised her that co-payments will be due for her provider because of his non-DSP status and if he charges above scheme rates she will be liable for the shortfall. An affidavit was submitted by the case manager.

47. The Scheme stated that despite being informed on several occasions of the above cost implications as they relate to the use of non-DSPs, the applicant proceeded to use the services of Professor B, subsequently amounting to a claim of R35 270.50 of which the Scheme paid R10 208.32 leaving the applicant liable for R25 062.18 of the total claim.

48. The Respondent stated that the co-payment that was stipulated on the pre-authorisation letter was in relation to the facility and not Professor B. The Respondent indicated that the Scheme could not specify the specific amount of the shortfall for Professor B, as it could only do that once the claim was received and will then determine whether the amount is above the scheme rate and whether the member is liable to pay

49. The Respondent argues that the Appellant advanced various arguments on why her use of a non-DSP was involuntary, specifically that Professor B has been her doctor since birth and was well acquainted with her history, but it is

the Schemes view that these do not satisfy the requirements of Regulation 8(3) of the Medical Schemes Act for involuntary use of a non-DSP.

50. The Scheme requests that the ruling of the Council dated 4th June 2024 be upheld and that the appeal of the Appellant be dismissed.

**DISCUSSION AND ANALYSES**

The Appeals Committee considered papers filed in this appeal; the further submissions the party's made; the relevant provisions of the Medical Schemes Act; and the Rules of the Scheme.

51. It is common cause that
    a. The Appellant has been a member of the Bestmed Medical Scheme and covered on the Beat 3 benefit option.
    b. The Member was born with a severe unilateral cleft lip and palate which is a Prescribed Minimum Benefit (PMB) condition.
    c. The Appellant was referred at birth to Professor B, a leading specialist in the field of cleft lip and palates. The repair of her deformity has been over a period of 25 years and Prof B has always been her treating specialist.
    d. The Scheme paid R10 208.32 leaving the applicant liable for R25 062.18 of the total claim, on the basis that it was the voluntary use of a non-DSP according to the rules of Bestmed.

52. The key issue to be determined is whether the use of the non-DSP provider, Professor B was voluntary or involuntary.

53. In terms of Regulation 8 of the regulations under the Act, medical schemes are entitled to stipulate in their rules that members must utilise DSP's for PMB conditions. In terms of Regulation 8(1) schemes must fund PMB conditions in full but, Regulation 8(1) must be read with Regulations 8(2) and 8(3) and cannot be read in isolation. In terms of regulation 8(2) a Scheme may apply a co-payment or deductible if a member made use of a non-DSP, unless it can be considered as "involuntary" use of a non-DSP as stipulated in Regulation 8(3)(a)(c).

*(1) A beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if -*

*a) The service is not available from the designated service provider or would not be provided without unreasonable delay*

*b) Immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or*

*a. There was no designated service provider within reasonable proximity of the beneficiary's ordinary place of business or personal residence*

54. The Scheme stated that the Appellant was informed on several occasions of that Professor B was a non-DSP and the scheme tariffs will apply (see below)[3].

55. The Appellant argues that the first pre-authorisation letter initially had co-payment of R13 078 and that upon enquiring the second pre-authorisation letter stated a reduced co-payment of R2500 and in the same letter next to "*Approved Amount: A Personal Liability of R00".* It was on this basis the Appellant assumed that there was no co-payment for Professor B as she had also explained that Professor B was her treating provider since birth.

56. The Appellant goes further to state that "*in this scenario my choice of DSP cannot be seen as voluntary, as the lack of alternative options, my particular medical history (including that Professor B performed all 10 of my previous operations and the risk of the operation), gave me no choice but to use the services of Professor B again. My use of Professor B as a non-DSP in this case was therefore not voluntary, even if DSP's on Bestmed's networks were available to perform the same procedures (which in any event is not admitted)….. In real and practical terms, taking my medical history and use of only Professor B in the past into account, there was no other surgeon DSP or otherwise, who realistically could or should have performed the operation on me. I had no choice but to use him and it was therefore not voluntary use.*

57. The Scheme clarified that the co-payment that was stipulated on the pre-authorisation letter was in relation to the facility and not Professor B. In addition,

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the Respondent provided proof that there were Maxillo-facial and Oral Surgeons within reasonable proximity of the Appellants ordinary place of business or personal residence.

58. It is understandable that the Appellant feels more comfortable with Professor B as he was a treating provider since birth and understands her medical history. She stated quite clearly in her affidavit: "*even if DSP's on Bestmed's networks were available" …."there was no other surgeon DSP or otherwise, who realistically could or should have performed the operation on me".*

59. It therefore was the intention of the Appellant to obtain services from the non-DSP service provider Professor B, regardless of whether there was another DSP provider that could have provided the service.

60. Having determined that this was a voluntary use of a non-DSP, a second issue is whether the co-payment is reasonable.

61. In Regulations published in GG 44469[4], The Registrar declared the following practice to be undesirable: "*Imposing a co-payment in terms of Regulation 8(2)(b) that exceeds the quantum of the difference between that charged by the medical schemes designated service provider and that charged by a provider that is not a designated service provider of such scheme. This includes any other co-payments which are unfair to members or beneficiaries or cannot otherwise be numerically justified.* Whilst the council has not published guidelines on co-payments as required, the principles of the regulations still apply.

62. As such the Scheme is requested to review the scheme tariff paid to the non-DSP, and close the parity gap between the amount paid to the DSP versus the non-DSP.

**FINDINGS**

63. The Members condition, is a Prescribed Minimum Benefit (PMB).

[4] GenN 214 in GG 44469 of 23 April 2021: Declaration of certain practices by medical schemes in selecting designated healthcare providers and imposing excessive co-payments on members as irregular or undesirable practices in terms of section 61 of the Act.

64. The Appeals Committee finds that the Member circumstances do not accord with any of the conditions outlined in Regulation 8(3) and her use of a non-DSP cannot be said to be involuntary.
65. The Member is deemed to have made voluntary use of a non-DSP.
66. The Scheme has correctly applied Regulation 8(2) in this case and funded the claims at schemes rates due to voluntary use of a non-DSP.

**ORDER**

Having considered the matter the Appeals Committee orders that:

b. The appeal is dismissed.
c. The decision of the Registrar is upheld.
d. There is no order to costs.

Dated at Johannesburg on 21 January 2025

Dr KS Chetty (For and on behalf of the Appeals Committee)

Concurring:

Dr X. Ngobese

Ms P. Beck

Dr S Naidoo.