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.

The CMS does not assume liability or accept responsibility for any claims for damages or any errors, omissions, arising out of use, misunderstanding or misinterpretation, or with regard to the accuracy or sufficiency of the information contained in these publications.

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

G v MEDIHELP MEDICAL SCHEME

The complaint concerned the Scheme's decision to decline to cover the full cost of the member's hospital admission, particularly her high care stay.

The member submitted that she was admitted to Hospital after being diagnosed with Diverticulitis. She was placed in high care from 26 to 27 February before moving to a general ward and was discharged on 29 February. The hospital billed her high care stay as 3.5 days, which she disputed, stating that it was 1 day and 2 nights.

In its response to the complaint, the Scheme indicated that it initially authorised 3.5 days but later retracted the approval for high care, resulting to a shortfall of R31,599. The Scheme stated that it approved the general ward stay but declined high care coverage due to insufficient clinical justification. The Scheme cited hospital documentation indicating that the member was in high care for only two hours on 28 February. Furthermore, the medication she received could have been administered in a general ward.

The Scheme argued further that the hospital failed to submit updates on the member's condition within the agreed 48-hour timeframe, as per its agreement with the hospital. The Scheme stated that the member should not be held responsible for the outstanding amount however was not prepared to engage the hospital to resolve the issue.

The Registrar's Clinical Review Committee (CRC) confirmed that high care was not clinically justified. However, it found that the failure by the hospital in providing timely updates contributed to the dispute. The Registrar found that the failure of the hospital to comply with the Scheme's service agreement should not financially burden the member.

The Registrar directed that the Scheme must resolve the outstanding R31,599 with the hospital (its contracted provider) and if unsuccessful, the Scheme must cover the amount to prevent financial prejudice to the member.