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Dr. V.D.K obo Mrs B v Discovery Health Medical Scheme

Voluntary use of a non-Designated Service Provider

This matter was referred to the Office of the Registrar by Dr. V.D.K ("the Complainant"), acting on behalf of his patient, Mrs. B ("the Member"), against Discovery Health Medical Scheme ("the Respondent"). The dispute concerns the Respondent's decision to decline full funding of emergency medical treatment following unforeseen complications during the Member's hospital admission in April 2024.

The Member was admitted to Panorama Hospital on 8 April 2024 for an elective total knee replacement performed by the Complainant. The Complainant explained that although he is contracted with the Respondent under Classic Plans, the Member was enrolled on the Essential Delta Saver Plan. He stated he was willing to charge medical aid rates for the procedure.

While hospitalised, the Member experienced two sudden knee dislocations the first on 9 April 2024 and the second on 10 April 2024, both requiring urgent surgical intervention. The Complainant emphasised that these were unforeseen emergencies, not complications of the initial elective surgery. He submitted a PMB motivation letter, supported by X-rays, requesting full funding for the additional surgeries under the in-hospital PMB benefits. The Respondent declined, citing the Member's use of a non-Designated Service Provider (non-DSP).

In response, the Respondent confirmed that it had authorised the initial admission and knee replacement. It argued that full PMB funding was not available because the Complainant was not a DSP under the Member's plan. The Respondent indicated that alternative DSP providers were available at Mediclinic Louis Leipoldt and asserted that the Member voluntarily chose a non-DSP, thereby assuming liability for shortfalls. The Respondent maintained that its decision was consistent with its rules, the Essential Delta Saver Plan, and the Medical Schemes Act 131 of 1998.

The core dispute became whether the Member's post-operative emergencies constituted circumstances of involuntary use of a non-DSP, which would trigger full funding under Regulation

8(3) of the Act. The matter was referred to the Registrar's Clinical Review Committee (CRC) for expert guidance.

The CRC concluded that the two dislocations were emergency medical conditions, requiring immediate surgical intervention to prevent serious impairment of limb function. It further confirmed that the revision surgeries performed on 9 and 10 April 2024 constituted PMB-level care. The CRC's opinion established that, in this case, the emergency circumstances reasonably precluded the Member from accessing a DSP, thereby meeting the criteria for involuntary use of a non-DSP under Regulation 8(3)(b).

The investigation also highlighted inconsistencies in the Respondent's communication. During the authorisation process, the Respondent indicated that the Complainant formed part of its Major Joint Benefit Network, which reasonably led the Member to believe she was consulting a DSP. However, the Respondent later asserted that the Complainant was not a DSP for her plan type. This lack of clarity deprived the Member of the opportunity to make an informed choice about her provider and created a legitimate expectation of full coverage.

The Registrar found that the Respondent's reliance on scheme rules overlooked the statutory protections afforded by PMBs. Even though the initial knee replacement was elective and performed by a non-DSP, the subsequent dislocations were new emergency events requiring immediate care. The Respondent's refusal to cover the full costs was inconsistent with both the purpose and spirit of the PMB framework.

The Registrar concluded that the Respondent is obligated to fund the Member's hospital admissions and all related costs for the surgeries performed on 9 and 10 April 2024 in full, without co-payment or deductibles.

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