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RULINGS ISSUED BY THE OFFICE OF THE REGISTRAR

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L v DISCOVERY HEALTH MEDICAL SCHEME

Short funding of claims

The complaint concerns the Scheme's decision to short fund claims related to the Complainant's procedure The Complainant indicated that The Complainant explained that he underwent a series of diagnostic procedures following a GP referral, which led to his direct admission by a pulmonologist and subsequent surgery to remove a lung lobe where a severe infection was found. Despite obtaining prior authorisation, the Scheme declined to cover significant portions of the expenses, citing voluntary use of a non-Designated Service Provider (DSP). The Complainant indicated that this reasoning is retrospective and does not reflect the circumstances at the time. He further highlighted that, given his uncertain prognosis and his wife's concurrent thyroid cancer surgery, he took proactive steps to confirm coverage with both treating doctors.

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In response, the Scheme stated that the Complainant was admitted to Life Fourways Hospital from 29 April to 2 May 2024 under the care of non-DSP cardiothoracic surgeon, and again from 28 May to 6 June 2024 for further treatment, including a pulmonary lobectomy. The Scheme explained that funding for both admissions were approved in line with plan benefits, with accounts of non-DSP providers paid up to Scheme rates and shortfalls were the Complainant's responsibility. While all accounts related to the first admission were subsequently covered in full as it was deemed an emergency, the Scheme maintained that, for the second admission, sufficient time existed for the Complainant to use DSP providers. Accordingly, although shortfalls for cardiothoracic surgeon and the attending anesthesiologist were covered due to DSP unavailability, the shortfalls for non-DSP pulmonologist remain the Complainant's responsibility.

The issue which fell for determination was whether the Scheme was justified in short the pulmonologist's account on the basis that the Complainant voluntarily chose a non-DSP provider.

Upon investigation, the submissions made by both the Complainant and the Scheme were reviewed, as well as the applicable Regulations. The Under Regulations 8 of the Act, medical schemes are required to cover prescribed minimum benefit (PMB) conditions in full, subject to members using DSPs, unless services are obtained involuntarily from non-DSPs. Regulation 8(3) sets out the circumstances in which such use is deemed involuntary, including unavailability of services, unreasonable delay, emergencies, or lack of reasonable proximity. The Appeal Committee in DHMS v Registrar and Dr V confirmed that the onus rests on the Complainant to prove involuntary use of non-DSPs. In this case, the Scheme's pre-authorisation letters informed the Complainant that it does not have payment arrangement with the admitting doctor, it also indicated steps to take to avoid co-payments. Given that a DSP pulmonologist was available at the same hospital, and that the Complainant had time to make arrangements between the first and second admissions, his use of non-DSP providers could not be considered involuntary. Accordingly, there was no lawful basis to compel the Scheme to fund the full cost of the claims.

Accordingly, a ruling was issued confirming that the Complainant's circumstances do not accord with any of the ones outlined in Regulation 8(3) and for that reason, his use of non-DSPs could not be said to be involuntary. In the absence of evidence of involuntary use of non-DSP, there was no lawful reason to compel the Scheme to fund the full cost of the pulmonologist's account.