Reference: Appeal Board ruling clarifies application of S59(2) of the MSA
Contact person: Customer Care Centre
Tel: 0861 123 267
Fax: 0866783598
E-mail: information@medicalschemes.com
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Press release 10 of 2016: Appeal Board ruling clarifies application of section 59(2) of the Medical Schemes Act

The ruling by the Appeal Board to dismiss a claim lodged by a medical doctor against the South African Police Service Medical Scheme (POLMED) (appellant) has helped to provide clarity on the application of section 59(2) of the Medical Schemes Act, 131 of 1998 (MSA). The section states that when there is a benefit owing to a member, the scheme has the right to pay either the member or the service provider directly within 30 days after the claim was received by the scheme. This interpretation had been confirmed by the High Court previously, but a recent judgment concerning claims submitted to a liquidated scheme created confusion in the industry as to whether the scheme has a discretion to elect who to pay, following a claim.

In the Sechaba judgment (Sechaba Medical Solutions Ltd v Sekete 2015 JDR 0426 Pty), the Supreme Court of Appeal found that the accounts by a certain hospital had to be included in the claims against the insolvent scheme, as a contract came into existence between the medical scheme and the hospital when the scheme issued authorization for the services rendered to the members of that scheme.

In a recent matter, the Appeal Board set aside a decision by the Appeals Committee, which had ordered POLMED to make direct payment on all accounts that have been submitted to it by the healthcare provider. Relying on the Sechaba judgment, the Appeals Committee had ruled that the scheme's conduct in refusing to pay claims directly to the provider after she had rendered services to the scheme's members was inconsistent with section 59(2) of the MSA, which outlines the terms of payment by medical schemes for services rendered by service providers. The Committee further stated that the scheme's withholding of claims for a period in excess of 18 months, while conducting an analysis on her purchased medicine records, was inconsistent with Regulations 6(2), 6(3) and 6(4) to the MSA, which stipulates the procedure for dealing with erroneous or unacceptable claims.

The Appeal Board, however, dismissed the assertion that Regulation 6 of the MSA was relevant in this case. Judge Ngoepe agreed with the Registrar of the Council for Medical Schemes' (CMS) ruling dated 13 May 2015, stating that Regulation 6 was not applicable in this instance as there were no erroneous claims identified by the scheme in the matter. The Registrar's ruling was overturned by the Appeals Committee in April 2016, which ruled in favor of the provider. The matter was subsequently taken on appeal by the scheme.

"The whole premise of Regulation 6 is that the scheme adjudicates the claims before payment. If the premise does not hold, then the whole Regulation does not apply. The respondent was aware that direct payment had been withdrawn and this implied that there should be no direct claims submitted to the scheme. It stands to reason then that Regulation 6 cannot apply until such time that direct payment resumes," the Appeal Board stated in its ruling." The Appeal Board also stated the service provider has the right to claim unpaid amounts from members who can then approach the scheme to enquire about unpaid benefits.

"The CMS welcomes the Appeal Board ruling as it provides clarity in a matter, which was subject to misinterpretation in certain quarters. It gives a straightforward interpretation of section 59(2) and Regulation 6 of the MSA concerning the issue of the withdrawal of direct payment of medical schemes to service providers," said Dr. Humphrey Zokufa, Chief Executive & Registrar of the CMS.

End

Prepared by:
Pulane Molefe
Manager: Communication
Council for Medical Schemes
012 431 0512
p.molefe@medicalschemes.com

For more information
Customer Care Centre
0861 123 267
information@medicalschemes.com

Media enquiries
Dr Elsabé Conradie
General Manager: Stakeholder Relations
Council for Medical Schemes
012 431 0430
e.conradie@medicalschemes.com