

**BEFORE THE APPEAL BOARD OF THE COUNCIL FOR
MEDICAL SCHEMES**

Case No. 15666

In the matter between:

YATISH KARA

Appellant

and

GOVERNMENT EMPLOYEES MEDICAL SCHEME

Respondent

DECISION OF THE APPEAL BOARD

1. On 14 December 2007 a committee of the Council for Medical Scheme dismissed an appeal against a ruling made by the Registrar of Medical Schemes on 17 September 2007 that the Respondent was not obliged to fund an amount of R7 040.00 (Seven Thousand and Forty Rand) as this amount exceeded the Respondent's tariff amount for the treatment provided by the Appellant. The Appellant now appeals, in terms of Section 50(4) of the Medical Schemes Act 131 of 199(a) ("the Act"), against the decision of the committee of the Council.

2. On 30th January 2007, a member of the Respondent gave birth to premature twins at the St Augustine's Hospital in Durban. The Appellant who is a paediatrician at the hospital provided medical care to the twins during the days immediately following their birth. The twins required resuscitation, ventilation, incubation and neonatal ICU care. The Appellant in due course invoiced the Respondent for various amount and the Respondent paid a large portion of the amount claimed but refused to pay the balance on the grounds that the services claimed for was not provided for under the code under which Dr Kara claimed for it..

3. It was common cause that the Respondent had not appointed designated service providers at the time when the services were rendered and consequently that Appellant was not a designated service provider of the Respondent's. It was further common cause that the Respondent's member involuntarily obtained Appellant's services on the basis set out in Regulation 8(3) of the regulations made in terms of the Act. It was further common cause that the twin's medical condition formed part of the categories (diagnosis and treatment pairs) constituting the Prescribed Minimum Benefits under Section 29(9)(o) of the Medical Schemes Act.
4. Thus the essential issue in this matter is whether the Respondent is obliged to pay the Appellant's fees in full or whether it is only obliged to pay him in accordance with its prescribed tariff In terms of its Rules.
5. The fees charged by the Appellant were his usual fees and it was not suggested that these fees were unreasonable or unprofessional or that there was any legitimate reason why Respondent's member was not obliged to pay such fees. The fees charged were in accordance with the South African Medical Association Doctors Billing Manual.
6. Regulation 8(1) reads:

“Subject to the provisions of this regulation, any benefit option that is offered by a Medical Scheme must pay in full, without co-payment or the use of deductibles, the diagnose, treatment and care costs of the prescribed minimum benefit conditions.”
7. Regulation 8(2) allows a scheme to impose a co-payment or deductible if use is made of a service provider other than a designated service provider. Schemes usually have contracts with designated service providers who agree to charge certain specified fees. However, the regulation has the following proviso:

“No co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.”

8. No contractual or statutory relationship existed between the Appellant and the Respondent and accordingly no basis exists entitling the Respondent to prescribe what fees the Appellant was entitled to charge his patient.
9. Between the Appellant and his patients, the normal common law position would apply vis in the absence of an agreement to the contrary, the Appellant would be entitled to charge his usual and normal fees provided such fees were not unreasonable or unprofessional. If a party considers a health provider's fees to be unprofessional, such party can lay a complaint with the Health Professions Council of South Africa, a statutory body created to, *inter alia*, deal with such matters. Further a patient is not obliged to pay a fee if it is unreasonable or is not the usual fee charged by the health service provider.
10. Regulation 8(1) clearly and unambiguously states that a Medical Scheme must pay in full the costs of the treatment of the prescribed minimum benefit condition. The word “cost” is given the following meaning in the shorter Oxford English Dictionary (third edition) -

“That which must be given in order to acquire, produce or effect something; the price paid for a thing.”

The cost of treatment therefore means the amount which the member has to legitimately pay to acquire the necessary medical services.

11. If the Medical Scheme was only obliged to pay the service provider its prescribed tariff in terms of its Rules, the patient would be liable to pay the excess to the doctor and would, contrary to the proviso to Regulation 8(2)(b), be making a co-payment.
12. It was submitted that to give Regulation 8(1) its clear meaning would be absurd as it would give Medical Practitioners a “blank cheque” when

treating patients for prescribed minimum benefit conditions. This contention is without substance in that, as has been pointed above, there are clear limitations on the fees which a health service provider can legitimately charge his patients. However, if the regulation would only entitle the Medical Practitioner to charge the tariff imposed by a Medical Scheme in terms of its Rules,, it would create serious anomalies and difficulties. Without attempting to be exhaustive, a few examples are given below:

- 12.1 different fee structures would apply depending upon which scheme or plan the patient belonged to;
- 12.2 the doctor would have to charge a fee based on a tariff of which he may have no knowledge;
- 12.3 a service provider might not be prepared to render services at the prescribed tariff and the patient would not be able to be treated for a prescribed minimum benefit condition even though it was the intention of the Legislature that every scheme pay for the treatment of such a condition;
- 12.4 Medical Schemes could impose tariffs on persons with whom they have no contracts and who are not designated services providers.
13. For the foregoing reasons we are satisfied that the decision of the committee of the Council for Medical Schemes was wrong and must be corrected.
14. The Respondent, in its written Heads of Argument submitted that the Appellant had no *locus standi* to seek payment from the Respondent and accordingly had no *locus standi* to bring this appeal. This issue had never been raised before. This is not surprising as the Respondent had at all times agreed to pay the Appellant for the services rendered by him to its member and had merely disputed the amount payable. In the light of the foregoing, we are satisfied that the Respondent's belated attack on the

Appellant's right to claim payment is without merit or substance and must be dismissed.

15. We accordingly make the following order;
- 15.1 the appeal is upheld and the decision of the Council for Medical Schemes Appeal Committee on the 17th September 2007 is set aside;
- 13.2 the Respondent is obliged to pay the full amount claimed by the Appellant.

SIGNED this 11th day of November..... **2008**

L I GOLDBLATT
CHAIRMAN

for DR S M PILLAY
MEMBER OF THE BOARD

for D TERBLANCHE
MEMBER OF THE BOARD