

**IN THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL
SCHEMES**

In the matter between:

██████████ Dr M

Appellant

and

METROPOLITAN MEDICAL SCHEME

Respondent

RULING

- 1 This matter concerns the determination of two issues. The first is whether the practice by which Dr ██████████ applies the billing codes is appropriate. The second is whether the scheme and its administrator are entitled (or have discretion) to pay directly to the member after a service provider had already rendered a service to the member and submitted his bill to the scheme or the administrator. We deal first with the second issue.

- 2 The second issue arose in *Alimag v Allcare* where this appeal committee found that there is no such entitlement or discretion. We can think of no feature that distinguishes this case from the *Alimag* case, thus requiring a departure from the finding in that case. The scheme has not pointed us to any.
- 3 The applicable provisions of the Medical Schemes Act, 131 of 1998 (“the MSA”) in this regard are section 59 and regulation 6. Reference was made to those provisions during the course of argument. Both counsel are conversant with those provisions. It is unnecessary to reproduce them here.
- 4 The SCA judgment in *Medscheme Holdings (Pty) Ltd and Another v Bhamjee* 2005 (5) SA 339 (SCA) to which the scheme refers is clearly distinguishable. First, there is no allegation that Dr [REDACTED] signed an acknowledgement of debt. Second in *Bhamjee* the SCA found that since no foundation had been laid for Dr Bhamjee’s claim for payment, either in the pleadings or in evidence, his claim for payment should have been dismissed. Thus if a proper foundation has been laid for payment (such as that a service has been rendered bona fide to the member and an account submitted) it is not open to the scheme to withhold payment outside the provisions of regulation 6, or to make direct payment to the member.
- 5 Second, there is nothing in section 59(2) of the MSA to suggest that payment for services already rendered by a service provider, and in respect of which accounts have already been submitted for payment, is nonetheless to be made directly to the member.

6 Third, it is unconscionable that the scheme (or its agent acting on the scheme's instructions) should withhold payment indefinitely on allegations of fraud which it has been unable to prove. Regulation 6 read together with section 59(2) of the MSA make provision for what must be done where the service provider's account is disputed.

7 Thus, as regards the second issue of direct payment, the scheme has no right or lawful justification not to make payment to Dr [REDACTED] for services already rendered to its members and in respect of which accounts have been submitted for payment. Indeed, it emerged at the hearing of this matter that Dr [REDACTED] is now being paid directly since he has modified his billing practice.

8 As regards the first issue, the following emerges both from the written submissions and in argument:

8.1 the Registrar expressed the view that the matter of the propriety of the billing codes applied by Dr [REDACTED] must be referred to the Department of Health for directions;

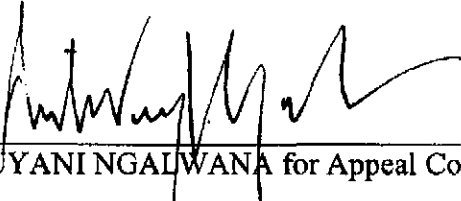
8.2 Dr [REDACTED] wants the matter of the appropriate use of billing codes investigated by the Society of Cardiothoracic Surgeons of South Africa and that the determination of this issue be held over by the Registrar until the Society has given a formal and definitive directive; and

8.3 The Society has indicated its willingness to perform the exercise.

- 9 In these circumstances, it would seem a pointless exercise for this appeals committee to busy itself with a matter on which it has no expert understanding, while experts are willing to perform the exercise and give direction conclusively.
- 10 Since it is the scheme's agent ██████ that is questioning Dr ██████ use of the billing codes, it would ordinarily be it that should provide definitive proof of its allegations against Dr ██████. That would entail it paying for the cost of conducting the exercise, in much the same way that insurance companies that wish to satisfy themselves on the condition of a disability claimant would refer the claimant to a medical practitioner of their choice at their own expense.
- 11 However, at the hearing of the matter Dr ██████ in answer to a question put to him by a member of this appeals committee, undertook to show that his billing practice was appropriate. Not only has he not done that; he has also changed his billing practice to be consonant with that acceptable to the scheme. This seems to us to indicate his acceptance that his billing practice may not have been appropriate. It may also be an indication that he has decided to adopt a pragmatic approach of, as it were, "pay now and argue later" (that is, modify his billing practice and argue about its appropriateness later, thus ensuring that he is at least being paid in the meantime).

12 Whatever his motivation, this committee is of the view that he needs to satisfy the scheme (or its agent) why his billing practice is different from that of his peers, as he has undertaken to do. That should also serve to resolve the issue of the R [REDACTED] that is being claimed from him by [REDACTED] which may be related to his billing practice. We say so because Dr [REDACTED] raised this issue in his appeal.

13 In the result, while Dr [REDACTED] has not satisfied the scheme and/or Qualsa of the appropriateness of his billing practice, this appeal cannot succeed.


VUYANI NGALWANA for Appeal Committee

For the Appellant:

[REDACTED]

For the Respondents:

Messrs Melunsky, Timothy, Mazibuko

Date of hearing:

09 March 2009

Date of Ruling:

20 April 2009

~~IN THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL~~
~~SCHEMES~~

In the matter between:

POLMED

Appellant

and

REGISTRAR FOR MEDICAL SCHEMES

Respondent

RULING

- 1 This is an appeal against the decision of the Registrar in terms of section 48 of the Medical Schemes Act, 131 of 1998 ("the MSA"). The Registrar found that [REDACTED] did not terminate his continuation membership of Polmed and ordered the scheme to re-instate it prospectively.

- 2 The question that arises is whether the Registrar was correct in so finding.

3 On the written submissions before us it would seem the Registrar's finding
may not be correct on the facts.

4 [REDACTED] was medically boarded in January 1999 and thereafter became a
continuation member in terms of rule 6.2.1 of the scheme rules. The rule
provides, in material terms, as follows:

“A member may retain his or her membership of the Scheme with his
or her registered dependants, if any, in the event of his or her
retirement from the service of the employer or his or her employment
being terminated by the employer

- 6.2.1.1 on account of age;
- 6.2.1.2 on account of ill-health;
- 6.2.1.3 ...
- 6.2.1.4 ...”

5 His employment having been terminated “on account of ill-health”, he became
a continuation member pursuant to rule 6.2.1.2.

6 But in March 2001 he ceased to be a continuation member when, according to
the scheme, he failed to make contributions. In a letter addressed by [REDACTED]
to the scheme on 10 July 2007 he says he was

“never informed by staff at Polmed Office's Durban that should I
cancel my Medical Aid at any time, that I will not be able to make an
application for membership in the future”.

7 Although not much was said about this at the hearing, [REDACTED] talk of
cancellation of his Medical Aid in his letter seems to give some credence to
the scheme's allegation that his continuation membership was terminated as a
result of non-payment of contributions. But because this can only be done

within the strictures of section 29(2)(a) of the MSA read together with whatever the rules say about termination of membership, and we were not addressed on that issue, we do not think it fair to rely on this ground.

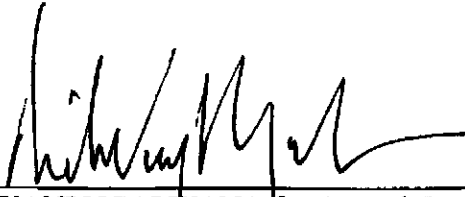
8 But then [REDACTED] wife, who was also a [REDACTED] became a main member on 16 September 2000. He then became a dependent on his wife's membership on 1 May 2003. During the intervening period between March 2001 and 1 May 2003 he was neither continuation member nor dependent member on Polmed. A dependant member cannot be a continuation member at the same time.

9 In October 2007 the wife resigned as a [REDACTED] and therefore could not become a continuation member because she had not retired on account of age or ill-health. With her resignation went [REDACTED] dependent membership status. He cannot now, as he seeks to do, come back as a main or continuation member. Rule 6.2.5 of the scheme rules is clear in this regard. It provides:

“Where a continuation member voluntarily terminates his or her Membership from the Scheme, he shall not be readmitted as a member unless he is newly employed as an employee by the employer...”


10 [REDACTED] voluntarily terminated his continuation membership and subsequently became a dependant on his wife's membership. He says he was so advised by the scheme but there is no evidence of this. He has not sought to be re-employed so he could be eligible for readmission as a member under rule 6.2.5.

11 In the result, the appeal must succeed.



VUYANI NGALWANA for Appeal Committee

For the Appellant: *Messrs Tshabala and Maphalane*

For the Respondents: 

Date of hearing: *09 March 2009*

Date of Ruling: *20 April 2009*