

**THE COUNCIL FOR MEDICAL SCHEMES  
APPEAL COMMITTEE**

In the Appeal between:

**MEDIHELP**

Appellant

and

**L S**

Respondent

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**APPEAL RULING**

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1. The dispute between the parties concerns the refusal by the Appellant to pay for certain hospital costs incurred by Mr P W, who is a dependant member of the Appellant, as a result of his hospitalisation and subsequent treatment following an attempted suicide.
  
2. The Appellant received a hospital account for Mr PW's hospitalisation from 8 May 2006 until 11 May 2006, and paid for this expenditure.

3. However, Mr PW was further hospitalised between 12 and 15 May 2006 in respect of which Wilgers Hospital has rendered an account totalling approximately R23 000.00.
4. The basis for the Appellant's refusal to pay for this further account is that, firstly, no pre-authorisation was sought for this hospitalisation as is required by the Appellant's Rules and secondly, that no account in respect of this hospitalisation was submitted to the Appellant timeously.
5. There has been some debate between the parties concerning the nature of the condition that required Mr PW's further hospitalisation, and whether the Appellant would, had all the correct procedures been followed, be liable to meet these costs..
6. For the purposes of the determination of this appeal it is not necessary to resolve this particular dispute. It appears, in any event, that the parties accept that the hospitalisation in dispute was in respect of a prescribed minimum benefit (PMB) condition.
7. Whilst it is true that regulation 8 promulgated under the Medical Scheme's Act requires a medical scheme to pay in full, without

co-payment of the use of deductibles, the diagnosis, treatment and care costs of the PMB conditions, regulation 8(4) specifically authorises medical schemes to employ "appropriate interventions to improve the efficiency and effectiveness of healthcare provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies".

8. Acting in accordance with the regulation the Appellant has, in Annexure 2 to its Rules, introduced a requirement of pre-registration in respect of prescribed minimum benefits.
9. The relevant provision of the Medihelp Rules provides as follows:

*"In order to qualify for prescribed minimum benefits the prescribed minimum benefit condition as well as each separate service relating to the condition must be pre-registered in the manner as prescribed by Medihelp, except for a psychiatric admission which shall be regarded as a prescribed minimum benefit condition during pre-registration of the admission; provided that in the case of an emergency*

*medical condition, registration should take place on the subsequent day of business after the incident".*

10. It would appear that it is common cause between the parties that no pre-registration was sought in respect of the period of hospitalisation which form the subject matter of this dispute. The condition of the dependant member, Mr P Smit, cannot be used as a reason for the failure to obtain such authorisation since that responsibility would have lain with the principal member, Mr J M, the father of the patient.
  
11. The Appellant also contends that it received the account in respect of this subsequent period of hospitalisation for the first time on 7 June 2007. In this regard there is a factual dispute between the parties. Mr & Mrs PW have contended that they were telephonically informed by the Appellant on 19 July 2006 that the disputed account had been received. This is disputed by the Appellant, which says that it has no record of such phone call in its telephonic records. The Smits contend that the hospital confirmed that it had submitted its account directly to the Appellant, however at the appeal hearing no representative of

the hospital was prepared to confirm either that the account had been submitted or that the PWs had been so informed.

12. Rule 15 of the Appellant's rules requires members to submit their claims not later than the last working day of the fourth calendar month following the month in which the service was rendered.
13. The onus is on the member to provide the Appeal Committee with proof of the timeous submission of a claim. The scheme cannot be expected to prove a negative, i.e. the non-receipt of the claim in question. Obviously it is difficult for a member to prove receipt on the part of the scheme, but members are generally in a position, at least, to prove submission of a claim, whether in the form of a fax transmission slip or a record of registered post.
14. In the current dispute there is no evidence before the appeal committee upon which it can conclude that the Wilgers Hospital account was indeed submitted to and/or received by the Appellant. If the members' contention is correct and he was advised by the hospital that the account had been submitted, and it turns out that the account was not in fact submitted, his

complaint must lie with the hospital. The Appellant cannot be compelled to pay an account that was not received in accordance with its rules.

15. In the circumstances it would appear that the Appellant has correctly applied its rules in its refusal to meet the cost of the dependant member's hospitalisation between 12 and 15 May 2006. The appeal must, in the circumstances, succeed.
  
16. The ruling of the Registrar, as amended, is therefore set aside and replaced with a ruling to the effect that the Appellant's refusal to pay the disputed accounts is in line with the provisions of its registered rules and is, in the circumstances, justified.

DATED at JOHANNESBURG on the                      day of DECEMBER 2007

**P R JAMMY**

For: Appeal Committee