

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

In the matter between:

**VWF**

Appellant

and

**MEDIHELP**

Respondent

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**RULING**

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[1] This appeal turns on the proper interpretation of the rules of Medihelp. The rule in question is paragraph 2.4.4 of schedule B to the rules. It reads as follows:

“**First case**’ shall mean the first time that benefits are granted for one of the items in the subcategory “medical, surgical and orthopaedic appliances” under General Services during the period of a member’s and/or dependant’s uninterrupted membership as a beneficiary: provided that benefits for the second and subsequent case(s) shall be granted in accordance with the annual limit for General Services.”

[2] The following items<sup>1</sup> appear in schedule B1 under the category “medical, surgical and orthopaedic appliances”:

- Wheelchairs
- Artificial limbs
- Artificial eyes
- Back, leg, arm and neck supports as well as trusses
- Crutches
- Orthopaedic footwear

[3] In his ruling the Registrar interpreted the definition of “first case” to mean

“if benefits were granted for a specific appliance [among the six listed above] . . . then it will be deemed to be a “first case” and the same benefit may not be claimed again by a member. However, if a member received crutches then there is nothing preventing him from claiming for another appliance, which is for artificial limb as he has not received any benefit for this specific appliance yet from his benefits . . . .”

[4] Medihelp takes issue with this interpretation. It says on a proper interpretation of the rule “first case” relates to all items appearing in

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<sup>1</sup> Under the Medihelp Plus option to which Mr W belonged at the time

schedule B1 and not in relation to each type of service separately. On that interpretation, once a member has claimed for one item he cannot claim again for any of the other items as a core benefit.

- [5] The member in this case claimed in 2007 for crutches and Medihelp paid for them in full. During the same year he subsequently claimed for a prosthetic leg (or artificial limb) but Medihelp says that should be paid for from his General Services annual limit (if there is still anything left in that pool of funds) and not from the core benefits limit since he has already claimed for crutches which constituted “first case”.
- [6] In our view the definition is ambiguous and is capable both of the Registrar’s interpretation and that of Medihelp. In these circumstances, our courts have resorted to a purposive interpretation which seeks to give effect to the purpose of the instrument sought to be interpreted. It seems to us the purpose of the rule was to prevent abuse characterised by multiple claims for the same service. This is in line with the purpose of the Medical Schemes Act<sup>2</sup> as captured in the preamble, namely, “to protect the interests of members of medical schemes”. It is also consistent with, for example, section 28 of the MSA which prohibits dual memberships.

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<sup>2</sup> 131 of 1998 – “the MSA”

- [7] While it is in the interests of members to prevent multiple claims in respect of the same service, the same cannot be said in relation to what has happened here. A simple practical example should illustrate this point clearly. Member X is involved in a car accident and damages his right leg. Member Y in the same accident damages her left leg. They are both taken to the same hospital and are both members of the same scheme and same benefit option. Member X's treating physician holds the view that his leg has been irreparably damaged and that he must get a prosthetic leg. He does and claims successfully from the scheme. The same physician says the same thing to member Y but she and her family will have none of that and insist that the leg can still be saved. The physician then suggests crutches for six months just to see what progress she will make. She claims for the crutches and the scheme pays. When the leg deteriorates, both she and her family decide to accept the physician's advice to get a prosthetic leg. In our view, it could never have been the intention behind the rule – or the Registrar in approving it – to deny member Y the benefit for a fully-funded prosthetic leg in these circumstances, otherwise the effect would be to encourage members to elect the more expensive treatment option even if it is not in their long-term interest to do so.

[8] In this example, Member X is rewarded for not treating the leg while member Y is punished for first attempting to rescue it. This can never be in the interests of members.

[9] In the circumstances, our view is that the more prudent interpretation is that members may not claim more than once for the same item because that would be abuse and therefore not in the interests of members. There is nothing in the rule, on a purposive interpretation of the rule read in the context of the MSA, that prevents members from claiming for one item and then another depending on the diagnosis and treatment. The same applies where a member, for instance, claims for a wheelchair believing that he will never again be able to walk, but later recovers and requires crutches.

[10] In the result, the appeal cannot succeed.

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V NGALWANA for the appeal committee

*Date of Hearing:* 12 August 2008

*Date of Ruling:* 8 September 2008

*For Van Wyk:* No representation

*For Medshield:* Dr Moses and Messrs Wambag and Coetsee

*For Registrar:* Mr Louis Pautz