Decisions In Dispute Resolution Forums Likely To Benefit Medical Scheme Members

The medical scheme industry's practice of meeting benefits owed to members through direct payment to medical service providers has been questioned, with schemes refusing to pay service providers for accounts lodged for services rendered.

Generally, the basis for such refusal is suspicion of fraudulent activity.

Yet may a medical scheme refuse to pay a service provider that has lodged an account for services rendered to one of its members? The decisions in dispute resolution forums will impact on all stakeholders, including members and the medical schemes themselves.

Service providers have argued that the Medical Schemes Act , specifically section 59(2), creates a basis for direct payment by stating that a medical scheme may dispose of any benefit owing to a member – either to the service provider directly or to the member - within 30 days of the scheme receiving the claim.

The issue is whether section 59(2) of the Act merely allows medical schemes to pay service providers directly or whether it obliges them to do so directly. The Council for Medical Schemes (CMS), a regulatory body supervising private health financing through medical schemes, has a dispute tribunal to which members may lodge complaints, which would initially be heard by the Appeal Committee, after which they may be referred to its Appeal Board.

In Alimag Pharmacy v Registrar for Medical Schemes, the question raised was whether a scheme could withhold payment from a service provider In this case the scheme was withholding payment to a group of four pharmacies for services rendered owing to a fraudulent claims investigation.. The scheme alleged that the Act gave medical schemes the discretion to pay either the service provider or the scheme member.

The Appeal Committee disagreed, stating that there was nothing in section 59(2) to suggest a scheme could pay a member directly for an account that had already been submitted by the service provider. The Appeal Committee took the same view.

In both cases the submission of an account by a service provider was considered sufficient to oblige the scheme to pay that provider directly, leaving the schemes with little recourse when they suspected fraudulent activity.

The Appeal Board differed when faced with the same question in Government Employees Medical Scheme (GEMS) v Omphemetse Pharmacy CC. GEMS had given notice to Omphemetse that it would no longer pay claims to it directly. Rather, GEMS would pay any benefit owing directly to its members; Omphemetse would need to recover payment directly from the members. Omphemetse subsequently lodged a complaint against GEMS alleging that GEMS had not paid moneys owed to it for services rendered to its members.

The Appeal Board found there was no automatic contractual relationship between a medical scheme and a service provider entitling the service provider to such payment. The Board noted that a medical scheme existed and was registered for the purpose of assisting its members in defraying expenditure incurred in accordance with the rules of the scheme in return for contributions paid to it by the member. Thus, a medical scheme may lawfully discharge its obligations owed to a member by paying the service provider directly. But in the absence of a separate contract between the service provider and the medical scheme there exists no legal nexus upon which a service provider may enforce direct payment from the medical scheme.

The medical scheme has a duty to reimburse its members.. The Appeal Board explained that it was the member and not the medical scheme that was indebted to the service provider.
The Board referred to the SCA judgment of Medscheme Holdings (Pty) Ltd and another v Bhamjee wherein it was found that Mr Bhamjee, a medical practitioner, had no basis upon which to demand that Medscheme pay him directly. The SCA appeared to recognise that although section 59(2) created a basis upon which medical schemes were allowed to discharge obligations owed to members by reimbursing service providers directly, the section did not oblige the medical scheme to do so where the provider had lodged an account with the medical scheme.

Hence, unlike the relationship between members and medical schemes, there was no contractual or other automatic relationship between medical schemes and service providers. Accordingly, for a service provider to hold a medical scheme liable to pay an account there

would have to be an agreement between the scheme and the service provider.

How do these decisions impact industry stakeholders?

To be ensured payment, service providers must either claim payment directly from their patients, or ensure that they have contractual agreements with medical schemes, which will have to decide whether or not to enter into contractual relations with service providers, which service providers and how many.

Seemingly the only potential beneficiaries of these decisions are medical schemes, since they will have more control over the payment of benefits. However, the effect of fraudulent activities in the private medical insurance industry must not be underestimated. It is estimated that the health sector is defrauded of between R4 and R13 billion a year, with grave consequences for member contributions.

Hopefully the added control that medical schemes will have over disposing of benefits owed will decrease the occurrence of fraudulent activities and decrease the escalating costs of private medical aid membership.

Written by Michelle David, senior associate, and Rebecca Jansch