Fit-Tribunal tal-Konsumatur

Patricia Doris Blundon Jack

vs

Global Capital Health Insurance Agency Ltd

CCT11/14

September 4, 2017

The Tribunal

Having seen the plaintiff's claim of the 16th January 2014 whereby plaintiff premised that on the 3rd April 2012 she entered St. James hospital for a knee replacement and was due to be discharged on the 9th April 2012. Her consultant Mr Anthony Bernard subsequently maintained that she needed a further six (6) nights in hospital to recover.

Having seen that defendant company is refusing to pay for these extra nights claiming that they do not form part of the insurance cover.

Having seen also that the amount in dispute is €1,134; in effect plaintiff is requesting that this Tribunal order defendant company to pay said amount to St. James Hospital which is not a Party to the suit.

Having seen the defendant company's reply of the 11th February 2014, whereby it refuted plaintiff's claim as unfounded primarily because she did not observe the terms of the cover which stipulates that for an in-patient stay lasting 5 days or more, a consultant's certificate would be required before the 3rd night. This certificate was not produced within the stipulated time

Having seen that defendant company authorised direct settlement for the total length of stay of 6 nights and paid the sum of €8,136 in full, in accordance with the level of cover that plaintiff had with defendant company.

Having seen the minutes of the sitting of the 24th February 2014, whereby Dr. Leontine Calleja on behalf of plaintiff, requested that proceedings be conducted in the English language.

Having seen that defendant company did not object.

Having seen that the Tribunal as previously composed did not authorise proceedings to be conducted in the English language but nevertheless continued to hear proceedings in the English language.

The Tribunal therefore considers this to be a tacit and implicit authorisation for proceedings to be so conducted.

Having seen the note-verbal of 27th December 2016, whereby the Tribunal brought to the notice of the Parties an anomaly regarding the procedure adopted in this case and requested submissions on the issue as to whether St. James Hospital should be called into the suit.

Having seen the note-verbal of the 13th March 2017 whereby the Tribunal ordered St. James Hospital to be called into the suit, after having seen that the parties had no objection to this.

Having seen that St. James Hospital did not enter a formal plea but sent a letter on the 30 March 2017 registering its contestation.

Having seen the records and documents of the case;

Having heard the testimony of witnesses on oath and final submissions;

Considers

That as far as the merits of the case are concerned, there is no apparent controversy between the parties. Both agree that on the dates in question, plaintiff had a valid health insurance cover with defendant company.

Plaintiff was due to undergo a surgical knee replacement operation on the 3rd of April 2012. To this end, on the 22 March 2012 Mr. Anthony Bernard (orthopaedic consultant) sent a letter to St. James hospital, advising a total left-knee replacement. This letter was subsequently forwarded to defendant company (paragraph 3 - Affidavit Charles Zarb) and St. James hospital sent defendant company a pre-authorisation form (Doc. GC2) whereby the estimated length of stay was declared to be between 5 - 10 nights. Although Doc GC2 is

not dated and no insurance authorisation details are listed, in an email dated 26th March 2012 (Doc GC8), defendant company authorises direct settlement for the procedure covering a length of stay of 5 nights.

On the 7th April 2012, on the day before plaintiff was due to be discharged, Mr. Tonio Agius issued a medical report (Doc GC10) advising that plaintiff was due for discharge on the 9th April 2012 and advised that she be provided with domiciliary nursing services for one and a half to two months. To this end and on the basis of this report, defendant company authorised an extra night at hospital extending the stay to six nights.(GC 9, GC 11; email 10th April 2013 15:04 from Christine Borg.) In a previous email dated 26th March 2012, said Christine Borg had authorised 5 nights and had also requested that a medical report be filed for any extra nights.

Considers

That it transpired that although plaintiff was authorised an extra night for recovery, she was not discharged after 6 nights but after 12. When the bill covering twelve (12) nights was presented to defendant company, it refused to honour the additional six (6) extra nights which were not originally authorised claiming also that according to the insurance cover, in-patient stays longer than five (5) days must be authorised after client sends a medical report from a consultant before the third night confirming diagnosis, treatment already given, treatment planned and discharge date.

That once this certificate was not forthcoming before the third day defendant company refused to acknowledge cover for the extra six (6) days.

Considers

That, according to Step 2 of Chapter 1 'How to use your Bupa Malta Health Plan) client must contact Bupa ***whenever possible*** (highlighted by the Tribunal) before in-patient or day-case treatment for pre-authorisation. Accordingly, this process puts Bupa *directly in-touch with* client's *hospital so that Bupa can look after the details whilst* client *concentrates on getting better.*

From this it emerges that Bupa is acknowledging that circumstances may arise where it would not be possible for a client to contact Bupa **before** treatment for pre-authorisation and that once authorisation is given a direct contractual relationship arises between Bupa and the hospital.

The Tribunal therefore observes that at this early stage when client/patient has been given authorisation for treatment, client assumes a back-seat and it is the hospital and Bupa which are to look after the finer details as explained in the same paragraph. As a natural consequence of this, it would be illogical and absurd to assume that a patient should suddenly be expected to provide information to defendant company as to the state of his/ her health and have to worry about medical reports being submitted and filed on time, particularly since patient might not know (or might not be in a position to submit) information about the finer details of his/ her medical condition.

Page 14 of the Membership Guide which details the requirements for an in-patient stay in excess of 5 days reverses the contractual relationship and puts the onus on the patient to contact the defendant company.

This however would seem to contradict the paragraph above mentioned where the relationship between hospital and defendant company is paramount, in the best interest of client/patient. This Tribunal feels that it is unrealistic to expect a patient undergoing treatment in hospital to be concerned with the finer details of this requirement. It is up to the hospital to see that the requirements demanded by defendant company are observed and certainly not the responsibility of the patient/client who has no control over whether a medical report has been filed or not. For even if it were to be argued that plaintiff did in fact ask the consultant to send a medical report, there is no way client can ever be in a position to guarantee that this report is in fact sent. In such a scenario, where would that leave client?

That having contacted defendant company in March, requesting a 5 - 10 day in-house stay (Doc GC2), the hospital was already in a position to know that 5 days would probably not suffice and that they ought to have been vigilant in sending the certificate on time, knowing that their patient, a Bupa client, was occupying one of their beds. The fact that all correspondence relating to this case was subsequently deleted does not augur well for the hospital administration and puts them at a further disadvantage.

That, in this particular case, although defendant company was given a clear indication at a very early stage that estimated length of stay was between 5 -10 nights (Doc. GC2), Christine Borg made it clear in her email of the 26th March 2012 that 'A medical report is required for any extra-nights'. In actual fact, a medical report was provided on the 19th June 2012 (Doc GC23) but that was over two months after the operation.

Considers

That the fact that this medical report was filed after the time-lapse as provided by the Bupa contract is not the fault of the patient and certainly not the fault of insurance company. If any blame is to be found, this should be placed squarely on the hospital's shoulders for failing to observe the requirements detailed by insurance company that were well known to it from the moment the patient (an elderly lady) entered hospital for treatment. It was the hospital, after all, which initially estimated a 5 - 10 day stay and it was in their interest to monitor patient and communicate with insurance company as to patient's progress or otherwise. The fact that it did not do so in time, puts it at fault.

For these reasons, the Tribunal therefore decides that plaintiff's request as far as Global Capital Insurance Health Insurance is concerned, should not be upheld, in the sense that the insurance company should not be made to pay any sum of money to St. James Hospital. That the latter should in turn, bear the consequences of its inaction and delay thereby being condemned to pay the costs of this case.

Michela Spiteri LL.D
Arbiter