# RULINGS ISSUED BY THE OFFICE OF THE REGISTRAR

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E v GEMS

The complaint concerned the Scheme's purported failure to extend the authorisation granted to the Member's dependent for her medical condition.

In its response to the complaint, the Scheme submitted that during the period 28 November 2022 and 19 January 2023 it received claims from a service provide on behalf of the Member's dependent. It indicated that the diagnosis related to ICD10 code G80.9 (cerebral palsy, unspecified). That the treatment plan for the latter condition made provision for tariff codes 66311 x1 and 66201 x2. It stated that Tariff code 66201 for service dates 2 November 2022 and 9 November 2022 under code G80.9 were approved within the PMB entitlement. It further stated that the approved treament was however exceeded with the service dates of 28 November 2022 and 15 December 2022. Therefore, the two additional sessions were then declined because they were not clinically appropriate. The Scheme averred that it rejected to extend authorisation and thus the Member was liable for the additional sessions.

Upon investigation, the submissions made by both the Member and the Scheme were reviewed by the Registrar. The matter was referred to the Clinical Review Committee (CRC) for a clinical opinion. The CRC advised that the dependent's condition, G80.9 - Cerebral palsy, unspecified, is only a PMB where there is difficulty in breathing, eating, swallowing, bowel, or bladder control due to a non-progressive neurological (including spinal) condition or injury. The description for tariff code 66201 is observation and screening. That the Scheme provided the member with a care plan for the follow-up of the condition Cerebral palsy. It indicated that the Scheme paid for tariff code 66201 x2 as per available care plan benefit. It advised that there is no clinical information to confirm that the treatment related to difficulty in breathing, eating, swallowing, bowel, or bladder control, hence the condition is not PMB. CRC concluded that the Scheme's decision was correct.

Prescribed Minimum Benefit conditions(PMB) are those conditions listed in the Diagnosis and Treatment Pairs in Annexure A of the Regulations or any emergency medical condition. PMBs consist of a set of defined benefits to ensure that all medical schemes members and their

beneficiaries have access to certain minimum health services irrespective of which benefit option the member belongs to. In terms of the provisions of Regulation 8(1) of the Act, the diagnosis, treatment and care of a PMB condition must be paid in full by a medical scheme.

A ruling was therefore issued confirming that the Scheme's decision was compliant with the Act and its rules since the dependent's condition was non-PMB. It was found that the Scheme discharged its funding liability in accordance with its protocol. The complaint was effectively dismissed.