BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES

Ref.: CMS 81215

MR J Appellant

And

PROFMED MEDICAL SCHEME Respondent

RULING AND REASONS

THE PARTIES

1. The Appellant is Mr J, (The “Appellant”), a member of the scheme.
2. The Respondent is Profmed Medical Scheme (the "Respondent" or the “Scheme”), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the “MSA)
3. This is an appeal under section 48(1) of the MSA, providing that –

“(1) Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council.”

INTRODUCTION

4. The Appeals Committee heard the Appeal on 4th June 2024 via face-to-face meeting.
5. Mr J, the Appellant, represented himself at the hearing. He was accompanied by his friend, Mr W.
6. Dr T, the medical advisor, from Profmed medical scheme, appeared for the Respondent.
7. The meeting was held as a face to face sitting as the Appellant, had a severe hearing impediment and could not participate in the initial meeting of the 7th March 2024, whereupon the committee resolved to hold the meeting face to face and for the hearing to start de novo.

BACKGROUND

7. The Appellant, Mr J, is 79 years of age and has been a member of the Profmed Scheme since his late twenties.

8. He is on the ProSecure plus plan option, which is subject to scheme rules and managed care plans.

9. The Appellant was authorised for an MRI scan on the 21st July 2022, which he went for on the 22nd July 2022.

   a. He received an authorisation letter from the scheme confirming that R5100 shall be reserved and paid towards the scan from his day-to-day benefits.
   b. The amount was to be paid from this benefit if the diagnosis is confirmed to be a non PMB condition.
   c. It transpired that this amount was not paid towards the MRI scan but to other claims received from the member.

10. The Appellant in his interaction with the scheme wanted to specifically establish why the scheme in terms of the authorisation had confirmed the amount of R5100 towards the MRI scan and not obliged with the payment.

11. Not comfortable with the Scheme response, the Appellant submitted a section 47 complaint to the CMS, which was acknowledged on the 28th October 2022.

12. In responding to the CMS, the Scheme provided their response on the 13th December 2022, confirming that the diagnosis of the MRI scan did not reveal a PMB diagnosis and that other claims had depleted the day to day benefits before the MRI claim could be paid from those benefits.

13. The Registrar ruled on the 3rd April 2023, confirming that the legal issue is whether the Scheme was correct in declining the R5100 funding towards the MRI scan costs in terms of the authorisation letter; and found that the Scheme is not compelled to fund these costs based on the scheme rules in place

14. The Appellant felt his legal query was not answered specifically and submitted the Section 48 (1)Appeal to the CMS on the 19th April 2023.

DISCUSSION AND LEGAL FRAMEWORK

APPELLANTS SUBMISSION

15. Mr J commenced his submission by stating that the Scheme had erred in law by initially authorising funds for the MRI scan and then declining the claim based on the date of the claim being received by the Scheme.
16. From the bundle, the Appellant had received an MRI for his lower back from Drs R and partners at Wilgeheuwel hospital on the 22nd of July 2022.
    a. According to the radiologist, the scheme would be paying for the scan and the member would be responsible for the balance of R6486.00, which was paid.
    b. The radiologist's account of R9598.01 was rejected as the day-to-day benefits were used up by the time the claim reached the Scheme.
17. The Appellant put forward that the rule applied by the scheme conflicts with the authorisation
    a. There was R5100 available in day-to-day benefits on the date of service, but this was not used or reserved for the MRI scan.
    b. The authorisation was therefore misleading.
18. Mr J emphasised that the Scheme had misinterpreted their own rules
19. In terms of the authorisation letter, as contained below:

20. Mr J informed that the authorisation letter states that funding is dependent on what is available on the date of service, which was per paragraph 7 of the letter.
    a. He informed that the Scheme had misinterpreted their own rules, and these rules differ from what is contained in the authorisation letter.
    b. He also stated that the scheme had changed their contents to attend certain ambiguities in their authorisation letter, post his case with the scheme.
    c. From a legal perspective, where there is ambiguity, then the specific must trump the general, referring to points 1 and 7 contained in the letter.

21. The Appellant concluded by stating that his case is about a matter of principle, wherein the Scheme had committed to make the payment from the day-to-day benefits on the date of service per the authorisation letter and feels that the Appeal committee should set aside the Registrar's ruling and order the scheme to fund the R5100.

RESPONDENTS SUBMISSION

22. Dr T informed that the main issue before the Appeal committee was whether the condition diagnosed was a PMB level of care and whether the Scheme had applied its rules correctly in its funding decision on the MRI claim.
23. He submitted that at a section 47 level, the Registrar has found that the Scheme has complied with its rules in adjudicating the claim of Mr J.
    a. The scheme rules are not contradicting the authorisation letter, which should be read in its entirety and lists certain subject to conditions.
24. He stated that the Scheme was receptive to look at the humanistic aspect in reviewing the Member's claim.
25. He confirmed that the Scheme has an obligation to fund all PMB conditions in full in terms of the MSA, but from their perspective, the diagnosis received with supporting ICD 10 codes did not confirm a PMB level of care diagnosis.
    a. The MRI report[1] contained the DTP code 941A, which did not confirm any spinal cord compression or cauda equina syndrome.
26. The Respondent stated that the day-to-day benefits are not reserved and upon the member's query, this was communicated clearly.
    a. By the time the claim was received about 2 weeks after the service date, the day-to-day benefits were depleted from other claims of the Member.
27. Dr T reiterated that the Scheme was empathetic to the Member and shall consider the following upon queries from the committee:
    a. If it is that the specific treatments require an answer to relooking at whether the diagnosis may be a PMB, then the scheme shall do so again with the service provider.
    b. The ex-gratia process can be considered but this is an application process involving disclosure of financial hardship and showing the critical need for the clinical funding.

[1] Per paginated page 30 & 31 in bundle of documents

28. The Respondent concluded that the members diagnosis is not a PMB.
    a. The Scheme does understand that the member's contention.
    b. The ProSecure plus plan option is subject to scheme rules and managed care plans.
    c. There's also an obligation for members to familiarize themselves with ways to navigate their claims and use of the day-to-day benefits.
    d. The Scheme according to their rules cannot reserve funds in the day to day benefit and has to pay upon claims being received
    e. In this instance despite the authorisation provided, the day to day benefit was depleted and could not therefore pay the R5100
29. The Respondent feels the Appeal should be dismissed on the above grounds; and notwithstanding shall engage with the member if the committee so decides.

RELEVANT STATUTORY AND REGULATORY PROVISIONS.

30. The relationship between the member and the scheme is governed by the terms of the contract ('*the scheme rules*') that the appellant concluded with Profmed Medical Scheme.
31. The Contract in turn is governed by the Medical Schemes Act 131 of 1998 and the regulations (as amended) contained in the Act.

LEGAL FRAMEWORK AND EVALUATION

32. According to section 30 of the MSA . General provisions to be contained in rules.—(1) A medical scheme may in its rules make provision for—
    (*b*) the granting of loans to any of its members or to make *ex gratia* payments on behalf of or to members in order to assist such members to meet commitments in regard to any matter specified in the definition of "business of a medical scheme" in section 1;
    (*e*) the allocation to a member of a personal medical savings account, within the limit and in the manner prescribed from time to time, to be used for the payment of any relevant health service;

33. According to section 32 of the MSA. Binding force of rules.—The rules of a medical scheme and any amendment thereof shall be binding on the medical scheme concerned, its members, officers and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming.

34. According to section 8 of the MSA, Prescribed Minimum Benefits(PMB)—

(1) *Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.*

(2) Subject to section 29 (1) (p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that—

(a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.

(6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.

ANALYSIS AND FINDINGS

35. The Appeals Committee considered the papers filed in this Appeal; the further submissions the parties made; the relevant provisions of the MSA; and the rules of the Scheme.
36. It is common cause that:
    a. The Appellant joined the Scheme in his late 20's and has been a member of the scheme for close to 50 years.
    b. The Appellant is on the Prosecure plus plan option, which has managed care rules in place.
    c. The Appellant required to have an MRI scan done on his lower back, which was authorised by the Scheme.
37. It is not in dispute that the Member's condition required an MRI scan and that dependent on the diagnosis being a PMB, a PMB level of care and funding would be warranted.

a. In this case the Appellant's condition was diagnosed to be Spinal stenosis, lumbar region (M48.06) and M99 Intervertebral disc stenosis of neural canal, lumbar (M99.53).
b. There was no confirmation of the presence of spinal cord compression, ischaemia or degenerative disease and hence the MRI report therefore did not confirm a PMB condition under the Diagnosis and Treatment Pairs (DTPs) code 941A.
c. This was verified by the clinical review committee of the CMS in their findings.
d. Notwithstanding the Respondent put forward in their papers and in response to the Committee's query, that they are willing to have the diagnosis reviewed, per the Member's consent to see if it qualifies as a PMB condition.

38. Mr. J alleges that the scheme was at fault for not funding his out-of-hospital MRI scan, after authorising the scan and contends that the letter was misleading, and the scheme's rules contradict the authorisation letter.
39. The issue for adjudication is whether the Respondent/ Scheme was correct in declining the authorised funding of R5100 upon receipt of the claim.
40. According to the Scheme:
    a. An authorisation was provided to the Member for an MRI scan on 21/07/2022.
    b. The authorisation letter states under point 7 that "This authorisation is subject to available benefits and valid membership of member/dependent on the day of service."
    c. The available benefits and valid membership allow for facilitation of release of the authorisation only.
    d. With specific reference to this case, the Scheme would not have released authorisation if the Member's day-to-day benefits were depleted, or their membership was invalid.
    e. Payment of the claim is still subject to available benefits at the time that the claim is received.
41. The Scheme hence declined the funding in terms of rule 5A6 from the bundle of documents:

With reference to Rule 5A6 on page 35 of the Schedule of Benefits, (please refer to the screenshot below) PSP members are limited to two investigations per family in or out of hospital for MRI, radio - isotope and CT scans. In the instance that the scan is out of hospital, it is funded at 80% of Negotiated Tariff and is further subject to the day-to-day limit. Profmed's Schedule of Benefits is attached for ease of reference.

When the account for the MRI scan was submitted to the Scheme for payment, some two weeks later, it was declined with rejection code 464: Benefits depleted. This is because other claims were paid by the Scheme against the benefits available prior to us receiving the account for the MRI scan. This left nothing in his day-to-day benefit to pay for the scan.

42. Based on the evidence before the Committee, the authorisation letter received by the Member, does reference the available benefits on the date of the service:
    a. The authorisation letter also indicated that funding was based on the registered Scheme rules and the available benefits.
    b. The authorisation letter is silent on whether funds are reserved based on the authorisation but in effect dependent on available benefits
    c. The Scheme has apparently updated its authorisation letter to clarify the issue around when payment is made according to the Rules of the Scheme.
    d. The fact that the Member's day to day benefits were utilised for other claims means in essence that these claims would have to be paid by the Member, if the R5100 would have been paid or reserved towards the MRI scan.
43. Mr J in his supplementary heads of argument avers that:

> 5. This appeal turns on the crisp point as to whether Profmed is entitled to avoid paying for a medical procedure which it agreed in writing to pay for, which authorisation letter clearly stated that the effective date on which to calculate if benefits were available to the member is the date of service because the rules of the scheme differ from that letter and state that the effective date is the date on which Profmed received the account from the service provider.
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> 6. It is my submission that [redacted] erred in law when she came to the conclusion that the rules of the scheme must prevail and that Profmed's written agreement to pay may be ignored if no benefits were available to me on the date the account was received, notwithstanding the contents of the authorisation letter.

    a. The Appellant states that in the case of a conflict between provisions of the law, then the specific must override the general.
    b. The Appellant further argues that the *contra prefentem rule*, provides that where there is doubt about the meaning of a contract, in this case the authorization letter, the words will be construed against the person who proffered them, ie the scheme.

44. The committee is of view that the legal principle and hierarchy is that the MSA is the overriding legislative framework, and the Scheme rules are valid and apply in this instance regarding the adjudication of the claim:

a. The committee agrees with the Respondent, that the entire letter must be read and interpreted in terms of the MSA and Rules of the Scheme.
b. Therefore, the specific point on 'payment' is subject to available benefits.
c. The committee notes the Scheme has amended the letter going forward.
d. Further it is evident that the day-to-day benefits cannot be reserved, and claims shall be funded upon receipt and per the rules of the scheme, meaning that the Scheme declining the funding of the R5100 towards the MRI scan for the reason of depleted funds in the day to day benefit is correct
e. Based on all the above and the registered Scheme rules and the applicable day-to-day limits, the committee agrees that the Scheme complied with its Rules and could not fund the claim.

FINDING

45. The Appeal Committee is of the view that whilst there was a misleading point on authorization of funds for date of service in the communication to the Member, there were ample grounds and evidence in the overall letter, and in the supporting valid rules applied by the Scheme, that it acted reasonably towards the Members query and was compliant within the ambit of the MSA in not funding the R5100 towards the MRI scan authorization.

46. The committee suggests a further engagement, pending the Member's consent, that there is a review of the MRI report findings, to determine whether the diagnosis fits that of a PMB diagnosis and concomitant PMB level of care funding.

47. The committee takes note that the Member may not be interested in an ex-gratia application process in consequence of the matter arising, but nonetheless includes this option in its findings, noting the specific requirements of such an application process, and that the Respondent may consider such an application.

48. The Committee agrees that in terms of the MSA, the relationship between the Member and the Scheme is contractual in nature and in terms of section 32 of the Act the scheme's rules are binding on members as well as the scheme.

a. "Binding force of the rules – the rules of a medical scheme and any amendment thereof shall be binding

on the medical scheme concerned, its members, officers, and on any person who claims any benefit under the rules or whose claim is derived from a person so claiming".

ORDER

49. The Appeals Committee accordingly:

    a. Dismisses the Appeal and upholds the Registrar's decision of 3rd April 2023.

    b. Requests the Respondent to review the diagnosis with a 2nd radiology opinion of the MRI scan result, based on the findings in this case, and pending the Member's consent

        i. Provides such report to the Member and Committee within 10 days of the Appeal Ruling being issued

    c. Makes no cost order

DATED AT CAPE TOWN ON THIS 12th June 2024.

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Dr S Naidoo

For: The Appeal Committee (Chairperson)

WITH –

Ms P Beck

Dr K Chetty

Dr T Mabeba

Ms M Ramagaga

Dr X Ngobese

CONCURRING, IT SO BE RULED