IN THE APPEAL BEFORE THE APPEALS COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES

HELD VIA THE MICROSOFT TEAMS VIDEO AND AUDIO CONFERENCING TECHNOLOGY

(Instituted in terms of the Medical Schemes Act No.131 of 1998)

Case number: **CMS/75990**

In the matter between:

B **APPELLANT**

And

BONITAS MEDICAL FUND **RESPONDENT**

ORDER AND REASONS

THE PARTIES

1. The Appellant is B ("the member or the Appellant") a member of the scheme in terms of the definition accorded to a "*member*" under the Medical Schemes Act 131 of 1998 ("the Act.")[1]

2. The Respondent is Bonitas Medical Fund, ("the Scheme or Bonitas") a Medical Scheme duly registered and regulated under the Medical Schemes Act 131 of 1998 (the "MSA.")

3. The Appellant represented herself at the hearing.

4. The Respondent was represented by the legal manager of the scheme; Ms. D, duly authorised to represent the scheme at the appeal hearing.

INTRODUCTION

5. This is an appeal in terms of section 48(1) of the Council for Medical Schemes Act 31 of 1998 ("the Act") pertaining to a decision of the Registrar dated 12 July 2021.[2]

6. This section provides 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."

7. The appeal arises out of the Appellant's complaint that there is non-compliance with the Registrar's ruling dated 12 July 2021.

8. The appeals committee heard the Appeal on 20 November 2024 via an audio and video conferencing link.

9. The Appellant seeks an order as follows "*I want Bonitas to pay for the appliances as they've been paying previously if the rules have changed I want a clear response on which rules have changed in 2020. If there is another service provider that can provide the same level of care at*

[1] '"member" means a person who has been enrolled or admitted as a member of a medical scheme, or who, in terms of the Rules of a medical scheme, is a member of such medical scheme.
[2] Page 35-37 of the Bundle

their rate they must then let me know so that I can get another quotation that will suite their rates. The patient need appliances that will improve her day to day life and that are safe and supportive for her condition as per doctor's motivation, we cannot buy any appliances as there is a huge possibility that they might worsen her condition."[3]

FACTUAL BACKGROUND

10. The Appellant is registered as the main member on the scheme. She has a special needs child with the conditions Hydrocephalus, Cerebral Palsy and Epilepsy.

11. In May 2020, Dr. P, the patients Paediatrician Orthopaedic Surgeon, submitted a request for appliances that the patient, the member's daughter, Z. , requires for day to day support. The Respondent requested a motivation, quotation and X-rays/MRI for PMB approval.

12. The Appellant submitted all of the requested documents to the Respondent.

13. In a complaint form dated 25 September 2020, the Appellant filed a complaint with the Registrar of the CMS. The basis of the complaint was that the Respondent declined the funding of the request for a wheelchair and related appliances

14. In a Ruling dated 12 July 2021, the Registrar upheld the complaint and ordered the Respondent to fund the dependant member's request for a wheelchair, standing frame, walker and splints in full in accordance with the provisions of Regulation 8 of the MSA.

15. The Appellant alleges that the Respondent has not complied with the Ruling of the Registrar and filed an appeal in terms of section 48 of the Act.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

16. The relationship between the member and the scheme is governed by the terms of the contract ("the schemes rules") that the member concluded with the scheme. The contract in turn is governed by the Act and the regulations (as amended) made in terms of the Act.

[3] Page 2 and 3 of the Bundle.

17. Section 32 of the Act stipulates as follows: *"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."*

WIDE APPEAL

18. This is a wide appeal. The Appeal Committee may therefore consider the matter afresh and is not restricted to the record of proceedings that were before the Registrar.

19. The burden of proof rests on the Appellant who must prove on a balance of probabilities that the appeal should succeed.

THE ISSUE IN DISPUTE

20. The issue to be determined is whether the scheme is in non-compliance with the ruling of the Registrar; and whether the Ruling of the Registrar is within the ambit of the Act read with the Regulations and enforceable against the Respondent.

THE APPELLANT

21. The Appellant submitted that she submitted a request to the Respondent for the following appliances for her disabled daughter:
    21.1 A wheelchair;
    21.2 Splints;
    21.3 A walker; and
    21.4 A standing frame.

22. The Appellant submitted that she makes application on an annual basis to the Respondent for the aforementioned appliances because her daughter is growing and the appliances become unsuitable for a growing child's needs.

23. The Respondent declined the funding of the appliances, despite funding these appliances previously upon the request of the Appellant.

24. Following the decline by the Respondent, the Appellant filed a complaint dated 25 September 2020 with the Registrar.

25. The Appellant resigned from the scheme on 31 December 2020.

26. The Registrar in a ruling dated 12 July 2021 upheld the complaint and ordered the Respondent to fund all the appliances requested by the Appellant citing Regulation 8 as the basis for upholding the complaint.

27. The Appellant alleges that the Respondent is in non-compliance with the Order of the Registrar and seeks an Order from the Appeals Committee that the Respondent complies with the Order of the Registrar.

THE RESPONDENT

28. The Respondent submitted that after the ruling of the Registrar was handed down, instructing the Respondent to "*fund the wheelchair, standing frame, walker and splints in full in accordance with regulation 8 of the MSA*", the Respondent dispatched correspondence to the Council for Medical Schemes indicating that the Fund accepts the ruling and will honour all claims submitted during the period of cover.

29. Further to the aforementioned letter and in another letter dated 19 July 2023 the Respondent indicated that whilst the ruling is accepted, the Respondent could not legally comply with the ruling.

30. The Respondent submitted that where a request / application is made, such as that made by the Appellant for the appliances, the first determination by the scheme is whether the condition of the member is a PMB and whether the appliances requested amounted to a PMB level of care. Once this two fold determination is confirmed, the Respondent has specific internal processes that must be followed for the request to be honoured and in this case for the appliances to be provided to the Appellant.

31. In terms of the Respondent's internal processes an application / request for the appliances must be made by the Appellant which is the "claim" for the appliances. Once the request is received by the Respondent it must be approved by the Respondent and the claim and quotations for the appliances is then forwarded to the Respondent's PMB department. In this instance the Appellant has not submitted a valid claim for all of the appliances and thus the Appellant has failed to comply with the Respondent's internal processes for the remaining appliances.

32. The Respondent placed on record that it funded the claim for the appliances in accordance with the Registrars ruling as follows:

    32.1 it funded the standing frame in the amount of R8 672.00';

    32.2 no claim for the wheelchair was received whilst the Appellant was still a member of the scheme only a quotation for the wheelchair from the Appellant and thus the scheme did not fund the wheelchair; further the Appellant requested an electronic wheelchair which is not a PMB level of care; and

    32.3 the splints and the walker were not funded by the scheme due to non-compliance with the Respondents internal processes.

33. The Respondent placed on record that the Appellant resigned as a member of the scheme whilst the request for the appliances was still being considered by the PMB department of the Respondent; and before the scheme received the Registrar's ruling.

34. The Respondent placed on record that it is not privy to all the reasons why some of the appliances were not funded by the Respondent's PMB department, other than that the request for an electronic wheelchair does not constitute PMB level of care; and that in terms of Regulation 5 and 6 of the CMS in the absence of a valid claim that complies with Regulations 5 and 6, and only a quotation from the member, the scheme is not legally compelled to Fund all the appliances requested by the Appellant.

CONSIDERATION OF THE MERITS

Common Cause

35. It is common cause that the member requested that the scheme funds a walker, standing frame, wheelchair, and splints for the members disabled daughter; that the member annually puts in a request to the scheme for these appliances; that the member's daughter has a PMB condition; that the four (4) appliances are PMB level of care; that the member resigned from the scheme on 31 December 2020; that the request from the member for the four (4) appliances was made at a time when the member was in good standing and prior to the member's resignation from the scheme; that the Registrar's ruling was issued after the member had resigned from the scheme; and that the scheme admitted that it accepts the Ruling of the Registrar and did not appeal the Registrar's ruling.

The Hearing

36. At the hearing it was not very clear why the Respondent did not comply with the Registrar's ruling.

37. What can be gleaned from the submissions of the Respondent is that the Respondent holds the view that it is not legally possible to comply with the Registrar's ruling because the member did not follow the prescribed internal processes of the scheme to submit an application for the appliances as required by the scheme; and the member only submitted a quotation for some of the appliances. Furthermore, the request of the member for the funding of the appliances does not comply with regulation 5 and 6 of the Act and hence it is impossible for the scheme to comply with the Registrar's ruling in full.

38. Regulation 8 of the Medical Schemes Act provides that the diagnosis, treatment and care of a PMB condition must be paid in full by the medical Scheme and read as follows:
"8. Prescribed Minimum Benefits.—(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."

39. No evidence was led by the Respondent to support a finding that the four (4) appliances are not PMB level of care or that the member's daughter does not have a PMB condition. Accordingly, the Appeals Committee is satisfied that the Registrar's decision was correct in this respect. and

that the internal processes of a scheme can never trump the schemes obligation to fund a PMB condition and the appliances requested where they are found to be a PMB level of care.

40. The Appeals Committee is further satisfied and finds that the facts of this case do not reflect that the Scheme was requested to fund an electronic wheelchair. This was confirmed by the Appellant at the hearing. Thus, the Scheme's decision to decline the funding of a wheelchair for the Appellant's daughter cannot be sustained.

41. We now turn to the Schemes reliance on Regulation 5 and 6 upon which the scheme relies as detailed in its Heads of Argument, which stipulate as follows –

"Regulation 5. Accounts by suppliers of services.—The account or statement contemplated in section 59 (1) of the Act must contain the following—
(a) The surname and initials of the member; (b) the surname, first name and other initials, if any, of the patient; (c) the name of the medical scheme concerned; (d) the membership number of the member; (e) the practice code number, group practice number and individual provider registration number issued by the registering authorities for providers, if applicable, of the supplier of service and, in the case of a group practice, the name of the practitioner who provided the service; (f) the relevant diagnostic and such other item code numbers that relate to such relevant health service; (g) the date on which each relevant health service was rendered; (h) the nature and cost of each relevant health service rendered, including the supply of medicine to the member concerned or to a dependant of that member; and the name, quantity and dosage of and net amount payable by the member in respect of the medicine; (i) where a pharmacist supplies medicine according to a prescription to a member or to a dependant of a member of a medical scheme, a copy of the original prescription or a certified copy of such prescription, if the scheme requires it;
(j) where mention is made in such account or statement of the use of a theatre— (i) the name and relevant practice number and provider number contemplated in paragraph (e) of the medical practitioner or dentist who performed the operation; (ii) the name or names and the relevant practice number and provider number contemplated in paragraph (e) of every medical practitioner or dentist who assisted in the performance of the operation; and (iii) all procedures carried out together with the relevant item code number contemplated in paragraph (f); and (k) in the case of a first account or statement in respect of orthodontic treatment or other advanced dentistry, a

treatment plan indicating— (i) the expected total amount in respect of the treatment; (ii) the expected duration of the treatment; (iii) the initial amount payable; and the monthly amount payable.

Regulation 6 - Manner of payment of benefits.—(1) A medical scheme must not in its rules or in any other manner in respect of any benefit to which a member or former member of such medical scheme or a dependant of such member is entitled, limit, exclude, retain or withhold, as the case may be, any payment to such member or supplier of service as a result of the late submission or late re-submission of an account or statement, before the end of the fourth month - (a) from the last date of the service rendered as stated on the account, statement or claim; or (b) during which such account, statement or claim was returned for correction. (2) If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant health care provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion. (3) After the member and the relevant health care provider have been informed as referred to in sub-regulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned for correction. (4) If a medical scheme fails to notify the member and the relevant health care provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of sub-regulation (2) or fails to provide an opportunity for correction and resubmission in terms of sub-regulation (3), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute. (5) If an account, statement, or claim is correct or where a corrected account, statement or claim is received, as the case may be, a medical scheme must, in addition to the payment contemplated in section 59 (2) of the Act, dispatch to the member a statement containing at least the following particulars— (a) the name and the membership number of the member; (b) the name of the supplier of service; (c) the final date of service rendered by the supplier of service on the account or statement which is covered by the payment; (d) the total amount charged for the service concerned; and (e) the amount of the benefit awarded for such service."

42. In its heads of argument the scheme argued as follows: "*Where valid claims (as contemplated in Regulations 5 and 6 in particular) were received, the Scheme duly paid those claims in compliance with the Ruling. It is therefore common cause that where a member obtains a healthcare service, the claim for such healthcare service must have actually been received by the member, and the claim must comply with the provisions of Regulations 5 and 6 of the Regulations. Accordingly, the scheme has acted in terms of its internal processes; regulation 5 and 6 and the appeal should be dismissed."*[4]

43. With respect to the scheme, other than the schemes says so, and without any evidence of the member's alleged non-compliance with Regulation 5 and 6, or the scheme taking the Appeals Committee into its confidence, it is simply not the duty of the Appeals Committee to make out the case of the Respondent. The reliance on Regulations 5 and 6 are at best unsubstantiated and fails the test dismally of "*he who alleges must prove*."

44. At this juncture, no appeal to the Registrar's ruling has been filed by the scheme in the time frame permitted by section 48(3) of the Act.

45. It also remains undisputed that the member was in good standing at the time when the member requested the four (4) appliances.

46. Accordingly, the scheme, in the absence of a compelling defence to the appeal and the ruling of the Registrar, is obligated to comply with the Ruling of the Registrar.

FINDING

47. Accordingly, the Appeals Committee after considering the evidence is satisfied and finds that:

47.1 the dependant member is disabled and the dependant members' condition is a PMB.
47.2 the four (4) appliances requested by the Appellant are PMB level of care.

ORDER

[4] Page 2 of the Respondent's Heads of Argument.

48. The Appeals Committee makes the following order:

48.1. The Appeal is upheld.

48.2 The Registrar's decision is confirmed and must be complied with by the Respondent.

48.3 There is no order as to costs.

THUS DONE AND SIGNED AT JOHANNESBURG ON THIS THE 23rd DAY OF DECEMBER 2024.

SIGNED
PA BECK
PRESIDING MEMBER

Dr. T Mabeba, Dr. H. Mukhari. Dr. X. Ngobese, Dr. K.S. Chetty and Dr. S Naidoo concur.