BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES (SECTION 48 APPEAL)

HELD VIA MICROSOFT TEAMS VIDEO AND AUDIO-CONFERENCING TECHNOLOGY.

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

In the matter between	**Ref number: CMS 84077**
Mr. M	**Appellant**
And	
Bestmed Medical Scheme	**Respondent**

Panel: Dr K. Chetty; Ms M. Ramagaga; Dr. H. Mukhari

Date of hearing: 12th February 2025.

Date of ruling: 11th March 2025.

RULING AND REASONS

THE PARTIES

1. The Appellant is Mr. M (The “Appellant” or “Member”), a member of Bestmed Medical Scheme.
2. The Respondent is Bestmed Medical Scheme (The “Respondent or the “Scheme”), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the “MSA” or “Act”).
3. Ms J, Legal Representative from Ngeno and Mteto Inc. appeared for the Respondent.
4. Mr V, senior complaints specialist for Bestmed was also present.

BACKGROUND

5. The Appellant, Mr. M is a Member of the Bestmed Medical Scheme.
6. Mr. M filed a formal complaint against Bestmed Medical Scheme, alleging improper handling of claims related to his son's dental procedure, including unauthorized deductions from his savings account and short payments to service providers.
7. Mr. M initially faced issues with authorisation for the procedure by Dr. M, with Bestmed limiting the approved theatre time to 45 minutes, declining certain procedure codes and confirming that Dr M is a Designated Service Provider (“DSP”).
8. Due to authorisation issues with Dr. M, Mr. M switched to Dr. U for his son's procedure. However, claims were still partially paid from his savings account and some codes were not covered.
9. Mr M stated that Bestmed said that Dr. M was part of their network, which Bestmed later disputed.

10. As a result Mr. M experienced a shortfall of R3,172.29 for the theatre usage and additional shortfalls for services provided by Dr. S, the anaesthetist, who charged 200% of the scheme tariff.

THE REGISTRAR'S RULING

11. The Registrar's Ruling was issued on 22nd May 2024.
12. The Registrar ruled that the Scheme's decision to decline funding procedure Code 8129 was incorrect as there is no code for hospital visit during regular hours. The Scheme is therefore directed to reprocess the procedure code for funding from the Scheme Benefit and refund the amount initially charged on the PMSA.
13. There is no legal basis to compel the Scheme to fund an incorrect procedure code (8355). The Complainant must liaise with the treating doctor in this regard.
14. There is no legal basis to compel the Scheme to fund Dr S' account above the Scheme tariff. The Complainant remains responsible for the shortfall.
15. The Member is now appealing this decision in terms of Section 48 Appeal.

APPLICATION TYPE AND RELIEF SOUGHT

16. This is an appeal under section 48(1) of the Medical Schemes Act (the "MSA or the Act").[1] This section provides that:
    a. *"(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".*
17. The Appeals Committee heard the appeal on 12th January, 2025 via an audio and video conferencing link.

[1] Medical Schemes Act 131 of 1998 as amended by Act 55 of 2001; Section 48(1); Proc 13/GG 19725/19990129

RELEVANT STATUTORY AND REGULATORY PROVISIONS

18. The relationship between the Scheme and the Member is governed by the terms of the contract ("the Schemes rules") the Scheme concluded with Member. The contract in turn is governed by the "MSA" and the regulations (as amended) made in terms of the Act[2].
19. This is a wide appeal. The Appeals Committee may consider the matter afresh and is not restricted to the record of proceedings that were before the Registrar.
20. 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

21. The issue in dispute is whether the Scheme was correct to not fund the account for services rendered in full according to the Schemes Rules.

POINT IN LIMINE

22. At the start of Mr. M's oral submission, he was requested to clarify if this was a new complaint that he was bringing, or whether it was the same complaint.
23. It was explained to him that whilst this is a wide appeal, new evidence can be submitted, but it must relate to the original complaint heard by the Registrar.
24. He indicated that it was the original complaint, and therefore the Appeal Hearing continued.

[2] Medical Schemes Act 131 of 1998. Section 32: **Binding Forces 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.*"

APPELLANTS SUBMISSION

25. The Appellant Mr. M, a member of Bestmed, lodged a complaint against Bestmed Medical Scheme regarding shortfalls incurred in respect of an in-theatre dental procedure for L (his son and dependant).
26. Specifically, he is aggrieved by the Scheme's decision not to fund Dr. S and Dr. U's claims in full and by the Scheme funding part of the in-theatre procedure from his Personal Medical Savings Account (PMSA).

27. On 03 August 2023, Dr. M, requested authorisation for dental treatment to be performed in theatre on four teeth. The Scheme provided authorization with certain limitations, including a 45-minute theatre time, while Dr. M requested 2 hours. Additionally, certain treatment codes requested by Dr. M were declined as they were not covered under the in-hospital benefit.

28. The member stated that as Bestmed rejected the first doctor on the basis of the theatre time of two hours being too long, and only 45 minutes would be authorised, he requested Bestmed to provide him with the list of doctors within the network, but claimed they refused. The member then approached Dr. M who he said that the Scheme stated was in their network of doctors, but this was later denied by the Scheme.

29. On 12 September 2023 the member’s son, L, was admitted to Cure Day Hospital for an in-theatre dental procedure performed by Dr. M. The Scheme authorized funding for dental treatment on eight teeth within a maximum of 45 minutes theatre time.

30. After the procedure the Scheme processed the claims and paid R3,942.40 from Scheme Benefits and R3,916.50 from the PMSA, with a shortfall of R220.10 for Dr. M's account. The Scheme also paid R2,481.83 out of R5,654.12 claimed by Dr. S, the Anaesthetist, due to the claims being 200% above the Scheme rate.

31. The Appellant believes that the Scheme is not clear when information is provided. In particular, he states that it is unrealistic to expect patients to have detailed knowledge of all doctors who have been involved in a theatre

procedure. He alleges that the scheme failed to provide a clear and comprehensive list of all relevant network providers, including anaesthetists.

32. The Appellant is also aggrieved that he repeatedly requested the Scheme to provide the scheme rates for the services rendered by Dr S and Dr M and he has received no response. He also requested an explanation as to why his claim was processed from his PMSA for a procedure that involved hospitalisation.

33. The Appellant requests that thorough re-evaluation of this case.

RESPONDENTS SUBMISSION

34. In summary the Respondents state that "*the Appellant sought recourse for shortfall amounts owed to non-Designated Service Providers (DSP) and a refund for funds deducted from his Personal Medical Savings Account (PMSA) following a dental procedure performed on his dependant in September 2023*."

35. The Council for Medical Schemes initially found that Bestmed's decision to decline funding for procedure code 8129 was incorrect and directed a refund. However, it upheld the decision not to fund procedure code 8355 due to its incorrectness.

36. The Appellant was instructed to address the incorrect procedure code with the treating doctor.

37. The Scheme argues that the Appellant's appeal introduces new issues, including alleged misrepresentation and miscommunication by Bestmed, which were not part of the initial complaint.

38. The Scheme argues that appeal should not introduce new issues but address errors in the initial hearing.

39. In summary the authorisation provided for Dr. M, and the procedure codes declined by the Scheme were[3]:

    a. **Infection control/barrier techniques (Code 8109)**: Declined, no in-hospital benefit.

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b. **Sterilized instrumentation (Code 8110)**: Declined, no in-hospital benefit.

c. **Local anaesthetic - per visit (Code 8145)**: Declined, no in-hospital benefit.

d. **Isolation of tooth/teeth - per arch (Code 8304)**: Declined, no in-hospital benefit.

e. **Resin - two surfaces anterior (Code 8352 X 4):** Authorised, dental/oral surgery benefit.

f. **Topical application of fluoride - child (Code 8161):** Authorised, preventative benefit.

g. **Theatre attendance (MaxFac prosthod) / hour (Code 9175)**: Declined, not a multidisciplinary case.

h. **Veneer - resin (chair-side) (Code 8355)**: Declined.

i. **Office/hospital visit - after regularly scheduled hours (Code 8129)**: Declined.

40. The Scheme states that after the request to fund dental treatment by Dr M the scheme received a request to amend this authorisation for the procedure to be performed by another dentist Dr. M. M .The scheme states that authorisation was provided which included the treatment codes authorised as well as the treatment codes declined, the authorised theatre time of 45 minutes and the confirmation that Dr. M is not a DSP[4].

41. The Scheme maintains that the Appellant was informed about coverage limitations and the need to confirm funding and DSP status for healthcare providers.

42. The scheme emphasises that members are responsible for understanding scheme rules and that co-payments are required for non-DSP services.

43. The Scheme stated that it communicates coverage limitations through authorisation approvals sent to the Appellant. These approvals provided direction on how to confirm funding of dental codes with the Scheme's dental

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department and where to access the list of Designated Service Providers (DSPs). The authorisation approvals specifically indicate whether the healthcare provider in question is a DSP or not.

44. Additionally, the approvals inform the Appellant that anaesthetic fees should be discussed and agreed upon with the doctor prior to the procedure. The Scheme also highlights the potential need for co-payments if non-DSPs are used, as non-DSPs may charge rates outside of the Scheme's coverage.

45. The Scheme supports the Council's initial findings and requests the appeal be dismissed.

DISCUSSION AND ANALYSES

The Appeals Committee considered papers filed in this appeal; the further submissions the party's made; the relevant provisions of the Medical Schemes Act; and the Rules of the Scheme.

46. As per the Point in Limine only the complaints that were referred to the Registrar will be dealt with.

47. **Dr. M:** The scheme provided authorisation for Dr. M, with certain limitations. This event did not take place and no claims exist for it.

48. **Dr M:** The Scheme received a request to amend the authorisation for Dr. M as the procedure was going to be performed by another dentist Dr. M. The amendment included a request for authorisation for dental treatment on 8 teeth within a maximum of 90 minutes theatre time. The scheme stated that authorisation was provided which included the treatment codes authorised, as well as the treatment codes declined, authorised theatre time of 45 minutes, and confirmation that Dr. M is not a DSP as shown in the following extract[5].

49. The Appellant's submission that the scheme did not inform him that Dr. M was a DSP was not accurate as the authorisation clearly shows that the treating

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dentist was not a DSP. The Scheme also provided a list of dentists who are in close proximity to the members place of residence who are on the DSP network. This list is available on the website.

50. **Short-paid Account and Payment from PMSA:** The scheme indicated that the claim for Dr. M amounted to R8 079.00 and was paid from scheme benefits R3 942.40; from PMSA R3 916.50 with a shortfall of R220.10. The scheme explained that the amount paid from the PMSA relates to procedure codes 8355 and 8129 that were not authorised to be paid from scheme benefits, hence the payment from the PMSA. The shortfall of R220.10 relates to procedure codes that are not claimable for in-hospital procedures.

51. The Clinical Review Committee submitted that:

    a. *The tariff code 8355 – veneer/resin chair side - this code was correctly declined as it is the incorrect code to charge for resin fillings that was performed in theatre.*

    b. *Tariff code 8129 – office/hospital visit - after regularly scheduled hours - this code was incorrectly declined as there is no code to charge for hospital visits in scheduled hours*.

    c. *The CRC advised that the member's diagnosis is not a PMB condition*.

52. **Dr. S:** Dr. S was the anaesthetist during the dental procedure and is not a DSP. Dr. S claimed R5 654.12 of which R2 481.83 was paid. The shortfall was because the claims for Dr. S were above the scheme rate. The scheme states that it informed the member prior to the procedure that the anaesthetist will be funded at scheme rates and that he would be liable for any amounts exceeding scheme rates[6], as confirmed in a letter sent to the member on 7 September, 2023. In addition, the Scheme provided a list of anaesthetists in the area who are part of the DSP network.

53. **Inadequate Information and Communication:** The Appellant submitted the information provided and the communication from the scheme was poor. He further submitted that he sent several emails to Bestmed requesting the scheme rates for the services rendered by Dr. M and Dr. S, and that he did not receive satisfactory responses, and the scheme continued to provide conflicting information.

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54. The Scheme provided evidence that the information requested was provided. The following is an extract from the correspondence sent[7].

55. If a condition is not a PMB, then the Scheme rules apply. Section 32 of The Medical Schemes Act 131/1998 confirms the binding force of the schemes 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 benefits under the rules or whose claim is derived from a person so claiming".*

FINDINGS

56. The Members dependants condition is not a Prescribed Minimum Benefit (PMB) and therefore the Schemes rules apply.
57. The Appeals Committee agrees with the Registrar's finding that the schemes decision to decline funding procedure code 8129 was incorrect as there is no code for hospital visits during regular hours.
58. The Appeals Committee agrees with the Registrar's finding that there is no legal basis to compel the scheme to fund an incorrect procedure code (8355), and that's the complainant must liaise with the treating doctor in this regard
59. The Appeals Committee agrees with the Registrar's finding that there is no legal basis to compel the scheme to fund Dr. S's account above scheme tariff, and that the complainant remains responsible for the shortfall.
60. The Appeals Committee finds that there has been adequate information and communication to the member.

ORDER

Having considered the matter the Appeals Committee orders that:

b. The appeal is dismissed.

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c. The decision of the Registrar is upheld.
d. There is no order to costs.

Dated at Johannesburg on 11th March 2025

Dr KS Chetty (For and on behalf of the Appeals Committee)

Concurring:

Dr H. Mukhari

Ms M. Ramagaga