



**BEFORE THE APPEALS COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES:**  
(Instituted in terms of the Medical Schemes Act No.131 of 1998)

REF: CMS 771485

In the matter between:

Dr M

APPELLANT

and

MEDSCHEME HOLDINGS

FIRST RESPONDENT

REGISTRAR

SECOND RESPONDENT

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**RULING AND REASONS**

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**INTRODUCTION (‘THE PARTIES’)**

1. The Appellant is Dr M, herein referred to as “(The Appellant,)”, a qualified Medical doctor working in Kagiso township as a private general practitioner.
2. The First Respondent is Medscheme Holdings (PTY) LTD, an accredited Administrator providing managed care services and forensic services to different medical schemes, registered under the Medical Schemes Act 131 of 1998(the “MSA”), herein referred to as (‘The Respondent’) or (“Medscheme”).
3. The Second Respondent is the Registrar of the Council for Medical Schemes (the “Registrar”). The Council for Medical Scheme (“the CMS”) is a juristic person established under Section 3(1) of the Medical Schemes Act 131 of 1998 (the ”MSA”).

4. 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.”*
5. The Appeals Committee heard the Appeal on the 11th February 2025 via Microsoft Teams audio and video link.
6. Appeals before the Appeals Committee are wide appeals. The Appeals Committee may consider the matter afresh and is not restricted to the records of proceedings that was before the Registrar. The burden of proof rests on the Appellant who must prove on the balance of probabilities that the appeal should succeed.
7. Dr M appeared before the hearing and was represented by Advocate Kenneth Mosime, and her Attorney, Mr M as the Appellant.
8. The First Respondent, Medscheme Holdings (PTY) LTD also appeared and was represented by Ms C, The Scheme legal advisor.
9. The Second Respondent, The CMS Registrar, did not appear but indicated through the Office of the Council Secretariat of the CMS that the Second Respondent will abide by the Appeals Committee’s decision.

## **BACKGROUND**

10. The Appeal relates to the Registrar’s ruling that directed the Appellant to provide the 1<sup>st</sup> Respondent with patients confidential medical records and the Registrar upholding Medscheme’s decision to invoke the application of Section 59(3) by withholding the claims and payments due to the Appellant in order to recover the loss suffered by the Scheme.
11. The Appellant, a general practitioner operating under the trade name M Healthcare, submitted claims for services rendered to members of medical schemes administered by Medscheme.
12. A desktop audit conducted by Medscheme Holdings (Pty) Ltd (“Medscheme”) for the period 1<sup>st</sup> January 2017 to 24th June 2020 identified irregularities in the Appellant’s claiming patterns, which were significantly higher than her peers, as highlighted by Medscheme REPI random forensic report.
13. As part of the verification process and in order to provide the Appellant an opportunity to justify the claims submitted, Medscheme sent the Appellant a list of 20 members requesting patient medical

records and their dependants for verification of the claims submitted by the Appellant via letters dated 15 July 2020, 27 July 2020, and 14 August 2020.

14. The Appellant refused to provide the requested patient records, citing concerns about patient confidentiality and lack of written consent from the affected patients or members.

15. When the Appellant refused to cooperate with Medscheme demand to provide confidential medical records for verification of services rendered, the 1<sup>st</sup> Respondent invoked Section 59(3) of the MSA Act, and withhold funds due to the Appellant in order to recover irregular payments which according to the 1<sup>st</sup> Respondent the Appellant was not entitled to, amounting to R286 298.62.

16. Subsequently the Appellant lodged a section 47(1) complaint with the Registrar for investigation.

4. On the 21<sup>st</sup> September 2021, the Registrar issued a ruling and a finding in favour of the 1<sup>st</sup> Respondent: *“Therefore, the complaint cannot succeed and is hereby dismissed as the Complainant refused to act within the confines of the law governing the disclosure of patient confidential medical records, which would in one way or the other rebut and/or confirm the audit findings of the Administrator. In the absence of the said clinical information, the Registrar’s hands are tied and cannot intervene.”*

17. It is this ruling of the Registrar that Dr M is appealing before the Appeals Committee of CMS.

## **SUBMISSIONS BY APPELLANT**

18. Dr M put forward a layered and nuanced argument in support of her appeal that the provision of confidential medical records without informed consent of patients, and the withholding of payments by revoking of recovery in terms of Section 59(3) of MSA is unlawful : –

18.1. Firstly, that providing confidential personal patients information will be in violation of the POPI Act which governs the law of data protection and privacy in South Africa, and that the rights to privacy is enshrined in the Bill of Rights of the country’s Constitution.

18.2. Secondly, that the 1<sup>st</sup> Respondent conducted itself unilaterally and unlawfully in withholding funds without due process as per Regulation 6 and Section 59 of the MSA Act and amended Regulations. Medscheme acted as the investigator, the prosecutor and the judge in this matter without any due process.. Letters sent to the Appellant did not enlist any specific irregularities that are alleged to have been committed, and the Appellant was never afforded an opportunity to respond to any allegations. The Appellant further submitted that the irregularities are alleged to have happened in 2017, 4 years after it was allegedly committed. It is important to note that the 1<sup>st</sup>

Respondent never alleged any suspicion of fraud, theft or misconduct against the Appellant.

- 18.3. Thirdly, that Regulation 6(2)(3)(4) of the MSA is clear in terms of processes to be followed where there is suspicion of irregularities in a submitted account, claim or statement by the healthcare provider. This Regulation mandates that the Scheme must inform both the member and the relevant healthcare provider within 30 days after receipt of such an irregular account or claim, and that the member and the provider must be afforded an opportunity to correct and resubmit such account or claim within a period of 60 days.

Regulation 6(2)(3)(4) of the Act reads as follows:

*(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 healthcare provider within 30 days after receipt of such account, statement or claim that is erroneous or unacceptable for payment and state the reasons for such an opinion.*

*(3) "After the member and the relevant healthcare provider have been informed as referred to in subregulation (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 healthcare provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of subregulation (2), or fails to provide an opportunity for correction and resubmission in terms of subregulation (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."*

- 18.4. Fourthly, that the 1<sup>st</sup> Respondent wanted the Appellant to disclose private and confidential medical records of members and patients without their informed consent. The Appellant is adamant that as a doctor she cannot disclose confidential medical records without the patients informed consent. The Appellant refers to the HPCSA Booklet 4 on Guidelines For Good Practice in the Healthcare Professions: Seeking Patients Informed Consent-The Ethical Considerations published in December 2021, which state that before disclosing the patient confidential medical records the patient must be informed fully as to why the medical records must be disclosed, the specific purpose of the disclosure, the reasons for the disclosure and the likely consequences of the disclosure.

- 18.5. The Appellant submits that Medscheme misinterpreted Section 15 of the National Health Act in terms of disclosing of medical records, and that Section 15 refers to disclosing of personal

information of a user, if the disclosure is in the interest of the user, and in this case if the member has been informed of alleged irregularities or dispute.

18.6. Fifth, that the Appellant wrote a letter on the 31<sup>st</sup> March 2021 to Medscheme asking for written consent of members so that the Appellant can make medical records available to Medscheme, however Medscheme failed to provide the written consent.

18.7. Sixth, that the Appellant tried requesting consent from some patients but they refused to give consent for their medical records to be disclosed citing their rights and privacy. The Appellant submit that Medscheme is better placed to request written consent from the identified members as they are contracted to Medscheme.

18.8. Seventh, that the Appellant does not have a problem to disclose the patients confidential medical records, provided that there is a written consent by members to do so,

18.9. Eighth, that the Appellant is not bound by the contents of the IPA Doctor Network agreement as it was not signed by both parties.

19. As a result of this submissions the Appellant requested the Appeals Committee to set aside the Registrar's ruling, and to rule that the Respondent's decision to invoke recovery in terms of Section 59(3) is unlawful.

#### **SUBMISSIONS BY THE 1<sup>st</sup> RESPONDENT**

20. The 1<sup>st</sup> Respondent submits that the Appellant was given an opportunity to state her side on the allegations of the audit outcome through the provision of requested medical records of the identified members and patients for verification, and that the Appellant failed, or alternatively refused, to provide the requested patient medical records, citing concerns about patient confidentiality and lack of written consent from members and patients.

21. The 1<sup>st</sup> Respondent further submits that forensic audits are conducted to ensure compliance with the rules of medical schemes and to protect the interests of all members by curbing fraud, waste, and abuse.

22. The requested patient records were necessary to validate the claims under review. Without verification, Medscheme cannot assess the legitimacy of claims and/or be said to have lawfully disbursed funds.
23. The REPI report and subsequent desktop audit revealed claim irregularities that warranted further investigation. The Appellant was informed of the audit findings and afforded multiple opportunities to provide the necessary documentation but failed to comply.
24. Medscheme adhered to the principles of procedural fairness by engaging with the Appellant, providing her with the audit findings, and granting extensions to submit documentation
25. The Appellant's allegations of bias are unfounded. Medscheme acted in accordance with its statutory duties and provided the Appellant with ample opportunity to participate in the verification process
26. The Appellant is bound by the rules of medical schemes and the obligations imposed under the Act, regardless of her contention that no formal agreement exists between her practice and Medscheme.
27. The 1<sup>st</sup> Respondent further submitted that the Scheme is entitled to medical records of members and their beneficiaries as per Regulation 15J (2) (c) of the MSA which state as follows:

*"Subject to the provision of any other legislations,, a medical scheme is entitled to access any treatment record held by a managed health care organisation OR health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but such information may not be disclosed to any other person without the express consent of the beneficiary;"*

28. The 1<sup>st</sup> Respondent argued that consent to patients' medical information is already tendered by members upon the commencement of their respective memberships for the purpose of continuing the business of its administered medical schemes.

29. The 1<sup>st</sup> Respondent further submits that Section 15 of the National Health Act permits healthcare providers to disclose patient information for legitimate purposes, such as claim verification, provided it is necessary and in the interests of members.
30. The 1<sup>st</sup> Respondent refers to Section 14(2)(b) of the National Health Act, 61 of 2023 which provides as follows:
- “(2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless-*
- (a) the user consents to that disclosure in writing;*
- (b) a court order or any law requires that disclosure; or*
- (c) non-disclosure of the information represents a serious threat to public health.”*
31. Medscheme submits that all Scheme members consent to their respective medical schemes and the appointed administrators to have access to their patient records in order to comply with the provisions of the Act and protect the member interest.
32. In terms of the validity of the IPA Doctor Network Agreement, Medscheme states that even in the absence of a signed contract, the Appellant’s participation in the schemes’ claims process subjects the Appellant to the statutory and ethical obligations governing healthcare providers.
33. The 1<sup>st</sup> Respondent further submit that Regulation 6 (2)(3)(4) of the Act does not apply in this case as the disputed accounts, statement or claims were a result of an audit outcome.
34. The 1<sup>st</sup> Respondent further submitted that Section 59(3) of the Act empowers medical schemes to recover funds paid in good faith where *inter alia* a supplier of service is/was not entitled to payment of such amount(s).
35. The 1<sup>st</sup> Respondent submit that as a result, the Appellant was not entitled to any
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payments made by Medscheme in terms of the provisions of the Act. This necessitated a recovery of the claims payments as permitted by Section 59(3) of the Act. The quantified amount that Medscheme seeks to recover for the payments which the Appellant was not entitled to is R286,298.62.

## **APPLICABLE LEGAL FRAMEWORK AND EVALUATION**

36. The relevant Provisions of the Medical Schemes Act, ('MSA') and the Regulations Promulgated under the MSA in this case reads as follows:

### **Section 59(3):**

37. Section 58(3) provides that:-

*"Notwithstanding anything to the contrary contained in any other law, a medical scheme may, in the case of-*

*(a) any amount which has been paid bona fide in accordance with the provisions of this Act to which a member or a supplier of health service is not entitled to; or*

*(b) any loss which has been sustained by the medical scheme through theft, fraud, negligence or any misconduct which comes to the notice of the medical scheme, deduct such amount from any benefit payable to such a member or supplier of health service ."*

### **Regulation 6(2)(3)(4):**

38. (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 healthcare provider within 30 days after receipt of such account, statement or claim that is erroneous or unacceptable for payment and state the reasons for such an opinion.*

*(3) "After the member and the relevant healthcare provider have been informed as referred to in subregulation (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 healthcare provider within 30 days that an account, statement or claim is erroneous or unacceptable for*



*payment in terms of subregulation (2), or fails to provide an opportunity for correction and resubmission in terms of subregulation (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.”*

**Regulation 15J (2) (c):**

39. *“Subject to the provisions of any other legislation, a medical scheme is entitled to access any treatment record held by a managed health care organisation OR health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but such information may not be disclosed to any other person without the express consent of the beneficiary;”*
40. The relevant Provisions of the National Health Act No.16 2003, (‘NHA’) reads as follows:

**Section 14: Confidentiality**

- (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.
- (2) Subject to section 15, no person may disclose any information contemplated in subsection (1) unless—
  - (a) the user consents to that disclosure in writing;
  - (b) a court order or any law requires that disclosure; or
  - (c) non-disclosure of the information represents a serious threat to public health.

**Section 15: Access to health records**

- (1) A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interests of the user.
- (2) For the purpose of this section, “personal information” means personal information as defined in section 1 of the Promotion of Access to Information Act, 2000 (Act 2 of 2000).

41. The relevant Provisions of the Protection Of Personal Information Act No.4 2013, ('POPI Act') reads as follows:

**Section 2: Purpose of the POPI Act:**

(2) The purpose of this Act is to-

(a) give effect to the Constitutional right to privacy, by safeguarding personal

information when processed by a responsible party, subject to justifiable limitations that are aimed at –

- I. Balancing the right to privacy against other rights, particularly the right of access to information; and
- II. Protecting important interests, including the free flow of information within the Republic and across international borders.

**DISCUSSION AND ANALYSIS**

42. Appeals before the Appeals Committee are wide appeals. The Appeals Committee may consider the matter afresh and is not restricted to the records of proceedings that were before the Registrar.
43. Both the Appellant and the 1<sup>st</sup> Respondent have made very strong submissions for consideration by the Appeals Committee.
44. The parties differ in that the Appellant believes that confidential personal patients medical records cannot be disclosed to the 1<sup>st</sup> Respondent without the written consent of the members or patients, while the 1<sup>st</sup> Respondent believes that Medscheme is entitled to access their members confidential medical records as members are contracted and already given consent to their respective medical Schemes.
45. This is the matter that is before the Appeals Committee for determination.
46. The Appeals Committee has considered the Appellant's strong submission that her refusal to disclose the patients confidential medical records without informed consent is informed by national legislations with reference to the POPI Act, The Bill of rights of the Constitution, Section 14 of The National Health Act, and the HPCSA Booklet 4 on

Guidelines For Good Practice in the Healthcare Professions: Seeking about Patients Informed Consent for the disclosure of confidential personal medical records.

47. The Appeals Committee also considered the 1<sup>st</sup> Respondent submission that the medical schemes are entitled to private medical records as all contracted members of schemes have already given consent to their respective medical schemes and the appointed administrators to have access to their members medical records in order to comply with the provisions of the Act and protect their members interests. The 1<sup>st</sup> Respondence further referred to Regulation 15J (2)(c) of the MSA which entitles Schemes to access private medical records of members.
48. The Appeals Committee is of the view that access to confidential private medical records and informed consent must not only be subjected to Scheme contractual requirements and Scheme rules only, but must also comply with the provisions of other legislations such as POPI Act, Bill of Rights, National Health Act and the HPCSA Regulations guidelines on privacy and confidentiality. Medical records must be given with informed consent, and consent cannot be generalized, but must be specific and the member must fully understand the purpose and the implication of the written consent.
49. The Appeals Committee has further considered the Appellant's submission that the Appellant is ready to disclose the requested confidential medical records, on condition that the 1<sup>st</sup> Respondent provide her with written consent from the identified members or patients.
50. Regulation 6(2)(3)(4)) of the Regulations promulgated under the MSA provides for the processes to be followed by the Schemes in case of disputes of payment of benefits for services rendered by healthcare providers to its members.

*“(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 healthcare provider within 30 days after receipt of such account, statement or claim that is erroneous or unacceptable for payment and state the reasons for such an opinion.*

*(3) “After the member and the relevant healthcare provider have been informed as referred to in subregulation (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 healthcare provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of subregulation (2), or fails to provide an opportunity for correction and resubmission in terms of subregulation (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."*

51. In the view of the Appeals Committee, the decision in this matter is also informed in the application of Regulations 6(2)(3)(4) of the Regulations promulgated under MSA, referred to in paragraph 50 above, whereby in case of suspected irregularities or disputes in the submitted account, statement or claim, the 1<sup>st</sup> Respondent must inform both the member and the relevant healthcare provider about the unacceptable claims submitted and give them an opportunity to explain or resubmit.
52. The Appeals Committee is of the view that Regulation 6(2)(3)(4) is applicable in this case without any precondition. Regulation 6(4) clearly indicates that if the Scheme fails to notify the member and the relevant healthcare provider within 30 days that the claim is unacceptable, or fails to provide an opportunity for correction and resubmission, the Scheme shall bear the responsibility to prove that the account is not acceptable for payment.
53. The Appeals Committee is of the view that in this case the 1<sup>st</sup> Respondent bears the onus of informing both the member and the provider about the disputed claims, and to ensure that the member gives consent to the healthcare provider to provide the Appellant with a written consent to disclose the member's medical records for verification of the audited claims.
54. The Appeals Committee expressed concern about the due process followed by the 1<sup>st</sup> Respondent in this matter, the procedural fairness and the legal basis in the way in which the 1<sup>st</sup> Respondent has initiated the recovery and acted upon the Appellant in this Section 59(3) investigation. The 1<sup>st</sup> Respondent acted as the investigator, the prosecutor and the judge at the same time.

55. The Appeals Committee further noted the Appellant's submission that the 1<sup>st</sup> Respondent has not laid any charges of fraud, theft, negligence or misconduct by the Appellant which could have been the reasons for the recovery and the withholding of the Appellant's claims by the respondent as per Section 59(3) of the MSA.

## **FINDING**

56. The 1<sup>st</sup> Respondent bears the responsibility of providing written consent from its members so that the Appellant can provide confidential medical records to the 1<sup>st</sup> Respondent for verification.
57. The 1<sup>st</sup> Respondent must comply with due process as outlined in Regulation 6(2)(3)(4) of the MSA in terms of disputes about payments of benefits.
58. No charges of fraud, theft, negligence or misconduct has been laid against the Appellant

## **ORDER**

59. Having considered the matter and heard the parties, the Appeals Committee rules that:
- 59.1. The Appeals Committee upholds the Appeal.
- 59.2. The Appeals Committee dismisses the ruling of the Registrar,.
- 59.3. The revoking of Section 59(3) by the 1<sup>st</sup> Respondent is unlawful.

**DATED AT CENTURION ON 20 JUNE 2025.**

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**DR HH MUKHARI**

**(For and on behalf of the Appeals Committee)**

**CONCURRING WITH –**  
**DR THANDI MABEBA**

**DR XOLANI NGOBES**

**DR SUGEN NAIDOO**