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

REFERENCE No: CMS 84655

In the matter between

Medihelp medical scheme **Appellant**

And

E **Respondent**

Date of Appeal Hearing:
6 June 2025

RULING AND REASONS

THE PARTIES

1. The Appellant is Medihelp Medical Scheme (the “Appellant” or the “Scheme”), registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the “MRA”).

2. The Respondent is Mr E (the “Respondent" or “Member”), a member of the Medihelp Medical Scheme.

3. This is an appeal under section 48(1) of the MRA, 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

1. The Appeals Committee heard the Appeal on 6th June 2025, *via* audio and video conferencing.
2. Ms A ,legal advisor for the Scheme, appeared for the Appellant.
3. Mr E , appeared for the Respondent, as the Scheme member.
4. The Appellant lodged an appeal against the Registrar’s ruling of the 16th of October 2024, that found that the Scheme should fund the costs of the hospitalization following the Member being admitted on the 25th December 2023 for a period of 4 days.

BACKGROUND

5. Mr E has been a member of the Medihelp Medical Scheme for 5 years and is on the MedVital Option.
6. The member presented to the emergency unit of the Bloemfontein Mediclinic on the 25th December 2023, with imbalance and dizziness.
7. He was admitted to the hospital until the 29th December 2023, during which he required treatment and investigations, noting that he had an underlying chronic condition of Hypertension.
8. An authorization by the hospital was provided to the Scheme on the 27th December 2023 which was pended, as it requested the hospital treatment plan and clinical information.
9. The Scheme after reviewing the motivation letters from the service provider, on the 18th and

29th January 2024, denied the funding of the hospitalization, due to lack of clinical information and evidence to support the admission to hospital.

10. The account from the hospital admission, treating providers and investigations in total amounts to R 51 444.39[1].
11. On the 18th April 2024, a section 47 complaint was registered by the Respondent, after repeated engagement with the Scheme and the dispute raised, did not resolve the matter.
12. The Respondent stated that he had a 'profound sense of imbalance and lightheadedness' and due to his practitioner being closed on the public holiday, measured his blood pressure, and presented to the Emergency unit of the hospital, whereupon the treating doctor at the unit consulted a physician, Dr F, and he decided on the admission as the patient was not in a state to be discharged.
13. The Scheme responded on the 23rd April 2024[2] confirming that they pended the hospital authorization for the 25th to the 29th December 2023, as the clinical information was vague and it did not indicate the need for in hospital treatment.
    a. Their review of the clinical indicators received on the 28th December 2023 did not indicate raised blood pressure readings and maintained the pending status of the authorization and requested further motivation from the treating service providers.
    b. The motivation letters received from Dr F, on the 18 January 2024 and 22 January 2024, did not provide sufficient clinical information to support the hospital admission.
    c. "The Scheme therefore declined the hospital admission, as the evaluation and investigations the doctor and the occupational therapist performed on the patient does not explain the need for a four-day admission."
14. The Clinical Review Committee (CRC)[3], after receiving the referral from the Registrar, found that the member's condition, Hypertension is a PMB:
    a) The ICD10 code I10 (Primary Hypertension) was provided and various tests including a Sleep study, Heart Ultrasound, Holter ECG, 24-hour BP monitor and Vascular Sonography were done.
    b) The CRC reviewed the clinical presentation and supporting literature for a patient with hypertension with such presentation and found that causes of "dizziness is vast and varied. Broadly, it can be separated into central/neurologic, peripheral/vestibular, or cardiovascular causes. Central causes of dizziness include cerebellar or brainstem strokes or posterior circulation TIAs (Transient ischemic attack).."
    a) In reviewing the Scheme's Hypertension protocol, found that it does not account for all symptoms that might indicate severe complications, such as dizziness (which 'can sometimes be a symptom of high blood

[1] Received by email from the Scheme (per request of the committee) on 9th June 25

[2] Paginated pages 10 - 11 of 139 page bundle

[3] Paginated pages 109 – 126 of 139 page bundle

pressure, but it is more commonly associated with severe complications from uncontrolled high blood pressure, such as heart attacks or strokes').

b) Hence the protocol cannot be seen as clinically comprehensive or fully based on evidence, refuting the Scheme's view that the Member does not qualify for admission based on the protocol.

c) The CRC's concluded that the investigations to evaluate secondary hypertension causes were in line with evidence-based medicine, hence confirming that the investigations and treatment constituted a PMB level of care.

15. The Registrar ruled on the 16th October 2024 that the Scheme should fund the cost of the treatment, investigations and hospitalization, as the treatment provided was required to exclude complications from the Hypertension, and hence a PMB level of care.

16. The Scheme, submitted their Section 48 Appeal on the 15th January 2025.

DISCUSSION AND LEGAL FRAMEWORK

APPELLANTS SUBMISSION

18. Ms A , for the Appellant, commenced her submission by informing that the Scheme stood by its decision not to fund the 4-day hospital stay.
19. The Appellant accepted that the member's condition of Hypertension is a PMB condition.
20. In terms of the Scheme protocols and managed care principles there was assessment of the clinical information requested to support the admission and various investigations carried out.
21. Their protocol aligns with the code of conduct for PMB level of care with supporting managed care principles for diagnosis and treatment and is subject to Section 29(1) of the MSA.
22. From the Scheme information, the authorization was received on the 27th December 2023 from the hospital and was pended due to insufficient clinical information:
    a. The subsequent letters of motivation by the treating doctor in January 2024 did not confirm that the blood pressure was high or placing the patient at risk for complications.
    b. After receiving the section 47 complaint, the case was reviewed by the medical advisory team who still felt that there is not sufficient evidence for the various investigations to be carried out in hospital, that the blood pressure readings assessed from the information was normal (129/65 and 126/72)[4].
    c. The Scheme was of the view that there was no evidence of emergency or acute treatment rendered from the case notes in the hospital and felt that these investigations could be carried out as an outpatient.
23. Ms A in noting the CRC decision and criticism of the Scheme's protocol, submitted that if the committee finds that the Member warranted hospital admission, then a length of hospital stay of 2 days rather than the 4 days would be more reasonable and appropriate.
24. Ms A undertook to provide to the committee a detailed breakdown of what is still due on the account because the full bill was not present in the bundle of documents and committed to do this within 1 business day of the appeal hearing.
25. In ending their submission, the Scheme stated that it had followed its managed healthcare protocol for hypertension correctly, in terms of its rules and based on their submissions were not obliged to fund the hospitalization and would like the Registrars ruling to be overturned.

[4] Per paginated pages 55 & 79 of the appeal bundle

RESPONDENTS SUBMISSION

26. Mr E, for the Respondent, commenced his submission by stating he started feeling ill on Christmas day, 25th December 2023 and when checked his blood pressure, it was fluctuating and with his normal general practitioner closed, presented to the emergency unit of the Bloemfontein MediClinic hospital.
27. The doctors treating him felt that the concerning symptoms aligned with his hypertension condition and together with the lump in his calf could lead to serious complications.
28. He confirmed that the treating doctors admitted him in hospital and carried out the various investigations to determine the cause to his symptoms; and to see if it was a precursor to serious complications associated with hypertension
    a. He refuted the Scheme's version that his blood pressure was not high, indicating that the 24-hour ambulatory blood pressure monitoring carried out whilst in hospital showed that 91% of all readings were above the systolic and diastolic normal levels.
    b. Tests like the Doppler scan, D Dimer, ECG, and an EEG were all carried out to exclude underlying causes and potential complications to his underlying condition of hypertension.
    c. He was also referred to an occupational therapist for the limb pain and cognitive impairment whilst in hospital.
    d. He had to be moved around in a wheelchair and his symptoms did not abate in the initial days he was in hospital.
    e. He was referred to consult a neurologist, was diagnosed to have sleep apnoea and was booked for a MRI scan as well
29. The Respondent stated that Dr F was surprised by the Scheme's query for more information in January 2024.
30. Mr E stated that all his bills from that stay were not settled, and he had already been taken to the small claims court over his hospital bill, confirming that the Registrar's ruling in his favour did not trigger any of the claims to be paid as yet.
31. For the reasons set out above, it is submitted that this Appeal Committee uphold the decision of the Registrar, and find in favour of the Respondent.

ISSUE IN DISPUTE

32. The issue before the Appeal Committee, is whether the Scheme's decision to decline the authorisation and funding of the hospital admission in December 2023, correct or not.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

33. The relationship between the member and the scheme is governed by the contract ('*the scheme rules*') that the member concluded with the Medihelp Medical Scheme.
34. The Contract in turn is governed by the Medical Schemes Act 131 of 1998 and the regulations (as amended) contained in the Act; and wherein there are managed care and service provider contractual obligations and arrangements.

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 MRA; and the rules of the Scheme.

36. It is common cause that-
    a) Mr E is a member of the Medihelp medical scheme and has been on the MedVital option.
    b) He is 32 years old and suffers from Hypertension.
    c) The service providers, from the Bloemfontein MediClinic, the emergency unit doctor and the physician, are regulated under the HPCSA and are in private practice.

37. The Scheme denied the hospitalization from the 25th to 29th December 2023 as it did not meet their protocol for payment, per correspondence dated 7th March 2024[5].

[5] Per paginated pages 5 - 6 of the appeal bundle

38. From the evidence provided, there is no dispute that the treated condition of Hypertension is a PMB condition.
39. The Member was seen at the emergency unit and in consultation with a treating physician was admitted in hospital for a period of 4 days under ICD code I10 - Essential (Primary) Hypertension, undergoing investigative tests to exclude underlying causes to his presenting symptoms and potential complications to his underlying condition:
    a. The Member was treated and monitored for his fluctuating blood pressure and symptoms of dizziness, imbalance and pain in the calf.
    b. The Member was also seen by a neurologist and consulted an occupational therapist during this period of hospitalisation.
    c. Tests including the Doppler scan, D Dimer, 24 hour ambulatory BP, ECG, and an EEG were all carried out.
    d. The initial authorisation by the hospital on the 27th December 2023 was pended due to a lack of supporting clinical information for the admission.
    e. The treating provider had provided a motivation to the scheme on the 18th and 22nd January 2024 [6]

40. From the Scheme perspective, there was no clear clinical evidence to support the hospital admission, putting forward that the investigations could have been done on an outpatient basis; also stating that the case records did not show evidence of needing emergency treatment nor was there a raised blood pressure.
    a. Although the underlying condition was that of hypertension, the treatment and investigations was therefore not considered at a PMB level of care.
41. From the Member perspective, he strictly followed his treating doctors' advice in terms of being admitted on his concerning symptoms. Given his relatively young age, various causes including secondary causes to hypertension had to be excluded, necessitating the tests:

[6] Per paginated pages 7 and 12 of the appeal bundle

a. He required a wheelchair in hospital due to the dizziness and imbalance.
b. The referral to the occupational therapist was not due to stress but due to the pain in the calf and to check on the mental cognition due to the imbalance.

42. In this case, from both the bundle of documents and the submissions during the hearing, the Member went to the emergency unit as his normal general practitioner was closed:
    a. The symptoms were of such a level, that a differential diagnosis for the underlying causes had to be considered
    b. It is not before the committee to challenge the recommendation of the treating provider, and it is the committee's view that the investigations performed are appropriate to the context and picture provided by the Member.
    c. In a similar vein the Committee cannot comment on the levels of treatment carried out in the hospital to monitor and treat the patient for the symptoms, noting that the ICD10 provided was that of Hypertension.
    d. Whilst the treating provider complied with the various Scheme requests for information and motivation; it is the Committee's view that these could be more explicit and clearer to explain the hospital admission.
    e. Equally noteworthy is the evidence from the Scheme that their medical advisory team (with the Member's consent) did not make any concerted effort to ascertain from a collegial and direct engagement to the treating providers, to obtain that clarification of clinical information or reasons for the investigations during the retrospective authorization review.
    f. Instead, the Scheme, opted to maintain its position to deny the authorization based on its managed care rules and hypertension algorithm.
43. The committee agrees with clinical review committee (CRC) of the CMS that the treatment for Hypertension is specified under the PMB regulations under the Chronic Disease List.
    a. In this instance, whilst the Scheme was correct in their assessment that investigations were performed, "the possibility of a medical emergency could not be ruled out hence the necessity to admit the member to hospital".
    b. The Scheme did not interrogate the case properly from their medical advisory team relaying on case management processes rather than direct and meaningful professional and collegial engagement to determine the authenticity of the treatment carried out.

c. The Committee is further in agreement with the CRC findings on the causes of dizziness being vast and varied and that other secondary causes of hypertension must be excluded in a known patient with hypertension[7]:

"The member presented with a profound sense of imbalance and dizziness. The reason for the admission was to perform investigations to fully evaluate secondary hypertension as per the international guidelines. Primary and secondary hypertension can co-exist; particularly, when there's an acute worsening of blood pressure, a new secondary cause should be considered.(Cleveland Clinic. 2021)

Dizziness is an inexact term people often use to describe various related sensations, including:

• Faintness (feeling about to pass out)

• Light-headedness

• Dysequilibrium (feeling off balance or unsteady)

• A vague spaced-out or swimmy-headed feeling

• Vertigo (a sensation of movement when there is no actual movement)

Dizziness without vertigo may occur when the brain receives insufficient oxygen and glucose (low blood sugar), such as may be related to non-neurologic disorders including heart and lung disorders or severe anaemia. People with panic disorder, shortness of breath, anxiety, or depression may experience dizziness.

Less common causes of dizziness include a tumor of the vestibulocochlear nerve (vestibular schwannoma); a tumor, stroke, or transient ischemic attack (TIA) affecting the brain stem; an injury to the eardrum, inner ear, or base of the skull; multiple sclerosis; and pregnancy. (David M. Kaylie, 2022)

Dizziness that appears alongside high blood pressure is a serious symptom that could be an indication of a medical emergency, such as a heart attack or stroke. (Rachael Zimlich, 2023)"

d. The Committee agrees with the CRC that the treatment and investigations carried out, therefore as PMB level of care and should be funded as such.

44. The Appeal Committee is of the view that the Respondent had abided by the rules of the Scheme in terms of Regulation 8 of the MRA, which sets out rules for the scheme to pay for the diagnosis and treatment of a PMB benefit condition.

    a. Regulation 8(1)[8] must be paid in full.

    b. Regulation 8(2) [9](a) read with 8(2)(b) allows for schemes to charge a co-payment, if the

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[7] Per paginated pages 121 and 122 of the appeal bundle

[8] 8(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

[9] Regulation 8(2) provides:
Subject to section 29(1)(p) of the Act, the rules of a medical scheme, 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
(b) a co-payment or deductible, the quantum of which is specified in the rule of the medical Scheme, may be imposed on a member if that member or his or her dependent obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member of the service was involuntarily obtained from a provider other than a designated service provider."

member uses a non-DSP under voluntary circumstances; and which is not applicable in this case

c. The Appeal Committee is further of the view that the Appellant's case does not meet the criteria for Regulation 8(3)[10], which is the basis for payment in full and preventing the Scheme from imposing a co-payment when a PMB Condition is being treated by a non-DSP, and where a member has involuntarily obtained the service of a non-DSP and is not applicable in this case.

45. For ease of reference, the bill[11] is contained below:

a. In reviewing the above-mentioned bill and the bundle, the committee noted the billing and supporting NAPPI codes, which were not in dispute.
b. The committee takes cognizance of the members submission that all aspects of the hospital bill have not been covered by the Scheme.
c. The committee also acknowledges receipt of the correspondence from the Scheme of the bill as contained above

FINDING

46. The Scheme did not exercise a specific enough due diligence regarding its managed care processes and the specific circumstances', clinical context and potential complications by the Member on his presenting symptoms for the hospital admission and as such relied only on case management and protocols to deny the authorization.
47. The Scheme had ample opportunity to properly liaise with the treating provider and review the treatment and investigations and failed to do so.
48. The Scheme has not made attempts to settle the bill given the finding of the Registrar that the treatment qualifies as a PMB level of care
49. Section 32[12] of the MRA stipulates that the binding force of the Rules of a medical scheme.

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[10] *) Regulation 8(3) reads as follows*
For the purposes of subregulation (2) (b), a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if—
(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;
(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circuMrtances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider;
(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence."

[11] As received from the Scheme via email on 9th June 2025

[12] Section 32. The 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.

ORDER

50. The Appeals Committee dismisses the Appeal and upholds the Registrar's decision of 14th October 2024.
51. The Scheme is instructed to thoroughly review the bill from the various service providers, check on the validity of the codes in terms of its rules and to settle the outstanding bill within 30 business days of the issuing of this Ruling.

DATED AT CAPE TOWN ON THIS 18th July 2025

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Dr S Naidoo

For: The Appeal Committee (Chairperson)

WITH –

Dr K Chetty

Dr T Mabeba

Dr X Ngobese

CONCURRING, IT SO BE RULED