



**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/85035**

In the matter between:

THE SOUTH AFRICAN POLICE SERVICE SCHEME

APPELLANT

And

THE REGISTRAR FOR MEDICAL SCHEMES

1ST RESPONDENT

MR V OBO MS. K

2ND RESPONDENT

ORDER AND REASONS

THE PARTIES

1. The Appellant is the South African Police Services Scheme, (“POLMED or the Appellant”) a Medical Scheme duly registered and regulated under the Medical Schemes Act 131 of 1998 (the “MSA.”)
2. The Appellant was represented by Adv. Z, duly authorised to represent the scheme at the Appeal Hearing.
3. The 1st Respondent is the Registrar of the Council for Medical Schemes.
4. The 1st Respondent was not represented at the hearing and agreed to abide by the decision of the Appeals Committee.
5. The 2nd Respondent is Mr. V (duly authorised) acting on behalf of Ms. K (“the member or the 2nd Respondent”) a member of the scheme in terms of the definition accorded to a “member” under the Medical Schemes Act 131 of 1998 (“the Act.”)

INTRODUCTION

6. 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 30 August 2024.¹
7. 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.”
8. The Appeals Committee heard the Appeal on 7 August 2025 via an audio and video conferencing link.
9. The Appellant seeks an order that the scheme cannot be compelled by the Registrar to fund the

¹ Page 273 of the Bundle.

members' prosthesis in full.

FACTUAL BACKGROUND

10. The member is on the Marine Benefit Option of the scheme.
11. The member is a bilateral amputee due to gangrene that set in the lower limbs. This resulted in bi-lateral amputations and as such the member requires an external prosthesis.
12. On 22 January 2024, the member submitted a letter of motivation and a quotation for a prostheses trans-tibial endo-skeletal to be approved as a PMB level of care. The quoted value was R282 727.72.
13. On 16 February 2024, the Appellant informed the member that the motivated and quoted prostheses is not PMB level of care and declined funding of the prosthesis.
14. On 07 May 2024, the member submitted a claim of R350 562.40 for treatment dated 03 May 2024.
15. On 13 June 2024, the Appellant paid R75 180.00 as per the maximum amount benefit entitlement in terms of the prosthesis benefit of the members selected benefit option in terms of the scheme rules.
16. The Appellant also paid R443.80 from the allied health services benefit, R938.60 from the out-of-hospital benefit and R7 883.00 from the member's appliance benefit.
17. The member was paid a total of R84 445.40.
18. The member filed a complaint in terms of section 47 of the Act with the Registrar against the funding decision of the Appellant.
19. The Registrar ruled in favour of the member directing the Appellant to fund the prosthesis in full, as a PMB level of care in accordance with the provisions of Regulation 8(1) of the Act.
20. The Appellant then filed a section 48 appeal to the Registrar's decision, the subject matter of this Ruling.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

21. 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.
22. 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.”*
23. Section 29(1) “Matters for which rules shall provide- (1) *The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters- Section 29(1)(o) The scope and level of minimum benefits that are to be available to members and dependants as maybe prescribed; and 29(1)(p) No limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph (o) and may not be different from the entitlement in terms of a service available to a public hospital patient.”*
24. Regulation 8 stipulates 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.”

WIDE APPEAL

25. This is a wide appeal. The Appeals Committee may therefore consider the matter afresh and is not restricted to the record of proceedings that were before the Registrar.
26. 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

27. The issue to be determined is whether the scheme must fund the prosthesis as prescribed by the member's treating doctor in full, as a PMB level of care for the member.

THE APPELLANT

28. The Appellant acknowledged at the outset that the member's condition is a PMB condition.
29. The Appellant however submits that in terms of the scheme rules the external prosthesis benefit in terms of the member's benefit option is only R75 180.00 per beneficiary and is a stand-alone benefit. The members claim therefore exceeds the member's PMB level of care entitlement.
30. The Appellant argued that the member cannot rely on Regulation 8 for the proposition that the Appellant must pay in full the cost of a prosthetic demanded by a private practitioner or service provider because to do so it "at odds²" with the Act; the scheme Rules registered by the Registrar; section 29(1)(o) and 29(1)(p.)
31. The Appellant submitted that if the Registrar does "*not like*"³ the registered rules of the scheme, the Registrar should take the scheme rules on review.
32. The quoted prosthesis initially quoted at R282 727.72 and the subsequent claim of R350 562.40 exceeds the member's benefit limit of R75 180.00 the maximum prosthesis benefit entitlement of the member.
33. The Appellant argued that to interpret the Act in the way that the member and Registrar have done exposes a scheme, absent a DSP network for prosthesis and orthotists, to unlimited liability. The Registrar further erred in directing that the Appellant should source the prosthesis at a discounted rate if no DSP's are in place. The member has procured and is using the prosthesis so to direct the Appellant to source a prosthesis is superfluous and the ruling of the

² Page 278 of the Bundle

³ Page 278 of Bundle.

Registrar stands to be set aside on this score alone. The Registrar erred further by failing to recognise the cost-based cap in the Appellant's rules.

34. The Regulations, per the Appellant, envisaged by section 67(1)(g) of the Act must be construed consistently with the Act and not in a way that departs from the intention of the Act. Regulation 8 is subordinate legislation and must be interpreted in the light of its empowering legislation. The Appellant submits that consistent with Regulation 8 there are no limitations on the reimbursement of PMB benefits obtained by a member from a public hospital; and PMB coverage does not provide for unlimited coverage. PMB level of care does not entitle a member to a benefit above the level of care in a public hospital.
35. The Registrar registered a cost-based cap which is consistent with the 1997 policy document that heralded the PMB provisions; the scheme rules have not been challenged and remain binding on the scheme, the member in terms of section 32 of the Act. The Appellant submitted that it is evident from the Health Market Inquiry Interim Report that the failure to review PMB's has resulted in ineffective DSP's or a refusal by certain specialists to be part of a medical scheme DSP network. Pertinent is that there are no DSP networks for prosthetists or orthotists in South Africa.
36. A further dimension argued by the Respondent is that the Registrar's ruling is invalid in that it is inconsistent with the Constitution and that the Bill of Rights which provides for limitations to the right of access to health care services.⁴
37. The Appellant had thus met all its obligations to the member legislatively and contractually and for the Registrar to rule otherwise is a violation of the sanctity of contract and the Registrar's ruling stands to be set aside by the Appeals Committee.
38. Furthermore, the prosthesis that falls to be treated as a PMB level of care is one that is available to a public hospital patient; and the diagnosis, treatment and care costs in relation to the member's prosthesis should be at the level obtainable from a public hospital to meet the PMB criteria.
39. The Appellant argued that the Registrar's ruling is based on errors of law in that-

⁴ Page 296 of the Bundle.

- 39.1 it pivots on regulation 8(1) without considering the other provisions of the Act read with the regulations;
 - 39.2 the Registrar failed to consider in particular Regulation 29(1)(o) and 29(1)(p); should the Registrar be dissatisfied with the Rules of POLMED it should take it on review as the Registrar has registered a cost-based cap scheme rule which is binding on the scheme and member in terms of section 32 of the Act;
 - 39.3 the Registrar directed that the scheme funds the prosthesis in full at a private rate in the absence of a DSP. Absent a DSP network for Prosthetists and Orthoptists, the Registrar's ruling opens a scheme up to unlimited liability;
 - 39.4 the Registrar erred in directing that the Appellant should source the prosthesis at a discounted rate when no DSPS are in place is incorrect because the prosthesis has already been procured by the member who is using it and the Registrar's ruling should be set aside for this reason alone;
 - 39.5 the Registrar failed to apply the scheme Rule 16.8 and 17.1 Marine Benefit schedule Annexure Protheses regarding the cost-based cap thus requiring the scheme to contravene its own rules;
 - 39.6 the Ministers failure to conduct two yearly reviews of PMB's has resulted in ineffective DSP's as well as the refusal of specialists to be part of the DSP network;
 - 39.7 The Registrar's ruling is inconsistent with the Constitution in that the Bill of Rights provides for rights subject to limitations;
 - 39.8 the claim by the member is excessive and may be because of anti-competitive pricing; and;
 - 39.9 Regulation 8(1) cannot be interpreted to broaden as the Registrar has done, the scope of section 29(1)(p) of the Act.
40. The Appellant highlighted section 29(1)(o) and 29(1)(p) of the Act, which per the Appellant affords the Appellant a discretion as to the benefits it wishes to afford its members. However, regulation 8 is subject to section 29(1)(p) of the Act, which stipulates that no limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in paragraph 29(1)(o) and may not be different from the entitlement in terms of a service available to a public hospital patient.

41. The Registrar for the afore-mentioned reasons cannot therefore compel the Scheme to fund expenses incurred which is not within the benefit entitlements in respect of the membership, as this would be the equivalent of an instruction to the Scheme to contravene its own rules, which have been approved by the Registrar. Further, it does not take into consideration the impact of approving such funding on the Scheme's viability and affordability to members
42. Therefore, the Appellant submits that in terms of section 32 of the Act and Rule 10.7 of the Rules of the scheme, the rules of a medical scheme remain binding on every beneficiary and on the scheme, and there is no legal basis to compel the scheme to fund this treatment in full, which is limited by the member's benefit entitlements.
43. The Appellant submits for the afore-mentioned reasons that the appeal should succeed.

THE 2nd RESPONDENT

44. The 2nd Respondent submitted that the member's condition is a PMB condition and that it is not in dispute that the funding requested for the prosthesis is a PMB level of care.
45. The 2nd Respondent submitted further that *"Polmed is incorrect to limit the funding of the prosthesis (Trans-tibial / Below knee) based on scheme/ fund benefits. Scheme Rules/ limits do not apply in the case of PMB re-imburement. In terms of Regulation 8(1) of the Act, the diagnosis, treatment and care costs of a PMB condition must be paid in full by the medical scheme. Ex gratia payments are not part of the funding model either, and we should not need to apply for ex gratia funding for the balance of the prosthesis."*⁵
46. The 2nd Respondent referred the Appeals Committee to numerous Rulings of the Appeals Committee (CMS/77424; CMS/72656; CMS/78441; and CMS/81651) wherein the Appeals Committee found that a scheme must fund PMB conditions in full.
47. It was submitted by the 2nd Respondent that the same dispute arose with the funding of the member's right leg prosthesis based on the same arguments, but ultimately, it was funded in full by the same scheme. Hence, there is no legal basis for the Appellant to refuse the funding

⁵ Page 70 of the main bundle.

of the prostheses for the member's left leg both of which were governed by the same scheme rules.

48. Accordingly, the 2nd Respondent requests that the decision of the Registrar be confirmed by the Appeals Committee.

CONSIDERATION OF THE MERITS

49. In this matter it is common cause that the member's condition is a Prescribed Minimum Benefit (PMB) condition and that the prosthesis is a PMB level of care. The request for the prosthesis was made on the basis of an undisputed PMB condition under ICD10 code 170.21 (arteriosclerosis of arteries of extremities with gangrene) and E11.5 (Diabetes) PMB Code 915E.
50. The dispute is whether the prosthesis must be funded in full without co-payment or any deductibles.
51. 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 -
"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."
52. Before the Registrar arrived at a finding the Registrar sought the guidance of the Clinical Review Committee ("CRC") of the CMS. The CRC advised that *"the requested trans-tibial prosthetic limb is included in PMB level of care for the member's leg amputation. PMB level of care for the prosthesis refers to the type of prosthesis that is available in the public sector. It does not refer to the Rand value that the public sector spends to procure the prosthesis. The scheme must fund this prosthesis at the quoted private price, or source the prosthesis themselves at a discounted rate if no DSP's are in place."*

53. Overlooked by the Appellant was the key issue of the intention of Designated Service Providers (“DSP’s”) in the Act; and the applicability of relevant CMS Scripts to the facts of this case.
54. The definition of a Designated Service Provider in the Act means a healthcare provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members’ diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions.
55. CMS Script October 2008 states *“Provision for DSP’s in the Medical Schemes Act was intended to encourage DSP arrangements between medical schemes and health care providers to ensure the proper delivery of prescribed minimum benefits to all beneficiaries of all schemes.... The Registrars’ office strongly advises schemes to ensure that services will be readily available for their members before identifying DSPs as their preferred service provider in their rules”*
56. CMS Script October 2008 goes further to state *“When approving scheme rules the Registrar’s office requires schemes to demonstrate that they have conducted an assessment of the DSPs and that they have the assurance of the availability of services. The Council for Medical Schemes has made it clear that DSP arrangements should be more than just a listing of a name, the very reason why DSPs were introduced is mainly for schemes to ensure that their members get proper care at a proper place and at an appropriate cost. This could not be easily determined without some mutual partnership and interaction between the scheme and the health care provider.”*
57. In the Supreme Court of Appeal (“SCA”) case, Council for Medical Schemes and another v Genesis Medical Scheme and others⁶ the judge stated that *“the relationship between a medical scheme on the one hand and its members on the other, is not governed solely by that scheme’s rules but also by the obligations imposed by statute upon medical schemes.”* The Judge went further to quote DL Pearmain - The Law of Medical Schemes in South Africa⁷ correctly observes that *“although the Act states that the scheme is bound by its rules, if one or more of these rules is contrary to the law the law will take precedence”*. In the aforementioned SCA judgement, the judge ruled that *“Genesis had the opportunity to appoint DSP’s. It could even have concluded agreements with the public sector as its DSP, which would not have been*

⁶ Supreme Court of Appeal: Council for Medical Schemes and another v Genesis Medical Scheme and others (20518) [2015] ZASCA 161 (16 November 2015). Para 43

⁷ DL Pearmain The Law of Medical Schemes in South Africa para 7.1.1

offensive if the Registrar was satisfied that there was a clear agreement between it and the relevant public health authorities.”

58. The SCA judgement also stated that *“the provisions referring to DSP's clearly indicating that private sector treatment was envisaged - such provisions allowing a medical scheme to select DSPs with whom it may reach agreement on charges beneficial to it and thereby limit its exposure to liability under regulation 8(2.)”*
59. From the SCA judgement and various CMS Scripts the key issue in selecting a DSP is a mutual partnership, agreement and interaction between the scheme and the health care provider which is to ensure cost effective, affordable and available treatment to members of a scheme; and that private sector treatment was envisaged.
60. No evidence was provided by the Appellant that it entered into any DSP arrangements save to submit that the 2nd Respondent used a DSP that exceeds the cost of a public facility. This view is contrary to that of the SCA and cannot be sustained. Other than the Appellant's “say so”, no evidence was led by the Appellant that the cost of the prosthesis is excessive or that the pricing of the prosthesis is anti-competitive as alleged.

FINDING

61. Accordingly, the Appeals Committee after considering the evidence is satisfied and finds that-
- 61.1 the Member's condition is a Prescribed Minimum Benefit (PMB) condition and a PMB level of care is required.
- 61.2 The Scheme therefore must fund the Member's prosthetic leg in full, as provided for in Regulation 8(1) of the Act.

ORDER

62. The Appeals Committee makes the following order:
- 62.1 The Appeal is dismissed.
- 62.2. The Registrar's decision is confirmed.

62.3 There is no order as to costs.

THUS DONE AND SIGNED AT JOHANNESBURG ON THIS THE 28th DAY OF AUGUST 2025

SIGNED

PA BECK
PRESIDING MEMBER

Dr. T. Mabeba; Dr. K. Chetty and Dr. S Naidoo concur.