



**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/84723**

In the matter between:

RM

APPELLANT

And

BONITAS MEDICAL FUND

RESPONDENT

ORDER AND REASONS

THE PARTIES

1. The Appellant is Mr. RM (“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.
2. The Appellant represented himself at the hearing.
3. The Respondent is Bonitas Medical Fund (“Bonitas, the Scheme or the Respondent”) a Medical Scheme duly registered and regulated under the Medical Schemes Act 131 of 1998 (the “MSA.”)
4. The Respondent was represented by Mr. JT, duly authorised to represent the Respondent 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 September 2024.¹
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 Appeals Committee heard the Appeal on 10 September 2025 via an audio and video conferencing link.

BACKGROUND

8. On or about 5 May 2023, the Appellant experienced severe back pain. He went to the Netcare Alberton Hospital casualty, where he was turned back because there was no authorization for his admission.

¹ Page 273 of the Bundle.

9. Later he was informed by the hospital and the treating provider that the Respondent had authorized his admission. Upon arrival back at the hospital and on 8 May 2023 an L4/S1 laminectomy for radiculopathy procedure was performed. He was discharged on 11 May 2023.
10. Initially, the hospital and all the treatment providers were paid by the Respondent.
11. Almost nine (9) months later, the Respondent reversed the payments to everyone stating that the pre-authorization was not obtained for the procedure; that a forensic assessment revealed that the procedure was paid for in error because it was an exclusion in terms of the member's policy.
12. The member filed a complaint in terms of section 47 of the Act with the Registrar against the funding decision of the Respondent alleging procedural unfairness.
13. The Registrar ruled in favour of the scheme directing that the scheme acted in accordance with its registered rules.
14. The Appellant then filed a section 48 appeal to the Registrar's decision, the subject matter of this Ruling.
15. The member submitted that the Registrar's ruling did not address his main complaint. Thus he seeks a ruling that the Respondent treated him unfairly; failed to communicate directly with him; he seeks an explanation as to why the Respondent paid for the procedure if there was no pre-authorization because had the Respondent done its due diligence he would not have been in this position as a pensioner of *"having to pay thousands of rands in medical bills which were never part of his budget."*² He seeks a further Order that the Respondents pays all his medical expenses.

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.

² Page 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.”*
18. Section 57(4) stipulates as follows – *“The duties of the Board of Trustees is to ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the rules of the medical scheme.”*

WIDE APPEAL

19. 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.
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 to be determined is whether the scheme acted in a manner that was procedurally fair towards the member; in accordance with the scheme rules and the Act.

THE APPELLANT

22. The Appellant testified that he attended at casualty Netcare Alberton Hospital on 5 May 2023, with severe back pain radiating down to both of his legs. He was initially turned away, returned home, because there was no pre-authorisation for his admission and treatment.
23. Later, on the same day he received a telephone call from the hospital that the necessary authorisations were obtained. He returned to the hospital, was admitted. An MRI was carried out.
24. On 8 May 2023 he had surgery and was discharged on 11 May 2023.

25. All the service providers at the hospital were initially paid by the Respondent. At no time during his stay at the hospital or at the time of his discharge was he informed by the Respondent, the Hospital or Professor (who performed the procedure) that either his admission or that the procedures were not approved by the Respondent.
26. The Appellant submitted that the reversal of all the payments in February 2024, made to the hospital and treatment providers, some nine (9) months later, were never discussed with him as the member by the Respondent. All communication of the reversals was received from the hospital and the treatment providers.
27. The member submitted on his complaint form that *"I feel unfairly treated as my medical aid has not prioritised communication on this case with me. Several requests for information were sent and no response obtained. Even after going to their offices, I have never received any detailed explanation on what the problem is besides being told is an exclusion. I need to understand how they paid the doctors in the first place if there was no authorisation as they claim. If they had done all due diligence, I would not be in this position of having to pay thousands of rands of medical bills which were never part of my budget."*³
28. The Appellant placed on record that he was a pensioner when he went for the procedure, his first major claim with the Respondent, and he does not have the financial means to pay the hospital bill in excess of R58 000.00 (fifty-eight thousand Rand.) He entered into an arrangement with the hospital to settle the hospital bill in instalments of R1000.00 per month.
29. The Appellant submits for the afore-mentioned reasons stated above that his appeal should succeed and requests an order that the hospital bill is paid by the Respondent; and that the Appeals Committee rules that he was treated unfairly by the Respondent.

THE RESPONDENT

30. The Respondent submitted that on 5 May 2023, the Appellant was admitted at Netcare Alberton Hospital for lower backache. The Respondent received an electronic authorisation request from the hospital on 5 May 2023 for medical admission and authorisation number (87911659) was

³ Members Complaint form Page 2 and 3

generated and automatically approved based on the information supplied by the hospital. Correspondence was sent to all parties on the same day.

31. The Respondent testified that on 8 May 2023, an L4/S1 - laminectomy for radiculopathy which is not a PMB-Prescribed Minimum Benefit, was done without pre-authorisation.
32. On 10 May 2023 the hospital provided an update about the procedure that was already performed on the Appellant.
33. The Respondent subsequently requested the treatment provider to confirm whether the member had Cauda Equina Syndrome ("CES.") On 10 June 2023 the hospital confirmed that the member did not have CES. On 10 June 2023, the case was referred to the Medical Advisors of the Respondent for review. On 12 June 2023, the feedback from Medical Advisors was that there was no CES. This meant, per the Respondent, that there was no Prescribed Minimum Benefit ("PMB") pathology. Furthermore, the member's condition was not an emergency.
34. It is the Respondent's submission that on 19 June 2023, correspondence was sent that funding was declined after a forensic assessment of the claim concluded that the claim was paid in error because the procedure is a Scheme Rule Exclusion in that the member's current benefit option has no spinal surgery benefits unless PMB, which is not the case in this instance.
35. On 06 September 2023, the member called querying the reason for the declined procedure and it was explained to the member that the procedure was reviewed and declined and that the approved authorisation was for *medical admission*.
36. The Respondent submitted that it acted in accordance with the Act and the scheme rules to decline funding of the member's procedure.
37. The Respondent asks that the Registrar's decision is confirmed.

CONSIDERATION OF THE MERITS

38. In this matter, the Registrar ruled in favour of the Respondent after studying the contents of the complaint as well as the response from the Respondent. The Registrar arrived a decision after referring the case to the CMS Clinical Review Committee (“CRC”) for a clinical opinion on whether the procedure is a PMB level of care for the member’s condition.
39. The CRC advised that: *“ICD10 code M48.06 – “Spinal stenosis, lumbar region” is a Prescribed Minimum Benefit (PMB) condition under Diagnosis and Treatment Pair (DTP) code 941A if there is “Spinal cord compression, ischaemia or degenerative disease NOS”. In this case, MRI Lumbar spine dated 5 May 2023 reported evidence of cauda equina impingement at L4/L5 level caused by a broad-based disc bulge as well as bilateral ligamentum flavum hypertrophy. Although there was pathology at L4/L5 level, there was no evidence of spinal compression considering that the spinal cord ends at L1/L2. The member’s condition was therefore not a PMB, and the procedure performed in this case was not PMB level of care.”*
40. The Appeals Committee takes note of the Registrar’s decision and findings.
41. Turning to the matter before the Appeals Committee, a careful reading of the Appellant’s affidavit confirms that the basis of the members appeal is not whether the member’s condition was a PMB condition and thus requiring a PMB level of care.
42. Instead the member submitted on affidavit that his case before the Appeals Committee is that the Registrar focussed on the clinical merits of his procedure; his benefit options; and did not make any findings on the conduct of the Respondent post approving his admission to the hospital.
43. The basis of the member’s appeal is that the Respondent approved the admission to hospital; paid the hospital, the treatment providers and anaesthetist in full and then some nine (9) months later reversed all the payments, placing the member in the precarious situation of being liable for a hospital bill that he had not budgeted for and was liable to pay.
44. The Appellant submitted that he wants the Appeals Committee to consider and make findings on the -

- 44.1 “procedural unfairness”⁴ on the part of the scheme in that the scheme initially authorised his admission to hospital and later after his procedure avers it is outside his benefit options;
- 44.2 withdrew the initial authorisation without any formal communication of such withdrawal to him as the member; and
- 44.3 paid all the service provides for his procedure then reversed such payments nine (9) months later without informing him as the member.
45. The Appellant submitted that the Respondent lacked accountability for their actions that caused him, as a pensioner, an undue financial burden because of their failure to communicate their funding decision with him directly.
46. The Appellant submitted that except for his initial admission where he was advised of the related authorisation, at no point during and after his release from Hospital did the Respondent advise him of the non-approval of the procedure. Nor was at any advised by the doctor (Prof Kelly) that the procedure was not approved.
47. The Respondent does not dispute that on 5 May 2023, the Appellant was admitted for at Netcare Alberton Hospital for lower backache; that the Respondent received an electronic authorisation request from the hospital on 5 May 2023 for medical admission; that authorisation number, 87911659, was generated and automatically approved based on the information supplied by the hospital. The Respondent submitted that correspondence in the latter regard was sent to *all* parties on the same day.
48. On 8 May 2023, an L4/S1 - laminectomy for radiculopathy (not PMB-Prescribed Minimum Benefit eligible) was done *without pre-authorisation*. An automated update was received from the hospital, the system updated; and the requested codes and correspondence sent to all parties per the Respondent.
49. Between 10 May 2023 and 7 June 2023, various queries and information was requested of the hospital and the treating doctor by the case manager of the Respondent. On 6 June 2023, correspondence was sent to the *hospital and the doctor* to confirm whether the member had Cauda Equina Syndrome (“CES”).

⁴ Member’s affidavit dated 15 November 2024 Page 77 of the Bundle.

50. On 7 June 2023, an automated update was received confirming that the member did not have CES but that the member has lumbar spondylosis. The Respondent found that the member's condition is not a PMB; there is a Scheme rule exclusion on the member's benefit option; hence funding of the procedure was declined on 19 June 2023. The Respondent confirmed that all payments to the hospital and doctors were reversed in February 2024.
51. The evidence supports that there was no communication with the member pertaining to any of the above; and that the member was only informed on or about September 2023 that funding for the procedure was declined after a forensic audit was conducted by the scheme which found that the procedure was paid for in error by the scheme. Further, the procedure should not have been funded due to an exclusion on the member's benefit options.

PMB Condition – as Ruled upon by the Registrar

52. ICD10 code M48.06 – “*Spinal stenosis, lumbar region*” is a Prescribed Minimum Benefit (PMB) condition under Diagnosis and Treatment Pair (DTP) code 941A if there is “*Spinal cord compression, ischaemia or degenerative disease NOS.*” Code 941A was quoted on the member's statement by the treating doctor. Thus code 941A brings the member's condition into the ambit of a PMB condition as stipulated in the Act.
53. According to the Registrar the MRI Scan dated 5 May 2023 reported evidence of CES impingement at L4/L5 level caused by a broad-based disc bulge as well as bilateral ligamentum flavum hypertrophy. Although there was pathology at L4/L5 level, there was no evidence of spinal compression considering that the spinal cord ends at L1/L2.
54. After a referral to the Clinical Review Committee (“CRC”) the Registrar determined that the member's condition was therefore (i) not a PMB, (ii) the procedure performed in this case was not PMB level of care (iii) the member was not diagnosed with any PMB condition; and therefore, (iv) funding rules apply; and the Respondent was correct to decline the claim as a PMB condition.

Discussion – Findings of the Registrar

55. The Appeals Committee is not limited in appeal hearings to what was before the Registrar at the time when the Registrar considered the complaint because this is a wide appeal.
56. The Appeals Committee is satisfied on the undisputed documentary evidence of the statement of account on record of the treating doctor Professor A. Kelly on Page 35 of the Bundle that the stipulated codes appear as follows: *“Place of service: Inpatient Hospital 21 (NETCARE ALBERTON) ICD-10: M21.37,M48.06,M54.50 PMB code: 941A EDI: Approved by medical scheme.”*
57. The Appeals Committee is further satisfied that the above-mentioned code 941A brings the member’s condition within the realm of a PMB condition and PMB level of care, contrary to the Registrar’s decision.
58. The only MRI scan on record is the one dated 5 May 2023⁵ which referenced that the member has CES. This condition was excluded in a report dated 7 June 2023, confirming that there was no CES, but that the member has lumbar spondylosis which was confirmed by the medical advisors of the Respondent. The member’s surgery of 8 May 2023 was an L4/S1 - laminectomy for radiculopathy which the Respondent submitted was not PMB eligible; and an exclusion in the member’s benefit options.
59. In this matter the Respondent paid in full and only reversed such payments on 22 February 2024 some nine (9) months later The reason provided by the Respondent for the reversal of the claim is that a forensic assessment of the claim concluded that the claim was paid in error; and because the member’s benefit option excludes spinal surgery.
60. When questioned on the withdrawal of the funded procedure nine (9) months later, the Respondent was not able to provide the Appeals Committee with an explanation other than to reiterate that the treatment was not PMB and an exclusion in terms of the members benefit option. At the hearing the Appeals Committee requested the MRI scan relied upon by the Respondent. It could not be produced on the day of the hearing; nor was a member of the clinical team of the Respondent available on the day to address any clinical issues pertaining to the member’s medical condition or on the reversal of the funded procedure. The Appeals Committee draws a dim view of the non-availability of the schemes clinical team.

⁵ Page 33 of the Bundle.

61. The only information on record is the statement of account of Dr. X confirming the code as 941A which is a category that qualifies the member for PMB level of care treatment and cannot be excluded by scheme rules. There is therefore no compelling evidence before the Appeals Committee to suggest otherwise.
62. On the further evidence before the Appeals Committee, it is alleged by the Respondent that the procedure was not an emergency. The evidence on record however is that the pain experienced by the member was sudden and unexpected resulting in his attendance at the casualty section of the Alberton Netcare Hospital. The undisputed evidence is that this was not a planned procedure. The Appeals committee is therefore satisfied and finds that the allegation of the Respondent that it was not an emergency was not proven by the Respondent.

Procedural Unfairness as alleged by the member

63. Section 33 of the South African Constitution guarantees the right to just administrative action, and the Promotion of Administrative Justice Act (“PAJA”) is the legislation that gives effect to this right. The action of the Respondent when considering a request for hospital authorisation is administrative action. PAJA requires that such administrative decisions must be lawful, reasonable, and procedurally fair, and that affected individuals be given reasons for decisions and informed of their rights.
64. Section 57(4) of the Act stipulates that the Trustees of a scheme must “*ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the rules of the medical scheme.*”
65. After listening to the parties, the Appeals Committee finds that the Respondent failed to dispute the evidence of the member that it complied with the Act in its communications with the member. On the Respondent’s own version the reversal of the funding was communicated with the hospital and treatment providers and not with the member, which was a statutory requirement of the Respondent. This failure prejudiced the member, exposed the member to financial risk as a pensioner who because of the Respondent’s non-compliance with the Act, had to enter into an arrangement to settle the bill of the hospital and the treatment providers in instalments of R1000.00 per month
66. *The conduct of the Respondent cannot be condoned by the Appeals Committee.*

FINDING

67. Accordingly, the Appeals Committee after considering the evidence is satisfied and finds that-

67.1 the Member's condition is a Prescribed Minimum Benefit (PMB) condition and a PMB level of care is required.

67.2 It was not proven that it was not an emergency.

67.2 The scheme failed to treat the member fairly and failed in its duty towards the member as required by section 57(4) of the Act.

ORDER

68. The Appeals Committee makes the following order:

68.1 The Appeal is upheld.

68.2. The Scheme must fund the Member's procedure in full.

68.3 There is no order as to costs.

THUS DONE AND SIGNED AT JOHANNESBURG ON THIS THE 20th DAY OF OCTOBER 2025

SIGNED

PA BECK
PRESIDING MEMBER

Dr. T. Mabeba; Dr. H. Mukhari; Dr. X. Ngobese and Adv. Maphike concur