BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES HELD VIA THE MICROSOFT TEAMS VIDEO AND AUDIO CONFERENCE TECHNOLOGY INSTITUTED IN TERMS OF MEDICAL SCHEMES ACT NO 131 OF (1998) - CASE NUMBER (CMS-86593)

In the matter between:

DISCOVERY HEALTH MEDICAL SCHEME	**APPELLANT**
AND	
B obo E	**RESPONDENT**

HEARD ON:	**3rd DECEMBER 2025**
DATE OF RULING:	**19 DECEMBER 2025**

RULING AND REASONS

PARTIES

1. The Appellant in this matter is Discovery Health Medical Scheme, a registered medical scheme established in terms of the Medical Schemes Act 131 of 1998 ("the Scheme"). The Appellant challenges the ruling issued by the Registrar concerning the funding obligations applicable to the treatment provided to one of its beneficiaries during an admission for a Prescribed Minimum Benefit ("PMB") condition. The Appellant in this matter, was represented by Miss X who appeared alongside Dr Y on behalf of Discovery Health Medical Scheme. The Respondent was represented by Miss Z.

2. The Respondent opposes the appeal and supports the Registrar's determination that the Scheme was required to fund the relevant services in full in accordance with Regulation 8 of the Regulations to the Act. The matter comes before the Appeals Committee in terms of section 48 of the Medical Schemes Act, following the Appellant's request that the Registrar's ruling be reconsidered.

BACKGROUND

3. This matter concerns an appeal lodged in terms of section 48 of the Medical Schemes Act 131 of 1998 ("the Act") against a decision of the Registrar relating to the funding of treatment rendered to a member during an admission for a Prescribed Minimum Benefit ("PMB") condition. The facts giving rise to the dispute are largely common cause.
4. The member was admitted to a Designated Service Provider ("DSP") hospital for a planned procedure relating to a PMB diagnosis. Although the admission itself was scheduled and non-emergent, the clinical course of events changed materially when the member experienced an unexpected and significant deterioration while in the Intensive Care Unit ("ICU"). The treating clinical team determined that immediate surgical intervention was required to prevent further harm and to stabilise the member.
5. In the context of the ICU environment, the urgency of the deterioration, and the need for prompt surgical expertise, the attending clinicians referred the member to a specialist who was not designated under the Scheme's DSP arrangement.
6. The Clinical Review Committee ("CRC") confirmed that the diagnoses and associated surgical procedures constituted PMB-level care; that the deterioration requiring surgery arose during the same admission and was neither elective nor foreseen; and that the referral to a non-DSP surgeon occurred while the member was in ICU, where any delay in identifying or accessing a DSP surgeon would have posed a material clinical risk. The member and the clinicians had no practical or reasonable opportunity to navigate DSP authorisation requirements at the point of deterioration.

7. Following a review of the clinical facts and the Scheme's DSP rules, the Registrar found that the circumstances triggered the application of Regulation 8(3) of the Regulations to the Act, which requires full funding of PMB services where the use of a non-DSP is involuntary. The Registrar held that the statutory obligations under Regulation 8 supersede scheme-level contractual DSP limitations, particularly where emergency-related circumstances arise during an admission.
8. The Scheme subsequently appealed the Registrar's decision, contending that the use of a non-DSP surgeon should not have been funded in full and that the Registrar incorrectly applied the PMB Regulations. The Appellant argued that the admission was planned and therefore DSP arrangements should have applied throughout the episode of care.
9. This appeal therefore concerns whether the Registrar correctly interpreted and applied the statutory framework governing PMB funding, specifically Regulation 8(1), 8(3) and 8(6), and whether the factual circumstances surrounding the member's deterioration constitute involuntary use of a non-DSP provider.

ISSUES FOR DETERMINATION

10. The central issue for determination in this appeal is whether the Registrar correctly applied the statutory framework governing Prescribed Minimum Benefits ("PMBs"), particularly Regulations 8(1), 8(3) and 8(6), in concluding that the Scheme was obliged to fund in full the surgical intervention performed by a non-DSP specialist during the member's ICU admission.

This question requires the Appeals Committee to determine:

1. Whether the clinical circumstances constituted PMB-level care as defined in the Regulations and confirmed by the Clinical Review Committee (CRC).
2. Whether the member's use of a non-DSP provider was involuntary within the meaning of Regulation 8(3)(a), (c), considering the ICU deterioration, clinical urgency, and unavailability of a DSP surgeon without unreasonable delay.
3. Whether Regulation 8(6) applied, thereby prohibiting the Scheme from imposing administrative or DSP restrictions that could delay emergency intervention.
4. Whether the Registrar's interpretation correctly recognised that statutory obligations supersede Scheme Rules where the two conflict in the context of PMB funding.

5. Whether the Registrar's decision falls within the range of reasonable conclusions that could be reached by a rational decision-maker on the available clinical and statutory record.

11. The resolution of these issues will determine whether the Scheme was lawfully required to fund the full cost of the non-DSP surgical intervention and whether the appeal ought to succeed.

SCOPE OF THE APPEAL

12. This matter comes before the Appeals Committee as a wide appeal contemplated under section 48 of the Medical Schemes Act. In this context, the Committee is not confined merely to assessing procedural correctness or reviewing the matter on narrow grounds. Rather, it is required to consider the matter afresh, to evaluate the full evidentiary record placed before the Registrar, to assess the Registrar's reasoning, and to determine whether the decision reached was substantively correct in both law and fact.
13. In exercising its wide appellate jurisdiction, the Committee reassesses the clinical evidence, interprets the statutory obligations arising under Regulation 8, evaluates the application and limits of the Scheme's Designated Service Provider (DSP) rules, and applies the body of jurisprudence relating to Prescribed Minimum Benefits (PMBs). Within this framework, the Committee considers whether the Registrar's decision constitutes a reasonable and justifiable outcome on the facts and within the applicable regulatory scheme.
14. The Committee must therefore determine not only whether the Registrar acted within the bounds of legality, but also whether the decision itself is objectively correct, justifiable and proportionate in light of the member's unexpected clinical deterioration in ICU, the immediate surgical intervention that was required, the Clinical Review Committee's confirmation that the condition and procedures constituted PMB-level care, the practical impossibility of utilising a DSP during the emergency, and the statutory protections afforded under Regulations 8(1), 8(3) and 8(6).
15. Accordingly, the Appeals Committee undertakes a substantive reconsideration of the merits and is empowered, on the strength of its own assessment of the totality of the evidence and the applicable law, to confirm, vary or overturn the Registrar's ruling.

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[1] Clinical Review Committee report, page 59 -67, Registrars ruling 68-75, section 48 Notice of Appeal 76-87 of the bundle. Supporting documents from the Appellants, page 88 -148 of the Bundle.

APPELLANT'S SUBMISSION

16. The Appellant argued that, the Registrar erred in concluding that the Scheme was required to fund the non-DSP surgical intervention in full. The Scheme contended that the admission was planned, elective in nature, and initiated within the parameters of the DSP arrangements applicable to the member's benefit option. According to the Appellant, the member and treating clinicians were aware that care for the PMB condition was required to be obtained from a Designated Service Provider in order for full funding to apply.
17. The Scheme argued that any deviation from this arrangement obligated the member to comply with Scheme Rules, including the requirement to utilise designated providers, unless prior authorisation was sought or unless the circumstances clearly satisfied the statutory criteria for involuntary use of a non-DSP. In the Scheme's view, these criteria were not met.
18. The Appellant further submitted that the Registrar incorrectly interpreted Regulation 8(3) by treating the use of a non-DSP surgeon as involuntary solely because clinical deterioration occurred during the admission. The Scheme argued that the deterioration did not transform the clinical episode into an emergency within the meaning of the Regulations, and that the treating clinicians ought to have contacted or arranged for intervention from a DSP surgeon rather than proceeding with a non-DSP provider. The Scheme asserted that no evidence was presented to demonstrate that a DSP surgeon was unavailable, inaccessible, or unable to intervene within a clinically appropriate timeframe. On this basis, the Appellant maintained that the requirements of Regulation 8(3)(a)–(c) were not satisfied.
19. The Scheme also submitted that the Registrar placed undue reliance on the ICU setting and the fact that the deterioration was not anticipated. The Appellant argued that the Regulations require a more stringent test for involuntariness and that the mere presence of clinical urgency does not automatically displace DSP rules. The Scheme contended that the clinicians should have engaged the DSP network, and that the absence of such engagement meant that the use of a non-DSP surgeon must be regarded as voluntary. The Appellant took the view that the Registrar did not give sufficient weight to the Scheme Rules governing DSP compliance and authorisation protocols.
20. Finally, the Appellant contended that the Registrar's decision failed to strike a proper balance between the statutory PMB obligations and the Scheme's contractual framework designed to manage costs and maintain benefit sustainability. It asserted that the Registrar exceeded the bounds of reasonableness by interpreting the Regulations in a manner that, in the Scheme's view, afforded overly broad protection to members in planned admissions.

21. The Appellant therefore sought the setting aside of the Registrar's ruling and the confirmation that the Scheme was not liable to fund the non-DSP surgical intervention in full.

RESPONDENT'S SUBMISSION

22. The Respondent submitted that, it reiterates and abides by the facts and findings already placed before the Registrar and the Clinical Review Committee in terms of section 47. It emphasised that the same factual matrix underpinning the section 47 complaint remains applicable. In particular, the Respondent maintained that although the admission had initially been planned, the member's clinical condition changed materially when he experienced an unforeseen deterioration while in the Intensive Care Unit. According to the Respondent, this deterioration necessitated immediate surgical intervention and placed the treating team in a position where any delay, whether to identify or secure the services of a Designated Service Provider surgeon, would have exposed the member to unnecessary and significant clinical risk.
23. The Respondent confirmed that at the point of deterioration, the member could not meaningfully choose a provider or comply with administrative DSP requirements, and that the treating clinicians were legally and ethically compelled to act without delay.
24. The Respondent relied on the findings of the Clinical Review Committee (CRC), which confirmed that the underlying diagnosis and surgical procedures constituted Prescribed Minimum Benefit ("PMB") care, and that the deterioration arose during the same admission in a manner that was neither planned nor elective. The Respondent highlighted that the CRC further confirmed that the referral to a non-DSP surgeon occurred exclusively because of the immediate clinical demands of the ICU environment. In the Respondent's view, these facts established that the use of the non-DSP provider was involuntary, squarely satisfying the statutory criteria under Regulation 8(3) of the Regulations to the Act.
25. The Respondent submitted that Regulation 8(1) obliges medical schemes to fund PMB diagnoses, treatment and care in full, without co-payments or deductibles, and that Regulation 8(3) extends this obligation to situations where a non-DSP is used involuntarily. The Respondent argued that the clinical reality of the member's emergency constituted a classic instance where Regulation 8(3)(a) and (b) apply, as a DSP surgeon was either not available or could not provide the necessary intervention without unreasonable delay, and the circumstances reasonably prejudiced the member from obtaining treatment from a designated provider. The Respondent further referred to Regulation 8(6), which prohibits schemes from imposing authorisation requirements that delay the initiation of emergency

care, contending that the Scheme's interpretation would improperly restrict clinicians from responding immediately to a deteriorating patient in ICU.

26. The Respondent also submitted that the Scheme's reliance on its internal DSP rules was misplaced, as such rules cannot override statutory PMB entitlements. The Respondent contended that PMB jurisprudence has consistently affirmed that when statutory obligations conflict with scheme rules, the former prevail. The Respondent argued that the Scheme's position ignored both the regulatory framework and the urgency of the clinical situation, and that the appeal seeks to enforce contractual arrangements that cannot be sustained in law when a PMB emergency is present.
27. In conclusion, the Respondent submitted that the Registrar correctly applied the statutory framework, properly evaluated the clinical record, and reached a decision entirely consistent with reasonableness, fairness and proportionality. The Respondent accordingly prayed for the dismissal of the appeal and the confirmation of the Registrar's ruling.

LEGISLATIVE REVIEW AND EVALUATION

28. The appeal requires a careful examination of the statutory framework governing Prescribed Minimum Benefits ("PMBs"), particularly the obligations imposed by Regulation 8 of the Regulations to the Medical Schemes Act 131 of 1998. The legislative structure is designed to guarantee that beneficiaries receive essential healthcare services without financial barriers, and to ensure that medical schemes do not restrict access to clinically necessary interventions through contractual or administrative mechanisms.
29. Regulation 8(1) establishes the foundation of the PMB system by providing that any benefit option offered by a medical scheme must pay in full, without co-payment or the use of deductibles, for the diagnosis, treatment and care costs of PMB conditions. This provision reflects legislator's intention to create a statutory minimum level of protection that insulates beneficiaries from undue financial exposure when experiencing PMB-related conditions. It also underscores that the duty to fund PMBs is a statutory obligation that supersedes conflicting scheme rules or benefit restrictions.
30. Regulation 8(3) extends this obligation to situations where PMB services are rendered by a provider other than a Designated Service Provider ("DSP") if the use of such provider was involuntary. The Regulation provides that involuntariness is deemed to exist where the service was not available from a DSP or could not be provided without unreasonable delay, where immediate surgical or medical treatment was required under circumstances or at locations that reasonably prejudiced the beneficiary from obtaining care from a DSP, or where no DSP was within reasonable proximity to the beneficiary's ordinary place of business or residence.

31. These circumstances must be evaluated in real time and in relation to the clinical conditions present at the point of care. The legislative objective is clear: beneficiaries cannot be penalised for circumstances beyond their control, particularly when urgent or emergent clinical decisions must be made to preserve life, limb, or function.
32. Regulation 8(6) further reinforces this protective framework by prohibiting schemes from restricting or preventing the initiation of appropriate emergency interventions prior to receiving authorisation. This provision recognises that emergency medical contexts, including ICU deterioration, do not allow for administrative delays or procedural negotiations. It explicitly prevents schemes from imposing requirements, whether through scheme rules, DSP arrangements, or pre-authorisation protocols, that would delay essential treatment.
33. When these provisions are read together, the statutory intention is unambiguous. The Act and its Regulations prioritise clinical necessity, patient safety and uninterrupted access to PMB services above contractual DSP arrangements. The legislative scheme places the onus on medical schemes to ensure that PMB care is funded in full, and it prevents schemes from creating rules or processes that undermine this statutory guarantee.
34. Evaluating the present matter against this legislative framework, the Committee is satisfied that the Registrar's reasoning aligns with the statutory obligations. The CRC-confirmed facts demonstrate that the member experienced an unexpected deterioration in ICU that required immediate surgical intervention. At that moment, the treating clinicians were neither required nor able to delay treatment in order to identify or contact a DSP surgeon. The circumstances fit squarely within Regulation 8(3)(a) and (b), as the DSP service could not be provided without unreasonable delay and the location and urgency of the deterioration reasonably prejudiced the member from accessing a DSP. Moreover, Regulation 8(6) prevented the Scheme from imposing any authorisation requirement that could delay the emergency intervention.
35. The legislative framework therefore supports the Registrar's conclusion that the Scheme was obliged to fund the PMB services in full, notwithstanding the involvement of a non-DSP surgeon. The statutory protections embedded in Regulation 8 operate precisely to prevent the type of financial burden that the Scheme sought to impose under its DSP rules. The Registrar's interpretation is consistent with both the text of the Regulations and the broader purpose of the PMB regime, and falls well within the bounds of legality, reasonableness and proportionality.

EVALUATION OF FACTS AND COMPARATIVE ANALYSIS

36. The factual matrix in this matter is largely undisputed in its broad contours, although the parties differ sharply on the legal consequences of those facts. The evidence demonstrates that the member was admitted to a Designated Service Provider hospital for a planned procedure relating to a Prescribed Minimum Benefit ("PMB") condition. During the course of this admission, and while in the Intensive Care Unit ("ICU"), the member experienced an unexpected clinical deterioration that necessitated immediate surgical intervention. The treating clinicians referred the member to a specialist who was not contracted as a DSP, and the surgery was performed without delay due to the clinical urgency of the situation.
37. The Clinical Review Committee ("CRC") findings are central to the factual evaluation. The CRC confirmed that the underlying diagnosis and the subsequent surgical procedures constitute PMB-level care; that the deterioration requiring surgery arose within the same admission and was not elective or foreseeable; and that the referral to the non-DSP specialist occurred in circumstances where any delay in locating or engaging a DSP surgeon would have posed a material risk to the member's health. These facts are consistent with the clinical records and ICU documentation placed before the Registrar and this Committee.
38. The Appellant, however, maintains that the planned nature of the initial admission should govern the entire episode of care and asserts that the treating team ought to have contacted or sourced a DSP surgeon even at the point of deterioration. According to the Scheme, the deterioration did not create an emergency within the meaning of the Regulations and did not justify bypassing DSP arrangements. The Scheme's argument rests on the premise that DSP rules remained fully operational throughout the admission and that the clinicians' failure to comply with DSP protocols renders the use of the non-DSP surgeon voluntary.
39. When these submissions are evaluated against the factual record, they do not withstand scrutiny. The medical evidence demonstrates that the member's deterioration was sudden and clinically significant, that the ICU setting necessitated prompt intervention, and that any delay in securing appropriate surgical expertise could reasonably have compromised the member's safety. The Scheme has not provided evidence to show that a DSP surgeon was available, accessible, or able to perform the necessary intervention without unreasonable delay at the critical moment. Nor has the Scheme rebutted the CRC's findings regarding the emergent nature of the situation.
40. A comparative analysis of the parties' positions shows that the Respondent's submissions align more closely with the statutory framework governing involuntary use of a non-DSP

provider. Regulation 8(3)(a) contemplates situations where a DSP service is not available or cannot be provided without unreasonable delay. Regulation 8(3)(b) applies where immediate medical or surgical treatment is required in circumstances that reasonably prejudice the beneficiary from accessing a DSP. The undisputed ICU circumstances fall squarely within both of these grounds. The Appellant's characterisation of the episode as non-emergent is inconsistent with the clinical facts and fails to recognise the functional meaning of "immediate treatment" contemplated in the Regulation.

41. The Committee also notes that the Appellant's reliance on the planned nature of the admission is misplaced. PMB jurisprudence draws a clear distinction between the character of an admission at its commencement and the clinical realities that may arise during the admission. The law recognises that clinical circumstances evolve, and once a member's condition deteriorates to the point of requiring urgent intervention, DSP arrangements cannot operate as a practical or legal barrier to treatment. Regulation 8(6) expressly prohibits schemes from imposing authorisation or DSP requirements that could delay emergency care. In contrast, the Respondent's position is consistent with this statutory protection and with the clinical necessity established by the record.
42. In light of the factual evidence, the Committee concludes that the member's use of a non-DSP surgeon was involuntary within the meaning of Regulation 8(3), and that the Appellant has not demonstrated otherwise. The comparative analysis therefore favours the Registrar's interpretation: the emergency circumstances arising within the ICU triggered the statutory protections afforded under the PMB Regulations, notwithstanding the planned nature of the initial admission.

APPEALS COMMITTEE PERSPECTIVE

43. From the perspective of the Appeals Committee, the present matter engages both the core protective purpose of the Prescribed Minimum Benefit framework and the supervisory role entrusted to the Registrar under the Medical Schemes Act. The Committee approaches this appeal with the understanding that section 48 confers a wide appellate jurisdiction, requiring a fresh evaluation of the facts, the applicable law and the Registrar's reasoning.
44. In doing so, the Committee is guided by the principles of legality, reasonableness and proportionality, as well as the imperative that PMB entitlements must be interpreted in a manner that prioritises patient access to essential care.
45. The Committee recognises that the PMB regime was deliberately constructed to shield beneficiaries from financial exposure in circumstances where clinical need demands immediate or essential treatment. Regulation 8, read in conjunction with section 29(1)(o) of the Act, imposes mandatory funding obligations on medical schemes and limits their

ability to rely on contractual arrangements such as DSP rules where these undermine, delay or obstruct the delivery of necessary PMB treatment. In evaluating this matter, the Committee is mindful that legislative protections must be applied with sensitivity to the realities of clinical practice, especially where deterioration occurs suddenly in high-acuity environments such as an Intensive Care Unit.

46. The Committee's assessment is heavily informed by the uncontested clinical evidence and the findings of the Clinical Review Committee. The circumstances in which the deterioration occurred, namely during an ICU admission requiring urgent surgical intervention, rendered compliance with formal DSP authorisation processes practically impossible and clinically unsafe. The Committee therefore approaches the matter with the view that involuntariness under Regulation 8(3) must be assessed at the point of care, not retrospectively or abstractly, and that any legal interpretation must align with the professional obligations of healthcare providers to act immediately in the interests of patient safety.
47. In this context, the Committee views the Registrar's application of Regulations 8(1), 8(3) and 8(6) as not only legally sound but also consistent with established PMB jurisprudence, which emphasises that statutory obligations override conflicting scheme rules. The Registrar correctly identified that DSP arrangements cannot be enforced in situations where their operation would compromise timely access to essential care. The Committee notes that the Appellant's submissions did not sufficiently address the realities of the ICU circumstances or provide evidence undermining the immediacy of the clinical demands. The Scheme's reliance on the planned nature of the admission fails to appreciate that PMB protections attach not to the scheduled procedure itself, but to the emergent clinical intervention that subsequently became necessary.
48. Ultimately, the Committee's perspective is that the legislative framework requires a purposive and context-sensitive application. Where immediate intervention is required to prevent harm, PMB protections must operate robustly to ensure that neither administrative constraints nor DSP contractual structures impede clinically necessary care. The Registrar's decision reflects this approach and falls within the range of reasonable and rational outcomes open to a decision-maker acting under the Act.

FINDINGS

49. Having considered the full record, the parties' submissions, the Registrar's reasoning and the applicable legislative framework, the Appeals Committee is satisfied that the Registrar's decision is correct in both fact and law. The Committee accepts the clinical findings of the Clinical Review Committee ("CRC"), which establish that the underlying

diagnosis and surgical procedures fall squarely within the Prescribed Minimum Benefit ("PMB") package and that the member's sudden deterioration in the Intensive Care Unit required immediate surgical intervention. These findings provide a reliable and credible basis for determining whether the statutory criteria for involuntary use of a non-DSP provider were met.

50. The Committee finds that the Appellant has not discharged the onus of demonstrating that the use of the non-DSP surgeon was voluntary or that the DSP arrangements could reasonably have been complied with at the point of care. The evidence shows that the ICU deterioration created an urgent clinical scenario in which delay for the purposes of identifying or engaging a Designated Service Provider would have materially compromised the member's safety. The Scheme has presented no evidence that a DSP surgeon was available or able to intervene without unreasonable delay, and its reliance on the planned nature of the initial admission is misplaced. The operative legal enquiry concerns the circumstances prevailing at the moment the emergency arose, not the nature of the admission at its commencement.
51. In assessing the statutory framework, the Committee finds that the member's circumstances satisfy the involuntariness provisions under Regulation 8(3). The service required was not available from a DSP without unreasonable delay; the urgency and location of the deterioration reasonably prejudiced the member from accessing a DSP; and the treating clinicians were compelled to act immediately in accordance with their professional obligations. Regulation 8(6) further prohibits schemes from imposing restrictions that delay emergency treatment. Together, these provisions make clear that the Scheme was required to fund the intervention in full, notwithstanding its DSP rules.
52. The Committee therefore finds that the Registrar correctly applied Regulations 8(1), 8(3) and 8(6) and properly concluded that statutory PMB protections supersede conflicting Scheme Rules where immediate or essential clinical care is required. The Registrar's decision is consistent with PMB jurisprudence, accords with the protective purpose of the Act and reflects a proportionate response to the clinical realities of the case.
53. In light of the above, the Committee finds that the appeal lacks merit and that the Registrar's decision must be upheld.

ORDER

54. In light of the foregoing analysis, and having considered the full record, the submissions of the parties, the applicable statutory framework and the Registrar's reasoning, the Appeals Committee makes the following order:
55. The appeal is dismissed.
56. The decision of the Registrar is confirmed.
57. The Scheme is directed to comply with its statutory obligations in terms of Regulation 8(1), 8(3) and 8(6) of the Regulations to the Medical Schemes Act and to fund the relevant Prescribed Minimum Benefit services in full.
58. No order as to costs is made**.**

THUS, DONE AND SIGNED AT CENTURION ON THIS THE 19th DAY OF DECEMBER 2025.

SIGNED

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DR X NGOBESE
Presiding Member
Date: 19 December 2025

Advocate T Maphike and Dr H Mukhari, members of the appeal panel concurring.