"BEFORE THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES

Ref: CMS 87246

Profmed Medical Scheme Appellant

And

Z Respondent

RULING AND REASONS

THE PARTIES

1. The Appellant is Profmed Medical Scheme, (The "Appellant" or the "Scheme") registered and regulated under the Medical Schemes Act, Act 131 of 1998 (the "MSA").
2. The Respondent is Z (the "Respondent"), a member of the scheme.
3. This is an appeal under section 48(1) of the MSA, providing that –

"(1) Any person who is aggrieved by any decision relating to the settlement of a complaint or dispute may appeal against such decision to the Council."

INTRODUCTION

4. The Appeals Committee heard the Appeal on 20th November 25 via MS Teams.
5. Dr X, the medical advisor, from Profmed medical scheme, appeared for the Appellant. He was accompanied by the clinical executive for the scheme, Ms Y.
6. Ms M represented the Respondent, at the hearing, having received consent from the Member, Mr Z, who was also present and made representation as well.

BACKGROUND

7. The Appellant appealed the decision of the Registrar on the basis that there are no clear guidelines that the Progressive Supranuclear Palsy (PSP) condition is a PMB condition and as such should not be entitled to the corresponding PMB level and hence the Scheme was in its right to deny the funding of the claims related to the condition.

8. The dependant of Mr Z is Mrs Z, and she is a dependent member of the Profmed Scheme.

9. Z, is 54 years old and was diagnosed with PSP in February 2022 with an MRI scan being done at the time.

10. PSP is an uncommon neurological disorder involving protein deposits in the basal ganglia of the brain leading to various challenges like eye opening, mobility difficulty and muscle tone affecting both upper and lower limbs.

a. The condition is progressive with no cure and requires constant allied medical professional care and helpers in addition to regular check-ups at the specialist neurologist level.
b. The Allied medical professionals include occupational therapists, physiotherapists, speech therapists, physiologists and bio kineticists.

11. Ms M laid a section 47 complaint with the Council of Medical Schemes (CMS) on the 17th February 2025 when the Scheme failed to fund the various allied medical professional claims.

12. The Scheme provided their response to the CMS, informing that there were 2 components to this case: the Dystonia diagnosis which was a PMB and the PSP condition which is not clearly demarcated as a PMB.

13. The Registrar ruled on the 3rd June 2025, stating that, "*In the context of Progressive Supranuclear Palsy (PSP), which is a complex and progressively debilitating neurological disorder, these therapies are not secondary but integral to the comprehensive management of the condition. Allied health interventions are essential to preserving function, promoting safety, and maintaining quality of life for individuals living with PSP. Accordingly, the involvement of occupational therapy, speech therapy, and physiotherapy constitutes medically necessary treatment and should therefore be covered under the Prescribed Minimum Benefits (PMBs).Having considered the merits of this complaint, the Respondent submissions and the clinical opinion cited above, the Registrar finds that in this case the member's condition a PMB and treatment therefore constitutes PMB level of care. The Respondent is hereby directed to fund treatment of the member's condition in accordance with Regulation 8(1) of the Act.*"

14. The Appellant, the Scheme felt that it was correct in its assessment that the PSP condition is not to be funded at a PMB level, and submitted the Section 48 (1) Appeal to the CMS on the 3rd September 2025.

DISCUSSION AND LEGAL FRAMEWORK

APPELLANTS SUBMISSION

15. Dr X, on behalf of the Scheme, reiterated its position that there were 2 components to this case:
    a. The Dystonia condition which is a PMB condition and shall be funded as such.
    b. That there is no clear demarcation in the PMB guidelines for the PSP condition and it further cannot be diagnosed as Parkinson's Disease.
    c. Hence with no clear demarcation in the PMB guidelines for it to be deemed as a PMB diagnosis, the related claims were not funded.
16. He mentioned that the Scheme was empathetic to the patient's condition, and their submission should not be interpreted as an attempt to deny care or funding of valid claims.
17. He stated that the claims for Dystonia were partially funded as they did not receive comprehensive or progress reports from the treating providers
    a. The Scheme, however, shall look retrospectively to any legitimate claims with Botox and upon analysis look to fund these claims as there is no dispute that this condition needed to the treated at a PMB level of care.
18. On the PSP condition and in understanding that there were various allied medical professionals used, the Scheme had also requested clinical reports, progress on the condition to verify these claims.
    a. The scheme reviews each case on its merits
    b. From a fiduciary risk, the Scheme does need to prevent over servicing and to apply its rules on the option, the patient was on
    c. Claims for the neurologists have been paid in full.
19. He confirmed that there no designated service provider arrangements in place for these conditions, but managed care principles would apply in terms of its Scheme rules.
20. He concluded that the Scheme has an obligation to fund all PMB conditions in full in terms of the MSA, but the clarity is sought on whether the PSP does qualify for a PMB level of care.
21. The Scheme therefore feels the Appeal should be upheld on the above grounds; and added that the Scheme would look at settling all valid claims and would look into the records on whether the co-morbidities of Diabetes and Hyperlipaemia have been registered as chronic conditions and have been funded.

RESPONDENTS SUBMISSION

22. Mr Z submitted that his wife had a serious condition needing 2 full time helpers
    a. He understands that there is no cure for the condition and that it is progressive
    b. He along with family members did everything possible to make the patient's life as normal as possible
    c. He had to fund all the allied healthcare workers in cash and then would claim from the Scheme
    d. Letters of motivation had been provided from the treating specialist neurologists, and this necessitated all the supportive and ongoing medical care
23. He confirmed that without ongoing treatment, the condition became worse
    a. Without quarterly Botox injections, the patient cannot open her eyes
    b. Without speech therapy, the patient cannot be understood when she talks
    c. Without the occupational therapist and bio kineticist, walking and mobility is an ongoing challenge
    d. Without physiotherapy and other treatments, pain in the upper and lower limbs becomes worse
24. Ms M in her submission informed that she had provided in the pack an organised and sequential list of all claims not paid by the Scheme from 2022 to date[1]:
    a. Speech/language therapist R51 621.94
    b. Physiotherapist R20 750
    c. Bio kineticist R 27 020
    d. 2nd Bio kineticist R 46 616.40
    e. Occupational Therapist R51 826.90
25. Ms M referenced the comprehensive opinion sort from the Neurological Association of South Africa (NASA), which found clearly that PSP warrants PMB level of care and multidisciplinary treatment[2]
    a. The Scheme's narrow interpretation of the initiation of treatment required is flawed
    b. Treatment has to be ongoing
26. The Respondent concluded that the average monthly costs to keep the patient, living a best quality of life as is possible ranges between R10 000 to R12 000 per month – helpers, allied healthcare worker consultations, medication and specialist consultations, where required
27. The patient's conditions of Diabetes and Hyperlipidaemia have been registered as chronic conditions and were being kept under control with treatment
28. The Respondent feels that the Appeal committee should dismiss the Appeal, uphold the Registrar's ruling and that all claims submitted should be honoured by the Scheme.

[1] In supplementary bundle – list of treatments
[2] In supplementary 19 page bundle – medico legal opinion

RELEVANT STATUTORY AND REGULATORY PROVISIONS.

29. The relationship between the member and the scheme is governed by the terms of the contract ('*the scheme rules*') that the Appellant concluded with Profmed Medical Scheme.

30. The Contract in turn is governed by the Medical Schemes Act 131 of 1998 and the regulations (as amended) contained in the Act.

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

32. 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

33. The issue in dispute is whether the scheme was correct in its interpretation for this case in denying the funding of the PSP condition part of the PMB level of care.

LEGAL FRAMEWORK AND EVALUATION

34. According to section 8 of the MSA, Prescribed Minimum Benefits (PMB)—

(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.*

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

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.

(6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.

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 MSA; and the rules of the Scheme.
36. It is common cause that:
    a. The Member and his dependent are on an option with Profmed medical scheme, which has managed care rules in place.
    b. The Member's dependent has been diagnosed in February 2022 with Dystonia and Progressive Supranuclear Palsy after an MRI scan showed these findings
    c. The Dependent's condition is an uncommon and progressive neurological disorder to which there is no cure.
37. It is not in dispute that the Dystonia condition is a PMB Diagnosis (G24.8) and requires such level of care.

38. According to the Scheme:
    a. There is no clear demarcation in the PMB guidelines for the PSP condition and it further cannot be diagnosed as Parkinson's Disease.
    b. Hence with no clear demarcation in the PMB guidelines for it to be deemed as a PMB diagnosis, the related claims were not funded.
    c. Clinical reports were not forthcoming from the allied healthcare workers on the progress of the patient's condition
    d. The Dystonia treatment has been funded and that any payments not processed would be reviewed
    e. The treatments for the Diabetes and Hyperlipidaemia should be funded in line with the Scheme processes of a properly registered chronic condition and authorised chronic medication

39. According to the Member:
    a. The patient requires ongoing and regular healthcare provision on a monthly basis
    b. Without these treatments, the condition worsens and the patient falls easily, is unable to move, has very slurred speech, is unable to open her eyes and is unable to swallow
    c. All the specialist's neurologists consulted had recommended the ongoing allied healthcare worker care in addition to medical treatment like Botox
    d. The patient's chronic conditions of Diabetes and Hyperlipidaemia are well controlled
    e. He is paying between R10 000 to R12 000 per month out of pocket for the above mentioned healthcare worker help to keep the patient living as best quality life as is possible.

40. Based on the evidence before the Committee, and the verbal responses from both parties to the Committee's questions, the following can be deduced:
    a. The Scheme accepts that the Dystonia diagnosis is at a PMB level of care and all such treatment must be funded in this manner
    b. From the time of the patient's diagnosis in February 2022, the patient has needed to seek out specialist neurological consultation and treatment plans
        i. Reports from Prof Bhigjee, Dr XXXX, Dr XXX[3]
    c. The Member has proactively sought and attended to the patient's condition by following the treating neurologist's advice and has engaged to return to work as a medical doctor at the coalface of seeing patients in a profession, where skills are limited and where healthcare service at a primary care level, is to be promoted and supported.
        i. Reports from Allied healthcare workers – S Ismail, A Randeree, Z Ayob[4]

41. The committee is of view that the Member's dependant has a serious, progressive and uncommon neurological condition with multiple symptoms and does experience worsening if not on regular and proper treatment based on the multidisciplinary approach recommended.

[3] Paginated pages 30 – 36 of the Bundle of Documents
[4] Paginated pages 39 – 43 of the Bundle of Documents

a. In this case in point, there is a clear and timeous history of the illness, the seeking of professional healthcare services and the resulting referrals to allied healthcare workers for the appropriate supportive level of care required.
b. The committee raises it concerns on the Scheme's continuous emphasis on the technical aspects around the PSP condition and whether it does qualify as a PMB level of care or not
    i. The Scheme and its medical advisors should be more engaged about understanding the overall complexity of the illness and its fatal sequelae without such a multidisciplinary approach
    ii. At a basic level, there could have been more collegial engagement from peer to peer with the treating specialists upfront and then with the allied healthcare workers

42. The committee agrees with the findings of the Clinical Review Committee (CRC) of the CMS:

The member's condition, Other Dystonia (G24.8) is a Prescribed Minimum Benefit (PMB) condition under the Diagnosis Treatment Pair (DTP) code 341A with description of *Basal ganglia, extra-pyramidal disorders; other dystonias NOS.* The member's condition, G23.1 - Progressive supranuclear palsy (PSP) is also a PMB condition under the DTP 314A as it is categorised as basal ganglia disorder and extrapyramidal disorder, and it involves dystonia as a key feature.
Therapy provided by allied health professionals, including occupational therapists, speech therapists, and physiotherapists, should be funded as part of PMB-level care, provided it forms part of the medically necessary treatment for the diagnosed condition. In the context of Progressive Supranuclear Palsy (PSP), which is a complex and progressively debilitating neurological disorder, these therapies are not secondary but integral to the comprehensive management of the condition. Allied health interventions are essential to preserving function, promoting safety, and maintaining quality of life for
individuals living with PSP. Accordingly, the involvement of occupational therapy, speech therapy, and physiotherapy constitutes medically necessary treatment and should therefore be covered under the Prescribed Minimum Benefits (PMBs).

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[5] Paginated pages 77 – 78 of Appeal Bundle

43. From the evidence of the Neurological Association of South Africa (NASA) provided in the Supplementary Bundle:
    a) “Progressive Supranuclear Palsy is a severe, progressive neurodegenerative disorder that is correctly classified as a Prescribed Minimum Benefit under the "Basal ganglia, extra-pyramidal disorders" category (DTP 341A/314A).”
    b) “The standard of care for PSP, both internationally and within the South African public sector benchmark, is ongoing management by a multidisciplinary therapeutic team. These therapies are not supplementary but are integral and medically necessary for managing the disease's most debilitating symptoms and preventing life-threatening complications.”
    c) It is noted that the Scheme did not provide any neurological opinion of their own accord in its submissions.
44. The Committee agrees with the NASA opinion that the Scheme’s interpretation of "initiation of medical management" is incorrect and that the treatment must be continuous, ongoing and for such conditions - multidisciplinary as the baseline and not as an exception.
45. It is for the Scheme to note in their future reviews of such conditions, that it is a complex condition with ‘overlapping descriptions’, varying symptoms and signs but should be reviewed and treated under the same spectrum of Parkinsonian Disorders.
46. In terms of submissions and the information provided for the member’s condition, the Appeal committee agrees with the Registrar’s ruling that the treatment should constitute a PMB level of care for the member’s condition and that Regulation 8(1)[6] of the MSA provides that the diagnosis, treatment and care of a PMB condition must be paid in full.
47. The scheme confirmed that that there are not any designated service provider agreements in place in this matter and as such the rules of the Scheme in terms of Regulation 8(2)[7] do not apply at this juncture.

[6] Regulation 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.

[7] 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

48. The Appeal Committee, for the reasons above, accepted that the requirements of Regulation 8 for payment in full have been met and concurred with the Registrar's findings.
49. The Appeal Committee agrees that the relationship between a Scheme and its member is contractual. The terms of the contract between the member and the Scheme consist of the Scheme Rules, the Medical Schemes Act and its Regulations.

FINDING AND ORDER

50. The Scheme has not appropriately applied diligence to the overall nature of this case.
51. The Registrar is correct in his findings in terms of Regulation 8 of the MSA.
52. Section 32[8] of the MSA stipulates that the Appellant is bound by the Rules of a medical scheme.
53. The Appeal is dismissed and the Registrar's decision of 3rd June 2025 upheld.
54. The scheme is ordered to pay the costs of all valid claims relating to the required multidisciplinary treatment rendered to the patient/ dependent member as well as ongoing treatment in line with the MSA and the Scheme Rules.

DATED AT CAPE TOWN ON THIS 5th January 2026

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Dr S Naidoo
For: The Appeal Committee (Presiding Officer)
WITH –
Ms P Beck
Dr K Chetty
CONCURRING, IT SO BE RULED

(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."

[8] 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.