

**IN THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL
SCHEMES**

In the matter between:

MEDIHELP

Appellant

and

REGISTRAR OF MEDICAL SCHEMES

Respondent

RULING

[1] While walking her dog on 13 July 2007, Mrs H was “knocked over” by three large dogs which were, in her words, “running at full speed”. She was then transported by ambulance to the False Bay Provincial Hospital where she was hospitalised for a dislocated knee and patella and severed knee ligaments.

[2] Because that hospital did not have MRI scan facilities, she was transferred to the Constantiaberg Medi-Clinic which did. The full extent of Mrs H’s injuries was discovered after the MRI scan. A surgical

procedure was then performed on her knee on 18 July 2007. Subsequently she received physiotherapy treatment.

- [3] Because the appellant considered Mrs H's condition as falling within the definition of Prescribed Minimum Benefits,¹ it funded some of the accounts but refuses to fund others. Its basis for refusing is essentially two-fold. First, it says Mrs H did not obtain a pre-authorisation for the treatments in question and so for that reason the relevant items were paid for at cost and not in full as required by regulation 8. It thus requires Mrs H to make a co-payment in relation to those items. Second, it says the surgical procedure and other treatment performed on 18 July 2007 and later were elective procedures and thus did not qualify as Prescribed Minimum Benefits.
- [4] Mrs H complained to the Registrar requiring that the scheme pay her accounts in full because hers was a Prescribed Minimum Benefit condition. The Registrar found in her favour. Now the scheme appeals against the Registrar's decision.
- [5] The scheme accepts that the Prescribed Minimum Benefit in question falls under code 902H in terms of which the diagnosis is "Closed fractures/dislocations of limb bones/epiphyses – excluding fingers and

¹ See Regulation 7

toes” and the treatment “reduction/relocation”. But it maintains that treatment under that code does not include surgical intervention or aftercare.

- [6] But this is too literal a reading of the code in the appeal committee’s view. Our courts have consistently held that where a literal meaning of a legislative provision would lead to absurdity which could never have been intended by the legislature, the court will be justified in departing from such literal meaning. As Schutz JA pointed out in a unanimous judgment of the Supreme Court of Appeal in *Poswa v Member of the Executive Council for Economic Affairs, Environment and Tourism, Eastern Cape*,² **“the literal meaning of an Act (in the sense of strict literalism) is not always the true one”**. Where that literal meaning would result in **“absurdity so glaring that it could never have been intended by the Legislature”**,³ or in **“absurdity, inconsistency, hardship or anomaly which from a consideration of the enactment as a whole a court of law is satisfied the Legislature could not have intended”**,⁴ then a court is justified in departing from the clear and unambiguous meaning of the section.⁵

² 2001 (3) SA 582 (SCA) at para [10]

³ per Innes CJ in *Venter v R* 1907 TS 910 at 914

⁴ per Stratford JA in *Bhyat v Commissioner for Immigration* 1932 AD 125 at 129

⁵ see also *Hanekom v Builders Market Klerksdorp (Pty) Ltd and Others* 2007 (3) SA 95 (SCA) at para [7]

- [7] Thus, while on the face of it the code does not countenance surgical intervention and aftercare for a patient who has dislocated a knee, a suggestion that such intervention will in all cases never form part of the treatment regime for such injury would in our view give rise to absurd outcomes that could never have been intended by the Legislature. Relocation of a dislocated knee may very well require surgical intervention, and physiotherapy may very well be required as part of that process. The Legislature could not reasonably be required, as the scheme clearly does, to have included under the code every conceivable treatment for a dislocated knee, so that what is not included is taken to have been deliberately omitted.
- [8] A clear illustration of this can be demonstrated by comparative exercise. The treatment for a fractured hip (under Code 178H) is “reduction, hip replacement”. It cannot validly be argued that surgery falls outside that treatment. Hip replacement requires surgery. That surgery is not expressly mentioned as one of the treatment regimes under the code does not take it out of the realm of possible treatments for this PMB condition. We can thus not agree with the scheme on this score.
- [9] Relying on regulation 8(4) the scheme says the surgical intervention and physiotherapy were in any event obtained voluntarily from a non-designated service provider by Mrs H and thus fall outside PMB. The

applicable provision in this regard is regulation 8(2)(b) which provides that co-payment is competent where a member voluntarily obtains a service from a non-designated service provider. On the facts, it is clear that Mrs H did not elect to transfer to the Constantiaberg Medi-Clinic for MRI scan and further treatment. She was taken there because the False Bay Provincial Hospital (the DSP) did not have MRI scan facilities. That scenario falls squarely within the proviso to regulation 8(2)(b) read together with regulation 8(3)(a). The import of these regulations read together is this: where a service is not available from the designated service provider, or cannot be provided without unreasonable delay, then no co-payment is payable by a member who obtains that service from a non-designated service provider.

- [10] Pre-authorisation of treatment is a measure intended to improve the scheme's "efficiency and effectiveness" in providing healthcare to its members. It is not intended as a barrier to members' access to PMB diagnosis, treatment or care. Regulation 8(4) is thus not intended to enable medical schemes to put measures in place that would have the effect of depriving members of appropriate treatment and care if they do not follow such measures. Thus, a provision in the rules that says failure to obtain pre-authorisation will result in co-payment being imposed is not consistent with the PMB provisions of the Medical Schemes Act. It matters not that the rule has been registered. A rule

that is inconsistent with the applicable legislation cannot trump that legislation by reason only of registration. It remains invalid to the extent of inconsistency with the Act.

[11] This finding, however, calls for qualification. In the appeal committee's view the efficiency and effectiveness of the scheme's provision of healthcare to its members would be compromised if members were free to submit claims for procedures in respect of a PMB condition some months after the onset of the condition without a pre-authorisation. Mrs H sustained her injuries on 13 July 2007 and underwent surgery 5 days later by reason of MRI facilities not being available at the designated service provider. This delay is in our view justifiable and falls squarely within the provisions of the proviso to regulation 8(2)(b) read together with regulation 8(3)(a). The surgical intervention was thus involuntarily obtained.

[12] But the same cannot reasonably be said of the physiotherapy treatment which Mrs H obtained between 12 September 2007 and 27 September 2007, two months after the surgical intervention. For that she should at least have obtained pre-authorisation because of the time lag since the surgical intervention.

[13] In the result, the appeal succeeds only in part. The scheme is not obliged to pay for the physiotherapy in accordance with the PMB provisions but is obliged to so pay in respect of the surgical intervention and other diagnosis, treatment and care that precede it.

V NGALWANA for the appeal committee

Date of Hearing: 12 August 2008
Date of Ruling: 8 September 2008

For Heuer: Mrs H
For Medihelp: Dr Moses and Adv. Coetsee
For Registrar: Prof Van der Merwe