CIRCULAR

Reference: Benefit Definition Ischaemic Heart Disease
Contact person: Dr Selaelo Mametja
Tel: 012 431 0507
Fax: 012 431 0676
E-mail: s.mametja@medicalschemes.com
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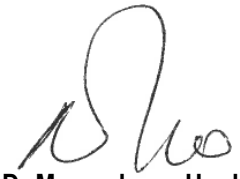
Circular 22 of 2015: Benefit definition for Ischaemic heart disease

Council for Medical Schemes has developed a benefit definition for ischaemic heart disease. The process of defining this benefit definition was started in 2011 when the first submissions were made to be considered by the clinical advisory committees (see figure 1). The first draft benefit definition was published in 2012 for comments from stakeholders. After careful consideration of the submissions a second consultation process took place with stakeholders which resulted in the publication of a second draft benefit definition. Comments on the second draft were received from stakeholders and analysed by CMS (see table 1 and 2 attached). This final benefit definition incorporates comments from all stakeholders and consists of the following documents:

(i) Ischaemic Heart disease (ST- segment elevation myocardial infarction)

(ii) Ischaemic Heart disease (Unstable angina/Non-ST segment elevation myocardial infarction)

Stakeholders are reminded that the benefit definition process is an ongoing process that follows the process that was first agreed upon in 2010. The submissions and committee members' names are available on the CMS website.



Dr Mamaqhawe Hoohlo
Senior Manager: Clinical Unit

Figure 1: Consultative process for finalising benefit definitions

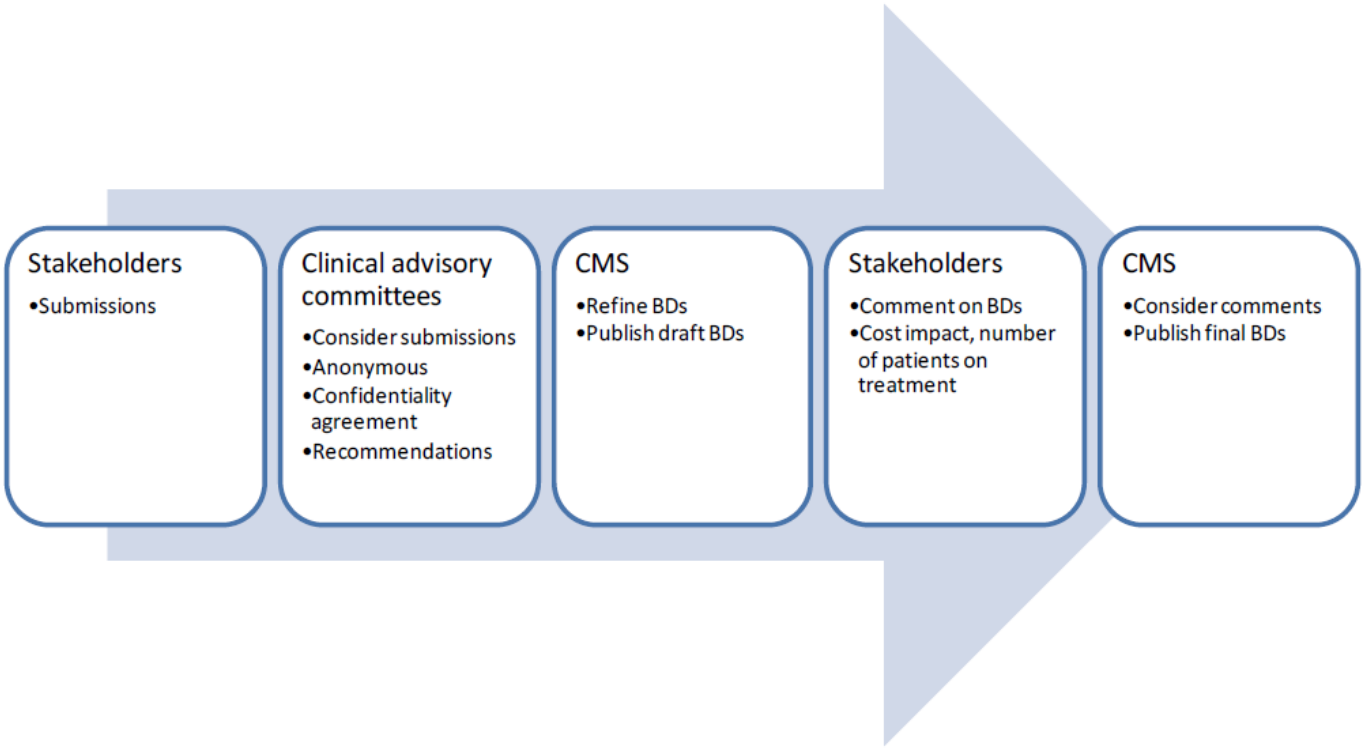


Table 1: Stakeholder comments unstable angina/N-STEMI

From	Comment	Decision
Medscheme	IVUS is not a prevailing practice in the Public Sector tertiary facilities. It is therefore considered to be PMB level of care	According to PMB conduct, state desired level of care should be considered. IVUS is available in some state hospital and therefore desired state level of care. The indication for IVUS were reviewed, an addendum attached.
	Code 1297 incorrectly listed	Revise code
	Lipid lowering agents not in line with the current PMB algorithm where current target is LDLC ≤3mmol/l or a reduction of 45%	Section revised
	There is an error regarding the maintenance dose of Clopidrogel which should be 75 mg daily	Change the maintenance dose of Clopidogrel
	Erroneous description of 1252, this is not Effort cardiogram with the aid of a special bicycle ergometer	Check code and change accordingly
Liberty	Authors of the document not included as well as their conflict of interest	Clearly state the process that was followed in drafting the benefit definition document
	NSTEMI not defined	Section revised
	There is uncertainty as to the true clinical value of CRP and ESR	CRP and ESR are valuable for determining severity of CAD and for prognosis. (1, 2)
	While there may be a requirement to evaluate left ventricular function, it is uncertain as to whether this would be appropriate for all patients or whether this should rather be reserved for patients where there is a high degree of suspicion for LV dysfunction	According to ESC guidelines (2012) Echo is indicated in all patients.

	Provision appears to have been made for routine CT angiography	The document already states that "when troponin and ECG reading are non-conclusive"
	Contest that nifedipine may in fact be used provided the long-acting/extended release formulation is administered.	ESC guidelines were used to make this recommendation. It should be noted this was a Class III, based on level B evidence. The section would be reviewed with further submission of concrete evidence supporting the comment.
	Minimum standards for anticoagulant use.	Recommended anticoagulants tabulated in table 2
	The point regarding the preference of bare metal stents for patients with contra-indications to or who are likely to interrupt clopidogrel therapy is noted, however, it should be made clear that both subsets of patients (i.e. patients receiving drug-eluting or bare metal stents) require an appropriate duration of clopidogrel therapy, in combination with aspirin.	Noted
	Some concern is raised regarding the provision of anaesthetic services as well as the requirement for a second cardiologist as minimum standards of care	Comments noted; indications for second physician or anaesthetist have been stated. Schemes may ask providers to motivate such use.
	Reduction of LDL by 25% is a deviation from the legislated Dyslipidaemia algorithm	This is target is secondary not primary prevention. These patients must be started on treatment regardless of LDL level.
Discovery	The draft should include a defined basket which should provide for the typical /average patient	It will not be possible to include all procedure codes. The current documents list possible procedure codes. The challenge with including procedure codes is that it provides a shopping list for providers and schemes will only pay for what is on the list.
	The current document no longer includes frequency and quantity of services as published in the first draft	The challenge with including quantity and frequency is that it will lead to supplier induced demand. The quantity and frequency should be backed by clinical evidence and need by the patient. The current available evidence is not prescriptive on quantity but more focus on indications. EBM principles ensures that right patient get right treatment at right times. It also enables schemes and MCO to determine when services are over utilised.
	The benefit definition should not explicitly endorse one medicine within a particular therapeutic class over another	For the treatment of IHD, current clinical guidelines clearly state which drugs to use, e.g. Aspirin. Some therapeutic classes have a whole list of medicines that

		are not indicated. In this BD a combination of therapeutic class and specific drug names were used. Specific drug names were used where not all drugs in the class would be considered to be at PMB level of care.
	Pharmacological stress – what this entails, what drugs are used, in what setting and which codes	Review and define better. Indications were stated. There are various old and new drugs. Not clear what is the current practice in South Africa and currently not an area of contention, therefore drugs not indicated.
	There is very limited guidance on the role of DSP's.	Include additional information
	CRP and ESR are alternatives of each other and not done simultaneously	Inflammatory markers can estimate severity and prognosis of ischaemia.
	There are more applicable codes for chest X-ray	Include codes
	Why are the procedures codes 1282 and 1283 applicable in this scenario	Code 1282 and 1283 are not applicable therefore deleted.
	Would Troponin I and T be always done together	Review section
	"Nifedipine, or other dihydropyridines, should not be used unless combined with beta-blockers" Conflicts with CDL algorithm for CAD	True. EDL is outdated although a minimum benefit. The recommendation is an esc guideline recommendation and based on week evidence.
	Factor-Xa inhibitors (fondaparinux) not included in the current 2012 EDL	Fondaparunix is not included in EDL, but has low risk of stroke, which can be a cost driver in private sector. The costs between fondaparunix and enoxaparin are not different. The section was changed to class name: Low molecular weight heparin
	Which patients will require angiography	Documents already state which patients
	Phonocardiography –What is it used for, is it PMB level of care	Procedure and code deleted as they are not applicable.
	Prasugrel is a trade name for a specific drug and not on EDL	Revise section

Table 2: Stakeholder comments STEMI

From	Comment	Decision
Medscheme	Medscheme is of the view that where a contract for DSP provision exists between a scheme and a Public healthcare facility, the provisions of Regulation 8 apply.	The matter to utilise state as DSP is under review by Council.
Liberty	Authors of the document not included as well as their conflict of interest	Process was outlined in the initial cover letter. CMS is responsible for drafting the BD, interventional cardiologist were consulted to ensure that BD is clinically correct. Interventional Cardiologists have vested interest in the document and to have a balanced view of the industry the document was published for comments for industry. Please note this is draft 2.
	There is uncertainty as to the true clinical value of CRP and ESR	ESR and CRP have diagnostic and prognostic value in M
	Please could Council provide its definition of affordability as well as its cost effectiveness equations and thresholds that Schemes should utilise in their policy development processes?	Generally as cost to save one life is used, although this is not a true cost-effective study it does provide a rough idea. . Affordability is calculated by amount which will need to be added to make benefit available at PMB and therefore refers to contribution increase affordability and risk of falling from medical aid. Generally when contributions are >15% of household income, medical scheme becomes unaffordable. CMS does not use thresholds.
	Some concern is raised regarding the provision of anaesthetic services as well as the requirement for a second cardiologist as minimum standards of care.	Comments noted indications for second physician or anaesthetist have been stated. Schemes may ask providers to motivate such use.
	The issue regarding the optimal duration of clopidogrel therapy requires clarification and should reflect the prevailing public sector practice.	Section revised, PMB dose of Clopidogrel is 6 months after DES
Discovery	The draft should include a defined basket which should provide for the typical /average patient	It will not be possible to include all procedure codes. The current documents list possible procedure codes. The challenge with including procedure codes is that it provides a shopping list for providers and schemes will only pay for what is on the list.

	The current document no longer includes frequency and quantity of services as published in the first draft	The challenge with including quantity and frequency is that it will lead to supplier-induced demand. The quantity and frequency should be backed by clinical evidence and indications, which are clearly outlined in the document.
	The benefit definition should not explicitly endorse one medicine within a particular therapeutic class over another	For the treatment of IHD, current clinical guidelines clearly state which drugs to use, e.g. Aspirin. Some therapeutic class have a whole list of medicines that are not indicated for STEMI. This particular definition is explicit, for example not all anticoagulants are appropriate for treatment of STEMI
	Pharmacological stress – what this entails, what drugs are used, in what setting and which codes	Revised, codes and drugs included
	There is very limited guidance on the role of DSP's.	Include additional information
	CRP and ESR are alternatives of each other and not done simultaneously	The physiology of the two tests differs. With History certainty a suitable test maybe required. When history is uncertain then provider may request both
	Why are the procedures codes 1282 and 1283 applicable in this scenario	Removed
	Would Troponin I and T be always done together	Can use either or.
	"Nifedipine, or other dihydropyridines, should not be used unless combined with beta-blockers" Conflicts with CDL algorithm for CAD	This was based on weak evidence but ESC recommendation. Review section
	Factor-Xa inhibitors (fondaparinux) not included in the current 2012 EDL	True, but Fondaparinux cost similar to Enoxaparin., with less risk of stroke. Section replaced with LMW heparins
	Which patients will require angiography	Documents already state which patients
	Prasugrel is a trade name for a specific drug and not on EDL	Section revised. Prasugrel not a PMB level of care as it offers marginal benefit compared to Clopidogrel however cost 4 times. See Annexure A.
	Streptokinase, Alteplase, Tenecteplase – not all drugs are listed on EDL	Section revised. See Annexure B.