Guidelines for the Identification of Beneficiaries with Risk Factors in Accordance with the Entry and Verification Criteria

Version 10.1

Applicable from 1 January 2016

Council for Medical Schemes

The Council for Medical Schemes (CMS) was established in terms of the Medical Schemes Act 131 of 1998 to provide regulatory oversight to the medical schemes industry

10 November 2016

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Changes made to version 10.1 since the publication of version 9.1 of the guidelines for 2015.

1. The Chronic Renal Disease (Table 8) diagnostic criteria ACR rate was corrected to be Albumin-to-Creatinine Ratio (ACR) of ≥ (equal to or greater than) 3.4 mg/mmol (or 30mg/g).
2. The CD4 count that was used to determine eligibility for treatment is not applicable anymore, as the new National Antiretroviral Treatment Guidelines removed the CD4 count as treatment criteria.
3. The sentence "This includes Rheumatoid Arthritis in cases where a DMARD is not used" was added in paragraph 5.17.
4. ICD-10 code I27.9 was removed from Table 7 (Cardiac Failure & Cardiomyopathy).
5. The ATC codes J05AX09 and J05AX12 has been added to Table 28 – HIV and to the list of ATC codes
6. ICD-10 codes (E10.2, E11.2, E12.2, and Z94.0) were added to the Chronic Renal Disease as these codes indicate diabetes mellitus with renal complications. The ICD-10 coding rules determine that the combination of Diabetes Mellitus that lead to renal disease be coded with the added codes.
7. Codes E13.0, E13.1, E13.2, E13.3, E13.4, E13.5, E13.6, E13.7, E13.8, E13.9, E14.0, E14.1, E14.2, E14.3, E14.4, E14.5, E14.6, E14.7, E14.8 and E14.9 were added to tables 13 and 14 (Diabetes Mellitus Type 1 and Type 2) in the previous version as the codes indicate PMB conditions under specific Diagnostic Treatment Pairs and in the Chronic Disease List.
8. Codes N18.0 and N18.8 were deleted from Table 8 (Chronic Renal Disease) and Table 19 (Hyperlipidaemia) as the codes were discontinued in the ICD-10 Master Industry Table.

1. Introduction

- Following the Risk Equalisation Fund (REF) shadow process, a decision was taken that the Council for Medical Schemes (CMS) should continue to collect risk factor data in a manner similar to the REF shadow process. The Scheme Risk Measurement (SRM) process replaces the REF shadow process.
- The Industry Technical Advisory Panel (ITAP) has been established as a successor to the Risk Equalisation Technical Advisory Panel (RETAP). It is a forum created by the CMS for participation by all stakeholders involved in the medical schemes industry, in clearly defined initiatives and investigations approved by the Chief Executive & Registrar, that will have a systemic impact on the industry.
- The SRM process involves the collection of risk factor data from medical schemes to estimate changes in scheme risk profiles and estimate the costs of prescribed minimum benefits (PMBs).
- Successful implementation of the clinical risk management for South Africa is contingent on the accurate identification of beneficiaries with specified risk factors within medical schemes. The SRM variables include all the 25 Chronic Disease List (CDL) conditions, HIV, maternity events and age[1].
- The purpose of this guideline is to define criteria that must be met in the identification of beneficiaries with the above-mentioned risk factors.
- The entry and verification criteria are intended for this purpose alone, and should not be construed to be limitations or expansions on the entitlements of beneficiaries of medical schemes to PMBs in terms of the Medical Schemes Act 131 of 1998.
- Therefore, there might be instances where a beneficiary is legally entitled to a PMB in respect of a particular condition, but cannot be included in the SRM returns.
- Similarly, certain medicines that are not included in the CDL therapeutic algorithms may be included as proof of treatment for the purpose of identifying a beneficiary with a condition qualifying for inclusion in the SRM returns. Inclusion of such medicines in the entry and verification criteria does not create an entitlement of a beneficiary to access that medicine as a PMB.
- These criteria have been developed with the emphasis on the verifiability of cases and will be used to ensure that there is uniformity in the way that medical schemes identify SRM risk factors.
- These guidelines provide specific clinical codes that serve to identify patients who were treated for CDL conditions.
- These guidelines will be reviewed as the need arises.

[1] The CDL is the list of conditions included under the heading “Chronic Conditions” in the Prescribed Minimum Benefit schedule included as Annexure A to the General Regulations made in terms of the Medical Schemes Act, 131 of 1998.

2. Implementation date

- These criteria (as amended) are applicable from 1 January 2016.

Existing CDL cases

- The diagnoses of cases that have been started on treatment before 1 January 2006 are acceptable for the purposes of SRM.

- Cases diagnosed after 1 January 2006 must meet the criteria applicable at the time of diagnosis as specified in Table 1 below, or the diagnosis criteria specified in this document.

Table 1: Periods for the application of entry & verification diagnostic criteria

Period	***Version applicable***
Before 2006	None
January 2006 to December 2006	Version 1
January 2007 to December 2007	Version 2.1
January 2008 to December 2008	Version 3.2
January 2009 to December 2009	Version 4
January 2010 to December 2011	Version 5
January 2012 to December 2012	Version 6.1
January 2013 to December 2013	Version 7.1
January 2014 to December 2014	Version 8.1
January 2015 to December 2015	Version 9.1
January 2016 to December 2016	Version 10.1

New CDL cases

- All newly diagnosed cases from 1 January 2016 onwards must meet the diagnosis criteria specified in this document (Version 10.1).

All CDL cases

- All CDL cases, *existing or* newly diagnosed must meet the "proof of treatment" component stipulated in version 10.1 of the guidelines from 1 January 2016.

Note on cases identified with previous versions of the guidelines

- Medical schemes are requested to ensure that their administration systems (as employed by medical scheme administrators, clearing houses, managed care organisations, providers, and others) are capable of applying different sets of criteria strictly on the dates when they become effective. Adequate version control is therefore a requirement.

3. **Preparation of data**

General

3.1 SRM data will be solely collected through the ASR Healthcare Utilisation System. Schemes will still be required to apply the entry and verification criteria for identifying beneficiaries.

3.2 The data is submitted separately for each option in a particular medical scheme, for male and female beneficiaries.

3.3 A beneficiary is counted if he/she is entitled to benefits in respect of that month.

3.4 The service date is used to establish in which month a beneficiary is counted. (See paragraphs 5.7 - 5.9)

Age bands

3.5 The age band is determined by taking age at the last birthday on 1 January. This value will always be an integer. The beneficiary is then placed in the appropriate age band: “Under 1”, “1-4”, “5-9”, “10-14”... or “85+”. The same age bands are applicable for the statutory returns.

3.6 A new-born child is to be incorporated into the age structure by taking the age of the beneficiary as on 1 January of the year of evaluation. The naming of the category as “Under 1” allows for that calculation to produce either a zero or a negative result.

Only claims paid from a risk benefit could result in a case eligible for inclusion in SRM

3.7 All beneficiaries that are reported in the SRM data must receive their benefits for the relevant condition from a risk pool (as opposed to a personal medical savings account) to qualify for eligibility.

CDL cases

3.8 A beneficiary is counted for a specific CDL condition for SRM Count and SRM prevalence based on the SRM entry and verification criteria for each chronic disease, as specified in this document. Please note that the age band “Under 1” must not be populated with CDL or HIV information, all beneficiaries under one with CDLs must be defaulted to “NON”.

3.9 For the SRM count data each beneficiary must be counted for only one – CDL condition. For a person with two or more CDL conditions (or HIV and one or more CDL conditions), the scheme may choose the condition with the highest cost of the combination. A beneficiary with multiple diseases will only be counted once –for a CDL condition. Thus the total of beneficiaries – for each of the CDL conditions including “NON”, and excluding “MAT” must equal the beneficiaries in the option for the period.

3.10 Note that with the combination of cardiac heart failure (CHF) and cardiomyopathy (CMY) into one condition, from 1 January 2006, the CHF column must be left blank. All CHF and CMY cases must be entered in the CMY column. The contribution table will be adjusted to reflect the new rates.

Multiple chronic conditions

3.11 Once the most expensive disease has been allocated to columns 2 - 28, the multiple disease columns 29 - 31 need to be populated according to the number of chronic diseases. Hence a beneficiary with multiple chronic diseases will reflect twice in the SRM count data, once for the most expensive disease, and once for the number of multiple diseases.

Exclusion of specific diseases as multiple chronic conditions in the count data

3.11.1 For SRM count data purposes, certain CDL diseases that co-occur in the same patient will not be counted as multiple diseases. *(However, if these conditions do co-occur, they must be reflected in the prevalence data – see paragraph 3.16).* Cases encountered with co-occurring conditions as described in paragraphs 3.11.1.1 – 3.11.1.8 below are not eligible to be counted as multiple diseases in the count grids (CC2, CC3, or CC4 modifiers). The most expensive condition must be counted as a single disease in the count data. The conditions are arranged in descending cost order as determined by the contribution table 2009, which includes the following hierarchy:

Table 2: Disease ranks

Updated CDL ranks (2009 PMB Costing Study, applicable for cases reported from 1 January 2016)		
CDL Condition	**Description**	**Rank**
HAE	**Haemophilia**	1
CRF	**Chronic renal disease**	2
MSS	**Multiple sclerosis**	3
COP	**Chronic obs. Pulmonary disease**	4
CMY	**Cardiomyopathy**	5
CSD	**Crohn's disease**	6
DBI	**Diabetes insipidus**	7
DM1	**Diabetes mellitus 1**	8
BCE	**Bronchiectasis**	9
PAR	**Parkinson's disease**	10
BMD	**Bipolar mood disorder**	11
SCZ	**Schizophrenia**	12
DYS	**Dysrhythmias**	13
SLE	**Systemic LE**	14
IBD	**Ulcerative colitis**	15
EPL	**Epilepsy**	16
HIV	**HIV/aids**	17
IHD	**Coronary artery disease**	18
ADS	**Addison's disease**	19
RHA	**Rheumatoid arthritis**	20
AST	**Asthma**	21
DM2	**Diabetes mellitus 2**	22
HYP	**Hypertension**	23
HYL	**Hyperlipidaemia**	24
GLC	**Glaucoma**	25
TDH	**Hypothyroidism**	26

3.11.1.1 For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: *chronic obstructive pulmonary disease, bronchiectasis and asthma.*

3.11.1.2 For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: c*ardiomyopathy and cardiac failure, coronary artery disease, dysrhythmias; and hypertension.*

3.11.1.3 For count purposes, only one of c*hronic renal disease or hypertension* may be assigned to the same patient.

3.11.1.4 For count purposes, only one of the following gastro intestinal conditions can be assigned to the same patient: c*rohn's disease or ulcerative colitis.*

3.11.1.5 For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: *bipolar mood disorder or schizophrenia.*

3.11.1.6 For count purposes, only one of the following neurological/psychiatric conditions can be assigned to the same patient: *multiple sclerosis*, *bipolar mood disorder, or epilepsy.*

3.11.1.7 For count purposes, only one of the following auto-immune conditions can be assigned to the same patient: *systemic lupus erythematosus or rheumatoid arthritis.*

3.11.1.8 Diabetes mellitus type 1 and type 2 cannot co-occur (see table 13 and Table 14 in section 6).

Maternity

3.12 The maternity modifier relates to "all the codes that indicate the delivery of a single/multiple foetus either stillborn or alive; following a pregnancy of at least 24 weeks duration". Codes that apply to the delivery modifier are presented in Table 29.

3.13 The beneficiary qualifying for the maternity modifier is only entered ONCE — in the month corresponding to the date of admission of the mother into the service facility, or in instances where no admission occurred, the actual date of the confinement is used. The amount payable from risk benefits is an annual amount and not a monthly amount as with the other modifiers.

Beneficiaries without chronic diseases

3.14 To complete the "NON" column: After completing columns 2 - 28 of the SRM count data, beneficiaries who have not been allocated to these columns need to be counted and reflected in column 1. This column now includes **all** beneficiaries from the "Under 1" age band. This completion of columns 1 - 28 will reflect each beneficiary of an option in only one cell of the grid.

Prevalence data

3.15 In the SRM prevalence data, the beneficiary is reflected for each one of the diseases he/she has. This rule does not apply to the "Under 1" age band, which must be defaulted to "NON".

3.16 The SRM prevalence data contains the total number of beneficiaries in the cell for the period. Each beneficiary must be placed in as many cells in columns 1 - 28 as they have chronic conditions (CDL conditions or HIV). For a person with three CDL conditions the scheme will place the beneficiary in the three relevant columns. Thus the total of beneficiaries for columns 1 - 28 will be more than the beneficiaries in the option for the period.

3.17 Each of the conditions listed in paragraph 3.11.1 and its sub-paragraphs must be reported on in the SRM prevalence data.

3.18 The same number of beneficiaries in column 1 of the SRM count data should be reflected in column 1 of the SRM prevalence data. Hence for both grid types, the "Under 1" age band is defaulted to "NON".

Availability of information from capitated providers

3.19 Medical schemes have indicated that they frequently have difficulties to obtain the information required to complete the grids from managed care organisations (MCOs) and from capitated providers. It is important to note that:

3.19.1 In terms of Regulation 15B(2)(d) to the Medical Schemes Act 131 of 1998, it is required that an accredited MCO has the necessary resources, systems, skills and capacity to render the managed care services which it wishes to provide. Further, should an MCO comply with Regulations 15D (a) and (c), such an organisation would be capable of providing the medical scheme with the data required for the SRM return.

3.19.2 Regulation 15E(a) makes it clear that a medical scheme is not absolved of its responsibility towards members if any other party is in default to provide any service.

3.20 Schemes must ensure that their contracts with preferred providers make provision for the availability of the information that is required to prepare for the submission of the SRM data. (See paragraph 5.19)

4. Submission of SRM count and prevalence data to the CMS.

- The SRM data should be submitted through the Annual Statutory Returns submission process via the Healthcare Utilisation System on Table A.7, for both Count and Prevalence.
- Data Officers should consult the Data Specification documents, detailing the submission process.

5. Specific rules applicable to the identification of CDL cases based on entry and verification criteria

Purpose of Boolean tables in section 6

5.1 Each of the tables in section 6 consists of a section on diagnosis related information and a section on proof of treatment. To qualify for inclusion as a beneficiary, a case must have gone through an authorisation process and must meet both the diagnosis related criteria as well as the proof of treatment criteria.

5.2 Authorisation must be performed to collect the diagnosis related information required in the Boolean tables, and does therefore imply a specific process that must be used to ensure that a beneficiary meets all of the requirements listed in the Boolean tables.

5.3 The authorisation process cannot happen automatically or without the application of managed care protocols. "Auto chronic" methods are therefore not acceptable. Diagnosis information gleaned from claims (medicine or services) is not acceptable for SRM.

5.4 Existing patients on active treatment should not be compromised through the withholding of treatment to prove that they meet the diagnosis related requirements. (See section 2). Cases that are on treatment for one of the PMB CDLs when they transfer from one scheme to another must not be compromised and must therefore continue to receive treatment. The E & V criteria therefore has to rely on the proof of treatment information rather than on the diagnosis related information. Information of such members must be transferred from one scheme to another.

Notes on the collection and archiving of diagnosis related information

5.5 Diagnosis related information must be recorded in an auditable format; this includes voice recordings, electronic submissions (digital storage, PDF, etc.) and written hardcopies.

- The provider codes (PCNS or HPCSA codes – see paragraph 5.18) of providers who are diagnosing and/or treating in accordance with the SRM entry and verification criteria must be documented in all cases
- MCOs and administrators may provide diagnosis codes on the information provided by the providers (or their employees) specified in section 6. The source documentation (voice recordings, electronic recordings and/or paper copies) underlying the coding decision must however be archived in an auditable format
- Where the diagnosis can be established by any medical practitioner, and such a provider has not submitted a pre-authorisation request with the given diagnosis, the diagnosis may be communicated to the MCO or administrator on behalf of the diagnosing doctor by either the employees of such a provider or the pharmacist dispensing medication for such a condition, provided that this diagnostic information is part of the authorisation process (see paragraph 5.2 and 5.3)

- Where the diagnosis should be from a provider from a specified group (e.g. specialists), and such a provider has not submitted a pre-authorisation request with the given diagnosis, the treating provider should submit the name of the diagnosing specialist and the diagnosis during the authorisation process.

- Where the diagnosis should be supported by results of diagnostic tests specified in the entry and verification criteria, proof of original laboratory or other test results must be kept. These results can be submitted by the diagnosing or treating provider or the laboratory, if the information is in an auditable format. (See paragraphs 5.5 and 5.16).

- Hospitalisation or other treatment records may be used as proof of a specific clinical event or diagnosis specified in the entry and verification criteria (e.g. multiple sclerosis).

5.6 The use of diagnosis codes provided on claims alone is not acceptable. The diagnosis related information specified in paragraphs 5.2 and 5.3 is required, implying that a separate authorisation process must exist for each of the conditions specified in section 6.

Proof of treatment information based on claims data

5.7 Proof of treatment information must be based on paid claims data.

- Procedure codes are used as evidence for the performance of specified procedures in the entry and verification criteria (see chronic renal disease Table 8).

- Anatomical Therapeutic Chemical Classification System (ATC codes) are used in the definitions of the entry and verification criteria to describe specific medicines (See paragraphs 5.25 and 5.26).

- Proof of treatment is valid only if proof of diagnosis has been obtained separately, through an authorisation process; and benefits must be paid from a risk pool. (See paragraphs 3.7 and 5.1 - 5.3). In the instance of DM1 and DM2, an authorisation for either DM1 or DM2 is acceptable (see Table 13 and Table 14).

Two-out-of-three and one-out-of three month rules

- In most instances, evidence is required that a patient has received the specified treatment during at least two preceding calendar months in the three calendar months preceding the current month (the month for which the beneficiary's risk status is established). The schedule below indicates that, to count a beneficiary in December, payment towards treatment must have been made for services rendered in two of the three calendar months of

September, October, and November. In instances where treatment occurs less frequently, the beneficiary does not qualify as a risk measurement beneficiary. To clarify:

Application of proof of treatment requirements in instances where proof of treatment is required for two calendar months in the three months preceding the calendar month for which eligibility is determined:		
Month:	**Treatment provided and paid for from a risk pool:** *(Use service date to allocate to a specific month)*	**Eligible for inclusion in the grids:**
Jan	Yes	No
Feb	Yes	No
Mar	Yes	Yes
Apr	Yes	Yes
May	Yes	Yes
Jun	No	Yes
Jul	No	Yes
Aug	Yes	No
Sep	Yes	No
Oct	Yes	Yes
Nov	No	Yes
Dec	No	Yes
Jan	Yes	No
Feb	Yes	No

5.8 Specified conditions require proof of payment for services rendered at least once during the three calendar months preceding the period for which scheme risk eligibility is determined. These conditions and *the specific drugs for which the less frequent issue of medicines is a requirement,* are specified in Table 4: Asthma, Table 9: Chronic Obstructive Pulmonary Disease, Table 13: Diabetes Mellitus (Type 1), Table 14: Diabetes Mellitus (Type 2) and Table: 18 Haemophillia.

5.9 For those conditions that need to have proof of treatment less frequently for specific ATC codes, the following table provides an explanation:

Application of proof of treatment requirements in instances where proof of treatment is required for one calendar month in the three months preceding the calendar month for which SRM eligibility is determined:		
Month:	**Treatment provided and paid for from a risk pool:** *(Use service date to allocate to a specific month)*	**Eligible for Inclusion in the SRM grids:**
Jan	Yes	No
Feb	Yes	Yes
Mar	Yes	Yes
Apr	Yes	Yes
May	Yes	Yes
Jun	No	Yes
Jul	No	Yes
Aug	Yes	Yes
Sep	Yes	Yes
Oct	Yes	Yes
Nov	No	Yes
Dec	No	Yes
Jan	No	Yes
Feb	Yes	No

5.10 The tables in section 6 serve as an illustration to assist in the development of Boolean statements that will be used by schemes to identify beneficiaries correctly with SRM risk factors. This information must be made available to the CMS and the auditors on request. It is critical that proper version control is applied, since it is likely that these criteria will change at least once a year. The tables describe the logic that must be applied to:

- Test whether a case meets the criteria for inclusion as a CDL or HIV/AIDS beneficiary in the SRM.

5.11 Categorise diabetes mellitus cases as either type 1 or type 2.

Days of therapy (DOT) method as alternative to the two-out-of-three and one-out-of three month rules

5.12 Under specific exceptional circumstances, schemes may apply to the CMS to be exempted from the two-out-of-three and one-out-of three month rules and to apply the DOT method. Such an application must be accompanied by details of the DOT method that is applied, which must conform to the requirements set out in paragraphs 5.13 - and section 8. The outcome of such an application to the CMS will be communicated to the scheme in writing.

5.13 To qualify for the application of the DOT method, schemes must provide CDL medication to their beneficiaries in larger than 30 days quantities on a regular basis for at least 20% of their beneficiaries, and the total cost of these medicines must exceed 20% of their total CDL medicine costs. For the purposes of this definition the average volume and cost of bulk medication dispensed over the most recent three month period for which data is available must be considered.

5.14 As far as the DOT method is concerned:

- The source of the estimated days-of-therapy must be the prescribing clinician, as recorded on the script, and must be verified by comparing the maximum / minimum daily therapeutic quantity with information as provided by reputable sources of DOTs, including SA package insert specifications and peer-reviewed scientific publications.

- The DOT estimates must be rounded down to the closest 30 days, and no single issue of medication can have a DOT value exceeding 90 days.

5.15 Section 8 describes the DOT method in detail.

Results of special investigations

5.16 For chronic obstructive pulmonary disease, chronic renal disease, haemophilia, HIV/AIDS, and hyperlipidaemia, it is required that the results of special investigations are kept by schemes. This information must also be made available to auditors on request but may be in the form of voice recordings or other electronic records.

Specialist diagnosis required for certain CDL conditions

5.17 The tables in section 6 specify the specialists that are required for the diagnosis of the following conditions: addison's disease, crohn's disease, diabetes insipidus, glaucoma, genetic hyperlipidaemia (in the absence of total cholesterol values supporting the diagnosis), multiple sclerosis, schizophrenia, systemic lupus erythematosus and ulcerative colitis. This includes Rheumatoid Arthritis in cases where a DMARD is not used.

5.18 The "provider codes" required in section 6 refer to the Board of Healthcare Funders (BHF) Discipline list. Health Professions Council for South Africa (HPCSA) numbers should only be used if the provider does not have a Practice Code Numbering System (PCNS) code. In instances where neither an HPCSA nor a PCNS number is available, but the diagnosis was made by a provider employed by a state hospital, the state hospital code is adequate to meet the requirements for specialist diagnosis specified in paragraph 5.17.

Verifiability and auditing of categorisation

5.19 Medical schemes or their contractors must store the information that is required to apply the logic set out in the tables for a period of at least three years. Schemes must ensure that their contracts with third party service providers must specify the period for which the information must be kept, and indicate how this information will be transferred from one contractor to the other where more than one contractor is involved or when contracts are terminated.

5.20 This information must be auditable and must be provided to the CMS and auditors on request, either may also conduct on-site audits.

Ambiguous ICD-10 codes to identify CDL cases

5.21 Some of the ICD-10 codes specified in the PMB algorithms have been presented in a different context in section 6 to ensure that a case cannot be assigned to more than one CDL condition in each specific instance.

5.22 As a rule, if an ICD-10 code indicates more than one of the CDL conditions, only the most expensive condition can be selected for the SRM count data, while all conditions must be included in the SRM prevalence data. In both instances, the proof of treatment criteria must have been met.

- *I11.0: Hypertensive heart disease with (congestive) heart failure (**or** O10.1: Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium).*

If the "proof of treatment" criteria are met, this condition must be categorised in the SRM Count data to: Cardiac failure and cardiomyopathy *Or* Hypertension (See Table 7 for the cardiac failure and cardiomyopathy criteria and Table 20 for the hypertension criteria).

For the SRM prevalence data, these cases must be counted as cardiac failure and Cardiomyopathy a*nd* as hypertension.

- *I12.0: Hypertensive renal disease with renal failure (***or** *O10.2: Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium).*

If the "proof of treatment" criteria are met, this condition must be categorised in the SRM count data to: Chronic renal disease *Or* Hypertension (See Table 8 for the chronic renal disease criteria and Table 20 for the hypertension Criteria).

For the SRM prevalence data, these cases must be counted as chronic renal disease *and* hypertension.

- *I13.0: Hypertensive heart and renal disease with (congestive) heart failure (***or** *010.3: Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium).*

and / or

I13.2: Hypertensive heart and renal disease with both (congestive) heart failure and renal failure.

If the proof of treatment and diagnosis criteria is met, this condition must be in the SRM count data categorised to: Cardiac failure and cardiomyopathy *Or* Chronic renal disease *Or* Hypertension (See Table 8 for the chronic renal disease criteria and Table 20 for the hypertension criteria).

For the SRM prevalence data, these cases should be counted as chronic renal disease *and* hypertension *and as* cardiac failure and cardiomyopathy.

- *I25.5: Ischaemic cardiomyopathy*

For SRM purposes, this code is applicable only to coronary artery disease and is not relevant in cardiac failure and cardiomyopathy in the count grid.

Note that for the prevalence grid, these cases should be counted as only coronary artery disease.

Use of Five-digit ICD-10 codes

5.23 As an interim measure, previous versions of the entry and verification criteria allowed three digit ICD-10 codes in spite of the fact that more specific five-digit codes could be used. This was an interim measure to make provision

for the gradual improvement in the quality of ICD-10 coding. Since version 3 of the criteria requires that the most specific ICD-10 code, in accordance with the industry master ICD 10 table, must be used as proof of diagnosis.

Use of ATC and NAPPI codes

5.24 Medical schemes, administrators, providers, and clearing houses make use of National Pharmaceutical Product Index (NAPPI) codes to identify and bill for pharmaceuticals.

5.25 The entry and verification criteria are based on ATC codes, which change less frequently and are widely used. Crosswalks between NAPPI and ATC codes are available from clearing houses and major administrators. Please note the following with regard to ATC codes:

- The classification of a substance in the ATC system is not a recommendation for use, nor does it imply any judgements about efficacy or relative efficacy of medicines or group of medicines. The ATC system is not applicable for making a diagnosis.
- ATC codes may change over the years. An updated version of the ATC Index is issued annually.
- The ATC Index is published by the World Health Organisation (WHO) Collaborating Centre for Drug Statistics Methodology and is available at www.whocc.no.

Use of specific medicines to identify CDL cases

5.26 The medicines represented by ATC codes in section 6 do not imply that the CMS recommends that these medicines be used. Neither is it implied that these medicines are required by the regulations on PMBs or the CDL Therapeutic Algorithms published by the Minister of Health. In all instances, the inclusion of a case is based on the information required in the table on “diagnosis–related information” as well as the information related to “proof of treatment” (see paragraph 5.1).

5.27 The use of a medicine to assign a diagnosis to a patient is not acceptable in terms of the criteria specified in section 6. In all instances, an authorisation process (see paragraphs 5.2 and 5.3) together with proof of diagnosis and proof of treatment is required.

6. Entry and verification criteria for CDL conditions

Each of the conditions specified in the subsequent Tables are subject to the overriding rules on the exclusion of specific multiple diseases specified in paragraph 3.11.1 as well as the rules on ambiguous ICD-10 codes in paragraphs 5.21 and 5.22.

Table 3: Addison's Disease

Addison's Disease				
Diagnosis-related information				***Proof of Treatment***
Provider code of the diagnosing provider:	**AND**	ICD-10 Codes	**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, paediatrician or endocrinologist or diagnosis must be made by a provider employed by a state hospital 018000 056001 032000 056002 056000 056003		E27.1		H02AB H02AA02

Table 4: Asthma

Asthma						
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: *chronic obstructive pulmonary disease, bronchiectasis and asthma*						
Diagnosis-related information					***Proof of Treatment***	
Provider code of the diagnosing provider:		ICD-10 Codes (Any of the following)			Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:	
Any registered medical practitioner	**AND**	J45.0 J45.1 J45.8	J45.9 J46	**AND**	R03AC R03AK R03BA R03DX05	R03BB01 R03CC R03DA04 R03DC

Table 5: Bipolar Mood Disorder

Bipolar Mood Disorder					
For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: *bipolar mood disorder or schizophrenia and may* not co-occur with epilepsy or multiple sclerosis.					
Diagnosis-related information				**AND**	***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)			Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		F31.0 F31.1 F31.2 F31.3 F31.4	F31.5 F31.6 F31.7 F31.8 F31.9		N05AN01 N03AX09 N03AF01 N03AG01 N05AH03 N05AH04 N05AX08 N05AX12

F31.8 - ? SASOP for Bipolar Mood Disorder

Table 6: Bronchiectasis

Bronchiectasis					
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: *chronic obstructive pulmonary disease, bronchiectasis and asthma.*					
Diagnosis-related information				**AND**	***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)			Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		J47 Q33.4			H02AB R03AC R03AK R03BA R03BB01 R03CC R03DA04

Table 7: Cardiac Failure and Cardiomyopathy

Cardiac Failure and Cardiomyopathy					
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: *cardiomyopathy and cardiac failure, coronary artery disease, dysrhythmias; and hypertension.*					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		I50.0 I50.1 I50.9 I11.0 I13.0 I13.2 I42.0 I42.1	I42.2 I42.3 I42.4 I42.5 I42.6 I42.7 I42.8 I42.9 O10.1 O10.3		C01AA05 C01DA C02DB C03 C07 C09 C01EB17

Add all ICD-10 codes on new algorithms and to the algorithm update

Table 8: Chronic Renal Disease

<table>
<tr><th colspan="11">Chronic Renal Disease</th></tr>
<tr><td colspan="11">For count purposes, only one of hypertension or chronic renal disease may be assigned to the same patient.</td></tr>
<tr><td colspan="5">Diagnosis-related information</td><td rowspan="2"></td><td colspan="4">Proof of Treatment</td></tr>
<tr><td>Provider code of the diagnosing provider</td><td rowspan="2"></td><td>Result of Special investigations</td><td rowspan="2"></td><td colspan="2">ICD-10 Codes (Any of the following)</td><td colspan="4">Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:</td></tr>
<tr><td rowspan="20">Any registered medical practitioner</td><td>Creatinine clearance value of < 30 ml / min</td><td>N03.0
N03.1
N03.2
N03.3
N03.4
N03.5
N03.6
N03.7
N03.8
N03.9
N04.0
N04.1
N04.2
N04.3
N04.4
N04.5
N04.6
N04.7
N04.8
N04.9
N05.0
E10.2
E11.2
E12.2
Z94.0</td><td>N05.1
N05.2
N05.3
N05.4
N05.5
N05.6
N05.7
N05.8
N05.9
N11.0
N11.1
N11.8
N11.9
N18.1
N18.2
N18.3
N18.4
N18.5
N18.9
I12.0
I13.1
I13.2
O10.2
O10.3</td><td colspan="2">B05D
B05Z
B03XA01
C03
C07
C08
C09
B03AA</td><td colspan="2">V03AE
A11CC
L04A
B03AC
B03BB01
A12AA04
H05BX01</td></tr>
<tr><td>AND</td><td>AND</td><td>AND</td><td colspan="4">OR</td></tr>
<tr><td>A Glomerular Filtration Rate estimate of < 60 ml / min</td><td colspan="4">Evidence of payment for peritoneal or haemodialysis for at least 8 sessions in the preceding three months, as evidenced by any of the following NHRPL* or UPFS** codes:</td></tr>
<tr><td>OR</td><td>Medical Practitioners
1843
1845
1847
1849
1851
1852</td><td>Clinical Technologists
145
146
148
147
176
177
149
150
151
152
154
156
153
155</td><td>Registered Nurses:
092
608
610
612
090
UPFS
0310
0311
0312
0313
0320
0321
0322
0323</td></tr>
<tr><td>Albumin-to-Creatinine Ratio (ACR) of ≥ (equal to or greater than) 3.4 mg/mmol (or 30mg/g)</td></tr>
</table>

** NHRPL = National Health Reference Price List*
*** UPFS = Uniform Patient Fee Schedule*

Table 9: Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease						
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: *chronic obstructive pulmonary disease, asthma and bronchiectasis.*						
Diagnosis-related information						***Proof of Treatment***
Any registered medical practitioner	**AND**	Result of Special investigations	**AND**	ICD-10 Codes (Any of the following)	**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
Any registered medical practitioner		Lung function tests demonstrating FEV1/FVC post-bronchodilator values below 70% and FEV1 post-bronchodilator values of less than 80% of predicted		J43.0 J43.1 J43.2 J43.8 J43.9 J44.0 J44.1 J44.8 J44.9		R03AC R03AK R03BA R03BB R03CC R03DA04 R03DX07 V03AN01 H02AB06 H02AB07

Table 10: Coronary Artery Disease

Coronary Artery Disease					
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: *cardiomyopathy and cardiac failure, coronary artery disease, dysrhythmias; and hypertension.*					
Diagnosis-related information				**AND**	***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)			Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		I20.0 I20.1 I20.8 I20.9 I25.0 I25.1	I25.2 I25.3 I25.4 I25.5 I25.6 I25.8 I25.9		C01DA C07 C08 C01EB17

Table 11: Crohn's Disease

Crohn's Disease					
For count purposes, only one of the following Gastro Intestinal conditions can be assigned to the same patient: *crohn's disease or ulcerative colitis.*					
Diagnosis-related information			**AND**	***Proof of Treatment***	
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:	
Must be a specialist physician, paediatrician, surgeon or gastroenterologist or diagnosis must be made by a provider employed by a state hospital 018000 056000 032000 056001 042000 056002 019000 056003		K50.0 K50.1 K50.8 K50.9		A07E H02AB J01XD01 J01MA L04AD01 L01BB02	L04AB04 L04AB02 L04AX01 L04AX03 L01BA01 P01AB01

Table 12: Diabetes Insipidus

Diabetes Insipidus				
Diagnosis-related information			**AND**	***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, paediatrician, neurosurgeon, neurologist or endocrinologist or diagnosis must be made by a provider employed by a state hospital		E23.2		H01BA
018000 056000 032000 056001 024000 056002 020000 056003				

Table 13: Diabetes Mellitus (Type 1)

<table>
<tr><th colspan="5">Diabetes Mellitus Type 1</th></tr>
<tr><td colspan="5">Note:
• For SRM purposes, type 1 and type 2 diabetes cannot occur concurrently.
• Where there is <u>only insulin use (ATC A10A)</u>, the doctor's diagnosis (based on the ICD-10 codes below) of type 1 versus type 2 must be accepted
• Cases meeting the proof of treatment criteria must be counted in accordance with the classification as type 1 in accordance with the rules below, regardless of the type for which authorisation was given.</td></tr>
<tr><td colspan="3">Diagnosis-related information</td><td rowspan="3">AND</td><td>Proof of Treatment</td></tr>
<tr><td>Provider code of the diagnosing provider</td><td rowspan="2">AND</td><td colspan="2">ICD-10 Codes
(Any of the following)</td><td>Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:</td></tr>
<tr><td>Any registered medical practitioner</td><td>E10.0
E10.1
E10.2
E10.3
E10.4
E10.5
E10.6
E10.7
E10.8
E10.9
O24.0</td><td>E13.0
E13.1
E13.2
E13.3
E13.4
E13.5
E13.6
E13.7
E13.8
E13.9
E14.0
E14.1
E14.2
E14.3
E14.4
E14.5
E14.6
E14.7
E14.8
E14.9</td><td>A10A</td></tr>
</table>

Table 14: Diabetes Mellitus (Type 2)

<table>
<tr><th colspan="8">Diabetes Mellitus Type 2</th></tr>
<tr><td colspan="8">Note:
• For SRM purposes, type 1 and type 2 diabetes cannot occur concurrently.
• Evidence of use of oral euglycemia medicines in the preceding three months automatically leads to the classification of a diabetic case as type 2.
• Cases meeting the proof of treatment criteria must be counted in accordance with the classification as type 2 in accordance with the rules below, regardless of the type for which authorisation was given.</td></tr>
<tr><td colspan="6">Diagnosis-related information</td><td rowspan="2"></td><td>Proof of Treatment</td></tr>
<tr><td>Provider code of the diagnosing provider</td><td rowspan="2">AND</td><td colspan="2">ICD-10 Codes
(Any of the following)</td><td rowspan="2">AND</td><td>Evidence of use of oral hypoglycaemic or euglycemic agents in the preceding three months. This includes any product in the A10B ATC category:</td><td>Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:</td></tr>
<tr><td rowspan="2">Any registered medical practitioner</td><td>E11.0
E11.1
E11.2
E11.3
E11.4
E11.5
E11.6
E11.7
E11.8
E13.0
E13.1
E13.2
E13.3
E13.4
E13.5
E13.6
E13.7
E13.8
E13.9
E14.0
E14.1
E14.2
E14.3
E14.4
E14.5
E14.6
E14.7
E14.8
E14.9</td><td>E11.9
E12.0
E12.1
E12.2
E12.3
E12.4
E12.5
E12.6
E12.7
E12.8
E12.9
O24.1
O24.2
O24.3
O24.4
O24.9</td><td>OR
Any ICD-10 code indicative of Non-Insulin Dependent Diabetes:
E11.0
E11.1
E11.2
E11.3
E11.4
E11.5
E11.6
E11.7
E11.8
E11.9
O24.1</td><td>AND</td><td>A10B
OR
Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
A10A</td></tr>
</table>

Table 15: Dysrhythmias

Dysrhythmias				
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: *cardiomyopathy and cardiac failure, coronary artery disease, dysrhythmias; and hypertension.*				
Diagnosis-related information				***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)	**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		I47.2 I48.0 I48.1 I48.2 I48.3 I48.4 I48.9		B01AA03 C01A C01B C07 C08D B01AF01 B01AE07

Table 16: Epilepsy

Epilepsy					
For count purposes, *bipolar mood disorder and multiple sclerosis may not co-occur with epilepsy*					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		G40.0 G40.1 G40.2 G40.3 G40.4 G40.5 G40.6 G40.7	G40.8 G40.9 G41.0 G41.1 G41.2 G41.8 G41.9		N03

Table 17: Glaucoma

Glaucoma					
Diagnosis-related information					***Proof of Treatment***
Provider code of the initial /confirmation diagnosing specialist provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Specialist ophthalmologist or provider employed by a state hospital (26000, 056000, 056001, 056002, 056003)		H40.0 H40.1 H40.2 H40.3 H40.4	H40.5 H40.6 H40.8 H40.9 Q15.0		S01E

Table 18: Haemophilia

Haemophilia					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
Any registered medical practitioner		D66 D67			B02AA02 B02BD02 B02BD03 B02BD08
		AND			B02BD04 B02BD06 H01BA
		Laboratory evidence of Factor VIII or IX levels lower than or equal to 5%			

Table 19: Hyperlipidaemia

Hyperlipidaemia

Note:

- *Information supporting the diagnosis must be kept in a format that could be audited. This includes paper copies or the electronic storage of voice recordings that could substantiate the diagnosis, the results of special investigations and the data underlying the risk assessment (Framingham score).*
- Only *a diagnosis by an endocrinologist will be accepted to diagnose genetic hyperlipidaemias without supporting high Total Cholesterol values.*

Diagnosis-related information									***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	Diagnosis of symptomatic atherosclerotic disease Including any of the following ICD-10 codes					**AND**	ICD-10 Codes (Any of the following)	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner.		G45.0 G45.1 G45.2 G45.3 G45.4 G45.8 G45.9 I20.0 I20.1 I20.8 I20.9 I21.0 I21.1	I21.2 I21.3 I21.4 I21.9 I22.0 I22.1 I22.8 I22.9 I24.0 I24.1 I24.8 I24.9 I25.0	I25.1 I25.2 I25.3 I25.4 I25.5 I25.6 I25.8 I25.9 I63.0 I63.1 I63.2 I63.3 I63.4	I63.5 I63.6 I63.8 I63.9 I64 I65.0 I65.1 I65.2 I65.3 I65.8 I65.9 I66.0 I66.1	I66.2 I66.3 I66.4 I66.8 I66.9 I67.6 I70.0 I70.1 I70.2 I70.8 I70.9		E78.0 E78.1 E78.2 E78.3 E78.4 E78.5	C10
		OR							
		Diagnosis of Diabetes mellitus type 2, or Diabetes mellitus type 1 with micro-albuminuria/proteinuria							
		OR							
		Chronic kidney disease (GFR <60 ml/min/1.73 m_2) – only N18.3, N18.4 and N18.5							
		OR							
		10 year CVD risk ≥ 15% as per Framingham Risk Score (2012 version)							
		OR							
		Genetic hyperlipidaemias diagnosed by:							
			By any registered medical practitioner **where** TC>7.5mmol/l						
			OR						
			TC> 7 mmol/l	**AND**	Positive family history of a premature vascular event in a 1st degree male relative < 55 yrs				
			OR						

			TC> 7 mmol/l	**AND**	Positive family history of a premature vascular event a 1st degree female relative <65 yrs				
			OR						
			The presence of tendon Xantomata						
An endocrinologist (PCNS Practise type: 11801)									

Table 20: Hypertension

Hypertension						
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: *cardiomyopathy and cardiac failure, coronary artery disease, dysrhythmias; and hypertension.* For count purposes, only one of *Hypertension or Chronic Renal Disease* may be assigned to the same patient.						
Diagnosis-related information					***Proof of Treatment***	
Provider code of the diagnosing provider		ICD-10 Codes (Any of the following)			Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:	
Any registered medical practitioner	**AND**	I10 I11.0 I11.9 I12.0 I12.9 I13.0 I13.1 I13.2 I13.9 I15.0 I15.1	I15.2 I15.8 I15.9 O10.0 O10.1 O10.2 O10.3 O10.4 O10.9 O11	**AND**	C02 C03 C07	C08 C09 G04CA03

Table 21: Hypothyroidism

Hypothyroidism					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		E01.8 E02 E03.0 E03.1 E03.2 E03.3	E03.4 E03.5 E03.8 E03.9 E89.0		H03AA

Table 22: Multiple Sclerosis

<table>
<tr><th colspan="6">Multiple Sclerosis</th></tr>
<tr><td colspan="6">For count purposes, bipolar mood disorder and epilepsy may not co-occur with multiple sclerosis.</td></tr>
<tr><td colspan="3">Diagnosis-related information</td><td rowspan="3">AND</td><td colspan="2">Proof of Treatment</td></tr>
<tr><td>Provider code of the diagnosing provider</td><td rowspan="2">AND</td><td>ICD-10 Codes (Any of the following)</td><td colspan="2">Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:</td></tr>
<tr><td>Must be a specialist physician, or neurologist or diagnosis must be made by a provider employed by a state hospital
018000
020000
056000
056001
056002
056003</td><td>G35</td><td>Disease Modifying agents

L03AB07
L03AB08
L03AX13
L04AA23
L04AA27
G04BD</td><td>Symptomatic supportive treatment

N03AF01
N06AA09
M03BX01
N06AA02
H02AB04
L04AA31</td></tr>
<tr><td colspan="4"></td><td colspan="2">OR</td></tr>
<tr><td colspan="4"></td><td colspan="2">Evidence of hospitalisation (admission date) in the preceding 3 months for acute exacerbation of Multiple Sclerosis (G35).</td></tr>
</table>

Table 23: Parkinson's Disease

<table>
<tr><th colspan="6">Parkinson’s Disease</th></tr>
<tr><td colspan="3">Diagnosis-related information</td><td rowspan="3">AND</td><td colspan="2">Proof of Treatment</td></tr>
<tr><td>Provider code of the diagnosing provider</td><td rowspan="2">AND</td><td colspan="2">ICD-10 Codes (Any of the following)</td><td>Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:</td></tr>
<tr><td>Any registered medical practitioner</td><td>G20
G21.0
G21.1
G21.2</td><td>G21.3
G21.8
G21.9</td><td>N04</td></tr>
</table>

Table 24: Rheumatoid Arthritis

Rheumatoid Arthritis							
For count purposes, *systemic lupus erythematosus* may not co-occur with *rheumatoid arthritis.*							
Note: Where a patient is not using disease modifying anti-rheumatic medicines, the diagnosis must be verified by a specialist physician or rheumatologist.							
Diagnosis-related information							***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)				**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		M05.00	M05.35	M06.10	M06.45		A07EC01
		M05.01	M05.36	M06.11	M06.46		H02AB
		M05.02	M05.37	M06.12	M06.47		L01AA01
		M05.03	M05.38	M06.13	M06.48		L01BA01
		M05.04	M05.39	M06.14	M06.49		
		M05.05	M05.80	M06.15	M06.80		M01AB
		M05.06	M05.81	M06.16	M06.81		M01AC
		M05.07	M05.82	M06.19	M06.82		M01AE
		M05.08	M05.83	M06.17	M06.83		M01AG
		M05.09	M05.84	M06.18	M06.84		M01AH
		M05.10	M05.85	M06.20	M06.85		M01C
		M05.11	M05.86	M06.21	M06.86		P01BA01
		M05.12	M05.87	M06.22	M06.87		L04AX01
		M05.13	M05.88	M06.23	M06.88		L04AX03
		M05.14	M05.89	M06.24	M06.89		L04AA13
		M05.15	M05.90	M06.25	M06.90		L04AD01
		M05.16	M05.91	M06.26	M06.91		L04AB02
		M05.17	M05.92	M06.27	M06.92		L04AB04
		M05.18	M05.93	M06.28	M06.93		L04AB01
		M05.19	M05.94	M06.29	M06.94		L04AB06
		M05.20	M05.95	M06.30	M06.95		L04AC07
		M05.21	M05.96	M06.31	M06.96		L04AA24
		M05.22	M05.97	M06.32	M06.97		L01XC02
		M05.23	M05.98	M06.33	M06.98		
		M05.24	M05.99	M06.34	M06.99		
		M05.25	M06.00	M06.35	M08.00		
		M05.26	M06.01	M06.36	M08.01		
		M05.27	M06.02	M06.37	M08.02		
		M05.28	M06.03	M06.38	M08.03		
		M05.29	M06.04	M06.39	M08.04		
		M05.31	M06.05	M06.40	M08.05		
		M05.30	M06.06	M06.41	M08.06		
		M05.32	M06.07	M06.42	M08.07		
		M05.33	M06.08	M06.43	M08.08		
		M05.34	M06.09	M06.44	M08.09		

Table 25: Schizophrenia

Schizophrenia					
For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: *bipolar mood disorder or schizophrenia*.					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a psychiatrist or paediatric psychiatrist or diagnosis must be made by a provider employed by a state hospital 022000 056002 056000 056003 056001		F20.0 F20.1 F20.2 F20.3 F20.4	F20.5 F20.6 F20.8 F20.9		N05A

Table 26: Systemic Lupus Erythematosus

Systemic Lupus Erythematosus						
For count purposes, *systemic lupus erythematosus* may not co-occur with *rheumatoid arthritis*						
Diagnosis-related information					***Proof of Treatment***	
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:	
Must be a specialist physician, paediatrician or rheumatologist or diagnosis must be made by a provider employed by a state hospital 018000 056002 018012 056003 032000 031000 056000 056001		M32.0 M32.1 M32.8 M32.9	L93.0 L93.1 L93.2		B01AA03 H02AB L01AA01 L01BA01 L04AD01 L04AX03 D07A M04AC01	L04AD02 L04AA06 L04AX01 M01AB M01AC M01AE M01AG M01AH

Table 27: Ulcerative Colitis

Ulcerative Colitis					
For count purposes, only one of the following gastro intestinal conditions can be assigned to the same patient: *crohn's disease or ulcerative colitis.*					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD-10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, surgeon or gastroenterologist or diagnosis must be made by a provider employed by a state hospital 042000 018000 019000 056000 056001 056002 056003		K51.0 K51.1 K51.2 K51.3	K51.4 K51.5 K51.8 K51.9		A07E H02AB L04AB02 L04AB04 L04AB06 L04AX01 L01BB02 L04AD01 L01BA01

Table 28: HIV/AIDS

<table>
<tr><th colspan="8">HIV/AIDS</th></tr>
<tr><td colspan="8">Documented proof that demonstrates that the patient qualifies for ART in accordance with the National Antiretroviral Treatment Guidelines must be made available to auditors on request but may be in the form of voice recordings or other electronic records.</td></tr>
<tr><td colspan="5">Diagnosis-related information</td><td rowspan="2">AND</td><td colspan="2">Proof of Treatment</td></tr>
<tr><td>Provider code of the diagnosing provider</td><td rowspan="2">AND</td><td colspan="2">ICD-10 Codes(Any of the following)</td><td rowspan="2">AND</td><td rowspan="2">Documented proof to demonstrate that patient qualifies for ART in accordance with the National Antiretroviral Treatment Guidelines (CD4 count not applicable anymore as new National Antiretroviral Treatment Guidelines)</td><td colspan="2">Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:</td></tr>
<tr><td>Any registered medical practitioner</td><td>B20.0
B20.1
B20.2
B20.3
B20.4
B20.5
B20.6
B20.7
B20.8
B20.9
B21.0
B21.1
B21.2
Z20.6</td><td>B21.3
B21.7
B21.8
B21.9
B22.0
B22.1
B22.2
B22.7
B23.0
B23.1
B23.2
B23.8
B24</td><td colspan="2">J05AE
J05AF
J05AG
J05AR
J05AX08
J05AR06
J05AX09
J05AX12</td></tr>
</table>

Table 29: Maternity

<table>
<tr><th colspan="4">Maternity Codes</th></tr>
<tr><td rowspan="5">Admission date

OR

Confinement Date</td><td rowspan="5">AND</td><td colspan="2">Procedure codes (Any of the following)</td></tr>
<tr><td colspan="2">2614, 2615, 2616, 2653</td></tr>
<tr><td colspan="2">OR</td></tr>
<tr><td colspan="2">Diagnosis codes (Any of the following)</td></tr>
<tr><td>O60.0 Preterm labour without delivery
O60.1 Preterm labour with preterm delivery
O60.2 Preterm labour with term delivery
O61.0 Failed medical induction of labour
O61.1 Failed instrumental induction of labour
O61.8 Other failed induction of labour
O61.9 Failed induction of labour, unspecified
O62.0 Primary inadequate contractions
O62.1 Secondary uterine inertia
O62.2 Other uterine inertia
O62.3 Precipitate labour
O62.4 Hypertonic, incoordinate, and prolonged uterine contractions
O62.8 Other abnormalities of forces of labour
O62.9 Abnormality of forces of labour; unspecified
O63.0 Prolonged first stage (of labour)
O63.1 Prolonged second stage (of labour)
O63.2 Delayed delivery of second twin; triplet; etc.
O63.9 Long labour; unspecified
O64.0 Obstructed labour due to incomplete rotation of fetal head
O64.1 Obstructed labour due to breech presentation
O64.2 Obstructed labour due to face presentation
O64.3 Obstructed labour due to brow presentation
O64.4 Obstructed labour due to shoulder presentation
O64.5 Obstructed labour due to compound presentation
O64.8 Obstructed labour due to other malposition and malpresentation
O64.9 Obstructed labour due to malposition and malpresentation; unspecified
O65.0 Obstructed labour due to deformed pelvis
O65.1 Obstructed labour due to generally contracted pelvis
O65.2 Obstructed labour due to pelvic inlet contraction
O65.3 Obstructed labour due to pelvic outlet and mid-cavity contra
O65.4 Obstructed labour due to fetopelvic disproportion; unspecified
O65.5 Obstructed labour due to abnormality of maternal pelvic organs
O65.8 Obstructed labour due to other maternal pelvic abnormalities
O65.9 Obstructed labour due to maternal pelvic abnormality; unspecified
O66.0 Obstructed labour due to shoulder dystocia
O66.1 Obstructed labour due to locked twins
O66.2 Obstructed labour due to unusually large fetus
O66.3 Obstructed labour due to other abnormalities of fetus
O66.4 Failed trial of labour; unspecified
O66.5 Failed application of vacuum extractor and forceps, unspecified
O66.8 Other specified obstructed labour
O66.9 Obstructed labour; unspecified
O67.0 Intrapartum haemorrhage with coagulation defect
O67.8 Other intrapartum haemorrhage
O67.9 Intrapartum haemorrhage, unspecified
O68.0 Labour and delivery complicated by fetal heart rate anomaly
O68.1 Labour and delivery complicated by meconium in amniotic fluid
O68.2 Labour and delivery complicated by fetal heart rate anomaly
O68.3 Labour and delivery complicated by biochemical evidence of fetal stress
O68.8 Labour and delivery complicated by other evidence of fetal stress</td><td>O71.7 Obstetric haematoma of pelvis
O71.8 Other specified obstetric trauma
O71.9 Obstetric trauma, unspecified
O72.0 Third-stage haemorrhage
O72.1 Other immediate postpartum haemorrhage
O72.2 Delayed and secondary postpartum haemorrhage
O72.3 Postpartum coagulation defects
O73.0 Retained placenta without haemorrhage
O73.1 Retained portions of placenta and membranes, without haemorrhage
O74.0 Aspiration pneumonitis due to anaesthesia during labour and delivery
O74.1 Other pulmonary complications of anaesthesia during labour and delivery
O74.2 Cardiac complications of anaesthesia during labour and delivery
O74.3 Central nervous system complications of anaesthesia during labour and delivery
O74.4 Toxic reaction to local anaesthesia during labour and delivery
O74.6 Other complications of spinal and epidural anaesthesia during labour and delivery
O74.7 Failed or difficult intubation during labour and delivery
O74.8 Other complications of anaesthesia during labour and delivery
O74.9 Complication of anaesthesia during labour and delivery, unspecified
O75.0 Maternal distress during labour and delivery
O75.1 Shock during or following labour and delivery
O75.2 Pyrexia during labour, not elsewhere classified
O75.3 Other infection during labour
O75.4 Other complications of obstetric surgery and procedures
O75.5 Delayed delivery after artificial rupture of membranes
O75.6 Delayed delivery after spontaneous or unspecified rupture of
O75.7 Vaginal delivery following previous caesarean section
O75.6 Delayed delivery after spontaneous or unspecified rupture of membranes
O75.7 Vaginal delivery following previous caesarean section
O75.8 Other specified complications of labour and delivery
O75.9 Complication of labour and delivery, unspecified
O80.0 Spontaneous vertex delivery
O80.1 Spontaneous breech delivery
O80.8 Other single spontaneous delivery
O80.9 Single spontaneous delivery, unspecified
O81.0 Low forceps delivery
O81.1 Mid-cavity forceps delivery
O81.2 Mid-cavity forceps with rotation
O81.3 Other and unspecified forceps delivery
O81.4 Vacuum extractor delivery
O81.5 Delivery by combination of forceps and vacuum extractor
O82.0 Delivery by elective caesarean section
O82.1 Delivery by emergency caesarean section
O82.2 Delivery by caesarean hysterectomy
O82.8 Other single delivery by caesarean section</td></tr>
</table>

		O68.9 Labour and delivery complicated by fetal stress; unspecified O69.0 Labour and delivery complicated by prolapse of cord O69.1 Labour and delivery complicated by cord around neck; with co O69.2 Labour and delivery complicated by other cord entanglement O69.3 Labour and delivery complicated by short cord O69.4 Labour and delivery complicated by vasa praevia O69.5 Labour and delivery complicated by vascular lesion of cord O69.8 Labour and delivery complicated by other cord complications O69.9 Labour and delivery complicated by cord complication; unspecified O70.0 First degree perineal laceration during delivery O70.1 Second degree perineal laceration during delivery O70.2 Third degree perineal laceration during delivery O70.3 Fourth degree perineal laceration during delivery O70.9 Perineal laceration during delivery, unspecified O71.0 Rupture of uterus before onset of labour O71.1 Rupture of uterus during labour O71.2 Postpartum inversion of uterus O71.3 Obstetric laceration of cervix O71.4 Obstetric high vaginal laceration alone O71.5 Other obstetric injury to pelvic organs O71.6 Obstetric damage to pelvic joints and ligaments	O82.9 Delivery by caesarean section, unspecified O83.0 Breech extraction O83.1 Other assisted breech delivery O83.2 Other manipulation-assisted delivery O83.3 Delivery of viable fetus in abdominal pregnancy O83.4 Destructive operation for delivery O83.8 Other specified assisted single delivery O83.9 Assisted single delivery, unspecified O84.0 Multiple delivery, all spontaneous O84.1 Multiple delivery, all by forceps and vacuum extractor O84.2 Multiple delivery, all by caesarean section O84.8 Other multiple delivery O84.9 Multiple delivery, unspecified Z37.0 Single live birth Z37.1 Single stillbirth Z37.2 Twins; both liveborn Z37.3 Twins; one liveborn and one stillborn Z37.4 Twins; both stillborn Z37.5 Other multiple births; all liveborn Z37.6 Other multiple births; some liveborn Z37.7 Other multiple births; all stillborn Z37.9 Outcome of delivery; unspecified Z38.0 Singleton; born in hospital Z38.1 Singleton; born outside hospital Z38.2 Singleton; unspecified as to place of birth Z38.3 Twin; born in hospital Z38.4 Twin; born outside hospital Z38.5 Twin; unspecified as to place of birth Z38.6 Other multiple; born in hospital Z38.7 Other multiple; born outside hospital Z38.8 Other multiple; unspecified as to place of birth

7. ATC code descriptions

The purpose of this section is merely to provide descriptions for the codes that are used in the algorithms and must not be interpreted to append the criteria stipulated in section 6.

Addison's disease	
H02AB	Glucocorticoids
H02AA02	Fludrocortisone
Asthma	
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB01	Ipratropium bromide
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
R03DC	Leukotriene receptor antagonists
R03DX05	Omalizumab
Bipolar mood disorder	
N05AN01	Lithium
N03AX09	Lamotrigine
N03AF01	Carbamazepine
N03AG01	Valproic acid
05AH03	Olanzapine
N05AH04	Quetiapine
N05AX08	Risperidone
N05AX12	Aripiprazole
Bronchiectasis	
H02AB	Glucocorticoids
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB01	Ipratropium bromide
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
Cardiac Failure and Cardiomyopathy	
C01AA05	Digoxin
C01DA	Organic nitrates
C02DB	Hydrazinophthalazine derivatives
C03	Diuretics
C07	Beta blocking agents
C09	Agents acting on the renin-angiotensin system
C01EB17	Ivabradine

Chronic renal disease	
B05D	Peritoneal dialytics
B05Z	Haemodialytics and haemofiltrates
B03XA01	Erythropoietin
V03AE	Drugs for treatment of hyperkalemia and hyperphosphatemia
A11CC	Vitamin D and analogues
L04A	Immunosuppressive agent
C03	Diuretics
C07	Beta-blocking agents
C08	Calcium channel blockers
C09	Drugs acting on the renin-angiotensin system
B03AA	Oral iron
B03AC	Parenteral iron
B03BB01	Folic acid
A12AA04	Calcium carbonate
H05BX01	Cinacalcet
Chronic obstructive pulmonary disease	
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB	Anticholinergics
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
R03DX07	Roflumilast
V03AN01	Oxygen
Coronary artery disease	
C01DA	Organic nitrates
C07	Beta blocking agents
C08	Calcium channel blockers
C01EB17	Ivabradine
Crohn's disease	
A07E	Intestinal antiinflammatory agents
H02AB	Glucocorticoids
J01XD01	Metronidazole
J01MA	Fluoroquinolones
L04AD01	Ciclosporin
L04AD02	Tacrolimus
L04AB02	Infliximab
L04AX01	Azathioprine
L04AX03	Methotrexate
L01BA01	Methotrexate
P01AB01	Metronidazole
L04AB04	Adalimumab
L01BB02	6-mercaptopurine

Diabetes insipidus	
H01BA	Vasopressin and analogues
Diabetes mellitus	
A10A	Insulins and analogues
A10B	Oral blood glucose lowering drugs
Dysrhythmias	
B01AA03	Warfarin
C01A	Cardiac glycosides
C01B	Antiarrhythmics, class i and iii
C07	Beta blocking agents
C08D	Selective calcium channel blockers with direct cardiac effects
B01AF01	Rivaroxaban
B01AE07	Dabigatran
Epilepsy	
N03	Antiepileptics
Glaucoma	
S01E	Antiglaucoma preparations and miotics
Haemophilia	
B02AA02	Tranexamic acid
B02BD02	Coagulation factor VIII
B02BD03	Factor VIII inhibitor bypassing activity
B02BD06	Von Willebrand factor and coagulation factor VIII in combination
B02BD04	Coagulation factor IX
H01BA	Vasopressin and analogues
B02BD08	Eptacog alfa (activated)
Hyperlipidaemia	
C10	Serum lipid reducing agents
Hypertension	
C02	Antihypertensives
C03	Diuretics
C07	Beta blocking agents
C08	Calcium channel blockers
C09	Agents acting on the renin-angiotensin system
G04CA03	Terazosin
Hypothyroidism	
H03AA	Thyroid hormones
Multiple sclerosis	
L03AB07	Interferon beta-1a
L03AB08	Interferon beta-1b
L03AX13	Glatiramer acetate
L04AA23	Natalizumab
N03AF01	Carbamazepine
N06AA09	Amitriptyline

M03BX01	Baclofen
N06AA02	Imipramine
L04AA27	Fingolimod
G04BD	Drugs for urinary frequency
H02AB04	Parenteral methylprednisolone
L04AA31	Terflunomide
Parkinson's disease	
N04	Anti-parkinson drugs
Rheumatoid Arthritis	
A07EC01	Sulfasalazine
H02AB	Glucocorticoids
L01AA01	Cyclophosphamide
L01BA01	Methotrexate
M01AB	Acetic acid derivatives and related substances
M01AC	Oxicams
M01AE	Propionic acid derivatives
M01AG	Fenamates
M01AH	Coxibs
M01C	Specific antirheumatic agents
P01BA01	Chloroquine
L04AX01	Azathioprine
L04AX03	Oral methotrexate
L04AA13	Leflunomide
L04AD01	Cyclosporine
L04AB02	Infliximab
L04AB04	Adalimumab
L04AB01	Etanercept
L04AB06	Golimumab
L04AC07	Tocilizumab
L04AA24	Abatacept
L01XC02	Rituximab
Schizophrenia	
N05A	Antipsychotics
Systemic lupus erythematosus	
B01AA03	Warfarin
H02AB	Glucocorticoids
L01AA01	Cyclophosphamide
L01BA01	Methotrexate
L04AD01	Ciclosporin
L04AD02	Tacrolimus
L04AA06	Mycophenolic acid
L04AX01	Azathioprine
M01AB	Acetic acid derivatives and related substances

M01AC	Oxicams
M01AE	Propionic acid derivatives
M01AG	Fenamates
M01AH	Coxibs
L04AX03	Oral methotrexate
D07A	Topical corticosteroids
M04AC01	Colchicine
Ulcerative colitis	
A07e	Intestinal antiinflammatory agents
H02ab	Glucocorticoids
L04ab02	Infliximab
L04AB04	Adalimumab
L04AB06	Golimumab
L04AX01	Azathioprine
L01BB02	6-mercaptopurine
HIV / AIDS	
J05AE	Protease inhibitors
J05AF	Nucleoside and nucleotide reverse transcriptase inhibitors
J05AG	Non-nucleoside reverse transcriptase inhibitors
J05AR	Antiviral treatment for HIV infections
J05AX08	Raltegavir
J05AX09	Maraviroc
J05AX12	Dolutegravir

8. Details for the days-of-therapy (DOT) method

8.1 This methodology considers the Days of Therapy equivalent of issued medication when determining compliance with medication for SRM purposes. This is done in addition to the two-in-three-months and one-in-three-months rules specified in paragraphs 5.7 to 5.9.

8.2 This method is applicable only to schemes that have applied in accordance with paragraphs 5.12 to 5.15 to use this additional method.

8.3 This section only provides an additional technique to the two-in-three-months and one-in-three-months rules dealing with proof of treatment, and does not affect other elements of these criteria.

8.4 Instead of verifying claim frequency based on actual received claims across the three month compliance evaluation period specified in paragraphs 5.7 to 5.9, the DOT method is an additional technique that may be applied by qualifying schemes to derive a compliance status for patients that do not meet the two-in-three-months and one-in-three-month rules.

Days of therapy (DOT) method

8.5 For individuals not meeting the compliance requirements of the two-in-three-months and one-in-three-month rule specified in paragraphs 5.7 to 5.9, matching claims for the preceding five months must be selected(for example, to determine the SRM status for June of a specific year, the DOT method will select claims for medications issued in January to May).

8.6 The first step is to round the DOT value down to the nearest multiple of thirty.

8.7 For claims received in the ***first*** month of the selected five month period the DOT value is considered:

- If a zero Rounded DOT value is received on claims, a default value of 30 Days is allocated for these claims
- If the Rounded DOT value on the claim is >= 60 Days, an indicator is set to indicate that a claim was received the first month of the three months compliance evaluation period.

8.8 For claims received in the ***second*** of the selected five months claim selection, the DOT is evaluated:

- If the Rounded DOT value is >= 30 Days, an indicator is set to indicate that a claim was received in first month of three months compliance evaluation period.
- If the Rounded DOT value is >= 60 Days, an indicator is set to indicate that a claim was received in first month ***and*** second of the three months compliance evaluation period.

8.9 For claims received in the ***third*** month of the selected five months claim selection (the first month of the three month compliance evaluation period), the DOT is evaluated:

- An indicator is set that a claim was received in the first month of the three months compliance evaluation period
- If the Rounded DOT value is >= 30 Days an indicator is set to indicate that a claim was also received in the second month of the of the three months compliance evaluation period
- If the Rounded DOT value is >= 60 Days an indicator is set to indicate that a claim was also received in the second month ***and*** third month of the three months compliance evaluation period.

8.10 For claims received in the ***fourth*** month of the selected five months claim selection (the second month of the three months compliance evaluation period), the DOT is evaluated.

- An indicator is set that a claim was received in the second month of the three months compliance evaluation period
- If the rounded DOT value is >= 30 Days, an indicator is set to indicate that a claim was also received in the third month of the three months compliance evaluation period.
- If the rounded DOT value is >= 60 Days, the same procedure is followed as in .

8.11 For claims received in the ***fifth*** month of the selected five months claim selection (the third month of the three month compliance evaluation period), the DOT is not considered, but an indicator is set that a claim was received in the third month of the three months compliance evaluation period.

8.12 Schemes applying the DOT method must submit grids after application of the DOT method in accordance with the specifications in section 4, but must also provide the CMS with additional grids that reflect the compliance in accordance with the standard compliance measurements.

9. Changes recommended on version 10.0, but not actioned

The following list of recommended changes were not actioned due to the reasons listed.

Changes recommended	Reason
There was a suggestion that only the N-range of ICD-10 codes be kept as primary codes on the Chronic Renal Disease table and that all other codes be specified as secondary codes.	The request is not in line with ICD-10 coding rules and the codes cannot be split to indicate primary and secondary codes. The N-code can be added as a secondary code. The table was not changed as requested. Example 1: Hypertensive end stage renal failure PDX: I12.0 Hypertensive renal disease with renal failure SDX: N18.0 End-stage renal disease Example 2: Patient admitted with hypertension, chronic renal failure and congestive heart failure PDX: I12.0 Hypertensive renal disease with renal failure SDX: N18.9 Chronic renal failure, unspecified SDX: I50.0 Congestive heart failure
The request to update the version to 10.1 on page 7 of version 10.0.	Version 10.0 contains proposed changes to version 9.1 and is published for comment to the industry. The version 10.1 contains all accepted changes and represents the version applicable to all cases from 1 January 2016.
A request to delete code K51.1 from Table 27 (Ulcerative Colitis) as it is not a PMB condition was not actioned.	K51.1 - Ulcerative (chronic) ileocolitis is included in the PMB Chronic Disease List.