PMB review consultation document

Third draft

25 March 2009

COUNCIL FOR MEDICAL SCHEMES

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

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List of abbreviations

BD	-	Benefit Definition
CDL	-	Chronic Disease List
CMS	-	Council for Medical Schemes
DoH	-	Department of Health
DSP	-	Designated Service Provider
DTP	-	Diagnosis Treatment Pair
EDL	-	Essential Drug List
LIMS	-	Low income medical scheme
MSA	-	Medical Savings Account
MSAB	-	Medical Schemes Amendment Bill
NHI	-	National Health Insurance
REF	-	Risk Equalisation Fund
RETAP	-	Risk Equalisation Technical Advisory Panel
UPFS	-	Uniform Patient Fee Schedule

1 Introduction and purpose of this document

Following two workshops on prescribed minimum benefits (PMBs) with stakeholders and affected parties in February and March 2008, the Department of Health (DoH) and the Council for Medical Schemes (CMS) published a consultation document on the PMB review process on 27 March 2008[*]. Stakeholder comments on this document were considered and incorporated in the second draft of the PMB review consultation document, which was published in September 2008[†]. A list of stakeholder comments on the second draft appears in Annexure K (page 104). Considering these comments and other considerations, the PMB review steering committee incorporated numerous revisions into this document. The committee's responses to stakeholder comments are included in Annexure J (page 85).

The PMB review has the following terms of reference:

- identify gaps and inconsistencies in PMBs and make recommendations to address them;
- specify a broad set of essential healthcare benefits;
- identify those PMBs that should accompany the implementation of the Risk Equalisation Fund (REF) if not the broad set of essential healthcare benefits;
- identify the specific constraints associated with the implementation of a broad set of essential healthcare benefits;
- identify the interventions that should be undertaken to ensure the financial sustainability of any PMB package;
- identify measures required to ensure cost-effectiveness; and
- document the relationship between PMBs and the public healthcare system.

Section 2 deals with the legislated mandate, while section 3 presents the context of the review. Section 4 presents the recommendations on the PMB review, while the principles for the revised PMB construct and a framework for the revised PMBs is presented in section 5.

[*] **"2008 PMB review consultation document. Proposed construct and work plans. 27 March 2008",** available at http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/PMB%20Review%20consultation%20document.pdf

[†] "**2008 PMB review consultation document. Second draft. 12 September 2008",** available at http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/PBM%20Review%20consultation%20document%20-%20Second%20draft.pdf

2 The mandate for the PMB review

The context and legislated mandate for the PMB review impact on the principles that are applicable to this review. The existing regulations, an extract of which is presented in Box 1, make provision for the consideration of the current context and developments in health policy, which are presented in section 3 below. This review therefore takes account of the REF and related reforms, which are not mentioned in the regulations.

2.1 Medical Schemes Act 131 of 1998

The explanatory note on PMBs in the Medical Schemes Act 131 of 1998 (Act) is presented in Box 1.

Box 1: Explanatory note to Annexure A of the Regulations to the Medical Schemes Act 131 of 1998: on prescribed minimum benefits

The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness, and appropriateness of the prescribed minimum benefits provisions. A review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, provincial health departments and consumer representatives. In addition, the review will focus specifically on the development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of:

i. inconsistencies or flaws in the current regulations;
ii. the cost-effectiveness of health technologies or interventions;
iii. the consistency with developments in health policy; and
iv. the impact on medical scheme viability and its affordability to members.

Since these regulations have become effective, there has been considerable development in the management of HIV/AIDS. A number of inconsistencies and flaws in the current regulations have been identified. The cost-effectiveness of health technologies or interventions has changed. Further developments of health policy with respect to the protection of risk pools are to be introduced, and the impact of PMBs on medical scheme viability and affordability has been considered.

These matters all have an impact on the context that influences the PMB review, and are elaborated on in section 3.

2.2 Other legislation

Section 3(1) of the National Health Act places the responsibility on the Minister of Health to, within the limits of available resources, develop the policies and measures which will protect, promote, improve, and maintain the health of the population. The Act specifically requires the Minister to ensure the provision of essential health services, which must include at least primary healthcare services, to the population.

Section 27 of the Constitution states that everyone has the right to access healthcare services, inclusive of reproductive healthcare, and that no one may be refused emergency medical treatment. The section requires of the state to take reasonable legislative and other measures within the grasp of its resources to progressively realise these rights. In addition, section 28 of the Constitution specifies that children have the right to access basic healthcare services. In accordance with section 36, these rights may be limited in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open democratic society based on human dignity, equality, and freedom.

In the context of a developing country with limited resources, the progressive realisation of these rights to healthcare services requires an effective and equitable process. It is therefore required that this PMB review must be aligned with the progressive realisation of the right to healthcare of the population.

3 Context of the PMB review

The private healthcare sector forms part of the overall national health system, and consumes the majority of healthcare funds while less than 20% of the public are members of medical schemes. Health policy needs to realise the right of access to healthcare irrespective of whether services are offered in the public or private sectors.

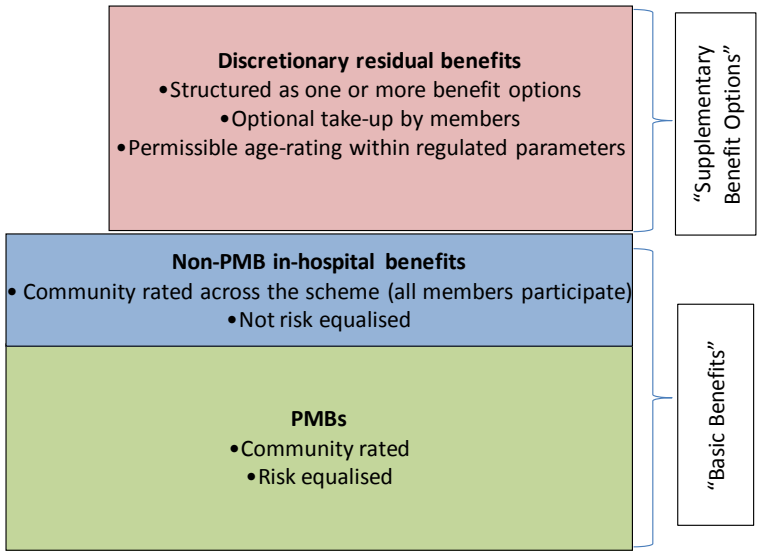
3.1 Imminent reforms in healthcare funding

The role played by PMBs in the protection of risk pools is complementary to other reforms presented in draft legislation.

The Medical Schemes Amendment Bill (MSAB) makes provision for strengthening medical scheme governance, introduces REF, and makes provision for a revised benefit structure and medical scheme products for low-income individuals. These reforms will introduce a strict version of community rating.

The revised benefit structure will remove the de facto risk rating through benefit design, and introduce scheme community rating. The implementation of REF will lead to industry-wide community rating in respect of the PMBs. The revised benefit structure will permit a distinction between "basic benefits" that must conform to strict community rating and "supplementary benefit options" that may be subject to limited age rating (see Figure 1).

Figure 1: Revised benefit structure introduced in the MSAB



An analysis of public comments on the draft MSAB has demonstrated that the introduction of risk equalisation without the expansion of PMBs will reduce the positive effects of risk equalisation. The larger the non-PMB in-hospital portion is, the smaller is the portion that is equalised, reducing the impact of REF (Figure 1). For REF to have its required impact, the PMBs must be broadened to improve the positive effects of REF.

3.2 Potential objectives that could be met through PMBs

During the revision to the PMBs, careful attention needs to be paid to the potential objectives that could be attained through the mandating of a package of minimum benefits in different contexts. Box 2 lists eight possible objectives; some of these objectives are in conflict and could not be met simultaneously. These potential objectives are considered in relation to the role of minimum benefits in the private and public sectors, the achievement of public health goals and the use of burden of disease data, the need for regulation in the medical schemes environment, other requirements specific to the medical scheme environment, and sustainability threats to the PMB framework.

Box 2: Potential objectives of a minimum set of defined benefits

1. Facilitating catastrophic insurance cover
2. Ensuring risk based cross subsidies
3. Improving allocative efficiency
4. Reducing burden of disease
5. Improving equity
6. Controlling moral hazard and cost escalation
7. Fostering competition
8. Facilitating transparency & participatory democracy

Source: Söderlund[‡]

3.2.1 The distinction between mandating minimum benefits in different contexts

The fundamental distinction between PMBs in the insurance (and fee-for-service) environment, as opposed to a minimum package of services offered in the public sector (applying a service provider model), must be observed.

The supply-driven public sector model has a distinct focus on being a planned gatekeeper and referral system. This focus is consistent with a publicly provided and tax-funded vertically integrated system.

The medical schemes environment, which is demand-driven and faces specific market failures, requires a different focus to protect the served population.

3.2.2 Achievement of public health objectives and the use of burden of disease data

The achievement of public health objectives, such as the Millennium Development Goals (MDGs), requires strategic public and community health interventions, which may include non-medical interventions.

Burden of disease data is important in the selection of priority public health interventions to improve population health status. Public sector interventions should be aimed at alleviating commonly occurring and serious conditions. However, in the medical schemes environment, it is important to address catastrophic costs and to prevent discrimination based on health status. The aim is to prevent restriction of access to health insurance for high-risk individuals

[‡] Neil Söderlund, *Possible objectives and resulting entitlements of essential health care packages*, **Health Policy 45 (1998) 195–208**

3.2.3 Need for regulatory intervention in the medical schemes environment

A systemic outcome of unregulated competition in the private sector is greater exclusivity rather than inclusivity. Unguided commercial imperatives largely contradict the obligation on government to ensure access as it is easier for schemes to compete based on risk selection rather than on price, efficiency, and the quality of coverage. The natural consequence of this market conduct is the permanent exclusion of individuals or groups with predictably high healthcare costs. In other forms of insurance, this problem does not arise as the risks of claiming are not known in advance or, where they are, it is appropriate to exclude such individuals.

In healthcare, excluding individuals with known health conditions or those known to be at a higher risk of claiming results in a loss of access to health insurance as well as access to healthcare. PMBs structurally reduce discrimination based on health status because if PMBs are broad enough, the ability to separate insurable and uninsurable individuals through benefit design is eliminated.

3.3 Other requirements specific to the insurance environment

In the health insurance environment, it is not necessary or socially beneficial for regulatory interventions to impose risk pooling for events that are low-cost, occur frequently, and are subject to a high degree of member discretion. These are Rand-for-Rand benefits and need not be risk-pooled.

Given that the need to insure these benefits is low (because most people will claim what they contribute up to a certain level of contribution), gaps in cover here have limited social and risk-pooling implications.

3.4 Sustainability threats to the current PMB framework

Threats to the sustainability of the revised PMB package are presented as being related to affordability, quality and/or pricing.

3.4.1 Affordability and access to medical scheme membership and private healthcare

If the PMB package is too broad and adequate measures to protect it against abuse are not in place, the underwriting risk to medical schemes may be too high, leading to unsustainably high increases in contributions. Given the fact that there is no mandatory membership, young and healthy members may choose not to belong to a medical scheme, resulting in further cost increases to the sicker and older members remaining on schemes. This scenario could lead to stagnant membership and increases in non-healthcare costs, further reducing access to care.

3.4.2 Quality of care, utilisation of services, and the efficiency of care

An inappropriate definition of PMBs might contribute to increases in managed care costs that would result in inefficiencies. A poorly defined PMB package could lead to unrealistic member expectations that require extra costly initiatives to manage.

An uncontrolled introduction of new healthcare technology may result in cost increases without an improvement in the quality of care.

3.4.3 Pricing and the cost of the PMB package

Poor harmonisation of regulatory provisions for the determination of the scope of provider practice and tariffs could lead to the abuse of PMB legislation by providers. In addition, a poor definition of “at cost” in the legislation may result in a “blank cheque” approach by some healthcare providers charging excessively high fees for PMB conditions.

Diagnosis creep, whereby related conditions are coded as PMB conditions, could become commonplace if PMB services are remunerated at higher-than-average levels.

3.5 Clarity of the PMB package

The manner in which PMBs are currently defined makes it difficult for members to know in advance whether specific benefits are covered or not. This is because diagnosis frequently involves costly diagnostic work and expensive procedures may need to be performed only to establish that a beneficiary suffers from a condition that is not included in the Diagnosis and Treatment Pair (DTP) list.

Another factor that reduces the ability for members to know their entitlements in advance lies therein that, due to inadequate clarity in the regulations in respect of some DTPs, there is presently no uniformity of benefit entitlements. This contributes to the complexity that consumers face when choosing between schemes.

Conditions of similar severity, affecting similar systems, with similar underlying pathology for which treatment of similar cost and effectiveness is available are included or excluded without apparent reason in the current PMB construct.

4 Recommendations

4.1 Recommendations on the objectives of PMBs in the medical schemes environment

The protection of risk pools is critical in a contributory third-party system. In the medical schemes environment, the focus must be on risk pooling to eliminate significant financial impacts on households through the protection that insurance offers against catastrophic healthcare expenses.

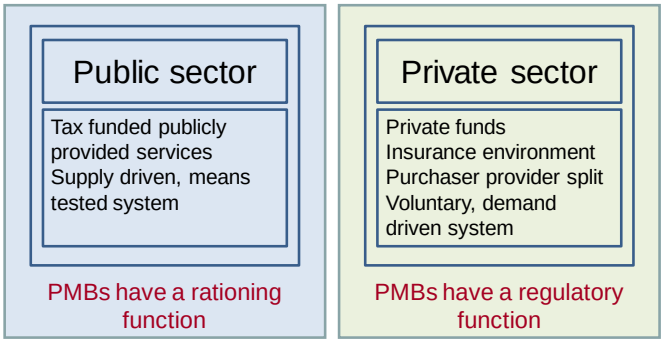
Due to extensive gaps in the current PMB package, the PMBs do not provide adequate protection against risk selection activities, particularly out-of-hospital benefits, by schemes. This weakens the capacity for risk pooling within the medical schemes environment.

Whenever essential healthcare is not a PMB, it becomes a basis for risk selection and the permanent exclusion from insurance of sicker and less healthy risk groups and individuals.

The outcome of unregulated competition in the medical schemes environment undermines the constitutional imperative to give effect to the right of access to healthcare. The social security objective of medical schemes, whereby access to healthcare is protected and catastrophic out-of-pocket payment is prevented, will be thwarted unless conditions are established for insurable groups to be risk-pooled together with otherwise uninsurable individuals and groups. PMBs therefore protect access to healthcare by protecting access to "insurance" for less preferred risks.

Due to the differences in the private and public sectors, the mandating of a minimum set of benefits plays distinctively different roles. In the medical schemes environment, PMBs predominantly represent regulatory interventions to address market failure, while a mandated minimum set of benefits in the public sector chiefly represents rationing of scarce resources (Figure 2).

Figure 2: Key differences between the private and public healthcare sectors



Recommendations

1. The primary objectives of the PMBs must be recognised to facilitate medical schemes cover that offers protection against catastrophic healthcare expenses, and to ensure risk-based cross-subsidies. Through the attainment of these objectives, the constitutional right of access to healthcare is guaranteed.
2. Secondary objectives include control of moral hazard and cost escalations, and the fostering of competition (see recommendations 13 and 14, and Figure 1 respectively).

4.2 Recommendations on the PMB construct relating to the implementation of REF and revised benefit design

The implementation of the revised benefit structure and REF will lead to much stricter community rating, but requires a broadening of the PMB package to meet its objectives.

Recommendations

3. The PMBs must be broadened to give adequate effect to the stricter community rating requirements introduced in draft legislation.
4. The impact that these would have on contributions must be carefully studied and the impact on the industry must be modelled.

4.3 Recommendations on affordability constraints and pricing of PMB benefits

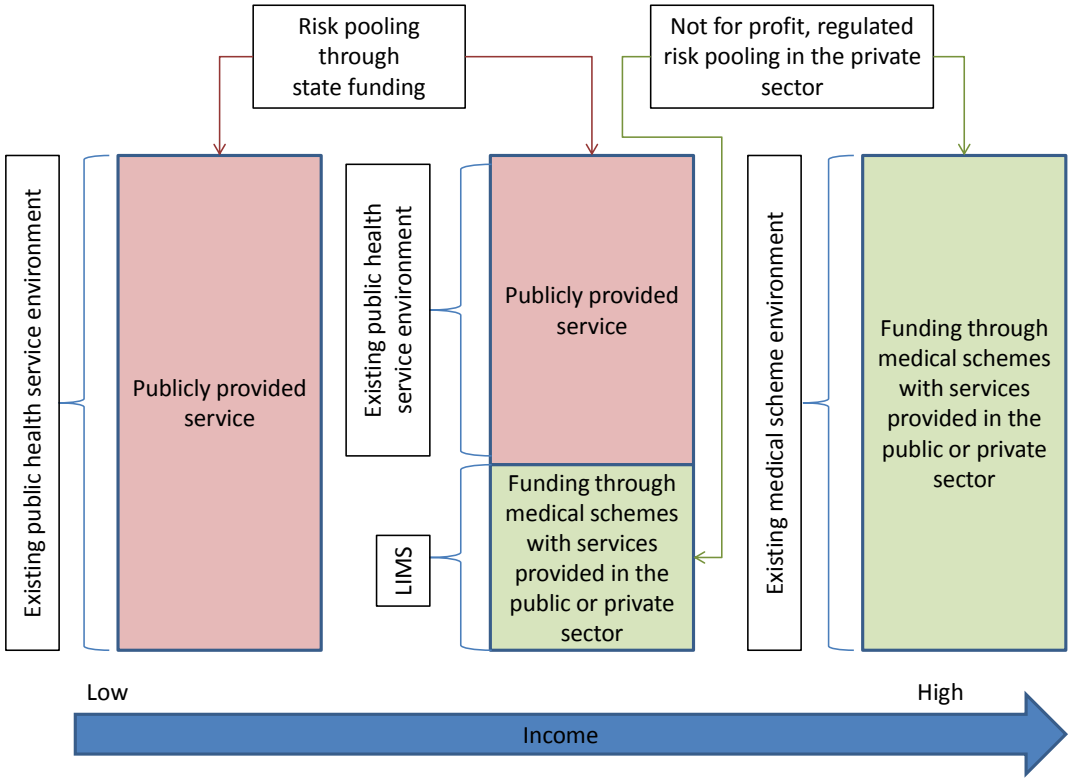
Some low-income beneficiaries cannot afford an expansion of the PMBs in the absence of income cross-subsidies.

The previous draft of this consultation document has linked PMB payments to the National Health Reference Price List (NHRPL). Considering public comments and other considerations, the committee agreed that this would convert the NHRPL to a tariff schedule, which is not appropriate.

Recommendations

5. A separate dispensation must be established for low-income earners. Figure 3 indicates possible funding arrangements for access to essential healthcare by income group. Note that the current medical population will continue to be funded through medical schemes, who would continue to purchase services in the private or public sector. Exemption from some of the PMB provisions must be made for yet-to-be-developed low-income options. These exemptions must include provisions to prevent anti-selection and risk-pool splitting through “buy-down” to low-income options.
6. More work must be done to investigate mechanisms whereby PMB remuneration is based on a negotiated fee that does not result in any balance billing for patients.

Figure 3: Access to essential healthcare



4.4 Recommendation on measures to improve clarity on entitlements and liabilities

Disputes frequently arise between medical scheme members or service providers and the schemes because of uncertainty about member entitlements and scheme liabilities in respect of PMBs.

Recommendation

7. Benefit Definitions (BDs) must be expanded to consist of comprehensive descriptions of benefits available under PMB regulations and must include condition-specific standardised entry and verification criteria, defined baskets of services and goods associated with this entitlement, formularies, as well as treatment protocols that include specification of the most appropriate setting and level of care for the provision of these services.
8. The CDL algorithms meet most of these conditions, but much more work needs to be done on the DTPs.

4.5 Recommendation on a continuous review process

The complete review of PMBs will be an ongoing process that must be constantly reviewed and updated.

Recommendation

9. The PMB review steering committee will make recommendations to ensure that a satisfactory mechanism is introduced to achieve an effective continuous review process.

4.6 Recommendation on transitional arrangements

The revision of the PMBs may result therein that individuals currently receiving benefits may not qualify for these benefits after the implementation of the various provisions recommended in this draft.

Recommendation

10. Adequate transitional arrangements must be made to ensure that individuals currently enjoying prescribed benefits are not compromised through this review.

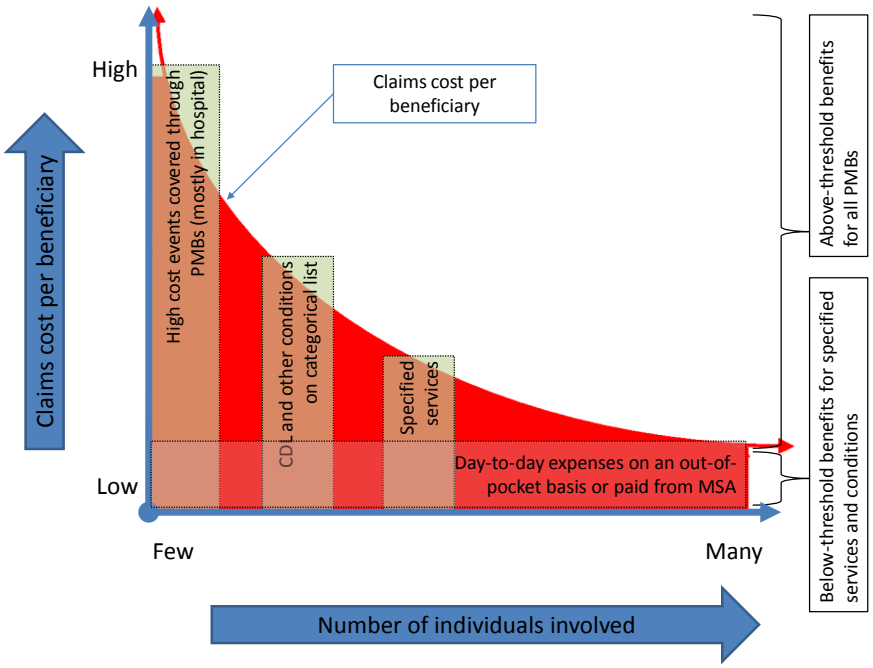
4.7 Recommendations on the development of the revised PMB construct

Protection for low-cost events must be extended to individuals with poor health status (for instance through above-threshold benefits and a requirement that there be no limits applicable to specific conditions). Systemically sicker people need protection over and above a particular threshold, as their needs exceed those with good health status. The central challenge is therefore to risk-pool for those health needs that will impose a significant or catastrophic financial burden on individuals and/or families such that their access to healthcare will be compromised.

Recommendations

11. Modalities applied to describe the PMB package must include a categorical list of conditions that must be covered, a list of services that must be covered, a list of essential drugs that must be covered (which must be developed), and a list of conditions or services that are not included (negative list).
12. To meet the primary objectives, Figure 4 illustrates the benefits that must be included in the revised PMB construct. High-cost but less frequently occurring events, such as hospitalisation, would be covered from first Rand, but will affect a small number of beneficiaries. Conditions on a categorical list will also be covered from first Rand and will affect more individuals. Most individuals will make use of the specified services and be covered from first Rand. Other instances that do not enjoy first-Rand cover will be covered by above-threshold benefits to protect individuals with predictable high healthcare costs for some chronic conditions that do not appear on the categorical list.

Figure 4: The impact of the proposed benefit construct on individuals



4.8 Recommendations to control moral hazard

The committee recognises that moral hazard could be worsened through the expansion of the PMBs, and that specific measures need to be implemented to prevent these.

Recommendations

13. Benefit definitions must be developed in order to assist in the control of moral hazard for services that have to be covered form first Rand.
14. The level of the threshold for full cover of essential services must be investigated to limit moral hazard for services that have only above-threshold benefits.

5 Proposed PMB construct

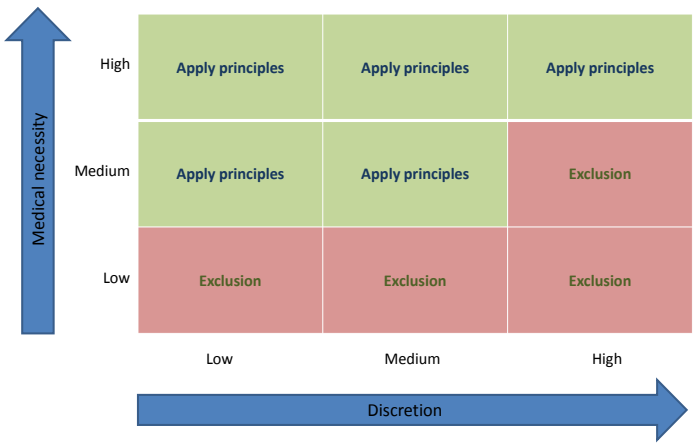
Note that the construct as presented here is the broad set of essential healthcare benefits (see the review's terms of reference in section 1), and does not necessarily represent the package that will be implemented with REF. After this package has been costed, it may be altered before the package that will be implemented with REF is developed. The broad package of essential healthcare benefits may be phased in over time.

5.1 Principles guiding the PMB definition process

The key objectives that must be met and the principles that must be applied in the definition of PMBs during the review are:

1. There must be legislative and regulatory consistency.
2. Risk-pooling must be ensured. Access to essential healthcare for people with and without predictable health needs must be assured, with PMBs providing an effective basis for risk equalisation.
3. Essential healthcare, within the context of a contributory third-party payer system, must be defined. This includes the removal of gaps in the existing DTP and CDL structures.
4. Evidence-based medicine principles must be upheld.
5. In accordance with the decision matrix presented in Figure 5 below, conditions where the treatment is associated with higher member and provider discretion and which are not medically essential, are excluded. By contrast, conditions with low member discretion, which are medically necessary, will be included.

Figure 5: PMB decision matrix



5.2 Objectives of protocol driven benefit definitions

1. Members must have certainty concerning their coverage.
2. Schemes must be able to unambiguously identify member entitlements.
3. Schemes must be enabled to fairly and reasonably manage their liabilities in respect of members.
4. PMBs must not reinforce inefficient provider or patient conduct.
5. PMB regulations must not result in the unfair exclusion of defined vulnerable groups.

5.3 Principles applicable to the development of condition-specific BDs and CDL algorithms

The envisaged benefit definitions (BDs) are comprehensive descriptions of benefits available under PMB regulations and must include condition-specific standardised entry and verification criteria, defined baskets of services and goods associated with this entitlement, formularies, as well as treatment protocols that include specification of the most appropriate setting and level of care for the provision of these services. The CDL algorithms meet most of these conditions, but much more work needs to be done on the 270 DTPs.

The following factors must inform the development of BDs:

1. Evidence-based medicine;
2. Cost-effectiveness, including the specification of the most appropriate level and setting of care;
3. Administrative simplicity;
4. Commonly occurring conditions, with high cost implications or that result in frequent disputes due to inadequate clarity, must be prioritised; and
5. Exposure to member abuse.

5.4 Guidelines for the development of specified primary care services

Due to its nature, this basket can be neither diagnosis- nor condition-specific. It must be clearly defined in respect of minimum service entitlements.

1. Special care must be taken to ensure that preventative care is cost-effective.
2. In accordance with the overriding principles, a list of basic essential dentistry services should be developed. Some condition-specific guidelines should also be developed.
3. Basic specific optometry services must be considered. Specific descriptions around limitations for corrective lenses must be considered.

5.5 Guidelines for the development of a list of essential drugs

A list of essential drugs, which would not be prone to abuse, with ample international evidence of being essential, of offering superior clinical efficacy when compared to other drugs in the same class, of being cost-effective and efficient, must be developed.

5.6 Guidelines for the development of a negative list in respect of services and conditions

Conditions and services that do not meet the “essential care” requirements or any of the other principles in these sections must be excluded from care.

5.7 Guidelines on step-down care

To ensure that hospitalisation is used only in an appropriate and cost-effective manner, step-down care must be offered where it could lead to demonstrable cost savings.

5.8 Recommended comprehensive PMB construct

Considering the context as discussed in detail in the preceding sections, the PMB review steering committee recommends that a PMB structure be adopted that provides first-Rand cover for:

- Hospitalisation (excluding items on a negative list);
- In-and-out-of-hospital treatment for specified items on a categorical list (DTPs and CDLs);
- Specified services (including basic optometry, dentistry, basic primary care and preventative services); and
- Essential drug list.

In addition to the first-Rand cover specified above, the PMB regime should require mandatory risk pooling for individual expenses exceeding a yet-to-be-specified amount per annum.

Supporting the conclusions reached in this section, the PMB review steering committee proposes a PMB construct as depicted in Box 3 below.

Note that the construct suggested here might not be affordable to lower-income groups, and the regulations should prescribe exemptions from these PMBs for low-income earners (see recommendation 5).

Box 3: Recommended PMB construct

1. In-hospital services: subject to –
   - *1.1. a general definition of hospital services*
   - *1.2. step-down services, including home-based nursing care*
   - *1.3. a categorical list of conditions and treatments (DTPs and the CDL)*
   - *1.4. a negative list*

   NOTE: All hospitalisation is covered in this framework. The categorical list of conditions serves to limit scheme liability to the extent defined in the list. The negative list serves to exclude inter alia, specific types of treatment, or treatment(s) provided under specific conditions. First-Rand cover must be offered for these services
2. Out-of-hospital services: subject to –
   - *2.1. a general definition of out-of-hospital service*
   - *2.2. a categorical list of conditions and treatments (DTPs and the CDL)*
   - *2.3. specified primary care services inclusive of:*
     - *2.3.1. a basket of defined preventative care*
     - *2.3.2. a basket of defined basic dentistry*
     - *2.3.3. a basket of defined basic optometry*
   - *2.4. a basket of essential drugs*
   - *2.5. a negative list*

   NOTE: First-Rand cover must be offered for the services specified in paragraphs 2.2, 2.3, and 2.4, while above-threshold benefits must be available for all out-of-hospital services not specified in paragraph 2.5.

This structure must be interpreted in consideration of the principles, objectives and caveats presented in this section.

A significant benefit of a broad general definition is the removal of any ambiguity in benefit entitlements for members who are unable to relate to condition-specific entitlements when joining a medical scheme.

Over and above these limitations, a negative list of conditions or treatments that can be excluded from the basic package is necessary. This negative list is particularly important in respect of hospitalisation as an additional measure to prevent the unnecessary hospitalisation of cases that could be treated more appropriately on an out-of-hospital basis.

The following Annexures support the PMB construct:

Annexure A: List of definitions

1 Essential healthcare

Essential healthcare is made up of *critical and relevant* services that are:

a. necessary to preserve or improve the health of an individual;
b. scientifically sound, cost-effective, and of good quality;
c. if not available, will result in death or serious morbidity; and
d. delivered in a timely manner.

2 Evidence-based medicine and healthcare

Evidence-based healthcare is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of healthcare, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors. Evidence-based clinical practice is an approach to decision-making in which the clinician uses the best evidence available in consultation with the patient to decide upon the option that suits that patient best. Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research[§].

3 Out-of-hospital services

Any services rendered to a beneficiary while that beneficiary is not an in-patient in a hospital.

4 In-hospital services

Any admission to hospital overnight or several weeks or months and inclusive of:

a. bed and board;
b. nursing and related services;
c. drugs and biologicals;
d. supplies, appliances and equipment;
e. other diagnostic and therapeutic services; and
f. medical or surgical services provided by healthcare professionals.

[§] **http://www.cochrane.org/docs/ebm.htm Last sourced on 26 January 2009**

Annexure B: Diagnosis Treatment Pairs (DTPs)

Throughout Annexure B, text included in blue font represents additions while text in red font represents words that will be removed in accordance with this proposal.

1. BRAIN AND NERVOUS SYSTEM		
Code	Diagnosis	Treatment
906A	Acute generalised paralysis, including polio and Guillain-Barre	Medical management; ventilation and plasmapheresis
341A	Basal ganglia, extra-pyramidal disorders; other dystonias NOS	Initial diagnosis; initiation of Medical management
950A	Benign and malignant brain **and spinal cord** tumours, treatable	Medical and surgical management which includes radiation therapy and chemotherapy
49A	Compound/depressed fractures of skull	Craniotomy/craniectomy
213A	Difficulty in breathing, eating, swallowing, bowel, or bladder control due to non-progressive neurological (including spinal) condition or injury	Medical and surgical management; ventilation
83A	Encephalocele; congenital hydrocephalus	Shunt; surgery
902A	Epilepsy (status epilepticus, initial diagnosis, candidate for neurosurgery)	Medical management; ventilation; neurosurgery
211A	Intraspinal and intracranial abscess	Medical and surgical management
905A	Meningitis – acute and sub acute	Medical and surgical management
513A	Myasthenia gravis; muscular dystrophy; neuro-myopathies NOS	Initial diagnosis; initiation of Medical management; therapy for acute complications and exacerbations
510A	Peripheral nerve injury with open wound	Neuroplasty
940A	Reversible CNS abnormalities due to other systemic disease	Medical and surgical management
1A	Severe/moderate head injury: haematoma/oedema with loss of consciousness	Medical and surgical management; ventilation
84A	Spina Bifida	Surgical management
941A	Spinal cord compression, ischaemia or degenerative disease NOS	Medical and surgical management
901A	Stroke – due to haemorrhage, or ischaemia	Medical management; surgery
28A	Subarachnoid and intracranial hemorrhage/hematoma; Compression of brain	Medical and surgical management
305A	Tetanus	Medical management; ventilation
265A	Transient cerebral ischaemia; life-threatening cerebrovascular conditions NOS	Evaluation; medical management; surgery
109A	Vertebral dislocations/fractures, open or closed with injury to spinal cord	Repair/reconstruction; medical management; inpatient rehabilitation up to 2 months
684A	Viral meningitis, encephalitis, myelitis and encephalomyelitis	Medical management

2. EYE

Code	Diagnosis	Treatment
47B	Acute orbital cellulitis	Medical and surgical management
394B	Angle-closure glaucoma	Iridectomy; laser surgery; medical and surgical management
586B	Bell's palsy; with exposure keratoconjunctivitis	Tarsorrhaphy; medical and surgical management
950B	Cancer of the eye and orbit - treatable	Medical and surgical management, which includes radiation therapy and chemotherapy
901B	Cataract; aphakia	Extraction of cataract; lens implant
911B	Corneal ulcer; Superficial injury of eye and adnexa	Conjunctival flap; medical management
405B	Glaucoma associated with disorders of the lens	Surgical management
386B	Herpes zoster & herpes simplex with ophthalmic complications	Medical management
389B	Hyphema	Removal of blood clot; observation
485B	Inflammation of lacrimal passages	Incision; medical management
909B	Open wound of eyeball and other eye structures	Medical and surgical management
407B	Primary and open angle glaucoma with failed medical management	Trabeculectomy; other surgery
419B	Purulent endophthalmitis	Vitrectomy
922B	Retained intraocular foreign body	Surgical management
904B	Retinal detachment, tear and other retinal disorders	Vitrectomy; laser treatment; other surgery
906B	Retinal vascular occlusion; central retinal vein occlusion	Laser surgery
409B	Sympathetic uveitis and degenerative disorders and conditions of globe; sight threatening thyroid optopathy	Enucleation; medical management; surgery

3. EAR, NOSE, MOUTH AND THROAT

Code	Diagnosis	Treatment
33C	Acute and chronic mastoiditis	Mastoidectomy; medical management
482C	Acute otitis media	Medical and surgical management, including myringotomy
900C	Acute upper airway obstruction, including croup, epiglottitis and acute laryngotracheitis	Medical management; intubation; tracheostomy
950C	Cancer of oral cavity, pharynx, nose, ear, and larynx - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
241C	Cancrum oris	Medical and surgical management
38C	Choanal atresia	Repair of choanal atresia
133C	Cholesteatoma	Medical and surgical management
910C	Chronic upper airway obstruction, resulting in cor pulmonale	Medical and surgical management
901C	Cleft palate and/or cleft lip without airway obstruction	Repair
12C	Deep open wound of neck, including larynx; fracture of larynx or trachea, open	Medical and surgical management; ventilation
346C	Epistaxis – not responsive to anterior packing	Cautery / repair / control hemorrhage
521C	Foreign body in ear & nose	Removal of foreign body; and medical and surgical management
29C	Foreign body in pharynx, larynx, trachea, bronchus & oesophagus	Removal of foreign body
339C	Fracture of face bones, orbit, jaw; injury to optic and other cranial nerves	Medical and surgical management
219C	Leukoplakia of oral mucosa, including tongue	Incision/excision; medical management
132C	Life-threatening diseases of pharynx NOS, including retropharyngeal abscess	Medical and surgical management
457C	Open wound of ear-drum	Tympanoplasty; medical management
240C	Peritonsillar abscess	Incision and drainage of abscess; tonsillectomy; medical management
347C	Sialoadenitis; abscess / fistula of salivary glands	Surgery
543C	Stomatitis, cellulites and abscess of oral soft tissue; Vincent's angina	Incision and drainage; medical management

4. RESPIRATORY SYSTEM		
Code	Diagnosis	Treatment
903D	Bacterial, viral, fungal pneumonia	Medical management, ventilation
158D	# Respiratory failure, regardless of cause	# Medical management; oxygen; ventilation
157D	Acute asthmatic attack; pneumonia due to respiratory syncytial virus in persons under age 3	Medical management
125D	Adult respiratory distress syndrome; inhalation and aspiration pneumonias	Medical management; ventilation
315D	Atelectasis (collapse of lung)	Medical and surgical management; ventilation
340D	Benign neoplasm of respiratory and intrathoracic organs	Biopsy; lobectomy; Medical management; radiation therapy
950D	Cancer of lung, bronchus, pleura, trachea, mediastinum & other respiratory organs - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
170D	Empyema and abscess of lung	Medical and surgical management
934D	Frank haemoptysis	Medical and surgical management
203D	Hypoplasia and dysplasia of lung	Medical and surgical management
900D	Open fracture of ribs and sternum; multiple rib fractures; flail chest	Medical and surgical management, ventilation
5D	Pneumothorax and haemothorax	Tube thoracostomy / thoracotomy

5. HEART AND VASCULATURE

Code	Diagnosis	Treatment
155E	Myocarditis; cardiomyopathy; transposition of great vessels; hypoplastic left heart syndrome	Medical and surgical management; cardiac transplant
108E	Pericarditis	Medical and surgical management
907E	Acute and sub acute ischemic heart disease, including myocardial infarction and unstable angina	Medical management; surgery; percutaneous procedures
284E	Acute pulmonary heart disease and pulmonary emboli; pulmonary hypertension.	Medical and surgical management
35E	Acute rheumatic fever	Medical management
908E	Aneurysm of major artery of chest, abdomen, neck, - Unruptured or ruptured NOS	Surgical management
26E	Arterial Embolism/thrombosis: abdominal aorta, thoracic aorta, vena cava and other major blood vessels	Medical and surgical management
204E	Cardiac failure: acute or recent deterioration of chronic cardiac failure	Medical treatment
98E	Complete, corrected and other transposition of great vessels Congenital malformations of great large vessels	Repair
97E	Coronary artery anomaly	Anomalous coronary artery ligation
309E	Diseases and disorders of aortic valve NOS	Aortic valve replacement
210E	Diseases of endocardium; endocarditis	Medical management
314E	Diseases of mitral valve	Valvuloplasty; valve replacement; medical management
902E	Disorders of arteries: visceral	Bypass graft; surgical management
18E	Dissecting or ruptured aortic aneurysm	Surgical management
915E	Gangrene; severe atherosclerosis of arteries of extremities; diabetes mellitus with peripheral circulatory disease	Medical and surgical management including amputation
294E	Giant cell arteritis, Kawasaki disease hypersensitivity angiitis; polyarteritis nodosa	Medical management
450E	Hereditary hemorrhagic telangiectasia	Excision and medical management
901E	Hypertension – acute life-threatening complications and malignant hypertension; renal artery stenosis and other curable hypertension	Medical and surgical management
111E	Injury to major blood vessels - trunk, head and neck, and upper limbs	Repair
19E	Injury to major blood vessels of extremities	Ligation
903E	Life-threatening cardiac arrhythmias	Medical and surgical management, pacemakers, cardioversion
900E	Life-threatening complications of elective cardiac and major vascular procedures	Medical and surgical management
497E	Multiple valvular disease	Surgical management
355E	Other aneurysm of artery – peripheral	Surgical management
905E	Other correctable congenital cardiac conditions	Surgical repair; medical management
100E	Patent ductus arteriosus; aortic pulmonary fistula - persistent	Ligation

209E	Phlebitis & thrombophlebitis, deep	Ligation and division; medical management
914E	Rheumatic pericarditis; rheumatic myocarditis	Medical management
16E	Rupture of papillary muscle	Medical and surgical management
627E	Shock / hypotension – life-threatening	Medical management; ventilation
99E	Tetralogy of Fallot (TOF)	Total repair tetralogy
93E	Ventricular septal defect - persistent	Closure

6. GASTRO-INTESTINAL SYSTEM

Code	Diagnosis	Treatment
920F	Anal Fissure; Anal fistula	Fissurectomy ; Fistulectomy; medical management
41F	Abscess of intestine	Drain abscess; medical management
489F	Acquired hypertrophic pyloric stenosis and other disorders of the stomach and duodenum	Surgical management
254F	Acute diverticulitis of colon	Medical and surgical management, including colon resection
124F	Acute vascular insufficiency of intestine	Colectomy
337F	Amoebiasis; typhoid	Medical management
264F	Anal and rectal polyp	Excision of polyp
9F	Appendicitis	Appendectomy
952F	Cancer of retroperitoneum, peritoneum, omentum & mesentery - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
950C	Cancer of the gastro-intestinal tract, including oesophagus, stomach, bowel, rectum, anus - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
95F	Congenital anomalies of upper alimentary tract – excluding tongue	Medical and surgical management
214F	Oesophageal stricture	Dilatation; surgery
516F	Oesophageal varices	Medical management; surgical shunt; sclerotherapy
902F	Gastric or intestinal ulcers with hemorrhage or perforation	Surgery; endoscopic diagnosis; medical management
901F	Gastroenteritis and colitis with life-threatening haemorrhage or dehydration, regardless of cause	Medical management
6F	Hernia with obstruction and/or gangrene; uncomplicated hernias under age 18	Repair; bowel resection
20F	Intestinal obstruction without mention of hernia; symptomatic foreign body in stomach, intestines, colon & rectum	Excision; surgery; medical management
232F	Paralytic ileus	Medical management
498F	Peritoneal adhesion	Surgical management
3F	Peritonitis, regardless of cause	Medical and surgical management
555F	Rectal prolapse	Partial colectomy
292F	Regional enteritis; idiopathic proctocolitis – acute exacerbations and complications only	Medical and surgical management
900F	Rupture of intra-abdominal organ	Repair; splenectomy; resection
507F	Thrombosed and complicated haemorrhoids	Haemorrhoidectomy; incision

7. LIVER, PANCREAS AND SPLEEN

Code	Diagnosis	Treatment
325G	Acute necrosis of liver	Medical management
327G	Acute pancreatitis	Medical management, and where appropriate, surgical management
36G	Budd-Chiari syndrome, and other venous embolism and	Thrombectomy / ligation
910G	Calculus of bile duct with cholecystitis	Medical management; cholecystectomy; other open or closed surgery
950G	Cancer of liver, biliary system and pancreas – treatable	Medical and surgical management
255G	Cyst and pseudocyst of pancreas	Drainage of pancreatic cyst
156G	Disorders of bile duct	Excision; repair
910G	Gallstone with cholecystitis and/or jaundice	Medical management; cholecystectomy; other open or closed surgery
743G	Hepatorenal syndrome	Medical management
27G	Liver abscess; pancreatic abscess	Medical and surgical management
911G	Liver failure; hepatic vascular obstruction; inborn errors of liver metabolism; biliary atresia	Liver transplant, other surgery, medical management
231G	Portal vein thrombosis	Shunt

8. MUSCULOSKELETAL SYSTEM; TRAUMA NOS

Code	Diagnosis	Treatment
353H	Abscess of bursa or tendon	Incision and drainage
32H	Acute osteomyelitis	Medical and surgical management
950H	Chronic osteomyelitis and osteonecrosis	Medical and surgical management, which includes chemotherapy and radiation therapy
206H		Incision and drainage
902H	Closed fractures/dislocations of limb bones / epiphyses – excluding fingers and toes	Reduction/relocation
85H	Congenital dislocation of hip; coxa vara and valga; congenital clubfoot	Repair/reconstruction
147H	Crush injuries of trunk, upper limbs, lower limbs, including blood vessels	Surgical management; ventilation; acute renal dialysis
491H	Dislocations/fractures of vertebral column without spinal cord injury	Medical management; surgical stabilisation
500H	Disruptions of the achilles / quadriceps tendons	Repair
178H	Fracture of hip	Reduction; hip replacement
445H	Injury to internal organs	Medical and surgical management
900H	Open fracture/dislocation of bones and joints	Reduction/relocation; medical and surgical management
34H	Pyogenic arthritis	Medical and surgical management
901H	Traumatic amputation of limbs, hands, feet , and digits	Replantation / amputation

9. SKIN AND BREAST

Code	Diagnosis	Treatment
465J	Acute lymphadenitis	Incision and drainage; medical management
900J	Burns, greater than 10% of body surface, or more than 5% involving head, neck, hands, perineum	Debridement; free skin graft; medical management
950J	Cancer of breast - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
954J	Cancer of skin, excluding malignant melanoma - treatable	If histologically confirmed, Medical and surgical management, which includes radiation therapy
952J	Cancer of soft tissue, including sarcomas and malignancies of the adnexa - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
349J	Cellulitis and abscesses with risk of organ or limb damage or septicaemia if untreated; necrotizing fasciitis	Medical and surgical management
901J	Disseminated bullous skin disease, including pemphigus, pemphigoid, epidermolysis bullosa, epidermolytic hyperkeratosis	Medical management
951J	Lethal midline granuloma	Medical management, which includes radiation therapy
953J	Malignant melanoma of skin - treatable	Medical and surgical management, which includes radiation therapy
373J	Non-superficial open wounds – non life-threatening	Repair
356J	Pyoderma; body, deep-seated fungal infections	Medical management
112J	Toxic epidermal necrolysis and staphylococcal scalded skin syndrome; Stevens-Johnson syndrome	Medical management

10. ENDOCRINE, METABOLIC AND NUTRITIONAL		
Code	Diagnosis	Treatment
331K	Acute thyroiditis	Medical management
951K	Benign and malignant tumours of pituitary endocrine glands with/without hypersecretion syndromes	Medical and surgical management; radiation therapy
30K	Benign neoplasm of islets of Langerhans	Excision of tumour; medical management
950K	Cancer of endocrine system, excluding thyroid - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
952K	Cancer of thyroid - treatable; carcinoid syndrome	Medical and surgical management, which includes chemotherapy and radiation therapy
61K	Congenital hypothyroidism	Medical management
902K	Disorder of adrenal secretion NOS	Medical management; adrenalectomy
447K	Disorders of parathyroid gland; benign neoplasm of parathyroid gland	Medical and surgical management
904K	Hyper and hypothyroidism with life-threatening complications or requiring surgery	Medical management; Surgery
31K	Hypoglycemic coma; hyperglycemia; diabetic ketoacidosis	Medical management
236K	Iron deficiency; vitamin and other nutritional deficiencies – life-threatening	Medical management
901K	Life-threatening congenital abnormalities of carbohydrate, lipid, protein and amino acid metabolism; cystic fibrosis	Medical management
903K	Life-threatening disorders of fluid and electrolyte balance, NOS	Medical management

11. URINARY AND MALE GENITAL SYSTEM

Code	Diagnosis	Treatment
354L	Abscess of prostate	TURP; drain abscess
904L	Acute and chronic pyelonephritis; renal and perinephric abscess	Medical and surgical management
903L	Acute glomerulonephritis and nephritic syndrome	Medical management
954L	Cancer of penis and other male genital organ - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
953L	Cancer of prostate gland - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
950L	Cancer of testis - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
952L	Cancer of urinary system including kidney and bladder - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
906L	Congenital anomalies of urinary system - symptomatic and life-threatening	Nephrectomy/repair
901L	End stage renal disease regardless of cause	Dialysis and renal transplant where Department of Health criteria are met only (see criteria published in GPS 004-9001)
900L	Hyperplasia of the prostate, with acute urinary retention or obstructive renal failure	Transurethral resection; medical management
905L	Obstruction of the urogenital tract, regardless of cause	Catheterisation; surgery; endoscopic removal of obstructing agent: lithotripsy
436L	Torsion of testis	Orchidectomy; repair
43L	Trauma to the urinary system including ruptured bladder	Cystorrhaphy; suture; repair
289L	Ureteral fistula (intestinal)	Nephrostomy
359L	Vesicoureteral reflux	Medical management; replantation

12. FEMALE REPRODUCTIVE SYSTEM

Code	Diagnosis	Treatment
539M	Abscesses of bartholin's gland and vulva	Incision and drainage; medical management
288M	Acute pelvic inflammatory disease	Medical and surgical management
954M	Cancer of cervix - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
952M	Cancer of ovary - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
950M	Cancer of uterus - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
953M	Cancer of vagina, vulva and other female genital organs NOS - treatable	Medical and surgical management, which includes chemotherapy and radiation therapy
960M	Cervical and breast cancer screening	Cervical smears; periodic breast examination
645M	Congenital abnormalities of the female genitalia	Medical and surgical management
266M	Dysplasia of cervix and cervical carcinoma-in-situ; cervical condylomata	Medical and surgical management
53M	Ectopic pregnancy	Surgery
460M	Fistula involving female genital tract	Closure of fistula
951M	Hydatidiform mole; choriocarcinoma	D & C; hysterectomy; chemotherapy
902M	Infertility	Medical and surgical management
528M	Menopausal management, anomalies of ovaries, primary and secondary amenorrhoea, female sex hormones abnormalities NOS, including hirsutism	Medical and surgical management, including hormone replacement therapy
434M	Non-inflammatory disorders and benign neoplasms of ovary, fallopian tubes and uterus	Salpingectomy; oophorectomy; hysterectomy; medical and surgical management
237M	Sexual abuse, including rape	Medical management; psychotherapy
903M	Spontaneous abortion	Medical and surgical management
435M	Torsion of ovary	Oophorectomy; ovarian cystectomy
530M	Uterine prolapse; cystocele	Surgical repair
296M	Voluntary termination of pregnancy	Induced abortion; Medical and surgical management

13. PREGNANCY AND CHILDBIRTH		
Code	Diagnosis	Treatment
67N	# Low birth weight (under 1000g) with respiratory difficulties	# Medical management not including ventilation
967N	# Low birth weight (under 2500 grams & > 1000g) with respiratory difficulties	# Medical management, including ventilation; intensive care therapy
71N	Birth trauma for baby	Medical management; surgery
901N	Congenital systemic infections affecting the newborn	Medical management, ventilation
904N	Haematological disorders of the newborn	Medical management
54N	Necrotizing enterocolitis in newborn	Medical and surgical management
74N	Neonatal and infant GIT abnormalities and disorders, including malrotation and atresia	Medical and surgical management
902N	Neonatal endocrine, metabolic and toxin-induced conditions	Medical management
903N	Neurological abnormalities in the newborn; including cerebral palsy	Medical management
52N	Pregnancy	Antenatal care, and Obstetric care necessitating hospitalisation, and Delivery
56N	Respiratory conditions and correctable congenital abnormalities of newborn	Medical management; ventilation

14. HAEMATOLOGICAL, INFECTIOUS AND MISCELLANEOUS SYSTEMIC CONDITIONS

Code	Diagnosis	Treatment
50S	Syphilis - congenital, secondary and tertiary	Medical management
168S	# HIV-infection	# HIV voluntary counselling and testing Co-trimoxazole as preventative therapy Screening and preventative therapy for TB Diagnosis and treatment of sexually transmitted infections Pain management in palliative care Treatment of opportunistic infections Prevention of mother-to-child transmission of HIV Post-exposure prophylaxis following occupational exposure or sexual assault Medical management and medication, including the provision of anti-retroviral therapy, and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector
260S	# Imminent death regardless of diagnosis	# Comfort care; pain relief; hydration
113S	Acquired haemolytic anaemias	Medical management
901S	Acute leukemias, lymphomas	Medical management, which includes chemotherapy, radiation therapy, bone marrow transplantation
277S	Anaerobic infections – life threatening; and complications of radiation therapy	Medical management; hyperbaric oxygen
48S	Anaphylactic shock	Medical management; ventilation
900S	Aplastic anaemia; agranulocytosis; other life-threatening hereditary immune deficiencies	Bone marrow transplantation; medical management
197S	Botulism	Medical management
338S	Cholera; rat-bite fever	Medical management
196S	Chronic Granulomatous disease	Medical management, which includes radiation therapy
916S	Coagulation defects	Medical management
246S	Cysticercosis; other systemic cestode infection	Medical management
903S	Deep-seated (excluding nail infections), disseminated and systemic fungal infections	Medical management; surgery
44S	Erysipelas	Medical management
179S	Hereditary angioedema; angioneurotic adema	Medical and surgical management
174S	Hereditary haemolytic anaemias (e.g. sickle cell); dyserythropoietic anaemia (congenital)	Medical management
201S	Herpetic encephalitis; Reye's syndrome	Medical management
913S	Immune compromise NOS and associated life-threatening infections NOS	Medical management
912S	Leprosy and other systemic mycobacterial infections, Excluding tuberculosis	Medical management
336S	Leptospirosis; spirochaetal infections NOS	Medical management

252S	Life-threatening anaemia NOS	Medical management; transfusion
908S	Life-threatening conditions due to exposure to the elements, including hypo and hyperthermia; lighting strikes	Medical management
907S	Life-threatening rickettsial and other arthropod-borne diseases	Medical management
172S	Malaria; trypanosomiasis; other life-threatening parasitic disease	Medical management
904S	Metastatic infections; septicaemia	Medical management
910S	Multiple myeloma and chronic leukaemias	Medical management which includes chemotherapy and radiation therapy
247S	Poisoning by ingestion, injection, and non-medicinal agents	Medical management
911S	Sexually transmitted diseases with systemic involvement not elsewhere specified	Medical management
128S	Tetanus; anthrax; Whipple's disease	Medical management
122S	Thalassemia and other haemoglobinopathies – treatable	Medical management; bone marrow transplant
316S	Toxic effect of gasses, fumes, and vapours	Medical therapy
11S	Tuberculosis	Diagnosis and acute medical management; successful transfer to maintenance therapy in accordance to DOH guidelines Medical and surgical management.
937S	Tumour of internal organ (excludes skin): unknown whether benign or malignant	Biopsy
15S	Whooping cough, diphtheria	Medical management

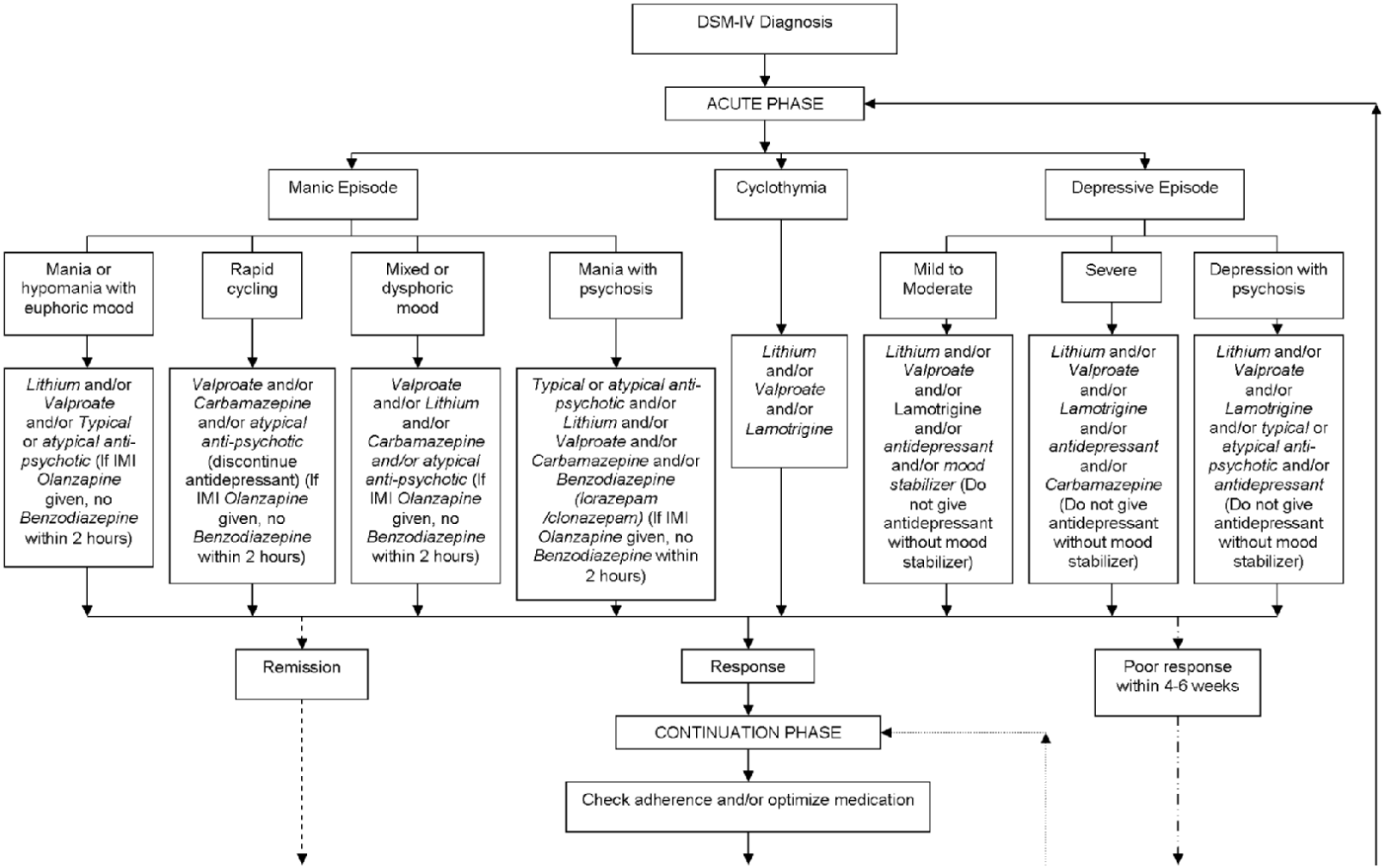
15. MENTAL ILLNESS

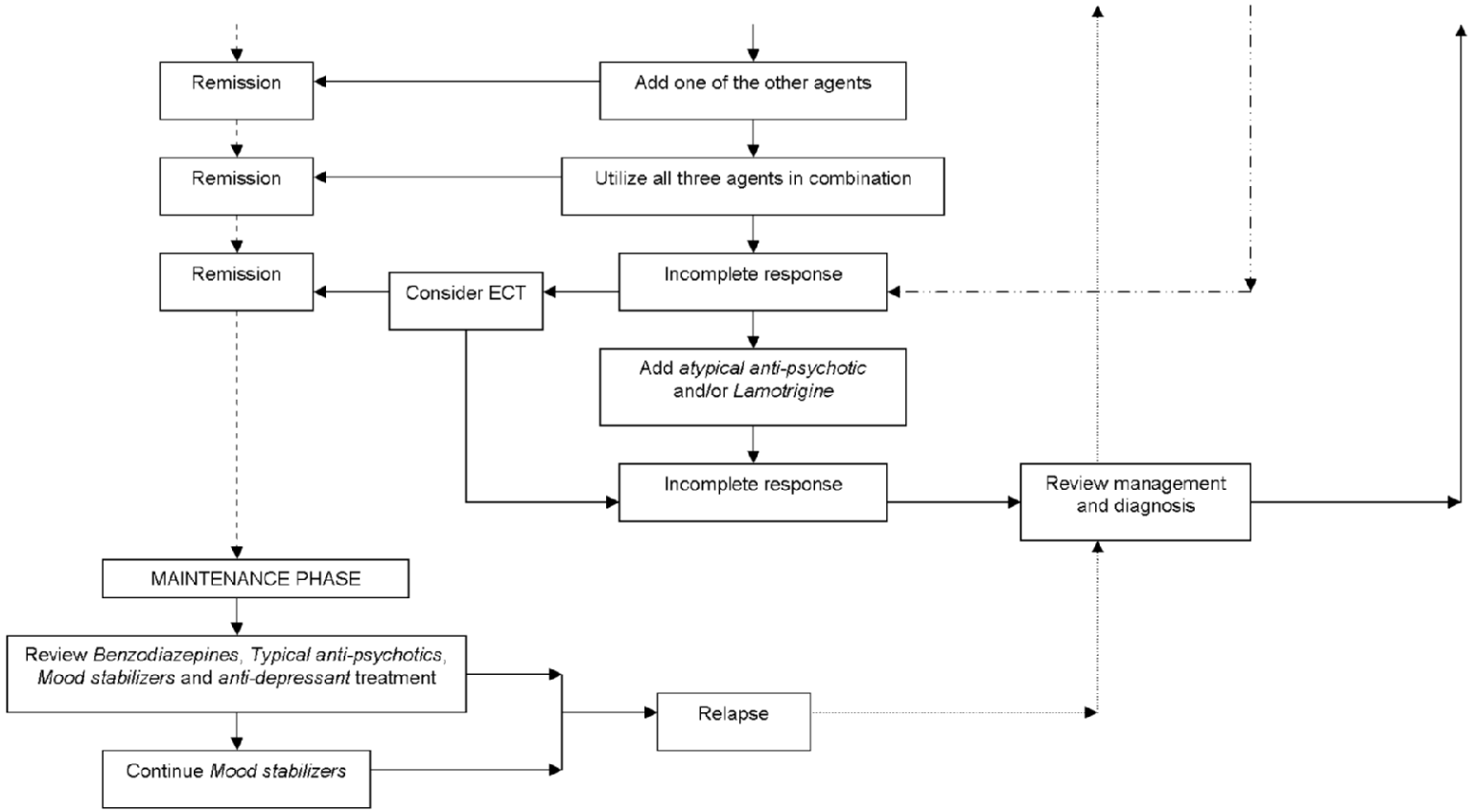
Code	Diagnosis	Treatment
182T	Abuse or dependence on psychoactive substance, including alcohol Mental and behavioural disorders due to psychoactive substance use	Hospital-based management up to 3 weeks/year or up to 15 outpatient contacts
910T	Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse Reaction to severe stress, and adjustment disorders	Hospital–based management admission for psychotherapy/counselling up to 3 days or up to 12 outpatient psychotherapy/counselling contacts
901T	Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse	Hospital admission for psychotherapy / counselling up to 3 days, or up to 12 outpatient psychotherapy / counselling contacts
910T	Alcohol withdrawal delirium; alcohol intoxication delirium	Hospital-based management up to 3 days leading to rehabilitation
908T	Anorexia Nervosa and Bulimia Nervosa Eating disorders	Hospital-based management up to 3 weeks/year or minimum of up to 15 outpatient contacts
903T	Attempted suicide, irrespective of cause	Hospital-based management up to 3 days or up to 6 outpatient contacts
184T	Brief reactive psychosis Acute and transient psychotic disorders	Hospital-based management up to 3 weeks/year
910T	Delirium : Amphetamine, cocaine, or other psychoactive substance	Hospital-based management up to 3 days
902T	Major Mood (affective) disorders, including unipolar or bipolar depression	Hospital-based management up to 3 weeks/year (including inpatient electro-convulsive therapy and inpatient psychotherapy) or up to 15 outpatient psychotherapy contacts
907T	Schizophrenic and paranoid delusional disorders	Hospital-based management up to 3 weeks/year or up to 15 outpatient contacts
909T	Treatable dementia	Admission for initial diagnosis; management of acute psychotic symptoms - up to 1 week

Annexure C: Chronic Disease List (CDL) and CDL algorithms

Addison's Disease
Asthma
Bipolar Mood Disorder
Bronchiectasis
Cardiac Failure
Cardiomyopathy
Chronic Renal Disease
Chronic Obstructive Pulmonary Disease
Coronary Artery Disease
Crohn's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1 & 2
Dysrhythmias
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple Sclerosis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythromatosis
Ulcerative Colitis

1. BIPOLAR MOOD DISORDER




Remission
Add one of the other agents
Remission
Utilize all three agents in combination
Remission
Consider ECT
Incomplete response
Add *atypical anti-psychotic* and/or *Lamotrigine*
Incomplete response
Review management and diagnosis
MAINTENANCE PHASE
Review *Benzodiazepines*, *Typical anti-psychotics*, *Mood stabilizers* and *anti-depressant* treatment
Relapse
Continue *Mood stabilizers*

Glossary:

- DSM-IV – Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition
- ECT – Electroconvulsive Therapy

Applicable ICD-10 Coding:

- F31 Bipolar Affective Disorder
  - F31.0 Bipolar affective disorder, current episode hypomanic
  - F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms
  - F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms
  - F31.3 Bipolar affective disorder, current episode mild or moderate depression
  - F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms
  - F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms
  - F31.6 Bipolar affective disorder, current episode mixed
  - F31.7 Bipolar affective disorder, currently in remission
  - F31.8 Other bipolar affective disorders
  - F31.9 Bipolar affective disorder, unspecified

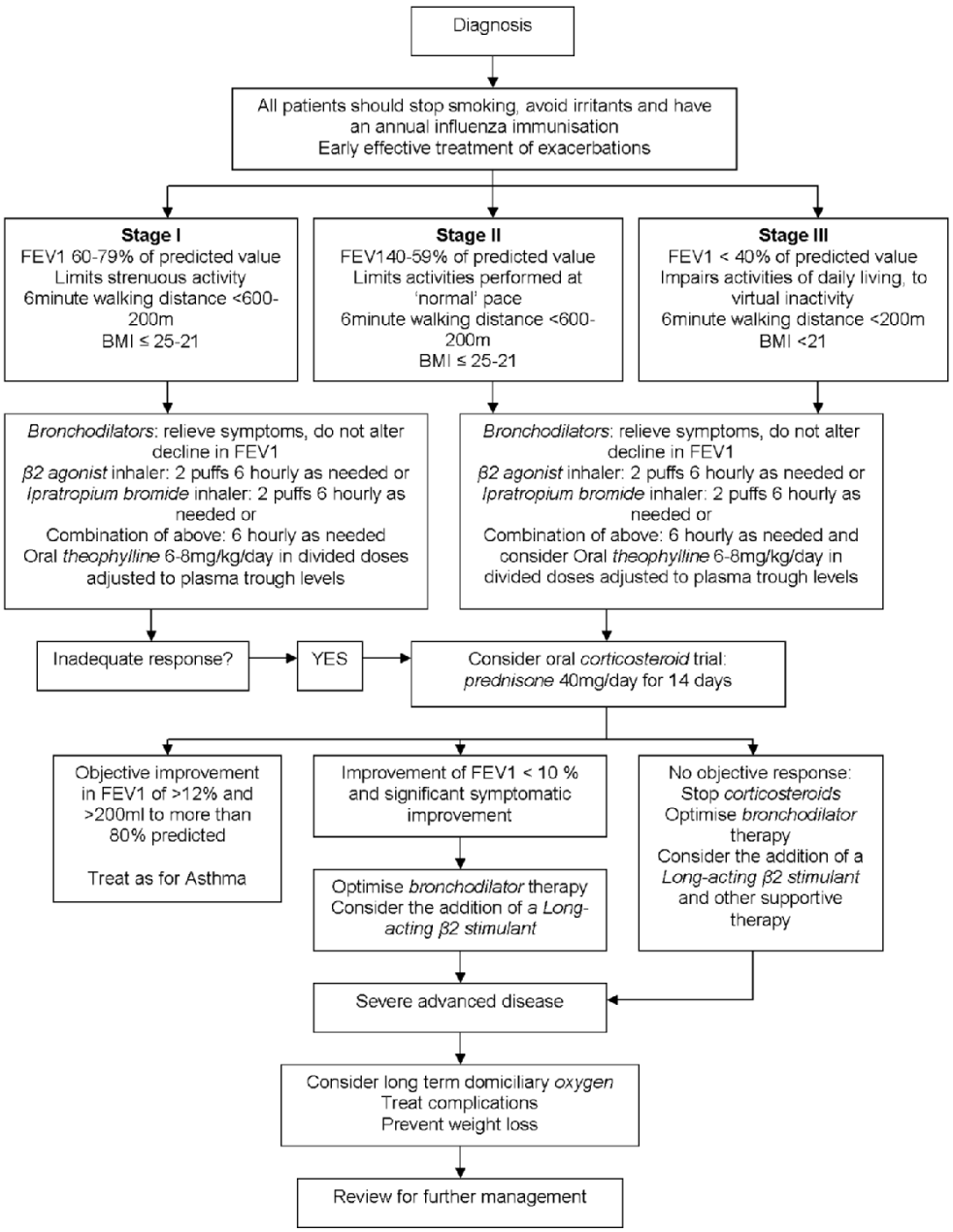
Note:

1. **Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.**

2. **To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –**
   a. **not be inconsistent with this algorithm;**
   b. **be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and**
   c. **comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998**

3. **This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.**

2. Chronic Obstructive Pulmonary Disease



Glossary:

- FEV1 – Forced expiratory volume in 1 second
- *β2* – Beta-2 receptor
- PFT – Predicted

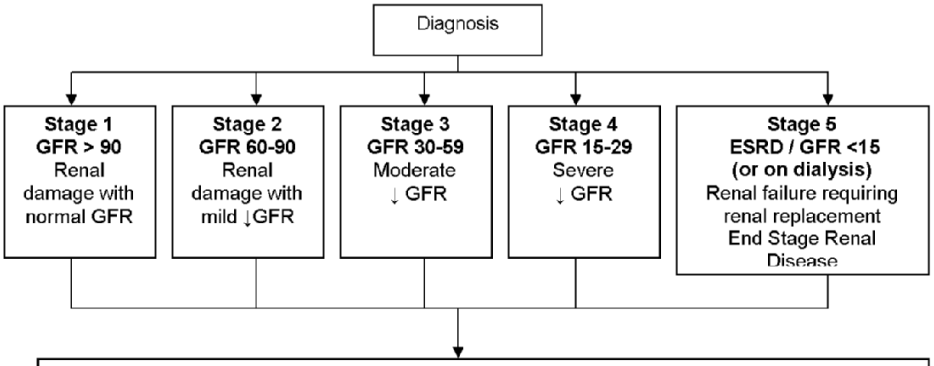
Applicable ICD-10 Coding:

- J43 Emphysema
  - J43.0 MacLeod's syndrome
  - J43.1 Panlobular emphysema
  - J43.2 Centrilobular emphysema
  - J43.8 Other emphysema
  - J43.9 Emphysema, unspecified
- J44 Other chronic obstructive pulmonary disease
  - J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
  - J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified
  - J44.8 Other specified chronic obstructive pulmonary disease
  - J44.9 Chronic obstructive pulmonary disease, unspecified

Note:

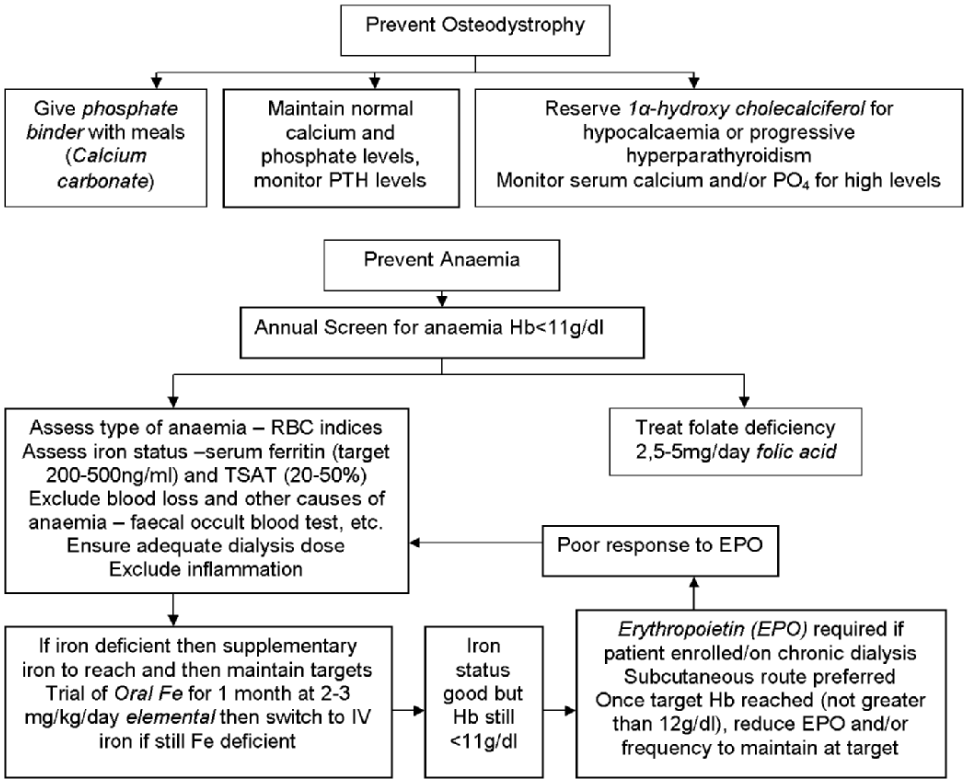
1. **Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.**
2. **To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –**
   a. **not be inconsistent with this algorithm;**
   b. **be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and**
   c. **comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998**
3. **This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.**

3. CHRONIC RENAL DISEASE



Progressive Management Stage 1 to Stage 5:

- Ideal target is proteinuria <1g/24h to induce remission in deterioration and <0.3g for regression.
- Aim for a stable or increasing GFR. Note that a normal decline is observed with ageing at a GFR decline of 1 mL/min/1·73 m2 per year after 45years.
- Start with low dose sodium diet or *Thiazide* diuretic therapy, or both
- Add low dose *ACE inhibitor* or start immediately with an *ACE inhibitor* (Best effects when used with a *diuretic* e.g. *hydrochlorothiazide* or *loop diuretic* if required)
- Up titrate the *ACE inhibitor* to the maximum dose tolerated every one to two weeks. A decline in function may occur but patients should be observed every one to two weekly allowing GFR to settle. (Consult a specialist if necessary)
- Checking of serum potassium only required when using higher doses of *ACE inhibitors* and CRD stage 3 or greater is present. If hyperkaliaemia a problem then use other anti-proteinuric drugs i.e. *beta blocker* or *calcium antagonist*. Note: These drugs are not as good as *ACE inhibitors* for proteinuria reduction.
- Add and up titrate *beta blocker* and/or *non-dihydropyridine CCB's* even if blood pressure is controlled.
- Optimise blood pressure control with other antihypertensive agents; Blood Pressure <130/80mmHg; lower if diabetes or proteinuria (morning pre-treatment value)
- Patients require early nephrological referral for management and assessment for dialysis and transplant when GFR < 60ml/min



Glossary:

- *1α-hydroxy* – 1-alpha-hydroxy
- *ACE inhibitor* – Angiotensin converting enzyme inhibitor
- CCB – Calcium channel blocker
- CRD – Chronic renal disease
- EPO – Erythropoietin
- ESRD – End stage renal disease
- Fe – Iron
- GFR - Glomerular filtration rate
- Hb - Haemoglobin
- PO_4 – Phosphate
- PTH – Parathyroid hormone
- RBC – Red blood cell
- TSAT – Total iron saturation

Applicable ICD-10 Coding:

- N03 Chronic nephritic syndrome
  - N03.0 Chronic nephritic syndrome, minor glomerular abnormality
  - N03.1 Chronic nephritic syndrome, focal and segmental glomerular lesions
  - N03.2 Chronic nephritic syndrome, diffuse membranous glomerulonephritis

Applicable ICD 10 Coding: (continued)

- N03.3 Chronic nephritic syndrome, diffuse mesangial proliferative glomerulonephritis
- N03.4 Chronic nephritic syndrome, diffuse endocapillary proliferative glomerulonephritis
- N03.5 Chronic nephritic syndrome, diffuse mesangiocapillary glomerulonephritis
- N03.6 Chronic nephritic syndrome, dense deposit disease
- N03.7 Chronic nephritic syndrome, diffuse crescentic glomerulonephritis
- N03.8 Chronic nephritic syndrome, other
- N03.9 Chronic nephritic syndrome, unspecified

- N11 Chronic tubulo-interstitial nephritis
  - N11.0 Nonobstructive reflux-associated chronic pyelonephritis
  - N11.1 Chronic obstructive pyelonephritis
  - N11.8 Other chronic tubulo-interstitial nephritis
  - N11.9 Chronic tubulo-interstitial nephritis, unspecified
- N18 Chronic renal failure
  - N18.0 End-stage renal disease
  - N18.8 Other chronic renal failure
  - N18.9 Chronic renal failure, unspecified
- I12.0 Hypertensive renal disease with renal failure
- I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
- O10.2 Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium
- O10.3 Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium

Note:

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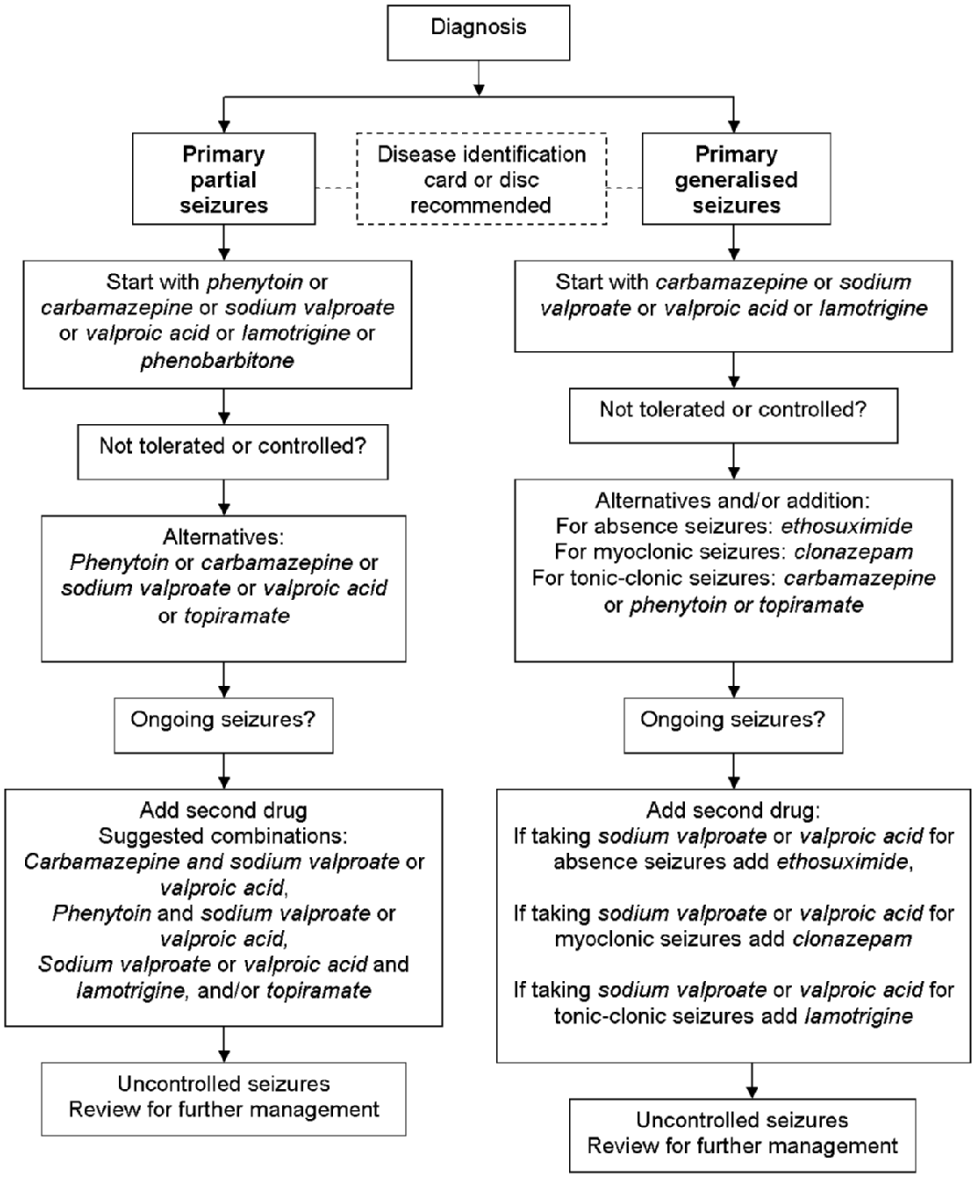
4. EPILEPSY


Diagnosis
Primary partial seizures
Disease identification card or disc recommended
Primary generalised seizures
Start with *phenytoin* or *carbamazepine* or *sodium valproate* or *valproic acid* or *lamotrigine* or *phenobarbitone*
Not tolerated or controlled?
Alternatives:
Phenytoin or *carbamazepine* or *sodium valproate* or *valproic acid* or *topiramate*
Ongoing seizures?
Add second drug
Suggested combinations:
Carbamazepine and sodium valproate or *valproic acid*,
Phenytoin and *sodium valproate* or *valproic acid*,
Sodium valproate or *valproic acid* and *lamotrigine*, and/or *topiramate*
Uncontrolled seizures
Review for further management
Start with *carbamazepine* or *sodium valproate* or *valproic acid* or *lamotrigine*
Not tolerated or controlled?
Alternatives and/or addition:
For absence seizures: *ethosuximide*
For myoclonic seizures: *clonazepam*
For tonic-clonic seizures: *carbamazepine* or *phenytoin or topiramate*
Ongoing seizures?
Add second drug:
If taking *sodium valproate* or *valproic acid* for absence seizures add *ethosuximide*,
If taking *sodium valproate* or *valproic acid* for myoclonic seizures add *clonazepam*
If taking *sodium valproate* or *valproic acid* for tonic-clonic seizures add *lamotrigine*
Uncontrolled seizures
Review for further management

Applicable ICD-10 Coding:

- G40 Epilepsy
  - G40.0 Localization-related (focal)(partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset
  - G40.1 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures
  - G40.2 Localization-related (focal)(partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures
  - G40.3 Generalized idiopathic epilepsy and epileptic syndromes
  - G40.4 Other generalized epilepsy and epileptic syndromes
  - G40.5 Special epileptic syndromes
  - G40.6 Grand mal seizures, unspecified (with or without petit mal)
  - G40.7 Petit mal, unspecified, without grand mal seizures
  - G40.8 Other epilepsy
  - G40.9 Epilepsy, unspecified
- G41 Status epilepticus
  - G41.0 Grand mal status epilepticus
  - G41.1 Petit mal status epilepticus
  - G41.2 Complex partial status epilepticus
  - G41.8 Other status epilepticus
  - G41.9 Status epilepticus, unspecified

Note:

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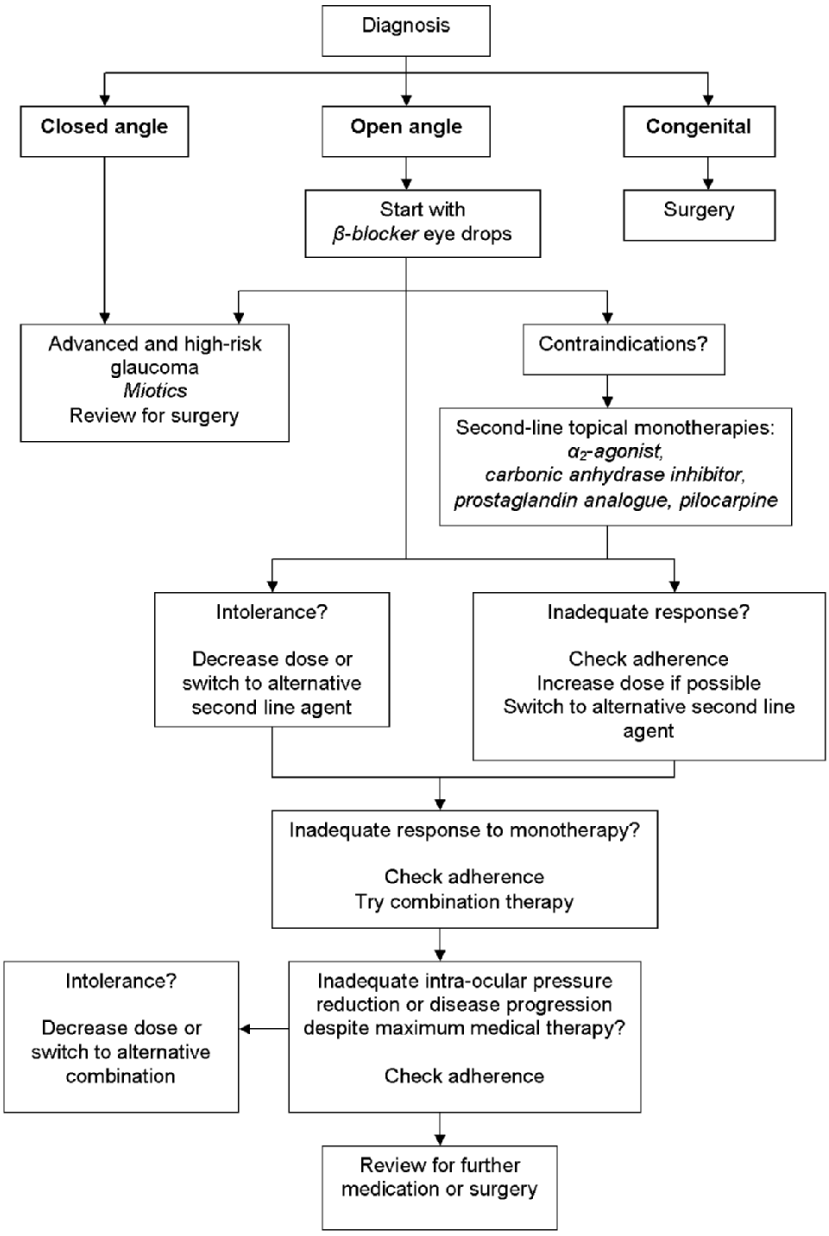
5. GLAUCOMA


Diagnosis
Closed angle
Open angle
Congenital
Start with
β-blocker eye drops
Surgery
Advanced and high-risk glaucoma
Miotics
Review for surgery
Contraindications?
Second-line topical monotherapies:
α2-agonist,
carbonic anhydrase inhibitor,
prostaglandin analogue, pilocarpine
Intolerance?
Decrease dose or switch to alternative second line agent
Inadequate response?
Check adherence
Increase dose if possible
Switch to alternative second line agent
Inadequate response to monotherapy?
Check adherence
Try combination therapy
Intolerance?
Decrease dose or switch to alternative combination
Inadequate intra-ocular pressure reduction or disease progression despite maximum medical therapy?
Check adherence
Review for further medication or surgery

Glossary:

- *β-blocker* – Beta-receptor blocker
- *α_2-agonist* – Alpha-2 receptor agonist

Applicable ICD-10 Coding:

- H40 Glaucoma
  - H40.0 Glaucoma suspect
  - H40.1 Primary open-angle glaucoma
  - H40.2 Primary angle-closure glaucoma
  - H40.3 Glaucoma secondary to eye trauma
  - H40.4 Glaucoma secondary to eye inflammation
  - H40.5 Glaucoma secondary to other eye disorders
  - H40.6 Glaucoma secondary to drugs
  - H40.8 Other glaucoma
  - H40.9 Glaucoma, unspecified
- Q15.0 Congenital glaucoma

Note:

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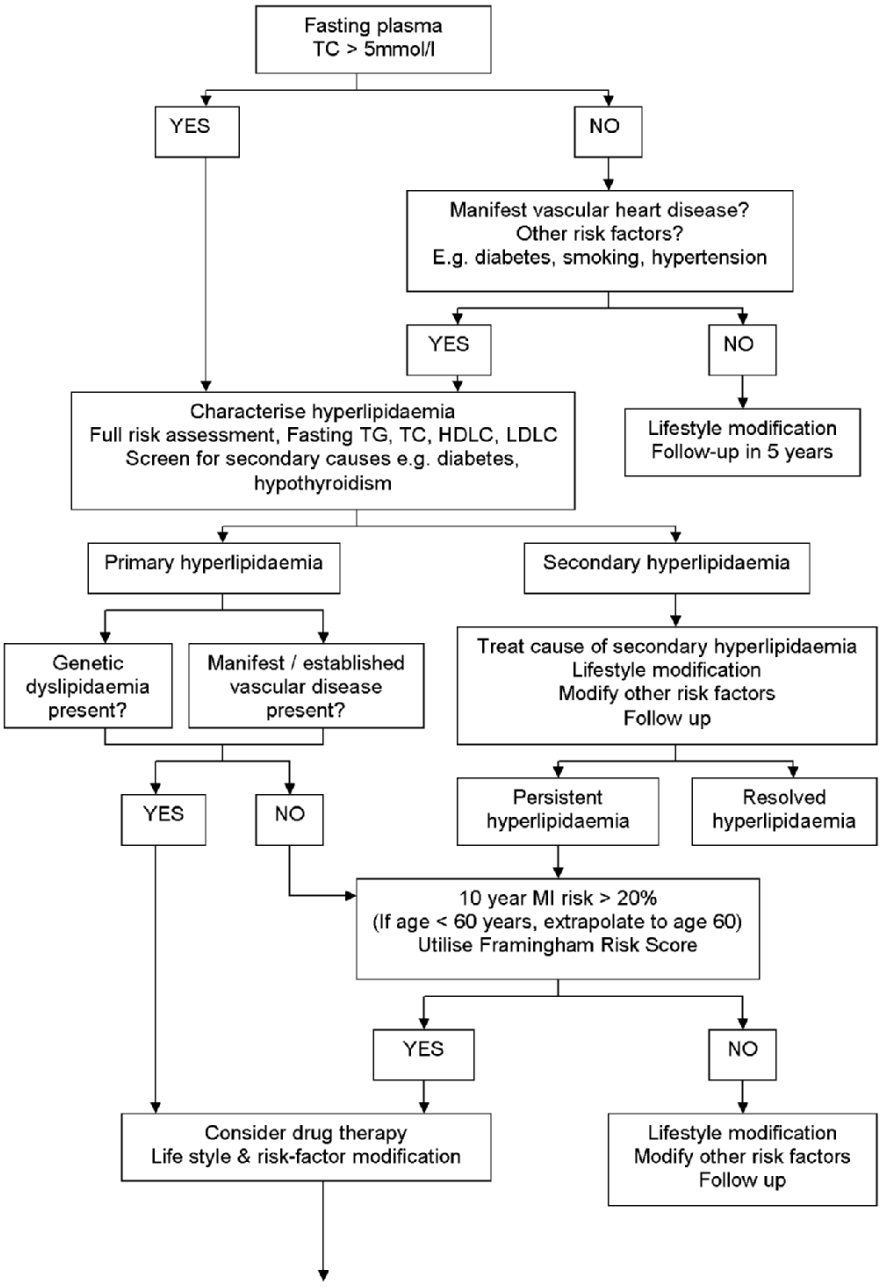
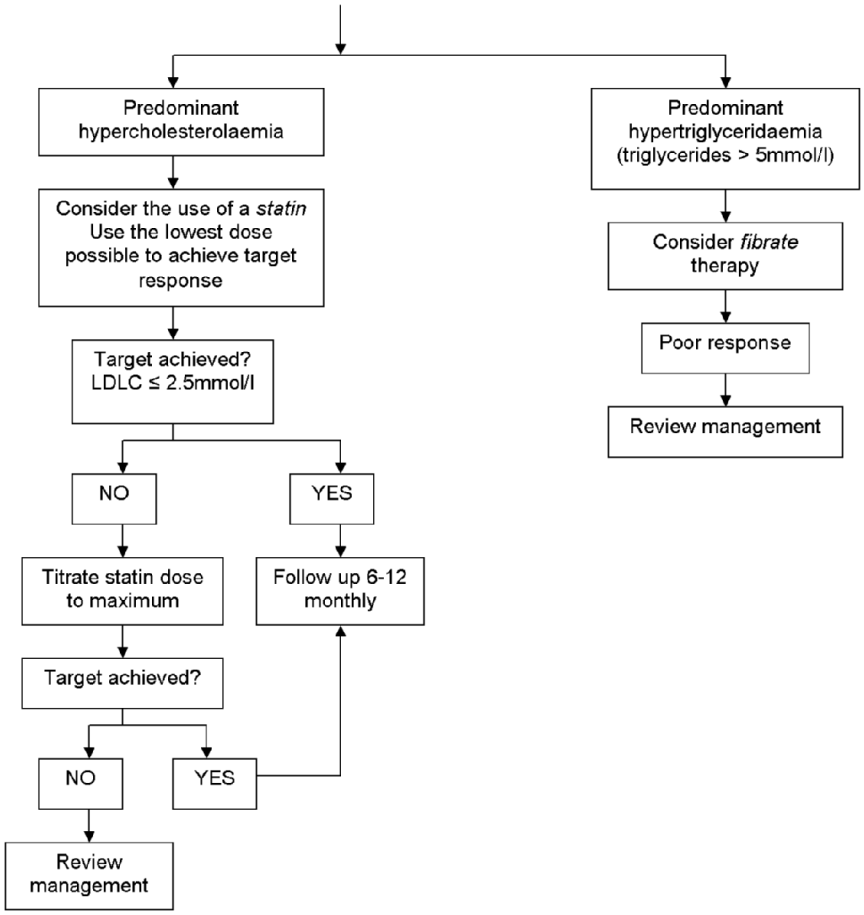
6. HYPERLIPIDAEMIA




Predominant hypercholesterolaemia
Consider the use of a *statin* Use the lowest dose possible to achieve target response
Target achieved? LDLC ≤ 2.5mmol/l
NO
YES
Titrate statin dose to maximum
Follow up 6-12 monthly
Target achieved?
NO
YES
Review management
Predominant hypertriglyceridaemia (triglycerides > 5mmol/l)
Consider *fibrate* therapy
Poor response
Review management

Glossary:

- TC – Total cholesterol
- TG – Triglycerides
- HDLC – High density lipoprotein cholesterol
- LDLC – Low density lipoprotein cholesterol
- MI – Myocardial infarction

Applicable ICD-10 Coding:

- E78.0 Pure hypercholesterolaemia
- E78.1 Pure hyperglyceridaemia
- E78.2 Mixed hyperlipidaemia
- E78.3 Hyperchylomicronaemia
- E78.4 Other hyperlipidaemia
- E78.5 Hyperlipidaemia, unspecified

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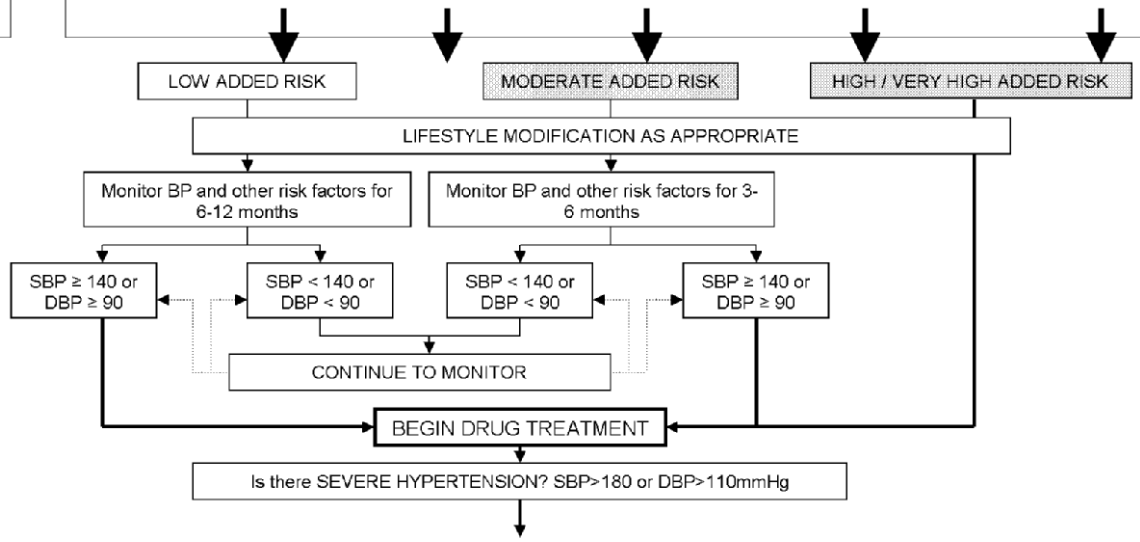
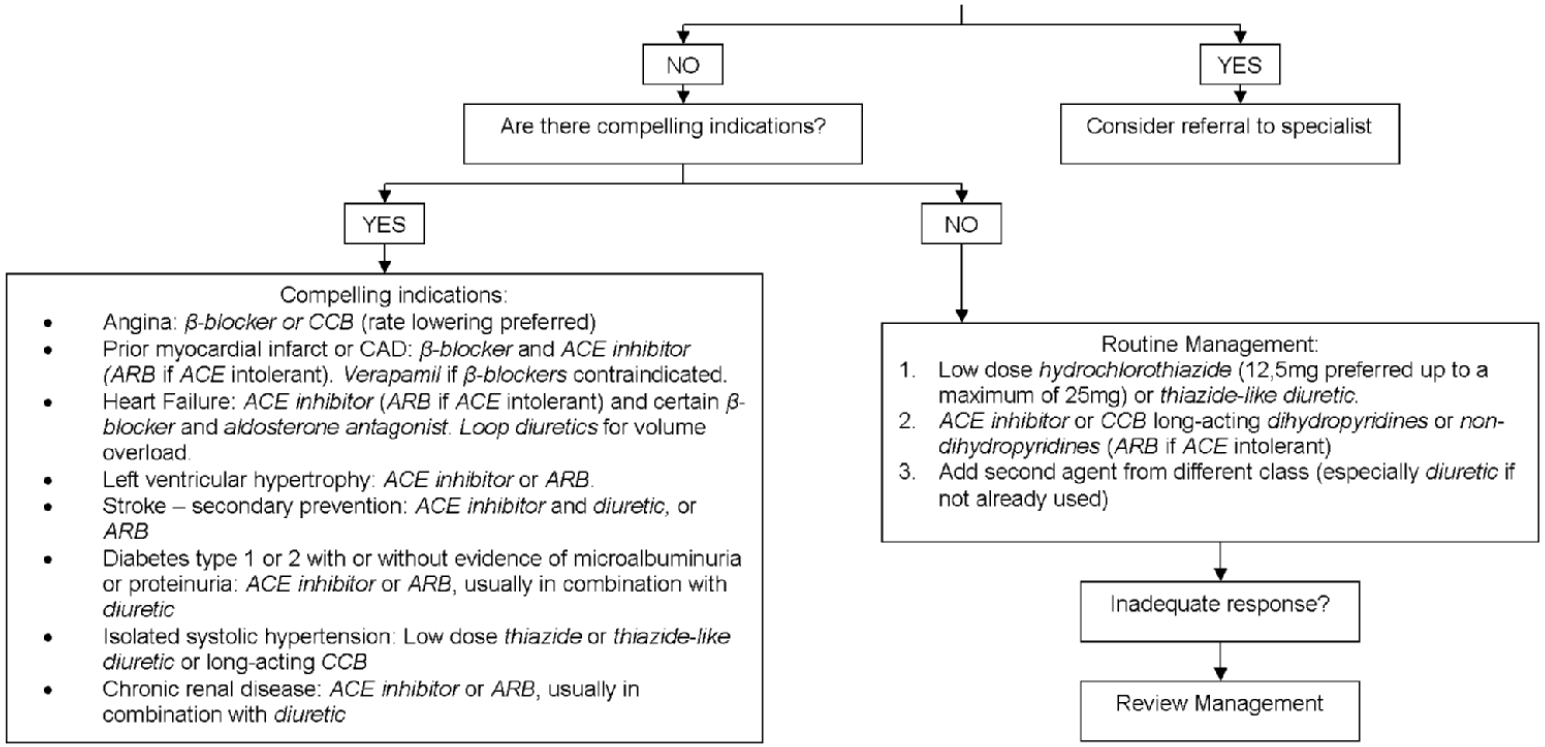
7. HYPERTENSION

Assessment	Measure Blood Pressure					
	OTHER RISK FACTORS AND DISEASE HISTORY	NORMAL SBP120-129 or DBP 80-84 mmHg	HIGH NORMAL SBP 130-139 or DBP 85-89 mmHg	STAGE 1 MILD HYPERTENSION SBP 140-159 or SBP 90-99mmHg	STAGE 2 MODERATE HYPERTENSION SBP 160-179 or DBP 100-109 mmHg	STAGE 3 SEVERE HYPERTENSION SBP >180 or DBP >110 mmHg
Major Risk Factors: • Levels of systolic & diastolic BP • Smoking • Dyslipidaemia • Diabetes Mellitus • Men > 55years and Women > 65 years • Family history of early onset of cardiovascular disease • Waist circumference–abdominal obesity	No other major risk factors	Average risk	Average risk	Low added risk	Moderate added risk	High added risk
	1-2 major risk factors	Low added risk	Low added risk	Moderate added risk	Moderate added risk	Very High added risk
Target Organ Disease: • Left Ventricular Hypertrophy • Microalbuminuria: albumin creatinine ratio • Slightly elevated creatinine	≥ 3 major risk factors or target organ damage or diabetes mellitus	Moderate added risk	High added risk	High added risk	High added risk	Very High added risk
Associated Clinical Conditions: • Coronary Heart Disease • Heart Failure • Chronic Renal disease • Stroke or transient ischaemic attack • Peripheral arterial disease • Advanced retinopathy	Associated clinical conditions	High added risk	Very High added risk	Very High added risk	Very High added risk	Very High added risk





TARGETS FOR BP-LOWERING TREATMENT	
Ideally these targets should be reached in 3 months	
Stage	**BP Level (mmHg)**
All stages	<140/90
Isolated Systolic Hypertension	Do not lower the DBP to < 65
High-risk patients (e.g. stroke, transient ischaemic attack, heart failure, angina, MI, diabetes, renal disease, etc.)	<130/80

Glossary:

- BP – Blood pressure
- SBP – Systolic blood pressure
- DBP – Diastolic blood pressure
- *α-blocker* – Alpha-receptor blocker
- *ACE inhibitor* – Angiotensin converting enzyme inhibitor
- *ARB* – Angiotensin receptor blocker
- *β-blocker* – Beta-receptor blocker
- *CCB* – Calcium channel blocker
- MI – Myocardial infarct

Applicable ICD-10 Coding:

- I10 Essential (primary) hypertension
- I11 Hypertensive heart disease
  - I11.0 Hypertensive heart disease with (congestive) heart failure
  - I11.9 Hypertensive heart disease without (congestive) heart failure
- I12 Hypertensive renal disease
  - I12.0 Hypertensive renal disease with renal failure
  - I12.9 Hypertensive renal disease without renal failure
- I13 Hypertensive heart and renal disease
  - I13.0 Hypertensive heart and renal disease with (congestive) heart failure
  - I13.1 Hypertensive heart and renal disease with renal failure
  - I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
  - I13.9 Hypertensive heart and renal disease, unspecified
- I15 Secondary hypertension
  - I15.0 Renovascular hypertension
  - I15.1 Hypertension secondary to other renal disorders
  - I15.2 Hypertension secondary to endocrine disorders
  - I15.8 Other secondary hypertension
  - I15.9 Secondary hypertension, unspecified
- O10 Pre-existing hypertension complicating pregnancy, childbirth and the puerperium
  - O10.0 Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium
  - O10.1 Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium
  - O10.2 Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium
  - O10.3 Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium
  - O10.4 Pre-existing secondary hypertension complicating pregnancy, childbirth and the puerperium
  - O10.9 Unspecified pre-existing hypertension complicating pregnancy, childbirth and the puerperium
- O11 Pre-existing hypertensive disorder with superimposed proteinuria

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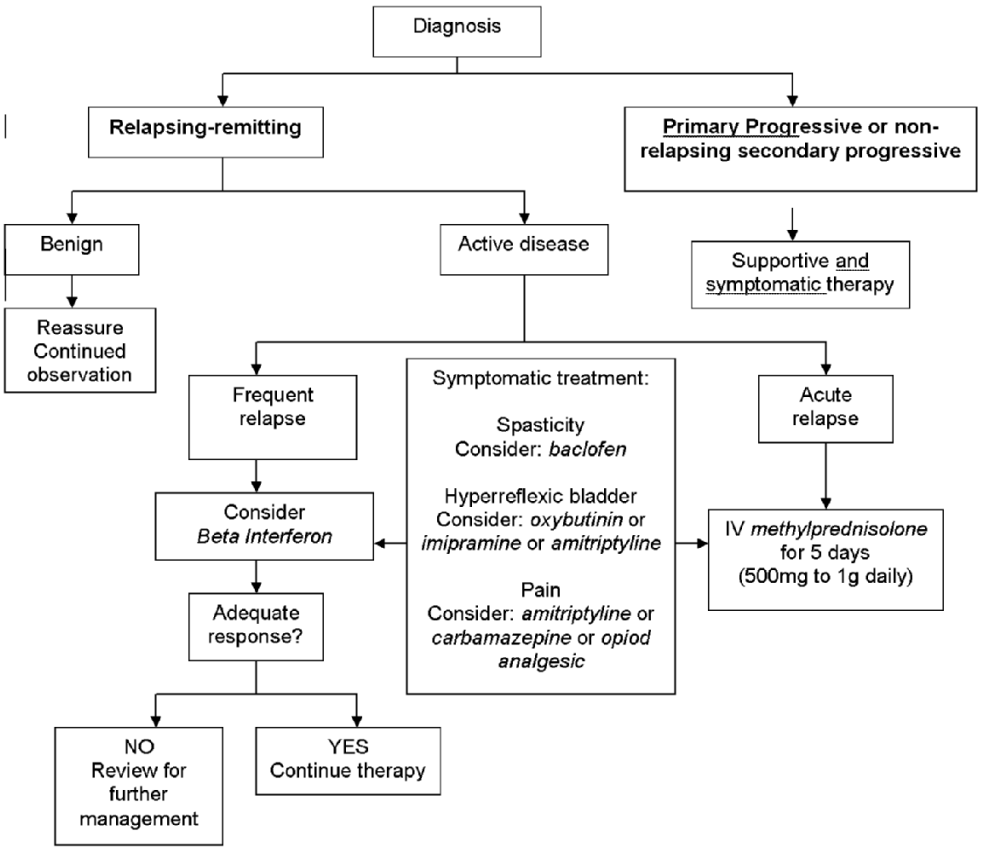
8. MULTIPLE SCLEROSIS



Glossary:

- IV – Intravenous
- EDSS – Expanded Disability Status Scale

Applicable ICD-10 Coding:

- G35 Multiple sclerosis

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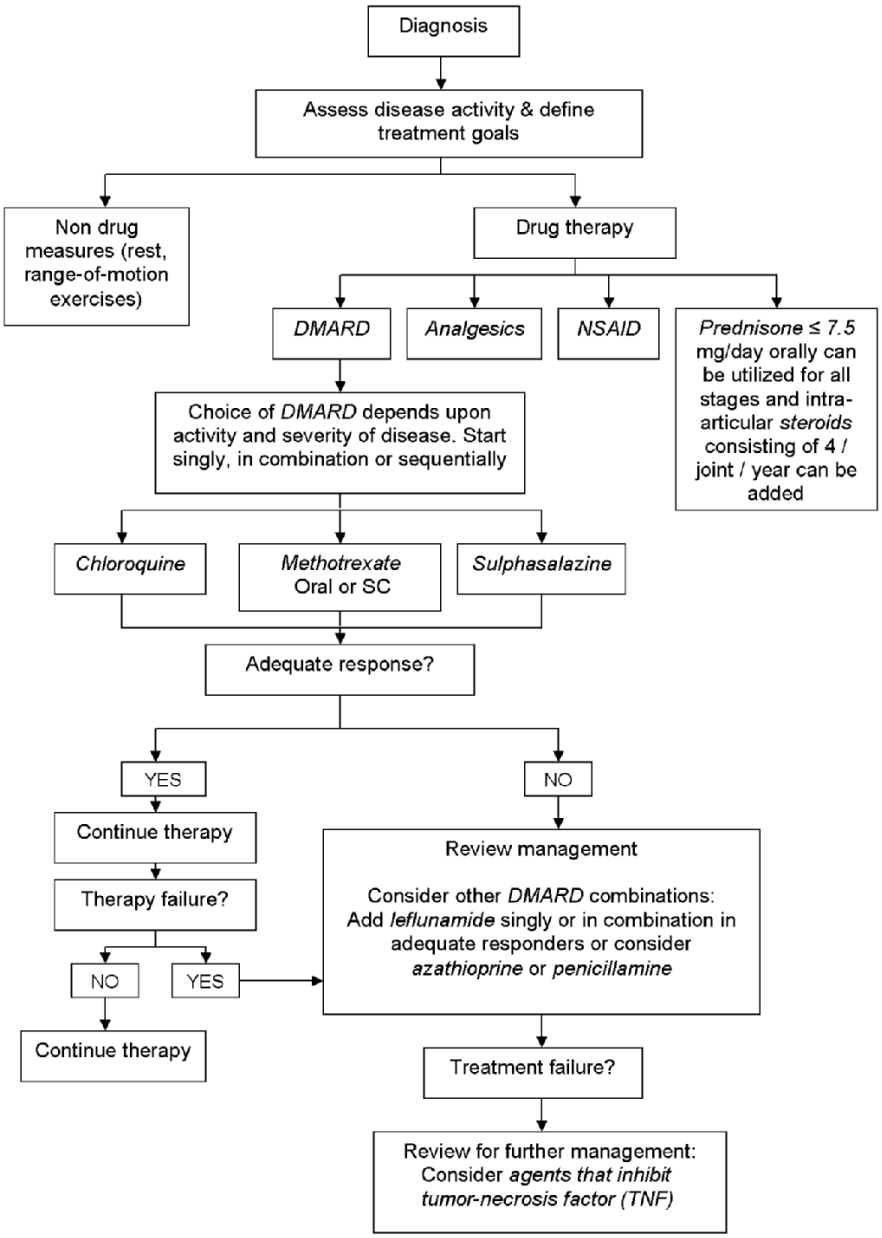
4. **Entry Criteria for the use Beta-interferon:**

   a. **The occurrence of at least 2 clinically significant attacks/relapses in the previous 2 years.**
   b. **Patients must be aged 18 years or older.**
   c. **Patients must be able to stand and step/walk independently with an EDSS score of < 5.5 in the stable/remission phase / walk 100 meters or more without assistance.**
   d. **The patient must not have any contraindications to the use of Beta-interferon.**

5. **Exit criteria for the use of Beta-interferon:**

   a. **The presence of intolerable adverse/ side effects (medical contraindications).**
   b. **Being pregnant or planning pregnancy.**
   c. **Development of non-relapsing secondary progressive multiple sclerosis with loss of ability to walk.**
   d. **Occurrence of 2 disabling relapses within a 12 month period.**
   e. **Loss of ability to walk, with or without assistance that has persisted for longer than 6 months (i.e. EDSS score of 7 or more).**

9. RHEUMATOID ARTHRITIS



Glossary:

- *DMARD* – Disease modifying antirheumatic drugs
- *NSAID* – Non-steroidal anti-inflammatory agents
- *SDAI* – Simplified Disease Activity Index

Applicable ICD-10 Coding:

- M05 Seropositive rheumatoid arthritis
  - M05.0 Felty's syndrome
  - M05.1 Rheumatoid lung disease (J99.0*)
  - M05.2 Rheumatoid vasculitis
  - M05.3 Rheumatoid arthritis with involvement of other organs and systems
  - M05.8 Other seropositive rheumatoid arthritis
  - M05.9 Seropositive rheumatoid arthritis, unspecified
- M06 Other rheumatoid arthritis
  - M06.0 Seronegative rheumatoid arthritis
  - M06.1 Adult-onset Still's disease
  - M06.2 Rheumatoid bursitis
  - M06.3 Rheumatoid nodule
  - M06.4 Inflammatory polyarthropathy
  - M06.8 Other specified rheumatoid arthritis
  - M06.9 Rheumatoid arthritis, unspecified
- M08.0 Juvenile rheumatoid arthritis

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4. **Entry Criteria for the use of *tumor-necrosis factor (TNF) inhibitors*:**
   a. **Active disease defined as a SDAI score of ≥ 20 . The swollen and tender joint must at least be 6 each**
   b. **A history of at least 3 *DMARDs* used serially or in combination at maximum tolerated doses. *Methotrexate* must be one of the *DMARDs* unless contra-indicated.**
   c. ***DMARD* use, as described for at least 6 months.**

5. **Exit criteria for the use of *tumor-necrosis factor (TNF) inhibitors*:**
   a. **Failure to achieve adequate improvement in SDAI score; defined as an improvement of ≥ 7 points from entry score, after 3 months of a *tumor-necrosis factor (TNF) inhibitor* use.**
   b. **Failure to achieve a low disease state; defined as a SDAI score ≤ 11 or a major SDAI response of ≥ 17 points after 6 months of treatment.**
   c. **Intolerance to *tumor-necrosis factor (TNF) inhibitor*.**

Annexure D: List of basic dentistry services

1. Preventative services

a. Basic oral examinations (up to two per year)

b. Intraoral X-rays

c. Non-surgical treatment, e.g. scaling, polishing, periodontal treatments, oral hygiene instruction (up to two per year)

d. Fluoride for children under 16 years

2. Basic services

a. Relief of oral pain and drug therapy for oral infections

b. Restorative services for dental caries, e.g. treatment of dental cavities, sealants, marginal fillings, fillings

c. First aid for oral infections and dento-alveolar trauma, e.g. suture of wounds

d. Extractions under local anaesthesia (tooth, exposed roots, residual roots, impacted teeth/wisdom teeth)

e. Post-extraction complication treatment such as dry sockets, septic sockets, bleeding

f. Incision and drainage of localised abscesses

g. Removal of jaw cyst

h. Root canal treatment

3. Emergency dental care includes:

a. Diagnosis of acute dental problem, including exam and radiographs

b. Procedures to arrest bleeding of dental origin, including suturing, packing, dressing

c. Preliminary case of trauma to the mouth

d. Procedures for the immediate relief of pain, including sedative fillings, incision/open and drainage, pulpectomy, pulpotomy, extraction

Annexure E: List of basic optometry services

1. Optometric primary and preventive services

a. Eye and vision examination, annually for children below 16 and annually for adults

b. Eye and vision examinations include the following:

i. case history

ii. external examination of the eye

iii. assessment of visual acuity

iv. profile of ocular motility

v. objective and subjective measurement of refraction

vi. assessment of binocular coordination

vii. glaucoma tests for adults >40 years or at risk (retinal threshold test with computer disc storage (Delta / Statpak programs) to be performed by an ophthalmologist)

c. Screening for refractive errors >60 years (assessment of amplitude of accommodation, when required)

d. Screening for major ocular diseases >60 years (using direct ophthalmoscope)

2. Appliances to be paid in full

a. One pair of clear single vision, bifocal or multifocal lenses with basic frame, or basic contact lenses per person bi-annually

Annexure F: List of basic preventative services

1. **Maternal and child health preventive services**
    a. Family planning
        i. Contraception should be offered up to the age of 21 years and only up to options available in public Primary Heath Care (PHC) facilities
        ii. Termination Of Pregnancy (TOP) and sterilization services
        iii. TOP services should include anaesthetist, surgical and medical intervention
    b. Antenatal visits
        i. Four visits at the primary care level, with referral to higher levels according to protocols, must be allowed
        ii. Women must register with scheme to qualify for these benefits and
    c. Prevention of mother to child transmission, and occupational and traumatic exposure to HIV
        i. Subject to HIV tests and PEP public sector guidelines
2. **Communicable diseases**
    a. Routine child immunisation in accordance with DoH guidelines
        i. DoH guidelines are available on the national department website at www.doh.gov.za/factsheets/guidelines
    b. Adult immunisation: anti-tetanus, hepatitis B, pneumococcal and influenza vaccine
        i. Pneumococcal vaccine should be provided to people ≥ 65 years and high-risk individuals
        ii. Influenza vaccines should be provided to people ≥ 18 and 65 years and high-risk individuals
        iii. Anti-tetanus vaccination to be provided every 10 years and Hep B for occupational exposure
    c. Male circumcision
    d. Human Papilloma Virus (HPV) vaccine
        i. For women 9-26 years of age or not sexually active
3. **Non-communicable diseases**
    a. Routine general physical checks performed by a GP
        i. People 30-40 years every three years

ii. People 41-59 years every two years

iii. People ≥ 60 years annually

(The above will be subjected to co-payment if performed by a specialist)

b. Unlimited HIV screening tests

i. Both Elisa and rapid (finger pricks) acceptable

ii. HIV Western Blot / HIV Nucleic Acid Amplification Test (NAAT) tests are excluded

c. Baseline body mass index (BMI), blood sugar, cholesterol, blood pressure (BP)and glaucoma tests

i. People ≥ 35 years are entitled to preventive medical checkups focusing on diseases that impose a high burden of disease can be effectively treated or screened.

ii. Baseline tests will be reimbursed once a year only.

iii. Further investigations performed due to abnormal baseline tests should be paid from risk pool.

d. Breast cancer screening

i. Physical examination and mammograms for women ≥ 40 years every two years

e. Cervical cancer screening

i. Pap smears done by a GP for women above 15 once a year. Will be subjected to co-payment if performed by a specialist

f. Dual Energy X-ray Absorptiometry (DEXA) bone density scan

i. People ≥50 years every two years (performed by a radiologist, GP, specialist)

g. Screening tests for prostate cancer

i. Men 40-49 years every five years

ii. Men 50-59 years every three years

iii. Men 60-70 years every two years

Annexure G: Essential drugs for adults

The essential drug list for adults is adapted from *WHO Model List of Essential Medicines*, 15th list, March 2007, available at: http://www.who.int/medicines/publications/essentialmedicines/en/index.html

1. ANAESTHETICS

1.1 General anaesthetics and oxygen

Halothane

Ketamine

Nitrous oxide

Oxygen

Thiopental

1.2 Local anaesthetics

Bupivacaine

Lidocaine

Lidocaine + epinephrine (adrenaline)

Ephedrine

1.3 Preoperative medication and sedation for short-term procedures

Atropine

Diazepam

Morphine

Promethazine

2. ANALGESICS, ANTIPYRETICS, NON-STEROIDAL ANTI-INFLAMMATORY

MEDICINES (NSAIMs), MEDICINES USED TO TREAT GOUT AND DISEASE

MODIFYING AGENTS IN RHEUMATOID DISORDERS (DMARDs)

2.1 Non-opioids and non-steroidal anti-inflammatory medicines (NSAIMs)

Acetylsalicylic acid

Ibuprofen

Paracetamol

2.2 Opioid analgesics

Codeine

Morphine

2.3 Medicines used to treat gout

Allopurinol

2.4 Disease modifying agents used in rheumatoid disorders (DMARDs)

Chloroquine

Azathioprine

Methotrexate

Penicillamine

Sulfasalazine

3. ANTIALLERGICS AND MEDICINES USED IN ANAPHYLAXIS

Chlorphenamine

Dexamethasone

Epinephrine (adrenaline)

Hydrocortisone

Prednisolone

4. ANTIDOTES AND OTHER SUBSTANCES USED IN POISONINGS

4.1 Non-specific

Charcoal

4.2 Specific

Acetylcysteine

Atropine

Calcium gluconate

Deferoxamine

Dimercaprol

Dl-methionine

Methylthioninium chloride (methylene blue)

Naloxone.

Penicillamine

Potassium ferric hexacyano-ferrate(II)-2H20 (Prussian blue)

Sodium calcium edetate

Sodium nitrite

Sodium thiosulfate

5. ANTICONVULSANTS / ANTIEPILEPTICS

Carbamazepine
Diazepam
Magnesium sulfate*
Phenobarbital
Phenytoin
Valproic acid
Ethosuximide

6. ANTI-INFECTIVE MEDICINES

6.1 Anthelminthics

6.1.1 Intestinal anthelminthics

Albendazole
Levamisole
Mebendazole
Niclosamide
Praziquantel
Pyrantel

6.1.2 Antifilarials

Ivermectin
Diethylcarbamazine
Suramin sodium

6.1.3 Antischistosomals and antitrematode medicine

Praziquantel
Triclabendazole
Oxamniquine

6.2 Antibacterials

6.2.1 Beta Lactam medicines

Amoxicillin
Amoxicillin + clavulanic acid
Ampicillin
Benzathine benzylpenicillin
Benzylpenicillin
Cefazolin
Cefixime
Cloxacillin
Phenoxymethylpenicillin
Procaine benzylpenicillin
Ceftazidime
Ceftriaxone
Imipenem + cilastatin

6.2.2 Other antibacterials

Azithromycin
Chloramphenicol
Ciprofloxacin
Erythromycin
Gentamicin
Metronidazole
Nitrofurantoin
Spectinomycin
Sulfamethoxazole + trimethoprim
Trimethoprim
Clindamycin
Sulfadiazine
Vancomycin

6.2.3 Antileprosy medicines

Clofazimine
Dapsone
Rifampicin

6.2.4 Antituberculosis medicines

Ethambutol
Isoniazid
Isoniazid + ethambutol
Pyrazinamide
Rifampicin
Rifampicin + isoniazid
Rifampicin + isoniazid + ethambutol
Rifampicin + isoniazid + pyrazinamide
Rifampicin + isoniazid + pyrazinamide + ethambutol
Streptomycin
Amikacin
Capreomycin
Cycloserine
Ethionamide
Kanamycin
Ofloxacin*(* levofloxacin may be an alternative based on availability and Programme considerations.)
P-aminosalicylic acid

6.3 Antifungal medicines

Clotrimazole

Fluconazole
Griseofulvin
Nystatin
Amphotericin B
Flucytosine
Potassium iodide

6.4 Antiviral medicines

6.4.1 Antiherpes medicines

Acyclovir

6.4.2 Antiretrovirals

6.4.2.1 Nucleoside/Nucleotide reverse transcriptase inhibitors

Abacavir (ABC)
Didanosine (ddi)
Emtricitabine (FTC)
Lamivudine (3TC)
Stavudine (d4t)
Tenofovir disoproxil fumarate (TDF)
Zidovudine (ZDV or AZT)

6.4.2.2 Non-nucleoside reverse transcriptase inhibitors

Efavirenz (EFV or EFZ)
Nevirapine (NVP)

6.4.2.3 Protease inhibitors

Indinavir (IDV)
Lopinavir + ritonavir (LPV/r)
Nelfinavir (NFV)
Ritonavir
Saquinavir (SQV)

FIXED-DOSE COMBINATIONS

Efavirenz + emtricitabine* + tenofovir
Emtricitabine* + tenofovir
Stavudine + lamivudine + nevirapine
Zidovudine + lamivudine
Zidovudine + lamivudine + Nevirapine

6.4.3 Other antivirals

Ribavirin

6.5 Antiprotozoal medicines

6.5.1 Antiamoebic and antigiardiasis medicines

Diloxanide
Metronidazole

6.5.2 Antileishmaniasis medicines

Meglumine antimoniate
Paromomycin
Amphotericin B
Pentamidine

6.5.3 Antimalarial medicines

6.5.3.1 For curative treatment

Amodiaquine
Artemether
Artemether + lumefantrine
Artesunate
Chloroquine
Doxycycline
Mefloquine
Primaquine
Quinine
Sulfadoxine + pyrimethamine

6.5.3.2 For prophylaxis

Mefloquine
Proguanil (For use only in combination with chloroquine)

6.5.4 Antipneumocystosis and antitoxoplasmosis medicines

Pyrimethamine.
Sulfamethoxazole + trimethoprim
Pentamidine

6.5.5 Antitrypanosomal medicines

6.5.5.1 African trypanosomiasis

Pentamidine
Suramin sodium
Eflornithine
Melarsoprol

6.5.5.2 American trypanosomiasis

Benznidazole
Nifurtimox

7. ANTIMIGRAINE MEDICINES

7.1 For treatment of acute attack

Acetylsalicylic acid
Paracetamol

7.2 For prophylaxis

Propranolol

8. ANTINEOPLASTIC, IMMUNOSUPPRESSIVES AND MEDICINES USED IN PALLIATIVE CARE

8.1 Immunosuppressive medicines

Azathioprine

Ciclosporin

8.2 Cytotoxic medicines

Asparaginase

Bleomycin

Calcium folinate

Chlorambucil

Cisplatin

Cyclophosphamide

Cytarabine

Dacarbazine

Dactinomycin

Daunorubicin

Doxorubicin

Etoposide

Fluorouracil

Mercaptopurine

Methotrexate

Procarbazine

Vinblastine

Vincristine

8.3 Hormones and antihormones

Dexamethasone

Hydrocortisone

Prednisolone

Tamoxifen

8.4 Medicines used in palliative care

9. ANTIPARKINSONISM MEDICINES

Biperiden

Levodopa + Carbidopa

10. MEDICINES AFFECTING THE BLOOD

10.1 Antianaemia medicines

Ferrous salt

Ferrous salt + folic acid

Folic acid

Hydroxocobalamin

10.2 Medicines affecting coagulation

Heparin sodium

Phytomenadione

Protamine sulfate

Warfarin

11. BLOOD PRODUCTS AND PLASMA SUBSTITUTES

11.1 Plasma substitutes

Dextran 70

11.2 Plasma fractions for specific use

Human normal immunoglobulin

Factor VIII concentrate Dried.

Factor IX complex (coagulation factors, II, VII, IX, X) concentrate **Dried.**

12. CARDIOVASCULAR MEDICINES

12.1 Antianginal medicines

Atenolol

Glyceryl trinitrate

Isosorbide dinitrate

Verapamil

12.2 Antiarrhythmic medicines

Atenolol

Digoxin

Epinephrine (adrenaline)

Lidocaine

Verapamil

Procainamide

Quinidine

12.3 Antihypertensive medicines

Amlodipine

Atenolol

Enalapril

Hydralazine

Hydrochlorothiazide

Methyldopa

Sodium nitroprusside

12.4 Medicines used in heart failure

Digoxin

Enalapril

Furosemide

Hydrochlorothiazide
Dopamine
12.5 Antithrombotic medicines
Acetylsalicylic acid
Streptokinase
12.6 Lipid-lowering agents
Simvastatin
13. DERMATOLOGICAL MEDICINES (topical)
13.1 Antifungal medicines
Benzoic acid + salicylic acid
Miconazole
Sodium thiosulfate
Selenium sulfide
13.2 Anti-infective medicines
Methylrosanilinium chloride (gentian violet)
Neomycin sulfate + Bacitracin
Potassium permanganate
Silver sulfadiazine
13.3 Anti-inflammatory and antipruritic medicines
Betamethasone
Calamine lotion
Hydrocortisone
13.4 Astringent medicines
Aluminium diacetate
13.5 Medicines affecting skin differentiation and proliferation
Benzoyl peroxide
Coal tar
Dithranol
Fluorouracil
Podophyllum resin
Salicylic acid
Urea
13.6 Scabicides and pediculicides
Benzyl benzoate
Permethrin
14. DIAGNOSTIC AGENTS
14.1 Ophthalmic medicines
Fluorescein
Tropicamide
14.2 Radiocontrast media
Amidotrizoate
Barium sulfate
Lohexol.
Meglumine iotroxate
15. DISINFECTANTS AND ANTISEPTICS
15.1 Antiseptics
Chlorhexidine
Ethanol
Polyvidone iodine
15.2 Disinfectants
Chlorine base compound
Chloroxylenol
Glutaral
16. DIURETICS
Amiloride
Furosemide
Hydrochlorothiazide
Mannitol
Spironolactone
17. GASTROINTESTINAL MEDICINES
17.1 Antacids and other antiulcer medicines
Aluminium hydroxide
Ranitidine
Magnesium hydroxide
17.2 Antiemetic medicines
Metoclopramide
Promethazine
17.3 Anti-inflammatory medicines
Sulfasalazine
Hydrocortisone
17.4 Laxatives
Senna
17.5 Medicines used in diarrhoea
17.5.1 Oral rehydration
Oral rehydration salts
17.5.2 Medicines for diarrhoea in children

Zinc sulfate

17.5.3 Antidiarrhoeal (symptomatic) medicines in adults

Codeine

18. HORMONES, OTHER ENDOCRINE MEDICINES AND CONTRACEPTIVES

18.1 Adrenal hormones and synthetic substitutes

Addison's disease is a rare condition; adrenal hormones are already included in section 3.

18.2 Androgens

Testosterone.

18.3 Contraceptives

18.3.1 Oral hormonal contraceptives

Ethinylestradiol + Levonorgestrel

Ethinylestradiol + Norethisterone

Levonorgestrel

18.3.2 Injectable hormonal contraceptives

Medroxyprogesterone acetate

Medroxyprogesterone acetate +Estradiol cypionate

Norethisterone enantate

18.3.3 Intrauterine devices

Copper containing device

18.3.4 Barrier methods

Condoms

Diaphragms

18.3.5 Implantable contraceptives

Levonorgestrel releasing implant

18.4 Estrogens

Ethinylestradiol

18.5 Insulins and other antidiabetic agents

Glibenclamide

Insulin injection (soluble)

Intermediate acting insulin

Metformin

18.6 Ovulation inducers

Clomifene

18.7 Progestogens

Norethisterone

Medroxyprogesterone acetate

18.8 Thyroid hormones and antithyroid medicines

Levothyroxine

Potassium Iodide

Propylthiouracil

19. IMMUNOLOGICALS

19.1 Diagnostic agents

Tuberculin, purified protein derivative (PPD)

19.2 Sera and immunoglobulins

Anti-D immunoglobulin (human)

Antitetanus immunoglobulin (human)

Antivenom immunoglobulin

Diphtheria antitoxin

Rabies immunoglobulin

19.3 Vaccines

As per NDOH guidelines – see Annexure F, page 64.

20. MUSCLE RELAXANTS (PERIPHERALLY-ACTING) AND CHOLINESTERASE INHIBITORS

Alcuronium

Neostigmine

Suxamethonium

Pyridostigmine

Vecuronium

21. OPHTHALMOLOGICAL PREPARATIONS

21.1 Anti-infective agents

Aciclovir

Gentamicin

Tetracycline

21.2 Anti-inflammatory agents

Prednisolone

21.3 Local anaesthetics

Tetracaine

21.4 Miotics and antiglaucoma medicines

Acetazolamide

Pilocarpine

Timolol

21.5 Mydriatics

Atropine

Epinephrine

22. OXYTOCICS AND ANTIOXYTOCICS

22.1 Oxytocics

Ergometrine

Oxytocin

Misoprostol

Mifepristone –Mmisoprostol

22.2 Antioxytocics (tocolytics)

Nifedipine

23. PERITONEAL DIALYSIS SOLUTION

Intraperitoneal dialysis solution (of appropriate composition)

24. PSYCHOTHERAPEUTIC MEDICINES

24.1 Medicines used in psychotic disorders

Chlorpromazine

Fluphenazine

Haloperidol

24.2 Medicines used in mood disorders

24.2.1 Medicines used in depressive disorders

Amitriptyline

Fluoxetine

24.2.2 Medicines used in bipolar disorders

Carbamazepine

Lithium carbonate

Valproic acid

24.3 Medicines used in generalized anxiety and sleep disorders

Diazepam

24.4 Medicines used for obsessive compulsive disorders and panic attacks

Clomipramine

24.5 Medicines used in substance dependence programmes

Methadone

Buprenorphine.

25. MEDICINES ACTING ON THE RESPIRATORY TRACT

25.1 Antiasthmatic and medicines for chronic obstructive pulmonary disease

Beclometasone

Epinephrine (adrenaline)

Ipratropium bromide

Salbutamol

25.2 Other medicines acting on the respiratory tract

Caffeine citrate

26. SOLUTIONS CORRECTING WATER, ELECTROLYTE AND ACID-BASE

DISTURBANCES

26.1 Oral

Oral rehydration salts (See section 17.5.1.)

Potassium chloride

26.2 Parenteral

Glucose

Glucose with sodium chloride

Potassium chloride

Sodium chloride

Sodium hydrogen carbonate

Sodium lactate, compound solution

26.3 Miscellaneous

Water for injection 2-ml; 5-ml; 10ml ampoules.

27. VITAMINS AND MINERALS

Ascorbic acid

Ergocalciferol

Iodine

Nicotinamide

Pyridoxine retinol

Riboflavin

Sodium fluoride

Thiamine

Calcium gluconate

Annexure H: Essential drugs for children

The essential drug list for children is adapted from:"WHO Model List of Essential Medicines for Children, First List, October 2007, available at: http://www.who.int/medicines/publications/essentialmedicines/en/index.html

1. ANAESTHETICS

1.1 General anaesthetics and oxygen

Halothane

Ketamine

Nitrous oxide

Oxygen

Thiopental

1.2 Local anaesthetics

Bupivacaine

Lidocaine

Lidocaine + epinephrine (adrenaline)

1.3 Preoperative medication and sedation for short-term procedures

Atropine

Diazepam

Morphine

2. ANALGESICS, ANTIPYRETICS, NON-STEROIDAL ANTI-INFLAMMATORY

MEDICINES (NSAIMs), MEDICINES USED TO TREAT GOUT AND DISEASE

MODIFYING AGENTS IN RHEUMATOID DISORDERS (DMARDs)

2.1 Non-opioids and non-steroidal anti-inflammatory medicines (NSAIMs)

Ibuprofen

Paracetamol

Acetylsalicylic acid

2.2 Opioid analgesics

Codeine

Morphine

~~**2.3 Medicines used to treat gout**~~

2.4 Disease modifying agents used in rheumatoid disorders (DMARDs)

3. ANTIALLERGICS AND MEDICINES USED IN ANAPHYLAXIS

Chlorphenamine

Diphenhydramine

Dexamethasone

Epinephrine (adrenaline)

Hydrocortisone

Prednisolone

4. ANTIDOTES AND OTHER SUBSTANCES USED IN POISONINGS

4.1 Non-specific

Charcoal

4.2 Specific

Acetylcysteine

Atropine

Calcium gluconate

Deferoxamine

Dimercaprol

Naloxone.

Penicillamine

Sodium calcium edetate

5. ANTICONVULSANTS/ANTIEPILEPTICS

Carbamazepine

Diazepam

Phenobarbital

Phenytoin

Valproic acid (sodium valproate)

Ethosuximide

6. ANTI-INFECTIVE MEDICINES

6.1 Anthelminthics

6.1.1 Intestinal anthelminthics

Albendazole

Levamisole

Mebendazole
Niclosamide
Praziquantel
Pyrantel

6.1.2 Antifilarials

Ivermectin
Diethylcarbamazine

6.1.3 Antischistosomals and antitrematode medicine

Praziquantel
Triclabendazole
Oxamniquine

6.2 Antibacterials

6.2.1 Beta Lactam medicines

Amoxicillin
Amoxicillin + clavulanic acid
Ampicillin benzathine benzylpenicillin
Benzylpenicillin
Cefazolin
Ceftriaxone
Cloxacillin
Phenoxymethylpenicillin
Procaine benzylpenicillin
Ceftazidime
Imipenem +Cilastatin

6.2.2 Other antibacterials

Azithromycin
Chloramphenicol
Ciprofloxacin
Doxycycline
Erythromycin
Gentamicin
Metronidazole
Nitrofurantoin
Sulfamethoxazole + trimethoprim
Trimethoprim
Clindamycin
Sulfadiazine
Vancomycin

6.2.3 Antileprosy medicines

Clofazimine
Dapsone
Rifampicin

6.2.4 Antituberculosis medicines

Ethambutol
Isoniazid
Pyrazinamide
Rifampicin
Rifampicin + isoniazid
Rifampicin + isoniazid + pyrazinamide
Streptomycin
Amikacin
Capreomycin
Cycloserine
Ethionamide
Kanamycin
Ofloxacin
Levofloxacin may be an alternative based on availability and programme considerations.
P-aminosalicylic acid

6.3 Antifungal medicines

Fluconazole
Griseofulvin
Nystatin
Amphotericin b
Flucytosine
Potassium iodide

6.4 Antiviral medicines

6.4.1 Antiherpes medicines

Acyclovir

6.4.2 Antiretrovirals

6.4.2.1 Nucleoside/Nucleotide reverse transcriptase inhibitors

Abacavir (ABC)
Didanosine (ddi)
Emtricitabine (FTC)
Lamivudine (3TC)
Stavudine (d4t)
Zidovudine (ZDV or AZT)

6.4.2.2 Non-nucleoside reverse transcriptase inhibitors

Efavirenz (EFV or EFZ)
Nevirapine (NVP)

6.4.2.3 Protease inhibitors

Lopinavir + ritonavir (LPV/r)

Nelfinavir (NFV)

Ritonavir

Saquinavir (SQV)

FIXED-DOSE COMBINATIONS

Stavudine + lamivudine +nevirapine

Zidovudine + lamivudine

Zidovudine + lamivudine +nevirapine

6.4.3 Other antivirals

Ribavirin

6.5 Antiprotozoal medicines

6.5.1 Antiamoebic and antigiardiasis medicines

Diloxanide

Metronidazole

6.5.2 Antileishmaniasis medicines

Paromomycin

Meglumine antimoniate

Amphotericin b

6.5.3 Antimalarial medicines

6.5.3.1 For curative treatment

Amodiaquine

Artemether

Artemether + lumefantrine

Artesunate

Doxycycline

Mefloquine

Primaquine

Quinine

Sulfadoxine + pyrimethamine

6.5.3.2 For prophylaxis

Doxycycline

Mefloquine

Proguanil (for use only in combination with chloroquine)

6.5.4 Anti-pneumocystosis and antitoxoplasmosis medicines

Pyrimethamine

Sulfamethoxazole + trimethoprim

6.5.5 Antitrypanosomal medicines

6.5.5.1 African trypanosomiasis

Pentamidine

Suramin sodium

Eflornithine melarsoprol

6.5.5.2 American trypanosomiasis

Benznidazole

Nifurtimox

7. ANTIMIGRAINE MEDICINES

7.1 For treatment of acute attack

Ibuprofen

Paracetamol

7.2 For prophylaxis

Propranolol

8. ANTINEOPLASTIC, IMMUNOSUPPRESSIVES AND MEDICINES USED IN PALLIATIVE CARE

8.1 Immunosuppressive medicines

Azathioprine

Ciclosporin

8.2 Cytotoxic medicines

Allopurinol

Asparaginase

Bleomycin

Calcium folinate

Chlorambucil

Cisplatin

Cyclophosphamide

Cytarabine

Dacarbazine

Dactinomycin

Daunorubicin

Doxorubicin

Etoposide

Fluorouracil

Mercaptopurine

Methotrexate

Procarbazine

Vinblastine

Vincristine

8.3 Hormones and antihormones

Dexamethasone

Hydrocortisone

Prednisolone

Prednisone

8.4 Medicines used in palliative care

Medicines still under review by WHO

~~**9. ANTIPARKINSONISM MEDICINES**~~

10. MEDICINES AFFECTING THE BLOOD

10.1 Antianaemia medicines

Ferrous salt

Folic acid

Hydroxocobalamin

10.2 Medicines affecting coagulation

Phytomenadione

Heparin sodium

Protamine sulfate

Warfarin

11. BLOOD PRODUCTS AND PLASMA SUBSTITUTES

11.1 Plasma substitutes

11.2 Plasma fractions for specific use

Human normal

Immunoglobulin.

Factor VIII concentrate D**ried.**

Factor IX complex (coagulation factors, ii, vii, ix, x) concentrate D**ried.**

12. CARDIOVASCULAR MEDICINES

~~**12.1 Antianginal medicines**~~

12.2 Antiarrhythmic medicines

The WHO will review medicines submitted under this section to determine if they are essential for children

12.3 Antihypertensive medicines

The WHO will review medicines submitted under this section to determine if they are essential for children

12.4 Medicines used in heart failure

Digoxin

Furosemide

Dopamine

12.5 Antithrombotic medicines

The WHO will review medicines submitted under this section to determine if they are essential for children

13. DERMATOLOGICAL MEDICINES (topical)

13.1 Antifungal medicines

Benzoic acid + salicylic acid

Miconazole

Selenium sulfide

13.2 Anti-infective medicines

Methylrosanilinium chloride (gentian violet)

Neomycin sulfate + Bacitracin

Potassium permanganate

Silver sulfadiazine

13.3 Anti-inflammatory and antipruritic medicines

Betamethasone

Calamine lotion

Hydrocortisone

13.4 Astringent medicines

13.5 Medicines affecting skin differentiation and proliferation

Benzoyl peroxide

Coal tar

Dithranol

Podophyllum resin

Salicylic acid

Urea

13.6 Scabicides and pediculicides

Benzyl benzoate

Permethrin

14. DIAGNOSTIC AGENTS

14.1 Ophthalmic medicines

Fluorescein

Tropicamide

14.2 Radiocontrast media

Barium sulfate

15. DISINFECTANTS AND ANTISEPTICS

15.1 Antiseptics

Chlorhexidine

Ethanol

Polyvidone iodine

15.2 Disinfectants

Chlorine base compound

Chloroxylenol

Glutaral

16. DIURETICS

Furosemide

Hydrochlorothiazide

Mannitol

Spironolactone

17. GASTROINTESTINAL MEDICINES

17.1 Antacids and other antiulcer medicines

Aluminium hydroxide

Magnesium hydroxide

Ranitidine

17.2 Antiemetic medicines

Metoclopramide

Promethazine

~~**17.3 Anti-inflammatory medicines**~~

17.4 Laxatives

The WHO will review medicines submitted under this section to determine if they are essential for children

17.5 Medicines used in diarrhoea

17.5.1 Oral rehydration

Oral rehydration salts

17.5.2 Medicines for diarrhoea in children

Zinc sulfate

18. HORMONES, OTHER ENDOCRINE MEDICINES AND CONTRACEPTIVES

18.1 Adrenal hormones and synthetic substitutes

18.2 Insulins and other antidiabetic agents

Insulin injection (soluble)

Intermediate-acting insulin

Metformin

18.3 Thyroid hormones and antithyroid medicines

Levothyroxine

Lugol's solution

Potassium iodide

Propylthiouracil

19. IMMUNOLOGICALS

19.1 Diagnostic agents

Tuberculin, purified protein

Derivative (PPD)

19.2 Sera and immunoglobulins

Antitetanus immunoglobulin (human)

Antivenom immunoglobulin

Diphtheria antitoxin

Rabies immunoglobulin

19.3 Vaccines

As per NDoH guidelines – see Annexure F, page 64.

20. MUSCLE RELAXANTS (PERIPHERALLY-ACTING) AND CHOLINESTERASE INHIBITORS

Neostigmine

Suxamethonium

Vecuronium

Pyridostigmine

21. OPHTHALMOLOGICAL PREPARATIONS

21.1 Anti-infective agents

Acyclovir

Gentamicin

Tetracycline

21.2 Anti-inflammatory agents

Prednisolone

21.3 Local anaesthetics

Tetracaine

21.4 Mydriatics

Atropine

Epinephrine (adrenaline)

~~**22. OXYTOCICS AND ANTIOXYTOCICS**~~

~~**22.1 Oxytocics**~~

~~**22.2 Antioxytocics (tocolytics)**~~

23. PERITONEAL DIALYSIS SOLUTION

Intraperitoneal dialysis -Solution (of appropriate Composition)

24. PSYCHOTHERAPEUTIC MEDICINES

24.1 Medicines used in psychotic disorders

Chlorpromazine

Haloperidol

24.2 Medicines used in mood disorders

24.2.1 Medicines used in depressive disorders

Fluoxetine

24.2.2 Medicines used in bipolar disorders

24.3 Medicines used in generalized anxiety and sleep disorders

24.4 Medicines used for obsessive compulsive disorders and panic attacks

24.5 Medicines used in substance dependence programmes

25. MEDICINES ACTING ON THE RESPIRATORY TRACT

25.1 Antiasthmatic and medicines for chronic obstructive pulmonary disease

Budesonide

Epinephrine (adrenaline)

Salbutamol

25.2 Other medicines acting on the respiratory tract

Caffeine citrate

26. SOLUTIONS CORRECTING WATER, ELECTROLYTE AND ACID-BASE DISTURBANCES

26.1 Oral

Oral rehydration salts

Potassium chloride

26.2 Parenteral

Glucose

Glucose with sodium chloride

Potassium chloride

Sodium chloride

Sodium hydrogen carbonate

Sodium lactate, compound Solution

26.3 Miscellaneous

Water for injection

27. VITAMINS AND MINERALS

Ascorbic acid

Cholecalciferol (ergocalciferol can be used as an alternative).

Iodine

Pyridoxine

Retinol

Riboflavin

Sodium fluoride.

Thiamine

Calcium gluconate.

Table 1: Medicines with age restrictions

Atropine >3 months

Azithromycin >6 months

Benzyl benzoate >2 years

Betamethasone topical preparations, hydrocortisone preferred in neonates

Cefazolin >1 month

Chlorphenamine >1 year

Clindamycin >1 month

Diloxanide >25 kg weight

Doxycyline >8 years

Efavirenz >3 years or >10 kg weight

Emtricitabine >3 months

Fluoxetine >8 years

Ibuprofen >3 months

Mefloquine >5 kg or >3 months

Metoclopramide not in neonates
Procaine benzylpenicillin not in neonates >1 month
Promethazine >2 years
Saquinavir >25 kg weight
Silver sulfadiazine >2 months
Tetracaine not in preterm neonates
Trimethoprim >6 months

Annexure I: List of exclusions

1. **Hospitalisation for diagnostic work-up**
    a. All endoscopies such as:
        i. Gastroscopy
        ii. Athroscopy
        iii. Diagnostic cystoscopy
        iv. Colonoscopy
        v. Sigmoidoscopy
        vi. Breast biopsy
        vii. Diagnostic laparoscopy
        viii. Diagnostic Dilatation and Curettage (D&C)
2. **Minor surgical procedures that do not require hospitalisation, including but not limited to:**
    a. Marsupialisation of a Bartholin's cyst
    b. Dilation and curettage
    c. Laparoscopic sterilization
    d. Cone biopsy
    e. Cauterisation of warts
    f. Colposcopy
    g. Tonsillectomy
    h. Nasal polypectomy
    i. Nasal cautery
    j. Meibomian cyst excision
    k. Cataract removal
    l. Bunionectomy
    m. Circumcision
    n. Drainage of superficial abscess
    o. Superficial foreign body removal
3. **Hospitalisation where alternatives are available**
    a. Hospitalisation is excluded for conditions / circumstances where alternative clinically appropriate options are available. These include step-down care, hospice care or rehabilitation facilities, where available.
4. **Hospitalisation at a level that is not required**
    a. Hospitalisation in an ICU or high-care ward where explicit clinical indications are not present must be reimbursed at the level of a standard ward.
    b. Similarly, clear medical indications must exist for hospitalisation in a private ward.
5. **Alternative and/or complementary health services that are not supported by evidence-based medicine are excluded from the benefit. These may typically include the following services:**
    a. Acupuncture

b. Alternative medicine
c. Aromatherapy
d. Ayurvedics
e. Chiropractors, except where these services meet clinical protocol
f. Herbalists
g. Homeopathy
h. Iridology
i. Masseurs
j. Osteopathy
k. Phytotherapy
l. Reflexology
m. Traditional medicine

6. **Medical or health conditions that do not meet the criteria set for essential health care Annexure A, page 20, and are typically covered in higher options**
    a. Behavioural problems
    b. Chronic fatigue syndrome, myelo-encelopathy, yuppie flu
    c. Complications resulting from excluded conditions unless complication is a PMB
    d. Concentration / learning / reading problems
    e. Coordination abnormalities
    f. Costs incurred for surrogate parenting
    g. Delayed speech development
    h. Dyslexia
    i. Oral appliances specified for the treatment of headaches
    j. Posture abnormality
    k. Ptosis repairs
    l. Sexual disorders /sex changes / loss of libido
7. **Consultative services and professional fees are excluded under the following circumstances**
    a. After-hour consultation through member's preference and not because of an emergency
    b. Appointments not honoured by beneficiaries
    c. Charges for interest by healthcare provider, if due to member negligence
    d. Costs incurred for medical examinations for licensing purposes, such as pilot or motor-sport licenses
    e. Fees for medical reports and motivations by any service provider, unless required by scheme
    f. Fees of services or prescriptions by the member in respect of him-/herself or any of his/her dependants
    g. Discretionary conditions and services with hospital admissions not authorised

h. NOTE: Consultations / writing of a repeat script for six months for a PMB chronic condition and other non-health related services such as motivations, requested by the scheme, must be covered.

8. Cosmetic services

i. All cosmetic procedures / treatment / medication are excluded, except if these services are rendered to rectify the effects of defects / abnormalities due to accidents, illness or disease.

j. The following are excluded:

i. Cosmetics and beauty preparations
ii. Face lifts
iii. Genioplasty
iv. Hair removal
v. Periodontal plastic procedures for cosmetic purposes
vi. Removal of scars, tattoos by salabrasion, chemosurgery or any other skin abrasion procedures
vii. Removal of skin blemishes
viii. The treatment of these conditions is discretionary to the scheme, and the scheme may exclude benefits for these conditions

9. Dental procedures and treatments

a. Discretionary procedures: elective treatments and surgery for personal reasons that are not directly caused or related to illness, accident or disease, are excluded.

b. Dental claims that are not consistent with the clinical protocols of the scheme are excluded.

10. Optometry

a. Discretionary procedures such as surgery to correct refractive errors, other elective treatments and surgery, appliances such as spectacles and contact lenses not listed in Annexure E, page 63.

11. Facilities

a. Healthcare facilities not related to basic life support services or not registered as a relevant health service or a healthcare facility, which may include:

i. Chiropractic / homeopathic resorts
ii. Clinics for the treatment of headaches
iii. Health farm (exercise) treatment
iv. Health resorts / spas
v. Places of rest
vi. Resorts for recuperative or other similar purposes
vii. Resorts for slimming
viii. Respite care
ix. Stress relief clinics

b. Schemes may exclude benefits for services that are not life-supporting. Basic life-support services where applicable medical interventions occur may not be excluded from the scheme rules.

12. Non-evidence-based medicine or the treatment of low medically necessity conditions, healthcare services with low impact on healthcare status are excluded and the following are excluded:

a. Adjustment of frames
b. Chelation therapy
c. Examination for lawsuits or similar purposes, admission to schools or universities, emigration or immigration, medical court reports, fitness examination, employment, school camp, visas, medical insurance, executive examinations
d. Group exercises
e. Gymnasium exercise treatment

13. Certain pharmaceuticals are excluded

a. Aphrodisiacs
b. Appetite suppressants

Annexure J: Summary of stakeholder comments on the second draft of the PMB review consultation document

All submissions were supportive of the PMB review process and grateful for the inclusiveness of the process. The stakeholders are committed and keen to participate in the BD working group and other working groups. The submissions covered comments centred on: context, benefits, primary healthcare, definitions, algorithms, access, affordability, risks / sustainability, positive / negative lists, managed care, and protocols. In addition, concerns regarding non-competitiveness of standardised guidelines, lack of a specific plan for defining the essential package, consensus and clarification of the terms evidence-based medicine (EBM) and cost-effectiveness were prominent in the submissions. Some submissions gave lengthy substantiations of their arguments using reason, clinical data, and reports. The points made by each stakeholder should be considered in the context of the whole submission made, which is available on the CMS website (see Annexure K (page 104) for details).

1. Context

Comment ***(Note that comments on the second draft are presented in red)***	***PMB review steering committee response*** ***(limited to comments on second draft)***
Discovery Health – PMB revisions should recognize that the inclusion of "less insurable individuals" in the insured pool is only one of the pertinent policy objectives of the PMB regulations. They appreciate the clearer context of the second draft, which will strengthen the realisation of access to affordable health care. They however caution that a PMB package should be designed such that it does not encourage anti-selection, option down –grading or scheme-splitting	The cost information and economic impact model currently developed will address these concerns. The risk of scheme splitting and option downgrading will be mitigated through the REF in conjunction with the revised benefit package, proposed efficiency discounts , limited risk rating for supplementary benefits and demarcation for low –income options.
PIASA- suggests that the proposed PMB standardization exercise should take notice of the implications of the limitations of cover. They need clarity on how PMB assessments will be undertaken. They are of the opinion that the exercise should focus on cost reductions of the PMBs. They need clarity on the essential health care and essential services and the principles that would be employed to realise these concepts. They need clarity as to how the principles of EBM will assist in prioritisation and rationing, as well as the actual process to be followed in the revision of the PMBs. They are also questioning the linkages to NHI in the absence of legislation.	The principles are laid out clearer in this document and draft categorical lists are attached.
SASP- Supports the inclusion of physiotherapy as part of the essential health care package. Further, motivates for physiotherapists to be recognised as first line practitioners/ "gate-keepers" as endorsed by HPCSA both in the public and private sectors and particularly in rural areas	Physiotherapists are included as primary care providers – the revised PMB construct makes provision for specific primary care services. BD development will included mare details.

Comment ***(Note that comments on the second draft are presented in red)***	***PMB review steering committee response*** ***(limited to comments on second draft)***
IMSA – the review should consider inconsistencies in current regulations, cost effectiveness, consistency in health policy, and the impact on medical scheme viability and affordability. PMBs should be monitored in the areas of impact, effectiveness, and appropriateness. Current problems with PMBs relate to poor clarity of definitions, which leads to poor interpretation, which in turn leads to poor implementation. Standardization in the current environment would be equivalent to collusion since benefit payouts would be set, but not scheme income or design. Patients have existing rights created by the current PMBs, which must be considered in the review process. The LIMS discussions should be kept separate from the current PMB review. The entry criteria for REF should not become the access criteria for PMBs as this may limit access to care. Clarity of definitions could increase competition and level playing fields. The institution of regular & transparent review mechanism is a requirement. Despite the need to ensure that PMBs are aligned with NHI, the current PMB design should reflect the needs of the current insured population. They accept that the LIMS proposal needs to be considered in the context of NHI but request clarity on the principles that will underpin that process. They are still strongly convinced that standardisation contravenes competition laws; examples given are that the system will reduce patient choice, and potentially limit provider clinical independence. Needs more information on the transitional measures that will be taken to protect patients who currently enjoy PMBs. Request a concrete framework within which EBM will be applied in the PMB review and the next plan of action.	The section on context in this document has been largely reviewed. The committee is of the view that standardisation will lead to improved competition

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
BHF – the definition of the PMB package must take place in the context of the Governments current constitutional mandate to progressively realize the right to access to healthcare for everyone, in the context of the constitutional prohibition on denial of emergency care, and in the context of the right of the child to basic health services. The definition of the package should not cause undue complexity to scheme benefits. The revision must not lead to an increase in non health expenditure, must not create or contribute to balances of power between providers and suppliers, and must not be over prescriptive with regard to treatment modalities or protocols. The review should also take place within the proper regulatory framework, including the constitution, the national health act, the medical schemes amendment bill, the health charter and public private partnerships. A review framework should be established that would allow a review of PMBs every 2 years, mechanisms to be put in to identify problems early, monitor access etc through a Health Impact Assessment mechanism, monitor other key indicators, and ensure that administrators, managed care companies, and service providers are able to manage, collect, and submit necessary data. Low cost events must be included if they are considered to be part of an essential care package that includes PHC. Affordability must be considered in the inclusion of high cost events. They do not support the use of CDL in future, as they believe that all chronic conditions should be part of PMBs, which are equivalent to essential health care, making positive lists unnecessary. Guiding principles for the review should be prioritised as essential care including PHC, SA's burden of disease followed by other 'insurable events' as prioritised by Oregon.	The section on context in this document has been extensively changed to reflect the importance of the protection of risk pools, the importance of recognising the difference between mandating minimum benefits in the public health and insurance environments respectively is documented in this draft.
Momentum – PMBs should be offered with limits. Vague terminology such as EBM and cost benefit should be defined.	The document deals with the preferred PMB benefit construct and has a section on definitions.

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Arthritis Foundation- believes that LIMS should be made self-funding when decisions are made regarding the contents of baskets of care. LIMS should not be subsidised by members of other types of medical insurance packages in the same scheme. They do not believe that the current PMB review should be delayed by a lengthy political process of the proposed health sector reform (NHI).	The third draft of the PMB Review consultation document makes provision for possible future health policy developments. Risk cross-subsidies between existing scheme members and future LIMS members have not yet been considered in depth.
SpesNet- Many medical schemes are very inefficient in implementing or communicating the full extent of the PMBs to their brokers, patients, and health care providers. Schemes exclude conditions and certain procedures, which should part of PMBs, they also have complex managed care, and administrative processes which are barriers to access to care. There should be better systems in place for arbitration of urgent PMB issues by the funding industry, patients, and providers. The PMBs should be reviewed on a regular basis as stipulated in the legislation.	The proposed PMB construct would improve clarity on entitlements and liabilities.
Ben Broens- Agrees with the principles, which will foster should equity and efficiency. Concerns are: the emphasis placed on the catastrophic cover by the current PMBs, supplier induced demand, inadequate public health facilities.	This document deals with this argument.
SAMED- Needs more information on the constituency of the PMB review steering committee and the manner in which interactions with stakeholders are structured. They are suggest that membership of work groups should be open to all. They are concerned that the level of limits set in the current PMBs contravene Competition Laws and propose that advice be solicited from the Competition Commission.	The PMB Review Steering Committee is a management body of the CMS, with members consisting of officials from the DOH and CMS.

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Roche- Welcomes legislative framework for the continuing review of the PMBs and would suggest specified timeframes and frequency.	Noted
PHANGO- Welcomes the broader health sector reforms (NHI) and acknowledge that it may cause elements of BDs and PMBs to change but are of the opinion that the two processes should be separated but run concurrently. Believe that DoH and CMS have failed in their mandate to review PMBs every two years. Would like to see other pieces of legislation, which affect access to health care such as the Medicines and Related Acts, mentioned in the document. Argue that SA lacks data to quantifying the burden of disease and risk and would advise that independent epidemiologic and economic studies be commissioned.	The third draft of the consultation document addresses this concern.
NETCARE- It is their opinion that the NHI and PMB review processes are separate and the PMB review should continue with its legislative mandate.	The third draft of the consultation document addresses this concern.
CANSA- Would like to see the PMB review separated from the broader health care reform (NHI) and the former taking precedence to address their concerns. They support the proposed changes to the legislation to allow for timely and speedy review of the PMBs.	The third draft of the consultation document addresses this concern.

2. Primary healthcare versus catastrophic cover

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
IMSA – supports the move to include primary care, basic dentistry, and basic optometry. They also recommended explicit criteria on aspects that constitute a PHC package as it could potentially increase costs because of quantity involved. EBM and cost factors must be considered in the definition of a PHC package. The document refers to both 'essential and primary' healthcare without making distinctions, they require clarity on what constitutes 'essential healthcare'.	The 3rd draft of the PMB review consultation document addresses these concerns.
SASP-Believes that physiotherapy should be included as an integral part of both in- and out- hospital care. The out-patient preventative and primary basket of care should include the skills and the expertise of physiotherapy. They have started developing guidelines as a matter of priority	Agreed and noted, details to be included in the BDs
SAOSA- Welcomes the move to include basic optometry into PMB package and motivates that it should start at school going age.	The 3rd draft of the PMB review consultation document includes a definition of the proposed optometry benefit.
PHANGO- Patients should be involved in the definition of PHC packages and the parameters for preventative care.	Stakeholders are free to submit proposals to the steering committee.

3. Expansion

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Arthritis Foundation- Believes that there is need to expand PMBs to include neglected conditions to the list such as osteoporosis, clarify confusions regarding RA, and add other related RA conditions.	Noted, but the principles and criteria for the definition of BDs will be upheld for all conditions to be considered.
SpesNet-recognises the challenge in defining the current PMB conditions and ICD-10 codes but believes that some conditions are not fully covered or are incorrectly excluded, they advocate for the review and expansion of PMBs.	
Heart and Stroke Foundation- The preventative basket of care should include risk scoring for women at risk of IHD, regular lipograms for high risk individuals and monitoring tests for side effects arising from medication.	
Medihelp- Are of the opinion that REF should be implemented before the PMB list is expanded.	The document argues that the expansion of PMBs should be aligned with the introduction of REF.
CANSA- BDs should cover both solid and haematological tumours and palliative care as well as oncology emergencies that can be treated by cancer modalities.	Noted, but the principles and criteria for the definition of BDs will be upheld for all conditions to be considered.

4. Definitions

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Discovery Health – the review should provide the highest level of clarity and certainty for application of PMBs. This round should aim for complete clarity on conditions and treatments in the PMB package. Entry and verification criteria, level of care, duration of care, definition of treatment failure, cost-effectiveness, and baskets of care, formularies, and protocols should be defined and published for the industry as a whole. Criteria (inclusion and exclusion) for the selection of specific conditions to the DTPs and CDLs should be clearly defined.	The development of BDs should address this matter.
IMSA – current PMBs should be clarified so that scheme's obligations are clear. A model is proposed in their submission to derive greater clarity.	This draft addresses this matter.
SAMED- Concerned that the definition of benefits will lead to reduction in PMB cover for beneficiaries, increase co-payments, and arbitrations. They acknowledge that the adoption of EBM will mitigate this. The definition of the PMBs should not constitute 'minimum set of care' but rather 'standard care'. They request criteria to be used to establish 'essential care/conditions should be clearly defined. The current PMBs are medicine focused and should be broadened to include all aspects of treatment.	The development of BD's would address this concern.
SAOSA- criteria for defined basic optometry are already in place and will tailor them for the definition group.	The third draft contains the first draft of the optometry package.
CANSA- Medical insurers currently not clear or transparent on the benefits covered in risk pools e.g. 'unlimited funds' for oncology often not the case.	This draft addresses the concerns.

5. Algorithms

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Roche – algorithms for the treatment of cancer need to be updated to reflect advances in technology with improved survival benefits. The definition of treatable cancers should also be reviewed and extended. Algorithms need to be updated more frequently (e.g. Rheumatoid arthritis where several new technologies and drug classes are available, and chronic renal disease). An independent review committee could meet regularly to fulfil this function. Propose that various expert panels such as clinical and surgical professional bodies be consulted in the development of guidelines.	Experts will be involved in the BD development process.
IMSA- Opposes EDL arguing that it is accompanied by algorithms in the state sector to ensure appropriate care rather than limit care; furthermore, principles for the development of the EDL have not been outlined.	The PMB definitions task group must consider this when BDs are developed.
SpesNet- they believe the algorithms are outdated and in many instances, the state does not have protocols. Certain drugs are also excluded for out of hospital treatment, adversely affecting patient control.	
Heart and Stroke Foundation- Current algorithm should be modified for high risk individuals such as patients with DM to allow them access to statins and lifestyle modifications as part of PMBs. Treatment targets for cholesterol are outdated and need to be in line with current trends.	
SAOSA- Optometry algorithms are in place; there are recommended time frames (annually for children and every two years for adults-in the absence of pathology- and criteria for basic appliances.	The PMB definitions task group must consider this when BDs are developed.
PHANGO- Does not agree that the current PMB algorithms meet treatment guidelines for most conditions; some are outdated and often misinterpreted by schemes.	The draft CDL algorithms are included in this draft for comments

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Medihelp- Has previously submitted comments requesting the review of the PMB BD algorithm prompted by the request on circular 45 of 2006. Have experienced difficulty accessing public sector algorithm where no PMB algorithm exists. Will welcome standardised protocols for all DTPs.	The draft CDL algorithms are included in this draft for comments
Sanofi-Aventis- They do not support the use of the EDL because of procurement and supply constraints (which are peculiar to the public sector and not necessarily accessible to the private sector) but support the CMS CDL molecule based formulary.	The draft CDL algorithms are included in this draft for comments

6. Access and affordability

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Discovery Health – PMBs should be affordable to the current scheme population, and assist in cost containment for expansion to low income populations. If benefit options pay the same price for common benefits, then low income options will experience a sharp increase. Affordability is a key consideration, especially for low income options. Council should research and publish the cost impact of proposed expansion. They welcome the proposal that the maximum reimbursement price should NHRPL.	The PMB review steering committee is in discussion with providers.
Momentum – State protocols are not easily accessible or publicised. Should co-payments be considered?	The BD process will identify priority DTP conditions that will receive attention before less critical DTPs
Ben Broens – Impact of introducing PHC should be low as these costs represent only 7% of the total spend. Capping fees for PMBs as well as use of DSPs is welcomed in order to ensure affordability. A 'vertically integrated' and a 'gate-keeper and referral' system should not be viewed as inappropriate for the third-party (medical cover) system	This argument is considered in the proposed PMB construct.
Arthritis Foundation- They do not support capping the fee at NHRPL whilst "forcing" the patient to frequently consult specialists at frequent intervals. The patients are left to co-pay for these visits. In addition, they argue that they have mechanisms to control the costs of new technologies such as a self-regulating revolving committee made up of rheumatologists who examine applications for biologicals.	The benefit structure proposed in this draft makes provision for above-threshold benefits.
SpesNet- Supports the payment of reasonable rates –rates which the specific health care provider would have charged irrespective of PMB condition and not necessarily the NHRPL rate.	The PMB review steering committee is engaging with providers and requests proposals to deal with the pricing of consultation services.

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
SAMED- Proposes that the utilisation of cost-effectiveness and affordability criteria must be clearly defined in the PMB and that cost-effectiveness evaluations be done by independent agencies.	With the assistance of RETAP, the REF working group will deal with this issue.
SAOSA- Support the use of NHRPL rates to ensure affordability	The PMB review steering committee is engaging with providers and requests proposals to deal with the pricing of consultation services.
PHANGO- Does not endorse limiting fees to NHRPL rates, as patients will be subject to balance-billing but support capping of fees. They hope that a reasonable fee can be negotiated. They would like to see the definition of cost-effectiveness negotiated and agreed upon.	
NETCARE- Wants to clarify that they do not view PMBs as blank cheques and have instituted cost saving measures in the past such as discounting PMB related expenses. They have also been active participants in the determination of current NHRPL rates, a process that has delayed due to disagreements with methodology. A study commissioned by them has shown they would lose 15 cents for every value of Rand billed.	
Medihelp- Welcomes statutory initiatives to determine tariffs at which PMBs should be reimbursed.	
Sanofi-Aventis - Have provided a model of health technology assessment (HTA) which can be used for prioritising and assessing health interventions and technologies for inclusion in the PMB package.	The PMB review steering committee will consider this.

7. Risks / sustainability

Comment ***(Note that comments on the second draft are presented in red)***	***PMB review steering committee response (limited to comments on second draft)***
Discovery Health – expansion of services for the sick is difficult since services will be provided to the healthy and the sick. Over servicing of PMBs depends on tariff prices (high price – incentive to over service), setting, and subjectivity of diagnosis. Cost of PMBs dependent on tariffs for providers – currently without upper limits. Conversely, setting prices too low will put additional pressure on supply and will incentivise abusive coding behaviour. A key concern still remains cost-effectiveness and sustainability; willing to provide CMS with data that may be required in this regard.	Careful attention to the development of the BDs could address this concern Costs and pricing are discussed in the document.
Momentum- Pricing mechanism should consider the tariff codes to be applied, the level of remuneration, define maximum tariffs, and establish whether prices would be regulated by MSA or by the NH Amendment Bill.	The PMB review steering committee is engaging with providers and requests proposals to deal with the pricing of consultation services.
SA Society of Head &Neck Surgery- Believes NHRPL rates should only be used if costed properly (which they are currently not in his opinion); believes that discounting NHRPL will lead to reimbursement rates below those of the public sector (provincial)	
NETCARE- Does not support capping prices at NHRPL rates are still actively engaging the NDoH in reviewing the 2009 price list.	

8. Positive / negative lists

Comment ***(Note that comments on the second draft are presented in red)***	***PMB review steering committee response (limited to comments on second draft)***
Discovery Health – disagrees with using all hospital admissions excluding a negative list. Rather ensure clarity of information of members. Recognizes issue of members not knowing condition until diagnosed, however risks of the alternative are greater. Recommends positive condition list, since managed care protocols can only be applied to a condition list. Strongly recommend that PMBs be based on positive condition / treatment list(s). Supplier induced demand is strengthened if benefits are defined by setting and will discourage the development of alternate, more cost-effective settings. Discovery is of the opinion that it is not appropriate to include CDL list in in-hospital (IH) positive list, as this would increase admission unnecessarily. Hospitalisation should only be limited to treatment that cannot be administered elsewhere or to life-threatening conditions.	THE requirements for the BDs deal with mechanisms to promote the use of appropriate levels and setting of care. The first draft of the negative list is included in this draft, suggestions on how to improve the list to specifically prevent unnecessary hospitalisation is requested.
Momentum – Caution to be exercised about including ALL in-hospital cases as this would increase the cost of PMBs. Specific definition of the conditions and services to be included essential. Affordability of the main package should be the focus.	The first draft of the negative list is included in this draft.
Arthritis Foundation- They are concerned that the positive and negative lists might leave patients without access to certain treatment needs.	Without these measures, the PMBs would simply be too costly and unaffordable. The benefit design and above threshold benefits does address some of these concerns.
Heart and Stroke Foundation- they do not endorse the use of these lists as patients might be denied access to medication because it falls under a negative list	
SAMED- Does not support the use of 'lists' related to treatment or procedures but for the conditions included in PMBs.	
PHANGO- Agree with principle of positive and negative lists for controlling in and out-of hospital expenditure but are concerned that the design of the lists will not be weighted in the interests of patients- want a degree of flexibility.	

Comment (Note that comments on the second draft are presented in red)	*PMB review steering committee response (limited to comments on second draft)*
IMSA-Does not support the use of lists as these have proven to be rigid, may potentially result in the exclusion of vulnerable groups (severely diseased), hospital lists might be used by schemes to deny patients care (co—morbidities in hospital denied because they do not fall in the positive list).	

9. Managed care and protocols

Comment ***(Note that comments on the second draft are presented in red)***	***PMB review steering committee response (limited to comments on second draft)***
IMSA – PMBs should be provided for in full without co-payments. This application should remain in the revised PMBs. DSP contracting should be done within a proper framework that enables mutually beneficial contracting between providers and schemes. Managed care and savings tools should be defined more clearly. Price capping for PMBs should not be considered before quality monitoring measures are in place. Argues that healthcare professionals should be allowed to provide benefits in excess of the standard package. Payment in full must be maintained and not watered down. Fear that medical schemes will still impose limits through managed care in the already limited PMB package. With the implantation of REF, managed care should be evaluated so that it is cost-effective and affordable. Protocols and processes of managed care (often viewed as intellectual property of the MCO) should also be transparent and open to public scrutiny.	The committee is of the view that managed care tools should be applied to PMBs and that a standardised package must be developed.
Momentum –PMBs should be limited to a maximum rate of NHRPL. PMBs should include guidelines for developing 'SEPs' for non medication benefits. A 'case rate' should be considered for standard procedures to prevent padding of the accounts. MCC should be requested to register a medication for a specific condition.	This document suggests a framework to deal with costs and pricing, "alternative reimbursement" strategies are supported and may in future support the development of BDs.
PIASA-They are concerned that "cost-effectiveness" in the criteria for managed care regulations does not appear in the over-arching principles set out in part 4.1 but is mentioned for condition–specific PMBs and other health technologies. They suggest that the related terms of 'affordability and pricing' used throughout then report should be defined and not be restricted only to medicine but to other health interventions. They are also questioning whether cost-effectiveness analysis will be determined by schemes or by the Council	Noted, the definition of essential health care refers to cost-effectiveness.

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
SASP- the guidelines for the management of stroke and COPD are the final phase of development. They will await guidance from the CMS on how their input will be incorporated in the next phase of the PMB review.	The CMS will include the SASP on the relevant PMB working groups.
SpesNet- Instead of promoting pharmaceutical formularies for PMB conditions, they suggest costing or attaching a monetary value to each condition and leaving the patient and service provider to discuss best treatment options before deciding on the financial considerations and co-pays. Schemes appoint DSPs (especially state institutions) without ensuring access and availability for the patients and penalise them for non-compliance. SpesNet is of the opinion that schemes should detail the capacity of the DSP in the SLA.	The proposed PMB benefit construct is incorporated into this draft of the document.
SAMED- Are concerned that schemes and MCO will impose further limits to the PMBs through their contracted agents and suggests that they should not be allowed to override standards set by CMS.	The CMS will monitor compliance with regulations.
Sanofi-Aventis - Are critical of the current regulations that give medical schemes and their contracted agents (managed care organisations) the responsibility to develop criteria used to assess cost-effectiveness	Noted.
CANSA- Current PMB does not address scientifically best practise modules for the treatment of cancer- therefore urge for the development of EDL for cancer care to include drugs such as rituximab, imatinib, and capecitabine, which have been proven to be cost-effective	The teams working on the development of BDs will consider these statements.

10. Benefits

Comment (Note that comments on the second draft are presented in red)	***PMB review steering committee response (limited to comments on second draft)***
Roche – conditions covered as PMBs should not be restricted only to high profile infectious diseases but should also include asymptomatic diseases (e.g. Hepatitis C). Similarly, patients with conditions representing a low burden disease should not be penalised with co-payments.	This document specifies the objectives of the PMBs.
PIASA- The vagueness of 'medical and surgical management' of DTPs lends itself to uncertainty as what is covered under PMBs for beneficiaries. PIASA further argues that the lack of clarity, information, and transparency of medicals scheme rules exacerbate confusion. They do not believe that standardisation of current PMBs will resolve the issue but rather EBM, risk–sharing between providers and schemes as well as outcomes-based systems will provide better outcomes.	The development of BDs should address this concern.
CANSA- Schemes should clearly define benefit structure and desist from using 'unlimited' oncology benefits, which are often misleading.	The development of BDs should address this concern.

Annexure K: List of stakeholders who have submitted comments on the second draft of the PMB review consultation document

Organisation	*Comments available at:*
Arthritis Foundation	http://www.medicalschemes.com/publications/ZipPublications/PMB%20Review/Athritis%20Foundation%20comment.pdf
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