

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

Version 1

Council for Medical Schemes

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

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1. Introduction

- 1.1 The Risk Equalisation Fund in South Africa revolves on the accurate identification of beneficiaries with risk factors within medical schemes and aims to equalise the risk between medical schemes based on their risk profiles.
- 1.2 Risk factors currently included in the REF formula are the number of beneficiaries suffering from CDL conditions, HIV / AIDS, have had maternity events, with multiple CDL conditions and the age characteristics of schemes.
- 1.3 The purpose of this guideline is to provide criteria that must be met by CDL cases before they could be included as beneficiaries, with any of the defined risk factors, in the Risk Equalisation Fund (REF).
- 1.4 These guidelines are the result of work done by the Risk Equalisation Technical Advisory Panel (RETAP), who published the document “**Definitions of Entry Criteria for Determining the REF Grids, RETAP Recommendations Report No. 2 of 2005**” during February 2005. This document was expanded to include verification criteria and the requirements of data that must be kept by schemes, which was published as a discussion document “**Definitions of Entry and Verification Criteria for Determining the REF Grids**” during September 2005 for public comment. Both documents are available at www.medicalschemes.com. Subsequent comments from the industry were incorporated into these guidelines, which represent the official view of the Council for Medical Schemes (CMS).
- 1.5 The guidelines serve to ensure that the Risk Equalisation Formula is based on comparable data received from different medical schemes. Using these criteria, cases deemed to be eligible as beneficiaries of the Risk Equalisation Fund can now be identified on a uniform basis throughout the industry.
- 1.6 Even though harmonisation of these guidelines with the Prescribed Minimum Benefits (PMB) regulations is important and has been attempted, this was not always possible.
- 1.7 The PMB Regulations aim to ensure that beneficiaries have access to certain benefits. The REF Entry and Verification Criteria has been developed to ensure that all beneficiaries receiving benefits are identified in a uniform manner. Therefore, there might be instances where patients meet all the requirements to be treated as a PMB case but they do not qualify for inclusion in the REF. Similarly, certain drugs that are not included in the PMB algorithms might be included as proof of treatment to categorise a case as a REF beneficiary. This must not be interpreted that the CMS is endorsing these drugs or that these drugs must now be made available to beneficiaries under the PMB regulations.

- 1.8 These criteria have been developed with the emphasis on the verifiability of cases and will be used by CMS and other auditors to ensure that gaming is identified and addressed.
- 1.9 This first set of guidelines provides concrete clinical codes that serve to identify patients that were treated for CDL conditions.
- 1.10 Initially these guidelines will be reviewed as the need arises, once stabilised, an annual revision will probably suffice.

2. Implementation Date

Existing CDL Cases

- 2.1 Schemes are requested to apply these criteria as soon as possible, but no later than 1 January 2006.
- 2.2 The criteria are based on “diagnosis-related” information as well as on “proof of treatment information”. In many instances the diagnosis-related information may not be available for cases that are already on treatment, and it might constitute a medical risk to confirm the diagnosis in accordance with the criteria. Therefore the diagnoses assigned to cases that have been started on treatment before 1 January 2006 is acceptable to REF. Some of these diagnoses might be reviewed in a systematic manner at a future date.

New CDL Cases

- 2.3 All new cases that commence treatment after 1 January 2006 must meet the criteria stipulated in this document.

CDL Cases transferred between Medical Schemes

- 2.4 Cases that are on treatment for one of the PMB CDLs when they transfer from one scheme to another must not be compromised and must therefore continue to receive treatment. Similar to the situation in paragraph 2.2, REF therefore has to rely on the “proof of treatment” information rather than on the “diagnosis related information”.

All CDL Cases

- 2.5 All CDL cases, whether existing, newly diagnosed or transferred cases, must meet the “proof-of treatment” component stipulated in the guidelines from 1 January 2006.

3. Preparation of REF Grids

General

- 3.1 The REF Grids are submitted separately for each option in the scheme with separate sections for male and female beneficiaries.
- 3.2 A beneficiary is counted for the REF Grid if a full monthly contribution is received for that person in respect of that month.

Age Bands

- 3.3 The age band is determined by taking age last birthday on 1 January. The beneficiary is then placed in the appropriate age band: Under 1, 1-4, 5-9, 10-14... 75-79, 80-84, or 85+. Note that the same age bands are applicable for the statutory returns.
- 3.4 The new-born child is to be incorporated into the age structure by taking the age of the beneficiary as on 01 January of the year of evaluation. The naming of the category as "Under 1" allows for that calculation to produce either a zero or a negative result.

Only Claims paid from a Risk Benefit could result in a case eligible for REF benefits

- 3.5 All beneficiaries that are reported on in the REF grids must receive their benefits from a risk pool to qualify for eligibility.

CDL Cases

- 3.6 Columns 2 to 28 of the REF Grid Count and REF Grid Prevalence are populated *based on the clinical entry and verification criteria for each chronic disease, as specified in this document.*
- 3.7 For the REF Grid Count each beneficiary must be placed in only one cell in Columns 1 to 28. For a person with two or more CDL conditions (or HIV and one or more CDL conditions), the scheme may choose the highest cost cell of the combination. A beneficiary with multiple diseases will only be counted once in columns 1 to 28. Thus the total of beneficiaries for columns 1 to 28 must equal the beneficiaries in the option for the period.
- 3.8 Note that with the combination of Chronic Heart Failure and Cardiomyopathy into one condition that, from 1 January 2006 (See section 2 on the implementation date), the CHF column must be left blank. All Chronic Heart Failure and Cardiomyopathy cases must be

entered in the CMY column. The contribution table will be adjusted to reflect the new rates.

Multiple Chronic Conditions

- 3.9 Where a beneficiary suffers from more than one chronic condition, such beneficiary should be entered into columns 2 to 28 as a first entry. The disease in the group of diseases of the beneficiary that reflects as the most expensive in the REF grid dictates the position in the grid for columns 2 to 28. Once the most expensive disease has been allocated the multiple disease beneficiary needs to be allocated to modifier for the number of chronic diseases. A beneficiary with multiple chronic diseases will reflect twice in the REF Grid Count once for the most expensive disease and once for the number of multiple diseases.

Exclusion of Specific Diseases as Multiple Chronic conditions

- 3.9.1 Note that, for REF Grid Count purposes, certain CDL diseases will not be considered if they do co-occur in the same patient. *(However, if these conditions do co-occur, it must be reflected in the REF Grid Prevalence tables – see paragraph 3.14).* Cases encountered with more than one of the conditions listed below are not eligible to be counted as multiple diseases. The conditions are arranged in descending cost order. Schemes must assign the most expensive condition to these cases, these co-occurring conditions must not be counted as multiples in the disease count grids:

3.9.1.1 Only one of the following chronic respiratory diseases can be assigned to the same patient: *Chronic Obstructive Pulmonary Disease, Asthma and Bronchiectasis*

3.9.1.2 Only one of the following cardiovascular diseases can be assigned to the same patient: *Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension*

3.9.1.3 Only one of the following Gastro Intestinal conditions can be assigned to the same patient: *Crohn's disease or Ulcerative Colitis*

3.9.1.4 Note that, in accordance with the Diabetes Mellitus table in section 6, Diabetes Mellitus Type 1 and Type 2 cannot co-occur.

Maternity

- 3.10 The maternity modifier relates to "all the codes that indicate the delivery of a single/multiple foetus either stillborn or alive; following a pregnancy of at least 24 weeks

duration”. Codes that apply to the delivery modifier are as follows:

ICD-10: Pre-term labour O60

All other Vaginal and c/s: O80, O81, O82, O83 and O84

NHRPL: 2614, 2615 and 2616

- 3.11 The beneficiary qualifying for the maternity modifier is only entered ONCE — in the month where the event happened. The amount payable from the REF is an annual amount and not a monthly amount as with the other modifiers.

Beneficiaries without Chronic Diseases

- 3.12 To complete the “Non” column: After completing columns 2 to 28 of the REF Grid Count, beneficiaries that have not been allocated to these columns need to be counted and reflected in column 1. This completion of columns 1 to 28 will reflect each beneficiary of an option in only one cell of the grid.

Grid Prevalence Tables

- 3.13 In the REF Grid Prevalence, the beneficiary is reflected for each one of the multiple diseases.
- 3.14 The **REF** Grid Prevalence contains the total number of beneficiary months in the cell for the period. Each beneficiary must be placed in as many cells in Columns 1 to 28 as they have chronic conditions (CDL conditions or HIV). For a person with three CDL conditions the scheme will place the beneficiary in the three relevant columns. Thus the total of beneficiaries for columns 1 to 28 will be more than the beneficiaries in the option for the period.
- 3.15 Note that each of the respiratory conditions listed in paragraph 3.9.1.1 must be reported on in the REF Prevalence Grid.
- 3.16 The same number of beneficiaries in column 1 of the REF Grid Count should be reflected in column 1 of the REF Grid Prevalence.

Availability of Information from Capitated Providers

- 3.17 Schemes have indicated that they frequently have difficulties to obtain the information required to complete the grids from Managed Care Organisations and from Capitated Providers. It is important to note that:
- 3.17.1 In terms of Regulation 15B (2) (d) it is required that an accredited managed health care organisation has the necessary resources, systems, skills and capacity to

render the managed health care services which it wishes to provide. Further, should a managed care organisation comply with Regulations 15D (a) and (c), such an organisation would be capable of providing the medical scheme with the data required for the REF return.

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

3.18 Schemes must ensure that their contracts with preferred providers makes provision for the availability of the information that is required to prepare the REF grids.

4. Submission of REF Grid Count and REF Grid Prevalence data to the Council for Medical Schemes.

- 4.1 The Statutory Returns Portal on the CMS website accommodates the manual entry of the REF grids. (www.medicalschemes.com)
- 4.2 Manual data entry is very time-consuming and leads to many errors during the capturing process.
- 4.3 Schemes are urged to make use of the e-mail facility that has been created to speed up the submission process.

4.3.1 Excel templates will be e-mailed to scheme administrators, who must distribute these to the relevant people that will do the REF submissions. ***Please do not change the file name.***

4.3.2 The layout of these templates is in accordance with the current REF grids – note that separate count and prevalence files need to be completed for each option and period respectively.

4.3.3 After the completion of these grids, they must be saved as *.CSV files.

(Click on Files, select “Save As”, in the “Save as type” dialogue box, select “CSV (Comma delimited)”. ***Do not change the filename.***

4.3.4 E-mail the completed files to refsubmissions@medicalschemes.com

4.3.5 Allow one day for processing and then log on to the statutory returns portal at www.medicalschemes.com

4.3.6 A dialog box will appear that indicates which submissions have been received.

(Depending on the number of submissions received, it might take more than one day after e-mailing the CSV file before it will appear on the list. Should the scheme name not appear within 24 hours after the files have been e-mailed, please send an e-mail to refqueries@medicalschemes.com)

4.3.7 Click on “Submit”. The system will validate results and will send an e-mail with the errors to the person that has done the submission.

4.3.8 After corrections have been made, the corrected file must be e-mailed to the same address.

4.3.9 Once all the validation criteria have been met, a final copy for signature will be e-mailed to the person doing the submissions.

5. Specific Rules Applicable to the Identification of CDL cases Based on REF Entry and Verification Criteria

Purpose of Boolean tables in Section 6

- 5.1 Each of the tables in Section 6 consists of a section on diagnosis related information and a section on proof of treatment. To qualify for inclusion as a REF beneficiary, a case must meet both the diagnosis related criteria as well as the proof of treatment criteria.
- 5.2 Note that existing patients on active treatment should not be compromised through the withholding of treatment to prove that patients meet the diagnosis related requirements. (See section 2).

5.2.1 Diagnosis Related information:

- 5.2.1.1 The provider codes of providers (PCNS or HPCSA codes – see section 5.6) who have diagnosed in accordance with the REF Entry Criteria (See **“Definitions of Entry Criteria for Determining the REF Grids, RETAP Recommendations Report No. 2 of 2005”**, available at www.medicalschemes.com).
- 5.2.1.2 Where the diagnosis should be from a provider from a specified group, and such a provider has not submitted a claim with the given diagnosis, the treating provider should submit in writing the name of the diagnosing specialist.
- 5.2.1.3 The results of diagnostic tests specified in the REF Verification Criteria. Where applicable, proof of original laboratory or other test results must be kept. This may be in an electronic format, provided that the information is available to CMS and other auditors. (See section 5.4).
- 5.2.1.4 Hospitalisation or other treatment records providing proof of a specific clinical event specified in the REF Verification Criteria (See Coronary Artery Disease, on page 23)

5.2.2 Proof of treatment information is based on claims data.

- 5.2.2.1 Procedure codes as evidence for the performance of specified procedures in the REF Verification Criteria
- 5.2.2.2 ATC codes are used in the definitions of the REF Entry and Verification Criteria to describe specific drugs. (See paragraphs 5.12 and 5.13).

- 5.2.2.3 Hospitalisation records may be used as proof of treatment in instances where a case has recently been put on treatment has not yet received treatment for 60 days in the preceding three calendar months.
- 5.2.2.4 Note that proof of treatment must result only from benefits paid from a risk pool. (See paragraph 3.5)
- 5.2.2.5 Evidence is required that a patient has received treatment for a 60 day period in the preceding three calendar months. In instances where a beneficiary requires treatment less frequently, the beneficiary does not qualify as a REF beneficiary. The exception is that a case with Bronchiectasis must have received a course of antibiotics in the preceding two calendar months (See Table 3 on page 17).
- 5.3 The tables in Section 6 have been written to assist in the development of Boolean statements that will be used by schemes to correctly identify CDL cases. These queries must be made available to the CMS and Auditors on request. The tables describe the logic that must be applied to:
- 5.3.1 Test whether a case meets the criteria for inclusion as a CDL beneficiary in the REF, and;
- 5.3.2 Categorise Diabetes Mellitus cases as either Type 1 or Type 2 diabetes.

Results of Special Investigations

- 5.4 For Chronic Obstructive Lung Disease, Chronic Renal Disease and Hyperlipidaemia, it is required that the results of special investigations are kept by schemes. For HIV / AIDS documented proof is required that a patient qualifies for ART in accordance with the National Antiretroviral Treatment Guidelines. This information must also be made available to auditors on request but may be in the form of voice recordings or other electronic records.

Specialist Diagnosis required for Certain CDL Conditions

- 5.5 Note that the tables in section 6 specify specific specialists that are required for the diagnosis of the following conditions: Addison's disease, Crohn's disease, Diabetes Insipidus, Genetic Hyperlipidaemia (in the absence of Total Cholesterol values supporting the diagnosis), Multiple Sclerosis, Rheumatoid Arthritis (if the patient is not taking disease modifying drugs) Schizophrenia, Systemic Lupus Erythematosus and Ulcerative Colitis.

- 5.6 Note that the “provider codes” required in section 6 refer to the Practise Code Numbering System (PCNS) codes. Health Professions Council for South Africa (HPCSA) numbers should only be used if the provider does not have a PCNS code.

Verifiability and Auditing of Categorisation

- 5.7 Medical schemes or their contractors must store the information that is required to apply the logic set out in the tables for a period of at least three years.
- 5.8 This information must be auditable and must be provided to the Council for Medical Schemes and Auditors at request, which might also do on-site audits.

Ambiguous ICD10 Codes to Identify CDL Cases

- 5.9 Some of the ICD10 codes specified in the PMB algorithms have been presented in a different context in section 6 to ensure that a case can not be assigned to more than one CDL condition in each specific instance:

5.9.1 I25.5: Ischaemic Cardiomyopathy

For REF purposes, this code is applicable only to Coronary Artery Disease and is not relevant in Cardiac Failure and Cardiomyopathy in the REF Grid Count.

Note that for the REF Grid prevalence, these cases should be counted as only Coronary Artery Disease.

5.9.2 *I13.0: Hypertensive heart and renal disease with (congestive) heart failure*

And / or

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

If the “proof of treatment” criteria are met, this condition would be categorised to Cardiac Failure and Cardiomyopathy, if the results of special investigations are also met, this must be classified as Chronic Renal Failure in the REF Grid Count (See page 21 for the Chronic Renal Failure criteria and page 31 for the Hypertension Criteria).

For the REF Grid prevalence, these cases should be counted as only Chronic Renal Disease and Hypertension

or as

Cardiac Failure and Cardiomyopathy *or* Hypertension (If the Chronic Renal Disease proof of treatment criteria are not met).

5.9.3 *I11.0: Hypertensive heart disease with (congestive) heart failure*

If the “proof of treatment” criteria are met, this condition would be categorised to Cardiac Failure and Cardiomyopathy in the REF Grid Count (See page 20 for the Cardiac Failure and Cardiomyopathy criteria and page 31 for the Hypertension Criteria)

For the REF Grid Prevalence, these cases should be counted as Cardiac Failure and Cardiomyopathy *and* Hypertension.

Use of Three-digit ICD10 codes

- 5.10 As an interim measure, the Entry and Verification criteria makes use of three digit ICD10 codes in spite of the fact that more specific five-digit codes could be used. This is an interim measure to make provision for the gradual improvement in the quality of ICD10 codes that are submitted by providers to schemes and will be reviewed in future.

Use of ATC and NAPPI codes

- 5.11 Schemes, administrators, providers and clearing houses make use of NAPPI codes to identify and bill for pharmaceuticals.

5.12 The REF Entry and Verification Criteria are therefore based on ATC codes, which change less frequently and are widely used. Crosswalks between NAPII and ATC codes are available from clearing houses and major administrators. Please note the following with regard to ATC codes:

5.12.1 The classification of a substance in the ATC system is not a recommendation for use, nor does it imply any judgements about efficacy or relative efficacy of drugs or group of drugs. The ATC system is not applicable for making diagnosis.

5.12.2 ATC codes may change over the years. An updated version of the ATC Index is issued annually.

5.12.3 The ATC Index is published by the WHO Collaborating Centre for Drug Statistics Methodology and is available at www.whocc.no

Use of specific drugs to identify CDL cases

5.13 Note that the drugs represented by ATC codes in Section 6 do not imply that the CMS recommends that these drugs are used. Neither is it implied that these drugs are required by the regulations on Prescribed Minimum benefits or the Treatment Algorithms published by the CMS. In all instances, the inclusion of a case is based on the information required in the table on “diagnosis –related information” as well as the information related to “proof of treatment”. (See paragraph 5.1)

6. Entry and Verification Criteria for CDL Conditions

Note that each of the conditions specified in Table 1 to Table 24 are subject to the overriding rules on the exclusion of specific multiple diseases specified in section 3.9.1 as well as the rules on ambiguous ICD 10 codes in section 5.9.

Table 1: Addison's disease

Addison's Disease				
Diagnosis-related information				Proof of Treatment
Provider code of the diagnosing provider:	AND	ICD10 Codes		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:
Must be a specialist physician, paediatrician or endocrinologist 11800 13200 11801		E27.1	AND	H02AB H02AA02

Table 2: Asthma

Asthma				
<i>Diagnosis-related information</i>			<i>Proof of Treatment</i>	
Provider code of the diagnosing provider:	AND	ICD10 Codes (Any of the following)	Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Any registered medical practitioner		J45 J45.0 J45.1 J45.8 J45.9 J46	H02AB R03AC R03AK R03BA	R03BB01 R03CC R03DA04 R03DC
			OR	
			Evidence of short-term use of glucocorticosteroid therapy (systemic) in the preceding three calendar months. This includes products in the following ATC category:	
			H02AB	
			OR	
			Evidence of an asthma-related hospital admission during the preceding three months	

Table 3: Bronchiectasis

Bronchiectasis					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Any registered medical practitioner		J47 Q33.4		<div>H02AB R03AC R03AK R03BA</div> <div>R03BB01 R03CC R03DA04</div>	
				OR	
				Evidence of a course of drugs used in the preceding two calendar months. This includes products in the following ATC categories:	
				J01	
				OR	
				Evidence of a hospital admission during the preceding three calendar months relating to treatment of haemoptysis or a chest infection in a patient with underlying bronchiectasis	

Table 4: Cardiac Failure and Cardiomyopathy

Cardiac Failure and Cardiomyopathy					
<i>Diagnosis-related information</i>				<i>Proof of Treatment</i>	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:
Any registered medical practitioner		I27.9	I42.1		C01AA05 C03
		I50	I42.2		C01DA C07
		I50.0	I42.3		C02DB C09
		I50.1	I42.4		OR
		I50.9	I42.5		
		I11.0	I42.6		
		I13.0	I42.7		
		I13.2	I42.8		
		I42	I42.9		
		I42.0			
					Evidence of a hospital admission during the preceding three calendar months relating to treatment of cardiac failure / cardiomyopathy

Table 5: Chronic Renal Disease

Chronic Renal Disease						
Diagnosis-related information					AND	Proof of Treatment
Provider code of the diagnosing provider	AND	Result of Special investigations	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:
				N03		A02AC01
				N03.0		A12AA04
				N03.1		A11CC
				N03.2		B03A
				N03.3		B03BB
				N03.4		B03XA01
				N03.5		V03AE
				N03.6		OR Evidence of hospital admission relating to chronic renal failure in the preceding three calendar months or procedure codes for peritoneal or haemodialysis for at least 8 sessions in the preceding three months
				N03.7		
Any registered medical practitioner	AND	Creatinine clearance value of ≤ 30 ml / min	AND	N03.8		
				N03.9		
				N04		
				N04.0		
				N04.1		
				N04.2		
				N04.3		
				N04.4		
				N04.5		
				N04.6		
				N04.7		
				N04.8		
				N04.9		
				N05		

Table 6: Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease						
<i>Note that, for REF purposes, neither asthma, nor bronchiectasis can occur with COPD</i>						
Diagnosis-related information					Proof of Treatment	
Provider code of the diagnosing provider	AND	Result of Special investigations	AND	ICD10 Codes (Any of the following)	Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
				J43 J43.0 J43.1 J43.2 J43.8 J43.9 J44 J44.0 J44.1 J44.8 J44.9	H02AB R03AC R03AK R03BA	R03BB R03CC R03DA04
Any registered medical practitioner	AND	Lung function tests demonstrating FEV1/FVC values below 60% and FEV1 post-bronchodilator values of less than 60% of predicted	AND		OR	
					Evidence of a hospital admission during the preceding three calendar months relating to acute exacerbation of COPD or complication of COPD (e.g. pneumothorax)	
					OR	
					Evidence of short-term use of glucocorticosteroid therapy (systemic) in the preceding three calendar months. This includes products in the following ATC category:	
					H02AB	

Table 7: Coronary Artery Disease

Coronary Artery Disease									
Diagnosis-related information						AND	Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of an in- or outpatient event leading up to the diagnosis of Coronary Artery disease with one of the following ICD10 codes		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:		
Any registered medical practitioner							C01DA	C08	
							C07	C09	
							OR		
		Evidence of a hospital admission during the preceding three calendar months relating to treatment of unstable angina or myocardial infarction							
		I20	I25.2		I20	I21.3			
		I20.0	I25.3		I20.0	I21.4			
		I20.1	I25.4		I20.1	I21.9			
		I20.8	I25.5		I20.8	I22			
		I20.9	I25.6		I20.9	I22.0			
		I25	I25.8		I21	I22.1			
		I25.0	I25.9		I21.0	I22.8			
		I25.1			I21.1	I22.9			
					I21.2				

Table 8: Crohn's Disease

Crohn's Disease					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Must be a specialist physician, paediatrician, surgeon or gastroenterologist		K50 K50.0 K50.1 K50.8 K50.9		A07E H02AB J01XD01 J01MA L04AA01 L04AA05	L04AA11 L04AA12 L04AX01 L04AX03 L01BA01 P01AB01
11800 13200 14200 11900				OR	
				Evidence of a hospital admission during the preceding three calendar months relating to treatment of Crohn's disease	

Table 9: Diabetes Insipidus

Diabetes Insipidus					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Must be a specialist physician, paediatrician, neurosurgeon, neurologist or endocrinologist		E23.2		H01BA	
11800 13200 12400 12000 11801				OR	
				Evidence of a hospital admission during the preceding three calendar months relating to treatment of Diabetes Insipidus	

Table 10: Diabetes Mellitus (Type 1 and 2)

Diabetes Mellitus (Type 1 and 2)							
<p><i>Note:</i></p> <ul style="list-style-type: none">• For REF purposes, Type 1 and Type 2 diabetes cannot occur concurrently.• Evidence of use of oral euglycaemic drugs automatically leads to the classification of a diabetic case as Type 2.• Where there is <u>only insulin use (ATC A10A)</u>, the doctor's diagnosis (based on the ICD10 codes below) of Type 1 versus Type 2 must be accepted.							
Diagnosis-related information						Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND IF		Evidence of use of oral hypoglycaemic or euglycaemic agents. This includes any product in the A10B ATC category:	Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:
Any registered medical practitioner		E10	E11.9		OR	Any ICD10 code indicative of Non-Insulin Dependent Diabetes:	A10
		E10.0	E12				
		E10.1	E12.0				
		E10.2	E12.1				
		E10.3	E12.2				
		E10.4	E12.3				
		E10.5	E12.4				
		E10.6	E12.5				
		E10.7	E12.6				
		E10.8	E12.7				
		E10.9	E12.8				
		E11	E12.9				
		E11.0	O24				
		E11.1	O24.0				
		E11.2	O24.1				
		E11.3	O24.2				
		E11.4	O24.3				
		E11.5	O24.4				
		E11.6	O24.9				
		E11.7					
		E11.8					
		E11	E11.5	AND	OR		
		E11.0	E11.6				
		E11.1	E11.7				
		E11.2	E11.8				
		E11.3	E11.9				
		E11.4	O24.1				
		THEN					
		Classify as Type 2 diabetes					
		ELSE					
		Classify as Type 1 Diabetes					

Table 11: Dysrhythmias

Dysrhythmias					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Any registered medical practitioner		I47.2 I48		B01AA03	C01A C01B C07 C08D
				OR	
				Evidence of a hospital admission during the preceding three calendar months relating to control of dysrhythmias (cardioversion, radio-frequency ablation or pacemaker insertion))	
				OR	
				Evidence of a hospital admission during the preceding three calendar months relating to an embolic complication of dysrhythmias (e.g. cerebrovascular event):	

Table 12: Epilepsy

Epilepsy						
Diagnosis-related information			AND	Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:		
Any registered medical practitioner		G40		G40.8	N03	
		G40.0		G40.9	OR	
		G40.1		G41	Evidence of a hospital admission during the preceding three calendar months relating to control of seizures due to Epilepsy	
		G40.2	G41.0			
	G40.3	G41.1				
		G40.4	G41.2			
		G40.5	G41.8			
		G40.6	G41.9			
		G40.7				

Table 13: Glaucoma

Glaucoma						
Diagnosis-related information			AND	Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:		
Any registered medical practitioner		H40		H40.5	S01E	
		H40.0		H40.6	OR	
		H40.1		H40.8	Evidence of a hospital admission during the preceding three calendar months relating to glaucoma surgery	
		H40.2		H40.9		
		H40.3	Q15.0			
	H40.4					

Table 14: Haemophilia

Haemophilia					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Any registered medical practitioner		D66 D67		<table><tr><td>B02AA02 B02BD02 B02BD03</td><td>B02BD04 H01BA</td></tr></table>	B02AA02 B02BD02 B02BD03
B02AA02 B02BD02 B02BD03	B02BD04 H01BA				
			OR		
			Evidence of a hospital admission during the preceding three calendar months relating to haemophilia-associated haemorrhage		

Table 15: Hyperlipidaemia

Hyperlipidaemia									
<p><i>Note:</i></p> <ul style="list-style-type: none">Information supporting the diagnosis must be kept in a format that could be audited. This includes paper copies or the electronic storage of voice recordings that could substantiate the diagnosis, the results of special investigations and the data underlying the risk assessment (Framingham score).Only a diagnosis by an endocrinologist will be accepted to diagnose genetic hyperlipidaemias without supporting high Total Cholesterol values									
Diagnosis-related information							AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	Doctor diagnosis of symptomatic atherosclerotic disease Including any of the following ICD10 codes				ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
		G45	I21.9	I25.8	I66.1				
		G45.0	I22	I25.9	I66.2				
		G45.1	I22.0	I63.0	I66.3				
		G45.2	I22.1	I63.1	I66.4				
		G45.3	I22.8	I63.2	I66.8				
		G45.4	I22.9	I63.3	I66.9				
		G45.8	I24	I63.4	I67.6				
		G45.9	I24.0	I63.5	I70				
		I20	I24.1	I63.6	I70.0				
		I20.0	I24.8	I63.8	I70.1				
		I20.1	I24.9	I63.9	I70.2				
		I20.8	I25	I64	I70.8				
		I20.9	I25.0	I65.0	I70.9				
		I21	I25.1	I65.1					
		I21.0	I25.2	I65.2					
		I21.1	I25.3	I65.3					
		I21.2	I25.4	I65.8					
		I21.3	I25.5	I65.9					
I21.4	I25.6	I66.0							
Any registered medical practitioner.	AND	OR				E78 E78.0 E78.1 E78.2 E78.3 E78.4 E78.5	AND	C10	
		10 year MI risk > 20% and/or risk at age 60 years >30% as per Framingham Risk Score							
		OR							
		Genetic hyperlipidaemias diagnosed by:							

		An endocrinologist (PCNS Practise Type: 11801)					
		OR					
		By any registered medical practitioner where TC>7.5mmol/l					
		OR					
		TC> 7 mmol/l	AND	Positive family history of a premature vascular event in a 1 st degree male relative < 55 yrs			
				OR			
				Positive family history of a premature vascular event a 1 st degree female relative <65 yrs			
		OR					
		The presence of tendon Xantomata					

Table 16: Hypertension

Hypertension						
Diagnosis-related information			AND	Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:		
Any registered medical practitioner		I10		I15.0	C02	C08
		I11		I15.1	C03	C09
		I11.0		I15.2	C07	G04CA03
		I11.9		I15.8	OR	
		I12		I15.9	Evidence of hospital admission during the preceding three calendar months relating to control of hypertension	
		I12.0		O10		
		I12.9		O10.0		
		I13		O10.1		
		I13.0	O10.2			
	I13.1	O10.3				
I13.2	O10.4					
I13.9	O10.9					
I15	O11					

Table 17: Hypothyroidism

Hypothyroidism						
Diagnosis-related information				AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)			Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Any registered medical practitioner		E01.8	E03.3		H03AA	
		E02	E03.4		OR	
		E03	E03.5			
		E03.0	E03.8		Evidence of a hospital admission during the preceding three calendar months relating to treatment of hypothyroidism	
		E03.1	E03.9			
E03.2	E89.0					

Table 18: Multiple Sclerosis

Multiple Sclerosis					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Must be a specialist physician, or neurologist 11800 12000		G35		G04BD	N02A
				L03AB07	N03
				L03AB08	N06AA
				M03BX01	
				OR	
Short-course therapy with glucocorticosteroids. This includes products in the H02AB ATC category					
OR					
Evidence of a hospital admission during the preceding three calendar months relating to acute exacerbation of multiple sclerosis					

Table 19: Parkinson's disease

Parkinson's disease						
Diagnosis-related information			AND	Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:		
Any registered medical practitioner		G20		G21.2	N04	
		G21		G21.3	OR	
		G21.0		G21.8		
		G21.1	G21.9	Evidence of hospital admission for stabilisation of Parkinsonism in the preceding three calendar months		

Table 20: Rheumatoid Arthritis

Rheumatoid Arthritis							
Note: Where a patient is not using disease modifying anti-rheumatic drugs, the diagnosis must be verified by a specialist physician or rheumatologist							
Diagnosis-related information					AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	Evidence of use of Disease Modifying drugs for at least 60 days in the preceding three months. This includes products in the following ATC categories:	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Any registered medical practitioner				M05 M05.0 M05.1 M05.2 M05.3 M05.8 M05.9 M06 M06.0 M06.1 M06.2 M06.3 M06.4 M06.8 M06.9 M08.0			
		A07EC01 L01AA01 L01BA01 L04A M01C P01BA01		A07EC01 H02AB L01AA01 L01BA01		L04A M01A M01C P01BA01	
OR				OR			
Diagnosis of rheumatoid arthritis by a specialist physician, paediatrician or rheumatologist				Evidence of a hospital admission for stabilisation of Rheumatoid arthritis or joint replacement in the preceding three calendar months			
11800							
13200							
13100							

Table 21: Schizophrenia

Schizophrenia						
Diagnosis-related information				AND	Proof of Treatment	
Provider code of the diagnosing provider.	AND	ICD10 Codes (Any of the following)			Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Must be a psychiatrist or paediatric psychiatrist 12200 12201		F20	F20.4		N05A	N06A
		F20.0	F20.5		OR	
		F20.1	F20.6		Evidence of hospital admission for stabilisation of schizophrenia in the preceding three calendar months	
		F20.2	F20.8			
	F20.3	F20.9				

Table 22: Systemic Lupus Erythematosus

Systemic Lupus Erythematosus					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
		M32 M32.0 M32.1 M32.8 M32.9 L93 L93.0 L93.1 L93.2		B01AA03 H02AB L01AA01 L01BA01 L04AA01	
L04AA05 L04AA06 L04AX01 M01A					
OR					
Evidence of hospital admission in the preceding three calendar months for treatment of acute flares of SLE					
Must be a specialist physician, paediatrician or rheumatologist					
11800					
13200					
13100					

Table 23: Ulcerative Colitis

Ulcerative Colitis						
Diagnosis-related information				AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)			Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Must be a specialist surgeon, physician or gastroenterologist: 14200 11800 11900		K51	K51.4		A07E	H02AB
		K51.0	K51.5		L04AA11	L04AA12
		K51.1	K51.8		OR	
		K51.2	K51.9		Evidence of hospital admission during the preceding three calendar months relating to treatment of ulcerative colitis	
	K51.3					

Table 24: HIV / AIDS

HIV / AIDS							
Documented proof that demonstrates that the patient qualifies for ART in accordance with the National Antiretroviral Treatment Guidelines must be made available to auditors on request but may be in the form of voice recordings or other electronic records							
Diagnosis-related information					AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes(Any of the following)		AND		Evidence of drug use for at least 60 days in the preceding three calendar months. This includes products in the following ATC categories:	
Any registered medical practitioner		Z21	B21.3			J05AE	J05AG
		B20	B21.7			J05AF	
		B20.0	B21.8			OR	
		B20.1	B21.9		Evidence of a hospital admission for HIV-related disease during the preceding three calendar months		
		B20.2	B22				
		B20.3	B22.0				
		B20.4	B22.1				
		B20.5	B22.2				
		B20.6	B22.7				
		B20.7	B23				
		B20.8	B23.0				
		B20.9	B23.1				
		B21	B23.2				
		B21.0	B23.8				
B21.1	B24						
B21.2							

000 – End – 000