

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

Version 3.1

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.

6 DECEMBER 2007

Applicable to all REF cases from 1 January 2008

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A. Changes to Version 3.1 since the publication of Version 3 of the Guidelines on 30 October 2007.

The correct ICD10 code for Parkinsonism was inadvertently removed in the previous version.

This error is corrected in this version:

- The ICD10 code for Parkinson's disease, G20, has been reinstated in Table 21 on page 35.

1. Introduction

- 1.1 Successful implementation of the Risk Equalisation Fund (REF) in South Africa is contingent on the accurate identification of beneficiaries with specified risk factors within medical schemes.
- 1.2 Risk factors currently included in the REF methodology are: conditions specified in the chronic disease list (CDL)¹; HIV / AIDS; maternity events; and multiple CDL conditions. The age profile of medical schemes is also used in the REF methodology.
- 1.3 The purpose of this guideline is to define criteria that must be met in the identification of beneficiaries with the above-mentioned risk factors for purposes of application of the REF methodology.
- 1.4 The guidelines serve to ensure that the Risk Equalisation methodology is applied to comparable data received from different medical schemes. Using these criteria, cases which qualify as beneficiaries of the Risk Equalisation Fund are identified on a uniform basis in all medical schemes.
- 1.5 The REF Entry and Verification Criteria are intended for this purpose alone, and should not be construed to be limitations or expansions on the entitlements of beneficiaries of medical schemes to minimum benefits prescribed in terms of the Medical Schemes Act (PMBs).
- 1.6 Therefore, there might be instances where a beneficiary is legally entitled to a PMB in respect of a particular condition, but does not qualify for purposes of the REF as a beneficiary with the risk factor pertaining to that condition.
- 1.7 Similarly, certain medicines that are not included in the CDL therapeutic algorithms might be included as proof of treatment to categorise a case as a REF beneficiary. Inclusion of such medicines in the REF Entry and Verification Criteria does not create an entitlement of a beneficiary to access that medicine as a PMB.
- 1.8 These criteria have been developed with the emphasis on the verifiability of cases and will be used to ensure that gaming of the REF is identified and addressed.
- 1.9 These guidelines provide specific clinical codes that serve to identify patients that were treated for CDL conditions.

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

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- 1.10 Initially these guidelines will be reviewed as the need arises, and once stabilised, an annual revision will probably suffice.

2. Implementation Date

2.1 These criteria (as amended) are applicable from 1 January 2008.

Existing CDL Cases

2.2 The diagnoses of cases that have been started on treatment before 1 January 2006 is acceptable to REF.

2.3 Other cases must meet the criteria applicable at the time of diagnosis as specified in Table 1 below, or the diagnosis criteria specified in this document

Table 1: Periods for the application of E&V diagnostic criteria

<i>Period</i>	<i>Version Applicable</i>
Before 2006	None
January 2006 to December 2006	Version 1
January 2007 to December 2007	Version 2.1

2.4 A systematic review of previously diagnosed cases (as specified in Table 1 above) is in the best interest of schemes. The systematic revision of cases may be required in future.

New CDL Cases

2.5 All newly diagnosed cases from 1 January 2008 onwards must meet the diagnosis criteria specified in this document (Version 3.1).

CDL Cases transferred between Medical Schemes

2.6 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

2.7 All CDL cases, whether existing, newly diagnosed or transferred cases, must meet the “proof of treatment” component stipulated in this, Version 3.1 of the guidelines from 1 January 2008.

Note on Cases Identified with Previous Versions of the Guidelines

2.8 Schemes are requested to ensure that their administration systems (as employed by medical scheme administrators, clearing houses, managed care organisations,

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providers and others) are capable of applying different sets of criteria strictly on the dates when they become effective. Proper version control is therefore a requirement.

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. In instances where a contribution in respect of a beneficiary is not receivable because scheme rules provides for “free” membership for the beneficiary, such an individual must also be counted.
- 3.3 Note that service date is used to establish in which month a beneficiary is counted. (See sections 5.7 (page 16) to 5.9 (page 18))

Age Bands

- 3.4 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.
- 3.5 The new-born child is to be incorporated into the age structure by taking the age of the beneficiary as on 1 January of the year of evaluation. The naming of the category as “Under 1” allows for that calculation to produce either a zero or a negative result.

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

- 3.6 All beneficiaries that are reported on in the REF grids must receive their benefits for the relevant condition from a risk pool (as opposed to a personal medical savings account) to qualify for eligibility.

CDL Cases

- 3.7 Columns 2 to 28 of the REF Grid Count and REF Grid Prevalence are populated based on the REF Entry and Verification criteria for each chronic disease, as specified in this document. Please note that the age band “Under 1” is not to be populated with CDL or HIV information, all beneficiaries below one with CDL's must be included in the “NON” column. Hence all CDL and HIV columns for under 1 age band will read zero.

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- 3.8 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.
- 3.9 Note that with the combination of Cardiac Failure and Cardiomyopathy into one condition, from 1 January 2006, the CHF column must be left blank. All Cardiac 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

- 3.10 Once the most expensive disease has been allocated the multiple disease columns 29 to 31 need to be populated according to the number of chronic diseases. Hence 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. NB: This rule no longer applies to the "Under 1" age band as these beneficiaries are defaulted to the "NON" column.

Exclusion of Specific Diseases as Multiple Chronic conditions in the Count Grids

- 3.10.1 Note that, for REF Grid Count purposes, certain CDL diseases that co-occur in the same patient will not be counted as multiple diseases. *(However, if these conditions do co-occur, it must be reflected in the REF Grid Prevalence tables – see paragraph 3.15).* Cases encountered with co-occurring conditions as described in paragraphs 3.10.1.1 to 3.10.1.8 below are not eligible to be counted as multiple diseases in the count grids (CC2, CC3 or CC4 modifiers). The most expensive condition must be counted as a single disease in the REF grid count. The conditions are arranged in descending cost order as determined by the REF Contribution table 2008, which includes the following hierarchy:

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Sorted alphabetically		Sorted by Rank	
Disease	Ranking	Disease	Ranking
ADS	26	CRF	1
AST	22	HAE	2
BCE	18	MSS	3
BMD	9	DM1	4
CHF	-	COP	5
CMY	8	SLE	6
COP	5	CSD	7
CRF	1	CHF	-
CSD	7	CMY	8
DBI	14	BMD	9
DM1	4	HIV	11
DM2	19	PAR	12
DYS	17	IHD	13
EPL	15	DBI	14
GLC	24	EPL	15
HAE	2	SCZ	16
HIV	11	DYS	17
HYL	23	BCE	18
HYP	25	DM2	19
IBD	20	IBD	20
IHD	13	RHA	21
MSS	3	AST	22
PAR	12	HYL	23
RHA	21	GLC	24
SCZ	16	HYP	25
SLE	6	ADS	26
TDH	27	TDH	27

- 3.10.1.1 For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: *Chronic Obstructive Pulmonary Disease, Bronchiectasis and Asthma*
- 3.10.1.2 For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: *Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension*
- 3.10.1.3 For count purposes, only one of *Chronic Renal Disease or Hypertension* may be assigned to the same patient.

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- 3.10.1.4 For count purposes, only one of the following Gastro Intestinal conditions can be assigned to the same patient: *Crohn's disease or Ulcerative Colitis*
- 3.10.1.5 For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: *Bipolar Mood Disorder or Schizophrenia*
- 3.10.1.6 For count purposes, only one of the following neurological/psychiatric conditions can be assigned to the same patient: *Multiple Sclerosis, Bipolar Mood Disorder, or Epilepsy*
- 3.10.1.7 For count purposes, only one of the following auto-immune conditions can be assigned to the same patient: *Systemic Lupus Erythematosus or Rheumatoid Arthritis*
- 3.10.1.8 Note that, in accordance with the Diabetes Mellitus table in section 6, Diabetes Mellitus Type 1 and Type 2 cannot co-occur.

Maternity

- 3.11 The maternity modifier relates to “all the codes that indicate the delivery of a single/multiple foetus either stillborn or alive; following a pregnancy of at least 24 weeks duration”. Codes that apply to the delivery modifier are presented in Table 27 on page 40.
- 3.12 The beneficiary qualifying for the maternity modifier is only entered ONCE — in the month corresponding to the date of admission of the mother into the service facility, or in instances where no admission occurred, the actual date of the confinement is used. The amount payable from the REF is an annual amount and not a monthly amount as with the other modifiers.

Beneficiaries without Chronic Diseases

- 3.13 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 column now includes **all** beneficiaries from the “Under 1” age band. This completion of columns 1 to 28 will reflect each beneficiary of an option in only one cell of the grid.

Grid Prevalence Tables

- 3.14 In the REF Grid Prevalence, the beneficiary is reflected for each one of the diseases he/she has. This rule does not apply to the “Under 1” age band which must be defaulted to the “NON” column.

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- 3.15 The REF Grid Prevalence contains the total number of beneficiaries 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.
- 3.16 Note that each of the conditions listed in paragraph 3.10.1 and its sub-paragraphs must be reported on in the REF Prevalence Grid.
- 3.17 The same number of beneficiaries in column 1 of the REF Grid Count should be reflected in column 1 of the REF Grid Prevalence. Hence for both grid types, the "Under 1" age band is defaulted to "NON".

Availability of Information from Capitated Providers

- 3.18 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:
- 3.18.1 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.
- 3.18.2 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.
- 3.19 Schemes must ensure that their contracts with preferred providers make provision for the availability of the information that is required to prepare the REF grids. (See section 5.14, page 19)

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.

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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 have gone through an authorisation process and must meet both the diagnosis related criteria as well as the proof of treatment criteria.
- 5.2 Authorisation must be performed to collect the diagnosis related information required in the Boolean tables, and does therefore imply a specific process that must be used to ensure that a beneficiary meets all of the requirements listed in the Boolean tables.
- 5.3 The authorisation process cannot happen automatically or without the application of managed care protocols. "Autochronic" methods are therefore not acceptable. Diagnosis information gleaned from claims (medicine or services) is not acceptable for REF.
- 5.4 Note that existing patients on active treatment should not be compromised through the withholding of treatment to prove that they meet the diagnosis related requirements. (See section 2).

Notes on the collection and archiving of diagnosis related information

- 5.5 Diagnosis related information must be recorded in an auditable format; this includes voice recordings, electronic submissions and written hardcopies.
 - 5.5.1 The provider codes of providers (PCNS or HPCSA codes – see section 5.13) who are diagnosing and/or treating in accordance with the REF Entry and Verification Criteria must be documented in all cases.
 - 5.5.2 Managed care organisations and administrators may provide diagnosis codes on the information provided by the providers (or their employees) specified in section 6. The source documentation (voice recordings, electronic recordings or paper copies) underlying the coding decision must however be archived in an auditable format.
 - 5.5.3 Where the diagnosis can be established by any medical practitioner, and such a provider has not submitted a pre-authorisation request with the given diagnosis, the diagnosis may be communicated to the managed care company or administrator on behalf of the diagnosing doctor by both employees of such a provider or the

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pharmacist dispensing medication for such a condition, provided that this diagnostic information is part of the authorisation process (See section 5.2 and section 5.3).

- 5.5.4 Where the diagnosis should be from a provider from a specified group (e.g. specialists), and such a provider has not submitted a pre-authorisation request with the given diagnosis, the treating provider should submit the name of the diagnosing specialist and the diagnosis during the authorisation process.
- 5.5.5 Where the diagnosis should be supported by results of diagnostic tests specified in the REF Entry and Verification Criteria, proof of original laboratory or other test results must be kept. These results could be submitted by the diagnosing or treating provider or the laboratory, provided that the information is in an auditable format. (See paragraphs 5.5 and 5.11).
- 5.5.6 Hospitalisation or other treatment records may be used as proof of a specific clinical event or diagnosis specified in the REF Entry and Verification Criteria (e.g. Multiple sclerosis in Table 20, page 36)
- 5.6 The use of diagnosis codes provided on claims alone is not acceptable. The diagnosis related information specified in paragraphs 5.2 and 5.3 is required, implying that a separate authorisation process must exist for each of the conditions specified in section 6.

Proof of treatment information is based on claims data

- 5.7 Proof of treatment information must be based on paid claims data.
 - 5.7.1 Procedure codes are used as evidence for the performance of specified procedures in the REF Entry and Verification Criteria (See Chronic Renal Disease table 7 on page 26)
 - 5.7.2 ATC codes are used in the definitions of the REF Entry and Verification Criteria to describe specific medicines. (See paragraphs 5.20 and 5.21).
 - 5.7.3 Note that proof of treatment is valid only if proof of diagnosis has been obtained separately, through an authorisation process; and benefits must be paid from a risk pool. (See paragraphs 3.6, and 5.1 to 5.3). In the instance of DM1 and DM2, an authorisation for either DM1 or DM2 is acceptable (See Table 12, page 30)
 - 5.7.4 In most instances, evidence is required that a patient has received the specified treatment during at least two preceding calendar months in the three calendar months preceding the current month (the month for which the beneficiary's REF status is established). The schedule below indicates that, to count a beneficiary in

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December, payment towards treatment must have been made for services rendered in two of the three calendar months of September, October and November. In instances where treatment occurs less frequently, the beneficiary does not qualify as a REF beneficiary. To clarify:

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

- 5.8 Specified conditions require proof of payment for services rendered at least once during the three calendar months preceding the period for which REF eligibility is determined. These conditions and *the specific drugs for which the less frequent issue of medicines is a requirement*, are specified in: Table 3: Asthma, page 23, Table 8: Chronic Obstructive Pulmonary Disease, page 27, Table 7: Chronic Renal Disease, page 26, Table 12: Diabetes Mellitus (Type 1 and 2), page 30 and Table 16: Haemophilia, page 32.

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

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

5.10 The tables in section 6 have been written to assist in the development of Boolean statements that will be used by schemes to correctly identify beneficiaries with REF risk factors. These queries must be made available to the CMS and Auditors on request. It is critical that proper version control is applied, since it is likely that these criteria will change at least once a year. The tables describe the logic that must be applied to:

5.10.1 Test whether a case meets the criteria for inclusion as a CDL or HIV/AIDS beneficiary in the REF, and;

5.10.2 Categorise Diabetes Mellitus cases as either Type 1 or Type 2 diabetes.

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Results of Special Investigations

- 5.11 For Chronic Obstructive Pulmonary Disease, Chronic Renal Disease, Haemophilia, HIV/AIDS and Hyperlipidaemia, it is required that the results of special investigations are kept by schemes. This information must also be made available to auditors on request but may be in the form of voice recordings or other electronic records.

Specialist Diagnosis required for Certain CDL Conditions

- 5.12 Note that the tables in section 6 specify 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 medicines) Schizophrenia, Systemic Lupus Erythematosus and Ulcerative Colitis.
- 5.13 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

- 5.14 Medical schemes or their contractors must store the information that is required to apply the logic set out in the tables for a period of at least three years. Schemes must ensure that their contracts with third party service providers must specify the period for which the information must be kept, and indicate how this information will be transferred from one contractor to the other where more than one contractor is involved or when contracts are terminated.
- 5.15 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

- 5.16 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.
- 5.17 As a general rule, if an ICD10 code indicates more than one of the CDL conditions, only the most expensive condition can be selected for the REF Grid Count table, while all conditions must be included in the REF Grid Prevalence tables. In both instances the proof of treatment criteria must however have been met.

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

If the “proof of treatment” criteria are met, this condition must be categorised in the REF Grid Count to:
Cardiac Failure and Cardiomyopathy
Or
Hypertension
(See page 25 for the Cardiac Failure and Cardiomyopathy criteria and page 34 for the Hypertension Criteria)

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

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

If the “proof of treatment” criteria are met, this condition must be categorised in the REF Grid Count to:
Chronic Renal Disease
Or
Hypertension
(See page 26 for the Chronic Renal Disease criteria and page 34 for the Hypertension Criteria)

For the REF Grid Prevalence, these cases must be counted as Chronic Renal Disease *and* Hypertension.

5.17.3 *I13.0: Hypertensive heart and renal disease with (congestive) heart failure (or O10.3: Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium)*

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and / or

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

If the proof of treatment and diagnosis criteria are met, this condition must be in the REF Grid Count categorised to:

Cardiac Failure and Cardiomyopathy

Or

Chronic Renal Disease

Or

Hypertension

(See page 26 for the Chronic Renal Disease criteria and page 34 for the Hypertension criteria).

For the REF Grid prevalence, these cases should be counted as Chronic Renal Disease *and* Hypertension *and as* Cardiac Failure and Cardiomyopathy.

5.17.4 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.

Use of Five-digit ICD10 codes

- 5.18 As an interim measure, previous Versions of the REF Entry and Verification criteria allowed three digit ICD10 codes in spite of the fact that more specific five-digit codes could be used. This was an interim measure to make provision for the gradual improvement in the quality of ICD10 coding. Version 3 and Version 3.1 of the criteria requires five digit ICD 10 coding as proof of diagnosis.

Use of ATC and NAPPI codes

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

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

5.20.1 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 medicines or group of medicines. The ATC system is not applicable for making a diagnosis.

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

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

Use of specific medicines to identify CDL cases

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

5.22 Note that the use of a medicine to assign a diagnosis to a patient is not acceptable in terms of the criteria specified in section 6. In all instances an authorisation process (See sections 5.2 and 5.3) together with proof of diagnosis and proof of treatment is required.

6. Entry and Verification Criteria for CDL Conditions

Note that each of the conditions specified in Table 2 to Table 27 are subject to the overriding rules on the exclusion of specific multiple diseases specified in section 3.10.1 as well as the rules on ambiguous ICD10 codes in sections 5.16 and 5.17.

Table 2: Addison's disease

Addison's Disease					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider:	AND	ICD10 Codes		AND	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, paediatrician or endocrinologist 11800 13200 11801		E27.1			
			H02AB H02AA02		

Table 3: Asthma

Asthma							
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: <i>Chronic Obstructive Pulmonary Disease, Bronchiectasis and Asthma</i>							
Diagnosis-related information				Proof of Treatment			
Provider code of the diagnosing provider:	AND	ICD10 Codes (Any of the following)				AND	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
Any registered medical practitioner		J45.0	J45.9				
		J45.1	J46				
		J45.8					
			R03AC R03AK R03BA	R03BB01 R03CC R03DA04 R03DC			

Applicable to cases reported from 1 January 2008

Table 4: Bipolar Mood Disorder

Bipolar Mood Disorder																
For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: <i>Bipolar Mood Disorder or Schizophrenia and may not co-occur with Epilepsy or Multiple Sclerosis</i>																
Diagnosis-related information			Proof of Treatment													
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:													
Any registered medical practitioner		<table border="0"> <tr><td>F31.0</td><td>F31.5</td></tr> <tr><td>F31.1</td><td>F31.6</td></tr> <tr><td>F31.2</td><td>F31.7</td></tr> <tr><td>F31.3</td><td>F31.8</td></tr> <tr><td>F31.4</td><td>F31.9</td></tr> </table>	F31.0	F31.5	F31.1	F31.6	F31.2	F31.7	F31.3	F31.8	F31.4	F31.9	<table border="0"> <tr><td>N05AN01</td></tr> <tr><td>N03AX09</td></tr> <tr><td>N03AF01</td></tr> <tr><td>N03AG01</td></tr> </table>	N05AN01	N03AX09	N03AF01
F31.0	F31.5															
F31.1	F31.6															
F31.2	F31.7															
F31.3	F31.8															
F31.4	F31.9															
N05AN01																
N03AX09																
N03AF01																
N03AG01																

Table 5: Bronchiectasis

Bronchiectasis												
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: <i>Chronic Obstructive Pulmonary Disease, Bronchiectasis and Asthma</i>												
Diagnosis-related information			Proof of Treatment									
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:									
Any registered medical practitioner		<table border="0"> <tr><td>J47</td></tr> <tr><td>Q33.4</td></tr> </table>	J47	Q33.4	<table border="0"> <tr><td>H02AB</td><td>R03BB01</td></tr> <tr><td>R03AC</td><td>R03CC</td></tr> <tr><td>R03AK</td><td>R03DA04</td></tr> <tr><td>R03BA</td><td></td></tr> </table>	H02AB	R03BB01	R03AC	R03CC	R03AK	R03DA04	R03BA
J47												
Q33.4												
H02AB	R03BB01											
R03AC	R03CC											
R03AK	R03DA04											
R03BA												

Applicable to cases reported from 1 January 2008

Table 6: Cardiac Failure and Cardiomyopathy

Cardiac Failure and Cardiomyopathy					
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>					
<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 payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		I27.9	I42.2		C01AA05
		I50.0	I42.3		C01DA
		I50.1	I42.4		C02DB
		I50.9	I42.5		C03
		I11.0	I42.6		C07
		I13.0	I42.7		C09
		I13.2	I42.8		
		I42.0	I42.9		
		I42.1	O10.1		
			O10.3		

Applicable to cases reported from 1 January 2008

Table 7: Chronic Renal Disease

Chronic Renal Disease									
For count purposes , only one of <i>Hypertension or Chronic Renal Disease</i> may be assigned to the same patient									
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 payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:			
Any registered medical practitioner		OR		Creatinine clearance value of < 30 ml / min	N03.0	N05.1	B05D		
					N03.1	N05.2	B05Z		
					N03.2	N05.3	B03XA01		
					N03.3	N05.4	V03AE		
					N03.4	N05.5	OR		
					N03.5	N05.6	Evidence of payment for peritoneal or haemodialysis for at least 8 sessions in the preceding three months, as evidenced by any of the following NHRPL or UPFS codes:		
					N03.6	N05.7	Medical Practitioners	Clinical Technologists	Registered Nurses:
					N03.7	N05.8	1843	145	092
					N03.8	N05.9	1845	146	608
	N03.9	N11.0	1847	148	610				
N04.0	N11.1	1849	147	612					
N04.1	N11.8	1851	176	UPFS					
N04.2	N11.9	1852	177	80090					
N04.3	N18.0		149	0310					
N04.4	N18.8		150	0311					
N04.5	N18.9		151	0312					
N04.6	I12.0		152	0320					
N04.7	I13.1		154	0321					
N04.8	I13.2		156	0322					
N04.9	O10.2		153						
N05.0	O10.3		155						

Applicable to cases reported from 1 January 2008

Table 8: Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease						
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: <i>Chronic Obstructive Pulmonary Disease, Asthma and Bronchiectasis</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)	AND	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
Any registered medical practitioner		Lung function tests demonstrating FEV1/FVC post-bronchodilator values below 70% and FEV1 post-bronchodilator values of less than 70% of predicted		J43.0 J43.1 J43.2 J43.8 J43.9 J44.0 J44.1 J44.8 J44.9		R03AC R03AK R03BA R03BB R03CC R03DA04

Applicable to cases reported from 1 January 2008

Table 9: Coronary Artery Disease

Coronary Artery Disease																	
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>																	
Diagnosis-related information			AND	Proof of Treatment													
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:												
Any registered medical practitioner		<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">I20.0</td> <td style="width: 50%;">I25.2</td> </tr> <tr> <td>I20.1</td> <td>I25.3</td> </tr> <tr> <td>I20.8</td> <td>I25.4</td> </tr> <tr> <td>I20.9</td> <td>I25.5</td> </tr> <tr> <td>I25.0</td> <td>I25.6</td> </tr> <tr> <td>I25.1</td> <td>I25.8</td> </tr> <tr> <td></td> <td>I25.9</td> </tr> </table>	I20.0		I25.2	I20.1	I25.3	I20.8	I25.4	I20.9	I25.5	I25.0	I25.6	I25.1	I25.8		I25.9
I20.0	I25.2																
I20.1	I25.3																
I20.8	I25.4																
I20.9	I25.5																
I25.0	I25.6																
I25.1	I25.8																
	I25.9																

Table 10: Crohn's Disease

Crohn's Disease							
For count purposes, only one of the following Gastro Intestinal conditions can be assigned to the same patient: <i>Crohn's disease or Ulcerative Colitis</i>							
Diagnosis-related information			AND	Proof of Treatment			
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:		
Must be a specialist physician, paediatrician, surgeon or gastroenterologist 11800 13200 14200 11900		<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">K50.0</td> <td style="width: 50%;">K50.1</td> </tr> <tr> <td>K50.8</td> <td>K50.9</td> </tr> </table>	K50.0		K50.1	K50.8	K50.9
K50.0	K50.1						
K50.8	K50.9						

Applicable to cases reported from 1 January 2008

Table 11: Diabetes Insipidus

Diabetes Insipidus					
<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 payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, paediatrician, neurosurgeon, neurologist or endocrinologist			E23.2		
11800	12000				H01BA
13200	11801				
12400					

Applicable to cases reported from 1 January 2008

Table 13: Dysrhythmias

Dysrhythmias			
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>			
<i>Diagnosis-related information</i>			<i>Proof of Treatment</i>
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)	AND
Any registered medical practitioner		I47.2 I48	
			Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
			B01AA03 C01A C01B C07 C08D

Table 14: Epilepsy

Epilepsy			
For count purposes, <i>Bipolar Mood Disorder and Multiple Sclerosis may not co-occur with Epilepsy</i>			
<i>Diagnosis-related information</i>			<i>Proof of Treatment</i>
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)	AND
Any registered medical practitioner		G40.0 G40.1 G40.2 G40.3 G40.4 G40.5 G40.6 G40.7	
			Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
			N03

Applicable to cases reported from 1 January 2008

Table 15: Glaucoma

Glaucoma				
<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 payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		H40.0 H40.1 H40.2 H40.3 H40.4	H40.5 H40.6 H40.8 H40.9 Q15.0	

Table 16: Haemophilia

Haemophilia				
<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 payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
Any registered medical practitioner		D66 D67		
		AND Laboratory evidence of Factor VIII or IX levels lower than or equal to 5%		B02BD04 B02BD06 H01BA

Applicable to cases reported from 1 January 2008

Table 17: 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					Proof of Treatment		
Provider code of the diagnosing provider	AND	Doctor diagnosis of symptomatic atherosclerotic disease Including any of the following ICD10 codes			AND	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:	
		G45.0	I21.9	I25.8			I65.8
		G45.1	I22.0	I25.9			I65.9
		G45.2	I22.1	I63.0			I66.0
		G45.3	I22.8	I63.1			I66.1
		G45.4	I22.9	I63.2			I66.2
		G45.8	I24.0	I63.3			I66.3
		G45.9	I24.1	I63.4			I66.4
		I20.0	I24.8	I63.5			I66.8
		I20.1	I24.9	I63.6			I66.9
		I20.8	I25.0	I63.8			I67.6
		I20.9	I25.1	I63.9			I70.0
		I21.0	I25.2	I64			I70.1
		I21.1	I25.3	I65.0			I70.2
Any registered medical practitioner.	OR			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			E78.0 E78.1 E78.2 E78.3 E78.4 E78.5				
By any registered medical practitioner where TC>7.5mmol/l							
OR							

Applicable to cases reported from 1 January 2008

				Positive family history of a premature vascular event in a 1 st degree male relative < 55 yrs				
			AND	OR				
				Positive family history of a premature vascular event a 1 st degree female relative <65 yrs				
			OR					
					The presence of tendon Xantomata			

Table 18: Hypertension

Hypertension					
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>					
For count purposes, only one of <i>Hypertension or Chronic Renal Disease</i> may be assigned to the same patient					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:	
Any registered medical practitioner		I10 I11.0 I11.9 I12.0 I12.9 I13.0 I13.1 I13.2 I13.9 I15.0 I15.1	I15.2 I15.8 I15.9 O10.0 O10.1 O10.2 O10.3 O10.4 O10.9 O11	AND	C02 C03 C07

Applicable to cases reported from 1 January 2008

Table 22: Rheumatoid Arthritis

Rheumatoid Arthritis								
For count purposes, <i>Systemic Lupus Erythematosus</i> may not co-occur with <i>Rheumatoid Arthritis</i>								
<i>Note: Where a patient is not using disease modifying anti-rheumatic medicines, the diagnosis must be verified by a specialist physician or rheumatologist</i>								
Diagnosis-related information							Proof of Treatment	
Provider code of the diagnosing provider	AND	Evidence of use of Disease Modifying medicines in two different calendar months in the three calendar months preceding the current month. This includes products in the following ATC categories:	AND	ICD10 Codes (Any of the following)				Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner				M05.00	M05.91	M06.22	M06.82	
		M05.01	M05.92	M06.23	M06.83			
		M05.02	M05.93	M06.24	M06.84			
		M05.03	M05.94	M06.25	M06.85			
		M05.04	M05.95	M06.26	M06.86			
		M05.05	M05.96	M06.27	M06.87			
		M05.06	M05.97	M06.28	M06.88			
		M05.07	M05.98	M06.29	M06.89			
		M05.08	M05.99	M06.30	M06.90			
		M05.09	M06.00	M06.31	M06.91			
		M05.20	M06.01	M06.32	M06.92			
		M05.21	M06.02	M06.33	M06.93			
		M05.22	M06.03	M06.34	M06.94			
		M05.23	M06.04	M06.35	M06.95			
		M05.24	M06.05	M06.36	M06.96			
		M05.25	M06.06	M06.37	M06.97			
		M05.26	M06.07	M06.38	M06.98			
		M05.27	M06.08	M06.39	M06.99			
		M05.28	M06.09	M06.40	M08.00			
		M05.29	M06.10	M06.41	M08.01	A07EC01		
		M05.80	M06.11	M06.42	M08.02	H02AB		
		M05.81	M06.12	M06.43	M08.03	L01AA01		
		M05.82	M06.13	M06.44	M08.04	L01BA01		
		M05.83	M06.14	M06.45	M08.05	L04A		
		M05.84	M06.15	M06.46	M08.06	M01AB		
		M05.85	M06.16	M06.47	M08.07	M01AC		
		M05.86	M06.17	M06.48	M08.08	M01AD		
		M05.87	M06.18	M06.49	M08.09	M01AE		
		M05.88	M06.20	M06.80		M01AF		
		M05.90	M06.21	M06.81		M01AG		
						M01AH		
						M01C		
						P01BA01		
OR								
Diagnosis of rheumatoid arthritis by a specialist physician, paediatrician or rheumatologist								
11800								
13200								
13100								

Applicable to cases reported from 1 January 2008

Table 23: Schizophrenia

Schizophrenia					
For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: <i>Bipolar Mood Disorder or Schizophrenia</i>					
<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 payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a psychiatrist or paediatric psychiatrist 12200 12201		F20.0 F20.1 F20.2 F20.3 F20.4	F20.5 F20.6 F20.8 F20.9		N05A

Table 24: Systemic Lupus Erythematosus

Systemic Lupus Erythematosus					
For count purposes, <i>Systemic Lupus Erythematosus</i> may not co-occur with <i>Rheumatoid Arthritis</i>					
<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 payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, paediatrician or rheumatologist 11800 13200 13100		M32.0 M32.1 M32.8 M32.9	L93.0 L93.1 L93.2		B01AA03 H02AB L01AA01 L01BA01 L04AA01 L04AA05 L04AA06 L04AX01 M01AB M01AC M01AD M01AE M01AF M01AG M01AH

Applicable to cases reported from 1 January 2008

Table 25: Ulcerative Colitis

Ulcerative Colitis				
For count purposes, only one of the following Gastro Intestinal conditions can be assigned to the same patient: <i>Crohn's disease or Ulcerative Colitis</i>				
Diagnosis-related information			Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)	AND	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, surgeon or gastroenterologist: 14200 11800 11900		K51.0 K51.1 K51.2 K51.3		K51.4 K51.5 K51.8 K51.9

Applicable to cases reported from 1 January 2008

Table 26: HIV / AIDS

HIV / AIDS							
<i>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</i>							
Diagnosis-related information				Proof of Treatment			
Provider code of the diagnosing provider	AND	ICD10 Codes(Any of the following)		AND	Documented proof to demonstrate that patient qualifies for ART in accordance with the National Antiretroviral Treatment Guidelines		Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		AND	B20.0 B20.1 B20.2 B20.3 B20.4 B20.5 B20.6 B20.7 B20.8 B20.9 B21.0 B21.1 B21.2		B21.3 B21.7 B21.8 B21.9 B22.0 B22.1 B22.2 B22.7 B23.0 B23.1 B23.2 B23.8 B24	AND	AND

Applicable to cases reported from 1 January 2008

Table 27: Maternity

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

Applicable to cases reported from 1 January 2008

<p>unspecified O69.0 Labour and delivery complicated by prolapse of cord O69.1 Labour and delivery complicated by cord around neck; with co O69.2 Labour and delivery complicated by other cord entanglement O69.3 Labour and delivery complicated by short cord O69.4 Labour and delivery complicated by vasa praevia O69.5 Labour and delivery complicated by vascular lesion of cord O69.8 Labour and delivery complicated by other cord complications O69.9 Labour and delivery complicated by cord complication; unspecified O70.0 First degree perineal laceration during delivery O70.1 Second degree perineal laceration during delivery O70.2 Third degree perineal laceration during delivery O70.3 Fourth degree perineal laceration during delivery O70.9 Perineal laceration during delivery, unspecified</p>	<p>O82.8 Other single delivery by caesarean section O82.9 Delivery by caesarean section, unspecified O83.0 Breech extraction O83.1 Other assisted breech delivery O83.2 Other manipulation-assisted delivery O83.3 Delivery of viable fetus in abdominal pregnancy O83.4 Destructive operation for delivery O83.8 Other specified assisted single delivery O83.9 Assisted single delivery, unspecified O84.0 Multiple delivery, all spontaneous O84.1 Multiple delivery, all by forceps and vacuum extractor O84.2 Multiple delivery, all by caesarean section O84.8 Other multiple delivery O84.9 Multiple delivery, unspecified</p>
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7. ATC Code Descriptions

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

Addison's Disease	
H02AB	Glucocorticoids
H02AA02	Fludrocortisone
Asthma	
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB01	Ipratropium bromide
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
R03DC	Leukotriene receptor antagonists
Bipolar Mood Disorder	
N05AN01	Lithium
N03AX09	Lamotrigine
N03AF01	Carbamazepine
N03AG01	Valproic acid
Bronchiectasis	
H02AB	Glucocorticoids
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB01	Ipratropium bromide
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
Cardiac Failure and Cardiomyopathy	
C01AA05	Digoxin
C01DA	Organic nitrates
C02DB	Hydrazinophthalazine derivatives
C03	DIURETICS
C07	BETA BLOCKING AGENTS
C09	AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM

Applicable to cases reported from 1 January 2008

Chronic Renal Disease	
B05D	Peritoneal dialytics
B05Z	Haemodialytics and haemofiltrates
B03XA01	Erythropoietin
V03AE	Drugs for treatment of hyperkalemia and hyperphosphatemia
Chronic Obstructive Pulmonary Disease	
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB	Anticholinergics
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
Coronary Artery Disease	
C01DA	Organic nitrates
C07	BETA BLOCKING AGENTS
C08	CALCIUM CHANNEL BLOCKERS
Crohn's Disease	
A07E	INTESTINAL ANTIINFLAMMATORY AGENTS
H02AB	Glucocorticoids
J01XD01	Metronidazole
J01MA	Fluoroquinolones
L04AA01	Ciclosporin
L04AA05	Tacrolimus
L04AA11	Etanercept
L04AA12	Infliximab
L04AX01	Azathioprine
L04AX03	Methotrexate
L01BA01	Methotrexate
P01AB01	Metronidazole
Diabetes Insipidus	
H01BA	Vasopressin and analogues
Diabetes Mellitus	
A10A	INSULINS AND ANALOGUES
A10B	ORAL BLOOD GLUCOSE LOWERING DRUGS

Applicable to cases reported from 1 January 2008

Dysrhythmias	
B01AA03	Warfarin
C01A	CARDIAC GLYCOSIDES
C01B	ANTIARRHYTHMICS, CLASS I AND III
C07	BETA BLOCKING AGENTS
C08D	SELECTIVE CALCIUM CHANNEL BLOCKERS WITH DIRECT CARDIAC EFFECTS
Epilepsy	
N03	ANTIEPILEPTICS
Glaucoma	
S01E	ANTIGLAUCOMA PREPARATIONS AND MIOTICS
Haemophilia	
B02AA02	Tranexamic acid
B02BD02	Coagulation factor VIII
B02BD03	Factor VIII inhibitor bypassing activity
B02BD06	Von Willebrand factor and coagulation factor VIII in combination
B02BD04	Coagulation factor IX
H01BA	Vasopressin and analogues
Hyperlipidaemia	
C10	SERUM LIPID REDUCING AGENTS
Hypertension	
C02	ANTIHYPERTENSIVES
C03	DIURETICS
C07	BETA BLOCKING AGENTS
C08	CALCIUM CHANNEL BLOCKERS
C09	AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM
G04CA03	Terazosin
Hypothyroidism	
H03AA	Thyroid hormones
Multiple Sclerosis	
L03AB07	Interferon beta-1a
L03AB08	Interferon beta-1b
Parkinson's disease	
N04	ANTI-PARKINSON DRUGS

Applicable to cases reported from 1 January 2008

Rheumatoid Arthritis	
A07EC01	Sulfasalazine
H02AB	Glucocorticoids
L01AA01	Cyclophosphamide
L01BA01	Methotrexate
L04A	IMMUNOSUPPRESSIVE AGENTS
M01AB	Acetic acid derivatives and related substances
M01AC	Oxicams
M01AE	Propionic acid derivatives
M01AG	Fenamates
M01AH	Coxibs
M01C	SPECIFIC ANTIRHEUMATIC AGENTS
P01BA01	Chloroquine
Schizophrenia	
N05A	ANTIPSYCHOTICS
Systemic Lupus Erythematosus	
B01AA03	Warfarin
H02AB	Glucocorticoids
L01AA01	Cyclophosphamide
L01BA01	Methotrexate
L04AA01	Ciclosporin
L04AA05	Tacrolimus
L04AA06	Mycophenolic acid
L04AX01	Azathioprine
M01AB	Acetic acid derivatives and related substances
M01AC	Oxicams
M01AE	Propionic acid derivatives
M01AG	Fenamates
M01AH	Coxibs
Ulcerative Colitis	
A07E	INTESTINAL ANTIINFLAMMATORY AGENTS
L04AA11	Etanercept
H02AB	Glucocorticoids
L04AA12	Infliximab
HIV / AIDS	
J05AE	Protease inhibitors
J05AF	Nucleoside and nucleotide reverse transcriptase inhibitors
J05AG	Non-nucleoside reverse transcriptase inhibitors

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