

**Recommendations by the Risk Equalisation Technical
Advisory Panel**

to the Council for Medical Schemes

Definitions of Entry Criteria for Determining the REF Grids

RETAP Recommendations Report No. 2 of 2005

Approved at RETAP Meeting: 1 February 2005

Risk Equalisation Technical Advisory Panel (RETAP)

Following the approval of the Social Health Insurance (SHI) policy by the National Department of Health, the Minister of Health appointed a Ministerial Task Team (MTT) on Social Health Insurance to support the implementation of the SHI system in South Africa over the next five years. The MTT is made up of officials from the Department of Health, the Department of Social Development and the Council for Medical Schemes. In late January 2005 Cabinet approved the implementation of the Risk Equalisation Fund (REF) and placed the responsibility for implementation of the REF with the Council for Medical Schemes.

The Risk Equalisation Technical Advisory Panel (RETAP) was established on 20 October 2004 as a consultative group used to assist in the development of technical requirements for implementation of the REF. RETAPs role flows from some of the key recommendations made by the original Formula Consultative Task Team (FCTT). In particular, the panel must focus its attention on the practical requirements for the implementation of the REF formula. Its recommendations should enable an action plan to be developed for implementing the formula, taking into account all the practical and technical issues that will arise in the implementation phase.

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1. Introduction and Background

1.1 Purpose of the Report

RETAP are required to advise on appropriate definitions for the data to be collected for use in applying the risk equalisation formula for the shadow period of operation of the Risk Equalisation Fund (REF). During the shadow period, medical schemes are to submit data and will receive notification of the amounts that would be payable from the REF, however no money will change hands.

The purpose of the shadow period is to ensure that medical schemes and the REF Authority are able to handle the technical and administrative requirements of the full implementation of the Risk Equalisation Fund. The REF Authority is the Council for Medical Schemes during this period.

RETAP delegated the preparation of this report to Dr Izak Fourie. The document was discussed, amended and adopted by a full meeting of RETAP on 1 February 2005. This report is thus the formal recommendations from RETAP to the Council for Medical Schemes which is responsible for the implementation of the REF. The Council for Medical Schemes will need to satisfy itself as to the appropriateness of the recommendations and to formalise a decision on the REF Grid entry criteria. That decision or the need for further consultation will need to be communicated to stakeholders by the Registrar of Medical Schemes.

1.2 The REF Grids

The REF Contribution Table is a table of amounts payable by the REF per beneficiary, according to the REF risk factors. The amount is determined from historic data and other inputs on costs per disease. The amount is set in order to cover:

- a defined benefit package (the Prescribed Minimum Benefits (PMBs));
- for the entire medical scheme industry population that is expected for the next year (the Target Population); and
- with an agreed dispensation of cost and other (managed care) efficiencies.

Each scheme will collect data in a defined format which mirrors the REF Contribution Table. This data collection format is known as the REF Grids. There are two forms of REF Grid collected where the number of beneficiaries is counted:

- **REF Grid Count** (illustrated in Appendix A and available on www.refsa.co.za): contains the total number of beneficiary months in the cell for the period. 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. Thus the total of beneficiaries for columns 1 to 28 must equal the beneficiaries in the scheme for the period. Counts of beneficiaries for the modifiers are done separately. This REF Grid Count used in the calculation of the REF Contribution Table is not prevalence of the disease. It is arrived at by taking the most expensive disease in any multiple disease combination. It can NOT be compared directly to prevalences in published medical literature.
- **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 scheme for the period.

The scheme multiplies the cell from the REF Grid Count by the amount in the same cell of the REF Contribution Table. This is summed across all cells in the table to obtain the amount payable to the scheme from the REF.

1.3 Choice of Risk Factors for 2005

RETAP recommended the following risk factors for use in the REF Contribution Table for 2005:

- Age last birthday on 1 January, summarised into age bands Under 1, 1-4, 5-9, 10-14... 75-79, 80-84, 85+.
- The 25 PMB–CDL conditions. Where a beneficiary has more than one CDL conditions, the scheme may choose the most expensive of the conditions for the placement of the beneficiary in the REF Grid Count.
- HIV/Aids provided the beneficiary is receiving or has received anti-retroviral therapy according to the PMB definition;
- A modifier for maternity, defined as the delivery of a single/multiple foetus either stillborn or alive;

A modifier for the number of multiple CDL conditions. Allowance is made for 2, 3, and 4+ simultaneous CDL conditions.

This report sets out the clinical entry criteria for these risk factors.

1.4 Principles for Development of Entry Criteria

The following principles were considered and incorporated in the development of the definitions for entry criteria:

- The principles and purpose of the proposed Risk Equalisation Fund for Medical Schemes (REF) as per the Report on the Determination of the Formula for the Risk Equalisation Fund in South Africa (January 2004) by the Formula Consultative Task Team and the subsequent comments by the International Review Panel;
- Although the REF has a different perspective (i.e. risk equalization) than the Prescribed Minimum Benefits under the Medical Schemes Act (entitlement, anti-skimming and anti-dumping on the public health sector), every effort should be made to harmonise the two systems. For example, where a PMB Algorithm contains an entry criteria or definition, the same should be used for REF purposes wherever possible;
- Because the REF is fundamentally based on short-term (3 months to 1 year) financial risk rather than longer term medical risk, the entry criteria/definition should be aimed at the “treated patient” rather than the early or “pre-clinical stages” of a chronic medical condition. This implies that medical schemes (or their administrators) must maintain verifiable records of the entry criteria and treatment (chronic medication) of beneficiaries in columns 2-28 of the REF Grid; and
- The definitions/entry criteria should apply to all new patients registered for treatment and inclusion in columns 2-28 of the REF Grid after a certain date. Although the definitions/entry criteria (and treatment records) would in principle also apply to exiting chronic patients, such patients will not be required to stop their medication to prove compliance if it is medically contra-indicated to do so.

1.5 Compulsory ICD-10 Coding

The CDL conditions have been described in terms of ICD-10 codes since they became part of PMBs with effect from 1 January 2004. The quality of submission for ICD-10 codes has typically been better for the PMB-CDLs than for PMB-DTPs as many medical schemes have required practitioners to submit a diagnosis as part of the motivation for the granting of chronic medicine benefits.

The Council for Medical Schemes has worked extensively with the Department of Health, industry stakeholders and healthcare providers in particular on the issue of a common diagnosis code. Late in 2004 this process was brought to fruition with the announcement that ICD-10 codes would begin to be compulsorily implemented from January 2005.

Circular 58 of 2004, dated 17 December 2004, from the Registrar of Medical Schemes states:

The implementation of ICD-10 in the medical scheme environment takes effect on 1 January 2005. All health service providers are encouraged to begin submission of ICD-10 diagnosis codes in their accounts for administrative and statistical purposes.

The implementation process will entail a phase-in period of 6 months, to allow stakeholders to finalise their preparations for the implementation of ICD-10. During this period, no outright rejection of accounts without ICD-10 codes will be permitted. However regular monthly meetings will be held in order to monitor and review the implementation process.

Submission of ICD-10 codes will be compulsory from 1 July 2005. All health service providers will be required to include ICD-10 codes in their accounts to medical schemes in compliance with legislation. Any claim that is submitted without ICD-10 codes will be liable for rejection from 1 July 2005.

It is thus expected that medical schemes will increasingly have ICD-10 codes submitted to them in order to ensure that the PMB-CDL definitions can be applied.

2. Entry Criteria for the PMB-CDL Conditions

2.1 Addison's Disease

PMB-CDL Algorithm Definition: None provided

REF Entry Criteria: Inappropriately low serum cortisol level plus abnormal response to ACTH stimulation test.

Serum cortisol levels:

- <275 nmol/l (<10 ug/dl) suggest possibility of diagnosis
- <80 nmol/l (<3 ug/dl) confirms adrenal insufficiency

ACTH stimulation test (abnormal) confirms diagnosis and is used to distinguish primary from secondary adrenal insufficiency. (The PMB-CDL Algorithm deals with primary Addison's disease only).

2.2 Asthma

PMB-CDL Algorithm Definition: Asthma is defined and classified as:

- Mild intermittent
- Mild persistent
- Moderate persistent
- Severe persistent

REF Entry Criteria (i.e. for mild intermittent asthma): Combination of:

- Episodic symptoms of airflow obstruction, including wheezing, difficulty in breathing, chest tightness and/or cough, particularly worse at night; and
- Spirometric demonstration of at least partially reversible airflow obstruction with a FEV₁ improvement of $\geq 15\%$ after short acting B2 agonist.

The diagnostic criteria for the more severe forms of asthma are provided in the PMB-CDL Algorithm.

The above criteria (and the PMB-CDL Algorithm) may not be applicable to children (especially ≤ 7 years) where one has to rely on a clinical diagnosis. For REF entry criteria purposes it is proposed that this should be made or confirmed by a specialist paediatrician.

2.3 Bronchiectasis

PMB-CDL Algorithm Definition: None provided.

REF Entry Criteria: A combination of the following:

- Chronic cough with mucopurulent sputum, especially during (frequent) acute respiratory infections;
- Physical examination consistent with the diagnosis. Clinical signs may include dyspnoea, finger clubbing, cyanosis, moist rales over affected area; and
- Radiological examination (x-ray chest or CT scan) suggestive of the diagnosis.

2.4 Bipolar Mood Disorder

PMB-CDL Definition: No therapeutic algorithm published as yet.

REF Entry Criteria: To be developed once a therapeutic algorithm is published.

2.5 Cardiac Failure

PMB-CDL Definition: None provided

REF Entry Criteria:

- Any structural or functional cardiac disorder that impairs the ability of the heart (ventricle) to fill with, or eject, blood; and
- Patient must meet the criteria for stages II to IV functional incapacity as per the New York Heart Association's Classification (see infra); and/or
- Patient must meet the criteria for stage C and D of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (see infra).

The New York Heart Association (NYHA) classification grades the functional incapacity of patient with cardiac disease. NYHA levels can be described as follows:

Class I : Cardiac disease without resulting limitations of physical activity;

Class II : Slight limitation of physical activity – comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnoea, or anginal pain

Class III : Marked limitation in physical activity – comfortable at rest, but less than ordinary physical activity causes fatigue, palpitation, dyspnoea, or anginal pain;

Class IV : Inability to carry on any physical activity without discomfort or symptoms at rest.

The Stages of Cardiac Failure (CF) according to the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (February 2002) are as follows:

Stage A – Patients at high risk of developing CF because of the presence of conditions that are strongly associated with the development of CF. Example: systemic hypertension, coronary artery disease, diabetes mellitus, history of cardiotoxic drug therapy or alcohol abuse, personal history of rheumatic fever, family history of cardiomyopathy.

Stage B – Patients who have developed structural heart disease that is strongly associated with the development of CF but who have never shown signs or symptoms of CF. Example: Left ventricular hypertrophy or fibrosis, left ventricular dilatation or hypocontractility, asymptomatic valvular heart disease, previous myocardial infarction.

Stage C – patients who have current or prior symptoms of CF associated with underlying structural heart disease. Example: Dyspnoea or fatigue due to left ventricular systolic dysfunction, asymptomatic patients who are undergoing treatment for prior symptoms of CF.

Stage D – Patients with advanced structural heart disease and marked symptoms of CF at rest despite maximal medical therapy and who require specialized interventions. Example: Patients who are frequently hospitalized for CF or cannot be safely discharged from the hospital, patients in the hospital awaiting heart transplantation, patients at home receiving continuous intravenous support for symptom relief or being supported with a mechanical circulatory assist device, patients in a hospice setting for the management of CF.

2.6 Cardiomyopathy

PMB-CDL Definition: None provided.

Cardiomyopathic diseases are typically divided into:

- Dilated congestive cardiomyopathy – patient has dilated hypokinetic left or right ventricle or both with cardiomegaly and left and/or right cardiac failure.
- Hypertrophic cardiomyopathy – patient has thickened left ventricular wall (usually \geq 15mm) and non-dilated, hyperdynamic chamber in the absence any other cardiac or systemic diseases.
- Restrictive cardiomyopathy – patient has endomyocardial fibrosis or eosinophilic endomyocardial disease affecting one or both ventricles and restricting filling.

The diagnoses (of the various cardiomyopathies) are made via a combination of clinical findings, ECG abnormalities, Chest radiology, echocardiographic findings and, in occasional cases, via cardiac catheterizations and myocardial biopsy.

REF Entry Criteria: Confirmation of the diagnosis by a specialist physician or cardiologist.

2.7 Chronic Renal Disease

PMB-CDL Algorithm Definition: Chronic renal disease is defined and classified as:

- Mild chronic renal failure – serum creatinine 100-200 u mol/l.
- Moderate chronic renal failure – serum creatinine 200 – 400 u mol/l.
- Severe chronic renal failure – serum creatinine >400 u mol/l.

REF Entry Criteria: Serum creatinine > 100 u mol/l for a period of more than 3 months.

2.8 Chronic Obstructive Pulmonary Disease (COPD)

PMB-CDL Definition: COPD is defined and classified as follows:

- Stage I: Mild effort-related dyspnoea and a FEV₁ of at least 50% of predicted.
- Stage II: Continuous dyspnoea and a FEV₁ of 35 – 49% of predicted.
- Stage III: Respiratory failure or cor pulmonate and a FEV₁ < 35% of predicted.

RETAP Note: The British Thoracic Society classifies COPD as follows:

- Mild: Mild or no dyspnoea, a smoker's cough and a FEV₁ of 60 – 80% of predicted.
- Moderate: Dyspnoea on moderate exertion and a FEV₁ of 40 – 59% of predicted.
- Severe: Continuous dyspnoea to respiratory failure with a FEV₁ < 40% of predicted.

REF Entry Criteria: Mild effort-related dyspnoea and a FEV₁ post-bronchodilator of ≤ 80% of predicted. (This also in line with the GOLD classification).

2.9 Coronary Artery Disease

PMB-CDL Definition: None provided.

REF Entry Criteria: Angina pectoris with supportive findings on ECG (exercise or stress), Duke Treadmill test, echocardiography or angiography.

2.10 Crohn's Disease

PMB-CDL Algorithm Definition: None provided.

REF Entry Criteria: Gastro-intestinal symptoms or complications (fistula, abscess and/or obstruction) supported by typical x-ray (barium enema) and/or histological findings. Diagnosis to be confirmed by specialist physician or gastro-enterologist.

2.11 Diabetes Insipidus

PMB-CDL Algorithm Definition: Positive water deprivation test.

REF Entry Criteria: Positive water deprivation test.

2.12 Diabetes Mellitus (Type 1 and 2)

PMB-CDL Algorithm Definition: None provided.

The REF formula and PMB-CDL Algorithms differentiates Type 1 and Type 2 diabetes mellitus. It is recommended that the following definitions and entry criteria be used:

- Type 1 diabetes: patient that complies with WHO criteria for diagnosis of diabetes due to beta cell destruction usually resulting in absolute insulin deficiency.
- Type 2 diabetes: patient that complies with WHO criteria for diagnosis of diabetes due to:
 - Predominant insulin resistance with relative insulin deficiency; or
 - Predominant defect in insulin secretion with or without insulin resistance.

REF (WHO) Entry Criteria: In both symptomatic and asymptomatic patients the diagnosis is based on the following plasma venous blood values:

- Random blood glucose > 11.1 mmol/l
- Fasting blood glucose > 7.0 mmol/l

A single finding is inadequate for diagnosis. The abnormal value must be confirmed at least twice before diabetes is diagnosed.

If the results are equivocal, a glucose tolerance test (GTT) is required. The following guidelines apply to the GTT:

- Adults, ingest 75g oral glucose (in 250-300ml of water over 5 minutes) after an overnight fast (10 hours)
- For children, use 1,75g of glucose per kg body weight up to total of 75g
- Confirm diagnosis if:
 - Fasting blood glucose \geq 7.0 mmol/l and/or
 - 2 hours post prandial glucose load \geq 11.1 mmol/l

2.13 Dysrhythmias

PMB-CDL Algorithm Definition: No definition(s) is provided but the Algorithm covers three dysrhythmias, namely Chronic Atrial Fibrillation, Chronic Atrial Flutter and Ventricular Tachycardia.

REF Entry Criteria: All three of the dysrhythmias listed have typical clinical and ECG findings and it is recommended that the diagnosis be made/confirmed by a specialist physician or cardiologist.

2.14 Epilepsy

PMB-CDL Algorithm Definition: None provided.

REF Entry Criteria:

- The occurrence of two or more unprovoked seizures within a 12 month period; or
- The occurrence of a single unprovoked seizure associated with:
 - Focal neurological abnormality on clinical examination or cerebral imaging; or
 - EEG epileptiform activity.

2.15 Glaucoma (Open and Closed Angle)

PMB-CDL Algorithm Definition: None provided.

REF Entry Criteria: Elevated intro-ocular pressure (\geq 21mm Hg).

2.16 Haemophilia

PMB-CDL Algorithm Definition: The definitions for Haemophilia A and B are summarised in the following table

	MILD	MODERATE	SEVERE
Haemophilia A	Factor VIII 5-40% of normal	Factor VIII 1 – 5% of normal	Factor VIII < 1% of normal
Haemophilia B	Factor IX 5-25% of normal	Factor IX 1 – 5% of normal	Factor IX < 1% of normal

REF Entry Criteria:

Haemophilia A: Factor VIII < 40% of normal

Haemophilia B: Factor IX < 25% of normal

2.17 Hyperlipidaemia

PMB-CDL Algorithm Definition: Total cholesterol > 5 mmol/l.

RETAP Note: The following table summarises the recommendations of the “South African Guidelines for the Diagnosis, Management and Prevention of Common Dyslipidaemias (2000)”:

	Hypercholesterolaemia		Mixed Hyperlipidaemia	Hypertriglyceridaemia	
	Moderate	Severe		Moderate	Severe
TG	<1.5	<1.5	1.5 – 5.0	5 – 15	>15
TC	5 – 7.5	>7.5	>5.0	>5.0	>5.0
LDLC	3.0 – 5.0	>5.0	Variable	Variable	Variable
HDLC	Variable	Variable	Low	Low	Low

TC : Total cholesterol

TG : Triglycerides

LDLC : Low density lipoprotein cholesterol

HDLC : High density lipoprotein cholesterol

REF Entry Criteria: In compliance with the PMB-CDL Algorithm, the following persons with hyperlipidaemia should qualify for REF purposes:

- Patient with primary hyperlipidaemia and:
 - Genetic dyslipidaemia with LDLC>3mmol/l;
 - Established vascular disease;
 - 10 year MI risk > 20% (Framingham Risk Score); and/or

- 60 years age risk > 30% (Framingham Risk Score).
- Patient with secondary hyperlipidaemia, unresolved after treatment of the cause, and:
 - 10 year MI risk >20% (Framingham Risk Score); and/or
 - 60 years age risk > 30% (Framingham Risk Score).

2.18 Hypertension

PMB-CDL Algorithm Definition:

- In diabetic or congestive cardiac failure (CCF) patients:
 - Systolic blood pressure (SBP) > 130 mmHg; and
 - Diastolic blood pressure (DBP) > 85 mmHg.
- In non-diabetic and non-CCF Patients;
 - SBP > 140 mmHg or DBP > 90 mmHg, and
 - Target organ disease; or
 - Persistent SBP > 140mmHg or DBP > 90mgHg for 6 months
 - SBP > 160 mmHg or DBP > 100 mmHg.

REF Entry Criteria: As per the PMB-CDL Algorithm based on the average of 2 or more properly measured, seated BP readings on each of 2 or more visits.

2.19 Hypothyroidism

PMB-CDL Algorithm Definition:

- Overt hypothyroidism: Elevated thyroid stimulating hormone TSH and decreased free thyroxine (FT₄).
- Sub clinical hypothyroidism: persistently elevated TSH and normal FT₄ with symptoms.

REF Entry Criteria: As per PMB-CDL Algorithm.

2.20 Multiple Sclerosis

PMB-CDL Algorithm Definition: None provided.

REF Entry Criteria: The diagnosis of multiple sclerosis is a clinical one, supported by MRI findings. For REF entry criteria purposes it is recommended that the diagnosis be confirmed by a specialist physician or neurologist.

2.21 Parkinson's Disease

PMB-CDL Algorithm Definition: None provided.

RETAP Note: There are currently no biological markers or imaging studies that can reliably diagnose Parkinson's Disease and the diagnosis must be made on clinical grounds.

REF Entry Criteria: A patient with at least two or three of the following cardinal motor signs:

- Rest tremor
- Bradykinesia
- Rigidity
- Postural instability

2.22 Rheumatoid Arthritis (RA)

PMB-CDL Algorithm Diagnosis: None provided.

RETAP Note: To date, the only universally accepted and used diagnostic criteria for RA are those proposed by the American College of Rheumatology (ACR) for classification of the disease.

According to the ACR, the diagnosis of RA requires confirmation of at least four of the following criteria:

1. Morning stiffness lasting at least one hour before maximal improvement, for at least 6 consecutive weeks.
2. Soft tissue swelling or effusion, observed by a physician, in at least three of the following joint areas (right or left): proximal interphalangeal (PIP), metacarpophalangeal (MCP), wrist, elbow, knee, ankle, or metatarsophalangeal (MTP) joints, for at least 6 consecutive weeks.
3. Swelling or effusion, observed by a physician, in the proximal interphalangeal, metacarpophalangeal, or wrist joints, for at least 6 consecutive weeks.
4. Symmetrical (right and left sides) swelling or fluid in the joints mentioned in point 2, observed by a physician, for at least 6 consecutive weeks.
5. Subcutaneous nodules over bony prominences or extensor surfaces, or in juxta-articular regions, observed by a physician.
6. Demonstration of serum rheumatoid factor (RF) detected by any method that has been positive in less than 5% of control subjects.
7. Radiographic evidence in the hands or wrists of articular erosions or osteopenia in or around the affected joints.

The diagnostic criteria for Juvenile Rheumatoid Arthritis (JRA) are:

1. \leq 16 years of age.
2. Persistent arthritis of at least 6 weeks duration in one or more joints.
3. Exclusion of other causes of arthritis.

REF Entry Criteria: As per the ACR criteria.

2.23 Schizophrenia

PMB-CDL Algorithm Diagnosis: None provided.

RETAP Note: In the absence of a biological or other marker, the diagnosis of schizophrenia relies on the examination of the mental state of a patient through a clinical interview(s) and observation of the patient's behaviour.

REF Entry Criteria: The diagnosis of Schizophrenia should be made by a psychiatrist with reference to the World Health Organisation's ICD 10 or DSM IV Diagnostic Criteria.

2.24 Systemic Lupus Erythematosus (SLE)

PMB-CDL Algorithm Definition: None provided.

RETAP Note: The most widely accepted diagnostic criteria for SLE are those of the American Rheumatism Association (ARA). According to the ARA Classification Criteria four or more of the following criteria must be present for the diagnosis of "classic" SLE:

1. Malar rash
2. Discoid rash
3. Photosensitivity
4. Oral ulcers
5. Arthritis
6. Serositis
7. Renal disorder (proteinuria, cellular casts)
8. Neurological disorder
9. Haematological disorder (haemolysis, leucopenia, etc.)
10. Immunological disorder
11. Positive Antinuclear Antibody (ANA)

REF Entry Criteria: The ARA Classification Criteria for SLE.

2.25 Ulcerative Colitis

PMB-CDL Algorithm Definition: None provided.

REF entry Criteria: Diagnosis based on clinical, radiological and/or endoscopic findings confirmed by specialist physician or gastroenterologist.

3. Entry Criteria for Other REF Grid States

3.1 Age Bands

Age last birthday on 1 January, summarised into age bands Under 1, 1-4, 5-9, 10-14... 75-79, 80-84, 85+.

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.

3.2 HIV/AIDS

The amended Regulations (Notice No. R1410, Government Gazette No. 27055, dated 3 December 2004) refer to “The national guidelines as set out in the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa; and the National Antiretroviral Treatment Guidelines” published by the National Department of Health.

It is recommended that only patients receiving antiretroviral treatment (ART) be included in the REF formula and that the criteria for commencing ART as per the National Antiretroviral Treatment Guidelines be used for REF purposes. These are:

Adults and adolescents – including pregnant woman

- CD4 < 200 cells/mm³ irrespective of stage; or
- WHO Stage IV AIDS-defining illness, irrespective of CD4 count; **and**
- Patient expresses willingness and readiness to take ART adherently.

Children

- Recurrent hospitalisations (>2 admissions per year) for HIV-related disease, or prolonged hospitalisation (>4 weeks); or
- Modified WHO Stage II and III disease; or
- CD4 percentage < 20% in a child under 18 months old, irrespective of disease stage; or
- CD4 percentage < 15% in a child over 18 months old, irrespective of disease stage; **and**
- Adherence is at least probable in terms of social circumstances and availability of reliable adult caregiver.

3.3 Maternity Modifier

"Delivery" will include all the codes that indicate the delivery of a single/multiple fetus either stillborn or alive following a pregnancy of at least 24 weeks duration.

Codes that apply to this modifier are as follows:

ICD-10 :	Pre-term labour: O60
	All other Vaginal and c/s: O80, O81, O82 and O84
NHRPL :	2614, 2615 and 2616

3.4 No Chronic Conditions (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 a scheme in one column of the grid.

The same number of beneficiaries in column 1 of the REF Grid Count should be reflected in column 1 of the REF Grid Prevalence.

3.5 Multiple Chronic Conditions

Where a beneficiary has more than one CDL condition, the scheme may choose the most expensive of the conditions for the placement of the beneficiary in the REF Grid Count.

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 Contribution Table dictates the position in the REF Grid Count for columns 2 to 28. Once the most expensive disease has been allocated the multiple disease beneficiary needs to be allocated to columns 29 to 31 according to the number of disease that the beneficiary suffers from. 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.

In the REF Grid Prevalence, the beneficiary is reflected for each one of the multiple diseases.

4. Recommendations to Council for Medical Schemes

- (A) RETAP recommends to the Council for Medical Schemes that this document be circulated to stakeholders, inviting feedback on the extent to which these entry criteria differ from those in use at each scheme/administrator.
- (B) These definitions/entry criteria should primarily be used for new patients from 1 July 2005 onwards. Currently treated chronic medical scheme patients (up to 30 June 2005) should not be subjected to these criteria if it would be medically irresponsible to stop patient's treatment to prove that he/she meets the REF definition/entry criteria.
- (C) RETAP recommends that further work be done to add appropriate codes to these definitions in order to ensure that the future auditing of REF data by the REF Authority is transparent and clearly defined.
- (D) RETAP recommends that this report be issued by the REF Authority as a guideline to be used by medical schemes in preparing entry criteria for admission of patients to the PMB-CDLs. Although schemes cannot be required to implement the guideline, in the event of significant deviation from the guidance given, and should the actions of a scheme or its administrator be questioned by the REF Authority, the scheme may be required to demonstrate that such deviation was justified.

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Further details on the clinical documents used can be obtained from Dr Izak Fourie at izakf@healthmonitor.co.za

Appendix A: Section of REF Grid Count for 2005

Obtainable as a spreadsheet in electronic form from www.refsa.co.za

REF Grid Count for data submission in Shadow Year		Scheme name		A		
Total number of beneficiary months in the cell for the period		Scheme number		1	Period	Apr-2005
Explanation: 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), you may choose the highest cost cell of the combination. Thus the total of beneficiaries for columns 1 to 28 must equal the beneficiaries in the scheme for the period. Counts of beneficiaries for the modifiers are done separately.				Automatic calculation		
Total Beneficiaries [Calculated automatically]						

Age Bands	No CDL Diseases NON	Chronic Disease List (CDL) Conditions															
		ADS	AST	BCE	BMD	CHF	CMY	COP	CRF	CSD	DBI	DM1	DM2	DYS	EPL	GLC	
Column	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Under 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
5-9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
10-14	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
15-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
20-24	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
25-29	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
30-34	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
35-39	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
40-44	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
45-49	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
50-54	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
55-59	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
60-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
65-69	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
70-74	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
75-79	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
80-84	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
85+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total by Condition	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

(a) must sum to total exposed beneficiaries in the scheme for the period

(b) count number of deliveries (as defined). Count delivery only once, not in "beneficiary months".

Female Beneficiaries

Age Bands	No CDL Diseases NON	Chronic Disease List (CDL) Conditions															
		ADS	AST	BCE	BMD	CHF	CMY	COP	CRF	CSD	DBI	DM1	DM2	DYS	EPL	GLC	
Column	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Under 1																	
1-4																	
5-9																	

Male Beneficiaries

Age Bands	No CDL Diseases NON	Chronic Disease List (CDL) Conditions															
		ADS	AST	BCE	BMD	CHF	CMY	COP	CRF	CSD	DBI	DM1	DM2	DYS	EPL	GLC	
Column	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Under 1																	
1-4																	
5-9																	

Diseases/Conditions	
Code	Explanation
NON	No CDL disease
ADS	Addison's Disease
AST	Asthma
BCE	Bronchiectasis
BMD	Bipolar Mood Disorder
CHF	Cardiac failure
CMY	Cardiomyopathy
COP	Chronic Obs. Pulmonary Disease
CRF	Chronic Renal Disease
CSD	Crohn's Disease
DBI	Diabetes Insipidus
DM1	Diabetes Mellitus 1
DM2	Diabetes Mellitus 2
DYS	Dysrhythmias
EPL	Epilepsy
GLC	Glaucoma
HAE	Haemophilia
HYL	Hyperlipidaemia
HYP	Hypertension
IBD	Ulcerative Colitis
IHD	Coronary Artery Disease
MSS	Multiple Sclerosis
PAR	Parkinson's Disease
RHA	Rheumatoid Arthritis
SCZ	Schizophrenia
SLE	Systemic LE
TDH	Hypothyroidism
HIV	HIV/AIDS
MAT	Caesarean / NVD in period
CC2	Two simultaneous conditions
CC3	Three simultaneous conditions
CC4	Four or more simultaneous conditions

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