

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

**DRAFT DISCUSSION DOCUMENT:
FOR COMMENTS BEFORE 17 APRIL 06.
FOR IMPLEMENTATION ON 1 JANUARY 2007**

Version 2.A3

Council for Medical Schemes

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

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Applicable to all REF cases from 1 January 2007



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A. Changes to Version 2.A3 since the publication of Version 1.0 of the Guidelines on 22 November 2005

The first version of the **Guidelines for the Identification of Beneficiaries with REF Risk Factors in Accordance with the REF Entry and Verification Criteria** that was published by the Council for Medical Schemes on 22 November 2005 has led to a considerable volume of comments from the industry, necessitating changes to some of the criteria.

This Draft Publication will be published on 27 March 05 and interested parties are invited to submit comments to b.steenekamp@medicalschemes.com before 17 April 06. These comments will be considered by RETAP on 20 April and incorporated into Version 2.0 of the guidelines that will be published by 15 May 06 and must be applied to all REF Cases from 1 January 2007.

Areas modified in this draft version 2.A include the following:

- a A more detailed explanation of the differences between the PMB-DTP's (Diagnosis Treatment Pairs), the CDL-PMB's (Chronic Disease List) and their relationship to the REF Entry and verification criteria is offered in paragraphs 1.6 to 1.11. It should now be clear that if a patient suffers from a PMB condition but does not meet the REF Entry & Verification criteria that the patient is still entitled to receive PMB benefits as prescribed.
- b The effective date of these criteria has been specified as 1 January 2007 (Paragraph 2.1 on page 10)
- c A note on the requirement that schemes must in future be able to apply these criteria for a defined time period. As soon as financial REF transfers start, non-synchronous changes in the application of these criteria could lead to major unfairness. (See paragraphs 2.5 and 2.6 on page 10)
- d The NHRPL code 2653 (Caesarian hysterectomy) is added to the maternity codes. (See paragraph 3.10 on page 4).
- e Proof of treatment now requires evidence of two issues of drugs from the specified ATC categories in two of the three preceding calendar months (See section 5.2.2.5 on page 19).
 - i This change has been necessary to prevent the complexities associated with specifying the dosage and treatment duration for each drug that is issued.

- ii Note that the criteria now clearly specify that the treatment must have been issued in the three months preceding the month for which the beneficiary's REF eligibility status is evaluated.
 - iii It must be noted that, for most of the conditions involved, the issue of treatment during only two calendar months out of every three calendar months, does not constitute adequate compliance. Two issues are therefore considered acceptable only due to practical and administrative reasons and might be reconsidered in future.
 - iv This implies that those conditions for which treatment is issued less frequently under appropriate conditions, such as the three monthly issue of adequate insulin for diabetics, or the use of some inhalers for asthmatics, do not qualify for inclusion in the REF grids.
- f Evidence of hospitalisation for a specific condition during the preceding three calendar months no longer serves as proof of treatment for CDL conditions. The following factors necessitated this change:
 - i Most patients identified via a hospital admission are likely to also be using chronic medication. Exceptions to this would be newly-diagnosed or non-compliant patients. For newly-diagnosed patients, non-use of hospital data would simply mean a delay in REF contributions by 60 days.
 - ii The ICD-10 codes would have to be far more comprehensive than in their current format if hospitalization data as entry criteria are to be retained.
- g The short term use of H02AB (Glucocorticoids) is no longer considered to be proof of treatment in neither Asthma, nor Chronic Obstructive Pulmonary Disease nor in Multiple Sclerosis. (See Table 2, Table 7 and Table 19 on pages 24 , 28 and 34).
- h For similar reasons, the use of J01 (Antibacterials for systemic use) no longer qualifies as proof of treatment in the identification of Bronchiectasis patients. (See Table 4 on page 25)
- i A set of verification criteria are included for Bipolar Mood Disorder (Table 3 on page 25).
 - i Even though an algorithm for Bipolar Mood Disorder has not been published, it is a PMB condition, specified both in the Diagnosis Treatment Pair section (902T) and in the CDL list in the regulations.

- ii Since an algorithm has not been published, the minimum level of treatment must be interpreted as the prevailing treatment practise for Bipolar Mood Disorder. The fact that an algorithm has not been published does not detract from the fact that Bipolar Mood Disorder is a Prescribed Minimum Benefit condition.
 - iii Paragraphs 1.6 and 1.11 should address questions arising from the fact that the ICD10 codes, ATC Codes and entry levels in this document might differ from the Algorithms and PMB regulations. Paragraph 1.8 makes it clear that a beneficiary is entitled to receive PMB benefits even if the REF Entry and Verification criteria are not met.
 - iv Paragraph 1.9 on page 9 should be adequate to explain that CMS neither approves nor recommends the use of any of these drugs.
- j More clarity on some ICD10 Codes that might be ambiguous, or codes that were excluded in error, is presented now.
- i The wording in sections 5.9 and 5.10 on page 20 now makes it clear that if ICD10 codes are used that include more than one CDL condition, that only one condition must be selected for the REF Grid Counts but that all conditions for which the proof of treatment criteria are met must be included in the REF Grid Prevalence tables.
 - ii O10.3 (*Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium*) has been included in the Cardiac Failure and Cardiomyopathy criteria (See Table 5 on page 26)
 - iii The interpretation of I12.0: *Hypertensive renal disease with renal failure* is presented in section 5.10.2 on page 21.
 - iv The interpretation of O10.2 and O10.3 (*Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium* and *Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium*) is presented in sections 5.10.2 and 5.10.3 on pages 21 and 21.
- k The following amendments were made to the Chronic Renal Failure criteria. (See Table 6 on page 27).
- i A Glomerular Filtration Rate estimate is now accepted as an alternative to a Creatinine Clearance Value.

- ii Due to the fact that existing diagnosis will have to be grandfathered, and the fact that this condition has been over-reported by many schemes during the first 3 quarters, the proof of treatment criteria has been made stricter through:
 - 1 The removal of the following ATC Codes, that may be used in other conditions as well: A02AC01 and A12AA04 (Calcium Carbonate); B03A (Iron preparations); B03BB (Folic Acid and Derivatives).
 - 2 Only AA11CC (Vitamin D and analogues), VO3AE (Drugs for treatment of hyperkalemia and hyperphosphatemia- Polystyrene sulfonate, Sevelamer, Lanthanum carbonate) and B03XA01 (Erythropoietin) has been kept as drugs accepted for the proof of treatment
 - 3 In addition to the above changes, evidence of haemodialysis is now a requirement and applicable NHRPL codes have been specified
- l In addition to the changes made to the Chronic Renal Disease Entry Criteria, a new limit has been introduced therein that Chronic Renal Disease patients may not also be counted as suffering from Hypertension. (See paragraph 3.9.1.3 on page 13)
- m The criteria for Chronic Obstructive Pulmonary Disease have been adjusted to correct an error in the previous document. The minimum FEV1/FVC ratio as well as the FEV1 values has been increased from 60% to 70% (See Table 7 on page 28). This is in line with the guidelines of the South African Thoracic Society, the Global Initiative for Chronic Obstructive Lung Disease (GOLD), the American Thoracic Society and the Canadian Thoracic Society.
- n Section 7 on page 38 has been included and gives the ATC code descriptions of all the ATC codes applicable in the REF Entry & Verification criteria.

1. Introduction

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

- 1.9 Similarly, certain drugs that are not included in the PMB algorithms might be included as proof of treatment to categorise a case as a REF beneficiary. This must not be interpreted that the CMS is endorsing these drugs or that these drugs must now be made available to beneficiaries under the PMB regulations.
- 1.10 In cases where an algorithm has been published, the application of the algorithm, including the use of drugs specified therein, constitutes the minimum benefit that a beneficiary is entitled to. In instances where an algorithm has not been published, the prevailing treatment practise shall be the minimum level of benefits that a beneficiary is entitled to.
- 1.11 These criteria have been developed with the emphasis on the verifiability of cases and will be used by CMS and other auditors to ensure that gaming is identified and addressed.
- 1.12 These guidelines provide concrete clinical codes that serve to identify patients that were treated for CDL conditions.
- 1.13 Initially these guidelines will be reviewed as the need arises, once stabilised, an annual revision will probably suffice.

2. Implementation Date

Existing CDL Cases

- 2.1 Schemes are requested to apply these criteria as soon as possible, but no later than 1 January 2007.
- 2.2 The criteria are based on “diagnosis-related” information as well as on “proof of treatment information”. In many instances the diagnosis-related information may not be available for cases that are already on treatment, and it might constitute a medical risk to confirm the diagnosis in accordance with the criteria. Therefore the diagnoses assigned to cases that have been started on treatment before 1 January 2006 is acceptable to REF. Some of these diagnoses might be reviewed in a systematic manner at a future date.

New CDL Cases

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

CDL Cases transferred between Medical Schemes

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

All CDL Cases

All CDL cases, whether existing, newly diagnosed or transferred cases, must meet the “proof-of treatment” component stipulated in the guidelines from 1 January 2007.

Note on Cases Identified with Previous Versions of the Guidelines

- 2.5 Note that during the shadow period, before the transfer of funds commences, it is not critical that the case definitions, as defined here are applied only from 1 January 2007. The criteria, as defined here may be applied before the 1st of January 2007.
- 2.6 As was previously stipulated, the criteria defined in Version 1.0 of these guidelines must be applied on all cases for the period starting 1 January 2006.

2.7 Schemes are requested to ascertain that their administration systems (As employed by medical scheme administrators, clearing houses, managed care organisations, providers and others) are capable of applying different sets of criteria strictly on the dates when they become effective. 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.

Age Bands

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

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

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

CDL Cases

- 3.6 Columns 2 to 28 of the REF Grid Count and REF Grid Prevalence are populated *based on the clinical entry and verification criteria for each chronic disease, as specified in this document.*
- 3.7 For the REF Grid Count each beneficiary must be placed in only one cell in Columns 1 to 28. For a person with two or more CDL conditions (or HIV and one or more CDL conditions), the scheme may choose the highest cost cell of the combination. A beneficiary with multiple diseases will only be counted once in columns 1 to 28. Thus the total of beneficiaries for columns 1 to 28 must equal the beneficiaries in the option for the period.
- 3.8 Note that with the combination of Chronic Heart Failure and Cardiomyopathy into one condition that, from 1 January 2006 (See section 2.3, page 10 on the implementation date), the CHF column must be left blank. All Chronic Heart Failure and Cardiomyopathy

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

Multiple Chronic Conditions

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

Exclusion of Specific Diseases as Multiple Chronic conditions

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

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

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

3.9.1.3 Only one of *Hypertension or Chronic Renal Failure* may be assigned to the same patient.

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

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

Maternity

3.10 The maternity modifier relates to “all the codes that indicate the delivery of a single/multiple foetus either stillborn or alive; following a pregnancy of at least 24 weeks duration”. Codes that apply to the delivery modifier are as follows:

ICD-10: Pre-term labour O60

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

NHRPL: 2614, 2615, 2616, and 2653

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

Beneficiaries without Chronic Diseases

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

Grid Prevalence Tables

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

3.14 The **REF** Grid Prevalence contains the total number of beneficiary months in the cell for the period. Each beneficiary must be placed in as many cells in Columns 1 to 28 as they have chronic conditions (CDL conditions or HIV). For a person with three CDL conditions the scheme will place the beneficiary in the three relevant columns. Thus the total of beneficiaries for columns 1 to 28 will be more than the beneficiaries in the option for the period.

3.15 Note that each of the respiratory conditions listed in paragraph 3.9.1.1 must be reported on in the REF Prevalence Grid.

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

Availability of Information from Capitated Providers

3.17 Schemes have indicated that they frequently have difficulties to obtain the information required to complete the grids from Managed Care Organisations and from Capitated Providers. It is important to note that:

- 3.17.1 In terms of Regulation 15B (2) (d) it is required that an accredited managed health care organisation has the necessary resources, systems, skills and capacity to render the managed health care services which it wishes to provide. Further, should a managed care organisation comply with Regulations 15D (a) and (c), such an organisation would be capable of providing the medical scheme with the data required for the REF return.
- 3.17.2 Regulation 15E (a) makes it clear that the scheme is not absolved of its responsibility towards members if any other party is in default to provide any service
- 3.18 Schemes must ensure that their contracts with preferred providers make provision for the availability of the information that is required to prepare the REF grids.

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

4.1 The Statutory Returns Portal on the CMS website accommodates the manual entry of the REF grids. (www.medicalschemes.com)

4.2 Manual data entry is very time-consuming and leads to many errors during the capturing process.

4.3 Schemes are urged to make use of the e-mail facility that has been created to speed up the submission process.

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

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

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

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

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

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

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

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

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

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

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

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

Purpose of Boolean tables in Section 6

5.1 Each of the tables in Section 6 consists of a section on diagnosis related information and a section on proof of treatment. To qualify for inclusion as a REF beneficiary, a case must meet both the diagnosis related criteria as well as the proof of treatment criteria.

5.2 Note that existing patients on active treatment should not be compromised through the withholding of treatment to prove that patients meet the diagnosis related requirements. (See section 2).

5.2.1 Diagnosis Related information:

5.2.1.1 The provider codes of providers (PCNS or HPCSA codes – see section 5.6) who have diagnosed in accordance with the REF Entry Criteria (See **“Definitions of Entry Criteria for Determining the REF Grids, RETAP Recommendations Report No. 2 of 2005”**, available at www.medicalschemes.com).

5.2.1.2 Where the diagnosis should be from a provider from a specified group, and such a provider has not submitted a claim with the given diagnosis, the treating provider should submit in writing the name of the diagnosing specialist.

5.2.1.3 The results of diagnostic tests specified in the REF Verification Criteria. Where applicable, proof of original laboratory or other test results must be kept. This may be in an electronic format, provided that the information is available to CMS and other auditors. (See section 5.4).

5.2.1.4 Hospitalisation or other treatment records providing proof of a specific clinical event specified in the REF Verification Criteria (See Coronary Artery Disease, on page 28)

5.2.2 Proof of treatment information is based on claims data.

5.2.2.1 Procedure codes as evidence for the performance of specified procedures in the REF Verification Criteria

5.2.2.2 ATC codes are used in the definitions of the REF Entry and Verification Criteria to describe specific drugs. (See paragraphs 5.13 and 5.14).

5.2.2.3 Hospitalisation records may be used as proof of treatment in instances where a case has recently been put on treatment has not yet received treatment for 60 days in the preceding three calendar months.

5.2.2.4 Note that proof of treatment must result only from benefits paid from a risk pool. (See paragraph 3.5)

5.2.2.5 Evidence is required that a patient has received 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 December, the beneficiary must have received treatment in two of the three calendar months of September, October and November. In instances where a beneficiary requires treatment less frequently, the beneficiary does not qualify as a REF beneficiary.

| Month: | Treatment Issued: | 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 |

5.3 The tables in Section 6 have been written to assist in the development of Boolean statements that will be used by schemes to correctly identify CDL cases. These queries must be made available to the CMS and Auditors on request. The tables describe the logic that must be applied to:

5.3.1 Test whether a case meets the criteria for inclusion as a CDL beneficiary in the REF, and;

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

Results of Special Investigations

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

Specialist Diagnosis required for Certain CDL Conditions

- 5.5 Note that the tables in section 6 specify specific specialists that are required for the diagnosis of the following conditions: Addison's disease, Crohn's disease, Diabetes Insipidus, Genetic Hyperlipidaemia (in the absence of Total Cholesterol values supporting the diagnosis), Multiple Sclerosis, Rheumatoid Arthritis (if the patient is not taking disease modifying drugs) Schizophrenia, Systemic Lupus Erythematosus and Ulcerative Colitis.
- 5.6 Note that the "provider codes" required in section 6 refer to the Practise Code Numbering System (PCNS) codes. Health Professions Council for South Africa (HPCSA) numbers should only be used if the provider does not have a PCNS code.

Verifiability and Auditing of Categorisation

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

Ambiguous ICD10 Codes to Identify CDL Cases

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

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

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

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

5.10.2 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 would be categorised to:
Chronic Renal Disease
Or
Hypertension in the REF Grid Count
(See page 27 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.

5.10.3 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)

and / or

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

If the proof of treatment and diagnosis criteria is met, this condition must be categorised to:
Cardiac Failure and Cardiomyopathy

Or

Chronic Renal Failure in the REF Grid Count

(See page 27 for the Chronic Renal Failure 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.

5.10.4 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 Three-digit ICD10 codes

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

Use of ATC and NAPPI codes

- 5.12 Schemes, administrators, providers and clearing houses make use of NAPPI codes to identify and bill for pharmaceuticals.
- 5.13 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:
- 5.13.1 The classification of a substance in the ATC system is not a recommendation for use, nor does it imply any judgements about efficacy or relative efficacy of drugs or group of drugs. The ATC system is not applicable for making diagnosis.

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

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

Use of specific drugs to identify CDL cases

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

6. Entry and Verification Criteria for CDL Conditions

Note that each of the conditions specified in Table 1 to Table 25 are subject to the overriding rules on the exclusion of specific multiple diseases specified in section 3.9.1 as well as the rules on ambiguous ICD10 codes in sections 5.9 and 5.10.

Table 1: Addison's disease

| Addison's Disease | | | | | |
|---|------------|-------------|------------------|---------------------------|---|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider: | AND | ICD10 Codes | | AND | Evidence of claims for any product included in the ATC categories below, 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 2: Asthma

| Asthma | | | | | | |
|---|------------|---------------------------------------|-----------------------|----------------------------------|---------------------------|---|
| <i>Diagnosis-related information</i> | | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider: | AND | ICD10 Codes (Any of the following) | | | AND | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: |
| Any registered medical practitioner | | J45 J45.0 J45.1 | J45.8 J45.9 J46 | H02AB R03AC R03AK R03BA | | R03BB01 R03CC R03DA04 R03DC |

Table 3: Bipolar Mood Disorder

| Bipolar Mood Disorder | | | | | |
|--|------------|---|----------------------------------|---|--|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | F31.0 F31.1 F31.2 F31.3 F31.4 | F31.5 F31.6 F31.8 F31.9 | N05AN01 N03AX09 N03AF01 N03AG01 | |

Table 4: Bronchiectasis

| Bronchiectasis | | | | | |
|--|------------|---------------------------------------|------------|---|-----------------------------|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | J47 Q33.4 | | H02AB R03AC R03AK R03BA | R03BB01 R03CC R03DA04 |

Table 5: Cardiac Failure and Cardiomyopathy

| Cardiac Failure and Cardiomyopathy | | | | | |
|---|------------|---------------------------------------|-------|------------|---|
| <i>Diagnosis-related information</i> | | | | | <i>Proof of Treatment</i> |
| Provider code of the diagnosing provider | | ICD10 Codes (Any of the following) | | | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: |
| Any registered medical practitioner | AND | I27.9 | I42.1 | AND | C01AA05 |
| | | I50 | I42.2 | | C01DA |
| | | I50.0 | I42.3 | | C02DB |
| | | I50.1 | I42.4 | | C03 |
| | | I50.9 | I42.5 | | C07 |
| | | I11.0 | I42.6 | | C09 |
| | | I13.0 | I42.7 | | |
| | | I13.2 | I42.8 | | |
| | | I42 | I42.9 | | |
| | | I42.0 | O10.3 | | |

Table 6: Chronic Renal Disease

| Chronic Renal Disease | | | | | | | | |
|--|------------|--|------------|---|-------|---|---|--|
| Note that for REF purposes Hypertension cannot occur with COPD | | | | | | | | |
| 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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | | |
| Any registered medical practitioner | | OR | | Creatinine clearance value of < 30 ml / min | N03 | N05.0 | A11CC | |
| | | | | | N03.0 | N05.1 | B03XA01 | |
| | | | | | N03.1 | N05.2 | V03AE | |
| | N03.2 | N05.3 | AND | | | | | |
| N03.3 | N05.4 | Evidence of peritoneal or haemodialysis for at least 8 sessions in the preceding three months, as evidenced by any of the following NHRPL codes: | | | | | | |
| N03.4 | N05.5 | | | | | | | |
| N03.5 | N05.6 | | | | | | | |
| N03.6 | N05.7 | | | | | | | |
| N03.7 | N05.8 | | | | | | | |
| N03.8 | N05.9 | | | | | | | |
| N03.9 | N11 | | | | | | | |
| N04 | N11.0 | | | | | | | |
| N04.0 | N11.1 | | | | | | | |
| N04.1 | N11.8 | | | | | | | |
| N04.2 | N11.9 | | | | | | | |
| N04.3 | N18 | | | | | | | |
| N04.4 | N18.0 | | | | | | | |
| N04.5 | N188 | | | | | | | |
| N04.6 | N189 | | | | | | | |
| N04.7 | I12.0 | | | | | | | |
| N04.8 | I13.2 | | | | | | | |
| N04.9 | O10.2 | | | | | | | |
| N05 | O10.3 | | | | | | | |
| | | A Glomerular Filtration Rate estimate of < 30 ml / min | | | | Medical Practitioners: 1843 1845 1847 1849 1851 1852 | Clinical Technologists: 145 146 148 147 176 177 149 150 151 152 154 156 153 155 | Registered Nurses: 092 608 610 612 |

Table 7: Chronic Obstructive Pulmonary Disease

| Chronic Obstructive Pulmonary Disease | | | | | | | |
|--|------------|---|------------|---|---|------------|---|
| <i>Note that, for REF purposes, neither asthma, nor bronchiectasis can occur with COPD</i> | | | | | | | |
| Diagnosis-related information | | | | Proof of Treatment | | | |
| Provider code of the diagnosing provider | AND | Result of Special investigations | AND | ICD10 Codes (Any of the following) | | AND | Evidence of claims for any product included in the ATC categories below, in two different calendar months 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 J43.0 J43.1 J43.2 J43.8 J43.9 J44 J44.0 J44.1 J44.8 J44.9 | J43 J43.0 J43.1 J43.2 J43.8 J43.9 J44 J44.0 J44.1 J44.8 J44.9 | | H02AB R03AC R03AK R03BA R03BB R03CC R03DA04 |

Table 8: Coronary Artery Disease

| Coronary Artery Disease | | | | | | | |
|--|------------|--|---|---------------------------|---|------------|---|
| Diagnosis-related information | | | | Proof of Treatment | | | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | AND | Evidence of an in- or outpatient event leading up to the diagnosis of Coronary Artery disease with one of the following ICD10 codes | AND | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: |
| Any registered medical practitioner | | I20 I20.0 I20.1 I20.8 I20.9 I25 I25.0 I25.1 | I25.2 I25.3 I25.4 I25.5 I25.6 I25.8 I25.9 | | | | I20 I20.0 I20.1 I20.8 I20.9 I21 I21.0 I21.1 I21.2 |

Table 9: Crohn's Disease

| Crohn's Disease | | | | | |
|--|-----|---|---|---------------------------|---|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | AND | Evidence of claims for any product included in the ATC categories below, 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 | | K50 K50.0 K50.1 K50.8 K50.9 | A07E H02AB J01XD01 J01MA L04AA01 L04AA05 | | L04AA11 L04AA12 L04AX01 L04AX03 L01BA01 P01AB01 |

Table 10: Diabetes Insipidus

| Diabetes Insipidus | | | | | |
|--|-----|---------------------------------------|-------|---------------------------|---|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | AND | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: |
| Must be a specialist physician, paediatrician, neurosurgeon, neurologist or endocrinologist 11800 13200 12400 | | E23.2 | H01BA | | |

Table 11: Diabetes Mellitus (Type 1 and 2)

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

Table 12: Dysrhythmias

| Dysrhythmias | | | | |
|--|------------|---------------------------------------|---------------------------|---|
| <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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: |
| Any registered medical practitioner | | I47.2 I48 | | B01AA03 C01A C01B C07 C08D |

Table 13: Epilepsy

| Epilepsy | | | | | |
|--|------------|---------------------------------------|------------|---|-----|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | G40 | G40.8 | AND | N03 |
| | G40.0 | G40.9 | | | |
| | G40.1 | G41 | | | |
| | G40.2 | G41.0 | | | |
| | G40.3 | G41.1 | | | |
| | G40.4 | G41.2 | | | |
| | G40.5 | G41.8 | | | |
| | G40.6 | G41.9 | | | |
| | G40.7 | | | | |

Table 14: Glaucoma

| Glaucoma | | | | | |
|--|------------|---------------------------------------|------------|---|------|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | H40 | H40.5 | AND | S01E |
| | H40.0 | H40.6 | | | |
| | H40.1 | H40.8 | | | |
| | H40.2 | H40.9 | | | |
| | H40.3 | Q15.0 | | | |
| | H40.4 | | | | |

Table 15: Haemophilia

| Haemophilia | | | | | |
|--|------------|---------------------------------------|------------|---|---------|
| <i>Diagnosis-related information</i> | | | AND | <i>Proof of Treatment</i> | |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | D66 | | AND | B02AA02 |
| | D67 | | B02BD02 | | H01BA |
| | | | B02BD03 | | |

Table 16: 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 | | | ICD10 Codes (Any of the following) | Evidence of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| | | G45 | I21.9 | I25.8 | | | I66.1 |
| Any registered medical practitioner. | AND | G45.0 | I22 | I25.9 | I66.2 | AND | C10 |
| | | G45.1 | I22.0 | I63.0 | I66.3 | | |
| | | G45.2 | I22.1 | I63.1 | I66.4 | | |
| | | G45.3 | I22.8 | I63.2 | I66.8 | | |
| | | G45.4 | I22.9 | I63.3 | I66.9 | | |
| | | G45.8 | I24 | I63.4 | I67.6 | | |
| | | G45.9 | I24.0 | I63.5 | I70 | | |
| | | I20 | I24.1 | I63.6 | I70.0 | | |
| | | I20.0 | I24.8 | I63.8 | I70.1 | | |
| | | I20.1 | I24.9 | I63.9 | I70.2 | | |
| | | I20.8 | I25 | I64 | I70.8 | | |
| | | I20.9 | I25.0 | I65.0 | I70.9 | | |
| | | I21 | I25.1 | I65.1 | | | |
| | | I21.0 | I25.2 | I65.2 | | | |
| | | I21.1 | I25.3 | I65.3 | | | |
| | | I21.2 | I25.4 | I65.8 | | | |
| | | I21.3 | I25.5 | I65.9 | | | |
| I21.4 | I25.6 | I66.0 | | | | | |
| OR | | | | | | | |
| 10 year MI risk > 20% and/or risk at age 60 years >30% as per Framingham Risk Score | | | | | | | |
| OR | | | | | | | |
| Genetic hyperlipidaemias diagnosed by: | | | | | | | |
| An endocrinologist (PCNS Practise Type: 11801) | | | | | | | |
| OR | | | | | | | |
| By any registered medical practitioner where TC>7.5mmol/l | | | | | | | |
| AND | | | | | | | |
| | | | | | E78 E78.0 E78.1 E78.2 E78.3 E78.4 E78.5 | | |

Table 17: Hypertension

| Hypertension | | | | | |
|--|------------|---------------------------------------|---------------------------|---|---------|
| <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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | I10 | I15.0 | | |
| | | I11 | I15.1 | | |
| | | I11.0 | I15.2 | | |
| | | I11.9 | I15.8 | | |
| | | I12 | I15.9 | | |
| | | I12.0 | O10 | | |
| | | I12.9 | O10.0 | | |
| | | I13 | O10.1 | | |
| | | I13.0 | O10.2 | | |
| | | I13.1 | O10.3 | | |
| | | I13.2 | O10.4 | | |
| | | I13.9 | O10.9 | | |
| | I15 | O11 | | | |
| | AND | | | C02 | C08 |
| | | | | C03 | C09 |
| | | | | C07 | G04CA03 |

Table 18: Hypothyroidism

| Hypothyroidism | | | | | |
|--|------------|---------------------------------------|---------------------------|---|--|
| <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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | E01.8 | E03.3 | | |
| | | E02 | E03.4 | | |
| | | E03 | E03.5 | | |
| | | E03.0 | E03.8 | | |
| | | E03.1 | E03.9 | | |
| | | E03.2 | E89.0 | | |
| | AND | | | H03AA | |

Table 19: Multiple Sclerosis

| Multiple Sclerosis | | | | | |
|--|------------|---------------------------------------|---------------------------|---|-------|
| <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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Must be a specialist physician, or neurologist 11800 12000 | | G35 | | | |
| | AND | | | G04BD | N02A |
| | | | | L03AB07 | N03 |
| | | | | L03AB08 | N06AA |
| | | | | M03BX01 | |

Table 20: Parkinson’s disease

| Parkinson’s disease | | | | |
|--|-----|---------------------------------------|----------------------------------|--------------------|
| Diagnosis-related information | | | AND | Proof of Treatment |
| Provider code of the diagnosing provider | AND | ICD10 Codes (Any of the following) | | AND |
| Any registered medical practitioner | | G20 G21 G21.0 G21.1 | G21.2 G21.3 G21.8 G21.9 | |

Table 21: Rheumatoid Arthritis

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

Table 22: Schizophrenia

| Schizophrenia | | | | | |
|---|------------|---|---|------------|---|
| <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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: |
| Must be a psychiatrist or paediatric psychiatrist 12200 12201 | | F20 F20.0 F20.1 F20.2 F20.3 | F20.4 F20.5 F20.6 F20.8 F20.9 | | |

Table 23: Systemic Lupus Erythematosus

| Systemic Lupus Erythematosus | | | | | |
|--|------------|--|---------------------------|------------|---|
| <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 claims for any product included in the ATC categories below, 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 M32.0 M32.1 M32.8 M32.9 L93 | L93.0 L93.1 L93.2 | | |

Table 24: Ulcerative Colitis

| Ulcerative Colitis | | | | | |
|---|------------|---|----------------------------------|------------|---|
| <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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: |
| Must be a specialist surgeon, physician or gastroenterologist: 14200 11800 11900 | | K51 K51.0 K51.1 K51.2 K51.3 | K51.4 K51.5 K51.8 K51.9 | | |

Table 25: 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 claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month: | |
| Any registered medical practitioner | | Z21 | B21.3 | | AND | AND | J05AE |
| | | B20 | B21.7 | | | | J05AF |
| | | B20.0 | B21.8 | | | | J05AG |
| | | B20.1 | B21.9 | | | | |
| | | B20.2 | B22 | | | | |
| | | B20.3 | B22.0 | | | | |
| | | B20.4 | B22.1 | | | | |
| | | B20.5 | B22.2 | | | | |
| | | B20.6 | B22.7 | | | | |
| | | B20.7 | B23 | | | | |
| | | B20.8 | B23.0 | | | | |
| | | B20.9 | B23.1 | | | | |
| | | B21 | B23.2 | | | | |
| | | B21.0 | B23.8 | | | | |
| | | B21.1 | B24 | | | | |
| | | B21.2 | | | | | |

7. ATC Code Descriptions

| Asthma | |
|---|---|
| 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 |
| 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 |
| Chronic Renal Disease | |
| A11CC | Vitamin D and analogues |
| B03XA01 | Erythropoietin |
| V03AE | Drugs for treatment of hyperkalemia and hyperphosphatemia |

| Chronic Obstructive Pulmonary Disease | |
|--|--|
| H02AB | Glucocorticoids |
| 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 |
| C09 | AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM |
| 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 |
| A10B | ORAL BLOOD GLUCOSE LOWERING DRUGS |
| A10 | DRUGS USED IN DIABETES |
| 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 | ANTIPILEPTICS |
| Glaucoma | |
| S01E | ANTI GLAUCOMA PREPARATIONS AND MIOTICS1) |

| Haemophilia | |
|-----------------------------|---|
| B02AA02 | Tranexamic acid |
| B02BD02 | Coagulation factor VIII |
| B02BD03 | Factor VIII inhibitor bypassing activity |
| B02BD04 | Coagulation factor IX |
| H01BA | Vasopressin and analogues |
| Hyperlipidaemia | |
| C10 | SERUM LIPID REDUCING AGENTS |
| 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 | |
| G04BD | Urinary antispasmodics |
| L03AB07 | Interferon beta-1a |
| L03AB08 | Interferon beta-1b |
| M03BX01 | Baclofen |
| N02A | OPIOIDS |
| N03 | ANTIEPILEPTICS |
| N06AA | Non-selective monoamine reuptake inhibitors |
| Parkinson's disease | |
| N04 | ANTI-PARKINSON DRUGS |
| Rheumatoid Arthritis | |
| A07EC01 | Sulfasalazine |
| H02AB | Glucocorticoids |
| L01AA01 | Cyclophosphamide |
| L01BA01 | Methotrexate |
| L04A | IMMUNOSUPPRESSIVE AGENTS |
| M01A | ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STERIODS |
| M01C | SPECIFIC ANTIRHEUMATIC AGENTS |
| P01BA01 | Chloroquine |
| Schizophrenia | |
| N05A | ANTIPSYCHOTICS |
| N06A | ANTIDEPRESSANTS |

| Systemic Lupus Erythematosus | |
|-------------------------------------|--|
| B01AA03 | Warfarin |
| H02AB | Glucocorticoids |
| L01AA01 | Cyclophosphamide |
| L01BA01 | Methotrexate |
| L04AA01 | Ciclosporin |
| L04AA05 | Tacrolimus |
| L04AA06 | Mycophenolic acid |
| L04AX01 | Azathioprine |
| M01A | ANTIINFLAMMATORY AND ANTIRHEUMATIC PRODUCTS, NON-STEROIDS |
| 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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