

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

Version 2

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 since the publication of Version 1.0 of the Guidelines on 22 November 2005

Version 1 of the **Guidelines for the Identification of Beneficiaries with REF Risk Factors in Accordance with the REF Entry and Verification Criteria**, 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.

Various drafts of this publication has been in the public domain since March 06 and final changes were suggested by RETAP on 20 April and incorporated into Version 2 of the guidelines and must be applied to all REF Cases from 1 January 2007. Since some of the changes will have an impact on schemes' IT systems, schemes are urged to incorporate these changes as soon as possible.

Areas modified in this document, Version 2 of the guidelines 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 3)
- 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 2.6 and 2.7 on page 3)
- d Section 3.9.1 on page 6 specifies that certain conditions may not co-occur for REF Grid Count purposes. All conditions must however be included in REF Prevalence Grids.
- e The NHRPL code 2653 (Caesarian hysterectomy) is added to the maternity codes. (See paragraph 3.10 on page iii).
- f The specific source of diagnosis related information is defined in section 5.3 on page 11.

- g With the exception of specified diseases (See paragraph A.h below), proof of treatment now requires evidence of two issues of medicines from the specified ATC categories in two of the three preceding calendar months (See section 5.4.4 on page 13).
 - i Note that the criteria clearly specify that evidence must exist of payment for treatment during the three months preceding the month for which the beneficiary's REF eligibility status is evaluated.
 - ii 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.
- h Exceptions to the proof of treatment periods specified in paragraph A.g above have been made for conditions that require treatment on a less frequent basis. The following conditions therefore require less frequent proof of payment for specified medicines:
 - i Table 2: Asthma, page 19
 - ii Table 7: Chronic Obstructive Airways Disease, page 23
 - iii Table 6: Chronic Renal Disease, page 19
 - iv Table 11: Diabetes Mellitus (Type 1 and 2), page 26
 - v Table 15: Haemophilia, page 28
- i With the exception of Multiple Sclerosis (Table 19: Multiple Sclerosis, page 31) 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.

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- j The short term use of H02AB (Glucocorticoids) is no longer considered to be proof of treatment in neither Asthma, Chronic Obstructive Pulmonary Disease nor in Multiple Sclerosis. (See Table 2, Table 7 and Table 19 on pages 19 , 23 and 31).
- k 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 20)
- l A set of verification criteria are included for Bipolar Mood Disorder (Table 3 on page 20).
 - 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 2 should be adequate to explain that CMS neither approves nor recommends the use of any of these medicines.
- m 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 5.13 and 5.14 on page 15 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 O10.1 (*Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium*) and O10.3 (*Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium*)

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has been included in the Cardiac Failure and Cardiomyopathy criteria (See Table 5 on page 21)

- iii The interpretation of I12.0: *Hypertensive renal disease with renal failure* is presented in section 5.14.2 on page 16.
 - iv The interpretation of O10.1; O10.2 and O10.3 (*Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium ; 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 5.14.1, 5.14.2 and 5.14.3 on pages 16 and 16.
- n The following amendments were made to the Chronic Renal Disease criteria. (See Table 6 on page 22).
- 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 of the Shadow Period, 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); A11CC (vitamin D and analogues); B03A (Iron preparations); B03BB (Folic Acid and Derivatives).
 - 2 Only VO3AE (Medicines for treatment of hyperkalemia and hyperphosphatemia- Polystyrene sulfonate, Sevelamer, Lanthanum carbonate), B05D (Peritoneal Dialytics), B05Z (Haemodialytics and haemofiltrates) and B03XA01 (Erythropoietin) has been kept as medicines accepted for the proof of treatment
 - 3 In addition to the above changes, evidence of payment for treatment with the medicines above or evidence of peritoneal or haemodialysis is now a requirement; applicable NHRPL or UPFS codes have been specified
 - 4 I13.1 (*Hypertensive heart and renal disease with renal failure*) has been included as an acceptable diagnosis code.

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- o 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 6)
- p 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 23). 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.
- q The requirement of evidence of a specific event leading up to the diagnosis has been removed from Table 8: Coronary Artery Disease on page 24. This was done to reduce the complexity of the algorithm. To prevent gaming of this condition, the ATC code C09 (Agents acting on the rennin angiotensin system) has been removed from the proof of treatment criteria.
- r Due to the fact that Haemophilia is a low prevalence high cost disease with large potential for gaming, laboratory information supporting the diagnosis is now a requirement in Table 15: Haemophilia on page 28.
- s Multiple sclerosis is not only difficult to diagnose accurately, a large range of medicines could be used in the treatment thereof. To improve specificity, only Beta-interferon or evidence of hospitalisation has been retained as proof of treatment in Table 19: Multiple Sclerosis, on page 31.
- t The ATC Category M01AB (Anti-inflammatory and anti-rheumatic products, non-steroids, inclusive of other anti rheumatic agents less specific for Rheumatoid Arthritis) has been removed from Systemic Lupus Erythematosus and Rheumatoid Arthritis tables and has been replaced with the following more specific anti rheumatics:
 - M01AB Acetic acid derivatives and related substances
 - M01AC Oxicams
 - M01AE Propionic acid derivatives
 - M01AG Fenamates
 - M01AH CoxibsSee Table 21: Rheumatoid Arthritis, and Table 23: Systemic Lupus Erythematosus on pages 32 and 33.
- u The ATC Code N06A (Antidepressants) has been removed from Table 22: Schizophrenia on page 33.

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- v Section 7 on page 36 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 medicines 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 medicines or that these medicines 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 medicines 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 Version 1 of the guidelines, cases commencing treatment after 1 January 2007 must meet the criteria specified in this document (Version 2).

CDL Cases transferred between Medical Schemes

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

All CDL Cases

- 2.5 All CDL cases, whether existing, newly diagnosed or transferred cases, must meet the “proof-of treatment” component stipulated in the Version 2 of the guidelines from 1 January 2007

Note on Cases Identified with Previous Versions of the Guidelines

- 2.6 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.

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- 2.7 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.
- 2.8 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 3 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 in the Count Grids

- 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 in the count grids (CC2, CC3 or CC4 modifiers). 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 For count purposes, 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 For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: *Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension*

3.9.1.3 For count purposes, only one of *Chronic Renal Disease or Hypertension* may be assigned to the same patient.

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

Maternity

- 3.10 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 and its sub-paragraphs 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).

Notes on the collection and archiving diagnosis related information

- 5.3 Diagnosis related information must be recorded in an auditable format; this includes voice recordings, electronic submissions and written hardcopies.
 - 5.3.1 The provider codes of providers (PCNS or HPCSA codes – see section 5.10) who are diagnosing and/or treating in accordance with the REF Entry Criteria must be documented in all cases. (See “**Definitions of Entry Criteria for Determining the REF Grids, RETAP Recommendations Report No. 2 of 2005**”, available at www.medicalschemes.com).
 - 5.3.2 Managed care organisations and administrators may provide diagnosis codes on the information provided by the providers (or their employees) specified in section 6. The source documentation (voice recordings, electronic recordings or paper copies) underlying the coding decision must however be archived in an auditable format.
 - 5.3.3 Where the diagnosis can be established by any medical practitioner, and such a provider has not submitted a claim or pre-authorisation request with the given diagnosis, the diagnosis may be communicated to the managed care company or administrator on behalf of the diagnosing doctor by both employees of such a provider or the pharmacist dispensing medication for such a condition.
 - 5.3.4 Where the diagnosis should be from a provider from a specified group (e.g. specialists), and such a provider has not submitted a claim or pre-authorisation request with the given diagnosis, the treating provider should submit the name of the diagnosing specialist and the diagnosis.

5.3.5 Where the diagnosis should be supported by results of diagnostic tests specified in the REF Verification Criteria, proof of original laboratory or other test results must be kept. These results could be submitted by the diagnosing or treating provider or the laboratory, provided that the information is in an auditable format. (See paragraphs 5.3 and 5.8).

5.3.6 Hospitalisation or other treatment records may be used as proof of a specific clinical event or diagnosis specified in the REF Verification Criteria (e.g. Coronary Artery Disease, on page 24)

Proof of treatment information is based on claims data

5.4 Proof of treatment information must be based on claims data.

5.4.1 Procedure codes are used as evidence for the performance of specified procedures in the REF Verification Criteria (See Chronic Renal Disease table on page 22)

5.4.2 ATC codes are used in the definitions of the REF Entry and Verification Criteria to describe specific medicines. (See paragraphs 5.17 and 5.18).

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

5.4.4 In most instances, evidence is required that a patient has received the specified treatment during at least two preceding calendar months in the three calendar months preceding the current month (the month for which the beneficiary's REF status is established). The schedule below indicates that, to count a beneficiary in December, payment towards treatment must have been made in two of the three calendar months of September, October and November. In instances where payment for the specified medicines occurs less frequently, the beneficiary does not qualify as a REF beneficiary.

Application of Proof of treatment requirements in Instances where proof of treatment is required for two calendar months in the three months preceding the calendar for which REF eligibility is determined			
Month:	Treatment paid for:	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	

5.5 Specified conditions require proof of payment on at least one occasion in the three calendar months preceding the period for which REF eligibility is determined. These conditions and *the specific drugs for which the less frequent issue of medicines is a requirement*, are specified in: Table 2: Asthma, page 19, Table 7: Chronic Obstructive Airways Disease, page 23, Table 6: Chronic Renal Disease, page 19, Table 11: Diabetes Mellitus (Type 1 and 2), page 26 and Table 15: Haemophilia, page 28

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

Application of Proof of treatment requirements in Instances where proof of treatment is required for one calendar months in the three months preceding the calendar for which REF eligibility is determined			
Month:	Treatment paid for:	Eligible for Inclusion in the REF grids:	
Jan	Yes		No
Feb	Yes		Yes
Mar	Yes		Yes
Apr	Yes		Yes
May	Yes		Yes
Jun	No	→	Yes
Jul	No		Yes
Aug	Yes		Yes
Sep	Yes		Yes
Oct	Yes	→	Yes
Nov	No		Yes
Dec	No		Yes
Jan	No		Yes
Feb	Yes		No

5.7 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. It is critical that proper version control is applied, since it is likely that these criteria will change at least once a year. The tables describe the logic that must be applied to:

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

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

Results of Special Investigations

5.8 For Chronic Obstructive Lung Disease, Chronic Renal Disease, Haemophilia and Hyperlipidaemia, it is required that the results of special investigations are kept by

schemes. This information must also be made available to auditors on request but may be in the form of voice recordings or other electronic records.

Specialist Diagnosis required for Certain CDL Conditions

- 5.9 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 medicines) Schizophrenia, Systemic Lupus Erythematosus and Ulcerative Colitis.
- 5.10 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

- 5.11 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.
- 5.12 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

- 5.13 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:
- 5.14 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.

5.14.1111.0: Hypertensive heart disease with (congestive) heart failure (or O10.1: Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium

If the "proof of treatment" criteria are met, this condition must be categorised to: Cardiac Failure and Cardiomyopathy
--

Or
Hypertension in the REF Grid Count
(See page 21 for the Cardiac Failure and Cardiomyopathy criteria and page 30 for the Hypertension Criteria)

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

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

If the “proof of treatment” criteria are met, this condition must be categorised to:
Chronic Renal Disease
Or
Hypertension in the REF Grid Count
(See page 22 for the Chronic Renal Disease criteria and page 30 for the Hypertension Criteria)

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

5.14.3 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 are met, this condition must be categorised to:

Cardiac Failure and Cardiomyopathy

Or

Chronic Renal Disease in the REF Grid Count

Or

Hypertension in the REF Grid Count

(See page 22 for the Chronic Renal Disease criteria and page 30 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.

/

5.14.425.5: 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

- 5.15 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

- 5.16 Schemes, administrators, providers and clearing houses make use of NAPPI codes to identify and bill for pharmaceuticals.
- 5.17 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:
- 5.17.1 The classification of a substance in the ATC system is not a recommendation for use, nor does it imply any judgements about efficacy or relative efficacy of medicines or group of medicines. The ATC system is not applicable for making a diagnosis.
- 5.17.2 ATC codes may change over the years. An updated version of the ATC Index is issued annually.
- 5.17.3 The ATC Index is published by the WHO Collaborating Centre for Drug Statistics Methodology and is available at www.whocc.no

Use of specific medicines to identify CDL cases

- 5.18 Note that the medicines represented by ATC codes in Section 6 do not imply that the CMS recommends that these medicines are used. Neither is it implied that these medicines are required by the regulations on Prescribed Minimum benefits or the 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)
- 5.19 Note that the use of a medicine to assign a diagnosis to a patient is not acceptable in terms of the criteria specified in Section 6. In all instances proof of Diagnosis is required in addition to proof of treatment.

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 5.13 and 5.14.

Table 1: Addison's disease

Addison's Disease			
Diagnosis-related information			Proof of Treatment
Provider code of the diagnosing provider:	AND	ICD10 Codes	Evidence of payment 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				
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: <i>Chronic Obstructive Pulmonary Disease, Asthma and Bronchiectasis</i>				
Diagnosis-related information			Proof of Treatment	
Provider code of the diagnosing provider:	AND	ICD10 Codes (Any of the following)		Evidence of payment 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
			OR	
			Evidence of payment of claims for any product included in the ATC categories below, in one calendar month during the three calendar months preceding the current month:	
		R03AC R03AK R03BA	R03BB01 R03CC R03DA04 R03DC	

Table 3: Bipolar Mood Disorder

Bipolar Mood Disorder				
For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: <i>Bipolar Mood Disorder or Schizophrenia</i> and may not co-occur with Epilepsy or Multiple Sclerosis				
Diagnosis-related information			AND	Proof of Treatment
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		F31 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				
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: <i>Chronic Obstructive Pulmonary Disease, Asthma and Bronchiectasis</i>				
Diagnosis-related information			AND	Proof of Treatment
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of payment of claims for any product included in the ATC categories below, 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				
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>				
Diagnosis-related information			Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		I27.9	I42.2	
		I50	I42.3	C01DA
		I50.0	I42.4	C02DB
		I50.1	I42.5	C03
		I50.9	I42.6	C07
		I11.0	I42.7	C09
		I13.0	I42.8	
		I13.2	I42.9	
		I42	O10.1	
	I42.0	O10.3		
	I42.1			

Table 6: Chronic Renal Disease

Chronic Renal Disease												
<i>For count purposes , only one of Hypertension or Chronic Renal Disease may be assigned to the same patient</i>												
Diagnosis-related information				Proof of Treatment								
Provider code of the diagnosing provider	AND	Result of Special investigations	AND	ICD10 Codes (Any of the following)		Evidence of payment of claims for any product included in the ATC categories below, in one calendar month in the three calendar months preceding the current month:						
Any registered medical practitioner		OR		Creatinine clearance value of < 30 ml / min	AND	N03	N05.1	B05D				
						N03.0	N05.2	B05Z				
						N03.1	N05.3	B03XA01				
						N03.2	N05.4	V03AE				
						N03.3	N05.5	OR				
						N03.4	N05.6	Evidence of peritoneal or haemodialysis for at least 8 sessions in the preceding three months, as evidenced by any of the following NHRPL or UPFS codes:				
						N03.5	N05.7	AND	Medical Practitioners:		Registered Nurses:	
						N03.6	N05.8		1843			092
						N03.7	N05.9		1845			608
	N03.8		N11			1847	176		610			
N03.9	N11.0	1849	177	612								
N04	N11.1	1851	149	UPFS								
N04.0	N11.8	1852	150	80090								
N04.1	N11.9	Clinical Technologists:										
N04.2	N18	145	151	0310								
N04.3	N18.0	146	152	0311								
N04.4	N18.8	148	154	0312								
N04.5	N18.9	147	155	0320								
N04.6	I12.0			0321								
N04.7	I13.1			0322								
N04.8	I13.2											
N04.9	O10.2											
N05	O10.3											
N05.0												

Table 7: Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease						
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: <i>Chronic Obstructive Pulmonary Disease, Asthma and Bronchiectasis</i>						
Diagnosis-related information				Proof of Treatment		
Provider code of the diagnosing provider	AND	Result of Special investigations	AND	ICD10 Codes (Any of the following)	AND	Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
						OR
				J43 J43.0 J43.1 J43.2 J43.8 J43.9 J44 J44.0 J44.1 J44.8 J44.9		Evidence of payment of claims for any product included in the ATC categories below, in one calendar month during 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				R03AC R03AK R03BA R03BB R03CC R03DA04

Table 8: Coronary Artery Disease

Coronary Artery Disease					
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of payment 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	C01DA C07 C08

Table 9: Crohn's Disease

Crohn's Disease					
For count purposes, only one of the following Gastro Intestinal conditions can be assigned to the same patient: <i>Crohn's disease or Ulcerative Colitis</i>					
Diagnosis-related information			AND	Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of payment 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>			<i>Proof of Treatment</i>	
Provider code of the diagnosing provider		AND	AND	Evidence of payment 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	12000 11801			

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 medicines automatically leads to the classification of a diabetic case as Type 2. • Where there is <u>only insulin use (ATC A10A)</u>, the doctor's diagnosis (based on the ICD10 codes below) of Type 1 versus Type 2 must be accepted. 							
Diagnosis-related information				Proof of Treatment			
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND IF	Evidence of use of oral hypoglycaemic or euglycaemic agents. This includes any product in the A10B ATC category:	Evidence of payment 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:	
		E10	E11.9				OR
E10.0		E12	OR		Any ICD10 code indicative of Non-Insulin Dependent Diabetes:	AND	OR
E10.1		E12.0					
E10.2		E12.1	THEN		Classify as Type 2 diabetes	ELSE	
E10.3		E12.2					THEN
E10.4		E12.3	ELSE		Classify as Type 1 Diabetes		
E10.5		E12.4				THEN	Classify as Type 2 diabetes
E10.6		E12.5	ELSE		Classify as Type 1 Diabetes		
E10.7		E12.6				THEN	Classify as Type 2 diabetes
E10.8		E12.7	ELSE		Classify as Type 1 Diabetes		
E10.9		E12.8				THEN	Classify as Type 2 diabetes
E11		E12.9	ELSE		Classify as Type 1 Diabetes		
E11.0		O24				THEN	Classify as Type 2 diabetes
E11.1		O24.0	ELSE		Classify as Type 1 Diabetes		
E11.2		O24.1				THEN	Classify as Type 2 diabetes
E11.3		O24.2	ELSE		Classify as Type 1 Diabetes		
E11.4		O24.3				THEN	Classify as Type 2 diabetes
E11.5	O24.4	ELSE	Classify as Type 1 Diabetes				
E11.6	O24.9			THEN	Classify as Type 2 diabetes		
E11.7		ELSE	Classify as Type 1 Diabetes				
E11.8				THEN	Classify as Type 2 diabetes		
Any registered medical practitioner							

Table 12: Dysrhythmias

Dysrhythmias					
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, 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					
For count purposes, <i>Bipolar Mood Disorder and Multiple Sclerosis may not co-occur with Epilepsy</i>					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		G40	G40.8		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					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		H40	H40.5		S01E
		H40.0	H40.6		
		H40.1	H40.8		
		H40.2	H40.9		
		H40.3	Q15.0		
		H40.4			

Table 15: Haemophilia

Haemophilia					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, in one calendar month during the three calendar months preceding the current month:
		D66			
		D67			
		AND			
Any registered medical practitioner		Laboratory evidence of Factor VIII or IX levels lower than or equal to 5%			
				B02AA02	B02BD04
				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 payment 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					

			OR				
		TC > 7 mmol/l	AND	Positive family history of a premature vascular event in a 1 st degree male relative < 55 yrs			
				OR	Positive family history of a premature vascular event a 1 st degree female relative < 65 yrs		
		OR					
		The presence of tendon Xantomata					

Table 17: Hypertension

Hypertension																																					
For count purposes, only one of the following cardiovascular diseases can be assigned to the same patient: <i>Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension</i>																																					
For count purposes, only one of <i>Hypertension or Chronic Renal Disease</i> may be assigned to the same patient																																					
Diagnosis-related information			Proof of Treatment																																		
Provider code of the diagnosing provider		ICD10 Codes (Any of the following)		Evidence of payment 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	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%;">I10</td><td style="width: 50%;">I15.0</td></tr> <tr><td>I11</td><td>I15.1</td></tr> <tr><td>I11.0</td><td>I15.2</td></tr> <tr><td>I11.9</td><td>I15.8</td></tr> <tr><td>I12</td><td>I15.9</td></tr> <tr><td>I12.0</td><td>O10</td></tr> <tr><td>I12.9</td><td>O10.0</td></tr> <tr><td>I13</td><td>O10.1</td></tr> <tr><td>I13.0</td><td>O10.2</td></tr> <tr><td>I13.1</td><td>O10.3</td></tr> <tr><td>I13.2</td><td>O10.4</td></tr> <tr><td>I13.9</td><td>O10.9</td></tr> <tr><td>I15</td><td>O11</td></tr> </table>	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	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 50%;">C02</td><td style="width: 50%;">C08</td></tr> <tr><td>C03</td><td>C09</td></tr> <tr><td>C07</td><td>G04CA03</td></tr> </table>	C02	C08	C03	C09	C07	G04CA03	
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																																				
C02	C08																																				
C03	C09																																				
C07	G04CA03																																				

Table 18: Hypothyroidism

Hypothyroidism					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		E01.8 E02 E03 E03.0 E03.1 E03.2	E03.3 E03.4 E03.5 E03.8 E03.9 E89.0		H03AA

Table 19: Multiple Sclerosis

Multiple Sclerosis					
For count purposes, <i>Bipolar Mood Disorder and Epilepsy may not co-occur with Multiple Sclerosis</i>					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, or neurologist 11800 12000		G35			L03AB07 L03AB08
OR					
Evidence of hospitalisation in the preceding three months for acute exacerbation of Multiple Sclerosis (G35)					

Table 20: Parkinson's disease

Parkinson's disease					
Diagnosis-related information			Proof of Treatment		
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		AND	Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		G20 G21 G21.0 G21.1	G21.2 G21.3 G21.8 G21.9		N04

Table 21: Rheumatoid Arthritis

Rheumatoid Arthritis						
For count purposes, Systemic Lupus Erythematosus may not co-occur with Rheumatoid Arthritis						
<i>Note: Where a patient is not using disease modifying anti-rheumatic medicines, the diagnosis must be verified by a specialist physician or rheumatologist</i>						
Diagnosis-related information				Proof of Treatment		
Provider code of the diagnosing provider	AND	Evidence of use of Disease Modifying medicines in two different calendar months in the three calendar months preceding the current month. This includes products in the following ATC categories:	AND	ICD10 Codes (Any of the following)	AND	Evidence of payment 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		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 M01AB M01AC M01AD M01AE M01AF M01AG M01AH M01C P01BA01
OR						
Diagnosis of rheumatoid arthritis by a specialist physician, paediatrician or rheumatologist 11800 13200 13100						

Table 22: Schizophrenia

Schizophrenia														
For count purposes, only one of the following psychiatric conditions can be assigned to the same patient: <i>Bipolar Mood Disorder or Schizophrenia</i>														
<i>Diagnosis-related information</i>			<i>Proof of Treatment</i>											
Provider code of the diagnosing provider.	AND	ICD10 Codes (Any of the following)	AND	Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:										
Must be a psychiatrist or paediatric psychiatrist 12200 12201		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">F20</td> <td style="width: 50%;">F20.4</td> </tr> <tr> <td>F20.0</td> <td>F20.5</td> </tr> <tr> <td>F20.1</td> <td>F20.6</td> </tr> <tr> <td>F20.2</td> <td>F20.8</td> </tr> <tr> <td>F20.3</td> <td>F20.9</td> </tr> </table>	F20	F20.4	F20.0	F20.5	F20.1	F20.6	F20.2	F20.8	F20.3	F20.9		N05A
F20	F20.4													
F20.0	F20.5													
F20.1	F20.6													
F20.2	F20.8													
F20.3	F20.9													

Table 23: Systemic Lupus Erythematosus

Systemic Lupus Erythematosus																																				
For count purposes, <i>Systemic Lupus Erythematosus</i> may not co-occur with <i>Rheumatoid Arthritis</i>																																				
<i>Diagnosis-related information</i>			<i>Proof of Treatment</i>																																	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)	AND	Evidence of payment of claims for any product included in the ATC categories below, 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		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">M32</td> <td style="width: 50%;">L93.0</td> </tr> <tr> <td>M32.0</td> <td>L93.1</td> </tr> <tr> <td>M32.1</td> <td>L93.2</td> </tr> <tr> <td>M32.8</td> <td></td> </tr> <tr> <td>M32.9</td> <td></td> </tr> <tr> <td>L93</td> <td></td> </tr> </table>	M32	L93.0	M32.0	L93.1	M32.1	L93.2	M32.8		M32.9		L93			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">B01AA03</td> <td style="width: 50%;">L04AA05</td> </tr> <tr> <td>H02AB</td> <td>L04AA06</td> </tr> <tr> <td>L01AA01</td> <td>L04AX01</td> </tr> <tr> <td>L01BA01</td> <td>M01AB</td> </tr> <tr> <td>L04AA01</td> <td>M01AC</td> </tr> <tr> <td></td> <td>M01AD</td> </tr> <tr> <td></td> <td>M01AE</td> </tr> <tr> <td></td> <td>M01AF</td> </tr> <tr> <td></td> <td>M01AG</td> </tr> <tr> <td></td> <td>M01AH</td> </tr> </table>	B01AA03	L04AA05	H02AB	L04AA06	L01AA01	L04AX01	L01BA01	M01AB	L04AA01	M01AC		M01AD		M01AE		M01AF		M01AG		M01AH
M32	L93.0																																			
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B01AA03	L04AA05																																			
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L04AA01	M01AC																																			
	M01AD																																			
	M01AE																																			
	M01AF																																			
	M01AG																																			
	M01AH																																			

Table 24: Ulcerative Colitis

Ulcerative Colitis				
For count purposes, only one of the following Gastro Intestinal conditions can be assigned to the same patient: <i>Crohn's disease or Ulcerative Colitis</i>				
Diagnosis-related information			Proof of Treatment	
Provider code of the diagnosing provider	AND	ICD10 Codes (Any of the following)		Evidence of payment 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, surgeon or gastroenterologist: 14200 11800 11900		K51 K51.0 K51.1 K51.2 K51.3	K51.4 K51.5 K51.8 K51.9	AND

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 payment 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
		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

Addison's Disease	
H02AB	Glucocorticoids
H02AA02	Fludrocortisone
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	
B05D	Peritoneal dialytics
B05Z	Haemodialytics and haemofiltrates
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
Crohn's Disease	
A07E	INTESTINAL ANTIINFLAMMATORY AGENTS
H02AB	Glucocorticoids
J01XD01	Metronidazole
J01MA	Fluoroquinolones
L04AA01	Ciclosporin
L04AA05	Tacrolimus
L04AA11	Etanercept
L04AA12	Infliximab
L04AX01	Azathioprine
L04AX03	Methotrexate
L01BA01	Methotrexate
P01AB01	Metronidazole
Diabetes Insipidus	
H01BA	Vasopressin and analogues
Diabetes Mellitus	
A10A	INSULINS AND ANALOGUES
A10B	ORAL BLOOD GLUCOSE LOWERING DRUGS

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 MIOTICS
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
Hypertension	
C02	ANTI HYPERTENSIVES
C03	DIURETICS
C07	BETA BLOCKING AGENTS
C08	CALCIUM CHANNEL BLOCKERS
C09	AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM
G04CA03	Terazosin
Hypothyroidism	
H03AA	Thyroid hormones
Multiple Sclerosis	
L03AB07	Interferon beta-1a
L03AB08	Interferon beta-1b
Parkinson's disease	
N04	ANTI-PARKINSON DRUGS

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

000 – End – 000