PMB definition guideline: COVID-19 v6

Published date: 10 November 2020

Disclaimer:

This document may change as guidance from the National Institute of Communicable Diseases (NICD), World Health Organisation (WHO) and Department of Health (NDOH) evolves. The contents are up to date as at the time of publishing. Please always check for updates on the National Institute for Communicable Diseases (NICD) and the National Department of Health (DOH) websites.

Major changes in this version:

- *There are changes around the use of wording "may" and "recommend". CMS has noted that the use of such wording is resulting in misinterpretation and non-compliance to PMB regulations by some stakeholders.*
- *Wording on the use of pre-existing tools to managed care protocols (7.1.8)*
- *Further clarity on the funding of oseltamivir has also been provided (9.5)*
- *Further clarity on therapeutic and prophylactic dosing of heparin (10.4)*

1. Introduction

The World Health Organization (WHO) was alerted of a cluster of pneumonia of unknown aetiology in patients in Wuhan City, Hubei Province of China on 31 December 2019.

The respiratory tract infection was identified as being caused by a coronavirus, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the illness was named coronavirus disease 2019 (COVID-19) on 11 February 2020. The following month, the WHO declared the outbreak as a pandemic and on 15 March 2020, a National State of Disaster was declared in South Africa.

The National Department of Health (NDoH), in collaboration with the National Institute for Communicable Diseases (NICD), has been providing the nation with guidance in respect of the management of the COVID-19 pandemic within the Republic of South Africa.

The Minister of Health approved a submission from the Council for Medical Schemes (CMS) for the inclusion of COVID-19 as a Prescribed Minimum Benefit (PMB). As such, on 7 May 2020 the Minister of Health, in terms of section 67 of the Medical Schemes Act, 1998 (Act No. 131 of 1998), published an amendment to the Medical Schemes Act Regulations in Notice 515 in Government Gazette 43295.

The amendment includes an insertion of the Diagnosis and Treatment Pair (DTP) in the list of PMBs under the heading "Respiratory System". The treatment component includes screening, clinically appropriate diagnostic tests, medication, medical management including hospitalisation and treatment of complications, and Rehabilitation of COVID-19. The Regulations came into effect on 7 May 2020.

For this reason, this guideline seeks to clarify PMB entitlements of medical scheme beneficiaries within the context of the pandemic, ensuring that there is uniform interpretation amongst all stakeholders. It sets out recommendations for the screening, diagnosis, treatment and care of individuals with suspected and confirmed COVID-19 as per WHO case definitions.

2. Scope and purpose

2.1. The WHO has published ICD-10 codes to be used for the COVID-19 and CMS recommends that correct coding be used to enable correct identification and reporting thereof.
2.2. A new DTP has been assigned to ICD-10 codes to ensure the correct PMB classification of COVID-19.
2.3. The surveillance for COVID-19 is essential to permit early recognition of suspected cases, early diagnosis, containment and prevention of onward transmission.
2.4. It is also important to note that COVID-19 is a Category 1 Notifiable Medical Condition that requires immediate reporting by the most rapid means available upon diagnosis followed by a written or electronic notification to the Department of Health within 24 hours of diagnosis by health care providers, private or public health laboratories.
2.5. Medical schemes are also required to notify and submit COVID-19 related information to the CMS, consistent with Circular 29 of 2020.

Possible ICD-10 codes for identifying COVID-19

PMB code	PMB description		ICD-10 code	ICD-10description
177D	COVID-19	Screening, Testing, Medical management including Ventilation, Rehabilitation.	U07.1	COVID-19, virus identified
			U07.2	COVID-19, virus not identified

Source: WHO list of official ICD-10 updates: https://www.who.int/classifications/icd/icd10updates/en/

2.6. The ICD-10 code U07.2 includes the following:

- Clinically-epidemiologically diagnosed COVID-19
- Probable COVID-19
- Suspected COVID-19

2.7. Below are the updated NICD case definitions published on 25 May 2020.

Confirmed cases	A confirmed case is a person with laboratory confirmation (RT -PCR assay) of infection with the COVID-19 virus, irrespective of clinical signs and symptoms. Symptomatic cases are considered infectious from 2 days before symptom onset to 14 days after symptom onset.
Suspected case *i.e. A person to be tested for COVID-19*	A suspected COVID-19 case includes any person presenting with an acute (≤14 days) respiratory tract infection or other clinical illness compatible with COVID-19, or an asymptomatic person who is a close contact to a confirmed case*. In the context of COVID-19, the key respiratory syndrome consists of ANY of: · Cough · Sore throat · Shortness of breath · Anosmia (loss of sense of smell) or dysgeusia (alteration of the sense of taste) with or without other symptoms (which may include fever, weakness, myalgia, or diarrhoea). *Note: Asymptomatic close contacts should not be routinely tested despite meeting the suspected case definition. However, testing may be indicated in certain circumstances (e.g. institutions such as care homes)

2.8. A close contact is defined by NICD as:
A person having had face-to-face contact (≤1 metre) or having been in a closed space with a confirmed COVID-19 case for at least 15 minutes. This includes, amongst others:

- All persons living in the same household as a COVID-19 case, and people working closely in the same environment as a case.
- Healthcare workers or other people providing direct care for a COVID-19 case while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, N95 respirator, eye protection).

- A contact in an any mode of transportation where passenger details are captured sitting within two seats (in any direction) of the case, travel companions or persons providing care, and crew members serving in the section where the case was seated.

2.9. NICD had previously defined high-risk persons separately to the suspected case definition. CMS has noted that high-risk persons are now included in the new definition with the exception of people who are admitted with pneumonia.

2.10. The purpose of the document is to provide detailed clarification in respect of benefit and entitlements to members and beneficiaries of medical schemes. Subject to the managed care protocols, PMB level of care benefits must be paid in full from the risk benefit irrespective of member's plan type or benefit option

3. Epidemiology

3.1. Coronaviruses are a large family of viruses that are common in many different species of animals, including camels, cattle, cats, and bats. These viruses cause illness ranging from the common cold to more severe diseases such as bronchitis, pneumonia and respiratory and multi-organ failure. Coronaviruses are also responsible for previous epidemics including severe acute respiratory syndrome (SARS) and middle east respiratory syndrome (MERS).

3.2. These viruses were originally transmitted between animals and people. In the case of SARS, viruses were transmitted from civet cats to humans while in MERS, the infection travelled to humans from a type of camel.

3.3. In the case of COVID-19, scientists have pointed to infected animal species, including pangolins and bats as the original source of the virus. While it is suspected that the initial COVID-19 epidemic started through animal-to-human transmission, the current epidemic is being fuelled by human-to-human transmission and the virus has spread to more than 208 countries and territories, including South Africa.

3.4. As of the 9th of November 2020, there were 50,852,619 confirmed cases globally with 1,262,781 deaths and 35,855,878 recoveries.

3.5. Data from the 9th of November 2020 showed that South Africa had conducted 4,980,440 tests, 737,278 confirmed as positive, 679,688 people had recovered, and 19,809 deaths were reported.

3.6. Additionally, the mortality rate in South Africa is currently at 2,7%. The global mortality has reduced to 2,5%; from 3,3% on the 4th of September 2020 when version 5 of this guideline was published.

3.7. South Africa has developed a COVID-19 exposure notification application called COVID Alert SA to help South Africans know when they have been in close contact with someone who has tested positive for COVID-19. Additional information on the app can be found here.

4. Route of transmission from COVID-19 patients

4.1. New evidence on the transmission has been evolving and there is evidence on the following modes of transmission

- Symptomatic: Data from published epidemiology and virologic studies provides evidence that COVID-19 is primarily transmitted from symptomatic people to others who are in close contact through respiratory droplets, by direct contact with infected persons, or by contact with contaminated objects and surfaces.
- Pre- symptomatic: The incubation period for COVID-19, which is the time between exposure to the virus (becoming infected) and symptom onset, is on average 5-6 days, however, this period can take up to 14 days. During this period, also known as the "pre-symptomatic" period, some infected persons can be contagious. Therefore, transmission from a pre-symptomatic case can occur before symptom onset.
- Asymptomatic: There are few reports of laboratory-confirmed cases who are truly asymptomatic, and to date, there has been no documented asymptomatic transmission. This does not exclude the possibility

that it may occur. Asymptomatic cases have been reported as part of contact tracing efforts in some countries. The proportion of asymptomatic carriers is currently unknown.

4.2. The World Health Organization (WHO) has acknowledged that there is "evidence emerging" of the airborne spread of the novel coronavirus, after a group of scientists urged for an update to its guidance on how the respiratory disease passes between people especially in closed, poorly ventilated spaces.

4.3. A PHIRST-C study is being conducted in South Africa to gain a better understanding of the transmission dynamics of SARS-CoV-2, asymptomatic infection prevalence, and the transmission from asymptomatic infection.

4.4. According to the WHO, the reproductive number (R) for the virus is approximately 2.2 (meaning that on average each person spreads the infection to two others). In South Africa, the reproductive number was 1.33 at the start of the pandemic and rose to its highest in April 2020, to 1.5. The NICD reported an R of 1.1. on 26 August 2020, indicating a decline in the number of new cases and the slowing down of COVID-19 transmissions.

5. Risk factors

Risk factors for acquiring the infection include:

- Individuals with a recent travel history to high-risk countries
- History of exposure to individuals infected with COVID-19

Risk factors for severe disease once infected include:

- Individuals 60 years and older: Among more than 44,000 confirmed cases of COVID-19 in China, the case fatality rate was highest among older persons:
  - ≥80 years: 14.8%
  - 70–79 years: 8.0%
  - 60–69 years: 3.6%
  - 50–59 years: 1.3%
  - 40–49 years: 0.4%
  - <40 years: 0.2%.
- Individuals who live in a nursing home or long-term care facility
- People with severe obesity (body mass index [BMI] of 40 or higher)
- Individuals at any age with underlying comorbidities, particularly if not well controlled. Patients with no reported underlying medical conditions have had an overall case fatality of 0.9%, but case fatality was higher for patients with comorbidities
  - Cardiovascular disease
  - Diabetes mellitus
  - Hypertension
  - Chronic respiratory disease
  - Immunosuppression: this could be due to cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
  - People with chronic kidney disease undergoing dialysis
  - People with liver disease

Disease in children appears to be relatively rare and mild with approximately 2.4% of the total reported cases reported amongst individuals aged under 19 years. A very small proportion, that is 2.5% of those aged under 19 years have developed severe disease while only 0.2% became critical.

6. Signs and symptoms

6.1. Eighty percent of symptomatic patients develop mild disease, an estimated 15% develop severe disease (with hypoxaemia, dyspnoea and tachypnoea) while 5% become critically ill (with respiratory failure, septic shock and/or multiorgan dysfunction).

6.2. The most common presenting symptoms have been:

- Fever (~90%, but only present in 44% on admission).
- Dry cough (68%)
- Anosmia and ageusia (30%)
- Fatigue (38%),
- Sputum production (34%)
- Shortness of breath (19%),
- Myalgia or arthralgia (15%),
- Sore throat (14%),
- Headache (13.6%)
- Chills (12%)

6.3. Gastrointestinal symptoms such as nausea or vomiting (5.0%) and diarrhoea (3.8%) appear to be uncommon.

6.4. In addition to the above symptoms, it has been observed that children between the ages of 2 – 15 years are at risk of developing Paediatric Inflammatory Multisystem Syndrome (PIMS) associated with COVID-19, which may include some of the following symptoms:

- abdominal pain
- skin rash
- red, cracked lips
- red eyes
- swelling of the hands or feet
- reddish, swollen toes ('COVID toes')
- swollen glands on one or both sides of the neck
- vision problems
- paleness

7. Diagnostic workup

7.1. Consultations

7.1.1. Given the modes of transmission discussed earlier, surveillance for COVID-19 is essential to permit early recognition of suspected cases, early diagnosis, containment and prevention of further spread.

7.1.2. Screening is questionnaire based and may be part of virtual or face to face consultation. The consultation for screening by a healthcare worker (nurses or doctors) for COVID-19 is PMB level of care. Some of the questions that can be asked by the healthcare worker during screening include:

- § Recent travel to a high-risk country (in the last 14 days)
- § Any contact with anyone with confirmed COVID-19 (in the last 14 days)
- § Any history of visiting live animal markets

- § Any history of attending or working at a facility where COVID-19 patients were being treated
- § Any symptoms such as fever, sore throat, cough and difficulty in breathing
- § Any underlying condition (including high blood pressure, diabetes mellitus, asthma, respiratory illnesses, systemic illnesses)
- § Any medications being taken (including immunosuppressive therapy)

7.1.3. RT-PCR testing for COVID-19 is PMB level of care upon referral from a health care worker (doctor or nurse) who has screened a patient. Patients to be tested are individuals who meet the criteria for a suspected case as provided in section 2.7 and 2.8 above.

7.1.4. To further reduce the person to person risk of transmission and reduce the number of patients at doctors rooms, telehealth delivered through online platforms must be reimbursed as PMB level of care in line with the latest Health Professions Council of South Africa (HPCSA) communication as published on their website.

7.1.5. In accordance with the HPCSA recommendations, "*Telehealth should preferably be practiced in circumstances where there is an already established practitioner-patient relationship. Where such a relationship does not exist, practitioners may still consult using Telehealth provided such consultations are done in the best clinical interest of patients."*

7.1.6. In addition, HPCSA, emphasise that "*Although practitioners may charge fees for consultations undertaken through Telehealth platforms, the Council [HPCSA] strongly cautions against practices that may amount to over-servicing, perverse incentives and supersession."*

7.1.7. In the out of hospital setting, no prior authorisation is required for telehealth consultations with a general practitioner, specialist consultations may require pre-authorisation.

7.1.8. Schemes may use designated service providers (DSPs) and managed care protocols may apply.

7.2 Laboratory workup

7.2.1 From the South African Health Products Regulatory Authority (SAHPRA) report, two different types of in-vitro tests are possible, molecular tests and serological tests.

7.2.2 Molecular tests detect the presence of the SARS-CoV-2 virus' genetic material (nucleic acid) and are performed on material obtained by means of nasopharyngeal and oropharyngeal swabs. Such tests are good at detecting the virus early in the infection and can detect the virus in a person before they become symptomatic. The NICD guidelines recommends the use of molecular testing for diagnosis of SARS-CoV-2 virus.

7.2.3 Serological tests are tests that detect antibodies to the SARS-CoV-2 virus and are conducted on samples likely to have antibodies, such as finger-pick blood samples. Serological tests are conducted at the point-of-care and detect the presence of immunoglobulin M (IgM) and/or immunoglobulin G (IgG) antibodies to SARS-CoV-2.

7.2.4 On 25 August 2020, SAHPRA issued a section 21 authorisation of one serological rapid (point of care test) and 5 laboratory-based SARS-Cov-2 serology tests. SAHPRA has provided a list of both serological and RT-PCR tests that are registered in South Africa and this is available on their website.

7.2.5 SAHPRA and the NDoH both emphasise that RT-PCR remains the modality for diagnosis of COVID-19 due to the lower sensitivities reported with the serological tests, however the role of serological tests has been clarified.

7.2.6 The table below summarises the role and PMB recommendations of the serological and molecular tests.

Test type	Reporting requirements	Role in SARS-CoV-2 and corresponding PMB recommendation

RT -PCR	All confirmed tests must be reported	Modality for acute clinical diagnosis is PMB level of care
Point of care (rapid diagnostic) serology test	All results must be recorded and reported to the National Health Laboratory Service (NHLS) Must be administered by suitably qualified and trained health professionals only.	No role in clinical diagnosis of acute COVID-19 due to low sensitivity – Not PMB level of care Retrospective diagnosis for those who have recovered from COVID-19 compatible illness and tested negative by RT- PCR - Not PMB level of care
Laboratory based serological test	All results must be recorded and reported to the NHLS Should be conducted in ISO15189 accredited facilities only.	Diagnosis of COVID-19 in patients who are admitted with suspected SARS-CoV2 infection and test negative for RT-PCR including children with suspected multi system inflammatory syndrome. –PMB level of care on motivation. Seroprevalence surveys - Not PMB level of care Scientific research and clinical trials including assessing antibody reactivity for prognosis, identification of SARS-CoV-2 vaccine responses – Not PMB level of care

7.2.7 The RT-PCR test is therefore PMB level of care for the diagnosis of COVID-19.

7.2.8 In addition to a RT- PCR, and where clinically indicated, the following laboratory investigations are also PMB level of care for confirmed cases depending on the severity of symptoms:

- Full blood count including differential count
- Nasopharyngeal swabs or aspirates and oropharyngeal swabs for detection of viral and atypical pathogens
- Sputum for MCS and Mycobacterium tuberculosis detection (GeneXpert MTB/RIF Ultra)
- Other adjunct investigations that may be clinically appropriate or indicated will require motivation e.g. liver function tests, renal function tests, CRP, glucose, D-dimer levels, prothrombin, blood gas, and urine for lipoarabinomannan (LAM) test if HIV positive.

Funding of RT-PCR test

7.2.9 The RT-PCR test must be funded from the risk benefit irrespective of the RT-PCR result.

7.2.10 A single positive RT-PCR test is sufficient proof of COVID-19 infection, and there is no role of repeat confirmatory test. A repeat confirmatory RT-PCR test is not PMB level of care.

7.2.11 An RT-PCR test can however be falsely negative due to factors such as sampling technique or timing of the test. If alternative diagnosis has been explored and there is still clinical suspicion of COVID-19, a motivation should be submitted to the scheme for a repeat test.

7.2.12. According to the WHO, as of 24 April 2020, no study had evaluated whether the presence of antibodies to SARS-CoV-2 confers immunity to subsequent infection by this virus in humans. There is currently no evidence that people who have recovered from COVID-19 and have antibodies are protected from a second infection. As such the number of RT-PCR tests per member should not be capped for a member who presents with COVID-19 symptoms and meets the NICD case definition.

7.2.13. As per NICD guidance, asymptomatic people should not be routinely tested. CMS therefore recommends discretionary funding for the testing of asymptomatic people. This includes asymptomatic people who are returning to work or those intending to travel.

7.3 Imaging radiology

7.3.1 Imaging modalities are not PMB level of care for screening or diagnosis of COVID – 19, as the definitive test for SARS-CoV-2 is the RT-PCR.

7.3.2 Chest X-ray is PMB level of care for patients with confirmed COVID-19.

7.3.3 CT scan is PMB level of care in patients presenting with features indicating worsening respiratory function. CT scan is also recommended in COVID-19 patients with functional impairment and/or hypoxemia after recovery from COVID-19.

8. Management of suspected and confirmed cases with mild to moderate disease

8.1. The clinical management of a suspected or a confirmed COVID-19 case depends on the severity and the presenting symptoms and not the risk of deterioration. High risks patients who present with mild symptoms should therefore be managed based on their symptoms.

8.2. Suspected and confirmed cases who are medically well, or who have mild disease may be managed at home.

8.3. On the 22nd of October 2020, the Food and Drug Association (FDA) approved the first medicine for the treatment of COVID-19. Remdesivir is approved for use in adult and pediatric patients 12 years of age and older; weighing at least 40 kilograms for the treatment of COVID-19 requiring hospitalization the treatment of severe hospitalised COVID-19 patients.

8.4. Although antibiotics do not treat viral infections, empiric treatment for secondary bacterial and fungal infections might be required.

8.5. All underlying pre-existing comorbid chronic conditions such as diabetes mellitus, HIV, asthma etc, should be managed as per the corresponding Diagnostic Treatment Pair (DTP) and/ or Chronic Disease List (CDL) are deemed PMB level of care.

8.6. Treatment and care for the management of mild to moderate disease is PMB level of care.

8.7. Cough suppressants, such as codeine-containing cough mixtures, are not indicated, and are not available in public sector health facilities. These cough mixtures are not PMB level of care for COVID-19.

8.8. Given that the scheme is notified of all positive cases of COVID-19, irrespective of the severity, medication prescribed by the doctor for managing COVID-19 symptoms must be funded as PMB level of care. The provider should include the correct ICD 10 code (U07.1) on the prescription. To reduce the administrative burden, and given that this is not a chronic condition, no prior authorisation is required. Generic substitution is permissible, unless the provider instructs otherwise.

9. Management of severe cases

9.1. Patients with severe disease are closely monitored and any signs of clinical deterioration (e.g. respiratory failure and sepsis) are managed appropriately.

9.2. Based on clinical diagnosis, treatment of co-infections with empiric antibiotics is recommended and this may include treatment of pneumocystis pneumonia (PCP), influenza and atypical bacterial pathogens.

9.3. Supportive treatment includes oxygen therapy in patients who are short of breath. The target oxygen saturation (SpO2) rates are ≥90% in non-pregnant adults and SpO2 ≥92-95 % in pregnant patients.

9.4. Funding of oxygen therapy for COVID-19 is based on the oxygen saturation results. Given the pandemic and limited health resources, blood gases are not a pre-requisite for oxygen funding. Hence the only criterion is for a patient to meet the oxygen saturation required.

9.5. Routine use of oseltamivir for all patients with influenza is not PMB level of care. Oseltamivir is PMB level of care for severely ill patients when administered within 72 hours of symptom onset when prevalence of influenza is moderate to high.

9.6. Patients with severe disease are generally hospitalised and the cost of their management must be funded according to the PMB Regulations.

9.7. Patients might be admitted to the intensive care unit (ICU) and the use of mechanical ventilators where indicated is PMB level of care.

9.8. If clinical setting is appropriate and there is provider preference, non- invasive ventilation is PMB level of care in line with the NICD guidelines. In the absence of an indication for endotracheal intubation, a trial of high-flow nasal oxygen (HFNO), continuous positive airway pressure (CPAP), synchronized inspiratory positive airway pressure (SiPEP) or other non-invasive ventilation (NIV) technique may be considered for adults with COVID-19 and acute hypoxaemic respiratory failure failing standard oxygen therapy.

10. Pharmacological management

10.1. All pharmacological management recommendations are based on the guidance issued in the NDoH/ NICD version 5 guidance on the clinical management of suspected or confirmed COVID-19 cases and the NEMLC subcommittee medicine reviews.

10.2. The use of a short duration of low-dose systemic corticosteroids in hospitalised severe COVID-19 patients receiving respiratory support (as either invasive mechanical ventilation or non-invasive oxygen supplementation) and for COVID-19 patients with septic shock is PMB level of care.

10.3. Hospitalised patients not on respiratory support should not routinely be administered systemic corticosteroids, unless indicated for another reason such as an acute exacerbation of asthma or chronic obstructive pulmonary disease.

10.4. Prophylactic doses of either unfractionated or low molecular weight heparin is PMB level of care for all hospitalised patients. In line with the NEMLC recommendations, there is insufficient evidence for the use of therapeutic doses of either unfractionated or low molecular weight heparin as thromboprophylaxis for patients with severe COVID-19. Therapeutic doses are PMB level of care for patients with a hypercoagulable state as clinically indicated.

10.5. Remdesivir is currently available as a section 21 medicine and is not PMB level of care. Funding of remdesvir is based on scheme rules.

10.6. Hydroxychloroquine/chloroquine is not PMB level of care for the prevention of COVID-19, unless there is new evidence of efficacy that shows benefit.

10.7. In line with the NEMLC recommendations, the following are not currently PMB level of care for the treatment of COVID-19:

- Convalescent plasma
- Interferon beta
- Intravenous immunoglobulin
- Tocilizumab
- Azithromycin

- Convalescent plasma
- Favipiravir

11. Palliative care for COVID-19

11.1. Palliative care is a multifaceted, integrated approach to improving the quality of life of adults and paediatric patients, and their families facing the problems associated with life-threatening illness such as COVID-19. CMS is cognisant of the WHO definition of palliative care. However, palliative care for confirmed COVID-19 cases is PMB level of care.

11.2. Palliative care includes but not limited to:

- complex symptom management
- advance care planning or goals of care conversations
- complex discussions with patient, and more often with family:
    - § diagnoses and current/future care plans,
    - § when a patient's condition deteriorates, or withdrawal of treatment decisions needs to be made
    - § family's own (mental)health
- integration of psychosocial support especially for families on the outside:
    - § isolation causing mayor distress and mental health issues with patients and families
    - § primary physicians do not have capacity to always keep loved ones updated or discuss when difficult decisions need to be made quickly
- bereavement support to families

11.3. Palliative care includes a multi-disciplinary team approach. The team may consist of doctors (GPs and specialists), psychologists, social workers, palliative care home nurses. Palliative care can be provided in different settings including:

- in the home (even if severe and patient so wishes e.g. frail elderly or people with dementia),
- long term care facilities,
- hospices,
- and in hospital including general ward, ICU and high care

11.4. CMS recommends the funding of palliative care. Where a multi-disciplinary team is involved in the treatment and care of COVID-19 patients, the primary provider must submit an initial treatment plan to the scheme for pre-authorisation and weekly updates to allow the scheme to make informed continued funding decisions.

12. Management of COVID-19 in special populations – children, newborns, pregnant and breastfeeding women and people living with HIV

12.1. Management of children

12.1.1. Although the understanding of COVID-19 related symptoms continues to evolve, the current guidance from NICD states that the clinical presentation and case definition of adults and children are the same.

12.1.2. All suspected children with an acute respiratory infection should be tested for COVID-19.

12.2. Management of newborns

12.2.1. The case definition is the same as adults and children, although atypical presentation is expected in neonates.

12.2.2. COVID-19 should be included in differential diagnosis of any neonate presenting with acute respiratory symptoms and such neonates should be tested for COVID-19.

12.2.3. Babies in good health, who are born from a COVID-19 infected mother do not need a COVID-19 test, and such testing is therefore not PMB level of care.

12.2.4. Unwell or symptomatic babies should have a COVID-19 test on day 3 of life if the case definition is met, or at another time if clinically indicated.

12.2.5. According to the NICD guidelines, tests done before 72 hours may give a false negative result and should be repeated on day 5 of life if the first test is negative.

12.3. Management of pregnant and breastfeeding

12.3.1. According to the NICD guidelines, there is currently no indication that pregnant women are at higher risk of either contracting COVID-19 or of worse maternal outcomes with COVID-19.

12.3.2. Pregnant women with COVID-19 can have a vaginal delivery. COVID-19 is not an indication of caesarean section.

13. Funding of PPE

The department of Labour has issued guidance on workplace preparedness for COVID-19 and employers are obligated to provide their workers with personal protective equipment (PPE) needed to keep them safe while performing their duties. The types of PPE required during a COVID-19 outbreak will be based on the risk of being infected with SARS-CoV-2 while working and tasks that may lead to exposure. PPE for non-healthcare workers is currently not PMB level of care irrespective of the level of risk and these costs cannot be transferred to members or schemes.

PPE for health workers who are treating and managing suspected and confirmed COVID-19 patients is PMB level of care. Claims should be backdated to 7 May 2020, when the PMB regulations for COVID-19 were promulgated.

14. Off label medication

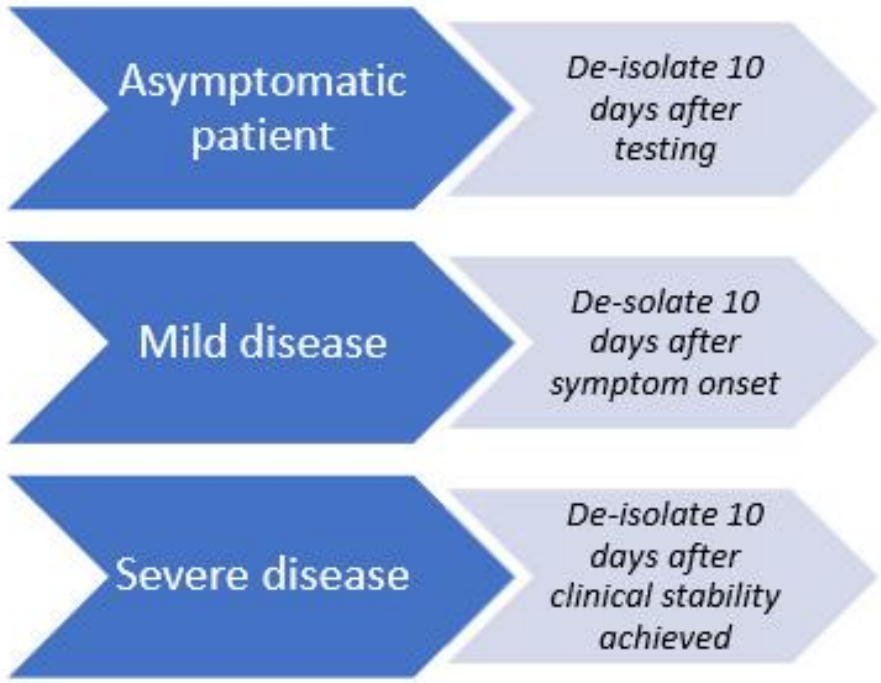
There is consensus in literature as reported by the WHO and SAHPRA, that currently there are no pharmaceutical products that have shown to be safe and effective for the treatment of COVID-19. CMS recommends discretionary funding of off-label use of medications that show clinical benefit. The NDoH acknowledges that investigational medicines should be used in the realm of a clinical trial, but given the nature of the pandemic, a pragmatic approach might be required, and such medicines should be used under the Monitored Emergency Use of Unregistered Interventions (MEURI) framework.

Any medicines, including vaccines that become available for COVID-19 and listed on the national essential medicines list are PMB level of care.

15. Follow up care

Patients may continue to be PCR positive after clinical resolution, although for how long such virus is viable (and thus infectious) remains to be determined. A repeat RT-PCR test to ensure that the patient is no longer positive will be funded at the discretion of the scheme based on the scheme rules.

A patient can de-isolate after the recommended period without further testing. Health minister Dr Zweli Mkhize, announced on 17 July 2020 that the isolation period had been reduced to 10 days from 14 days on condition that the patient does not have a fever and the symptoms are improving.



On referral by the treating provider, chest physiotherapy and other rehabilitative modalities such as psychotherapy are also PMB level of care for confirmed COVID-19 cases.

16. What is not PMB level of care for COVID-19

The following is not PMB level of care:

- Follow-up treatment and care for any person who tests negative for COVID-19 (RT-PCR test).
- Routine RT-PCR testing of asymptomatic, unscreened and unreferred patients which turns out negative is based on scheme rules.
- Routine preadmission (including elective admissions) RT-PCR testing for asymptomatic patients which turns out negative is based on scheme rules.
- Off label medication and investigational medicine is not PMB level of care
- Serological and point of care testing for COVID-19 is not currently PMB level of care.
- Testing of asymptomatic people returning to work is not PMB level of care.
- Testing of asymptomatic people intending to travel is not PMB level of care.
- PPE for non-healthcare workers is not PMB level of care

Applicable codes in relation to COVID-19 funding

Consultation codes	Diagnosis Related information		Treatment	
	Laboratory	Imaging	Procedure Codes	ATC codes
0130 0132 0133 0145 0146 0147 0149 0190 0191 0192 0197 0198 0199 0201 Inpatient Codes 0109 1204 1205 1206 1207 1208 1209 1210 1211 1212 1213 1214	U07.1 U07.2 Z11.5 3755 - Full blood count including differential count 3891 / 3892 / 3893 / 3894 / 3895 / 3896 / 3897 - Blood cultures 3867 / 3895 - Sputum for MCS 3915 / 3919 / 3920 / 4655 / 4656 / 4657 - Mycobacterium tuberculosis detection 4434 / 3930 (GeneXpert MTB/RIF Ultra) 4130 / 4131 - Liver function tests 4137 - Lactate dehydrogenase 3856 - D-dimer levels 3974 – Polymerase chain reaction	30100 X-ray of the chest, single view 30110 X-ray of the chest two views, PA and lateral 30120 X-ray of the chest complete with additional views 30130 X-ray of the chest complete including fluoroscopy 30300 CT of the chest, limited study 30310 CT of the chest uncontrasted 30320 CT of the chest contrasted 30330 CT of the chest, pre and post contrast 30340 CT of the chest, limited high resolution study 30350 CT of the chest, complete high resolution study 30355 CT of the chest, complete high resolution study with additional prone and expiratory studies 30360 CT of the chest for pulmonary embolism 30370 CT of the chest for pulmonary embolism with CT venography of abdomen, pelvis and lower limbs	Evidence of payment for COVID related Procedures	Evidence of payment for COVID related medicines

Additional resources

NICD website on COVID-19:	http://www.nicd.ac.za/diseases-a-z-index/covid-19/
National Department of Health:	https://www.gov.za/; https://www.gov.za/coronavirus/guidelines; https://www.sacoronavirus.co.za/
The WHO website:	www.who.int/emergencies/diseases/novel-coronavirus
Medicine rapid reviews	http://www.health.gov.za/index.php/national-essential-medicine-list-committee-nemlc/category/633-covid-19-rapid-reviews

COVID Alert SA app

Join the COVID Alert SA app community and help South Africa to curb the spread of COVID-19.

What is COVID Alert SA?

COVID Alert SA is South Africa's free exposure notification app. It lets people know when they have been in close contact with someone who has tested positive for COVID-19.

Who can use it?

Everyone in South Africa who has a Bluetooth-enabled smartphone can access this app. You can make a difference by adding your phone to the fight.

Is my privacy protected?

COVID Alert SA is entirely anonymous. The app protects your privacy and security at all times. It does not need or store any of your personal information.

Download the COVID Alert SA app today

By downloading and using the COVID Alert SA app, you become a part of a powerful digital network of app users who choose to work together for the benefit of everyone in the app community while all enjoying complete privacy and anonymity. App users understand their exposure to COVID-19 and help others to do the same. We can all work together to curb the spread of COVID-19 and, ultimately, to save lives.

The app is available for Android and iOS.

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