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

Version 2.1

Council for Medical Schemes

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

20 April 2007

Applicable to all REF cases from 1 January 2007

COUNCIL FOR MEDICAL SCHEMES

Table of Contents

A. Changes to Version 2.1 since the publication of Version 2.0 of the Guidelines on 11 May 2006

Due to the findings of the REF pricing study that has recently been completed and comments received from the industry, a number of changes to Version 2 of these guidelines has become necessary. Certain technical omissions have also been corrected. Changes are made to the following areas:

- The month in which a beneficiary is counted is now based on service date and not on payment date
- It is now specified that authorisation is the only source for ICD10 diagnosis codes
- CDL' s occurring in beneficiaries under one year of age can no longer be counted. These cases must be reflected in the NON column
- The admission date is to be used to determine when a maternity event is recorded
- The ATC code, B02BD06 (Von Willebrand factor and coagulation factor VIII in combination) has been added as proof of treatment for haemophilia

To effect the above, changes were made to the following sections:

a. Clarification of ambiguous wording:

Sections 3.9, 3.9.1, 3.15,

b. Definition of service date for maternity

Section 3.11:

c. The following sections have been altered to deal with the inclusion of all beneficiaries in the under one age-band in the NON column:

Sections 3.3 (A) , 3.6, 3.12, 3.13

d. The use of diagnoses obtained through authorisation is specified:

Sections 5.1, 5.3(A), 5.3.3, 5.4.3, 5.19

e. Clarification that service date must be used to define a beneficiary's month for eligibility

Sections 5.4.4, 5.6, all the Boolean tables in Section 6,

f. Technical oversights

H02AB (Glucocorticoids) have been removed from the Boolean tables for Asthma, COPD, and Multiple sclerosis

Addition of the ATC code, B02BD06 (Von Willebrand factor and coagulation factor VIII in combination) for Haemophilia (Table 15 and ATC code descriptions in Section 7)

The cost hierarchy of the respective CDL's are now presented in section 3.9.1. Note that the hierarchy for respiratory conditions has changed (Section 3.9.1.1)

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 who have CDL conditions; HIV / AIDS; those who have had maternity events; beneficiaries 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 2.1).

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 2.1 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.

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.

3.3 (A) Note that service date is used to establish in which month a beneficiary is counted. (See sections 5.4.4 and 5.6)

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. Please note that the age band "Under 1" is not to be populated with CDL information, all beneficiaries below one with CDL's must be included in the "NON" column. Hence all CDL, and HIV columns for under 1 age band will read zero.

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 Cardiac Failure and Cardiomyopathy into one condition that, from 1 January 2006 (See section 2.3, page 6 on the implementation date), the CHF column must be left blank. All Cardiac Failure and Cardiomyopathy cases must be entered in the CMY column. The contribution table will be adjusted to reflect the new rates.

Multiple Chronic Conditions

3.9 Where a beneficiary has more than one chronic condition, such beneficiary should be entered once into columns 2 to 28. This entry reflects the most expensive condition the beneficiary has, and this is determined by the REF Contribution table 2007. Once the most expensive disease has been allocated the multiple disease columns 29 to 31 need to be populated according to the number of chronic diseases. Hence a beneficiary with multiple chronic diseases will reflect twice in the REF Grid Count once for the most expensive disease and once for the number of multiple diseases. NB: This rule no longer applies to the “Under 1” age band as these beneficiaries are defaulted to the “NON” column.

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

3.9.1 Note that, for REF Grid Count purposes, certain CDL diseases that co-occur in the same patient will not be counted as multiple disease. *(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 most expensive condition must be counted as a single disease in the REF grid count. The conditions are arranged in descending cost order as determined by the REF Contribution table 2007, which includes the following hierarchy:

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

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, Bronchiectasis and Asthma*

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.

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: *Systemic Lupus Erythematosus or Rheumatoid Arthritis*

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 corresponding to the date of admission of the mother into the service facility, or in stances where no admission occurred, the actual date of the confinement is used. The amount payable from the REF is an annual amount and not a monthly amount as with the other modifiers.

Beneficiaries without Chronic Diseases

3.12 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 column now includes **all** beneficiaries from the "Under1" age band. This completion of columns 1 to 28 will reflect each beneficiary of an option in only one cell of the grid.

Grid Prevalence Tables

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

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 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. Hence for both grid types, the "Under 1" age band is defaulted to "NON".

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 have gone through an authorisation process and 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, provided that this diagnostic information is part of the authorisation process.

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. Multiple sclerosis in Table 19, page 37)

5.3(A) The use of diagnosis codes provided on claims alone is not acceptable. The diagnosis related information specified in paragraphs 5.3.1 to 5.3.6 is required, implying that a separate authorisation process must exist for each of the conditions specified in Section 6

Proof of treatment information is based on claims data

5.4 Proof of treatment information must be based on paid 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 28)

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 is valid only if proof of diagnosis has been obtained separately, such as through an authorisation process ;and benefits must be 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 for services rendered in two of the three calendar months of September, October and November. In instances where treatment occurs less frequently, the beneficiary does not qualify as a REF beneficiary. To clarify:

- Only beneficiaries for whom payments have been made in respect of services rendered, are included
- Payments must be from a risk pool
- The date of service (provision of medication or other services as specified in section 6) must be used to allocate the month for which a beneficiary qualifies. (For example, a beneficiary that has received treatment in January, for whom payment occurred in March, must be counted for January)

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 provided and paid for from a risk pool:** *(Use service date to allocate to a specific month)*	**Eligible for Inclusion in the REF grids:**
Jan	Yes	No
Feb	Yes	No
Mar	Yes	Yes
Apr	Yes	Yes
May	Yes	Yes
Jun	No	Yes
Jul	No	Yes
Aug	Yes	No
Sep	Yes	No
Oct	Yes	Yes
Nov	No	Yes
Dec	No	Yes
Jan	Yes	No
Feb	Yes	No

5.5 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 25, Table 7: Chronic Obstructive Airways Disease, page 23, Table 6: Chronic Renal Disease, page 25, Table 11: Diabetes Mellitus (Type 1 and 2), page 32 and Table 15: Haemophilia, page34

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 provided and paid for from a risk pool:** *(Use service date to allocate to a specific month)*	**Eligible for Inclusion in the REF grids:**
Jan	Yes	No
Feb	Yes	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 beneficiaries with REF risk factors. These queries must be made available to the CMS and Auditors on request. It is critical that proper version control is applied, since it is likely that these criteria will change at least once a year. The tables describe the logic that must be applied to:

5.7.1 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 Pulmonary 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 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.

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

If the "proof of treatment" criteria are met, this condition must be categorised to: Cardiac Failure and Cardiomyopathy *Or* Hypertension in the REF Grid Count (See page 27 for the Cardiac Failure and Cardiomyopathy criteria and page 36 for the Hypertension Criteria)

For the REF Grid Prevalence, these cases must be counted as Cardiac Failure and Cardiomyopathy a*nd* 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 28 for the Chronic Renal Disease criteria and page 36 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** 010.3: 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 28 for the Chronic Renal Disease criteria and page 36 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.

5.14.4 I25.5: Ischaemic Cardiomyopathy

For REF purposes, this code is applicable only to Coronary Artery Disease and is not relevant in Cardiac Failure and Cardiomyopathy in the REF Grid Count.

Note that for the REF Grid prevalence, these cases should be counted as only Coronary Artery Disease.

Use of Three-digit ICD10 codes

5.15 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 an authorisation process together with proof of diagnosis and proof of treatment is required.

6. Entry and Verification Criteria for CDL Conditions

Note that each of the conditions specified in Table 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	**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, paediatrician or endocrinologist 11800 13200 11801		E27.1		H02AB H02AA02

Table 2: Asthma

Asthma					
For count purposes, only one of the following chronic respiratory diseases can be assigned to the same patient: *Chronic Obstructive Pulmonary Disease, Bronchiectasis and Asthma*					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider:	**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
Any registered medical practitioner		J45 J45.0 J45.1	J45.8 J45.9 J46		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: *Bipolar Mood Disorder or Schizophrenia 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, for services / treatment that was provided 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: *Chronic Obstructive Pulmonary Disease, Bronchiectasis and Asthma*					
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, for services / treatment that was provided 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: *Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension*					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		I27.9 I50 I50.0 I50.1 I50.9 I11.0 I13.0 I13.2 I42 I42.0 I42.1	I42.2 I42.3 I42.4 I42.5 I42.6 I42.7 I42.8 I42.9 O10.1 O10.3		C01AA05 C01DA C02DB C03 C07 C09

Table 6: Chronic Renal Disease

Chronic Renal Disease

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

Diagnosis-related information							***Proof of Treatment***		
Provider code of the diagnosing provider	**AND**	Result of Special investigations	**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:		
				N03 N03.0 N03.1 N03.2 N03.3 N03.4 N03.5 N03.6 N03.7 N03.8 N03.9 N04 N04.0 N04.1 N04.2 N04.3 N04.4 N04.5 N04.6 N04.7 N04.8 N04.9 N05 N05.0	N05.1 N05.2 N05.3 N05.4 N05.5 N05.6 N05.7 N05.8 N05.9 N11 N11.0 N11.1 N11.8 N11.9 N18 N18.0 N18.8 N18.9 I12.0 I13.1 I13.2 O10.2 O10.3		B05D B05Z B03XA01 V03AE	
Any registered medical practitioner		Creatinine clearance value of < 30 ml / min					**OR**		
		OR					Evidence of payment for peritoneal or haemodialysis for at least 8 sessions in the preceding three months, as evidenced by any of the following NHRPL or UPFS codes:		
		A Glomerular Filtration Rate estimate of < 30 ml / min					***Medical Practitioners:*** 1843 1845 1847 1849 1851 1852 ***Clinical Technologists:*** 145 146 148 147	 176 177 149 150 151 152 154 156 153 155	***Registered Nurses:*** 092 608 610 612 ***UPFS*** 80090 0310 0311 0312 0320 0321 0322

Table 7: Chronic Obstructive Pulmonary Disease

<table>
<tr><th colspan="7">Chronic Obstructive Pulmonary Disease</th></tr>
<tr><td colspan="7">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</td></tr>
<tr><td colspan="5">Diagnosis-related information</td><td rowspan="2">AND</td><td>Proof of Treatment</td></tr>
<tr><td rowspan="2">Provider code of the diagnosing provider</td><td rowspan="2">AND</td><td rowspan="2">Result of Special investigations</td><td rowspan="2">AND</td><td>ICD10 Codes (Any of the following)</td><td>Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:</td></tr>
<tr><td>Any registered medical practitioner</td><td>Lung function tests demonstrating FEV1/FVC post-bronchodilator values below 70% and FEV1 post-bronchodilator values of less than 70% of predicted</td><td>J43
J43.0
J43.1
J43.2
J43.8
J43.9
J44
J44.0
J44.1
J44.8
J44.9</td><td>R03AC
R03AK
R03BA
R03BB
R03CC
R03DA04</td></tr>
</table>

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: *Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension*					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
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: *Crohn's disease or Ulcerative Colitis*						
Diagnosis-related information					***Proof of Treatment***	
Provider code of the diagnosing provider	**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:	
Must be a specialist physician, 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

<table>
<tr><th colspan="5">Diabetes Insipidus</th></tr>
<tr><th colspan="3">Diagnosis-related information</th><th rowspan="5">AND</th><th>Proof of Treatment</th></tr>
<tr><td colspan="2">Provider code of the diagnosing provider</td><td rowspan="4">AND</td><td>ICD10 Codes
(Any of the following)</td><td rowspan="4">Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:</td></tr>
<tr><td colspan="2">Must be a specialist physician, paediatrician, neurosurgeon, neurologist or endocrinologist</td><td>E23.2</td></tr>
<tr><td>11800
13200
12400</td><td>12000
11801</td><td>H01BA</td></tr>
</table>

Table 11: Diabetes Mellitus (Type 1 and 2)

Diabetes Mellitus (Type 1 and 2)

Note:

- *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 only insulin use (ATC A10A), 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:	**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
		E10 E10.0 E10.1 E10.2 E10.3 E10.4 E10.5 E10.6 E10.7 E10.8 E10.9 E11 E11.0 E11.1 E11.2 E11.3 E11.4 E11.5 E11.6 E11.7 E11.8	E11.9 E12 E12.0 E12.1 E12.2 E12.3 E12.4 E12.5 E12.6 E12.7 E12.8 E12.9 O24 O24.0 O24.1 O24.2 O24.3 O24.4 O24.9		**OR**		A10B
					Any ICD10 code indicative of Non-Insulin Dependent Diabetes:		**OR**
Any registered medical practitioner					E11 E11.0 E11.1 E11.2 E11.3 E11.4 E11.5 E11.6 E11.7 E11.8 E11.9 O24.1		Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
					THEN		A10A
					Classify as Type 2 diabetes		
					ELSE		
					Classify as Type 1 Diabetes		

Table 12: Dysrhythmias

Dysrhythmias				
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*				
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, for services / treatment that was provided 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, *Bipolar Mood Disorder and Multiple Sclerosis may not co-occur with Epilepsy*					
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, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		G40 G40.0 G40.1 G40.2 G40.3 G40.4 G40.5 G40.6 G40.7	G40.8 G40.9 G41 G41.0 G41.1 G41.2 G41.8 G41.9		N03

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, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		H40 H40.0 H40.1 H40.2 H40.3 H40.4	H40.5 H40.6 H40.8 H40.9 Q15.0		S01E

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, for services / treatment that was provided in one calendar month in the three calendar months preceding the current month:
		D66 D67			
Any registered medical practitioner		**AND**		B02AA02 B02BD02 B02BD03	B02BD04 B02BD06 H01BA
		Laboratory evidence of Factor VIII or IX levels lower than or equal to 5%			

Table 16: Hyperlipidaemia

Hyperlipidaemia

Note:

- *Information supporting the diagnosis must be kept in a format that could be audited. This includes paper copies or the electronic storage of voice recordings that could substantiate the diagnosis, the results of special investigations and the data underlying the risk assessment (Framingham score).*
- *Only a diagnosis by an endocrinologist will be accepted to diagnose genetic hyperlipidaemias without supporting high Total Cholesterol values*

Diagnosis-related information										***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	Doctor diagnosis of symptomatic atherosclerotic disease Including any of the following ICD10 codes				**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
		G45 G45.0 G45.1 G45.2 G45.3 G45.4 G45.8 G45.9 I20 I20.0 I20.1 I20.8 I20.9 I21 I21.0 I21.1 I21.2 I21.3 I21.4	I21.9 I22 I22.0 I22.1 I22.8 I22.9 I24 I24.0 I24.1 I24.8 I24.9 I25 I25.0 I25.1 I25.2 I25.3 I25.4 I25.5 I25.6	I25.8 I25.9 I63.0 I63.1 I63.2 I63.3 I63.4 I63.5 I63.6 I63.8 I63.9 I64 I65.0 I65.1 I65.2 I65.3 I65.8 I65.9 I66.0	I66.1 I66.2 I66.3 I66.4 I66.8 I66.9 I67.6 I70 I70.0 I70.1 I70.2 I70.8 I70.9					
							E78 E78.0 E78.1 E78.2 E78.3 E78.4 E78.5			C10
Any registered medical practitioner.		**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 1st degree male relative < 55 yrs			
					OR			
					Positive family history of a premature vascular event a 1st 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: *Cardiomyopathy and Cardiac Failure, Coronary Artery Disease, Dysrhythmias; and Hypertension* For count purposes , only one of *Hypertension or Chronic Renal Disease* may be assigned to the same patient						
Diagnosis-related information					***Proof of Treatment***	
Provider code of the diagnosing provider	**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:	
Any registered medical practitioner		I10 I11 I11.0 I11.9 I12 I12.0 I12.9 I13 I13.0 I13.1 I13.2 I13.9 I15	I15.0 I15.1 I15.2 I15.8 I15.9 O10 O10.0 O10.1 O10.2 O10.3 O10.4 O10.9 O11		C02 C03 C07	C08 C09 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, for services / treatment that was provided 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, *Bipolar Mood Disorder and Epilepsy may not co-occur with Multiple Sclerosis*				
Diagnosis-related information				***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD10 Codes (Any of the following)	**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, 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, for services / treatment that was provided 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

<table>
<tr><th colspan="7">Rheumatoid Arthritis</th></tr>
<tr><td colspan="7">For count purposes, Systemic Lupus Erythematosus may not co-occur with Rheumatoid Arthritis</td></tr>
<tr><td colspan="7">Note: Where a patient is not using disease modifying anti-rheumatic medicines, the diagnosis must be verified by a specialist physician or rheumatologist</td></tr>
<tr><td colspan="5">Diagnosis-related information</td><td rowspan="2">AND</td><td>Proof of Treatment</td></tr>
<tr><td>Provider code of the diagnosing provider

Any registered medical practitioner</td><td rowspan="3">AND</td><td>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:

A07EC01
L01AA01
L01BA01
L04A
M01C
P01BA01</td><td rowspan="3">AND</td><td>ICD10 Codes (Any of the following)

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</td><td>Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:

A07EC01
H02AB
L01AA01
L01BA01
L04A
M01AB
M01AC
M01AD
M01AE
M01AF
M01AG
M01AH
M01C
P01BA01</td></tr>
<tr><td colspan="3">OR</td></tr>
<tr><td colspan="3">Diagnosis of rheumatoid arthritis by a specialist physician, paediatrician or rheumatologist
11800
13200
13100</td></tr>
</table>

Table 22: Schizophrenia

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

Table 23: Systemic Lupus Erythematosus

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

Table 24: Ulcerative Colitis

Ulcerative Colitis					
For count purposes, only one of the following Gastro Intestinal conditions can be assigned to the same patient: *Crohn's disease or Ulcerative Colitis*					
Diagnosis-related information					***Proof of Treatment***
Provider code of the diagnosing provider	**AND**	ICD10 Codes (Any of the following)		**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Must be a specialist physician, surgeon or gastroenterologist: 14200 11800 11900		K51 K51.0 K51.1 K51.2 K51.3	K51.4 K51.5 K51.8 K51.9		A07E L04AA11 H02AB L04AA12

Table 25: HIV / AIDS

HIV / AIDS							
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							
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	**AND**	Evidence of payment of claims for any product included in the ATC categories below, for services / treatment that was provided in two different calendar months in the three calendar months preceding the current month:
Any registered medical practitioner		Z21 B20 B20.0 B20.1 B20.2 B20.3 B20.4 B20.5 B20.6 B20.7 B20.8 B20.9 B21 B21.0 B21.1 B21.2	B21.3 B21.7 B21.8 B21.9 B22 B22.0 B22.1 B22.2 B22.7 B23 B23.0 B23.1 B23.2 B23.8 B24				J05AE J05AF J05AG

7. ATC Code Descriptions

Addison's Disease	
H02AB	Glucocorticoids
H02AA02	Fludrocortisone
Asthma	
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB01	Ipratropium bromide
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
R03DC	Leukotriene receptor antagonists
Bipolar Mood Disorder	
N05AN01	Lithium
N03AX09	Lamotrigine
N03AF01	Carbamazepine
N03AG01	Valproic acid
Bronchiectasis	
H02AB	Glucocorticoids
R03AC	Selective beta-2-adrenoreceptor agonists
R03AK	Adrenergics and other drugs for obstructive airway diseases
R03BA	Glucocorticoids
R03BB01	Ipratropium bromide
R03CC	Selective beta-2-adrenoreceptor agonists
R03DA04	Theophylline
Cardiac Failure and Cardiomyopathy	
C01AA05	Digoxin
C01DA	Organic nitrates
C02DB	Hydrazinophthalazine derivatives
C03	DIURETICS
C07	BETA BLOCKING AGENTS
C09	AGENTS ACTING ON THE RENIN-ANGIOTENSIN SYSTEM
Chronic Renal Disease	
B05D	Peritoneal dialytics
B05Z	Haemodialytics and haemofiltrates
B03XA01	Erythropoietin
V03AE	Drugs for treatment of hyperkalemia and hyperphosphatemia

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

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

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

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