

Diabetes Mellitus/Pre-Diabetes Hypertension Lipid Disorders Stroke Asthma
COPD Schizophrenia Major Depression Dementia Bipolar Disorder
Osteoarthritis BPH Anxiety Parkinson's Disease CKD (Nephritis/Nephrosis)
Epilepsy Osteoporosis Psoriasis Rheumatoid Arthritis Ischaemic Heart Disease

Chronic Disease Management Programme

2018

Handbook for Healthcare Professionals

Includes instructions on use of MediSave for CDMP and chronic subsidies under Community Health Assist Scheme (CHAS)

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CHAPTER ONE: THE CHRONIC DISEASE MANAGEMENT PROGRAMME (CDMP) AND COMMUNITY HEALTH ASSIST SCHEME (CHAS)

1 Overview

1.1 MediSave for Chronic Disease Management Programme (CDMP)

1.1.1 The CDMP was introduced at the end of 2006, and involves: (a) evidence-based structured Disease Management Programmes (DMPs¹), where applicable and (b) the option for patients to draw on their MediSave to help reduce out-of-pocket payments for outpatient treatment required in the management of their chronic diseases.

1.2 Community Health Assist Scheme (CHAS)

1.2.1 CHAS, formerly known as the Primary Care Partnership Scheme (PCPS), was introduced in Jan 2012 to enable lower- to middle-income Singapore Citizens to receive subsidies for medical and dental care at CHAS General Practitioner (GP) and dental clinics.

1.2.2 Since its introduction, chronic conditions under CHAS and CDMP have been kept the same, allowing CHAS to complement CDMP. Eligible patients with selected chronic conditions are thus able to enjoy CHAS subsidies, as well as tap on their MediSave for the outpatient treatment of their chronic conditions.

1.2.3 The Pioneer Generation Package (PGP) was introduced in Sep 2014 to allow all Pioneers to receive special subsidies under CHAS. This would also help CHAS GPs provide holistic care for Health Assist (HA)/Pioneer Generation (PG) cardholders under their care, in line with the vision of “One Family Physician for every Singaporean”.

1.3 Covered Conditions

1.3.1 It is recognised that the treatment of chronic diseases is costly when administered collectively over a long period. However, CDMP/CHAS will help reduce out-of-pocket payments and also reduce the barriers for patients to seek medical treatment. With the inclusion of more chronic conditions under CDMP/CHAS, GPs will be able to take on a greater role in the management of their patients’ chronic diseases.

1.3.2 The use of CDMP/CHAS will apply to the conditions listed below:

¹ Components of disease management include: (a) population identification process; (b) evidence-based practice guidelines; collaborative practice models to include physician and support-service providers; (d) patient self-management education; (e) process and outcome management, evaluation, and management; and (f) routine reporting/feedback loop.

Table 1.1: Chronic Conditions under CDMP/CHAS

	Conditions under CDMP/CHAS
Chronic Conditions with Established DMPs (Requiring the reporting of clinical indicators)	1) Diabetes Mellitus and Pre-Diabetes 2) Hypertension 3) Lipid Disorders 4) Asthma 5) Chronic Obstructive Pulmonary Disease (COPD) 6) Chronic Kidney Disease (Nephritis/Nephrosis)
CDMP-Mental Illnesses (Requiring participation of clinic/doctor in a Shared Care Programme)	7) Schizophrenia 8) Major Depression 9) Bipolar Disorder 10) Anxiety
Other Chronic Conditions	11) Stroke 12) Dementia 13) Osteoarthritis 14) Parkinson’s Disease 15) Benign Prostatic Hyperplasia (BPH) 16) Epilepsy 17) Osteoporosis 18) Psoriasis 19) Rheumatoid Arthritis (RA) 20) Ischaemic Heart Disease (IHD)

2 Clinical Guidelines and Clinical Data Submission

- 2.1 Participating clinics/medical institutions are expected to provide care to patients in line with the latest MOH Clinical Practice Guidelines (CPGs) and/or best available evidence-based practice, as well as to track clinical data at patient and clinic/medical institution level to monitor patient outcome. While participating clinics/medical institutions will still be required to submit relevant clinical indicators, clinical data submission is needed for only six of the conditions under CDMP/CHAS. For the other conditions, essential care components are expected to be documented and may be subjected to periodic audits.
- 2.2 Please refer to Chapter Two: The Clinical Guidelines for further details on the essential care components, indications for referral and specific examples of claimable/non-claimable items. These are recommended by Subject-Matter-Experts based on best available medical evidence. The list of clinical indicators to be submitted is detailed in Chapter Four: Capture and Submission of Clinical Data.

CHAPTER TWO: THE CLINICAL GUIDELINES

1 Enrolling Patients

- 1.1 Clinics participating in the CDMP/CHAS are required to provide all the essential care components detailed in this handbook. The basis for establishing a diagnosis of the chronic diseases should conform to the prevailing MOH Clinical Practice Guidelines (CPGs), where applicable.
- 1.2 The essential care components of each condition are recommended by the Clinical Advisory Committee appointed by MOH. These components are recommended based on current available evidence. They can be found in Chapter Two: The Clinical Guidelines of this handbook.
- 1.3 To facilitate integration of care across the various settings so that patients are able to continue and receive the appropriate management of their chronic conditions, MOH has worked with relevant specialists to develop continuing care guidelines:
 - a) To identify suitable patients who are stable and can be managed in the community by their primary care physician rather than in a tertiary setting;
 - Or**
 - b) To identify patients who are at risk and may benefit from specialist opinion.
- 1.4 Patients often have one or more of the three common metabolic and cardiovascular diseases, namely Diabetes Mellitus, Hypertension and Lipid Disorders. For these patients, they should be enrolled into the respective DMPs according to [Annex A](#) (page 10).
- 1.5 For new diagnosis of Dementia or suspected cognitive impairment, when in doubt, it is advisable to refer to a geriatrician/psychiatrist/neurologist for confirmation as the diagnosis carries long term medical and legal implications.

2 Shared Care Programme for CDMP Mental Illnesses (CDMP-MI)

- 2.1 Mental health conditions, i.e. Schizophrenia, Major Depression, Bipolar Disorder and Anxiety, are included in the CDMP-MI. Doctors interested in making CDMP/CHAS claims for the above-mentioned conditions are required to attend training for CDMP-MI, and participate in Shared Care or GP Partnership Programmes with a public hospital to ensure that they have sufficient training and confidence in treating patients with mental health conditions.
- 2.2 For new diagnosis of mental health conditions, when in doubt, it is advisable to refer to a psychiatrist, as the diagnosis may carry medical, social and legal implications.
- 2.3 With effect from 1 Jan 2014, Dementia is no longer a CDMP-MI condition, and therefore doctors who wish to manage Dementia patients under CDMP/CHAS are no longer required to participate in the Shared Care or GP Partnership Programme.

3 Guidelines on MediSave Use for CDMP

- 3.1 Only doctors and clinics/medical institutions which are accredited for MediSave use and participating in the CDMP can make MediSave claims. Doctors and participating clinics/medical institutions on the CDMP have to comply with these guidelines.
- 3.2 From June 2018, package claims will be discontinued under MediSave500, and by extension, CDMP. Package claims made before 1 June 2018 will still be valid up to one year from the first date of visit for the package.
- 3.3 MediSave use is only allowed for outpatient treatments of the approved chronic conditions in [Table 1.1](#) and/or its associated complications. Clinics must indicate the relevant MediSave Scheme or Diagnosis of patients in the MediSave Authorisation Form or Medical Claims Authorisation Form when they make MediSave claims.
- 3.4 MediSave claims will be accepted only if:
- The patient is diagnosed to have one of the approved chronic conditions listed in [Table 1.1](#);
 - The claim must be related to the essential care components in the management of that specific DMP or for the treatment of the condition and its complications. The doctor in-charge must clearly document this causal relationship or link between the condition and its treatment;
 - In this regard, MediSave claims will generally not be allowed for sleeping pills, slimming pills or erectile dysfunction drugs used for lifestyle purposes;
 - Under certain equivocal circumstances, the auditors will seek further clarification with the prescribing doctor and decide on acceptance of claim on a case-by-case basis;
 - Essential care components are to be documented in the doctor's clinical notes. Audits may call for essential care components to be submitted at random.
- 3.5 Certain items including non-evidence-based treatments are not MediSave-claimable. This is to ensure judicious usage of patients' MediSave dollars so that they cover essential care components and medications. A general list of claimable and non-claimable items is included in [Table 2.1](#) below for reference.

Table 2.1: General List of Claimable and Non-Claimable Items/Services

Claimable	Not claimable
<ul style="list-style-type: none">Services delivered at participating healthcare institutions	<ul style="list-style-type: none">Telehealth services
<ul style="list-style-type: none">Relevant investigations (laboratory and radiological) leading to diagnosis of approved chronic conditions, for management of condition and/or their complications	<ul style="list-style-type: none">Investigations unrelated to the diagnosis, management of the disease or its complicationsScreening tests, e.g. STD screen, Hepatitis screen, Tumour markers

<ul style="list-style-type: none"> • Investigations for good prescribing practice to avoid drug-related complications 	
<ul style="list-style-type: none"> • Medications for the management of approved chronic conditions, their complications (e.g. gastro-protectants when prescribed with NSAIDs), and/or their risk factors (e.g. nicotine replacement therapy for smoking cessation) 	<ul style="list-style-type: none"> • Traditional and complementary medicine (e.g. herbal medicine, Ayurveda) • Vitamins and/or dietary supplements (except for cases with established deficiencies²) • Lifestyle modifying medications (e.g. hair-loss or weight-loss medications) except where clinically indicated based on prevailing CPGs (e.g. weight-loss medications for obese patients) • Non-HSA registered medications • Off-label use of medications • Sedatives-hypnotics
<ul style="list-style-type: none"> • Nursing and allied health services as referred by physicians in accordance with patients' integrated care plans, and which fulfil the criteria in para 3.6. 	<ul style="list-style-type: none"> • Complementary, non-evidence-based therapies e.g. massage therapy, chiropractic, homeopathy, acupuncture • Medical devices, such as blood pressure monitoring machines, splints, nasogastric tubes and ambulatory devices (e.g. walking sticks, wheelchairs) • Home meal delivery, transport • Non-healthcare services (e.g. cooking courses, gym classes)

*More disease-specific examples of claimable and non-claimable items/services can be found in the rest of Chapter Two: The Clinical Guidelines.

3.6 Support services should meet the following criteria for them to be claimable. A general list of claimable and non-claimable support services is included in **Table 2.2** below for reference.

- The support service should be widely regarded as a mainstream healthcare or support service;
- There is evidence of the support service being effective in contributing to the positive management of the chronic disease concerned;
- The support service should be delivered by a qualified personnel, or where relevant, an accredited professional³; and
- The support service provided should be within the scope of practice empowered under the relevant professional registration Act (if relevant), or otherwise generally accepted for the professional based on his/her professional qualifications.

² In the absence of laboratory tests to definitively diagnose clinical deficiency, other supporting documented evidence (e.g. patient history, physical exam and/or other lab tests) can be accepted to support the clinical diagnosis of deficiency.

³ Accredited professionals include doctors, dentists, nurses, physiotherapists, occupational therapists, speech therapists, diagnostic radiographers, radiation therapists, optometrists and opticians.

Table 2.2: Examples of Claimable and Non-Claimable Support Services

Claimable
<ul style="list-style-type: none">• <u>Nursing and related services delivered by registered nurses</u><ul style="list-style-type: none">○ Including nursing care (e.g. diabetic foot wound care, nasogastric tube care), nurse counselling• <u>Allied health services</u><ul style="list-style-type: none">○ Therapy services, including physiotherapy, occupational therapy, speech therapy services delivered by registered AHPs○ Services by non-registered professions specified in the AHP Act, including podiatry, dietetics, psychotherapy, prosthetics, orthotics• <u>Other key support services for chronic disease care</u><ul style="list-style-type: none">○ Including diabetic retinal photography, diabetic foot screening, smoking cessation
Not claimable
<ul style="list-style-type: none">• Exercise support• Stress management• Sleep management• Nutritional counselling• Health coaching• Cooking courses• Gym classes

3.7 The maximum amount that can be withdrawn for chronic disease treatments/attendances taking place from June 2018 and thereafter is \$500 per Medisave account per calendar year.

3.8 Eligible patients can use their personal MediSave account and immediate family members' MediSave accounts for payment of their chronic disease treatments. Immediate family members refer to the spouse, parent or child of the patient. Patients who are Singapore Citizens or Permanent Residents will also be able to use their grandchildren's Medisave accounts to pay for their treatment.

Scenario 1

Mr Lim is a retiree with 2 working children. He is suffering from COPD and has MediSave from his earlier years of work. Mr Lim can make use of a maximum of \$1,500 of MediSave from his and his children's MediSave accounts (total of 3 accounts) every year to pay for his outpatient treatment for COPD.

Scenario 2

The grandmother and parents of Ms Tan are suffering from Diabetes Mellitus. However, they have no MediSave. Ms Tan can make use of a total of \$500 (annual withdrawal limit) of her own MediSave every year to pay for the outpatient treatments of all 3 of her elders.

Scenario 3

Mdm Haslina is a working adult and has no children. She has Hypertension and Asthma and can use up to \$500 (annual withdrawal limit) from each of

her and her spouse's MediSave accounts to pay for treatment related to Hypertension and Asthma.

- 3.9 Patients may have employer benefits and outpatient insurance that can be used to pay for outpatient treatments. Bills should be paid using employers' benefits and any relevant insurance that the patient may have first, before claiming from MediSave for the balance.
- 3.10 In cases where only part of the chronic disease outpatient treatment bill is payable by employer companies and the patient chooses to use MediSave for the balance of the bill, clinics would:
 - a) Follow the current arrangements it has with the employer to seek payment; and
 - b) Help patients submit the MediSave claim.

4 Guidelines on Use of CHAS Subsidy for CDMP Conditions

- 4.1 Only doctors and clinics which are participating in the CHAS can make CHAS subsidy claims.
- 4.2 Doctors and participating clinics on the CHAS have to comply with the guidelines in this handbook.
- 4.3 The guidelines in paras 3.4 to 3.6 on CDMP apply to CHAS claims for CDMP conditions as well.
- 4.4 For patients who are eligible for both employee benefits and CHAS, the CHAS subsidies will apply before the employee benefits.

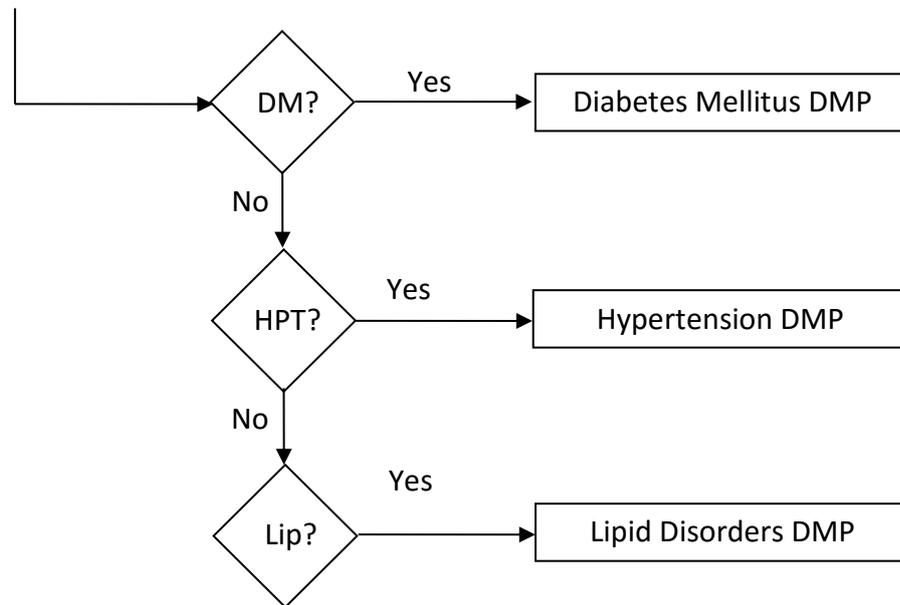
5 Disease-Specific Guidelines for the CDMP Conditions

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5	Chronic Obstructive Pulmonary Disease (COPD)	21
6	Chronic Kidney Disease (Nephritis/Nephrosis)	23
7*	Schizophrenia	25
8*	Major Depression	As above
9*	Bipolar Disorder	As above
10*	Anxiety	As above
11	Stroke	28
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* Conditions under the CDMP-MI

Enrolling patients with Diabetes Mellitus, Hypertension, and/or Lipid Disorders



Diabetes Mellitus and Pre-diabetes (Requires reporting of clinical indicators)

Diabetes mellitus is a heterogeneous metabolic disorder characterised by presence of hyperglycaemia resulting from defects in insulin secretion, insulin action, or both. Chronic hyperglycaemia is associated with long-term sequelae resulting from damage to various organs and tissues, particularly the kidney, eye, nerves, heart and blood vessels.

Diagnosing Diabetes

In patients with hyperglycemic crisis, diabetes mellitus can be diagnosed without further testing.

In patients with typical symptoms, diabetes mellitus can be diagnosed if any one of the following is present.

1. Casual plasma glucose ≥ 11.1 mmol/L
2. Fasting plasma glucose ≥ 7.0 mmol/L
3. 2-hour post-challenge plasma glucose ≥ 11.1 mmol/L

Pre-diabetes is defined by glycaemic levels that are higher than normal, but lower than the diabetes thresholds. Patients are asymptomatic but the condition puts individuals at higher risk of developing type 2 diabetes and cardiovascular disease. The pre-diabetic state includes impaired fasting glucose (IFG) and impaired glucose tolerance (IGT), which can be diagnosed as follows.

Pre-diabetes	Fasting Plasma Glucose (mmol/L)	2-hr Post-load Glucose (mmol/L)*
IFG	6.1 – 6.9	< 7.8
IGT	< 7.0	7.8 – 11.0

*2-hour 75g oral glucose tolerance test (OGTT)

HbA1c is not currently recommended as a screening and diagnostic tool for diabetes mellitus. Its performance in our multi-ethnic population is being evaluated.

Part Ia: Clinical Indicators for Diabetes Mellitus

Essential Care Components	Minimum Frequency for Reporting*	Remarks
Glycated Haemoglobin (HbA1c)	Twice a year	General HbA1c target of $\leq 7.0\%$, but target of treatment should be personalised (e.g. for elderly)
Blood Pressure Measurement	Twice a year	For patients with type 2 diabetes mellitus who have hypertension, an acceptable treatment-initiation and target blood pressure is $<140/80$ mmHg
Weight and BMI Assessment	Twice a year	Keep $<25\text{kg/m}^2$ (For Asian population, keep BMI $<23\text{ kg/m}^2$)

Part Ia: Clinical Indicators for Diabetes Mellitus (continued)

Essential Care Components	Minimum Frequency for Reporting*	Remarks
Lipid Profile	Annually	All patients should be risk stratified (as recommended in the Lipids CPG) Targets of treatment should be personalised by levels of risk
<u>Nephropathy Assessment</u> Serum Cr and eGFR, and Urine Albumin-Creatinine (uACR)	Annually	Good glycaemic control and good BP control with Angiotensin Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) preferred to slow progression of Diabetic Nephropathy Annual screening of serum Cr, eGFR in all patients Submission of uACR required only for patients with Nephropathy
Eye Assessment	Annually	Includes retinal photography and visual acuity <u>Patients with T1 DM:</u> First assessment within 3-5 years after diagnosis of diabetes once patient is aged ten years or older, then annually <u>Patients with T2 DM:</u> First assessment at diagnosis, then annually
Foot Assessment	Annually	Screen for peripheral neuropathy, peripheral vascular disease, bone, joint, skin and nail abnormalities, and poor footwear
Smoking Assessment	Annually	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Cardiac Assessment#	At diagnosis before initiating medications	Includes baseline ECG

*More frequently if clinically indicated

#Non-reportable care component; may be subjected to periodic audits

Part Ib: Clinical Indicators for Pre-diabetes

Essential Care Components	Minimum Frequency for Reporting*	Remarks
Screen for CVD Risk Factors	Annually	To screen for hypertension (BP measurement) and lipid disorders (lipid panel)
Blood Glucose Test (FPG, OGTT, HbA1c)	Twice a year	<u>For Patients not on Metformin:</u> - FPG +/- OGTT to monitor glycaemic control and screen for diabetes for patients not on metformin - HbA1c may be used to monitor glycaemic control in patients for whom regular FPG +/- OGTT may not be feasible

Part Ib: Clinical Indicators for Pre-diabetes (continued)

Essential Care Components	Minimum Frequency for Reporting*	Remarks
		<p><u>For Patients on Metformin:</u></p> <ul style="list-style-type: none"> - HbA1c is required for patients on metformin to monitor treatment response. Target HbA1c <6.5% - If HbA1c ≥6.5%, withhold metformin for 4-6 weeks and perform FPG +/- OGTT to confirm T2DM diagnosis
Weight and BMI Assessment	Twice a year	Keep <25kg/m ² (For Asian population, keep BMI <23 kg/m ²)
Renal Function Monitoring	Annually	Yearly renal function test if on Metformin; more frequently if there is evidence of renal impairment

*more frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended

Special Patient Population

- Adults with suspected Type 1 DM
- Children and adolescents with suspected DM (regardless of type)
- Pregnant women or those planning pregnancy who require pre-conception intensive glycaemic control
- Patients with morbid obesity who are open to the option of intensive weight management including bariatric surgery

Complications Requiring Active Specialist Management

- Nephrology referral if any of the following:
 - Patients with Stage 3b or higher CKD
 - Unexpected or rapid decline in renal function
 - Difficult management issues (blood pressure, hyperkalaemia control)
 - Atypical features (e.g. haematuria, presence of casts in the urine sediment, presence of renal bruit, nephritic range proteinuria (>3g/day), absence of retinopathy)
- Ophthalmology referral if any of the following:
 - Hard exudates/retinal thickening within one-disc diameter of the fovea (diabetic macular oedema)
 - Severe non-proliferative diabetic retinopathy
 - Unexplained drop in visual acuity/eye findings

Early referrals

- Neovascularisation from proliferative diabetic retinopathy
- Pre-retinal and/or vitreous haemorrhage
- Rubeosis iridis (new vessels on the iris)

Urgent referrals

- Sudden loss of vision
- Retinal detachment
- Neovascular glaucoma

Specialist Referral Recommended (continued)

- Foot-care team (podiatry, orthopaedics surgery, vascular surgery) if any of the following:
 - Ulceration, gangrene, severe foot infection
 - Suspected acute Charcot's foot
 - Vascular claudication

Consider Specialist Input

High Risk Individuals

- Individuals with or at risk for recurrent severe hypoglycaemia*, diabetic ketoacidosis (DKA) or hyperglycaemic hyperosmolar state (HHS) regardless of HbA1c, for specialist input on personalised targets and medication titration to reduce such risks
- Patients with difficulty achieving satisfactory control of blood glucose and/or other risk factors

Consider Collaborative Care or Anchoring Care with Primary Care Physician

In patients who

- Are able to achieve satisfactory HbA1c control and/or for optimisation/management of glycemic control
- Are able to recognise and manage episodes of hypoglycaemia
- Complications of DM are stable, or are under regular review by the appropriate specialist.

* Severe hypoglycaemia refers to hypoglycaemia where assistance from another person is required.

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable Items:

Claimables⁴

- Drugs related to the treatment of DM complications, e.g. Ischaemic Heart Disease, Chronic Renal Failure, Neuropathic pains (e.g. Amitriptyline and Carbamazepine) and Peripheral Vascular Diseases (e.g. Pentoxifylline)
- Items involved in drug administration, such as insulin pens, insulin pumps, syringes and needles dispensed in appropriate quantities, necessary for the patient's own use
- Drug therapy for weight management (e.g. orlistat), as an adjunctive to lifestyle modification and combined with diet and physical activity, when BMI is ≥ 27.5 kg/m²
- Smoking cessation
- Lancets and glucose test strips for self-monitoring of blood glucose levels for Type 1 diabetes patients and Type 2 diabetes patients on insulin

Non-claimables

- Other items involved in disease monitoring, such as lancing devices, glucometers and blood pressure monitoring equipment
- Slimming pills and drugs for erectile dysfunction
- Vitamins/supplements such as Vitamin B/B12 (except for cases with documented deficiency)

⁴ Providers should also refer to the prevailing Appropriate Care Guide (ACG) on Managing Pre-diabetes for recommendations on the care to be provided for pre-diabetics.

Hypertension

(Requires reporting of clinical indicators)

Blood Pressure (BP) levels are continuously related to the risk of cardiovascular disease (CVD). Even within the normotensive range, people with higher levels of BP have higher rates of CVD.

BP is characterised by large spontaneous variations. The diagnosis of hypertension should be based on multiple BP measurements taken on several separate occasions. When the systolic and diastolic BP fall into different categories, the higher category should apply.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency for Reporting*	Remarks
Blood Pressure Measurement	Twice a year	
Weight and BMI Assessment	Twice a year	Keep BMI <25kg/m ² . (For Asian population, keep BMI < 23 kg/m ²)
Smoking Assessment	Annually	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Lipid Profile[#]	At or soon after diagnosis	All patients should be risk stratified (as recommended in the Lipids CPG) Targets of treatment should be personalised by levels of risk
Cardiac Assessment[#]	At diagnosis before initiating medications	Includes baseline ECG

*More frequently if clinically indicated

[#]Non-reportable care component; may be subjected to periodic audits

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
<ul style="list-style-type: none">• Emergency or urgent treatment indicated e.g. malignant hypertension, hypertensive cardiac failure or other impending complications• Hypertension difficult to manage e.g. unusually labile BP, hypertension refractory to multiple drug regimens (3 or more)• Secondary hypertension i.e. hypertension due to an underlying cause, such as hyperaldosteronism• Hypertension in special circumstances e.g. pregnancy, young children
Consider Specialist Input
<ul style="list-style-type: none">• Young hypertensive patients who are less than 30 years old• Patients suspected to have secondary causes of hypertension
Consider Collaborative Care with Primary Physician
<ul style="list-style-type: none">• In patients who are able to achieve satisfactory blood pressure control and/or for optimisation/management of anti-hypertensive medication

Part III: Claimable/Non-claimable Items

Specific Examples of Claimable/Non-claimable:

Claimable

- For patients with complications of Hypertension, such as Ischaemic Heart Disease, investigations like 2D Echocardiogram, MIBI scans
- Drug therapy for weight management (e.g. orlistat), as an adjunctive to lifestyle modification and combined with diet and physical activity, when BMI is ≥ 27.5 kg/m²
- Smoking cessation

Non-claimable

- Purchase of blood pressure monitoring equipment

Lipid Disorders

(Requires reporting of clinical indicators)

Lipid disorders (dyslipidaemia) play a major role in the pathogenesis of coronary heart disease. It is a modifiable cardiovascular risk factor that may be inherited or acquired. Hypercholesterolaemia, mixed (combined) dyslipidaemia and hypertriglyceridaemia are the three commonest dyslipidaemias.

Common causes of secondary dyslipidaemia should be excluded in any patient presenting with dyslipidaemia.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency for Reporting*	Remarks
Lipid Profile	Annually	All patients should be risk stratified (as recommended in the Lipids CPG) Targets of treatment should be personalised by levels of risk
Smoking Assessment	Annually	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Serum transaminases[#]	Before starting statins and 8-12 weeks after; Annually	Especially when the statin dose is increased or when combination therapy is initiated Stop the statin / fibrate if patient is symptomatic
Serum creatine kinase[#]	Before starting statins and 8-12 weeks after; Annually	Look out for rapid increase in creatine kinase post-initiation or increase of statin or fibrate. Stop the medication if the CK is three times ULN) or at about 800 IU/L (whichever is lower)

*More frequently if clinically indicated

[#]Non-reportable care component; may be subjected to periodic audits

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
Referral to A&E <ul style="list-style-type: none">• If the ALT/AST is $\geq 5X$ ULN (upper limit of normal) or if patient is clinically ill/decompensating
Referral to Endocrinologist <ul style="list-style-type: none">• Initiation of rosuvastatin at doses higher than 20mg
Referral to Gastroenterologist <ul style="list-style-type: none">• For clinical presentation of acute hepatitis
Consider Specialist Input
Consider Referral to Endocrinologist <ul style="list-style-type: none">• Triglyceride level more than 4.5mmol/L despite dietary changes and maximum tolerated drug therapy• Target parameters not achieved despite maximal drug therapy• Definite or possible familial hypercholesterolemia on Simon Broome Trust diagnostic criteria (or other validated criteria)

Consider Referral to Gastroenterologist

- Pre-treatment transaminases are 1.5 to 3 times above normal range
- Persistently high transaminases (at least 3 times above normal range) during statin therapy or when statin has been stopped

Consider Collaborative Care with Primary Physician

In patients who are

- Able to achieve satisfactory lipid control and/or for optimisation/management of lipid disorder medication

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:

Claimable

- Omega 3 fish oils, only for patients with severe hypertriglyceridemia (e.g. TG >4.5mmol/L [400mg/dL]) where fibrates alone may not adequately lower the markedly elevated TG levels
- Drug therapy for weight management (e.g. orlistat), as an adjunctive to lifestyle modification and combined with diet and physical activity, when BMI is ≥ 27.5 kg/m²
- Smoking cessation

Non-claimable

- Red yeast supplements (Hypocol) and Co-enzyme Q10

Asthma

(Requires reporting of clinical indicators)

Asthma is a chronic reversible airway disorder that is common in people of all ages. It can be severe and may be fatal. Asthma may present with cough, wheezing, and unexplained dyspnoea and chest tightness. Symptoms are often transient, may be persistent and tend to be worse at night or in the early mornings.

Asthma symptoms may be precipitated or aggravated by upper respiratory tract infections, cigarette smoke, environmental haze, exercise, drugs (e.g. aspirin, NSAIDs, β -blockers, ACE inhibitors), pets and occupational exposure to triggers.

Spirometry is the most reliable test of reversible airway obstruction. Improvement in FEV1 of more than 12% is significant. Peak expiratory flow rate is a less reliable test but patients may improve by 15% or more in response to inhaled bronchodilators, or present with diurnal variability for PEFr of > 10% in adults and >15% in children.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency for Reporting*	Remarks
Asthma Control Test (ACT) score	Twice a year	Recommended for assessment of control at every visit, for patients 4 years and above. For those below 4 years old, proper documentation of symptom frequency and severity (e.g. daytime or night-time symptoms, whether symptoms affect the patient's sleep, feeding, activities) from patient's carer is required
Self-Management Education (with Written Asthma Action Plan)#	At diagnosis	Check for compliance to treatment Provide and review patient's Written Asthma Action Plan when there is any change in treatment Inhaler technique assessment
Smoking Assessment	Annually	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling

*More frequently if clinically indicated

#Non-reportable care component; may be subjected to periodic audits

Part II: Consideration for Collaborative Care

Specialist Referral Recommended

Control: Failure to achieve asthma control despite optimal treatment

- Patients who are currently on or recently stopped daily oral corticosteroid therapy to achieve control
- History of near-fatal asthma requiring intubation and ventilation
- Severe asthma requiring step 4 care and yet experiencing exacerbation despite compliance to treatment

Specialist Referral Recommended (continued)

Control: Failure to achieve asthma control despite optimal treatment

- Poorly controlled asthmatics with ≥ 2 hospitalisations and/or requires ≥ 2 courses of burst therapy with oral corticosteroids in the past one year

Confusing Sign and Symptoms

- Suspected occupational asthma will require further diagnostic determination of the industrial trigger agent
- Patient with atypical signs and symptoms such as unilateral wheeze to exclude other tracheobronchial pathology

Children

- Has poor asthma control with frequent urgent care needs
- Is below 3 years with atypical features e.g. failure to thrive and/or are not responding to low dose inhaled steroid (BUD < 200 mcg/day BDP/ FP < 100 / day)
- Requires high dose steroids. (BUD / FP > 400 mcg/day or BDP > 200 mcg/day)
- Is on prolonged inhaled steroid therapy for more than 6 months and remains symptomatic
- Suffered from a severe acute attack and requires prolonged or repeated oral steroids for control
- Diagnosis is uncertain

Consider Specialist Input

Co-Morbidity

- Concurrent heart failure which may complicate management
- Psychiatric disease or multiple psychosocial problems, including the use of sedative
- Concurrent active GERD which may mimic asthma

Consider Collaborative Care with Primary Care Physician

In patients who

- Require symptom monitoring and optimisation/management of asthma medications
- Require social support to cope with their disease

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:

Claimables

- Investigations for management of the disease and complications (e.g. CXR, pulmonary function tests, allergy tests)
- Investigations for good prescribing practice to avoid drug-related complications (e.g. serum theophylline)
- Items involved in drug administration, such as spacers and accompanying masks dispensed in appropriate quantities, necessary for the patient's own use
- Smoking cessation

Non-claimables

- Investigations unrelated to the diagnosis or follow-up of Asthma
- Non-evidence based investigations such as hand-held spirometry

Chronic Obstructive Pulmonary Disease (COPD)

(Requires reporting of clinical indicators)

Chronic Obstructive Pulmonary Disease (COPD) is a heterogeneous disorder characterised by airflow obstruction that is not fully reversible. The airflow limitation is usually both progressive and associated with exposure to noxious particles or gases. Smoking is by far the most important risk factor.

Patients may present with chronic productive cough and breathlessness. Acute exacerbations of COPD may require hospitalisation. The prevalence of COPD is highest after age 50, and is generally higher in men than women.

A pulmonary function test/spirometry result will establish the diagnosis of COPD for CDMP/CHAS purposes.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency for Reporting*	Remarks
COPD Assessment Test (CAT) Score	Annually	
Smoking Assessment	Annually	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Influenza Vaccination	Annually	
Weight and BMI Assessment	Annually	Nutritional intervention should be considered in all COPD patients with BMI <18.5kg/m ² or significant involuntary weight loss (>10% during the last 6 months or > 5% in the past month)
Self-Management Education#	At diagnosis	Educate on what to do during acute exacerbations; Inhaler technique assessment
Spirometry#	At or soon after diagnosis	

*More frequently if clinically indicated

#Non-reportable care component; may be subjected to periodic audits

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
Severe Cases <ul style="list-style-type: none">• Rapidly progressive course of disease• Acute exacerbation of COPD not responsive to therapy• Development of new symptoms (e.g. haemoptysis) or new physical signs (e.g. cyanosis, peripheral oedema)• End stage COPD (requiring long term oxygen therapy or considering surgery)

Consider Specialist Input

Severe or Complex Cases

- Severe COPD (i.e. FEV1<50% predicted)
- Frequent exacerbations (e.g. two or more a year) despite compliance to treatment

Consider Collaborative Care with Primary Care Physician

In patients who

- Require follow-up monitoring for onset of new symptoms, decreased effort tolerance, adherence to medication and smoking cessation advice

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:

Claimables

- Items involved in drug administration, such as spacers and accompanying masks dispensed in appropriate quantities, necessary for the patient's own use
- Investigations for good prescribing practice to avoid drug-related complications (e.g. serum theophylline)
- Smoking cessation

Non-claimables

- Medications not approved for COPD, including mast cell stabilisers (e.g. Ketotifen)
- Investigations unrelated to the diagnosis or follow-up of COPD
- Non-evidence based investigations such as hand-held spirometry
- Purchase of oxygen tanks, nebulisers or other home nursing equipment

Chronic Kidney Disease (Nephritis/Nephrosis)

(Requires reporting of clinical indicators)

Haematuria and proteinuria are the hallmarks of glomerular disease. In addition, hypertension, impaired renal function and fluid retention can be present to varying extents. The nature and severity of the underlying glomerular injury often dictate the nature and severity of these symptoms.

Conditions covered include (a) Chronic Glomerulonephritis (presenting as nephritic or nephrotic syndromes), (b) Nephropathies (e.g. secondary to underlying diabetes or other conditions) and (c) Chronic Kidney Diseases (with or without known underlying aetiology).

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency for Reporting*	Remarks
Blood Pressure Measurement	Twice a year	ACE-I and ARBs should be used for BP control when proteinuria is present
Renal Function – eGFR or Serum Creatinine	Annually	If eGFR is submitted, it should be using the MDRD formula; Serum Creatinine to be submitted for calculation (for calculation) if lab does not generate MDRD-eGFR
Urinary Protein – Urine Protein Creatinine Ratio (uPCR) or Albumin-Creatinine Ratio (uACR)	Annually	

*More frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
Significant Proteinuria <ul style="list-style-type: none">Urine protein > 1 g/day (or its equivalent i.e. uPCR>100mg/mmol or ACR>70mg/mmol)
Persistent Haematuria
Declining Renal Function <ul style="list-style-type: none">eGFR < 45 ml/min/1.73 m² or rapid decline (> 5 ml/min/1.73 m² per year)
Difficult BP Control <ul style="list-style-type: none">BP>150/90mmHg despite 3 anti-hypertensive medications at maximal doses
Consider Collaborative Care with Primary Care Physician
In patients who <ul style="list-style-type: none">Are able to reach individualised BP target reached based on severity of glomerulonephritis and proteinuriaHave stable renal function (decline <30% over 4-month follow-up)Are not hyperkalaemic

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:

Claimables

- Pre- and post-dialysis investigations
- The treatment of complications, such as renal osteodystrophy, as well as complications of dialysis
- Drug therapy for weight management (e.g. orlistat), as an adjunctive to lifestyle modification and combined with diet and physical activity, when BMI is ≥ 27.5 kg/m²
- Smoking cessation

Non-claimables

- Supplements such as Iron/Calcium/Vitamin D (except in cases with documented deficiency)
- Unrelated investigations, e.g. myeloma panels
- Transplant-related investigations and/or procedures

CDMP-Mental Illness

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Schizophrenia is a mental illness characterised by delusions, hallucinations, disorganised speech, disorganised or catatonic behaviour, and negative symptoms. Other psychotic disorders and organic brain disorders should be excluded.

Major Depression is a mental illness characterised by low mood, anhedonia, significant weight loss/gain, insomnia, psychomotor agitation or retardation, fatigue or loss of energy, feeling of worthlessness or inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of suicide. Other milder psychiatric conditions, organic conditions or prescription medication-induced depression should be excluded.

Bipolar Disorder is a mental illness characterised by episodes of mania and depression. During acute episodes, there may be either an elevation of mood with increased energy and activity, or a lowering of mood with decreased activity. Manic episodes may last between two weeks and five months (with median duration of four months), while depressive episodes may last longer.

Anxiety is an emotion experienced by everyone in everyday life to perceived threats, but it is considered to be a disorder when it is of greater intensity and/or duration than would be expected in the given circumstances, affects daily life, gives rise to unexplained physical symptoms, or leads to avoidance of situations and places.

In order to provide greater support (e.g. professionally as well as drugs) for family physicians managing patients with mental illness, family physicians are required to participate in Shared Care or GP Partnership Programmes with Restructured Hospitals before CDMP/CHAS claims can be made.

**Anxiety disorders claimable under CDMP/CHAS are General Anxiety Disorder, Panic Disorder, Phobic Anxiety Disorders, Obsessive-Compulsive Disorder, and Post-traumatic Stress Disorder.*

Part I: Clinical Indicators

Applicable to all Mental Illnesses

Essential Care Components	Minimum Frequency*	Remarks
Clinical Global Impression (CGI) Scale	Annually	CGI assessment for <ul style="list-style-type: none">Severity (Scores 1-7)Clinical improvement (Scores 1-7) *1 indicates "normal/no mental illness" or "very much improved"
Consultations for CDMP Mental Health	Twice a year	Consultation includes assessment for symptoms, response and adherence to medications, psychosocial interventions, risk of harm to self or others and general physical health

*More frequently if clinically indicated

Part II: Consideration for Collaborative Care

a) Schizophrenia

Specialist Referral Recommended

Initial assessment

- Assessment, diagnosis and initiation of treatment, when in doubt

High Risk Individuals

- Risk of violence to self or others
- Unstable/uncontrolled symptoms, e.g. recent hospitalisation within last 6 months

Consider Specialist Input

Special Patient Population

- Pregnant, paediatric or geriatric patients
- Forensic or medico-legal issues involved

Complex Cases

- Unexpected changes in symptomatology
- Drug-related complications
- Treatment resistance

Consider Collaborative Care with Primary Care Physician

Follow up

- Monitoring for adherence, early signs of relapse, medication side effects and medication adjustment
- Optimisation of metabolic risk factors (especially for patients on anti-psychotics)

b) Major Depression and c) Bipolar Disorder

Specialist Referral Recommended

Initial assessment

- Assessment, diagnosis and initiation of treatment, when in doubt

High Risk Individuals

- Patients experiencing manic episode
- Risk of violence to self or others, especially patients with suicidal risk
- Having psychosis (hallucinations or odd beliefs)
- Symptoms of catatonia (refusing to talk, eat or drink)
- Need for hospitalisation

Failure of treatment

- Failure of one or two trials of medication
- Need for augmentation or combination therapy (e.g. with mood stabilisers, psychotherapy)
- Need for specialised treatment (e.g. Electroconvulsive treatment)

Consider Specialist Input

Special Patient Population

- Pregnant or paediatric patients
- Forensic or medico-legal issues involved

Consider Specialist Input (continued)

Complex Cases

- Complicated by medical, psychiatric and/or psychosocial co-morbidities, including addiction disorders and substance abuse
- Unstable/uncontrolled symptoms, e.g. recent hospitalisation within last 6 months

Consider Collaborative Care with Primary Care Physician

Follow up

- Monitoring for adherence, early signs of relapse, medication side effects and medication adjustment
- Optimisation of metabolic risk factors (especially for patients on anti-psychotics)

d) Anxiety

Specialist Referral Recommended

Initial assessment

- Assessment, diagnosis and initiation of treatment, when in doubt

High Risk Individuals

- Patients with suicidal risk
- Unstable/uncontrolled symptoms, e.g. recent hospitalisation within last 6 months

Failure of treatment

- Marked functional impairment, disruptive personality disorders
- Failure of one or two trials of medication
- Need for hypnotics (e.g. Benzodiazepines, Zolpidone), and/or formal psychotherapy

Consider Specialist Input

Special Patient Population

- Paediatric patients

Complex Cases

- Complicated by medical, psychiatric and/or psychosocial co-morbidities, including addiction disorders and substance abuse

Consider Collaborative Care with Primary Care Physician

- Monitoring for adherence, early signs of relapse, medication side effects and medication adjustment

Part III: Claimable/Non-Claimable items

Applicable to all Mental Illnesses

Specific Examples of Claimable/Non-Claimable:

Claimable

- Treatments such as Psychological Therapy, Electro-Convulsive Therapy (ECT), Occupational Therapy, Physiotherapy and Speech Therapy

Non-claimable

- Sedatives-hypnotics

Stroke

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Cerebrovascular disease (CVD) is a heterogeneous disease. There are clear pathological subtypes – transient ischaemic attack (TIA), cerebral infarction, primary intracerebral haemorrhage and subarachnoid haemorrhage – with over 100 potential underlying causes. It may affect men and women of any age, and can manifest as a minor episode lasting less than 24 hours (TIA), to a major life threatening or disabling event, and even death. Survivors of strokes may make a complete recovery, or have varying degrees of disability.

Part I: Clinical Indicators

Essential Care Component	Minimum Frequency*	Remarks
Thromboembolism Risk Assessment	As clinically indicated	Evaluate for atrial fibrillation, cardiac murmurs, fasting glucose and need for anti-thrombotic therapy
Rehabilitation Need Assessment	Baseline	
Blood Pressure Measurement	Twice a year	
Lipid Profile	Annually	All patients should be risk stratified (as recommended in the Lipids CPG) Targets of treatment should be personalised by levels of risk
Smoking Assessment	Annually	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling

*More frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
<ul style="list-style-type: none">• New (suspected) onset of TIA or Stroke• New onset of atrial fibrillation or cardiac murmurs requiring further evaluation
Consider Collaborative Care with Primary Care Physician
In patients who are <ul style="list-style-type: none">• On long term anticoagulation (i.e. warfarin) for dose adjustment• On anti-platelet therapy and require continued management of their cardiovascular risk factors

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Claimable <ul style="list-style-type: none">• Treatment of stroke complications such as depression• Drug therapy for weight management (e.g. orlistat), as an adjunctive to lifestyle modification and combined with diet and physical activity, when BMI is ≥ 27.5 kg/m²• Smoking cessation

Non-claimables

- Supplements such as Vitamin B/B12 (except for cases with documented deficiency)
- Dietary supplements (e.g. Glucerna, Ensure)
- Purchase of medical equipment such as blood pressure monitoring equipment, walking aids, wheelchairs and other home nursing equipment
- Nootropics (e.g. piracetam)

Dementia

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Dementia is a neurodegenerative disease that is characterised by progressive impairment of cognitive function. As the disease increases in severity, patients may experience some or all of the following: memory loss, language impairment, disorientation, changes in personality, difficulty with activities of daily living, self-neglect, neuropsychiatric symptoms and out of character behaviour.

Part I: Clinical Indicators

Essential Care Component	Minimum Frequency*	Remarks
Assessment of Memory	Annually	For patients on cognitive enhancers, objective documentation of memory assessment with a bedside cognitive screening instrument (e.g. Mini-Mental State Examination) must be performed.
Assessment of Mood and Behaviour	Annually	Enquiring about mood and behaviour and initiating appropriate non-pharmacological and/or pharmacological treatment where appropriate
Assessment of Social Difficulties and Caregiver stress (if any)	Annually	Assessment and referral to care coordinator, medical social worker or appropriate community services may be required
Functional Needs Assessment	Annually	To assess home safety, driving safety, falls, functional decline and swallowing difficulties

*More frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
<ul style="list-style-type: none">• Young onset Dementia (YOD) i.e. onset before the age of 65• Patients who decline rapidly (based on feedback from caregiver and clinical impression)• Patients in whom diagnosis of Dementia is uncertain• Uncontrolled behavioural and neuropsychiatric symptoms despite trial of pharmacological / non-pharmacological interventions
Consider Collaborative Care with Primary Care Physician
In patients who <ul style="list-style-type: none">• Have minimal behaviour problems or behaviours that are well controlled with modest doses of medications• Are stable with minimal coping issues in both patient and caregiver• Have mild/moderate dementia and are keen to drive will require a driving assessment by the Occupational Therapist

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Non-claimables

- Off-label/non-HSA registered/non-evidence-based medications or therapies (e.g. NSAIDs, COX2 inhibitors and Prednisolone) for prevention of cognitive decline
- Dietary supplements (e.g. Vitamin E, Ginkgo) or traditional medications/therapies (e.g. aromatherapy or massage therapy)

Osteoarthritis

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Osteoarthritis typically affects older people. The diagnosis can be made clinically based on history and physical examination, with laboratory and radiologic investigations selectively undertaken to exclude inflammatory arthritis, secondary osteoarthritis and non-articular causes of joint pain.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency*	Remarks
Joint Pain and Function	Annually	
Prescription and Review of Exercise Plan	Annually	In the form of a directed or supervised muscle strengthening or aerobic exercise programme Can be undertaken by physiotherapist
Weight and BMI Assessment	Annually	Weight reduction should be advocated for patients with BMI of ≥ 23 kg/m ² . Obese patients with BMI ≥ 30 kg/m ² should be referred to a medically-supervised weight reduction programme
Activities of Daily Living (ADL) Assessment	Annually	Referral to physiotherapy/occupational therapy assessment for assisted devices made, should ADL be impaired

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
Lack of Response to Conservative Treatment <ul style="list-style-type: none">• Unsatisfactory improvement of pain, stability or function despite adequate conservative (non-pharmacological and pharmacological) treatment
Consider Collaborative Care with Primary Care Physician
In patients who <ul style="list-style-type: none">• Require long-term follow up of mild to moderate disease• Pain is adequately controlled with analgesics and physiotherapy• Have severe disease with multiple co-morbidities, not a suitable candidate for surgical management

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Claimables <ul style="list-style-type: none">• Intra-articular steroid injections• Investigations related to the management (e.g. X-ray, MRI) and complications (e.g. diagnostic knee aspiration after intra-articular steroid injections) of Osteoarthritis• Drug therapy for weight management (e.g. orlistat), as an adjunctive to lifestyle modification and combined with diet and physical activity, when BMI is ≥ 27.5 kg/m²
Non-claimables <ul style="list-style-type: none">• Off-label/non-HSA registered medications, dietary supplements or alternative therapies (e.g. Glucosamine, Calcium, and Acupuncture and Chiropractic)• Intra-articular viscosupplementation, oral steroids and therapeutic knee aspirations, due to weak evidence

Parkinson's Disease

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Parkinson's disease is an age-related chronic progressive neurodegenerative disorder. In its early stages, Parkinson's disease usually presents with asymmetric tremor, bradykinesia and rigidity. In later stages, non-motor features, such as autonomic dysfunction, falls, sleep disturbances, and cognitive abnormalities, appear. While the disease may occur in a younger population, the average age of onset is in the early to mid-60s.

For the purpose of CDMP/CHAS, this is defined to include Parkinson's disease and Parkinsonism (excluding Drug-induced Parkinsonism).

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency*	Remarks
Review of Diagnosis	Annually	The diagnosis would be reviewed regularly and reassessed if there are atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression to Hoehn & Yahr stage 3 in 3 years, lack of tremor or dysautonomia)
Review of Treatment	Annually	Review and discussion with regard to medical and surgical treatment options, as well as need for rehabilitative therapies (physiotherapy, occupational therapy and speech therapy)
Review of Complications	Annually	Assessment for cognitive impairment, psychiatric disorders (e.g. depression, psychosis), autonomic dysfunction (e.g. constipation, incontinence, orthostatic hypotension), falls, sleep disorders, and medication-related side effects

*more frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
Complicated or Atypical Parkinsonism <ul style="list-style-type: none">• Young-onset (≤ 55 years old) Parkinson's disease• Atypical Parkinsonism• Parkinson's disease complicated by dyskinesia, dystonia, myoclonus or gaze palsies
Consider Specialist Input
Complicated or Atypical Parkinsonism <ul style="list-style-type: none">• Patients who do not respond to levodopa or dopamine agonists• Patients with cognitive impairment or neuropsychiatric dysfunction• Family history of Parkinson's disease
Consider Collaborative Care with Primary Physician
In patients who <ul style="list-style-type: none">• Require long-term follow up and medication

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:

Claimable

- Laxatives for bedbound/wheelchair bound patients

Non-claimable

- Dietary supplements or traditional medications/therapies (e.g. CoEnzyme Q10)

Benign Prostatic Hyperplasia (BPH)

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Benign Prostatic Hyperplasia (BPH) is among the commonest urological problems in the elderly. Patients present with acute retention of urine, or lower urinary tract symptoms, such as hesitancy, poor stream, intermittency, and feeling of incomplete voiding. Irritative symptoms are nocturia, frequency and urgency.

Important differential diagnoses are carcinoma of the prostate and bladder, occult neuropathic bladders due to ageing, diabetes mellitus or Parkinson's disease.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency*	Remarks
Review of Lower Urinary Tract Symptoms	Annually	Recommended tool for assessment of LUTS is the - International Prostate Symptom /Quality of Life Score
Clinical Examination – Abdominal and Digital Rectal Exam	Initial assessment	Abdominal examination includes assessment for a palpable bladder. Rectal examination to assess size, consistency and regularity of prostate
Co-Morbidity Assessment (includes medication review)	Initial assessment	
Urine Labstick or Microscopy	Initial assessment	Screen for haematuria, pyuria and glycosuria

*more frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
<ul style="list-style-type: none">• Hard and/or irregular prostate
Consider Specialist Input
<ul style="list-style-type: none">• Retention of urine, palpable bladder and/or high residual urine• Urinary incontinence and/or other persistent bothersome symptoms• Haematuria• Proven urinary tract infection• Bladder stones
Consider Collaborative Care with Primary Physician
In patients whose <ul style="list-style-type: none">• Symptoms well controlled, require long term follow up and assessment

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Claimable <ul style="list-style-type: none">• Investigations related to the management of Benign Prostatic Hyperplasia and complications (e.g. PSA tests)

Non-claimables

- Phosphodiesterase-5 inhibitors
- Testosterone tests
- Dietary supplements or traditional medications/therapies (e.g. Saw palmetto extract)

Epilepsy

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Diagnosis of Epilepsy

Epilepsy is a chronic disorder of the brain characterised by recurrent seizures. Seizures are episodes of involuntary shaking which may involve a part of the body (partial) or the entire body (generalised), sometimes accompanied by loss of consciousness and control of bowel or bladder function, and result from excessive electrical discharges in a group of brain cells and may occur in different parts of the brain.

The diagnosis of epilepsy in adults should be established by a neurologist who will have better access to the investigative tools necessary to confirm the diagnosis including classifying the epilepsy syndrome.

The diagnosis of epilepsy in children and adolescents should be established by a paediatric neurologist.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency*	Remarks
Seizure Frequency	Annual	
Seizure Type	Annual	
Seizure Free Duration	Annual	

*more frequently if clinically indicated

Part II: Consideration for Collaborative Care

Consider Specialist Input
<ul style="list-style-type: none">Inadequate seizure control (e.g. in general less than 1 year between seizures while on anti-epileptic drug (AED))Potential withdrawal of AEDs in patients with more than one AED
Consider Collaborative Care with Primary Care Physician
<ul style="list-style-type: none">Able to achieve good seizure control (i.e. seizure-free for at least 1 year)Titration and review of AEDs by the family physician according to a weaning regimen prescribed by the specialist for patients who have been seizure-free for at least 2 years

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimables/Non-Claimables:
Claimables <ul style="list-style-type: none">Investigations (except genetic testing) to evaluate etiology, e.g. EEG and MRI brainInvestigations to monitor epilepsy and related disease complications, e.g. full blood count, renal panel, liver function test, vitamin D and calcium levelsKetogenic diet initiated by a specialist in neurology or paediatrics for children who have drug resistant epilepsy (i.e. child has failed to become seizure free / stay seizure free with adequate trials of two AEDs) and where medically necessary as treatment for those who are on enteral feeding or predominately on milk feeds

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimables/Non-Claimables (continued):

Claimables

- Investigations to monitor/guide treatments, e.g. AED blood levels for detection of non-adherence, suspected toxicity, adjustment of phenytoin dose, HLA-B 1502 genotyping for susceptibility to carbamazepine allergy
- Investigations to monitor complications of treatments (including ketogenic diet)
- Supplements in specific situations where there is documented deficiency or where medically indicated (e.g. supra-physiological doses of pyridoxine, pyridoxal phosphate and folic acid for vitamin-responsive seizures, and carnitine for those on sodium valproate and at risk of secondary carnitine deficiency)

Non-Claimable

- Genetic testing for epilepsy
- Nootropics (e.g. piracetam)

Table 2.3: List of Claimable Investigations for Patients on Ketogenic Diet

At baseline and on routine follow-up if indicated:

Full blood count	Urine organic acids
Renal panel	Urine ketones
Liver panel	Magnesium
Lipid panel	Serum amino acids
ECG	Lactate
AED level	Ammonia
Betahydroxybutyrate	EEG
Random urine calcium & creatinine	Renal ultrasound

Osteoporosis

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Diagnosis of Osteoporosis

Osteoporosis is a 'progressive systemic skeletal disease characterised by low bone mass and microarchitectural deterioration of bone tissue, with a consequent increase in bone fragility and susceptibility to fracture'.⁵

Common sites of fracture are the vertebral bodies of the spine, the hip, the forearm and the proximal humerus.

Osteoporosis should be diagnosed based on Dual Energy X-Ray Absorptiometry (DXA) of hip and spine, and/or previous fragility fracture. Currently, the use of methods other than hip dual energy X-ray absorptiometry to diagnose osteoporosis is not recommended.

Individuals found to have osteoporosis should have relevant clinical, laboratory and radiological assessments to exclude diseases that mimic, cause or aggravate osteoporosis, so that appropriate management may be implemented.

Table 2.4: WHO definitions based on BMD

BMD T-score (S.D.)	Definition
≥ -1	Normal
< -1 to > -2.5	Low bone mass (osteopenia)
≤ -2.5	Osteoporosis
≤ -2.5 and a fragility fracture	Severe or established osteoporosis

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency*	Remarks
DEXA scan	At least once every 2 years ⁶	BMD readings at femoral neck, total hip and lumbar spine. Minimal measurement: BMD of femoral neck.
WHO Fracture Risk Assessment Tool (FRAX Score)	Annual	http://www.shef.ac.uk/FRAX/tool.jsp to access FRAX score calculator

*more frequently if clinically indicated

Part II: Consideration for Collaborative Care

Consider Specialist Input
<ul style="list-style-type: none">• Male or pre-menopausal female patients

⁵ Consensus development conference: prophylaxis and treatment of osteoporosis. Am J Med. 1991 Jan;90(1):107-10.

⁶ When BMD has normalised, frequency of DEXA scans should be based on patient's osteoporosis risk (viz low, moderate or high) as defined in Osteoporosis Self-Assessment Tool for Asians (OSTA).

Consider Specialist Input (continued)

- Patients with / suspected of secondary osteoporosis (e.g. disproportionately low Z-scores, long-term steroid use, co-existing endocrine diseases such as hyperparathyroidism, hypogonadism, hypercortisolism and hyperthyroidism)
- Patients with structural or congenital bone condition

Consider Collaborative Care with Primary Care Physician

- Patients with primary osteoporosis and on bone protective agent
- Patients with secondary osteoporosis who are stable and compliant with medications

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimables/Non-Claimables:

Claimables

- Oral bisphosphonates and evidence supported therapies, e.g.
 - IV Zoledronic acid, raloxifene, s/c teriparatide, and denosumab where medically indicated, such as for patients at high risk of fractures and unable to comply with oral bisphosphonates
 - Vitamin D analogues (e.g. alfacalcidol and calcitriol) for glucocorticoid-induced osteoporosis
- Investigations related to the management of osteoporosis (DEXA scans and blood tests for levels of calcium, vitamin D, thyroid stimulating hormone, parathyroid hormone)
- Calcium and vitamin D for patients with established deficiencies or those who are unlikely to meet the respective daily requirements

Non-Claimable

- Testosterone and hormone replacement therapy (HRT)

Psoriasis

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Diagnosis of Psoriasis

Psoriasis is a chronic inflammatory skin disease that typically follows a relapsing and remitting course. Plaque psoriasis presents with well-delineated erythematous, scaly plaques, with or without pustules.

Typical sites of involvement are the scalp, behind the ears or in the concha, on extensor surfaces (i.e. elbows and knees), and the sacral area and natal cleft.

It is associated with characteristic nail changes (more than 5 pits on any nail, onycholysis or subungual hyperkeratosis) and joint pains, especially fingers showing dactylitis or sausage shaped joints.

Psoriatic arthritis is an inflammatory polyarthritis that may develop in up to 30% of people with psoriasis. There is no definitive test to diagnose psoriatic arthritis. Some associated conditions are achilles tendinitis and plantar fasciitis.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency*	Remarks
Assessment of psoriatic arthritis	Annual	Monitor for joint pain. If present, to proceed with recommended tool for assessment – Psoriasis Epidemiology Screening Tool (PEST) and refer to specialist
Body Surface Area (BSA) affected by psoriasis	Annual	Use patient's palm as an estimate of 1% BSA and consider referral to specialist if BSA > 10%

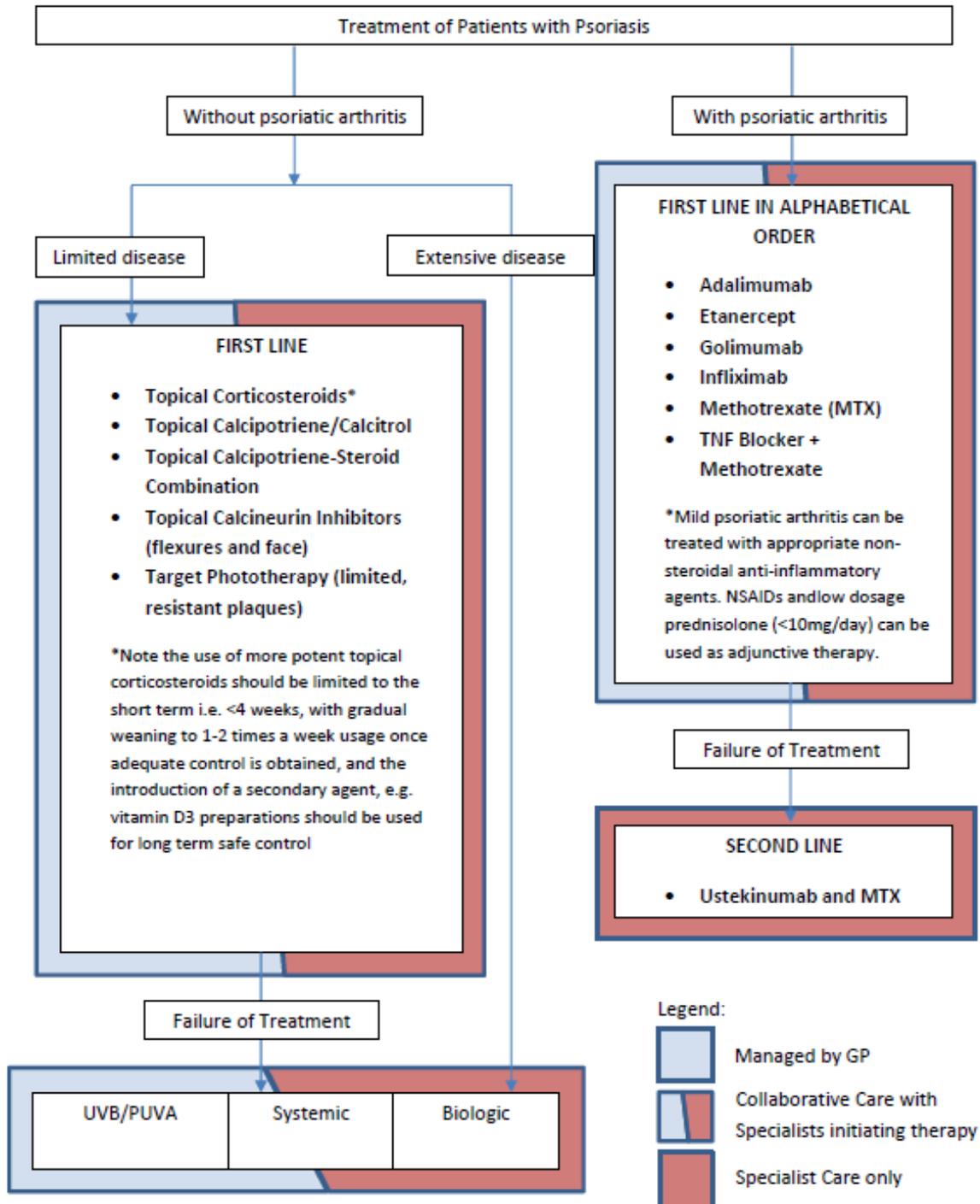
*more frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
<ul style="list-style-type: none">• Psoriatic arthritis• Patients with rash that cannot be controlled with topical therapy• Patients with such severity or type of psoriasis potentially requiring systemic agent or phototherapy
Consider Specialist Input
<ul style="list-style-type: none">• Patient with “unstable” rash i.e. rapid and/or considerable change in psoriasis (e.g. rapid BSA extension, frequent flares, plaque psoriasis fluctuating between pustulation and remission)• Patients with generalised pustular psoriasis or erythroderma
Consider Collaborative Care with Primary Care Physician
In patients who <ul style="list-style-type: none">• Have stable/low disease activity• Are on long term methotrexate[#] (with specialist review every six months to one year)

In the management of these patients, primary care physicians should be guided by detailed management plans set out by the specialist (who should oversee the monitoring of the lifetime dose for patients, as well as perform drug titration if necessary).

Figure 1: Decision tree for collaborative care



Based on American Academy of Dermatology Guidelines for Psoriasis 2011

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimables/Non-Claimables:

Claimables

- Phototherapy
- Systemic non-biologic therapy, e.g. Methotrexate, Cyclosporine, Acitretin
- Biologics treatment
- Baseline investigations before starting systemic and biologics therapy (e.g. full blood count, renal panel, liver panel, chest radiograph, hepatitis B and C screening)
- Routine investigations for patients on oral systemic and biologics therapy
- Investigations to monitor joint involvement
- Topical applications where prescribed:
 - Standard moisturisers (e.g. aqueous cream, urea cream and white soft paraffin) and
 - Corticosteroid creams/ointment (e.g. hydrocortisone, betamethasone valerate, betamethasone dipropionate)
 - Coal tar, salicylic acid, olive oil
 - Vitamin D analogues

Non-Claimable

- Over-the-counter products (e.g. moisturisers, emollients, bath solutions) purchased without a prescription

Table 2.5: List of Claimable Investigations for Patients who are presently on or initiating Oral Systemic and Biologic Therapy

At baseline:	On routine follow-up:
Full blood count	<u>For patients on MTX:</u>
Liver panel	Full blood count
Renal panel	Liver panel
Chest x-ray	Creatinine (periodically)
Hep B and C screening	Liver fibroscan/Magnetic resonance elastography if indicated
TB-spot (for pre-biologic)	
Liver fibroscan/Magnetic resonance elastography if indicated	<u>For patients on Cyclosporin:</u>
	Renal panel
<u>Before starting Acitretin</u>	Liver Panel
Fasting lipids	
	<u>For patients on Acitretin:</u>
<u>Before starting Cyclosporine</u>	Liver Panel
Fasting lipids	Fasting lipids
Serum magnesium	

Rheumatoid Arthritis (RA)

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Diagnosis of Rheumatoid Arthritis (RA)

Rheumatoid arthritis is a chronic inflammatory autoimmune disease of unknown etiology. It is characterised by inflammatory pain and stiffness of synovial joints, with progressive joint destruction if untreated. It is associated with extra-articular manifestations (such as sicca symptoms, interstitial lung disease, and vasculitis), and systemic comorbidities (such as cardiovascular disease and osteoporosis).

A rheumatoid arthritis flare is characterised by worsening disease activity, commonly accompanied by raised ESR or CRP that requires a change in therapy. It must be distinguished from non-inflammatory causes of worsening joint pain, swelling, and septic arthritis.

Patients who meet one of the following classification criteria will be eligible for claims under Rheumatoid Arthritis.

- 1) Patients who meet the 1987 ARA criteria for rheumatoid arthritis or the 2010 ACR/EULAR Diagnostic criteria for rheumatoid arthritis.
- 2) Established rheumatoid arthritis with characteristic features such as joint swelling and deformity
- 3) Early rheumatoid arthritis previously diagnosed and followed up by a rheumatologist.
- 4) Juvenile rheumatoid arthritis previously diagnosed and followed up by a rheumatologist.

Spondyloarthritis/Ankylosing Spondylitis, Adult Onset Still's Disease are not claimable under the CDMP Rheumatoid Arthritis.

Part I: Clinical Indicators

Essential Care Components	Minimum Frequency*	Remarks
Assessment of RA Disease Activity	Annually	Number of tender / swollen joints, CRP or ESR; Measures of disease activity must be obtained and documented regularly, as frequently as monthly for patients with high/moderate disease activity, or less frequently (at least at 6 month intervals) for patients in sustained low disease activity or remission.

*more frequently if clinically indicated

Part II: Consideration for Collaborative Care

Specialist Referral Recommended
<ul style="list-style-type: none">• Patients requiring new initiation of DMARD therapy• Patients with RA flares requiring either high dose (e.g. prednisolone >10mg/day) or long term (≥6 months) glucocorticoid therapy (which should be accompanied by appropriate dose adjustment of DMARDs)• Patients with extra-articular manifestations of RA• Patients on biologic DMARD therapy

- Paediatric patients with six weeks or more of persistent joint swelling, and joint pain

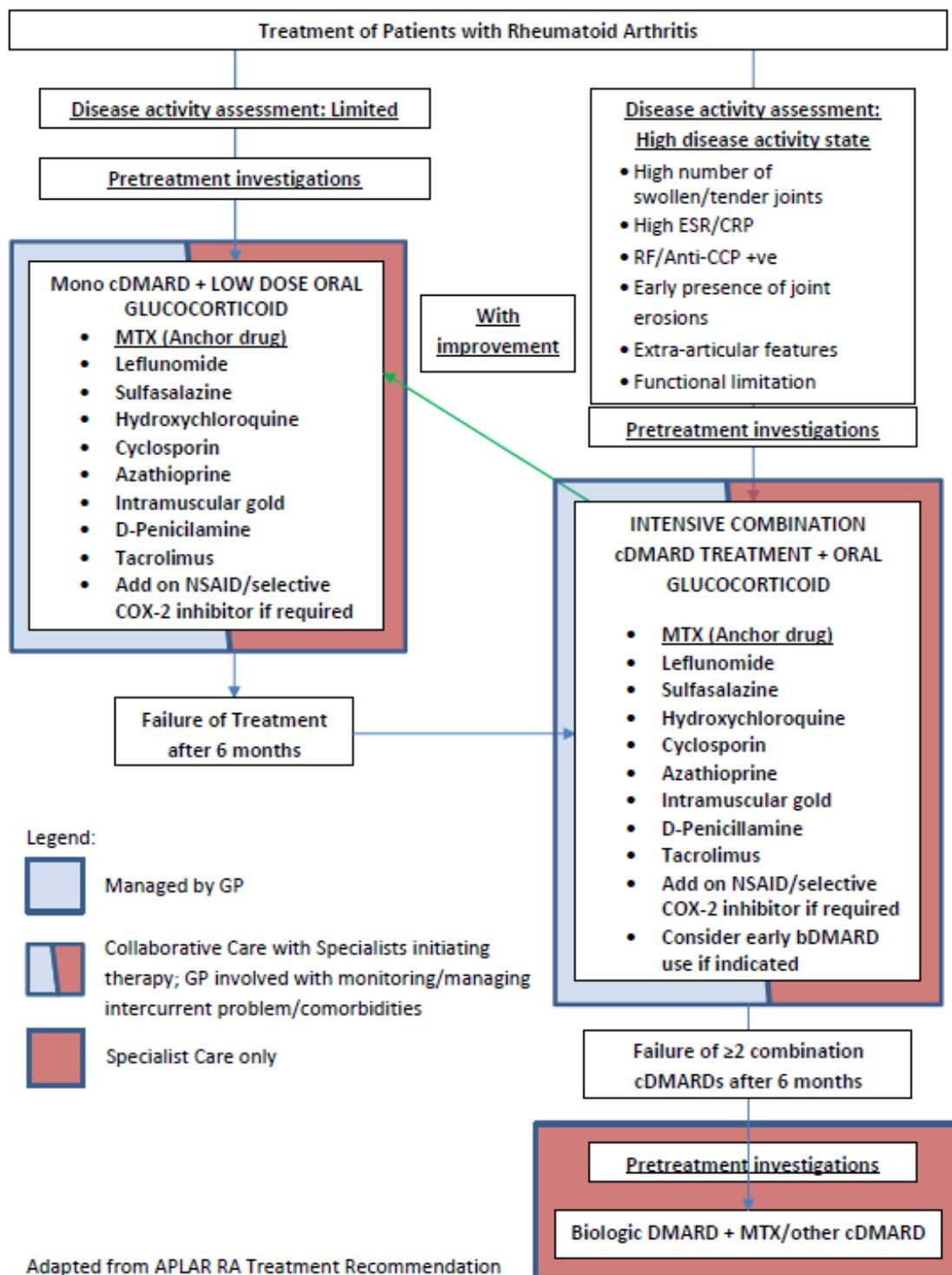
Consider Specialist Input

- Patients who develop active disease (1 or more swollen and/or tender joints, high ESR/CRP) while on collaborative care

Consider Shared Care with Primary Care Physician

- Patients deemed to be in DMARD-free remission
- Patients deemed to have quiescent/low disease activity (no swollen and/or tender joints, ESR/CRP within normal range) for at least 3-6 months under a specialist's care
- Patients on (non-biologic) DMARD therapy at maintenance dosage

Figure 2: Decision tree for collaborative care



Adapted from APLAR RA Treatment Recommendation 2014 (bDMARD: biologic DMARD; cDMARD: conventional DMARD)

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimables/Non-Claimables:

Claimables

- Investigations for the monitoring of the disease and related complications (e.g. full blood count, renal panel, liver function test, CRP, ESR, X-rays)
- Non-biologic DMARD therapy
- Biologic DMARD therapy where medically indicated (e.g. where disease is inadequately controlled with non-biologic DMARD therapy)
- Investigations performed **prior** to the initiation of DMARD (biologic & non-biologic) therapy, e.g. hepatitis B and C serology, T-spot TB
- Baseline eye screening, and annually after five years of drug institution, for patients on hydroxychloroquine
- Anti-inflammatory agents (e.g. NSAIDS, selective COX-2 inhibitors and glucocorticoids) as adjunct treatments

Non-Claimable

- Serum Rheumatoid Factor (RF), anti-CCP Antibody testing and other investigations done prior to and not leading to diagnosis of disease

Ischaemic Heart Disease (IHD)⁷

(While clinical indicator submission is not currently required, clinicians are required to document these assessments in case notes)

Ischaemic heart disease (IHD)/ coronary artery disease (CAD) includes stable and unstable angina pectoris, myocardial infarction (MI), current complications following MI, and plaques visualised in the coronary arteries without ischaemia.⁸

IHD results when coronary artery plaque develops and reduces the oxygen supply to the myocardium. Early intervention is required to prevent disease progression and recurrent cardiovascular events. This includes lifestyle modification and medical therapy as indicated.

Evidence to support a diagnosis of IHD (for purposes of claims under CDMP) could include:

- a) Past history of symptoms, prior diagnosis of IHD, current symptoms and/or investigation findings (e.g. electrocardiogram (ECG), stress test, angiography) consistent with cardiac ischaemia
- b) Post-acute myocardial infarction (AMI)
- c) Prior percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG)

Part I: Clinical Indicators (see Appendix for references)

Essential Care Component	Minimum Frequency*	Remarks
Lipid Profile	Annually	Target LDL <2.1mmol/L as patients with IHD/CAD are in the “very high risk” group
Blood Pressure Measurement	Twice a year	
Smoking Assessment	Annually	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provision of smoking cessation counselling
Weight and BMI Assessment	Twice a year	Keep BMI <25kg/m ² . (For Asian population, keep BMI < 23 kg/m ²)
Diabetes Screening	Annually or once every three years, as the case may be	Screening should be carried out every three years for those with normal glucose tolerance, and annually for those with impaired fasting glycaemia (IFG) or impaired glucose tolerance (IGT). Refer to Diabetes Mellitus chapter for diagnostic criteria
Renal Function Monitoring		Especially for patients on ACE inhibitors. Serum Cr and eGFR ⁺ , and Urine Albumin-Creatinine (uACR) may be considered.

*More frequently if clinically indicated

⁷ Includes coronary artery disease for purposes of claims under CDMP.

⁸ Non-ischaemic heart diseases, such as non-ischaemic cardiomyopathy, congenital heart diseases, arrhythmias and valvular defects, are not covered.

Part II: Consideration for Collaborative Care

Specialist Referral Recommended

- Emergency or urgent treatment indicated, e.g. unstable angina, myocardial infarction, and acute decompensated heart failure
- Suboptimal control of IHD risk factors despite lifestyle modification and optimised medical therapy, e.g. lipids and blood pressure

Consider Collaborative Care or Anchoring Care with Primary Physician

- Stable IHD, e.g. stable angina, history of MI but otherwise stable condition

Part III: Claimable/Non-claimable Items

Specific Examples of Claimable/Non-claimable:

Claimable

- Investigations for evaluation of IHD severity, monitoring of progression, detection of complications and guidance on further treatment, e.g. ECG, stress test, transthoracic echocardiography, cardiac CT angiogram, and cardiovascular risk factor monitoring such as lipid profile
- Smoking cessation
- Cardiac Rehabilitation

Non-claimable

- Monitoring devices for cardiovascular risk factors, e.g. blood pressure monitoring equipment, glucometer and strips

CHAPTER THREE: REGISTRATION AND MEDISAVE USE

1. Policy on MediSave Use

1.1. The primary purpose of MediSave is to help Singaporeans afford costly hospitalisation bills. For chronic conditions, early detection and good management help patients avoid subsequent costly hospitalisations. To bring about better health outcomes, MOH has allowed MediSave to cover selected chronic conditions in the outpatient setting.

1.2. From 1 July 2014, the \$30 deductible applicable for each outpatient CDMP bill using MediSave has been removed. Nonetheless, to ensure prudent use of MediSave funds, two safeguards remain in place under the CDMP:

- a) **Co-payment:** A co-payment of 15% will apply on each outpatient CDMP bill; and
- b) **Annual withdrawal limit:** An annual withdrawal limit of \$500 per MediSave account applies⁹. This will be reset on 1 January of each year.

Example:

For a CDMP bill of \$100, the patient pays \$15 out-of-pocket. The remaining \$85 can be claimed from MediSave.

1.3 Only doctors and clinics/medical institutions which are accredited for MediSave use and participating in the CDMP can make MediSave claims for patients. To make claims for Mental Illnesses¹⁰ (i.e. Schizophrenia, Major Depression, Bipolar Disorder and Anxiety), doctors also need to attend training for CDMP-MI and participate in a Shared Care or GP Partnership Programme with a public hospital¹¹. Doctors with the qualifications below are exempted from having to attend training for CDMP-MI:

- a) GPs on the existing Mental Health GP Partnership Programme;
- b) Doctors with MMed(FM), GDFM or on the Register of Family Physicians need not attend CDMP Mental Health training if the mental health training modules of these programmes include all the conditions in CDMP Mental Illnesses.
- c) Doctors with Family Medicine (FM) training who had 3 months posting at psychiatric departments at the various Restructured Hospitals from May 2007;
- d) Doctors (Family Physicians, Family Doctors, Medical Officers) who had 6 months posting at psychiatric departments at the various Restructured Hospitals; OR
- e) Holders of the Graduate Diploma in Mental Health.

⁹ The withdrawal limit was raised from \$400 from June 2018.

¹⁰ Dementia will not be considered a mental illness under the CDMP as of 1 Jan 2014, and therefore physicians who wish to manage Dementia under CDMP are not required to participate in the Shared Care Programme.

¹¹ The Shared Care Programme was meant to provide specialised support (e.g. from psychiatrists and mental health trained nurses, as well as supply of drugs for mental illness) to primary care doctors and ensure that they have sufficient training and confidence in treating patients with mental health conditions.

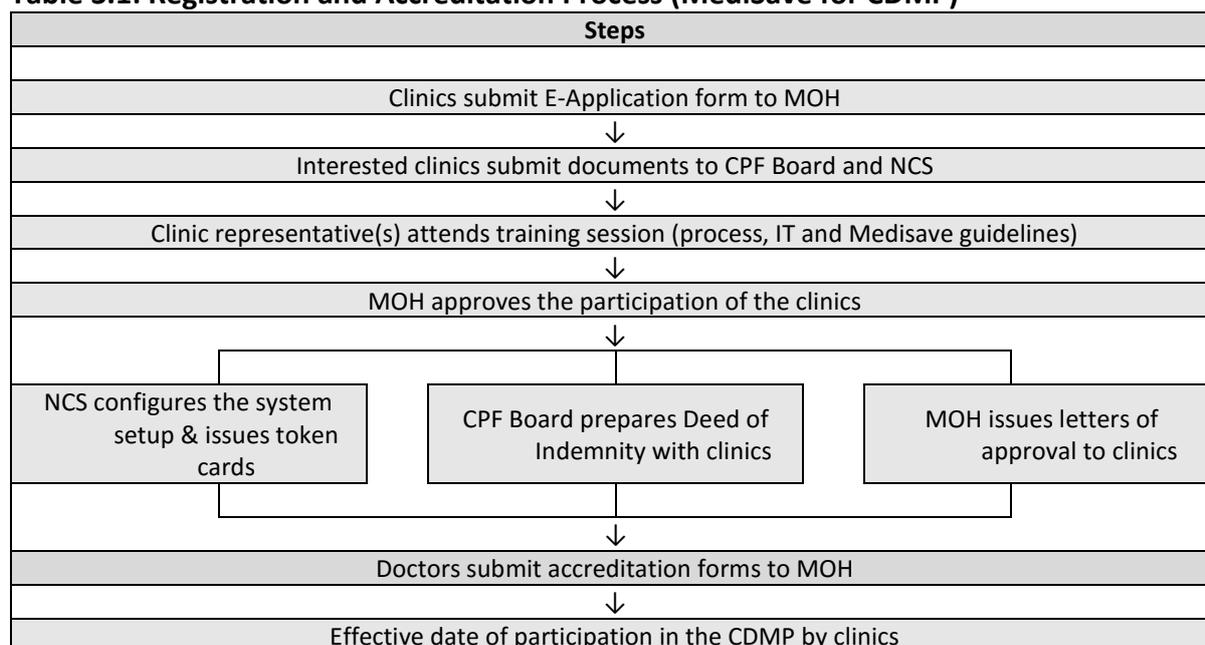
2. Registration Process for MediSave for CDMP

2.1. Clinics That Wish to Participate in the CDMP

2.1.1. To be in the CDMP, both the clinic/medical institution and its doctor(s) have to register with and be accredited by MOH. Upon accreditation, the doctors can then make MediSave claims for their patients.

2.1.2. An outline of the registration and accreditation process is provided in Table 3.1.

Table 3.1: Registration and Accreditation Process (MediSave for CDMP)



2.2 Registration of Clinic/Medical Institution with MOH

2.2.1 To join the CDMP, clinics/medical institutions will need to fulfil the following criteria:

- a) Be able to make MediSave claims for patients through the online MediClaim system¹², the MOH Healthcare Claims Portal (MHCP) system, or other Clinic Management Systems such as ClinicAssist;
- b) Sign a Deed of Indemnity with CPF Board; and
- c) Submit clinical data to MOH.

2.2.2 To make claims for patients through the online MediClaim system, clinics/ medical institutions need to have:

- a) A MediClaim User account;
- b) A Security Token Card (Incurs a non-refundable cost of \$191.20 (inclusive of 7% GST and delivery fee) for two to three years of use. The subsequent token is priced at \$171.20.);

¹² Clinics which are not ready to make claims through MediSave e-service could opt to submit claims via other Clinic Management Systems such as ClinicAssist.

- c) A Personal Computer/Laptop with the following configuration:
 - (i) CPU Pentium III and above,
 - (ii) Memory (RAM) Minimum of 256MB,
 - (iii) Operating System Windows XP,
 - (iv) Browser Internet Explorer 6.0, and
 - (v) Internet connection;
- d) GIRO arrangement with CPF Board for MediSave payments to be credited into the clinic/medical institution's bank account; and
- e) Attended training to process MediSave claims.

2.2.3 To make claims for patients through the online MHCP system, clinics/medical institutions need to have:

- a) A CorpPass account
- b) A Personal Computer/Laptop with the following configuration:
 - (i) 1 gigahertz (GHz) or faster processor,
 - (ii) 4GB RAM or above,
 - (iii) 10GB of free space in HDD,
 - (iv) 1366 x 768 display resolution for optimum viewing,
 - (v) 10 Mbps Internet bandwidth,
 - (vi) Browser Internet Explorer 10.0 or above (Chrome, Firefox and Safari browsers are also supported),
 - (vii) Adobe Acrobat Reader,
 - (viii) Microsoft Excel 2007 and above; and
 - (ix) Internet connection
- c) GIRO arrangement with CPF Board for MediSave payments to be credited into the clinic/medical institution's bank account; and
- d) Attended training to process MediSave claims.

2.2.4 Clinics/medical institutions interested in joining the CDMP will need to submit the following forms to MOH:

- a) E-Application for Clinics to Participate in the MediSave for CDMP (by MOH); and
- b) Direct Authorisation Credit Form (by CPF Board).

The E-Application website can be accessed via:

<https://www.mediclaim.moh.gov.sg/mmae/OverviewApplication.aspx>

2.2.5 Clinic/medical institution staff who will be making MediSave claims are required to attend a free half-day training session on MediSave claims process, MediSave use guidelines and use of the MediClaim system.

2.2.6 Clinics/medical institutions participating in the CDMP will be subjected to:

- a) Clinical quality checks conducted by MOH on patients who make MediSave claims through the clinics/medical institutions;
- b) Professional medical audits conducted by MOH on MediSave claims; and/or

- c) Operational audits conducted by CPF Board on MediSave claims.

2.3 Registration of Doctor with MOH

2.3.4 Doctors practising at accredited clinics/medical institutions need to register with MOH to participate in the CDMP before they can make MediSave claims for their patients.

2.3.5 Interested doctors can submit an E-Application to participate in the CDMP. The website is: <https://www.mediclaim.moh.gov.sg/mmae/OverviewApplication.aspx>
Registration for MediSave accreditation of doctors needs to be renewed every 2 years.

2.3.6 Registered doctors will be audited by MOH and CPF Board on the clinical outcomes and MediSave claims of their patients.

3 **Process of Making a MediSave Claim**

A typical process of making a MediSave claim for a patient is described below:

3.1 What to convey to patient or immediate family members who wish to use MediSave:

- a) The treatment components
- b) The cost of treatment
- c) Estimated amount that can be claimed from MediSave, and
- d) Out-of-pocket cash payment that the patient needs to make

3.2 Administrative Procedure

- a) Each MediSave account holder will need to sign a MediSave Authorisation Form or a Medical Claims Authorisation Form to authorise the CPF Board to deduct his/her MediSave funds for the treatment of the patient. The authorisation can be made on a per treatment basis or over a period of time¹³. Authorisations over a period of time will stand until revoked in writing.
- b) Clinic/medical institution staff should witness the identity and the signature by the patient or account holder. Clinic/medical institution staff should also verify relationships declared, where possible.
- c) Clinics/medical institutions are to submit the MediSave claims electronically to CPF Board for processing via the MediClaim System.

3.3 If the patient is deemed to be mentally incapacitated (see definition of mentally incapacitated person below), his donee/deputy or immediate family members would need to authorise the use of the patient's own MediSave. The doctor in charge would need to certify on the relevant part of the form that the patient is mentally incapacitated.

Definition: A mentally capacitated person either:

¹³ Authorisation can be for a period of 3, 6 or 12 months, or for an open-ended length of time subject to revocation in writing.

- a) has a medical report from a psychiatrist declaring that the patient is permanently mentally incapacitated; or
- b) is determined by a doctor, at the material time, to be unable to make a decision for himself. An inability to make a decision is when a patient is unable to:
 - (i) Understand the information relevant to the decision;
 - (ii) Retain that information relevant to the decision;
 - (iii) Use or weigh that information as part of the decision making process;
 - and
 - (iv) Communicate his decision (by any means).

3.4 Payment will be made daily to MediSave-accredited clinics/medical institutions via InterBank Giro (IBG) on the 3rd working day after the approval date of the MediSave claims.

Where a clinic/medical institution has made an over-claim or unauthorised deduction from MediSave, it will have to refund the amount deducted to the MediSave account. The clinic/medical institution will have to pay the interest lost by individuals if it is the clinic's/medical institution's error. The interest will be computed at the prevailing CPF interest at the time of the adjustment.

3.5 From June 2018, package claims will be discontinued under CDMP. Package claims made before 1 June 2018 will still be valid up to one year from the first date of visit for the package. Where such package lapses or is cancelled with remaining treatments, clinics/medical institutions should refund the unused MediSave amount to the appropriate payer.

3.6 Clinics submit Medisave claims electronically.

4 Audit

4.1 All MediSave claims for CDMP conditions may be subjected to audit. The CPF Board may carry out regular audits of the participating clinic's/medical institution's records for MediSave claims. There are 2 types of audits for the MediSave claims:

- a) Operational audit: This audit looks at the operational aspect of making MediSave claims such as proper documentation and the completion of Medical Claims Authorisation Form;
- b) Professional audit: This audit looks at treatments and investigations administered for each MediSave claim to determine if it is related to the diagnosis.

4.2 MediSave claims for all CDMP conditions may be subject to audit. Prior notice will be given to identify the cases to be audited. The following documents may be required for the audit:

- a) Hard copies of Claim Forms submitted electronically,
- b) MediSave Authorisation Forms / Medical Claims Authorisation Forms,

- c) Itemised bills/Payment records (detailing consultation charges, individual drug charges, DRP, nursing charges, other services),
- d) Photocopies of identification papers (where necessary),
- e) Case records of the patient for the visits which were claimed (For claims on the complications of the approved chronic diseases, doctors have to document the causal relationship. For packages, please indicate dates of visits which are claimed),
- f) Investigation/Test reports where available e.g. HbA1c results, lipid results,
- g) Prescription records, and
- h) Evidence supporting diagnosis e.g. documentation in case records or laboratory reports.

4.3 Routine clinical data submission will only be required for Diabetes Mellitus/Pre-diabetes, Hypertension, Lipid Disorders, COPD, Asthma, CKD (Nephritis/Nephrosis). Please note that in case the MediSave claim includes treatment for complication(s) due to the chronic disease, the doctor would need to document clearly the causal relationship between the approved chronic condition and the complication(s) which arose from it.

4.4 Clinics/medical institutions or doctors found guilty of wrong claims will be required to refund the amount to the affected MediSave accounts. Each time the doctor is found making wrong claims for his/her patients, he/she will be issued a warning letter. Repeated infringements by a doctor can lead to suspension of the MediSave accreditation of the doctor.

CHAPTER FOUR:
CAPTURE AND SUBMISSION OF CLINICAL DATA

1 Commencement of Clinical Data Submission

Data submission should commence at the patient’s first visit to the doctor for selected CDMP/CHAS conditions. These are **Diabetes Mellitus/Pre-diabetes, Hypertension, Lipid Disorders, Asthma, COPD, CKD (Nephritis/Nephrosis)**.

1.1 The quality of patient care for these six chronic conditions will be evaluated according to whether the relevant process and care components have been met as listed below:

Table 4.1: List of Clinical Indicators for CDMP/CHAS (For Submission)

Chronic Condition	Care Components Per Year ¹⁴
Diabetes Mellitus	<ul style="list-style-type: none"> • Two blood pressure measurements • Two bodyweight measurements • Two haemoglobin A1c (HbA1c) tests • One serum cholesterol level (LDL-C) test • One smoking habit assessment • One eye assessment • One foot assessment • One nephropathy assessment (Additional indicators for patients with nephropathy will follow that of Nephritis/Nephrosis)
Pre-diabetes	<ul style="list-style-type: none"> • One blood pressure measurement • Two bodyweight measurements • Two or more blood glucose tests (FPG, OGTT, HbA1c) as appropriate¹⁵ • One serum cholesterol level (LDL-C) test • One nephropathy assessment (if on metformin)
Hypertension	<ul style="list-style-type: none"> • Two blood pressure measurements • Two bodyweight measurement • One smoking habit assessment
Lipid Disorders	<ul style="list-style-type: none"> • One serum cholesterol level (LDL-C) test • One smoking habit assessment
Asthma	<ul style="list-style-type: none"> • Two Asthma Control Test (ACT)¹⁶ scores • One smoking habit assessment
COPD	<ul style="list-style-type: none"> • One smoking habit assessment • One bodyweight measurement • One COPD Assessment Test (CAT) score • One influenza vaccination
CKD (Nephritis/ Nephrosis)	<ul style="list-style-type: none"> • Two blood pressure measurements • One renal function – creatinine and/or eGFR • One urine protein – urine protein : creatinine ratio

¹⁴ ‘Per year’ refers to 12 months from the first visit of the patient for the chronic condition(s).

¹⁵ Refer to Clinical Guidelines for Pre-diabetes (p11-14) for more details.

¹⁶ This is only applicable for patients aged 4 and above. For patients aged 4 to < 12 years, please use the Childhood ACT, and for those aged 12 years and above, the ACT.

1.2 Although data submission is not required for the remaining conditions, clinicians are advised to manage according to best clinical practices and document essential care components as listed below:

Table 4.2: List of Clinical Indicators for CDMP/CHAS (Routine Data Submission not required)

Chronic Condition	Minimum Clinical Indicators (Per Year) ¹⁷
Schizophrenia	<ul style="list-style-type: none"> • Two consultations for CDMP Mental Health • One Clinical Global Impression (CGI) Scale for each item (severity, improvement) • Blood test for fasting glucose and fasting lipids¹⁸
Major Depression	<ul style="list-style-type: none"> • Two consultations for CDMP Mental Health • One Clinical Global Impression (CGI) Scale for each item (severity, improvement)
Bipolar Disorder	<ul style="list-style-type: none"> • Two consultations for CDMP Mental Health • One Clinical Global Impression (CGI) Scale for each item (severity, improvement)
Anxiety	<ul style="list-style-type: none"> • One Clinical Global Impression (CGI) Scale for each item (severity, improvement)
Stroke	<ul style="list-style-type: none"> • Two blood pressure measurements • One serum cholesterol level (LDL-C) test • One smoking habit assessment • One clinical thromboembolism risk assessment • One rehabilitation need assessment
Dementia	<ul style="list-style-type: none"> • Documentation of: <ol style="list-style-type: none"> i. Assessment of mood and behaviour ii. Assessment of social difficulties and caregiver stress (if any) iii. Assessment of functional needs assessment • Two consultations for CDMP Dementia • For patients on cognitive enhancers, documentation of objective assessment of memory (MMSE or CMMSE testing or other validated instruments)
Osteoarthritis	<ul style="list-style-type: none"> • One Joint function assessment • One bodyweight measurement • One exercise and/or weight loss plan (if indicated) • One Activities of Daily Living (ADL) assessment
Parkinson's Disease	<ul style="list-style-type: none"> • One Unified Parkinson's Disease Rating Scale (for falls) • One Schawb and England Activities of Daily Living Scale • One review of diagnosis

¹⁷ 'Per year' refers to 12 months from the first visit of the patient for the chronic condition(s).

¹⁸ Only for patients with Schizophrenia on atypical antipsychotic medications.

Chronic Condition	Minimum Clinical Indicators (Per Year) ¹⁷
BPH	<ul style="list-style-type: none"> • One International Prostate Symptom Score (I-PSS) • One Abdominal examination/Digital rectal examination • One Urine dipstick test
Epilepsy	<ul style="list-style-type: none"> • One seizure frequency assessment • One seizure type assessment • One seizure free duration assessment
Osteoporosis	<ul style="list-style-type: none"> • At least one DEXA scan every 2 years • One WHO Fracture Risk Assessment Tool (FRAX Score)
Psoriasis	<ul style="list-style-type: none"> • One psoriatic arthritis assessment • One Body Surface Area (BSA) percentage assessment
Rheumatoid Arthritis	<ul style="list-style-type: none"> • One RA disease activity assessment
Ischaemic Heart Disease	<ul style="list-style-type: none"> • Two blood pressure measurements • Two bodyweight measurements • One diagnostic diabetes test for those with impaired fasting glycemia or impaired glucose tolerance, or one diagnostic diabetes test for those with normal glucose tolerance • One serum cholesterol level (LDL-C) test • One smoking habit assessment • One nephropathy assessment

2 Collection and Submission of Clinical Data

- 2.1 The collection of clinical data can be carried out by:
- Manually recording the clinical data on a hardcopy template (Annex B, page 54-55). Please note that for *submission* purposes the data will subsequently have to be keyed in via the online CIDC e-Service (see Chapter Five: User Manual for e-Service Clinical Data Submission) or the MHCP system (see the MHCP User Guide available in the MHCP Resource Hub);
 - Recording the clinical data directly onto electronic records through the Clinic Management System installed for electronic submission of clinical data for CDMP/CHAS enrolled patients.

3 Deadlines for Submission of Clinical Data to MOH

- 3.1 Submission of clinical data is an essential component of the CDMP/CHAS.
- 3.2 We encourage clinics to submit clinical data as soon as possible, during or immediately after the patient's clinic visit. Doing this would reduce the backlogs in submitting clinical data.

- 3.3 Clinics are allowed to accumulate patient records for submission in batches. However, for batch submissions, regular (e.g. weekly or monthly) submissions are encouraged.
- 3.4 When using the electronic Clinic Management System to capture data during the consultation, the system may allow submission of data automatically at the end of each patient consultation.
- 3.5 The deadline for the clinical data submission will be fourteen days after the end of each quarter. As an example, for the quarter from Jan to Mar 2017, the deadline for data submission will be 14 Apr 2017.

Data Fields Required for Clinical Data Submission

Patient Details	
Patient Name	
NRIC/FIN	
DOB (dd/mm/yyyy)	
Gender	Male (<input type="checkbox"/>), Female (<input type="checkbox"/>)
Race	Chinese (<input type="checkbox"/>), Malay (<input type="checkbox"/>), Indian (<input type="checkbox"/>), Others (<input type="checkbox"/>)
Height (m)	
Current Smoker	Yes (<input type="checkbox"/>), No (<input type="checkbox"/>)
Year Started Smoking (yyyy)	

Medical History	Yes (✓)	Year of Diagnosis (yyyy)
Hypertension		
Hyperlipidemia		
Ischaemic Heart Disease (IHD)		
Diabetes (DM)		
Pre-diabetes		
DM Retinopathy		
DM Nephropathy		
DM Foot Complications		
Asthma		
Chronic Obstructive Pulmonary Disease (COPD)		
Chronic Kidney Disease (Nephritis/Nephrosis)		

Diabetes Treatment	Yes (✓)	Year of Diagnosis (yyyy)
Oral Medications		
Insulin		
Hypertension Treatment	Yes (✓)	Year of Diagnosis (yyyy)
Oral Medications		
Hyperlipidemia Treatment	Yes (✓)	Year of Diagnosis (yyyy)
Oral Medications		
Asthma Treatment	Yes (✓)	Year of Diagnosis (yyyy)
Requires Controller		

A) Diabetes, Hypertension and Lipid Disorders DMP

	For Diabetes, Pre-diabetes, Hypertension and Lipid Disorders				For Diabetes, Hypertension and Lipid Disorders
Date of Visit (dd/mm/yy)	LDL-C (mg/dL)/(mmol/L)	Systolic BP (mmHg)	Diastolic BP (mmHg)	Weight (kg)	Avg no. cigs/day

	For Diabetes only			
Date of Visit (dd/mm/yy)	Glucose HbA1c (%)	Eye (v)	Foot (v)	Nephropathy (v)

	For Pre-diabetes only		
Date of Visit (dd/mm/yy)	FPG (mmol/L)	OGTT (mmol/L)	Nephropathy (v)

	For DM Nephropathy only		
Date of Visit (dd/mm/yy)	Serum Creatinine ($\mu\text{mol/L}$)	eGFR (ml/min/1.73m ²)	Urine ACR (mg/mmol)

B) Asthma and Chronic Obstructive Pulmonary Disease (COPD) DMP

	For Asthma, COPD	For Asthma only	For COPD only		
Date of Visit (dd/mm/yy)	Avg no. cigs/day	Asthma Control Test (ACT) Score	Weight (kg)	COPD Assessment Test (CAT) Score	Influenza Vaccination (v)

C) Chronic Kidney Disease (Nephritis/Nephrosis) DMP

	For Chronic Kidney Disease (Nephritis/Nephrosis)				
Date of Visit (dd/mm/yy)	Systolic BP (mmHg)	Diastolic BP (mmHg)	Serum Creatinine ($\mu\text{mol/L}$)	eGFR (ml/min/1.73m ²)	Urine ACR or Urine PCR (mg/mmol)

CHAPTER FIVE: USER MANUAL FOR CLINICAL DATA SUBMISSION VIA CIDC E-SERVICE

1 Introduction

1.1 Purpose

1.1.1 The manual serves as a guide on how to use the Clinical Indicators Data Collection (CIDC) e-Service for the submission of data to MOH as part of CDMP.

1.1.2 The manual is intended for the hospital/clinic staff who are doing clinical data and indicators submission. The staff should already be familiar with web browsing and the MediClaim e-Service.

1.2 System Requirements

1.2.1 In order to use the CIDC e-Service, an Internet-enabled computer with the following is required:

a) Hardware Requirements

The minimum recommended hardware configuration is:

- Pentium III MHz Processor with 256MB RAM
- At least 200 MB free hard disk space

b) System Software Requirements

- Windows XP
- Internet Explorer 6.0 and above
- Broadband Internet Connection

c) Other Requirements

- RSA token card
- MediClaim user account

2 Getting Started

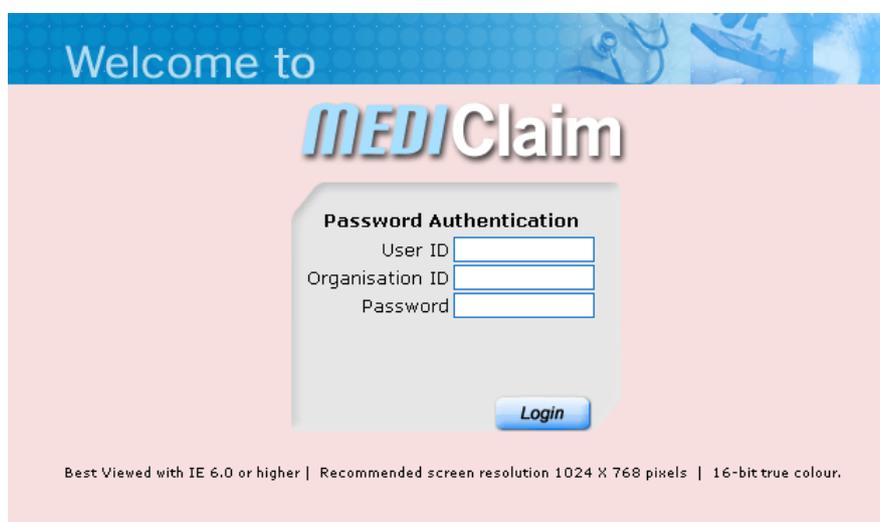
2.1 User Account

2.1.1 You will be using your MediClaim system user account to access the CIDC e-Service. The MediClaim account is the same one used for the submission of claims.

2.1.2 If you do not have an account for the claims submission, you will need to approach MOH for the creation of a new account.

2.2 Accessing the CIDC e-Service

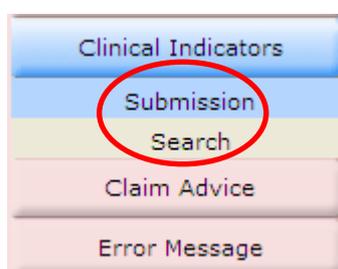
2.2.1 The web URL to access the MediClaim system is: <https://access.medinet.gov.sg>. Refer to the MediClaim user manual for details on login procedures.



Screen 1: MediClaim Login Screen

2.2.2 Upon successful login to the MediClaim system, you will be able to see the CIDC e-Service in the left hand menu as shown on Screen 2 below. All users with access to the Chronic Disease Claim Form e-Service will have access to the CIDC e-Service.

2.2.3 Click on the menu to display the functions available:



Screen 2: Menu

- a) *Submission* is used to submit a new report.
- b) *Search* is used to retrieve submitted reports.

3 **Clinical Indicators Report Submission**

3.1 This function is used to submit clinical data on patients who have used their MediSave under the CDMP. A new submission can be made each time there is additional indicator information for the patient either on a per visit basis or consolidated over a few visits. All submissions are distinct and will be used for analysis by MOH on a cumulative basis.

3.2 To submit a new set of clinical data for a patient to MOH, click on the “Submission” sub-menu. The following screen will appear.

→ Clinical Indicators > **Submit**

New Submission:

Patient ID Type: **Select patient ID Type**

Patient NRIC/FIN:* **Enter patient NRIC/FIN**

(as entered in Medisave claim form)

Diseases:*

Diabetes Hypertension Lipid Disorder
 Stroke Asthma COPD
 Major Depression Schizophrenia Bipolar Disorder

Select the medical conditions applicable to the patient, more than one medical condition may be chosen.

Compulsory fields marked with asterisk *

Click to go to Clinical Indicator Form in Screen 4

Condition	Care Components Per Year
Diabetes mellitus	<ul style="list-style-type: none"> Two blood pressure measurements Two bodyweight measurements Two haemoglobin A1c (HbA1c) tests One serum cholesterol level (LDL-C) test One smoking assessment One eye assessment One foot assessment One nephropathy screening test
Hypertension	<ul style="list-style-type: none"> Two blood pressure measurements One bodyweight measurement One smoking assessment
Lipid Disorder	<ul style="list-style-type: none"> One serum cholesterol level (LDL-C) test One smoking assessment
Stroke	<ul style="list-style-type: none"> Two blood pressure measurements One serum cholesterol level (LDL-C) test One smoking assessment One clinical thromboembolism risk assessment
Asthma	<ul style="list-style-type: none"> One inhaler technique assessment One smoking assessment Two Asthma Control Test (ACT) scores
COPD	<ul style="list-style-type: none"> One inhaler technique assessment One smoking assessment One bodyweight measurement One influenza vaccination
<i>The following care components are only for CDMP Mental Health Programme Patients:</i>	
Major Depression	<ul style="list-style-type: none"> One Clinical Global Impression (CGI) Scale for each item (severity, improvement) Two consultations for CDMP Mental Health
Schizophrenia	<ul style="list-style-type: none"> One Clinical Global Impression (CGI) Scale for each item (severity, improvement) Two consultations for CDMP Mental Health One blood test for fasting lipids One blood test for fasting glucose
Bipolar Disorder	<ul style="list-style-type: none"> One Clinical Global Impression (CGI) Scale for each item (severity, improvement) Two consultations for CDMP Mental Health One blood test for fasting lipids One blood test for fasting glucose
Dementia	<ul style="list-style-type: none"> One assessment of memory One assessment of mood and behaviour One assessment of functional and social difficulties (if any) One assessment of rehabilitation Needs Two consultations for CDMP Mental Health For patients on cognitive enhancers, documentation of objective assessment of memory (MMSE or CMMSE testing or other validated instruments)

Screen 3: New Submission

- 3.2.1 Select the Identification Type and enter the Patient NRIC/FIN.
- 3.2.2 Select the chronic condition applicable to this patient. You can select one or more conditions, as applicable.
- 3.2.3 Click on [Next] to proceed to the Clinical Indicator Form.

Patient Details:

Patient Name: *	<input type="text" value="Tan Ah Kun"/>	Patient NRIC/FIN: *	<input type="text" value="S1234567D"/>
Date of Birth (DDMMYYYY):	<input type="text" value="14041971"/>	Sex:	<input checked="" type="radio"/> Male <input type="radio"/> Female
Race:	<input type="text" value="Chinese"/>	Height (Metres):	<input type="text" value="1.62"/> <i>(use 9.99 if not measurable)</i>
Current Smoker	<input type="radio"/> Yes <input checked="" type="radio"/> No	<input type="text"/>	Year Started Smoking(YYYY)

* denotes a mandatory field

Known Medical History:

Medical Condition	Diagnosis Year	Medical Condition	Diagnosis Year
<input checked="" type="checkbox"/> Diabetes	<input type="text" value="2007"/> (YYYY)	<input type="checkbox"/> Hypertension	<input type="text"/> (YYYY)
<input type="checkbox"/> DM Retinopathy	<input type="text"/> (YYYY)	<input type="checkbox"/> Lipid Disorder	<input type="text"/> (YYYY)
<input type="checkbox"/> DM Nephropathy	<input type="text"/> (YYYY)	<input type="checkbox"/> Cerebrovascular Accident (CVA)	<input type="text"/> (YYYY)
<input type="checkbox"/> DM Foot Complications	<input type="text"/> (YYYY)	<input type="checkbox"/> Coronary Heart Disease (CHD)	<input type="text"/> (YYYY)
<input checked="" type="checkbox"/> Asthma	<input type="text"/> (YYYY)	<input checked="" type="checkbox"/> COPD	<input type="text"/> (YYYY)
<input checked="" type="checkbox"/> Major Depression	<input type="text" value="2007"/> (YYYY)	<input checked="" type="checkbox"/> Schizophrenia	<input type="text" value="2007"/> (YYYY)
<input type="checkbox"/> Bipolar Disorder	<input type="text"/> (YYYY)	<input type="checkbox"/> Dementia	<input type="text"/> (YYYY)

Diabetes Treatment:

Treatment	Year Started	Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text"/> (YYYY)	<input type="checkbox"/> Insulin	<input type="text"/> (YYYY)

Hypertension Treatment:

Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text"/> (YYYY)

Lipid Disorder Treatment

Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text"/> (YYYY)

Asthma Treatment:

Treatment	Year Started
<input type="checkbox"/> Preventer	<input type="text"/> (YYYY)

Schizophrenia Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input checked="" type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text" value="2008"/> (YYYY)

Bipolar Disorder Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text"/> (YYYY)

Dementia Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text"/> (YYYY)

Clinical Indicators:

Date of Visit (DDMMYYYY):* 

Blood Pressure (Systolic/Diastolic): /

LDL-C:

HbA1c (%):

Weight (kg):
(use 999 if not measurable)

Smoking Assessment # :

Cigarettes smoked per day (average) ## :

ACT Score (Asthma only):

The following care components are only for CDMP Mental Health Programme Patients:

CGI - Severity of Illness:

CGI - Global Improvement:

Consultation for CDMP Mental Health (Indicate the patient attendance):

For patients on cognitive enhancers, documentation of objective assessment of memory (MMSE or CMMSE testing or other validated instruments):

Assessment of Functional and Social Difficulties (if any):

DM - Eye Assessment:

DM - Nephropathy Assessment:

DM - Foot Assessment:

Stroke - Thromboembolism Risk Assessment:

Inhaler Technique Assessment (Asthma & COPD only):

Influenza Vaccination Assessment (COPD only):

Fasting Lipids Blood Test ###:

Fasting Glucose Blood Test ###:

Assessment of Memory:

Assessment of Mood and Behaviour:

Assessment of Rehabilitation Needs:

** denotes a mandatory field*

For current smokers, smoking cessation advice should be given; For non- or ex-smoker, please reinforce the benefits of not smoking cigarettes

Applicable to current smokers only

Only for patients on Schizophrenia and Bipolar Disorder - Atypical Antipsychotics Medication. To check the box if test is done.

Add Indicators Click to add clinical indicators (only those performed)

Attending Physician Information:

Doctor Name:*

Specialty/Training:

Role:*

Attending Doctor is the patient's regular primary physician

The Clinic is the patient's regular primary provider

None of the Above

Registration Number:*

Healthcare Establishment:

Date of Submission: 06-Jan-2008

** denotes a mandatory field*

Screen 4: Clinical Indicator Form

3.3 The Clinical Indicator Form consists of 4 sections:

- a) Patient Details,
- b) Known Medical History,
- c) Clinical and Assessment Indicators, and
- d) Attending Physician Information.

4 Patient Details

4.1 This section details the patient's basic bio-data. If it is your first submission for the patient, only Patient NRIC, Name, Date of Birth, Sex, Race, and Current Smoker is required. For subsequent submissions, only the Patient NRIC and Name are mandatory.

4.2 In the event of differences between two submissions, the data from the latest submission will be considered as the up-to-date information.

Patient Details:

Patient Name: *	<input type="text" value="Lee Yong Kun"/>	Patient NRIC/FIN:*	<input type="text" value="S1234567D"/>
Date of Birth (DDMMYYYY):	<input type="text" value="02121970"/>	Sex:	<input checked="" type="radio"/> Male <input type="radio"/> Female
Race:	<input type="text" value="Chinese"/>	Height (Metres):	<input type="text" value="1.7"/> <i>(use 9.99 if not measurable)</i>
Current Smoker	<input checked="" type="radio"/> Yes <input type="radio"/> No	<input type="text" value="1990"/> Year Started Smoking(YYYY)	

** denotes a mandatory field*

Screen 5: Patient Details

5 Known Medical History

5.1 This section details the patient’s medical history. If it is your first submission for the patient, please enter all the details. For subsequent submissions, you can omit the details if there are no changes.

5.2 If you are unsure whether you have submitted the information, it is recommended you fill in the details.

Known Medical History:

Medical Condition	Diagnosis Year	Medical Condition	Diagnosis Year
<input checked="" type="checkbox"/> Diabetes	<input type="text" value="2007"/> (YYYY)	<input type="checkbox"/> Hypertension	<input type="text" value=""/> (YYYY)
<input type="checkbox"/> DM Retinopathy	<input type="text" value=""/> (YYYY)	<input type="checkbox"/> Lipid Disorder	<input type="text" value=""/> (YYYY)
<input type="checkbox"/> DM Nephropathy	<input type="text" value=""/> (YYYY)	<input type="checkbox"/> Cerebrovascular Accident (CVA)	<input type="text" value=""/> (YYYY)
<input type="checkbox"/> DM Foot Complications	<input type="text" value=""/> (YYYY)	<input type="checkbox"/> Coronary Heart Disease (CHD)	<input type="text" value=""/> (YYYY)
<input type="checkbox"/> Asthma	<input type="text" value=""/> (YYYY)	<input type="checkbox"/> COPD	<input type="text" value=""/> (YYYY)
<input checked="" type="checkbox"/> Major Depression	<input type="text" value=""/> (YYYY)	<input checked="" type="checkbox"/> Schiz	<input type="text" value=""/> (YYYY)
<input type="checkbox"/> Bipolar Disorder	<input type="text" value=""/> (YYYY)	<input type="checkbox"/> Dementia	<input type="text" value=""/> (YYYY)

If selected, the corresponding date must be filled up as well

Textbox is disabled unless corresponding checkbox is checked

Diabetes Treatment:

Treatment	Year Started	Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text" value=""/> (YYYY)	<input type="checkbox"/> Insulin	<input type="text" value=""/> (YYYY)

Hypertension Treatment:

Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text" value=""/> (YYYY)

Lipid Disorder Treatment

Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text" value=""/> (YYYY)

Schizophrenia Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input checked="" type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text" value="2008"/> (YYYY)

Bipolar Disorder Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text" value=""/> (YYYY)

Dementia Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text" value=""/> (YYYY)

Screen 6: Known Medical History and Treatment Sections

5.3 Enter the relevant medical conditions for the patient. If a particular condition is selected, then the year of diagnosis is mandatory. You only need to fill in medical conditions that apply to the patient.

6 Clinical Indicators and Assessment

6.1 This section enables you to enter the indicator measurement and assessment done on the patient over any period. Only measurements and assessments not reported previously need to be entered in this section.

6.2 Initially there will be no clinical indicators added to the report.

6.3 Fill in all the clinical indicators and use the [Add Indicators] button to save them (as shown in Screen 7).

6.4 There must not be any unsaved data left in the Clinical Indicators Section before submitting the form.

Clinical Indicators:

*Date of Visit (DDMMYYYY):** 

Blood Pressure (Systolic/Diastolic): /

LDL-C:

HbA1c (%):

Weight (kg):
(use 999 if not measurable)

Smoking Assessment #:

Cigarettes smoked per day (average) ##:

ACT Score (Asthma only):

The following care components are only for CDMP Mental Health Programme Patients:

CGI - Severity of Illness:

CGI - Global Improvement:

Consultation for CDMP Mental Health (Indicate the patient attendance):

For patients on cognitive enhancers, documentation of objective assessment of memory (MMSE or CMMSE testing or other validated instruments):

Assessment of Functional and Social Difficulties (if any):

DM - Eye Assessment:

DM - Nephropathy Assessment:

DM - Foot Assessment:

Stroke - Thromboembolism Risk Assessment:

Inhaler Technique Assessment (Asthma & COPD only):

Influenza Vaccination Assessment (COPD only):

Fasting Lipids Blood Test ###:

Fasting Glucose Blood Test ###:

Assessment of Memory:

Assessment of Mood and Behaviour:

** denotes a mandatory field*

For current smokers, smoking cessation advice should be given; For non- or ex-smoker, please reinforce the benefits of not smoking cigarettes

Applicable to current smokers only

Only for patients on Schizophrenia and Bipolar Disorder - Atypical Antipsychotics Medication. To check the box if test is done.

Add Indicators *Click to add clinical indicators (only those performed)*

Add all Clinical Indicators into the table below after filling in the form above

Date	Indicators	Value
<input type="checkbox"/> 11-May-2007	Systolic BP(mmHg)	150
<input type="checkbox"/> 11-May-2007	Diastolic BP(mmHg)	100
<input type="checkbox"/> 11-May-2007	LDL(mg/dL)	40
<input type="checkbox"/> 11-May-2007	HbA1c(%)	30
<input type="checkbox"/> 11-May-2007	Weight(kg)	90
<input type="checkbox"/> 11-May-2007	Cigarettes smoked per day(Avg)	10
<input type="checkbox"/> 11-May-2007	DM-Eye Assessment	Y
<input type="checkbox"/> 11-May-2007	DM-Nephropathy Assessment	Y
<input type="checkbox"/> 11-May-2007	DM-Foot Assessment	Y
<input type="checkbox"/> 11-May-2007	Stroke-Thromboembolism Risk Assessment	Y

Delete Indicators

Click to delete selected clinical indicators

Screen 7: Filling in the Clinical Indicators

Click to sort the records

Date	Indicators	Value
<input type="checkbox"/> 11-May-2007	Systolic BP(mmHg)	150
<input type="checkbox"/> 11-May-2007	Diastolic BP(mmHg)	100
<input type="checkbox"/> 11-May-2007	LDL(mg/dL)	40
<input type="checkbox"/> 11-May-2007	HbA1c(%)	30
<input type="checkbox"/> 11-May-2007	Weight(kg)	90
<input type="checkbox"/> 11-May-2007	Cigarettes smoked per day(Avg)	10
<input type="checkbox"/> 11-May-2007	DM-Eye Assessment	Y
<input type="checkbox"/> 11-May-2007	DM-Nephropathy Assessment	Y
<input type="checkbox"/> 11-May-2007	DM-Foot Assessment	Y
<input type="checkbox"/> 11-May-2007	Stroke-Thromboembolism Risk Assessment	Y

Delete Indicators *Click to delete selected clinical indicators*

Delete after selecting the checkboxes of the unwanted Clinical Indicators

All entries saved in the table will be submitted to the CIDC system

Screen 8: Clinical and Assessment Indicators

6.5 After saving the data, you can use the delete button to remove any mistakes.

6.6 By default, the data displayed is sorted by date of visit and indicators. You can also click on the “Indicators” and “Date” headers to sort the data according to your preference.

6.7 After saving the data, you can use the delete button to remove any mistakes.

6.8 By default, the data displayed is sorted by date of visit and indicators. You can also click on the “Indicators” and “Date” headers to sort the data according to your preference.

7 Attending Physician Information

7.1 This section details the physician attending to the patient. It is required for each submission.

7.2 If there is more than one physician attending to the patient, the main physician information should be entered here.

Attending Physician Information:

Doctor Name:*
Registration Number:*

Specialty/Training:
Healthcare Establishment:

Role:*
 Attending Doctor is the patient's regular primary physician
 The Clinic is the patient's regular primary provider
 None of the Above

Date of Submission: 06-Jan-2008

** denotes a mandatory field*

Screen 9: Physician Information

8 Report Submission

8.1 Once you have completed the data entry, you can submit the report to MOH by clicking on the [Submit] button.

8.2 If you are not yet ready to submit, you can click on the [Save Draft] button and retrieve the report later from the search function for submission.



The Table below describes the function for each button:

Button	Function Description
Submit	Submits the form after completion. Deletes any existing drafts saved previously.
Save Draft	Saves the inputs in the unfinished form as a draft for completion in the future.
Close	Closes the current form and returns to the main menu.

9 Search Clinical Indicator Reports

9.1 After you have submitted a report or created a draft, you can retrieve the reports at a later stage using the search function. This function allows you to specify search criteria and retrieve all reports matching the criteria.

9.2 After retrieving the report, you can also proceed to “Amend” it if there was any mistake in the previous submission, or delete it altogether.

9.3 To access this function, click on the “Search” sub-menu under the “Clinical Indicators” main menu as shown on Screen 10.



Screen 10: Search Menu

9.4 The Search page will be shown. Enter your search criteria and click on the [Search] button. The search is case insensitive.

9.5 At least one of the search criteria must be entered before you can proceed with the search.

Search:

Patient Name:

Patient NRIC/FIN:

From Date: 
(DDMMYYYY)

To Date: 
(DDMMYYYY)

Sort By: Patient Name Ascending

Fill in at least one search criteria before doing a search

Screen 11: Search Criteria

9.6 All submissions made by your clinic which matches the criteria will be displayed as shown on Screen 12.

Search:

Patient Name:

Patient NRIC/FIN:

From Date:

(DDMMYYYY)

To Date:

(DDMMYYYY)

Sort By: Patient Name Ascending

Click to retrieve all records that match the specified criteria

3 records retrieved.

Patient Name	Patient NRIC/FIN	Submission Date
<input type="checkbox"/> Jean Pang		12-Dec-2006
<input type="checkbox"/> Jimmy Fong		12-Dec-2006
<input type="checkbox"/> Tang Mui Kiong		12-Dec-2006
1		

Check only one record for amendment or many records for deletion

Click on the hyperlink to retrieve a read-only page of the record

Amend selected record

Delete selected records

Screen 12: Search Results

9.7 If the number of search results is too large, you can either specify more restrictive search criteria or use the page number to navigate through the results.

9.8 Click on the Patient Name hyperlink to view the report submitted.

9.9 When the [Amend] button is clicked, the selected record will be displayed in editable mode as shown on Screen 13.

Patient Details:

Patient Name: **Patient NRIC/FIN:**

Date of Birth (DDMMYYYY): **Sex:** Male Female

Race: **Height (Metres):**
(use 9.99 if not measurable)

Current Smoker Yes No Year Started Smoking(YYYYY)

** denotes a mandatory field*

Known Medical History:

Medical Condition	Diagnosis Year	Medical Condition	Diagnosis Year
<input checked="" type="checkbox"/> Diabetes	<input type="text" value="2007"/> (YYYY)	<input type="checkbox"/> Hypertension	<input type="text"/> (YYYY)
<input type="checkbox"/> DM Retinopathy	<input type="text"/> (YYYY)	<input type="checkbox"/> Lipid Disorder	<input type="text"/> (YYYY)
<input type="checkbox"/> DM Nephropathy	<input type="text"/> (YYYY)	<input type="checkbox"/> Cerebrovascular Accident (CVA)	<input type="text"/> (YYYY)
<input type="checkbox"/> DM Foot Complications	<input type="text"/> (YYYY)	<input type="checkbox"/> Coronary Heart Disease (CHD)	<input type="text"/> (YYYY)
<input checked="" type="checkbox"/> Asthma	<input type="text"/> (YYYY)	<input checked="" type="checkbox"/> COPD	<input type="text"/> (YYYY)
<input checked="" type="checkbox"/> Major Depression	<input type="text" value="2007"/> (YYYY)	<input checked="" type="checkbox"/> Schizophrenia	<input type="text" value="2007"/> (YYYY)
<input type="checkbox"/> Bipolar Disorder	<input type="text"/> (YYYY)	<input type="checkbox"/> Dementia	<input type="text"/> (YYYY)

Diabetes Treatment:

Treatment	Year Started	Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text"/> (YYYY)	<input type="checkbox"/> Insulin	<input type="text"/> (YYYY)

Hypertension Treatment:

Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text"/> (YYYY)

Lipid Disorder Treatment

Treatment	Year Started
<input type="checkbox"/> Oral Medications	<input type="text"/> (YYYY)

Asthma Treatment:

Treatment	Year Started
<input type="checkbox"/> Preventer	<input type="text"/> (YYYY)

Schizophrenia Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input checked="" type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text"/> 2008 (YYYY)

Bipolar Disorder Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text"/> (YYYY)

Dementia Treatment (Only for CDMP Mental Health Programme patients):

Treatment	Year Started
<input type="checkbox"/> Atypical Antipsychotics Prescribed	<input type="text"/> (YYYY)

Clinical Indicators:

Date of Visit (DDMMYYYY):*	<input type="text"/>		
Blood Pressure (Systolic/Diastolic):	<input type="text"/> / <input type="text"/>	DM - Eye Assessment:	<input type="checkbox"/>
LDL-C:	<input type="text"/> mg/dL	DM - Nephropathy Assessment:	<input type="checkbox"/>
HbA1c (%):	<input type="text"/>	DM - Foot Assessment:	<input type="checkbox"/>
Weight (kg):	<input type="text"/>	Stroke - Thromboembolism Risk Assessment:	<input type="checkbox"/>
	<i>(use 999 if not measurable)</i>		
Smoking Assessment # :	<input type="checkbox"/>	Inhaler Technique Assessment (Asthma & COPD only):	<input type="checkbox"/>
Cigarettes smoked per day (average) ## :	<input type="text"/>	Influenza Vaccination Assessment (COPD only):	<input type="checkbox"/>
ACT Score (Asthma only):	<input type="text"/>		
The following care components are only for CDMP Mental Health Programme Patients:			
CGI - Severity of Illness:	<input type="text"/>	Fasting Lipids Blood Test ###:	<input type="checkbox"/>
CGI - Global Improvement:	<input type="text"/>	Fasting Glucose Blood Test ###:	<input type="checkbox"/>
Consultation for CDMP Mental Health (Indicate the patient attendance):	<input type="checkbox"/>	Assessment of Memory:	<input type="checkbox"/>
For patients on cognitive enhancers, documentation of objective assessment of memory (MMSE or CMMSE testing or other validated instruments):	<input type="checkbox"/>	Assessment of Mood and Behaviour:	<input type="checkbox"/>
Assessment of Functional and Social Difficulties (if any):	<input type="checkbox"/>	Assessment of Rehabilitation Needs:	<input type="checkbox"/>
<i>* denotes a mandatory field</i>			
<i># For current smokers, smoking cessation advice should be given; For non- or ex-smoker, please reinforce the benefits of not smoking cigarettes</i>			
<i>## Applicable to current smokers only</i>			
<i>### Only for patients on Schizophrenia and Bipolar Disorder - Atypical Antipsychotics Medication. To check the box if test is done.</i>			

Add Indicators [Click to add clinical indicators \(only those performed\)](#)

Date	Indicators	Value
<input type="checkbox"/> 11-May-2007	Systolic BP(mmHg)	150
<input type="checkbox"/> 11-May-2007	Diastolic BP(mmHg)	100
<input type="checkbox"/> 11-May-2007	LDL(mg/dL)	40
<input type="checkbox"/> 11-May-2007	HbA1c(%)	30
<input type="checkbox"/> 11-May-2007	Weight(kg)	90
<input type="checkbox"/> 11-May-2007	Cigarettes smoked per day(Avg)	10
<input type="checkbox"/> 11-May-2007	DM-Eye Assessment	Y
<input type="checkbox"/> 11-May-2007	DM-Nephropathy Assessment	Y
<input type="checkbox"/> 11-May-2007	DM-Foot Assessment	Y
<input type="checkbox"/> 11-May-2007	Stroke-Thromboembolism Risk Assessment	Y

Delete Indicators *Click to delete selected clinical indicators*

Attending Physician Information:

Doctor Name:* **Registration Number:***

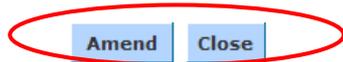
Specialty/Training: **Healthcare Establishment:**

Role:*

- Attending Doctor is the patient's regular primary physician
- The Clinic is the patient's regular primary provider
- None of the Above

Date of Submission: 06-Jan-2008

** denotes a mandatory field*



Screen 13: Editable Page of Patient Record

10 CIDC Clinic Reports

10.1 This function provides standard report(s) for use by clinics. One report is currently available and additional reports may be added in future releases.

10.2 To access this function, click on the CIDC Clinic Reports under the Reports menu button. A page displaying all the available reports and their description will be loaded.

MEDIClaim

NCS0.NCS0001 → Reports > **CIDC Statistics Summary Reports**

CIDC Clinic Summary Reports:

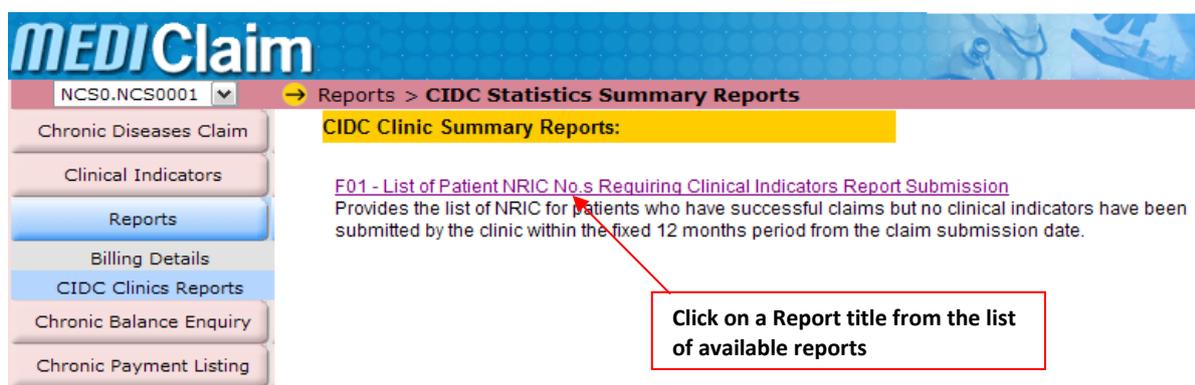
[F01 - List of Patient NRIC No.s Requiring Clinical Indicators Report Submission](#)
Provides the list of NRIC for patients who have successful claims but no clinical indicators have been submitted by the clinic within the fixed 12 months period from the claim submission date.

Click on Reports menu and select CIDC Clinics Reports

Screen 14: CIDC Clinic Reports

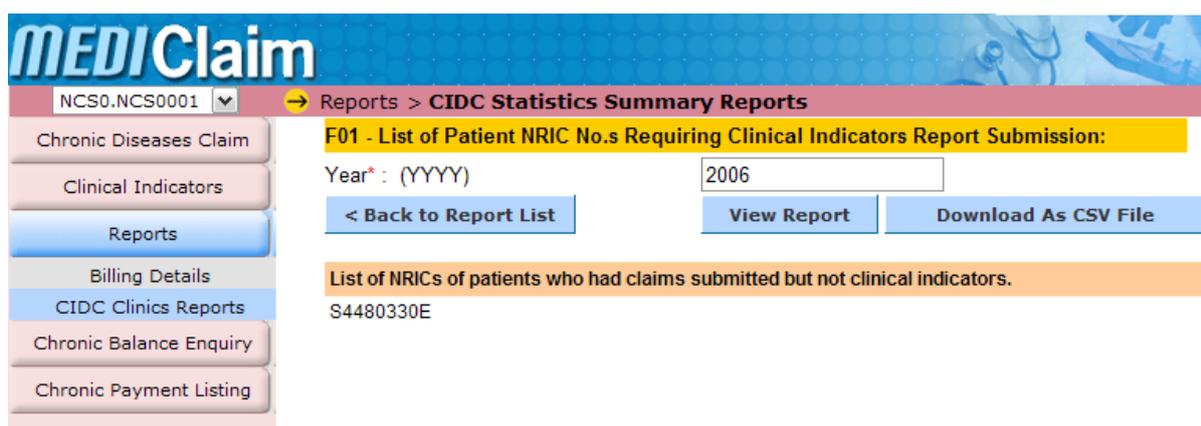
10.3 List of NRICs for patients for whom Clinical Indicators have not been submitted:

- a) This report enables the clinics to have a listing of all the patients' NRICs for whom the clinics had made claims in the specified year but no clinical indicator reports were submitted within a fixed period of 12 months from the claim submission date of each patient. This report is built in to assist doctors and clinics to keep track of the outstanding clinical indicator reports they would require to submit with each claim.
- b) Click on the report title from the list of available reports as shown on Screen 15. A report page with a textbox would appear for the user to key in the year of the requested report, as shown below.



Screen 15: Selecting a Report

- c) Upon entering a valid year, a list of patient NRIC numbers will be generated. The report generated below shows the record of a patient who had a claim submitted but with no submission of any clinical indicator.

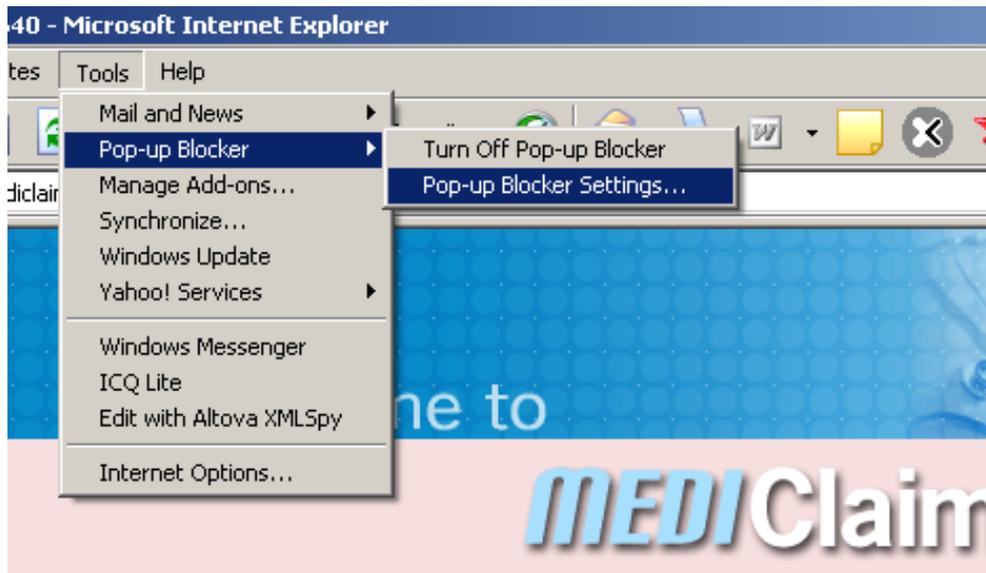


Screen 16: Viewing a Report

11 Troubleshooting

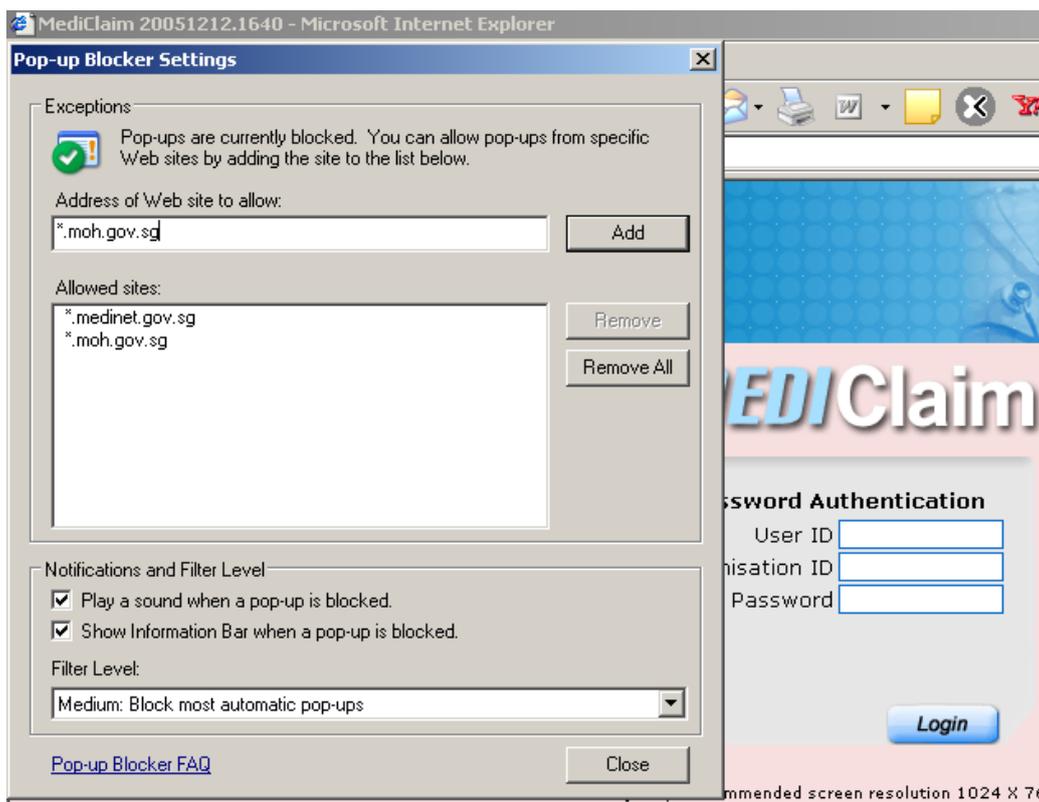
11.1 Enabling of Pop Ups: Certain screens within the application will be displayed as pop-up windows. In order to access the full system functionality, you need to enable pop-up windows for the MediClaim website. To enable this feature, follow the steps below:

a) Select Tools>Pop-up Blocker> Pop-up Blocker Settings...



Screen 17: Internet Explorer Menu

b) Enter "*.medinet.gov.sg" and "*.moh.gov.sg", then click on Add.



Screen 18: Configuring Pop-up Blocker

12 Fall-Back Procedures

12.1 In the event that the submission cannot be done online immediately, you can keep a record of the information and submit it at a later date.

13 Contact Information for Queries Related to Clinical Data Collection and Submission

13.1 For online e-service related technical queries, please e-mail to medicclaim@ncs.com.sg, or contact NCS at: 6776 9330 (Mon - Fri, excluding public holidays, 8:30 am to 6:00 pm).

13.2 For clinical data collection and submission issues related feedback, please email to moh_cds@moh.gov.sg (preferred method), or contact at: 6325 1757 (Mon - Fri, excluding public holidays, 8:30 am to 6:00 pm).

CHAPTER SIX:
FREQUENTLY ASKED QUESTIONS

A. CLINICAL MATTERS

For Doctors who have already registered in the CDMP/participating in CHAS

Q1. I have a patient with Diabetes Mellitus, Hyperlipidaemia and Asthma. Which DMPs should I enrol him/her into?

Your patient should be enrolled into both Diabetes AND Asthma DMPs. He/She will then be able to use MediSave/CHAS to co-pay for the total bill for the treatment administered for all 3 conditions. However, you will also need to submit clinical outcome data based on the essential care components of Diabetes, Lipid Disorders and Asthma. (Please refer to Annex A on page 10 for details.)

Q2. My patient has DM, however, he also has symptoms and signs of Hypothyroidism. Can I use his MediSave/CHAS to co-pay the thyroid function test?

In this instance, thyroid function test was done to screen for a possible condition and not for monitoring of the primary condition or its complication(s). Hence, it is suggested that his bill be itemised so that the patient can use cash to pay for the thyroid function test and MediSave/CHAS to co-pay the rest of the bill which is related to DM care components. (Please refer to Chapter 2.)

Q3. Who decides on the stipulated clinical care components?

The clinical care components were drawn from the MOH Clinical Practice Guidelines, with inputs from professional bodies, which include leading specialists in the respective fields and respected primary care physicians. They were also endorsed by the Clinical Advisory Committee.

Q4. What if the patient has symptoms suggestive of both Asthma and COPD? Which DMP should I enrol him into?

For patients whose signs and symptoms are not so distinct between the two conditions, spirometry and/or bronchodilator reversibility testing may be performed to help classify the patient into one of the two diagnoses or to differentiate these conditions from other diseases that may mimic its presentation.

It is important to try to classify the patient into the correct DMP as this will help to determine the management of the patient and also prevent any issues with respect to the MediSave/CHAS claims.

(Please refer to the MOH Clinical Practice Guidelines for more information on diagnosis and management of Asthma and COPD).

Q5. Can the patient use MediSave/CHAS to pay for pulmonary rehabilitation?

Yes, only if the patient has been diagnosed to have COPD, and it is clinically deemed to be beneficial for the patient.

Q6. Can I make claims for ambulatory aids (e.g. walking sticks) for my patient with Stroke, or for oxygen concentrators for my patient with COPD requiring long-term oxygen therapy?

Currently, medical devices not used for the purposes of drug administration are generally not claimable items under MediSave for CDMP/CHAS. However, for a patient with COPD, he may claim up to \$75 per month for rental of devices for long-term oxygen therapy.

The Seniors' Mobility and Enabling Fund (SMF) may be used to subsidise purchases of mobility devices for means-tested patients above the age of 60 years old.

Q7. Can I make claims for Glucosamine/Chondroitin supplements for my patient who has Osteoarthritis?

You may prescribe Glucosamine/Chondroitin supplements for suitable patients, but they are currently not claimable items under CDMP/CHAS.

Although Glucosamine and Chondroitin supplements are commonly prescribed for patients with Osteoarthritis, their benefits have not been supported by sufficient clinical evidence. Patients' MediSave/CHAS should only be claimed for evidence-based medications and treatment modalities, such as physiotherapy.

Q8. Can I claim for outpatient vaccinations and/or health screenings?

MediSave claims for the following are allowed, but not under the CDMP framework. However, these claims fall under the same withdrawal limit as CDMP, i.e. \$500 per Medisave account per year.

Vaccinations

Vaccinations for recommended groups under the National Childhood Immunisation Schedule (NCIS) and National Adult Immunisation Schedule (NAIS)

Health Screenings

- a) Mammogram screening for women aged 50 and above; and
- b) Selected screening tests for newborns in the outpatient setting.

CHAS claims can be made in the following circumstances:

Vaccinations

- a) The cost of consultation for vaccinations, but not the cost of the vaccines, can be claimed under the acute tier of CHAS subsidies; and

- b) For patients with COPD, the cost of consultation and influenza vaccine can claimed under the chronic tier of CHAS subsidies, as it is an essential care component of COPD.

Health Screenings

Tests for recommended health screening by the Health Promotion Board (HPB) are free at participating CHAS clinics (doctor's consultation charges apply). HA/PG/PA cardholders are eligible for CHAS subsidies for doctor's consultation charges for health screening.

B. REGISTRATION MATTERS

For Doctors and Clinics which wish to be registered into the CDMP:

Q1. What are the requirements to be on the CDMP?

Clinics that wish to participate in the CDMP must agree to:

- c) Provide treatment to chronic disease patients through evidence-based DMPs. These DMPs will include MOH-recommended key treatment components;
- d) Treat patient medical information with confidentiality;
- e) Submit to MOH, with the informed consent of patient, data on patient care delivery on an annual basis or as specified by MOH, for the purpose of medical audits. Relevant aggregated performance data will be published to assist patients in making informed choices;
- f) Be accredited for the use of MediSave for CDMP; and
- g) Be periodically reviewed and audited, both clinically and administratively. Any clinic/medical institution that fails to satisfy the minimum standards of clinical performance set by MOH, will be asked to withdraw from the Programme. (See Chapter Two: The Clinical Guidelines).

Q2. How do I register for the CDMP?

For clinics who are not in the CDMP, they must submit the following forms for registration:

- a) E-Application for Clinics to Participate in the MediSave for Chronic Disease Management Programme (by MOH);
- b) Direct Authorisation Credit Form (by CPF Board);
- c) GIRO Form (MediClaim charges by NCS); and
- d) GIRO Form (MediSave charges by CPF Board).

The E-Application website can be accessed via

<https://www.mediclaim.moh.gov.sg/mmae/OverviewApplication.aspx>

Clinics participating in the CDMP will also have to sign a Deed of Indemnity with the CPF Board.

Doctors need to be individually registered under the Programme in order to process MediSave claims for their patients. Doctors can do so by submitting the Application Form for Medical Professionals, which can be found in the link: <http://www.mediclaim.moh.gov.sg/mmae/DoctorApplication.aspx>.

Q3. My clinic is already participating in CDMP. Can I make MediSave claims for my patient who is suffering from Schizophrenia, Major Depression, Bipolar Disorder or Anxiety?

In addition to participating in CDMP, your clinic will also need to be participating in a Shared Care or GP Partnership Programme with a Restructured Hospital before your clinic is registered as a “CDMP-MI” clinic, and MediSave claims for patients with mental illnesses can be made. This is part of an assurance framework to ensure quality of care for patients.

Q4. How do I register for a Shared Care or Partnership Programme with a Restructured Hospital?

You may register via MOH’s MMAE website (<http://www.mediclaim.moh.gov.sg/mmae/overview.aspx>) by selecting the “Chronic Disease Management Programme (CDMP) – Shared Care Programmes”.

Q5. What will be the cost of registration and start-up?

Apart from computer hardware and Internet access subscription (which may already be in place), there is a one-time non-refundable cost of \$191.20 (inclusive of 7% GST and delivery fee) for the security token to access the MediSave claims system. The token is valid for two to three years. The subsequent token is priced at \$171.20. This security token is required only when using the MediClaim e-service.

You or your staff will need to attend a half-day training session on MediSave claims process, guidelines on MediSave use and the use of the MediClaim system. This training session is free-of-charge.

Q6. How do patients sign up for the CDMP?

All patients treated by a MediSave and CDMP accredited doctor for at least one of the approved chronic conditions are eligible for CDMP. The patient need to complete the MediSave Authorisation Form / Medical Claims Authorisation Form to allow the doctor to make MediSave claims on the patient’s behalf.

C. MEDISAVE CLAIMS, REIMBURSEMENT, BILLING

For Doctors and Clinics that wish to be registered into the CDMP:

Q1. In total, how much can patients claim from MediSave for chronic disease treatments?

Patients can claim up to \$500 per MediSave account per year for outpatient treatment of the approved chronic conditions, regardless of the number of chronic conditions they might have.

Q2. Whose MediSave account(s) can a patient make use of, apart from his/her own?

Patients can use their own MediSave account(s) and the account(s) of their immediate family members (i.e. parents, children, and spouse). In addition, patients who are Singapore Citizens or PRs can also use the MediSave accounts of their grandchildren. Claims can be made once the MediSave payer has signed the relevant MediSave Authorisation Form.

Q3. What will be the exact level of deductible and co-payment?

The \$30 deductible has been removed since 1 July 2014. There is still a 15% co-payment of the CDMP bill for each claim that the patient has to pay in cash.

Q4. Who should submit MediSave claims?

Any of the permanent staff of a MediSave-accredited clinic/medical institution who has attended the training sessions, e.g. doctors, nurses, counter staff, clinic managers, can submit MediSave claims.

Q5. If the patient sees me for both a chronic condition and an acute condition at the same time, can the entire bill be claimed?

MediSave can only be used for treatment related to the CDMP conditions listed, subject to a cap of \$500 per MediSave account per year. If patient attendance is purely for an acute or unrelated condition, MediSave deduction is not allowed even though the patient may have an existing chronic condition. Checks will be made during audits to ensure that claims made are only in relation to the approved chronic conditions and/or their complication(s).

Q6. How does the annual cycle of the \$500 limit apply? Is it calculated based on the time that the patient first seeks treatment under the scheme?

The \$500 annual limit is reset at the start of each calendar year, i.e. \$500 for the period from 1 Jan to 31 Dec.

Q7. Will MediSave use be allowed for purchasing equipment (e.g. blood pressure monitoring equipment or glucometer, etc.)?

In line with existing MediSave guidelines, MediSave use generally does not cover equipment purchase, whether for chronic disease treatment or other uses. From 1 Jun 2015, MediSave can be used for the purchase of spacers and accompanying masks if necessary, for Asthma/COPD patients, as well as insulin pens, syringes and needles for Diabetic patients. From 1 Jun 2018, MediSave can be used for the purchase of lancets and glucose test strips for self-monitoring of blood glucose levels for Type 1 Diabetes

patients and Type 2 Diabetes patients on insulin. These should be dispensed in appropriate quantities, necessary for the patient's own use.

Q8. How will I know if the patient has sufficient balance left for claims?

To help patients and their family members keep track of the amount of MediSave used under MediSave500, participating clinics can check the MediSave balances under the CDMP on behalf of their patients, upon authorisation from patient.

An enquiry function to check the available withdrawal amount is available via the MediClaim e-service and MHCP. Clinics may use this function to check the remaining balance of the MediSave account holder with his/her consent.

Alternatively, you can request for the MediSave holders to show you a print-out or electronic statement of their current MediSave balance. They can obtain their current MediSave balance from the CPF Board's website (www.cpf.gov.sg) under My CPF Online Services - My Statement, by logging in with their SingPass. You may wish to ask your patients to bring along a copy of the MediSave balance of the Medisave payers if you do not have a computer terminal at your clinic.

Q9. If the MediSave balance is insufficient to cover the costs, can the patient top up the difference in cash?

Yes.

Q10. Can the bill be split among two or more accounts according to a given percentage?

Yes, a claim can be shared by a maximum of 10 MediSave accounts.

Q11. Will patients have to pay the full amount upfront and then be reimbursed or can they make partial payment based on estimated MediSave payout?

This decision will depend on the individual clinics. However, clinics should explain to their patients on the mode of payment clearly so as to avoid any confusion or unhappiness.

Q12. How will refunds for MediSave withdrawals be handled (e.g. if a patient opts out of a package)?

The clinic will have to amend the approved MediSave claim through the MediClaim system to return the money back to the relevant MediSave accounts. CPF Board will liaise with the clinics to debit and credit the amounts accordingly. MediSave will have first claim on any refunds. Clinics should refund the patient the unutilised cash co-payment collected from the patient previously.

Q13. If patients have signed up for the Programme, can they opt out of it at a later date? Do I need to refund the amount that he had paid up for a package?

Patients can opt out at a later date by informing the clinic from which he/she is receiving care. Funds withdrawn from MediSave must be reimbursed to the MediSave accounts. Refunds on cash co-payment is a private arrangement between the provider and the patient. Patients should find out the provider's policy on refunds before signing up for packages.

Q14. Is MediSave withdrawal dependent on the patient having only one specific primary care provider?

No. Patients are encouraged to have continuity of care with one family physician but they are free to choose and switch providers. Hence, they can make MediSave claims at any MediSave-accredited clinic.

Q15. How will claims be made if a patient is referred to an unaccredited provider?

MediSave claims will not be allowed at an unaccredited clinic. However, the referring party can make arrangements to bill on behalf of his unaccredited partners. The referring party is expected to bear full responsibility for any such arrangements made. In addition, the referring party is also responsible for the submission of clinical data for the patient.

Q16. How will the scheme apply to Permanent Residents and Foreigners?

Current MediSave rules apply. As long as Permanent Residents or Foreigners have MediSave accounts or their immediate family members have MediSave accounts, they are eligible for the scheme.

Q17. How will the scheme apply to those who have employer medical benefits or an existing comprehensive insurance plan?

Claims can be made under employer plans. This also applies to pensioners. Employer medical benefits or an existing comprehensive insurance plan can be used to cover the cost of the deductible and co-payment. Any amount in excess of the employer medical benefits or the insurance plan can be paid using MediSave, subject to co-payment. Clinics will have to liaise directly with their partnering employers for payment under employer plans as per their current arrangements.

Q18. What is the process of making MediSave claims like? Will it involve a huge change in my clinic operations?

The process is as follows:

- a) The clinic/doctor should explain the following to patients suffering from any of the approved chronic conditions and their immediate family member(s) whose MediSave account(s) is/are being used (if any):
 - the treatment components
 - the cost of treatment
 - estimated amount that can be claimed from MediSave

- the out-of-pocket cash payment that the patient will need to make
- b) When the patient and/or his/her immediate family member(s) have decided to use MediSave for the bill, each MediSave account holder who wishes to make use of his/her MediSave account need to sign a MediSave Authorisation Form / Medical Claims Authorisation Form to authorise the CPF Board to deduct his/her MediSave savings for the treatment of the patient. The authorisation can be made on a per treatment basis or over a period. Authorisations over a period of time stands until revoked in writing. Clinic/medical institution staff should witness the signing and verify the relationship(s) to the patient as stated in the MAF.
 - c) Clinics/medical institutions can then submit the MediSave claims electronically to the CPF Board for processing via the MediClaim System.
 - d) Payment will be made daily to MediSave-accredited medical institutions via InterBank Giro (IBG) on the 3rd working day after the approval date of the MediSave claims.

Q19. Can GPs who are contracted by nursing homes to provide outpatient care for their residents help the ones suffering from one of the approved chronic conditions make MediSave claims?

Yes, if the GP and his/her clinic are accredited for MediSave use for CDMP. He/She can help the nursing home patients to make a MediSave claim for their outpatient chronic disease treatment(s) through his/her clinic.

D. DATA SUBMISSION, CLINICAL IMPROVEMENT AND AUDITS

Q1. Why is the patient's medical and treatment history required?

The data collected will provide a better profile of patients on CDMP/CHAS. This information will be useful for fine-tuning for programme planning and management purposes.

Q2. Must the medical history be captured at each visit?

The items in the medical history data will only need to be captured once but should be updated as and when there are changes.

Q3. How do I record the actual year of diagnosis of patients with long standing chronic diseases?

The estimated year of diagnosis for the patient's chronic condition can be recorded if the exact year is not known.

Q4. Will data on all clinical parameters be required at every visit?

No. Only data on assessments or tests performed during the visit need to be captured.

Q5. Would I need to repeat HbA1c or LDL cholesterol if my patient is able to produce the results of a test done elsewhere?

You can submit the relevant details of your patient's test results that have been performed elsewhere instead of repeating the test. If you do so, please keep a copy of the record of the test results.

Q6. What if the patient is lost to follow up?

Please note it down in your clinical documentation. Alternatively, if you are using the web-based CIDC e-Service for data submission, you may also document the information using the textbox available under the Patient Participation Module present on the navigation bar. If you are using CMS for data submission, please contact your CMS provider for more details on capturing of this type of information electronically.

Q7. What if the patient refuses certain tests?

Tests are performed, when indicated, as part of the proper management of the chronic disease. As such, the physician should inform the patient as to the rationale and provide other key information regarding these tests. If the patient refuses the tests, please note this response in the patient's clinic notes.

Q8. If I missed the previous deadline for submission of clinical data, do I still need to submit the data for that period?

Yes, you should still submit the relevant data for that period as well as the current data.

Q9. Which healthcare provider should submit clinical data if the patient makes MediSave/CHAS claims at three different healthcare providers during one year?

It would be appropriate for each provider to collect relevant data for the care that has been provided, and to submit the data. If they are not able to make the submission, they should forward the data to the primary physician who is coordinating the care of the patient's chronic condition so that he/she may be updated and make the submission.

Q10. If a patient starts making MediSave/CHAS claims from June onwards, must I submit clinical information captured before June?

You can capture the relevant clinical data of the patient. However, for the purpose of assessing the care process and outcome of the chronic condition, the period of one year (taken from the date when the patient first enrolled into the CDMP/CHAS for the chronic condition) will be used.

Q11. My patient claimed MediSave/CHAS for treatment of a chronic condition when he first consulted me on 5 Jan 2014, but paid cash for three subsequent visits (in Mar, Jul, Oct

2014) for the same chronic condition. Would I still need to submit clinical data for the latter three visits?

Yes, you should continue to submit the patient's clinical data on this chronic condition for one year from 5 Jan 2014.

Q12. Can the clinical data submitted be shared by different healthcare providers within the same clinic / institution / cluster?

This will depend on the electronic Clinic Management System (if any) that is used by the healthcare institution.

Q13. If I have already fulfilled the number of care components for the chronic condition, do I still need to submit clinical data subsequently?

The care components are the essential aspects of medical care that are recommended for management of the chronic conditions. The data submission system allows you to submit more than the recommended number of care components.

Q14. Will clinical data submitted be shared with the providers?

The clinical data received will be used to monitor the success of the CDMP/CHAS, and also to give feedback routinely to the registered clinics for quality improvement. Clinical data submitted have been routinely fed back to the clinic as the online CDMP outcome reports via the Medclaim system from the first quarter 2008 onwards. In these reports, a clinic will be able to compare its performance against the aggregated local and national performance. Over time, each clinic will also be able to track its own performance trends.

Q15. What will the clinical quality improvement process be like?

The clinical data that is monitored is useful for clinical quality improvement in the care of chronic conditions. When meaningfully used, it will empower patients to take charge of managing their chronic condition as guided and supervised by their family physician. This can improve compliance with the recommended care of the chronic condition(s) with better longer term outcomes.

Q16. What will the clinical audit process be like?

Periodic audits will be carried out to ensure accuracy of clinical data submission and to ensure that minimum standards of performance are met. Due consideration will be given so that such audits do not disrupt clinic operations and patient care processes.

Q17. What documents must I submit if my clinic is selected for audit?

Photocopies of the following documents should be submitted by post:

- a) Doctor's clinical notes for the visit/visits submitted for specified claim;

- b) Laboratory results relevant to the medical condition(s) for which claim was made e.g. HbA1c, Lipid Panel, Spirometry test etc;
- c) Prescription or clinical notes with documentation of details of the drugs prescribed (i.e. name of drug, frequency, dose, duration); and
- d) Invoices/receipts showing the itemized breakdown (medication(s), investigation (if any), consultation & total claim amount) of the bill(s) submitted for claim.

Q18. Am I allowed to divulge patients' medical information to the CDMP/CHAS Audit Teams for audit?

Yes, clinics are subject to audits by CDMP/CHAS Auditors appointed by MOH, as stated in the Agreements. In addition, the patient would have provided consent to sharing his/her medical information for the purpose of the audit when he/she signed the MediSave Authorisation Form/Medical Claims Authorisation Form/CHAS Patient Consent Form.

Q19. How do I submit my bills for audit?

All items claimed need to be itemised.