CHRONIC DISEASE MANAGEMENT PROGRAMME

HANDBOOK FOR HEALTHCARE PROFESSIONALS

MINISTRY OF HEALTH
SINGAPORE

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FOREWORD

This Handbook is written for all medical practitioners and healthcare institutions participating in the Chronic Disease Management Programme (CDMP). We hope that it will be especially useful to general practitioners on the Community Health Assist Scheme (CHAS) and Healthier SG, who will care for individuals with chronic conditions as Singapore's population ages.

2. The CDMP was first introduced in 2006. To reduce out-of-pocket expenses for outpatient management of their chronic conditions and promote care-seeking behaviour, eligible patients can utilise MediSave and enjoy subsidies at CHAS GP clinics for these conditions. The launch of Healthier SG in 2023 aims to build upon our goals of appropriate chronic disease management in the community, with a strong emphasis on preventive care measures.

3. MOH reviews the list of CDMP conditions regularly based on various considerations, such as disease burden and effectiveness of early intervention to reduce complications. All chronic conditions covered under CDMP are automatically extended to be in the list of conditions eligible for CHAS Chronic subsidies.

4. This Handbook aims to serve as a quick guide on the CDMP, covering a range of practical issues from administrative and claims-related matters to broad guidelines on the recommended key components of clinical care. The CDMP Handbook is not intended to be a comprehensive clinical guide, but consolidates key components of locally relevant practice guidelines and incorporates evidence-based advice to provide a succinct reference for evidence-based practice.

5. In addition to keeping abreast of the latest clinical updates, primary care clinicians are also reminded to care for patients holistically. This involves considering how multimorbidity may affect treatment priorities, giving advice on health promotion and preventive aspects of care, and working with patients on individualised care plans to maximise each person's health. Primary care clinicians must ensure that claims are appropriate to support to judicious use of their patients' MediSave.

6. We wish to thank healthcare professionals for your dedication and hard work in caring for patients with chronic conditions, and hope you will find this Handbook useful.

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CHAPTER ONE:
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 in 2006 and provides 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 Chronic and CDMP have been aligned, 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. In Nov 2019, CHAS was enhanced to cover all Singaporeans with selected chronic conditions, regardless of their income. In addition, the Merdeka Generation Package (MGP) was introduced to provide special subsidies under CHAS to the Merdeka Generation (MG).

1.3 Healthier SG

1.3.1 In July 2023, Healthier SG was launched to foster stronger relationships between family doctors and residents, with an aim to optimise chronic disease management and further encourage the uptake of preventive health measures. Healthier SG also facilitates an increased involvement of patients and community providers in efforts towards achieving healthier habits and lifestyle choices.

1.4 Covered Conditions

1.4.1 Treatment of chronic diseases is costly when administered collectively over a long period. CDMP/CHAS will help to reduce out-of-pocket payments and reduce 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.

1.4.2 The use of CDMP/CHAS will apply to the conditions listed below in Table 1.1:

Table 1.1: Chronic Conditions under CDMP/CHAS

	Conditions under CDMP/CHAS
Chronic Conditions with data submission requirements (Requiring the reporting of clinical indicators as detailed in Chapter Four: Capture and Submission of Clinical Data)	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 clinics/doctors in the Mental Health GP Partnership Programme)	7) Anxiety Disorders 8) Major Depressive Disorder 9) Bipolar Disorder 10) Schizophrenia
Other Chronic Conditions	11) Stroke 12) Major Neurocognitive Disorder (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) 21) Allergic Rhinitis 22) Gout 23) Chronic Hepatitis B

2 Clinical Guidelines and Clinical Data Submission

2.1 Participating clinics/medical institutions are required to provide care to patients in line with the latest MOH Clinical Practice Guidelines (CPGs)[1], ACE Clinical Guidances (ACGs)[2], Healthier SG care protocols, and/or best available evidence-based practice, as well as track and submit clinical data to monitor and improve patient outcomes.

2.2 Proper and conscientious clinical data submission is a key tool to assess the effectiveness and appropriateness of patients' management plans at both the individual and population level. While participating clinics/medical institutions are required to submit clinical indicators, clinical data submission is needed for only six of the conditions under CDMP/CHAS and these are largely aligned to Healthier SG data submission requirements. For the other conditions, recommended care components outlined in this handbook are expected to be documented and may be subjected to audits.

[1] MOH clinical practice guidelines are considered withdrawn five years after publication unless otherwise specified in individual guidelines. Users should keep in mind that evidence-based guidelines are only as current as the evidence that supports them and new evidence can supersede recommendations made in the guidelines.

[2] ACGs are available at https://www.ace-hta.gov.sg/healthcare-professionals/ace-clinical-guidances-(acgs).

2.3 Please refer to Chapter Three: The Clinical Guidelines for further details on the recommended 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 lists of reportable and non-reportable clinical indicators are detailed in Chapter Four: Capture and Submission of Clinical Data.

CHAPTER TWO:
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. To ensure prudent use of MediSave funds, two safeguards are in place under the CDMP:

a) **Co-payment**: A co-payment of 15% will apply to each outpatient CDMP bill; and

b) **Annual withdrawal limit**: An annual withdrawal limit of $500/700 per patient applies. 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 From 1 Feb 2024, patients seeking CDMP treatment at their enrolled Healthier SG clinics will have the 15% co-payment waived. They can use MediSave to fully pay for their CDMP bills, up to the relevant annual limits under the MediSave 500/700 scheme.

1.4 Only doctors and clinics/medical institutions which are accredited for MediSave use can make MediSave claims for patients. To make claims for Mental Illnesses (i.e. schizophrenia, major depressive disorder, bipolar disorder, and anxiety disorders), GPs additionally need to participate in the Mental Health GP Partnership Programme (MHGPP) and attend the CDMP-MI training provided under MHGPP[3]. Doctors who are registered specialists in psychiatry do not need to join MHGPP and are exempted from CDMP-MI training. GPs are exempted from having to attend CDMP-MI training (but are still required to take part in MHGPP) if they have the following qualifications/ background[4]:

a) Doctors with MMed(FM), GDFM or on the Register of Family Physicians, if the mental health training modules of these programmes include all the conditions in CDMP Mental Illnesses.

b) Doctors with Family Medicine (FM) training who had 3 months posting at psychiatric departments at the various Restructured Hospitals from May 2007;

c) Doctors who had 6 months posting at psychiatric departments at the various Restructured Hospitals from May 2007; OR

d) Holders of the Graduate Diploma in Mental Health.

[3] The MHGPP is 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.

[4] GPs are to refer to latest MOH circulars on any changes to these criteria.

2. Registration Process for MediSave for CDMP

2.1. Clinics Intending to Participate in the CDMP

2.1.1. Only the clinic/medical institution and its doctor(s) accredited under the MediSave Scheme may submit CDMP claims and make MediSave claims on behalf of their patients.

2.1.2. An outline of the registration and accreditation process is provided in Table 2.1.

Table 2.1: Registration and Accreditation Process (MediSave for CDMP)

Steps
Clinics submit E-Application form to MOH/Doctors submit E-Application form to MOH (concurrently) via https://fsae.moh.gov.sg
↓
• Clinic representative(s) register(s) and complete(s) online e-learning courses • Clinics submit documents to CPF Board
↓
MOH approves the participation of the clinics
↓ Clinics to endorse CPF Board's Terms and Conditions MOH notifies clinics the approval via system generated emails ↓
Effective start date of participation in the CDMP by clinics

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, including but not limited to:

a) Have a valid licence under the Healthcare Services Act 2020 (as applicable) to carry out the procedures and treatments to be claimed under MediSave scheme;

b) Complete the necessary e-learning modules;

c) The applicant, the person(s) indicated as the licensee, any person(s) having management or control of the clinics/medical institution is not in breach or suspected to be in breach of (i) the terms and conditions of any public scheme administered by the Government or its appointed agents, including public schemes administered by MOH; (ii) any health service licensing legislation and regulations, including the Medical Registration Act (Cap. 174) or the Dental Registration Act (Cap. 76); and/or (iii) all applicable laws and legislation (including the CPF Act, the Medisave Accounts Withdrawal Regulations, and MediShield Life Scheme Regulations), and all prevailing relevant guidelines and requirements issued or imposed by MOH, including and not limited to the guidelines and requirements in the MediSave Manual and circulars;

d) The applicant, licensee(s), and persons employed by the Applicant have a satisfactory track record under any applicable legislation or MOH healthcare financing or assistance schemes, including but not limited to (i) whether the applicant, licensee(s), and/or clinic manager owe any monies to the Government and/or have not completed their remedial actions for breaches in relation to any Government healthcare financing or assistance schemes; (ii) whether the applicant, licensee(s), and/or clinic manager was/is suspended or terminated from any Government healthcare financing or assistance schemes, whether in the past or present; (iv) whether applicant, licensee(s) and/or clinic manager has been convicted of or is subject of ongoing criminal or disciplinary investigations or proceedings;

e) The applicant, licensee(s), and/or clinic manager had no involvement or suspected involvement in the following, whether past or present: (i) conviction of an offence, or found by the relevant professional board (Singapore Medical Council or Singapore Dental Council) to be guilty of misconduct involving dishonesty or fraud; (ii) suspended or struck off the register maintained by the SMC or the SDC; (iii) engaged or engaging in over-servicing or over-charging his patients (as determined by the Government in its sole discretion); and/or (iv) convicted of or subject of ongoing investigation by the Government and/or other relevant authorities relating to the MediSave and MediShield Life Scheme, dishonesty and/or fraud;

f) Be able to submit clinical data for patients through the CIDC Online portal[5], or selected Clinic Management Systems (CMS) with SmartCMS services[6]; and

g) CEO/Director-level officer to accept CPF Board's Terms and Conditions via FormSG

2.2.2 To make claims for patients through the online MOH claims system(s)[7] , clinics/medical institutions need to have:

a) A CorpPass account;

b) A Personal Computer/Laptop with the following configuration:-

MediClaim:

(i) Minimum 1 gigahertz (GHz) or faster processor
(ii) 4GB or above Memory (RAM)
(iii) 10GB of free space in HDD
(iv) Operating System Windows 10
(v) Browser Internet Explorer 11
(vi) Internet connection

NPHC:

(i) Processor: Intel i5 or AMD equivalent
(ii) 8GB or above Memory RAM
(iii) Internet Connection

[5] The CIDC Online Portal can be accessed at https://cidc.moh.gov.sg/cidcweb/CorpPass/CorpPassLogin.aspx
[6] Clinic Management Systems (CMSes) offering smartCMS services can be found on https://www.synapxe.sg/partner-us/smartcms
[7] Claims system – National Platform for Healthcare Claims (NPHC) - will take over MediClaim in Nov 2024.

(iv) Google Chrome 121 and above, Microsoft Edge 121 and above, Safari 16 and 17

c) GIRO arrangement with CPF Board for MediSave payments to be credited into the clinic/medical institution's bank account; and

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

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

a) E-Application for Clinics to Participate in the MediSave for CDMP via https://fsae.moh.gov.sg/mmae/Overview.aspx ;
b) Direct Debit Authorisation Form (DDA) – Pay MediSave Refunds, Interest and Fees (by CPF Board); and
c) Direct Debit Authorisation Form (DDA) – Pay Financial Penalty/Interest (by CPF Board);

The E-Application website can be accessed via: https://fsae.moh.gov.sg

2.2.5 Clinic/medical institution representative(s) who will be making MediSave claims are required to register for online e-learning courses on MediSave claims process, MediSave use guidelines and use of the MOH claims system(s).

The E-Learning application website can be accessed via:
https://fsae.moh.gov.sg/mmae/OverviewTraining.aspx

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

a) Clinical quality checks conducted by MOH and/or its appointed auditors on patients who make MediSave claims through the clinics/medical institutions;
b) Professional medical audits conducted by MOH and/or its appointed auditors on MediSave claims and clinical indicators submitted; and/or

c) Operational audits conducted by CPF Board and/or its appointed auditors on MediSave claims.

2.3 Registration of Doctor with MOH

2.3.1 Doctors practising at accredited clinics/medical institutions need to be accredited under MediSave Scheme and/or MediShield Life Scheme under MOH to participate in the CDMP before they can make MediSave claims for their patients. They need to hold a valid practising certificate issued by Singapore Medical Council. The approval is subject to their compliance with the Terms and Conditions of Approval under MediSave Scheme, and MediShield Life Scheme, all applicable laws and legislation, the guidelines and requirements in the MediSave Manual, relevant circulars or any forms of communication that may be issued or imposed by MOH in relation to MediSave and/or MediShield Life Scheme(s), and any conditions issued or imposed by MOH for specific cases.

2.3.2 Interested doctors can submit an E-Application to participate in the CDMP. The website is: https://fsae.moh.gov.sg/mmae/DoctorApplication.aspx. Registration for MediSave accreditation of doctors is on a 2-year renewal basis, subject to MOH's prevailing guidelines and requirements.

2.3.3 Registered doctors will be audited by MOH, CPF Board and/or its appointed auditors on the clinical indicators 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 Medical Claims Authorisation Form (MCAF) to authorise the CPF Board to deduct his/her MediSave funds for the treatment of the patient. The relevant fields[8] in the MCAF should be properly filled. The authorisation can be made on a per treatment basis or over a period of time[9]. Authorisations over a period of time will stand until revoked in writing.

[8] Under section C of the MCAF form, patients/payers should indicate "Y" for Approved chronic diseases, vaccination and screenings

[9] 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.

b) Clinic/medical institution staff should ensure that the particulars stated on the form match those stated in the NRIC or identification document provided. Clinic/medical institution staff should also verify relationships declared, where possible.

c) The clinic/medical institution's staff should ensure that the patient and additional MediSave payer(s) understand and acknowledge the relevant paragraphs in the form.

d) A witness has to verify that the patient and additional MediSave payer(s) have completed and signed the form. The witness must be a Singapore Citizen or Permanent Resident aged 21 years and above and must not lack mental capacity. Where the institution's staff is acting as a witness, the SC/PR and age requirements are lifted.

e) Clinics/medical institutions are to submit the MediSave claims electronically to CPF Board for processing via the MOH claims system(s).

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.

A mentally incapacitated person is defined as a person who either:

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 decide for himself. An inability to decide 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 Clinics submit MediSave claims electronically.

4 Audit

4.1 All MediSave claims and clinical indicators for CDMP conditions submitted by the participating clinic/medical institution may be subjected to regular audit by the CPF Board, the Ministry of Health and/or its appointed auditors. There are 2 types of audits for MediSave claims:

a) Operational audit: This audit looks at the operational aspect of making MediSave claims such as proper documentation and completion of the MCAF;
b) Professional audit: This audit looks at treatments and investigations administered for each MediSave claim to determine if it is related to the diagnosis, whether reportable clinical indicator data was submitted, and the accuracy of clinical indicator data submitted.

4.2 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 and Clinical Indicator Reports submitted electronically,
b) 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 (details under para 5.1). 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), unless otherwise stated via circular. Please note that in cases where the MediSave claim includes management 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 (i.e. claims non-compliant to the CDMP Handbook and prevailing guidelines/circulars) will be required to return the relevant amount to the affected MediSave account(s) with interest. In addition, the doctor will be issued a warning letter. A doctor who makes non-compliant claims will be subjected to prevailing enforcement and escalation frameworks as MOH deems appropriate.

5 Recommended Standards of Documentation to Support Claims

5.1 Clinical records are expected to be accurate, clear, and complete with the following information to support claims under CDMP:

a) Key findings from focused history taking and physical examination, which should include the patient's chief complaint (if any), and reflect diagnoses of **current** acute and/or chronic medical issues

b) Indicated laboratory and/or radiological investigations, if any, to assist in diagnosis and/or management

c) Diagnoses and/or problem list

d) Treatment plan

e) Recommended care components as elaborated on in Chapter Three: The Clinical Guidelines

CHAPTER THREE:
THE CLINICAL GUIDELINES

1 Guidelines for Participating Clinics and Practitioners

1.1 Clinics participating in the CDMP/CHAS are expected to provide the recommended care components detailed in this handbook as appropriate to the individual patient's clinical needs. The basis for establishing a diagnosis of the chronic diseases should conform to the prevailing MOH CPGs, ACGs and best available evidence-based practice, where applicable.

1.2 The recommended care components of each condition are recommended by the Clinical Advisory Committee appointed by MOH and are based on current available evidence. They can be found in Chapter Three: The Clinical Guidelines of this handbook.

1.3 In general, the management of metabolic risk factors and lifestyle advice such as smoking cessation are relevant to many CDMP conditions. While these may not be explicitly specified as a recommended care component under the specified disease section, it is advised that each individual's chronic care needs are considered in a holistic manner, and management of metabolic risk factors carried out where indicated.

1.4 To facilitate integration of care across the various settings so that patients continue to receive appropriate management of their chronic conditions, MOH has worked with the 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.

1.5 The diagnosis of all chronic conditions must be clearly documented in the clinical notes. For avoidance of doubt, causal relationship of claims related to complications of approved CDMP conditions must be documented.

1.6 Clinics and practitioners under CDMP are reminded to comply with the prevailing standards in the Healthcare Services (Advertisement) Regulations, including not providing information to the public to solicit or encourage the use of the services provided by or at any healthcare institution.

2 Mental Health GP Partnership Programme (MHGPP) 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. GPs making CDMP/CHAS claims for the above-mentioned conditions are required to participate in the Mental Health GP Partnership

Programme (MHGPP) and attend the CDMP-MI training provided under the MHGPP to ensure that they have sufficient training and confidence in treating patients with mental health conditions.

2.2 In addition to access to CDMP/CHAS for mental health conditions, GPs are supported with the following by participating in MHGPP:

a) Psychiatric drugs at a lower cost
b) Community mental health services, such as case management and counselling
c) Direct access to specialist(s) assigned by Restructured Hospitals (RHs) to assist GPs with clinical consults

2.3 A liaison coordinator will facilitate GPs' patients' referrals between the clinic, hospital and community support services. In addition, continuing medical education (CME) talks and case discussion platforms are also regularly organised to enhance GPs' competencies in the latest treatment modalities of mental health care.

2.4 Doctors who are registered specialists in psychiatry do not need to join MHGPP and are exempted from CDMP-MI training. More details on the requirements for MHGPP are under para 1.4 of Chapter Two: Registration and MediSave Use.

2.5 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/or legal implications.

2.6 Since 1 Jan 2014, Dementia is no longer a CDMP-MI condition. Therefore, doctors who wish to manage Dementia patients under CDMP/CHAS are no longer required to participate in the MHGPP. For any patient with suspected Dementia or cognitive impairment, when in doubt, it is advisable to refer the patient to a geriatrician/psychiatrist/neurologist for confirmation as the diagnosis may carry medical, social and/or legal implications.

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 the relevant guidelines.

3.2 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 Medical Claims Authorisation Form when they make MediSave claims.

3.3 MediSave claims will be accepted only if:

a) The patient is diagnosed with an approved chronic condition(s) listed in Table 1.1;

b) The claim must be related to 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;

c) In this regard, MediSave claims will generally not be allowed for sleeping pills, slimming pills or erectile dysfunction drugs used for lifestyle purposes;

d) 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;

e) There are accurate, clear and complete clinical notes and supporting documents (e.g. referrals, memos, prescriptions or medications from other institutions) to substantiate claims under CDMP. Recommended care components are expected to be documented in the doctor's clinical notes. Audits may call for clinical notes, supporting documents and recommended care components to be submitted at random. Guidelines on the recommended standards of documentation are elaborated in Chapter Two, Section 5: "Recommended Standards of Documentation to Support Claims".

f) The patient is regularly managed by the participating clinic/doctor for the approved chronic condition(s) (generally, consultations should be performed at least once every 6 months).

3.4 Certain items including non-evidence-based treatments are not MediSave-claimable. This is to ensure that patients' MediSave dollars are judiciously used to cover recommended care components and medications. A general list (not exhaustive) of claimable and non-claimable items is included in **Table 3.1** below for reference.

Table 3.1: General List of Claimable and Non-Claimable Items/Services

Claimable	Not Claimable
✓ Consultations and services related to the management of the approved chronic conditions and their associated complications[10], delivered in the following manner: • On premise at participating healthcare institutions • Via video and phone consultations by the healthcare team (e.g., doctors, nurses) • At patient's home (by MOH-subvented homecare providers) • Repeat prescriptions without consultation	✗ Consultations unrelated to the diagnosis/management of the approved chronic conditions or their complications ✗ Other forms of telehealth services or video and phone consultations unless otherwise stated in relevant MOH circulars ✗ Home-based services provided by non-MOH-subvented homecare providers.

[10] Examples of this include the follow-up management of post-total knee replacement (osteoarthritis), post-renal transplant (chronic kidney disease) and post-bariatric surgery (management of obesity as a risk factor for relevant CDMP conditions e.g. diabetes mellitus, hypertension, hyperlipidaemia, chronic kidney disease, ischemic heart disease, stroke and/or osteoarthritis).

Table 3.1: General List of Claimable and Non-Claimable Items/Services	
Claimable	**Not Claimable**
✓ Relevant investigations (laboratory and radiological) leading to the positive diagnosis[11] of approved chronic conditions or for management of the condition and/or their complications ✓ Investigations for good prescribing practice to avoid drug-related complications	× Investigations unrelated to the positive diagnosis or management of the approved chronic conditions or their complications × Medical examination to meet statutory requirements and/or for administrative purposes (e.g., pre-employment, insurance, driving licence application) × Laboratory test packages which include investigations unrelated to the positive diagnosis or management of the approved chronic conditions or their complications
	× Asymptomatic health screening and review of screening results outside of SFL e.g., STD screening, Tumour markers × Investigations without corresponding evidence that they were conducted e.g., laboratory test reports or results recorded in the case notes, or invoice from laboratory

[11] This refers only to investigations that definitively establish the diagnosis of a CDMP condition, where such a definitive test is available for the condition, namely: (a) HbA1c, random plasma glucose, fasting plasma glucose and/or 2-hour 75g oral glucose tolerance test for diabetes mellitus; (b) lipid profile for lipid disorders (including use of a non-fasting lipid profile as an alternative initial screening test); (c) formal spirometry/pulmonary function test for asthma and COPD; (d) Kidney Function and/or urine protein- or albumin-creatinine ratio for CKD; (e) CT/MRI Brain for stroke; (f) DXA scan of hip and spine for osteoporosis; and (g) electrocardiogram, stress test, transthoracic echocardiography, and/or cardiac CT angiogram for IHD. Investigations that are not definitive for the diagnosis, and/or used to rule out differential diagnoses, are not claimable.

Table 3.1: General List of Claimable and Non-Claimable Items/Services	
Claimable	**Not Claimable**
✓ Medications for the management of approved chronic conditions, their complications (e.g., gastro-protectants when prescribed with Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), weight-loss medications for obese patients if clinically indicated based on prevailing local guidelines for the relevant CMDP conditions), and/or their risk factors (e.g., nicotine replacement therapy for smoking cessation)	✗ Medications unrelated to the diagnosis/management of the approved chronic conditions or their complications ✗ Traditional or complementary medicine (e.g., massage therapy, chiropractic, homeopathy, acupuncture, herbal medicine, Ayurveda) ✗ Health supplements, dietary supplements and vitamins (except for cases with established deficiencies[12]) ✗ Sedatives-hypnotics (e.g., Benzodiazepines, zolpidem, zopiclone)[13] ✗ Lifestyle-modifying medications (e.g., hair-loss or weight-loss medications)) ✗ Excessive quantities of medications (i.e., more than medically necessary and/or exceeding recommended prescribing limits according to available clinical guidelines) ✗ Non-HSA registered medications ✗ Off-label use of medications ✗ Moisturisers, except where (i) clinically indicated based on the latest CPGs or ACGs issued by MOH, and/or best available evidence-based practice; (ii) prescribed by a doctor; and (iii) are on the MOH List of Subsidised Drugs

[12] 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.

[13] It is recommended that other medications with addictive potential should be prescribed according to the latest national guidelines (e.g. National Guidelines for the Safe Prescribing of Opioids 2021 (First Edition)).

Table 3.1: General List of Claimable and Non-Claimable Items/Services	
Claimable	**Not Claimable**
	✗ Topical creams, except (i) Prescription Only Medicines as classified by HSA; (ii) where clearly indicated in the treatment notes; and (iii) where clinically indicated based on the latest CPGs or ACGs issued by MOH, and/or best available evidence-based practice ✗ Vaccinations not listed as a recommended care component of a CDMP chronic condition ✗ Medications delivered/collected on a patient's behalf which do not meet the requirements detailed in MOH Circular No. 222/2020 or 223/2020[14]
✓ Consumables for the purposes of drug/treatment administration as part of care delivery, for the management of approved chronic conditions and/or their complication(s), which are delivered at participating healthcare institutions[15] (e.g. customised and prefabricated customised insoles or orthoses for relevant CDMP conditions and personalised by a podiatrist during care delivery, at up to two pairs per patient per year)	✗ Consumables or dressing products for home use (i.e., not part of care delivery at the participating healthcare institution), unless otherwise stated in the CDMP handbook
✓ Nursing, pharmacists, and allied health services as referred by physicians in accordance with patients' management plans, and which fulfil the criteria in para 3.5.	✗ Rental/purchase of medical devices, such as blood pressure monitoring machines, splints, nasogastric tubes and ambulatory devices (e.g. walking sticks, wheelchairs), unless otherwise stated in the CDMP handbook in relevant MOH circulars ✗ Non-healthcare services (e.g. cooking courses, gym classes)

[14] Circulars can be found on mohalert.moh.gov.sg

[15] Only for approved consumables collected at the outpatient dispensary. The MCR number of ordering doctor (if ordered by the doctor) and other requisite information for Medisave claims (e.g. diagnosis, visit date) need to be documented. Patient's case notes/records must indicate that the patient meets the criteria to claim for the specific consumables and the total quantity claimed for. Approved consumables can only be claimed if: (i) the approved consumable is listed on a prescription indicated for CDMP claim (i.e. CDMP prescription), and the patient is verified to have the associated CDMP condition; or (ii) the approved consumable is not listed on a CDMP prescription but the patient requests for it when filling out the CDMP prescription for the associated CDMP condition. For such situations, pharmacists may add on approved consumables related to the CDMP prescription for MediSave claim, even if they are not listed in the prescription.

Table 3.1: General List of Claimable and Non-Claimable Items/Services	
Claimable	**Not Claimable**
	× Home meal delivery, transport × Employment of caregiver or nursing aide, and all related costs

More disease-specific examples of claimable and non-claimable items/services can be found in the Disease-Specific Clinical Guidelines.

3.5 Support services should meet the following criteria for them to be claimable. A general but non-exhaustive list of claimable and non-claimable support services is included in **Table 3.2** below for reference.

a) The support service should be widely regarded as a mainstream healthcare or support service;
b) There is evidence of the support service being effective in contributing to the positive management of the chronic disease concerned;
c) The support service should be delivered by qualified personnel, or where relevant, an accredited professional[16]; and
d) 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.

Table 3.2: Examples of Claimable and Non-Claimable Support Services

Claimable
✓ Nursing and related services delivered by registered nurses ○ Including nursing care (e.g. diabetic foot wound care, nasogastric tube care), nurse counselling ✓ Pharmacist services (if ordered/referred by the attending doctor) ○ Including medication review and reconciliation, pill boxing services ✓ Allied health services ○ Therapy services, including physiotherapy, occupational therapy, speech therapy services delivered by registered Allied Health Professionals (AHPs) ○ Services by non-registered professions specified in the Allied Health Professions Act, including podiatry, dietetics, psychotherapy, prosthetics, orthotics ✓ Other key support services for chronic disease care ○ Including diabetic retinal photography, diabetic foot screening, smoking cessation
Not Claimable
× Stress management × Sleep management × Commercial weight management programmes / exercise support (e.g. gym classes) × Health coaching × Cooking courses

[16] Accredited professionals include doctors, dentists, nurses, pharmacists, physiotherapists, occupational therapists, speech therapists, diagnostic radiographers, radiation therapists, optometrists and opticians.

3.6 The maximum amount that can be withdrawn for chronic disease treatments/attendances under MediSave500/700 limit is $500 per patient per calendar year for patients with simple chronic conditions, and $700 per patient per calendar year for patients with complex chronic conditions (refer to **Table 3.3** below).

Table 3.3: Simple Chronic and Complex Chronic Patients under CDMP

Patient Status	Description	Withdrawal Limit
Complex Chronic	Patients who have: (a) Received treatment for two or more CDMP conditions in a visit; or (b) Received treatment for at least one CDMP condition with a recognised complication (Please refer to MOH Circulars for the latest list of recognised complications.)	$700 per year
Simple Chronic	Any other CDMP patient who does not meet the criteria above	$500 per year

3.7 Eligible patients can use their personal MediSave account and approved family members' MediSave accounts for payment of their chronic disease treatments under CDMP limits, up to the patient's annual withdrawal limit. Approved family members include the spouse, parent, or child of the patient. Patients who are Singapore Citizens or Permanent Residents will also be able to use their siblings' and grandchildren's MediSave accounts to pay for their treatment.

3.8 Eligible patients who are aged 60 and above can also use an additional $300 under the Flexi-MediSave scheme, for the treatment of their chronic disease. This withdrawal can be made from their MediSave and spouse's MediSave (if the spouse is also aged 60 and above).

3.9 See Scenario 1 for an illustration of how patients could tap on MediSave to pay for chronic disease treatments:

Scenario 1

Mr Raja is a 61-year-old adult with 2 working children. He is suffering from hypertension without complications and has MediSave from his earlier years of work. Mr Raja can make use of a maximum of $500 of MediSave for his treatments. He may tap on his own, his spouse's or his children's MediSave accounts to pay for his outpatient treatment for hypertension, up to the $500 limit (i.e. MediSave500/700 limit for the simple chronic patients).

If Mr Raja had suffered (a) any recognised complication of hypertension, or (b) two chronic conditions (e.g. hypertension and Chronic Obstructive Pulmonary Disease), then a $700 limit (i.e. MediSave500/700 limit for the complex chronic patients) would apply instead.

As he is above 60, he can also tap on the Flexi-MediSave limit to pay for his outpatient hypertension treatments, up to his annual withdrawal limit. With this, he can use up to a total of $800 (i.e. the sum of the simple chronic CDMP limit and prevailing Flexi-MediSave limit).

3.10 See Scenario 2 for an illustration of how multiple patients could tap on the same approved family member's MediSave account to pay for chronic disease treatments under CDMP limits:

Scenario 2

Ms Tan as well as her father, mother, and grandmother all suffer from diabetes without complications. However, Ms Tan's parents and grandmother have no MediSave. Ms Tan can make use of $500 from her MediSave to pay for her own diabetes treatment, as well as the treatment of each of her 3 elders.

In total, she will be able to utilise up to $2,000 of her MediSave each year for her father, mother, grandmother and herself.

3.11 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.

3.12 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 participating in CHAS can make CHAS subsidy claims.

4.2 Doctors and participating clinics in CHAS must comply with the guidelines in this handbook.

4.3 The guidelines in paras 3.1 to 3.5 on Medisave use for CDMP apply to CHAS claims for CDMP conditions as well.

a) The CHAS visit limit will be based on the chronic conditions managed during the visit. The visit limit for complex chronic will apply if more than one chronic condition or a single chronic condition with related complication was managed during the visit. Otherwise, the visit limit for simple chronic will apply.
b) The CHAS annual limit will be based on whether the patient meets the definition of a Complex Chronic patient as defined in **Table 3.3,** during the year.

4.4 For patients who are eligible for both employment benefits and CHAS, there is no requirement to apply CHAS subsidies before employer benefits.

DISEASE-SPECIFIC CLINICAL GUIDELINES

5 Disease-Specific Clinical Guidelines for the CDMP Conditions

The Disease-Specific Clinical Guidelines

*Conditions under the CDMP-MI

1. Diabetes Mellitus[17] and Pre-diabetes

(Requires reporting of clinical indicators as detailed in Chapter Four: Capture and Submission of Clinical Data)

Diabetes mellitus is a heterogeneous metabolic disorder characterised by presence of hyperglycaemia resulting from defects in insulin production, 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.

Screening for Type 2 Diabetes

The recommended investigations for screening of diabetes in asymptomatic individuals aged ≥ 40 years and/or with risk factors for diabetes are as follows:

1. Fasting plasma glucose (FPG)
2. HbA1c (not suitable for those with haemoglobinopathy)

If HbA1c is used as the screening test, the following interpretation and follow-up testing is recommended.

Table 3.4: Interpretation of Screening HbA1c Results and Recommended Follow-up Tests

HbA1c Result	Interpretation and Recommended Follow-up Tests
≤ 6.0%	**Low probability of diabetes mellitus** No further tests needed if there are no symptoms of diabetes. Further testing with an FPG or 2-hr oral glucose tolerance test (OGTT) is recommended in the presence of clinical suspicion of diabetes
6.1% to 6.9%	**Proceed to conduct FPG or 2-hr OGTT** Refer to section on diagnosing diabetes and pre-diabetes
≥ 7.0%	**High probability of diabetes mellitus** No further tests needed for diagnosis of diabetes

Diagnosing Diabetes and Pre-Diabetes Mellitus

In patients with hyperglycemic crisis (e.g. diabetic ketoacidosis), diabetes mellitus can be diagnosed without further testing.

In patients with typical symptoms (e.g. polydipsia, polyuria), diabetes mellitus can be diagnosed if any one of the following is present.

1. Casual plasma glucose ≥ 11.1 mmol/L
2. FPG ≥ 7.0mmol/L
3. 2-hour post-challenge plasma glucose ≥ 11.1 mmol/L
4. HbA1c ≥ 7.0%

[17] Type 1 and Type 2 diabetes mellitus are covered under CDMP/CHAS. Gestational diabetes mellitus is not covered under CDMP/CHAS.

In asymptomatic individuals, a repeat test should be done on a subsequent day. For these individuals, when two different tests are available and the results are above the diagnostic thresholds, the diagnosis of diabetes is confirmed.

Pre-diabetes is defined by glycaemic levels that are higher than normal, but lower than the diabetic 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:

Table 3.5: Definition of Pre-diabetes by Glycaemic Levels

Pre-diabetes	Fasting Plasma Glucose (FPG) (mmol/L)~	2-hr Post-challenge Plasma 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)
~All patients with FPG between 6.1 to 6.9 will require a follow-up 2-hr Post-challenge Plasma Glucose

Part Ia: Recommended Care Components for Diabetes Mellitus

Recommended Care Components	Minimum Frequency*	Remarks
Blood Pressure Measurement˜	Twice a year	For those with hypertension, an acceptable treatment-initiation and target blood pressure is generally < 130/80mmHg; Clinicians may personalise the targets accordingly based on the patient's risk factors
Weight and BMI Assessment˜	Twice a year	Keep BMI < 23kg/m^2 (For Non-Asian population, keep BMI < 25 kg/m^2)
Glycated Haemoglobin (HbA1c)˜	Twice a year	General HbA1c target of ≤ 7.0%, but target of treatment should be personalised (e.g. for elderly)
Lipid Profile˜	Annually	All patients should be stratified according to their cardiovascular risk (as recommended in the Lipids ACG); Targets of treatment should be personalised by levels of risk
Kidney Assessment[18]~ (i) Serum Creatinine (Cr) and/or eGFR, and (ii) Urine Albumin-Creatinine Ratio (uACR) or Urine Protein-Creatinine Ratio (uPCR)	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. Consider prescribing an SGLT2 inhibitor or GLP-1 RA for patients with T2DM who need to reduce their risk of adverse cardiorenal outcomes

[18] Kidney Assessment includes both kidney function assessment (Serum Cr and/or eGFR) and urinary protein (uACR/uPCR).

Recommended Care Components	Minimum Frequency*	Remarks
		Annual screening of (i) serum Cr and/or eGFR and (ii) uACR in all patients, or uPCR if significant levels of proteinuria (as defined in evidence-based practice guidelines)
Eye Assessment~	At least annually or at appropriate intervals thereafter as recommended by a healthcare provider	Includes retinal assessment (e.g. diabetic retinal photography) and visual acuity Patients with Type 1 DM: First assessment within 3-5 years after diagnosis of diabetes once patient is aged ten years or older, then annually Patients with Type 2 DM: First assessment at diagnosis, then annually
Foot Assessment~	At least annually or at recommended intervals based on risk category	Screen for peripheral neuropathy, peripheral vascular disease, bone, joint, skin and nail abnormalities, and poor footwear
Smoking Assessment~	Annually for smokers; Once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling where applicable
Cardiac Assessment	At diagnosis before initiating medications	Includes baseline ECG
Influenza Vaccination#	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS)
Pneumococcal Vaccination (PPSV23 only)#	1 or 2 doses depending on age and other medical conditions	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS)

*More frequently if clinically indicated
~This is also a reportable clinical indicator
#This is also a non-reportable clinical indicator

Part Ib: Recommended Care Components for Pre-Diabetes Mellitus

Recommended Care Components	Minimum Frequency*	Remarks
Blood Pressure Measurement~	Annually	Clinicians may personalise the treatment target accordingly based on the patient's risk factors
Weight and BMI Assessment~	Twice a year	Keep BMI < 23kg/m^2 (For Non-Asian population, keep BMI < 25 kg/m^2)
Lipid Profile~	Annually	All patients should be risk stratified (as recommended in the Lipids ACG); Targets of treatment should be personalised by levels of risk
Blood Glucose Test (HbA1c/FPG/ 2-hr OGTT)~	Twice a year (for HbA1c/FPG)	Follow up at least 6-monthly FPG with 2-hr OGTT, or HbA1c as appropriate, and screen for DM If FPG ≥ 7.0 mmol/L, 2-hr glucose on OGTT ≥ 11.1 mmol/L, or HbA1c ≥ 7%, proceed to manage as per T2DM <u>For Pre-DM Patients on metformin:</u> HbA1c is required for patients on metformin to monitor treatment response
Kidney Function Assessment~ (i) Serum Cr and/or eGFR	Annually (if on metformin)	<u>For Pre-DM Patients on metformin</u> Measure kidney function before initiating metformin Yearly screening of serum Cr and/or eGFR for patients on metformin; may be done more frequently if there is evidence of renal impairment If there is evidence of renal impairment to support a diagnosis of Chronic Kidney Disease (CKD), the recommended care components under CKD should be adhered to
Smoking Assessment~	Annually for smokers; Once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling

*More frequently if clinically indicated

~This is also a reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended

Special Patient Population

- Children and adults with suspected Type 1 DM
- 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 for any of the following:
  - Patients with Stage 3b or higher CKD
  - Unexpected or rapid decline in renal function
  - Difficult management issues (e.g. with high blood pressure or hyperkalaemia control)
  - Atypical features (e.g. haematuria, presence of casts in the urine sediment, presence of renal bruit, nephrotic range proteinuria (> 3g/day),
- Ophthalmology referral for any of the following:
  - Hard exudates/retinal thickening within one-disc diameter of the fovea (diabetic macular oedema)
  - Severe non-proliferative diabetic retinopathy
  - Unexplained eye findings / drop in visual acuity

  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
- Multidisciplinary diabetic foot clinic[19] (podiatry, orthopaedics surgery, vascular surgery, neurology) for 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 Anchoring Care with Primary Care Physician

[19] Providers should also refer to the prevailing ACE Clinical Guidance (ACG) on Foot Assessment in People with Diabetes Mellitus

In patients who:

- Can achieve satisfactory HbA1c control and/or for optimisation/management of glycaemic control
- Can recognise and manage episodes of hypoglycaemia
- Complications of DM are stable/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
Claimable[20] • Drugs related to the treatment of DM complications, e.g. Ischaemic Heart Disease, Chronic Kidney Disease, 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/m^2 • Smoking cessation (services and/or medications) • Lancets and glucose test strips for self-monitoring of blood glucose levels for Type 1 DM patients and Type 2 DM patients on insulin • Referrals to podiatry for foot care with clearly documented indication for referral • Custom-made insoles and prefabricated customised insoles or orthoses prescribed by podiatrists (up to two pairs per patient per year)
Non-Claimable × Other items involved in disease monitoring, such as lancing devices, glucometers and blood pressure monitoring equipment, unless otherwise specified via MOH circular × Slimming pills if BMI < 27.5kg/m^2 and drugs for erectile dysfunction × Vitamins/supplements except for cases with deficiency e.g. peripheral neuropathy secondary to metformin-related Vitamin B12 deficiency

References for further information

Pre-diabetes and Diabetes

1. ACE Appropriate Care Guide on Managing pre-diabetes – a growing health concern (updated July 2021)
2. ACE Clinical Guidance on Type 2 diabetes mellitus — personalising management with non-insulin medications (17 May 2023)
3. ACE Clinical Guidance on Initiating basal insulin in type 2 diabetes mellitus (updated 10 June 2022)
4. ACE Clinical Guidance on Foot Assessment in Patients with Diabetes Mellitus (8 Aug 2024)
5. MOH Clinical Practice Guidelines on Diabetes Mellitus (July 2014) – MOH Clinical Practice Guidelines*

[20] Providers should also refer to the prevailing ACE Clinical Guidance (ACG) on Managing Pre-diabetes for recommendations on the care to be provided for pre-diabetics.

6. MOH Circular No. 08/2019 on Release of New Screening Test Review Committee Guidelines, Including Changes to Diabetes Mellitus, Lipid Disorders and Cervical Cancer Screening (March 2019)

**MOH clinical practice guidelines are considered withdrawn five years after publication unless otherwise specified in individual guidelines. Users should keep in mind that evidence-based guidelines are only as current as the evidence that supports them and new evidence can supersede recommendations made in the guidelines.*

2. Hypertension

(Requires reporting of clinical indicators as detailed in Chapter Four: Capture and Submission of Clinical Data)

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

The diagnosis of hypertension should be based on multiple BP measurements taken on several separate occasions, as BP may be subjected to spontaneous variations. When the systolic and diastolic BP fall into different categories, the higher category should apply.

Definitions are given in Table 3.6 for subjects who are not on antihypertensive medication and not acutely ill.

Table 3.6: Definition and classification of BP levels for adults aged 18 years and older

Category	Systolic BP	Diastolic BP
Normal BP	< 130 mmHg	< 85 mmHg
High-normal BP	130 – 139 mmHg	85 – 89 mmHg
Grade 1 hypertension	140 – 159 mmHg	90 -99 mmHg
Grade 2 hypertension	160 – 179 mmHg	100 – 109 mmHg
Grade 3 hypertension	≥ 180 mmHg	≥ 110 mmHg
Isolated systolic hypertension	≥ 140 mmHg*	< 90 mmHg
*Isolated systolic hypertension is graded according to the same level of systolic BP		

Part I: Recommended Care Components for Hypertension

Recommended Care Components	Minimum Frequency*	Remarks
Blood Pressure Measurement~	Twice a year	
Weight and BMI Assessment~	Twice a year	Keep BMI < 23kg/m^2 (For Non-Asian population, keep BMI < 25 kg/m^2)
Kidney Assessment~ (i) Serum Cr and/or eGFR, **and** (ii) Urine Albumin-Creatinine Ratio (uACR) or Protein-Creatinine Ratio (uPCR)	Annually	If patient also has DM, Angiotensin Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) are preferred antihypertensives to slow progression of diabetic nephropathy Annual screening of (i) serum Cr and/or eGFR **and** (ii) uACR in all patients, or uPCR if significant levels of proteinuria (as defined in evidence-based practice guidelines)
Smoking Assessment~	Annually for smokers; Once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Lipid Profile#	At baseline	All patients should be stratified for their risk of developing coronary events (as recommended in the Lipids ACG) 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
~This is also a reportable clinical indicator
#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
• 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) • Secondary hypertension i.e. hypertension due to an underlying cause, such as hyperaldosteronism • Hypertension in special circumstances e.g. pregnancy, young children • Acute or recent cardiovascular complications from hypertension
Consider Specialist Input
• Young hypertensive patients who are less than 30 years old • Patients suspected to have secondary causes of hypertension
Consider Anchoring Care with Primary Care Physician
• In patients who can 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/m^2 ✓ Smoking cessation
Non-Claimable • Purchase of blood pressure monitoring equipment

References

1. ACE Clinical Guidance on Hypertension - tailoring the management plan to optimise blood pressure control (15 December 2023)
2. MOH Clinical Practice Guidelines on Hypertension (November 2017) – MOH Clinical Practice Guidelines*
3. ACE Clinical Guidance on Lipid management: focus on cardiovascular risk (15 Dec 2023)
4. MOH Clinical Practice Guidelines on Lipids (December 2016) – MOH Clinical Practice Guidelines*
   HPB-MOH Clinical Practice Guidelines on Obesity (June 2016) – MOH Clinical Practice Guidelines*

**MOH clinical practice guidelines are considered withdrawn five years after publication unless otherwise specified in individual guidelines. Users should keep in mind that evidence-based guidelines are only as current as the evidence that supports them and new evidence can supersede recommendations made in the guidelines.*

3. Lipid Disorders

(Requires reporting of clinical indicators as detailed in Chapter Four: Capture and Submission of Clinical Data)

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 hypertriglyeridaemia are the three commonest dyslipidaemias.

Lipid disorders can be diagnosed either through a fasting or non-fasting lipid profile, which should include total cholesterol (TC), triglycerides (TG), Low-Density Lipoprotein Cholesterol (LDL-C) and High-Density Lipoprotein Cholesterol (HDL-C). Fasting lipid profiles instead of non-fasting lipid profiles should be considered whenever there is uncertainty over the potential validity of the results (e.g. high fat consumption prior to test, borderline TG or LDL-C levels) especially if pharmacological therapy is being considered.

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

Part I: Recommended Care Components for Lipid Disorders

Recommended Care Components	Minimum Frequency*	Remarks
Lipid Profile~	Annually	All patients should be risk stratified (as recommended in the Lipids ACG) Targets of treatment should be personalised by levels of risk
Smoking Assessment~	Annually for smokers; Once-off for non-smokers**,** unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Serum transaminases (ALT/AST)#	Before starting statins and as clinically indicated (e.g. symptoms suggestive of hepatotoxicity, increase in statin dose)	Especially when the statin dose is increased or when combination therapy is initiated Stop the statin/fibrate if patient is symptomatic or if transaminases exceed 3 times the upper limit of normal range
Serum creatine kinase#	Before starting statins and as clinically indicated (e.g. muscle symptoms)	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 upper limit of normal or at about 800 IU/L (whichever is lower)

*More frequently if clinically indicated
~This is also a reportable clinical indicator
#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
Referral to Gastroenterologist • Pre-treatment transaminases 3 times above normal range • Clinical presentation of acute hepatitis • If the ALT/AST is persistently elevated ≥ 3 times upper limit of normal despite stopping statins
Consider Specialist Input
Consider Referral to Endocrinologist • Triglyceride level > 4.5mmol/L (400mg/dL) despite dietary changes and maximum tolerated drug therapy • Triglyceride level > 10.0 mmol/L (885md/dL) • Target parameters not achieved despite maximal drug therapy • Definite or possible familial hypercholesterolemia on Dutch Lipid Clinic Network criteria or Simon Broome Trust diagnostic criteria (or other validated criteria)
Consider Anchoring Care with Primary Care 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 ✓ Drugs related to the treatment of complications of lipid disorders e.g. ischaemic heart disease and peripheral vascular diseases (e.g. pentoxifylline) ✓ 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/m^2 ✓ Smoking cessation
Non-Claimable • Supplements with no strong evidence for benefit in managing the condition (e.g. Red yeast supplements (Hypocol) and Co-enzyme Q10)

References

1. ACE Clinical Guidance on Lipid management: focus on cardiovascular risk (15 Dec 2023)
2. MOH Clinical Practice Guidelines on Lipids (December 2016) – MOH Clinical Practice Guidelines*
3. HPB-MOH Clinical Practice Guidelines on Obesity (June 2016) – MOH Clinical Practice Guidelines*
4. MOH Circular No. 08/2019 on Release of New Screening Test Review Committee Guidelines, Including Changes to Diabetes Mellitus, Lipid Disorders and Cervical Cancer Screening March 2019)*

**MOH clinical practice guidelines are considered withdrawn five years after publication unless otherwise specified in individual guidelines. Users should keep in mind that evidence-based guidelines are only as current as the evidence that supports them and new evidence can supersede recommendations made in the guidelines.*

4. Asthma

(Requires reporting of clinical indicators as detailed in Chapter Four: Capture and Submission of Clinical Data)

Asthma is a chronic reversible airway disorder that is common in people of all ages. It can be severe and may progress to be fatal. Asthma may present with recurrent episodic cough, wheezing, unexplained dyspnoea, and/or chest tightness, together with variable airflow limitations that may become permanent over time. Symptoms are often variable in intensity, duration and type. They tend to be worse at certain times of the day (at night or in the early mornings) and may be precipitated or aggravated by upper respiratory tract infections, cigarette smoke, environmental haze, exercise, drugs (e.g. aspirin, NSAIDs, ß-blockers, ACE inhibitors), pets, and occupational exposure to triggers.

A diagnosis of asthma is based on clinical presentation of characteristic symptoms and where possible, documentation of variable expiratory airflow limitation.

The following tests can support the diagnosis of asthma:

a) Spirometry: airflow obstruction with/without a positive bronchodilator reversibility test (defined as an increase in FEV1 or FVC of ≥ 12% AND ≥ 200ml in asthmatics ≥ 12 years old. For children aged 6-11 years old: defined as in increase in FEV1 from baseline of ≥ 12% predicted.).
b) Excessive variability in twice daily peak expiratory flow (PEF) over 2 weeks (defined as > 10% in adults or adolescents and > 13% in children aged 6-11 years old).
c) Improvement of PEF by ≥ 20% from baseline after 4 weeks of treatment with anti-inflammatory medications (e.g. inhaled corticosteroids) and excluding recent respiratory infections in the last 28 days.

Initiation of inhaled corticosteroids should not be delayed on the basis of a normal expiratory airflow test as these tests can be normal in mild or well controlled asthma.

In children < 6 years old, a confident diagnosis of asthma may be challenging as episodic respiratory symptoms such as wheezing and cough are also common in children without asthma. A diagnosis of asthma may be based on:

a) Symptom patterns (recurrent episodes of wheeze, cough, breathlessness, and nocturnal symptoms.
b) Presence of risk factors for development of asthma, such as family history of atopy, allergic sensitisation, allergy or asthma, or a personal history of food allergy or atopic dermatitis.
c) Therapeutic response to controller treatment.
d) Exclusion of alternate diagnoses.

Part I: Recommended Care Components for Asthma

Recommended Care Components	Minimum Frequency*	Remarks
Asthma Control Assessment (e.g. Global Initiative for Asthma (GINA) score)~	Twice a year	Asthma symptom control can be assessed using a composite assessment tool(e.g. Global Initiative for Asthma (GINA) score). An assessment of asthma control is recommended at every visit, for patients ≥ 4 years old . For those < 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 (including Written Asthma Action Plan)#	At diagnosis, and whenever there is a change of medication	Check for compliance to treatment and assess inhaler technique; Provide education on symptom recognition and trigger avoidance; Provide and review patient's Written Asthma Action Plan at diagnosis and when there is any change in treatment Inhaler technique assessment
Smoking Assessment~	Annually for smokers; Once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Spirometry#	At or soon after diagnosis, or when clinically indicated	
Influenza Vaccination#	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS)
Pneumococcal Vaccination (PPSV23 only)#	1 or 2 doses depending on age and other medical conditions	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS)

*More frequently if clinically indicated
~This is also a reportable clinical indicator
#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
Confusing or atypical signs and symptoms • Difficulty confirming asthma diagnosis • Suspected occupational asthma will require further diagnostic determination of the industrial trigger agent • Symptoms suggestive of complications or subtypes of asthma (e.g., allergic bronchopulmonary aspergillosis, eosinophilic asthma) **Difficult to control asthma** • Persistent uncontrolled asthma or frequent exacerbations despite being on medium to high dose ICS containing treatment or patients who may need biologic agent • Uncontrolled asthma with risk factor(s) for poor asthma outcomes (e.g., history of intubation or admission to ICU because of asthma, low FEV1, over-use of short acting beta$_2$ agonist (SABA)) • Evidence of significant treatment side effects **Specific patient groups** • Children with poor asthma control and/or frequent urgent care needs • Pregnant women • Athletes

Part II: Consideration for Right-Siting Care (continued)

Consider Specialist Input
Co-morbidity • Concurrent heart failure which may complicate management • Concurrent active GERD which may mimic asthma
Consider Anchoring 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
Claimable ✓ 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 ✓ Items involved in drug administration, such as spacers necessary for the patient's own use ✓ Smoking cessation
Non-Claimable × Investigations unrelated to the diagnosis or follow-up of asthma × Non-evidence-based investigations such as hand-held spirometry

References

1. ACE Clinical Guidance on Asthma — optimising long-term management with inhaled corticosteroid (15 October 2020)
2. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2024. Updated May 2024.

5. Chronic Obstructive Pulmonary Disease (COPD)[21]

(Requires reporting of clinical indicators as detailed in Chapter Four: Capture and Submission of Clinical Data)

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 the following symptoms: chronic cough (with or without sputum production) and breathlessness, wheezing, and recurrent lower respiratory tract infections. Acute exacerbations of COPD may require hospitalisation. The prevalence of COPD is highest after age 50, and is generally higher in men than women.

Part I: Recommended Care Components for COPD

Recommended Care Components	Minimum Frequency*	Remarks
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)
COPD Assessment Test (CAT) Score~	Annually	
Smoking Assessment~	Annually for smokers; Once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Self-Management Education	At diagnosis, and whenever there is a change of medication	Educate on what to do during acute exacerbations; Inhaler technique assessment
Spirometry#	At diagnosis	
Influenza Vaccination~	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS)
Pneumococcal Vaccination (PPSV23 only)#	1 or 2 doses depending on age and other medical conditions	As recommended under the National Adult Immunisation Schedule (NAIS)

*More frequently if clinically indicated
~This is also a reportable clinical indicator
#This is also a non-reportable clinical indicator

[21] A pulmonary function test/spirometry is necessary for the diagnosis of COPD for CDMP/CHAS purposes.

Part II: Consideration for Right-Siting Care

Consider Specialist Referral

Severe Cases or Complex Cases
• Management difficulties:
  ○ Cor pulmonale
  ○ Bullous disease
  ○ For initiation of home oxygen therapy, i.e., long term oxygen therapy
• Rapid decline in FEV_1 (> 60 ml/year decrease)
• Symptoms disproportionate to FEV_1
• Frequent infections
• Development of new symptoms (e.g. haemoptysis) or new physical signs (e.g. cyanosis, peripheral oedema)
• Frequent exacerbations (e.g. two or more requiring antibiotics or steroids per year or at least one leading to hospitalisation in the previous year) despite compliance to treatment
• Patients with features of both asthma and COPD

Consider Anchoring 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:
Claimable ✓ Drugs related to the treatment of COPD and its complications ~~of COPD~~ ✓ 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) ✓ Pulmonary rehabilitation ✓ Smoking cessation
Non-Claimable × 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

References

1. ACE Clinical Guidance on Chronic Obstructive Pulmonary Disease – Diagnosis and management (updated 3 June 2024)
2. MOH Clinical Practice Guidelines on Chronic Obstructive Pulmonary Disease (Dec 2017) – MOH Clinical Practice Guidelines*

***** *MOH clinical practice guidelines are considered withdrawn five years after publication unless otherwise specified in individual guidelines. Users should keep in mind that evidence-based guidelines are only as current as the evidence that supports them, and new evidence can supersede recommendations made in the guidelines.*

6. Chronic Kidney Disease (Nephritis/Nephrosis)

(Requires reporting of clinical indicators as detailed in Chapter Four: Capture and Submission of Clinical Data)

Chronic Kidney Disease (CKD) is defined by persistent abnormalities of kidney structure or function for more than 3 months. Diagnosis and staging of CKD is based on eGFR, uACR or other markers of kidney damage including structural abnormalities on imaging studies. The duration of 3 months differentiates acute and chronic kidney disease.

Common causes of CKD in Singapore include diabetic nephropathy and hypertension. Other causes of CKD include cystic disease (e.g., polycystic kidney disease), glomerulonephritis (both primary or secondary due to conditions like autoimmune disease), or structural causes such as chronic pyelonephritis, urinary flow obstruction.

Part I: Recommended Care Components for Chronic Kidney Disease (Nephritis/Nephrosis)

Recommended Care Components	Minimum Frequency*	Remarks
Blood Pressure Measurement~	Twice a year	ACE-I and ARBs should be used for BP control when proteinuria is present
Weight and BMI Assessment	Twice a year	Keep BMI < 23kg/m^2 (For Non-Asian population, keep BMI < 25 kg/m^2)
Kidney Function Monitoring – eGFR and/or Serum Creatinine~	Annually	If eGFR is submitted, either the CKD-EPI or MDRD formula may be used. The CKD-EPI is more accurate, particularly at higher GFR.
Urinary Protein – Urine Protein Creatinine Ratio (uPCR) or Albumin-Creatinine Ratio (uACR)~	Annually	Monitoring of uACR in all patients, or uPCR if significant levels of proteinuria (as defined in evidence-based practice guidelines)
Albumin/ Calcium/ Phosphate	Annually	For patients with CKD stage G3aA3
Full blood count	Annually with eGFR 30-59 ml/min/1.73 m2 and twice a year with eGFR < 30 ml/min/1.73m2	For patients with CKD stage G3aA2 or G1-3A3 To rule out causes of iron-deficiency anaemia before managing for anaemia of chronic disease
Lipid Profile	Annually	All patients should be risk stratified (as recommended in the Lipids ACG) Targets of treatment should be personalised by levels of risk
Diabetes Screening	Annually or once every three years, as clinically indicated	Screening should be carried out every three years for those with normal glucose tolerance
Influenza Vaccination#	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS)

Recommended Care Components	Minimum Frequency*	Remarks
Pneumococcal Vaccination#	1 or 2 doses depending on age and other medical conditions	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS)

*More frequently if clinically indicated
~This is also a reportable clinical indicator
#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
• Later stages of CKD (e.g., CKD 3b to 5) • Primary cause of CKD is suspected (e.g., glomerulonephritis or autoimmune diseases) • Nephrotic syndrome • Further diagnostic assessment needed (e.g., kidney biopsy) • Rapidly progressive CKD (i.e., a ≥ 25% decline in eGFR from baseline or > 5 mL/min/1.73m^2/year decline) • Acute kidney injury (AKI) • Anaemia secondary to CKD • Resistant hypertension or refractory hypertension suspected to be secondary to CKD • Multiple comorbidities, such as heart failure or rheumatological conditions • Persistent hyperkalaemia • Bone disease or abnormal calcium metabolism
Consider Anchoring Care with Primary Care Physician
In patients who: • Are able to reach individualised BP target based on severity of chronic kidney disease and proteinuria • Have stable kidney function (decline <30% over 4-month follow-up) • Are not hyperkalaemic

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable
Claimable ✓ 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-Claimable × Unrelated investigations, e.g. myeloma panels × Transplant-related investigations and/or procedures

References

1. ACE Clinical Guidance on Chronic Kidney Disease — Early Detection (7 October 2022)
2. ACE Clinical Guidance on Chronic Kidney Disease — Delaying Progression and Reducing Cardiovascular Complications (27 October 2023)

CDMP-Mental Illnesses

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

7. **Anxiety Disorders**[22] differ from normal anxiety by being of greater intensity and/or duration (e.g. lasting more than 6 months) than would be expected in the given circumstances. The disorders can affect daily life, give rise to unexplained physical symptoms, or lead to avoidance of situations and places.

8. **Major Depressive Disorder** is a mental illness characterised by low mood, anhedonia, significant weight loss/gain, insomnia/hypersomnia, 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.

9. **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.

10. **Schizophrenia** [23] 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.

** In order to provide greater support (e.g. professionally as well as drugs) for general practitioners (GPs) managing patients with mental illness, GPs are required to participate in the Mental Health GP Partnership Programmes with Restructured Hospitals before CDMP/CHAS claims can be made.*

[22] Anxiety disorders claimable under CDMP/CHAS are General Anxiety Disorder, Panic Disorder, Phobic Anxiety Disorders. While Obsessive-Compulsive Disorder and Post-traumatic Stress Disorder are no longer classified as anxiety disorders under the DSM 5, they may continue to be claimed under anxiety disorders under CDMP/CHAS.

[23] Delusional disorder is claimable under CDMP/CHAS.

Part Ia: Additional Recommended Care Components for Anxiety Disorders

Recommended Care Components	Minimum Frequency*	Remarks
GAD-7 score[#]	At the intake assessment, prior to step-down/discharge and 6-monthly	
World Health Organisation Disability Assessment Schedule (WHODAS 2.0)[#]	Annually	Administer at first consultation, and at 6-monthly or at discharge whichever is earlier

*More frequently if clinically indicated
[#]This is also a non-reportable clinical indicator

Part Ib: Recommended Care Components for Major Depressive Disorder

Recommended Care Components	Minimum Frequency*	Remarks
PHQ-9 score[#]	At the intake assessment, prior to step-down/discharge and 6-monthly	
World Health Organisation Disability Assessment Schedule (WHODAS 2.0)[#]	Annually	Administer at first consultation, and at 6-monthly or at discharge whichever is earlier

*More frequently if clinically indicated
[#]This is also a non-reportable clinical indicator

Part Ic: Recommended Care Components for Bipolar Disorder

Recommended Care Components	Minimum Frequency*	Remarks
Clinical Global Impression (CGI) Scale[#]	Annually	CGI assessment for • Severity (Scores 1-7) • Clinical improvement (Scores 1-7) *1 indicates "normal/no mental illness" or "very much improved"
World Health Organisation Disability Assessment Schedule (WHODAS 2.0)[#]	Annually	Administer at first consultation, and at 6-monthly or at discharge whichever is earlier

*More frequently if clinically indicated
[#]This is also a non-reportable clinical indicator

Part Id: Recommended Care Components for Schizophrenia

Recommended Care Components	Minimum Frequency*	Remarks
Monitoring for metabolic side effects (e.g. fasting blood glucose and lipid profile)#	Annually	Only for patients with Schizophrenia on atypical antipsychotic medications
Clinical Global Impression (CGI) Scale#	Annually	CGI assessment for • Severity (Scores 1-7) • Clinical improvement (Scores 1-7) *1 indicates "normal/no mental illness" or "very much improved"
World Health Organisation Disability Assessment Schedule (WHODAS 2.0)#	Annually	Administer at first consultation, and at 6-monthly or at discharge whichever is earlier

*More frequently if clinically indicated

#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

a) Anxiety Disorders

Specialist Referral Recommended
Initial assessment • Assessment, diagnosis and initiation of treatment, when in doubt **High Risk Individuals** • With symptoms of mania or psychosis • Risk of violence to self or others, especially patients with suicidal risk • Substance misuse, addiction, and abuse • Complex psychiatric conditions (e.g., feeding and eating disorders, personality disorders) • Patients with medicolegal and forensic issues • Severe impairment to self-care, or inability to go to work or school for sustained periods **Failure of treatment** • Failure of one or two trials of medication • Need for hypnotics (e.g. Benzodiazepines, Zopiclone) and/or formal psychotherapy
Consider Specialist Input
Special Patient Population • Pregnant, postpartum/breastfeeding, or paediatric patients • Military/uniformed personnels **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 Anchoring Care with Primary Care Physician

- Monitoring for adherence, early signs of relapse, medication side effects and medication adjustment
- Non-pharmacological interventions, e.g. counselling or psychotherapy

b) Major Depressive Disorder 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
- Having psychosis (hallucinations or odd beliefs)
- Symptoms of catatonia (refusing to talk, eat or drink)
- Risk of violence to self or others, especially patients with suicidal risk
- Need for hospitalisation
- Substance misuse, addiction, and abuse
- Complex psychiatric conditions (e.g., feeding and eating disorders, personality disorders)
- Patients with medicolegal and forensic issues
- Severe impairment to self-care, or inability to go to work or school for sustained periods

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, postpartum/breastfeeding women, or paediatric patients
- Military/uniformed personnels

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 Anchoring 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)
- Non-pharmacological interventions, e.g. counselling or psychotherapy

d) 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 Anchoring 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)

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 ✓ Counselling and mental health support services
Non-Claimable ✗ Sedatives-hypnotics

11. 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 sub-types – 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: Recommended Care Components for Stroke

Recommended Care Components	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	At baseline	
Blood Pressure Measurement#	Twice a year	
Lipid Profile#	Annually	All patients with ischaemic stroke are at high risk of cardiovascular events and do not require further risk stratification Patients with haemorrhagic stroke should be risk stratified in the absence of significant medical conditions (as recommended in the Lipids ACG)
Smoking Assessment#	Annually for smokers; Once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provide smoking cessation counselling
Influenza Vaccination#^	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS)

*More frequently if clinically indicated

#This is also a non-reportable clinical indicator

^ Note on Pneumococcal Vaccines: While stroke alone is not an indication for pneumococcal vaccination under NAIS in an 18–64-year-old patient, such patients with stroke often have comorbidities such as diabetes or cardiovascular disease for which NAIS does recommend pneumococcal vaccination. Refer to NAIS for more details.

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
• New (suspected) onset of TIA or Stroke • New onset of atrial fibrillation or cardiac murmurs requiring further evaluation
Consider Anchoring Care with Primary Care Physician
In patients who are • 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 ✓ Treatment of stroke complications such as pressure ulcers ✓ 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/m^2 ✓ Smoking cessation
Non-Claimable ✗ 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)

12. Major Neurocognitive Disorder (Dementia)

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

Major neurocognitive disorders (dementia) encompass a spectrum of disorders where there is a primary deficit in cognitive function. It may be due to one or more aetiologies that are acquired later in life, rather than developmental in origin. Examples of possible aetiologies include Alzheimer's disease, vascular disease, and Parkinson's disease.

Diagnosis of a major neurocognitive disorder (dementia) involves evidence of significant cognitive decline from a previous level of performance in one or more of the following cognitive domains: complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition; with interference with independence in everyday activities.

Part I: Recommended Care Components for Major Neurocognitive Disorder (Dementia)

Recommended Care Components	Minimum Frequency*	Remarks
Cognitive assessment	Annually	For patients on cognitive enhancers, objective documentation of memory assessment with a validated instrument (e.g. Montreal Cognitive Assessment (MoCA)) 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
Influenza Vaccination[#]	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS)

*More frequently if clinically indicated

[#]This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
• Young onset dementia (YOD) i.e. onset < 65 years of age • Patients who decline rapidly (based on feedback from caregiver and clinical impression) • Patients in whom diagnosis of major neurocognitive disorder (dementia) is uncertain • Uncontrolled behavioural and neuropsychiatric symptoms despite trial of pharmacological/non-pharmacological interventions
Consider Anchoring Care with Primary Care Physician
In patients who • 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 to moderate dementia and are keen to drive. These patients will require a driving assessment by an Occupational Therapist

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Claimable ✓ Drugs for the management of major neurocognitive disorder (dementia) (e.g. cognitive enhancers) or the behavioural and psychological symptoms of major neurocognitive disorder (dementia) (e.g. acetylcholinesterase inhibitors, antipsychotics)
Non-Claimable × 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)

13. Osteoarthritis

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

Osteoarthritis is characterised by focal areas of loss of articular cartilage within synovial joints, leading to pain and gradual loss of function, and 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. Evidence that led to the eventual diagnosis of osteoarthritis (i.e. diagnostic symptoms, signs, laboratory and radiologic investigations) should be clearly documented in the clinical notes.

Part I: Recommended Care Components for Osteoarthritis

Recommended Care Components	Minimum Frequency*	Remarks
Assessment of joint pain	Annually	
Prescription and Review of Exercise Plan	Annually	In the form of a directed or supervised muscle strengthening or aerobic exercise programme May be undertaken by physiotherapist
Weight and BMI Assessment (if applicable, e.g., osteoarthritis of the knee)#	Annually	Consider keeping BMI < 23kg/m^2 (For Non-Asian population, consider keeping BMI < 25 kg/m^2)
Basic Activities of Daily Living (ADL) Assessment (if appropriate)# *Six basic ADLs: washing, toileting, dressing, feeding, mobility and transferring*	Annually	Helps to determine functional status Should be considered for patients deemed to have limitations in certain daily activities through history and/or physical examination Referral to physiotherapy/ occupational therapy assessment for assisted devices should be considered if bADLs are affected

*More frequently if clinically indicated

#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
Lack of Response to Conservative Treatment ✓ Lack of significant improvement of pain, stability or function despite adequate conservative (non-pharmacological and pharmacological) treatment
Consider Anchoring Care with Primary Care Physician
In patients who ✓ 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
Claimable ✓ 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/m^2 ✓ Post-total knee replacement management
Non-Claimable × Off-label/non-HSA registered medications, dietary supplements or alternative therapies (e.g. glucosamine/chondroitin, calcium, and acupuncture and chiropractic therapy) × Intra-articular viscosupplementation, oral steroids and therapeutic knee aspirations as evidence for these procedures are weak

14. Parkinson's Disease[24]

(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 with an increase in incidence after the age of 60 years. The predominant motor features of Parkinson's disease include asymmetric tremor, bradykinesia and rigidity. Non-motor symptoms include autonomic dysfunction, falls, sleep disturbances, and cognitive abnormalities.

Part I: Recommended Care Components for Parkinson's Disease

Recommended Care Components	Minimum Frequency*	Remarks
Review of Diagnosis	Annually	The diagnosis should 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 regarding 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
Influenza Vaccination#	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS)

*More frequently if clinically indicated

#This is also a non-reportable clinical indicator

[24] For the purpose of CDMP/CHAS, Parkinson's disease encompasses Idiopathic Parkinson's and secondary Parkinsonism due to other aetiologies.

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
Complicated or Atypical Parkinsonism • 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 • Patients who do not respond to levodopa or dopamine agonists • Patients with cognitive impairment or neuropsychiatric dysfunction • Family history of Parkinson's disease
Consider Anchoring Care with Primary Care Physician
In patients who: • Require long-term follow up and medication

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable	
Claimable ✓ Drugs related to management of Parkinson's Disease (e.g. levodopa) ✓ Medications for management of complications or side effects of Parkinson's Disease medications (e.g. postural hypotension, laxatives for constipation)	
Non-Claimable ✗ Dietary supplements or traditional medications/therapies (e.g. CoEnzyme Q10)	

15. 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) can be defined as prostate adenoma and is one of the most common urological disorders amongst elderly males. Patients may present with symptoms such as urinary retention, and lower urinary tract symptoms which can be further subdivided into voiding (poor stream, hesitancy, intermittency, straining and terminal dribbling) and storage (frequency, urgency, incontinence, nocturia) symptoms.

Important differential diagnoses to rule out are carcinoma of the lower urinary tract, and neuropathic bladders due to aetiologies such as diabetes mellitus, Parkinson's disease, or infective causes.

Part I: Recommended Care Components for BPH

Recommended Care Components	Minimum Frequency*	Remarks
Review of Lower Urinary Tract Symptoms	Annually	Recommended tool for assessing the severity of LUTS is the International Prostate Symptom-Quality of Life (IPSS-QoL) 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	
Urinalysis [#]	Initial assessment	Screen for haematuria, pyuria and glycosuria

*More frequently if clinically indicated

[#]This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Consider Specialist Input
• Gross (refer urgently)/microscopic haematuria (normal referral to urology) • Worsening/persistent symptoms despite treatment • Urinary incontinence • Recurrent urinary tract infection • Hard or nodular prostate on digital rectal exam • Complications arising from obstruction like hydronephrosis, acute retention of urine. • Abnormal PSA levels (> 4.0 µg/L/ml) • A rise in PSA while on 5 Alpha Reductase Inhibitor

Consider Anchoring Care with Primary Care Physician
In patients whose • Symptoms well controlled, require long term follow up and assessment

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable
Claimable ✓ Investigations related to the management of Benign Prostatic Hyperplasia and its complications (e.g. PSA tests)
Non-Claimable × Phosphodiesterase-5 inhibitors × Testosterone tests × Dietary supplements or traditional medications/therapies (e.g. Saw palmetto extract)

16. Epilepsy

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

Epilepsy is defined when an individual has recurrent unprovoked seizures due to the abnormal or excessive neuronal discharge. Seizures may be focal or generalised and may result in sensory, motor, or autonomic disturbances, which may sometimes be accompanied by loss of consciousness and control of bowel or bladder function.

The diagnosis of epilepsy in adults is best 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: Recommended Care Components for Epilepsy

Recommended Care Components	Minimum Frequency*	Remarks
Review of seizure control (including seizure frequency and type, and seizure free duration)	Annually	
Influenza Vaccination[#]	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS)

*More frequently if clinically indicated

[#]This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Consider Specialist Input
• 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 Anchoring Care with Primary Care Physician
• 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 Claimable/Non-Claimable:
Claimable ✓ Investigations (except genetic testing) to evaluate seizure aetiology, e.g. EEG and MRI brain ✓ Investigations related to the management of epilepsy and its complications, e.g. full blood count, renal panel, liver function test, vitamin D and calcium levels ✓ Ketogenic 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 2 AEDs) and where medically necessary as treatment for those who are on enteral feeding or predominately on milk feeds ✓ 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 folinic 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 3.7: 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

17. Osteoporosis

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

Osteoporosis is a skeletal disease in which bone density and quality are reduced. Unrecognised or untreated osteoporosis increases fracture risk.

Common sites of fracture are the vertebral bodies of the spine, the femoral neck, forearm and proximal humerus. Recognising the patient's risk of osteoporosis or fragility fractures can enable appropriate diagnosis and management, keeping the patient fracture-free.

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 DXA to diagnose osteoporosis is not recommended.

Individuals found to have osteoporosis should have relevant clinical, laboratory and radiological assessments to exclude differentials and secondary causes of osteoporosis, so that appropriate management may be implemented.

Table 3.8: 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: Recommended Care Components for Osteoporosis

Recommended Care Components	Minimum Frequency*	Remarks
DXA scan[#]	At least once every 1-3 years[25]	For treatment monitoring, consider DXA at baseline, after one to two years of treatment (to establish clinical effectiveness), and every two to three years thereafter. Clinicians may review the frequency of DXA assessment accordingly based on patients' risk factors and response to treatment.
WHO Fracture Risk Assessment Tool (FRAX Score)[#]	Annually	http://www.shef.ac.uk/FRAX/tool.jsp to access FRAX score calculator

*More frequently if clinically indicated

[#]This is also a non-reportable clinical indicator

[25] When BMD has normalised, frequency of DXA scans should be based on patient's osteoporosis risk (viz low, moderate, or high) as defined in Osteoporosis Self-Assessment Tool for Asians (OSTA). For detailed practice recommendations, clinicians are advised to refer to updated clinical guidance (e.g. ACGs).

Part II: Consideration for Right-Siting Care

Consider Specialist Input
• Male or pre-menopausal female patients • 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 • Patients with multiple fragility fractures AND very low DXA BMD (T-score <-3.0) • Patients who adhere to treatment and experience fragility fractures or continued bone loss (>4-5% deterioration in DXA BMD) after at least a year of treatment • Creatinine clearance estimated by Cockcroft-Gault equation <30ml/minute
Consider Anchoring 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 Claimable/Non-Claimable:
Claimable ✓ Oral bisphosphonates and evidence supported therapies, e.g. o IV Zoledronic acid, raloxifene, subcutaneous teriparatide, and denosumab where medically indicated, such as for patients at high risk of fractures and unable to comply with oral bisphosphonates o Vitamin D analogues (e.g. alfacalcidol and calcitriol) for glucocorticoid-induced osteoporosis ✓ Investigations related to the management of osteoporosis (DXA 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 ✓ Treatment of osteopenia for individuals with no fractures (i.e. no history of any clinical fracture or asymptomatic vertebral fracture), but with high fracture risk (calculated using the Fracture Risk Assessment Tool (FRAX) and/or assessment of other relevant risk factors), after weighing risk and benefits with patients.
Non-Claimable × Testosterone and hormone replacement therapy (HRT)

References

1. ACE Clinical Guidance on Osteoporosis - Identification and management in primary care (November 2018)

18. Psoriasis

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

Psoriasis is a chronic inflammatory skin disease that typically follows a relapsing and remitting course. Plaque psoriasis is the most common subtype of psoriasis and is characterised by well-delineated erythematous plaques with overlying scales, with or without pustules.

Typical sites of involvement are the scalp, behind the ears or in the concha, on extensor surfaces of joints (i.e. elbows and knees), and the sacral area and intergluteal cleft. It is commonly associated with characteristic nail changes (e.g. > 5 pits on any nail, onycholysis or subungual hyperkeratosis) and joint pains, especially fingers showing dactylitis.

Psoriatic arthritis is an inflammatory polyarthritis that may develop in up to 30% of people with psoriasis. The most common clinical manifestations are peripheral arthritis, axial skeletal disease, enthesitis, and dactylitis. There is no definitive test to diagnose psoriatic arthritis.

Part I: Recommended Care Components for Psoriasis

Recommended Care Components	Minimum Frequency*	Remarks
Assessment of psoriatic arthritis	Annually	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#	Annually	Use patient's palm as an estimate of 1% BSA and consider referral to specialist if BSA > 10%

*More frequently if clinically indicated

#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
• Psoriatic arthritis • Patients with rash that cannot be controlled with topical therapy • Patients potentially requiring systemic agent or phototherapy for management of psoriasis
Consider Specialist Input
• Patient with 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 Anchoring Care with Primary Care Physician
In patients who: • 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 as necessary).

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable
Claimable ✓ 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 • Moisturisers and other over-the-counter topical applications, which are (i) clinically indicated based on the latest CPGs or ACGs issued by MOH, and/or best available evidence-based practice; (ii) prescribed by a doctor; and (iii) are on the MOH List of Subsidised Drugs, e.g.: ○ moisturisers: aqueous cream, urea cream, white soft paraffin ○ other over-the-counter topical applications: coal tar, salicylic acid, olive oil • Topical applications which are (i) Prescription Only Medicines as classified by HSA; (ii) clearly indicated in the treatment notes; and (iii) clinically indicated based on the latest ACGs issued by MOH, and/or best available evidence-based practice, e.g.: ○ Corticosteroid creams/ointment (e.g. hydrocortisone, betamethasone valerate, betamethasone dipropionate) ○ Vitamin D analogues
Non-Claimable × Over-the-counter products (e.g., 'branded' moisturisers, emollients, bath solutions) purchased without (i) a prescription as classified by HSA, (ii) clear indications in treatment notes, and/or (iii) clinical indications based on the latest CPGs or ACGs issued by MOH, and/or best available evidence-based practice

Table 3.9: 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 Liver panel Renal panel Chest X-ray Hepatitis B and C screening TB-spot (before starting biologics) Liver fibroscan/Magnetic resonance elastography (if indicated) <u>Before starting acitretin</u> Fasting lipids	<u>For patients on MTX</u>: Full blood count Liver panel Creatinine (periodically) Liver fibroscan/Magnetic resonance elastography (if indicated) <u>For patients on cyclosporin</u>: Renal panel Liver Panel <u>For patients on acitretin</u>:

At baseline	On routine follow-up
Before starting cyclosporin	Liver Panel
Fasting lipids	Fasting lipids
Serum magnesium	

19. Rheumatoid Arthritis (RA)[26]

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

Rheumatoid arthritis is a chronic inflammatory autoimmune disease of unknown aetiology. Affected patients typically present with inflammatory pain and stiffness of synovial joints, with progressive joint destruction and loss of physical function in advanced stages. Patients may also have 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 inflammatory markers. It must be distinguished from non-inflammatory causes of worsening joint pain and swelling, as well as emergency causes like 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, or
2) Established rheumatoid arthritis with characteristic features such as joint swelling and deformity, or
3) Early rheumatoid arthritis previously diagnosed and followed up by a rheumatologist, or

Part I: Recommended Care Components for RA

Recommended 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

[26] Juvenile rheumatoid arthritis previously diagnosed and followed up by a rheumatologist is claimable under CDMP/CHAS. Spondyloarthritis/Ankylosing spondylitis and adult-onset Still's disease are not claimable under CDMP/CHAS.

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
• 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 ≥ 6 weeks 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, or extra-articular disease) while on maintenance therapy
Consider Anchoring 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 low and stable maintenance dosages

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Claimable ✓ Investigations for the monitoring of rheumatoid arthritis and its 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

20. Ischaemic Heart Disease (IHD)[27]

(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), complications following MI, and plaques visualised in the coronary arteries without ischaemia.[28]

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) 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) History of acute coronary syndrome
c) Prior percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG)

[27] Includes coronary artery disease for purposes of claims under CDMP/CHAS.

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

Part I: Recommended Care Components for IHD

Recommended Care Components	Minimum Frequency*	Remarks
Blood Pressure Measurement#	Twice a year	
Weight and BMI Assessment#	Twice a year	Keep BMI < 23kg/m^2 (For Non-Asian population, keep BMI < 25 kg/m^2)
Lipid Profile#	Annually	Target LDL < 1.8 mmol/L as patients with IHD/CAD are in the "very high risk" group (target < 1.4 mmol/L if post-acute coronary syndrome)
Smoking Assessment#	Annually for smokers; Once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and provision of smoking cessation counselling
Diabetes Screening#	Annually or once every three years, as clinically indicated	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
Kidney Function Monitoring#	Annually	Especially for patients on ACE inhibitors. Serum Cr and eGFR, and Urine Albumin-Creatinine (uACR) may be considered.
Influenza Vaccination#	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS)
Pneumococcal Vaccination (PPSV23 only)#	1 or 2 doses depending on age and other medical conditions	As recommended under the National Adult Immunisation Schedule (NAIS)

*More frequently if clinically indicated

#This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting 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, blood pressure, and diabetes mellitus
Consider Anchoring Care with Primary Care 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 ✓ Gastro-protectants for patients on aspirin or anticoagulation ✓ Smoking cessation ✓ Cardiac rehabilitation
Non-Claimable ✗ Monitoring devices for cardiovascular risk factors, e.g. blood pressure monitoring equipment

21. Allergic Rhinitis[29]

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

Allergic rhinitis (AR) is a symptomatic disorder of the nose induced by exposure to allergens. It involves IgE-mediated inflammation of the mucous membranes lining the nose and results in the cardinal symptoms of sneezing, nasal obstruction, rhinorrhoea, postnasal drip, and/or itching (of the eyes, nose, palate). The diagnosis is made clinically when ≥ 2 symptoms are present on ≥ 2 consecutive days for > 1 hour on most days. AR can be classified based on symptom frequency (intermittent or persistent) and severity (mild or moderate/severe)[30]. Allergen triggers include, but is not limited to, house dust mite (most common trigger locally), pets, rodents, cockroaches, indoor moulds, and tobacco smoke.

Evidence that led to the eventual diagnosis of allergic rhinitis (i.e. diagnostic symptoms and signs) should be clearly documented in the clinical notes.

It is important to treat AR due to its impact on asthma. Other associated atopic conditions which often present together include allergic conjunctivitis and eczema. Another related condition is chronic rhinosinusitis, which has distinct diagnostic criteria and is managed differently from AR.

[29]Allergic conjunctivitis, eczema, and acute or chronic rhinosinusitis are not covered under CDMP/ CHAS

[30] According to Allergic Rhinitis and its Impact on Asthma (ARIA) 2008, AR can be subdivided into intermittent or persistent AR and its severity classified as 'mild' or 'moderate/severe'.

1. Classification of allergic rhinitis
    a. Intermittent: symptoms present <4 days/week or for <4 consecutive weeks
    b. Persistent: symptoms present >4 days/week or for >4 consecutive weeks
2. Severity of AR
    a. Mild: none of the following (sleep disturbance, impairment of daily activities, leisure and/or sport, impairment of school or work) or symptoms present but not troublesome
    b. Moderate/severe: ≥1 of the following are present (sleep disturbance, impairment of daily activities, leisure and/or sport, impairment of school or work); symptoms are troublesome

Part I: Recommended Care Components for Allergic Rhinitis

Recommended Care Component	Minimum Frequency*	Remarks
Assessment and Education on Allergen Avoidance	At diagnosis; thereafter, as clinically indicated	Patient education regarding disease course and measures to control exposure to allergens. Allergen testing is not routinely indicated
Smoking Assessment#	Annually for smokers; once-off for non-smokers, unless there is a change in smoking habit	Assessment on smoking habits (estimated sticks/day; zero for non- or ex-smoker) and smoking cessation counselling.

*More frequently if clinically indicated

This is also a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended

- Persistent symptoms despite compliance to treatment
- Red flag symptoms, such as persistent unilateral symptoms, nasal obstruction without other symptoms, recurrent epistaxis, anosmia
- Associated atopy/asthma requiring specialist evaluation (for example, evaluation of allergies by allergy specialist with consideration for specific immunotherapy)
- Children under 2 years of age (allergic rhinitis is uncommon in this age group)

Consider Anchoring Care with Primary Care Physician

In patients who:

- Have well controlled symptoms who require long term follow-up and assessment

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:

Claimable

- ✓ Investigations for management of the disease or to evaluate for potential co-morbid conditions (e.g. allergen-specific IgE tests, CT/MRI scans of paranasal sinuses)
- ✓ Treatment options including intranasal steroid sprays and antihistamines
- ✓ Smoking cessation

Non-claimable

- × Purchase of equipment such as High Efficiency Particulate Air (HEPA) filters or anti-dust mite covers and mattresses
- × Surgical procedures (e.g., nasoendoscopy, cryoablation) where the application for claims under day surgery is more appropriate
- × Supplements such as vitamin C
- × Non-HSA-registered medications (e.g. Allergen-specific immunotherapy)

- ✖ In general, nasal irrigation preparations (e.g. isotonic solutions that are available over-the-counter) are non-claimable, except for nasal irrigation preparations that are available in the MOH List of Subsidised Drugs (Sodium bicarbonate & sodium chloride for use in nasal irrigation).

References

1. Allergic Rhinitis and its Impact on Asthma (ARIA) guidelines and revisions
    a. Allergic Rhinitis and its Impact on Asthma (ARIA) 2008. Allergy. 2008; 63:8-160.
    b. Allergic Rhinitis and its Impact on Asthma (ARIA) guidelines: 2010 Revision. J Allergy Clin Immunol. 2010; 126(3):466-476
    c. Allergic Rhinitis and its Impact on Asthma (ARIA) guidelines – 2016 revision. J Allergy Clin Immunol. 2017; 140(4):950-958.
2. MOH Clinical Practice Guidelines Rhinosinusitis and Allergic Rhinitis (Feb 2010)*

**MOH clinical practice guidelines are considered withdrawn five years after publication unless otherwise specified in individual guidelines. While some components of previously issued guidelines may still be relevant, users should keep in mind that evidence-based guidelines are only as current as the evidence that supports them and new evidence can supersede recommendations made in the guidelines*

22. Gout

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

Gout is a form of inflammatory arthritis caused by deposition of monosodium urate (MSU) crystals in and around joints due to underlying chronic serum uric acid elevation. It typically presents episodically as painful acute flares that may increase in frequency or severity without appropriate management. In the long-term, complications of gout include joint damage, urate nephrolithiasis, and chronic kidney disease. Gout is associated with multiple comorbidities including renal impairment, obesity, diabetes mellitus, hypertension, and hyperlipidaemia.

Gout can be both primary or secondary gout, with secondary gout caused by aetiologies that are potentially reversible once the offending substance is removed, such as diuretic- or lead-induced gout.

The diagnosis of gout is a clinical one[31], and patients typically present with acute onset of severe pain and asymmetrical swelling affecting joints, most commonly the first metatarsophalangeal joint (MTPJ) and ankle joints, and occasionally the knees and small joints of the hands (proximal interphalangeal joints or PIPJs). Physical examination usually yields erythema, warmth, swelling and tenderness of the affected joint, with joint deformities noted in patients with chronic gout. Some patients also report a strong family history of gout.

A patient can be further assessed to have one of the following:

1. 1st episode of acute gout
2. 1st episode of acute onset of periarticular gout (present at bursae or tendon sheaths)
3. Recurrent gout (≥3-4 episodes per year)
4. Chronic tophaceous gout
5. Inter-critical gout (time between gout attacks)

[31]Asymptomatic hyperuricemia alone does not support a diagnosis of gout

Part I: Recommended Care Components for Gout

Recommended Care Component	Minimum Frequency*	Remarks
Blood Pressure Measurement	Twice a year	To personalise target blood pressure based on patient's risk factors.
Weight and BMI Assessment	Twice a year	Keep BMI <23kg/m^2 (for non-Asian population, keep BMI <25 kg/m^2).
Serum Uric Acid	At baseline and thereafter as clinically indicated, as treatment requires	Frequency of monitoring to be tailored based on clinical indication, as treatment required. If patient is treated with urate lowering therapy (ULT), repeat serum uric acid 4 to 8 weeks after dose adjustment. Consider serum uric acid < 360 µmol/L. Reducing serum uric acid to < 300 µmol/L may further reduce flare frequency and tophi, although higher ULT doses may be required.
Kidney Function Monitoring	At baseline	Baseline creatinine and eGFR to assess kidney function. Consider yearly monitoring if patient on periodic NSAID use. Frequency of monitoring to be tailored based on clinical indication.
Alanine Aminotransferase (ALT), Aspartate Transaminase (AST)	At baseline	Baseline to exclude hepatic impairment and to detect fatty liver (feature of metabolic syndrome). If starting xanthine oxidase inhibitor (e.g. allopurinol), consider repeating 4-8 weeks after initiation and as clinically indicated thereafter to monitor for deranged liver function.
Full Blood Count (FBC)	At baseline	Consider FBC to exclude infection or haematological disorders. If starting xanthine oxidase inhibitor (e.g. allopurinol), consider repeating 4-8 weeks after initiation and as clinically indicated thereafter to monitor for leukocytosis and eosinophilia.
Erythrocyte Sedimentation Rate (ESR)	At baseline (where applicable)	Consider ESR to exclude other suspected inflammatory arthritis (e.g. after acute gout attack resolves).
Diabetes screening	At baseline; consider yearly thereafter	To detect insulin resistance and diabetes mellitus (features of metabolic syndrome).
Lipid profile	At baseline; consider yearly thereafter	To detect dyslipidaemia (feature of metabolic syndrome). All patients should be risk stratified with targets of treatment tailored accordingly.
X-ray of Relevant Joints	If clinically indicated	Consider imaging to differentiate from other inflammatory arthritides.
Assessment of Diet and Lifestyle	Annually	All patients should be advised on low purine diet and lifestyle modification (alcohol avoidance and smoking cessation).

*More frequently if clinically indicated

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
Specialist referral recommended in patients with recurrent/chronic gout and any of the following: • Severe or refractory gout (e.g. recurrent flares) despite reaching target serum urate levels with adequate ULT treatment • Difficulty in achieving the management goal with ULT, particularly with renal impairment • Chronic kidney disease with eGFR < 30 ml/min/1.73m^2 • Serious adverse effects from treatment including hypersensitivity to ULT
Consider Anchoring Care with Primary Care Physician
In patients who: • Have good disease control with infrequent acute flares and good ULT tolerability

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Claimable ✓ Investigations leading to the positive diagnosis of gout, including serum uric acid tests and joint aspiration ✓ Investigations for the management of gout, such as serum uric acid and renal panel ✓ Medications used for the management of acute gout flares (e.g. colchicine, oral NSAIDs, oral corticosteroids) ✓ Medications used for the long-term management of gout (e.g. ULT including allopurinol) ✓ Investigations and management of complications of gout including urate nephrolithiasis, if relevant ✓ Dietetics services for low-purine diet
Non-claimable × Investigations to evaluate for hyperuricaemia when the patient is asymptomatic or does not have a clinical history suggestive of gout × ULT in patients with asymptomatic hyperuricaemia × Traditional or complementary medicine

References

1. ACE Clinical Guidance on Gout – Achieving the management goal (updated 14 December 2023)
2. 2020 American College of Rheumatology Guideline for the Management of Gout (June 2020)

23. Chronic Hepatitis B

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

Chronic hepatitis B virus (HBV) infection is defined as either one of the following:
(a) Two HBsAg positive results taken at least 6 months apart, or
(b) A negative test for IgM-anti-HBc together with a positive test for HBsAg in a single blood sample identifies chronic HBV infection.

Chronic HBV infection is usually asymptomatic, with symptoms only occurring late in the disease course. However, HBV is one of the most common and preventable causes of liver cirrhosis, hepatocellular carcinoma (HCC) and liver failure, thus regular follow-up is important for early detection of abnormalities.

In Singapore, hepatitis B vaccination is part of the National Childhood Immunisation Schedule (NCIS) and National Adult Immunisation Schedule (NAIS). Hepatitis B screening is recommended in certain patient populations[32] and can be performed with a blood test. An antibody titre >10 IU/L is protective.

[32] As recommended by the Screening Test Review Committee (STRC), hepatitis B screening is recommended in the following individuals:

i. Asymptomatic Singapore residents with no known hepatitis B carrier status born before 1987 who did not undergo the local catch-up immunisation programmes from 2001 to 2004
ii. Pregnant women
iii. Healthcare workers
iv. Foreigners and immigrants from countries where HBV is endemic
v. At risk groups: chronic haemodialysis patients, past or present injection drug users, individuals who underwent invasive procedures in health-care facilities with inadequate infection control practices, individuals with known exposures to HBV (e.g. healthcare workers following needle stick injury involving HBV-positive blood, or recipients of blood or organs from a donor who tested HBV-positive), individuals whose past or present sex partners were/are HBV-infected or injection drug users, HIV patients

Table 1: Viral Protein Tests and Clinical Significance

Viral Protein Test	Clinical Significance
HBsAg *Hepatitis B surface antigen*	Detected in high levels in serum during acute infection and persists for an average of 4 weeks after exposure to the virus. Persistence beyond 6 months indicates chronic HBV infection.
Anti-HBs *Hepatitis B surface antibody*	Indicates recovery and immunity from HBV infection. Also develops in a person successfully vaccinated against HBV.
IgM anti-HBc *IgM class antibody to core antigen*	Indicates recent infection with HBV (<6 months).
HBeAg *Hepatitis B envelope antigen*	Those positive for HBeAg circulate HBV at very high titres in their blood. This indicates high infectivity. Persistence of HBeAg beyond 40 years old is associated with poorer prognosis.
Anti-HBe *Antibody to HBeAg*	Anti-HBe becomes detectable when HBeAg is lost and is associated with low infectivity.

Table 23.2: Hepatitis B Screening Results and Clinical Interpretation

Results HBsAg	Anti-HBs	Vaccination status (course of 3 doses)	Interpretation	Recommended Action
Negative (or non-reactive)	<10 IU/L	No	Not immune to HBV	Administer hepatitis B vaccination.
Negative (or non-reactive)	<10 IU/L	Completed recently within last few months	Not immune to HBV	Repeat hepatitis B course of 3 doses and recheck serology 6-8 weeks later. If no antibody response, consider referral to Infectious Diseases.
Negative (or non-reactive)	<10 IU/L	Completed many years ago	Antibody levels may have waned	Administer 1 dose and recheck Anti-HBs 6-8 weeks later. High titres >100 convey immunity for life. If no antibody response, to complete course of 3 doses and recheck.
Negative (or non-reactive)	>10 IU/L	Regardless	Immune to HBV	No vaccination required.
Positive (or reactive)	-	Regardless	HBV infection	Look for signs and symptoms of acute hepatitis. Repeat HBsAg in 6 months.

Part I: Recommended Care Components for Chronic Hepatitis B

Recommended Care Component	Minimum Frequency*	Remarks
HBeAg#	At first visit	If positive at first visit, to recheck at age 40 years, or age 35 years if high-risk factors present [33]; if still positive, to consider specialist referral. Frequency of monitoring to be tailored based on clinical indication.
Anti-HBe antibody#	At first visit	
Liver Function Test (LFT)#	At first visit, and minimally ALT once every 6 months thereafter	Frequency of monitoring and specialist referral to be tailored based on previous ALT values and trends as well as HBeAg status.
Alpha-fetoprotein (AFP)#	At first visit and once every 6 months thereafter	AFP is a tumour marker used for HCC surveillance.
Full Blood Count (FBC)	Consider at first visit and once every 6 months thereafter	To monitor for thrombocytopenia associated with liver disease.
Ultrasound Hepatobiliary System (US HBS)#	At first visit and annually thereafter	Frequency of imaging to be tailored based on HCC risk.
Hepatitis A Screening/ Vaccination#	Consider anti-HAV screening and vaccination	Unless contraindicated, hepatitis A vaccination should be given to prevent superimposed acute hepatitis A in patients with chronic hepatitis B virus infection.
Sexually Transmitted Infections and Hepatitis C Screening	Screening in patients with high-risk behaviours[34]	
Metabolic Disease Screening - blood pressure measurement, lipid profile, weight and BMI assessment, diabetes screening	As per guidelines	Development of fatty liver and metabolic risk factors further increases risk of liver cirrhosis and HCC.
Influenza Vaccination#	Annually or per season	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS).
Pneumococcal Vaccination (PPSV23 only)#	As per guidelines depending on age and other medical conditions	As recommended under the National Adult Immunisation Schedule (NAIS) and National Childhood Immunisation Schedule (NCIS).

* More frequently if clinically indicated

This is a non-reportable clinical indicator

Part II: Consideration for Right-Siting Care

Specialist Referral Recommended
Gastroenterology referral recommended in patients with: • Persistently elevated ALT • Abnormal AFP • Other abnormal lab results: low albumin, raised bilirubin, low platelets • Signs of cirrhosis, HCC or other abnormal lesions on US HBS • Positive HBeAg at 40 years old and beyond • Clinical signs of chronic liver disease[35] • HIV or hepatitis C co-infection **Emergency department referral recommended in patients with:** • Clinical signs suggestive of acute liver injury or hepatic decompensation[36]
Consider Anchoring Care with Primary Care Physician
In patients who: • Are in stable condition/inactive carrier state without complications (e.g. liver cirrhosis)

Part III: Claimable/Non-Claimable Items

Specific Examples of Claimable/Non-Claimable:
Claimable ✓ HBsAg and IgM anti-HBc tests leading to the positive diagnosis of chronic hepatitis B infection ✓ Routine investigations for chronic hepatitis B follow-up and surveillance for HCC (blood tests, US HBS) ✓ Medications for the management of chronic hepatitis B including antivirals (e.g. Peginterferon alfa-2a, Entecavir) ✓ Medications for the treatment of complications of chronic hepatitis B including liver cirrhosis, but excluding HCC

[33] High-risk factors include family history of HCC, regular alcohol consumption or immunocompromised state (history of HIV, long-term use of steroids, chemotherapy or immunotherapy).
[34] High-risk behaviours include men who have sex with men, unprotected sex with multiple sexual partners, injection drug users, tattoos, sharing of household articles contaminated with blood.
[35] Clinical signs include jaundice, hepatomegaly, ascites, pedal oedema and other stigmata of chronic liver disease (palmar erythema, spider naevi, telangiectasia, bleeding gums, purpura).
[36] Clinical signs include new onset of clinical jaundice, acute or overt gastrointestinal bleeding or ALT ≥1000 U/L.

Part III: Claimable/Non-Claimable Items (continued)

Specific Examples of Claimable/Non-Claimable:
Non-claimable
× HBsAg tests for asymptomatic screening purposes not leading to the positive diagnosis of chronic hepatitis B infection
× Health supplements or vitamins such as vitamin B (except for cases with established deficiencies)
× Traditional or complementary medicine such as herbal medicine or homeopathy
× Neoplasm treatment (including for HCC), which should be claimed under other existing MediSave limits instead, such as limits for neoplasm scans, chemotherapy or radiotherapy[37]

References

1. SingHealth Polyclinics Doctors' Guidebook: Hepatitis B (updated Mar 2023)
2. National Healthcare Group Clinical Practice Guidelines: Management and Follow-up of Chronic Hepatitis B infection (updated Nov 2019)
3. National University Polyclinics Clinical Practice Guidelines: Chronic Hepatitis B (updated Feb 2024)
4. Academy Of Medicine, Singapore Report of the Screening Test Review Committee (March 2019) Guidelines
5. Ministry of Health Clinical Practice Guidelines for Chronic Hep B Infection (2011) *

**MOH clinical practice guidelines are considered withdrawn five years after publication unless otherwise specified in individual guidelines. While some components of previously issued guidelines may still be relevant, users should keep in mind that evidence-based guidelines are only as current as the evidence that supports them and new evidence can supersede recommendations made in the guidelines.*

[37] While HCC is recognised as a complication for chronic hepatitis B so that patients are identified as having a complex chronic condition, treatment for HCC will not be claimable under CDMP/CHAS. Cancer patients are generally monitored for about 5 years after treatment completion, and scans or other diagnostics done in this period are claimable under the $600 MediSave limit for neoplasm scans; surveillance for HCC as a care component for chronic hepatitis B which is conducted 5 years after cancer treatment completion should be claimed under the CDMP limit, and not the $600 neoplasm scans limit.

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 and CKD (Nephritis/Nephrosis)**.

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

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

Chronic Condition	Reportable Clinical Indicators Per Year[38]
Diabetes Mellitus	• Two blood pressure measurements • Two bodyweight measurements • Two haemoglobin A1c (HbA1c) tests • One serum cholesterol level (LDL-C) test • One kidney assessment (additional indicators for patients with nephropathy will follow that of Chronic Kidney Disease) • One eye assessment • One foot assessment • One smoking assessment[39]
Pre-diabetes	• One blood pressure measurement • Two bodyweight measurements • One serum cholesterol level (LDL-C) test • Two or more blood glucose tests (HbA1c, FPG, 2-hr OGTT) as appropriate[40] • One kidney function assessment (if on Metformin; additional indicators for patients with nephropathy will follow that of Chronic Kidney Disease) • One smoking assessment[39]
Hypertension	• Two blood pressure measurements • Two bodyweight measurements • One kidney assessment (additional indicators for patients with nephropathy will follow that of Chronic Kidney Disease) • One smoking assessment[39]
Lipid Disorders	• One serum cholesterol level (LDL-C) test • One smoking assessment[39]

[38] 'Per year' refers to 12 months from the first visit of the patient for the chronic condition(s).
[39] Annual reporting for smokers, and once-off reporting required for non-smokers unless there is a change in smoking habit.
[40] Refer to Clinical Guidelines for Pre-diabetes (page 26) for more details.

Chronic Condition	Reportable Clinical Indicators Per Year[38]
Asthma	• Two Asthma Control Assessments (GINA score) • One smoking assessment[39]
COPD	• One bodyweight measurement • One COPD Assessment Test (CAT) score • One smoking assessment[39] • One influenza vaccination (per year/season)
Chronic Kidney Disease (Nephritis/Nephrosis)	• Two blood pressure measurements • One kidney function– serum creatinine and/or eGFR • One urinary protein – urine Protein Creatinine Ratio (uPCR) or Albumin-Creatinine Ratio (uACR)

1.2 Although data submission is not required for the remaining conditions, clinicians are advised to manage according to best clinical practices and document recommended 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 [38]
Diabetes Mellitus	• One influenza vaccination (per year/season) • One or two pneumococcal vaccinations (depending on age and other medical conditions)
Hypertension	• One serum cholesterol level (LDL-C) test (at baseline)
Lipid Disorders	• One serum transaminase (before starting statins and as clinically indicated) • One serum creatine kinase (before starting statins and as clinically indicated)
Asthma	• One spirometry (at or soon after diagnosis, or when clinically indicated) • One influenza vaccination (per year/season) • One or two pneumococcal vaccinations (depending on age and other medical conditions)
COPD	• One spirometry (at diagnosis) • One or two pneumococcal vaccinations (depending on age and other medical conditions)
Chronic Kidney Disease (Nephritis/ Nephrosis)	• One influenza vaccination (per year/season) • One or two pneumococcal vaccinations (depending on age and other medical conditions)
Schizophrenia	• One blood test for fasting blood glucose and lipid profile[41] • One Clinical Global Impression (CGI) Scale for each item (severity, improvement)

[41] Only for patients with Schizophrenia on atypical antipsychotic medications.

Chronic Condition	Minimum Clinical Indicators Per Year [38]
	• One World Health Organisation Disability Assessment Schedule (WHODAS 2.0) (at the intake assessment, prior to step-down/discharge and 6-monthly)
Major Depressive Disorder	• One PHQ-9 score (at the intake assessment, prior to step-down/discharge and 6-monthly) • One World Health Organisation Disability Assessment Schedule (WHODAS 2.0) (at the intake assessment, prior to step-down/discharge and 6-monthly)
Bipolar Disorder	• One Clinical Global Impression (CGI) Scale for each item (severity, improvement) • One World Health Organisation Disability Assessment Schedule (WHODAS 2.0) (at the intake assessment, prior to step-down/discharge and 6-monthly)
Anxiety Disorders	• One GAD-7 score (at the intake assessment, prior to step-down/discharge and 6-monthly) • One World Health Organisation Disability Assessment Schedule (WHODAS 2.0) (at the intake assessment, prior to step-down/discharge and 6-monthly)
Stroke	• One thromboembolism risk assessment (as clinically indicated) • Two blood pressure measurements • One serum cholesterol level (LDL-C) test • One smoking assessment[39] • One influenza vaccination (per year/season)
Major Neurocognitive Disorder (Dementia)	• One influenza vaccination (per year/season)
Osteoarthritis	• One bodyweight measurement (if applicable, e.g., osteoarthritis of the knee) • One Basic Activities of Daily Living (ADL) assessment (if appropriate)
Parkinson's Disease	• One influenza vaccination (per year/season)
BPH	• One Urinalysis (at initial assessment)
Epilepsy	• One influenza vaccination (per year/season)
Osteoporosis	• One DXA scan (at least once every 1-3 years) • One WHO Fracture Risk Assessment Tool (FRAX Score)
Psoriasis	• One Body Surface Area (BSA) percentage assessment
Ischaemic Heart Disease	• Two blood pressure measurements • Two body weight measurements • One serum cholesterol level (LDL-C) test • One smoking assessment[39] • One diagnostic diabetes test (annually or once every 3 years)

Chronic Condition	Minimum Clinical Indicators Per Year [38]
	• One kidney function monitoring • One influenza vaccination (per year/season) • One or two pneumococcal vaccinations (depending on age and other medical conditions)

2 Collection and Submission of Clinical Data

2.1 The recording of clinical data can be carried out by:

a) Recording the clinical data directly onto electronic records through the CMS installed for electronic submission of clinical data for CDMP/CHAS enrolled patients; **or**

b) Manually recording the clinical data on a hardcopy template. Please note that for *submission* purposes the data will subsequently have to be keyed in via the online CIDC e-Service (see **Annex A**: User Manual for e-Service Clinical Data Submission on page 101) and/or the MHCP system (see the MHCP User Guide available on the MHCP Resource Hub).

3 Deadlines for Submission of Clinical Data to MOH

3.1 Submission of clinical data is an essential and mandatory 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, to minimise backlog in submitting clinical data.

3.3 Clinics can accumulate patient records for submission in batches. However, for batch submissions, regular (e.g. weekly) submissions are encouraged.

3.4 When using the CMS 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 one month after the end of each visit.

CHAPTER FIVE:
FREQUENTLY ASKED QUESTIONS

A. CLINICAL MATTERS

Q1. I have a patient with Diabetes Mellitus, Hyperlipidaemia and Asthma. Is my patient eligible to claim for CDMP MediSave?

Your patient will be able to use MediSave/CHAS to co-pay for the total bill for the treatment administered for all 3 conditions. You will also need to submit clinical data based on the reportable clinical indicators of Diabetes, Lipid Disorders and Asthma.

Q2. My patient has Diabetes Mellitus. 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 Diabetes care components. (Please refer to Chapter Three).

Q3. Who decides on the recommended care components?

The recommended care components were drawn from the MOH Clinical Practice Guidelines, MOH ACE Clinical Guidances (ACGs) and best available evidence-based practice where relevant, 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. 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 withdraw up to $150 per month from MediSave for rental of devices for long-term oxygen therapy, though it is not covered under CDMP/CHAS. Patients may approach public hospitals for more information.

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.

Q5. Can I claim for outpatient vaccinations and/or health screenings?

MediSave claims for the following conditions under the CDMP framework are allowed. These claims fall under the same MediSave500/700 withdrawal limit as the CDMP, i.e. $500/700 per patient per year from 1 January 2021.

Vaccinations

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

Selected 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) For patients who are included under recommended groups for vaccination based on the National Childhood Immunisation Schedule (NCIS) and National Adult Immunisation Schedule (NAIS) due to their chronic condition under the CDMP, vaccination subsidies should be applied under the Vaccination and Childhood Developmental Screening Scheme (VCDSS) subsidies implemented since 1 Nov 2020. Any remaining co-payment required after applying VCDSS subsidies can be claimed for under the chronic tier of CHAS subsidies as it is a recommended care component of the relevant chronic condition and under the MediSave500/700 scheme; and
b) For patients not under recommended groups for vaccination based on the NCIS and NAIS, the cost of consultation for vaccinations, but not the cost of the vaccines, can be claimed under the acute tier of CHAS subsidies.

Selected Health Screenings

Tests for recommended health screening by the Health Promotion Board (HPB) are subsidised at participating CHAS clinics under the Screen for Life (SFL) programme.

B. REGISTRATION MATTERS

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

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

a) Treat patient medical information with confidentiality;
b) Submit to MOH, with the informed consent of patient, data on patient care delivery on a monthly basis or as specified by MOH. Relevant aggregated performance data will be published to assist patients in making informed choices;
c) Be accredited for the use of MediSave for CDMP; and
d) 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.

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 Debit Authorisation Form (by CPF Board); and
c) CEO/Director-level officer to accept CPF Board's Terms and Condition via FormSG.

The E-Application website can be accessed via https://fsae.moh.gov.sg/mmae/OverviewApplication.aspx

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://fsae.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 participate in the Mental Health GP Partnership Programme (MHGPP) and attend the CDMP-MI training provided under MHGPP. Upon fulfilling these requirements, your clinic can apply for "CDMP-MI" accreditation via https://fsae.moh.gov.sg/mmae/OverviewApplication.aspx, and MediSave claims for patients with mental illnesses can be made upon approval. This is part of an assurance framework to ensure quality of care for patients. More details on the requirements for MHGPP are under para 1.4 of Chapter Two: Registration and Medisave Use.

Q4. How do I register for a Mental Health GP Partnership Programme with a Restructured Hospital?

You may register via MOH's FSAE website (http://fsae.moh.gov.sg/mmae/overview.aspx) by selecting the "Chronic Disease Management Programme (CDMP) – Shared Care Programmes". Alternatively, you may reach out to AIC at enquiries@aic.sg for more details on the Mental Health GP Partnership Programme.

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), 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 -accredited doctor in a MediSave accredited clinic for at least one of the approved chronic conditions are eligible for CDMP. The patients need to complete the Medical Claims Authorisation Form in order for MediSave claims to be made.

C. MEDISAVE CLAIMS, REIMBURSEMENT, BILLING

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

From 1 January 2021, patients can claim up to $500 per year for outpatient treatment of their simple chronic conditions under the CDMP, and up to $700 per year for outpatient treatment of their complex chronic conditions under the CDMP.

Patients aged 60 and above may also further claim up to $300 per year for such treatments under the prevailing Flexi-MediSave limits. Taken together with CDMP limits, they may claim up to $800 per year for simple chronic conditions, and $1,000 per year for complex chronic conditions.

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 siblings or grandchildren. Claims can be made once the MediSave payer has signed the relevant Medical Claims Authorisation Form. The total amount that patients can claim from MediSave, whether from their own account or account of family members, remains subject to the relevant annual limits for chronic disease treatments (see q1).

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

There is a 15% co-payment of the CDMP bill for each claim that the patient has to pay in cash. Patients who are aged 60 and above may tap on Flexi-MediSave to cover this co-payment. Since 1 February 2024, the 15% co-payment is waived for patient seeking CDMP treatment at their enrolled HSG clinic. They can use MediSave to fully pay for their CDMP bills, up to the relevant annual limits (see q1).

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 patient per year. Patients with complex chronic conditions will be

eligible to withdraw up to $700 per patient 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 $500/700 limit apply? Is it calculated based on the time that the patient first seeks treatment under the scheme?

The $500/700 annual limit is reset at the start of each calendar year, i.e. $500/700 for the period from 1 January to 31 December. By default, the withdrawal limit will be reset to $500, and will increase to $700 after a claim for a complex chronic condition is made.

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, unless otherwise specified in Chapter Three: The Clinical Guidelines of the Handbook.

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 MediSave500/700, 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 / NPHC e-service, MHCP and selected Clinic Management Systems under the SmartCMS Programme. 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) by logging in with their SingPass at My CPF Online Services - My Statement. You may wish to ask your patients to bring along a copy of the MediSave balance of all relevant 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 to avoid any confusion or unhappiness.

Q12. 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. However, patients will not be eligible for the 15% co-payment waiver if treatment is sought at clinics other than the one they have enrolled at under Healthier SG.

Q13. 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 billing arrangements on behalf of his unaccredited partners, as long as the referral is clinically relevant to support treatment and/or support of the approved CDMP condition. The referring party is expected to bear full responsibility for any such arrangements made, including if incorrect claim submissions are subsequently discovered. In addition, the referring party is also responsible for the submission of clinical data for the patient. For avoidance of doubt, CDMP withdrawals should not be made for patients managed by overseas doctors or institutions.

Q14. How will the scheme apply to Permanent Residents and Foreigners?

Current MediSave rules apply. Permanent Residents are able to tap on their immediate family members (parent, child, spouse), siblings or grandchildren's MediSave accounts. Foreigners are able to tap on their immediate family members' MediSave accounts.

Q15. How will the scheme apply to those who have employer medical benefits or an existing comprehensive insurance plan?

Employer medical benefits (including for pensioners) or an existing comprehensive insurance plan should be applied before MediSave use. Any amount in excess of the employer medical benefits or the insurance plan can be paid using MediSave, and is similarly subject to 15% cash co-payment. Clinics will have to liaise directly with their partnering employers for payment under employer plans as per their current arrangements.

Q16. 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 Medical Claims Authorisation Form (MCAF) 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. Authorisation over a period of time stands until revoked in writing. Clinic/medical institution staff should ensure that the particulars stated on the form match those stated in the NRIC or identification document provided and also verify relationships declared, where possible. The clinic/medical institution staff should ensure that the patient and additional MediSave payer(s) understand and acknowledge the relevant paragraphs in the form. A witness has to verify that the patient and additional MediSave payer(s) have completed and signed the form. The witness must be a Singapore Citizen or Permanent Resident aged 21 years and above, and must not lack mental capacity. Where the institution's staff is acting as a witness, the SC/PR and age requirements are lifted.

c) Clinics/medical institutions can then submit the MediSave claims electronically to the CPF Board for processing via the MediClaim / NPHC 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.

Q17. Can admin fees be charged for claims?

No, clinics are not allowed to charge admin fees for MediSave claims.

Q18. 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.

Q19. Am I allowed to waive the 15% cash co-payment requirement for my patient?

No. Clinics that wish to provide discounts to the patients based on the clinics' own business model should account for the discount in the final bill amount submitted in the claim system i.e. the final bill amount submitted in the claim system should be the charge after the discount is applied. The 15% cash co-payment and MediSave-claimable amount will be computed based on the charges after discounts are applied.

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 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 it has not been submitted by the other clinic. 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 over the 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, but paid cash for three subsequent visits (in Mar, Jul, Oct in the same calendar year) 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.

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

It is only allowed if consent has been obtained from patients to share their clinical data with other clinics managing their conditions, through the Medical Claims Authorisation Form (Single). Alternatively, clinics can have their own data sharing policies (in line with the Personal Data Protection Act (PDPA)) which patients have to consent to.

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

The reportable clinical indicators are part of 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 frequency of reportable clinical indicators.

Q14. How will the clinical data submitted be used?

The clinical data received will be used to monitor clinical effectiveness of the CDMP.

If the patient had signed the MCAF (Single) form, the clinical data can also be used:

a. to facilitate the patient's treatment;

b. to check the patient's healthcare information, withdraw from the patient's MediSave and/or claim for health insurance policies; and
c. for data analysis, evaluation, and policy-making and review by the Government and CPF Board.

If the patient had signed the MCAF (Multiple) form, the clinical data can also be used:
a. to check the patient's Medisave and Health Insurance Policy information in order to facilitate the patient's claims;
b. to process and administer the patient's claims;
c. to assess and audit the patient's Claims and adjudicate claims-related disputes; and
d. for data analysis, evaluation and policy-making and review by the Government and CPF Board.

Clinical data submitted to CIDC is available to clinics via the CDMP Online[42] reports. In the CDMP Online reports, a clinic will be able to compare its performance against the aggregated local and national performance under CDMP. Over time, each clinic will also be able to track its own performance trends and is able to use the data for clinical quality improvement within the clinic.

Q15. What will the clinical audit process be like?

Periodic audits will be carried out to ensure completeness/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.

Q16. 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.

Q17. 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 MediSave Terms & Conditions. In addition, the patient would have provided consent to sharing his/her medical information under CDMP/CHAS for the purpose of the audit when he/she signed the Medical Claims Authorisation Form/provides deemed consent by presenting their CHAS card and/or accepting CHAS subsidies.

[42] This is accessible via CIDC online portal: https://cidc.moh.gov.sg/cidcweb/CorpPass/CorpPassLogin.aspx

Q18. How do I submit my bills for audit?

All items claimed need to be itemised.

Annex A

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:
- CPU 1 GHz or faster process with 4GB or above RAM
- At least 10 GB free hard disk space

b) System Software Requirements
- Windows 10
- Internet Explorer 11 or higher, Edge 42 or higher, Chrome 85 or higher, Firefox 81 or higher, Safari 14 or higher
- Broadband Internet Connection

c) Other Requirements
- CorpPass account

2 Getting Started

2.1 User Account

2.1.1 You will be using your CIDC system user account to access the CIDC e-Service.

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

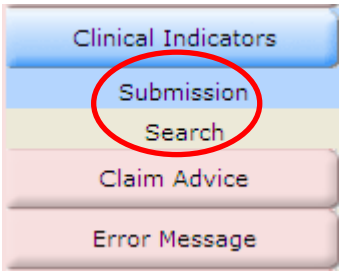
2.2 Accessing the CIDC e-Service

2.2.1 The web URL to access the CIDC system is: https://cidc.moh.gov.sg/cidcweb/CorpPass/CorpPassLogin.aspx.

Screen 1: CIDC Login Screen

2.2.2 Upon successful login to the CIDC 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:



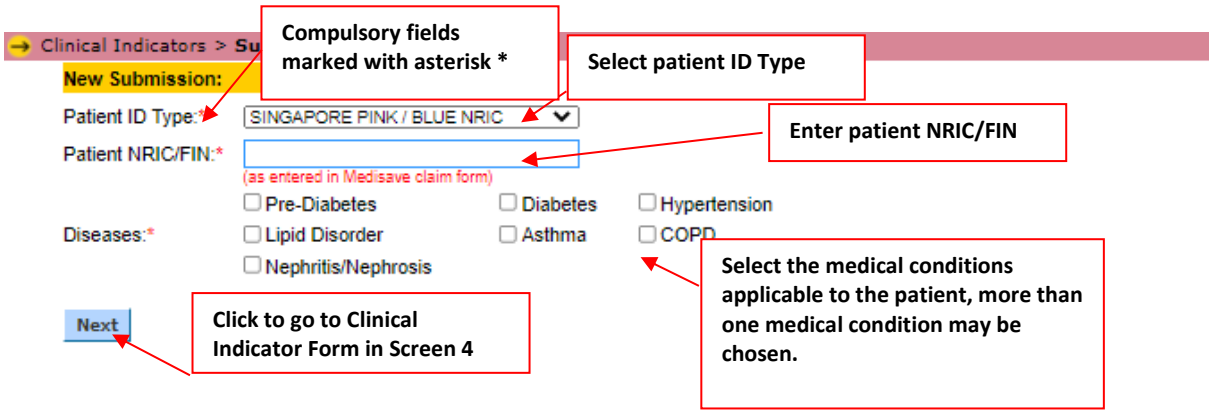
Screen 2: Menu

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.



Condition	Care Components Per Year
Pre-Diabetes Mellitus	• One Blood Pressure (Systolic) • One Blood Pressure (Diastolic) • Two Body Weight Measurement • One Serum Cholesterol Level (LDL-C) test (mg/dL) or (mmol/L) • One Serum Creatinine (µmol/L) • One eGFR (ml/min/1.73m^2) • Two or more Haemoglobin A1c (HbA1c) test/ Fasting Plasma Glucose (FPG) (mmol/L)/ 2-hour Oral Glucose Tolerance Test (OGTT) (mmol/L), as appropriate • One Smoking Habit Assessment - Estimated Number of Cigarettes Smoked/Day
Diabetes Mellitus	• Two Blood Pressure (Systolic) • Two Blood Pressure (Diastolic) • Two Body Weight Measurement • Two Haemoglobin A1c (HbA1c) test • One Serum Cholesterol Level (LDL-C) test (mg/dL) or (mmol/L) • One Estimated Number of Cigarettes Smoked/Day • One eye assessment • One foot assessment • One Urine ACR (mg/mmol) • One Urine PCR (mg/mmol) • One Serum Creatinine (µmol/L) • One eGFR (ml/min/1.73m^2)
Hypertension	• Two Blood Pressure (Systolic) • Two Blood Pressure (Diastolic) • One Body Weight Measurement • One Smoking Habit Assessment - Estimated Number of Cigarettes Smoked/Day • One Serum Creatinine (µmol/L) • One eGFR (ml/min/1.73m2) • One Urine ACR (mg/mmol) • One Urine PCR (mg/mmol)
Lipid Disorder	• One Serum Cholesterol Level (LDL-C) test (mg/dL) or (mmol/L) • One Smoking Habit Assessment - Estimated Number of Cigarettes Smoked/Day
Asthma	• One Smoking Habit Assessment - Estimated Number of Cigarettes Smoked/Day • Two Global Initiative for Asthma (GINA) Score
COPD	• One Smoking Habit Assessment - Estimated Number of Cigarettes Smoked/Day • One Body Weight Measurement • COPD Assessment Test (CAT) score • One Influenza Vaccination
Nephritis/Nephrosis	• One eGFR (ml/min/1.73m^2) • One Urine ACR (mg/mmol) • One Urine PCR (mg/mmol) • One Serum Creatinine (µmol/L) • Two Blood Pressure (Systolic) • Two Blood Pressure (Diastolic)

Screen 3: Submission Form

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.

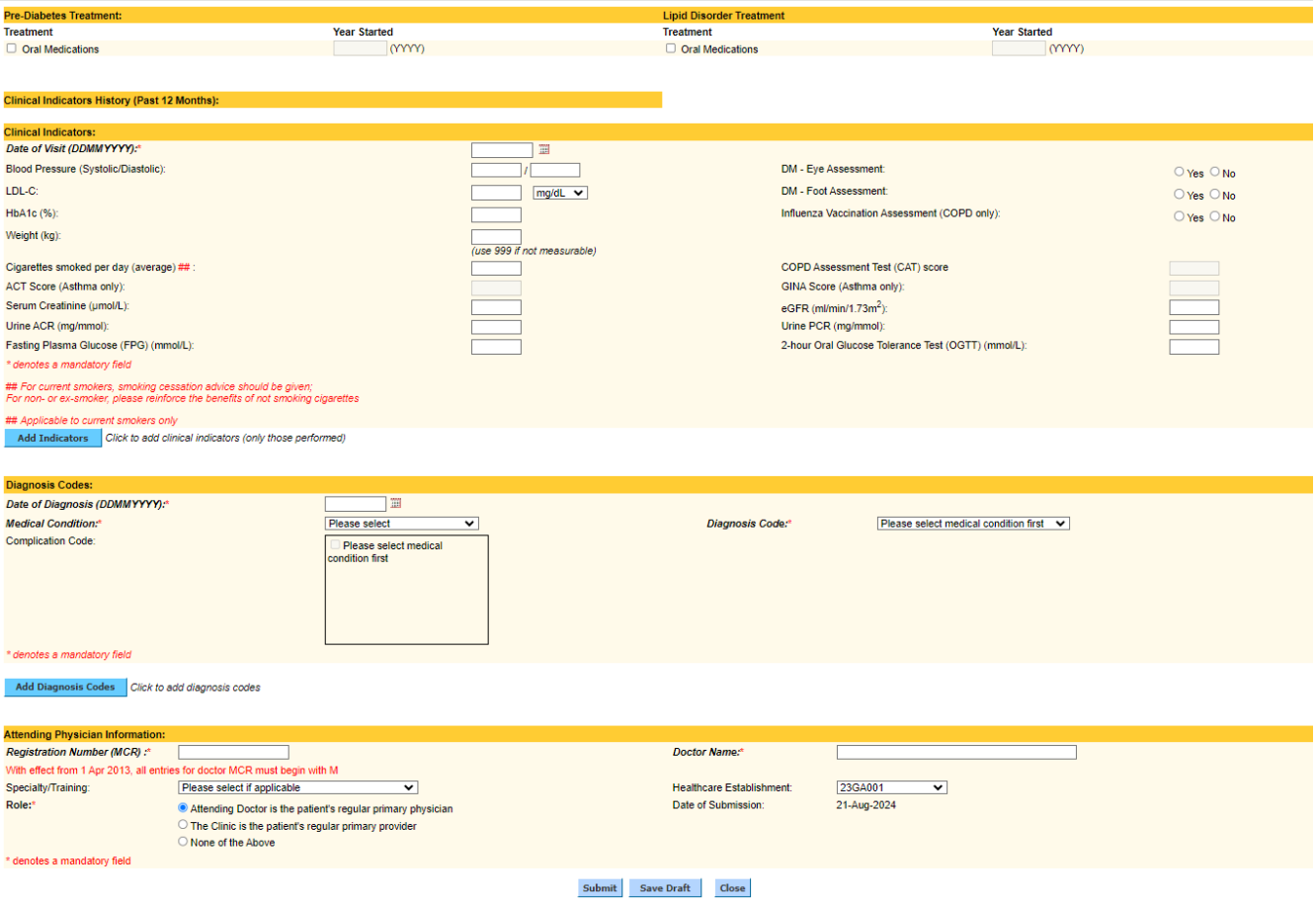
Patient Details:

Patient Name: *	Ramon	***Patient NRIC/FIN:*** *	S1234567D
Date of Birth (DDMMYYYY):	01011985	Sex:	◉ Male ○ Female
Race:	Chinese	Height (Metres):	1.78 *(use 9.99 if not measurable)*
Current Smoker	◉ Yes ○ No	2005	Year Started Smoking(YYYY)

** denotes a mandatory field*

Known Medical History:

Medical Condition	Diagnosis Year	Medical Condition	Diagnosis Year
☑ Pre-Diabetes	(YYYY)	☑ Hypertension	(YYYY)
☑ Diabetes	(YYYY)	☑ Lipid Disorder	(YYYY)
☐ DM Retinopathy	(YYYY)	☐ Coronary Heart Disease (CHD)	(YYYY)
☐ DM Nephropathy	(YYYY)	☐ COPD	(YYYY)
☐ DM Foot Complications	(YYYY)	☐ Nephritis/Nephrosis	(YYYY)
☑ Asthma	(YYYY)		



Screen 4: Clinical Indicator Form

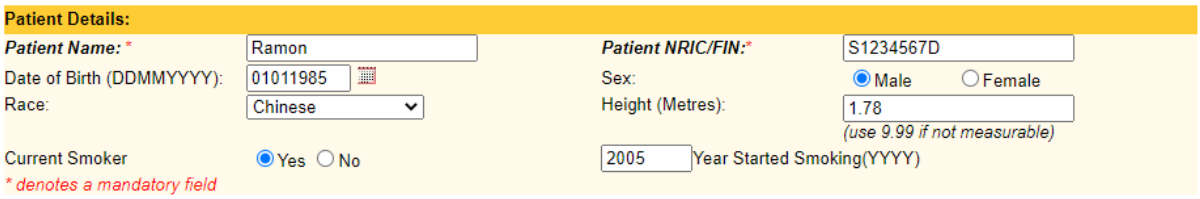
3.3 The Clinical Indicator Form consists of 5 sections:

a) Patient Details,
b) Known Medical History,
c) Clinical Indicators,
d) Diagnosis codes, and
e) 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.

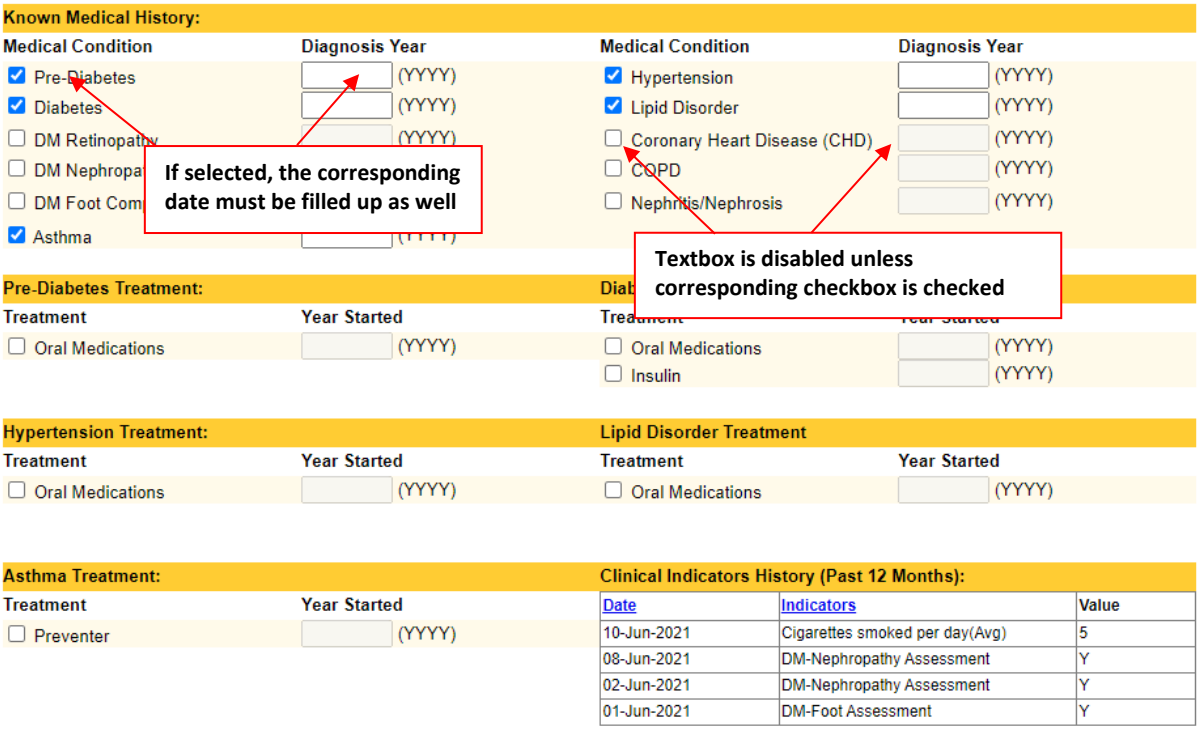


Screen 5: Patient Details

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.



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.

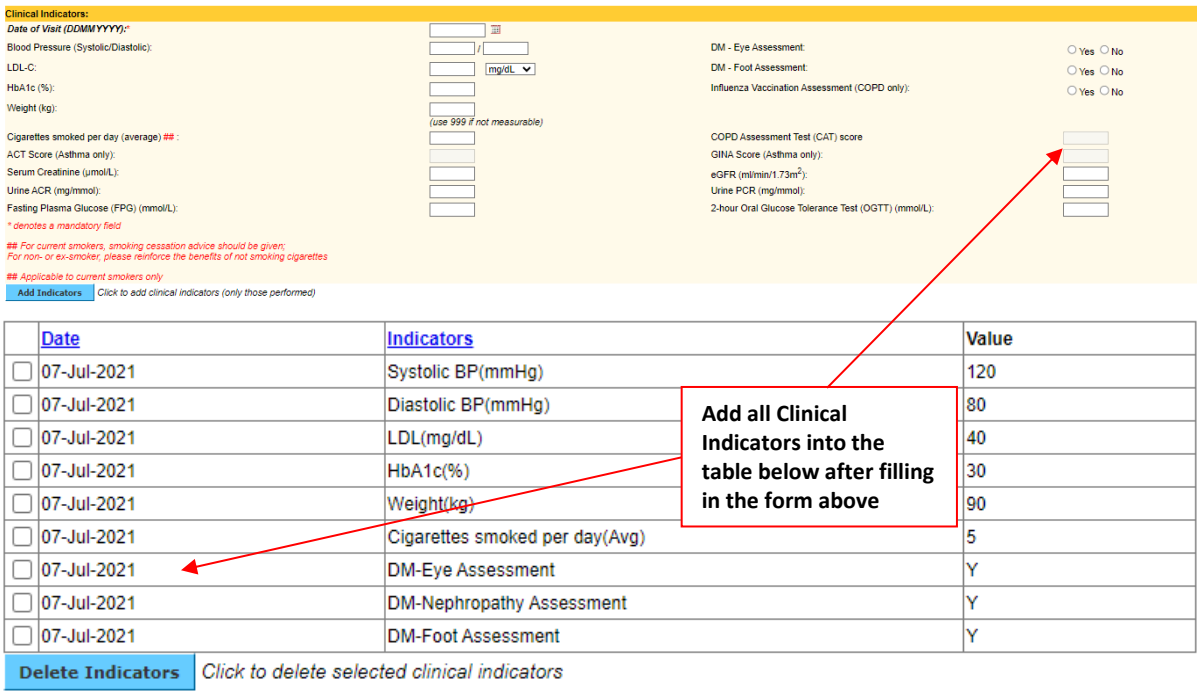
6 Clinical Indicators

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.

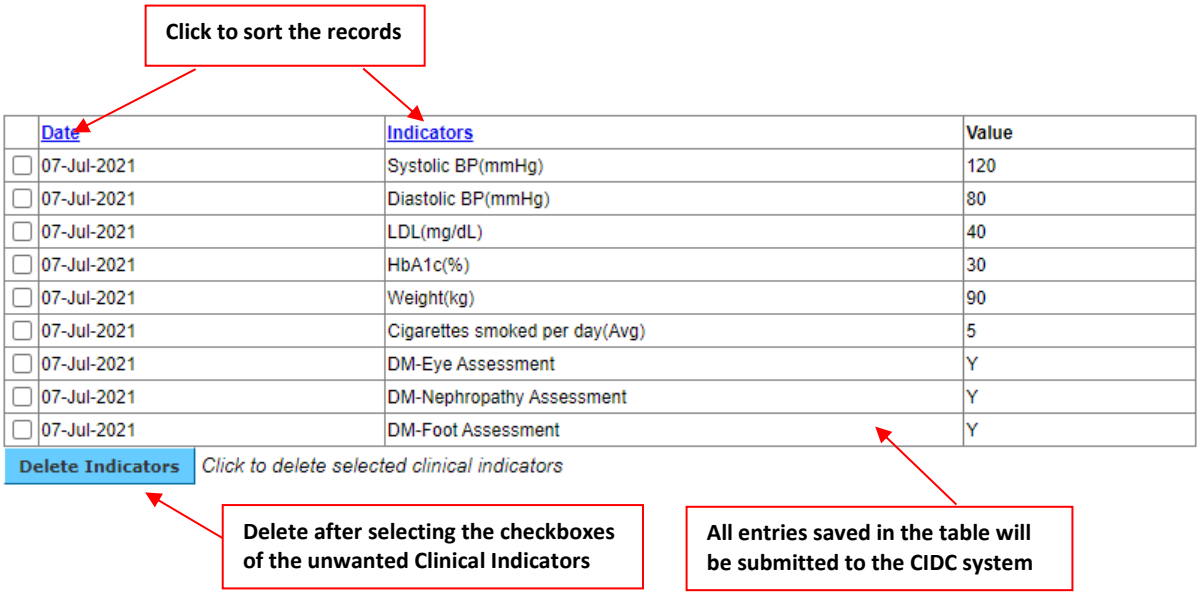
6.2 Initially there will be no clinical indicators added to the report.

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.



Screen 7: Filling in the Clinical Indicators



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.

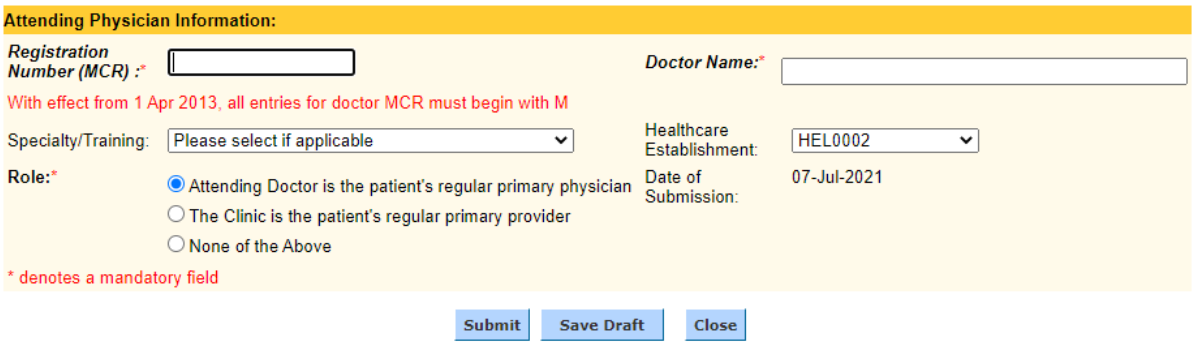
6.7 After saving the data, you can use the delete button to remove any mistakes.

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.



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.

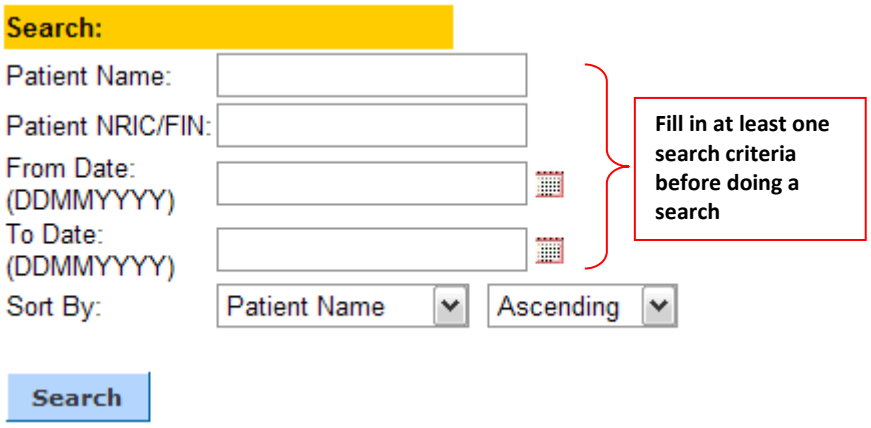
9.2 After retrieving the report, you can also proceed to "Amend" it if there was any mistake in the previous submission, or delete it altogether.

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

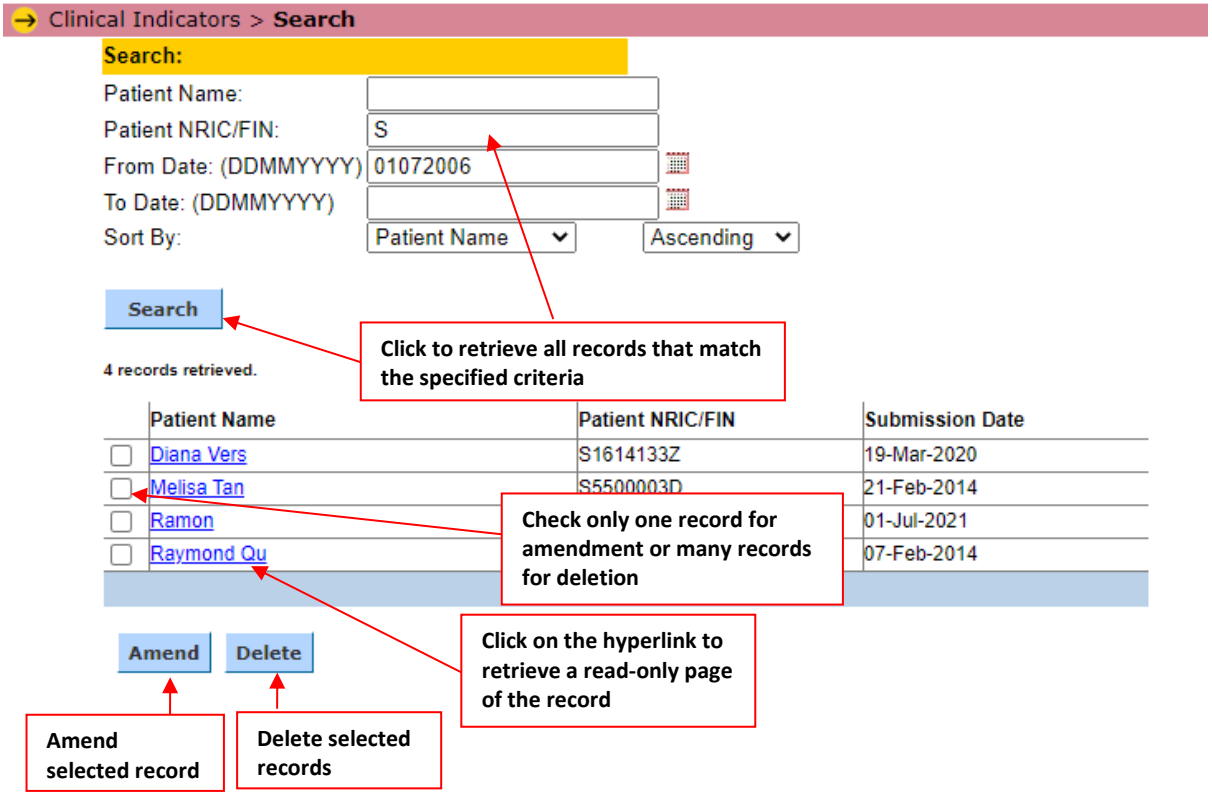
9.4 The Search page will be shown. Enter your search criteria and click on the [Search] button. The search is case insensitive.

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



Screen 11: Search Criteria

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



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: *	Ramon	***Patient NRIC/FIN:****	S1234567D
Date of Birth (DDMMYYYY):	01011985	Sex:	(•) Male ( ) Female
Race:	Chinese	Height (Metres):	1.78 *(use 9.99 if not measurable)*
Current Smoker	(•) Yes ( ) No	1999	Year Started Smoking(YYYY)

** denotes a mandatory field*

Known Medical History:

Medical Condition	Diagnosis Year	Medical Condition	Diagnosis Year
[x] Pre-Diabetes	2016 (YYYY)	[x] Hypertension	2013 (YYYY)
[x] Diabetes	2017 (YYYY)	[ ] Lipid Disorder	(YYYY)
[ ] DM Retinopathy	(YYYY)	[ ] Coronary Heart Disease (CHD)	(YYYY)
[ ] DM Nephropathy	(YYYY)	[ ] COPD	(YYYY)
[ ] DM Foot Complications	(YYYY)	[ ] Nephritis/Nephrosis	(YYYY)
[ ] Asthma	(YYYY)		

Pre-Diabetes Treatment:

Treatment	Year Started
[ ] Oral Medications	(YYYY)

Diabetes Treatment:

Treatment	Year Started
[ ] Oral Medications	(YYYY)
[ ] Insulin	(YYYY)

Hypertension Treatment:

Treatment	Year Started
[ ] Oral Medications	(YYYY)

Lipid Disorder Treatment

Treatment	Year Started
[ ] Oral Medications	(YYYY)

Clinical Indicators History (Past 12 Months):

Date	Indicators	Value
07-Jul-2021	Systolic BP(mmHg)	120
07-Jul-2021	Diastolic BP(mmHg)	80
10-Jun-2021	Cigarettes smoked per day(Avg)	5

Clinical Indicators:

Date of Visit (DDMMYYYY):*			
Blood Pressure (Systolic/Diastolic):	/	DM - Eye Assessment:	( ) Yes ( ) No
LDL-C:	mg/dL	DM - Foot Assessment:	( ) Yes ( ) No
HbA1c (%):		Influenza Vaccination Assessment (COPD only):	( ) Yes ( ) No
Weight (kg):	*(use 999 if not measurable)*		
Cigarettes smoked per day (average) ## :		COPD Assessment Test (CAT) score	
ACT Score (Asthma only):		GINA Score (Asthma only):	
Serum Creatinine (µmol/L):		eGFR (ml/min/1.73m^2):	
Urine ACR (mg/mmol):		Urine PCR (mg/mmol):	
Fasting Plasma Glucose (FPG) (mmol/L):		2-hour Oral Glucose Tolerance Test (OGTT) (mmol/L):	

** 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

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

	Date	Indicators	Value
[ ]	10-Jun-2021	Cigarettes smoked per day(Avg)	5
[ ]	07-Jul-2021	Systolic BP(mmHg)	120
[ ]	07-Jul-2021	Diastolic BP(mmHg)	80

Delete Indicators *Click to delete selected clinical indicators*

Attending Physician Information:

Registration Number (MCR) :*	M02437F	***Doctor Name:****	Teoh Guan Pin
With effect from 1 Apr 2013, all entries for doctor MCR must begin with M			
Specialty/Training:	Please select if applicable	Healthcare Establishment:	HEL0002
Role:*	(•) Attending Doctor is the patient's regular primary physician	Date of Submission:	01-Jul-2021
	( ) The Clinic is the patient's regular primary provider		
	( ) None of the Above		

** denotes a mandatory field*

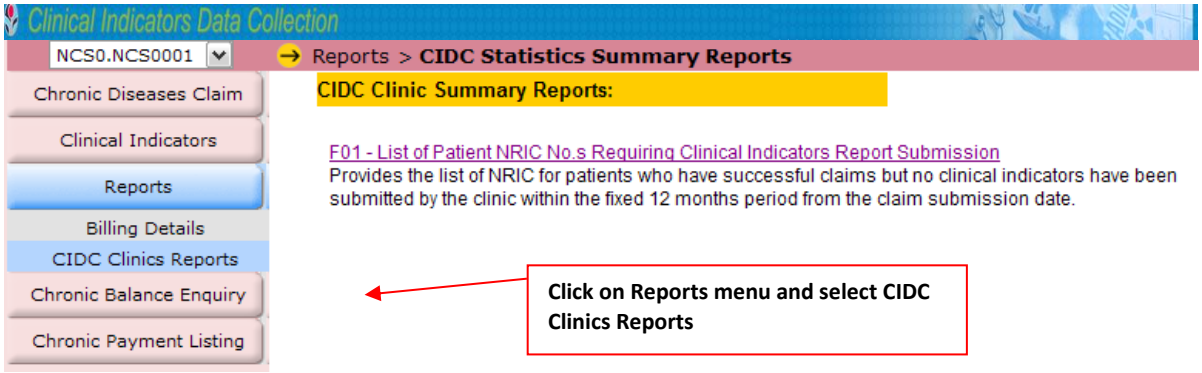
Amend Close

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.

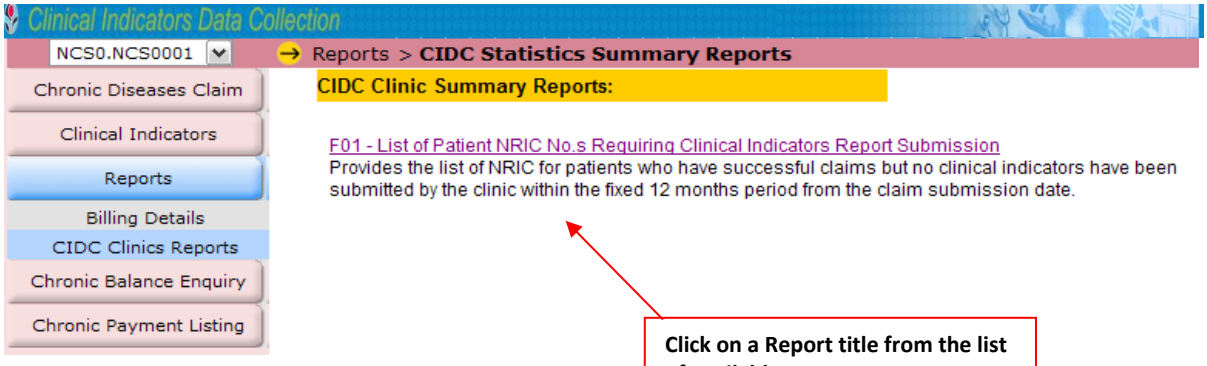


Screen 14: CIDC Clinic Reports

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

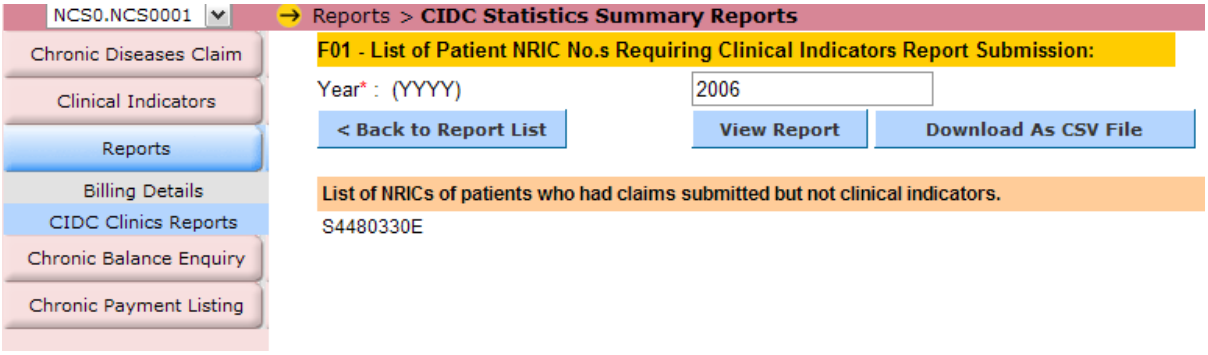
a) This report enables the clinics to have a listing of all the patients' NRICs for whom the clinics had made claims in the specified year but no clinical indicator reports were submitted within a fixed period of 12 months from the claim submission date of each patient. This report is built in to assist 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.

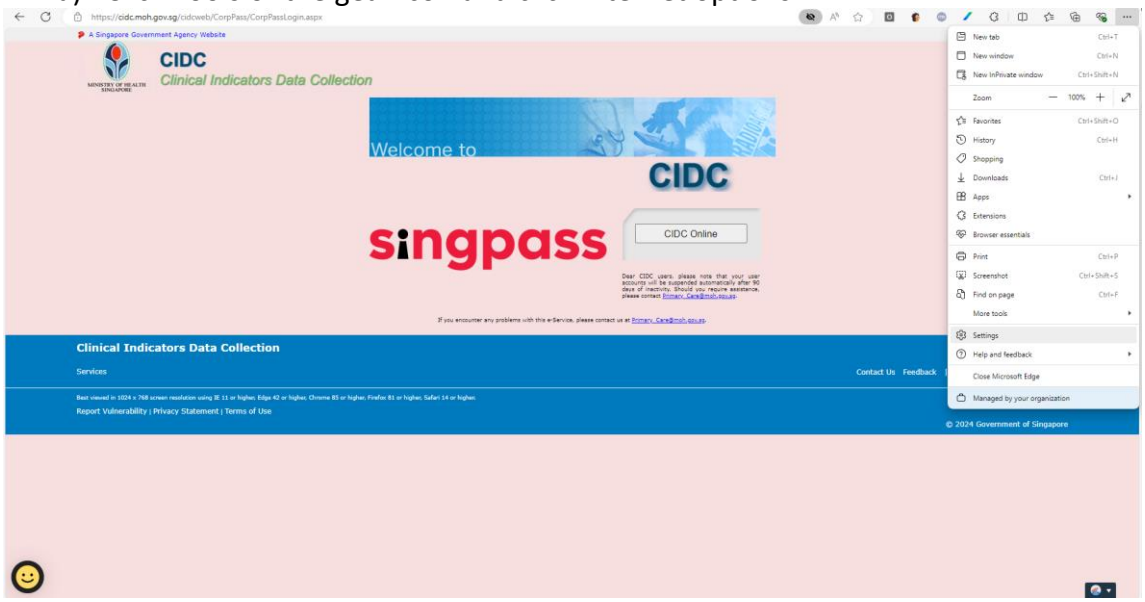


Screen 16: Viewing a Report

11 Troubleshooting

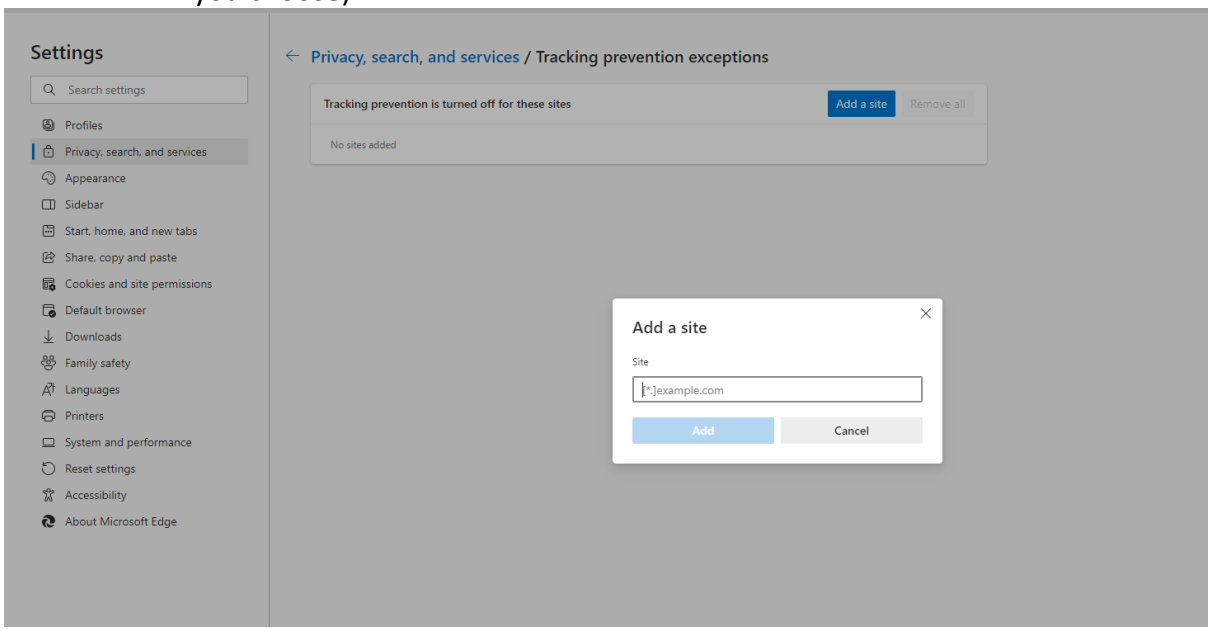
11.1 Enabling of Pop Ups: Certain screens within the application will be displayed as pop-up windows. In order to access the full system functionality, you need to enable pop-up windows for the MediClaim website. To enable this feature, follow the steps below:

a) Click Tools or the gear icon and click Internet options.



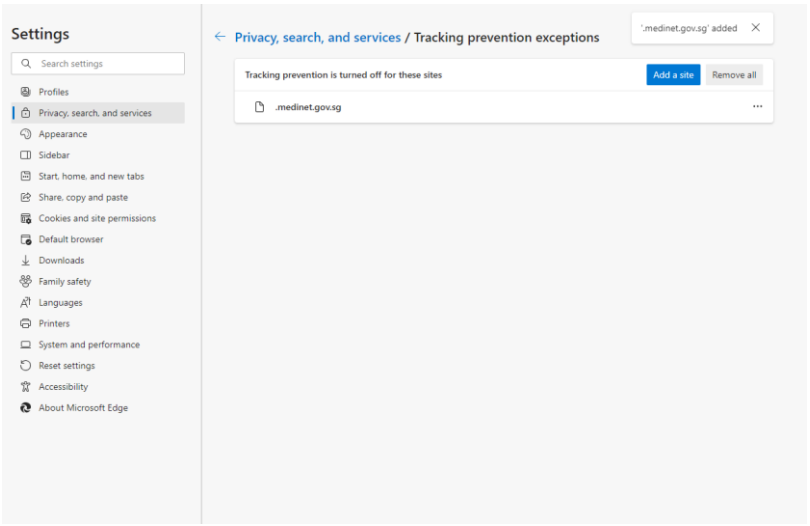
Screen 17: Internet Explorer Menu

b) select Privacy, search and services, and click “Exceptions (Allow all trackers on sites you choose)”



Screen 18: Internet Options – Privacy, search and services

c) Enter “*.medinet.gov.sg” and “*.moh.gov.sg” then click on Add.



Screen 19: 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 contact Primary_Care@moh.gov.sg.