Healthcare Partners Protocol and Solutions Committee (HPPSC) Circular 1/2026

BACKGROUND

HPPSC meetings were held on February 27, April 7 and April 28, June 10 and September 9. Amongst other agenda items, the need to clarify a number of claims issues relating to cancer treatments were discussed. It was agreed that the committee would meet with the Malaysian Society of Oncologists (MOS) and the Haematology Society of Malaysia (HSM). The meeting took place on 17 March. A number of issues were discussed, and views were expressed on both sides. The issues, together with input from the Societies were tabled at the 4th and 5th and 6th HPPSC meeting held on 28 April, 10 June and 9 September. The following items were discussed and agreed:

1. GENOMIC TESTING ISSUES:

a) There are questions and concerns around the number of genetic tests in one panel and its associated costs, where parts of the genetic tests may not be related to the diagnosis

b) When a diagnosis is made for colon or breast cancer, genetic tests for both must be tested given they share the same gene. However, there is inconsistent claims treatment from ITOs on this.

c) It would be useful to have a guideline on genomic testing from the Oncology Society.

DISCUSSED/AGREED

a) It was shared that most labs have packages for genomic testing and some unrelated areas may be included in the package. That to single out specific tests may be more expensive than the package tests, however it is preferred that only tests specific to the diagnosis be covered.

b) After the discussions with MOS and HSM, it was concluded that it is not medically necessary to conduct both breast cancer and colon cancer screening as the genes are not similar.

c) While it is useful for MOS to issue guidelines based on the National Comprehensive Cancer Network (NCCN) USA, the decision on whether to pay for packaged screening should be left to ITOs based on their policy coverage. On a query if insurance coverage is provided if a BRCA gene is detected after policy inception, it was agreed that the best practice in these instances should be to grant.

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2. RECONSTRUCTIVE SURGERY

a) Reconstructive surgery that is medically justified to restore function is eligible for coverage, except for the costs of implants, which is excluded. However, procedures performed solely for cosmetic purposes should be excluded from coverage.

b) Breast reconstructive surgery is covered if it is done concurrent to the mastectomy if the same care setting. However, if the patient needs chemotherapy and the reconstruction is done later, a query was raised as to whether such exceptions be covered.

DISCUSSED/AGREED

a) It was reported that the position of the MOH is that reconstructive surgery following a mastectomy should not be considered as cosmetic surgery. Best practice would be to cover reconstructive surgery following a mastectomy.

b) It is best practice for the justification for delay in reconstructive surgery be given at the time of mastectomy. This matter will be addressed by MOH in its Schedule of Fees guidelines, which is being finalised.

3. PROPHYLAXIS SURGERY

a) Prophylactic or preventative surgeries, such as contralateral mastectomy of a healthy breast in breast cancer patients (preventative in nature) and removal of ovaries and fallopian tubes in breast cancer patients, may be considered, either therapeutic or preventative, depending on the hormonal receptor status. For ER/PR positive cases that necessitates hormonal treatment, these cases may carry therapeutic value and should be covered, while in ER/PR-negative cases they are performed for preventative purposes to reduce future cancer risk and is not covered.

DISCUSSED/AGREED

a) Representatives from ITOs clarified that preventive surgeries are not covered in the policy contract as there is no way to determine that cancer will be detected in the future. This is still considered as preventive surgery and not medically necessary. It was highlighted that under the recent National Comprehensive Cancer Network (NCCN) guidelines, prophylactic mastectomy is not recommended.

b) TPAs enquired as to how insurers determine if a treatment is medically necessary or not. An example was made of cataract surgery where it is considered as medically necessary, as without the surgery, the patient will not be able to see clearly. Similarly for kidney transplant, the treatment is required to prolong the life of the individual. It is considered as medically necessary. It is a best practice that the patient should bear the costs for prophylactic surgery.

It is considered a best practice for doctors to provide financial counselling to their patients on the treatment costs that they must bear before the surgery.

4. CHEMOTHERAPY IN A DAYCARE SETTING

Questions were raised by both payors and providers about the coverage for chemotherapy in a daycare setting. A survey was conducted of LIAM members, and it found that the definition of daycare and its applicability to chemotherapy varies. Some enforced a six-hour rule while some treated it as outpatient.

DISCUSSED/AGREED

It was discussed and agreed that the best practice is for chemotherapy administered in a daycare setting to be covered and that there should not be a minimum number of hours required for daycare treatment to be covered. Further it was discussed that the best practice would be to consider immunotherapy, hormonal therapy, targeted therapy, and radiotherapy for cancer treatment as part of chemotherapy coverage, where medically indicated & coverage should be granted. Any hormonal therapy exclusion should not apply to hormonal therapy prescribed for cancer treatment, as it forms part of recognised oncology management.

5. DOCTOR TO DOCTOR HOTLINE

Feedback on the newly required doctor to doctor hotline has received generally very good response. Representatives from MAA did note that feedback from some doctors that the hotline wasn't always manned, and emails were sometimes never answered. The HPPSC would like to remind payers that the hotline can be an effective tool in bridging gaps in communication and expediting vital communication throughout the GL process. Strong efforts are appreciated in making sure this facility works well.

6. DOCTOR DE-PANELLING APPEAL PROCESS

The de-panelling and appeal process for doctors is now ready. Any doctors desirous of submitting an appeal can do so from 24 August. Doctors who have been removed from an insurer's panel on or after 1 January 2025 have until 24 November to make an appeal. Appeals should be sent directly with a copy to the hospital or sent through the hospital.

7. OT AND CLINICAL NOTES

The HPPSC would like to remind all payers that OT notes and clinical notes cannot be given to payers either directly or indirectly through the insured/patient. This is an MOH regulation. For clarity some examples of OT and clinical notes include: nursing report; intraoperative nursing report; surgical instrument records; recovery

observation notes, ward vital signs chart, etc. Blood investigation reports, culture reports, pathology reports and radiology reports are examples of reports that can be released to the payor on a need to haver basis. Please refer to link below.

Medical-Records-Medical-Reports_MMC: https://shorturl.at/lvBqi

8. DOCTORS CREDENTIALLING

The issue of doctor's credentials was discussed, and it was agreed that as a best practice, requests for doctors credentialling should not be required as part of the GL process. Other requests for credentialling outside of the GL process should be directed to the hospital.

9. CLAWBACKS

The issue of clawbacks from doctors from payers was discussed. There were reports of cases where clawbacks were made retrospectively following the revision of a guideline or fee schedule, applying the new revision. MOH would like to state that a new revision or guideline cannot be used as a basis for clawbacks prior to the effective date of the said revision.

Yours sincerely,

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