CNAS

National Health Insurance House

Guide on the rights of persons coming from the armed conflict area in Ukraine to the social health insurance system

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Contained

INTRODUCTION

Through this guide, we want to provide quality information necessary for people coming from the armed conflict area in Ukraine, regarding their rights in the Romanian social health insurance system.

This guide aims to ensure easy access for people coming from the armed conflict area in Ukraine to medical services, sanitary materials, medicines and medical devices provided by the Romanian social health insurance system.

The rights granted by the health insurance system to persons coming from the armed conflict zone in Ukraine

According to art. 1 para. (4) and (5) of Government Emergency Ordinance no. 15/2022, with subsequent amendments, persons in special situations coming from the armed conflict area of Ukraine **benefit from the package of basic services** stipulated in the framework contract on the conditions of providing medical assistance, medicines and medical devices within the social health insurance system and its implementing rules, **as well as medicines, sanitary materials, medical devices and medical services included in the national curative health programs**, **as well as the Romanian insured persons.**

Persons in special situations coming from the armed conflict area of Ukraine benefit from the rights granted by the social health insurance system, **without payment of the social health insurance contribution, of the personal contribution for the medicines granted in the outpatient treatment and with exemption from co-payment.**

In the case of these persons, **the medical services in specialized outpatient medical assistance** for the clinical specialties included in the package of basic services **are provided without the need to present the referral ticket,** which is a form with special regime used in the social health insurance system.

Registration in the social health insurance system of persons coming from the armed conflict zone in Ukraine

Persons who come from the armed conflict area of Ukraine and first request medical services from the providers, are registered by them in the computer application provided by the National Health Insurance House, in order to assign an identification number in the social health insurance system.

After registering the person in the application and assigning an identification number, the data displayed to be handed over to the beneficiary / patient are printed from the application; This document can be used later by patients at any medical facility in Romania without the need for a subsequent generation of an identification number.

Basic package of services

Within the social health insurance system, the insured persons, regardless of the form by which the quality of insured person was acquired, benefit from medical services, medicines and medical devices, included in the basic package, provided by the family doctor or the specialist doctor, in outpatient or in the hospital.

Areas of healthcare

Family doctor

The family doctor is the patient's first contact with the health system. Primary care services are based on the continuous relationship between the doctor andthe person ana included on his own list.

In the case of people coming from the armed conflict zone of Ukraine, the family doctor provides any medical service included in the package of basic medical services, without placing these persons on his own list.

The basic package in primary health care includes: medical services thatare urative, prevention and prophylactic, medical services at home, administration of medicines, as well as additional medical services, diagnostic and therapeutic services that the family doctor can provide according to the competences acquired by going through a specific educational program and respectively the curriculum of doctor's training and the necessary equipment.

Curative medical services include services for medical emergencies, as well as consultations for acute conditions (including small surgery interventions or specific maneuvers). Consultations for diseases with endemoepidemic potential that require isolation can also be provided at a distance.

Regular consultations for insured persons with chronic diseases are carried out by appointment and are granted for the continuation of therapy, to supervisethe evolution of the disease and its complications. Patients with chronic diseases can benefit from one consultation per month at the family doctor, at the office or at a distance.

Prevention services are provided by the family doctor for all age categories, as follows:

Thescope of the preventive services offeredat the level of the family doctor, includes the detection of diabetes mellitus in asymptomatic adults, aged 18 years and over, overweight / obese and / or who have one or more risk factors for diabetes mellitus. For patients in whom blood glucose levels or oral glucose tolerance or glycosylated hemoglobin test are within certain thresholds, family doctors may initiate treatment with Metforminum.

Family doctors, can offer patients a series of diagnostic and therapeutic medical services provided according to the doctor's training curriculum, such as: spirometry, ambulatory measurement of blood pressure 24 hours, measurement of the ankle-arm pressure index, performing and interpreting the electrocardiogram, aerosol medication administration, intramuscular, intravenous, subcutaneous treatments, intravenous infusions, surgical treatment of panaritium, abscess, furuncle, skin lesions - superficially cut wounds, superficially pricked, skin necrosis, bedsores, varicose ulcers, wound dehiscences, burns, extraction of foreign bodies soft tissue (anesthesia, excision, suture, including removal of threads, dressing), immobilization sprain, peakflowmetry, medical survey, etc.

The consultations provided by the family doctor can also be provided at home for non-displaced persons,for patients with chronic diseases or acute conditions that do not allow travel to the office, children aged 0-1 year, children 0-18 years old with infectious-contagious diseases and locusts. **For patients with chronic diseases, one consultation at home per month can be given.**

The family doctor can provide **remote** medical consultations for patients with chronic diseases, as well as for diseases with endemo-epidemic potential that require isolation. The documents resulting from the remote consultation are transmitted to the patient by means of electronic communication.

Thefamily edic can issue medical documents such as:

• referral ticket (for specialized consultations or investigations);

• prescription;

• medical leave certificate;

• medical certificates for children in case of illness;

• recommendation for home medical care / palliative care at home;

• Recommendation for medical devices for stoma prosthesis and urinary incotinence, except for the urinary catheter.

Specialist doctor

Specialized outpatient medical assistance is provided in medical offices, health units, specialized and integrated outpatient units within hospitals, diagnostic and treatment medical centers, palliative care offices, under contract with the health insurance house.

The basic package includes the following services provided by the specialist doctor: medical services for emergency situations, curative medical services for acute conditions, consultations for chronic diseases, detection of diseases with endemo-epidemic potential, consultations for the provision of family planning services (counseling, evaluation and monitoring of genitourinary status, treatment of complications), palliative care services, diagnostic services and therapeutic, pregnancy and lausion supervision services, medical services for diagnostic purposes (the latter are day hospitalization services and are provided in clinical specialty outpatients).

ATTENTION!

For people coming from the armed conflict area of Ukraine, the medical services in specialized outpatient medical assistance for the clinical specialties included in the package of basic services are granted without the need to present the referral ticket, which is a form with special regime used in the social health insurance system.

Patients with chronic conditions benefit from a maximum of 4 consultations per quarter, with the inclusion in no more than 2 consultations per month, for services that provide for the evaluation of the patient and of the laboratory investigations, the prescription of the treatment and the follow-up of the evolution of the disease.

For the insured persons with a confirmed diagnosis upon discharge from the hospital, a maximum of 2 consultations are reimbursed for:

• monitoring the evolutionunder the treatment established during the hospitalization;

• performing therapeutic maneuvers ;

• examination of the wound, removal of the threads, removal of gypsum, after surgery or orthopedic;

• recommendations for paraclinical investigations deemed necessary, as appropriate.

Consultations for cronice diseases, as well as for diseases with endemo-epidemic potential that require isolation, can also be provided remotely, by any means of communication, being exempted from the obligation to present the referral ticket from the family doctor or from another specialist doctor. The documents resulting from the consultations will be transmitted to the patient by means of electronic communication.

Within the specialized outpatient clinic, **day hospitalization** services can also be provided, the duration of which is less than 12 hours and includes a cumulation of clinical medical services and investigations. Some examples of such services: normal pregnancy surveillance, high-risk pregnancy surveillance, prenatal screening, early detection of precancerous breast lesions, early detection and diagnosis of dysplastic lesions of the cervix.

The specialist doctor may decide after consultations:

• establishing the therapeutic conduct and/or prescribing the medical and hygienic-dietary treatment;

• issuing the recommendation formedical / palliative care at home;

• issuing recommendation for medical devices, technologies and assistive devices;

• clinical and paraclinical evaluation, prescribing the treatment and monitoring the evolution of patients with chronic conditions, in the limita competenţelor, quarterly or, as the case may be, monthly;

• issuance of the referral ticket to other specialties, including for palliative care in outpatient / admission ticket, as the case may be;

• issuethe area of sick leave certificate , as the case may be.

Doctors with certain specializations (examples: neurologist, psychiatrist, rheumatologist, orthopedist, oncologist, cardiologist, pulmonologist, etc.) may recommend to the insured persons services provided by the psychologist or the physiotherapist, provided that the specialized outpatient unit in which the doctor carries out his activity has qualified staff or is in contract with a provider of psychological or physiotherapeutic services.

The services that can be provided by the psychologist are: psychological counseling and psychotherapy, special psycho-pedagogy counseling, through speech therapist.

The services that can be provided by the physiotherapist are: individual or group physical therapy, physical therapy on special devices, such as mechanical devices, electromechanical devices, robotic devices.

Psychiatric therapies, services provided by the psychologist, psychological counseling and psychotherapy, as well as services provided by the speech therapist, may also be provided at a distance, by any means of communication.

Patients with post-COVID-19 conditions or aggravations can benefit from physical therapy, psychological counseling and psychotherapy, on the recommendation of doctors from the cardiology and pulmonology clinical specialties.

Laboratory analysis and imaging investigations

In order to benefit from free laboratory tests and imaging investigations, patients must meet the following conditions:

• to hold a referral ticket from the family doctor or specialist doctor, who is under contract with the health insurance fund;

• to go to a laboratory under contract with the health insurance fund.

Patients can benefit from investigations based on the referral ticket to analysis laboratories and imaging centers under contract with any insurance house, regardless of the insurance house with which the doctor who issued the referral ticket is under contract.

Patients can benefit from different categories of laboratory tests, such as:

• hematological (*hemogram, etc.*);

• serum (*examples: uric acid, serum creatinine, blood glucose, cholesterol, triglycerides, sodium, potassium, calcium, magnesium, etc.*);

• of urine (*urinalysis and sediment, urinary albumin, urinary glucose, etc.*);

• immunological (*various hormones and antibodies*);

• microbiological (*analysis of secretions, excretions, antibiogram*);

• examination of tissues sampled;

• Babeș-Papanicolau testing.

Also, radiology analyzes are settled, as well as ultrasounds (*non-irradiating investigations*), Doppler and high-performance investigations (*CT, MRI, scintigraphies, angiographies*).

In order to identify the laboratories in the contract with the health insurance houses and the funds available at their level, patients can access the CNAS *website (www.cnas.ro)*, where you can find information on the contact details of the providers, by type of medical assistance. On the first page, in the "**Suppliers Information**" menu in the section "**Online reports providers (old website)**", by accessing the window "**Paraclinical reporting – see more**", there is the list of laboratories in contract with the health insurance houses, as well as the fund available at the level of each laboratory. This information can also be accessed on the web pages of the health insurance funds.

Attention!

• If the investigations cannot be performed on the spot, the laboratory has the obligation to schedule the patient during the period of validity of the referral ticket, passing on the back of the referral ticket the date of submission for the appointment and the date of the next appointment. If the patient refuses the appointment, the laboratory returns the referral ticket so that he can go to another investigation laboratory.

Fthe beneficiaries of paraclinical medical services have the obligation to carry out within 5 calendar days from the date of the request, the investigations recommended according to the medical practice guidelines approved by order of the minister of health, necessary for the monitoring of patients with COVID-19 (after discharge from the hospital or after the end of the isolation period), as well as of the patientsor with oncological diseases, diabetes, rare disease, cardiovascular disease, cerebrovascular diseases, neurological diseases, services that are provided by laboratories and above the contract value, provided that the prescribing doctor specifies on the referral note that the investigations are carried out for monitoring.

Investigations recommended by the family doctor during the prevention consultations for patients over the age of 40 years are settled from FNUASS and can be performed by providers under contract with the health insurance houses and above the contract value.

The referral ticket for laboratory investigations has a30-day vala. For all chronic diseases, as well as for analyzes involving tissue collections, the validity of the referral ticket for investigations is up to 90 days.

Hospital care

Hospital services are provided for **diseases that require hospitalization** and include: consultations, investigations, diagnosis, medical and / or surgical treatment, care, recovery, medicines and sanitary materials, medical devices, accommodation and meals. Medical services in hospital regime are provided, according to the appointment, based on the referral ticket issued by the family doctor or the outpatient specialist.

The referral ticket is not required in case of medical emergencies.

Medical services can be provided by day hospitalization, which means a toughadmission thread of a maximum of 12 hours, or by continuous hospitalization, which involves a duration of admission of more than 12 hours.

Some examples of conditions that can be treated in day hospitalization: anemia, respiratory tract infections, urinary tract infections, viral or bacterial intestinal infections, infectious diarrhea, irritable bowel syndrome, gastroesophageal reflux disease, varicose veins without inflammation, acute tonsillitis, autoimmune thyroiditis, diabetes mellitus, ischemic cardiomyopathy, mitral or aortic valve insufficiency without indication of surgery, alcoholic hepatitis.

Conditions for the provision of hospital services in public health facilities

Patients can benefit from **free medical services only in public hospitals** that have concluded contracts for the provision of hospital services with the health insurance funds.

The public hospital under contract with a health insurance fund is obliged to provide the medical services that are the subject of the contract and to bear for the hospitalized insured persons all the necessary expenses for solving the respective cases, including medicines, sanitary materials, laboratory investigations and imaging. The hospital also supports the amount for standard hotel services for attendants of sick children under the age of 3 years and for those of people with severe or accentuated disabilities.

Starting with April 1, 2022, the chemotherapy services with monitoring provided in the regime of day hospitalization, by the health units in contractual relations with the health insurance houses for this service, the dialysis services provided in the health units that carry out the National Program for the replacement of renal function in patients with chronic renal insufficiency, as well as the radiotherapy services provided by the health units that run the Radiotherapy Subprogram of the patients with oncological diseases are settled at the level achieved.

If the insured person addresses a hospital that is **NOT** under contract with the health insurance fund, **the insured person bears the value of the** medical services he/she has benefited from and cannot recover these amounts from the health insurance fund.

Public hospitals that reimburse medical services in relation to health insurance funds cannot collect another payment from the insured for the medical services provided.

Conditions for the provision of hospital services in private health facilities

Starting with July 1, 2021, private hospitals under contract with the health insurance houses may receive a **personal contribution** from patients who choose to benefit from hospitalization services, for a condition in acute form, in these units funded according to diagnostic groups (*DRG system*).

The personal contribution represents the difference between the tariff settled by the health insurance fund and the tariff practiced by the private hospital. In order to ensure transparency and respect for patients' rights, the following regulations have been introduced: the private hospital in contract with the health insurance fund has the obligation to publicly display, at the headquarters and on the website, the tariffs practiced, as well as the amount settled by the state and the value of

the personal contribution for the services contracted with the health insurance fund. **Before admission**, the patient will receive an **estimate of** the costs of the requested medical services, valid for 5 working days.

Any changes in costs to the initial estimate occurred during the admission will be made only with the written consent of the patient or his legal guardian. Upon discharge, the patient will be issued a statement, which will include all the expenses related to the hospitalization. The main elements of the estimate can be found below.

Deviz estimativ

Datele clinicii

Datele pacientului

Datele cazului tratat

Scurtă descriere a serviciului medical

Numărul zilelor de spitalizare estimate

Date financiare privind serviciile ce vor fi acordate

Tariful practicat de spital pentru rezolvarea cazului

Detalierea cheltuielilor
- cazare și hrană
- medicamente și materiale sanitare
- dispozitive medicale
- analize medicale
- radiologie și imagistică
- alte investigații și proceduri
- consulturi interclinice
- alte servicii și îngrijiri
- cheltuieli personal
- cheltuieli indirecte

Suma suportată din FNUASS

Contribuția personală

Valabil 5 zile lucrătoare

What happens in the situation when a patient, although he is admitted to the hospital, has to pay for the medicines from his own money?

If the doctor in the ward where the patient is admitted recommends, on the basis of medical documents, certain medicines, sanitary materials or laboratory investigations, and the expenses for these are borne by the patient, although he would have been entitled to benefit from them free of charge, **the hospital reimburses the patient for the value of** these expenses at the request of the insured.

The reimbursement of those expenses is an obligation which applies exclusively to public hospitals and is made from their own revenues. Public hospitals develop a methodology on the basis of which they reimburse these expenses, which is made available to the health insurance fund and **is made known to patients upon their admission to the hospital**.

Dentist/dentist

Patients can benefit from the services included in the basic package for dental medicine, which includes, but is not limited to: consultation, treatment of simple caries, treatment of oral mucosal

diseases, dental extractions, alveolar curettage and bleeding treatment, decapusion, acrylic prosthesis mobilizable on the arch, physiognomic or semi-physiognomic prosthetic element, devices and devices used in the treatment of congenital malformations.

The services provided in the package of basic medical services for dental medicine are settled in a percentage of 100% for the age category 0-18 years and in a percentage that varies between 60% and 100%, depending on the type of service, for people over the age of 18 years.

Within the age group over 18 years – only for young people from 18 years to the age of 26, if they are students, including high school graduates, until the beginning of the academic year, but not more than 3 months, apprentices or students and if they do not earn income from work, the health insurance houses settle 100% the tariffs related to dental services.

For people who benefit from special laws, the health insurance houses reimburse 100% the fees related to some of the dental services.

Medical recovery, physical medicine and rehabilitation services

Medical recovery, physical medicine and rehabilitation services may be provided to insured persons on an outpatient or inpatient basis.

Physical medicine and outpatient rehabilitation in the treatment bases

Physical medicine and rehabilitation services are provided on an outpatient basis in treatment bases, within the clinical specialty of physical medicine and rehabilitation. These services include specific procedures of physical medicine and rehabilitation within the framework of a series of procedures – performed in the basicof treatment such as physical therapy, hydrokinetic therapy, massage, aerosols, etc. Some procedures, such as mineral baths, natural mofettes, mud wraps, can be carried out only in the treatment bases of the spa resorts.

The specific procedures of physical medicine and rehabilitation within a series of procedures – performed in treatment bases are granted according to the Specific Procedure Plan of Physical Medicine and Rehabilitation, for periods and according to a rhythm established by the specialist doctor of physical medicine and rehabilitation.

Patients are entitled to specific physical medicine and outpatient rehabilitation procedures for a maximum period of **21 days / year / insured**, both for children and adults. Children aged 0-18 years with a confirmed diagnosis of cerebral palsy benefit from specific medical procedures of physical medicine and rehabilitation for a period of maximum 42 days / year / patient. The procedures can be divided into a maximum of two sessions, depending on the underlying condition, on the recommendation of the physical medicine and rehabilitation specialist in the Specific Procedure Plan of Physical Medicine and Rehabilitation.

The series of specific procedures of physical medicine and rehabilitation established by the specialist doctor settled for a patient includes a maximum of 4 procedures / day of treatment. For a series of specific procedures of physical medicine and rehabilitation performed in outpatient regime, which are carried out in the treatment centers of the balneoclimatic resorts, a maximum of4 procedures / day are decoutated.

Medical recovery in hospitals

Medical recovery services provided in hospital regime are provided in sanatoriums or sanatorium wards, which can have a spa profile, both for children and adults.

Medical services of physical medicine and rehabilitation, provided in balneary sanatoriums can be provided for a maximum duration of 14-21 days / year period that can be distributed in maximum two fractions, at the recommendation of the prescribing doctor and which include at least 4 procedures / day for at least 5 days / week. Medical services are also provided for durations of less than 14 days.

For balneary sanatoriums/ sanatorium wards in hospitals, patients pay a personal contribution. The medical services provided over the 21-day hospitalization period are fully supported by the patients.

The beneficiaries *of the Emergency Ordinance no. 15/2022* on the provision of support and humanitarian assistance by the Romanian state to foreign citizens or stateless persons in special situations, coming from the armed conflict area in Ukraine, with subsequent amendments and completions , are not required personal contribution.

The services are provided on the basis of the referral tickets for the treatment of physical medicine and rehabilitation in the spa sanatoriums, issued by the family doctors / the specialist doctors from the outpatients and from the hospital, who are in contractual relations with the health insurance houses. The criteria for issuing referral tickets for physical medicine and rehabilitation treatment take into account the specific pathology and associated conditions of the patient.

The period and pace of services are set by specialist doctors of physical medicine and rehabilitation.

Medical recovery services provided in sanatoriums other than spas and preventers are services provided in hospital, for periods and according to a rhythm established by the specialist doctors who carry out their activity in these units, not limited to a certain number of days.

Emergency consultations at home and unassisted transport

Patients can benefit from the following services for emergency consultations at home and unassisted sanitary transport activities, in addition to the services provided in the minimum package, without being limited to:

• transport at discharge (*including in another county*) for patients with severe cognitive disorders (*dementias of various etiologies, autistic* spectrum disorders*, severe or profound mental retardation);*

• transport of non-displaced patients with tetraparesis or motor insufficiency of the lower train, to the hospital for admission based on the admission ticket in the recovery health units;

• round-trip transport to the specialized office in the clinical specialties and from the office to the home, for bedridden patients, with severe cognitive disorders *(dementias of different etiologies, autism spectrum disorders, severe or profound mental delay),* with hemiparesis or paraparesis, moderately severe, for consultation in order to evaluate, monitor and prescribe the treatment in case of diseases chronic for which medication can be prescribed only by the specialized outpatient specialist;

• round-trip transport, to the laboratory of paraclinical investigations and from the laboratory to home, for bedridden patients , for performing paraclinical medical investigations in outpatient settings, recommended by family doctors or specialists in the clinical specialty outpatient clinic under contract with the health insurance houses.

Emergency consultations at home and unassisted sanitary transport are carried out by private

ambulances, which are under contract with the health insurance houses, through the emergency service 112.

Thus,if the patient finds himself in one of the situations described above, he or the caregiver can call the emergency service 112, and the dispatcher analyzes the described situation and decides what kind of ambulance to send.

Also, if it is necessary to transport the patient upon discharge from the hospital, the 112 emergency service can be called by both the patient or caregivers, as well as by the hospital staff.

Calling the 112 emergency service is done responsibly!

Home care

Home health care services are provided to patients on a recommendation basis, taking into account their state of health.

I can recommend medical care services at home: specialist doctors in outpatients or hospitals, when the insured persons are discharged, and family doctors, doctors under contract with the health insurance houses. Home health care services are recommended for patients with performance status ECOG3 *(immobilized 50% bed or armchair) or* ECOG4 *(completely bedridden, totally dependent on another person for basic care)*.

Home health care

The most common home health care services are: measurement of physiological parameters *(temperature, pulse, blood pressure, etc.)* , medication administration, therapeutic maneuvers to avoid vascular and pulmonary complications, injury care, physical therapy.

The duration for which a patient can benefit from home health care services is determined by the doctor who made the recommendation, but not more than 90 days of care in the last 11 months, provided in several stages *(episodes of care)*. A care episode is a maximum of 15 days, respectively a maximum of 30 days for situations medically justified by the doctor who makes the recommendation.

Home health care providers provide services according to a care plan established in accordance with the recommendations made by the prescribing physician, including Saturdays, Sundays and public holidays. The care plan can be modified only with the advice of the doctor who issued the recommendation for home health care.

Palliative care at home

Palliative care services at home are provided to patients on the basis of a recommendation, issued by family doctors, specialists in specialized outpatients, including doctors with a certificate of complementary studies in palliative care, or specialist doctors in the hospital, who are in a contractual relationship with health insurance houses.

The most common palliative care services at home are: the consultation that is carried out in holistic medicine, the elaboration of the interdisciplinary treatment and care plan, the evaluation of the functional status and the capacity of self-care, the application and monitoring of the pharmacological treatment, the education and information of the patient for self-care, terminal care, specialized psychological counseling of the patient and family, physical therapy.

The duration for which a patient can benefit from palliative care services at home is determined by

the doctor who made the recommendation, but not more than 90 days of care in the last 11 months, provided in several stages *(episodes of care)*. One episode of care is a maximum of 30 days.

Palliative care services at home are provided according to a care plan established by the doctor with a certificate in palliative care who carries out his activity at the palliative care provider, depending on the needs of the patient. The rhythmicity of providing palliative care services at home is established based on the monitoring protocol, depending on the patient's needs identified by the palliative care team. The care plan can be revised according to the patient's needs.

The doctor with a certificate in palliative care who carries out his activity at the palliative care provider may issue an electronic prescription for medicines with and without personal contribution, in order to control the patient's symptoms.

Conditions relating to medical and palliative care at home

A patient may receive 90 days of home health care and 90 days of palliative care at home in the last 11 months; the total number of days of medical care and palliative care at home may not exceed 180 days in the last 11 months.

The recommendation for home medical care or palliative care at home is issued in 2 copies, of which one copy remains with the doctor, and the second copy will be handed over to the patient, who will present it in original to the insurance house to certify compliance with the number of days of care he can benefit from. The health insurance fund, at the time of submitting the recommendation, will also hand over to the patient or his legal representative the list of providers of home health care or palliative care at home with whom they are in a contractual relationship, together with their contact details.

In order for the patient to receive free home care, these services must be provided by a provider under contract with the health insurance fund.

Compensated medicines

Patients can benefit from drugs supported by FNUASS, which are issued on the basis of an electronic medical prescription or a medical prescription with special regimen (*for psychotropic and narcotic - green or yellow forms*).

Within the social health insurance system, only those medicines included in the List of compensated medicines approved by Government Decision can be prescribed and settled.

Medicinal products settled from FNUASS may be dispensed only by Community pharmacies which are under contract with the health insurance funds.

Prescribing physician

Compensated medicines may be prescribed by the family doctor or specialist doctor (who carries out his activity in the specialized outpatient or in the hospital) who are in contract with a health insurance fund. Certain medications, restricted by therapeutic protocols, can only be prescribed by the specialist doctor.

The patient may also receive medicines compensated for the chronic disease already confirmed if he is admitted to a hospital that does not have those medicines. Thus, family doctors and doctors in the specialized outpatient clinic may issue a prescription for medicines from national health

programmes, as well as for medicines related to chronic conditions, other than those included in the list of medicines that the hospital submits to contracting. In this situation, the medical prescription is issued subject to the presentation of a document issued by the hospital showing that the patient is hospitalized. Theyare required to publish on their own website the **list of medicines available** in that hospital.

As a rule, the attending physician prescribes compensated medicines on the active substance *(international non-proprietary name – INN)*, but in certain situations, such as biological products, medicines under cost-volume or cost-volume-result contracts, or in medically justified situations, the prescription may also be on the trade name of the medicine.

A copy of the medical prescription is handed to the patient by the doctor, to be deposited at the pharmacy. In the case of electronic medical prescriptions issued as a result of a remote consultation carried out by the family doctor or the specialist doctor, the patient or the person who picks up the medicines on behalf of the patient may print the document sent by the doctor or transmit it to the pharmacy by means of electronic communication in order to print it.

ATTENTION!

• In the social health insurance system, the compensated medicines can be prescribed and settled for the conditions that are found in the "*Summary of product characteristics*" approved by the National Agency for Medicines and Medical Devices in Romania or under the conditions provided in the therapeutic protocols for those medicines restricted to prescription.

Validity of the electronic prescription

The periods for which the drugs can be prescribed are a maximum of 7 days in acute conditions, up to 8 - 10 days in subacute conditions and up to 30 - 31 days for patients with chronic conditions. For patients with stabilized chronic diseases and stable therapeutic scheme, drugs can be prescribed for a period of up to 90/91/92 days.

The medical prescription for chronic conditions is valid for a maximum of 30 days from the date of its issuance, and for acute and subacute conditions the medical prescription is valid for a maximum of 48 hours.

Prescriptions issued for a period of 90/91/92 days, prescribed online and signed by the prescribing doctor with extended electronic signature, can be issued fractionally for 30/31/32 days, and the validity of these prescriptions is maximum 92 days, depending on the prescribed period. The first release will be made within a maximum of 30 days from the date of issuance of the prescription.

Compensation lists

The maximum amount to be borne by the health insurance funds of FNUASS shall be that corresponding to the application of the percentage of compensation of medicinal products to the reference price. The percentage of compensation applied to the reference price is differentiated according to the sub-list in which the medicinal product prescribed by the attending physician is found, and may be:

- **90%** corresponding to the international non-proprietary names *(INNs)* referred to in sub-list A;
- **50%** corresponding to the international non-proprietary names *(INNs)* referred to in sub-list B;
- **100%** corresponding to the international non-proprietary names *(INNs)* referred to in sub-list C;

• **20%** corresponding to the international non-proprietary names *(INNs)* referred to in sub-list D.

ATTENTION!

People coming from the armed conflict zone in Ukraine **are exempted from paying personal contribution for medicines granted in outpatient treatment!**

Dispensing of medicines in the pharmacy

Medicamentele can be picked up by patients from any pharmacy in the country, who are under contract with the health insurance houses, regardless of the health insurance fund where the patient is registered or by the health insurance fund with which the doctor is under contract, except for medicines that are subject to cost-volume-result contracts.

Medical devices

Medical devices are granted to patients, for a fixed or indefinite period, based on the medical prescription issued by the doctor under contract with the health insurance fund. Medical prescriptions lose their validity if they are not submitted to the health insurance fund within 30 calendar days from the date of issue.

The devices are issued to patients only by providers who are under contract with the health insurance fund, by purchase or rental. For certain medical devices, for which their price is higher than the price that the CNAS reimburses for that category of device, there is a possibility that the insured will bear a personal contribution.

Beneficiaries of the Emergency Ordinance no. 15/2022 on the provision of support and humanitarian assistance by the Romanian state to foreign citizens or stateless persons in special situations, coming from the armed conflict area of Ukraine, with subsequent amendments and completions, are not required personal contribution.

The basic package for medical devices intended for the recovery of organic or functional deficiencies in outpatient settings includes: prosthetic devices in the field of ENT, devices for stoma prosthesis, devices for urinary retention and/or incontinence, prostheses for limbs, orthotic orthotic orthotics for spine or limbs, orthopedic shoes, devices for visual deficiencies, equipment for oxygen therapy and non-invasive ventilation, devices for limbs, orthotic orthotics for the spine or limbs, orthopedic shoes, devices for visual deficiencies, equipment for oxygen therapy and non-invasive ventilation, devices for aerosol therapy, walking devices, external breast prostheses.

Procedure for obtaining devices

The patient, a first or second degree relative, the spouse or the legal representative submits an application to the health insurance fund, together with the following documents:

• copy of the identity document;

• medical prescription for the device;

• the certificate of classification in grade and type of disability for oxygen therapy and non-invasive

ventilation equipment, as appropriate.

For children up to 14 years of age, the medical prescription for the device is attached, specifying the child's domicile, and the copy of the birth certificate. The documents may also be sent to the health insurance fund by post or by means of electronic communication.

The health insurance fund is obliged to analyze and decide to accept or reject the application, within a maximum of 3 working days from the date of its registration.

In case of acceptance, an approval decision will be issued for the purchase / rental of the device, within the limit of the fund approved for this purpose. The decision shall be taken from the health insurance fund by the beneficiary, a first or second degree relative, his/her spouse or his/her legal representative, or shall be sent by post upon request.

If applications for devices exceed the approved monthly fund, priority lists shall be drawn up, by category of devices. In this case, the decision shall be issued at the time when the fund approved for this purpose allows the device to be settled, in the order of the priority list.

In order to purchase the device, the patient, a first or second degree relative, the spouse or the legal representative shall address, during the period of validity of the decision, to one of the suppliers of devices under contract with the health insurance fund, with the following documents: the decision issued by the health insurance fund and the medical prescription. The documents can also be sent to the supplier by post/ courier.

Measures for COVID-19 patients

For the insured persons, the uninsured persons, as well as for other persons on the territory of Romania diagnosed with COVID-19, all the medical services and medicines necessary for their treatment are reimbursed from FNUASS.

At the same time, all persons in Romania who have symptoms suggestive of COVID-19 benefit from remote consultations provided by their family doctor or specialist doctor.

Based on the confirmation of the infection through a rapid antigen test or NAAT/RT-PCR test identified in the Corona Forms platform, medical services are provided in the assessment centers to all persons who do not require oxygen therapy, who have mild or medium clinical manifestations of COVID-19 and who have at least 2 risk factors, without the need to present the referral ticket, at the time of presentation.

In the list of medical services that can be provided in day hospitalization regime, the service "*Evaluation of the Post Covid-19 Syndrome*" was introduced, in order to support patients who continue to present symptoms for a long period of time, some even after having gone through a mild form of the disease.

Also, patients who have at discharge from the hospital medium or severe respiratory failure post COVID-19 or who have gone through a triage system specific to infection with the SARS-CoV-2 virus can benefit from **the device for continuous administration of oxygen** (*oxygen concentrator type*). Patients with certain conditions may benefit from non-invasive ventilation. Details of the procedure by which this equipment can be obtained are presented in the chapter ***Medical devices***.

Peoplewith post-COVID-19 conditions can benefit from **physical therapy, psychological counseling and psychotherapy**, on the recommendation of doctors from the cardiology and pulmonology clinical specialties. These services are settled in the health insurance system on condition that the doctors who provide them carry out their activity in clinics under contract with the health insurance funds. The way in which patients can access medical services is detailed in the chapter ***Specialist***

doctor.

Measures for the pregnant woman

The medical services provided to the pregnant woman are regulated on different levels of medical assistance, as follows:

- **Primary health care**

Consultations for monitoring the evolution of pregnancy and lausion:

- recording in the first quarter;
- surveillance, on a monthly basis,from the 3rd to the 7th month;
- surveillance, twice a month, from the 7th month to the 9th month inclusive;
- follow-up of the laudatory upon discharge from the maternity ward - at home;
- pursuit of the laudatory 4 weeksafter birth - at home.

In the framework of the surveillance of the pregnant woman, the exclusive breast feeding of the child up to the age of 6 months and its continuation up to a minimum of 12 months is made, a recommendation for testing for HIV, hepatitis of viral etiology with virus B and C, lues of the pregnant woman, as well as other necessary paraclinical investigations.

With the first presentation to the family doctor of the pregnant woman, the family doctor will issue the document certifying the existence of the pregnancy.

Inorder to support the pregnant woman, in order to ensure a better access to medical services in the basic package, there are also **two diagnostic and therapeutic medical services**: **labor surveillance without birth** and **unannounced birth** - **these services may be provided by the family doctor, including at the place of request, within the home program or outside the program declared in the contract with the health insurance fund.**

- **Specialized ambulatory medical assistance for paraclinical specialties**

Paraclinical medical services: Cervico-vaginal cytological examination Babes-Papanicolau, Vaginal discharge examinations - Native and colored microscopic examination, culture and bacterial identification, Vaginal discharge examinations - Native and colored microscopic examination, fungal culture and identification, Antibiogram and Antifungigram, are found in the package of basic medical services in specialized ambulatory medical care for paraclinical specialties . These services may also be recommended by family doctors.

Paraclinical medical investigations *Obstetrical ultrasound anomalies ii trimester and obstetrical ultrasound anomalies I trimester with TN* are found in the package of basic medical services in specialized ambulatory medical assistance for paraclinical specialties and are settled from FNUASS only for doctors in the obstetrics-gynecology specialty with overspecialization in maternal-fetal medicine.

- **Specialty ambulatory medical care for clinical specialties**

- **Pregnancy and lausion supervision services** - a consultation for each trimester of pregnancy and a consultation in the first trimester after birth.

- **Medical services for diagnostic purposes - case**

These services are day hospitalization services, are provided in an outpatient clinic specialty and are reimbursed **only if all the mandatory services have been performed:**

- **Surveillance of a normal pregnancy (in pregnant women who do not have medical documents attesting the existence in the personal pathological history of rubella, toxoplasmosis, CMV infection)**

Compulsory services: Obstetrics and gynecology specialist consultations, Complete blood count, Determination of the ABO blood group in pregnant, Determination of the rh blood group in pregnant, Serum urea, Serum uric acid, Serum creatinine, Blood glucose, TGP, TGO, TSH, Complete urine examination (summary + sediment), VDRL or RPR, HIV testing in pregnant women, Evaluation of pregnant women for infections at risk for pregnancy (for rubella, toxoplasmosis, CMV infection, hepatitis B and C), Vaginal secretion, Cervico-vaginal cytological examination Babes-Papanicolau (up to S23+6 days) or Glucose tolerance test per bone +/- Glycated hemoglobin (S24 – S28+6 days) or **Fetal biometrics (S29-S33+6 days)** or Detection of group B streptococcus (S34 – S37+6 days), Ultrasound confirming, viability and dating pregnancy.

This **medical service for diagnostic purposes – case iscontracted only with the obstetrics and gynecology specialized hospitals and with the other sanitary units with beds, which have in their structure wards or compartments of obstetrics-gynecology and neonatology ranked at level 3, 2 or 1**.

The specialties that provide this service are:

- clinical: obstetrics and gynecology, for which doctors must prove the competence / certificate of complementary training in obstetrical and gynecological ultrasonography;

- paraclinical: laboratory medicine.

The package of medical services corresponding both **to the Surveillance of a normal pregnancy (in the pregnant woman who does not have medical documents attesting the existence in the personal pathological history of rubella, toxoplasmosis, CMV infection)** and **to the Surveillance of a normal pregnancy (in the pregnant woman who holds medical documents attesting the existence in the personal pathological history of rubella, toxoplasmosis, CMV infection)** it is contracted only by the health units that have in their organizational structure an obstetrics and gynecology office within which the specialized consultation and ultrasound for confirmation, viability and pregnancy dating are performed, as well as a medical analysis laboratory for carrying out all the medical analyzes provided for in the package.

If the medical services corresponding **to the Surveillance of a normal pregnancy (in pregnant women who do not have medical documents)** and **the Surveillance of a normal pregnancy (in the pregnant woman who holds medical documents)** are provided during the period S11 - S19 + 6 days, they can be provided simultaneously with the medical services corresponding to **the Prenatal Screening (S11 - S19 + 6 days).**

- **Prenatal screening (S11 - S19 + 6 days)**

Mandatory services: Obstetrics and gynecology specialized consultation (integrative interpretation of the results), **Double test / triple test**, **Ultrasound for the detection of fetal anomalies (S11 - S19 + 6 days).**

This **medical service for diagnostic purposes – case iscontracted only with the obstetrics and gynecology specialized hospitals and with the other sanitary units with beds, which have in their structure wards or compartments of obstetrics-gynecology and neonatology ranked at level 1, 2 or 3**.

Specialties that provide the prenatal screening service:

- clinical: obstetrics and gynecology; doctors in the obstetrics and gynecology specialty must prove their competence/ certificate of complementary training in obstetrical and gynecological ultrasonography or overspecialization in maternal-fetal medicine;

- paraclinical: laboratory medicine.

- **Supervision of other high-risk pregnancies (gestational edema)**

Mandatory services: Obstetrics and gynecology specialized consultation, Complete blood count, Serum creatinine, Serum uric acid, TGP, TGO, Complete urine examination (summary + sediment), Urinary protein dosing, Total serum protein, Obstetrical and gynecological ultrasound.

These services are contracted only with the obstetrics and gynecology specialized hospitals and with the other sanitary units with beds, which have in their structure sections or compartments of obstetrics-gynecology and neonatology ranked at level 3 or 2.

Specialties that provide the above listed services:

- clinical: obstetrics and gynecology, for which doctors must prove the competence / certificate of complementary training in obstetrical and gynecological ultrasonography;

- paraclinical: laboratory medicine.

- **Surveillance of other high-risk pregnancies (mild pregnant hyperemesis)**

Mandatory services: Obstetrics and gynecology specialized consultation, Complete blood count, Serum sodium, Serum potassium, Complete urine examination (summary + sediment), Serum urea, Serum uric acid, Serum creatinine, Obstetrical and gynecological ultrasound.

These services are contracted only with the obstetrics and gynecology specialized hospitals and with the other sanitary units with beds, which have in their structure wards or compartments of obstetrics-gynecology and neonatology hierarchicalat level 3 or 2.

Specialties that provide the above listed services:

- clinical: obstetrics and gynecology, for which doctors must prove the competence / certificate of complementary training in obstetrical and gynecological ultrasonography;

- paraclinical: laboratory medicine.

- **Supervision of other high-risk pregnancies (evaluation of pregnant women with a cicatricial uterus in the III trimester)**

Mandatory services: Obstetrics and gynecology specialty consultation, Cardiotocography, Obstetrical and gynecological ultrasound.

These services are contracted only with the obstetrics and gynecology specialized hospitals and with the other sanitary units with beds, which have in their structure sections or compartments of obstetrics-gynecology and neonatology ranked at level 3 or 2.

Specialties that provide the above listed services:

- clinical: obstetrics and gynecology, for which doctors must prove the competence / certificate of complementary training in obstetrical and gynecological ultrasonography;

- paraclinical: laboratory medicine.

The medical services listed above are day hospitalization services that can be provided both in the specialty outpatient clinic for clinical specialties and in day hospitalization regime.

In addition, **monitoring of high-risk pregnancy in pregnant women with hereditary and acquired coagulation disorders / thrombophilias** is found in the basic package din hospital care.

Mandatory services: Specialized consultations obstetrics and gynecology, Antithrombin III, Protein C, Protein S, Serum hemocysteine dosing, Serum hemocysteine control, Leyden Factor V, Lupic anticoagulant screening, Confirmatory lupic anticoagulant, Obstetrical and gynecological ultrasound,

The service is provided in the I or II trimester of pregnancy, to pregnant women with at least one of the following vascular and obstetrical risk factors:

- personal history of thromboembolic disease;
- family history (first degree relatives with thromboembolic disease or positive heredocolateral history of thrombophilia);
- recurrent first trimester abortions of unknown cause;
- tasks stopped in evolution;
- premature birth;
- pregnancy-induced hypertension;
- detachment from the normally inserted placenta;
- placental insufficiency.

Also, in day hospitalization regime, amniocentesis, cordonocentesis, respectively biopsy of chorionic villi can be performed; bthe hypsy of chorionic villi is settled in pregnant women in the first trimester of pregnancy, and amniocentesis in pregnant women in the ii trimester of pregnancy, performed only by obstetrics and gynecology specialists with overspecialization in maternal-fetal medicine, for cases with major anomalies confirmed imaging prior to the procedure or in case of genetic pathology in the family with a risk of transmission to offspring - at the recommendation of the geneticist doctor or risk of aneuploidies higher than 1/250 following prenatal genetic screening: combined test (ultrasound markers and double test or triple test); genetic testing of the samples taken is also included in their respective tariffs. Cordonocentesis is settled in pregnant women in the second trimester of pregnancy, performed only by obstetrics and gynecology specialists with overspecialization in maternal-fetal medicine, for cases with indication for diagnostic or therapeutic purposes; genetic testing of the samples taken is also included in their respective tariffs.

The genetic testing of the samples taken by biopsy of chorionic villi, amniocentesis or cordonocentesis is performed by one of the following techniques: cytogenetics, FISH, MLPA, QF-PCR.

The medical services provided in day hospitalization regime can also be provided in continuous hospitalization regime if the patient presents complications or comorbidities with risk for the patient, major bleeding that poses the problem of volemic replete, anesthetic risk difficult to manage in day hospitalization, and postprocedural pain difficult to control, major invasive procedures associated.

NATIONAL CURATIVE HEALTH PROGRAMMES

National health programmes are a set of actions geared towards the main areas of intervention of public health care. The national public health programs (with emphasis on prevention) are carried out by the Ministry of Health, and the National Health Insurance House runs the national curative health programs (with emphasis on treatment).

The aim of the National Curative Health Programmes (NSP) is to ensure specific treatment for diseases with a major impact on public health. Patients can benefit from the following within the NSDP:

- Medicines
- sanitary materials,
- medical devices,
- specific services (e.g. radiotherapy, dialysis services),
- specific investigations (e.g. dosing of glycosylated hemoglobin, PET-CT investigations) depending on the condition treated in pnsc.

In the case of the national program of renal function replacement (dialysis) in patients with chronic renal insufficiency, in addition to medicines and sanitary materials and medical investigations, unmedicalized transport of hemodialysis patients from and to their home and monthly transport of medicines and sanitary materials specific to peritoneal dialysis to the patients' homes is ensured.

Within the PNSC are insured only those medicines included in the List of compensated medicines approved by Government Decision, which can be prescribed and settled only for the diseases that are subject to pnsc.

Medicinal products granted under the GNP may be dispensed through Community pharmacies (open circuit pharmacies) or hospital pharmacies (closed-circuit pharmacies).

Medicines for patients with multiple sclerosis, hemophilia, some rare diseases, endocrine diseases, for substitute treatment with methadone and for the treatment of chronic hepatitis relapse in patients with liver transplantation, included in the PNSC, are issued only through hospital pharmacies.

Medicines for patients with diabetes mellitus, for the treatment of the post-transplant condition, except for the treatment of chronic hepatitis relapse in patients with liver transplantation, for the treatment of patients with some rare diseases (mucoviscidosis, amyotrophic lateral sclerosis, hereditary angioedema, idiopathic pulmonary fibrosis, Duchenne's disease, Prader-Willi syndrome, hereditary optic neuropathy – Leber and lymphanggioleiomyomatosis) are dispensed through community pharmacies.

Medicines for patients with thalassemia, spinal muscular atrophy, chronic idiopathic immune thrombocytopenic purpura, Fabry disease is dispensed both through community pharmacies and hospital pharmacies.

Enrollment of patients in a national curative health program

Depending on the patient's condition and taking into account the eligibility criteria, the specialist doctor may decide to enroll in the PNSC.

The prescription of the treatment is carried out by the specialist doctor according to the conditions stipulated in the **chapter the Specialist Doctor.** For certain conditions, the treatment may still be prescribed by the family doctor based on the medical letter issued by the specialist doctor.

In order to benefit from the treatment offered by the PNSC, patients should contact a specialist doctor who carries out his activity in a health unit that runs the respective program. The list of these health units can be viewed on the web pages of the health insurance houses, in the

section **"Information for insured persons" – "National Curative Health Programs"**

The national curative health programs carried out by CNAS are:

- National Program of Cardiovascular Diseases;
- National Oncology Program;
- The national program for the treatment of deafness through implantable hearing aids;
- National Diabetes Program;
- National program for the treatment of neurological diseases;
- The national program for the treatment of hemophilia and thalassemia;
- National treatment program for rare diseases;
- National Mental Health Programme;
- National Programme of Endocrine Diseases;
- National program of orthopedics;
- National program for transplantation of organs, tissues and cells of human origin;
- National program of renal function replacement in patients with chronic renal insufficiency;
- National program of intensive care of liver failure;
- National program of diagnosis and treatment with the help of high-performance equipment
- National PET-CT program.