PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

May 7, 2009 Volume XLIII - #2

NOTICE TO PHYSICIANS

Inside this Issue

WELL BABY VISIT CLARIFICATION COMPREHENSIVE CARE INCENTIVE PROGRAM (CCIP)

The Physician Master Agreement includes a financial incentive program targeted to those family physicians who provide a breadth of primary health care services. Within the agreed to service categories, there is a measurement for Well Baby Visits as part of the overall breadth of services currently eligible under this program

In an effort to ensure Well Baby Visits are identified correctly as such and to ensure physician activity within this measurement area is captured, the following fee code with the modifier RO = WBCR must be used

Category	Code	Description	Unit Value
VIST	03.03	Well Baby Care LO=OFFC, RO=WBCR (RF=REFD)	13

FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM

A new Family Physician Chronic Disease Management Incentive program was approved to begin April 1, 2009

The program is intended to recognize the additional work of General Practitioners, beyond office visits, of providing an annual cycle of guidelines-based care to patients with selected qualifying chronic disease(s).

- A patient-centered approach rather than a disease-centered approach will be used for the CDM Incentive program. Priority indicators will be tracked on a per patient rather than a per disease basis, recognizing that many patients have more than one chronic disease and many chronic diseases have indicators/risk factors in common.
- Eligible GPs will be paid a base incentive annually for each patient they manage for one of the qualifying chronic disease conditions. Physicians may also receive an additional incentive amount per patient annually if the patient has an additional qualifying condition(s).
- A new fee code will be implemented for claiming the annual CDM incentive base payment. A modifier (or set of modifiers) to the fee code will be created to allow additional incentive amounts to be claimed for patients who have more than one qualifying chronic condition. The new fee code will be process specific, not disease specific, to allow for the addition of qualifying indicators/risk factors in later years without the need to add more fee codes.

- The family physician is being provided with CDM incentive payments for acting as a case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations or referrals.
- Patients must be seen a minimum of two times per year by a licensed health care provider in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive.
- Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
- Providing all eligibility requirements are met, the CDM incentive can be billed once per patient per fiscal year.
- The family physician claiming the CDM incentive fee must keep a record that supports the claim, either through chart notes or an optional one-page flow/tracking sheet.

Year One (2009/10) Program

Qualifying Chronic Diseases

The chronic diseases eligible for CDM incentive payments in year one (2009/10) are Type 1 and Type 2 Diabetes (FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L) and/or Post Myocardial Infarction (post-MI) follow-up for up to 5 years after the most recently diagnosed MI.

Required Indicators/Risk factors

In order to claim the year one CDM incentive, the following indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or post-MI. The required indicators include all the common indicators listed below plus the indicators for diabetes only, post-MI only, or diabetes and post-MI if both chronic diseases are present.

Common Indicators for Either Diabetes or Post-MI

- Blood pressure – 2 times per year
- Lipids – once per year
- Weight/nutrition counseling – once per year
- Smoking cessation – once per year if smoker (document smoker or nonsmoker)

PLUS EITHER OR BOTH OF THE FOLLOWING:

Indicators for Diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ordered once per year
- Foot exam with monofilament or 128hz tuning fork – referred or completed once per year
- Eye exam – referred once per year for routine a dilated eye exam

Indicators for Post MI only

- Beta-blocker – considered/reviewed once per year
- ACE/ARB – considered/reviewed once per year
- ASA/Anti-platelet therapy – considered/reviewed once per year

CDM Incentive Payment

- For 2009/10 (April 1, 2009 to March 31, 2010), family physicians will be paid a yearly base incentive payment of 17.70 units for managing an annual cycle of care addressing the required indicators/risk factors for each patient with a qualifying chronic disease. An additional annual incentive of 8.85 units will be paid if the patient has an additional qualifying chronic condition which is also addressed.
- In year one of the program (April 1, 2009 to March 31, 2010), the CDM incentive can be claimed if the following conditions are met:
  - the patient is seen by the physician in relation to their chronic disease(s) at least once in 2009/10;
  - the patient has had at least one other appointment with a licensed health care provider in relation to their chronic disease(s) in the previous 12 months; and,
  - the CDM indicators/risk factors required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional flow sheet at or before the time of billing.

The *Optional Family Physician Chronic Disease Management (CDM) Flow Sheet* is attached to this Bulletin

Please hold eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned, they will be published in the MSI Physicians' Bulletin

CASE MANAGEMENT CONFERENCE – CLARIFICATION OF ELIGIBLE SERVICES

There have been numerous inquiries requesting clarification of eligible services for the new Case Management Conference Fee. The Case Management Conference fee was published in the Bulletin Feb 26, 2009.

A case management conference is a formal, scheduled, multi-disciplinary health team meeting. It is initiated by an employee of the DHA/IWK to discuss the provision of health care to a specific patient. The *Case Management Conference Fee* is being implemented for both General Practitioners and Specialists.

The following new permanent Health Service code has been approved for inclusion in the Fee Schedule effective January 1, 2009:

Category	Code	Description	Unit Value
VIST	03.03D	Case Management Conference	14 units per 15 minutes for a GP and 16.5 units per 15 minutes for Specialists

Based on the extent of the inquiries surrounding clarification of this new fee, the following additional information is being provided:

- There is no restriction on specialties or on the location of where the fee can be claimed providing the case management conference has been initiated by a DHA/IWK employee and all other eligibility criteria are met. **The Health Service Code was initially set up as Location (Hospital) only. Please hold eligible service encounters for locations other than hospitals to allow MSI the required time to update the system.**

- The fee 'is not" restricted to larger centers (ie: CDHA & Cape Breton)

- Multi-disciplinary refers to the attendance of two or more licensed health care professionals in addition to a physician

- In order to qualify, the conference has to be called by **non-physician** DHA/IWK staff, who are required to be employees of the district

- It is not mandatory that more than one physician attend the case conference before the fee code may be claimed

- The Case Management Conference Fee is not to be used for attendance at regularly scheduled meetings concerning ongoing care planning or patient management for one or more patients i.e.: grand rounds, tumor board case rounds, teaching rounds, transplant rounds or other similar methods of specialist physicians conferring about the medical management of complex cases

- Physician attendance at case management conferences held by video conferencing or teleconferencing is eligible for payment providing all other eligibility requirements are met

- Each case conference must be specific to an individual patient; the time spent by the physician at the conference must be documented in the health record of that patient. However consecutive formal scheduled conferences, each pertaining to one named patient, with start and finish times recorded in each health record, would be permitted.

FAMILY PHYSICIAN AND REGIONAL SPECIALIST ALTERNATIVE PAYMENT PLAN UPDATE

A working group of the Master Agreement Steering Group has been established to develop new template contracts for all alternative payment plans (APPs) that are non-academic. All existing contracts have been extended, unless otherwise notified, at the agreed upon rates as outlined in the Master Agreement.

This working group is also responsible for establishing guidelines to enable GPs on a current remuneration of fee-for-service to convert to an APP. These guidelines will be published and communicated to physicians once they are completed.

FAMILY PHYSICIAN ENHANCED CONTINUING CARE PROGRAM

A new incentive program to support enhanced Continuing Care by Family Physicians was approved to begin April 1, 2009. To support this new initiative, a new permanent Health Service code has been approved for inclusion into the fee schedule effective April 1, 2009

- Effective April 1, 2009, family physicians will be remunerated for the completion of medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only. Please see attached listing of all provincially licensed Nursing Homes and Residential Care Facilities under the Department of Health. Being as this list may be updated periodically; physicians are encouraged to check for updates through the Doctors Nova Scotia website in the members section. A complete and up to date list can be found by clicking on the following links:

  Nursing Homes and Homes for the Aged Directory
  Residential Care Facilities for Seniors Directory

- A new fee code will be implemented payable at the rate of 11.95 units per medication review.

- To claim the fee, the physician must review, complete, date and sign the pharmacy-generated Medical Administration Recording System (MARS) drug review sheet for the resident.

- A maximum of two (2) medications reviews will be payable per resident per fiscal year, regardless of Nursing Home or RCF facility of residence. A facility transfer does not necessarily require a new medication review if the existing medication review is up-to-date.

- The medication review fee is payable in addition to any associated visit fee, if applicable.

- The date of service is the date the MARS form is signed by the physician.

- Please hold eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned they will be published in the MSI Physicians' Bulletin.

GP CONSULT FEE - MIDWIFERY

In support of the Midwifery Act that came into effect in March 2008, the Preamble has been amended to include midwife in the list of health care providers that can request a consultation from a physician.

Preamble 7.5.1

A consultation is a service resulting from a formal request by the patient's physician, nurse practitioner, midwife, optometrist or dentist, after appropriate evaluation of the patient, for an opinion from a physician qualified to furnish advice. This may arise when the complexity, obscurity or seriousness of the patient's condition demands a further opinion, when the patient requires access to specialized diagnostic or therapeutic services, or when the patient, or an authorized person acting on the patient's behalf, requests another opinion.

A consultation requires a written report to the referring physician, nurse practitioner, midwife, optometrist or dentist; an evaluation of relevant body systems; an appropriate record; and, advice to the patient. It may include the ordering of appropriate diagnostic tests and procedures as well as discussion with the patient, other persons relevant to the case, and the referring physician, nurse practitioner, midwife, optometrist or dentist. The composition of a consultation will vary with a particular specialty.

The following Health Service codes have been approved for use by General Practitioners, other than the patient's regular attending physician, who receive a formal request from a Midwife to provide consulting services .

Category	Code	Description	Unit Value
CONS	03.08	Consultation	30
CONS	03.07	**Repeat Consultation** RF=REFD, RP=REPT	13

The MSI midwife number of the referring midwife must appear on the service encounter.

NEW FEES

The following new fees have been approved by MASG for inclusion in the fee schedule effective April 1, 2009.

Category	Description	Unit Value	Anaes Units
MASG	Laparoscopic Assisted Vaginal Hysterectomy	220	6 + T
MASG	Laparoscopic Supracervical Hysterectomy	235	6 + T
MASG	Intrauterine Balloon for PPH Tamponade	70	4 + T
VADT	Percutaneous Image Guided retrieval of Intravascular Foreign Body	150	10 + T
VADT	Percutaneous Image Guided IVC Filter Removal	135	10 + T
VADT	Implantation Loop Recorder	70	4 + T

Category	Description	Unit Value	Anaes Units
ADON	Subintimal Recanalisation of Vascular Occlusion (as add on to Angioplasty or stent)	125	
	Percutaneous Image Guided Radiofrequency Ablation of Solid Tumour	250	4 + T
	Bilateral Breast MRI – first sequence units Subsequent sequence (maximum 3 multiples) units	46.6 23.3	

Please hold eligible service encounters to allow MSI the required time to update the system. Once Health Service Codes have been assigned and tested they will be published in the MSI Physicians' Bulletin. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.

NEW PROCESS FOR AMENDING THE MSI PHYSICIAN'S MANUAL

All new requests for fee codes, fee adjustments, and changes to the Preamble to the MSI Physician's Manual are being handled by the Fee Schedule Advisory Committee (FSAC), which was formed for this purpose by the Master Agreement Steering Group (MASG).

The Master Agreement provides dedicated funding and the new process for making adjustments to the Nova Scotia fee schedule. Total new funding of $2 million ($500,000 annually during the first four years of the agreement) is provided for adjustments to the existing fee codes and Preamble. Total new funding of $3.5 million ($1 million in years one, three and four, and $500,000 in year two) is provided to support the addition of new fees.

FEE SCHEDULE ADVISORY COMMITTEE

The Fee Schedule Advisory Committee is comprised of members from Doctors Nova Scotia, the Department of Health and the District Health Authorities. Its mandate is to provide advice and recommendations to the MASG on all matters pertaining to the fee schedule including:

- introduction of new fees;
- revisions or deletions of existing fee codes;
- additions, revisions or clarifications of the Preamble to the MSI Physician's Manual

Application submissions

Requests may be submitted by all stakeholders including physicians, Doctors Nova Scotia, MSI, the Department of Health, and the District Health Authorities/IWK.

There are two submission dates per year, April 1 and November 1. Applications received after either date will be considered for the following deadline.

All requests will be responded to within 30 days with an explanation of the process to be followed. More information may be requested from the applicant. If the necessary

information/documentation isn't received within the specified timeframe, the request will be removed from the FSAC's active list of submissions.

Decisions will be made by October 31 and March 31 for the April and November submission batches. To be considered and to have this deadline applied, submissions must be received complete by April 1 and November 1.

The April 1, 2009 deadline has been extended to June 1, 2009. After that the regular schedule will resume with the next intake scheduled for November 1, 2009.

The application form and information sheet are available from Doctors Nova Scotia on the members' side of the Doctors Nova Scotia web site (www.doctorsns.com) under Physician Payment/Fee-for Service. Information can also be obtained by contacting Doctors Nova Scotia Policy Analyst, Jennifer Girard.

The application forms must be completed electronically (no handwritten applications please) and submitted via e-mail, fax or mail to:

Jennifer Girard
Policy Analyst, Doctors Nova Scotia
25 Spectacle Lake Drive,
Dartmouth NS B3B 1X7
Phone: (902) 468-8935 ext 231 or 1-800-563-3427
Fax: (902) 468-6578
E-mail: jennifer.girard@doctorsns.com

Review of applications
All applications will be reviewed and directed to the most appropriate process: information request, fee request or Preamble request.

Each request will be subjected to an evidence-based screening process. At any time during this screening process, the FSAC may ask the applicant for more information or clarification to ensure the application is evaluated fairly.

At the end of the evaluation process, if there is a high volume of acceptable requests, a prioritization methodology will be applied to all applications awaiting final approval.

Recommendations
All funding recommendations will be submitted to MASG for final approval.

SURGICAL ASSISTANTS – UPDATE

The incentive payment for GP Surgical Assistants for the fiscal year 2008-2009 will be distributed within the next few weeks. Family Doctors will be eligible for the incentive payment if they have an annual MSI income of $75,000 or greater which includes an office based practice income of $25,000 or greater and in addition they have an annual income of less than $30,000 from elective (non-premium) surgical assists. The money available under this program will be distributed on a pro rata basis to the eligible Family Physicians in May, 2009.

HELPFUL BILLING HINTS

Several physicians noticed when the Family Physician Comprehensive Care Incentive Program (CCIP) letters and cheques went out earlier this year that their incentive payment was less than they expected. This is because the incentive payments are based on MSI billings. If incorrect health service codes or modifiers are used when

billing MSI for services, physicians may find that the service is not rejected in their adjudication file. Therefore, they may be unaware that the health service code or modifier used was incorrect until the code is either not captured by an incentive program or is audited post payment.

The Well Baby Visit modifier described earlier in this Bulletin is a good example. For instance, when a healthy baby is seen in the office for a Well Baby Visit but instead the service is billed as a regular office visit, a fee of 13 units will be paid. However, the Well Baby Visit fee will not be captured by the Comprehensive Care Incentive Program and eligibility for an incentive payment will be reduced.

VIST 03.03 **Office Visit**
LO-OFFC, RP=SUBS (REFD).....13

VIST 03.03 **Well Baby Care**
LO=OFFC, RO=WBCR (RF=REFD).....13

Please ensure your office staff are aware of the RO = WBCR modifier so that all your Well Baby Visits are properly captured, including the new Well Baby Visit at 18 months.

REMINDER: MAJOR/MINOR SURGERY RESTRICTION

Section 9.3.3 (c) of the Preamble of the Physician's Manual states: "When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed; e.g,, a laparotomy is not to be claimed to provide access to the abdominal cavity except when no definitive procedure is performed within the abdomen. When one physician provides surgical exposure for a procedure performed by a physician in another speciality, the exposure and definitive procedures may be claimed separately by the respective physicians."

Physicians are reminded that this section applies to both laparotomy and laparoscopy procedures.

LOCATION MODIFIER FOR EXERCISE STRESS TESTS

As per Section 9.2.2 (b) (i) of the Preamble of the Physician's Manual, exercise stress tests are approved for payment when performed in a hospital setting only (section 5.2.9 of the Billing Instruction Manual outlines the approved hospitals).

A review of stress test claims indicates that many are being submitted with the location "office", (as an ambulatory care centre clinic, or a private office), although they are being performed in the hospital setting. These claims should be submitted with the location of hospital (LO=HOSP) and the functional centre of out-patient department (FN=OTPT).

REMINDER TO ALL PHYSICIANS

The new "Master Agreement" is available on the Doctors Nova Scotia website in the member's only section

We would encourage you to take some time to review the contract and contact either Patrick Riley (Department of Health) or Carol Walker (Doctors Nova Scotia) should you have any specific questions.

REVISED PREAMBLE 2008

The newly revised Preamble to the MSI Physician's Manual has been posted on the Members Section of the Doctors Nova Scotia website. Physicians wanting a hard copy of the Preamble may contact Medavie Blue Cross at 1-866-553-0585. The Preamble will be regularly updated as the work of the Fee Schedule Advisory Committee progresses

Optional
Family Physician Chronic Disease Management (CDM) Flow Sheet

Patient Name: _____ Diabetes: ☐ Type I ☐ Type II ☐ Post MI 5 yr

Date of birth: _____ Date(s) of Diagnosis: _____ _____

Comorbidities: ☐ HTN ☐ Dyslipidemia ☐ PAD ☐ Renal Disease ☐ A Fib
☐ TIA/CVA ☐ Angina ☐ Mental Health Diagnosis
Other: _____

Interventions: PCI/Stent _____ CABG _____

Current Medication: _____
_____

	REQUIRED COMMON INDICATORS FOR DIABETES AND POST-MI	Date / /	Date / /	Date / /	Date / /
2/YR	Blood Pressure				
ANNUALLY	Smoker ☐ Yes ☐ No If yes, discuss smoking cessation				
ANNUALLY	Weight/Nutrition Counseling				
ANNUALLY	Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C				
	REQUIRED INDICATORS FOR DIABETES ONLY				
2/YR	HbgA1C				
ANNUALLY	Renal Function				
ANNUALLY	Foot Exam Check for lesions. Use 10-g monofilamant or 128Hz tuning fork				
ANNUALLY	Eye Exam Date Referred: Referred to:				
	REQUIRED INDICATORS FOR POST-MI UP TO 5 YEARS ONLY				
ANNUALLY	ASA/Anti-platelet Therapy Review				
ANNUALLY	Betablocker Review				
ANNUALLY	ACE/ARB Review				

OPTIONAL ITEMS

REMINDERS	Self Management Referrals	☐ Diabetic Clinic	☐ Cardiac Rehab	☐ Other: _____
	Screen for	☐ Depression	☐ Erectile Dysfunction	
	Vaccinations	☐ Influenza Date: _____	☐ Pneumovax Date: _____	
	Exercise/Activity	☐ Discussion		
	Lifestyle Choices	☐ Alcohol use	☐ Stress	
	Economics	☐ Pharmacare	☐ Provincial Diabetic Program	☐ Third Party Insurance ☐ No Insurance

Date CDM Incentive Code Billed: _____

SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

Common CDM Indicators	Target	Comments
Blood Pressure	<130/80 mmHg In children: <95th %ile for age, gender and height	
Lipids	LDL-C: ≤ 2.0 TC: HDL-C: <4	Test every 1-3 years as clinically indicated
Weight/Waist circumference/ Nutrition counseling	BMI: <25 kg/m^2 or In children: <85th %ile for age Waist circumference: M: <102 cm, F: <88 cm	
Smoking Cessation		

Diabetes Indicators	Target	Comments
HbA1C	≤ 7%	Measure every 6 mos in stable, well managed adults. If not achieved, can measure every 3 mos
Renal Function	ACR: <2.0 for males; <2.8 for females eGFR: >60 mL/min	In presence of CKD, at least every 6 months. Referral to nephrologist/internist if eGFR <30 mL/min
Routine foot examination		Test with monofilament or 128hz tuning fork
Routine eye examination		Routine dilated eye exam

Post MI Indicators (Medications)	Duration	Comments
Beta Blocker	STEMI: Indefinitely Non-STEMI: Indefinitely unless low risk	
ACE/ARB	Indefinitely unless low risk	ACE: Titrate to target dose. Consider ARB if contraindications or intolerance to ACE
ASA/Anti-platelet therapy: ASA 81 to 325 mg OD Clopidogrel 75 mg OD	ASA indefinitely -STEMI and Non-STEMI Clopidogrel: STEMI - Only if had PCI Minimum 1 mo. post bare metal stent Min. 12 mo. post drug-eluting stent Clopidogrel: Non-STEMI No PCI: Low risk - 3 mo; Inc. risk - 12 mo.; Very high risk - >12 mo. PCI: Low risk & bare metal stent - 3 mo.; Increased risk regardless of stent or ≥1 drug-eluting stent - 12 mo.; very high risk regardless of stent or ≥3 drug-eluting stents or complex PCI - >12 mo	Clopidogrel: STEMI Dependent on type of stent and risk profile Clopidogrel: Non-STEMI Depends on risk of recurrent event & stent type

CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES

1. The CDM Incentive fee can be claimed by family physicians starting April 1, 2009.
2. The base incentive fee may be claimed once per fiscal year for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has an additional qualifying condition.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients do not follow through on recommendations or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health care provider in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator does not necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year.
7. The qualifying chronic diseases eligible for the CDM incentive payment in 2009/10 are Type 1 and Type 2 Diabetes (FPG ³7.0 mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L) and/or Post Myocardial Infarction (post-MI) follow-up for up to 5 years after the most recently diagnosed MI.
8. In year one (April 1, 2009 to March 31, 2010), the CDM incentive can be claimed if the following conditions are met:
   * the patient is seen by the physician in relation to their chronic disease(s) at least once in the 2009/10 fiscal year;
   * the patient has had at least one other appointment with a licensed health care provider in relation to their chronic disease(s)in the previous 12 months; and,
   * the CDM indicators required for the CDM incentive payment have been addressed at the required frequency (see front of flow sheet) and documented in the clinical record or optinal flow sheet at or before the time of billing.