PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

May 14, 2010 Volume XLV - #2

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- CDM Flow Sheet

NEW FEES

Effective February 01, 2010 the following new Health Service Codes are available for billing:

Category	Code	Description	Unit Value
VADT	02.89A	**11-14 week prenatal screening ultrasound** for the determination of nuchal translucency	35
		In multifetal pregnancies each additional fetus is paid at 70%.	24.5
		Images of the nuchal area, nasal bones, intracranial contents, abdomen, heart and upper and lower extremities must be obtained in addition to the standard images for ultrasound <13 weeks.	
		To be billed by fetal maternal medicine specialists and radiologists only. Operators must be certified by the Fetal Maternal Medicine Foundation of Canada or the UK to perform NT measurements. Operators and the centre in which the service is provided, must supply evidence of current certification and quality assurance results annually to MSI to be kept on file. Only physicians with qualifications as stipulated will be eligible for remuneration for this service.	

Category	Code	Description	Unit Value
VADT	02.89B	**Genetic sonogram**	
		For known or suspected fetal anatomic or genetic abnormality in high risk pregnancies	60
		In multifetal pregnancies each additional fetus is paid at 70%	42
		Includes all standard biometry and anatomic review, a detailed fetal heart assessment, and an assessment of potential ultrasound markers (soft markers). Soft markers to include: Increased nuchal translucency, Absent nasal bone, Echogenic bowel, Pyelectasis, Ventriculomegaly, Shortened long bones (humerus, femur), Echogenic intracardiac focus, Choroid plexus cysts.	
		May be billed only once per patient per pregnancy.	
		Patients must be at an increased risk for genetic aneuploidy either by maternal age>40, or by past obstetrical or family history.	
		To be billed only by fetal maternal medicine specialists or radiologists with the credentials to perform fetal ultrasound/echocardiography.	
		Sonogram must be performed by the physician specialist for payment.	

Physicians holding eligible services must submit their claims from February 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

Effective April 01, 2010 the following new Health Service Codes are available for billing:

Category	Code	Description	Unit Value
		Continuous Peripheral Nerve Block (CPNB)	
PMNO	46.04G	Acute pain management (non-obstetrical) consultation unrelated to delivery of anaesthesia, insertion of CPNB catheter and care on day 1 …. (SP=ANAE)	75
PMNO	46.04H	Acute pain management (non-obstetrical) assessment and care following CPNB catheter placement, when the catheter is inserted by another physician, day 1 …. (SP=ANAE)	44
PMNO	46.04I	Acute pain management (non-obstetrical) insertion of CPNB catheter in conjunction with anaesthesia …. (SP=ANAE)	25
PMNO	46.04J	Acute pain management (non-obstetrical) maintenance of CPNB catheter by primary anaesthetist, day 1 …. (SP=ANAE)	25
PMNO	46.04K	Acute pain management (non-obstetrical) CPNB maintenance, per day, day 2 onwards …. (SP=ANAE)	25
		Invasive video EEG telemetry is the continuous electroencephalographic monitoring of an inpatient using intracranial electrodes with concurrent recorded video monitoring allowing analysis of both the clinical and electrographic features of a recorded event. The intracranial electrodes are placed by a neurosurgeon.	
VADT	03.16F	EEG Video Telemetry – Invasive Day 1	150
VADT	03.16G	EEG Video Telemetry – Invasive subsequent days (maximum 4 days)	100

Category	Code	Description	Unit Value
		Non-invasive video EEG telemetry is the continuous electroencephalographic monitoring of an inpatient using scalp electrodes with concurrent recorded video monitoring allowing analysis of both the clinical and electrographic features of a recorded event.	
VADT	03.16H	EEG Video Telemetry – Non-invasive Day 1	90
VADT	03.16I	EEG Video Telemetry – Non-invasive Subsequent days (maximum 5 days per week, maximum 2 weeks).	60
		The above VADT codes are all LO=HOSP, FN=INPT and are restricted to neurologists and neurosurgeons with subspecialty training in electroencephalography. These codes are for supervision and interpretation.	

Physicians holding eligible services must submit their claims from April 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

FEE ADJUSTMENTS

Effective February 01, 2010 the following fee adjustments are now available for billing:

Category	Code	Description	Adjustment MSUs
GENP	03.04	First Examination – Newborn Care Healthy Infant LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD)	16
GENP	03.03	Subsequent Care – Newborn Healthy Infant LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD)	16
OBGY	03.04	First Examination – Newborn Care LO=HOSP, FN=INPT, RO=NBCR, RP=INTL (RF=REFD)	16
OBGY	03.03	Subsequent Care – Newborn LO=HOSP, FN=INPT, RO=NBCR, RP=SUBS (RF=REFD)	16
GENP	03.03	Post Partum Visit LO=HOSP, FN=INPT, RO=PTPP (RF=REFD)	16

Category	Code	Description	Adjustment MSUs
OBGY	03.03	Post Partum Care, Per Visit LO=HOSP, FN=INPT, RO=PTPP (RF=REFD)	16

Claims for these codes with a service date from February 01, 2010 to May 13, 2010 will be identified and reconciliation will occur in the fall of 2010. The reconciliation will be calculated after the 90-day waiting period for the submission of claims.

Effective April 01, 2010 the following fee adjustments are now available for billing:

Category	Code	Description	Adjustment AUs
VEDT	02.79B	**PET/CT Scan and interpretation,** one body region	4+T
VEDT	02.79C	**PET/CT Scan and interpretation,** multiple body regions (including whole body scan)	4+T

Physicians holding eligible services must submit their claims from April 1st onward within 90 days of the date for this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

Also effective April 01, 2010 the following health service codes have been revised to include multiples (up to a maximum of 4):

Category	Code	New Description	Unit Value	
MISG	95.54A	**Suture extensor tendon –***plus multiples, if applicable*	50	4+T
MASG	95.54B	**Suture flexor tendon –** *plus multiples, if applicable*	106	4+T
MASG	95.65F	**Tendon Transfer -** *plus multiples, if applicable*	96	4+T

With these revisions, health service codes 95.54F, 95.54G, 95.54H, 95.54I, and 95.65B are no longer necessary and have been termed for March 31, 2010, although the system will still recognize these codes and pay claims up until May 13, 2010. *I you have submitted these health service codes with a date of service April 1, 2010 to May 13, 2010 please write to MSI attention Karen Gillis and your submission will be will be reviewed with an adjustment made of necessary based on the information provided.*

UPCOMING FEES

The following Interventional Radiology fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective April 1, 2010.

Category	Description	Unit Value
	Balloon dilation of ureteric stricture	
VEDT	This procedure is done for ureteric obstruction secondary to stones or malignancy. Under local anaesthetic and conscious sedation, a guidewire is advanced through a preexisting nephrostomy tube, which is then removed. A diagnostic catheter is introduced over the guidewire and then threaded down the ureter, past the obstruction and into the bladder. An angioplasty balloon is advanced over the guidewire and across the stricture and inflated. this may need to be repeated several times in order to alleviate the stricture.	100
	Renal access and nephroureteral stent placement for stone extraction	
VEDT	This procedure establishes a percutaneous tract to allow minimally invasive, percutaneous nephrolithotomy (PNL) for removal of renal calculi. Under local anaesthetic, an access needle is advanced into the specific renal calyx to allow direct access to the renal calculous. A guidewire is advanced through the needle and manipulated down the ureter past the stone(s) into the bladder. A nephroureteral catheter is then introduced. The patient is then transferred to the operating room for PNL under a general anaesthetic. The placement of the stent must be precise as the urologist will go on to dilate that access tract to a 30 French diameter.	160
	Antegrade ureteric stent insertion with or without balloon dilation	
VEDT	This procedure is done for ureteric obstruction secondary to stones or malignancy. Under local anaesthetic and conscious sedation, a guidewire is advanced through a preexisting nephrostomy tube, which is then removed. A diagnostic catheter is introduced over the guidewire and then threaded down the ureter, past the obstruction and into the bladder. A double J ureteric stent is advanced over the catheter into the bladder. A nephrostomy tube is then reinserted. A balloon dilation of the stricture may be required.	120

NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system . Once a new Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin.

PREAMBLE REVISION

The Master Agreement Steering Group (MASG) has approved the following preamble amendment, effective April 1, 2010.

8.2.3 Calculation of Anaesthetic Fees

(b) Anaesthetic Time Units, except where otherwise specified, are computed by allowing one unit for each fifteen minutes, or part thereof, of anaesthesia time. Double time units apply when anaesthetic time extends beyond one hour for procedures with basic anaesthetic values of 4 or 5 units and after two hours when the basic is 6 units or greater. *For the purposes of calculating anaesthesia time units and with reference Preamble Section 1.8.5, Physician Record Requirements to Support Claims, time should be calculated from the time documented in the perioperative record when both the patient and anaesthetist are present in the OR and time ends when both the patient and anaesthetist leave the OR. In addition to this documented time an additional 15 minutes may be claimed for the preoperative assessment and anaesthesia setup, another 15 minutes may be claimed for the postoperative attendance of the patient as per section 8.2.2 (c). These 2 additional units may be claimed without the need for any additional documentation requirements over and above that recorded in the perioperative record.*

In unusual circumstances where the preoperative care is prolonged or repeat trips back to PACU are required, additional time may be added to the anaesthesia time. This additional time must be clearly documented by the anaesthetist in the patient medical record with start and stop times as per Section 1.8.5 of the Preamble.

If resuscitation is necessary during the anaesthetic time, add the time for resuscitation to the anaesthetic time. Resuscitation and anaesthesia time cannot be claimed simultaneously.

It is understood that there may be overlapping time units in anaesthesia.

CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM

Effective April 01, 2010 the Chronic Disease Management (CDM) Incentive Program has been adjusted as follows:

Category	Code	Modifiers	Description	Adjustment MUs
DEFT	CDM1		Family Physician Chronic Disease Management Incentive Program	35.09
DEFT	CDM1	RP=CON2	Family Physician Chronic Disease Management Incentive Program – 2nd condition	17.55

Claims for these codes with a service date from April 01, 2010 to May 13, 2010 will be identified and reconciliation will occur in the fall of 2010. The reconciliation will be calculated after the 90-day waiting period for the submission of claims.

As outlined in the Physician Services Master Agreement, Schedule "K" Chronic Disease Management Incentives, additional funding is available for expansion of the existing Family Physician Chronic Disease Management Incentive Program in 2010/11.

The program strategy and general guidelines for the 2010/11 Family Physician Chronic Disease Management (CDM) Incentive Program remain the same as those for the 2009/10 program.

Qualifying chronic diseases are expanded in 2010/11 to include:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG ³7.0mmol/L ***or*** Casual PG ³11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ³11.1 mmol/L; and,

- **Ischaemic Heart Disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram. This patient population includes the 2009/10 program population of patients receiving post-MI care for up to 5 years.

In order to claim the 2010/11 incentive, the following indicators/risk factors are required to be addressed as part of the annual cycle of care for diabetes and/or IHD. The required indicators include all common indicators plus the indicators for diabetes only, IHD only, or diabetes and IHD if both chronic diseases are present.

Common indicators for either Diabetes or IHD

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

PLUS EITHER OF THE FOLLOWING:

Indicators for Diabetes only

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

Indicators for IHD only

- ASA/Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year
- ACEI/ARB – considered/reviewed once per year
- Discuss Nitroglycerin
- Consider further cardiac investigations

Eligible GPs will be paid a base incentive payment of $80 (35.09 MUs) once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease. An additional $40 (17.55 MUs) will be paid per fiscal year if the patient is managed for a second qualifying chronic condition.

CDM Incentive Billing Rules for 2010/11

1. The CDM incentive fee for 2010/11 can be claimed by family physicians starting April 1, 2010.

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 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.

4. Patients must be seen a minimum of two times per year by a licensed health care provider (includes physicians) 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 by March 31 of that year.

7. In 2010/11 (April 1, 2010 to March 31, 2011), the CDM incentive can be claimed if the following conditions are met:

    - The patient is seen by the family physician in relation to their chronic disease(s) at least once in the 2010/11 fiscal year;
    - The patient has had at least one other appointment with the physician or another 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 and documented in the clinical record or optional flow sheet at or before the time of billing.

The 2010/11 Family Physician Chronic Disease Management Flow Sheet has been revised to reflect the program changes and continues to be optional.

REMINDER UNBUNDLING OF CODES

Section 9.3.3 (a) of the Preamble in the Physician's Manual restricts the unbundling of a procedure fee into its constituent parts and billing for the parts individually or in combination with the procedural fee. For example, a laparoscopic assisted vaginal hysterectomy should be billed as 80.4B and not vaginal hysterectomy plus laparoscopy (80.4 + 66.83)

Effective July 01, 2010 MSI will begin an initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day.

Please be advised that the manual assessment of these claims may increase turnaround time, as well as a request for operative reports.

EXPLANATORY CODES

The following new explanatory codes have been added to the system:

GN046	Service encounter has been disallowed as text provided does not include the time of the encounter.
NR082	Please contact MSI regarding this claim.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, May 14th, 2010. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

Optional

Family Physician Chronic Disease Management (CDM) Flow Sheet 2010/11

Patient Name: _____ Diabetes: ☐ Type 1 ☐ Type 2 ☐ IHD

Date of birth: _____ (dd/mm/yy) Date(s) of Diagnosis: DM _____ (mm/yy) IHD _____ (mm/yy)

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

Interventions: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting
CABG _____ Cardiac Cath. _____

Current Medication: _____

_____

	REQUIRED COMMON INDICATORS FOR DIABETES AND IHD	Date / /	Date / /	Date / /	Date / /
2/YR	Blood pressure				
ANNUALLY	Smoker ☐ Yes ☐ No If yes, discuss smoking cessation				
	Weight/Nutrition Counselling				
	Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C				
	REQUIRED INDICATORS FOR DIABETES ONLY				
2/YR	HbA1C				
ANNUALLY	Renal Function ACR or eGFR				
	Foot Exam Check for lesions. Use 10-g monofilament or 128Hz tuning fork				
	Eye Exam Discuss and/or refer				
	REQUIRED INDICATORS FOR IHD ONLY				
ANNUALLY	ASA/Anti-platelet Therapy Review				
	Beta-blocker Review				
	ACEI/ARB Review				
	Discuss Nitroglycerin				
	Consider further cardiac investigations				

OPTIONAL ITEMS - REMINDERS

Self Management Referrals ☐ Diabetic Centre ☐ Cardiac Rehab ☐ Your Way to Wellness
Screen for ☐ Depression ☐ Erectile Dysfunction
Vaccinations ☐ Influenza Date: _____ ☐ Pneumovax Date: _____
Exercise/Activity ☐ Discussion
Lifestyle Choices ☐ Alcohol Use ☐ Stress
Economics ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance
End of Life Care Discussion ☐

Date CDM Incentive Code Billed: _____

SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

Common CDM Indicators	Target	Comments
Blood Pressure	If diabetic or CKD <130/80 mmHg No diabetes or CKD <140/90 mmHg In children: <95th %ile for age, gender and height	
Lipids	LDL-C: < 2.0 >50% reduction	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 dilated eye examination		By optometrist or ophthalmologist

IHD Indicators	Duration	Comments
Beta-blocker	STEMI: Indefinitely Non-STEMI: Indefinitely unless low risk	
ACEI/ARB	Indefinitely unless low risk	ACEI: Titrate to target dose. Consider ARB if contraindication or intolerance to ACEI
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
Discuss Nitroglycerin		
Consider further cardiac investigations		

CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES

1. The CDM Incentive fee for 2010/11 can be claimed by family physicians starting April 1, 2010.
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 (includes physicians) 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 by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment in 2010/11 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 **Ischaemic Heart Disease** (IHD) characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr).
8. In year two (April 1, 2010 to March 31, 2011), the CDM incentive can be claimed if the following conditions are met:
   - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the 2010/11 fiscal year;
   - the patient has had at least one other appointment with the physician or another 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 optional flow sheet at or before the time of billing.