PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

July 10, 2009 Volume XLIII - #3

NOTICE TO PHYSICIANS

Inside this Issue

ELECTRONIC MEDICAL RECORDS (EMR) - UPDATE

The 2008-2013 Physician Services Master Agreement between the Department of Health and Doctors Nova Scotia contains funding provisions for Electronic Medical Records.

The EMR funding provision consists of three specific funding envelopes:

1. One time EMR Investment Grant
2. Annual EMR Participation Grant
3. Annual EMR Utilization Grant

As of June 2009, funding for both the Investment and Participation portions of this incentive have been paid to a number of physicians across the province who have met the specific eligibility criteria related to both of these grants. Funding continues to be distributed in this fiscal year under the terms of the Master Agreement, to those physicians who continue to invest in EMR

With regards to the third envelope of funding (Annual Utilization Grant) and pursuant to schedule "I" item 2 (c) within the Physician Master Agreement:

"An Annual Physician –specific "EMR Utilization Grant" effective April 1st, 2009 of an amount to be determined, to recognize and value the extent of defined EMR functionality utilizations

The Electronic Medical Records (EMR) working group had been given an extension to July 30th, 2009 in an effort to present a more detailed and comprehensive recommendation to the Master Agreement Steering Group given the scope of the work involved in identifying key criteria for the Utilization Grant portion of the EMR Funding.

The intent of the EMR Utilization Grant is to encourage and recognize physicians financially for the extent of their efforts in the use of the EMR in their practice. The EMR Working group has been focusing on a Utilization Eligibility Grant Model that has the following two key components:

- Scaled EMR Functionality categories
- Scaled evidence-based EMR user utilization

The Working Group has committed to presenting their recommendations to the Master Agreement Steering Group in late July at which time further communication will be made including eligibility and payment levels

REMOTE PRACTICE ON-CALL

As per the current Master Agreement, Schedule "G" the Community Remote Practice On-Call program in effect as of March 31, 2008, has been extended to September 30, 2009 assuming a new program is in place or to when a new program subsequently begins for physicians who are currently paid through the program. No new physicians will be added to the program.

The On-Call Programs Redesign Working Group continues to meet regarding the design of a new revised program which will be presented to the Master Agreement Steering Group.

NEW FEES

The following new Health Service Codes are now available for billing effective April 01, 2009:

Category	Code	Description	Unit Value	
MASG	80.4B	Laparoscopic Assisted Vaginal Hysterectomy	220	6+T
MASG	80.2C	Laparoscopic Supracervical Hysterectomy	235	6+T
MASG	81.91B	Intrauterine Balloon for PPH Tamponade	70	4+T
VADT	50.0A	Percutaneous Image Guided retrieval of Intravascular Foreign Body	150	10+T
VADT	50.6D	Percutaneous Image Guided IVC Filter Removal	135	10+T
VADT	49.7A	Implantation Loop Recorder	70	4+T
ADON	48.0J	Subintimal Recanalisation of Vascular Occlusion (as an add on to Angioplasty or stent, but not both)	125	
VADT	06.39D	Percutaneous Image Guided Radiofrequency Ablation of Solid Tumour	250	4+T
VEDT	02.76A	Bilateral breast MRI – first sequence Subsequent sequence (maximum 3 multiples)	46.6 23.3	

UNITS PER HOUR

Effective June 1 2009 EC/IC claims will be assessed at the following the payment rates:

- 100 units per hour for surgical and interventional procedures
- 67 units per hour for specialist, non-surgical, non-interventional services and this rate will increase with the yearly increases for sessional rates as per the Master Agreement
- 60 units per hour will remain as the rate for any GP non-surgical, non-interventional services until such time as their sessional rate exceeds 60 units per hour

FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM

Effective April 01, 2009 this incentive is available for Family Physicians who manage patients with one or more selected qualifying chronic disease(s).

Category	Code	Modifier	Description	Unit Value
DEFT	CDM1		Family Physician Chronic Disease Management Incentive Program	17.70
DEFT	CDM1	RP=CON2	Family Physician Chronic Disease Management Incentive Program – 2nd condition	8.85

Billing Guidelines:

- 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)
- 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 (FPG3 7.0mmol/L or Casual PG3 11.1mmol/L + symptoms or 2hPG in a 75-g OGTT3 11.1mmol/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 and
- 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 and
- 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 and
- ASA/Anti-platelet therapy – considered/reviewed once per year

CDM Incentive Payment for 2009/10

- 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 of 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.

Clarification of Required CDM Indicators

Please note there was a misprint in the June 2009 Doctors Nova Scotia Magazine on the billing guidelines for the required CDM indicators for 2009/10. The billing guidelines outlined in the May 7, 2009 MSI Bulletin should be followed.

Clarification of Licensed Health Care Providers

The following bullet point regarding eligibility criteria was communicated in the May 7, 2009 MSI Physician Bulletin

- 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

For purposes of clarification the term **"licensed health care provider"** includes physicians as well as other licensed professionals including, but not limited to Nurse Practitioner, RN. i.e. the second required visit may also be the family physician.

Clarification for APP Physicians

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

Complete details surrounding this new programs were communicated in the May 7, 2009 MSI Physicians' Bulletin.

The Master Agreement Steering Group agreed that APP General Practitioners would be eligible to claim this incentive in addition to their contract, providing all other eligibility criteria have been met as communicated in the May 7,2009 MSI Physicians' Bulletin.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment under this incentive program. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this incentive program for APP physicians are October and May of each year, with the first payment to commence in October 2009.

FAMILY PHYSICIAN ENHANCED CONTINUING CARE PROGRAM

Effective April 01, 2009 this incentive is available for Family Physicians who complete medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only.

Category	Code	Description	Unit Value
DEFT	ENH1	Family Physician Enhanced Continuing Care Program	11.95

Billing Guidelines:

- 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.

NEW MODIFIER VALUE FOR BOOSTRIX® VACCINE

A new modifier has been created to use when billing the Boostrix® vaccine, which will be replacing Adacel® for booster immunization against infection by diphtheria, tetanus and whooping cough.

Category	Code	Modifier	Description	Unit Value
ADON	13.59L	RO=BOTR	Provincial Immunization Injections	6

TEMPORARY FEE CODE EXTENSIONS

The following temporary fee codes have been extended and will be in effect until December 31, 2009:

Category	Code	Description	Unit Value
VEDT	02.79B	PET/CT scan and interpretation, one body region	87
VEDT	02.79C	PET/CT scan and interpretation, multiple body regions (including whole body scan)	125

CASE MANAGEMENT CONFERENCE FEE - UPDATE

The restriction on specialties and on the location for Case Management Conference is now lifted as previously communicated in the May 7, 2009 MSI Bulletin. Physicians holding eligible service encounters should now submit their claims to MSI within 90 days.

UNATTACHED PATIENT BONUS

A new Unattached Patient Bonus Payment Program began July 1, 2008 for all eligible General Practitioners (GPs). An Unattached Patient is a patient who does not have a family physician.

Eligible GPs are able to claim a one-time Unattached Patient Bonus payment of $150 per new Unattached Patient providing the following criteria are met:

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.

- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.

- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

The GP is considered to have taken on the patient on the date of the initial office visit. The Unattached Patient Bonus may be claimed at the time of the initial visit

The Unattached Patient Bonus fee is billable in addition to the associated visit fee.

The Unattached Patient Bonus may be claimed by eligible GPs paid by fee-for-service and alternative payment plan contracts.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment under this incentive program. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this incentive program for APP physicians are December and June of each year, with the first payments beginning in December 2009

The Unattached Patient Bonus may not be claimed by Locum Physicians.

Starting July 14, 2009, the GP is expected to confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e. does not already have a regular family physician). Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice should also be recorded in the patient's record. This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation.

For Unattached Patients taken into a GP practice from July 1, 2008 to July 14, 2009, the Unattached Patient Bonus fee may be claimed retroactively. Documentation of the patient's unattached status and the associated hospital encounter, if not recorded on the patient's record, is not required for payment, however all other eligibility criteria must be met.

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

FEE SCHEDULE ADVISORY COMMITTEE UPDATE

The following new fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective July 1, 2009.

Category	Description	Unit Value	Anaes Units
MASG	Sterilisation by transcervical tubal occlusion (both tubes)	90	4 + T
VADT	Removal of Loop Recorder	40	4 + T
PMNO	Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when unrelated to delivery of anaesthesia	54	
PMNO	Acute pain management (non-obstetrical) insertion of interpleural catheter and care on day 1 when in addition to delivery of anaesthesia on that day	30	
PMNO	Acute pain management (non-obstetrical) interpleural catheter maintenance care, per day, day 2 onwards	20	

Please hold all 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. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.

FEE REVISION AND PREAMBLE CLARIFICATION

MASG has approved the following effective July 1st 2009:

- 07.08C Nerve conduction studies, per nerve studied will change from ADON to VADT .with a maximum of 6 multiples
- 07.08C will increase from 13.5 units to 27 units

Please hold all 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. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.

Billing Clarificaiton

- Codes 07.08A *Electromyography, major with muscles of more than one region examined and 07.08B Electromyography, minor, examination of a specific muscle/region*: "region" is intended to mean one of the four following anatomical

areas: head and neck; both upper limbs; both lower limbs; trunk (anterior and posterior)

- Code 07.08C *Nerve conduction studies, per nerve studied: "per nerve studied"* is intended to mean both the motor and sensory nerve conduction examination of a single nerve (mixed, motor or sensory). Multiples may be claimed when another nerve (mixed, motor or sensory) is examined and when separate nerve conduction studies of a major nerve branch are required.

FEE ADJUSTMENTS

Master Agreement Steering Group (MASG) has approved the following revisions effective July 1st 2009 subject to further consultation with MSI regarding implementation:

HSC 93.71A change description to read as follows: *Replacement of metacarpophalangeal or interphalangeal joint of hand by synthetic prosthesis - single (regions required) plus multiples* 150 4+T

HSC 93.71B suggested to be termed

HSC 94.44A change description to read as follows**:** *Suture flexor tendon - single (regions required) plus multiples* 106 4+T

HSC 94.44B and 94.44C suggested to be termed

HSC 94.45A change description to read as follows: *Suture extensor tendon - single (regions required) plus multiples* 50 4+T

HSC 94.45B and 94.45C suggested to be termed

HSC 94.55D change description to read as follows: *Tendon transfer - single (regions required) plus multiples* 96 4+T

HSC 94.55E suggested to be termed

Multiples will be limited to a maximum of 4 for each of the above codes.

Please hold all 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. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.

REMOTE ORTHOPAEDIC CONSULT WITH REVIEW OF PACS IMAGES

Remote Orthopaedic Consult with Review of PACS Images fee code has been termed as of June 30, 2009. Effective July 1, 2009 the Master Agreement Steering Group has agreed to increase the fee from 25 to 35 units as well as extend the fee to include all surgical designations.

Please hold all 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. The 90 day rule will be waived for these fees until the permanent code descriptions and modifiers are published.

MSI PREAMBLE REMINDER

A major consult will only be paid if the full preamble requirements for a comprehensive consult are met**.**

MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician “deliberately established a professional relationship with the patient for the purposes of removing, modifying or retarding existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.” There should be evidence of the discussions that took place between the physician and the patient, the patient’s response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by “long discussion,” “long talk,” “counselled,” “supportive psychotherapy,” etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service, then the service is not paid for or a lesser benefit is given.

Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

All service encounters claimed to MSI are the sole responsibility of the physician rendering the service with respect to appropriate documentation and claim submission.

NEW EXPLANATORY CODES

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

DE009	Service Encounter has been refused as this service has already been approved for this year
DE010	Service Encounter has been refused as two medication reviews have previously been approved for this year
DE011	Service Encounter has been refused as the second condition amount has already been approved for this year

The following explanatory codes have been changed to read as follows:

VT086	Service Encounter has been refused as only one well baby care visit is insured when patient age is 18 months
VT033	Service Encounter has be adjudicated according to the weekly maximum of 44 units allowed per week after 56 days from admission
VT044	Service Encounter has been refused as a modifier DA value is inappropriate after 56 days from admission

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, July 10, 2009. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT)