PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2014, the Medical Service Unit (MSU) value will be increased from $2.37 to $2.42 and the Anaesthesia Unit (AU) value will be increased from $20.15 to $20.55.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2014 the Workers' Compensation Board MSU Value will increase from $2.63 to $2.69 and the Workers' Compensation Board Anaesthetic Unit Value will increase from $22.39 to $22.83.

PSYCHIATRY FEES

Effective April 1, 2014 the hourly Psychiatry rate for General Practitioners will increase to $110.55 while the hourly rate for Specialists increases to $149.90 as per the tariff agreement.

SESSIONAL PAYMENTS

Effective April 1, 2014 the hourly Sessional rate for General Practitioners will increase to $145.20 while the hourly rate for Specialists increases to $169.40 as per the tariff agreement.

FEE REVISIONS

The following health service codes have been terminated effective March 27, 2014:

Category	Code	Description
MASG	65.51C	Recurrent hernia – by laparoscopy
MASG	65.59C	Recurrent hernia – by laparoscopy

These fees have been replaced by HSC 65.51E – Recurrent ventral or incisional hernia repair, by laparoscopy, reducible or strangulated, with mesh, with or without enterolysis. Please refer to the January 31, 2014 MSI Physicians' Bulletin for more details on this service.

CATARACT FEE REMINDER

As announced previously in the March 28, 2013 MSI Physicians' Bulletin, the following reduction in cataract fees are effective April 1, 2014:

	Cataract surgical fee reduction		Cataract anaesthesia fee reduction	
Code	Current MSU	April 1st, 2014	Current AU	April 1st, 2014
27.72	285	270	5+T	4+T
27.72B	309	293	5+T	4+T
27.49A	218.5	207	5+T	4+T
27.49B	218.5	207	5+T	4+T
27.59A	218.5	207	5+T	4+T
27.59B	218.5	207	5+T	4+T

FAMILY PHYSICIAN CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM
Revised April 1, 2014

The current *Physician Services Master Agreement, Schedule "K" Chronic Disease Management Incentive* is intended to recognize the additional work of General Practitioners, beyond office visits, of providing guidelines-based care to patients with chronic diseases.

The Master Agreement Steering Group (MASG) has recently approved changes to the existing Family Physician Chronic Disease Management (CDM) Incentive Program effective April 1, 2014 including:

- **Addition of chronic obstructive pulmonary disease (COPD) as an eligible chronic disease;**
- **Revisions to program requirements and documentation to incorporate COPD, reflect changes to clinical practice guidelines, and improve clarity; and,**
- **Increases to payment rates.**

The existing program strategy and general guidelines remain unchanged.

Qualifying Chronic Diseases
Effective April 1, 2014, the qualifying chronic diseases are:

- **Type 1 and Type 2 Diabetes** as evidenced by FPG ^{3}7.0 mmol/L ***or*** Casual PG ^{3}11.1 mmol/L + symptoms ***or*** 2hPG in a 75-g OGTT ^{3}11.1 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.
- **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator $FEV_1 < 80\%$ predicted and $FEV_1/FVC < 0.70$

Required Indicators/Risk factors

Effective April 1, 2014, in order to claim a CDM incentive payment the following indicators/risk factors, as applicable, are required to be addressed as part of the annual cycle of care. The required indicators include all relevant common indicators plus the specific indicators for each disease. For example, if diabetes and COPD are present, the three common indicators for diabetes, IHD and COPD plus the three common indicators for diabetes and IHD plus the specific indicators for diabetes and the specific indicators for COPD would all need to be addressed in order to claim annual incentive payments for the two diseases.

Common Indicators for Diabetes, IHD and COPD

- Smoking cessation – discussed once per year if smoker (document smoker or nonsmoker)
- Immunizations discussed and/or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

Common Indicators for Diabetes and IHD

- Blood pressure – 2 times per year
- Weight/nutrition counseling – once per year
- Lipids – once per year

PLUS THE FOLLOWING REQUIRED INDICATORS, DEPENDING ON THE APPLICABLE CHRONIC DISEASE:

Indicators for Diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year
- Eye exam – discussed and/or referred once per year for routine dilated eye exam

Indicators for IHD only

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

Indicator for COPD only

- **COPD Action Plan required – Develop and then review and complete once per year**

CDM Incentive Payments

Effective April 1, 2014 eligible GPs are paid as follows:

- $100 base incentive payment 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.
- $75 additional payment per fiscal year if the same patient is managed for a second qualifying chronic disease (total payment of $175)

- $50 additional payment per fiscal year if the patient is managed for three qualifying chronic diseases (total payment of $225).

NOTE: Completion of the COPD Action Plan, if applicable, is included in these payments.

The CDM incentive is claimed through a fee code. APP contract physicians are also eligible for the incentive and are paid by cheque twice a year based on their aggregate shadow billings.

CDM Incentive Billing Rules

1. The CDM Incentive fee can be claimed by family physicians only.

2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) 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 additional qualifying chronic diseases (s) for each qualifying disease.

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, including for investigations, follow-up visits and/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 are:

   - **Type 1 and Type 2 Diabetes** defined as: 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); and/or,

   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.

9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) 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 fiscal year for which the CDM incentive is being claimed;

- 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 CDM flow sheet at or before the time of billing.

CDM Flow Sheet

The Family Physician Chronic Disease Management Flow Sheet (attached) is revised effective April 1, 2014. Use of the Flow Sheet continues to be optional.

COPD Action Plan

A required indicator for COPD is the development and annual review and completion of a COPD Action Plan using the program COPD Action Plan template (attached).

Please Note: The system update for this revision is scheduled for May 23rd, 2014. At present time, please submit claims for managing up to two chronic diseases in the usual manner. Please hold all claims for the new 3rd chronic disease management incentive amount. A new modifier will be added during the May 23rd, 2014 migration to account for this additional incentive. Once the update is complete, effective claims with a service date from April 1, 2014 to May 22, 2014 will be identified and reconciliation will occur in the Fall of 2014.

BILLING REMINDERS

Critical Care Codes-Heath Service Code 03.05

As per Preamble section 7.9, Critical Care codes may be claimed for patients admitted to areas of the hospital that have been designated as Intensive Care Units by the Department of Health and Wellness by physicians who have been assigned to cover the ICU by the hospital because of their training or expertise.

It has come to MSI's attention that physicians other than those designated to cover the ICU are attempting to claim critical care codes. Critical care codes may be claimed only once per 24 hours by only one physician who is designated to cover the ICU that day. Non-designated physicians may not claim these codes.

While two (or more) physicians may share coverage of the ICU over a 24 hour period, Preamble rules do not permit both physicians to claim either the same ICU code or additional visits per patient (critical care or otherwise).

Supervision of Anticoagulant Therapy by Telephone, Fax or E-Mail- Health Service Code 13.99C

As per Preamble section 7.7.2, this health service code may be claimed once per month if the patient's treatment is managed by telephone, fax or e-mail. It may not be claimed within one month of hospitalization. As there will be months when a physician does not provide the monitoring necessary to claim this code, such as months during which the patient does not have an INR drawn or when they are hospitalized, physicians are discouraged from setting up automatic monthly billing systems for this health service code.

EXPLANATORY CODES

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

MJ043 Service encounter has been disallowed as the provider number is not valid for this service.

MA058 Service encounter has been refused as you have previously billed HSC 82.42.

MA059 Service encounter has been refused as you have previously billed HSC 83.61.

AD048 Service encounter has been refused as you have previously billed HSC 66.3E or 66.3F.

MA060 Service encounter has been refused as you have previously billed HSC 66.82A.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, March 28th, 2014. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanatory codes (EXPLAIN.DAT).

Family Physician Chronic Disease Management (CDM) Flow Sheet

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

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

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

Interventions/Investigations: PCI/Stent _____ ☐ Bare metal ☐ Drug-eluting ☐ Spirometry/PFT
CABG _____ Cardiac Cath. _____
Current Medication: _____
_____

REQUIRED COMMON INDICATORS FOR DIABETES, IHD AND COPD		Date / /	Date / /	Date / /	Date / /
ANNUALLY	Smoker ☐ Yes ☐ No If yes, discuss smoking cessation				
ANNUALLY	Immunizations Discussed and/or given				
ANNUALLY	Exercise/Activity				
REQUIRED COMMON INDICATORS FOR DIABETES and IHD		Date / /	Date / /	Date / /	Date / /
2/YR	Blood pressure				
ANNUALLY	Weight/Nutrition Counselling				
ANNUALLY	Lipids Discuss statins LDL-C (mmol/L) TC/HDL-C				
REQUIRED INDICATORS FOR DIABETES ONLY					
2/YR	HbA1C				
ANNUALLY	Renal Function ACR and eGFR				
ANNUALLY	Foot Exam Use 10-g monofilament				
ANNUALLY	Eye Exam Discuss and/or refer				
REQUIRED INDICATORS FOR IHD ONLY					
ANNUALLY	Anti-platelet Therapy Review				
ANNUALLY	Beta-blocker Review				
ANNUALLY	ACEI/ARB Review				
ANNUALLY	Discuss Nitroglycerin				
ANNUALLY	Consider further cardiac investigations				
REQUIRED INDICATORS FOR COPD ONLY					
1/YR	COPD Action Plan Develop. Review and complete annually				
RECOMMENDED ITEMS (Optional for CDM Incentive payment)					

Self Management Referrals: ☐ Diabetes Centre ☐ Cardiac Rehab ☐ Your Way to Wellness ☐ Pulmonary Rehabilitation
Screen for: ☐ Depression/Anxiety ☐ Erectile Dysfunction
Lifestyle: ☐ Alcohol Use ☐ Psychsocial Issues
Economics: ☐ Pharmacare ☐ Third Party Insurance ☐ No Insurance ☐ Financial Issues
End of Life: ☐ Care Discussion

Date CDM Incentive Code Billed: _____

SELECTED CHRONIC DISEASE MANAGEMENT GUIDELINE INDICATORS

Common Indicators: DM, IHD & COPD	Target	Comments
Smoking Cessation	Non-smoker	
Immunizations	Influenza annually. Pneumococcal once, then for DM & IHD repeat at 65 yr.; for COPD repeat every 5-10 years..	
Exercise/Activity	Discuss appropriate exercise/activity and possible referrals	For DM & IHD: 30 mins/day 5x/wk plus resistance exercise 3 x/wk. For COPD: pulmonary rehab program
Common Indicators: DM & IHD	**Target**	**Comments**
Blood Pressure	IHD without DM or CKD: <140/90 DM: <140/80* DM and CKD: <130/80** In children: <95th %ile for age, gender and height	*In DM with no end organ damage ** Where this can be achieved safely without undue burden
Lipids	For IHD or IHD plus DM LDL-C: < 2.0 >50% reduction For DM only LDL-C: < 2.6	Test every 1-3 years OR 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	

Diabetes Indicators	Target	Comments
HbA1C	< 7%	-q 6 mo. In stable DM -q 3 mo. For all others Individualize HbA1C based on age, DM duration & co-morbidity
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	Annually	Q3-6 mo. In moderate to high risk foot. Assess skin, neuropathy (10 –g monofilament) and perfusion.
Routine dilated eye examination	At diagnosis, then every 1-2 years based on degree of retinopathy.	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
Antiplatelet Therapy **ASA** 81 to 325 mg OD **Clopidogrel** 75 mg OD **Ticagrelor** 90 mg BID	**ASA** indefinitely –STEMI, Non-STEMI and Stable Coronary Artery Disease **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 **Ticagrelor** Prescribed to high risk Acute Coronary Syndrome patients, 12 months of therapy recommended.	**ASA** maximum dose 75-100 mg if on Ticagrelor **Clopidogrel: STEMI** Dependent on type of stent and risk profile **Clopidogrel Non-STEMI** Depends on risk of recurrent event & stent type **Ticagrelor**: Reduce ASA to 75-100 mg. Transient dyspnea can be early side effect. Usually mild and resolves with continued therapy.
Discuss Nitroglycerin		
Consider further cardiac investigations		

COPD Indicators	Target	Comments
COPD Action Plan	Include medications and emergency instructions for patient.	Copy given to patient.

PHARMACOTHERAPY IN COPD

INCREASING DISABILITY AND LUNG FUNCTION IMPAIRMENT

MILD	MODERATE	VERY SEVERE
↓		
SABD prn ↓ Persistent dyspnea	**Infrequent AECOPD (average of <1 per year)** **LAAC *or* LABA + SABA prn** ↓ Persistent dyspnea	**Frequent AECOPD (≥1 per year)** **LAAC + ICS/LABA +SABA prn** ↓ Persistent dyspnea
LAAC + SABA prn or **LABA + SABD prn**	**LAAC + LABA + SABA prn** ↓ Persistent dyspnea **LAAC + ICS/LABA* + SABA prn**	**LAAC + ICS/LABA + SABA prn** ± **Theophylline**

*refers to lower dose ICS/LABA

SABD = Short-acting bronchodilator (e.g. ipatropium or SABA)

LAAC = Long acting anticholinergic (e.g. tiotropium)

LABA = Long acting beta agonist (e.g. salmeterol; formoterol)

SABA = Short-acting beta agonist (e.g. salbutamol; terbutaline)

ICS/LABA = inhaled corticosteroid/LABA (e.g. fluticasone/salmeterol; budesonide/formoteral)

CHRONIC DISEASE MANAGEMENT (CDM) INCENTIVE FEE BILLING RULES

1. The CDM Incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) 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 additional qualifying chronic disease(s) for each qualifying disease.
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, including for investigations, follow-up visits and/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 are:
   - **Type 1 and Type 2 Diabetes** defined as: 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); and/or,
   - **Chronic Obstructive Pulmonary Disease (COPD),** a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV_1 < 80% predicted and FEV_1/FVC < 0.70.

8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) 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 fiscal year for which the CDM incentive is being claimed;
   - 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.

COPD ACTION PLAN

(Review annually with your doctor)

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

You have been diagnosed with Chronic Obstructive Pulmonary Disease (COPD). As someone with COPD, you are either in your stable, everyday state or having a flare up. This Plan will help you to quickly recognize and treat flare ups to manage your COPD and improve your health.

COPD (*Chronic Obstructive Pulmonary Disease*) can be stable or you could have a flare-up:

When you are stable:

1. Breathing with your usual shortness of breath
2. Able to do your usual daily activities
3. Mucous is easy to cough up

How to tell if you are having a flare-up

A flare up may occur after you get a cold, get run down or are exposed to air pollution, pollen or very hot or cold weather. There are 3 things that define a flare-up:

1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your usual level
3. Sputum changes from its usual colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

If any 2 or all of these symptoms persist for 48 or more hours do the following:

- ☐ Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- ☐ Take your prescribed antibiotic for a COPD flare-up (see over).
- ☐ Take your prescribed prednisone for a COPD flare-up (see over).
- ☐ Contact your doctor if you feel worse or do not feel better after 48 hours of treatment.
- ☐ Call 811 if you have questions
- ☐ Other _____

IF YOU ARE EXTREMELY BREATHLESS, ANXIOUS, FEARFUL, DROWSY, CONFUSED OR HAVING CHEST PAIN, CALL 911 FOR AN AMBULANCE TO TAKE YOU TO THE EMERGENCY ROOM.

Physician Signature_____

Patient/Caregiver Signature_____

COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

HCN: _____ Date of Birth: _____

Patients: Take the following maintenance medications **everyday** to help maintain control of your COPD symptoms.

Physicians: Please fill in prescribed maintenance medications.

Medication Prescribed	How Much to Take	When To Take

COPD FLARE-UP MEDICATION RECORD

Patients: Please fill in date when you start and finish your flare-up medications.

Physicians: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

Medication Prescribed	Start Date / Finish	Start Date / Finish	Start Date / Finish

Make sure you take your prescribed medications until finished.

Please review this plan with your doctor at least annually.