YOUR GUIDE TO NEW FEES:

Comprehensive Care

DECEMBER 2017

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DNS: HERE TO HELP

Doctors Nova Scotia staff members are available to help clarify fee codes and provide billing, audit and appeal support. For information, contact:

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Doctors Nova Scotia

Letter from DNS

DEAR COLLEAGUE,

After a long implementation process, I'm happy to present this guide to new and updated health service codes for fees supporting comprehensive care, negotiated as part of the 2015 Master Agreement. These fees are intended to replace the compensation physicians received from the Comprehensive Care Incentive Program (CCIP) by supporting a range of services typically provided by family physicians. Physicians who did not qualify for the CCIP but who provide these services will now be paid for their work.

Inside, you will find information about fee increases and new fees for comprehensive care services, including home visits; nursing home visits; inpatient visits, discharge management and post-discharge visits; maternity and newborn care; and select procedures performed by family physicians. These services were identified by physicians – both members of the Fee Committee and members of Doctors Nova Scotia, via a member-wide survey issued in August 2016 – as being areas that were in need of investment.

There are three categories that were part of the CCIP that will not see any fee increase or new fees: obstetrical deliveries, "well-baby" office visits for children under two years old, and Pap smears for women aged 40 to 75. In some cases, the payments that physicians would have received for these services will be offset by other fees (see page 10).

Inside, you'll find a guide to understanding and billing the new codes, resources that can assist with record-keeping, and a FAQ that provides answers to some common questions.

If you have any questions or comments, please don't hesitate to get in touch with Doctors Nova Scotia's staff members – you'll find their contact information on page 16.

Yours truly,

Dr. Ken Wilson
Fee Committee Co-chair
Doctors Nova Scotia Medical Consultant

WHAT IS THE FEE COMMITTEE?

The Fee Committee (previously the Fee Schedule Advisory Committee, or FSAC) reviews all applications to add, enhance or reduce fees; it can also make changes to the Preamble. The Fee Committee has the authority to make final decisions on fee applications, where there is unanimous agreement and sufficient budget. If the Fee Committee is unable to reach consensus, the issue will be referred to the Master Agreement Management Group for decision.

The Fee Committee includes representatives from Doctors Nova Scotia, the Department of Health and Wellness, and the Nova Scotia Health Authority.

Your Doctors Nova Scotia Fee Committee representatives are Dr. James Clarke (co-chair until November 2017), Dr. Michelle Raiche-Marsden, Dr. Kevork Peltekian, Dr. Alison Wellwood and Dr. Ken Wilson (co-chair as of November 2017). (Read more on page 16.)

WHAT YOU NEED TO KNOW

How the new fee codes were chosen

In June 2016, after more than a year of active negotiations, Doctors Nova Scotia (DNS) members ratified the 2015 Master Agreement contract. That contract included the transition of $13.5 million of incentive program funding into fee codes, $6 million of which was earmarked for fees that would replace the Comprehensive Care Incentive Program (CCIP).

These fees are intended to replace the compensation physicians received from the CCIP by supporting a range of comprehensive services typically provided by full-scope family physicians.

DEVELOPING FEES

As part of the new Master Agreement, the Fee Committee was tasked with deciding on appropriate fee codes and fee values to support comprehensive care following the transition of the CCIP to a fee-based structure. The intent was to develop fees that would remunerate care that was being provided under the incentive programs, target the same physician demographics and fully spend the budget from the transitioned program.

Members of the Fee Committee started this work in the spring of 2016. In August 2016, DNS asked family physicians to complete a comprehensive survey on the CCIP program transition to help identify priority investment areas.

SURVEY RESULTS

In total, 243 members responded to the CCIP survey, which asked for feedback on the incentives offered under the CCIP and sought suggestions for areas of investment that would benefit family physicians in Nova Scotia.

The survey respondents identified a number of areas that could benefit from additional investment, including:

- Home visits
- Nursing home visits
- Inpatient visits
- Maternity and newborn visits
- Select procedures provided by family physicians

THE NEW FEES

This process resulted in the new and increased fees outlined in the table on page 4. The fees are available to all family physicians – fee-for-service and APP. (These new codes are available to APP physicians to help meet shadow-billing thresholds). Physicians who did not previously qualify for the CCIP (such as part-time physicians or those who did not meet the CCIP thresholds), but who provide these services, are now eligible to bill for them.

These fees were announced in the Oct. 18, 2017, MSI *Physician's Bulletin*, came into effect on Nov. 1, 2017, and became billable as of Nov. 17, 2017.

THE NEW FEES

CATEGORY	FEE CODE	DESCRIPTION	OLD MSU RATE	OLD FEE VALUE	NEW MSU RATE	NEW FEE VALUE
HOME VISITS						
VIST	03.03	Home visit 0800–1700	21.3	$51.97	36	$87.84
VIST	03.03	Home visit 1701-2359, weekend/holiday	28.3	$69.05	47.8	$116.63
VIST	03.03	Home visit 0000-0800	38.3	$93.45	64.7	$157.87
VIST	03.03	Home visit emergency	35.2	$85.89	59.5	$145.18
VIST	03.03	Home visit extra patient	10.5	$25.62	13	$31.72
VIST	03.03	Home visit extra patient aged 65 years and older	N/A	N/A	16.5	$40.26
VIST	03.04	Home complete examination	24	$58.56	40.6	$99.06
ADON	HOVM1	Blended mileage and travel detention for home visits	N/A	N/A	0.46 MSU + MU	$1.12 per km; maximum claim 70 km ($78.57)
NURSING HOME VISITS						
DEFT	CP01	Care plan oversight – 15 to 29 minutes in a 30-day period	N/A	N/A	15	$36.60
DEFT	CP01	Care plan oversight – greater than 30 minutes in a 30-day period	N/A	N/A	30	$73.20
INPATIENT VISITS, DISCHARGE MANAGEMENT AND POST-DISCHARGE VISITS						
VIST	03.03 (DA=DA23)	Subsequent daily hospital visit – days 2, 3 and first day out of ICU	16	$39.04	23	$56.12
VIST	03.03 (DA=DA47)	Subsequent daily hospital visit – days 4 to 7	16	$39.04	19	$46.36
VIST	03.04F	Acute care hospital discharge day management – comprehensive	N/A	N/A	45	$109.80
ADON	03.03S	First visit after acute care in-patient hospital discharge – complex care	N/A	N/A	10	$24.40
MATERNITY AND NEWBORN VISITS						
VIST	03.04	First examination – newborn care healthy infant	16	$39.04	24	$58.56
ADON	03.03P	First visit after inpatient hospital discharge – maternal and newborn care	N/A	N/A	10	$24.40
SELECT PROCEDURES PERFORMED BY FAMILY PHYSICIANS						
MISG	98.22	Suture of skin and subcutaneous tissue of other sites	11	$26.84	20	$48.80
MISG	98.22A	Suture of simple wounds or lacerations – child's face	17	$41.48	25	$61.00
VADT	98.03	Other incision with drainage of skin and subcutaneous tissue (AN=LOCL)	6	$14.64	10	$24.40

FEE CODE EXPLANATIONS

An in-depth look

Transitioning of the CCIP meant that the funding that had been invested in the program was available to be redistributed as fees rather than incentive payments. In some cases, that meant that fees were increased; in other cases, it meant that new fee codes were developed. In both cases, the changes were intended to ensure that family physicians providing comprehensive care are appropriately remunerated for their work.

The changes to fees for comprehensive care can be grouped into five categories:

1) Home visits
2) Nursing home care
3) Inpatient care and care of patients following hospital discharge
4) Maternity and newborn care
5) Select procedures performed by family physicians

The changes

HOME VISITS

Almost 80 percent of DNS survey respondents indicated they provide home visits. The feedback provided consistently focused on the time home visits take away from a physician's practice.

The Fee Committee found that the MSI codes for home visits did not reflect the time and complexity of the work of physicians who provide those services. In order to pay physicians appropriately for the work they do, and to compensate for the fact that home visits take physicians away from their offices, where they could see a higher volume of patients, the Fee Committee recommended several significant rate increases – many at close to a 70 percent increase.

The initial home visit and extra patient visit fees have increased by 14.7 and 2.5 MSUs respectively. The complete exam has been increased by 16.6 MSU, while visits conducted on evenings and weekends have increased by 19.5 MSU. Finally, the home visit after midnight has been increased by 26.4 MSU.

The Fee Committee also recommended instituting a travel fee to compensate physicians for the time spent travelling to see homebound patients. Physicians are now able to bill for travel at a rate of 0.46 MSU per kilometre (up to a maximum of 70 km).

Detailed explanations are available in the Oct. 18, 2017, MSI Physician's Bulletin, *available at https://goo.gl/uK4bKt*

CATEGORY	FEE CODE	DESCRIPTION	NEW MSU RATE	FEE VALUE	DESCRIPTION	BILLING DETAILS
VIST	03.03	Home visit 0800–1700	36	$87.84	These adjusted health service code values apply to a homebound patient where the physician must travel to the patient's home in order to provide the clinical service	A home visit may only be claimed when the patient or the patient's representative has requested a visit with the physician, the patient's condition or situation justifies the service, and the patient is homebound. (See new definition of a homebound patient, and how that new definition will affect billing, below.)
VIST	03.03	Home visit 1701–2359, weekend/holiday	47.8	$116.63		
VIST	03.03	Home visit 0000–0800	64.7	$157.87		
VIST	03.03	Home visit emergency	59.5	$145.18		
VIST	03.03	Home visit extra patient	13	$31.72		
VIST	03.03	Home visit extra patient aged 65 years and older	16.5	$40.26		
VIST	03.04	Home complete examination	40.6	$99.06		
ADON	HOVM1	Blended mileage and travel detention for home visits	0.46 MSU + MU	$1.12 per km; maximum claim 70 km ($78.57)	This HSC is added on to a home visit HSC when the physician must travel to a patient's home in order to provide clinical services to a homebound patient.	Text for the claim must include: the start and finish time of the visit; point of origin; destination address; and distance in km. Maximum claim 70 km ($78.57).

WHAT IS A HOMEBOUND PATIENT?

As a result of the fee review process, the Preamble definition of a homebound patient has been updated. Only home visits for patients who meet the new definition (below) will qualify for the home visit fee codes.

Rules Specific to Location (5.1.44)

c) A home visit: Is a service rendered by a physician to a homebound patient or patients following travel to the patient's home on request by the patient or the patient's representative. A home visit may only be claimed when the patient's condition or situation justifies the service and the patient is homebound.

A patient is considered to be homebound when one or more of the following conditions are met and documented in the health record:

i. Leaving the home isn't recommended because of the patient's condition;

ii. The patient's condition keeps him or her from leaving home without help (such as using a wheelchair or walker, needing special transportation, or getting help from another person); or

iii. Leaving home takes a considerable and taxing effort.

Note: If the patient is not considered homebound, the visit is considered to be rendered at home for convenience. In this situation, the visit may be claimed at the regular office visit rate and travel may not be claimed.

GOING THE EXTRA MILE

Simple pencil and paper is great for tracking mileage, but if you'd like to try something higher-tech, consider one of these tracking apps:

- everlance.com
- triplogmileage.com
- mileiq.com

NURSING HOME VISITS

One-third of survey respondents said they perform nursing home visits as part of their practice. More than 60 percent of respondents who said they don't provide nursing home visits said that is because the visits aren't compensated appropriately or that they have restricted that area of their practice because their time was most effectively spent elsewhere.

Rather than adjusting MSU values for nursing home visit fees, the Fee Committee chose to invest in fees for care plan oversight. Essentially, this will remunerate physicians for managing and supervising the care of a patient in a nursing home, residential care facility or hospice who requires complex and multidisciplinary care that involves the physician to regularly develop and/or revise care plans.

Care plan oversight activities that can be billed include reviewing charts, reports and treatment plans; reviewing labs if not part of a visit; talking on the phone with other health professionals; discussing drug treatment and interactions with pharmacist; and discussing treatment plan changes with patient's family. This will not require the patient be present, and will be billable once per patient per 30-day period, to a maximum six times per year.

See page 12 for tips on billing care plan oversight health service codes.

CATEGORY	FEE CODE	DESCRIPTION	NEW MSU RATE	FEE VALUE	DESCRIPTION	BILLING GUIDELINES
DEFT	CP01	Care plan oversight – 15 to 29 minutes in a 30-day period	15	$36.60	Supervision of care for a nursing home, residential care facility or hospice patient requiring complex and multidisciplinary care modalities involving the regular development and/or revision of care plans by the physician most responsible for providing comprehensive care for that patient. Activities covered by the care plan oversight fees include: • Reviewing charts, reports and treatment plans • Reviewing labs (if not part of a visit) • Consulting with other health professionals by telephone • Discussing drug treatment and interactions with pharmacist • Discussing treatment plan changes with patient's family	Reportable for a 30-day period when more than 15 minutes of physician time is spent on the duties listed at left. Anything less than 15 minutes is considered to be included in the visit encounter service. Maximum reporting six times per calendar year. Only one physician may report for any given patient in a 30-day period. Must be the most responsible physician who provides definitive or comprehensive care for that particular patient. The physician must have seen the patient for a face to face visit at least once in the six months prior to reporting CP0. The physician must personally document the date, the time spent and a brief description of the activities provided in the patient's health record. For reporting purposes, activities, times and dates must be recorded in patient's health record. Do not report with other telephone service or non-face-to-face codes, such as: • 13.99C Supervision of Long-Term Anti-Coagulant Therapy – in the same calendar month • ENH1 Long-Term Care Medication Review – in the same calendar year
DEFT	CP01	Care plan oversight – greater than 30 minutes in a 30-day period	30	$73.20		

INPATIENT CARE, DISCHARGE MANAGEMENT AND POST-DISCHARGE VISITS

More than 50 percent of survey respondents said they provide inpatient care. Forty percent of those who do not provide inpatient care reported that they don't do so because it isn't an option in their community; 60 percent indicated that they don't provide inpatient care because it isn't compensated appropriately or because of concerns including workload, having to take on orphaned patients, and lack of time.

The approved fee codes reflect a significant investment in three areas:

- Increased inpatient visit fees (up to Day 7 in hospital);
- New fee for discharge day management services; and
- New add-on fee for family physicians who see patients within 14 days after discharge from hospital.

These new fees and fee increases are available only to family physicians because the funding is available only by virtue of the termination of the CCIP. These new fees may mitigate some of the loss that family physicians will experience with that program's termination.

Increased inpatient visit fees

Category	Fee Code	Description	New MSU Rate	Fee Value	Description	Billing Guidelines
VIST	03.03 (DA=DA23)	Subsequent daily hospital visit – days 2, 3 and first day out of ICU	23	$56.12	These codes apply to subsequent limited visits provided to patients admitted to hospital where the family doctor is the most responsible physician.	May only be claimed once per patient per day by the most responsible physician Note: First day out of ICU should be considered equivalent to Day 2 and subsequent inpatient days as 3, 4, 5, 6, 7 for the purpose of reporting these increased code values.
VIST	03.03 (DA=DA47)	Subsequent daily hospital visit – days 4 to 7	19	$46.36		

New fee for discharge day management services

Category	Fee Code	Description	New MSU Rate	Fee Value	Description	Billing Guidelines
VIST	03.04F	Acute care hospital discharge day management – comprehensive	45	$109.80	This code is to be used when services on day of discharge exceed 30 minutes of the physician's time. It is expected that the discharge doctor will make every effort to communicate with the community physician who will be most responsible for patient's care after discharge. When a complex comprehensive discharge process occurs over two days, the claim must be reported day of discharge.	This fee includes all discharge-day activities, including: • final exam • discussion of hospital stay • instructions for continuing care to patient/caregivers • preparation of discharge records, prescriptions and referral forms Services provided and time spent must be recorded Not reportable if the patient is admitted and discharged on the same day. Not reportable for hospital deaths.

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New add-on fee for family physicians who see patients within 14 days after discharge from hospital

Category	Fee Code	Description	New MSU Rate	Fee Value	Description	Billing Guidelines
ADON	03.03S	First visit after acute care in-patient hospital discharge – complex care	10	$24.40	This is an add-on to an office visit, billable for complex care patients (that is, patients who have two or more chronic conditions requiring active management) who have had a hospital stay of at least 48 hours. Reportable by the primary care provider responsible for the patient's ongoing care.	This add-on is restricted to: • 03.03 Office visit • 03.03A Geriatric office visit (patients 65+) • 03.03E Adults with developmental disabilities The physician's office must make every effort to communicate with the patient and/or caregiver within two business days of discharge. The visit must take place within 14 days of discharge; hospital stay must have been at least 48 hours. Not billable for walk-in clinics, or if the hospital admission was for elective surgery or fracture care. (Also not billable if the hospital admission was for obstetrical delivery or newborn care – those visits have a separate add-on, see below.) Not reportable in the same month as other monthly care fees (i.e., 13.99C – supervision of long-term anticoagulant therapy). Not reportable for services rendered in other locations such as nursing homes, residential care facilities or hospice. Claimable once per patient per inpatient admission. Not reportable for any subsequent discharges within 30 days. Billable a maximum of four times per patient per physician per year.

MONITORING UPTAKE

Doctors Nova Scotia physician representatives on the Fee Committee and MAMG felt that ADON 03.03s should be available any time a patient has been hospitalized for 24 hours or more, whether or not the patient has two or more chronic conditions. The government was not in agreement. Instead, DNS secured a commitment to review uptake of the add-on code within the next year. If uptake is less than projected, the patient eligibility criteria will be adjusted.

MATERNITY AND NEWBORN VISITS

Almost 75 percent of survey respondents indicated they provide maternity care as part of their practice. The remainder indicated they either didn't have the patient demographics or didn't have enough patients to support focusing in that area.

Fee reviews found that current MSI codes for maternity and newborn care, including obstetrical deliveries, are reasonable for the time and complexity of the physician work required to provide these services to a healthy mother and newborn. However, the committee recommended two changes:

(a) A 10 MSU add-on fee for the first maternal and newborn office visit within 14 days of discharge after obstetrical delivery – billable for the visit with both the new mom and the newborn; and

(b) a fee increase for the 03.04 first examination – newborn care healthy infant health service code.

CATEGORY	FEE CODE	DESCRIPTION	NEW MSU RATE	FEE VALUE	DESCRIPTION	BILLING GUIDELINES
VIST	03.04	First examination – newborn care healthy infant	24	$58.56	For almost 20 years, this code has been remunerated at 16 MSU, the same rate as 03.03 Subsequent Care – Newborn Healthy Infant. As a comprehensive visit is by definition more in-depth than a subsequent visit, the MSU value of HSC 03.04 has been increased by 50 percent, to 24 MSU.	This fee is billable by a family physician who provides an initial comprehensive visit to a healthy newborn in hospital.
ADON	03.03P	First visit after inpatient hospital discharge – maternal and newborn care	10	$24.40	This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the patient's most responsible physician.	This add-on fee is restricted to 03.03 Office Visit and 03.03 Well Baby Care. Reportable only if the visit occurs in the primary care physician's office or the patient's home within 14 calendar days after hospital discharge. The physician's office must make every effort to communicate with the patient within two business days of discharge. Only reportable if the reason for admission was for the purpose of obstetrical delivery; not reportable for any subsequent discharges within 30 days. Billable once per pregnancy (mother) and once per infant. Physician billing must be the physician most responsible for the mother and child's care at the time of the visit. Not billable by physicians working in walk-in clinics.

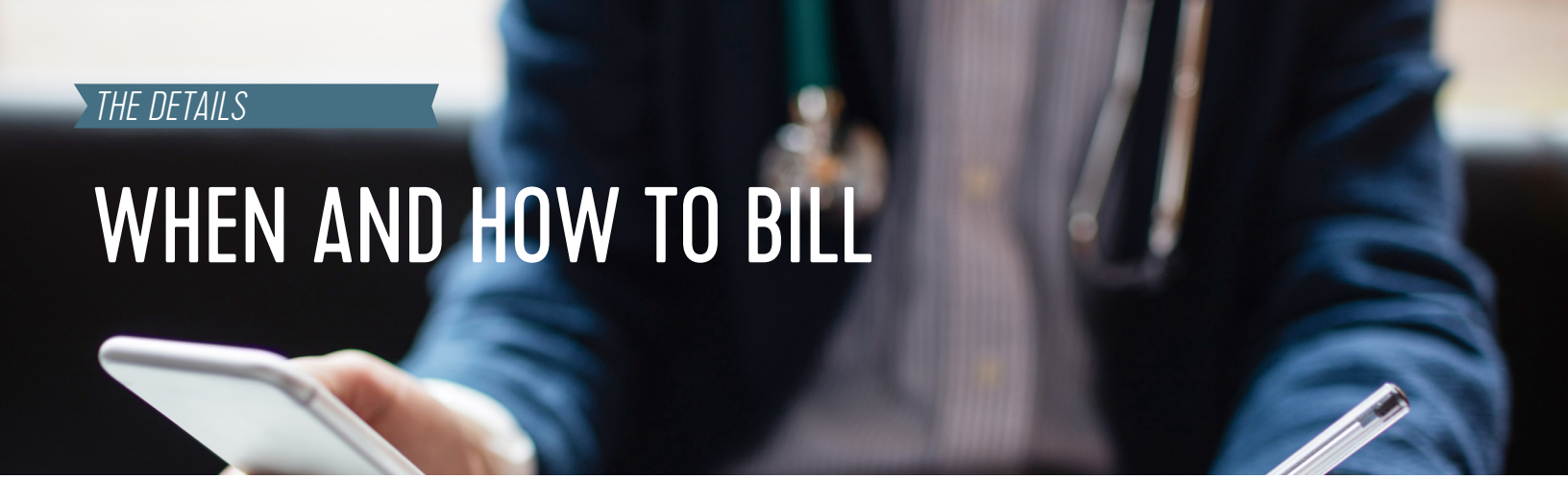
SELECT PROCEDURES PERFORMED BY FAMILY PHYSICIANS

Most survey respondents reported that they perform some type of GP procedure. In order to ensure that physicians are adequately paid for their work, the Fee Committee recommended that the value of three fees be increased.

CATEGORY	FEE CODE	DESCRIPTION	NEW MSU RATE	FEE VALUE	DESCRIPTION	BILLING GUIDELINES
MISG	98.22	Suture of skin and subcutaneous tissue of other sites	20	$48.80	The only change here is the fee increase.	Bill as instructed in the MSI *Physician's Manual.*
MISG	98.22A	Suture of simple wounds or lacerations – child's face	25	$61.00	The only change here is the fee increase.	Bill as instructed in the MSI *Physician's Manual.*
VADT	98.03	Other incision with drainage of skin and subcutaneous tissue (AN-LOCL)	10	$24.40	The only change here is the fee increase.	Bill as instructed in the MSI *Physician's Manual.*

Note: Two fees related to in-office procedures have been retired. The services described by MISG 98.04A and MISG 98.22E are now billable under the fee code MISG 98.22D.

OLD FEE	DESCRIPTION	NEW FEE	DESCRIPTION	MSU RATE	VALUE
MISG 98.04A	Suture minor laceration with removal of foreign body	MISG 98.22D	Suture minor laceration or foreign body wound	20	$48.40
MISG 98.22E	Suture minor lacerations or simple wounds				



WHEN AND HOW TO BILL

Effective Nov. 17, 2017, physicians may bill for the comprehensive care services rendered on or after Nov. 1, 2017.

Bill as usual for these codes, ensuring that you note the extra information noted below. For additional clarification, consult the Oct. 18, 2017, *MSI Physician's Bulletin*, available at https://goo.gl/uK4bKt

Physicians and billing clerks should review the requirements carefully before submitting claims for the new codes.

CAPTURING INFORMATION

It's crucial to include all the information needed when billing these codes. This information serves two purposes – to prove to MSI that the service was provided according to requirements (especially in the case of an audit) and to demonstrate to the Fee Committee that the fees are supporting patient care as intended.

TIPS ON HOW BEST TO BILL FOR CARE PLAN OVERSIGHT

Because the fees for care plan oversight (DEFT CPO1; see page 7) are billed for services provided within a 30-day period, it's important to track the time you spend on each associated task on an ongoing basis.

Establishing a monthly routine is the best way to ensure you are accurately reporting your CPO services.

First, create a master list of all patients for whom CPO is provided each month. This list will remind you which charts to pull when it's time to submit claims.

Second, keep a CPO log (see page 13) in each qualifying patient chart. Use the CPO log to document the date, total time spent and a brief description of the services provided each time you provide them. Record the diagnosis(es) for each patient, ensuring that information supporting the need for complex, multidisciplinary care is well documented in the health record. Be sure to sign the CPO documentation.

When you have reached 15 minutes or more in a 30-day period, have a staff person collect the CPO logs from the charts, total the time and report CPO for each patient for whom you provided more than 15 minutes of CPO during that time. Use the start and end dates of the 30-day period as the service dates. Finally, return the logs to the charts for use in the future. Note that this information must be documented in the nursing home, residential care facility or hospice record.

Using a reporting table like the one on the facing page will help you ensure you're capturing all the data you need.

Don't forget! CPO may be reported up to six times per patient per calendar year.

DEFINING TERMS

Activities that are *not* part of CPO:

- Renewing prescriptions
- Talking with fellow employees at the practice
- Travelling
- Preparing or submitting claims
- Holding informal consults with physicians who are not treating the patient
- Working on discharge services
- Interpreting test results during a visit

In addition, you may not report care plan oversight work performed by staff who are neither physicians nor non-physician practitioners.

CARE PLAN OVERSIGHT REPORTING TABLE

Location: _____

Patient name: _____

Diagnosis: _____

_____

CPO ACTIVITY	DATE	MINUTES	DATE	MINUTES	DATE	MINUTES
Develop care plan						
Revise care plan						
Activities to coordinate services						
Documentation						
Medical decision making						
Review (charts, treatment plans, lab or other test results)						
Communication with other health-care professionals						
Team conferences						
Adjustment of medication Discussion with pharmacist – may be by telephone or a face-to-face conversation						
Other (describe):						

Total minutes: * _____

*CPO: Time spent must be equal to at least 15 minutes in a 30-day period.

Physician signature: _____

EXAMPLE:

Dr. Franklin and Nurse MacDonald work together to manage Patient Doe's diabetes and hypertension.

April 27: Nurse MacDonald calls Dr. Franklin regarding a change in Patient Doe's medical condition, and the two health-care professionals discuss the patient's care. Dr. Franklin spends 15 minutes revising the patient's care plan in the CPO log.

May 1: Dr. Franklin and Nurse MacDonald have another telephone conversation related to Patient Doe's care plan, which requires another revision. The revision takes 20 minutes; Dr. Franklin documents all CPO activities and time spent.

May 3: Dr. Franklin tallies and reports all CPO services rendered in the last 30 days (a total of 35 minutes on April 27 and May 1) and is paid after meeting all CPO criteria.

May 4: Dr. Franklin's transcribed orders arrive at the office. It takes 10 minutes to review and sign the orders from April 27 and May 1. Using the CPO log, Dr. Franklin documents that work, being sure to record the amount of time spent.

May 8: Dr. Franklin reviews Patient Doe's lab results and revises the care plan again; this takes 20 minutes total. Again, the activity and time spent is recorded in the patient's CPO log.

June 1: Dr. Franklin reports all CPO services rendered in the past 30 days (a total of 30 minutes on May 4 and 8) and is paid after meeting all CPO criteria.

CARE PLAN OVERSIGHT REPORTING TABLE

Location: Yarmouth
Patient name: J. Doe
Diagnoses: Diabetes; hypertension

CPO ACTIVITY	DATE	MINUTES	DATE	MINUTES	DATE	MINUTES
Develop care plan						
Revise care plan	April 27	15	May 1	20		
Activities to coordinate services						
Documentation	May 4	10				
Medical decision making						
Review (charts, treatment plans, lab or other test results)	May 8	20				
Communication with other health-care professionals						
Team conferences						
Adjustment of medication Discussion with pharmacist – may be by telephone or a face-to-face conversation						
Other (describe):						

Total minutes: April 27 to May 1: 35 minutes; May 4 to 8: 30 minutes
Physician signature: _____

FREQUENTLY ASKED QUESTIONS

Derek Law, fee-for-service compensation manager at Doctors Nova Scotia, answers common questions about the new comprehensive care fee codes.

1. **Why did the Fee Committee decide to transition the Comprehensive Care Incentive Program to fees?**
   The Department of Health and Wellness (DHW) initiated this request as part of the 2015 contract negotiations. In addition, many Doctors Nova Scotia (DNS) members thought that the Comprehensive Care Incentive Program (CCIP) was complicated and hard to understand. Physicians told DNS that they did not know how their CCIP payment was calculated or how to increase it.

   Transferring the funding to fees makes the funding more widely available and means that more physicians can be incented to provide more comprehensive care. It also makes billing for comprehensive care easier, and allows physicians to better understand the full financial impacts of making any changes to their practice.

2. **Why develop a new fee for care plan oversight rather than just increasing the existing fee for nursing home care?**
   Physicians often tell DNS that they do lots of work that they are not paid for, including supervising the care of nursing home, residential care facility or hospice patients when there is no face-to-face patient interaction.

   The new care plan oversight fee means that physicians will now be compensated for this work, which includes reviewing subsequent reports on patients' status, reviewing related laboratory results and other studies not generated in a face-to-face encounter, and communication (including phone calls) for purpose of assessment or making care decisions with health-care professional(s) outside of that physician's practice.

   Care plan oversight can be billed in two blocks – from 15 to 29 minutes within a 30-day period or more than 30 minutes within a 30-day period. This fee is paid up to six times per patient per year. (Read more about care plan oversight on page 7.)

3. **Why wasn't there a fee increase for obstetrical deliveries?**
   The obstetrical delivery fee was not earmarked for an increase as it is already nationally competitive. Increasing fees for initial visit for healthy newborn and first family physician office visit after discharge should help offset the lack of an increase to the fees for obstetrical deliveries. (Read more on page 10.)

4. **Why were only three procedures selected for fee increases?**
   The three procedures that were selected for fee increases (suturing, suturing on a child's face and other incision with drainage of skin and subcutaneous tissue) were noted as having low values. The Fee Committee wanted to increase the fees for these procedures in order to incent physicians to provide these services away from acute care hospital infrastructure. (Read more on page 11.)

5. **The fee for home visits has increased dramatically. What is the reasoning behind this increase?**
   The Fee Committee found that fees for Nova Scotian physicians providing home visits were significantly lower than those for physicians providing home visits elsewhere in Canada. This increase will help compensate physicians fairly for the work that they do and hopefully incent more physicians to provide this service. Additionally, physicians are now able to bill for mileage. Previously, the lack of compensation for travelling to patients' homes was a barrier to service. (Read more on page 5.)

WHO'S WHO

MEET THE FEE COMMITTEE

The Fee Committee is responsible for providing decisions on all requests for amendments to the MSI *Physician's Manual*, including:

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

When the committee cannot reach consensus or has insufficient budget the matter will be referred to the Master Agreement Management Group.

The Fee Committee includes representatives from Doctors Nova Scotia, the Department of Health and Wellness, the Nova Scotia Health Authority and the IWK. Your physician representatives are:

DR. JAMES CLARKE

Dr. Clarke is a radiologist with a subspecialty in nuclear medicine at the QEII Health Sciences Centre in Halifax. He is also associate head of and assistant professor in the Department of Diagnostic Radiology at Dalhousie Medical School. Dr. Clarke concluded his term on the Fee Committee in November 2017.

DR. KEVORK PELTEKIAN

Dr. Peltekian is a hepatologist, professor and head of the Division of Digestive Care and Endoscopy in the Department of Medicine at Dalhousie University in Halifax.

DR. MICHELLE RAICHE-MARSDEN

Dr. Raiche-Marsden is a family physician at Woodlawn Medical Clinic in Dartmouth, N.S. She has served on the Fee Committee since October 2008.

DR. ALISON WELLWOOD

Dr. Wellwood is a family physician at the Wolfville Professional Centre in Wolfville, N.S.; she also provides inpatient care at the Valley Regional Hospital in Kentville, N.S. She is an assistant professor in the Department of Family Medicine at Dalhousie Medical School. She has served on the Fee Committee since September 2016.

DR. KEN WILSON, CO-CHAIR

Dr. Wilson worked as a pediatric plastic surgeon for 32 years before retiring. He is now Doctors Nova Scotia's medical consultant, providing billing, audit and appeal support to members of the association. Dr. Wilson became co-chair of the Fee Committee in November 2017.

DNS: HERE TO HELP

Doctors Nova Scotia staff members are available to help clarify fee codes and provide billing audit and appeal support. For more information, contact:

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