Nova Scotia
Physician Services Project

Frequently Asked Questions

August, 2013

NOVA SCOTIA CANADA

For doctors. For health. For you.
Doctors Nova Scotia

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PHYSICIAN'S MANUAL UPDATE PROJECT OVERVIEW

THE CURRENT PHYSICIAN'S MANUAL AND SUPPORTING DOCUMENTS

The primary intent of the Nova Scotia Medical Services Insurance (MSI) Program is to deliver insured physician services to the residents of Nova Scotia. At the core of this program are the patients and their diagnoses, physicians, and the insured services they provide to these patients. Being a publicly funded health service, formal accountabilities related to documenting and reporting patients seen and services provided are defined in legislation, regulations and a range of policy documents.

Within the MSI Program, the MSI Physicians Manual, MSI Physicians Billing Instructions Manual and MSI Physicians Bulletin are core documents that serve multiple purposes including stating DHW policy as well as being vehicles for physician and broader stakeholder communication and education.

THE PROBLEM WITH THE MSI DOCUMENTS

The MSI Physicians Manual, Billing Instructions Manual and Physicians Bulletins are used by physicians and all other stakeholders involved in the MSI Program across Nova Scotia. These documents define the requirement to record and report patient clinical diagnoses using the underlying 9th revision of the International Classification of Diseases, Clinical Modification (ICD-9-CM) and the specific insured clinical service descriptions, codes, modifiers and rules. This clinical content is foundation information that all components of the MSI Program are dependent upon.

These patient diagnoses and clinical service descriptions, code structure, modifiers and rules were originally intended to reflect the breadth of patients seen and the insured services provided by physicians. Being many years since the last comprehensive review and update, a number of problems now exist. Some of the issues include:

- (ICD-9-CM)classification for diagnoses and the Canadian Classification of Procedures (CCP) classification system used as the framework for the insured service descriptions are outdated
- The current clinical diagnoses and service descriptions are outdated and do not fully represent current clinical practice
- The layers of rules and modifiers added to be able to reflect specific service characteristics have become cumbersome
- The resulting data quality problems are affecting program accountability processes
- The supporting documentation is difficult to use

The physician service encounter claims data submitted is used for health system planning, physician payment, program monitoring and audit. The DHW uses the data for accountability, contract and grant management, human resource planning and allocation of funds, Medavie Blue Cross uses the data to administer the MSI program, and the District Health Authorities use the data for health service and program planning. Along with physicians, each of these organizations has indicated continued deterioration of the quality of the data submitted affects the reliability and use of these data, thus limiting their ability to effectively fulfill their roles.

Third Party Review

Recognizing the numerous issues with the MSI Physician's Manual, the DHW and DNS (through the MASG) decided to contract with a third party in April 2012 to conduct a review of the physician's manual as well as the other support documents (i.e Billing Instructions Manual and Physician Bulletins). Last year we contracted with RKL Consulting to do an initial review of the current MSI manual to determine where its weaknesses were and whether it simply required upgrading or if it should be completely rewritten. This project was titled the Nova Scotia MSI Physician's Manual Update Project - Phase I Scoping and Mapping.

RKL Consulting first steps were to put together a project team and governance model to ensure a fair decision making process was in place. A project working group and a steering committee were established and met on a regular basis. The working group was comprised of DHW staff and experts as well as Doctors Nova Scotia staff, and Medavie staff. The steering committee was comprised of DHW staff and experts, and Doctors Nova Scotia's physicians as voting members, and DHW, DNS and Medavie staff as supporting members. The project executive leads were Kevin Chapman, Director Health Policy and Promotion at DNS, and Dr. Anne Tweed, Medical Consultant for DHW. Executive sponsors were Nancy MacCready-Williams, CEO of Doctors Nova Scotia and Eleanor Hubbard, Chief of Partnerships and Physician Services at the Department of Health and Wellness.

The consulting team conducted interviews with physicians, our own Department of Health and Wellness as well as other government Departments of Health across Canada, other medical associations, and health information specialists (i.e. CIHI, Infoway). The basic questions asked of local professionals were to determine what is working well with the current physician's manual, what isn't working well, and what we would expect to see in an ideal physician's manual.

Some of the problems identified through these interviews are as follows:

- The current content does not reflect the complexity of the patients seen or intensity of services provided by physicians
- Outdated clinical diagnoses and service description content does not support and in some cases constrains modern clinical practice
- There are a number of specific clinical content problems that need to be addressed
- Supporting documentation has gaps, is outdated, is not structured to meet physicians needs and is prone to varying interpretations
- There are a number of data quality problems that need to be addressed
- Physicians have limited access to, and use of, the diagnoses and service data collected
- Incomplete or incorrect clinical content impacts audit integrity

As previously mentioned, interviewees were also asked what they thought a well written physician's manual would look like and the following responses have now become the goals for potential future work to create a new manual:

- The clinical content should incent quality clinical practice and reporting
- MSI physicians clinical diagnoses and service descriptions, codes and rules should reflect current clinical practice now and into the future
- Content and documentation should be relevant, user friendly, clear and transparent
- Updated processes should accommodate continuing changes
- There should be alignment of the data and information being shared between clinicians, organizations and other users. This will ensure that everyone's accountabilities are being met, clinicians and organizations are being fully supported, and that the insured services that are being provided and funded, are also being accurately reported.
- The data and information should be used for clinical practice and program planning, improving the health system as well as to support contracts, compensation models, monitoring and audit

Once the current state had been assessed, the future state goals were defined. The next part of the mandate for this review was to provide the Steering Committee with options of how to go forward with improving the physician's manual. The consultant team took a close look at other provinces to see if any other schedules of benefits were appropriate for consideration for Nova Scotia. The result was that while there were a couple of schedules that may be considered better than the MSI manual, they were also flawed and had many of the same problems as the MSI manual. The other options were to continue using the current physician's manual, or to create a new manual using SNOMED-CT, CPT, or a combination of the two with CPT mapped on to the framework of SNOMED-CT. The consultant presented these results to the steering committee (comprised of four physicians, DHW staff and Doctors Nova Scotia staff) and they unanimously agreed that there was no value in adopting any of the fee schedules from the other provinces or continuing with the current manual. The final recommendation from the steering committee was to test the feasibility of using SNOMED-CT, CPT or the combination of the two, and to create an entirely new schedule of benefits that addresses the needs and concerns of the physicians, government departments and academic groups who had provided feedback to the consultant.

Next Steps

Due to the volume of work and the many moving parts involved, the overall project goal of updating the Physician's Manual has been divided into six phases of work and is expected to take approximately four years to complete.

Currently, the Working Group and Steering Committee, along with RKL consulting have reconvened to do a fairly labour intensive portion of the first part of Phase II. This work is intended to improve some of the documentation now being used by physicians, to make it more readable, in the short-term. This work also involves parsing out the information contained in the current preamble, billing manual and physician bulletins to establish document baselines to be used for the rest of the project. It is important to note that no content will be changed during this phase and that everything that has been parsed out

will be documented and maintained for historical record keeping. This phase runs from May 2013 to the end of August 2013.

Pending project funding, the rest of the project will be broken down into five more phases (Phase II-VI) and is expected to take until 2017 to complete.

The Project Phases are as follows:

Phase I
Physician's Manual review and update scoping and mapping project (COMPLETE)

Phase II
MSI physician's clinical diagnoses and services reporting: content definition, development and documentation

Phase III
Clinical and service content use, policy and process modifications and IT assessment of requirements (including workload measurement, compensation modelling and clinical services plan)

Phase IV
Policy and process testing and IT modifications and testing

Phase V
Implementation-policy processing and information technology

Phase VI
Implementation- maintenance and evaluation (including ongoing clinical and service reporting maintenance, implementation evaluation and monitoring of impact)

There is a tremendous amount of work to be done and obviously it will take a number of years to complete. There is extensive physician engagement that will involve commitment from a large number of physicians to ensure each specialty provides input into their own clinical service descriptions in Phase III. This information provided by the physicians will ensure the new manual captures not only what you do, but the intensity and detail that is currently missing from the MSI Physician's Manual and other supporting documents.

FREQUENTLY ASKED QUESTIONS

PHASE I

1. What does the current Physician's Manual include?

Short answer:

The manual contains information about medically insured services available to Nova Scotians; the preamble outlines provincial policies and rules.

Companion document, Billing Instructions Manual, is a guide for physicians on how to submit claims for payment for insured services provided.

New fees, changes to fees, reporting reminders and policy changes are communicated through the Physician's Bulletin.

Long answer:

The current Physician's Manual contains information about medically insured services available to Nova Scotians.

The preamble at the beginning of the Physician's Manual outlines provincial health services policies as well as a number of associated rules. The rules are intended to explain who, when, where, how etc. a particular health service may or may not be insured by the province.

The main document is divided into specialties and contains health service codes, modifiers and fee values. The descriptions of health services are based on clinical diagnoses codes from the 9th revision of the International Classification of Diseases, Clinical Modification (ICD-9-CM) and the clinical service descriptions from the Canadian Classification of Procedures (CCP) as well as some locally developed descriptions. Each clinical service is identified by a health service code and there are usually a number of modifiers for each code that help to specify things like location or specialty.

The Billing Instructions Manual (BIM) is a separate document that is intended to be a guide for physicians on how to properly submit claims to MSI for health services they have provided. The BIM outlines all the requirements for the submission of service encounter claims.

The Physician's Bulletin document is intended to update providers on reporting reminders, holidays, Workers Compensation Board due dates, etc.

2. What are the problems?

Short answer:

Outdated clinical diagnoses and service codes cause ambiguity, which leaves physicians vulnerable during routine audits.

While it is prudent for physicians' billing practices to be audited, documentation guiding their reporting has to modernize so it reflects the services they provide to patients.

Once the documentation has been updated, physicians will be able to bill with confidence alleviating surprises during the audit process.

Long answer:

There are a number of issues with the current Physician's Manual and supporting documents. The primary problems that underlie many of the other issues are due to the languages used to describe clinical service descriptions and clinical diagnoses. The ICD-9-CM language for clinical diagnoses is out of date and the Canadian Classification of Procedures (CCP) has not been supported for over a decade and therefore is also not current. Since these are out of date, Nova Scotia (and any other provinces using these languages) has had to do their best to create their own clinical service definitions to create new health service codes whenever new health services have become insured in the province.

The many layers of rules and modifiers necessary to claim each health service have made the process confusing, cumbersome and highly prone to errors. This complexity has also made it difficult to create new health service codes in a timely manner so the entire breadth of insured services fails to capture many procedures, diagnoses and treatments that physicians are currently providing.

Other logistical issues are: a lack of linkages between the Physician's Manual, Billing Instructions Manual and Physician's Bulletin; inconsistent translation of new information from the bulletins back into the manual; inconsistent information contained within all manuals and supporting documents (i.e. currently, rules are found in both Physician's Manual and the Billing Manual, should be contained in one or the other).

3. What did physicians say they wanted to see in a good physician's manual?

Short answer:

Physicians identified the need for:

1. Content reflecting the services physicians provide to patients with clear alignment of rules and modifiers to make reporting easier.
2. Streamlined documentation that is easy to use, easy to update and can be clearly interpreted.
3. Clinical data should be provided back to physicians in a format useful for them and their practices.
4. A new and improved manual should support fair and effective audits.

Long answer:

Last year RKL consulting conducted a number of interviews with physicians as a part of the Phase I MSI Physician's Manual Scoping and Mapping project. Each physician was asked to consider what a useful, well-constructed physician's manual might look like.

The responses were divided into four main themes:

1. Specific clinical information: Physicians want to see improved clinical content that accurately reflects the services that they are providing. They want to see a clear alignment of the necessary rules and modifiers so that it is straightforward and makes reporting easier.
2. Supporting documentation: Physicians would like to see a manual with a redesigned documentation structure that makes the documentation easy to use, streamlined, and flexible enough to allow for timely and uncomplicated updates. All documentation should be clear for ease of interpretation across all users.
3. Information value, access and data quality: The clinical diagnoses and clinical health service information should accurately reflect each patient and each service provided to that patient. The language used for clinical diagnoses and clinical health service descriptions must be current, well supported, have an educational component, and have regular data quality checks in place. The clinical data collected would be provided back to physicians in a format useful for them and their practices.
4. Audit integrity impact: The purpose of an audit is to support good clinical practice, provide helpful feedback to physicians and other users, and to ensure timely payment for each service encounter claim reassessments. The current conditions of the Physician's Manual, Billing Instructions Manual and Physician Bulletin impact the integrity of the audit process. A new and improved Physician's Manual would support fair and effective audits.

4. Why not use another province's physician's manual?

Short answer:

The findings from a detailed review of insured clinical service used across Canada showed there were various problems with poor documentation in most of the physician manuals.

The lack of a supported, standard clinical language and the documentation issues across all physician manuals made them just as unsustainable as Nova Scotia's Physician's Manual.

Long answer:

One of the options that fell within the scope of Phase I of Physician's Manual Scoping and Mapping project was to consider the adoption of current best practices from other provinces with ongoing monitoring of changes.

The findings from this detailed review of insured clinical service used across Canada showed there were various problems reflecting poor documentation found in most of the physician manuals. Some of the documentation issues were:

- Illogical order of content
- No section overviews
- Confusing sentence structure
- Tariffs mixed in with preamble content
- No examples showing different claims scenarios or properly completed claims

More importantly, the review also showed that there was no current standard for reporting insured clinical services being used by any of the provinces. In other words, the other provinces have also had to use or create their own language for health service descriptions over the years because they are using the same languages as we are (ICD-9-CM, CCP) or some other language, and none have been updated or are currently supported.

The lack of a supported, standard clinical language and other shared concerns across all physician manuals make them just as unsustainable as Nova Scotia's Physician's Manual.

5. What were the options?

The final report brought forward to the project steering committee outlined the details, pros and cons, and the potential work required for the five following options to be considered:

1. Do nothing; continue to work with the current Physician's Manual.
2. Adopt current best practices from other provinces with ongoing monitoring of changes.
3. Examine Current Procedural Terminology (CPT) as a replacement for the currently used Canadian Classification of Procedures (CCP). **CPT is a clinical and diagnostic services language developed by physicians in the U.S.*

4. Examine SNOMED-CT (Systematized Nomenclature of Medicine Clinical Terms) as a replacement for the currently used CCP and ICD-9-CM. **SNOMED-CT is a clinical and diagnostic services language as well as a hierarchical framework/structure for organizing and linking services.*
5. Examine SNOMED-CT as a replacement for the currently used ICD-9-CM and CCP with SNOMED-CT mapped to CPT for use for physician compensation.

6. What did the Steering Committee recommend?

The Steering Committee reviewed each of the options in depth and decided that Options #1 Do nothing; continue to work with the current Physician's Manual and #2 Adopt current best practices from other provinces with ongoing monitoring of changes were not viable (please refer to FAQ's #2 and #4 respectively for more information).

The final recommendation was to investigate the feasibility of Options #3, #4 and #5 in the next phase(s).

PHASE II-VI

7. What are the goals of the Physician's Manual Update Project?

The goals for the future project related to updating the Physician's Manual (now referred to as Phases II-VI) were created based on the feedback given by physician's and other manual users during the Phase I interviews.

Goal 1
Modernize the schedule of insured services for the people of Nova Scotia.

Goal 2
Establish and implement the framework required to be able to accurately define clinical diagnoses and service descriptions now and into the future.

Goal 3
Prepare and sustain relevant and accurate supporting documentation.

Goal 4
Update related policy and operational processes.

Goal 5
Align required data and information flows to meet accountabilities and to support clinicians and organizations.

Goal 6
Retain current and increase future data and information use

8. How is the project going to be done?

Short answer:

A consulting firm has been hired to lead the project. Working in consultation with physicians and partners, they will work on improving some of the documentation to make it more user friendly in the short term. Physicians will be engaged to analyze and identify irrelevant health service codes and to describe the work they do that is not captured in present documentation. In the long term, a new manual reflecting the services physicians provide and new processes to support, maintain and update its use will be the goal.

Long answer:

Due to the volume of work and the many moving parts involved, the Physician's Manual Update project has been divided into six phases of work.

Phase I was the scoping and mapping aspect of the project and that work was completed in December 2012.

Currently, the Working Group and Steering Committee, along with RKL consulting have reconvened to do a fairly labour intensive portion of the first part of Phase II. This work is intended to improve some of the documentation now being used by physicians, to make it more user friendly, in the short-term. This work also involves parsing out the information contained in the current preamble, billing manual and physician bulletins to establish document baselines to be used for the rest of the project. It is important to note that no content will be changed during this phase and that everything that has been parsed out will be documented and maintained for historical record keeping. This phase runs from May 2013 to the end of August 2013.

Pending project funding, the rest of the project will be broken down into five more phases (Phase II-VI) and is expected to take until 2017 to complete.

9. What is the focus of each phase?

Phase I
Physician's Manual review and update scoping and mapping project (COMPLETE)

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10. What are the benefits for physicians?

Short answer:

Physician involvement will help ensure the issues identified by physicians are resolved. Physicians can ensure the patients they see and the services provided are accurately reflected in the new manual.

There are many benefits for physicians. The first benefit is participation in the project itself. The Department of Health and Wellness creates the insured health services policies and are not obligated to engage physicians in a potential update to the documentation of insured services. This project that we are seeking funding and approval for has already engaged physicians during Phase I, and there is extensive physician engagement required and expected during Phases II-VI. This is an excellent opportunity for physicians to be actively engaged in the process and for them to ensure that the new and improved MSI Physician's Manual truly reflects the patients that they are helping and accurately captures the work that they are doing.

The benefits of an improved manual will address most, if not all, of the concerns and wishes expressed during the physician interviews in Phase I including:

- Physician's MSI clinical service descriptions and rules will reflect actual clinical practice, will be intuitive for physicians, will use language that is readily understood by physicians and will be logical with clearly written clinical service and diagnoses descriptions and codes.
- The Physician's Manual preamble will be clearly written in plain English.
- The overall content of the manual will be developed in such a way that it will be easily maintained and updated. This flexibility will allow for changes in service delivery models, methods and providers to be captured in a timely manner.
- Through the use of standard terminology for clinical service descriptions, codes and rules will be more easily comparable across provinces and will appropriately reflect changing patient and service complexity and intensity.
- A fair and effective audit, and the data generated provided back to physicians in a format useful for them and their practices.

11. How is this relevant to a physician's practice?

Short answer:

Updated documentation will accurately reflect the services physicians provide. Reporting will be easier as the guess work and the need to choose 'look alike' codes will be eliminated. One document will house all of the information required to bill and report services.

Long answer:

With an updated physician's manual both physicians and their staff will be able to choose from clinical service descriptions that more accurately match the services provided. There should no longer be any need to use "look-alike" health service codes or have to guess at what service should be claimed. It will also simplify the process overall by providing one source of information. Currently physicians and billing staff are expected to consult the preamble, physician bulletins and the billing instructions manual to determine how to correctly claim some health services. A new manual would have all of this information in one document with linkages to relevant sections.

The focus on physician engagement for this project means that the content created will not only accurately represent the type and complexity of insured services provided by physicians but will also help to maintain content clinical relevance and currency now and into the future

The project will improve stakeholder relationships by establishing clearer language for clinical services that not only improves reporting, but ensures accuracy of the information being submitted. This will lead to a clearer understanding of what physicians do by all information users. These improved relationships will ultimately lead to better and more modern policies for patients, physicians and government.

Another important advantage of the project is an increased focus on providing clinical information back to physicians for them to use. Currently there is no feedback of relevant clinical information for physicians and their staff regarding patients or clinical services. Under this project, clinically relevant information generated using the new manual will be made available to physicians so they'll be able to manage their practices more effectively, identify specific patient populations for potential group sessions or special clinics, and consider other innovative ways to practice.

The project will help to improve processes by updating the clinical content and by eliminating redundant clinical content. This will help physicians and their staff save time, improve the accuracy of clinical services reporting and ultimately have fewer billing errors which will result in timelier physician fee-for-service payments.

12. How do other stakeholders benefit?

Short answer:

The Department of Health and Wellness will benefit from accurate data to develop policies, to improve the audit process and for health service planning.

Nova Scotians will benefit from new policies and funding for programs meant to better serve their needs.

Medavie Blue Cross will benefit from improved health service codes, rules and modifiers linked to health policies.

Long answer:

The Department of Health and Wellness also benefits by having modern, clean and accurate data upon which they base their policies, and by having an effective audit process. A new Physician's Manual will result in better processes which will, in turn, improve relationships with stakeholders.

Many of these benefits will also positively impact the people of Nova Scotia. Clean and accurate data will inform appropriate policies and funding for programs that are needed in communities throughout the province. Improved clinical information will make navigating the insured health care system much simpler for all users, including patients and their families.

Medavie Blue Cross, the administrator of Nova Scotia's insured health services benefits, will benefit from a new physician's manual by knowing that the health service codes, rules and modifiers that they work with are clearly linked to health policies. They also share some of the benefits that other stakeholders will such as improved data capture and quality, more timely change processes and clearly understood languages.

13. How long is this expected to take?

Short answer:

In total the project is expected to take five years. Phase I is complete, phase II is underway and will end in 2015. Phases III through VI are expected to take two more years.

Long answer:

Phase I was the scoping and mapping aspect of the project and that work ran from April 2012 until December 2012.

Currently, early Phase II work is underway that is intended to improve some of the documentation used by physicians in the short-term. This phase runs from May 2013 to the end of August 2013.

The rest of the project will be broken down into five more phases (Phase II-VI) and is expected to take until 2017 to complete.

14. How is the change from the old to the new manual to be managed?

Short answer:

A change management strategy has been developed to help capture changes, identify those most impacted and how the change will be relayed, for example through a communication, policy and education.

Long answer:

The most critical piece of this entire project is the human component. This project is completely dependent on the buy-in and participation of a large representation of physicians as well as other users of the Physician's Manual like the Department of Health and Wellness and Medavie. There will be physician involvement for the entirety of the project so effective education, engagement and active participation are crucial.

Numerous change management approaches will be used over the life of the project and these include the following:

- Stakeholder engagement over the life of the project
- Communication planning and implementation
- Education planning and implementation
- Critical appraisal, analyses of current state and state of readiness with the intent to better understand, define and document findings.
- Policy development (provincial, internal and operational) to define a course or method of action selected from among alternatives to guide and determine present and future decisions.
- Assessment of processes
- The use of various tools and methods including analytical methods, knowledge resources
- Formal pilot studies
- Formally defining the data to be collected based on the agreed upon language(s) and data uses
- The application of research methodologies to understand specific issues that might arise, or to inform decisions, as the project unfolds.

15. Why should physicians be involved?

Short answer:

As experts on the services provided to patients, physicians are integral to the success of the project. As subject matter experts, physicians will identify irrelevant codes and service descriptions as well as describe the services and diagnoses not currently captured by the current documentation.

Long answer:

Physicians should be involved in the process of updating the Physician's Manual because they are the primary providers of insured health services to Nova Scotians. The manual should accurately define the clinical descriptions of each health service that physicians provide to their patients as well as the clinical diagnoses to reflect the complexity of their patients. No other stakeholder group has that fulsome knowledge and understanding. This manual was written decades ago and the intention is for the new manual to be functional until at least 2030 so this is a rare opportunity for physicians to contribute to such a large, relevant and important project. With the more accurate data that would be generated by the use of a new and improved manual, the Department of Health and Wellness will gain a clearer understanding of the needs of Nova Scotia's patient populations and will be able to develop and implement health care policies that better reflect both patient needs and physician services. A new

manual will also encourage more innovation by physicians as it will be a flexible, living document that can be easily updated and changed to reflect changes in practice patterns or technologies.

16. What is going to happen to the existing FSAC, MASG processes?

The existing Fee Schedule Advisory Committee and Master Agreement Steering Group processes will continue until the Master Agreement expires March 2015. The work of the project will be designed to run in parallel with the work of these two groups and does not involve the negotiations process.

17. What will happen to the data that has been collected over the past 20 years?

The data that has been collected over the past 20+ years will be recorded and stored. Any new data generated will be cross-referenced with the old data so it can continue to be used as required.

18. Who are the project executive consultants, committee and working group members, etc?

Executive Sponsors

Nancy MacCready Williams, CEO of Doctors Nova Scotia
Eleanor Hubbard, Chief of Partnerships and Physician Services, Department of Health and Wellness

Project Executive Leaders

Dr. Anne Tweed, Medical Consultant, Department of Health and Wellness
Kevin Chapman, Director Health Policy and Promotion, Doctors Nova Scotia

Steering Committee Members

Department of Health and Wellness (Voting Members)

Dr. Anne Tweed, Medical Consultant, Department of Health and Wellness (steering committee chair)
Barb Harvie, Director Accountability and Performance Management
Angela Purcell, Director Physician Services
Angela Arsenault, Manager of Fee for Service and Insured Programs

Doctors Nova Scotia (Voting Members)

Dr. David Milne
Dr. Don Pugsley
Dr. Greg Clarke
Dr. Simon Jackson

Non Voting Members

Kevin Chapman, Director Health Policy and Promotion, Doctors Nova Scotia
Jennifer Girard, Policy Advisor, Doctors Nova Scotia

Ann Foran, Director Provincial Programs, Medavie Blue Cross
Denise Pellerin, Manager MSI Programs, Medavie Blue Cross
Robyn Kuropatwa, Project Manager, RKL Consulting

Working Group Members

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Dr. Anne Tweed, Medical Consultant, Department of Health and Wellness (working group co-chair)
Barb Harvie, Director Accountability and Performance Management
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Kevin Chapman, Director Health Policy and Promotion, Doctors Nova Scotia (working group co-chair)
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Jason Sidney, Research and Statistical Officer, Partnerships and Physician Services
Yasu Lu, Health Information Management Student
Robyn Kuropatwa, Project Manager, RKL Consulting
Dennis Wellborn, RKL Consulting
Shirley Groenen, RKL Consulting

19. What is the Nova Scotia Physician Services Project?

The Nova Scotia Physician Services Project is a joint initiative between Doctors Nova Scotia and the Nova Scotia Department of Health and Wellness to improve and modernize the terminology used to describe the services physicians provide to Nova Scotians. The result will be easier billing and reporting for physicians and the expanded use of information for health services planning at the practice level and provincial level.

20. Will MSI audits occur while the project is ongoing?

Yes, MSI audits will continue as usual.

21. Is this project an opportunity to add new services to the insured services list?

No, the focus of this project is to update documentation based on the services currently on the insured services list, not to add new services that currently aren't funded.

Application can be made by all parties to the Fee Schedule Advisory Committee requesting a new fee for a service currently not funded through the insured services.

22. Is this project an opportunity to change physician compensation for some services?

No, changes to physician compensation can only be negotiated through contract negotiations. Fees can be changed through the application process to the Fee Schedule Advisory Committee, if recommended by the committee and then approved by the Master Agreement Steering Group.

23. Are physicians represented on the project now?

Yes, four physicians have been and continue to be members of the project steering committee representing physician's interests in rebuilding the manual.

24. Will there be opportunities for more physicians to be engaged in the project?

Yes, in addition to physician representation at the steering committee level, more physicians will be required at various stages to participate on specific working groups.

Physicians will be paid an honoraria to support their involvement in rebuilding the manual.