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Physician's newsletter

Published by the Medical Services Plan for Medical Practitioners

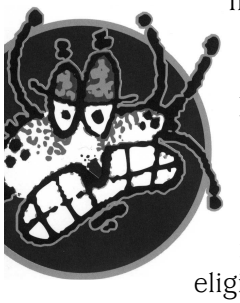
inside

Issue 2 Volume 26 Winter 2001

Flu Shots

Influenza vaccine will be available November 2001. Last year's influenza campaign demonstrated that a physician's recommendation for influenza immunization was the most significant factor in a patient's decision to be immunized. Encourage the patients in your care to get immunized against influenza.

Flu shots should be billed under fee item 00010 (intramuscular medications) for any person eligible to receive the free influenza vaccine. A visit fee should not be billed if the flu shot was the sole reason for the visit.



Influenza vaccine is provided free to people 65 and over, adults and children with chronic health conditions, independent health care practitioners (e.g. doctors, nurses, and dentists), health care workers and staff in care facilities, caregivers and emergency responders. Please refer to the following website for a detailed list of eligible people:

http://www.healthservices.gov.bc.ca/prevent/influenza

Only those persons eligible for publicly funded vaccine should have their flu shots billed to MSP. Charging an eligible person, for either the vaccine (serum) or the injection is in contravention of the *Medicare Protection Act* Part 4 Section 17(1).

Audit Review

General Practitioner - February, 2001

An MSC audit of a physician uncovered an inappropriate number of prolonged counselling visits and complete physicals, billed to MSP by the physician. The physician has agreed to repay the Commission $26,000 inclusive of fees and audit costs.

As part of the settlement, the physician has agreed to bill MSP only when the service is medically necessary and in compliance with the *MSC Payment Schedule.*

General Practitioner - April 2001

The MSC has settled a claim under section 37 of the *Medicare Protection Act* (the *Act*) involving nursing home visits. The practitioner's billing profiles showed a pattern of billing on behalf of almost all of his nursing home patients every two weeks. The Commission was not persuaded that all the services were medically necessary. Subject to medical necessity, claims for nursing home visits may be made to a maximum of one visit every two weeks. (Additional visits may be claimed in some cases. See the Preamble to the Payment Schedule for details.) The practitioner agreed to repay the Commission $45,000 on account of these errors, other billing errors, and audit costs.

Psychiatrist - May 2001

On May 3, 1999, the MSC started a civil action against Dr. Paul Devlin under section 30(2) of the *Act*. The Commission alleged Dr. Devlin had made inaccurate representations about his income to the Alternative Payments Branch of MSP in order to receive maximum sessional rates from 1993 to 1996. The Commission claimed an overpayment of $93,150. Dr. Devlin denied the Commission's allegations and made a counter-claim of $53,000 for services allegedly rendered but not billed to MSP.

Dr. Devlin and the Commission have agreed that Dr. Devlin will:

- Plead guilty to an offence under section 46 of the *Act;*
- Repay the Commission $93,150;
- Abandon his Counterclaim; and,
- Voluntarily de-enroll from MSP pursuant to section 15 of the *Act* for 2 months.

General Practitioner - June 2001

An MSC audit of a physician uncovered an inappropriate pattern of billing emergency visits, complete examinations and prolonged counselling services. The physician has agreed to repay the Commission $42,000 inclusive of fees and audit costs.

As part of the settlement, the physician has agreed to adopt an appropriate pattern of practice respecting these fee items and to bill MSP only for medically necessary services actually rendered.

General Practitioner - March 2001

A practitioner has agreed to repay the Commission $21,000 following an audit under the *Act*. After reviewing the Audit Report, the Commission was concerned about possible inappropriate billings including:

- unnecessary counselling visits;
- unnecessary complete examinations, some of which appeared to be routine annual physical examinations; and,
- direct billing for services considered benefits under the *Act*.

The practitioner has agreed to abide by a relevant pattern of practice directive.

General Practitioner - May 2001

MSC inspectors often encounter billing errors related to intramuscular injections and complete physical examinations. As a result of a recent audit, a physician agreed to repay the Commission $38,500 for injections, complete physicals, and the cost of the audit. Readers are reminded that fee item B00010 should be the only fee charged when the sole purpose of the visit is an intramuscular injection. A visit fee may be charged in place of fee item B00010 if a visit is required for a separate medical condition. Routine or periodic complete physical examinations are not benefits of MSP.

Your MSP Web Site

Do you know that MSP has a web site specifically for medical practitioners?

MSP is constantly adding features and services to make this site interesting and convenient for physicians and their office staff. Some of the features you may find useful include:

MSP Forms for Medical and Health Care Practitioners
Includes application forms for: registration, MSP billing number, Teleplan service, direct bank payment, assignment of payment, and insured out of country medical services. Forms can be downloaded and printed for completion and mailing. No need to fax or phone in your request for forms anymore!

Billing Procedures and Guidelines for Physicians
From here you can view and print sections of the MSP Resource Manual for Physicians , including billing procedures for General Practice and Specialty services.

MSC Payment Schedule
The complete MSC Payment Schedule is online and includes a search function for finding items by numerical fee code or text. Try it out!

Physician's Newsletter
Misplaced your recent or past issue(s) of the Physician's Newsletter? No problem! You'll find the past three issues of the newsletter online.

MSC Financial Statement (Bluebook)
The MSC Financial Statement for the fiscal year ended March 31, 2001 is now online. Select the "Publications" button listed on the MSP website.

MSP Fee-for-Service Payment Statistics
Each year MSP produces three booklets that provide practitioner and subscriber fee-for-service based statistics for the current year. Select the "Facts and Statistics" button listed on the MSP website.

MSP Tutor
Hone up on your claims billing skills with MSP Tutor – an online learning tutorial for medical office personnel. New modules are being added all the time.

Find these and more at:
http://www.healthservices.gov.bc.ca/msp/index.html

Click on "MSP for Medical and Health Care Practitioners". Bookmark this site for future reference!

MSP Tutor is a series of on-line self-directed learning modules for physicians and medical office assistants (MOA's). This exciting new MSP service is now available on the MSP web site at: http://www.healthservices.gov.bc.ca/msp/msptutor/index.html.

MSP Tutor is designed to help medical offices understand and follow MSP claims billing procedures and rules so that their claims will be processed as accurately and quickly as possible. This easy-to-use tutorial package is broken up into short modules that focus on specific billing rules. Each module includes a short quiz that enables users to test their knowledge on a specific topic.

MSP Tutor has been tested by a small group of medical office assistants and MSP claims adjudication staff. Participants were enthusiastic about its use as a learning tool and found the content easy to understand and the design simple to navigate. The participants also said MSP Tutor was a useful and enjoyable way to learn.

MSP Tutor is featured on a site specific to medical practitioners where the *MSC Payment Schedule,* parts of the *Physician's Resource Manual,* and the MSP *Physician's Newsletter* can also be found.

For information please contact:
dianne.kirkpatrick@moh.hnet.bc.ca
or telephone 250 952-1059.

Billing Tips

Fee Item 00109

Fee item 00109 (First hospital visit) is intended to compensate the general practitioner that admits a patient to an acute care hospital for the admission examination. The fee item includes all the components of a complete examination, when the patient is admitted under the care of a general practitioner. The following tips will assist you in determining when to bill this item:

Fee item 00109 is payable when:

- Patient is admitted to an acute care hospital for continuing care by a GP;
- Patient is admitted by a general practitioner and subsequently referred to a specialist for daily care or surgery.

Fee item 00109 is not payable when:

- A complete physical examination (fee items 00101, 13101, 13201 or 13301) has been billed by the same physician within seven days prior to admission;
- The patient has already been admitted by another general practitioner (i.e. this is not payable once per physician, but rather once per hospitalization);
- The patient is admitted for planned surgery;
- The patient is admitted under the continuing care of a specialist;
- The patient is admitted to a facility other than an acute care hospital.

Free PSA Testing

Medically required testing for "free PSA" should be forwarded to the BC Cancer Agency. It is not appropriate to bill this test to the patient or under the listing for PSA testing (90710).

Pre-Anaesthetic Evaluation

Pre-anaesthetic Evaluation (fee items 01151 and 13052) will only be paid on the date of surgery under the following circumstances:

- When the time of the pre-anaesthetic evaluation is greater than two hours prior to the start time of the surgical anaesthesia;
- When the time of the pre-anaesthetic evaluation is less than two hours prior to the start time of the surgical anaesthesia and information is provided in the note record indicating that the pre-anaesthetic evaluation was performed outside of the operative suite.

Claims for fee items 01151 and 13052 that are submitted on the same day as surgical anaesthesia without a start time will be deemed to be included in the fee paid for surgical anaesthesia in accordance with Anaesthesia Preamble 1.

Updates to the Web-based Version of the MSC Payment Schedule

The MSC Payment Schedule is now available on our public web site at: http://www.healthservices.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html.

This version of the Payment Schedule has recently been updated, and includes all changes made up to September 14, 2001. The online version of the Payment Schedule will be updated on a quarterly basis. Changes will be done to the fee schedule itself, so there will be no need to check for separate updates.

We are also pleased to announce that the search function has been improved so that you will now be able to search the entire document (instead of searching by section). You may search by key word or fee item number. The alphabetical and numeric indexes have been removed from the web site, as the updated page numbers will not be in the indexes until the next printing.

Adjudication of Complex Claims by a Medical Advisor/Medical Advisors Council

Approximately 98% of all claims submitted to MSP are processed through MSP's automated claims processing system. Many of the remaining claims are not of a routine nature, and require manual adjudication by MSP staff using established payment policies.

For more complex cases, such as multiple surgical accounts, unique claims and disputed payments, MSP contracts with several practicing physicians and surgeons as Medical and Surgical Advisors. The Medical and Surgical Advisors assist with adjudication of those complex cases and provide advice to MSP staff regarding development of appropriate payment policies.

Although it is not feasible to have one Medical/Surgical advisor from each specialty, every effort is made to ensure that Medical/Surgical advisors adjudicate claims within the scope of their knowledge and experience. In addition, the Medical and Surgical Advisors, as well as the Medical Consultant to the Claims Branch, meet monthly to discuss particularly complex billings. In order to attract and retain practicing physicians as Medical and Surgical Advisors, MSP does not release the name of any physician contracted in this capacity.

You will be notified if your claim has been adjudicated by a Medical or Surgical Advisor (and payment was recommended at other than the billed amount) by letter and/or unique explanatory code (e.g. "UA") returned with your remittance statement.

To request a review of claims that have been reduced or refused, you need to rebill the claim in question and provide further supporting information in a note record or correspondence. A claim previously adjudicated by a particular Medical or Surgical Advisor is generally returned to that advisor. Though it is not possible to speak directly to an advisor you can communicate directly with experienced Claims staff who will discuss your concerns with an advisor on your behalf.

Diagnostic Facility Reminders

Under the *Medicare Protection Act,* Medical and Health Care Services Regulation and Part XV – Diagnostic Services and Facilities of the rules made under the *Medical Practitioners Act*, diagnostic facility owners and medical directors have a number of responsibilities.

It is the responsibility of owners and Medical Directors of Diagnostic Facilities to be familiar with the laws (statutes and regulations) under which they are licensed and funded. In particular, it is important for them to know and follow the conditions attached to their Diagnostic Facility Certificates of Approval.

Regulations state:

i) the prior approval of the Medical Services Commission (MSC) is required before the sale or transfer of shares in diagnostic facilities
ii) MSC must be notified of the temporary or permanent cessation of the provision of diagnostic facility services*
iii) the prior approval of the MSC is required for the expansion of capability or capacity to perform diagnostic services
iv) MSC must be notified of all changes to diagnostic facility medical staff or supervisory personnel*
v) diagnostic facility owners must submit claims to the MSP under the practitioner number of a physician who rendered or supervised the service
vi) approval of a diagnostic facility is for a specific address. Any change in the location of a diagnostic facility must have the prior approval of the MSC

* the Diagnostic Accreditation Program must also be notified

The legal requirements above apply to all Diagnostic Facility Certificates of Approval, issued to private (including office) and public (including hospital) facilities that provide diagnostic services funded through the Medical Services Plan. Please note, services that are not in compliance with a Certificate of Approval are not benefits under the *Medicare Protection Act*. Non-compliance could result in the Medical Services Commission seeking recovery and/or amending, suspending or cancelling the approval. In this event, the facility is entitled to a dispute resolution process, including the right to a formal hearing.

Updated list of Available guidelines & Protocols

Topic	Guideline /Protocol
Ankle injury	X-ray for Acute Ankle Injury, Revised 2000
ANA	Antinuclear Antibody (ANA) Testing for Connective Tissue Disease
Bone density	Bone Density Measurement
Bone scans in prostate cancer	Investigation of Metastatic Bone Disease in Newly Diagnosed Prostate Cancer Using Nuclear Medicine Techniques, Reviewed and unchanged April 2000
Bone scans in suspected osteomyelitis	Investigation of Suspected Osteomyelitis in Normal Bone Using Nuclear Medicine Techniques, Reviewed and unchanged April 2000
Cataracts	Treatment of Cataract in Adults, Revised 2000
Chest x-rays	Chest X-rays in Asymptomatic Adults
Cholesterol	Cholesterol Testing: Adults Under 69 Years
Colonoscopy after colorectal cancer	Follow-up of Patients After Curative Resection of Colorectal Cancer
Diabetes, glucose and HbA_{1C}	Use of Glucose and HbA_{1C} Tests in Diagnosis and Monitoring of Diabetes Mellitus
Diarrhea	Investigation of Suspected Infectious Diarrhea
Drugs of Abuse	Detection of Drugs of Abuse in Urine: Methadone Maintenance Program
Dyspepsia	Clinical Approach to Adult Patients with Dyspepsia
ECGs	• Ambulatory ECG Monitoring (Holter Monitor and Patient-Activated Event Recorder), Revised 2001 • Electrocardiograms, Revised 2000
ESR	Erythrocyte Sedimentation Rate, Revised 2000
Gallstones	Treatment of Gallstones in Adults, Revised 2001
Gastroesophageal reflux disease	Clinical Approach to Adult Patients with Gastroesophageal Reflux Disease
Genital specimens	Office and Laboratory Management of Genital Specimens
Helicobacter pylori	Detection and Treatment of Helicobacter pylori Infection in Adults
Hepatitis, viral testing	Viral Hepatitis Testing
Homocysteine	Use of Homocysteine Measurement in the Evaluation of Atherothrombotic Disease
House calls	House Calls, Reviewed and Unchanged April 2000
Iron	Use of Serum Ferritin and Total Iron and Iron Binding Capacity
Iron Overload	Investigation and Management of Iron Overload
Mammography	Use of Diagnostic Facilities for Mammography
Methadone Maintenance Program	Detection of Drugs of Abuse in Urine: Methadone Maintenance Program

Prenatal testing	• Prenatal Cytogenetic Testing, Revised 2000
	• Prenatal Ultrasound
Pre-operative testing	Routine Pre-Operative Testing, Revised 2000
Sleep disorders	• Assessment and Management of Obstructive Sleep Apnea in Adults, Revised 2000
	• Primary Care Management of Sleep Complaints in Adults
Stool testing for ova and parasites	Ova and Parasite Testing of Stool Samples
Throat sore	Diagnosis and Management of Sore Throat
Thyroid testing	Use of Thyroid Function Tests in the Diagnosis and Monitoring of Patients with Thyroid Disease
Urinalysis	Macroscopic and Microscopic Urinalysis and Investigation of Urinary Tract Infection

These guidelines were approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

Guidelines and Protocols Advisory Committee
1515 Blanshard Street 1-2
Victoria, B.C. V8W 3C8
Telephone: 250 952-1347
Fax: 250 952-1417

E-mail: guidelines.protocols@moh.hnet.bc.ca
Web site: www.healthservices.gov.bc.ca/msp

Guideline Reviewed and Unchanged

The Guidelines and Protocols Advisory Committee reviews its guidelines every few years to determine if new information calls for revisions.

We wish to advise you that the following guideline has been reviewed and will remain unchanged:

Ova and Parasite Testing of Stool Samples

All current guidelines and protocols are posted on the Medical Services Plan web site at www.healthservices.gov.bc.ca/msp.

Age Limitation on the Applicability of Guidelines and Protocols

Pursuant to Section 19(1) and 32(4) of the *Medicare Protection Act,* the Medical Services Commission hereby directs that all guidelines and protocols developed by the Guidelines and Protocols Advisory Committee apply to beneficiaries 19 years of age or over, unless otherwise specified in a particular guideline or protocol.

Payment Procedures for the *Mental Health Act*
Second Opinions on The Appropriateness of the Treatment (S.31)

In May 2000, the Directors of British Columbia's designated mental health facilities were advised of the compensation and billing procedures for rendering a second medical opinion regarding the appropriateness of treatment as described in the *Mental Health Act*. As a result fee items 96301, 96302 and 96201 were introduced.

Fee item 96301
Specialist Second Medical Opinion and completion of Form 12 Medical Report
First assessment $177.10

Fee item 96302
Specialist Second Medical Opinion and completion of Form 12 Medical Report
Follow up assessment $81.31

Fee item 96201
GP Second Medical Opinion and completion of Form 12 Medical Report.....$58.99

These fees may be billed for second opinions as authorized under the *Mental Health Act*. However, the Medical Services Commission has stated that second opinions in this instance are not medically required and therefore cannot be funded through the fee-for-service budget or the Alternate Payments Program. As a result, the Adult Mental Health Division (AMHD) is funding these services. To simplify the billing system for both physician and the Ministry, billings will continue to be submitted to MSP as any other FFS item. These payments will not come from the Available Amount.

This does not affect fee items 00065 (Investigation - with certificate of mental ill health) or 00066 (Completion of documents for certification of mental ill health on previously treated cases).

For further information or clarification on fee items 96301, 96302 and 96201, contact:
Dr John Gray, Manager,
Policy Development for Treatment Services,
Adult Mental Health Policy Division
Telephone 250 952-1632

Bluebook available on the MSP Website

The *Medical Services Commission Financial Statement* (Bluebook) for the fiscal year ending March 31 2001, contains an alphabetical listing of payments made to practitioners, groups, clinics, hospitals and diagnostic facilities for the past fiscal year.

The Bluebook can be accessed through the Ministry of Health Services MSP web site at:
http://www.healthservices.gov.bc.ca/msp

It is listed under both "Facts and Statistics" and "Publications" on the menu bar.

To purchase a copy contact either:

Crown Publications
521 Fort Street, Victoria, British Columbia, V8W 1E7
Telephone 250 386-4636, Fax 250 386-0221
Website mail order: http://www.crownpub.bc.ca

B.C. Government Publication Services (BCGPS)
563 Superior Street, Victoria, B.C. V8W 9V7
Telephone: 250 387-6409 or 1-800-663-6105
Fax 250 387-1120
Email: QPPublications@gems5.gov.bc.ca
website: http://www.publications.gov.bc.ca.

Note: Print-on-demand orders available only through BCGPS – cost is 10 cents per page.

BC SMOKERS' HELPLINE 1-877-455-2233

The BC Smokers' Helpline is the Canadian Cancer Society's free telephone smoking cessation program. It is available to all British Columbians. It can be used in conjunction with advice from a physician, or on its own.

Physicians know that the efficacy of Nicotine Replacement Therapies (both gum and patch), and also of Zyban increase when these methods are combined with behavioural strategies and supportive counselling. And behavioural strategies and supportive counselling are precisely the sort of help offered by the BC Smokers' Helpline.

Trained staff provide support and up-to-date information to help people quit smoking. The service is free of charge and there's no pressure. Hours are 10am to 6pm Monday to Friday.

Help is tailored to callers' individual situations, and may include free booklets, help in choosing an appropriate strategy, and ongoing encouragement.

Smoking is notoriously difficult to give up, and its health consequences are severe. It remains the single largest preventable cause of death in B.C., leading to an estimated 5,600 deaths in 2000. Within this 5,600 are 2,050 death from lung cancer (85% of all lung cancer deaths). And although B.C. has the lowest smoking rate of any province, this "low" rate of 23% still means that over 700,000 adults in BC smoke. Quitting smoking presents real challenges, and it is crucial that those who want to quit get the very best help we can offer.

The Helpline is staffed by Quit Specialists trained in all aspects of cessation. They are guided by a state-of-the-art computer software program designed by the Canadian Cancer Society together with scientists at the University of Waterloo. For all Quit Specialists the key is being supportive and non-judgemental, and providing accurate information.

Working with those with many past attempts, other addictions, depression

Physicians have asked how we work with callers in these groups, and you may wish to know the specifics of what we offer. Callers may be encouraged to reflect on the reasons for failure of past attempts, and about what can be learned and brought to a current attempt, or we may focus on motivation and make that the starting point of the intervention, hoping the call will increase confidence, thus increasing the chances of subsequent success.

The work of the BCSmokers' Helpline is limited to smoking cessation. We cannot assist callers with other addictions, depression or mental health problems. We refer these callers to their doctor for help with other difficulties they are facing.

The BC Smokers' Helpline can supply a range of free material to inform your patients about the service. A sample 3.75" x 8.5" Rack Card is enclosed with this newsletter. We can also provide a plexiglass rack card holder, and 8.5" x 11" posters. Cards, posters and holders are provided free of charge.

For more information call:
BC Smokers' Helpline
1-877-455-2233
or contact:
Sheila Craigie, Manager,
BC Smokers' Helpline
604-675-7137.

New Explanatory Codes

K0	92515/92516 not payable with 92510, 92520-92544 or 92546
RZ	MHR form fee – visit not payable in addition when seen for the same diagnosis

Wounds – Avulsed and Complicated
Fee items 06075, 06076, 06077

The following guidelines for billing complicated wound listings (fee items 06075, 06076, 06077) were approved by the Section of Plastic Surgery and the Tariff Committee.

Wounds – avulsed and complicated:

06075 Lips and eyelids
$210.33 Anaes. Level 3

06076 Nose and ear
$210.33 Anaes. Level 3

06077 Complicated lacerations of the scalp, cheek and neck
$210.33 Anaes. Level 3

The following conditions are necessary for fee item 06075, 06076, and 06077 to apply:

1. A layered closure* is required and at least one of:

   a) Injuries involving necrotic tissue requiring debridement such that simple suture closure is precluded, or
   b) Injuries involving tissue loss such that simple suture is precluded, or
   c) Wounds requiring tissue shifts for closure aside from minor undermining or advancement flaps, or
   d) Skived, ragged or stellate wounds where excision of tissue margins is necessary to obtain 90 degree closure, or
   e) Contaminated wounds that require excision of foreign material, or

2. Lacerations requiring layered closure* and key alignment sutures involving critical margins of the eyelid, nose, lip, oral commissure or ear; or

3. Lacerations into the subcutaneous tissue requiring alignment and repair of cartilage and layered closure.

* A layered closure is required when the defect would require too much tension for an acceptable primary closure. It involves at least two layers of deep dissolving sutures to close off dead space and take tension off the wound. A deep cartilage closure is also considered a layered closure.

Important Note:
Please ensure that each claim for fee item 06075, 06076, or, 06077 is accompanied by either a note record or an operative report that indicates how the service meets the above criteria. Claims received without supporting documentation will be paid as a "simple" laceration.

2002 Close-off Dates

January 3, 2002
January 21, 2002
February 5, 2002
February 18, 2002
March 5, 2002
March 18, 2002
April 3, 2002
April 18, 2002
May 3, 2002
May 21, 2002
June 4, 2002
June 18, 2002
July 3, 2002
July 19, 2002
August 2, 2002
August 20, 2002
September 3, 2002
September 18, 2002
October 2, 2002
October 21, 2002
November 4, 2002
November 19, 2002
December 3, 2002
December 16, 2002

TELEPLAN

UPGRADE INFORMATION

Teleplan Technical Upgrade – Invitation to Participate

The Teleplan Technical Upgrade Project has now released an upgrade to the Teleplan billing communications software. The new Teleplan system (version 4.0) allows you to securely check patient eligibility for services, submit claims, and retrieve remittance information over an encrypted Internet connection.

The upgrade provides a secure web browser application as a modern alternative to the DOS SIMPC Teleplan product in use in billing sites since 1988. It gives you the option to move away from DOS if you're ready. If you're not, you can stay with the existing DOS Teleplan version. From now until January 2002, MSP will be running a pilot of a limited number of billing sites (e.g. 100 sites). If you are interested in participating in the pilot, MSP is now accepting applications from billing sites and vendors who would like to use the new Teleplan web browser application prior to a large-scale release to all practitioner billing offices in January 2002.

Note that you do not require an Internet connection in your office in order to participate. If you already have an Internet Service Provider (ISP) dial-up or high speed access (e.g. cable or ADSL) account, you may use that account, or MSP will provide a SPAN/Dial account connection at no cost.

If you are interested in trying the new Teleplan v4.0 web application during this pilot period (November 2001 – January 2002), please contact MSP: 1-800-663-7206 or, in Victoria: 952-2668

In addition to the web browser application, we have worked with your vendors to develop a means to integrate the Teleplan Upgrade seamlessly with their billing software. We will also be working with your vendors to test their implementation of Teleplan v4.0 with their billing applications. Your vendors have asked that you contact MSP if you have questions or concerns about this project.

Teleplan Support – Hours of Work

Effective January 1, 2002 hours of work for Teleplan will be 8:00 am – 5:-00 pm, Monday to Friday with the exception of statutory holidays. The 5:00 pm – 7:00 pm shift scheduled for final claims submission closeoff will no longer be available.

The Teleplan Support Centre has been monitoring the volume of calls during the 5:00 pm to 7:00 pm hours of work and results show that there will be very little impact to the Teleplan users if this service is discontinued

List of Inserts

- MSP Bulletin
- Teleplan Technical Upgrade Letter
- Update to the Payment Schedule
- Chronic Disease Management Results from Physician Survey
- Chronic Disease Management Diabetes: Teasing Management Information from Accounting Data
- BC Smokers Helpline brochure

bcbedlines shows positive results

In the first six weeks of operation, bcbedline successfully facilitated the transfer of over 500 critically ill patients to acute care hospitals within the province.

The bcbedline program facilitates the transfer of critically ill patients to hospitals with the most appropriate level of acute care or those that provide specialized regional or provincial services such as neurosurgery or cardiac care.

"We have been handling an average of 12 patient transfers a day, and while we are experiencing a few 'hiccups' in the start-up phase, we are working these things out," says bcbedline Program Director Barbara Kinnon. She emphasized that the service provides a physician-to-physician link between sending and receiving hospitals.

"It's important for doctors and hospitals to understand that bcbedline was set up to facilitate the transfer of patients needing a 'higher' level of care than what is available within their own community. The system should not be handling 'lateral' transfers where patients are being moved from one hospital to another and receiving the same level of care," said bcbedline Medical Advisor Dr. Jim Russell.

He noted that in some cases, hospitals are requesting transfers because they have staffing problems.

"The program was not designed to help hospitals address issues resulting from staffing shortages or scheduling problems. These are issues that individual hospitals should be dealing with as part of their own operational management," said Dr. Russell.

"We need to make sure we don't overload the bcbedline system with these lateral transfers," Dr. Russell concluded.

Streamlining the system and the process of locating available acute care beds not only improves access for patient care, but also ensures that provincial health resources are used in the most efficient and effective way. bcbedline reduces the amount of time physicians and staff spend finding out which hospitals have the capacity to receive patients requiring transfer to a higher level of care.

Zone Medical Advisors Wanted

bcbedline needs five Zone Medical Directors (ZMAs) for the Lower Mainland,Island/Coast, North, Thompson/ Cariboo and Okanagan/Kootenays.

ZMA's provide promotion, direction, advice and liaison on bcbedline to health care communities.

for more information please contact:
Dr. Jim Russell, Chief Medical Advisor,
bcbedline
604 806-8272 or
email: jrussell@providencehealth.bc.ca.

A stipend is provided.

Designated Statutory Holidays – Year 2002

January 1, 2002	New Year's Day	Tuesday
March 29, 2002	Good Friday	Friday
April 1, 2002	Easter Monday	Monday
May 20, 2002	Victoria Day	Monday
July 1, 2002	Canada Day	Monday
August 5, 2002	B.C. Day	Monday
September 2, 2002	Labour Day	Monday
October 14, 2002	Thanksgiving Day	Monday
November 11, 2002	Remembrance Day	Monday

Hepatitis Treatment Adjudication Committee

Pharmacare has established a Hepatitis Treatment Adjudication Committee with Dr. Urs Steinbrecher as Chair and Drs. Frank Anderson and Eric Yoshida as members. This committee will help Pharmacare adjudicate antiviral treatment that may be clinically appropriate even though there is insufficient published data for inclusion in standard guidelines. When patients do not meet standard treatment eligibility criteria, the expert panel will provide a case-by-case assessment of treatment requests.

Chronic Disease Management

October 2001

Diabetes: Teasing Management Information from Accounting Data

The Medical Services Plan (MSP) collects accounting data from the submission of claims for services. What helpful management information can be extracted from claims data? This analysis is a preliminary attempt to explore the care of people with diabetes in British Columbia by examining specific claims data and to seek critical comments that may help improve its accuracy and usefulness.

The analysis attempts to identify MSP beneficiaries with apparent need for care (in this case diabetes) and then calculate the proportion of those who appear to have received the recommended care (according to accepted guidelines) over a certain period. For the purposes of this analysis, beneficiaries have been grouped by health region using their registered address. Some doctors who have reviewed an early draft of this report have asked if they could see the results for their own patients. If the methodology is acceptable after review, this should be possible.

Guidelines for the care of people with diabetes recommend that some services should be provided on a regular basis. These services include the measurement of hemoglobin A_{1C}, lipids, microalbumin and examination of the retina for microvascular damage. Provision of these services may be identified through billing claims submitted to MSP. Comments on any of the following details of the methodology, or more general issues, are welcome.

Identification of People with Diabetes

The identification methodology is being tested in conjuction with the Population Health Surveillance and Epidemiology Branch of the Ministry of Health Services.

For this study, beneficiaries insured under the MSP at the beginning of the time period (1999/2000) were assumed to be diabetic if:

- they had received two or more services (on different dates) paid by MSP over any two year period since 1992 where the ICD-9 diagnostic code given includes the first three digits 250 (diabetes mellitus), or
- they had one or more hospital discharges where an ICD-9 diagnostic code given included the first three digits 250.

This method does not identify undiagnosed diabetics, only those patients where the doctor has determined that diabetes is the most significant diagnosis. By requiring two services it is hoped that beneficiaries for whom diabetes was suspected but not confirmed would be excluded from the group of diagnosed diabetics.

The table on page 2 provides data on the number of identified patients with diabetes by health region and the percentage of these beneficiaries who received services.

BRITISH COLUMBIA **Ministry of Health Services**

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Distinct patient count of known patients with diabetes and the number and percentage who received each service by Health Region for 1999/2000

HR	Client Health Region	Diabetics	Retinal Exam		HbA1C		Lipid		Microalbumin	
01	East Kootenay	2620	405	15.46%	1676	63.97%	1098	41.91%	809	30.88%
02	West Kootenay-Boundary	3082	1396	45.30%	2076	67.36%	1248	40.49%	1158	37.57%
03	North Okanagan	4663	2453	52.61%	2902	62.23%	2068	44.35%	1885	40.42%
04	South Okanagan Similkameen	9206	4231	45.96%	5702	61.94%	3180	34.54%	1970	21.40%
05	Thompson	5245	1761	33.57%	3226	61.51%	2289	43.64%	2037	38.84%
06	Fraser Valley	10495	4784	45.58%	6174	58.83%	4207	40.09%	2278	21.71%
07	South Fraser Valley	25451	11002	43.23%	14914	58.60%	10971	43.11%	6030	23.69%
08	Simon Fraser	12140	5426	44.70%	7526	61.99%	5305	43.70%	2608	21.48%
09	Coast Garibaldi	2569	1046	40.72%	1590	61.89%	1065	41.46%	428	16.66%
10	Central Vancouver Island	10441	5875	56.27%	6739	64.54%	4210	40.32%	2337	22.38%
11	Upper Island/Central Coast	4253	1915	45.03%	2949	69.34%	1845	43.38%	1370	32.21%
12	Cariboo	2711	906	33.42%	1601	59.06%	1256	46.33%	859	31.69%
13	North West	2998	1350	45.03%	1821	60.74%	1498	49.97%	992	33.09%
14	Peace Liard	1684	401	23.81%	1034	61.40%	523	31.06%	548	32.54%
15	Northern Interior	4217	1654	39.22%	2679	63.53%	2169	51.43%	1314	31.16%
16	Vancouver	25349	11371	44.86%	15499	61.14%	12163	47.98%	5654	22.30%
17	Burnaby	9064	4527	49.94%	5700	62.89%	4221	46.57%	1883	20.77%
18	North Shore	5546	2768	49.91%	3380	60.94%	2482	44.75%	1554	28.02%
19	Richmond	7154	2970	41.52%	4800	67.10%	3602	50.35%	2023	28.28%
20	Capital	13633	6786	49.78%	9141	67.05%	5663	41.54%	3467	25.43%
99	Unknown	1114	353	31.69%	497	44.61%	346	31.06%	184	16.52%
		163635	73380	44.84%	101626	62.11%	71409	43.64%	41388	25.29%

The patients with diabetes in the study had insurance coverage in BC in 1999/2000 fiscal year and were identified as being diabetic according to the case definition in the current or previous years. This list includes those who died in 1999/2000. The case definition is two paid medical claims (with different dates) in two years or 1 hospitalization with ICD code of 250 (first three digits).

Patients were flagged for a retinal exam if they had a one of fee items 02010, 02011, 02015, 02040, 02039 over the two year period starting Oct 1, 1998 with a paid date cut off of March 31, 2001.

Patients were flagged for HbA_{1C} if they had one fee item 91745, for lipid if they had one of fee items 91375, 91780, 92350, and for microalbumin if they had one of fee items 92396, 91985 in 1999/2000 with a paid date cut off of September 30, 2001.

These data are limited to medical claims for BC patients receiving services from BC doctors only with specialties 00 to 21, 21, 23, 24, 28, 29, 33, 44, or 47, and service codes between 1 and 9, 22 and 30, 40 and 49, or 89 and 98. The health region for each patient was determined based on postal codes reported as of March 31, 2000.

Identification of Service Data

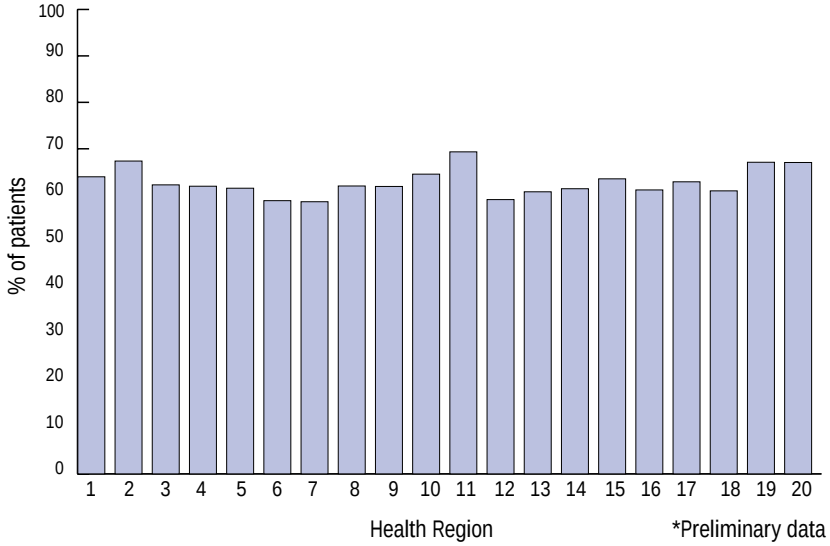
Provision of hemoglobin A_{1C}

There is a specific fee item (91745) for this service that is billed when provided in the community or through a hospital outpatient clinic. It is not billed for services provided to inpatients or emergency room patients.

Current guidelines recommend that all patients with diabetes be tested at least annually, so ideally the proportion of patients tested should approach 100 per cent.

Measures for Patients with Diabetes: Hemoglobin A1C*

Percentage of known patients with diabetes who had a HbA_{1C} test during fiscal year 1999/ 2000 by health region (at least one fee item 91745)



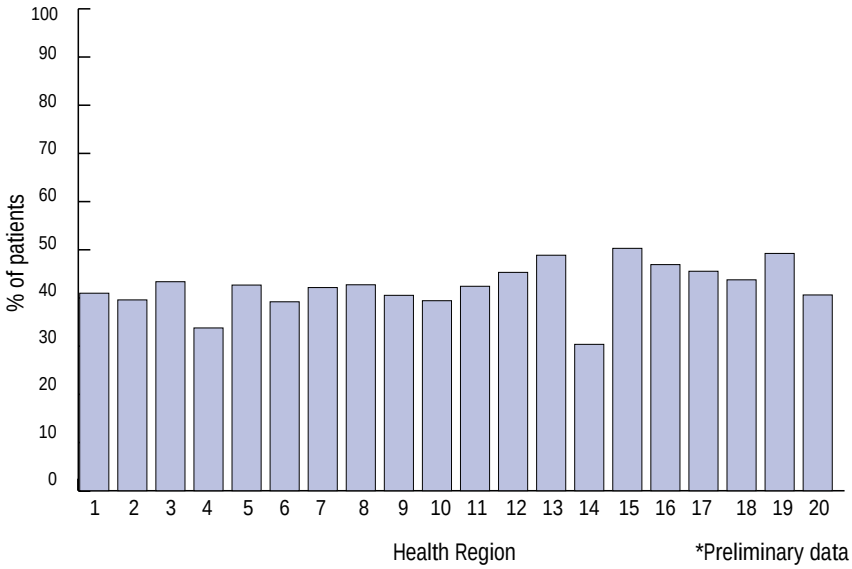
Provision of Lipid testing

Beneficiaries were classified as having had their lipids measured if any one of these series of fee items for lipid testing were billed during the year:

- 91375: Cholesterol, total
- 91780: High density lipoproteins cholesterol (HDL cholesterol)
- 92350: Triglycerides – serum/plasma

Measures for Patients with Diabetes: Lipids*

Percentage of known patients with diabetes who had a lipids test during fiscal year 1999/ 2000 by health region (at least one of fee items 91375, 91780, 92350).



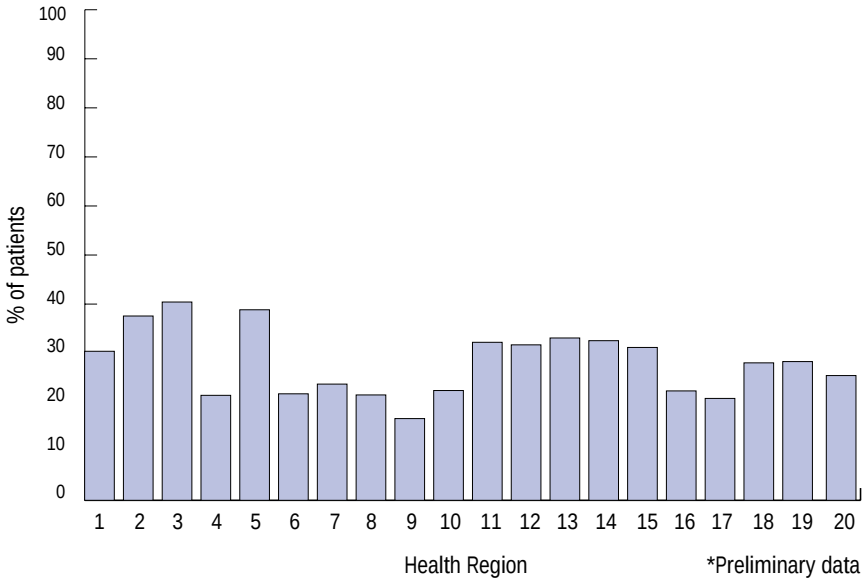
Microalbumin

Beneficiaries were classified as having had an assessment of microalbumin if either if these fee items had been paid during the year:

- 92396: Microalbumin, semiquantitative by urine dipstick
- 91985: Micro albumin

Measures for Patients with Diabetes: Microalbumin*

Percentage of known patients with diabetes who had a microalbumin test during fiscal year 1999/2000 by health region (at least one of fee items 92396, 91985).



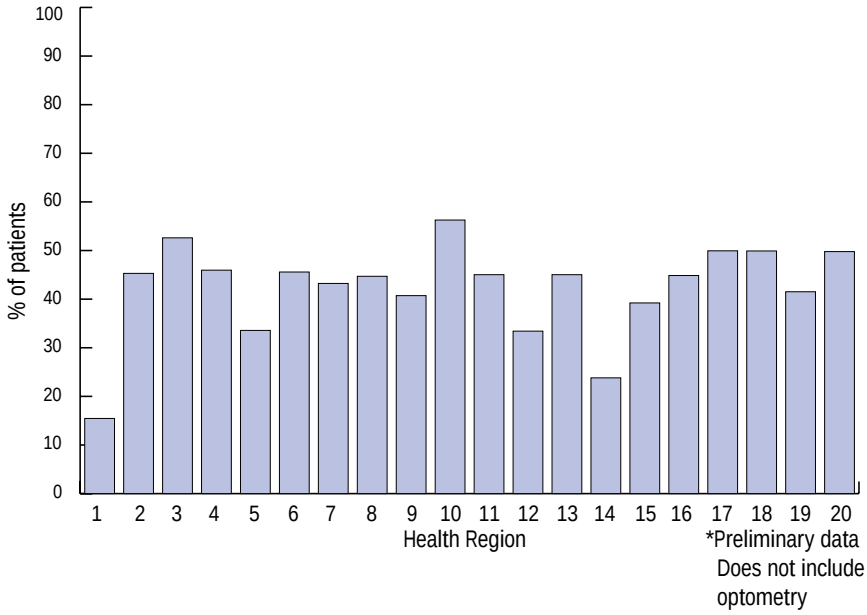
Retinal Examination

It is assumed that beneficiaries had a retinal examination by an ophthalmologist if any of the following fee items were paid over a two year period:

- 02010: Ophthalmology consultation
- 02011: Repeat or limited consultation
- 02015: Eye examination to include ophthalmoscopy
- 02040: Retinoscopy
- 02039: Fundus photography

Measures for Patients with Diabetes: Retinal Exam*

Percentage of known patients with diabetes who had a Retinal exam by an ophtamologist during fiscal year 1999/2000 plus six months before and after by health region (at least one of fee items 02010, 02011, 02015, 02040, 02039).



Chronic Disease Management

Results from Physician Survey

Introduction

Chronic disease management (CDM) is at the fore of health care issues and health care planning primarily because of the complexity and co-morbidity of chronic illness. In an effort to more fully understand physicians' perspectives on CDM, 7980 physicians and stakeholders were sent a questionnaire in the MSP *Physician's Newsletter* (Issue 1 Volume 25 Summer 2001).

By September 14 2001, 207 responses were submitted to the Utilization Management Branch of MSP – a response rate of 2.6 per cent. Included in the survey were questions on the usefulness of CDM tools, diseases considered to be the best candidates for CDM strategies, respondent involvement in CDM initiatives and/or strategies, barriers to providing CDM, and the interest of respondent participation in CDM initiatives (see attached survey).

Response

Given that patient care almost always originates in the general practitioner's office, it follows that the majority of respondents (70%) were general practitioners. The remaining 30% of responses represent twenty-one different specialties. The second highest rate of return was from internal medicine specialists (5%), followed by pediatricians (3.8%).

Use of Chronic Disease Management "Tools"

A significant percentage of respondents (82%) agreed that CDM tools would be helpful to them in their practices. Only 24% of respondents are currently involved in chronic disease initiatives or programs. Comments suggest that CDM tools can act as a safeguard or benchmark for physicians to assess whether their current approach to care is within an acceptable norm.

Important to know impact outcome of treatment and where improvements can be made.

Respondent #32

Prioritization of Chronic Diseases

Physicians identified diabetes mellitus (74%) as the top candidate for chronic disease management followed by hypertension (49%) and congestive heart failure (47%). One in four respondents included an "other" disease that they felt was more important to monitor. Arthritis (7%) and chronic pain (4%) were the chronic diseases most frequently mentioned under "other". Table 1 ranks chronic diseases by respondent choice.

Table 1: Best "Candidate" Diseases for Chronic Disease Management

	DISEASE	FREQUENCY	PERCENTAGE
1.	Diabetes Mellitus	153	74%
2.	Hypertension	101	49%
3.	Congestive heart failure	97	47%
4.	Asthma	88	43%
5.	Chronic lung diseases	72	35%
6.	Chronic depression	61	30%
7.	Chronic renal failure	59	29%
8.	End stage liver disease	31	15%
9.	Other – Arthritis [includes arthritis(7), chronic inflammatory arthritis (3) and osteoarthritis (5)]	15	7%
10.	Other – Chronic pain	8	4%

Barriers to Chronic Disease Management

The necessary time to explain treatment goals and expectations. It is very time consuming to teach patients enough to make them "co-managers".

Respondent #112

Co-morbidity; multiple chronic diseases; time and lack of skilled assistance.

Respondent #204

Biggest barrier is non-compliance especially with diabetics. I can offer lots of management/ support but not if they are pretending that "all is okay".

Respondent #151

Fragmentation of care– many patients have more than one chronic problem.

Respondent #49

Respondents were asked what barriers they thought might hamper their ability to provide chronic disease management. The most frequently mentioned barriers included time, complexity, workload, remuneration, and human resources. The notion of time as a barrier received an overwhelming response from physicians. Time, in itself, is a multi-faceted concept that includes the time required to research a disease prior to the patient's visit, as well as the time to examine, educate and follow-up with the patient. Lack of time to fulfill the huge requirements in order to be as effective and thorough as they would like was mentioned repeatedly.

The complex nature of chronic illness was also cited as a barrier to CDM. A strong relationship exists between disease complexity and physician time. Medication management and polypharmacy add to the intricacies of CDM. The increased workload required for patient management also adds to an already daunting amount of paper work which, in turn, impacts time for other patients and themselves.

Respondents identified patient compliance as an integral aspect of CDM. Typically, as the complexity of an illness increases, patient compliance decreases. The result is a challenging patient and high maintenance disease management.

Many chronic diseases are associated with other illnesses, and this comorbidity lends itself to fragmentation of care due to the lack of time to properly address each health issue. This can result in multiple patient visits. If a physician's patient load is high, patients may turn to walk-in clinics for quick, episodic care rather than seeking comprehensive care from their regular caregiver.

A lack of funding was also mentioned as a fundamental barrier. The current fee-for-service payment mechanism does not include fees for prolonged visits necessary to properly manage patients with chronic and/or multiple diseases.

Nearly impossible in solo practice; group practice "team" settings ideal but need time and money to set up.

Respondent #70

Respondents suggested better cooperation between specialists, general practitioners and patients, as well as more opportunity for multi-disciplinary teams is required if chronic diseases are to be properly managed. As one respondent inferred, a new paradigm of management is needed with less bureaucratic barriers.

A number of respondents mentioned the lack of focused educational material that is reliable, applicable and concise. Some respondents recognized guidelines as a useful tool and frequently refer to these materials in their practice.

I have installed guide-lines for asthma, diabetes mellitus, and hypertension in our 12-physician EMR so they are quickly available through four key strokes.

Respondent #106

Respondents also noted that physicians are given very little training in chronic disease management and that the medical school curriculum needs to be updated to address this void.

Chronic Disease Management – Areas of Interest

The final question in the survey explored potential areas of interest to physicians in the development CDM initiatives. Respondents indicated that they are most interested in reviewing and assessing guidelines and protocols or tools (37%), followed by sharing CDM with peers (32%). Table 2 lists responses for the five suggested areas for CDM participation.

Table 2: Chronic Disease Management – Areas of Interest

AREAS FOR CDM PARTICIPATION	FREQUENCY	PERCENTAGE
Review & assess guidelines & protocols or tools	76	37%
Sharing CDM with peers	65	32%
Participate in research on current practices	60	29%
Identify useful information systems	51	25%
Develop and test outcome measures	46	22%

Finally, respondents noted that chronic disease management can be discouraging for caregivers, patients and family members, alike. It takes time to talk to patients, educate them, and provide adequate follow-up. Physician interest is there; the road to change is the challenge.

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