Information and Procedures for Claiming the Cumulative Preventive Care Bonus

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Ontario

Table of Contents

Chapter 1. Program Overview 3

1. Influenza Vaccine 3
2. Pap Smear 3
3. Mammography 3
4. Childhood Immunizations 3
5. Colorectal Cancer Screening 3

Chapter 2. Physician Eligibility 4

Chapter 3. Preventive Care Target Population/Service Reports 4

1. TPSR - Previous Report 4
2. TPSR – Projected Report 4
3. Fee Schedule Codes that report on the TPSRs 5

Chapter 4. Tracking and Exclusion Codes 6

Chapter 5. Cumulative Preventive Care Bonus Payment Reporting 7

1. Harmonized Model Physicians 7
2. FHG and CCM Physicians 7

Sample A - Group Total – Summary Report 7
Sample B - Preventive Care Bonus Accumulations and Payment 7

Chapter 6. Steps to Claim for your Cumulative Preventive Care Bonuses 8

1. Calculate the coverage level as follows 8
2. Determine the Appropriate Q Code for the bonus and coverage level 9
3. Submit the Bonus Claim 9
4. Submission Deadlines 10
5. Documentation 10

Program Overview

Eligible Patient Enrolment Model (PEM) physicians may receive Cumulative Preventive Care Bonuses for maintaining specified levels of preventive care to their enrolled patients. There are five preventive care categories for which an individual physician may earn an annual bonus.

1. Influenza Vaccine

This bonus is based on the percentage of the target population who have received the influenza vaccine appropriate for that influenza season by January 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled patients who are 65 years or older as of December 31st of the fiscal year for which the bonus is being claimed (i.e. a patient who turns 65 on January 15th, 2011 would not be considered part of the 2010/2011 Influenza Vaccine target population).

2. Pap Smear

This bonus is based on the percentage of the target population who have received a Pap smear in the 30 months prior to March 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled female patients who are between 35 and 69 years of age, inclusive, as of March 31st of the fiscal year for which the bonus is being claimed (i.e. a patient who turns 70 on March 15th, 2011 would not be considered part of the 2010/2011 Pap smear target population).

3. Mammography

This bonus is based on the percentage of the target population who have received a mammogram in the 30 months prior to March 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled female patients who are between 50 and 69 years of age, inclusive, as of March 31st of the fiscal year for which the bonus is being claimed (i.e. a patient who turns 70 on March 15th, 2011 would not be considered part of the 2010/2011 Mammography target population).

4. Childhood Immunizations

This bonus is based on the percentage of the target population who have received all of the ministry-supplied immunizations as recommended by the National Advisory Committee on Immunization. The target population consists of enrolled patients who are aged 30 to 42 months of age, inclusive as of March 31st of the fiscal year for which the bonus is being claimed. These patients must have received all applicable immunizations by their 30th month of age.

5. Colorectal Cancer Screening

This bonus is based on the percentage of the target population who have received a Fecal Occult Blood Test (FOBT) in the 30 months prior to March 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled patients who are between 50 and 74 years of age, inclusive, on March 31st of the fiscal year for which the bonus is being claimed (i.e. a patient who turns 75 on March 15th, 2011 would not be considered part of the 2010/2011 Colorectal Cancer Screening target population).

Physician Eligibility

All signatory physicians who are active with a PEM on March 31st of each fiscal year (e.g. March 31st, 2011 for the 2010/2011 fiscal year) are eligible for the Cumulative Preventive Care Bonuses for that fiscal year.

Effective April 1, 2006 Family Health Group (FHG) and Comprehensive Care Model (CCM) physicians must meet the minimum roster size in order to be eligible for the bonuses. FHG and CCM physicians must also meet the minimum roster size in order to receive *Preventive Care Target Population/Service Report – Previous Reports* (*TPSR*s) distributed in April of each year.

The requirements for the FHG and CCM minimum roster sizes are as follows.

- Eligibility is based on a physician's roster size on March 31st of the current bonus year (e.g. March 31st, 2011, for the 2010/2011 fiscal year).
- In each bonus year, a physician must have a minimum roster size of 650 enrolled patients on the last day of each fiscal year (e.g. March 31st, 2011 for the 2010/2011 fiscal year)
- New Graduates in their first year of practice with a FHG or CCM will be required to have a minimum roster size of 450 enrolled patients.

It is important to remember that the minimum roster size is calculated based on the physician's enrolled patient roster on March 31st of each year.

Preventive Care Target Population/Service Reports

Each April PEM physicians will receive two reports – *TPSR – Previous Report* and a *TPSR – Projected Report*. Please note however, that in April of each year FHG and CCM physicians who do not meet the minimum roster size will only receive the *TPSR – Projected Report* in anticipation that they may reach the minimum roster size the next year.

1. TPSR - Previous Report

The *TPSR – Previous Report,* which is mailed to physicians in April of each year, is intended to assist physicians with submission of the bonuses for the previous fiscal year. This report provides physicians with their target population for each of the five categories as well as the preventive care services received, as recorded by the Ministry, by those patients for the specified period where consent exists for that patient.

2. TPSR – Projected Report

The *TPSR – Projected Report* is intended to assist physicians in managing preventive care services for the coming year. It shows a projected list of the target population for the current fiscal year (i.e. the year beginning April 1st) and lists any preventive care services, with the exception of the Influenza Vaccine, received by these patients in the 30 months prior to March 31st of the current fiscal year (e.g. the *TPSR – Projected Report* received in April 2011 will reflect the services received in the 30 months prior to March 31st, 2011). Physicians can then focus on providing any preventive care services not yet received by their target population in the coming year.

Each September physicians will receive a second *TPSR – Projected Report* which has been updated to reflect mid-year changes to target population and preventive care services, with the exception of the Influenza Vaccine, received by those patients since April.

Note that because the influenza vaccine is an annual service and is neither available nor administered to patients until late fall, this service will only appear on the *TPSR – Previous Report* received in April and cannot be shown on the *TPSR – Projected Reports* in April or September.

Physicians may augment the service information contained in the reports with data from their own clinical records and highlight those patients who remain non-compliant at this point in order to arrive at the appropriate bonus level to claim at year end.

Please see page 11 of this document for a sample *TPSR – Previous Report*.

3. Fee Schedule Codes that report on the TPSRs

Below is a list of the Fee Schedule Codes that are applicable for each Cumulative Preventive Care Bonus Category.

Cumulative Preventive Care Bonus Category	Applicable Services
Influenza	G590A, G591A, Q690A, Q691A, and tracking code Q130A
Pap Smear	G365A, L713A, L643A, E430A, Q678A, tracking code Q011A, and exclusion code Q140A
Childhood Immunizations	G538A, G539A, Q688A, Q689A, G840A, G841A, G844A, G845A, G846A and G848A and tracking code Q132A
Mammography	X185A, X185B, X185C, tracking code Q131A, and exclusion code Q141A
Colorectal Cancer Screening	G004A, L179A, L181A, Q700A, tracking code Q133A, and exclusion code Q142A

Service dates for the following Q codes may appear on your TPSRs; however, they can only be submitted by Nurse Practitioners (NPs) as part of the NP Service Encounter Reporting and Tracking (SERT) pilot project:

Q690A – Influenza Agent – with visit, each injection – N.P.
Q691A – Influenza Agent – sole reason – N.P.
Q678A – Gynaecology – Papanicolaou Smear – periodic – N.P.
Q688A – Immunization – with visit, each inject – N.P.
Q689A – Immunization – sole reason, first injection – N.P.
Q700A – Occult Blood – N.P.

Please note that a patient may appear on the TPSR even though services will not be reported if:

- the claim for a preventive care service was not processed as of the report date

- the patient received the service from a source that does not submit the claim to the Ministry
- consent does not exist for the patient (e.g. the patient was enrolled using the Q200A/Q201A and the enrolment form has not yet been processed or the patient has revoked consent)

Tracking and Exclusion Codes

To better assist physicians in monitoring patient status and determining service levels achieved, tracking and exclusion codes have been introduced. When submitted, these codes will identify the patient as having received the preventive care service or identify the patient as having met the criteria for being excluded from the target population for a specific preventive care service. For example, if your patient informs you that they received their influenza vaccination at a flu clinic at work, then the tracking code can be submitted.

Tracking and Exclusion codes may be submitted using the normal billing practices used to submit Fee for Service claims and premium codes applicable to their agreement. As with other tracking codes, the fee billed should be zero dollars, and the fee paid on the Remittance Advice (RA) will be zero dollars with explanatory code 30 – "This service is not a benefit of OHIP". Exclusion codes may be submitted if the patient meets the exclusion criteria listed below.

Category	Tracking Code	Exclusion Code and Criteria
Influenza Vaccine	Q130A	Not applicable
Pap Smear	Q011A	Q140A Exclusions apply for women who have had a hysterectomy, or who are being tested for cervical diseases that preclude regular screening Pap tests.
Mammography	Q131A	Q141A Exclusions apply for women who have had a mastectomy, or who are being treated for clinical breast disease.
Childhood Immunizations	Q132A	Not applicable
Colorectal Cancer Screening	Q133A	Q142A Exclusions apply for patients with known cancer being followed by a physician; with known inflammatory bowel disease; who have had a colonoscopy within the last **10** years; with a history of malignant bowel disease; or with any disease requiring regular colonoscopies for surveillance purposes. Please note that although the above change has increased the length of time that the colonoscopy is valid for exclusion, the Q142A must still be submitted every 30 months to be reported on the Target Population and Service Reports.

Submission of the tracking and exclusion codes is voluntary and is not required in order to receive a Cumulative Preventive Care Bonus. Tracking and exclusion codes will be reported on the TPSRs for 30 months from the date of service for all categories with the exception of Influenza Vaccine. The tracking code for the Influenza Vaccine will only be reported on the following April's *TPSR – Previous Report*.

Cumulative Preventive Care Bonus Payment Reporting

1. Harmonized Model Physicians

Reporting for Family Health Network (FHN), Family Health Organization (FHO), Group Health Centre (GHC), and Rural and Northern Physician Group Agreements (RNPGA), Weeneebayko Health Ahtuskaywin (WHA), Blended Salary Model (BSM), St. Joseph's Health Centre (SJHC), and South Eastern Academic Medical Organization (SEAMO) physicians:

- The total amount paid to the group is reported in the Group Total - Summary Report (Sample A) on both the group and solo RAs.
- Individual physician information is reported on the Payment Summary Report under Preventive Care Bonus Accumulations and Payment (Sample B) on the group and solo RAs.

2. FHG and CCM Physicians

- Individual physician information is reported on each physician's solo RA under Preventive Care Bonus Accumulations and Payment (Sample B).

Sample A - Group Total – Summary Report

GROUP TOTAL – SUMMARY REPORT

	CURRENT MONTH	YTD
TOTAL BASE RATE PAYMENTS	42,773.23	83,946.68
TOTAL FEE FOR SERVICE PAYMENTS	24,275.68	47,381.80
BLENDED FFS PAYMENT	3,600.63	7,889.97
SEMI-ANNUAL ACCESS BONUS PAYMENTS	.00	.00
TOTAL GMLP	367.44	719.39
PREVENTIVE CARE BONUS PAYMENTS	37,840.00	37,840.00
THAS	2,000.00	4,000.00
TOTAL PAID TO GROUP	110,856.98	181,777.84

Sample B - Preventive Care Bonus Accumulations and Payment

PREVENTIVE CARE BONUS ACCUMULATIONS AND PAYMENT:

INFLUENZA VACCINE	0%
PAP SMEAR	0%
MAMMOGRAPHY	0%
CHILDHOOD IMMUNIZATION	0%
COLORECTAL SCREENING	40%
CURRENT MONTH	1,100.00
YTD	1,100.00

Steps to Claim for your Cumulative Preventive Care Bonuses

1. Calculate the coverage level as follows

Each physician is responsible for calculating his/her coverage level for each of the bonus categories utilizing the TPSR along with information obtained from their clinical records and other data sources available to them. The coverage level is calculated as follows:

$$\frac{\text{Number of Covered Patients *}}{\left(\text{Number of patients on the } \textit{Preventive Care/Target Population Service Report} - \text{Excluded Patients (if applicable) **}\right)} \times 100$$

* Covered patients are those patients in the eligible Target Population that received the preventive care services previously defined.
**Physicians may adjust the number of patients on their *Preventive Care/Target Population Service Report* and remove any patients who meet the exclusion criteria for pap smear, mammography, and colorectal cancer screening.

Example:

- A physician receives a Preventive Care/Target Population Service Report that has a total number of 321 patients in the Colorectal Screening Bonus category (Target Population).
- A review of the Preventive Care/Target Population Service Report and patient records/charts determines that 13 patients may be excluded from the Target Population (321 – 13) = 308.
- A review of Preventive Care/Target Population Service Report and patient records/charts determines that 92 of the remaining 308 patients have had an FOBT in the 30 months preceding March 31st, 2010.
- The coverage level would be (92 / 308) X 100 = 29.87% = 30% (rounded to 2 significant digits).

$$\frac{92}{(321\text{-}13) = 308} \times 100 = 29.87\% \text{ rounded to } 30\%$$

2. Determine the Appropriate Q Code for the bonus and coverage level

Preventive Care Category	Achieved Compliance Rate	Fee Payable	Service Enhancement Code
Influenza Vaccine	60% 65% 70% 75% 80%	$220 $440 $770 $1100 $2200	Q100A Q101A Q102A Q103A Q104A
Pap Smear	60% 65% 70% 75% 80%	$220 $440 $660 $1320 $2200	Q105A Q106A Q107A Q108A Q109A
Mammography	55% 60% 65% 70% 75%	$220 $440 $770 $1320 $2200	Q110A Q111A Q112A Q113A Q114A
Childhood Immunization	85% 90% 95%	$440 $1100 $2200	Q115A Q116A Q117A
Colorectal Cancer Screening	15% 20% 40% 50% 60% 70%	$220 $440 $1100 $2200 $3300 $4000	Q118A Q119A Q120A Q121A Q122A Q123A

Example:

Based on the previous example the physician is eligible to submit Q119A for the Colorectal Cancer Screening Bonus.

3. Submit the Bonus Claim

Physicians submit for their Cumulative Preventive Care Bonuses similar to Fee-For-Service (FFS) claims. Bonus submissions must adhere to the following requirements:

- The claim for the bonus must be submitted using the billing number used to submit for all PEM services on March 31st of the current fiscal year (e.g. If you were in a FHG on March 31st, 2012 then you should submit using your solo billing number for the 2011/2012 fiscal year);
- The Service Date must be March 31st of the current year
- The Health Number field must be left blank;

- The Version Code field must be left blank; and
- The Birth Date field must be left blank

Please also note that if your system cannot support claims with a blank HN, a paper claim card may be submitted. Please contact your district office for details.

4. Submission Deadlines

Submission of the Cumulative Preventative Care Bonuses is subject to regular stale-dating rules. This means that physicians must submit bonus claims to their local Ministry office by the following dates:

- Paper claims submission – September 10th, 2012
- Diskette submission – September 17th, 2012
- Electronic Data Transfer (EDT) submission – September 17th, 2012

5. Documentation

Physicians are not required to submit documentation supporting any preventive care service received by their target population when submitting a claim for the Cumulative Preventive Care Bonus. However, in keeping with standard record-keeping practices and for Ministry audit purposes, physicians are required to make a notation in each patient's health record of each preventive care service received. This will validate any reported coverage and ensure that the appropriate payments are received.

Should you have any questions regarding your Cumulative Preventive Care Bonus claims, please contact your local Ministry office.

For general questions about preventive care bonuses, please contact Primary Health Care at 1-866-766-0266.

Sample *Preventive Care Target Population/Service Report – Previous Report*

REPORT ID : PCRP60R1-P PREVENTIVE CARE TARGET POPULATION/SERVICE REPORT
MOHLTC
REPORT DATE: 2010-04-03 **PREVIOUS REPORT**
PAGE: 01
CONFIDENTIAL HEALTH INFORMATION **REPORT PERIOD: OCT 01, 2007 TO MAR 31, 2010** *

GROUP (PCN): BXXX - UNIFIED PCN ADDRESS : DR. F LAST NAME
PHYSICIAN : 191919 – LAST NAME, FIRST NAME 12 THEORY LANE
QUARK, ON
PREVENTIVE SERVICE TYPE : PAP SMEAR ** A1A 1A1

HEALTH NUMBER	LAST NAME	FIRST NAME	BIRTH DATE	**AGE AS OF 2009-03-31**	SERVICE DATE***	EXCLUDED DATE
1111111111	BEAUVIER	ABIGAIL	1950-06-01	59	2009-01-15	
2222222222	HATCHET	MOLLY	1947-04-22	62	2008-11-05 2007-11-21	
3333333333	**LUMIERE**	**DULCIE**	**1941-12-14**	**69**		**2008-09-14**

TOTAL PATIENTS: 3

***** END OF PAP SMEAR TARGET POPULATION/SERVICE RPT *****

- CLAIMS RECEIVED AFTER REPORT DATE WILL NOT APPEAR ON THIS REPORT.
- THE TARGET GROUP CONSISTS OF ENROLLED FEMALE PATIENTS WHO ARE 35 TO 69 YEARS OF AGE INCLUSIVE ON MARCH 31ST OF THE PAYMENT YEAR.
- THIS REPORT CONTAINS OHIP APPROVED CLAIMS BASED ON CONSENT PERMISSIONS PROVIDED BY PATIENTS ON THEIR PATIENT ENROLMENT & CONSENT TO RELEASE PERSONAL HEALTH INFORMATION FORM AND MAY NOT INCLUDE ALL PREVENTIVE CARE SERVICES.

Please note that the *TPSR – Previous Report* (sample shown above for the 2009/2010 fiscal year) and the *TPSR – Projected Report* (not shown) are very similar. Differences between these two reports result from the reporting period only. For example, the *TPSR – Projected Report* for the 2010/2011 fiscal year that would accompany the *TPSR – Previous Report* for the 2009/2010 fiscal year (shown above) would reflect a Report Period of Oct 1, 2008 to March 31, 2011, the age of the patients would be as of March 31, 2011, and the patient Lumiere would not appear on the report as she would be 70 years of age on March 31, 2011 (therefore no longer part of the target population for the Pap Smear category).

Ontario