MINISTRY OF HEALTH AND LONG-TERM CARE
Primary Health Care Team

Fact Sheet

Title: **Information and Procedures for Claiming the 2005/2006 Colorectal Screening Bonus (September 1st, 2006 Service Date)**

Date: **October 2006**

Eligible Patient Enrolment Models (PEMs):

- ☑ Family Health Groups (FHGs)
- ☑ Comprehensive Care Models (CCMs)
- ☑ Family Health Networks (FHNs)
- ☑ Primary Care Networks (PCNs)
- ☑ Health Service Organizations (HSOs)
- ☑ South Eastern Ontario Academic Medical Organization (SEAMO)
- ☑ Group Health Centre (GHC)

Appendix E, Section 4.3 of the Memorandum of Agreement (MOA) between the Ministry of Health and Long-Term Care (the Ministry) and the Ontario Medical Association (OMA) includes provisions for a new Colorectal Screening Bonus for Patient Enrolment Model (PEM) physicians effective April 1st, 2006.

Eligible physicians may now submit for a Colorectal Screening Bonus for the 2005/2006 fiscal year. For this bonus year only, physicians must submit claims with a **September 1st, 2006 service date**. Regular stale-dating rules will apply.

Information regarding the new bonus category and detailed instructions on how to calculate and claim the 2005/2006 Colorectal Screening Bonus are provided below.

Note: For physicians participating in PEMs with Group Enrolment, references to a physician's enrolled patients are those patients who are enrolled to him/her by virtue of the physician's acknowledgement on the *Patient Enrolment and Consent to Release Personal Health Information* (E/C) form.

For more information please contact your local Ministry office or your site team at 1-866-766-0266.

Colorectal Screening Bonus - General Information

- The bonus is calculated annually on an individual physician basis.

- The bonus is based on the percentage of a physician's Target Population that has been screened for colorectal cancer by Fecal Occult Blood Testing (FOBT) in the 30 months preceding March 31st, 2006. A physician's Target Population is his/her enrolled patients who are between 50 and 74 years of age inclusive, on March 31st, 2006.

- Payments will be made to the group or individual physician depending on their Primary Care agreement in the month following submission, provided it is received by the regular claims cut-off date.

Minimum Roster Size Requirements

- The Primary and Community Care Committee (PCCC) has established minimum roster size requirements for determining FHG and CCM physicians' eligibility for all preventive care bonuses including Colorectal Screening. The requirements for FHG and CCM minimum roster sizes are:
  - Eligibility is based on a physician's roster size on March 31st of the current bonus year (e.g. March 31st, 2006 for the 2005/2006 fiscal year);
  - A physician must have a minimum roster size of 450 enrolled patients in the 2005/2006 fiscal year, and a minimum of 650 enrolled patients in the years thereafter; and
  - 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.

Reporting

1. *Preventive Care Target Population/Service Report*

- Eligible physicians will receive a Preventive Care Target Population/Service Report to assist in calculating their bonus for the 2005/2006 fiscal year. The report:
  - Identifies a physician's Target Population for the Colorectal Screening Bonus as of March 31st, 2006;
  - Identifies enrolled patients who have provided consent and received an FOBT from any source according to Ministry records;
  - Identifies enrolled patients who have provided consent for whom any physician has submitted a Q133A Tracking Code; and
  - Identifies enrolled patients for whom the rostering physician has submitted a Q142A Exclusion Code.

  Note: Services will not be reported if the claim for an FOBT was not processed as of the report date or if the patient received the service from a source that does not submit the claim to the Ministry.

2. Reporting for FHNs, HSOs, GHC, and SEAMO

- Group Level preventive care bonus information is provided on both the group and solo RAs on the *Group Total - Summary Report* (see sample below).

- Individual physician information is reported on their *Payment Summary Report* under *Preventive Care Bonus Accumulations and Payment (*see sample below) on the group and solo RAs.

Sample of *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	81,777.84

Sample of *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

3. Reporting for PCNs, FHGs and CCMs

- Individual physician information is reported on each physician's solo RA under *Preventive Care Bonus Accumulations and Payment* (see sample above).

4. Consent Data Reports (FHNs, PCNs, HSOs, and GHC)

- Please note that FOBT services (G004A and L181A) and Tracking Code Q133A will not appear on the "Preventive Care" section of the Consent Data Reports. These services will appear on the Target Population/Service reports with the other preventive care information.
- Like all other preventive care services, FOBT services (G004A and L181A) will report under the "Outside Usage" section when provided by a physician outside the PEM for enrolled patients who have provided consent.

Steps for Claiming the 2005/2006 Colorectal Screening Bonus

1. Calculate the Coverage Level

Each physician is responsible for calculating his/her coverage level as follows:

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

*Covered patients are those patients in the eligible Target Population that had an FOBT in the 30 months preceding March 31st, 2006.
**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 colorectal cancer screening.

A physician may exclude a patient from his/her Target Population if:

- The patient has known cancer being followed by a physician;
- The patient has known inflammatory bowel disease;
- The patient has had a colonoscopy within the last 5 years;
- The patient has a history of malignant bowel disease; or
- The patient has any disease requiring regular colonoscopies for surveillance purposes.

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 211 of the remaining 308 patients have had an FOBT in the 30 months preceding March 31st, 2006.
- The coverage level would be (211 / 308) X 100 = 68.51% = 69% (rounded to 2 significant digits).

2. Determine the Appropriate Q Code

New Q codes have been created for the Colorectal Screening Bonus. These are:

Coverage Level	Fee Payable	Q Code
15%	$220	Q118A
20%	$440	Q119A
40%	$1,100	Q120A
50%	$2,200	Q121A

3. Submit the Bonus Claim

Physicians submit for their 2005/2006 Colorectal Screening Bonus similar to Fee-For-Service (FFS) claims. Bonus submissions must adhere to the following requirements:

- The Health Number field must be left blank
- The Service Date must be **September 1st, 2006**
- The Version Code field must be left blank
- The Birth Date Field must be left blank

Note: Regular stale-dating rules apply to Colorectal Screening Bonus claims.

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. Documentation

Physicians are required to make a notation in the patient's health record, including the date and type of procedure received.