PREVENTIVE CARE
CUMULATIVE BONUS MANAGEMENT PROCEDURES

REVISED MARCH 2005

Ontario

Program Overview

Eligible primary care physicians may annually claim the payment of a cumulative preventive care bonus where high levels of preventive care have been administered to their enrolled patients over the course of a fiscal year. In order to qualify for this cumulative bonus payment, achieved preventive care service rates for targeted patients must be at or above contractually established levels. One claim is allowed per year for each group physician under each of the current preventive care categories as defined in each of the applicable contractual agreements. For the 2004/05 fiscal year, there are four preventive care categories:

- Influenza Vaccine for Enrolled Patients over 65
- Pap Smear for Enrolled Patients ages 35 to 69
- Mammogram for Enrolled Patients ages 50 to 69
- Immunizations for Enrolled Members up to 30 months old (childhood immunizations)

The Ministry of Health and Long-Term Care has adopted operational definitions that specify how the achieved patient coverage is determined in each category.

Influenza Vaccine for Enrolled Patients over 65

This fee is calculated annually on an individual physician basis based on the percentage of patients enrolled to the group physician who are over the age of 65 and who have received the influenza vaccine appropriate for that influenza season by December 31st of the fiscal year for which payment is being claimed.

Operational Definition: The target patient group consists of enrolled patients who are 65 years of age or over at the end of the fiscal year (March 31st) for which payment is being claimed. Note that patients who are still 64 years old in December, but who will turn 65 by March 31st form part of the target patient group. The achieved coverage is the percentage of patients in the target group who received the flu vaccine by December 31st of the fiscal year for which payment is being claimed.

Pap Smear

This fee is calculated annually on an individual physician basis based on the percentage of female patients enrolled to the group physician who are between 35 and 70 years of age and who have had a Pap smear in either the current or previous fiscal year.

Operational Definition: The target group consists of enrolled female patients who are between 35 and 69 years of age, inclusive, at the end of the fiscal year (March 31st) for which payment is being claimed. As per previously negotiated contractual amendments, the achieved coverage is the percentage of patients in the target group who have had a Pap smear in the 30 months previous to the fiscal year end.

Mammogram

This fee is calculated annually on an individual physician basis based on the percentage of female patients enrolled to the group physician who are between 50 and 70 years of age and who have had a mammogram in either the current or previous fiscal year.

Operational Definition: The target group consists of enrolled female patients who are between 50 and 69 years of age, inclusive, at the end of the fiscal year (March 31st) for which payment is being claimed. As per previously negotiated contractual amendments,

the achieved coverage is the percentage of patients in the target group who have had a mammogram in the 30 months previous to the fiscal year end.

Immunizations for Enrolled Patients under Two Years
This fee is calculated annually on an individual physician basis based on the percentage of patients between 18 and 24 months of age who are enrolled to the group physician and who have received all of the ministry supplied immunizations recommended by the National Advisory Committee on Immunization. For the purpose of claiming a bonus for this preventive care category for the 2004/05 payment year, the required immunizations are for Diphtheria, Pertussis, Tetanus, Polio, Infant Haemophilus influenza type B Vaccine (DPTP-Hib), and for Measles, Mumps and Rubella (MMR).

Operational Definition: As per previously negotiated contractual amendments, the target group for immunization purposes consists of all enrolled patients aged 30 months or less. The achieved coverage is the percentage of patients 2½ to 3½ years of age (30 months to 42 months of age) who received all applicable immunizations by their 30th month.

B. In-Year Reports to Physicians

Each group physician receives reports throughout the fiscal year to assist them in identifying eligible patients, tracking the preventive care services administered to or otherwise received by their eligible patients, and in calculating their achieved coverage levels.

In previous years, physicians received both a *Target Population for Preventive Care Report*, which identified eligible enrolled patients in each preventive care category, and a *Preventive Care Service Report*, which listed the preventive care services received by patients in each target group. Effective April 2005, these will be merged into one comprehensive report. A sample of the new *Preventive Care Target Population/Service Report* is included for reference below.

Sample *Preventive Care Target Population/Service Report*

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REPORT ID: PCCP57R1                                MINISTRY OF HEALTH AND LONG-TERM CARE
REPORT DATE: 2003/04/15                                                          PAGE: 1
                              PREVENTIVE CARE TARGET POPULATION/SERVICE REPORT
                                   FOR FISCAL YEAR ENDING MARCH 31, 2005
BILLING NUMBER          : 191919
PHYSICIAN               : LAST NAME, FIRST NAME
NETWORK IDENTIFIER      : BXXX
NETWORK NAME            : UNIFIED PCN
********************************************************************************
PREVENTIVE SERVICE TYPE : CHILDHOOD IMMUNIZATION *
                                                        AGE AS OF
  LAST NAME                    FIRST NAME              03/31/2003 SERVICE DATE **
  ---------------------------  ----------------------  ---------  ------------
  WALTON                        JOHN-BOY                   2.2     2001-06-15
                                                                   2002-01-15
                                                                   2002-05-17
                                                                   2003-01-25

  BRADY                         BOBBY                      2.4     2001-08-10
                                                                   2002-10-15
                                                                   2002-11-17

  KENT                          CLARK                      2.1
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DUCK	DAISY	2.9	2001-06-15 2002-01-15 2002-04-17
STARR	RINGO	2.7	
SIMPSON	BART	2.7	2002/01/18

ELIGIBLE PATIENT TOTAL 6

* THE TARGET GROUP CONSISTS OF CHILDREN 2 ½ TO 3 ½ YEARS OF AGE WHO SHOULD HAVE RECEIVED ALL 5 IMMUNIZATIONS BY 30 MONTHS OF AGE

** THIS REPORT CONTAINS OHIP APROVED CLAIMS DATA BASED ON THE CONSENT PERMISSIONS PROVIDED BY PATIENTS ON THEIR PATIENT ENROLMENT AND CONSENT TO RELEASE PERSONAL HEALTH INFORMATION FORM AND MAY NOT INCLUDE ALL PREVENTIVE CARE SERVICES

Please note that although the patient information contained in *the Target Population/Service Reports* strive to identify all currently enrolled patients that meet the target population age/sex requirements for each preventive care category up to the end of a particular fiscal year, such information fluctuates as patients are added to or removed from physician rosters. As well, physicians have the ability to adjust some target populations initially identified by the ministry and remove select patients not medically eligible to receive a given preventive care service. Physicians may remove those patients who have had a hysterectomy from the target population eligible for a Pap smear, and those who have been diagnosed with breast cancer or clinical breast disease from the target population eligible for mammography. Please note, however, that no other amendments to target populations may be made at this time.

Physicians are also responsible for ensuring the accuracy of services received by their targeted patients as such information may not always be available to the ministry and therefore not identified on the *Target Population/Service Reports*. Services may not be reported for a number of reasons: For example, patients may not have provided consent to have such services reported; the service claim may not have been processed at the time the *Target Population/Service Report* was produced; or the preventive care service was received from a source that does not submit a claim to the ministry, such as the Ontario Breast Screening Program.

Report Frequency

Target Population/Service Reports will be sent to each physician every April and September. Please note that two separate reports will be sent in April: The first report is to assist the physician in calculating achieved coverage for the previous fiscal year (i.e., the fiscal year that just ended on March 31st). This report contains the most current information available to the ministry as to the target population for each preventive care category as at March 31st and the preventive care services received by such patients within the previous 30 months.

The second April report is to assist physicians in managing preventive care services for the coming year. It shows a projected list of targeted patients for the current fiscal year (i.e., the fiscal year beginning April 1st) and lists any preventive care services received by these patients within the past 18 months. Physicians can thus identify service gaps and focus on providing any preventive care services not yet received by targeted patients in the coming year.

The *Target Population/Service Report* sent to physicians in September updates the projected information sent out in April and shows mid-year changes to target populations and preventive care services received by patients to date. For the Pap smear and mammography categories, services received by target patients are shown for the 30 months prior to the end of the current fiscal year. For the childhood immunization category, services received by target patients are shown for the first 30 months of life. Note that because the annual influenza vaccine is not available nor administered to targeted patients until the late fall, this service cannot be shown in the September report. Physicians may augment the information contained in this report with data from their own clinical records and highlight those target patients who remain non-compliant at this point in order to maximize the cumulative bonus fee payable at year-end.

C. Calculating Achieved Preventive Care Coverage

Q-Codes

Group physicians use a series of cumulative preventive care management service enhancement codes (Q-codes), as outlined in their respective contracts, to report their achieved patient coverage levels. The chart below lists the service enhancement Q-codes and the corresponding fees payable for the target rate achieved in each preventive care category.

Preventive Care Category	Achieved Target Rate	Fee Payable	Service Enhancement Code
Influenza Vaccination	60%	$220	Q100
	65%	$440	Q101
	70%	$770	Q102
	75%	$1100	Q103
	80%	$2200	Q104
Pap Smear	60%	$220	Q105
	65%	$440	Q106
	70%	$660	Q107
	75%	$1320	Q108
	80%	$2200	Q109

Mammography	55%	$220	Q110
	60%	$440	Q111
	65%	$770	Q112
	70%	$1320	Q113
	75%	$2200	Q114
Childhood Immunization	85%	$440	Q115
	90%	$1100	Q116
	95%	$2200	Q117

Physicians are responsible for calculating their own achieved coverage levels for each of the preventive care categories utilizing the *Preventive Care Target Population/Service Reports* and monthly *Consent Data Reports* provided by the ministry along with information obtained from their clinical records and other data sources available to them.

The coverage levels are calculated as follows:

Influenza Vaccine

(# of compliant patients* / # of patients in the target population) x 100%

* Compliant patients are those patients in the eligible target population that received an influenza vaccine by December 31st of the fiscal year.

Example:

- The *Target Population/Service Report* received in April for the past fiscal year shows a total of 106 eligible patients in the Influenza category
- A review of patient records/charts identifies that 82 of these targeted patients received the flu vaccine by December 31st
- The achieved coverage level would be:
  (82 / 106) X 100% = 77.36% = 77% (rounded to 2 significant digits)
- The physician submits Q-code Q103 for a bonus payment of $1100, which represents an achieved coverage level of 75% in this category

Pap Smear

(# of compliant patients* / # of eligible patients in the target population**) x 100%

* Compliant patients are those patients in the eligible target population that had a Pap smear in the 30 months prior to the fiscal year-end.

**Physicians may adjust the target population and remove any patients that have had a hysterectomy.

Example:

- The *Target Population/Service Report* received in April for the past fiscal year shows a total of 321 patients in the Pap smear category
- A review of patient records/charts reveals that 13 of these targeted patients have had a hysterectomy prior to the current fiscal year-end
- The target population is thus adjusted downwards (321 – 13 = 308)
- A review of patient records/charts reveals that 211 of the remaining 308 eligible patients had a Pap smear in the 30 months prior to the fiscal year-end
- The achieved coverage level would be:
  (211 / 308) X 100% = 68.51% = 69% (rounded to 2 significant digits)
- The physician submits Q-code Q106 for a bonus payment of $440, which represents an achieved coverage level of 65% in this category

Mammography

(# of compliant patients* / # of eligible patients in the target population)** x 100%

*Compliant patients are those patients in the eligible target population that have had a mammogram in the 30 months prior to the fiscal year-end.

**Physicians may adjust the target population and remove any patients that have been diagnosed with breast cancer or clinical breast disease.

Example:

- The *Target Population/Service Report* received in April for the past fiscal year shows a total of 267 patients in the mammography category
- A review of patient charts/records reveals that 23 of these targeted patients have been diagnosed with either breast cancer or clinical breast disease prior to the current fiscal year-end
- The target population is thus adjusted downwards (267 – 23 = 244)
- A review of patient charts/records identifies that 231 women of the remaining 244 eligible patients had a mammogram in the 30 months prior to the fiscal year-end
- The achieved coverage level would be:
  (231 / 244) X 100% = 94.67% = 95% (rounded to 2 significant digits)
- The physician submits Q-code Q 114 for a bonus payment of $2200, which represents a 75% coverage level and is the highest rate achievable for this category

Childhood Immunization

(# of compliant patients* / # of eligible patients in the target population) x 100%

* Compliant patients are those children between 30 – 42 months of age at the fiscal year-end that received **all applicable** immunizations by 30 months of age.

Example:

- The *Target Population/Service Report* received in April for the past fiscal year shows a total of 32 patients in the childhood immunization category
- A review of patient charts/records reveals that 29 of these targeted patients received all applicable immunizations before they reached 30 months of age
- The achieved coverage level would be:
  (29 / 32) X 100% = 90.63% = 91% (rounded to 2 significant digits)
- The physician submits Q-code Q 116 for a bonus payment of $1100, which represents a 90% coverage level in this category

D. Receiving Payment

Submitting Cumulative Preventive Care Bonus Claims

Effective for the 2004/05 fiscal year, Cumulative Preventive Care Bonus claims will be submitted to the ministry's Medical Claims System in a manner similar to fee-for-service claims. The submission will include basic claim information and a predefined Q-code as set out in the chart above for achieved coverage levels for the fiscal year ending March 31st.

Please note the following when submitting your electronic claim:

- The Health Number field must be left blank
- The Service Date must be March 31st
- The Version Code field must be left blank
- The Birth Date Field must be left blank

Cumulative Preventive Care bonus payments will be made to either the physician or to the physician's group as stipulated in each agreement. Payments by the ministry will be made in the month following the claim submission, assuming the claim was received by claims cut-off (generally the 18th of the month). Standard ministry stale-dating rules will apply to the new claims submission process.

Cumulative Preventive Care Bonus Payment Reports

Each physician or group will receive reporting on their Remittance Advice (RA) at the group and/or solo level depending on the agreement type about preventive care bonus payments.

Below is an example of Preventive Care reporting at the group level. This report is sent to both the Lead physician and the individual physicians in the group. Only elements paid to the group (as specified in each agreement model) are reported in this section.

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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
10% OF CORE SERVICES TO ENROLLED PATIENTS	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
FFS CORE SERVICE PAYMENT CEILING ADJUSTMENT	.00	.00

TOTAL PAID TO GROUP	110,856.98	181,777.84

Below is an example of Preventive Care reporting at the individual physician level. This report is sent to the individual physician and, according to agreement model, the group lead and is included in the payment summary report.

PAYMENT SUMMARY REPORT

PROVIDER : DR. ONE
IDENTIFIER : BBBB-123455

PREVENTIVE CARE BONUS ACCUMULATIONS AND PAYMENT:

				CURRENT MONTH	YTD
INFLUENZA VACCINE	PAP SMEAR	MAMMOGRAPHY	CHILDHOOD IMM		
80%	80%	75%	95%	8,000.00	8,800.00

E. Preventive Care Service Documentation

Physicians should not submit documentation supporting any preventive care services received by their targeted patients when submitting a claim for payment of the Cumulative Preventive Care Bonus. Nevertheless, in keeping with standard record-keeping practices and for ministry audit purposes, physicians are required to make a notation in each eligible targeted patient's health record of each preventive care service received in order to validate any reported coverage and to ensure that the appropriate payments are received.

Please note that some preventive care services require specific information to be entered in the patient's health record: In order to claim an annual preventive care bonus in the childhood immunization category, the physician must also retain records of the name of the vaccine, lot number, manufacturer, date of immunization, and route of administration. There may be situations, however, where the child received his/her immunizations from someone other than the group physician (e.g., a paediatrician or via a public health practitioner). In such cases, the group physician need not obtain the immunization records from the other health provider; simply recording the name of the vaccine and the date of immunization in the patient's health record is sufficient.

E. Contact Information

Should you have any questions related to the Preventive Care Program or to the payment of the annual cumulative bonus, please contact your site consultant at 1-866-766-0266.