CDM-QIP Payment
FAQs

Q. I have exported many patient visits to CDM-QIP. Why haven't I received any $75 payments yet?

The annual quality improvement payment would be generated after a patient's 12 month assessment period has ended (which is one year after the patient's first visit for that condition), and all indicators for that condition were met.

Q. Where do I see the amount I received for CDM-QIP payments?

On your return file, a service code of 994Y represents the early adopter payment amount and a service code of 996Y represents the quality improvement payment. CDM-QIP payments will appear as a single line item on your deposit advice.

Q. If my flow sheets are submitted to CDM-QIP more than 6 months after the visit date, will they be ignored for payment?

Currently, the program is still catching up on enabling exports from EMRs. Visits submitted to CDM-QIP more than 6 months later than the visit date will be valid for making quality improvement payment decisions. The backlog of exported visits should be caught up in the March - April 2015 timeframe. At that time the 180 day (6 month) time limit rule will take effect. Visits must be submitted to CDM-QIP no later than 180 days following the visit date, to be considered in the quality improvement payment decision process.

Q. What is the schedule for quality improvement payments?

CDM-QIP visit data will be analyzed shortly after each fiscal quarter, to determine which patients' 12 month assessment period for a condition has ended in that quarter, and whether or not the indicators for that condition were met. Payments will be issued quarterly in April, July, October and January each year.

Q. Where will I find a list of patients for whom I have received payment?

You will see a list of patients for which you have received a quality improvement payment by logging into MyeHealth, clicking the eHS Reporting link, and selecting the CDM-QIP Payment Details Report.

Q. Where will I find a list of patients for whom I have not received payment?

You will see a list of patients you have seen, but for whom you have not received a quality improvement payment by logging into MyeHealth, clicking the eHS Reporting link, and selecting the CDM-QIP Payment Exceptions Report.

Q. Why doesn't the Payment Exception Report tell me which indicators weren't met?

To determine which indicators were not met during the patient assessment period for that condition, log into the eHR Viewer and look at observations from the first visit with that patient through to the end of the 12 month period. Comparing those observations to the required indicators will illustrate which were missed. Indicators for each chronic condition can be found here: https://www.sma.sk.ca/resources/41/cdm-qip-frequently-asked-questions.html

Q. I addressed everything on the Recommended Care Report and I did not receive an annual payment for a patient. How can this be?

The Recommended Care Report is based on a rolling 2 year period. It won't always coincide with a patient's 12 month assessment period for that condition. The patient's first assessment period for a condition starts with the first visit in CDM-QIP for that condition, and each subsequent 12 month assessment period starts the same date every calendar year after that.

Q. Where can I find a patient's assessment period start and end date for one or all of their conditions?

The patient's first assessment period for a condition starts with the first visit in CDM-QIP for that condition, and each subsequent 12 month assessment period starts the same date every calendar year after that. Log into the eHR Viewer, search the patient in question, click on the Chronic Disease Management tab, and view all visits for that patient and condition.

Q. Why am I seeing odd payment amounts for some patients? I understood the payments were to be
$75 for each patient condition annually.

If you have received an amount less than $75 for a patient, it means there are additional providers, in your clinic or elsewhere, that have also submitted data for visits with the same patient that contributed to the indicators being met. Your payment will be pro-rated based on your number of visits with the patient, out of the total number of visits with the patient.

Q. Why are nurse practitioners who perform CDM visits and submit data to CDM-QIP independently not receiving CDM-QIP payments?

The program was designed to provide supplementary payments to family physicians. The CDM-QIP payment policy can be reviewed at http://www.saskatchewan.ca/live/health-and-healthy-living/health-care-provider-resources/treatment-procedures-and-guidelines/chronic-disease/chronic-disease-management

Q. I understand nurse practitioners are not eligible to receive CDM-QIP payments under the program. If a physician sees the same patient as a nurse practitioner, will the physician receive a supplementary payment for work performed by the nurse practitioner?

The payment process is designed to pro-rate payments so that physicians are receiving a partial payment, based solely on their visits with the patient, and not on visits performed by other providers. (For example, if a patient's indicators are met after a total of 5 visits and the physician performed 2 of the 5 visits, the physician will receive
2/5 of the annual payment for that patient).

Q. How much is the quality improvement payment?

The quality improvement payment amount is $75 annually, per patient per chronic condition. All indicators for that condition must have been met in a 12 month period.

Q. What is the 30 day grace period about?

A patient assessment period is the 12 month period, starting with the date of first visit in CDM-QIP for that condition and ending one calendar year later. There could be times when it is difficult to meet all indicators in that time frame, possibly due to the physician waiting for a lab test result, for example. For this reason, as long as indicators are met during the 12 month period plus 30 days, there will be a payment issued for that patient

for that year.

Q. Why are my payments going to my Medical Professional Corporation when my regular billings don't?

Billings that originate in the EMR are electronically sent into Medical Services Branch with an indicator to pay the corporation (or not). Program payments such as the Family Physician Comprehensive Care/Metro On-call, GP Specialist and CDM-QIP do not originate with the EMR. When these payments are generated, a database of physician information is used to create the payment transaction. Where a Medical Professional Corporation exists in the database for a physician, the default is to pay the Corporation. The default cannot be applied to some physicians and not others.

Q. How are quality improvement payment decisions made when there are multiple providers creating or adding to a CDM visit in the EMR?

Assuming all requirements are met for payment (such as appropriate number of visits, and indicators for that chronic condition have been met in the correct time frame), the EMR's "bill-to provider" will receive the annual quality improvement payment, as long as the bill-to provider is a family physician. In cases where some of the visits for a patient condition have a bill-to provider that **is not** a family physician (i.e. an NP), and some visits with the same patient have a bill-to provider that **is** a family physician, the physician will receive a pro-rated payment amount, based on the number of his or her visits, out of the total number of visits with the patient for that condition.