Annual General Meeting of BC Neurology section

April 12, 2019

Location: Doctors of BC Building
"Care Room" – main floor
1665 – W Broadway
Vancouver, B.C.

Agenda
5:30 PM- 1. Reception
6:00 PM- 2. Registration & Dinner
6:30 PM- 3. Meeting Starts, introductions, acknowledge Video/Teleconference, welcome new members, remembering past members
6:40 PM- 4. Accept Minutes from last AGM, March 9, 2018
7:00 PM- 5. Dr. Sam Bugis- Doctors of BC
7:00 PM- 6. Treasurer's report
7:05 PM- 7. Business Arising:

a) Annual dues
b) Membership numbers
c) Botox fee code
d) Chronic Migraine
e) APP Grid scale neurology
f) Labour Market Adjustment funding and complex care
g) New/Revised Fees Status
h) Overhead Survey
i) Diagnostic Accreditation Program Requirement (DAPR)

7:45 pm- 8. New Business:

a) Physician Master Agreement (PMA) for 2019 – already voted
b) Funding priorities for neurology and how best to allocate possible new monies (2019-2021)
   - Neuromuscular DMD treatment codes
   - Telestroke not requiring video
c) LP fee – should we increase it
d) Other fee proposals?

In attendance

1. Sharan Mann
2. Alina Webber
3. Laura Wilson
4. Bruce Bjornson
5. Ana-Luiza Sayao
6. Silke Cresswell
7. Dean Foti
8. Chantelle Hrazdil
9. Michelle Mezei
10. Marketa Van Den Elzen
11. Jonathan Squires
12. Matt Kula
13. Sara Simpson
14. Galina Vorobeychik
15. John Falconer
16. Katie Beadon
17. Kristine Chapman
18. Tara Rastin

19. George Medvedev
20. Rob Hsiung
21. Rob Carruthers
22. Tychicus Chen
23. Anish Kanuga
24. Christine Stables
25. John Diggle
26. Cory Toth

Remote access-

1. Niall Davidson
2. Tim McDowell
3. Olinka Hrebicek
4. Jennifer Takashi
5. Alexandre Henri-Bhargava

The meeting was called to order by John Falconer at 6:20 PM

3. Meeting Starts, introductions, acknowledge Video/Teleconference, welcome new members, remembering past members

New members: Sara, Tara, Katie, Anish, Tychicus, Christine, Niall

Passed members: Dr. David J. Novak- GN and EEG in Penticton.

4. Approval of Minutes

The minutes were read from the March 9, 2018 meeting and approved.

Motion to pass by John Falconer. Motion passed.

5. Invited Speaker: Dr. Sam Bugis- Doctors of BC

Background: General Surgeon.

1. In PMA:
    a. New agreement about working with health authorities to establish both physical and psychological safety where you work. Doctors are independent contractors.
        i. Physical: non-controversial
        ii. Psychological: contentious: Maybe the health authority is not treating them fairly.
        iii. What is the process for dealing with those? We haven't established a process in the PMA, but at least the framework is present to deal with it. What's the best way a physician
        iv. Will start at the provincial level.
    b. New fee fund- $2 million. Shared with GPs.
2. Outside of PMA:
    a. MSP services with audit and billing. How to prevent audit, business plan. E.g. billings are not the easiest to answer. Formalized program to understand fee guides.
    b. Sections: sections have representatives (SR) for the representative assembly.
        i. SR are unsure of what they can or can't bring up.

        ii. Staff will be assigned to a section, they'll connect with the reps of the sections and hear what's bothering you and inform you what's going on elsewhere.
        iii. The hope is that this exchange of information will be useful to the section and provide a way for the section representative for them to contribute at the assembly.
    c. Quality improvement activities and committees. Physician quality improvement committee. E.g. BC Medical Quality Initiative.
3. Last PMA:
    a. Was an opportunity for doctors to bring up what they found important.
    b. Auditor general and government are now expecting doctors to perform quality of improvement assessments and recommendations.
    c. This will be a joint effort between docs and government to see how to improve in their practice via a Measurement System for physician quality improvement.
    d. Two groups have already started: family physicians and surgery.
    e. Language is reassuring that information is collective and anonymized, please don't feel "attacked".
4. Provincial MOCAP review committee.
    a. Helping the health authorities make proper decisions about MOCAP. This has been a priority for health authorities, not a priority for physicians.
    b. Agreement to obtain objective data on how busy people are when they get MOCAP contracts.
    c. The data obtained didn't answer all questions as well as they thought they would. If the health authority chooses to use some of the information and process, then they can make better decisions.
    d. *Claim*: Didn't affect neurology
        i. *Objection*: Pediatric neurology were affected: we're busier than others. We were downgraded to Level 2 because we didn't approve acute strokes. But we cover epilepsy and pediatric strokes. Pediatrics got treated better.
            1. *Recommendation*: If you feel strongly about this issue, then write.
        ii. *Objection*: This has already done.
            1. *Recommendation*: You should be able to talk to the Health Authority.
    e. MOCAP: when levels were defined (have to answer within X time, and have to be here) people on both sides of the process (referring physician and attending physician) were affected.
        i. You need to see the patient based on what you need. Not based on contract. Comments about ten minutes. Levels are still about acuity but not entirely acuity. We wanted people to be on call for the patient.

6. Treasurer's Report

1. $41,000 this year in bank account.
2. Main expense is executive stipends.
    a. Olinka- $10,000; Galina- $2,000; John- $75,000

    b. Expectation: not to charge this year for John's stipend so the average over two years will end up being $35,000.
3. Want a cushion but we're sitting well.
4. *Question*: The goal last year was to enroll more members in the section. How good were we?
    a. *Answer*: We did really well: previous 50/113 FTEs paid. Paid membership 94/113 last year. This year 75-76/113 paid.
    b. We'll contact people individually to pay their fees. People tend to be happy to contribute.

7. Business arising

a. Annual Dues- $450/yr. Please support your section and consider supporting the Society of Specialists as well as this group lobbies hard for specialists

b. Membership numbers- 2017/2018 – 94/113 Paid dues, cf. 50/113 in previous year

c. Botox fee code: more or less permanently denied

- We tried several times to get the government to cover it. Probably no chance that the government would.
    - *Question*: Is it worth pursuing this code in the long run? If its covered by insurance, injection cost is also covered. Therefore, if we pursue it, the government can determine the price.
    - When's it's not covered, fee is set more to time.
    - *Objection*: It makes no sense that we can inject Botox for other things but its not covered for chronic migraine. My patients cover their own injections. Fee code excludes certain diagnoses.
        - *Response*: Lots of things under the standard of care are not covered by insurance.
- Government reviewed the data 2 separate times. Said the evidence was not good enough. Hopefully there'll be new data.

d. Migraine: Anti-CGRP monoclonal antibodies for chronic migraine will be a new treatment option for chronic migraine (galcanezumab, eptinezumab, erenumab). FDA approved and one option is to be released soon.

- Evidence is not drastically different from Botox, but we're more likely to get approval.
- About half of the neurologists present are currently using anti-CGRP monoclonal antibodies.
    - Efficacy is not known: only begun using them in the last 2-3 months.
- Patients self inject medication, easy to use.
- Couple of successes, however, some have reported Raynaud's phenomenon and renal failure after use which is not mentioned on the label.

- *Objection*: One of issues of Botox is not that it's not covered, it's that prescription is not specific to neurologists. If the anti-CGRP medications are targeting the same price range (~$500 per month) as Botox, will this bankrupt the system if everyone can prescribe it. Should we be restricting the prescription rights? Should we raise this with Pharmacare?
- *Recommendation*: other comprehensive fee codes, if we have problems getting comprehensive fee codes for Botox, what if we structure the codes so that we incorporate into a comprehensive fee code (similar pediatric transition codes, MS codes).
    - Identity to the patients. You "own" the patient.
    - *Objection*: Headaches patients move from one doctor to another. If we restrict a patient to one doctor, it will cause problems. Great idea but not sure if it's workable.

e. APP Grid scale neurology

Service Contract range for Neurology is $262,643 – $328,304

New 2019: $272,591-$340,740

Salary Contract range for Neurology is $234,503 – $293,128

New 2019: $243,386 - $304,232

- Gained a healthy increase in the APP grid. We'll probably see more APP contract for hospital neurology. We want neurology to be high on the grid scale.

f. Labour Market Adjustment funding and complex care

Completed LMA fee codes analysis sponsored by SSC. Final report on our website. New PMA envisions the complete transfer of all SSC and LMA fee codes into the general available amount. We did use one of our Disparity raises to move the 00457 into general available amount.

- First 18 months, codes are always provincial: Be judicious when using it for the next 18-20 months. Want steady usage and then use it as needed.
- Primarily for 00450 and 00457 codes. Integral part of some practices.
- LMA code review: we identified 6-8 neurologists that came to BC specifically for those codes.
- *Question*: Did the fee code get adjusted?
    - *Answer*: It was over subscribed. We used our disparity fund to take the 00457 to take into general available.
- *Question*: Does this apply to telephone codes.
- Those codes will also be enrolled into general available.
- *Question*: Over what period of time will these codes be enrolled?
    - *Answer*: March 31st, 2020 and marked as provincial code for 18 months. Hope to keep steady (2.4% growth rate allowed). Monitored quarterly (we will be checking). We've been stable the last couple of years.
- Three other codes involved: but the # being billed was insignificant.

g. New/Revised Fees Status

File #04-1-19(18) Amendment to 00480 DMT (Disease Modifying Treatment) management for active inflammatory disease of the Central Nervous System (CNS) Revised 5/29/2018 (1/18/2018 original submission)

File #04-1-21(A)(18) Amendment to 00487 Detailed cognitive assessment by Behavioral Neurologist-extra Revised 5/29/2018 (1/18/2018 original submission)

File #04-1-21(B)(18) Amendment to 00488 Detailed cognitive assessment-extra Revised 5/29/2018 (1/18/2018 original submission)

File #04-1-27(17) New Fee Item for Parkinson's Disease Quantitative Review PD Code for neurologists with a MD (Movement Disorder Fellowship) Revised 5/29/2018 (11/27/2017 original submission)

File #04-1-28(17) New Fee Item for Parkinson's Disease Quantitative Review PD Code for neurologists without a MD (Movement Disorder Fellowship) Revised 5/29/2018 (11/27/2017 original submission)

File #04-1-99(18) Amendment to 00406 Directive Care and 00476 Telehealth Directive Care Revised 5/29/2018 (1/18/2018 original submission)

- Remember: If they're in ICU, you bill 00408 daily, don't bill 406
- *Question*: Can we bill a non-ICU 00408?
    - *Answer*: If you're not the MRP: bill 00408.
- Pending application to increase 00406 from 2x per week to 4x per week. Takes about 2-3 years to go through submission and approval. Please be patient!
    - *Question*: 2x per week is across all sections. Is there a pre-amble committee to change this en mass so this doesn't take up sections fees (GI, respiratory same thing): other sections go through this?
    - *Answer*: I'll bring this up at the Specialists Committee Meeting.
- $2.5 million available for new fees but it's really competitive.
- 00406: Is not an overused or big-billed item.
- *Question*: Acute decompensation fee?
    - *Answer*: Has not been approached yet. Can be discussed for uses for new fee.
- *Question*: For GBS patients? Combined ICU and step down unit. Technically admitted to step down. Can we bill even though they're in ICU? Still requiring the high level of care.
    - *Answer*: Only thing is that there might be an audit risk. Technically, to bill 408 if you're not the MRP, then they should be in ICU.

h. Overhead Survey

The overhead survey has been completed. We have all received the gross-over all overhead rates, and the daytime-MSP only overhead rates for all sections. The OH study was plagued with methodological problems, but now includes "error bars".

- Non-responder bias permeates the study.
- We never know how many hours every doctor works.
- We came in at 29% as a section.
- Difficult to say how accurate it is: take +/-5%,

- *Question*: Where are the results?
    - *Answer*: You'll get a full report or synopsis from doctors of BC. So far, they sent it to each head of section.
    - *Answer*: Our result is on the website.
- Overhead ratio is primarily used to determine the raise in PMA. First half percentage raise goes as follows 1. General increase. 2. FTE increase. 3. Overhead increase proportionally.
    - Neurology receives .48%.
    - Used in negotiations and deciding benefits.
    - Relatively low player.
- *Question*: Is there any way we can gently remind people who receive the surveys? We're a small section and we want to be more well represented.
    - *Answer*: Required you to submit your taxes, so it wasn't that simple. They were working in other hospitals or clinics. Some misunderstandings occurred.
- First wave: 13-14 replied, second wave: 13-14 (We needed 25 people to reply).

i. Diagnostic Accreditation Program Requirement (DAPR)

No changes, except with "significant change" in location or service requires re-accreditation.

- EMG was simplified. Matt and Chantall agreed to do the same for EEG. Next goal: Stream-lined for satellite clinic.
    - *Question*: 4-5 months for EMG. EEG is a couple weeks. Can that process be stream-lined.
        - *Answer*: Representative is more involved in the lab, but will take that back.

j. CMPA fees for neurology

Following correspondence with CMPA last year, our rates were reduced from $15,708/year to $13,308/year. Net savings to all of us of $2,400/each.

- *Question*: Did we find out why it was suddenly increase so much originally?
    - *Answer*: Claimed privacy and that they can't release that information. But eventually they agreed to reduce our fees.
- We got a big rebate last year. Hopefully same thing happens this year.

8. New Business

a. Physician Master Agreement (PMA) for 2019 – already voted

- Overall increase in general is 8% physicians.
- Negotiations by doctors of BC went well.
- We're still not saddled by usage.

b. Funding priorities for neurology and how best to allocate possible new monies (2019-2021) - Neuromuscular DMD treatment codes - Telestroke not requiring video

- $334,821 still available to allocate: What do we want to increase?
- When we apply for a new fee code and have to wait 2-3 years, the money is available in the mean time for a one-time fund.
- *Proposal*: Many patients don't have family doctors. Lots of work falls on neurologists office. "Urgent fee" to see patient within a number weeks or months after discharge. E.g. see seizure patients are readmitted. Fee to handle patients that are being discharged.
- *Proposal*: Distribute the money around the board? Temporarily raise the budget.
- *Proposal*: Complex programming fee. Precedent in Ontario: DBS fee for physicians.
    - *Response*: We need an idea of how many neurologists would use it, how many patients, how much you would charge. Communicate about background information.
- 00462: Put the code in strategically. Similar to neurosurgeons for reviewing things over the phone. We have an established fee code. Re-structuring the 00462, reducing from 60 to 30 days or even 10.
    - *Proposal*: That fee code could encompass other things, change pre-amble, restrict to physicians trained for fMRI.
        - *Response*: We need an idea of how many neurologists would use it, how many patients, how much you would charge. Communicate about background information.
- Neurologists who provide hospital-based services see sometime have higher acuity and challenging patients. Concern with increasing some fees (00410), disproportionally helps those with 1 consultation.
- *Proposal*: Cut down time to bill 00457?
    - *Response*: Caution on time-based codes. Becomes the benchmark for everything you do.
- *Proposal*: 00411 is undervalued. Maybe increase 411? Patients seen every 3 months.
- Inflammatory Code for CNS/PNS and neuromuscular. Tried to put forward and it was denied. There is currently an increased number of patients on immunomodulators. Increased burden in neuromuscular. Had to cut down number of EMGs to see follow-ups for complex inflammatory disease.
    - *Proposal*: Fee code for monitoring people on immunomodulators.
    - When using these drugs, need to educate, consent, monitoring. These are people have 1 EMG and treat for 20 years. Rheumatology has a code for the exact same thing.
- *Proposal*: Acute deterioration fee in Yukon, can be billed with 407, 406, 411, 408.
- *Proposal*: Fee code for Orphan patient?
- Complex LP volume. Pre-post gait analysis.
- *Proposal*: Observation code? Lots of medications that require physicians to observe.
- *Proposa*l: Reimburse EEG readers to read prolonged EEG in their respective communities. Community EEG readers to characterize the spells.
    - One of the barriers: Category 1 EEG and Category 2 EEG have different training requirements. Ministry restricted EEG to public EEGs. Need a category two physician and site to bill. Maybe need to relax category 2 criteria.
- *Proposal*: Need unique fee code for prolonged EEG category.

- *Proposal*: Feed code that incorporates LP as one of the criteria.
- *Proposal*: Can you relax the criteria so that when doing an LP you could include 407.
    - *Objection*: Most general neurologists don't do a lot of LP (0-5 per year). 2. Labs don't have the capacity for long term EEG.
- Billing for simultaneous sleep and awake EEG: can bill both regular EEG and 50% sleep EEG if sleep-deprived EEG is requested. Bill a regular study and half a sleep study.
- Immunomodulatory review: rheumatology code. Just a general rheumatology code that would be used by all neurologists.
    - *Proposal*: Chat with rheumatology and grandfather in their codes.
- *Proposal*: Point of care diagnostic code.
- *Question*: Increased in patient fees over the years. If we look at new fees, should they be preferentially to inpatients, outpatients or no preference?
    - *Vote*: ?
- Incentivize people out of hospitals into communities during acute deterioration.
- General physicians have a code for complex patients (3 or more conditions)
    - *Objection*: Most neurology patients could be considered complex.
- *Question*: We spend a lot of times focusing on specific areas rather than general increase.
    - *Vote*: Focus on specific things.
- *Question*: Focus on spending money on existing codes instead of new codes? Should the one-time money go to 410 or follow up?
    - *Vote*: Most seem to be in favour of the follow-up.

c. LP fee – should we increase it

Not discussed in great detail

d. Other fee proposals?

Discussed in Section 8b.

Meeting adjourned at 8:38 PM.