Approved by Estonian Health Insurance Fund Management Board
Decision No. 395 of 2 September 2015
Amended in relation to Estonian Health Insurance Fund Management Board Decision No. 499 of 2 December 2015

GENERAL MEDICAL CARE FUNDING CONTRACT No. _____

Guided by the national health care policy, the primary care health care development plan, and the developments in the health care sector and health insurance; attaching primacy to shared interests in assuring the better availability of high-quality general medical care to insured persons; and recognising the need for the implementation of certain control mechanisms by the Estonian Health Insurance Fund for the purposes of the efficient and rational use of health insurance funds, a general medical care funding contract (hereinafter: the contract) is being concluded between.
Estonian Health Insurance Fund (hereinafter: the Health Insurance Fund or the party)

1. Object of the contract

1.1. Provision of general medical care services by a family physician for insured persons on the list of the family physician and the assumption of the obligation of paying remuneration for the health service provided for insured persons on the terms and in accordance with the procedure laid down in legislation and in the contract and annexes thereto;

1.2. Provision of school health services on the proposal of the operator of a school on the terms and in accordance with the procedure stipulated in legislation and in the contract and annexes thereto.

2. Integral components of the contract

2.1. General terms of a general medical care funding contract (Annex 1)

2.2. Additional terms of a general medical care funding contract (Annex 2)

2.3. Remuneration-related annexes:

2.3.1. Quarterly financial calculation of the services of a family physician for the list of the family physician (Annex 3)

2.3.2. Quarterly consolidated financial calculation of the services of a family physician (Annex 3A)

2.3.3. Financial calculation of additional remuneration paid for a family physician's effective work in preventing illnesses or monitoring chronically ill patients or their additional professional competence (Annex 3B)

2.3.4. Financial calculation of overtime outside business hours (Annex 3C)

2.3.5. Financial calculation of school health services (Annex 3D)

2.4. Instructions on the application of additional remuneration paid for effective work in preventing illnesses or monitoring chronically ill patients or additional professional competence (Annex 4)

2.5. List of family physicians with approved lists part of the make-up of a family physician's staff (Annex 5)

2.6. Provision of health care services to persons insured in another European Union Member State
(Annex 6)

2.7. Exchange of data between the Health Insurance Fund and a family physician (Annex 7)

2.8. Codes of activities within a capitation fee (Annex 8)

2.9. Guidelines on the electronic transmission of treatment invoice data (Annex 9)

2.10. Format of the electronic transmission of treatment invoices (Annex 10)

2.11. Application form for the funding of a second family nurse serving a family physician's list (Annex 11)

2.12. Application form for the funding of overtime outside business hours (Annex 12)

2.13. Terms of the funding of school health services (Annex 13)

2.14. Schools and the number of students for the provision of school health services (Annex 14)

2.15. Codes of activities within a capitation fee for school health services at schools for students with special educational needs (Annex 15)

2.16. School health services report form (Annex 16)

2.17. Guidelines on the completion of a school health services report (Annex 17)

2.18. Application of the quality management system (Annex 18)

The contract includes a list, available to the family physician via the national data exchange layer of information systems (X-road), of persons registered on the family physician's list by written application or designated to be on the list by the County Governor.

This contract is valid from ____ _____ 20___ until ____ _____ 20___.

This contract has been concluded electronically and signed digitally.

Annex 1

GENERAL TERMS OF A GENERAL MEDICAL CARE FUNDING CONTRACT

1. **General provisions**

1.1. A family physician provides a general medical care service (hereinafter: service), assuring the availability of general medical care agreed in legislation and the contract and its compliance with the quality requirements in case of persons who:

1.1.1. has been included on the list of the family physician specified in Annex 5 to the contract;

1.1.2. residing *or temporarily staying in their service area (emergency care*);

1.1.3. is insured in another European Union Member State (*service provided* in accordance with *Annex 6* to the contract).

1.2. The Health Insurance Fund assumes the obligation of paying for the services in accordance with the contract and the provisions of legislation if the person has been entered into the health insurance database and has valid insurance cover on the date of the commencement of treatment.

1.3. The Health Insurance Fund assumes the obligation of an insured person to pay for a service included on the "Estonian Health Insurance Fund's list of health services" (hereinafter: the *list of health services*) established by Regulation of the Government of the Republic under section 30 (1) of the Health Insurance Act and provided for medical purposes. Services are paid for on the basis of the price caps and application terms specified on the list of health services.

2. Provision of a service

2.1. When providing a service, the family physician undertakes to:

2.1.1. provide the insured persons specified *in clauses 1.1.1 and 1.1.3. of the contract* with the necessary services *and the persons specified in clause 1.1.2. of the contract with emergency care* during the entire term of the contract;

2.1.2. if necessary, refer the insured person to a health service provider with a treatment funding contract with the Health Insurance Fund for a consultation and/or treatment;

2.1.3. A family physician is not entitled to require an insured person to contribute payment for services included on the list of health services and provided for medical purposes in any other manner other than on the bases and terms specified *in section 6 of Chapter 3 of the Health Insurance Act*.

3. Provision of emergency care

3.1. The family physician will provide the insured person specified in clause 1.1.2. of the contract with *emergency* care if the insured person has come to need it whilst present in the service area of the family physician, without charging for the investigations or procedures factored into the capitation fee and without presenting an invoice to the insured person or the family physician on whose list the insured person has been included. The extent of emergency care is determined on every individual occasion by the family physician providing emergency care.

3.2. If in the provision of *emergency care* investigations, procedures or laboratory tests not factored into the capitation fee need to be performed due to the insured person's state of health, the family physician may not charge the insured person for them.

3.3. If the investigations and procedures specified in clause 3.2. are designated as services subject to additional remuneration in section 6 in the procedure (hereinafter: *procedure for the assumption of the obligation of paying remuneration*) established by Regulation of the Minister of Social Affairs under section 32 of the Health Insurance Act, the family physician presents an invoice for them directly to the Health Insurance Fund, doing so out of *the relevant own fund stipulated in Annex 2 to the contract*. The extent of necessary investigations and procedures is determined on every individual occasion by the family physician providing emergency care.

4. Terms of assuring the availability of service

4.1. To assure the availability of service, the family physician undertakes to:

4.1.1. assure the operation of the place of business of the family physician and the possibility of the registration of insured persons for reception on 5 days per week, for at least 8 hours per day;

4.1.2. organise the reception of insured persons:

4.1.2.1. on five business days per week, by a family physician for at least 4 hours per day, with at least 1 reception per week until 6 pm;

4.1.2.2. independent reception by a family nurse of at least 20 hours per week;

4.1.3. assure for insured persons the availability of general medical care on the terms provided for in the job description established by Regulation of the Minister of Social Affairs under section 8 (6^1) of the Health Services Organisation Act;

4.1.4. if necessary, extend reception times to assure the availability specified in clause 4.1.3. of the contract;

4.1.5. if necessary, provide receptions outside the business hours in accordance with the criteria laid down in section 3 (7) of the list of health services;

4.1.6. in accordance with legislation, organise preventive health checks of insured persons *18* or younger, make home visits if necessary, and advise insured persons on the list using means of communication;

4.1.7. notify the Health Insurance Fund immediately about any changes in the *reception hours* and location of the *family physician/s and family nurse/s* and about the resignation or hiring of a family nurse, providing the Health Insurance Fund with the *registration certificate number issued by the Health Board concerning the registration of the* nurse *or physician in the national register of health care professionals*;

4.1.8. consider the insured person included on their list from the first day of the calendar month following the month of the submission of the application at the latest;

4.1.9. hire a full-time family nurse or several family nurses whose working time in aggregate equals to at least one full-time workload;

4.1.10. hire another physician with medical qualifications but no list if the family physician's list includes *2001 or more persons and notify the Health Insurance Fund about it*;

4.1.11. post the following information visibly at both the family physician's place of business and on the family physician's website *or disclose it elsewhere online if there is no website:*

4.1.11.1. the names of the family physician, replacement physician, the physician specified in clause 4.1.10. and the family nurse and their reception times;

Terms of assuring the availability of service

4.1. To assure the availability of service, the family physician undertakes to:

4.1.1. assure the operation of the place of business of the family physician and the possibility of the registration of insured persons for reception on 5 days per week, for at least 8 hours per day;

4.1.2. organise the reception of insured persons:

4.1.2.1. on five business days per week, by a family physician for at least 4 hours per day, with at least 1 reception per week until 6 pm;

4.1.2.2. independent reception by a family nurse of at least 20 hours per week;

4.1.11.2. opening *hours, hours of reception, including overtime hours outside the business hours,* telephone number and e-mail address of the place of business;

4.1.11.3. information on the 1220 family physician advisory hotline of the Health Insurance Fund;

4.1.11.4. information about the list, price list and terms of provision for-fee services provided by the family physician.

4.1.11.5. Contact details for the Health Insurance Fund and the Health Board using which insured persons may submit suggestions, commendations or complaints to protect their rights.

4.2. The Health Insurance Fund publishes an address and a telephone number for the family physician's every *place of business* on its website *or elsewhere online*.

5. Terms of assuring the quality of services

5.1. A family physician undertakes to:

5.1.1. assure for the insured person the provision of services that conform to the general level of medicine, based on the principles of good clinical practices and the accepted or internationally recognised evidence-based standards of treatment and using investigation methods which preserve the patient's health best and are cost-efficient and for the provision of which the patient's consent has been received;

5.1.2. assure the provision of services by specialists with the required competence or refer the patient on for a specialised care consultation (using e-consultation if possible) or an investigation, first performing the necessary preliminary investigations and setting a clear objective for the referral in the letter of referral;

5.1.3. assure compliance with legislative requirements for the infrastructure needed for the provision of the service (equipment, apparatus and premises);

5.1.4. implement a quality management system agreed in the annex to the contract;

5.1.5. notify the patient (orally and/or in writing) about the nature and purpose of the service; the outcomes desired; the risks, side effects and consequences attending the provision of the service; other possible services or other significant support services and follow-up activities; the need for the patient's health behaviour in order to achieve the desired outcome; and any other legislative requirements;

5.1.6. provide patient consultation on health behaviour and/or living arrangements, including working conditions, for the achievement of the expected treatment outcome, recommend evidence-based activities to promote and prevent illness (including vaccination and undergoing screening), and document recommendations relevant to the patient's health;

5.1.7. in accordance with legislation, assure the documentation of services provided in a format enabling reproduction and use, including any deviations from treatment or performance standards, expected treatment outcomes, and identified complications;

5.1.8. transmit data and information about the provision of the service, on the terms and within the time limits provided for in legislation, to the Health Information System specified in Chapter 5^1 of the Health Services Organisation Act and to their databases in the national information system;

5.1.9 within 5 calendar days from the conclusion of the contract at the latest, conclude an interface contract with the Estonian e-Health Foundation (registry code 90009016) and transmit all the information and documents in accordance with the interface contract within the time limits established in accordance with Regulations of the Minister of Social Affairs under sections 59^2 (2) 1) and 2) and by Regulation of the Government of the Republic under section 59^1 (3) of the Health Services Organisation Act.

5.2. For the purposes of the development of service quality, the Health Insurance Fund:

5.2.1. in collaboration with the Guideline Advisory Board, supports the

development of clinical guidelines that match the Estonian circumstances and assures the availability of treatment guidelines, codes of practice and patient guidelines via www.ravijuhend.ee;

5.2.2. notifies family physicians in time about any activities to develop the health system and services;

5.3 The Health Insurance Fund is entitled to assess the quality of services provided, using for this the health insurance database or the data in the Health Information System, the data or documents (medical file, medical history or other documents required by legislation for proving the provision of a service) provided by the family physician, and commission clinical audits for the assessment of care quality and publish summaries of these.

5.4 When assessing the quality of services, the family physician:

5.4.1 during the entire contract period, provide the Health Insurance Fund or persons authorised by it with access to information or medical records (medical file or other documents required by legislation for proving the provision of a service) on services provided for insured persons. access is provided on the basis of a written application by the Health Insurance Fund setting out the purpose, a description of the information sought, the period of the use of the information and its users;

5.4.2. participates in discussions related to the above activities in case of conformity assessments (for example, checks of health insurance benefit documents or clinical audits) organised by the Health Insurance Fund, provides written feedback within 30 days from receiving an assessment report, and prepares and implements a plan of measures.

5.5. The Health Insurance Fund provides the family physician with the option of stating their opinion on the assessment criteria of the clinical audit and on the results of the conformity assessment and provides the family physician with feedback on the implementation of the plan of measures.

6. **Presentation of documents for the assumption of the obligation of paying remuneration**

6.1. The family physician presents the Health Insurance Fund *electronically* with *completed treatment invoices as at* the last day of the previous month by the 5th day of every month:

6.1.1. about investigations, procedures or activities performed for an insured person which are subject to remuneration out of the capitation fee in accordance with the procedure for the assumption of the obligation of paying remuneration;

6.1.2. for services subject to additional remuneration, specified in section 6 of the procedure for the assumption of the obligation of paying the remuneration. *Annex 2 to the contract lays down the terms for payment for the additional services specified in section 6;*

6.2. If the family physician does not perform the investigations, procedures or activities specified in clauses 6.1.1 to 6.1.3 themselves, the family physician will present the Health Insurance Fund with a treatment invoice after *the provider* of the said investigations, procedures or activities *has presented the family physician with a duly prepared invoice*.

6.3. On a treatment invoice, activities factored into the capitation fee are indicated with the codes listed in Annex 8 to this contract, “Codes of activities within a capitation fee”.

6.4. Treatment invoices have to meet the requirements established under the procedure for the assumption of the obligation of paying the remuneration specified in clause 3.3. The procedure for the numbering of treatment invoices is established by the family physician. The uniqueness of the series and number combination of a treatment invoice has to be assured for at least 3 calendar years.

6.5. The Health Insurance Fund assumes the obligation of paying for services provided for a traffic accident victim only if a treatment invoice is presented for them together with a copy of a reasoned decision by the Estonian Traffic Insurance Fund or the insurer refusing to pay, by the 5th day of the calendar month following the month in which a copy of the reasoned decision to refuse payment is received.

6.6. The Health Insurance Fund pays the family physician, into the bank account indicated in the contract, in advance the current month's basic funds, capitation fee and, *in instances provided for in the procedure for the assumption of the obligation of paying remuneration*, additional remuneration in accordance with the financial calculation of the family physician's services on the fifth day of the calendar month at the latest. The capitation fee is calculated on the basis of the number of insured persons included on the family physician's list on the 15th day of the month preceding the quarter.

6.7. *Annex 2 to the contract specifies the instances in which the family physician submits to the Health Insurance Fund an application for receiving additional remuneration and the procedure for the submission of an application and for the payment of additional remuneration.*

6.8. The Health Insurance Fund checks whether treatment invoices presented for services provided by the family physician to the insured person conform to the applicable requirements and pays accepted invoices by transfer into the bank account indicated in the contract within 20 calendar days from its receipt of the invoices.

7. **Electronic transmission of treatment invoices and other information**

7.1. A family physician provides the Health Insurance Fund with information via online processing over a data communication network through a secure online channel, adhering to the stipulated make-up, structure and transmission procedure of the data. *Information on certificates of incapacity for work are provided without delay but not later than on the business day following the date of the discharge.* Other information agreed in the contract and transmitted electronically are transmitted by the family physician on the terms and in accordance with the procedure agreed in the contract.

7.2. The instructions and formats for the transmission of data needed for the electronic exchange of data with the Health Insurance Fund have been published under the "Partnerile → IT lahendused" (For partners → IT solutions) menu on the Health Insurance Fund's website at http://www.haigekassa.ee/raviasutusele/toru/.

7.3. The Health Insurance Fund provides a continuous facility for the electronic transmission of treatment invoice data and other data agreed in the contract and remedies any faults due to the Health Insurance Fund within a reasonable period.

7.4. In the programme for the electronic transmission of treatment invoices (so-called) TORU), authentication is with an ID card.

7.5. A family physician complies with the provisions of the Personal Data Protection Act and the Public Information Act in the exchange of data. A family physician complies with the requirements of the security of information exchange and maintain the secrecy of the user IDs and passwords (if any) received from the Health Insurance Fund. If it is suspected that passwords have become known to unauthorised persons, the family physician is required to notify this to the Health Insurance Fund immediately.

7.6. A family physician notifies the Health Insurance Fund about the expiry of the authorisations provided for the transmission of treatment invoice information and seeks access privileges for the new authorised employee.

7.7. The parties assure that the files contain no malware.

7.8. The Health Insurance Fund is entitled to process treatment invoice information transmitted by the family physician electronically for the achievement of the objectives provided for by law and for the performance of functions provided for by law in accordance with clauses 11.2. and 11.3. of the contract.

7.9. The Health Insurance Fund assures the security of electronically transmitted treatment invoice data and the preservation of the secrecy of the sensitive and other personal data contained therein.

7.10. The family physician and the Health Insurance Fund are not responsible for any consequences resulting from disruptions to communication lines, power outages or the like if these are due to reasons beyond the control of the parties.

7.11. If treatment invoice information are transmitted to the Health Insurance Fund electronically by a third party using the access privileges granted for the family physician, the Health Insurance Fund will treat it as instructions issued by the family physician, and the Health Insurance Fund will not be liable for the spread of the information or any other consequences.

7.12. The Health Insurance Fund notifies the family physician about modifications introduced in treatment invoices or the electronic transmission of other data due to legislative amendments with an allowance to assure the transmission of data without disruption. The Health Insurance Fund notifies the family physician about any changes made on the initiative of the Health Insurance Fund at least two months before the changes are made.

8. **Refusal to assume the obligation of paying remuneration**

8.1. The Health Insurance Fund refuses to assume the obligation of paying remuneration for a service provided by the family physician to the insured person or requires indemnification of loss or damage incurred by the Health Insurance Fund if:

8.1.1. a service has not been actually provided or has been provided without basis or there was no indication for the provision of the service or the provision of the service has not been agreed in the contract;

8.1.2. the service has been provided below the general level of medicine *within the meaning of clause 5.1.1. of the contract*.

8.1.3. provision of the service has breached the rights of the insured person or the information specified in clause 9.1. about the physician who has provided the service and prepared a treatment invoice is missing;

8.1.4. a family physician, aware of a traffic accident, has not provided the Health Insurance Fund with the information of the victim of the accident in accordance with the procedure and by the deadline established in the Regulation of the Government of the Republic "Procedure for the notification of a traffic accident, ascertainment of its circumstances, and its formalisation, registration and record-keeping" under section 171 (2) of the Traffic Act;

8.1.5. the family physician does not provide the Health Insurance Fund, at the Fund's request, with treatment documents (medical files or other) on the provision of a service or other documents stipulated in legislation that prove the provision of a service, or these have not been duly prepared;

8.1.6. in providing a service, the family physician has breached the terms laid down in the Health Insurance Act, Health Services Organisation Act or other legislation or agreed in the contract;

8.2. The Health Insurance Fund notifies its refusal to assume the obligation of paying remuneration to the family physician within 20 calendar days from its receipt of duly submitted documents at the latest.

9. **Health care professionals in case of whom the Health Insurance Fund assumes the obligation of paying for the services provided by them**

9.1. Health care professionals working for a family physician have to have been registered in the national register of health care professionals. A family physician is required to notify any changes in the make-up of their health care professionals to the Health Board in accordance with section 30 (2) of the General Part of the Economic Activities Code Act.

10. **Ascertaining the validity of the insurance cover of the insured person**

10.1. When commencing treatment or issuing a certificate of incapacity for work or a concession medicine prescription, a family physician checks the validity of the insurance cover of

the insured person in the health insurance database at https://meri.haigekassa.ee/register/soodustus.php or at https://ookean.haigekassa.ee/register/soodustus.php. The Health Insurance Fund is responsible for the accuracy of the data in the health insurance database.

10.2. In order to obtain the privileges for querying the health insurance database to check the validity of insurance cover, the family physician submits a formal application as published at the website specified in clause 7 of the contract to the Health Insurance Fund via the website of the Health Insurance Fund.

10.3. The Health Insurance Fund issues the family physician with user IDs and passwords within five calendar days from its receipt of an application at the latest.

10.4. In the event of a failure during a query of the database, the family physician checks the validity of the person's insurance cover using the other address specified in clause 10.1. If the validity of insurance cover cannot be checked at this address either, the family physician will check the validity of the person's insurance cover over the telephone. If it is not possible to obtain information over the telephone (on weekends or outside the business hours of the Health Insurance Fund), the family physician attaches to the treatment invoice a printout proving the performance of a query in the health insurance database. In the event of the failure of a query of the health insurance database due to the Health Insurance Fund, the Health Insurance Fund will pay the family physician's treatment invoice or forgo the collection of the cost of a concession prescription if the occurrence of the failure has been proven.

11. **Assurance of confidentiality**

11.1. The family physician and the Health Insurance Fund assure the confidentiality of personal data, including sensitive personal data, processed in relation to insured persons in order to prevent the illegal or abnormal use of the data.

11.2. The family physician and the Health Insurance Fund shall undertake to keep confidential and not disclose to any third parties any information which has become known either during the performance of contractual obligations, except in instances provided for by law.

11.3. The family physician and the Health Insurance Fund assure that the personal data processed in relation to an insured person are not used for any purposes other than those provided for by law.

11.4. The family physician and the Health Insurance Fund implement organisational and technical measures to protect processed personal data against accidental or premeditated tampering or destruction, including unauthorised processing.

11.5. If the family physician or the Health Insurance Fund does not comply with the requirements, they will be liable for the breach in accordance with the legislation.

12. Submission of information

12.1. The Health Insurance Fund provides the family physician with:

12.1.1. a summary of the concession medicines prescribed by them;

12.1.2. a summary of the investigations and procedures specified by them;

12.1.3. a summary of the certificates of incapacity for work issued by them;

12.1.4. an overview of whether insured persons in the target group on the family physician's list are covered by the indicators of the quality system;

12.1.5. information about insured persons on the family physician's list who are in the target group for screening in a given calendar year and information about insured persons on the family physician's list who have not undergone the said screening in that calendar year.

12.1.6. age make-up of family physicians' lists.

12.2. The timing and manner of the transmission of the information stipulated in clause 12.1. are agreed in Annex 7 to the contract.

12.3. The family physician provides the Health Insurance Fund with the data of new insured persons included on the family physician's list within five business days but not later than by the last day of every month, through the data exchange layer of information systems (hereinafter: X-road). Insured persons whose information has not been received by the Health Insurance Fund within the above time limit are included on the family physician's list from the date of the receipt of the information by the Health Insurance Fund.

12.3.1. The Health Insurance Fund has to be provided with the following information about insured persons:

12.3.1.1. personal identification code;

12.3.1.2. date of the submission of the application.

12.4. Once per quarter, the family physician checks via X-road whether the family physician's database corresponds to the Health Insurance Fund's database of persons with health insurance introduces any relevant changes into the database. The Health Insurance Fund makes the make-up of data on the family physician's list available to the family physician via X-road.

12.5. A family physician preserves insured persons' applications for registration on the family physician's list for the period stipulated in the Regulation of the Minister of Social Affairs "Bases and procedure for the assembly, modification and comparison of the list of a family physician, and the quota for family physician lists" enacted under section 8 (4^{6}*) of the Health Services Organisation Act.*

13. Indemnification of loss or damage and liability in the event of a breach of the contract

13.1. The family physician indemnifies the Health Insurance Fund when a claim for the indemnification of loss or damage is presented:

13.1.1. the amount of benefits paid on the basis of a certificate of incapacity for work lasting over 120 calendar days (over 178 calendar days in case of tuberculosis), if the family physician has not presented the insured person's documents to the Estonian National Social Insurance Board on time;

13.1.2. the cost of a service provided below the general level of medicine *within the meaning of clause 5.1.1. of the contract* and the cost of the treatment of a complication developed *by an insured person as a result of this service*;

13.1.3. funds received as a result of the performance of the obligation of paying remuneration assumed by the Health Insurance Fund without basis;

13.1.4. an amount paid incorrectly or without basis by the Health Insurance Fund to a pharmacy or any other party contracted by the Health Insurance Fund on the basis of a concession medicine prescription issued or medical device card prescribed incorrectly or without basis by a health care professional providing a health service with a family physician;

13.1.5. the amount of benefits for temporary incapacity for work disbursed incorrectly or without basis on the basis of a certificate of incapacity for work issued incorrectly or without basis by a health care professional providing services with a family physician;

13.1.6. amounts disbursed by the Health Insurance Fund on the basis of a treatment invoice, concession prescription, *medical device card* or certificate of incapacity for work for the justification of which the family physician refuses *to provide documents proving the provision of health services or concerning which incomplete documents have been transmitted to the Health Information System specified in Chapter 5*^{1} *of the Health Services Organisation Act or concerning which the necessary documents are missing*

13.2. In instances specified in clause 13.1., the Health Insurance Fund is entitled to present the family physician with a claim for the indemnification of loss or damage in relation to an amount disbursed incorrectly or without basis and to withhold the amount from disbursements during the following periods if the family physician has not presented reasoned objections to the claim within the time limit indicated in the statement of claim.

13.3. A family physician pays the Health Insurance Fund a contractual penalty of up to *400 (four hundred)* euros in the following instances:

13.3.1. for the reasons specified in clause 13.1;

13.3.2. if the family physician has without basis and illegally omitted to provide a service to the insured person on the terms and within the time limits agreed in the contract;

13.3.3. if the family physician is unable to provide the agreed service for reasons due to the family physician. Reasons due to a family physician may include the absence of the equipment stipulated in the job description of a family physician or of necessary staff, or other circumstances preventing the performance of the contract;

13.3.4. in the event of the repeated breaches of the Health Insurance Act, Health Services Organisation Act, Medicinal Products Act or legislation enacted thereunder or the terms agreed in the contract or annexes thereto *if the breach has occurred in the course of the provision of a service to an insured person, for which the obligation of payment has been assumed by the Health Insurance Fund, or if material loss or damage has been caused for the insured person or the Health Insurance Fund by the breach*;

13.3.5. if the family physician has issued the Health Insurance Fund repeatedly with incorrect or misleading information about the insured person's state of health; services needed; prevention, examination or treatment methods used; and other significant circumstances;

13.4. In the event of delay in the payment of invoices, the Health Insurance Fund pays late interest of 0.05% of the amount of the outstanding invoice for every day of delay but not more *400 (four hundred) euros* than in total.

13.5. The Health Insurance Fund indemnifies the loss or damage incurred by the family physician as a result of the loss of documents (medical file or other) proving the provision of a health service and taken from the family physician for checks.

13.6. The Health Insurance Fund pays the family physician a contractual penalty of up to *400 (four hundred)* euros in the following instances:

13.6.1. for the reasons specified in clause 13.5;

13.6.2. In the event of an unjustified refusal to assume the obligation of paying remuneration for a service provided for an insured person by a family physician.

13.7. Payment of a contractual penalty will release the party in breach of the contract from the performance of the obligations breached by it or from its obligation to remedy the consequences of a breach of the contract or annexes thereto. Payment of a contractual penalty will not deprive the other party of its entitlement to cancel the contract because of a breach. The party in breach of the contract undertakes to indemnify the other party for any loss or damage resulting from the breach of the contract, in addition to paying a contractual penalty.

13.8. A party forfeits its entitlement to claim a contractual penalty if it does not notify the party in breach of its obligation about its intent to present a contractual penalty within 30 calendar days from the identification of the breach providing entitlement for the presentation of a contractual penalty claim. A party does not have to indicate the amount of the contractual penalty claimed by it. A notice is considered as provided on time also if a party notifies the other party about a breach of the contract during the term and states that it is reserving the right to claim a contractual penalty as a result of a breach of the contract.

13.9. If the party in breach of the obligation is or must be aware of the breach of the obligation, the time limit specified in clause 13.8 will not begin to run until the party in breach of the obligation has notified the other party about the breach of the contract in writing.

14. Other terms for the efficient and rational use of health insurance funds

14.1. The Health Insurance Fund is entitled to check the justification for and correctness of the services provided and of the certificates of incapacity for work, concession prescriptions and medical device cards issued in the 3 calendar years preceding the year of the conclusion of the

contract and from the conclusion of the contract by the family physician and to present the Health Insurance Fund with a claim for the indemnification of loss or damage caused.

14.2. The Health Insurance Fund is entitled to require the family physician to present the documents specified in clause 14.1. and, if necessary, provide the documents or copies thereof to be taken along for provision to the Health Insurance Fund for up to seven calendar days, assuming the responsibility for the preservation of the confidentiality of the information in the documents and of the documents. a list is prepared concerning the documents brought along and is signed by the family physician and the employee of the Health Insurance Fund;

14.3. The timing of the checks specified in clause 14.1. is agreed with the family physician by the Health Insurance Fund 14 days before the checks are begun.

14.4. in the event of a written complaint submitted to the Health Insurance Fund about the actions of the family physician, to check the circumstances related to the prescription of treatment or certificates of incapacity for work for insured persons, the family physician provides the Health Insurance Fund with documents within the following business day at the latest;

14.5. The parties to the contract are prohibited from transferring their rights or obligations under the contract to third parties without the written consent of the other party.

15. Amendment, suspension and termination of the contract

15.1. Any amendment to the contract is by written agreement between the parties.

15.2. The Health Insurance Fund and the family physician are obliged to seek amendment of the terms of the contract for the purposes of the rational and efficient use of the funds, allowing for the changes in the organisation of work or in the quality of the service created by merger, division or transformation of the family physicians.

15.3. If the family physician forfeits the legal basis for the provision of services, the Health Insurance Fund will be entitled to cancel the contract by giving a reasonable period of notice.

15.4. The Health Insurance Fund suspends the performance of the contract if the family physician does not begin to provide the services agreed in the contract within 30 calendar days from the conclusion of the contract at the latest. If the family physician does not begin to provide a service also after receiving a relevant written notice from the Health Insurance Fund, the Health Insurance Fund may withdraw from the contract.

15.5. In addition to the bases provided for by law, for the purposes of the contract a material breach of the contract is considered to be any repeated breach of an obligation specified in any clause of the contract during the term of the contract as well as a breach of any obligation under the contract which the family physician does not end or the consequences of which the family physician does not remedy within the designated time limit.

15.6. A written notice together with a statement of grounds for the suspension of the contract is sent to the other party at least 30 calendar days before the contract is suspended.

15.7. In the event of the cancellation of the contract, the other party will be sent a notice of cancellation at least 60 calendar days in advance.

15.8. The parties to the contract will be released from liability for the partial or complete non-performance of the contract if the non-performance of the contract is due to force majeure which arose after the conclusion of the contract as a result of extraordinary events and which the parties could not have foreseen or avoided by their reasonable efforts. Force majeure is the occurrence of events that the parties cannot influence and for which they are not responsible.

15.9. If a partial or complete failure to perform contractual obligations is due to force majeure, the time limit for the performance of the obligations will be considered to have been extended by the period of the occurrence of the obstacle.

15.10. Either party has to notify the other party immediately in writing about both force majeure and cessation thereof. Provisions on force majeure do not apply to a period during which a party knew about the existence or cessation of force majeure but omitted to notify this circumstances to the other party.

15.11. If performance of the contractual obligations proves to be impossible due to the aforementioned reasons for more than ninety (90) calendar days, the Parties shall have the right to cancel the contract by providing written notification to the other Party, without either Party to the contract having the right to request from the other Party for compensation of the damages arising from such decision.

The Health Insurance Fund assumes @@@ the obligation of paying remuneration for the service provided to the insured person by the health care professional.

9.3. A family physician assures that persons providing health services on the family physician's behalf handle concession medicine forms in accordance with the applicable procedure and prevent them from coming into the possession of persons not entitled to issue prescriptions.

Annex 2
Estonian Health Insurance Fund Management Board
Decision No. 499 of 2 December 2015

Additional terms of a general medical care funding contract

1. The services specified in section 6 in the procedure (hereinafter: *procedure for the assumption of the obligation of paying remuneration*) established by Regulation of the Minister of Social Affairs under section 32 of the Health Insurance Act and subject to additional remuneration are paid for as follows:

1.1. services listed in section 6 (1) subject to additional remuneration out of the investigation fund, allowing for the financial limit established in the same section;

1.2. services listed in section 6 (5) subject to additional remuneration out of the operating fund;

1.3. services listed in sections 6 (3), (4) *and (4¹)*, including the transportation of a deceased person to a pathoanatomical autopsy on the basis of a letter of referral from a family physician and the pathoanatomical investigations performed and the investigations needed for performing these and e-consultations performed by specialist physicians specified on the list of health services via the Health Information System (tervise infosüsteem, TIS) specified in Chapter 5[1] of the Health Services Organisation Act *and faeces investigations performed as part of colon screening.*[1]

1.4. services listed in section 6 (7) subject to additional remuneration out of therapeutic treatment fund, allowing for the financial limit established in the same section;

1.5. If the limit specified in clauses 1.1 and 1.4 is exceeded, services will be paid for on the terms listed in section 2 of the procedure for the assumption of the obligation of paying remuneration.

2. Procedure for the submission of an application by the family physician to the Health Insurance Fund to receive additional remuneration and for the payment of additional remuneration.

2.1. In order to receive additional remuneration marked with the code 3059, the family physician presents the Health Insurance Fund with an application in accordance with Annex 11 to the contract by the 10th day of the month preceding the receipt of remuneration at the latest. Remuneration marked with the code 3059 is paid if the family physician has met the terms of service established under the list of health services.

2.2. In order to receive additional remuneration marked with the codes 3067 and 3068, the family physician presents the Health Insurance Fund with an application to provide a service in accordance with Annex 12 to the contract by the 10th day of the month preceding the provision of the service at the latest. Based on an application, a quarterly remuneration-related Annex 3C is prepared to determine the maximum scope of service provision per quarter.

To receive additional remuneration, the family physician quarterly submits to the Health Insurance Fund a separate invoice with treatment type 17 for the retroactive funding of overtime, based on the number of overtime hours completed in the previous quarter. On an invoice presented, the number of overtime hours may not exceed the maximum number of overtime hours per quarter as indicated in Financial Annex 3C. An outstanding remainder of overtime cannot be transferred to the following quarter. Remuneration is paid under codes 3067 and 3068 if the family physician has met the terms of service established under the list of health services.

[1] *Faecal investigations performed as part of colon cancer screening are funded out of @@@ subject to additional remuneration*

Annex 4
Approved by Estonian Health Insurance Fund Management Board
Decision No. 499 of 2 December 2015

Instructions on the application of additional remuneration paid for effective work in preventing illnesses or monitoring chronically ill patients or additional professional competence

Objective:

1) encourage family physicians to actively engage in the prevention of illnesses to avoid subsequent high costs in relation to the treatment of those illnesses or people's premature incapacitation for work, invalidity or death.

2) prevention of the spread of infectious diseases in case of which it is important to achieve and maintain a certain level of vaccination.

3) in case of chronic illnesses, assure more effective monitoring of the illnesses to prevent the development of complications.

4) incentivise family physicians to provide insured persons with a more broad-based health service.

For the payment of additional remuneration to a family physician working with an approved list for the work of preventing illnesses or monitoring chronically ill patients or their additional professional competence, the following is assessed:

1) family physician's activity in preventing illness;
2) family physician's activity in monitoring chronically ill patients;
3) family physician's additional professional competence.

Definitions:
*Indicator – designation of a test, investigation, procedure or activity in the Regulation of the Minister of Social Affairs "Procedure for the assumption by the Estonian Health Insurance Fund of the insured person's obligation of paying remuneration and the methodology for the calculation of remuneration paid to the provider of a health service" (hereinafter: *procedure for the assumption of paying remuneration from the insured person*);
*Code – code indicated on a list of health services, in the procedure for the assumption of paying remuneration from the insured person or in a general medical care funding contract;
*Coverage – proportion of those covered in the target group for the relevant indicator;
*Points, coefficients – estimated unit for the assessment of the achievement of an indicator.

I Family physician's activity in preventing illness
Children

1. In the additional remuneration system, family physician activity codes beginning with 9 – agreed in this Annex and the Annex 'Codes of activities within a capitation fee' to the general medical care funding contract – have been introduced for record-keeping.

2. In case of children's vaccinations, a code referring to the relevant indicator is entered on a treatment invoice (if a code has additional notations, such as a, b, c or d, these are also always indicated), and a diagnosis code from section Z of RHK-10 is used (subsection corresponding to the vaccine). Vaccinations are performed in accordance with the national immunisation plan.

3. The target group for the examination of children and for the general health check of young children includes children who have turned 3 in the previous calendar year. A 3-year-

old child is considered to be covered if a family physician has performed on the child all the health checks as stipulated for the age group in the job descriptions of the family physician and of the health care professionals working with the family physician.

4. The vaccination target group includes children who have turned 3 in the previous calendar year. A 3-year-old child is considered to be covered if a family physician has performed on the child all the vaccinations under the national immunisation schedule in the previous three years.

5. If a preventive examination preceding vaccination reveals a medical condition, coding will be as follows:

5.1. if the medical condition does not prevent vaccination, the treatment invoice is marked with the code beginning with 9 referring to the relevant indicator (i.e. vaccination) and the diagnosis and code of the detected illness under RHK-10 and also the RHK-10 diagnosis code of the relevant vaccination.

5.2. if the detected medical condition prevents vaccination, the reception code 9001 and the diagnosis code under RHK-10 for the detected illness are indicated.

6. A parent's refusal of the vaccination of a child is formalised with a written statement from the parent, the code beginning with 9 for the relevant vaccination is entered on the treatment invoice with the additional notation 'v' and the RHK-10 diagnosis code Z28 together with the relevant supplementation (e.g.: Z28.2 "outstanding immunisation due to the patient's decision for other or unspecified reasons").

7. If there is a medical contraindication with respect to vaccination, the code beginning with 9 for the relevant vaccination is entered on the treatment invoice with the additional notation 'v' and the RHK-10 diagnosis code Z28.0 'outstanding immunisation due to a contraindication'.

8. The provision of the first vaccination of newborns against hepatitis B (if the provider is not the family physician) at a maternity hospital or other medical institution should be checked by the family physician, who should enter on the treatment invoice the relevant code beginning with 9 (with the additional indication a) corresponding to the indicator.

9. The code indicating the relevant activity is entered on the treatment invoice only if vaccination is done by the family physician (or their substitute) whose list includes the child, the only exception being the first vaccination against hepatitis B (see the preceding clause), and vaccinations done elsewhere are not taken into account @@@ vaccination, since the target group then includes children born in 2015, who have to have been vaccinated against the rotavirus.

The Estonian Health Insurance Fund notifies family physicians about persons on their lists who are in the target group for ***colon,*** **cervical and breast cancer screening** in order to enable family physicians to provide advice or refer for investigations.

II Family physician's activity in monitoring chronically ill patients

Procedure for documentation and for entering codes on invoices

1.1. A family physician has to monitor a hypertension patient's blood pressure values as needed but at least once a year and document the values in a format enabling subsequent periodic monitoring (in the defined data field in accordance with the out-patient epicrisis standard but not in the free text / objective finding section).

2. Presentation of a list of chronically ill patients

2.1. The Estonian Health Insurance Fund provides a family physician with lists of chronically ill patients as at 1 January via an electronic channel by **20 February** of the calendar year at the latest. For the purposes of these guidelines, a chronically ill patient is considered to

be a person who has had a diagnosis of the relevant illness in the family physicians' treatment invoice database of the Health Insurance Fund at least once in the past three years.

2.2. Positive microalbuminuria test results with the code 9041, glycated haemoglobins with values over (or equal to) 7.0% with the code 9050 and hypertension severity grades are taken from treatment invoices automatically.

2.2.1. If a person has a hypertension diagnosis on treatment invoices from the past three years but the degree of its severity has not been indicated, the person will be considered to have severity grade I in the records of the family physicians' quality system.

2.2.2. If a person has had several different severity grades in the past three years, the highest severity grade will be considered valid.

3. Procedure for entering codes on invoices

3.1. If a patient has a total cholesterol value over 5.0 mmol/l, the invoice is always marked with the code **9040** regardless of the patient's illness or condition.

3.2. If a patient tests positive for microalbuminuria, the invoice is marked with the code **9041**. Once a microalbuminuria test has come back positive, it does not have to be repeated.

3.3. If a Type II diabetes patient has a glycated haemoglobin test result over (or equal to) 7.0%, the invoice is always marked with the code **9050**.

3.4. A family physician has to always indicate on treatment invoices the relevant illness code under RHK-10 when chronically ill patients undergo tests or investigations.

3.5. A code marking the relevant indicator is entered on a treatment invoice only in instances where the activity is performed by the family physician (or their substitute) whose list includes the person. Analysis performed at another health care institution in the past 12 months will be included in the calculation of results for the quality system if the result of the analysis is documented in the family physician's medical file (preferably with a copy of the result of the analysis attached), and the family physician enters the relevant additional code beginning with 9 on the treatment invoice. The date of the test indicated by the family physician is the date on which the family physician assesses the result of the patient's test.

4. Procedure for grouping hypertension patients by severity grade

4.1. From 2009, hypertension patients have to be grouped by Levels 1, 2 and 3. When hypertension patients are monitored, in addition to blood pressure values also cardiovascular risk has to be taken into account for the purposes of patient treatment (Tables 2 and 3). Depending on the patient's risk level, treatment and monitoring vary in intensity[1]:

4.1.1. In the system of additional remuneration for a family physician, hypertension patients subject to various additional risk are allocated to 3 groups. Patients subject to regular risk are not involved in the completion of indicators in the additional remuneration system.

4.1.2. To assess organ damage, it is not necessary to perform additional tests or investigations but rather there are used results from investigations performed for the diagnosis or monitoring of an illness or as clinically indicated.

4.2. In case of hypertension patients (diagnosis I10-I15 under RHK-10), a **treatment invoice always** indicates **risk level numbers 1, 2, 3** (see Table 4) regardless of whether hypertension is the main or concomitant diagnosis:

Table 4. Classification of hypertension patients on treatment invoices:

1 Hypertension I Low risk
2 Hypertension II Moderate additional risk
3 Hypertension III High or very high (that is, extremely high) additional risk

5. Monitoring of chronically ill patients

5.1. Chronically ill patients are monitored in accordance with the clinical guidelines.

5.2. In the additional remuneration system, performance of an investigation at the frequency indicated in the table below is included in the calculation.

III Family physician's additional professional competence

1. In terms of a family physician's additional professional competence, activity is taken into account for its actual provider, that is, its acceptance is physician- not patient-centred.

2. Acceptance of the professional competence of a family physician or family nurse (indicator "Additional professional competence"):

2.1. A family physician is considered to have achieved the indicator if they have valid certification for the entire reference year, concerning which information is provided for the Health Insurance Fund by the Health Board by 31 March at the latest.

2.2. A family nurse is considered to have achieved an indicator if they have a valid assessed rating for the entire reference year, concerning which information is provided for the Health Insurance Fund by the Estonian Nurses Association (Pereõdede Seltsing) by 31 March at the latest. *Also nurses who have received professional certificates and have been registered in the register of health care professionals in the past five years are considered competent.* In the event that several family nurses are working with a family physician, their total working hours amounting to the full-time workload of one family nurse, the indicator will be considered as achieved if all these family nurses have valid certifications for the entire reference year.

2.3. The Estonian Nurses Association and the Health Board provide the Health Insurance Fund with the information specified in clauses 2.1. and 2.2. in the form of Excel tables, specifying the names of both family physicians and family nurses, their registration codes at the Health Board and whether they have ratings as at 31 December in the reference year.

3. In case of a gynaecological investigation (activity codes 66807, 66809 and 66811), if performed for the detection of a malignant tumour in a person with no complaints (prevention), the RHK-10 diagnosis Z12.4 "special screening for the detection of a cervical tumour" is used for coding.

IV Assessment of the quality of a health service provider

1. Health service providers who have general medical care funding contracts with the Health Insurance Fund are assessed.

2. Quality assessment of a health service provider is carried out by MTÜ Eesti Perearstide Selts.

2.1. The Estonian Society of family physicians provides the Health Insurance Fund with information on assessment results in the form of Excel tables by 31 March at the latest, specifying the service provider's name, commercial registry code, level and the date of the formalisation of the assessment.

3. A service provider is assessed to be of high quality if it has been assessed to meet Level A as a result of quality assessments by the Estonian Society of family physicians as at 31 December.

V Calculation of results and remuneration under the additional remuneration system

1. Results for 2016 are calculated on the basis of a family physician's list as at 1 January 2017.

2. Results are calculated for members on the list in 2012, 2013, 2014, 2015 and 2016 in accordance with the regulation and these application guidelines based on health services provided and based on the database of the Digital Prescription Centre.

3. Family physicians in the additional remuneration system in 2016 have to have met the additional remuneration criteria in accordance with the established coverage.

4. The Health Insurance Fund pays a family physician additional remuneration for the prevention of illness and the monitoring of chronically ill patients (service marked with the code 3061 *or 3069* on the list of health services) if the minimum required estimated points have been achieved.

4^1. The Health Insurance Fund pays a family physician additional remuneration for the prevention of illness and the monitoring of chronically ill patients (service marked with the code 3069 on the list of health services) if the minimum required estimated points have been achieved for seeking additional remuneration and the Health Insurance Fund has paid the family physician additional remuneration for a service marked with the code 3059 for 12 months during the reference year.

5. For a family physician whose list includes patients with the relevant chronic illness two times more than the Estonian average, points for the relevant chronic illness are calculated at a coefficient of 1.5 but not above the price cap of the above health service.

6. Calculation of results:

6.1. A family physician working with an approved list is paid remuneration at a coefficient of 0.8 of the price cap marked with the code 3061 or 3069 on the list of health services if at least 80% (512 points) in total of the criteria for effective work in preventing chronic illnesses and of the criteria for effective work in preventing chronic illnesses has been achieved.

6.2. A family physician working with an approved list is paid remuneration at a coefficient of 1.0 of the price cap marked with the code 3061 or 3069 on the list of health services if the family physician has achieved at least 90% (576 points) in total of the criteria for effective work in preventing chronic illnesses and of the criteria for effective work in preventing chronic illnesses.

7. If a family physician working with an approved list has met the conditions laid down in clause 6.1 or 6.2 of these guidelines, their additional professional competence will be assessed and service coefficients marked with the code 3062 will be determined. When additional professional competence is assessed, coefficients for achieved criteria are added up.

8. A health service provider is paid additional remuneration for quality, code 3050, if at least 60% of family physicians operating through the health service provider have met the terms laid down in clause 6.1 or 6.2.

9. Remuneration 3050 is paid to a health service provider with a general medical care funding contract for up to six lists. The link of a health service provider to a list will be considered as at 1 January 2017.

10. The Health Insurance Fund assesses the activities of a family physician working with a list approved on the basis of invoices presented by the family physician and the database of the Digital Prescription Centre and approves the results of the assessment by 1 July of the calendar year at the latest.

11. All the names of family physicians together with the score achieved by them for activities under the quality system and the price cap coefficients of the services designated by the codes 3061, 3069, 3062 *and 3050* assigned to them are published on the website of the Health Insurance Fund by 1 July. Health Insurance Fund:

Annex 8

Approved by Estonian Health Insurance
Fund Management Board
Decision No. 177 of 5 May 2016

Codes of activities within a capitation fee

CODE and ACTIVITY

9001 First reception by the family physician
9002 Repeat reception by the family physician
9003 Preventive reception by the family physician
9004 Repeat visit by the family physician
9016 Scheduled reception by the family physician of uninsured persons
9018 Consultation provided by the family physician over the telephone and documented in the patient's medical file
9019 Consultation provided by the family physician via e-mail and documented in the patient's medical file
9061 Consultative reception by the family nurse
9062 Nursing operation by the family nurse (manual activity)
9063 Repeat visit by the family nurse
9064 Consultation provided by the family nurse over the telephone and documented in the patient's medical file
9065 Consultation provided by the family nurse via e-mail and documented in the patient's medical file
9020(a,b,c,d) Vaccination against whooping cough
9020v Refusal of or medical contraindication in relation to the vaccination against whooping cough
9021(a,b,c,d) Vaccination against diphtheria
9021v Refusal of or medical contraindication in relation to the vaccination against diphtheria
9022(a,b,c,d) Vaccination against tetanus
9022v Refusal of or medical contraindication in relation to the vaccination against tetanus
9023(a,b,c,d) Vaccination against poliomyelitis
9023v Refusal of or medical contraindication in relation to the vaccination against poliomyelitis
9024 Vaccination against measles
9024v Refusal of or medical contraindication in relation to the vaccination against measles
9025 Vaccination against mumps
9025v Refusal of or medical contraindication in relation to the vaccination against mumps
9026 Vaccination against rubella
9026v Refusal of or medical contraindication in relation to the vaccination against rubella
9027(a,b,c,) Vaccination against hepatitis B
9027v Refusal of or medical contraindication in relation to the vaccination against hepatitis B
9028(a,b,c,d) Vaccination against Haemophilus influenza Type b
9028v Refusal of or medical contraindication in relation to the vaccination against Haemophilus influenza Type b
9029 (a,b,c) Vaccination against rotavirus infection
2
9029v Refusal of or medical contraindication in relation to the vaccination against rotavirus
9030 Examination for admission to an educational institution (children aged 6, 7 and 8)
9031 Preventive examination of children, 1st month of age
9032 Preventive examination of children, 3rd month of age
9033 Preventive examination of children, 12th month of age

9034 Preventive examination of children, 2 years of age
9035 Preventive examination of children, Year 2
9036 Preventive examination of children, Year 5
9037 Preventive examination of children, Year 9
9038 Consultation about screening for colon cancer*
9039 Faecal occult blood test kit*
9040 Total cholesterol level in blood over 5.0 mmol/l
9041 Microalbuminuria test positive
9042 Determined triglycerides.
9047 Bowel cleansing preparation**
*9048 Refusal of screening for colon cancer***
9050 Glycated haemoglobin over (or equal to) 7.0%
9060 SCORE risk over 5%
9101 Glucose test performed elsewhere at the health care institution and documented in the family physician's medical file
9102 Creatinine test performed elsewhere at the health care institution and documented in the family physician's medical file
9104 Total cholesterol test performed elsewhere at the health care institution and documented in the family physician's medical file
9105 Test of cholesterol fractions performed elsewhere at the health care institution and documented in the family physician's medical file
9117 Microalbuminuria test performed elsewhere at the health care institution and documented in the family physician's medical file
9118 Glycated haemoglobin test performed elsewhere at the health care institution and documented in the family physician's medical file
9320 Electrocardiography investigation performed elsewhere at the health care institution and documented in the family physician's medical file
9706 TSH test performed elsewhere at the health care institution and documented in the family physician's medical file
* *Effective from 1 July 2016*

Annex 18

Approved
to Estonian Health Insurance Fund Management Board
Decision No. 499 of 2 December 2015

Application of the quality management system

1. In accordance with clause 5.1.4. in Annex 1 to the general medical care funding contract (hereinafter: *general terms*), the family physician and the Health Insurance Fund agree on the family physician's quality management system as set out below.

2. A family physician undertakes to:

2.1. as part of the quality management system, introduce codes of practice and documentation forms and adhere to the performance standards (family physicians' quality system, clinical indicators etc.), together with a mechanism of regular checks and analysis, on the basis of the Regulation of the Minister of Social Affairs, "Quality assurance requirements for health services" enacted under section 56 (1) 7) of the Health Services Organisation Act;

2.2. regularly measure the conformity of the service provision process and results to the standards and instructions specified in clause 5.1.1. of the general terms of the general medical care funding contract and in clause 2.1. of this Annex, including the occurrence of any deviations or complications and the satisfaction of patients, using, among other things, the methods developed in collaboration with the Faculty of Medicine of the University of Tartu and published on the website of the Faculty, on the website of the Health Insurance Fund and/or on the website ravijuhend.ee.;

2.3. organise and participate in the assessment of the service provision process and results by internal and/or external experts (in particular, clinical audits, *peer review* and/or based on standardised report indicators) and, on the basis of the assessments, prepare a plan of measures for the family physician's activities, setting out the corrective measures, expected outcome, time limit and responsible person;

2.4. based on the Regulation of the Minister of Social Affairs enacted under section 56 (1) 7), disclose the requirements for assuring the quality of health services, the results of the analysis of patient satisfaction and a summary of activities related to the measurement and assessment of quality at the place of business and on the website (if any) of the family physician;

2.5. to a reasonable extent, make it possible for health care professionals contracted by a family physician in terms of the organisation of work to participate in the activities of the development of the health system and health services organised by the Health Insurance Fund (such as the preparation of clinical guidelines, updating of the list of health services or clinical audits) and the performance of related tasks.

3. On compliance with clauses 2.1., 2.3. and 2.4, the family physician is guided by the quality manual developed for general medical practices by the Estonian Society of family physicians[1], which is being reviewed in 2016 in collaboration with the Health Insurance Fund and will be updated at five-year intervals subsequently.

[1] QUALITY GUIDE FOR ESTONIAN FAMILY PRACTITIONERS [WWW] https://www.perearstiselts.ee/images/PAK%20kvaliteedijuhis/Eesti%20Perearstipraksiste%20Kvaliteedijuhis.pdf