Residential Care Initiative – January 2018

Billing Guide Fee Codes

Overview

The residential care initiative supports divisions, or self-organizing groups of family physicians where no divisions exist, to design and implement local solutions that deliver dedicated GP MRP services for patients in residential care facilities.

In addition to the initiative funding, there are a number of existing GPSC incentives available to support full-service family physician who provide residential care services

GPSC Codes

Physicians who have submitted the GPSC Portal code **G14070,** at the beginning of every calendar year have access to the following incentives that are applicable to patients in residential care: FPs who do not have a community practice but who are participating in a Residential Care Network are considered to have a community "practice" in the residential care site. As such, they are eligible to submit G14070 in order to access codes G14076 GP Patient Telephone Management, G14077 FP Allied Care Provider Conferencing & G14078 GP Email/Text/Telephone Medical Advice Relay, for the patients for whom they are MRP (or covering for the MRP). It is important to note that G14075 GP Frailty Complex Care is not applicable to patients in residential care.

G14076 GP Patient Telephone Management Fee – payable for telephone management for any patient in any location, including residential care, and is billable by physicians who have submitted the GPSC Portal Code G14070 (or G14071 for locums). G14076 is not payable on the same day as a visit. There is a maximum of 1500 telephone fees per calendar year per family physician.

G14077 GP Allied Care Provider Conference Fee – payable per 15 minutes or greater portion thereof, to a maximum of two units per calendar day and 18 units per calendar year per patient, for conferencing with at least one allied care professional (in person or by telephone). For physicians who have submitted the GPSC Portal Code G14070 (or G14071 for locums). Payable in addition to any visit fee provided the visit is done separate from the conference.

Chronic Disease Management Incentives – For those patients where it is clinically appropriate to provide guideline-informed care for the covered conditions, the Chronic Disease Management incentives also apply. These incentives are available after one full year of guideline-informed care with at least two visits in that 12-month period. *One of the two visits must be in person by the FP while one may be:*

1. *a telephone visit (G14076); or*
2. *a group medical visit (13763 – 13781); or*
3. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice*

G14050 CDM for patients with Diabetes

G14051 CDM for patients with Heart Failure

G14052 CDM for patients with Hypertension

G14053 CDM for patients with COPD

MSP Fees in Residential Care

When non-urgent/emergent visits are made to patients in LTC facilities (such as nursing homes, intermediate care, extended care units, rehabilitation, chronic care, convalescent care, and personal care), regardless of being situated on the campus of an acute care facility, claims may be made to a maximum of one visit every two weeks. It is not sufficient, however, for the physician simply to review the patient's chart. A face-to-face patient-physician encounter must be made. For acute inter-current illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation in the note claim area.

Billing for Non-urgent/non-emergent visit (00114, 13334)

Literature supports that regular, longitudinal care (versus episodic care) for patients in LTC facilities improves patient care by decreasing unnecessary transfers to acute care. With the aging and increasing complexity of the population, visits may be provided and billed every two weeks, with the ability to provide extra medically necessary visits when a note record (e.g., "Extra visit required due to ____") is submitted with the billing. For family physicians with a community-based office, the first visit to a LTC facility on any calendar day is subject to the community-based family physician, long term care facility visit – first visit of the day bonus fee (13334) billed in addition to the visit fee (00114).

Billing for Patients in Long Term Care when specially called (00115)

For care of a patient in a nursing home (LTC) when especially called, 00115 may be claimed seven days per week between 0800 – 2300 provided the visit occurs within 24 hours of the time called. Start/end time must be submitted with the claim. The first visit of the day bonus (13334) is not applicable when specially called. Any additional patients seen during the same call may be claimed under 00114.

Billing for Patients in LTC when Called to See at Night (01200/01201/01202 + 13200 series)

When especially called and for a visit with a patient in a nursing home (LTC) that occurs during the overnight time (2300 – 0759), the call-out fee is billable in addition to the out–of-office age appropriate visit fee. The call-out-fee used is dependent on when the physician was called. For calls before 2300 and patient visit is after 2300, must use either 01200 or 01202 as appropriate for day of week. When the physician is called and sees a nursing home (LTC) patient from 2300 - 0759 hours, the appropriate out-of-office visit fee (13200, 15200, 16200, 17200, or 18200), depending on the patients age, is billable in addition to the call-out charge (01201), if all of the out-of-office hours premium criteria are met. Start/end time of visit must be submitted with the claim. In the electronic note, indicate time called as well as time seen. Any additional patients seen during the same call may also be claimed using the out of office age differential fee codes (13200 series). *In addition, if the visit(s) meets the non-operative surcharge criteria, fee item 01205, 01206 or 01207 may be billed.*

Visits for Terminal Care (00127)

Once terminally ill patients with malignant disease, AIDS, end-stage respiratory, cardiac, liver and renal disease, neuromuscular degenerative disease and/or end-stage dementia are located in a residential care facility, patients are deemed to be palliative (in the last six months of life and eligible for the Palliative Care Benefits program whether applied for or not). It is appropriate to change to billing fee 00127 for their care, whether or not the patient is in a palliative care unit. These patients often require frequent visits for palliative care. Billing for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs. These fees may be billed on an ongoing basis, for medically necessary visits rendered for a period not to exceed 180 days from determination of palliative level of care to death. If a patient survives longer than 180 days from the time status is changed from active management to palliative management,

visits may still be submitted with fee code 00127 for up to a further 90 days, but an electronic note must accompany the billing to outline why the patient has survived beyond the six months. If the patient survives longer than 270 days, claims may be submitted with electronic notes and are subject to individual adjudication. Chemotherapy fees may not be billed when terminal care visit fees are being billed. This fee is also subject to the "first visit of the day" bonus (13338) that may be billed only once per day, per physician regardless how many eligible facilities you visit.

Billing for phone advice about patients in LTC (13005)

When called/faxed for advice about a patient in a LTC facility, other than for medication re-orders, it is appropriate to bill the fee 13005, as long as all other criteria are met. This fee is not billable for advice to a patient's family members. This fee is not billable if a visit has also occurred on the same day and is limited to one fee billable per day per patient. Documentation of the concern and advice given must be kept in a patient's chart.

Minor Procedures and Related Tray fees (Reference Guide to Fees p. C – 11 to 16)

A tray fee is billable in addition to the procedure fee when a physician brings a tray from their office to a residential care facility to perform minor procedures (e.g, laceration repair, lesion excision). When performed in addition to other procedure or visit, the rules regarding multiple services apply – bill the higher valued service at 100% and the lower valued service(s) at 50%. Note that Punch or Shave Biopsies are to be billed as age-appropriate office visit (00100 series) only and are not eligible for a tray fee. If biopsy is positive for carcinoma and the full lesion is removed at a later date, bill under appropriate excision fee (13622) for the later service.