Residential Care Initiative
Billing Guide Fee Codes

General Practice Services Committee

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. For family physicians who are participating in the A GP for Me initiative and who annually submit the G14070 Attachment Participation code are eligible for the following additional billing incentives.

A GP for Me incentives

Physicians who are participating in A GP for Me initiative must submit **G14070, the Attachment Participation code**, at the beginning of every calendar year in order to keep the portal open to the Attachment fees.

G14074 Unattached Complex/High-needs Patient Attachment Fee* – Patients who require residential care by definition are complex and/or high-needs patients. Therefore, the Unattached Complex/High-needs Patient Attachment fee (G14074) is applicable for patients in residential/long term care (LTC) who do not have a family physician to provide longitudinal care. If an unattached patient is being admitted to LTC from the community or hospital, the request of the residential/LTC staff for an attachment participating family physician to accept the patient into their practice qualifies for the purpose of billing the G14074. It is billable in addition to 00115 (especially called to see in LTC fee) on the day the family physician provides the admission assessment visit and completes the required admission documentation, provided this visit is within 24 hours of the call. If there is more than a 24-hour delay between the request to attach and the admission assessment visit,00114 (LTC Visit) is billable in addition to G14074.

G14076 Attachment Patient Telephone Fee* – Payable for telephone management for any patient in any location, including residential care, and who is attached to a community full-service family physician. G14076 is not payable on the same day as a visit. There is a maximum of 1,500 telephone fees per calendar year per family physician.

G14077 Attachment Patient 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 participating in the A GP for Me initiative, this has replaced the original 3 separate conference fees G 14015/16/17. Payable in addition to any visit fee provided the visit is done separate from the conference.

***G14015 Facility Patient Conference Fee -** For those physicians who are not participating in the A GP for Me initiative, G14074, G14076, and G14077 are not billable. Only the original G14015 Facility Patient Conference Fee is available for participation in person at care conferences with at least two other allied care providers. Each patient has a maximum of two units per calendar day and a maximum of six units per calendar year. 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.

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

G14079 GP Telephone/email Follow-up Management Fee – Payable for telephone management or two-way e-mail follow-up management for patients with paid portal planning fees or COPD CDM. For patients living in residential care, the planning fees are not applicable; however, the COPD CDM is billable when clinically appropriate as per above. There is a maximum of five G14079 fees per calendar year per patient for whom one of the portal incentives have been paid within the previous 18 months. G14079 is not payable on the same day as a visit.

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 be claimed under 00114. *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.

Billing Example:
You are called on Saturday about Mrs. J. who has fallen. She has hit her head and has a large laceration on her arm. You agree to come to see her immediately and bring a tray from your office to repair the laceration as well as assess the head injury and cause for the fall. You see Mrs. J at 1340 hour, note the cause of her fall, assess her head injury, and repair the laceration under local anesthetic. You determine that other than increased monitoring of her level of consciousness over the next 24 hours, there is no need for further intervention. You complete the assessment/repair at

1420 hour. You ask the staff to call you the next day to discuss her status and review any change needed for her short term management plan as a result of this fall. The conference the next day lasts 10 minutes.

While you are there, you are asked to see two other patients with persistent coughs, both of which are viral upper respiratory infections and only require symptomatic management.

Billings:

Mrs. J

00115 Dx 959.01 start time 1340 hour end time 1420 hour.

13611 Dx 881 @ 50%

00080Dx 881 major tray fee

Day 2 – 14077 X 1 unit for follow-up conference with LTC staff

Pt 2

00114 Dx 460 (if < 2 weeks since last saw, need to submit with e-note that you were asked to see the patient due to cough)

Pt 3

00114 Dx 460 (if < 2 weeks since last saw, need to submit with e-note that you were asked to see the patient due to cough)