NOVA SCOTIA MEDICAL SERVICES INSURANCE
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NOVA SCOTIA

FAMILY PHYSICIAN MASTER AGREEMENT PROGRAMS
Billing Reminders and Clarifications

March, 2011

The current Physician Services Master Agreement incorporates a number of new incentive programs and/or fees designed to provide enhanced funding to family physicians in an effort to support system improvement and change.

Each of these new incentive programs and/or new fees includes specific guidelines and eligibility criteria, all of which have been communicated to physicians through MSI bulletins and via the members' side of the Doctors Nova Scotia website, since April 2008.

A number of issues have been identified with some of these programs; specifically there have been issues with previously communicated criteria and billing guidelines not being adhered to on a consistent basis. Similar to all other fees, any new fees which have been approved by the Master Agreement Steering Group for inclusion into the fee guide are subject to audit as per the current process.

The purpose of this notice is to clarify the specific issues as well as offer additional detail (where applicable) pertaining to these programs in an effort to ensure accurate billing of these fees.

Long Term Care Medication Review

This incentive is available for Family Physicians who complete medication reviews for residents of provincially licensed Nursing Homes and Residential Care Facilities (RCFs) only. Information about eligible facilities can be found on the Department of Health Continuing Care web site at:

http://www.gov.ns.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_NH.pdf
http://www.gov.ns.ca/health/ccs/pubs/approved_facilities/Dir_approved_facilities_RCF.pdf

Category	Code	Description	Unit Value
DEFT	ENH1	Long Term Care Medication Review	11.95

Billing Guidelines:

- To claim the fee, the physician **must review, complete, date and sign** the **pharmacy-generated Medical Administration Recording System (MARS) drug review sheet** for the resident.
- **A maximum of two (2) medication reviews will be payable per resident per fiscal year**, regardless of Nursing home or RCF facility of residence. A facility transfer does not necessarily require a new medication review if the existing medication review is up-to-date.
- The medication review fee is payable in addition to any associated visit fee, if applicable.
- The date of service is the date the MARS form is signed by the physician.
- A copy of the completed and signed MARS form needs to be readily available within the patient record (located in the Nursing Home)

NOTE: This fee can only be claimed for reviewing, completing and signing the pharmacy-generated MARS form. The fee is not to be claimed for re-ordering of medications requested by the nursing home or the completion of any other type of form.

Unattached Patient Bonus

This incentive is available for all eligible General Practitioners (GPs) who take on a patient who does not have a family physician and meets the supplied criteria, into their community-based family practice. The program is intended to address the specific issue of hospitalized patients or patients treated in the emergency department for medical problems who require follow-up in the community and who do not have a family physician. It is not intended to cover every patient who does not have a family doctor; i.e., situations such as practice closures or patient transfers.

Category	Code	Description	Payment
DEFT	UPB1	Unattached Patient Bonus Payment Program	$150.00 (one time per patient)

Billing Guidelines

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.
- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or medically necessary emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.
- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

The GP is considered to have taken on the patient on the date of the initial office visit. The Unattached Patient Bonus may be claimed at the time of the initial visit.

The Unattached Patient Bonus fee is billable in addition to the associated visit fee.

The Unattached patient Bonus may be claimed by eligible GPs paid by fee-for-service and alternative payment plan contracts but not by Locums.

The GP must confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e., does not already have a regular family physician). **Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice must also be recorded in the patient's record.** This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation. **(Other documentation may include a note by the physician, documenting their discussion with the patient, confirming the hospital encounter)**

NOTE: Physicians are advised not to send patients to the emergency department to be referred in an effort to claim this fee. Upon audit, MSI will be verifying that an eligible hospital-based encounter did occur and that there was a medical necessity for the hospital encounter.

Complex Care Visit

This fee is billable for general practice office visit services only. It is not available to be billed in Long Term Care facilities at this time.

Category	Code	Description	Unit Value
VIST	03.03B	Complex Care	21
VIST	03.03B	Complex Care with modifier GPEW	26.25

Documentation must indicate the three eligible chronic diseases under active management or there must be a readily accessible patient profile listing the chronic diseases in the patient record. The documentation or profile may include the date of onset (when/if this is known by the physician)
A complex care visit code may be billed a **maximum of 4 times per patient per fiscal year (April 1 - March 31)** by the family physician and/or the practice (not by walk-in clinics) providing on-going comprehensive care to an eligible patient.

- An eligible patient must be under active management for **3 or more** of the following chronic diseases (**The diseases listed below are the only diseases currently eligible under this program.):**
  - **Asthma**
  - **COPD**
  - **Diabetes**
  - **Chronic Liver Disease**
  - **Hypertension**
  - **Chronic Renal Failure**
  - **Congestive Heart Failure**
  - **Ischaemic Heart Disease**
  - **Dementia**
  - **Chronic Neurological Disorders**
  - **Cancer**

NOTE: Chronic Renal Failure is defined as: (eGFR) <60 mL/min/1.73 m2 for three months or equivalent calculated creatinine clearance.

- The term **active management** is intended to mean that the patient requires on-going monitoring, maintenance or intervention to control, limit progression, or palliate a chronic disease.

- The term **chronic neurological disorders** is intended to include progressive degenerative disorders (such as Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease), stroke or other brain injury with a permanent neurological deficit, paraplegia, or quadriplegia and epilepsy.

- The physician must spend at **least 15 minutes** in direct patient intervention and the visit must address at least one of the chronic diseases either directly or indirectly.

- Start and finish times must be recorded on the patient's chart.

Case Management Conference

A case management conference is a formal, scheduled, multi-disciplinary health team meeting. It must be initiated by an employee of the DHA/IWK, or a Director of Nursing, Director of Care of an eligible Long Term Care facility to discuss the provision of health care to a specific patient. The Case Management Fee can be claimed by General Practitioners and Specialists.

Category	Code	Description	Unit Value
VIST	03.03D	Case Management Conference	14.5 units per 15 minutes for GP's and 17 units per 15 minutes for Specialists

Billing Guidelines

- It is a time based fee paid at the applicable GP or Specialist sessional rate in 15 minute increments.
- To claim the case management conference fee, the physician must participate in the conference for a minimum of 15 minutes and remuneration will be calculated in 15 minute time increments based on the sessional rate. **Start and finish times** are to be recorded on the patient's chart.
- 80% of a 15 minute time interval must be spent at the conference in order to bill that time interval.
- Neither the patient nor the family need to be present.
- It may be claimed by more than one physician simultaneously as necessary for case management.
- The case conference must be documented in the health record with a list of all physician participants.
- Multi-disciplinary refers to the attendance of two or more licensed health care professionals in addition to a physician.
- In order to qualify, the conference has to be called by non-physician DHA/IWK staff, who are required to be employees of the district, or by the Director of Nursing or Director of Care of an eligible Long Term Care facility. It is not mandatory that more than one physician attend the case conference before the fee code may be claimed.
- The Case Management Conference Fee is not to be used for attendance at regularly scheduled meetings concerning ongoing care planning or patient management for one or more patients; i.e., grand rounds, tumor board case rounds, teaching rounds, transplant rounds or other similar methods of specialist physicians conferring about the medical management of complex cases. It is not to be used in circumstances which are a usual part of patient care such as transfer of care between physicians on evenings and weekends.
- Physician attendance at case management conferences held by video conferencing or teleconferencing is eligible for payment providing all other eligibility requirements are met.

- Each case conference must be specific to an individual patient and the time spent by the physician at the conference must be documented in the health record of that patient. However, consecutive formal scheduled conferences, each pertaining to one named patient, with start and finish times recorded in each health record, would be permitted.

NOTE: If the patient is located in an institution, documentation pursuant to the billing guidelines must be located within the patient record in the institution. If the patient is not located in an institution, documentation regarding the case management conference must be readily available; e.g., in the patient record maintained by the physician claiming the fee. The onus will be on the physician billing the fee to ensure appropriate documentation is readily available.

GP Evening and Weekend Incentive

This incentive program is intended to promote enhanced evening and weekend access to primary care services provided in the offices of fee-for-service family physicians who have an established practice and provide comprehensive and on-going care for their patients.

Billing Guidelines:

- The eligible time periods for claiming the evening and weekend office visit incentive are 6 – 10 p.m. during weekday evenings and 9 a.m. – 5 p.m. on weekends (Saturday and Sunday).

- Physicians should offer and book appointments during these time periods in the same manner as they would for other (weekday) office hours.

- Evening and weekend services eligible for incentive funding are office visit services provided in a community-based family practice in which the physician maintains a comprehensive patient chart to record all patient encounters, provides all necessary follow-up care for each encounter and takes responsibility for initiation and follow-up on all related referrals.

- Eligible physicians may claim an incentive for evening and weekend office services provided for their own patients as well as for patients from the stable patient roster of other eligible physicians within the same practice location, providing the patient's record can be accessed and the encounter is recorded.

- Services provided in walk-in clinics are not eligible for the evening and weekend office visit incentive funding program. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing.

The following office services are eligible for the 25% evening and weekend incentive providing all other eligibility criteria are met. Only one incentive can be claimed per patient encounter regardless of the number of services provided during the encounter. Claims for eligible services should be submitted with the modifier TI = GPEW.

Category	Code	Modifiers	Description	Unit Value
VIST	03.04	TI=GPEW	Complete Examination	30.00
VIST	03.03	RP=SUBS TI=GPEW	Office Visit	16.25
VIST	03.03A	TI=GPEW	Geriatric Office Visit (for patients aged 65+)	20.63
VIST	03.03B	TI=GPEW	Complex Care	26.25
VIST	03.04	RO=PTNT RP=INTL TI=GPEW	Complete Pregnancy Exam	37.13
VIST	03.03	RO=ANTL TI=GPEW	Routine Pre Natal Visit	16.25
VIST	03.03	RO=PTNT TI=GPEW	Post Natal Care Visit	23.75
VIST	03.03	RO=WBCR TI=GPEW	Well Baby Care	16.25
PSYC	08.41	TI=GPEW	Hypnotherapy	15.88 per 15 mins
PSYC	08.44	TI=GPEW	Group Therapy (4-8 members)	4 per 15 mins
PSYC	08.45	TI=GPEW	Family Therapy (2 or more members)	16.06 per 15 mins
PSYC	08.49A	TI=GPEW	Counselling	15.88 per 15 mins
PSYC	08.49B	TI=GPEW	Psychotherapy	15.88 per 15 mins
PSYC	08.49C	TI=GPEW	Lifestyle Counselling	15.88 per 15 mins

NOTE: For services where the evening and weekend incentive has been claimed, a record must be maintained and readily available to verify that the patient was booked for an appointment during an incentive-eligible time period. The appointment time should be recorded in the patient's record or office appointment books retained.

APP contract physicians can shadow bill the GP Evening and Weekend Office Visit Incentive (GPEW)

The evening and weekend office visit incentive should not be claimed in circumstances where the patient is booked for an appointment time that is not eligible for the incentive and then the physician "runs late".

LONG-TERM CARE CLINICAL GERIATRIC ASSESSMENT (CGA)

Additional new incentive funding is available through the Physicians Master Agreement in 2010/11 to support new programs and/or incentives for family physicians participating in Continuing Care.

Effective January 1, 2011 the following new fee code (billable by general practitioners only) has been approved by the MASG for inclusion in the fee schedule

Category	Code	Description	Unit Value
DEFT	CGA1	Long-Term Care Clinical Geriatric Assessment	26.32

Description:

The Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviors, and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team. The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of care given.

Billing Guidelines:

- Effective January 1, 2011, family physicians will be remunerated for the completion of a *Long-Term Care Clinical Geriatric Assessment (CGA)* for residents of licensed Nursing Homes and Residential Care Facilities (RCF's) funded by the Department of Health only.

- The CGA may be billed twice per fiscal year (April 1 – March 31), per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient.

- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviours), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have

completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.

- The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA form. This service encounter is included in the CGA fee. The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the Preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be tracked on the CGA form.

- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.

- The date of service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.

- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible.

The CGA form is attached to this Bulletin and also available on the Doctors Nova Scotia members' web site.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this new fee are June and December of each year, with the first payments beginning in June, 2011.

Please hold eligible service encounters to allow MSI the required time to update the system. Once a Health Service Code has been assigned, it will be published in the MSI Physicians' Bulletin with directions regarding the submission of any held claims.

Long-Term Care
Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits ASST: Assisted
IND: Independent DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

Cr Cl/eGFR: _____

Infection Control
MRSA _____ Pos _____ Neg
VRE _____ Pos _____ Neg
Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

Cognitive Status
❒ WNL
❒ Dementia
❒ Delirium
MMSE _____

Emotional
❒ WNL ❒ ⇩Mood
❒ Depression ❒ Anxiety
❒ Other
❒ Hallucinations/Delusions
Date (d/m/y): _____

Behaviours
❒ Verbal Non-aggressive
❒ Verbal Aggressive
❒ Physical Non-aggressive
❒ Physical Aggressive

Communication:

Speech	Hearing	Vision
❒ WNL	❒ WNL	❒ WNL
❒ Impaired	❒ Impaired	❒ Impaired

Foot-care needed ❒ Yes ❒ No
Dental care needed ❒ Yes ❒ No
Skin Integrity Issues ❒ Yes ❒ No

Strength
❒ WNL ❒ Weak
Upper: Proximal Distal R L
Lower: Proximal Distal R L

Mobility	Transfers	❒ IND	❒ ASST	❒ DEP
	Walking	❒ IND Slow	❒ ASST	❒ DEP
	Aid	_____		
Balance	Balance	❒ WNL		❒ Impaired
	Falls	❒ No ❒ Yes		Frequency
Elimination	Bowel	❒ Constip	❒ Cont	❒ Incont
	Bladder	❒ Catheter	❒ Cont	❒ Incont
Nutrition	Weight	❒ STABLE	❒ LOSS	❒ GAIN
	Appetite	❒ WNL	❒ FAIR	❒ POOR
ADLs	Feeding	❒ IND	❒ ASST	❒ DEP
	Bathing	❒ IND	❒ ASST	❒ DEP
	Dressing	❒ IND	❒ ASST	❒ DEP
	Toileting	❒ IND	❒ ASST	❒ DEP

Personal Directives ❒ Yes ❒ No
Substitute Decision Maker:
_____
Tel #: _____

Code Status:
❒ Do Not Attempt to Resuscitate
❒ Do Not Hospitalize
❒ Hospitalize
❒ Attempt to Resuscitate

Marital Status
❒ Married
❒ Divorced
❒ Widowed
❒ Single

Family Stress
❒ None
❒ Low
❒ Moderate
❒ High

Problems/Past History/Diagnosis	Medication Adjustment Required	Associated Medication
1.	❒	
2.	❒	
3.	❒	
4.	❒	
5.	❒	
6.	❒	
7.	❒	
8.	❒	
9.	❒	
10.	❒	
11.	❒	
12.	❒	

Current Frailty Score
Scale ❒ 5. Mildly Frail ❒ 6. Moderately Frail ❒ 7. Severely Frail ❒ 8. Very Severely ill ❒ 9. Terminally Ill

Note: Shaded areas to be completed by physician.

Clinical Frailty Scale*

5. Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover from even a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173; 489-495

CGA Associated Visits	
Date	**Comments**

Physician Name (please print): _____ Physician Signature: _____

Signed on (d/m/y): _____ (Visit required on this date)