Workshop 404:

OPTIMIZING CARE: CODING AND BILLING IN LONG-TERM CARE

WORKSHOP #404-18

OPTIMIZING CARE: CODING AND BILLING IN LONG-TERM CARE

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Learning Objectives:

1. *Differentiate different billing methods available to Long-Term Care Physicians.*

2. *Reflect on how fees can be applied to optimize care.*

3. *Create recommendations to incentivize and reward Long-Term Care Physicians.*

CFPC CoI Templates: Slide 1 – used in Faculty presentation only.

Faculty/Presenter Disclosure

- **Faculty: Fred Mather, MD**

- **Relationships with financial sponsors:**
  - **Speakers Bureau/Honoraria:** Amgen.

Disclosure of Financial Support

- **This program has received no financial or in-kind support**

- **<u>Potential for conflict(s) of interest</u>:**
  - None

Mitigating Potential Bias

- No bias to the presentation

An Interactive Workshop

Share you experiences, recommendations and questions

Physician compensation models

- Fee for service
- Management fee
- Patient enrolment models (FHO, FHT)
- Salaried

Ontario

Schedule of Benefits

Physician Services
Under the
Health Insurance Act

(December 22, 2015 (effective March 1, 2016))

Ministry of Health and Long Term Care

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GP. General Preamble

LTC
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LTC codes
A14

A. Consultations and Visits

LONG-TERM CARE INSTITUTION: NON-EMERGENCY IN-PATIENT SERVICES ("W" PREFIX SERVICES)

These services apply to patients in chronic care hospitals, convalescent hospitals, nursing *homes*, *homes* for the aged and designated chronic or convalescent care beds in hospitals other than patients in designated *palliative care* beds - “W” prefix services.

W102
Type 1 General Assessment on Admission, $69.35

W104
Type 2 General Assessment on Admission, $20.60

W107
Type 3 General Assessment on Admission, $30.70

W109
Periodic Health Visit, $70.50

Type 1 Admission Assessment

A Type 1 admission assessment is a general assessment rendered to a patient on admission.

Payment rules:
If the physician has rendered a consultation, general assessment, or general re-assessment of the patient prior to admission, the amount payable for the service will be adjusted to a lesser fee.

Type 2 Admission Assessment
A Type 2 admission assessment occurs when the admitting physician makes an initial visit to assess the condition of the patient following admission and has previously rendered a consultation, general assessment or general re-assessment of the patient prior to admission.

Type 3 Admission Assessment

A Type 3 admission assessment is a general re-assessment of a patient who is re-admitted to the long-term care institution after a minimum 3 day stay in another institution.

Nursing *home* or *home* for the aged

W003	- first 2 subsequent visits per patient per month	per visit	32.20
W008	- additional subsequent visits (maximum 2 per patient per month)	per visit	21.20
W872	- palliative care (see General Preamble GP34)	per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP33).	per visit	31.00

Chronic care or convalescent hospital

W002	- first 4 subsequent visits per patient per month	per visit	32.20
W001	- additional subsequent visits (maximum 4 per patient per month)	per visit	21.20
W882	- palliative care (see General Preamble GP34)	per visit	32.20

W121
Additional visits due to intercurrent illness, $31.00

W777
Pronouncement of death, $33.70

W771
Certification of death, $20.60

W903
Pre-dental/Pre-operative General Assessment, $65.05

W010 Monthly Management $108.85

*Month*ly Management of a Nursing *Home* Patient is the provision by the *most responsible physician* (*MRP*) of routine medical care, management and supervision of a patient in a nursing *home* for one calendar *month*.

The service requires a minimum of two assessments of the patient each *month*, where these assessments constitute services described as "W" prefix assessments.

W010 Monthly Management includes

- **Services described by subsequent visits (e.g. W003, W008).**
- **Services described by additional visits due to “intercurrent illness” (W121)**
- **Services described by *palliative care* subsequent visits (e.g. W872)**
- **Services described by admission assessments (e.g. W102, W104, W107).**
- **Services described by pre-dental/pre operative assessments (e.g.W903).**

W010 Monthly Management includes

- **Services described by periodic health visit or general reassessments (e.g. W109, W004).**
- **Services described by visit for pronouncement of death (W777) or certification of death (W771) except if the services are performed in conjunction with a special visit.**
- **Service described by anticoagulation supervision (G271).**
- **Completion of CCAC application and *home* care supervision (K070, K071, K072).**

W010 Monthly Management includes

Services described by the following diagnostic and therapeutic procedures –

venipuncture (G489),

injection (G372, G373),

immunization (G538, G590),

Pap smear (G365, G394, E430, E431),

intravenous (G379), and

laboratory test codes.

W010 Monthly Management includes

- **All medication reviews.**
- ***All discussions with the staff of the institution related to the patient's care.***
- ***All telephone calls from the staff of the institution, patient, patient's relative(s) or patient's representative in respect of the patient between the hours of 0700 hours and 1700 hours Monday to Friday (excluding holidays).***
- **Ontario Drug Benefit Limited Use prescriptions/forms or Section 8 *Ontario Drug Benefits Act* requests.**

Palliative Care

K023	Palliative Care Support (>20 min.), $62.75/unit
K015	Counseling of Relatives, $62.75/unit
W872	LTC Palliative Care Subsequent Visit, $32.20

W102 LTC CONSULTATION

A consultation is an assessment rendered following a written request from a referring physician or *nurse practitioner* who, in light of his/ her professional knowledge of the patient, requests the opinion of a physician (the “consultant physician”) competent to give advice in this field because of the complexity, seriousness, or obscurity of the case, or because another opinion is requested by the patient or *patient’s representative*.

Certification of death

W777 Pronouncement of death, 33.70

W771 Certification of death, 20.60

Certification of death is payable to the physician who personally completes the death certificate on a patient who has been pronounced dead by another physician, medical resident or other authorized health professional. Claims submitted for this service must include the diagnostic code for the underlying cause of death as recorded on the death certificate. The service *may include* any counselling of relatives that is rendered at the same visit.

Long-Term Care Institution					
	Weekdays Daytime (07:00-17:00)	**Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours**	**Evenings (17:00-24:00) Monday through Friday**	**Sat., Sun. and Holidays (07:00-24:00)**	**Nights (00:00-07:00)**
Travel Premium	$36.40 W960	$36.40 W961	$36.40 W962	$36.40 W963	$36.40 W964
First person seen	$20.00 W990	$40.00 W992	$60.00 W994	$75.00 W998	$100.00 W996
Additional person(s) seen	$20.00 W991	$40.00 W993	$60.00 W995	$75.00 W999	$100.00 W997
Maximums (per time period)					
Travel premiums	2	2	2	6	unlimited
Persons seen (first person and additional person(s))	10	10	10	20	unlimited

Specific Neurocognitive Assessment K032 - $62.75

A specific neurocognitive assessment is an assessment of neurocognitive function *rendered personally by the physician* where all of the following requirements are met:

a. test of memory, attention, language, visuospatial function and executive function.

b. a minimum of 20 minutes (consecutive or non-consecutive) and must be dedicated exclusively to the is service (including administration of the tests and scoring) and must be completed on the same day; and

c. the start and stop time(s) must be recorded in the patient's medical record.

Telephone Consultation

K730 Physician to physician telephone consultation - Referring physician 31.35

K731 Physician to physician telephone consultation - Consultant physician..... 40.45

Telephone Consultation

This service is *only eligible for payment* for a physician to physician telephone consultation service:

a) that includes a minimum of 10 minutes of patient-related discussion for any given patient

b) where the referring physician/*nurse practitioner* and consultant physician are physically present in Ontario at the time of the service

<u>Not</u> eligible to arrange a transfer, future consultations or visits, discuss results of investigations.

Note must include the consultant's name, opinion and recommendations

Electronic Consultation

PHYSICIAN/NURSE PRACTITIONER TO PHYSICIAN E-CONSULTATION

Physician*/nurse practitioner* to physician e-consultation is a service where the referring physician or *nurse practitioner*, in light of his/her professional knowledge of the patient, requests the opinion of a physician (the “consultant physician”) who is competent to give advice in the particular field because of the complexity, seriousness, or obscurity of the case and where both the request and opinion are sent by electronic means through a secure server.

K738 Physician to physician telephone consultation - Referring physician, 16.00

K739 Physician to physician telephone consultation - Consultant physician, 20.50


Family meetings,
care conferences,
team meetings

Care conferences, family meetings

K002

Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act ..... per unit 62.75

K013 ..... per unit 62.75

K124

Long-term care/CCAC case conference.....per unit 31.35

K725

Long-term care – high risk patient conference ..... per unit 31.35

Time based units

- **In terms of a minimum required duration of time, the physician must record on the patient's permanent medical record or chart the time when the insured service started and ended. If the patient's permanent medical record or chart does not include this required information, the service is *not eligible for payment*.**

- **Based upon the number of "units" of service rendered, the physician must record on the patient's permanent medical record or chart the time when the insured service started and ended. If the patient's permanent medical record or chart does not include this required information, the service is *not eligible for payment*.**

Medical Director Fees

The minimum Medical Director fee is $0.30 per resident per day. This come some the nursing and personal care (NPC) envelope for funding. An additional envelope was available a few years ago. This allowed for an increase in Medical Director fees, incontinence supplies or both.

Thank you

Complete your evaluations

Give your questions and recommendations

Contact

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