Special Care Home Management (SCHM)
Frequently Asked Questions

Topics:

Getting Started: How to Bill

1. How do I start billing as the MRP, Most Responsible Physician?

The physician's first Special Care Home Management (SCHM) fee claims for the patient must include the comment: "will be providing continuous care", identifying yourself as the most responsible physician.

Subsequent (after 14 days) SCHM fee claims must be consecutive and continuous for the same patient by the same physician or clinic and will not require a comment.

Understanding the Codes

2. When do I use each code?

(627A) $24 every 2 weeks for non-urgent continuous management of each patient, physicians would provide Indirect care (627A) including phone calls, faxes, communications with families, facilities or healthcare personnel, during regular business hours. This is billed every two weeks.

(628A) $60 for non-urgent but medically necessary care, physicians can carry out a Direct care visit (628A) during regular business hours, up to a maximum of every two weeks, and document.

(5B) $35 for urgent or medically necessary care, a physician can visit the patient, as required and bill (5B).

(790A) $12.50 for urgent care, Telephone calls can occur after-hours/stats, in rare circumstances, billed by report.

For virtual care provided during the pandemic, physicians can claim two new temporary codes instead of a (5B). They are billable for direct patient care, or with a parent/caregiver on behalf of the patient. For Special Care Homes, the caregiver would include the nursing home staff.

(510A) $35 for Pandemic Telephone Assessment (510A) for direct patient care provided by physicians over the telephone in real time (i.e., not text).

(515A) $35 for Pandemic Video Assessment (515A) for patient care via secure healthcare appropriate virtual visit technology (not FaceTime or WhatsApp).

3. **Can I bill both an Indirect care (627A) and a Direct care (628A) fee code for a patient in a two-week time period?**

   Yes, you can bill both but only one code will process. There is a maximum of one (1) payment by any physician for each patient every 14 days for either Indirect care or Direct care.

   This means, if you bill Indirect care (627A), and then visit the patient in the same 14 day billing period, do not wait to bill the Direct care code (628A). When you bill the Direct care code (628A), the billing system automatically converts the Indirect care fee to the Direct care fee amount for those two weeks.

   If a patient requires additional medically necessary visits in the same 14 day time window, a partial assessment (5B) code should be used.

4. **Can I bill the Pandemic codes (510A/515A) in the same two-week time period as Indirect or Direct care?**

   Yes, as long as it is medically necessary, it is not for routine care (627A/628A), and it occurs at a different time of patient contact as any other service billed.

5. **I have a palliative care patient in a Special Care Home and their condition is worsening. How do I bill in this situation?**

   You continue to bill an Indirect care or a Direct care code every 2 weeks as usual. If you need to see that patient more frequently because of their condition, the extra visits should be billed as partial assessment (5B) codes.

6. **I have a palliative care patient in a Special Care Home and am getting very frequent phone calls and faxes about their worsening condition. How do I bill in this situation?**

   Telephone calls/facsimile/email for palliative care patients are not included in Indirect/Direct care and can be billed separately up to a maximum of three times in a day if needed, using the (793A) fee code.

7. **Can I bill phone calls (790A) to give urgent/emergent advice for all my patients?**

   If you're a colleague covering for a few days (I.e., 1 week), and the most responsible physician already billed the Indirect code, it is acceptable to bill phone calls.

   If you are the most responsible physician, phone calls after hours, stats, and/or weekends can be billed as (790A), by report. This is to be considered a rare circumstance. If it is urgent, you would likely go in for a visit and bill other codes (5B's + surcharges + age premiums + time of day premiums). If it is not urgent, you may want to discuss with the facility about the timing of non-urgent phone calls.

   You cannot bill a 5B and a phone call in the same day.

Covering for a Physician

8. **If a physician <u>from another clinic</u> is covering my patients while I'm away, how will we navigate Indirect billing?**

   The covering physician can bill for Indirect Care (627A), for a 14-day period if they include a comment of explanation with the billing submission, stating: "Covering for Dr. first name; last name".

   However, if coverage is for less than 14 days, it may be easier for the usual physician to bill and then directly compensate the covering physician per agreement between the two physicians.

9. **If a physician <u>from my clinic</u> is covering my patients while I'm away, how will we navigate Indirect billing?**

   The covering physician can bill the Indirect code and does not require any additional comment.

10. **We have a large group of physicians and we rotate coverage for Special Care Home patients. How do we bill in this situation?**

    Each Special Care Home patient will have a physician who assumes their ongoing care (much like in chronic disease management). That is the physician who would normally be billing for that patient. It will be left to the group of physicians to negotiate among themselves how the income generated should be divided.

Documentation

11. Do I need to document every time I bill Indirect care (627A)?

Not for billing. Once you initiate billing and indicate you are the most responsible physician, Indirect care does not require further documentation.

However, it may be necessary for the physician to document medication renewals or advice to staff for medical/legal purposes.

12. Do I need to document every time I bill Direct care (628A)?

Yes, a record of service is required and the physician needs to be able to verify that the visit occurred.

Medical Necessity for Direct Care (628A)

13. Direct care visits require a medical necessity in order to bill that code. How is medical necessity determined?

A Direct care visit requires a request or a physician reason that is medically necessary.

In one instance, medical necessity may be prompted by a request for assessment of a patient by Special Care Home staff. Medical necessity may also be prompted by a request by the patient or their family. However, physicians may also, on their own, decide that a direct care visit is needed. The medical necessity of that visit will be documented such that the reason for the direct visit would be clear to medical peers should an audit or review be conducted down the road.

14. If I see a patient, give them treatment, and there is a medical need to check on them 2 weeks later, can I bill Direct care?

Yes, Direct Care can be billed up to every 2 weeks.

15. If I visit a patient in a Special Care Home, is it automatically a direct care visit?

No. You may visit patients for whom you are providing Indirect care. The visit becomes a direct care visit only if there is a demonstrable medical need for them to be seen and all elements of the direct care code, including documentation, are fulfilled.

16. If I'm at the facility and think of visiting a patient, can I bill a Direct care code?

Yes, but only if it is determined that the visit to the patient is medically necessary, and documented accordingly.

17. If I visit the staff in a Special Care Home, is it considered a direct care visit?

No. A visit with the staff would be included as Indirect Care to the patient.

18. Some patients have relatives who want to be frequently updated on their relative's status. How do I get compensated for that?

Routine briefing or advice to relatives is considered part of the Indirect/Direct care service. If requests for briefing by family members are becoming too frequent or onerous, it may be prudent to set up a Case Conference. A case conference must be a formally scheduled session, it can be billed twice per year, and is listed under codes 42B/43B/44B. See the payment schedule for full details and requirements.

Urgent/Emergent Care

19. Are Special Calls excluded in SCHM?

Yes, Special Care Home Management is for non-urgent patient care and it excludes special calls (i.e. urgent/emergent). Where a physician visits a patient on a special call basis, payment will be at the special call rates, depending upon the time of day. Special call payments are claimable when a physician attends a patient on a priority basis, and the visit causes a degree of disruption of work or of out-of-hours activity, and travel (except in the case of additional patients seen).

20. What is considered urgent/emergent?

An urgent/emergent condition requires care in a timely manner (within 24 hours), and the physician would likely have been requested to make a special trip to see the patient on a day the physician was not scheduled for a regular visit to the facility.

An "urgent/emergent" condition is not:

- a condition which is chronic, or
- a condition which has previously been diagnosed by the physician, but is not in an acute phase that requires urgent care at the time of the visit.

What Else is Included/Excluded?

21. Are premiums and surcharges included?

No time-of-day or age premiums are allowed.
No surcharges are allowed, as these are prescheduled services.

22. Are admissions included in Special Care Home Management?

It depends on the services provided. Admissions are included in these circumstances:

- Indirect care includes admission into the facility if services were done indirectly, as per Indirect care requirements.
- Direct care includes admission if services include only a history and a physical.

A complete assessment (3B) is only billable for admission to the facility when all components of the code have been performed and documented, as per Payment Schedule requirements.

Indirect/Direct care cannot be billed in addition to a partial assessment or any other visit type service (3B, 5B, etc.), on the same patient, on the same day at the same patient contact.

If a (3B) is billed upon admission, the physician can begin billing Indirect/Direct the next day.

23. How do I bill a Medication Review?

If the medication review is done without the presence of the patient and without a multi-disciplinary team, the service is included in Indirect care.

If the medication review is done without the presence of the patient but with a multi-disciplinary team, bill a case conference (42B, 43B, 44B, max 2 per year).

If the medication review is done with the presence of the patient, the service is included in Direct care if all the Direct care criteria has been met.

The medication review is considered medically necessary to require a Direct care visit.

24. How do I bill a Case Conference?

A Case Conference (42B/44B) is not included in these fees and is payable in addition to Special Care Home Management, when the service provided meets the Payment Schedule criteria (2 per year).

Facilities

25. What facilities are included in Special Care Home Management?

Special Care Homes include:

a) Convalescent care
b) Long-term care or long-stay care
c) Palliative care
d) Respite Care

Hospitals* include:

e) Convalescent care
f) Long-term care or long-stay care
g) Palliative care
h) Respite Care
i) Level 4 care

*Community, northern, regional, provincial, rehabilitation or district as defined by The Facility Designation Regulations.

26. I look after patients who live in Personal Care Homes. Can I use these codes to bill for them?

No. These patients remain excluded as defined in *The Personal Care Homes Act*. They would be viewed the same way as patients who are living in their own homes. Services for these patients would be billed as they would for visits to any other patients in their own home.

27. How do I bill for patients who are in a hospital but who no longer need ongoing hospital care and are waiting for a special care home placement?

Once a patient is no longer deemed to be an acute care hospital inpatient it is appropriate to begin using the Special Care Home Management codes.

Operational Considerations

28. Are there things I can do help this change go more smoothly with facilities?

There is variation in how each physician and each facility operates. It is recommended to have a conversation with your facilities about the following:

- Vacation/Time Off – How to plan for continuous care while you are away.
- Establish a system of communication for Indirect care
  - Consider creating a time for non-urgent phone calls during regular business hours at least disruptive times.
  - Explore if emails/faxes can be batched, with highest priority first.
- Establish a system of arranging Direct visits
  - Plan a time when you would like to conduct medically necessary visits. Could a list of people who need visits be prepared in advance?
  - Plan to do Medication reviews during the Direct visits.
- Coordinate case conferences – these are formally scheduled, multi-disciplinary conferences (max 2/yr).