SASKATCHEWAN MEDICAL ASSOCIATION

Special Care Home Management Fee Codes
Frequently Asked Questions
Includes Information on Billing Virtual Care Pilot Fee Codes
Updated June 2021

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. Physicians from a different clinic providing coverage must submit with a comment.

Understanding the Codes, including Virtual Care Codes

2. When do I use each code?

(627A) Indirect Care for SCH Patients $24 – payable bi-weekly. This fee is payable for weeks in which non-urgent continuous management of indirect patient care has been provided (i.e., the physician is the most responsible physician). Indirect care includes prescription renewals, ordering and interpreting tests, monitoring anticoagulation therapy (763A), phone calls, faxes, communications with families, facilities, or healthcare personnel and being the most responsible physician during regular business hours. A facility visit is not required to bill Indirect care.

(628A) Direct Care for SCH Patients $60 – payable bi-weekly. Billable for a non-urgent but medically required in-person visit to evaluate the patient's condition and to provide

advice as necessary to the patient and/or the nursing/facility staff concerning the routine management of the patient during regular business hours. This fee is payable up to a maximum of once every two weeks in which direct patient care has been provided. 628A includes all components of indirect care (i.e.,628A is not payable in addition to 627A).

(5B) Partial Assessment or Subsequent Visit $39.80- for urgent or medically required care (e.g., a change in the patient's medical condition requiring reassessment), this fee is payable when a physician visits the patient in-person to evaluate the patient's condition as required and when service code criteria is met. Appropriate surcharges and premiums are payable.

(796A) Telephone Calls Initiated by Allied Health Care Personnel To Discuss Patient Care and Management $20.00- for urgent, medically required care when a condition, occurring after-hours, is of such a nature that it is considered urgent and requires advice in a timely manner (i.e. cannot wait until business hours of the next day), telephone calls from an allied healthcare professional, in rare circumstances, are payable by report. This code is not intended to cover after-hour calls regarding the routine management of a patient.

Virtual Care Pilot Codes: Effective January 1, 2021, the new Virtual Care Pilot service codes replaced the temporary Pandemic codes (510A/515A) for Family Physicians. Virtual Care Pilot codes are specific to a type of service and/or medical conditions and mostly resemble the in-person visit codes but are for medically required virtual care.

(805B) Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference $31.85- when billed in the same two-week period as a SCHM service code, this code is payable when direct physician-to-patient contact in real time via telephone or secure video conferencing for urgent or medically required care (e.g., a change in medical condition requiring reassessment), and the physician is unable to visit the patient in person due to pandemic restrictions. It may be initiated by either the physician or the patient/caregiver. For Special Care Homes, the caregiver includes the SCH nursing staff.

There are some scenarios when it is appropriate to bill 805B in the same two-week period as 627A or 628A (Question #5, #6). 805B is only payable once per day per patient. To avoid rejections and facilitate payment, include a comment on the 805B claim indicating "additional visit medically required" when billing 805B in the same two-week period as SCHM.

The *Virtual Care Pilot Payment Schedule* can be found here:

https://www.sma.sk.ca/kaizen/content/files/Virtual%20Care%20Pilot%20Payment%20Schedule%20-%20Jan%202021(1).pdf

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 may bill both, but only one code will process. This is because Direct Care (628A) incudes Indirect Care (627A). As such, there is a maximum of one (1) SCHM payment for 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-person 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 will automatically convert to 629A – Special Care Home Management Conversion and pay $36.00 – the difference between Direct and Indirect care.

NOTE – in the above scenario, your paylist will not show 628A as being paid because it converts to 629A. You should expect 627A and 629A to be paid.

If a patient requires additional medically required visits (e.g., a change in medical condition requiring reassessment in the same 14-day time window, a partial assessment (5B) code, or a virtual partial assessment (805B) may be appropriate if you are unable to visit in person due to pandemic restrictions. Neither 5B nor 805B is payable in addition for routine management of the patient.

4. Can I bill the Pilot Virtual Care code (i.e. 805B) in the same two-week time period as Indirect or Direct care?

Yes, as long as it is for urgent or medically required care and making an in-person visit is restricted due to pandemic conditions; it is not for routine care (627A/628A), and it occurs at a different time of patient contact as any other service billed. The reason for billing for the additional service must be documented.

5. What can I bill if there is a sudden change in a patient's condition and a face-to-face in-person visit is medically required for an urgent matter?

You would bill a 5B, and appropriate premiums and surcharges are payable (provided 5B criteria is met) or 805B (no premiums/surcharges) for a virtual visit if you are unable to visit the patient in person due to pandemic restrictions.

6. I have a palliative care patient in a SCH, and their condition is worsening, requiring additional physician care. How do I bill in this situation?

You continue to bill an Indirect care or a Direct care code every 2 weeks if you are the most responsible physician. If the patient requires direct physician-patient care more frequently because of their worsening condition, the extra in-person visits maybe billed as partial assessment (5B) or virtual partial assessment (805B) when the requirements of the service codes are met. Palliative Patient Telephone/Fax/Email 793A) is payable up to 3x per day per patient when the requirements of the service code (793A) are met. 793A is payable in addition to 627A/628A and 5B/805B.

7. If I require photos/visuals of a patient's evolving urgent condition or need to access lab results, imaging results or review hospital medical records via SCM portal, to enable me to plan and treat this urgent, potentially life-threatening acute condition that has occurred for this patient, what do I bill?

The payment for indirect patient care is included in 627A. If the patient is palliative, then additional calls/faxes/emails initiated by allied health care personnel is payable via 793A, when service code criteria is met.

Urgent medically required assessments are to be billed as mentioned above in #5.

Telephone Calls

8. For virtual care telephone or secure videoconferencing calls, see questions #2, #3, #4 and #5 above.

9. 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/faxes/email for palliative care patients are not included in Indirect/Direct care payments and can be billed separately up to a maximum of three times in a day per patient when medically required and not for routine management, using the 793A fee code.

10. Can I bill phone calls (796A) to give urgent/emergent advice for my SCH patients?

If you are the most responsible physician, telephone calls (796A) from an Allied healthcare professional are payable by report, providing the condition is of such a nature that it is considered urgent and requires advice in a timely manner (i.e. cannot wait until business hours of the next day). This code is not intended to cover after-hour calls regarding the routine management of a patient.

See #25 for further details on an "urgent/emergent" condition.

Covering for a Physician

11. Can I bill phone calls (796A) to give urgent/emergent advice for SCH patients when I'm covering for a physician?

If you're a colleague from a different clinic covering for a few days (i.e. 1 week), and the most responsible physician has already billed the Indirect care code, it is acceptable to bill the phone calls for urgent/emergent advice.

12. If a physician <u>from another clinic</u> is covering my patients while I'm away, how will we navigate Indirect Care 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" provided that the physician that typically is the most responsible physician has not billed 627A during the same 14-day period.

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.

13. If a physician from my clinic is covering my patients while I'm away, how will we navigate Indirect billing?

The covering physician can bill the Indirect code (627A) and does not require any additional comment.

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

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

Documentation

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

There may be instances when no indirect care services are required in a 2-week period, therefore no documentation of service provided is required. However, it is the expectation that the physician is able to demonstrate that they are the most responsible physician for providing indirect care services to the patient to support billing and services provided are documented for medical/legal purposes i.e. renewing prescriptions, ordering lab/tests, anticoagulation change, etc.

16. 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 demonstrate that a medically required in-person patient visit occurred.

17. Do I need to document every time I bill 5B or 805B?

Yes, a record of service is required as per the billing requirements of these codes. The physician needs to be able to demonstrate that the visit/virtual visit occurred and satisfied service code billing criteria.

Medical Necessity for Direct Care (628A)

18. Direct care visits require a medically necessary requirement in order to bill that code. How is medical necessity determined?

The medically necessary requirement for a Direct care visit is based on the professional judgment of the physician determining the need to make an in-person visit to the patient and documented such that the reason for the Direct care visit would be clear to medical peers, should an audit or peer review be conducted down the road.

19. If I see a patient, provide treatment, and there is a medical need to (re)assess the patient in-person 2 weeks later, can I bill Direct Care?

Yes, Direct care can be billed once every 14 days.

20. 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 the patient to be seen and all elements of the direct care code, including documentation, are fulfilled.

21. If I'm at the facility and am asked to see a patient, can I bill a Direct care code?

Yes, but only if it is determined that the visit to the patient is medically required and documented accordingly. If the visit is not medically required, it is considered part of Indirect Care.

22. If I visit the staff in a Special Care Home, is it considered a Direct Care visit?

No. A visit with the staff is a component of Indirect Care for the patient and not billable in addition

23. 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 and is not billable in addition However, when it is necessary to counsel a family member(s) because of the patient's serious and complex problem, a case conference may be appropriate (see Question #27)

Urgent/Emergent Care

24. Are Special Calls excluded in SCHM?

Yes, SCHM is for non-urgent patient care and it excludes special calls (i.e. urgent/emergent). When it is medically required for a physician to visit 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 payable 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).

25. What is considered urgent/emergent?

An urgent/emergent condition requires care in a timely manner (i.e. the same day), 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 when billing 627A and 628A?

26. Are premiums and surcharges included?

No time-of-day or age premiums or surcharges are payable for 627A/628A as these are prescheduled services.

27. 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 an in-person 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 the *Payment Schedule for Insured Services* requirements.

Indirect/Direct care cannot be billed in addition to a partial assessment or any other visit type service (3B, 5B, 805Betc.), 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 the appropriate Special Care Home Management service code the next day, provided that SCHM billing criteria is satisfied.

28. 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, a case conference (42B, 43B, 44B, max 2 per year) is payable per the billing criteria outlined in the Payment Schedule.

If the medication review is done in the presence of the patient, and all other Direct Care criteria have been met, Direct Care may be billed.

29. How do I bill a Case Conference?

A Case Conference (42B/44B) is not included in SCHM fees and is payable in addition when the service provided meets the service code criteria. A case conference must be a formally scheduled session, it can be billed to a maximum of twice per patient per year. See the *Payment Schedule for Insured Services* for full details and requirements.

30. How do the Counselling fee codes (40B/41B or 840B/841B) apply to the SCH care provision?

Counselling fee codes (40B/41B or 840B/841B) are payable on a third-party basis when a family member is counselled (either in person (40B/41B) or via telephone or secure videoconference (840B/841B)) because of the patient's serious and complex problem (not for routine briefing or advice). It must be provided at a booked separate appointment. The counselling codes are subject to a maximum of 30 minutes and should be submitted in the counselled individual's name. The diagnosis must be confirmed, or the diagnostic code Z84 must be used.

See the Payment Schedule for Insured Services for further service requirements.

Facilities

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

Facilities that are included are Special Care homes as defined in *The Facility Designation Regulations* for patients receiving:

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

Hospitals* or health centres as defined in *The Facility Designation Regulations* for patients receiving:

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

e) Level 4 care

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

Personal Care Homes as defined in *The Personal Care Homes Act* remain excluded from payment under this code.

32. 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.

33. 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

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

Because there is variation in how each physician and each facility operates it is recommended that you have a conversation with your facilities/management/staff about how patients, staff, and physicians' needs will be met with the SCHM codes:

- Establish a system of communication for Indirect care with SCH staff
  - Consider creating a regular time for non-urgent phone calls during regular business hours at least disruptive times.
  - Explore with SCH staff if emails/faxes can be batched, with highest priority first.
- Establish a system of arranging Direct care 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 care visits.
- Coordinate case conferences – these are formally scheduled, multi-disciplinary conferences (max 2 per year).
- Vacation/Time Off – How to plan for continuous care while you are away.