Billing in Long Term Care

Abhishek Narayan MD CCFP (COE)

Faculty/Presenter Disclosure

- Faculty: Abhishek Narayan

- Relationships with financial sponsors:
  - Any direct financial relationships including receipt of honoraria: Pfizer, OMA, OLTCC
  - Memberships on advisory boards or speakers' bureau: Pfizer
  - Patents for drugs or devices: Nil
  - Other: financial relationships/investments: nil

Disclosure of Financial Support

- Potential for conflict(s) of interest:
  - Abhishek Narayan has received payment from OLTCC for this program

Mitigating Potential Bias

- No Bias in any Presentations.
- However, should one advertently be introduced by a speaker a committee member will ask the presenter to address the bias at the end of his/her presentation.
- Also, a review of the evaluation forms post-conference will be reviewed for any bias noted and will follow up with the speaker.
- A resolution of bias will include altering control over content or independent content validation.

Billing For the Resident Journey

- General Considerations
  - Only Fee Codes are Presented
  - No $ given due to current flux in OMA RA relativity work / top up
  - Will work through the patient journey and explore typical billing situations
  - Base code stipulations apply (ie time, location, charting requirements)
  - Break down of PEM vs FSS
  - On-Call funding will be reviewed

Billing For the Resident Journey

- Admission to the Home
- Stay in the Home; Routine care,
- Care Conference, Family meetings
- Medical Instability during the Stay
  - On Call Billings
- EOL Care

Billing For the Resident Journey

- Admission to the Home
- Stay in the Home; Routine care
- Care Conference, Family meetings
- Medical Instability during the Stay
  - On Call Billings
- EOL Care

Admission to LTC

First and Only* Decision Point

- Fee For Service
  - Individual fee code for each separate assessment/encounter
- Monthly Management Fee
  - Basket of services included in 1 monthly assessment code

Admission to LTC

Fee For Service

- W102- Type 1
  - General Assessment on Admission
- W104 - Type 2
  - Admitting physician has rendered a consultation, general assessment or reassessment prior to admission
- W107 - Type 3
  - Readmission of a resident to LTC after a 3 day stay in another institution

Admission to LTC

First Decision Point

- Fee For Service
  - Individual fee code for each separate assessment/encounter
- Monthly Management Fee
  - Basket of services included in 1 monthly assessment code

Admission to LTC

Monthly Management

- W010
  - For managing the routine medical care of residents in LTC with one or more stable medical diagnoses.
  - Provision by the MRP (most responsible physician) of routine medical care, management and supervision of a patient in Long Term Care.
  - Requires a minimum of 2 assessments/month as described in the “W” prefix assessments.

Billing For the Resident Journey

- Admission to LTC
- Stay in LTC; Routine care,
- Care Conference, Family meetings
- Medical Instability during the Stay
  - On Call Billings
- EOL Care

Stay In LTC

- Fee For Service
  - Individual fee code for each separate assessment/encounter
- Monthly Management Fee
  - Basket of services included in 1 monthly assessment code

Stay in LTC – Routine Care

Fee For Service

- W003
  - First 2 visits per month
- W008
  - Subsequent visits max 2/month
- W872
  - Palliative Care – no limit
- W121
  - 5th Visit or more, needs manual review

All these codes pay the same amount.

Stay in LTC – Routine Care

Fee For Service

- W903 / W904 – Pre-op / Pre-dental
- W109, W004 – Periodic / Annual exam
- W777, W771 – Death related

Stay In LTC

- Fee For Service
  - Individual fee code for each separate assessment/encounter
- Monthly Management Fee
  - Basket of services included in 1 monthly assessment code

Stay in LTC – W010

Monthly Management

- All med reviews
- All telephone calls M-F (non holiday) from staff or SDM
- Any ODB LU Forms
- Any age related Premiums.

Stay in LTC – W010 What's IN?

Monthly Management

- W102/W104/W107 – Admission assessments
- W003 and W008
- W121
- W872 - Palliative care visits
- W903 – Pre-op
- W109, W004 – Annual exam
- W777, W771 – Death related
- G271

Stay in LTC – W010 What's OUT?

Monthly Management

- Visits which qualify for a special visit premium.
- Services described under interviews, psychotherapy or counselling with the patient / patient's relative(s) or patient's representative lasting 20 mins
- Services described as physician to physician telephone consultations.
- Services rendered by a specialist who is not the MRP or who is not replacing an absent MRP

Stay in LTC – W010

Monthly Management

- Must have signed contract with the facility
- Payment is once monthly to the MRP ONLY (suggested end of month)
- If the MRP only does one visit the month then only that “W” code is to be billed
- Exception to above is:
  - If the patient was newly admitted to the facility and an Admission Assessment was done, OR
  - Death of the patient while in LTC or within 48 hrs of transfer to hospital (submit with date of death)

Stay in LTC – W010 ?Exit

Monthly Management

- W010
  - Once W010 is claimed on a patient, only W010 can be claimed for the next 11 proceeding months on this patient.
  - Only exception occurs when a physician provides less than the minimum 2 W-prefix assessments during one month, in which case only the applicable W-prefix assessment code can be claimed.
- How to stop the W010?
  - Only one visit code each month for 12 consecutive months.
  - New physician
  - New facility

Stay in LTC – W010 While Fishing

Monthly Management

- If MRP is away, W010 remains payable to the patient's MRP if the service is performed by another physician.
  - Needs to meet 2 visit
- Covering Physician?
  - A codes as need

Stay in LTC

Virtual Care

- Virtual Care Services are not eligible for payment for services provided to hospital inpatients or patients in a Long-Term Care institution unless all of the following requirements have been met:
  - The physician providing the service is not the patient's MRP.
  - The hospital/Long-Term Care institution does not have a physician on staff and present in the community with the expertise to render the necessary service, as documented by the referring physician in the patient’s medical record.
  - An assessment with a direct physical encounter by the referring physician must have been completed within 30 days preceding a virtual in-patient specialist consultation to confirm the need for a consultation

Who Wins?

W010 = $115.25*

Over 1 year = $1383

*Based on unadjusted rates

Therefor there is case for non W010 billing if you are doing weekly visits.

Assume 3 visits / month, medically stable

Month 1: admission + 2 visits = $137.55

Months 2 – 12 = $1125.30

Total = $1262.84

Assume 4 visits / month

Months 2 – 12 = $1500.5

Total = $1637.95

Billing For the Resident Journey

- Admission to the Home
- Stay in the Home
  - Routine care,
- Care Conference, Family meetings, Interviews, Counselling
- Medical Instability during the Stay
  - On Call Billings
- EOL Care

6 week Care Conference

K124 - Long-term care case conference

- 1 unit = 10 mins, 2 units = 16mins, ect
- Maximum of 4 services per patient, per physician, per 12 month period.
- Maximum of 8 units of K124 are payable per physician, per patient, per day.
- Billing for MRP

Other Care Conferences

K705 - Long-term High Risk Care Case conference

- Maximum of 4 services per patient, per physician, per 12 month period.
- Maximum of 8 units of are payable per physician, per patient, per day
- Note
  - Non MRP can bill
  - High risk patient is a patient identified based on a change in the Resident Assessment Instrument - Minimum Data Set (RAI-MDS)

Family Interviews

K002

- The interview must be a booked, separate appointment lasting at least 20 minutes
- 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
- Interview is not for the sole purpose of obtaining consent.
- Must be in person

Primary Mental Health Care

K005

- Not to be billed in conjunction with other consultations and visits rendered during the same patient visit unless there are clearly different diagnoses for the two services.
- Use different diagnostic code
- Regular W visit and K005 on top based on documentation / reason for visit

Counselling

K013/K033

- Visit dedicated solely to an educational dialogue for the purpose of developing awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention.
  - Prebooked, inperson
  - Limited to 3 units per patient per physician per year at K013
  - >3 units, K033 (lesser value)

DM Codes to consider

- K029 Insulin therapy support (ITS) –
  - Maximum 6 units per patient, per physician, per year.
  - ITS rendered same patient same day as any other consultation or visit by the same physician is an insured service payable at nil.
- K030 Diabetic Management Assessment
- Q040 Diabetes management incentive
  - 1/12 month, after 3 K030

Billing For the Resident Journey

- Admission to the Home
- Stay in the Home
  - Routine care,
- Care Conference, Family meetings
- Medical Instability during the Stay
- On Call Billings
- EOL Care

Intercurrent Illness

Wxxx vs Axxx

- W121
  - Additional visits due to intercurrent illness.
  - Did not require a special visit
- “A” Codes
  - Should be used to assess another physician’s patients on an emergency basis as per General Listings (A001, A007, A003, A967……) OR if in association with a special visit

Special Visits

- Special visit means: a visit initiated by a patient or an individual on behalf of the patient for the purpose of rendering a non-elective service
- SVP are not eligible for patients seen during rounds at LTC
- Travel Premium - travel from one location to another location
- First Person Seen Premium – after hours, weekends, holidays, other
- Additional Person Premium – for non elective visits
- Add A Code for SVP

SPECIAL VISIT PREMIUM TABLE IV

Long-Term Care Institution

Premium	**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 (max. 2 per time period)	$36.40 W961 (max. 2 per time period)	$36.40 W962 (max. 2 per time period)	$36.40 W963 (max. 6 per time period)	$36.40 W964 (no max. per time period)
First person seen	$20.00 W990 (max. 10 (total of first and additional person seen) per time period)	$40.00 W992 (max. 10 (total of first and additional person seen) per time period)	$60.00 W994 (max. 10 (total of first and additional person seen) per time period)	$75.00 W998 (max. 20 (total of first and additional person seen) per time period)	$100.00 W996 (no max. per time period)
Additional person(s) seen	$20.00 W991 (max. 10 (total of first and additional person seen) per time period)	$40.00 W993 (max. 10 (total of first and additional person seen) per time period)	$60.00 W995 (max. 10 (total of first and additional person seen) per time period)	$75.00 W999 (max. 20 (total of first and additional person seen) per time period)	$100.00 W997 (no max. per time period)

Form 1

K623

- Application for psychiatric assessment in accordance with the Mental Health Act includes necessary history, examination, notification of the patient, family and relevant authorities and completion of form.
- Practical tip, submit right away!

?Resus Code – Other Critical Care

G395 / G391

- When a physician provides resuscitation assessment and procedures in an emergency in circumstances other than those described as "life threatening critical care", where there is a potential threat to life or limb of such a type that without resuscitation efforts by the physician, there is a high probability the patient will suffer loss of limb or require "life threatening critical care".
- G395 - first ¼ hour
- G391 - after first ¼ hour per ¼ hour
- Physician time spent fully devoted to the care of the patient
- Time units may include time which is consecutive or non-consecutive.

What about the E080?

- In short, no.
- This premium is not payable for visits rendered to patients in locations other than the physician's office or patient's home.
- As such, the premium is not payable for services rendered in places such as Nursing Homes, Homes for the Aged, chronic care hospitals, etc.

On Call Funding

As at 2021

- $12,943 annually for homes with 29 beds or less
- $15,532 annually for homes with more than 29 beds and less than 150 beds
- $103.54 per bed annually for homes with 150 beds or more
- +9.96% based on relativity adjustment

Billing For the Resident Journey

- Admission to the Home
- Stay in the Home
  - Routine care,
- Care Conference, Family meetings
- Medical Instability during the Stay
  - On Call Billings
- EOL Care

EOL Care

G512

- Terminally ill patient in the final year of life where the decision has been made that there will be no aggressive treatment of the underlying disease and care is to be directed to maintaining the comfort of the patient until death
- One per week (Monday to Sunday inclusive)
  - Discussion with and providing telephone advice to the patient, patient's family or POA
  - Eligible for payment only by the MRP or substitute
- G511, K071 or K072 are not eligible for payment to **any** physician
  - G512 is eligible for payment even if the service was not the entire week (ie in event of death of resident or care commences any day of the week)

EOL Care

K023

- Palliative care support is a time-based service payable for providing pain and symptom management, emotional support and counselling to patients receiving palliative care.
- Payment based on units

EOL Care

K015

- Counselling of relatives - on behalf of catastrophically or terminally ill patient
- Inperson
- Does not need to be pre-booked

EOL Care - Death

Certification of Death / eMCOD

- If MRP W777/W771 is included in W010
- If asked to do (e)MCOD outside of normal rounds OR not your patient
  - A771
  - MRP or Non MRP
- Counselling of relatives - on behalf of catastrophically or terminally ill patient

To Roster or Not?

- The other* decision point
- Q202 (LTC enrolment) to trigger rostering of LTC patients
- Negation if rostered patient assessed by non-FHO/FHN physician
- In-basket services
  - W010, A codes (A001, A004, A007, A008), K codes (K005, K013, K015)
- Out of basket services
  - K035, K032, K038, Special visit premiums
- A codes billed with SVP are still in basket and subject to negation

To Roster or Not?

- Rostering
  - Flat rate (not age and sex adjusted) of $1,223.22 per year base rate.
  - LTC patients qualify for ~~a 20.65% access bonus~~ and will receive 30% shadow billing on the fee value of the W010 ($115.25).
  - If you bill 12 W010 per year on your rostered patients, you would receive ($1,223.22) + (30% x 12 x $115.25) = $1,638/yr per patient ~~and a potential maximum of 20.65% x $1223.22 for Access Bonus.~~
  - $80/hr for time based payment
- FFS
  - (12 x W010) = (12 x $115.25)= $1,383/yr per patient.
- PEM also able to access greater BONUS

LTC and Hard-cap

- Long Term Care Codes and FFS cap:
  - Only FHO in-basket services to non-enrolled patients will count towards the FHO FFS limit.
  - The majority of LTC codes are out of the basket and as such do not contribute to the hard cap

Thank you

Abhishek Narayan
abhishek@narayanmd.com