UNDERSTANDING NEW BILLING CODES:

Your Guide to Non-Face-to-Face Fees

MAY 2017

CONTENTS

DNS: HERE TO HELP

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Doctors Nova Scotia

Letter from The Fee Committee

WHAT IS THE FEE COMMITTEE?

The Fee Committee (previously the Fee Schedule Advisory Committee, or FSAC) reviews all applications to add, enhance or reduce fees; it can also make changes to the Preamble. The Fee Committee has the authority to make final decisions on fee applications, where there is unanimous agreement and sufficient budget. If the Fee Committee is unable to reach consensus, the issue will be referred to the Master Agreement Management Group for decision.

The Fee Committee includes representatives from Doctors Nova Scotia, the Department of Health and Wellness and the Nova Scotia Health Authority.

Your Doctors Nova Scotia Fee Committee representatives are Dr. James Clarke (co-chair), Dr. Michelle Raiche-Marsden, Dr. Kevork Peltekian, Dr. Alison Wellwood and Dr. Ken Wilson (alternate). (Read more on page 11.)

DEAR COLLEAGUE,

After a long implementation process, I'm happy to present this guide to billing the four new non-face-to-face health service codes (HSC) that resulted from the 2015 Master Agreement contract negotiations.

These HSCs were negotiated as a means to improve patients' access to primary care and to remunerate physicians who are offering new modes of care. Replacing office visits with telephone conversations benefits patients, who can get timely advice without leaving home. We believe it will also create more flexibility for physicians to interact with their patients in new ways.

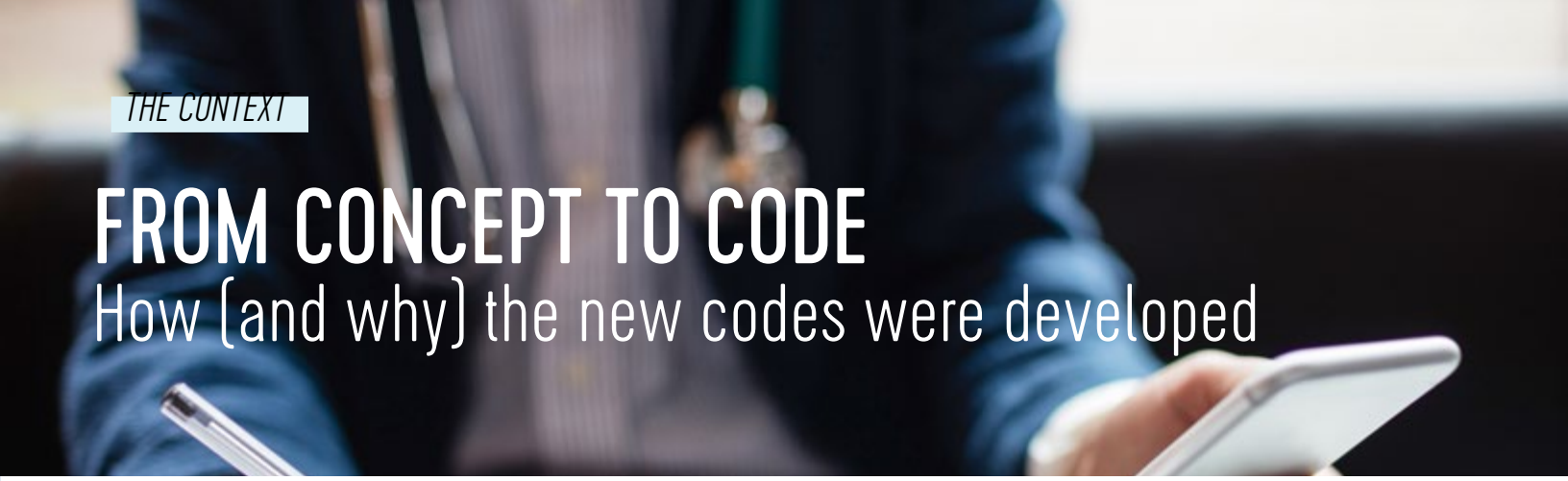
We know the billing rules are a bit cumbersome. The Fee Committee will be closely monitoring use of the codes over the coming months, and will have an opportunity to consider improvements as needed. In the meantime, we need to prove that the codes are effective – that's why the Fee Committee is tracking whether or not telephone conversations replace an in-person visit. (Read more on page 7.)

Inside, you'll find a detailed guide to understanding and billing the four new codes, examples of handy templates you can use to help you ensure you're recording the information required for each billing, and a FAQ that provides answers to some common questions.

If you have any questions or comments, please don't hesitate to get in touch with Doctors Nova Scotia's staff members – you'll find their contact information on page 12.

Yours truly,

Dr. James Clarke
Co-chair, Fee Committee



THE CONTEXT

FROM CONCEPT TO CODE

How (and why) the new codes were developed

In June 2016, after more than a year of active negotiations, Doctors Nova Scotia (DNS) members ratified the 2015 Master Agreement contract. That contract included $14 million in new investments, $3 million of which was earmarked to support non-face-to-face patient care – that is, patient-care services provided over the telephone.

After the contract was ratified, the Fee Committee began ironing out the details of the new, non-face-to-face health service codes (HSCs). This required multiple meetings of the Fee Committee.

On April 1, 2017, four new HSCs for reporting non-face-to-face telephone services came into effect. These fees are available to all family physicians and specialists – fee-for-service, APP and C/AFP. (These new codes are available to APP and C/AFP physicians to help meet shadow-billing thresholds).

Both family physicians and specialists may bill for physician-to-physician and physician-to-patient phone interactions that are charted in the patient's record.

- Physician-to-physician telephone interactions must be accompanied by a written request from a family physician and must be charted by both the specialist (or consultant) and family (or referring) physician.
- For family physicians, physician-to-patient telephone interactions will be billable only where the patient falls into *at least one* of the following three categories: (1) 65 years of age or older; (2) suffering from mental illness; or (3) suffering from two or more chronic diseases.
- For specialists, there are no restrictions on the type of patients who can receive care over the phone.

TIPS AND TRICKS:
For tips on recording this information, see page 8.

FAMILY PHYSICIANS

SERVICE	HEALTH SERVICE CODE	MSU	FEE VALUE	EFFECTIVE DATE	BILLABLE DATE
Family physician-to-specialist phone call (family physician requesting advice from specialist)	CONS 03.09L	11.5	$28.06	April 1, 2017	May 18, 2017
Family physician-to-patient phone call	CONS 03.03R	11.5	$28.06	April 1, 2017	May 18, 2017

SPECIALISTS

SERVICE	HEALTH SERVICE CODE	MSU	FEE VALUE	EFFECTIVE DATE	BILLABLE DATE
Specialist-to-physician (or NP) phone call (specialist providing advice to referring provider)	VIST 03.09K	25	$61.00	April 1, 2017	May 18, 2017
Specialist-to-patient phone call	VIST 03.03Q	11.5	$28.06	April 1, 2017	May 18, 2017

KEY POINTS:

1. The Negotiations Steering Committee identified fees for non-face-to-face patient care as a top priority for negotiations, based on member input.

2. This is the first time in Canada that physicians will have such wide access to fees supporting non-face-to-face care.

The Fee Committee has developed detailed billing rules, which were communicated in the March 24 and May 18 MSI *Physician's Bulletin*s. For a plain-language summary of the billing rules, see page 5.

EARNING OPPORTUNITIES

The non-face-to-face health service codes provide earning opportunities for both family physicians and specialists. A family physician who adds five telephone interactions per week will earn $7,295.60 per year, while a specialist who adds three telephone consults with family doctors and two telephone interactions with patients per week will earn $12,434.24 per year (assuming a 52-week year). In both cases, physicians will be creating improved access and convenience for patients.

EVALUATION

The Fee Committee will evaluate this program 18 months after implementation (see more on page 7). If the evaluation concludes the fees were not successful (based on success factors pre-determined by the Fee Committee) the funding will be re-directed to support other non-face-to-face patient care. The evaluation and decisions will be made jointly between DNS and the DHW.

INTO PRACTICE
Which code to use for which service

The health service codes CONS 03.09K and 03.09L , and VIST 03.03Q and 03.03R are to be used for reporting non-face-to-face telephone consultations between consultant and referring physicians and between physicians and patients.

Non-face-to-face services are intended to:

- replace an office visit for the patient, when a physical examination is not required
- provide timely advice
- avoid travel expenses for the patient
- improve access to comprehensive primary care
- allow care to be managed at a distance and close to home, when appropriate

The billing instructions and guidelines for this new service are very comprehensive. The following snapshot of the new codes is simply a guide; please refer to the May 18 MSI *Physician's Bulletin* for greater detail or contact a DNS staff member for assistance (see page 12).

PHYSICIAN-TO-PHYSICIAN PHONE CALLS (VIST 03.09K, VIST 03.09L)

	CONSULTANT PHYSICIAN - VIST 03.09K	REFERRING PHYSICIAN - VIST 03.09L
What is the HSC?	CONS 03.09K	CONS 03.09L
What is my role?	The **consultant physician** provides an expert opinion **in response to a written request** for a consult from a referring physician or nurse practitioner	The **referring physician** is a **family physician or specialist** (or nurse practitioner) who has **requested an expert opinion** in writing
What is required to schedule the call?	Consultant physician must receive a written (emailed or faxed) request for a consult from the referring physician Call must be scheduled for 15 minutes	Referring physician must send written (emailed or faxed) request for consult to consultant physician Call must be scheduled for 15 minutes
What has to happen during the call?	Two-way medical discussion must last for at least five minutes Call must include a discussion of the clinical situation followed by a management decision	Two-way medical discussion must last for at least five minutes Call must include a discussion of the clinical situation followed by a management decision
What must be documented in the patient's chart?	Written request sent to specialist must be available in patient's chart Name of referring physician (or NP) Patient name, identifying data, date and start/stop time of call Review of patient history, family history and history of present complaint Diagnosis, reason for referral, elements of history and physician, opinion of consultant physician and plan for future management Specialist must send written report to referring provider	Written request sent to specialist must be available in patient's chart Name of consultant physician Patient name, identifying data, date and start/stop time of call Review of patient history, family history and history of present complaint Diagnosis, reason for referral, elements of history and physician, opinion of consultant physician and plan for future management Copy of written report from specialist
What needs to be included in the MSI text field?	Call start and stop times Whether the call replaced a face-to-face visit (yes/no/maybe) Specialists must include: • Referring physician's billing number • Date referral received	Call start and stop times Whether the call replaced a face-to-face visit (yes/no/maybe)

	CONSULTANT PHYSICIAN - CONS 03.09K	REFERRING PHYSICIAN - CONS 03.09L
Which patients are eligible?	New patients or an established patient with a new condition or exacerbation of existing condition	New patients or an established patient with a new condition or exacerbation of existing condition
Which calls are billable?	Family physician to specialist Family physician to palliative care family physician Nurse practitioner to specialist Specialist to specialist Calls with out-of-province physicians (as long as all other eligibility criteria are met)	Family physician to specialist Family physician to palliative care family physician Nurse practitioner to specialist Specialist to specialist
Which calls are NOT billable?	The call lasted less than five minutes The providers work in the same institution or practice location The call is for an administrative task (for example, to arrange a transfer, hospital bed, telemedicine consult, lab or diagnostic imaging tests) The call is to discuss the results of lab tests or other diagnostic procedures The call is to decline a consult The call was delegated to another provider (such as a nurse practitioner or resident) The call is a follow-up call within 14 days, necessary to complete the consultation The call was preceded by a face-to-face visit with the patient within previous 14 days for consultant or their call group The call results in a face-to-face visit within 14 days or next available appointment for consultant The physician has provided any other service for same patient on same day	The call lasted less than five minutes The providers work in the same institution or practice location The call is for an administrative task (for example, to arrange a transfer, hospital bed, telemedicine consult, lab or diagnostic imaging tests) The call was delegated to another provider (such as a nurse practitioner or resident) The call is a follow-up call within 14 days, necessary to complete the consultation Note: Referring physician can bill for a patient visit on same day as a telephone consult when the matter is urgent

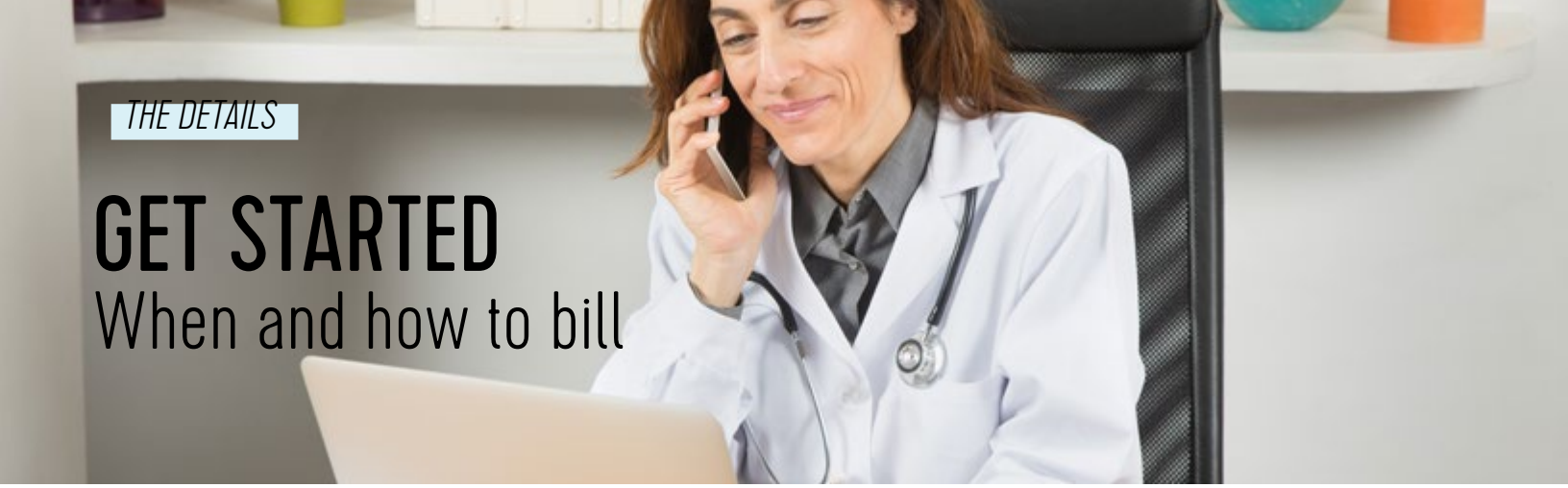
PHYSICIAN-TO-PATIENT PHONE CALLS (VIST 03.03Q, VIST 03.03R)

	SPECIALIST PHYSICIAN	FAMILY PHYSICIAN
What is the HSC?	VIST 03.03Q	VIST 03.03R
What is my role?	A **specialist** calling to talk to a patient (or their parent, guardian or written proxy) to discuss the patient's condition and management plan	A **family physician or nurse practitioner** calling to talk to a patient (or their parent, guardian or written proxy) to discuss the patient's condition and management plan
Which patients are eligible?	All patients *except* those who are facility-based Established patients (or parent, guardian, written proxy) only Patient must have been seen face-to-face within the previous nine months but *not* within the previous seven days	Non-facility-based patients who meet one of the following criteria: • 65 years of age or older • Suffering from a mental illness (DSM diagnosis) • Suffering from two or more chronic diseases (no list of qualifying diseases – see definition in Billing Rules) Established patients (or parent, guardian, written proxy) only Patient must have been seen face-to-face within the previous nine months, but *not* within the previous seven days
What is required to schedule the call?	Call must be scheduled for 15 minutes	Call must be scheduled for 15 minutes

	SPECIALIST PHYSICIAN - VIST 03.03Q	FAMILY PHYSICIAN - VIST 03.03R
What has to happen during the call?	Medical discussion must last for at least five minutes Call must include a discussion of the clinical situation followed by a management decision Affirm that patient (or parent, guardian, written proxy) understands and acknowledges the information provided	Medical discussion must last for at least five minutes Call must include a discussion of the clinical situation followed by a management decision Affirm that patient (or parent, guardian, written proxy) understands and acknowledges the information provided
What must be documented in the patient's chart?	Date of call, with start and stop times Content of the discussion and management plan Note that patient (or parent, guardian, written proxy) has indicated they understand and acknowledge the information provided (note: this is important for both medico-legal and billing/audit purposes) Specialist must send written report of call to referring provider	Date of call, with start and stop times Content of the discussion and management plan Note that patient (or parent, guardian, written proxy) has indicated that they understand and acknowledge the information provided (note: this is important for both medico-legal and billing/audit purposes)
What must be documented in the MSI text field?	Date of call, with start and stop times Whether the call replaced a face-to-face interaction (yes/no/maybe)	Date of call, with start and stop times Whether the call replaced a face-to-face interaction (yes/no/maybe) Family physicians should note "same-day access" if they were able to offer same-day telephone call
Which calls are NOT billable?	The call lasted less than five minutes The patient has been seen within the preceding seven days by same physician for same condition The decision is to see the patient at next available appointment The call is for an administrative task (such as arranging appointments or tests, renewing a prescription, informing patient of test results with no change in management plan) The call was to or about a facility-based patient The call was delegated to another provider (such as a nurse practitioner or resident) The call is in addition to any other service provided to the same patient by the same physician on the same day	The call lasted less than five minutes The patient has been seen within the preceding seven days by same physician for same condition The decision is to see the patient at next available appointment The call is for an administrative task (such as arranging appointments or tests, renewing a prescription, informing patient of test results with no change in management plan) The call was to or about a facility-based patient The call was delegated to another provider (such as a nurse practitioner or resident) The call is in addition to any other service provided to the same patient by the same physician on the same day The call is to or from a walk-in clinic (see definition in Billing Rules)
Is there a billing ceiling?	Yes. This code is billable a maximum of four times per patient per year	Yes. This code is billable a maximum of four times per patient per year

NOTE: THE NEW NON FACE-TO-FACE HEALTH SERVICE CODES REPLACED CODES 03.03F, 03.03I, 03.09D, 03.09E AND 03.09F (GI PILOT AND PACS) EFFECTIVE MARCH 31, 2017. PHYSICIANS SHOULD CEASE USING THE OLD CODES. SERVICES THAT WOULD HAVE BEEN SUBMITTED USING THE DISCONTINUED CODES SHOULD BE CLAIMED USING THE NEW CODES.

Read the full details in the May 18 Physician's Bulletin at goo.gl/qbmHIJ



THE DETAILS

GET STARTED
When and how to bill

Effective May 18, 2017, physicians may bill for select non-face-to-face services (as described on page 5) rendered on or after April 1, 2017.

Bill as usual for these codes, ensuring that you note the extra information noted below.

Physicians and billing clerks should review the requirements carefully before submitting claims for the new codes.

CAPTURING INFORMATION

It's crucial to include all the information needed when billing these codes. This information serves two purposes – to prove to MSI that the service was provided according to requirements (especially in the case of an audit) and to demonstrate to the Fee Committee that the fees are supporting the provision of non-face-to-face care.

Here are some examples of checklists you can create to ensure you're capturing all the data you need.

EXAMPLE 1:

These Excel forms were created by Beverly Thomas, billings coordinator in the department of obstetrics and gynecology at the IWK Health Centre, to track initial and follow-up telephone consultations.

Telephone Consultation Form Non Face to Face	Referring Doc Consultant	Provider # Provider #	Location Location
Date Written Referral Received			
Scheduled Date of Call	Start time	Stop Time	Call Back Urgent
Patient Name HCN DOB			
Reason for Referral:			
Last Face to Face visit: **			
Patient's History:			
Family History:			
Assessment:			
Plan:			
Diagnosis			
Has this service replaced a face face to face service? Yes No Maybe			

A written report must be sent to the referring provider

*Is reportable only if rendered **personally** by the physician - **no Medical student, resident or fellow**

* Not billable by the consulting physicain if the patient has had a face to face visit with the consultant or any member of his/her call group within the previous 14 days for the **same condition**, or if the telephone consultation results in a face to face service within the next 14 days or the next available appointment of the consultant.

*Not billable for calls between a referring provider and specialist in the same institution or practice location

*Not billable if call is less than 5 mintues

*if subsequent phone calls are necessary within 14 days to complete the consultation they are considered included in the telephone consultation.

*The consultant Physician HSC is not reportable in addition to any other services for the same patient by the same physician on the same day

Telephone Follow-up Form with patient	Referring Doc Consultant	Provider # Provider #	Location Location
Date of Face to Face Consultation			
Scheduled Date of Call	Start time	Stop Time	
Patient Name HCN DOB			
Reason for Referral:			
Last Face to Face visit: **			
Patient's History:			
Family History:			
Assessment:			
Plan:			
Does the patient understand and acknowledges the information provided? Yes No			
Diagnosis			

A written report must be sent to the referring provider

*Is reportable only for **scheduled** telephone appts. and rendered **personally** by the physician and is not reportable in addition to any other services for the same patient by the same physician on the same day

*This health service code may be reported for a scheduled **15 minute** telephine call (minimum of 5 minutes of two way medical discussion) between the specialist **physician and the patient** or quardian, who has **previously had a face to face consultation visit or procedure by the same phycician within the last 9 months and has not been seen within the last 7 days.**

*This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required.

* Limited to 4 times per patient per physician per year

* Not reportable for facility based patients

*The consultant Physician HSC is not reportable in addition to any other services for the same patient by the same physician on the same day

DOWNLOAD THE EXAMPLES
DIGITAL FILES OF THE WHEN AND HOW TO BILL EXAMPLES ARE AVAILABLE AT WWW.DOCTORSNS.COM/EN/HOME/PRACTICERESOURCES/NF2FTEMPLATES

EXAMPLE 2:

This checklist was created by Dr. Alison Wellwood, Fee Committee member and family physician in Wolfville, N.S. She saves the template as a note in her EMR, then copies and pastes items 7, 8 and 9 into the MSI text field, modifying as necessary.

PRE-BOOKED TELEPHONE APPOINTMENT

*REMINDER - update # of phone call appts in last 12 months in ALERTS (4 per 12 months permitted)

*START TIME:

*Reason for Phone Appointment:

*Discussion:

*Management Decision:

Reviewed understanding of information and plan with patient and/or consented guardian and they do acknowledge an understanding of the content of our documented discussion, above.

FOR BILLING

*1. Pt meets demographic criteria (one of the following):
   a. >65 years: Y/N
   b. Suffering from mental illness per DSM criteria: Y/N
   c. Two or more chronic diseases: Y/N
   Chronic disease defined as: "A condition expected to last at least 12 months or until the death of the patient. The chronic condition must place the patient at significant risk of acute exacerbation/decompensation, functional decline or death."

2. If communication with Pt's proxy, written consent on chart?: Y/N
3. Pt seen within last 9 mo with exam: Y/N
4. Pt seen for same issue in <7 days: Y/N
5. Pt seen for another service on same day as phone call: Y/N
6. Pt advised to be seen at next available office visit: Y/N
*7. Phone appointment replaced a face-to-face service: Y/N
*8. Same-day access?: Y/N
*9. TIME (start time: finish time):_____
   Times recorded above reflect medical discussion with patient or patient's proxy (with written consent)

FOR YOUR CONSIDERATION

Having trouble deciding when to claim the new codes or how to work non-face-to-face care into your routine? Here are some recommendations from Dr. Alison Wellwood.

Q. When might the physician-to-patient calls be useful to family physicians?

A. Telephone services are a good way to interact with frail, elderly and palliative patients when their situation does not indicate the need for an exam, for example: providing cardiovascular counselling if blood pressure has been taken recently; smoking cessation follow-up; bone mineral density follow-up if recent height is on chart; medication adjustments for palliative patients.

Q. When might the physician-to-physician calls be useful?

A. Physician-to-physician calls benefit patients who do not want to (or cannot easily) travel to see a specialist in person.

Physician-to-physician calls also help family physicians dealing with complex cases, where the family physician is comfortable with the medication and management as long as they can benefit from some specialist guidance and advice.

Finally, billing these HSCs provides physicians with good motivation to document calls between physicians that may be taking place already but are not often documented, since we know documenting those discussions is important for medico-legal purposes.

Q. How can I incorporate non-face-to-face care into my work?

A. Start by making room in your schedule for phone calls, either by adding calls to your daily schedule, replacing some face-to-face visit slots with non-face-to-face slots, or by combining the two.

Start suggesting the option of a phone consult in lieu of a regular consult in appropriate cases when writing referral letters to specialists.

Make it easy for yourself by setting up a standard note for these calls (see left) so no elements are omitted and you are reminded of the criteria each time you chart a call.

METRICS FOR SUCCESS

The Fee Committee will be monitoring the use of these codes over time. We are hopeful that usage will confirm the value of these codes for patients, providers and the system overall. In order to make this happen, the Fee Committee will need to prove that the codes are effective – that's why **it's important to track whether or not the telephone conversations replaced an in-person visit** when you're billing.

THE DETAILS

FREQUENTLY ASKED QUESTIONS

Derek Law, fee-for-service compensation manager at Doctors Nova Scotia, answers common questions about the new non-face-to-face health service codes (HSCs).

Q. The billing guidelines for the non-face-to-face HSCs state I must schedule a call for 15 minutes with the patient. What if the conversation doesn't require the full 15 minutes?

A. While the call has to be scheduled for 15 minutes, you may bill the fee code as long as the call lasts at least five minutes and the other eligibility criteria are met.

Q. I'm a family physician. Why does the scheduled follow-up call require that my patient must either be over 65, have two chronic diseases or have a mental illness, while specialists do not have to meet these requirements?

A. These codes are in many cases unprecedented in Canada, especially the family physician-to-patient codes. As a result, the Department of Health and Wellness felt it was important to define patient eligibility criteria; these three patient categories were agreed upon during negotiations. According to sample research done by Doctors Nova Scotia, the three categories represent a high proportion of family physicians' patients.

Q. Can I bill the non-face-to-face HSC when I encounter a specialist in the hallway and we talk about a patient?

A. No, that would not fulfil the criteria. In order to qualify for the non-face-to-face fee, the communication has to be conducted by telephone and it must be pre-arranged through a written request by the referring physician and a scheduled time for the call. Additionally, the service is not reportable for calls between a referring provider and specialist working in the same institution or practice location.

Q. I'm a radiologist. Can I charge the non-face-to-face HSC for a phone call to the physician to deliver test results?

A. No. This fee code is not intended for reporting test results to physicians, it is intended to replace or avoid a patient visit.

Q. I work at a hospital. If a family physician asks for advice about a patient who I have not seen at the hospital, the patient won't have a hospital ID number, and I can't dictate a report. What do I do?

A. You are correct – the patient needs a hospital ID number for you to dictate a report. If the patient has ever been seen at the hospital, they should have an ID number already. If not, your office should request an ID number for the patient through Health Records.

Q. I am a specialist. The requirements for billing the physician-to-physician codes look too cumbersome. Wouldn't it be better for me to see the patient in person?

A. The opportunity to save patients the cost and inconvenience of a trip to an appointment is a benefit to patients and may alleviate some hospital congestion. In addition, while the 25 MSU you can bill for a phone consult with another physician may be less than you can bill for face-to-face consult with a patient, it is often more than you can bill for a follow-up visit with a patient.

MEET THE FEE COMMITTEE

The Fee Committee is responsible for providing decisions on all matters pertaining to the MSI *Physician's Manual*.

The Fee Committee includes representatives from Doctors Nova Scotia, the Department of Health and Wellness and the Nova Scotia Health Authority. Your physician representatives are:

DR. JAMES CLARKE, CO-CHAIR

Dr. Clarke is a radiologist with a subspecialty in nuclear medicine at the QEII Health Sciences Centre in Halifax. He is also associate head of and assistant professor in the Department of Diagnostic Radiology at Dalhousie Medical School. He has served on the Fee Committee since February 2010 and has served as co-chair since July 2012.

DR. KEVORK PELTEKIAN

Dr. Peltekian is a hepatologist, professor and head of the Division of Digestive Care and Endoscopy in the Department of Medicine at Dalhousie University in Halifax. He has served on the Fee Committee since November 2012.

DR. ALISON WELLWOOD

Dr. Wellwood is a family physician in Wolfville, N.S with interests in preventative medicine, family practice obstetrics, and women's health. She has served on the Fee Committee since September 2016. Dr. Wellwood volunteers on the Baby Friendly Initiative Committee.

DR. KEN WILSON

Dr. Wilson worked as a pediatric plastic surgeon for 32 years before retiring from clinical practice. He is now Doctors Nova Scotia's medical consultant, providing billing, audit and appeal support to members of the association. Dr. Wilson serves as an alternate on the Fee Committee.

DR. MICHELLE RAICHE-MARSDEN

Dr. Raiche-Marsden is a family physician at Woodlawn Medical Clinic in Dartmouth, N.S. She has served on the Fee Committee since October 2008.

WHO TO CALL

Doctors Nova Scotia staff members are available to help clarify fee codes and provide billing audit and appeal support. For more information, contact:

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