FAMILY PRACTICE
RENEWAL PROGRAM

FEE CODE INITIATIVE

QUICK REFERENCE GUIDE

TABLE OF CONTENTS

THE FEE CODE INITIATIVE

The intent of the Fee Code Initiative is to enhance the current fee-for-service schedule through the introduction of new codes designed to achieve the following goals:

- Improved comprehensive care for patients.
- Improved access to appropriate patient care.
- Increased coordination and collaboration between family physicians and other primary health care providers.
- Improved health outcomes, particularly among high-needs populations and those living with chronic disease(s).
- Improved recruitment and retention of family physicians.
- Improved patient-physician longitudinal attachment, particularly for those living with chronic disease(s).

The program's first codes provide participating physicians with compensation for collaborative team-based care, conferencing with other health care providers on patient care and providing care to a patient by telephone.

FEE CODE	FEE CODE NAME	DESCRIPTION
520	**SHARED CARE CODE**	• Payable to fee-for-service family physicians for two-way collaborative conferencing, either by telephone or in person, between the family physician and at least one other primary health care provider, excluding other family physicians and specialists. The conferencing provider must be a licensed or regulated primary care professional in the province of NL. Examples include: - Licensed Practical Nurses - Paramedics - Registered Nurses - Nurse Practitioners - Psychologists - Social Workers - Licensed Therapists and Counsellors - Registered Dieticians - Physiotherapists - Occupational Therapists - Pharmacists - Audiologists - Respiratory Therapists - Speech-Language Pathologists • Conferencing cannot be delegated. • Participation of the patient is not required for the code to be billed. • If the patient is present, the conference is payable at $30 per 15 minutes (i.e. one unit), in addition to the normal visit fee. • If the patient is not present, the conference is payable at $30 per the greater part of 15 min (e.g. after 8 minutes of visit time). • The fee is payable on the same calendar day as a visit. • Conferences are payable to a maximum of 2 units per patient per day. • Conferences are payable to a maximum of 100 units per physician annually. • The care plan must be recorded in the patient's chart and must include: - Patient's name - Date(s) and time(s) of service - Diagnosis - Reason for need of clinical action plan - Health Care Providers with whom the physician conferred and their role in the provision of care - Clinical plan determined (including tests ordered and/or

		• This fee is <u>not</u> payable for situations where the purpose of the conference is to: - Book an appointment - Arrange for expedited consultation or procedure - Arrange for laboratory or diagnostic investigations - Arrange a hospital or long term care bed for a patient - Provide notification of services performed The conference must: - Be pertinent to the treatment of the patient's current condition - Involve two-way collaboration to determine an appropriate care plan for the patient • If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods. • The payment is made to the family physician regardless of who initiates the consultation. • The fee is <u>not</u> payable to physicians who are working under salary, service contract or sessional arrangements.

FEE CODE	FEE CODE NAME	DESCRIPTION
521	**PATIENT CARE TELEPHONE CODE**	• Payable to fee-for-service family physicians for two-way telephone communication between the physician (or other primary health care provider employed within the physician's office) and the patient (or the patient's medical representative). The primary healthcare provider employed within the physician's office would need to be one of the following: - Licensed Practical Nurses - Registered Nurses - Nurse Practitioners - Psychologists - Social Workers - Licensed Therapists and Counsellors - Registered Dieticians - Physiotherapists - Occupational Therapists - Pharmacists - Audiologists - Respiratory Therapists - Speech-Language Pathologists • This code is not tied to a specific condition. • Can be used at the discretion of the family physician for any patient for whom he/she is the designated primary care physician. • Telephone call is payable at $10 per 5 minutes (i.e. one unit). • Calls are payable for 4 units per patient per day. • Calls are payable to a maximum of 225 units per physician annually. • Chart entry must record: - Name of the person who communicated with the patient or patient's medical representative. - Elements of the care discussed. • The fee is payable on the same calendar day as a visit for a separate interaction with the patient (i.e. can be billed on the same day as an office visit with the patient). • Not payable for: - Simple prescription renewals - Notification of normal test results - Notification of office, referral, or other appointments • The payment is made to the family physician regardless of who initiates the call. • Not payable to physicians who are working under salary, service contract or sessional arrangements.

FEE CODE	FEE CODE NAME	DESCRIPTION
522	**COPD MANAGEMENT CODE**	…… 50.00 This code is an add-on to an office or hospital outpatient partial assessment or to a chronic disease management visit. This code is also payable as an add-on to the following visits which occur in a home or DHCS long term care facility: 210, 246a, 252, 285, 286a, 292. It is payable to the family physician who is most responsible for the majority of the patient's longitudinal care. Documentation of this service is based on the COPD Patient Care Visit Template for documenting guideline-informed care. Please see https://familypracticerenewalnl.ca/fee-code-program/#resources for further information. 1. Minimum requirements for the type of visit billed above in association with fee code 522 as set out in the General Preamble must be met. For example, if you are billing chronic disease management with fee code 522, please refer to preamble section 7.6 for billing requirements. 2. The diagnostic code submitted on the claim for the applicable visit as well as for fee code 522 must be one of the "Chronic Obstructive Lung Disease" ICD-9 diagnostic codes 491, 492, 494, or 496. 3. Fee code 522 can only be billed to a maximum of two billings per patient for a maximum of eighty patients per physician per billing year. 4. Minimum medical record requirements—COPD Patient Care Visit Template: For all billings: • Completed date, name, and MCP number. • Completion of the "Spirometry" section, indicating: **a)** the COPD diagnosis has been confirmed by a post-bronchodilator FEV_1/FVC ratio of < 0.7; **OR** **b)** a **medical** reason why the patient is unable to perform spirometry. For example, acceptable medical reasons why a patient may not be able to perform spirometry include anxiety or active tuberculosis, etc.; **OR**

		c) spirometry has been ordered. Please note that if this option is chosen, it is only valid for the first two billings of fee code 522. For the third billing, one of a) or b) above must be satisfied for billing to proceed. • Completion of the "Exacerbations" section. *Med Access EMR Users: click here for an **instructional document** and here for an **instructional video** on accessing and using the patient care visit template.* *Non-Med Access EMR Users (i.e. other EMRs, paper-based clinics): click here to access a downloadable PDF of the visit template.*

HELPFUL HINTS

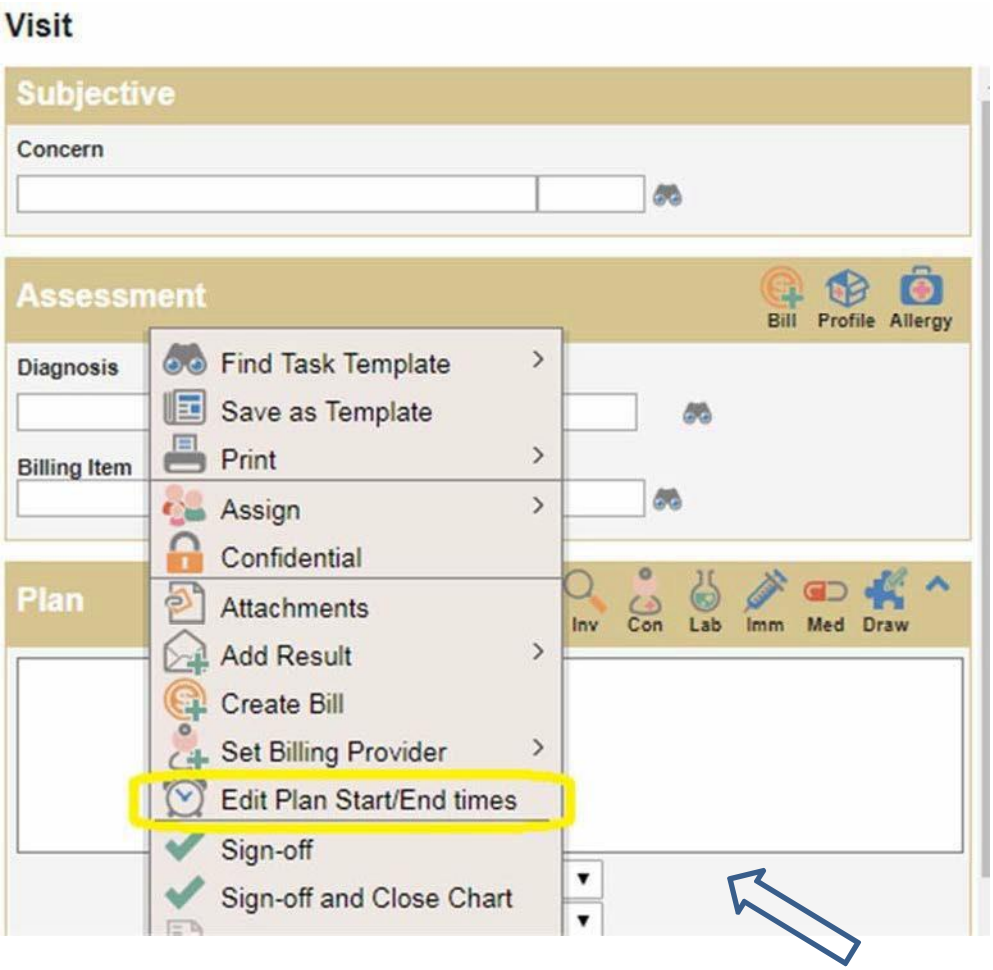
Helpful Hint #1:
Diagnostic codes are still encouraged with the use of billing codes!

HELPFUL HINTS: MED ACCESS EMR USERS

Helpful Hint #1:
The easiest and most efficient way to generate a billing code for a shared conference or a patient care telephone call is to enter each as a NEW VISIT.

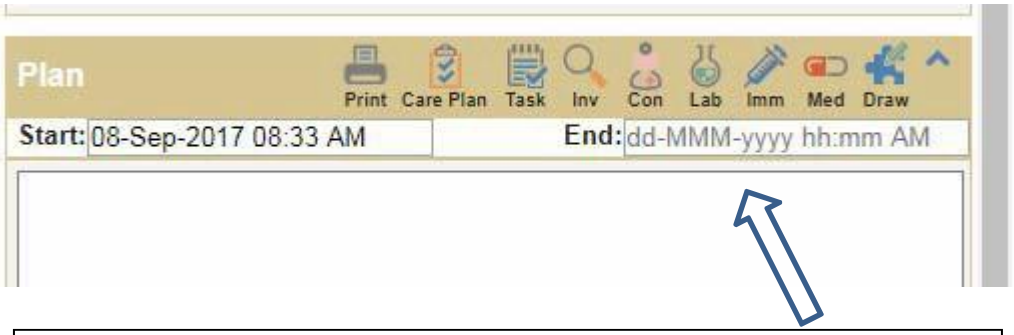
Helpful Hint #2:
As Fee Code 520 and 521 have time-based code conditions, it is important to document the start and end times for the Shared Care Conference AND the Patient Care Telephone call. The screen shot below highlights how to do this:

Adding Start and End Time to Visit Plan



Place the cursor anywhere in the grey area of the plan section and right click the mouse to make the drop-down menu appear. Next, select 'Edit Plan Start/End times'.

The following fields appear:



Enter the required information for `End` date and time.
***NOTE:** The start and end times will disappear but will remain embedded in the visit.