SUMMARY OF CONTINUING CARE PHYSICIAN FEES

Prepared by the Nova Scotia

District Medical Directors of Continuing Care

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Assistance was provided by:

Nova Scotia District Medical Directors of Continuing Care

This document has been prepared by the District Medical Directors of Continuing Care to facilitate identification of the physician fees applicable to continuing care settings. It is recognized that while this document provides guidelines for physicians providing services in continuing care settings, the Preamble is the ultimate authoritative document. Physicians are encouraged to review the current Preamble prior to claiming these or any other health service codes. Should a discrepancy exist between this document and the Preamble, the Preamble interpretation is to be used.

For further information, contact the Chair of the Council of District Medical Directors of Continuing Care, or the appropriate District Medical Director for your region, as follows:

DHA 1: South Shore District Health Authority
Dr Albert Doucet
T: 902-523-1543
E: adoucet@ssdha.nshealth.ca

DHA 2: South West Nova District Health Authority
Dr Winston Wertlen
T: 902- 742-8755
Cell: 902-302-0714
E: wwertlen@swndha.nshealth.ca

DHA 3: Annapolis District Health Authority
Dr Robin Bustin
T: 902-538-5590
Family Practice: 902- 538-7381
Cell: 902 698-2652
E: RBustin@avdha.nshealth.ca

DHA 4: Colchester-East Hants Heath Authority
Dr Harold Berghuis
E: harold.berghuis@cehha.nshealth.ca

DHA 5: Cumberland Health Authority
VACANT

DHA 6: Pictou County Health Authority
Dr Chris Elliott
T: 902-752-6162
E: Chris.elliott@pcha.nshealth.ca

DHA 7: Guysborough-Antigonish-Strait Health Authority
Dr Brian Steeves

T: 902-863-1775
F: 902-863-0572
Cell: 870-2583
E: brianrsteeves@gmail.com

DHA 8: Cape Breton District Health Authority
VACANT

DHA 9: Capital District Health Authority
(Chair, Provincial Council of District Medical Directors of Continuing Care)
Dr Barry Clarke
T: 902- 473-2443
Cell: 902-237-1476
E: barry.clarke@cdha.nshealth.ca

For Billing/MSI Inquiries

However, MSI staff are the most knowledgeable authority in interpretation of Preamble rules and billing inquiries should be directed to them. If a discrepancy exists between MSI's interpretation of Preamble rules and that of the individuals above, the former shall prevail.

Continuing Care Information Triage Line 1-800-225-7225
MSI Billing Inquiries/Assessments 1-866-553-0585
MSI Email…… **MSI_Assessment@Medavie.bluecross.ca**

SUMMARY OF CONTINUING CARE PHYSICIAN FEES

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SUMMARY OF CONTINUING CARE PHYSICIAN FEES

INTRODUCTION

Purpose of Document

This document was prepared by the NS Medical Directors of Continuing Care to facilitate the provision of services to clients and residents of Continuing Care services**.** It provides a simplified and concise summary of relevant MSI billing information for provincially funded Continuing Care environments. It should be noted that the MSI Physician's Manual, Billing Instructions Manual and the MSI Bulletins are the ultimate authority that the physicians should follow when submitting claims for payment.

This document will be updated as new fee codes are introduced and/or revisions to fee codes or modifiers occur.

Medical Service Unit Value

The MSI Fee Schedule uses Medical Service Units (MSUs) rather than dollars to represent the value of most services (the Anaesthetic Unit is used specifically for claiming anaesthetic services). The MSI Tariff or amount paid for a service is derived from the number of units applicable to a service multiplied by the negotiated unit value. The Medical Service Unit value table provides the rates for years 2007/08 to 2014/15

Unit value system (fee schedule) increases		
Date	Medical Service Unit (MSU)	Annualized Increase
2007/08 rate	$2.21	
April 1, 2008	$2.23	1.0 per cent
April 1, 2009	$2.26	1.5 per cent
April 1, 2010	$2.28	1.0 per cent
April 1, 2011	$2.30	1.0 per cent
April 1, 2012	$2.32	1.0 per cent
April 1, 2013	$2.37	2.0 per cent
April 1, 2014	$2.42	2.0 per cent

EXAMPLE: VIST 03.03 **Telephone calls** /Fax/E-mail advice and or Medical Chart Review for Acute Home Care, Chronic Home Care, and Palliative Care are insured under certain circumstance. (Section 4.6.5)

Value: 11.5 MSU * $2.42 (2014/15 rate) = $27.83

This fee is for up to three calls/faxes/emails per day
Note: Each additional group of three telephone calls, faxes or e-mails/per day/per patient can be claimed at 11.5 MSUs.

This code may only be claimed when contact is made with the physician by a health care provider and may not be used when the request is initiated by the physician, the patient, or family members.

In order to claim this code, the patient must be registered with Acute Home Care

Other potential sections 7.10.3, 7.7.2, 7.7.3

Modifiers

Modifiers are special codes added to the record of a service that identify the generic context within which the service was provided (specialty, time, place, etc.). Some modifiers are for the purpose of clarification; others **affect the tariff** applied to the service.

See Appendix A for a list of modifiers that are relevant to Continuing Care services.

In order to be paid the correct value for the service rendered, the appropriate modifiers and/or modifier combinations must be submitted. A complete list of modifiers is available in the Miscellaneous Section of the MSI Physicians manual p.1-5. The Physician's Manual provides a list of the base unit values for the Health Service Codes. The complete list of all unit values and modifiers or modifier combinations is also available on your computer system.

The modifier combination must be submitted to MSI with your fee code submission.

Section I:
Provincially Funded Nursing Homes, Residential Care Facilities (RCFs), Adult Residential Centres (ARCs) and Regional Rehabilitation Centres (RRCs)

Definition of Institution: Licensed and approved chronic care hospitals, residential centres, nursing homes and homes for special care (MSI Physician Manual- Preamble 2:12 p.4). Please confirm that the organization is a Provincial Government approved and Department of Health and Wellness funded organization prior to billing MSI for services. A list of approved/funded organizations can be found at http://www.gov.ns.ca/health/ccs/directories_facilities.asp

Residential Care Facilities (RCFs) visits should be claimed as home visits. Adult Residential Care Facilities (ARCs) visits should be claimed as home visits unless the facility has been designated by DHW as a long term care facility. Regional Rehabilitation Centres (RRCs) visits should be claimed as home visits unless the facility has been designated by DHW as a long term care facility.

A list of Nursing Homes, RCFs, ARCs, RRCs by district and how to bill at this facilities is included in appendix C in this document.

Chronic Disease Management Incentive Program

The General Practice Chronic Disease Management (CDM) Incentive Program for eligible Doctor Nova Scotia members has been expanded with additional funding effective April 1, 2014. The program has been in place since April 1, 2009.

Major program changes

Changes to the existing CDM program, effective April 1, 2014, include:

- Addition of chronic obstructive pulmonary disease (COPD) as an eligible chronic disease
- Revisions to program requirements and documentation to incorporate COPD, reflect changes to clinical practice guidelines, and improve clarity
- Increases to payment rates

Program strategy

The program recognizes the additional work of family physicians, beyond office visits, of providing guidelines-based care to patients with specific chronic diseases. Unlike other provinces, the Nova Scotia program is patient-centred rather than disease-centred, recognizing that many patients have more than one chronic disease which may have common risk factors.

Qualifying chronic diseases

The qualifying chronic diseases are:

- Type 1 and Type 2 diabetes (FPG ^{3}7.0 mmol/L or Casual PG ^{3}11.1 mmol/L + symptoms or 2hPG in a 75-g OGTT ^{3}11.1 mmol/L)
- Ischaemic heart disease (IHD) characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI; abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 years)
- Chronic obstructive pulmonary Disease (COPD), a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung

hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV1 < 80% predicted and FEV1/FVC < 0.70

Required indicators/risk factors

In order to claim a CDM incentive payment the following indicators/risk factors, as applicable, are required to be addressed as part of the annual cycle of care.

The required indicators include all relevant common indicators plus the specific indicators for each disease. For example, if diabetes and COPD are present, the three common indicators for diabetes, IHD and COPD plus the three common indicators for diabetes and IHD plus the specific indicators for diabetes and the specific indicators for COPD would all need to be addressed in order to claim annual incentive payments for the two diseases.

Common Indicators for diabetes, IHD and COPD

- Smoking cessation – discussed once per year if smoker (document smoker or nonsmoker)
- Immunizations discussed and/or given – once per year
- Exercise/activity – discussed, including possible referrals, once per year

Common Indicators for diabetes and IHD

- Blood pressure – 2 times per year
- Weight/nutrition counseling – once per year
- Lipids – once per year

Plus one, two or all three of the following as applicable:

Indicators for diabetes only

- HbA1C – ordered 2 times per year
- Renal function – ACR or eGFR ordered once per year
- Foot exam with 10-g monofilament – referred or completed once per year

  Eye exam – discussed and/or referred once per year for routine dilated eye exam

Indicators for IHD only

- Anti-platelet therapy – considered/reviewed once per year
- Beta-blocker – considered/reviewed once per year
- ACEI/ARB – considered/reviewed once per year
- Discuss nitroglycerin – considered/reviewed once per year
- Consider further cardiac investigations – considered/reviewed once per year

Indicator for COPD only

- COPD Action Plan required – Develop and then review and complete once per year

CDM incentive payments

Eligible GPs are paid as follows:

- $100 base incentive payment once per fiscal year for managing an annual cycle of care and addressing the required indicators/risk factors for each patient with one qualifying chronic disease
- $75 additional payment per fiscal year if the same patient is managed for a second qualifying chronic disease (total payment of $175)
- $50 additional payment per fiscal year if the patient is managed for three qualifying chronic diseases (total payment of $225)

Note: Completion of the COPD Action Plan, if applicable, is included in these payments.

The CDM incentive is claimed through a fee code. APP contract physicians are also eligible for the incentive and are paid by cheque twice a year based on their aggregate shadow billings.

CDM incentive billing rules

1. The CDM incentive fee can be claimed by family physicians only.
2. The base incentive fee may be claimed once per fiscal year (April 1 to March 31) for each patient managed for one qualifying chronic disease condition. An additional incentive amount per patient may be claimed once per fiscal year as part of the fee if the patient has additional qualifying chronic disease(s) for each qualifying disease.
3. The family physician is expected to act as case manager to ensure care based on key guidelines is provided for patients with selected chronic diseases. The physician may or may not provide this care directly and will not be held responsible if patients don't follow through on recommendations, including for investigations, follow-up visits and/or referrals.
4. Patients must be seen a minimum of two times per year by a licensed health-care provider (includes physicians) in relation to their chronic disease(s), including at least one visit with the family physician claiming the CDM incentive fee.
5. Every required CDM indicator doesn't necessarily have to be addressed at each visit but indicators should be addressed at the frequency required for claiming the annual CDM incentive.
6. Providing all eligibility requirements are met, the CDM incentive fee can be billed once per patient per fiscal year by March 31 of that year.
7. The qualifying chronic diseases eligible for the CDM incentive payment are:
    - **Type 1 and Type 2 Diabetes** defined as: FPG ³7.0 mmol/L or Casual PG ³11.1 mmol/L + symptoms or 2hPG in a 75-g OGTT ³11.1 mmol/L
    - I**schaemic heart disease (IHD)** characterized by reduced blood supply to the myocardium, most often due to coronary atherosclerosis, and as evidenced by: a failed stress test; abnormal EKG compatible with IHD; wall motion study; abnormal sMIBI;

abnormal myocardial perfusion scan; abnormal cardiac catheterization; and/or abnormal stress echocardiogram (includes post-MI <=5 yr)
    - **Chronic obstructive pulmonary disease (COPD)**, a respiratory disorder largely caused by smoking that is characterized by progressive, partially reversible airway obstruction and lung hyperinflation, systemic manifestations, and increasing frequency and severity of exacerbations. Spirometry is essential for diagnosis and requires both a postbronchodilator FEV1 < 80% predicted and FEV1/FVC < 0.70.
8. For patients managed for COPD, a COPD Action Plan must be developed and then reviewed and completed annually, with a copy given to the patient and a copy available in the patient's clinical record.
9. The CDM incentive can be claimed once per fiscal year (April 1 to March 31 inclusive) if the following conditions are met:
    - the patient is seen by the family physician in relation to their chronic disease(s) at least once in the fiscal year for which the CDM incentive is being claimed
    - the patient has had at least one other appointment with the physician or another licensed health care provider in relation to their chronic disease(s) in the previous 12 months
    - the CDM indicators required for the CDM incentive payment have been addressed at the required frequency and documented in the clinical record or optional CDM flow sheet at or before the time of billing

Chronic Disease Management flow sheet

The Family Physician Chronic Disease Management flow sheet has been revised, effective April 1, 2014. Use of the flow sheet continues to be optional.

COPD Action Plan

A required indicator for COPD is the development and annual review and completion of a COPD Action Plan using the COPD Action Plan template.

Both the Chronic Disease Management flow sheet and COPD Action Plan template can be found at:
http://www.doctorsns.com/en/home/compensation/master-agreement/funding-programs/chronic-disease-management-incentive-program.aspx

Clarification for APP Physicians

The new Family Physician Chronic Disease Management Incentive program was approved to begin April 1, 2009, with revisions to the program effective April 1, 2010.

The Master Agreement Steering Group agreed that APP General Practitioners would be eligible to claim this incentive in addition to their contract, providing all other eligibility criteria have been met.

Eligible APP Physicians are required to shadow bill the new fee code in order to receive payment under this incentive program. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this incentive program for APP Physicians are October and May of each year.

General Practice Comprehensive Care Incentive Program (CCIP)

The CCIP provides incentives and recognition to family physicians to providing a comprehensive breadth and depth of services for their patients.

Billing Guidelines (to qualify for CCIP payments, family physicians must):

- Have minimum insured fee-for-service or shadow billings of $100,000, including minimum office billings of $25,000, during the 12 month CCIP calculation period and
- Reach the first activity threshold for at least two CCIP eligible service categories.

CCIP Service Categories –

The CCIP eligible service categories for 2012/13 are:

- Nursing home visits
- Inpatient hospital care
- Obstetrical deliveries
- Maternity and newborn care
- Home visits (new)
- All office visits for children under two years, including well baby and other office visits (new)
- Selected GP procedures (http://www.doctorsns.com/en/home/compensation/masteragreement/fundingprograms/gpcomprehensivecareincentiveprogram/default.aspx)
- Pap smears for women ages 40 to 75

CCIP Activity Thresholds and Measures

Three activity thresholds have been established for each service category.

They are:

CCIP Service Categories: 2014-15								
	Nursing home visits	**Inpatient hospital care**	**Obstetrical deliveries**	**Maternity/newborn visits**	**All office visits for children under two years**	**Home visits**	**Selected GP procedures**	**Pap smears for Women 40-75 years**
Activity threshold #	Measure:	Measure:	Measure:	Measure:	Measure:	Measure:	Measure:	Measure:
	Total # of visits	Total $ value of all services provided	Total # of deliveries	Total # of visits: prenatal postnatal post partum newborn well baby	Total # of all visits (all types)	Total # of visits	Total # of approved procedures	Total # eligible women receiving a pap smear
Threshold 1	13	$5,473	6	5	38	3	6	16
Threshold 2	56	$21,894	25	18	106	10	20	44
Threshold 3	326	$48,184	54	70	206	29	53	84

For the calculation of the measures and eligible billings for each CCIP service category:

Nursing home visits: Includes all institutional visit codes (HSC 03.03 or 03.04) with LO = NRHM. Measure is total number of visits.

Inpatient hospital care: Includes all services (consultations, visits and procedures) provided for hospital inpatients (LO = HOSP, FN=INPT). Measure is total payments in dollars.

Obstetrical deliveries: Includes all billings for HSC 87.98 Delivery NEC. Measure is total number of deliveries.

Maternity and newborn visits: Maternity visits includes all prenatal, post natal and post partum visits (HSC
03.03 or 03.04) with the modifiers RO = ANTL or PTNT or PTPP in office or in hospital. Newborn visits includes all visits (HSC 03.03 or 03.04) with the modifier RO = NBCR in hospital. Measure is total number of visits.

All office visits for children under two years: Includes all office visits (HSC 03.03 or 03.04) for children under two years of age with LO = OFFC. This includes regular office visits and well baby visits. Measure is total number of visits.

Home visits: Includes all visits (HSC 03.03 or 03.04) with LO = HOME. Measure is total number of visits.

Selected GP procedures: Includes all eligible GP procedures in eligible locations as approved by the MASG. Measure is the total number of approved procedures.

Pap Smears for women ages 40 to 75 years: Includes pap smears for women ages 40-75 years claimed through HSC 03.26A Pap smear. Measure is the total count of unique women ages 40-75 years who received a Pap smear service claimed through this code.

(http://www.doctorsns.com/en/home/compensation/masteragreement/fundingprograms/gpcomprehensivecareincentiveprogram/default.aspx)

Annual CCIP payments are scheduled to be paid each December.

Case Management Conference Fee (VIST 3.03D) . . . . . 14.5 MSUs per 15 min

In effect for both family physicians and specialists since 2009.

Regarding a specific patient

Physicians requested to attend a case management conference regarding a specific patient for a specific health–related problem can now be remunerated for their time. A Case Management Conference Fee has been in effect for both family physicians and specialists since 2009.

For the purpose of the new fee, a case management conference is defined as a formal, scheduled, multi-disciplinary health team meeting to discuss the provision of health care to a specific patient. Multi-disciplinary refers to the attendance of two or more licensed health-care providers in addition to a physician.

To qualify

In order to qualify for payment of the new fee, the conference must be initiated by a non-physician district health authority/IWK employee, or a long-term care facility director of nursing or director of care.

The Case Management Conference Fee (Health Service Code 03.03D) provides physicians with time-based compensation at the general practice or specialist sessional rate for their participation in an eligible case management conference.

Specific billing rules

Specific billing rules for the fee are:

- The fee can be claimed by all specialties and for any location.
- Neither the patient nor the patient's family need to be present at the conference.
- To claim the fee, the physician must participate in the case management conference for a minimum of 15 minutes.
- The fee is paid in 15-minute increments and 80 per cent of a 15-minute interval must be spent at the conference in order to be claimed. Conference start and end times should be recorded on the patient's chart.
- The fee may be claimed by more than one physician simultaneously as necessary for case management.
- Physician attendance at case management conferences held by video conferencing is eligible for payment if all other eligibility requirements are met.

- The case management conference must be documented in the patient health record with a list of all physician participants.

  NOTE: If the patient is located in an institution, documentation pursuant to the billing guidelines must be located within the patient record in the institution. If the patient is not located in an institution, documentation regarding the case management conference must be readily available; e.g., in the patient record maintained by the physician claiming the fee. The onus will be on the physician billing the fee to ensure appropriate documentation is readily available.
- The Case Management Conference Fee isn't to be used for attendance at regularly scheduled meetings concerning ongoing care planning or patient management for one or more patients (i.e. grand rounds, tumour board case rounds, teaching rounds, transplant rounds or other similar methods of specialist physicians conferring about the medical management of complex cases). It's not to be used in circumstances which are a usual part of patient care such as transfer of care between physicians on evenings and weekends. It may not be claimed for routine care planning rounds in long term care facilities; there must be a documented health related concern that has necessitated physician involvement.

Complete Examination (VIST03.04)**(Not to be used for admission to Nursing Home)**

LO=NRHM (RF=REFD) . . . . . 24 MSUs
LO=NRHM, RO=DETE (RF=REFD) . . . . . 24 MSUs + MU

Nursing homes have a requirement that new residents must be seen and a complete exam must be performed upon entry into the institution. The preamble states ' services provided in circumstances where they are not medically necessary are not insured'. In this case there is no medical necessity therefore it is an uninsured service.

In order to claim this service, the patient must have health concerns that are medically complex, obscure or serious. The physician must conduct and document a complete history and physical examination. This code cannot be used to meet the administrative requirements for a history and physical as required by the institution.

Once the patient is in the nursing home the first payable visit arises when, at the specific request of an appropriate institutional authority, patient or patient's family or guardian, the physician visits and renders medically necessary services to the patient. (see preamble 7.2.6 (d).)

Fee Codes for Institutional Visits (Long Term Care Facilities)

MSUs

VIST 03.03 **Nursing Home Visit (0800 - 1700)**
LO=NRHM, PT=FTPT (RF=REFD) 21.3
LO=NRHM, PT=FTPT, RO=DETE (RF=REFD) . . . . . 21.3+MU

VIST 03.03 **Nursing Home Visit (1701 - 2000)**
LO=NRHM, PT=FTPT, TI=EVNT, US=UNOF (RF=REFD) 28.3
LO=NRHM, PT=FTPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) . . . . . 28.3+MU

VIST 03.03 **Nursing Home Visit (2001 - 2359)**

LO=NRHM, PT=FTPT, TI=ETMD, US=UNOF (RF=REFD) 28.3
LO=NRHM, PT=FTPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) . . . . . 28.3+MU

VIST 03.03 **Nursing Home Visit (0000 - 0800)**
LO=NRHM, PT=FTPT, TI=MDNT, US=UNOF (RF=REFD) 38.3
LO=NRHM, PT=FTPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) . . . . . 38.3+MU

VIST 03.03 **Nursing Home Visit (0801 - 1200) Sat., Sun., Holidays**
LO=NRHM, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF (RF=REFD) 28.3
LO=NRHM, DA=RGE1, PT=FTPT, TI=AMNN, US=UNOF, RO=DETE
(RF=REFD) . . . . . 28.3+MU

VIST 03.03 **Nursing Home Visit (1201 - 1700) Sat., Sun., Holidays**
LO=NRHM, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF (RF=REFD) 28.3
LO=NRHM, DA=RGE1, PT=FTPT, TI=NNEV, US=UNOF, RO=DETE
(RF=REFD) . . . . . 28.3+MU

VIST 03.03 **Nursing Home Visit - Extra Patient**
LO=NRHM, PT=EXPT (RF=REFD) 15.8
LO=NRHM, PT=EXPT, RO=DETE (RF=REFD). . . . . 15.8+MU

VIST 03.03 **Nursing Home Visit (1701 - 2000) Extra Patient**
LO=NRHM, PT=EXPT, TI=EVNT, US=UNOF (RF=REFD) 17.9
LO=NRHM, PT=EXPT, TI=EVNT, US=UNOF, RO=DETE (RF=REFD) . . . . . 17.9+MU

VIST 03.03 **Nursing Home Visit (2001 - 2359) Extra Patient**
LO=NRHM, PT=EXPT, TI=ETMD, US=UNOF (RF=REFD) 17.9
LO=NRHM, PT=EXPT, TI=ETMD, US=UNOF, RO=DETE (RF=REFD) . . . . . 17.9+MU

VIST 03.03 **Nursing Home Visit (0000 - 0800) Extra Patient**
LO=NRHM, PT=EXPT, TI=MDNT, US=UNOF (RF=REFD) 17.9
LO=NRHM, PT=EXPT, TI=MDNT, US=UNOF, RO=DETE (RF=REFD) . . . . . 17.9+MU

VIST 03.03 **Nursing Home Visit (0801 - 1200) Extra Patient, Sat., Sun., Holidays**
LO=NRHM, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF (RF=REFD) 17.9
LO=NRHM, DA=RGE1, PT=EXPT, TI=AMNN, US=UNOF, RO=DETE
(RF=REFD) . . . . . 17.9+MU

VIST 03.03 **Nursing Home Visit (1201 - 1700) Extra Patient, Sat., Sun., Holidays**
LO=NRHM, DA=RGE1, PT=EXPT, TI=NNEV, US=UNOF (RF=REFD) 17.9
LO=NRHM, DA=RGE1, PT=EXPT, TI=NNEV, US=UNOF, RO=DETE
(RF=REFD) . . . . . 17.9+MU

VIST 03.03 **Nursing Home - Emergency Visit**
LO=NRHM, US=UIOH (RF=REFD) 35.2
LO=NRHM, US=UIOH, RO=DETE (RF=REFD) . . . . . 35.2+MU

NOTE: For Residential Care Facilities, physicians are unable to bill Nursing Home Visits, instead they should bill the appropriate home visits.

NOTE: Modifier RO=DETE allows for billing of Detention Time (see preamble section 2.32 and 7.3) in Nursing Home environment. If time spent with one patient **exceeds 30 minutes**

Detention Time may be billed in addition to the visit fee at 12.5 MSUs per 15 minute increment. Start and finish times must be included in the text field on the claim when billing. The time claimed must be time spent directly with the patient. Time spent speaking with family members, nursing home staff or completing chart notes does not qualify.

As outlined in the Preamble, visits requested in one time period and performed in another must always be claimed using the lesser of the two rates. Additionally, visits made at the convenience of the physician must be claimed using the weekday 0800-1700h rate.

Palliative Care Fees

Palliative care fee codes can be billed in long-term care facilities by GP's and family physicians providing the billing rules are followed and the eligibility criteria met **but only physicians with specific training can claim the palliative care *consultation* code.**

MSUs

CONS 03.09C **Palliative Care Consultation** (Oct 2013 MSI Bulletin).....62 + MU

Billable once per patient per physician only by physician with recognized expertise and training and approval to work in palliative care.

VIST 03.03C **Palliative Care Support Visit**. ..... 25.4 per 30 min

(12.7 units per 15 min thereafter, maximum of 60 min per patient per day)

The patient must be registered with the DHA Integrated Palliative Care Service in order for this code to be claimed. As this is a time-based code physicians are required to document the start and stop time with the patient directly on the clinical record. 80% of the time claimed must be spent directly with the patient. Time spent speaking with family members, nursing home staff or completing chart notes does not qualify.

VIST 03.03 **Palliative Care Medical Chart Review and/or Telephone Call**..... 11.5

Up to 3 telephone calls Initiated by a health care professional per day per patient.

The patient must be registered with the DHA Integrated Palliative Care Service in order for this Health Service Code to be claimed.

Each additional group of 3 calls/per day/per patient 11.5

Long Term Medication Review Fee Code: ENH1 . . . . . 11.95 MSUs

NOTE: To claim fee physician must review, complete, date and sign the pharmacy generated Medicinal Administration Recording System (MARS) drug review sheet for the resident. A maximum of two (2) medication reviews will be payable per resident per fiscal year. The Medication Review Fee is payable in addition to any associated visit fee, if applicable. The date of service is the date the MARS form is signed by the physician.

Physicians may claim in approved long term care facilities and RCFs.

The list of approved LCT facilities and RCFs as of April 2014 can be found at:

http://novascotia.ca/dhw/ccs/documents/Nursing-Homes-and-Residential-Care-Directories.pdf

Also see appendix C at the end of this document.

Long Term Care Clinical Geriatric Assessment (CGA)

Additional new incentive funding is available through the Physicians Master Agreement in 2010/11 to support new programs and/or incentives for family physicians participation in continuing care.

Effective January 1, 2011 the following new fee code (billable by general practitioners only) has been approved by the MASG for inclusion in the fee schedule:

DEFT CGA 1 **Long Term Care Clinical Geriatric Assessment** …….. 26.32 MSUs

Description:
Long Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes.

The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviours and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments.

The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However, the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team.

The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives and all relevant baseline clinical information so any care outside the facility or by any

on-call physician can be provided with this vital clinical information that will enhance the quality for the care given.

Billing Guidelines:

- Effective January 1, 2011, family physicians will be remunerated for the completion of the Long Term Care Clinical Geriatric Assessment (CGA) for residents of licensed nursing homes and residential care facilities funded by the Department of Health and Wellness only.
- The CGA may be billed twice per fiscal year (April 1 – March 31) per resident. The initial CGA is recommended to be completed as soon as possible following nursing home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient.
- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviours), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.
- The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA tool. This service encounter is included in the CGA fee. The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be recorded on the CGA form.
- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA tool in the long term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.
- The date of the service is the date when the final CGA service encounter occurs and the CGA tool is completed and signed by the physician.
- The CGA fee is billable by eligible fee-for-service physicians and by eligible APP contract physicians, based on shadow billings.
- The tool must be completely filled out before the service is claimed.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter-facility transfers whenever possible. The CGA form is attached in Appendix B.

Physicians may claim Long Term CGAs in approved long term care facilities and RCFs.

The list of approved LCT facilities and RCFs as of April 2014 can be found at:

http://novascotia.ca/dhw/ccs/documents/Nursing-Homes-and-Residential-Care-Directories.pdf

Also see appendix C at the end of this document.

Section II: Home Care Nova Scotia Programs

DEFINITIONS:

1. **Chronic Home Care** is a provincial program which provides home support services, personal care services, nursing services and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. Services provided have the objectives of maintaining or improving the individual's level of functioning; addressing the individuals' needs during rehabilitation or convalescence; delaying or preventing admission into institutions; and/or providing family relief services to the individual's informal caregivers.

2. **Acute Home Care** is a provincial program designed to provide to patients in their homes, with acute episodic illnesses, short term acute care involving nursing and other services available normally only in hospital, thereby preventing or shortening a hospital admission.

Preamble extracts from Sections 7.2.4 and 7.2.5:

(e) Acute Home Care - A Limited Visit may be claimed when the physician provides daily care to the patient and may occur at the patient's home or OPD. Acute care services may be provided for up to 15 days but are to be discontinued when no longer required. The patient's requirement for Acute Home Care is reviewed regularly. An average length of stay of 5 to 7 days in Acute Home Care is anticipated. If appropriate, patients may be transferred to Chronic Home Care if they require ongoing home care services for convalescence or continuing care following the period of acute illness.

In exceptional circumstances, extended admissions for up to a total of 30 days may be authorized by the Care Co-ordinator in consultation with the attending physician.

(v) Acute Home Care - A Comprehensive Visit may be claimed for the direct admission to the Acute Home Care Program from the office, home, OPD and unscheduled emergency locations. This must follow notification to the appropriate Home Care Nova Scotia Coordinators. The service will include the first examination for diagnosis and treatment once per patient, per admission.

Fee Codes for Admission to Acute Home Care

NOTE: Fees for admission to acute home care are visit fees (03.04) and are intended to cover the examination of the patient and the necessary paperwork associated with arranging the admission to home care. They are high in comparison to visit fees unrelated to a home care admission.

MSUs

VIST 03.04 **Direct Admission to Acute Home Care from Home (0800 - 1700)**

LO=HMHC, OL=HOME, SP=GENP (RF=REFD) 46.3

LO=HMHC, OL=HOME, SP=GENP RO=DETE (RF=REFD) . . . . . 46.3+MU

VIST 03.04 **Direct Admission to Acute Home Care from Home (1701 - 2000)**
LO=HMHC, OL=HOME, TI=EVNT, SP=GENP (RF=REFD) 53.3
LO=HMHC, OL=HOME, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) . . . . . 53.3+MU
VIST 03.04 **Direct Admission to Acute Home Care from Home (2001 - 2359)**
LO=HMHC, OL=HOME, TI=ETMD, SP=GENP (RF=REFD) 53.3
LO=HMHC, OL=HOME, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) . . . . . 53.3+MU
VIST 03.04 **Direct Admission to Acute Home Care from Home (0000 - 0800)**
LO=HMHC, OL=HOME, TI=MDNT, SP=GENP (RF=REFD) 63.3
LO=HMHC, OL=HOME, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) . . . . . 63.3+MU
VIST 03.04 **Direct Admission to Acute Home Care from Home (0801 - 1200) Sat., Sun., Holidays**
LO=HMHC, DA=RGE1, OL=HOME, TI=AMNN, SP=GENP (RF=REFD) 53.3
LO=HMHC, DA=RGE1, OL=HOME, TI=AMNN, RO=DETE, SP=GENP
(RF=REFD) . . . . . 53.3+MU
VIST 03.04 **Direct Admission to Acute Home Care from Home (1201 - 1700) Sat., Sun., Holidays**
LO=HMHC, DA=RGE1, OL=HOME, TI=NNEV, SP=GENP (RF=REFD) 53.3
LO=HMHC, DA=RGE1, OL=HOME, TI=NNEV, RO=DETE, SP=GENP
(RF=REFD) . . . . . 53.3+MU

VIST 03.04 **Direct Admission to Acute Home Care from Office**
LO=HMHC, OL=OFFC, SP=GENP (RF=REFD) 35.5

VIST 03.04 **Direct Admission to Acute Home Care from Emergency**
LO=HMHC, OL=USEM, SP=GENP (RF=REFD) 59.91
LO=HMHC, OL=USEM, RO=DETE, SP=GENP (RO=REFD) . . . . . 59.91+MU

VIST 03.04 **Direct Admission to Acute Home Care from Outpatient (0801 - 1200)**
LO=HMHC, OL=OTPT, TI=AMNN, SP=GENP (RF=REFD) 35.4
LO=HMHC, OL=OTPT, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) . . . . . 35.4+MU
VIST 03.04 **Direct Admission to Acute Home Care from Outpatient (1201 - 1700)**
LO=HMHC, OL=OTPT, TI=NNEV, SP=GENP (RF=REFD) 35.4
LO=HMHC, OL=OTPT, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) . . . . . 35.4+MU
VIST 03.04 **Direct Admission to Acute Home Care from Outpatient (1701 - 2000)**
LO=HMHC, OL=OTPT, TI=EVNT, SP=GENP (RF=REFD) 35.4
LO=HMHC, OL=OTPT, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) . . . . . 35.4+MU
VIST 03.04 **Direct Admission to Acute Home Care from Outpatient (2001 - 2359)**
LO=HMHC, OL=OTPT, TI=ETMD, SP=GENP (RF=REFD) 40.5
LO=HMHC, OL=OTPT, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) . . . . . 40.5+MU
VIST 03.04 **Direct Admission to Acute Home Care from Outpatient (0000 - 0800)**
LO=HMHC, OL=OTPT, TI=MDNT, SP=GENP (RF=REFD) 40.5
LO=HMHC, OL=OTPT, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) . . . . . 40.5+MU

VIST 03.04 **Direct Admission to Acute Home Care from OPD, Sun and Holidays**
LO=HMHC, DA=RGE2, OL=OTPT, SP=GENP (RF=REFD) 40.5
LO=HMHC, DA=RGE2, OL=OTPT, RO=DETE, SP=GENP (RF=REFD) . . . . . 40.5+MU

VIST 03.04 **Transfer to Acute Home Care from Inpatient**
LO=HMHC, OL=INPT, SP=GENP, SP=EMMD, SP=COMD (RF=REFD) 28.6
LO=HMHC, OL=INPT, RO=DETE, SP=GENP, SP=EMMD, SP=COMD
(RF=REFD) . . . . . 28.6+MU

Patients in Acute Home Care:

VIST 03.03 **Acute Home Care - Home Visit (0800 - 1700)**
LO=HMHC, SP=GENP (RF=REFD) 21.3
LO=HMHC, SP=GENP, RO=DETE (RF=REFD) . . . . . 21.3+MU
VIST 03.03 **Acute Home Care - Home Visit (1701 - 2000)**
LO=HMHC, TI=EVNT, SP=GENP (RF=REFD) 28.3
LO=HMHC, TI=EVNT, RO=DETE, SP=GENP (RF=REFD) . . . . . 28.3+MU
VIST 03.03 **Acute Home Care - Home Visit (2001 - 2359)**
LO=HMHC, TI=ETMD, SP=GENP (RF=REFD) 28.3
LO=HMHC, TI=ETMD, RO=DETE, SP=GENP (RF=REFD) . . . . . 28.3+MU

VIST 03.03 **Acute Home Care - Home Visit (0000 - 0800)**
LO=HMHC, TI=MDNT, SP=GENP (RF=REFD) 38.3
LO=HMHC, TI=MDNT, RO=DETE, SP=GENP (RF=REFD) . . . . . 38.3+MU

VIST 03.03 **Acute Home Care - Home Visit (0801 - 1200) Sat., Sun., Holidays**
LO=HMHC, DA=RGE1, TI=AMNN, SP=GENP (RF=REFD) 28.3
LO=HMHC, DA=RGE1, TI=AMNN, RO=DETE, SP=GENP (RF=REFD) . . . . . 28.3+MU
VIST 03.03 **Acute Home Care - Home Visit (1201 - 1700) Sat., Sun., Holidays**
LO=HMHC, DA=RGE1, TI=NNEV, SP=GENP (RF=REFD) 28.3
LO=HMHC, DA=RGE1, TI=NNEV, RO=DETE, SP=GENP (RF=REFD) . . . . . 28.3+MU

VIST 03.03 **Acute Home Care - Urgent Call-back By Staff**
LO=HMHC, US=UCHH, SP=GENP (RF=REFD) 35.2
LO=HMHC, US=UCHH, RO=DETE, SP=GENP (RF=REFD) . . . . . 35.2+MU

Fee Codes for Seeing Patients in Acute Home Care in OPD:

VIST 03.03 **Acute Home Care - Outpatient Visit (0801 - 1200)**
LO=HOSP, FN=OTPT, OL=HMHC, TI=AMNN, SP=GENP (RF=REFD) 10.5
LO=HOSP, FN=OTPT, OL=HMHC, TI=AMNN, RO=DETE, SP=GENP
(RF=REFD) . . . . . 10.5+MU
VIST 03.03 **Acute Home Care - Outpatient Visit (1201 - 1700)**
LO=HOSP, FN=OTPT, OL=HMHC, TI=NNEV, SP=GENP (RF=REFD) 10.5
LO=HOSP, FN=OTPT, OL=HMHC, TI=NNEV, RO=DETE, SP=GENP
(RF=REFD) . . . . . 10.5+MU
VIST 03.03 **Acute Home Care - Outpatient Visit (1701 - 2000)**
LO=HOSP, FN=OTPT, OL=HMHC, TI=EVNT, SP=GENP (RF=REFD) 10.5
LO=HOSP, FN=OTPT, OL=HMHC, TI=EVNT, RO=DETE, SP=GENP
(RF=REFD) . . . . . 10.5+MU
VIST 03.03 **Acute Home Care - Outpatient Visit (2001 - 2359)**
LO=HOSP, FN=OTPT, OL=HMHC, TI=ETMD, SP=GENP (RF=REFD) 15.5
LO=HOSP, FN=OTPT, OL=HMHC, TI=ETMD, RO=DETE, SP=GENP
(RF=REFD) . . . . . 15.5+MU
VIST 03.03 **Acute Home Care - Outpatient Visit (0000 - 0800)**
LO=HOSP, FN=OTPT, OL=HMHC, TI=MDNT, SP=GENP (RF=REFD) 15.5
LO=HOSP, FN=OTPT, OL=HMHC, TI=MDNT, RO=DETE, SP=GENP
(RF=REFD) . . . . . 15.5+MU

VIST 03.03 **Acute Home Care - Outpatient Visit, Sunday and Holidays**
LO=HOSP, FN=OTPT, DA=RGE2, OL=HMHC, SP=GENP (RF=REFD) 15.5
LO=HOSP, FN=OTPT, DA=RGE2, OL=HMHC, RO=DETE, SP=GENP
(RF=REFD) . . . . . 15.5+MU

ADON HHCMI **Blended Mileage/Detention Time for Acute Home Care**
0.46+ MU (one multiple = one km)
(0.46 units x $ 2.37= $ 1.09 per km) For 2013/14

VIST 03.03 **Acute Home Care Emergency Visit**
LO=HMHC, US=UIOH, SP=GENP, SP=EMMD, SP=COMD (RF=REFD) 35.2
LO=HMHC, US=UIOH, RO=DETE, SP=GENP, SP=EMMD, SP=COMD
(RF=REFD) . . . . . 35.2+MU

VIST 03.03 **Acute or Chronic Home Care, Medical Chart Review and/or Telephone Call, Fax, or email Advice**.. . . . . .11.5

NOTE: Telephone Advice - Telephone calls, fax or email to give advice or to review patient's chart information with the Care Co-ordinator or representative of Home Care Services for patients in Acute or Chronic Home Care. Up to 3 per day per patient. The request for the telephone/fax/email advice must come from another health care provider. Calls initiated by the physician, the patient or a family member do not qualify.
LO=HMHC, RO=HMTE, SP=GENP (RF=REFD) . . . . . 11.5 MSUs

Each additional group of 3 /per day/per patient can be claimed at 11.5 MSUs

When claiming any Comprehensive Visit (03.04) the physician must personally meet Preamble requirements for claiming this code, which include performing and documenting a complete history and physical examination.
When claiming a limited visit, (03.03) the physician must personally meet Preamble requirement for a limited visit, including performing an assessment of relevant body systems.

Section III: Any Environment

Counselling – see preamble MSI Physician Manual 8.8, 8.9 p. 28 and p. 29
The codes for counselling or lifestyle counselling are not locator specific and may be billed at long term care facilities.

Counselling is a prolonged discussion directed at addressing problems associated with acute adjustment reactions or bereavement

- May be claimed in 15 minute intervals
- Not more than 5 hrs per patient per physician per year
- Not more than 1 hr per patient per day
- Not more than 1 GP providing counselling to a particular patient
- Documentation is important. The physician must clearly document the specific advice to the patient. Listing the patient's symptoms together with the word "counselled" or "long talk" does not meet documentation requirements.
- As with all timed codes, start and finish times of the encounter (face ti face time with the patient) must be recorded directly on the clinical record.

Counselling fee code PSYC 08.49A . . . .25.4 MSUs per 30 min (12.7 per 15 min thereafter)

Lifestyle Counselling (Section 8.9) is a prolonged discussion where the physician attempts to direct the patient in the proper management of health related concerns e.g. lipid or dietary counselling, smoking cessation, healthy heart advice, etc.

- May be claimed in 15 min intervals. At least 80% of time claimed must be spent in direct patient intervention.
- Not more than 2 hrs per patient per physician per year
- Not more than 30 min per patient per day
- Not more than 1 GP providing lifestyle counselling to a particular patient at same service encounter
- Documentation of encounter is important. The physician must clearly document the specific advice to the patient. Listing the patient's symptoms together with the word "counselled" or "long talk" does not meet documentation requirements.
- As with all timed codes, start and finish times of the encounter (face to face time with the patient) must be recorded directly on the clinical record.

Lifestyle Counselling fee code PSYC 08.49C . . . . 12.7 MSUs per 15 min

APPENDIX A

Modifiers – Type and Value Descriptions

The following is a list of some of the modifiers that are relevant to Continuing Care.

DA=RGE1, Date range defining Saturday, Sunday and Holidays
DA=RGE2, Sundays and Holidays
LO=HMHC, Acute Home Care
LO=HOME, Home
LO=HOSP, Hospital
LO=NRHM, Nursing Home
LO=OFFC, Office
OL=HMHC, OPD visit from Acute Home Care
OL=HOME, Admission from home to Acute Home Care
OL=INPT, Admission from inpatient to Acute Home Care
OL=OFFC, Admission from office to Acute Home Care
OL=OTPT, Admission from OPD to Acute Home Care
OL=USEM, Admission from unscheduled emergency call to Acute Home Care
(means the admission to acute home care was generated by an unscheduled ER visit - in contrast to a scheduled OPD/ER visit)
PT=EXPT, Additional patient seen at same location
PT=FTPT, First patient seen
RO=CCDT, Continuing care and detention
RO=CCDX, Continuing care in conjunction with attending and describing a differential Diagnosis
RO=CNTC, Continuing care
RO=DETE, Detention
RO=GPEW, General practice evenings and weekends (for office visits only)
RO=HMTE, Acute or chronic home care, medical chart review/telephone calls
SP=COMD, Community Medicine
SP=EMMD, Emergency Medicine
SP=GENP, General Practitioner
TI=AMNN, 0801-1200
TI=ETMD, 2001-2359
TI=EVNT, 1701-2000
TI=MDNT, 0000-0800
TI=NNEV, 1201-1700
US=UCHH, Urgent call back by acute home care staff
US=UIOH, Urgent visit interrupting normal office hours
US=UNOF, Urgent visit not interrupting office hours

APPENDIX B

Long-Term Care
Clinical Geriatric Assessment (CGA)

PATIENT ID

WNL: Within Normal Limits ASST: Assisted
IND: Independent DEP: Dependent

Chief lifelong occupation: _____ Education: (yrs) _____

Cr Cl/eGFR:_____

Infection Control
MRSA _____ Pos _____ Neg
VRE _____ Pos _____ Neg
Flu shot given (d/m/y) _____
Pneumococcal vaccine given (d/m/y) _____
TB test done (d/m/y) _____
Tetanus (d/m/y) _____

Cognitive Status	**Emotional**		**Behaviours**
❒ WNL	❒ WNL	❒ ⇩Mood	❒ Verbal Non-aggressive
❒ Dementia	❒ Depression	❒ Anxiety	❒ Verbal Aggressive
❒ Delirium	❒ Other		❒ Physical Non-aggressive
MMSE _____	❒ Hallucinations/Delusions		❒ Physical Aggressive
Date (d/m/y): _____			

Communication:

Speech	**Hearing**	**Vision**
❒ WNL	❒ WNL	❒ WNL
❒ Impaired	❒ Impaired	❒ Impaired

Foot-care needed ❒ Yes ❒ No
Dental care needed ❒ Yes ❒ No
Skin Integrity Issues ❒ Yes ❒ No

Strength
❒ WNL ❒ Weak
Upper: Proximal Distal R L
Lower: Proximal Distal R L

Personal Directives ❒ Yes ❒ No
Substitute Decision Maker:
_____
Tel #: _____

Mobility	Transfers	❒ IND	❒ ASST	❒ DEP
	Walking Aid	❒ IND Slow	❒ ASST	❒ DEP
Balance	Balance	❒ WNL		❒ Impaired
	Falls	❒ No ❒ Yes		Frequency
Elimination	Bowel	❒ Constip	❒ Cont	❒ Incont
	Bladder	❒ Catheter	❒ Cont	❒ Incont
Nutrition	Weight	❒ STABLE	❒ LOSS	❒ GAIN
	Appetite	❒ WNL	❒ FAIR	❒ POOR
ADLs	Feeding	❒ IND	❒ ASST	❒ DEP
	Bathing	❒ IND	❒ ASST	❒ DEP
	Dressing	❒ IND	❒ ASST	❒ DEP
	Toileting	❒ IND	❒ ASST	❒ DEP

Code Status:
❒ Do Not Attempt to Resuscitate
❒ Do Not Hospitalize
❒ Hospitalize
❒ Attempt to Resuscitate

Marital Status	**Family Stress**
❒ Married	❒ None
❒ Divorced	❒ Low
❒ Widowed	❒ Moderate
❒ Single	❒ High

Problems/Past History/Diagnosis	Medication Adjustment Required	Associated Medication
1.	❒	
2.	❒	
3.	❒	
4.	❒	
5.	❒	
6.	❒	
7.	❒	
8.	❒	
9.	❒	
10.	❒	
11.	❒	
12.	❒	

Current Frailty Score
Scale ❒ 5. Mildly Frail ❒ 6. Moderately Frail ❒ 7. Severely Frail ❒ 8. Very Severely ill ❒ 9. Termina

Note: Shaded areas to be completed by physician.

Clinical Frailty Scale*

5. Mildly Frail – These people often have **more evident slowing**, and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. Moderately Frail – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and **need help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. Severely Frail – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover from even a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail**.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173; 489-495

CGA Associated Visits	
Date	**Comments**

Physician Name (please print): _____ Physician Signature: _____

Signed on (d/m/y): _____ (Visit required on this date)

APPENDIX C

Directory of Facilities
As at April 1, 2014
Billings For SSDHA (DHA 1)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
SSDHA (DHA 1)	Harbour View Haven	Blockhouse	143	Nursing Home	N	Y	Y
SSDHA (DHA 1)	Hillside Pines	Bridgewater	50	Nursing Home	N	Y	Y
SSDHA (DHA 1)	Hillsview Acres	Greenfield	29	RCF	H	Y	Y
SSDHA (DHA 1)	Lohnes Rest Home	Barss Corner	8	RCF	H	Y	Y
SSDHA (DHA 1)	Mahone Nursing Home	Mahone Bay	60	Nursing Home	N	Y	Y
SSDHA (DHA 1)	North Queen Nursing Home	Caledonia	43	Nursing Home	N	Y	Y
SSDHA (DHA 1)	Peter's Place (PJD Rehab Housing Inc)	Pleasantville	6	RCF	H	Y	Y
SSDHA (DHA 1)	Queens Manor	Liverpool	61	Nursing Home	N	Y	Y
SSDHA (DHA 1)	Rosedale Home for Special Care	New Germany	39	Nursing Home	N	Y	Y
SSDHA (DHA 1)	Ryan Hall	Bridgewater	50	Nursing Home	N	Y	Y
			15	RCF	H	Y	Y
SSDHA (DHA 1)	Shoreham Village	Chester	89	Nursing Home	N	Y	Y
SSDHA (DHA 1)	LaHave Manor	Dayspring	66	ARC	H	N	N

Visit Type
N = Nursing Home Visit
H = Home Visit

CGA/Medication Review
Y = Yes
N = No

Note: Refer to the MSI billing manual for rules on visits, CGA and medication reviews

Directory of Facilities
As at April 1, 2014
Billings For SWNDHA (DHA 2)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
SWNDHA (DHA 2)	Bay Side Home Corporation	Barrington	62	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	Foyer Celeste Inc	Meteghan	19	RCF	H	Y	Y
SWNDHA (DHA 2)	Mary's Abide-A-While Homes Ltd	Shelburne	14	RCF	H	Y	Y
SWNDHA (DHA 2)	Nakile Home for Special Care	Glenwood	35	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	Olson's Glo Estate Special Care	Yarmouth	11	RCF	H	Y	Y
SWNDHA (DHA 2)	Pont du Marais Home Ltd (Not a SEA participant)	Lower West Pubnico	23	RCF	H	Y	Y
SWNDHA (DHA 2)	Roseway Manor Inc	Shelburne	66	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	Surf Lodge Community Continuing Care Centre	Lockeport	36	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	The Meadows - Tidal View Manor	Yarmouth	104	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	Tideview Terrace	Conway	89	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	Villa Acadienne	Meteghan	85	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	Au Logis d'Meteghan Ltd	Meteghan	22	RCF	H	Y	Y
SWNDHA (DHA 2)	Villa Saint Joseph-du-Lac	Dayton	72	Nursing Home	N	Y	Y
SWNDHA (DHA 2)	The Meadows	Bridgetown	34	ARC	H	N	N
			9	Other	H	N	N
SWNDHA (DHA 2)	Harbourside Lodge	Yarmouth	32	ARC	H	N	N

Visit Type
N = Nursing Home Visit
H = Home Visit

CGA/Medication Review
Y = Yes
N = No

Note: Refer to the MSI billing manual for rules on visits, CGA and medication reviews

Directory of Facilities
As at April 1, 2014
Billings For AVDHA (DHA 3)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
AVDHA (DHA 3)	Annapolis Royal Nursing Home Limited	Annapolis Royal	53	Nursing Home	N	Y	Y
			12	RCF	H	Y	Y
AVDHA (DHA 3)	Blomidon Court	Greenwich	50	Nursing Home	N	Y	Y
AVDHA (DHA 3)	Evergreen Home for Special Care	Kentville	116	Nursing Home	N	Y	Y
AVDHA (DHA 3)	Grace Haven	Bridgetown	20	RCF	H	Y	Y
AVDHA (DHA 3)	Grand View Manor	Berwick	142	Nursing Home	N	Y	Y
AVDHA (DHA 3)	Heart of the Valley LTC Centre	Middleton	49	Nursing Home	N	Y	Y
AVDHA (DHA 3)	Mountain Lea Lodge	Bridgetown	104	Nursing Home	N	Y	Y
AVDHA (DHA 3)	New Visions Home for Seniors	South Berwick	25	RCF	H	Y	Y
AVDHA (DHA 3)	Orchard Court Continuing Care Residence	Kentville	62	Nursing Home	N	Y	Y
AVDHA (DHA 3)	Saunders Rest Home	Bridgetown	8	RCF	H	Y	Y
AVDHA (DHA 3)	Tibbetts Home for Special Care (Wilmot)	Kingston	25	RCF	H	Y	Y
AVDHA (DHA 3)	Wedgewood House for Seniors Ltd (Not a SEA participant)	Kentville	15	RCF	H	Y	Y
AVDHA (DHA 3)	Wolfville Nursing Home	Wolfville	67	Nursing Home	N	Y	Y
AVDHA (DHA 3)	Wolfville Elms (The Elms Rest Home)	Wolfville	23	RCF	H	Y	Y
AVDHA (DHA 3)	Kings Regional Rehabilitation Centre	Waterville	173	RRC	H	N	N
			42	Other	H	N	N

Visit Type
N = Nursing Home Visit
H = Home Visit

CGA/Medication Review
Y = Yes
N = No

Note: Refer to the MSI billing manual for rules on visits, CGA and medication reviews

Directory of Facilities
As at April 1, 2014
Billings For CEHHA (DHA 4)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
CEHHA (DHA 4)	Debert Court	Debert	36	Nursing Home	N	Y	Y
CEHHA (DHA 4)	Elk Court	Brookfield	35	Nursing Home	N	Y	Y
CEHHA (DHA 4)	Karlaine Place	Truro	8	RCF	H	Y	Y
CEHHA (DHA 4)	Mitchell's Rest Home	Upper Nine Mile River	3	RCF	H	Y	Y
CEHHA (DHA 4)	Maplewood Manor	Tatamagouche	6	RCF	H	Y	Y
CEHHA (DHA 4)	Serenity Lodge	Enfield	6	RCF	H	Y	Y
CEHHA (DHA 4)	The Magnolia	Enfield	59	Nursing Home	N	Y	Y
			12	RCF	H	Y	Y
CEHHA (DHA 4)	The Mira	Truro	89	Nursing Home	N	Y	Y
CEHHA (DHA 4)	Townsview Estates	Truro	51	RCF	H	Y	Y
CEHHA (DHA 4)	Vimy Court	Bible Hill	60	Nursing Home	N	Y	Y
CEHHA (DHA 4)	Willow Lodge	Tatamagouche	61	Nursing Home	N	Y	Y
CEHHA (DHA 4)	Wynn Park Villa	Truro	40	Nursing Home	N	Y	Y
			20	RCF	H	Y	Y
CEHHA (DHA 4)	Cedarstone Enhanced Care Limited	Truro	125	Nursing Home	N	Y	Y

Visit Type
N = Nursing Home Visit
H = Home Visit

CGA/Medication Review
Y = Yes
N = No

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Directory of Facilities
As at April 1, 2014
Billings For CHA (DHA 5)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
CHA (DHA 5)	Bayview Memorial Health Centre	Advocate Harbour	10	Nursing Home	N	Y	Y
CHA (DHA 5)	Centennial Villa	Amherst	43	RCF	H	Y	Y
CHA (DHA 5)	Chignecto Manor	Advocate Harbour	14	RCF	H	Y	Y
CHA (DHA 5)	East Cumberland Lodge	Pugwash	73	Nursing Home	N	Y	Y
CHA (DHA 5)	Gables Lodge Limited	Amherst	96	Nursing Home	N	Y	Y
CHA (DHA 5)	High-Crest Springhill Home for Special Care Ltd.	Springhill	65	Nursing Home	N	Y	Y
CHA (DHA 5)	Northumberland Hall Continuing Care Residence	Amherst	36	Nursing Home	N	Y	Y
CHA (DHA 5)	South Cumberland Community Care Centre	Parrsboro	14	Nursing Home	N	Y	Y
CHA (DHA 5)	Victoria Manor	Amherst	40	RCF	H	Y	Y
CHA (DHA 5)	White Birches Retirement Residence	Amherst	24	RCF	H	Y	Y
CHA (DHA 5)	Sunset Residential and Rehabilitation Services	Pugwash	80	ARC	H	N	N

Visit Type
N = Nursing Home Visit
H = Home Visit

CGA/Medication Review
Y = Yes
N = No

Note: Refer to the MSI billing manual for rules on visits, CGA and medication reviews

Directory of Facilities
As at April 1, 2014
Billings For PCDHA (DHA 6)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
PCDHA (DHA 6)	Glen Haven Manor	New Glasgow	202	Nursing Home	N	Y	Y
PCDHA (DHA 6)	High Crest Place	New Glasgow	27	RCF	H	Y	Y
PCDHA (DHA 6)	Ivey's Terrace Nursing Home	Trenton	36	Nursing Home	N	Y	Y
PCDHA (DHA 6)	Maritime Odd Fellow Home	Pictou	46	Nursing Home	N	Y	Y
PCDHA (DHA 6)	Shiretown Nursing Home	Pictou	36	Nursing Home	N	Y	Y
			17	RCF	H	Y	Y
PCDHA (DHA 6)	Valley View Villa	Stellarton	112	Nursing Home	N	Y	Y
PCDHA (DHA 6)	High-Crest Home New Glasgow	New Glasgow	29	RCF	H	Y	Y
PCDHA (DHA 6)	Riverview Home	Stellarton	51	ARC	H	N	N
			48	Other	H	N	N

Visit Type
N = Nursing Home Visit
H = Home Visit

CGA/Medication Review
Y = Yes
N = No

Note: Refer to the MSI billing manual for rules on visits, CGA and medication reviews

Directory of Facilities
As at April 1, 2014
Billings For GASHA (DHA 7)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
GASHA (DHA 7)	Canso Seaside Manor	Canso	15	Nursing Home	N	Y	Y
GASHA (DHA 7)	High-Crest Sherbrooke Home for Special Care	Nursing Home	39	Nursing Home	N	Y	Y
GASHA (DHA 7)	Highland Crest Residential Care Facility	Antigonish	35	RCF	H	Y	Y
GASHA (DHA 7)	Milford Haven Corporation	Guysborough	50	Nursing Home	N	Y	Y
GASHA (DHA 7)	Port Hawkesbury Nursing Home	Port Hawkesbury	59	Nursing Home	N	Y	Y
			5	RCF	H	Y	Y
GASHA (DHA 7)	Richmond Villa	St. Peter's	59	Nursing Home	N	Y	Y
			8	RCF	H	Y	Y
GASHA (DHA 7)	RK MacDonald Nursing Home	Antigonish	136	Nursing Home	N	Y	Y
GASHA (DHA 7)	Sisters of St. Martha (Not a SEA participant)	Antigonish	25	Nursing Home	N	Y	Y
GASHA (DHA 7)	St. Anne Community and Nursing Care Centre	Arichat	24	Nursing Home	N	Y	Y

Visit Type
N = Nursing Home Visit
H = Home Visit

CGA/Medication Review
Y = Yes
N = No

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Directory of Facilities
As at April 1, 2014
Billings For CBDHA (DHA 8)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
CBDHA (DHA 8)	Alderwood	Baddeck	59	Nursing Home	N	Y	Y
			11	RCF	H	Y	Y
CBDHA (DHA 8)	Carefield Manor Ltd	Sydney	12	RCF	H	Y	Y
CBDHA (DHA 8)	Celtic Court	Sydney	36	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Dominion Community Guest Home	Dominion	4	RCF	H	Y	Y
CBDHA (DHA 8)	Dutch Brook Guest Home	Dutch Brook	3	RCF	H	Y	Y
CBDHA (DHA 8)	Foyer Pere Fiset	Cheticamp	60	Nursing Home	N	Y	Y
			10	RCF	H	Y	Y
CBDHA (DHA 8)	Harbourstone Enhanced Care Limited	Sydney	270	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Highland Manor	Neil's Harbour	19	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Inverary Manor	Inverness	71	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Maple Hill Manor	New Waterford	50	Nursing Home	N	Y	Y
			13	RCF	H	Y	Y
CBDHA (DHA 8)	Miners' Memorial Manor	Sydney Mines	36	Nursing Home	N	Y	Y
			13	RCF	H	Y	Y
CBDHA (DHA 8)	My Cape Breton Home for Seniors	North Sydney	16	RCF	H	Y	Y
CBDHA (DHA 8)	My Cape Breton Home for Seniors	Sydney	17	RCF	H	Y	Y
CBDHA (DHA 8)	Northside Community Guest Home	North Sydney	144	Nursing Home	N	Y	Y
CBDHA (DHA 8)	RC MacGillivray Guest Home	Sydney	85	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Seaview Manor	Glace Bay	113	Nursing Home	N	Y	Y

Directory of Facilities
As at April 1, 2014
Billings For CBDHA (DHA 8) Con't

CBDHA (DHA 8)	Southview Guest Home Ltd	Sydney	3	RCF	H	Y	Y
CBDHA (DHA 8)	Taigh Na Mara Facility	Glace Bay	36	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Taigh Solas	North Sydney	22	Nursing Home	N	Y	Y
CBDHA (DHA 8)	The Cove Guest Home	Sydney	110	Nursing Home	N	Y	Y
CBDHA (DHA 8)	The Heritage House	Port Hood	11	RCF	H	Y	Y
CBDHA (DHA 8)	Victoria Haven Nursing Home	Glace Bay	52	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Waterford Heights	New Waterford	24	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Breton Ability Centre	Sydney	105	RRC	H	N	N
			10	Other	H	N	N

Temporary Licensed Nursing Home Beds

CBDHA (DHA 8)	Cape Breton Regional Health Care Complex - 3B	Sydney	18	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Glace Bay Health Care Facility	Glace Bay	18	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Northside General Hospital 4 East	North Sydney	11	Nursing Home	N	Y	Y
CBDHA (DHA 8)	Harbour View Facility	Sydney Mines	8	Nursing Home	N	Y	Y

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CGA/Medication Review
Y = Yes
N = No

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Directory of Facilities
As at April 1, 2014
Billings For CDHA (DHA 9)

District	Facility	Location	# of Beds	Classification	Visit Type	CGA	Medication Review
CDHA (DHA 9)	Arborstone Enhanced Care Limited	Halifax	190	Nursing Home	N	Y	Y
CDHA (DHA 9)	Bisset Court	Cole Harbour	50	Nursing Home	N	Y	Y
CDHA (DHA 9)	Clarmar Residential Care Facility	Dartmouth	24	RCF	H	Y	Y
CDHA (DHA 9)	Dykeland Lodge	Windsor	111	Nursing Home	N	Y	Y
CDHA (DHA 9)	Harbourview Lodge Continuing Care Centre	Sheet Harbour	28	Nursing Home	N	Y	Y
			4	RCF	H	Y	Y
CDHA (DHA 9)	Glasgow Hall - Parkland at the Lakes Ltd	Dartmouth	72	Nursing Home	N	Y	Y
CDHA (DHA 9)	Haliburton Place	Windsor	31	Nursing Home	N	Y	Y
CDHA (DHA 9)	Ivy Meadows Continuing Care Centre	Beaverbank	51	Nursing Home	N	Y	Y
CDHA (DHA 9)	Maplestone Enhanced Care Ltd	Halifax	87	Nursing Home	N	Y	Y
CDHA (DHA 9)	Melville Gardens Nursing Home	Halifax	31	Nursing Home	N	Y	Y
			60	RCF	H	Y	Y
CDHA (DHA 9)	Melville Lodge	Halifax	123	Nursing Home	N	Y	Y
CDHA (DHA 9)	Musquodoboit Valley Home for Special Care Assoc	Middle Musquodoboit	29	Nursing Home	N	Y	Y
CDHA (DHA 9)	Northwood Bedford Inc - Christina and Hedley G. Ivany Place	Bedford	130	Nursing Home	N	Y	Y
			26	RCF	H	Y	Y
CDHA (DHA 9)	Northwood Incorporated	Halifax	445	Nursing Home	N	Y	Y
			40	RCF	H	Y	Y
CDHA (DHA 9)	Oakwood Terrace	Dartmouth	111	Nursing Home	N	Y	Y
CDHA (DHA 9)	Ocean View Continuing Care Centre	Eastern Passage	176	Nursing Home	N	Y	Y

Directory of Facilities
As at April 1, 2014
Billings For CDHA (DHA 9) Con't

CDHA (DHA 9)	Parkstone Enhanced Care Ltd	Halifax	190	Nursing Home	N	Y	Y
CDHA (DHA 9)	PJD Rehab Housing Incorporated (Peter's Place Halifax)	Halifax	4	RCF	H	Y	Y
CDHA (DHA 9)	Precision Health - Washmill Lake Dr Apartments	Halifax	20	RCF	H	Y	Y
CDHA (DHA 9)	Precision Health - 16 Rannoch Road	Dartmouth	3	RCF	H	Y	Y
CDHA (DHA 9)	Precision Health - 21 Kincardine Street	Dartmouth	4	RCF	H	Y	Y
CDHA (DHA 9)	Precision Health - 24 Kincardine Street	Dartmouth	3	RCF	H	Y	Y
CDHA (DHA 9)	Saint Vincent's Nursing Home	Halifax	149	Nursing Home	N	Y	Y
CDHA (DHA 9)	Seabright Resthome Ltd.	Seabright	6	RCF	H	Y	Y
CDHA (DHA 9)	Sunshine Personal Home Care Inc	Halifax	3	RCF	H	Y	Y
CDHA (DHA 9)	The Admiral Long Term Care Centre	Dartmouth	65	Nursing Home	N	Y	Y
CDHA (DHA 9)	The Birches	Musquodoboit Harbour	41	Nursing Home	N	Y	Y
CDHA (DHA 9)	The Sagewood Continuing Care Centre	Sackville	36	Nursing Home	N	Y	Y
			13	RCF	H	Y	Y
CDHA (DHA 9)	Victoria Park Guest Home	Windsor	12	RCF	H	Y	Y
CDHA (DHA 9)	Windsor Elms Village for Continuing Care Society	Falmouth	107	Nursing Home	N	Y	Y
CDHA (DHA 9)	White Hills Long Term Care Centre	Hammond Plains	58	Nursing Home	N	Y	Y
CDHA (DHA 9)	Quest Regional Rehabilitation Centre	Sackville	24	RRC	H	N	N
			7	Other	H	N	N

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CGA/Medication Review
Y = Yes
N = No

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