Virtual Care Pilot Payment Schedule

For Virtual Care Services Provided by a Physician

January 1, 2021

Saskatchewan

OVERARCHING PRINCIPLES

- The Ministry of Health (Ministry) and the Saskatchewan Medical Association (SMA) have a joint interest in improving patient access and health outcomes through collaborative care and technology, for the provision of care with and on behalf of patients.

- The provision of medical services via telephone and secure video are intended to align with existing policies and standards, such as the CPSS's policy, *The Practice of Telemedicine*, *Walk-in Clinics and Episodic Care, and the Continuity of Care standard*

- The Ministry and the SMA are both supportive of compensating physicians for virtual care in a manner that is fair, equitable across specialties, cost effective, and that will lead to better patient health outcomes for Saskatchewan residents.

- Every effort should be made to ensure technology is widely used by patients and physicians, taking into consideration aspects such as affordability, prevalence of technology, and ease-of-use. Where necessary, integration of EMRs with new virtual care tools must ensure appropriate documentation for purposes of care, liability and audit.

PREAMBLE

For the purposes of this Virtual Care Pilot, virtual care is an interaction between patients and/or members of their circle of care, occurring remotely, using telephone or secure videoconferencing with the aim of facilitating or maximizing the quality and effectiveness of patient care. Remotely, within the context of the Virtual Care Pilot, is defined as without physical contact and does not necessarily involve long distances (unless explicitly stated in each service description).

Virtual Care Pilot services are temporary service codes; they are not insured services under *The Medical Care Insurance Act.* In order to facilitate payment, it is agreed that the Medical Services Branch (MSB) of the Ministry of Health will accept automated claim submissions for Virtual Care Pilot services provided by the physician to beneficiaries with respect to accounts submitted directly to MSB and the billing physician agrees to submit billings and accept payment according to the conditions outlined in the Virtual Care Pilot Payment Schedule and the *Direct Payment Agreement With Physicians* that has been signed by MSB and the physician.

To facilitate the above, existing explanatory codes will be used in the physician's payment list or file, reject file or returned claim when applicable. See the *Payment Schedule For Insured Services Provided by a Physician* "The Ministry of Health Explanatory Codes For Physicians".

Saskatchewan beneficiaries cannot be charged for any aspect of a publicly-funded Virtual Care Pilot service in an amount that exceeds the listed fee payable in the service description.

Compensation for virtual care services is limited to the parameters of the Virtual Care Pilot as agreed to by the Ministry and the SMA. For clarity:

- Unless stated otherwise, service is not restricted by SK location i.e., patient and physician may be located anywhere in SK, but both must be in SK at the time of the virtual care service.
- There is a maximum limit of 3,000 virtual care services payable per physician, per calendar year. Inclusive of this 3,000 maximum, is a maximum of 1,500 875A - Limited virtual care services payable per physician, per calendar year. For time-based Virtual Care Pilot service codes, only the base service code will count towards the annual service count limit.

Upon mutual agreement, the Ministry and the SMA may amend the Virtual Care Pilot as required, including but not limited to reduce, suspend or cancel these service code items, and/or make changes to the fees to ensure financial accountability/feasibility and effectiveness of the Pilot.

NOTE: Effective January 1, 2021, the Ministry and the SMA have mutually agreed to suspend the abovementioned maximum limit of 3,000 Virtual Care Pilot services payable per physician, per calendar year, until further notice.

LIST OF VIRTUAL CARE PILOT SERVICES

INTRODUCTION

This Payment Schedule is effective for services provided on and after January 1, 2021. It lists a payment for each Virtual Care Pilot service which will be made at 100% unless the "Assessment Rules" indicate that payment for the service:

a) is included in the composite payment made for another service; or,

b) is subject to an adjustment when billed in addition to another service.

All services billed to the Medical Services Branch are the sole responsibility of the physician rendering the service with respect to appropriate documentation and billing (see *Payment Schedule For Insured Services Provided by a Physician* "Documentation Requirements for the Purposes of Billing").

If a specific fee code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution. (e.g., Physicians may not bill an 805B for a 790A service).

Virtual Care Pilot service codes are EMR eligible where applicable (i.e. consistent with existing "visit services" eligibility).

BILLING INFORMATION

1. Virtual Care Pilot services are billable by Saskatchewan licensed fee-for-services (FFS) physicians who are also providing in-person services to Saskatchewan beneficiaries. An exception is 875A - Limited virtual care visit service: it may be billed by SK physicians and/or SK virtual care-only clinics that do not provide any in-person services.
    a) Virtual care-only clinics are virtual care clinics that do not provide in-person physician services. A physician is not expected to provide the in-person visit should the patient's condition be such that it is medically required to treat the patient in-person.
    b) Limited virtual care visit service is considered a single encounter with a patient who is unattached to the clinic and where neither the physician nor patient have the expectation of an ongoing care relationship. Limited virtual care visit service code is payable to physicians providing episodic care initiated by a patient via a virtual care clinic that does not provide in-person physician services.
    c) The new Limited virtual care service code recognizes that physicians working in virtual care-only clinics will be providing a patient-initiated single encounter episodic visit, where neither the physician nor patient have the expectation of an ongoing care relationship. This is simply different than the service and responsibility for the continuation of care which a family doctor would provide to their patient.

2. Unless stated otherwise, virtual care services are not restricted by Saskatchewan location i.e., patient and physician may be located anywhere in SK. For further clarity, both the physician and patient *must* be located in SK at the time the service is provided.

3. Virtual care services are not billable to out-of-province residents or reciprocally by out-of-province physicians. Physicians wishing to provide a virtual care service(s) to an out-of-province resident are advised to contact the resident's home province to confirm payment.

4. Virtual care services are not payable to physicians who are concurrently working under salary, service contract, APP or sessional arrangements (i.e. no duplication of payments). Physicians who are compensated by an alternate payment plan (APP), or directly by the Saskatchewan Health Authority (SHA) are permitted to "shadow bill" these services, but no payment will be eligible.

5. Virtual care services are payable to a maximum of 3,000 virtual care services per physician per calendar year (i.e. total sum of telephone and video visits, including limited virtual care visits (875A), cannot exceed 3,000 per physician per year, and the total number of limited virtual care visit services (875A) cannot exceed 1,500 per physician per year).

   NOTE: Effective January 1, 2021, the Ministry of Health and the SMA have mutually agreed to suspend the abovementioned maximum limit of 3,000 Virtual Care Pilot services payable per physician, per calendar year, until further notice.

6. Virtual care services must be medically required and all time requirements are for direct physician-patient interaction in real time.

7. Virtual care services must be direct physician-to-patient contact in real time. Time spent on indirect or administrative tasks cannot be claimed. Virtual care fees are <u>not</u> payable for notification of normal test results, or notification of office, referral or other appointments, "triaging" of patients, or other administrative tasks. For further clarity, the following time cannot be claimed via Virtual Care Pilot service codes:

   Telephone calls to/from patients in an acute care setting; phone calls to request/obtain sick notes; form completions and other third party requests; phone calls to obtain or provide updates on behalf of the patient related to referrals/tests/procedures; for consultations with other providers (physicians, allied health care professionals) on behalf/request of the patient.

8. When a medically required assessment is provided on behalf of a patient to the patient's parent/caregiver, communication regarding diagnosis, treatment and follow-up is considered part of the assessment that is to be billed under the HSN of the patient.

9. Unless indicated otherwise, virtual care services can be initiated by physician or patient. Service must be medically required and fulfill all the requirements of the virtual service code in order to be eligible for payment. Physician initiated check-in communication with patient is not eligible.

10. Virtual care services cannot be delegated by the physician to a non-physician.

11. Unless indicated otherwise, virtual care services which are payable when provided by a physician is also payable in certain instances when provided under the supervision of a physician. Payments can be made to the physician when supervised services are provided by:

    (a) a person during the period of registration on the educational register of the College of Physicians and Surgeons as an intern, a resident, an undergraduate junior rotating intern (JURSI) or as a person taking other postgraduate training in Saskatchewan as a physician, where that service is provided as part of the course of training being taken; <u>and</u>,

(b) the supervising physician is able to intervene promptly if necessary. Billings must include the comment: "supervision of medical learner".

12. Multiple virtual care services (telephone or video) cannot be billed by the same physician or a physician from the same clinic, for the same patient on the same day. If, due to extenuating circumstances, more than one virtual care service is medically required (e.g., a change in medical condition requiring reassessment) payment will be considered when a physician provides details. As per Assessment Rules - Visit Services:

    Any claim submitted for a second visit on the same date of service by either the same physician or another in the same clinic and specialty should state the reason for the second visit, the time, location and service provided.

    Explanatory Code **DA** (PPS page 45) - Only one visit type service is approved during a single patient contact. If there were 2 separate patient contacts, please resubmit with the reason and time of the second visit.

13. Virtual care services will be assessed, *mutatis mutandis*, according to applicable assessment rules as outlined in the *Payment Schedule For Insured Services Provided by a Physician,* unless otherwise indicated. See Virtual Care Pilot Assessment Rules.

14. A consultant may take more than one visit to make a proper diagnosis, but only one payment is made. For virtual consultations, only one consultation is payable for the same referral within 90 days. See Consultations – General Assessment Rules.

15. Services requiring physical in-person examination are not eligible for payment under virtual care codes. If during the course of a virtual visit it becomes apparent that an in-person visit is necessary, only the higher in-person service code is payable.

16. Unless indicated otherwise, virtual care services are not eligible for any premiums or surcharges.

17. Virtual care services may not be claimed for services payable under Monitoring Anticoagulant Therapy (763A), Monitoring Diabetic Patients on Insulin (764A-768A), Monitoring Home Parenteral Antimicrobial Intravenous Therapy (770A), monthly stipend for Overseeing Hepatitis C Treatment (57B), monthly stipend for Overseeing Methadone/Suboxone Management (60B-62B), or Special Care Home Management (627A/628A).

18. Secure videoconferencing must be provided on a secure platform that is compliant with *The Health Information Privacy Act*. The Saskatchewan EMR Program has released a Virtual Care Quick Start Guide to support physicians in providing virtual consultations during the COVID-19 pandemic. Please visit https://www.emr.sma.sk.ca/pages/virtual_care.html for more information.

19. Physicians are responsible to ensure appropriate documentation (that must include start and stop times for time-based codes) consistent with the *Payment Schedule for Insured Services Provided by a Physician* "Documentation Requirements for the Purposes of Billing".

VIRTUAL CARE PILOT ASSESSMENT RULES

All existing assessment rules outlined in the *Payment Schedule For Insured Services Provided by a Physician* (PPS) are applicable to the Virtual Care Pilot service codes, *mutatis mutandis*, unless otherwise indicated below.

Assessment Rules – Consultations (PPS page 18)

- # 6. (d) a virtual consultation on the same day or within 42 days after a partial/follow-up assessment, the consultation will be converted to a partial/follow up virtual assessment;
- # 7. When for a different condition a physician provides a virtual consultation on the same day or within 90 days prior to or 90 days after another consultation, by the same physician, the second consultation will be converted to a partial/follow up virtual assessment.

Explanatory Codes (PPS page 48)

EL Virtual Consultation converted to a partial/follow-up virtual assessment.
Re: Assessment Rules - "Consultations", #6 (b) and (d) and #7.

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S E C T I O N A – General Services

		Specialist/General Practitioner
875A	**Limited virtual care visit (patient to physician) provided via secure videoconference.** Maximum one per patient, per day. Cannot be billed with any additional service codes, virtual or in-person, by the same physician on the same day. Includes: a) history review; b) history of presenting complaint; c) functional enquiry; d) assessment; e) diagnosis; f) necessary treatment; g) advice to the patient; and, h) record of service provided	24.50

This service must be initiated by the patient. Limited virtual care visit service code is payable to physicians (General Practitioner or Specialist) providing episodic care initiated by a patient via a virtual care clinic that does not provide in-person physician services. This service code is not payable for services performed by a medical learner under the supervision of a physician.

Physicians providing services via a virtual care only clinic must use this service code and must deliver the service via secure video conference. For further clarity, 875A is not payable for virtual care services provided via telephone.

S E C T I O N B – General Practice

General Practitioner

805B **Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference**-- includes: $35.00

a) history review;
b) history of presenting complaint;
c) functional enquiry;
d) assessment;
e) diagnosis;
f) necessary treatment;
g) advice to the patient; and,
h) record of service provided.

Use 855B instead of 805B for a virtual visit where a specialist referral is made and continue using 805B for virtual visits where a specialist referral is not made.

855B **Virtual partial assessment or subsequent virtual visit provided via telephone or secure videoconference, involving a specialist referral** -- includes: $35.00

a) history review;
b) history of presenting complaint;
c) functional enquiry;
d) assessment;
e) diagnosis;
f) necessary treatment;
g) advice to the patient; and,
h) record of service provided.

S E C T I O N B – General Practice

General Practitioner

809B	**Virtual consultation provided via telephone or secure videoconference**-- includes: a) all visits necessary; b) history; c) review of laboratory and/or other data; and d) written submission of the consultant's opinion and recommendations to the referring doctor.	$67.50
811B	**Repeat virtual consultation provided via telephone or secure videoconference** A formal virtual consultation for the same or related condition repeated within 90 days by the same physician. Repeat virtual consultation is only to be billed when it is generated by a new formal request by the referring physician. It should not be used for routine virtual follow-up of the patient for which service code '805B' "Virtual partial assessment or subsequent virtual visit" is appropriate.	$32.75

Virtual counselling

1. Virtual counselling is where the physician engages with the patient on an individual basis, via telephone or secure videoconference, where the goal of the physician and patient is to become aware of the patient's problems or situation and of the modalities for prevention and/or treatment
2. Virtual counselling can also include an educational dialogue with the patient regarding prevention/health promotion, early detection of health problems, environmental issues related to the patient's health and occupational health and safety.
3. Payment for this service implies that it is a discrete service provided by the physician personally.
4. It is not a substitute for a virtual visit involving a partial examination or assessment.
5. This code is not to be used simply because a virtual assessment and/or treatment took 15 minutes or longer, such as in the case of multiple complaints.

Virtual third party counselling:

1. It is payable on a third party basis when a family member is counselled via telephone or secure videoconference because of the patient's serious and complex problem.
2. It is not payable for routine briefing or advice to relatives, which is considered part of the visit service fee.
3. Third party counselling must be provided at a booked separate appointment.
4. Third party counselling claims are subject to a maximum of 30 minutes and should be submitted in the counselled individual's name.
5. Diagnosis must be confirmed or the diagnostic code Z84 must be indicated.

Third party counselling for the provision of Medical Assistance in Dying (MAID) services provided by a willing practitioner

1. 840B is billable on a third party basis when a family member, caregiver, relative, friend, spouse, etc. is counselled via telephone or secure videoconference because of the patient's request for Medical Assistance in Dying (MAID) services.
2. Third party counselling for the provision of MAID claims should be submitted in the name of the patient requesting MAID services (not the family member, relative, caregiver, etc).
3. Diagnosis must be Z37 (third party counselling, MAID).

Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times documented in the medical record.

S E C T I O N B – General Practice

General Practitioner

840B **Virtual counselling provided via telephone or secure videoconference** – first 15 minutes, includes: $33.75

a) history review;
b) counselling;
c) educational dialogue;
d) intervention;
e) record of service provided, and;
f) time spent counselling.

841B **Virtual counselling provided via telephone or secure videoconference** – next 15 minutes or major portion thereof. $33.75

841B is payable to a maximum of 7 additional units (105 minutes), unless stipulated otherwise i.e., third party counselling is payable to a maximum of 1 additional unit (15 minutes).

For clarity:
The combination of 840B and 841B is payable to a maximum of 120 minutes total; i.e., 840B + 841B x 7.
For third party counselling, the two service codes are payable to a maximum of 30 minutes total; i.e., 840B + 841B x 1.

S E C T I O N B – General Practice

General Practitioner

864B	**Virtual Chronic Disease Management provided via telephone or secure videoconference**—maximum of two virtual CDM services per patient per year and must be preceded by at least one in-person CDM visit. Not billable with any additional service codes by the same physician on the same day. Service must involve at least 15 minutes of direct physician to patient interaction in real-time consistent with approved guidelines, but does not require a CDM flowsheet. For further clarity, when medically required, virtual CDM service includes, but is not limited to (i.e., this is not an exhaustive list): a) Review of medications and discussions about any side effects/adherence issues; b) Contraception or preconception planning in women with diabetes; c) Lifestyle, nutrition, diet and physical activity review; d) Discussion of any significant changes to medications or other management; e) Therapy adherence/comment; f) Patient goals/self-management; advanced care planning/health care directive.	$41.30

Virtual Chronic Disease Management

1. Virtual Chronic Disease Management (VCDM) fees are designed as an adjunct to the use of accepted clinical care pathways to optimize the patient management and the provision of in-person chronic disease management.
a) For the physician's first VCDM billing to be payable, the physician must have seen the patient in-person, submitted a CDM fee claim for the patient with the comment: "will be providing ongoing care to the patient".
b) VCDM does not satisfy the following Quality Improvement Payment criteria:

- Physicians must have billed at least one CDM base fee code (64B) for the patient within the 12 month period.

2. VCDM fees are billable only for patients with a confirmed diagnosis of diabetes mellitus, coronary artery disease, heart failure or chronic obstructive pulmonary disease (COPD) who require ongoing longitudinal care management of these diseases that may be safely and effectively provided via telephone of secure video technology.

3. Frequency:
a) VCDM fees are billable only once per patient, every 90 days; a maximum of two virtual chronic disease management services per patient, per year are payable.
b) To initiate billing of the VCDM service code, the physician's first CDM fee claim for the patient must be in-person and include the comment: "will be providing ongoing care to the patient".
c) Subsequent (after 90 days) VCDM and CDM fee claims must be consecutive and continuous for the same patient by the same physician or clinic and will not require a comment.
d) One chronic disease management service (either VCDM or CDM) fee is billable per patient, every 90 days; a maximum of four chronic disease management services (i.e., combination of VCDM—not to exceed maximum stipulated in a) above—or in-person CDM services) per patient, per year are payable.

4. Time Spent with Patient:
a) The VCDM fee includes a patient visit that involves at least 15 minutes of physician to patient interaction in real-time.
b) Virtual chronic disease management visits in excess of one every 90 days, or virtual visits involving less than 15 minutes of physician to patient interaction in real-time, should be billed using appropriate virtual care pilot visit codes (e.g. 805B).

5. More Than One Condition:
a) If the patient has more than one of these conditions, they will be dealt with at the same virtual visit.

6. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.