Primary Care's Relaunch – Practical Approaches for the "New Normal"

May 22, 2020

Q&A Summary

This information was gathered on May 22nd from the chat and the live question & answer period of the Primary Care's Relaunch – Practical Approaches for the "New Normal" Webinar.

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Virtual Care Billing Codes

For up to date information related to Alberta Physician Compensation, please see the AMA Virtual Care Billing Codes webpage.

Can I bill for virtual care group visits?

Response: At this time, only individual physician-to-patient direct contact time may be claimed using the virtual care codes referenced by Caroline Garland. Group visits are not currently claimable under the virtual care codes available.

Are we prepared if the government removes virtual care billing codes post-pandemic?

Response: We are working on a holistic proposal for government. However, at this time, they have been quite clear that the existing codes introduced in March are only in effect for the duration of the pandemic declaration. The previous codes for physician: patient phone call, email, videoconference (03.05JR, 03.01S, 03.01T) will remain, but they are limited to 14 each per week, per physician, so may not support care transformation to virtual care in the longer term. This is why there is a need to develop a more workable framework proposal.

Virtual care is convenient for patients and saves the government money. Post-pandemic, will the government continue to allow physician to bill for virtual care visits at the current rate or an increase rate?

Response: The AMA will continue to advocate for appropriate rates for physicians' virtual care for patients, both during the pandemic and thereafter.

I am really enjoying virtual visits and see a place for more of these in the future, but they don't make financial sense. How do we balance this discrepancy when virtual care is more patient centred, but we need to operate a business?

Response: More work is needed to determine appropriate rates for virtual services. At this time, AMA advocacy with Alberta Health has focused on high-needs areas such as palliative care and chronic pain. In the current environment where there is no existing agreement, AMA continues to advocate for appropriate remuneration for physicians' services; Alberta Health does take the AMA's suggestions under advisement, but views changes to the Schedule as at their sole discretion.

Virtual visits can be immensely helpful for palliative care and senior populations beyond just the COVID pandemic. Unfortunately, the virtual codes do not financially make sense for these types of patients. Can the AMA help us to advocate for changes to the virtual billing codes for seniors >75 and palliative care, much like the codes for mental health?

Response: On Friday, May 22, in response to significant AMA advocacy, Alberta Health released Bulletin MED228 which announced changes allowing chronic pain and palliative care to be claimed under health service code 08.19CW. We will continue to advocate to allow time-based claims for seniors >75 and advise members when Alberta Health has agreed to amend payment rates or codes to recognize the additional time requirements for that patient population.

Physicians are not allowed to bill unless the patient has initiated the encounter, so are you calling your diabetics for free?

Response: We have clarified the patient-initiated requirement with Alberta Health and posted the clarification here: https://www.albertadoctors.org/e-health/active-panel-mgmt-during-pandemic.pdf. Patient-initiated can include active patient panel management, follow-up of chronic conditions, and checking in with vulnerable and/or at-risk patients. Remember, only physician-to-patient direct contact may be claimed, and time is only physician-to-patient direct contact time.

In the Emergency Department, are people using the AZ codes? Or should the A codes be used?

Response: You should use the Z codes for all services in hospital, long-term care, and other publicly funded centres. The rates are now the same as the comparable office-based codes while AH and AHS work on in-hospital clinics where physicians are paying overhead to AHS. However, your services in the Emergency Department and inpatient wards will continue to require the Z codes.

In-Person & Virtual Patient Visits

Should we be masking all patients? My understanding is that only ILI symptomatic patients are masked as per AHS PPE Taskforce?

Response: AHS Guidelines for Continuous Masking in Healthcare settings can be found here: https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-ppe-continuous-use-guidance-masking.pdf. This document outlines standards for use of procedure masks by all healthcare workers (HCW) who work in patient care areas in AHS and community settings.

There are fully functioning clinics not screening their patients. How do we explain to our patients that we are following protocol by screening them?

Response: Physicians are encouraged to work with team members to fully explain to patients new protocols that have been put in place in their clinic and to explain that this is for the purposes of patient safety. Each clinic may choose to apply guidance provided to their own context.

If a GP refers a patient to a specialist as "urgent" is a phone consult still required, or is it justifiable for the specialist to bring the patient right in to expedite care based on the referring doc considering it "urgent" (after screening for COVID of course)?

Response: This will be dependent on several factors including, and not limited to, clinical condition, assessed urgency, specialist protocol. While no one common approach exists, clinicians are encouraged to work in collaboration to meet patient needs based on priority and safety.

Can I do home visits?

Response: There is no definitive policy as to whether home visits should be done. Consider and weigh the risk for both yourself and the patient vs. the clinical necessity of home visits. If it is deemed necessary then follow all guidelines related to safety (e.g. – physical distancing, use of PPE, etc.) and apply to context. Wherever possible utilize virtual visits to provide care and as a tool to assess the need for in-person visits whether in the home or at your clinic.

You may also find these resources helpful:

- Meeting Patient's Needs Algorithm
- Time and Space Safety Checklist
- CPSA Resources for Physicians During COVID

I am finding that virtual visits take just as long, if not longer that in-person visits. Have others found the same?

Response 1: I have found that virtual visits take longer when a prescription or requisition needs to be faxed.

Response 2: I have found that virtual visits take just as long as phone visits.

Response 3: Virtual appointments take longer because you have to make sure you have a rock-solid history and it is difficult to chart during the session. To make charting easier and more efficient, our clinic started using macros, templates, and headphones. We also had to educate patients so they know that virtual visits are for simple things like a one-off problem.

How long is it considered safe to continue putting off screening procedures (e.g. pap smears)?

Response: The decision should be based on the clinician's judgement and a conversation with the patient. For example, the TOP Alberta Clinical Practice Guideline for Cervical Cancer Screening advises "Every three years from initiation or the time of the last normal Pap test result". European guidelines advise every 3-5 years dependent upon age. The current health and safety restrictions related to COVID-19 may mean that for some patients, routine screening may be delayed, and it could be surmised that a few months delay can be safely accommodated. For those who have had past abnormal results or may be deemed high risk, where annual screening should be considered, physicians should exercise their clinical judgement and prioritize accordingly.

Decisions around screening, for all patients, whether routine or high risk, should be based on individual patient risks, patient judgement, and clinician judgement.

Panel Management

For up to date information related to panel management during the COVID-19 pandemic, please see the Meeting Patients' Needs Algorithm. You may also find the May 8th Panel Management Webinar helpful.

One strategy is to have a couple of physicians on site in clinics and other physicians at home. When using that strategy, can physicians work with shared panels where they see each others' patients?

Response 1: If patients need to be seen in person, I tell them to come on a day that I'm in the office. If the patient needs to be seen urgently, another physician can see them.

Response 2: My clinic uses a rotating process to separate our low-risk environment (medical clinic) and high-risk environment (hospital ER and acute care facilities). Two physicians work in the medical clinic to see palliative patients and patients with non-COVID concerns. These physicians work one full week and can see any physician's patients. Hospital physicians cover in-hospital patient visits, hospital rotations, and home visits for patients with COVID-related concerns. These physicians work a full two weeks in the hospital followed by a one-week break before working in the medical clinic.