PHYSICIANS' BULLETIN

msi
NOVA SCOTIA MEDICAL SERVICES INSURANCE

January 28, 2011 Volume XLVI - #1

Inside this issue

- Long-term Care
- Billing Guidelines
- The CGA form

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:

Category		Description		MSU
DEFT		Long-Term Care Clinical Geriatric Assessment		26.32 units ($60.00) per evaluation

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, behaviors 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 of 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 (RCF'S) funded by the Department of Health 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 Behaviors), 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 form. 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 form 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 form 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.

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 to this Bulletin and also on the Doctors Nova Scotia member's website.

Please hold eligible service encounters to allow MSI the required time to update the system. Once a Health Service Code has been assigned, it will be published in the MSI Physicians Bulletin with directions regarding the submission of any held claims.

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

Mobility	Transfers	❒ IND	❒ ASST	❒ DEP
	Walking	❒ IND Slow	❒ ASST	❒ DEP
	Aid	______________________________		
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

Personal Directives ❒ Yes ❒ No
Substitute Decision Maker:
____
Tel #: ______________________________

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. Terminally Ill

<u>Note</u>: 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

Adapted from Clinical Frailty Scale ©2007 – 2009. Version 1.2 All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada

CGA Associated Visits	
Date	**Comments**

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

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