

Health check guidelines and billing for family physicians caring for adults with intellectual and developmental disabilities

Incentives to improve care

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Abstract

Objective To examine the degree to which Canadian consensus guideline recommendations for annual comprehensive preventive care assessments of adults with intellectual and developmental disabilities (IDD) are being taken up by Nova Scotia family physicians since the introduction of incentive billing codes; and to discuss the importance of complete physical examinations for this patient population, extra time needed in clinic encounters, and challenges for practitioners providing care.

Design Analysis of family physicians' billing of codes 03.04C and 03.03E from April 2012 to December 2016.

Setting Nova Scotia.

Participants Family physicians.

Main outcome measures Number of billings through fee-for-service and alternative payment plans, and number of providers who used these fee codes.

Results Analysis yielded 3 key results. Use of incentivized billing codes for adult IDD visits and complete examinations in Nova Scotia has steadily increased for patients since the introduction of the modified codes. There is measurable uptake of the IDD adult visit code in total numbers and numbers of providers billing the code. There is poor uptake of the complete examination code.

Conclusion Enhanced billing codes will provide Nova Scotia family physicians with an incentive to employ the newly revised 2018 Canadian consensus guidelines in the care of adults with IDDs. With continued discussion and promotion of annual physical examinations for patients with IDD, more patients and caregivers might make this proactive care item a priority.

Editor's key points

- ▶ New fee codes have been introduced in Nova Scotia to support family physicians caring for adults with intellectual and developmental disabilities who require extra time to meet their complex needs.
- ▶ Since the codes were introduced in 2012, physicians' use has gradually increased, but uptake of the code for adult visits has been greater than that for complete physical examinations.

Points de repère du rédacteur

► De nouveaux codes de facturation ont été instaurés en Nouvelle-Écosse pour aider les médecins de famille qui soignent des adultes ayant des déficiences intellectuelles et développementales, et qui ont besoin de plus de temps pour répondre à leurs besoins complexes.

► Depuis l'instauration des codes, en 2012, leur utilisation par les médecins a augmenté graduellement, mais l'utilisation des codes pour les visites par des adultes a été supérieure à l'utilisation du code attribué à un examen physique complet.

Lignes directrices sur le bilan de santé et la facturation pour les médecins de famille qui soignent des adultes ayant des déficiences intellectuelles et développementales

Incitatifs pour améliorer les soins

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Résumé

Objectif Examiner la mesure dans laquelle les recommandations présentées dans les lignes directrices consensuelles canadiennes de procéder annuellement à une évaluation complète en soins préventifs des adultes ayant des déficiences intellectuelles et développementales (DID) sont suivies par les médecins de famille de la Nouvelle-Écosse depuis l'instauration des codes de facturation incitatifs, et discuter de l'importance des examens physiques complets dans cette population de patients, du temps additionnel nécessaire dans ces rencontres cliniques et des difficultés rencontrées par les professionnels qui dispensent ces soins.

Type d'étude Une analyse de l'utilisation des codes 03.04C et 03.03E par les médecins de famille entre avril 2012 et décembre 2016.

Contexte La Nouvelle-Écosse.

Participants Des médecins de famille.

Principaux paramètres à l'étude Nombre de facturations pour la rémunération à l'acte ou d'autres régimes de paiements, et nombre de professionnels qui ont utilisé ces codes de facturation.

Résultats L'analyse a produit 3 principaux résultats. L'utilisation des codes de facturation incitatifs pour les visites et les examens complets d'adultes ayant des DID en Nouvelle-Écosse a augmenté de manière constante pour ces patients depuis l'instauration des codes modifiés. Il y a une adoption accrue mesurable du code pour les visites d'adultes ayant de DID, en nombre total et en nombre de professionnels qui facturent avec ce code. Le code pour les examens complets est peu utilisé.

Conclusion Les codes de facturation modifiés offriront aux médecins de famille de la Nouvelle-Écosse un incitatif pour adopter les lignes directrices consensuelles canadiennes de 2018 sur les soins aux adultes ayant des DID. En continuant la discussion et la promotion entourant les examens physiques annuels pour les patients ayant des DID, un plus grand nombre de patients et d'aidants pourraient faire de cet aspect des soins proactifs une priorité.

In 2011, 2 of the authors (B.H., K.M.) responded to Doctors Nova Scotia's call for an expression of interest in new billing codes. They submitted a request for 2 billing codes for adults with intellectual and developmental disabilities (IDDs): an IDD adult visit code and a complete examination code.

The premise was that people with IDDs who have communication, mobility, and cognitive challenges require more time to complete histories, receive physical examinations, and negotiate management plans. The adult visit code would allow family physicians the extra time they need to attend to the communication and physical needs of their patients in routine visits. A complete examination code would encourage a physical examination annually and for undifferentiated presentations (eg, fever, unexplained behaviour, feeling generally unwell) of patients with IDD who have difficulty interpreting their internal cues.

Two important events supported the request for these billing codes: a precedent set for modified billing codes and recognition of disparities in specific health needs between adults with IDD and the general population.

The precedent for modified billing codes had been set in Nova Scotia with a code for an enhanced geriatric visit. This code recognized the complexity geriatric patients can bring to their encounters and allowed family physicians more time to complete the visit. A parallel was drawn to patients with IDD, acknowledging a similar level of complexity.

The Canadian consensus guidelines for primary care of adults with IDD published in *Canadian Family Physician* in May 2011¹ noted that disparities exist between primary care for adults with IDD and the general population, and that annual comprehensive preventive care assessments for adults with IDD (including physical examinations that attend to their specific health needs) resulted in more disease detection, health promotion, and prevention.¹⁻³

Doctors Nova Scotia and Medical Services Insurance of Nova Scotia approved the request for both developmental disability codes—for adult visits (19 units) and for complete examinations (36 units)—in April 2012 for use by primary care physicians. A standard office visit in 2012 was 13 units.

— Methods —

The Medical Services Insurance billing code data for fee code 03.03E (Developmental Disability Adult Visit) and fee code 03.04C (Developmental Disability Complete Examination—Adults) were pulled for the years 2012 to 2016. Most physicians in Nova Scotia are fee-for-service; a small percentage are paid through alternative payment plans.

— Results —

Tables 1 and 2 show the years of service, rates of total fee-for-service billings, total alternative payment plan billings, and total number of providers who used the billing codes. In 2012, the year the fee codes were launched, the Developmental Disability Adult Visit code (03.03E) caught the attention of 85 providers, who used it a total of 640 times. Use of the adult visit code steadily but modestly increased from 2012 to 2016, when 198 providers used it 2931 times. This represents approximately 18%* of physicians in Nova Scotia (**Table 1**).

The Developmental Disability Complete Examination—Adults code (03.04C) was used by 15 providers billing 33 times in 2012 and increased to 35 providers billing 128 times in 2016. This represents approximately 3%* of physicians in Nova Scotia (**Table 2**).

Table 1. Physicians using new fee code for visits with adults who have intellectual and developmental disabilities

YEAR OF SERVICE	DEVELOPMENTAL DISABILITY ADULT VISIT (FEE CODE 03.03E)		
	TOTAL FEE-FOR-SERVICE BILLINGS	TOTAL ALTERNATIVE PAYMENT PLAN BILLINGS	TOTAL NO. OF PROVIDERS
2012*	594	46	85
2013	1163	27	104
2014	1909	32	132
2015	2595	63	159
2016	2679	252	198

*The code was introduced in April of 2012.

Table 2. Physicians using new fee code for complete physical examination of adults who have intellectual and developmental disabilities

YEAR OF SERVICE	DEVELOPMENTAL DISABILITY COMPLETE EXAMINATION—ADULTS (FEE CODE 03.04C)		
	TOTAL FEE-FOR-SERVICE BILLINGS	TOTAL ALTERNATIVE PAYMENT PLAN BILLINGS	TOTAL NO. OF PROVIDERS
2012*	23	10	15
2013	45	17	21
2014	104	26	27
2015	92	26	32
2016	94	34	35

*The code was introduced in April of 2012.

*In fiscal year 2016, 1078 family physicians were billing in Nova Scotia.

— Discussion —

Developmental Disability Adult Visit

Patients with IDD present several challenges to family physicians. They often require nontraditional approaches to communication, help interpreting their internal milieu, monitoring of multiple medications, coordination of multiple medical problems, and advocacy for access to resources and services.⁴⁻⁶ With increasing complexity, increased supports should follow. A very evident support is extra time: time to listen, build rapport, alleviate anxiety, overcome physical barriers, assist the patient in shared and supported decision making, and locate suitable resources and services. An enhanced code that builds in this time is vital to providing patient care.

Our data show physicians gradually became aware of the adult visit code, and their use steadily increased to 18% over 4 years. Why not more? There are many reasons for the modest uptake of this billing code. First, many physicians lacked awareness of the adult visit code. Family physicians are inundated with vast amounts of information daily. Priorities often fall in the area of medical knowledge and patient safety. Unless a code is used every day, introduction of a new fee code might not draw attention. Second, using the code can be challenging. A physician must bill for the IDD diagnosis and not the presenting diagnosis for the code to be accepted. This is not intuitive; it only takes a few billing code rejections for physicians to abandon a new billing code that they use infrequently and revert to their old style of billing. Third, physicians might recognize a particular patient requires more time for their encounter, more accommodations, and more support to understand and appreciate their diagnosis and treatment, but the patient might not have an IDD diagnosis. Resources for assessing and diagnosing IDD in adults (psychoeducational assessments) are not easily acquired in Nova Scotia. Without a formal diagnosis, physicians could feel uncomfortable billing an IDD code. Fourth, uptake of shadow billings is known to be modest among physicians using alternative payment plans. These results could be underbilled for reasons similar to those of fee-for-service physicians. Also, physicians using alternative payment plans have less incentive to bill strategically or be aware of changes to fee codes that have limited effect on their own payment.

Developmental Disability Complete Examination—Adults

The evidence for an annual physical examination for patients with IDD has been compelling. The systematic review of the literature (1989 to 2013) by Robertson et al in 2014 included 48 publications from countries around the world and patients with varying abilities.⁷ Researchers demonstrated that health checks

consistently led to discovering unmet health needs and to targeted actions that would have otherwise been missed in traditional care. These health needs included “minor” diagnoses like cerumen and podiatry issues that can lead to behavioural, communication, and mobility challenges, and also life-threatening conditions such as cancer, heart disease, and compound fractures.⁷

The complete physical examination code had a 3% uptake by fee-for-service physicians over 5 years. Why not more? There are several plausible explanations: physician awareness, difficulties with implementation, lack of awareness in the general population, and compounding challenges. First the launch of the complete examination code and the IDD Canadian consensus guidelines could easily have gone unnoticed by physicians. People with IDD make up 1% to 3% of Canadians²; physicians with infrequent exposure to patients who have IDDs might not have had an occasion to make timely use of the complete examination code or commit it to memory. When physicians choose topics for continuing professional development, topics that apply to most of their population are often a priority.

Second are challenges associated with implementation—eg, scheduling 30- to 45-minute appointments for a complete physical examination among 10- to 15-minute appointments. Longer appointments are not the norm for primary care, and they can interfere with the flow of the day. Organizational barriers in the general practice setting were observed by family physicians in Australia as well.⁸ Despite these barriers, family physicians overall agreed health assessments were an opportunity for a structured encounter that improved communication with patients and caregivers and picked up on undiagnosed conditions.⁸ Canadian family physicians who take part in health assessments suggest multiple appointments and collaboration with family practice nurses could facilitate incorporating such assessments into primary care.⁹

Third is a lack of awareness for most people. Annual physical examinations for the general population are not routinely offered in Nova Scotia. Patients and caregivers are unaware of the importance of a complete examination yearly for people with IDD. Knowledge translation in the public realm could be a good place to focus. Public education could be powerful in the form of public service announcements and endorsements by health care providers.

Finally, there are compounding challenges. Some patients with IDD have anxiety, sensory, or mobility issues that constitute considerable barriers to the physical examination. Many of these patients also have severe or profound IDD and limited communication skills. These patients can have anxiety around health care environments, the instruments we use, or physical contact. These vulnerable patients need a patient-centred approach. Acknowledging their vulnerability and building on the relationship of patient, caregiver, and physician is key.¹⁰

Limitations

Our study has a number of potential limitations. As with many studies relying on provincial billing data, these results cannot be extrapolated to other provinces because billing codes and practices might differ. For example, in Ontario, annual health checks for this period would have been in the vicinity of 22% for patients with IDD. However, this likely reflects Ontario's support for health checks for the general population during this time period, as 26% of the general population also had an annual health examination.⁵ It is also possible some early entries of the new fee code in Nova Scotia might have been delayed as the new fee was implemented in early April 2012 and paid later retroactively. As a result, it is possible there is some underreporting in spring 2012.

Conclusion

Given that inadequate remuneration can be a disincentive to provision of good primary health care to people with IDD,⁸ having established billing codes should provide Nova Scotia family physicians with a good start in implementing the newly revised 2018 Canadian consensus guidelines for adults with IDD.¹¹

The 2018 Canadian consensus guidelines recommend physicians monitor and seek ways of improving rates and outcomes of comprehensive health assessments of people with IDD in their practice.¹¹ One approach that is under way is to educate patients on the importance of the annual physical examination, creating consumer demand. With continued discussion and promotion of annual physical examinations for patients with IDD, more patients and caregivers might make this proactive care item a priority.

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Contributors

All authors participated in the gathering, analysis, or interpretation of data. **Dr McNeil** wrote and edited the manuscript. **Dr Hennen** edited the manuscript and was the impetus for the billing codes and, thus, the topic of this article. **Mr Joyce** edited the manuscript and provided feedback. **Dr Marshall** wrote and edited the manuscript.

Competing interests

None declared

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