NURSE PRACTITIONER ENCOUNTER REPORTING

Encounter Records Submission

Encounter records must be submitted in the format approved for electronic submission through Teleplan. All encounter record submissions must include the following information unless otherwise stated:

(a) The NP's practitioner number

(b) The NP's payment (payee) number

(c) Patient/client last name, first initial

(d) Patient/client's Personal Health Number

(e) The appropriate encounter code(s) for the care provided for each patient/client

(f) The date of service

(g) ICD9 code(s) (1 code is mandatory and 3 is maximum number for each submission)

(h) Location code of the service

(i) Note or comment

REFERRALS

(k) Referred by practitioner number: Nurse practitioners receiving referrals from another provider must include the other provider's practitioner number in the referred "by" field when the encounter record is submitted.

(l) Referred to practitioner number: Nurse practitioners referring to another provider must include the other provider's practitioner number in the referred "to" field when the encounter record is submitted.

LOCATION CODES & DESCRIPTORS

Encounter record submissions must include a location code. Please use one of the codes below to indicate the location where the patient encounter took place. For example NPs working in primary care will use "A" for practice location or NPs working in acute care inpatient will use "I" or outpatient clinic "P", etc.

(A) Practitioner's Office – In Community
(C) Residential Care/Assisted Living Residence
(E) Hospital – Emergency Room (Unscheduled Patient)
(I) Hospital – Inpatient
(P) Hospital – Outpatient
(G) Hospital – Day Care (Surgery)
(F) Private Medical / Surgical Facility
(R) Patient's Private Home
(T) Practitioner's Office – In Publicly Administered Facility
(D) Diagnostic Facility
(M) Mental Health Centre
(Z) Other (e.g., accident site, in an ambulance, etc.)

LOCATION DESCRIPTORS:

(A) Practitioner's Office – In Community

Service is provided in a practitioner's office. (Note: Excludes practitioner's offices that are located within a publicly administered health care facility – see *Practitioner's Office – In Publicly Administered Facility*. Includes services provided by a physician, chiropractor, dentist, optometrist, podiatrist, physiotherapist, and massage therapist.)

(C) Residential Care/Assisted Living Residence

Service is provided to a patient in a licensed residential care facility or registered assisted living residence. (Note: Excludes small "group homes" where no professional health care support/care is available and includes extended care facility within a hospital.)

(E) Hospital – Emergency Room (Unscheduled Patient)

Service is provided in a hospital emergency department for a patient who presents for emergent or urgent treatment. (Note: Excludes hospital outpatients who receive services on a scheduled basis within an emergency department – see *Hospital Outpatient*)

(I) Hospital Inpatient

Service is provided for a patient who is an inpatient of a hospital. (Note: Excludes patients located within a designated "extended care unit" within a hospital – see *Residential Care/Assisted Living Residence*.)

(P) Hospital – Outpatient
Service is provided in outpatient and/or ambulatory clinics where outpatients receive scheduled services including emergency department, or any other hospital setting where outpatients receive services. (Note: Excludes day care surgical patients.)

(G) Hospital – Day Care Surgery
Service is provided within a hospital to a patient who is a day care surgery patient. (Note: Includes all patients who are in hospital on a day care basis primarily to receive a "procedure". Excludes scheduled services - see *Hospital – Outpatient*.)

(F) Private Medical / Surgical Facility
Service is provided within a private medical/surgical facility accredited by the College of Physicians and Surgeons of BC.

(R) Patient's Private Home
Service is provided in a patient's own home. (Note: Includes service provided in "group homes" where on-site nursing or other health professional support care is not provided, but excludes assisted living residences and other residential facilities – see *Residential Care/Assisted Living Residence*.)

(T) Practitioner's Office – In Publicly Administered Facility
Service is provided in a practitioner's office located within a publicly administered health care facility (e.g., Hospital, Primary Care Centre/Clinic, D&T Centre, etc.)

(D) Diagnostic Facility
Service is provided in a facility that primarily/exclusively provides diagnostic testing and has been granted a Medical Services Commission Certificate of Approval. (Note: Excludes diagnostic tests provided in practitioner's office. Also excludes diagnostic services provided in/by hospital and/or D&T centre facilities.)

(M) Mental Health Centre
Service is provided in a publicly administered mental health centre to an outpatient. (Note: Excludes mental health facilities that are primarily residential in nature – see *Residential Care/Assisted Living*, includes CRESST Facilities.)

(Z) Other (e.g. accident site, etc.)
Service is provided in any other location such as a temporary community or school clinic, ambulance, accident site, etc.

Encounter codes are divided into the following sections:

1. Codes for Patient Encounters using the Complexity Rating Scale
2. Codes for Patient Encounters **NOT** using Complexity Rating Scales
3. Services Coded **Annually**
4. Procedural Codes
5. Clinical diagnostic tests that may be performed by NPs in their office

The following list of Encounter Codes (ECs) have been revised and are to be used by NPs. ECs are used along with ICD-9 codes, and do not substitute for ICD-9 codes, ICD-9 codes are different from ECs.

Nurse Practitioner Encounter Codes Used with ICD-9 Codes	
Encounter Codes	**Type of Assessment and Encounter Codes**
03333	**Referral:** A request from one practitioner to another practitioner to render a service with respect to a specific patient; typically the service is one or more of a consultation, a laboratory procedure, or other diagnostic test, or specific surgical or medical treatment. Include the "referred to" physician's practitioner number and the NP practitioner number as the "referred by"practitioner on the encounter record submission. This code may be used for referral to an NP, GP or specialist physician.
Requesting Advice from a GP	
36200	**NP-Requesting Advice about a Patient from a GP** The intent of this encounter code is to support collaboration between nurse practitioners (NPs) and community general practitioners (GPs). This code is used by NPs who are the Most Responsible Provider (MRP) of care to patients and are not co-located with the GP from whom they are requesting advice. This code should not be claimed when the patient seen is attached to a GP. The request from the GP may occur by telephone or in person. **Notes:** *i) Applicable when an NP in independent practice requests advice by telephone or in person from a GP about a patient for whom the NP has accepted the responsibility of being the MRP.* *ii) Use when requesting advice regarding assessment and management by the NP and without the responding GP seeing the patient.* *iii) Excludes advice to an NP about patients who are attached to the GP.* *iv) Excludes written communication (i.e. fax, letter, e-mail).* *v) Use when an entry into the patient's chart, including advice received and by whom, is required.* *vi) Practitioner number of GP who provided advice is required in the referring practitioner field. (The NP puts the GP practitioner number into the "referred to" field when submitting the encounter record for this service.)*

	vii) Do not submit for situations where the purpose of the call is to: *a. book an appointment* *b. arrange for transfer of care that occurs within 24 hours* *c. arrange for an expedited consultation or procedure within 24 hours* *d. arrange for laboratory or diagnostic investigations* *e. inform the referring GP of results of diagnostic investigations* *f. arrange a hospital bed for the patient* *viii) Do not claim for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.* *ix) The corresponding GP is limited to one claim per patient per day with a maximum of 6 claims per patient per calendar year and a daily practitioner maximum of five (5).*

Complexity Encounter Codes

Complexity Encounter Codes are intended to capture the complexity of issues addressed by NPs during patient visits by using one encounter code (EC) that includes the history and physical assessment, education, psychosocial issues addressed, and the level of decision making/coordination required during the visit. The complexity rating scale is used to determine the level of complexity of the visit and to assign a complexity encounter code.

36420 (Age 0-1) 36442 (Age 2-19) 36421 (Age 20-49) 36422 (Age 50-59) 36423 (Age 60-69) 36424(Age 70-79) 36425 (Age 80+)	**Level 1** See Complexity Rating Scale Instruction Sheet for more information
36426 (Age 0-1) 36443 (Age 2-19) 36427 (Age 20-49) 36428 (Age 50-59) 36429 (Age 60-69) 36430 (Age 70-79) 36431 (Age 80+)	**Level 2** See Complexity Rating Scale Instruction Sheet for more information
36432 (Age 0-1) 36444 (Age 2-19) 36433 (Age 20-49) 36434 (Age 50-59)	**Level 3** See Complexity Rating Scale Instruction Sheet for more information

36435 (Age 60-69) 36436 (Age 70-79) 36437 (Age 80+)	
Codes for Patient Encounters NOT using Complexity Codes	
36315 (Age 0-1) 36445 (Age 2-19) 36316 (Age 20-49) 36438 (Age 50-59) 36317 (Age 60-69) 36318 (Age 70-79) 36319 (Age 80+)	**Initial visit of new patient in primary location of practice** Includes complete history and physical examination, review of imaging and laboratory findings, and establishing an ongoing plan of care. **This is a one-time visit for new patients being accepted into the NP's roster of patients or into the practice in which the NP works. The complexity scale is not used for this visit.** **It is also a way of tracking new patients coming into the practice.**
36523 (Age 0-1) 36524 (Age 2-19) 36525 (Age 20-49) 36526 (Age 50-59) 36527 (Age 60-69) 36528 (Age 70-79) 36529 (Age 80+)	**Walk-in visits** Includes unattached patients who are not accepted into the NP's roster of patients or into the practice. Typically a one time visit only.
36320 (Age 0-1) 36446 (Age 2-19) 36321 (Age 20-49) 36439 (Age 50-59) 36322 (Age 60-69) 36323 (Age 70-79) 36324 (Age 80+)	**Consultation** – A consultation applies when another practitioner, in light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of an NP competent to give advice in this field. Once a consultation has been rendered and the written report submitted to the referring practitioner, this aspect of the care of the patient normally is returned to the referring practitioner. The service includes the initial services of a consultant necessary to enable the NP to prepare and render a written report, including findings, opinions and recommendations to the referring practitioner. A consultation must not be claimed unless the attending practitioner specifically requested it, and unless the written report is rendered. It is expected that a written report will be generated by the NP providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable. Includes history and physical examination, review of imaging and laboratory findings, and a written report or plan of care to the referring practitioner.
36601(Age 0-1) 36447 (Age 2-19) 36602 (Age 20-49) 36440 (Age 50-59)	**Simple/Fast Track Visit** when primary location of practice in Emergency Department (includes assessment, therapeutic interventions and discharge of patient from the Emergency Department).

36603(Age 60-69) 36604 (Age (70-79) 36605 (Age 80+)	
36606 (Age 0-1) 36448 (Age 2-19) 36607 (Age 20-49) 36441 (Age 50-59) 36608 (Age 60-69) 36609 (Age (70-79) 36610 (Age 80+)	**Emergency Department Visit** requiring multiple assessments, higher level of complexity when primary location of practice in Emergency Department (includes initial and follow-up assessments, therapeutic interventions and discharge of patient from the Emergency Department).
36620	**Reassessment Visit** – When NP is required to make a secondary assessment during the same day to assess response to treatment or as requested by another care provider. Used in acute and long-term care. Will need to include practice location in coding.
36621	**Acute/Critical Status Visit** – When NP is called upon to provide urgent support for a patient who is experiencing an acute or critical change in condition. May be the only involvement the NP has with patient. Involves rapid assessment and consultation to appropriate care provider (Code Blue or pre-arrest situation; 911 situation in non-acute setting).
36288	**Completion of Forms**
36340	**Counselling**– code for 1st full hour. Used for groups of two or more patients who are provided counselling in a group session lasting 60 minutes or more. The group counselling code is not applicable when there is a discussion with the patient in the presence of a caregiver, spouse, or relative and the patient is the only person requiring care. Claims should be submitted under the Personal Health Number of only one of the patients, with the names of the other patients attending the session listed in the note record. Only patients with valid MSP coverage should be included. Use this code for patients who are having difficulty coping with life stressors or conditions, not for education which is included in the complexity code.
36342	**Counselling** for groups of two or more patients – code for second hour, per ½ hour or major portion thereof.
36360	**Prenatal visit** – Initial, uncomplicated pre-natal care includes a complete examination.
36361	**Prenatal visit** – Monthly visits to 32 weeks, then visits every second week to 36 weeks, and weekly visits thereafter to delivery. Other than during pre-natal or post-natal visits. Use appropriate complexity code to code visits,including counselling, for conditions unrelated to the pregnancy.
36363	**Post natal office visit** six weeks following delivery (vaginal or Caesarean Section)

36255	**Newborn care** – routine, in hospital care until baby is registered
36274	**Accompanying patient**(s) to a distance hospital where medically required
36285	**On-call telephone contact** with patient or family member/friend occurring after regular office hours and includes a single telephone call to or from a patient or family member/friend during which the patient's needs are identified and strategies are developed to ensure that the needs are addressed and expected outcomes will be met. This intervention includes activities such as goal-setting, designing resources and services that are required to address the patient's needs.
36280	**Telephone contact** to exchange information about a client/patient in community care in response to an enquiry initiated by a health care worker specifically assigned to the care of the patient. Includes verbal or written follow up communication with the referring service provider (e.g. consultants, MRP, allied health, community care providers). Dates of services under this code should be documented in the patient's record together with the name and position of the enquiring health care worker and a brief notation of the advice given. Alternatively the original of a fax or a copy of written advice will suffice to document these services.
36281	**Tele-management Visit** This code is used when contact is through telephone or electronically with patient, and/or family/friend during which patient needs are identified and strategies developed to ensure that needs are addressed and expected outcomes are met. This intervention will include assessment and treatment of an active problem, written documentation of plan of care and activities such as goal-setting and designing resources and services that are required.
36372	**Case conference** Meeting with members of the health care team, representatives from other agencies involved in the management of the client/patient to plan and coordinate activities and services and to share information necessary to meet the client's needs/goals and expected outcomes. (Used for any type of interdisciplinary team conference regarding a specific patient.)
36374	**Case management** Multiple telephone calls to develop a comprehensive service plan, link the client to the required services, coordinate and maintain links with formal resources, services/supports in the client's environment, and evaluate services provided. May include activities such as searching for the appropriate resources and negotiating with potential care providers (e.g. probation offices, child and family services, social assistance, education, housing, etc.). This does not include a patient encounter.
36377	**Family conference** A conference during scheduled office/work hours with the patients family/friend during which client needs are identified (based on previous assessment findings) and strategies are developed to ensure that needs are addressed and expected outcomes will be met. The intervention includes activities such as goal-setting and designing resources when required.
36640	**Palliative Care Planning** Palliative Care is applicable to the visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS, or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months. This code only applies where aggressive treatment of the underlying disease process is no longer taking place and care is directed instead to maintaining the comfort of the patient until death occurs. The visit includes meeting with patient and/or family members to

	discuss condition, prognosis, values and goals of care, end-of-life planning, advanced directives including DNR status, substitute decision makers, POA, etc.
Services Coded Annually	
36641	**Chronic Disease Management – Diabetes Mellitus** – submitted annually The Chronic Disease Management code was developed for NPs who manage patients with this chronic condition. This code is used only by the NP that accepts the role of Most Responsible Provider for the longitudinal, coordinated care of the patient; by submitting this code the NP accepts that responsibility of care for the ensuing calendar year. The Most Responsible NP may use this code when providing care only to community patients; i.e. residing in their homes or in assisted living/group home. The code includes self-management education, collaborative goal setting, monitoring, treatment of chronic conditions and participation in CDM toolkit/flow sheet maintenance and may be used with Complexity Visit Codes 36420-36437. The submission must include ICD9 Code 250
36642	**Chronic Disease Management – Heart Failure** – submitted annually The Chronic Disease Management code was developed for NPs who manage patients with this chronic condition. This code is used only by the NP that accepts the role of Most Responsible Provider for the longitudinal, coordinated care of the patient; by submitting this code the NP accepts that responsibility of care for the ensuing calendar year. The Most Responsible NP may use this code when providing care only to community patients; i.e. residing in their homes or in assisted living/group home. The code includes self-management education, collaborative goal-setting, monitoring, treatment of chronic conditions and participation in CDM toolkit/flow sheet maintenance and may be used with Complexity Visit Codes 36420-36437. The submission must include ICD9 Code 428
36643	**Chronic Disease Management – Hypertension** – submitted annually This Chronic Disease Management code was developed for NPs who manage patients with this chronic condition. This code is used only by the NP that accepts the role of Most Responsible Provider for the longitudinal, coordinated care of the patient; by submitting this code the NP accepts that responsibility of care for the ensuing calendar year. The Most Responsible NP may use this code when providing care only to community patients; i.e. residing in their homes or in assisted living/group home. The code includes self-management education, collaborative goal-setting, monitoring, treatment of chronic conditions and

	participation in CDM toolkit/flow sheet maintenance and may be used with Complexity Visit Codes 36420-36437. The submission must include ICD9 code 401 This code cannot be submitted with 33641 or 36642
36644	**Chronic Disease Management – COPD** – submitted annually The Chronic Disease Management code was developed for NPs who manage patients with this chronic condition. This code is used only by the NP that accepts the role of Most Responsible Provider for the longitudinal, coordinated care of the patient; by submitting this code the NP accepts that responsibility of care for the ensuing calendar year. The Most Responsible NP may use this code when providing care only to community patients; i.e. residing in their homes or in assisted living/group home. The code includes self-management education, collaborative goal-setting, monitoring, treatment of chronic conditions and participation in CDM toolkit/flow sheet maintenance and may be used with Complexity Visit Codes 36420-36437. The submission must include ICD9 codes 491, 492, 494 or 496
36630	**Mental health** – initial planned visit, submitted annually
36646	**Complex care plan visit in primary location of practice for patients with two or more chronic conditions - submitted annually** The Complex Care Management code was developed for NPs who manage complex patients who have at least 2 of the 8 chronic conditions listed below. This code is used only by the NP that accepts the role of Most Responsible Provider for the longitudinal, coordinated care of the patient; by submitting this code the NP accepts that responsibility of care for the ensuing calendar year. The Most Responsible NP may use this code when providing care only to community patients; i.e. residing in their homes or in assisted living/group home: 1) Diabetes Mellitus (Type 1 and 2) 2) Chronic Kidney Disease 3) Congestive Heart Failure 4) Chronic Respiratory Condition (asthma, COPD, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.) 5) Cerebrovascular disease 6) Ischemic Heart Disease, excluding the acute phase of myocardial infarct 7) Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, stroke or other brain injury with a permanent neurological deficit, paraplegia or

quadriplegia etc.)
8) Chronic Liver Disease with evidence of hepatic dysfunction

If a patient has more than 2 of the qualifying conditions, when coding the Complex Care Management visit the submitted diagnostic code from Table 1 (below) should represent the two conditions creating the most complexity.

A complex care plan requires documentation of the following elements in the patient's chart that:

- there has been a detailed review of the case/chart and of current therapies;
- there has been a face-to-face visit with the patient, or the patient's representative if appropriate, on the same calendar day that the Complex Care Management Code was submitted;
- specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care code;
- incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care code;
- outlines expected outcomes as a result of this plan, including any advance care planning for end-of life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care, their expected roles;
- identifies an appropriate time frame for re-evaluation of the plan;
- confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's representative, and to other involved health professionals as indicated.

The Complex Care Management Visit can be provided and coded once at any time in the calendar year.
Development of the care plan is done jointly with the patient &/or the patient representative as appropriate.
The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.
Notes:
Submitted once per calendar year;
Minimum required time 30 minutes in addition to visit time same day;
Diagnostic codes submitted with 36646 code must be from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

Table 1: Complex Care MSP Diagnostic Codes (use these instead of ICD9 codes)

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease

N428	Chronic Neurodegenerative Disorder	Congestive Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease (Renal Failure)
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Failure)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Congestive Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease (Renal Failure)
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Failure)
I428	Ischemic Heart Disease	Congestive Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease (Renal Failure)
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Failure)
H250	Congestive Heart Failure	Diabetes
H430	Congestive Heart Failure	Cerebrovascular Disease
H585	Congestive Heart Failure	Chronic Kidney Disease (Renal Failure)
H573	Congestive Heart Failure	Chronic Liver Disease (Hepatic Failure)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease (Renal Failure)
D573	Diabetes	Chronic Liver Disease (Hepatic Failure)
C585	Cerebrovascular Disease	Chronic Kidney Disease (Renal Failure)
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Failure)
K573	Chronic Kidney Disease (Renal Failure)	Chronic Liver Disease (Hepatic Failure)

36645	**Health Risk Assessment** Submit this code along with the age appropriate complexity visit code. This code is used by NPs who undertake a *Personal Health Risk Assessment* with a patient who belong to one of the designated target populations (obese, smoker, physically inactive, unhealthy eating) either as part of proactive care or in response to a request for preventative care from the patient. The NP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the *Lifetime Prevention Schedule* and *GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines*. The *Personal Health Risk Assessment*

requires a face to face visit with the patient or patient's medical representative.

Must submit using one of the following diagnostic codes: Smoking (786), Unhealthy Eating (783), physically inactive (785), Medical Obesity (783). Requires chart entry documenting discussion and preventative plan of action.

BC Lifetime Prevention Schedule Recommended Actions*

Clinical Condition	**MEN**	**WOMEN**
Colorectal Cancer Screening Fecal Occult Blood Testing annually age 50-75*	•	•
Mammography Screening 40-49 years: individualized decision to begin biennial screening according to patient's history; (50-74 yrs., every 2 years; ≥ no recommendation because of insufficient evidence to make a recommendation**		•
Cervical Cancer Screening women age 21-65 routine screening every 3 years**		•
Hypertension Screening** Blood pressure measurement at all appropriate primary care visits, e.g. new patient visits, periodic exams, patients with neurological and cardiovascular issues. It is not necessary to measure BP on every office visit if not clinically indicated). (Strong recommendation; moderate quality evidence) Blood pressure to be measured according to the current techniques described in the Canadian Hypertension Education Program CHEP recommendations for office and out-of-office (ambulatory) blood pressure measurement. (Strong recommendation; moderate quality evidence) For people who are found to have an elevated blood pressure during screening, the CHEP criteria for assessment and diagnosis of hypertension should be applied to determine whether the patient meets diagnostic criteria for hypertension. (Strong recommendation; moderate quality evidence)	•	•
Hyperlipidemia Screening Men 35 yrs. and older; women 45 yrs. or older who are at increased risk for CHD*	•	•
Diabetes Screening In absence of evidence, screening for type 1 Diabetes is not recommended*** Screen for type 2 Diabetes using Fasting Blood Glucose and/or A1C Adults ≥ 40 years or at **high risk** of Diabetes (determined with a validated risk calculator)every 3 yrs. *** Earlier screening or more frequent for those at **very high risk** of diabetes (determined with a validated risk calculator)***	•	•
Discussion of ASA use as clinically indicated (if high risk of Cardiovascular Disease or	•	•

	Stroke)			
	Smoking Cessation > 18 years ask about tobacco use, provide tobacco cessation interventions to smokers*		•	•
	Adult Immunization:	Influenza (Annually if at risk)	•	•
		Pneumococcal (if ↑Risk q 10 years)	•	•
		Tetanus /Diphtheria (q 10 years)	•	•
	Immunizations for patients < 19 years of age as per age appropriate publically funded schedule		•	•
	Diet Modification (if Cardiovascular Disease Risk)		•	•
	Exercise Recommendation (if Cardiovascular Disease Risk)		•	•

* US Preventive Services Task Force 2014 http://www.uspreventiveservicestaskforce.org/Page/Name/home
** Canadian Task Force on Preventive Health Care 2014: http://canadiantaskforce.ca/ctfphc-guidelines/overview/
*** Canadian Diabetes Association 2013 http://guidelines.diabetes.ca/

Procedural Codes

These codes to be used in addition to the primary visit code when a procedure is undertaken.
Use these codes instead of a ICD9- V-Codes

Integumentary and Musculoskeletal Procedures	
36411	Minor procedures including minor lacerations, foreign body removal, incision and drainage of superficial abscess, including furuncles, toenail removal, cryotherapy
36412	Complex procedures including major lacerations
36410	Skin biopsy including punch, ellipse, shaved
36369	Application of splints/casts
36210	Injections including: intramuscular, intravenous, venipuncture, subcutaneous, desensitization treatments, immunization for adults > 19 years (except HPV which is coded as 36233)
36230	TB Skin tests -including PPD, Mantoux
Immunizations	

36214 36215 36216 36217 36218 36219 36220 36221 36222 36223 36224 36225 36226 36227 36228 36229 36231 36232	**Immunization by NP Patient<19 years** DTAPP-P DTAP-P-HIB TD TDP TDAP INFLUENZA HEP A HEP B HIB POLIO INACTIV MEN-C-C MEN-P- ACYW135 MMR PNEU-C-7 PNEU –C–23 RABIES VARICELLA INFANRIX HEXA
36233 36235	**Immunizations by NP Patient >19** HPV Vaccine (Human Papilloma Virus) **Note:** Applicable only for females born in or after 1994 This is a 3 dose vaccine given as 3 shots over a 6 month period. This item is for cases where the child has missed one or more doses in the school based setting. Rotavirus vaccine, oral
ENT Procedures	
36292	Syringing ear, irrigation of external auditory canal
Gynecological Procedures	
36365	Insertion intrauterine device Removal of IUD

	Endometrial biopsy
36366	Routine pelvic exam including Papanicolaou smear The code is not submitted when done as a pre and post-natal service. The exam must include a pelvic examination and a pap smear
Cardiovascular	
36243	Anticoagulation therapy, review of coagulation profile and adjustments to therapy
36249	Preliminary ECG Interpretation
Procedures commonly carried out in acute care: must be within NP SOP	
36295	Insertion and removal of drains or lines (e.g. central venous catheter, PICC line, chest tubes pacemaker wires, etc.)
Clinical diagnostic tests performed by an NP	
36500	Glucose, semiquantitative
36501	Pregnancy test, immunologic, urine
36503	Candida culture
36504	Examination for pinworm ova
36505	Fern test
36507	Haemoglobin, cyanmethaemoglobin method
36508	Haemoglobin, other methods
36509	Occult blood, faeces
36511	Secretion smear for eosinophils
36512	Sedimentation rate
36513	Sperm, seminal exam, for presence or absence
36514	Stained smear
36515	Trichomonas and/or candida, direct examination
36516	Urinalysis, chemical or any part of
36517	Urinalysis, micro exam of centrifuged deposit
36518	Urinalysis, complete diagnosis, semi-quant & micro
36519	White cell count only (see haemoglobin protocol)
36520	Examination for eosinophils in secretions, excretions and other body fluids

NP Encounter Code-Complexity Rating Scale
Instruction Sheet

The Complexity Rating Scale is used to rate the *encounter,* not the patient – for example a patient with complex co-morbidities and mental health issues could score anywhere from 1 to 3 on the scale, depending on the nature of the visit, the comprehensiveness of care involved, impact of the mental health issues at the time, and the time the NP spent coordinating care and education of the patient.

The Scale applies to regular/routine office visits only and does not replace ICD-9 codes. The Scale is not used for all types of care NPs provide, for example a phone call to a patient the next day to review lab results, teleconferences, or services provided annually. NPs performing procedures during a patient encounter should include the procedure code listed above along with the EC in the encounter record submission.

NPs use the Complexity Rating Scale as a guide to assign a level of complexity of patient encounters (visits). The Scale is not intended to provide a set formula or score. It is divided into five categories: 1) history, 2) physical examination, 3) education, 4) psychosocial issues, and 5) coordination and level of decision making required of the NP during the encounter. An explanation each category follows.

NP Encounter Code-Complexity Rating Scale
Instruction Sheet

NPs determine the level of complexity of the patient visit by selecting one box in each column of the Scale that best represents their activities and the patient's presentation during the visit. Once the level of complexity is determined match the level and the patient's age to the Complexity EC (36420-36437).

Level	History	Exam	Education	Psychosocial Complexity	Decision Making/Coordination
1	CC*, HPI,** Focused ROS***	Brief focused exam – single system	**Simple, single problem** with basic education. May include a demonstration or discussion	Good to Superior functioning Absent or mild psychological symptoms None or mild difficulty in social, occupational or school functioning Supportive social relationships Able to identify and access social supports and community resources	Low complexity of decision making Minimal or no coordination
2	1 or more CC, HPI, Focused ROS, Focused family and Social History	Focused exam of one or more systems	1 or more co-morbid conditions Where a risk assessment maybe required, explanation and a management plan initiated	Moderate to severe psychological symptoms Moderate or severe difficulty in social, occupational or school functioning Inconsistent social relationships Requires direction identifying and/or accessing social supports and/or community resources	Low to moderate complexity of decision making Moderate Coordination Required
3	1 or more CC, HPI, Complete ROS, Complete family and social	Complete exam of multiple systems or extensive exam of single system	2 or more co-morbid conditions, and/or a client with cognitive decline, disability or extended time required. Use of interpreter	Severe psychological symptoms Severe impairment in ability to function Absent/dysfunctional social relationships Unable to access supports and/or community resources without extensive assistance	Moderate to high complexity of decision making Extensive coordination In acute care setting patient may require multiple visits in a day for the same problem.

*CC- Chief Concern **HPI – History of presenting illness ***ROS – Review of system

The Complexity of Education is based on:

- Extensiveness of education,
- May range from simple instructions to developing a management/treatment plan, and
- Increases in difficulty depending on barriers to communications such as language or cognitive deficits.

EXAMPLES OF EDUCATION

Level 1	The NP provides simple, single condition/concerns with basic education: (examples) 1) Instruction on fever management in a child, 2) Side effect of a new medication, or 3) When to follow-up after a visit 4) Diagnosis of GERD and new medication is prescribed, life style issues are discussed, and a handout may be provided or a link to an online resource is given to the patient
Level 2	This visit may or may not include goal setting but could be required at a later date. During the visit there is a focus on self-care management, for example a patient with Diabetes and self-care management strategies
Level 3	This visit may include the involvement of family or other individuals or agencies, for example palliative patients, frail elderly, or patients cognitively impaired. Goal-setting may be a feature but not a requirement as it may it be inappropriate.

The Complexity of Psychosocial is based on the impact of psychosocial issues that must be addressed.
These factors may not be a feature of every encounter but provide examples of psychosocial issues:

- Psychological symptoms
- Involvement with the legal system or government agencies such as the Ministry of Children and Families
- Stability of interpersonal relationships
- Ability to access support systems (personal and community agencies)
- Substance addiction/abuse
- Personal safety (e.g. Violence in relationship)
- Effects of past trauma
- Cultural health attributions, beliefs and practices
- Spiritual health attributions, beliefs and practices

EXAMPLES OF PSYCOSOCIAL COMPLEXITY

Level 1	Good to superior functioning Absent or mild psychological symptoms None or mild difficulty in social, occupational or school functioning Supportive social relationships Able to identify and access community and social supports
Level 2	Moderate to severe psychological symptoms Moderate or severe difficulty in social, occupational or school functioning Inconsistent social relationships Requires direction identifying and/or accessing social supports or community resources
Level 3	Severe psychological symptoms Severe impairment in ability to function Absent/dysfunctional social relationships Unable to access social supports &/or community resources without extensive assistance

The Complexity of Decision Making/Coordination is based on activities directly connected to the office visit:
Examples:

- The amount of time required to coordinate activities
- The number of differential diagnoses and risk of complications
- The amount of coordination activities directly connected to the office visit, such as;
- Referral to specialists, community resources. A short referral is more complex than a longer referral requiring a complete review of records
- Form completion. Forms involving check boxes and signature is less complex than a disability form requiring written description of impacts of illness on ability to function
- Review of records
- Telephone calls. Phone call the next day to review results is a different encounter code
- Reviewing PharmaNet
- Consult with colleague
- Completing clinical flow sheets per Ministry mandated clinical pathways

EXAMPLES OF COMPLEXITY of DECISION MAKING/COORDINATION

Level 1	Low complexity, straight forward decision making Low risk of complications Minimal number of diagnostic options Minimal or no coordination
Level 2	Moderate complexity of decision making Moderate risk of complications Limited number of diagnostic options Moderate coordination with patient, family and/or community resources
Level 3	High complexity of decision making High risk of complications Multiple diagnostic options Extensive coordination with patient, family and/or community resources Patient in acute care may require multiple visits in a day for the same problem

The following case examples demonstrate how the Complexity Rating Scale captures the NP's encounter with patients

Primary Care

A. A 65-year-old female patient presents for refills of her Ramipril and HTCZ. She has a history of hypertension but is otherwise well. She recently had blood work completed and this was all within normal limits. Her BP today is 129/78, HR 68. She was in 2 months ago for a complete physical exam. This visit would be coded **Complexity Level 1 (EC 36423)**

B. You visit an 82-year-old patient in her home. She has diabetes, hypertension and macular degeneration. She is well and manages independently, but is no longer able to drive. Her family called as they noticed that she seemed more confused and had not been eating well. Because this visit requires review of multiple systems, likely a screening test, referral and work-up this visit would be coded **Complexity Level 3 (EC 36437)**

C. A 17-year-old male presents to your office following an injury to his ankle at school during Gym class. He is well other wise and has no other complaints. You examine a single system and may include ordering an X-ray or referral to physiotherapy. You provide a handout on ankle sprains and explain the recovery process. This visit would be coded **Complexity Level 1 (EC 36442)**

D. A 49-year-old male presents to the office to review his recent lab work. The results indicate he has a new diagnosis of type 2 diabetes. He currently is taking an antihypertensive and no other medications. The visit requires education about the diagnosis, discussion of treatment options and a possible referral to a Diabetes Education Program. This visit would be coded **Complexity Level 2 (EC 36427)**

NP Encounter Code-Complexity Rating Scale
Instruction Sheet

Acute Care

A. A 75 year old patient with multiple co-morbidities is admitted to hospital with a hip fracture. During the encounter you obtained a complete history including MOCA and MMSE, performed a head to toe physical examination, provided education to the family and patient, discussed discharge planning, contacted the patient's most responsible provider for more patient information and results of recent diagnostic tests, and addressed issues concerning delirium, COPD, DM with the patient, family and nursing staff. This visit would be coded as **Complexity Level 3 (EC 36436)**

B. 30 year old male fell 25 feet while cliff-jumping and is admitted to hospital. You obtained a history, which revealed that he smokes 1 ppd of cigarettes and has a history of asthma, works on an oil rig as a rough hand, is single, and lives with father when not working; and completed a physical examination revealing that he is morbidly obese, sustained a degloving injury of his left heel, and has a large hematoma to his right hip and thigh. In addition to obtaining the history and physical examination, you debrided and sutured the injury, wrote admission orders including numerous investigations (CBC results HGB 95), consulted with Respiratory Services, implemented measures to address his smoking, and contacted his family. This would be coded **Complexity Level 3 (36433)**

C. You reassess the same 30 year old patient discussed above on day 3 of his admission. His wound is healing and there is no evidence of infection and lab results indicate that his HGB has improved. You discussed with the nursing staff transferring him to another ward, assessed his pain management and wrote new pain management orders. This visit would be coded **Complexity Level 2 (EC 36427)**