Nanaimo
Division of Family Practice
A GPSC initiative

Creating a Community of Care

Nanaimo Residential Care Initiative
A Nanaimo Division of Family Practice Initiative

Residential Care Billing Guide

Nanaimo Division of Family Practice
Residential Care Initiative
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Questions about Billing Guide?
Feel free to contact Leanne – bulmero@gmail.com
-contact details also in Appendix A

Billing Cheat Sheet – most commonly used fees

Billing Code	Description	Amount	Reason
Typical Resident Care Billing			
00114	Long term care facility visit	35.50	One per patient seen, billable twice monthly, add note for additional visits.
P13334	First visit of day bonus	33.48	Billable for first patient of the day in addition to visit.
Advice/Conferences			
13005	Advice about patient in community care - fax/call	15.45	Use for short telephone interactions on patient care. Typical to LTC orders, any pt. in community care, no limit
14076	Telephone Management Fee	20.00	Document time, with patient, patient's medical representative or physician, 1500 limit per year. Cannot be billed with 00114.
14077	Facility patient conference fee – for attached physicians (have billed 14070 or 14071)	40.00	Document time (15 min or > portion thereof) with 1 other care providers, maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day, bill in addition to visit, can be a phone conversation
14019	Consult with NP	40.00	Providing advice to NP, not billable if signed as a sessional provider or an attached GP, 5pts/day, 6 total per pt./year, NP must be MRP for pt. not billable in addition to visit
Attachment Fees			
14070	Attachment Participation Code	0.00	Annual code billed to participate in GP for Me program, allows billing of 14077 and 14074
14028	Allied Care Provider Visit	0.00	Oct 2017 – indicates visit was provided by AHP for chronic care bonuses
14050-14053	Chronic Care Bonuses	50-125.00	Billed annually for care of chronic diseases, 14050 (DM), 14051 (CHF), 14052 (HTN), 14053 (COPD), must see twice for same/yr, **Oct 2017 - 1 visit can be call with AHP**
Special Call Visits			
00115	Special call long-term care 0800-2300h	113.15	One patient, must be called by facility, document time, must be within 24h of request
00127	Terminal care visit	52.66	For any pt. with end stage disease, billable daily up to 180 days when pt. is seen

01200	Call out charge – evening	60.42	Bill with out of office consult (eg.18200), call out b/w 1800-2300, visit b/w 1800-0800, document time
01201	Call out charge - night	84.86	bill with out of office consult, call out and visit b/w 2300-0800, document time
01202	Call out STAT/weekend	60.42	bill with out of office consult, call b/w 0800-2300, document time
Out of Office Visits			
13200 (2-49), 15200, 16200, 17200, 18200	Visit out of office	40.81-55.65	For visit that does not fall under parameters of 00114, routine long-term care visit
13201 (2-49), 15201 (50+), 16201 (60+), 17201 (70+),18201 (80+)	Complete exam out of office	90.60-123.56	for condition requiring complete exam, exclusive of 00114
13210, 15210, 16210, 17210, 18210 (same ages as above)	Consult out of office	99.58-135.81	must be asked by another practitioner to examine pt. (GP/NP)
13220, 15220, 16220, 17220, 18220	Counselling out of office	71.01-96.84	Must be greater than 20 min, 4 per pt./year
Minor Diagnostic/Therapeutic Procedures			Must bring tray from office, bill in addition to visit if unrelated to main visit otherwise bill only one.
13600	Biopsy of skin/mucosa	50.77	
13611	Repair Minor Laceration (<5cm)	64.87	
13620	Excision of tumor of skin	64.87	
00014	Intra-articular injection - hip	25.00	Initial injection billable in addition to visit with same dx code
13605	Opening Superficial Abscess	43.49	
13612	Repair Major Laceration (>5cm)	13.02	
13621	Additional tumor excision (6 max)	32.43	
00015	Intra-articular injection (all other joints)	16.62	Initial injection only billable in addition to visit with same dx code
00190	Cryotherapy	30.59	No tray fee

Billing Examples

Typical scheduled day during start-up in new facility

You are scheduled to see 5 of your own patients for routine care and then have a care conference for a 6th patient with RN/Pharmacist. Later in the day you discuss a patient with the pharmacist.

Billing for the day:
00114 + P13334 - for first patient of the day (35.50+33.48 = 69.98)
00114 - for second patient of the day (35.50)
00114 - for third patient of the day (35.50)
00114 - for fourth patient of the day (35.50)
00114 - for fifth patient of the day (35.50)
14077 - for care conference which lasted 25 min, document times 0930-0955 (This conference USES 2 out of allowable 18 fifteen minute sessions per patient per year) (80.00)
14077 - for call pertaining to patient lasting 10 minutes (40.00)
Time Commitment: ~3h total
Total Billing Amount: 331.98 (MSP)/3h = 110.66/hr

if you take a call pertaining to a patient and it is very brief, the code 13005 is most appropriate

Second example for typical day

You are scheduled to see 6 of your own patients for routine care and then have a care conference for a 7th patient with the Pharmacist. You are also asked to see a patient of another MRP with a suspected UTI. Later in the day you are asked to take on a new patient being transferred from hospital with a hip fracture.

Billing for the day:
00114 + P13334 - for first patient of the day (35.50+33.48=69.98)
00114 - for second patient of the day (35.50)
00114 - for third patient of the day (35.50)
00114 - for fourth patient of the day (35.50)
00114 - for fifth patient of the day (35.50)
00114 - for sixth patient of the day (35.50)
00114 - for seventh patient of the day (35.50) – although not MRP, this is the most appropriate code unless performing a consult out of office or needing a complete exam. Be sure to include a note as well
14077 - for care conference which lasted 35 min, document times 0930-1005 This conference USES 2 out of allowable 18 per patient per year (80.00)
Time Commitment: ~3h total
Total Billing Amount: 362.98 (MSP= 120.99/hr)

What is missing from these examples-
Out of office examinations – perhaps done annually on patients or as needed for a new concern
Counselling fees – may be done based on patient need

Weekend call

You are called at 1000am to see a patient at the facility. While you are there at 1200pm you are asked to see another patient who is in need of care. You have seen this patient already once this week but are checking up.

Billing for the day:

00115- include time of call 1000, seen 1200-1245 for both the special call (113.15)
00114 - for second patient visit, make note of reason seen again (pneumonia f/u) as visit was within two-week time frame (35.50)
Time Commitment: ~ 1h
Total Billing Amount: 148.65/hr

After hours' call

The nursing home calls at 9pm to see a patient with CHF. You are there and see this patient and also receive a call from a local GP to provide advice on one of his patients at the home. You combine these visits.

Billing for the special call:
00115– include time call came in 21:00, time of visit, 22:00-22:45 (113.15)
18200 – out of office visit ages 80+, document time and GP who asked you to consult in notes (if complete physical needed can document 18201 (physical for 80+ year old individual) (55.65)
Time Commitment: ~ 1.5 h (considering time from call/travel)
Total Billing Amount: 168.80/1.5 = 112.53/hr.

Terminal care

You attend a care conference at a local nursing home where you review three patients who are under your care. At the care conference is the ward nurse, social worker, pharmacist and dietician. Patient A and B each take 20 minutes to review, but patient C family is present as he is recently deemed palliative for end stage CHF and this care conference takes 50 minutes. You see patient C first that day and then 4 times in the next 10 days (5 terminal care visits in total) until he passes away. You see patient A and B following the care conference for planned LTC visits starting with pt. A. You are an attached physician (have billed 14070 for the year to participate)

Billing for the day:
Patient A - 14077 (include time) + 00114 + P13334 (40.00+35.50+33.48)
Patient B - 14077 (include time) + 00114 (40.00+35.50)
Patient C - 14077 (include time) + 00127 (Dx 428) (80.00+52.66)

Time Commitment: ~2h
Total Billing Amount: 317.14/2 = 158.57/hr

Subsequent day Patient C - patient seen daily for 4 additional days 00127 each day.

MSP Remittance 2017

Month	MSP Cut-off 7:00 PM	Remittance Posted	Payment
January	3rd	11th	13th
	19th	27th	31st
February	2nd	10th	15th
	16th	24th	28th
March	3rd	13th	15th
	21st	29th	31st
April	3rd	11th	13th
	18th	29th	28th
May	3rd	11th	15th
	18th	29th	31st
June	5th	13th	15th
	20th	28th	30th
July	4th	12th	14th
	19th	27th	31st
August	2nd	11th	15th
	21st	29th	31st
September	5th	13th	15th
	19th	27th	29th
October	2nd	11th	13th
	19th	27th	31st
November	2nd	13th	15th
	20th	28th	30th
December	5th	13th	15th
	15th	27th	29th
January - 2018	3rd	12th	15th

When you receive remittance

- You will get the total amount you will be paid; it will differ typically from the amount billed
- Some billings are ‘held’ and will be paid at a later date
- Some billings will be rejected:

Link to the teleplan explanatory codes on rejections:
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/claim-submission-payment/explanatory-codes

To limit rejections

- Check patient demographic information to ensure name, DOB and PHN are all correct
- Ensure that notes are included for all 00114 codes that exceed one visit every other week
- Ensure that times are included on the 24h clock for all patient conferences and special call visits
- Watch for the new RV code – for chronic care bonuses – you must see the patient for the diagnosis twice annually (ie. To bill 14050 you must see patient and bill for 250 – diabetes twice in the year between billings of 14050).

Correcting rejections

- Fix the error and resubmit (ie. Add in the time, correct patient name etc.)
- Sometimes you will need to call MSP: Vancouver: 604-456-6950 and Other areas of B.C. (toll-free): 1-866-456-6950.. The MSP billing representatives will advise on what you need to do to correct the billing.

PWE – Paid with Exception

- For the most part a PWE is a rejection and can be handled as same
- Common example is the code RV – notifying you that you cannot bill this code unless you have seen the patient for chronic condition twice in the last calendar year (ie. 14050).
- Sometimes PWE codes just want to inform you of something (such as checking patient name to ensure spelled correctly etc.)

Detailed Billing Explanations

Billing Code	Description	Amount	Details
Typical Resident Care Billing			
00114	Long term care facility visit	35.50	One or multiple patients. Can be billed once every two weeks. Medically necessary visits can be billed before two weeks if a note is made when submitting to MSP.
P13334	First visit of day bonus	33.48	Billable for the first patient seen at the facility. One per provider per day. Must accompany a 00114 billing code.
Advice/Conferences			
13005	Advice about patient in community care - fax/call	15.45	This can be billed for providing advice/orders via fax or call. One per patient per physician per day. Advice provided should be documented in patient chart. Does not apply to advice for families. May not be claimed in addition to patient visit that day.
14076	Telephone Management Fee	20.00	Clinical discussion between patient or patient's medical representative or physician. Time must be documented.
14077	Facility patient conference fee – for attached physicians (have billed 14070 or 14071)	40.00	This is applicable to physicians participating in the attachment initiative. Time must be documented (billable after 7.5 min). Can take place on phone specific to a patient conference with at least one or more allied health professionals. Not payable in addition to 14015 – you would be billing one or the other of these codes. In all likelihood, 14015 will be removed from the billing list this year and replaced completely by 14077. Payable up to 18 times per patient per year (4.5h). Not to exceed more than 30 min in any visit. Payable in addition to a patient visit (00114).
14019	Consult with NP	40.00	Providing advice to NP, not billable if signed as a sessional provider or an attached GP, 5pts/day, 6 total per pt/year, NP must be MRP for pt seen. Not billable in addition to visit. NP billing number required.
Attachment Fees			
14070	Attachment Participation Code	0.00	Annual code billed to participate in GP for Me program, allows billing of 14077 and 14074 (as well as other in office codes 14076 etc.). This is submitted annually as a mock bill to MSP with a mock PHN and patient name available on the GPSC website.
14028	Allied Care Provider Visit	0.00	New Oct 2017 – allow a college certified AHP to provide one of the visits for chronic care bonuses. This fee indicates in-person visit provided by AHP and MRP has accepted responsibility for the provision of that care
14050-14053	Chronic Care Bonuses	50-125.00	Billed annually for care of chronic diseases, 14050 (DM), 14051 (CHF), 14052 (HTN), 14053 (COPD). You must also see/bill the

			patient twice during the year for the chronic health concern in order for this to be accepted (ie. Two 00114 visits for 250 – DM).For 14053 (COPD) a clinical action plan must be on file. For all must include flow sheets and document providing care for same. **New Oct 2017** – 1 visit can be a phone call with an AHP
Special Call Visits			
00115	Special call long-term care 0800-2300h	113.15	This is a special call to the facility at the request of the team there (nursing staff etc.). It is billable once per day – subsequent patients seen fall under 00114. Bonus is not applicable for this call or additional patient visits. Patient must be seen within 24h of call. If you are called to 2 different nursing homes – make note re: same and it will show in times as well.
00127	Terminal care visit	52.66	Applicable to a patient with end-stage disease. Can be billed daily for visits up to 180 days. Supporting documentation would include palliative orders on file.
01200	Call out charge - evening	60.42	bill in addition to out of office consult (eg. 18200), call out b/w 1800-2300, visit b/w 1800-0800, document time, other patient visits for the same call would be 00114, bonus is not applicable.
01201	Call out charge - night	84.86	bill in addition to out of office consult (eg 18200), call out and visit b/w 2300-0800, document time
01202	Call out STAT/weekend	60.42	bill in addition to out of office consult, call b/w 0800-2300 – same as above applies
Out of Office Visits			
13200 - 18200	Out of office visit	40.81-55.65	For visit that does not fall under parameters of 00114, routine long-term care visit. For example - seeing a patient with a new diagnosis or visit that falls outside routine. Could accompany a call-out charge.
13201 (2-49), 15201 (50+), 16201 (60+), 17201 (70+),18201 (80+)	Complete exam out of office	90.60-123.56	For any condition seen requiring a complete physical examination and detailed history. A complete physical examination shall include a complete detailed history and detailed physical examination of all parts and systems with special attention to local examination where clinically indicated, adequate recording of findings and if necessary, discussion with patient. The above should include complaints, history of present and past illness, family history, personal history, functional inquiry, physical examination, differential diagnosis, and provisional diagnosis.
13210, 15210, 16210, 17210, 18210 (same ages as above)	Consult out of office	99.58-135.81	GP Consultations apply when a medical practitioner, or a health care practitioner (midwife, for obstetrical or neonatal related consultations; nurse practitioner; oral/dental surgeon, for diseases of mastication), requests the opinion of a general practitioner competent to give advice in this field. A consultation must not be claimed unless it was specifically requested by the attending practitioner. The service consists of the initial services

			of GP consultant, including a history and physical examination, review of x-rays and laboratory findings, necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring practitioner. Consultations will not apply if referred patient has been attended by same GP or group of GPs within a six-month time frame.
Out of Office Counselling			
13220, 15220, 16220, 17220, 18220	Counselling out of office.	71.01-96.84	Applicable when extended counselling is necessary for the patient. Billable 4x/patient per annum. Start and end times should be noted in chart (not necessary for billing). Should not be billed in addition to a regular visit 00114.
Minor Diagnostic/Therapeutic Procedures Must bring tray from office, bill in addition to visit if unrelated to visit otherwise when both billed greater paid at 100%, lesser 50%			
13600	Biopsy of skin/mucosa	64.87	
13611	Repair Minor Laceration	64.87	(<5cm)
13620	Excision of tumor of skin	25.00	
00014	Intra-articular injection - hip	43.49	Initial injection only billable in addition to visit with same diagnostic code (i.e. 00114 + 00014 if injection done)
13605	Opening Superficial Abscess	13.02	
13612	Repair Major Laceration	32.43	(>5cm)
13621	Additional tumor excision	16.62	(6 max)
00015	Intra-articular injection (all other joints)	30.59	Initial injection only billable in addition to visit with same dx code
00190	Cryotherapy	30.41	Mini tray fee (if you bring your own liquid nitrogen)

References

General Practice Services Committee (2016). Complete Billing Guide: http://www.gpscbc.ca/what-we-do/longitudinal-care/billing-guides

General Practice Services Committee (2010). Billing Guide Tutorial Videos: http://www.gpscbc.ca/billing-fees/billing-guide-tutorial

Ministry of Health BC – MOA Billing Guide Module 5: Facility Fees for General Practitioners and Specialists (p7-11): http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/msp-tutor

Ministry of Health BC – MOA Billing Guide Module 9: GPSC Initiated Fees
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/medical-office-assistant-billing-guide

Ministry of Health BC –Medical Services Commission Payment Schedule July 1, 2017
https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msc-payment-schedule-july-2017.pdf

Society of General Practitioners -Simplified Guide to Billing - Residential Care Billing: http://sgp.bc.ca/fee-category/residential-care/
July 2016 update: accessible to registered members only

Appendix A – Billing Options

Contractor

1. Leanne Bulmer RN BSN MBA
bulmero@gmail.com
250 327 2816

Services Provided:

- Processing claims as received and calculating surcharges.
- Providing submission reports.
- Providing a full remittance report of all claims paid, held and refused bi-monthly.
- Reconciling claims, processing rejections and refusals, tracking and billing non paid or not paid as billed claims and researching any incomplete or incorrect patient information.
- Managing rejected claims.

Costs: Fees for submission service can be discussed upon contact. There is an annual fee for billing software and then monthly fees for billing services based on volume.

2. Ingrid Zaffino
Interior Medcom
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250 492 0530

Services Provided:

- Processing claims as received and calculating surcharges.
- Providing submission reports.
- Providing a full remittance report of all claims paid, held and refused bi-monthly.
- Reconciling claims, processing rejections and refusals, tracking and billing non paid or not paid as billed claims and researching any incomplete or incorrect patient information.
- Following-up on private insurance claims or bad debt claims.

Costs: For 5 doctors to bill 200 items a month it is $50 each per month. If she only has to produce one combined “remittance” for all five doctors per month (the sheet that explains what was billed and its status) then its $194.25 for all 5 per month.

Claim Processing Programs

http://www.claimmanager.ca/features/ (monthly (4.95) and annual fee options (200.00))
https://www.clinicaid.ca/pricing
https://www.dr-bill.ca/ (fee is 1% of amount billed, can bill via cell phone scanning of patient label)

Appendix B – Commonly used ICD9 Diagnostic Codes

303 – alcohol withdrawal
285 – anemia
493 – asthma
427 – atrial fibrillation
7245 – back pain
7243 - sciatica
466 – bronchitis
799 – cachexia
174 – breast cancer
185 – prostate cancer
162 – lung cancer
682 – cellulitis
436 – acute CVA
491 – COPD
428 – CHF
293 – delirium
2900 – dementia
311 – depression
250 – diabetes
562 – diverticulitis
305 – drug abuse
780 – fever of unknown origin
808 – hip fracture
807 – rib fracture
558 – gastroenteritis
578 – GI Bleed
401 – hypertension
959 – injury and trauma, site unspecified
592 – kidney stones
410 – MI
577 – pancreatitis
332 - Parkinson's
486 - pneumonia
415 – PE
585 – chronic renal failure
518 – respiratory failure
780 – seizure
038 – sepsis
786 – SOB
789 – symptoms involving abdomen
780 – syncope and collapse
599 – UTI
453 – venous embolism/thrombosis