BILLING QUESTIONS FAQ

June 1, 2020

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TEMPORARY CHANGES TO TELEHEALTH AND TELEPHONE SERVICES

Effective March 13, 2020 the Preamble definition of a Telehealth Service has been changed to include telephone calls: ***"Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient through the use of video technology or telephone."***

Use your professional medical judgement to determine what services can be provided by Telehealth, taking into account the expectations of regulated health professionals. These were outlined in the March 23, 2020 COVID-19 update from the Provincial Health Officer, sent to all physicians by the College of Physicians and Surgeons of BC.

In the Q+A below, references to Telehealth include services provided by **video or phone**.

Q: DOES THIS CHANGE IN DEFINITION OF "TELEHEALTH SERVICE" APPLY ONLY TO COVID-19 RELATED SERVICES?

A: No, the change applies to all services by family doctors that can be safely and appropriately provided by video or phone. If you provide a service related to COVID-19, please use diagnostic code **C19**.

Q: WHAT ARE THE NEW TEMPORARY AGE ADJUSTED FP TELEHEALTH FEE CODES? WHEN DO I START USING THEM?

A: The new temporary age adjusted fee codes are effective June 1, 2020. If the previous codes are used on June 1 or later, they will be rejected.

VISITS—0100 series equivalents		
T13237	Telehealth GP Visit (age 0-1)	$34.79
T13437	Telehealth GP Visit (age 2-49)	$31.62
T13537	Telehealth GP Visit (age 50-59)	$34.79
T13637	Telehealth GP Visit (age 60-69)	$36.36
T13737	Telehealth GP Visit (age 70-79)	$41.10
T13837	Telehealth GP Visit (age 80+)	$47.44

★Submission of fee codes **13037** and **13017** with dates of service on or after June 1 will be rejected.

COUNSELLING – 0120 series equivalents	*minimum time per visit 20 minutes*	
T13238	Telehealth GP Individual Counselling for a prolonged visit for counselling (age 0-1)	$62.05
T13438	Telehealth GP Individual Counselling for a prolonged visit for counselling (age 2-49)	$56.41
T13538	Telehealth GP Individual Counselling for a prolonged visit for counselling (age 50-59)	$62.05
T13638	Telehealth GP Individual Counselling for a prolonged visit for counselling (age 60-69)	$64.86
T13738	Telehealth GP Individual Counselling for a prolonged visit for counselling (age 70-79)	$73.32
T13838	Telehealth GP Individual Counselling for a prolonged visit for counselling (age 80+)	$84.60

★Submission of fee codes **13038** and **13018** with dates of service on or after June 1 will be rejected.

Notes:
i) MSP will pay up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth) per patient per year (see Preamble D. 3.3).
ii) Start and end time must be entered into both the billing claims and patient's chart
iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

CONSULTATIONS – 0110 series equivalents		
T13236	Telehealth GP Consultation (age 0-1)	$84.87
T13436	Telehealth GP Consultation (age 2-49)	$77.15
T13536	Telehealth GP Consultation (age 50-59)	$84.87
T13636	Telehealth GP Consultation (age 60-69)	$88.73
T13736	Telehealth GP Consultation (age 70-79)	$100.29
T13836	Telehealth GP Consultation (age 80+)	$115.75

★Submission of fee codes **13036 and 13016** with dates of service on or after June 1 will be rejected.

Click here to download a one page cheatsheet from our website.

Q: WHY ARE THE NEW TEMPORARY FP TELEHEALTH FEES (INTRODUCED ON JUNE 1st) DIFFERENT FOR EACH AGE GROUP?

A: The COVID-19 pandemic has resulted in Telehealth delivery for the majority of services done by family doctors, and Telehealth is expected to remain a significant part of care delivery for the foreseeable future.

Values of the previous GP telehealth visit (13037), counselling (13038) and consultation fees (13036) are set at the weighted average of the in-person 0100, 0120 and 00110 series, respectively. These fee code series were age-adjusted years ago as there is good evidence that age is a reasonable proxy for population-level complexity (though there are many individual exceptions).

By changing the telehealth fees to match their in-office versions, patient services will be remunerated the same amount, regardless of whether the care is delivered in-person or via Telehealth.

BOTTOM LINE, AS OF JUNE 1st:

- **USE THE AGE-APPROPRIATE TELEHEALTH VISIT CODES 13237-13837 FOR ALL VISITS THAT WOULD BE BILLED AS 0100 SERIES IF PROVIDED IN-PERSON.**

- **USE THE AGE-APPROPRIATE TELEHEALTH COUNSELLING CODE 13238-13838 FOR ALL VISITS THAT WOULD BE BILLED AS 0120 SERIES IF PROVIDED IN-PERSON.**

Q: WHY ARE THE NEW TEMPORARY FP TELEHEALTH FEES (INTRODUCED ON JUNE 1st) THE SAME FOR ALL LOCATIONS (BOTH IN AND OUT OF HEALTH AUTHORITY FACILITIES)?

A: When these Telehealth fees were originally developed years ago, the definition of a telehealth service included video only. At the time, available technology required community-based physicians to leave their office to go to a health authority site to access the Provincial Telehealth Network. Later, modifications to the fees were made to differentiate services that required the physician to attend a health authority facility, and those provided from office or home.

The June 1st temporary pandemic-related changes to age-adjusted Telehealth fees eliminates the two levels of payment for services delivered in and out of health authority facilities. With the advent of modern video platforms (and now with expansion to telephone during the duration of the pandemic), leaving the office/home to go to a health authority site to provide Telehealth services is rarely necessary.

Q: WHAT IF THERE IS NO TELEHEALTH CODE THAT CORRESPONDS TO THE SERVICE I PROVIDE?

A: Non-procedural interventions provided by video or telephone where there is no Telehealth fee should be billed under the equivalent face-to-face fee with a claim note record stating the service was provided via Telehealth.

Some examples of non-procedural interventions provided by family physicians for which there is no Telehealth fee code include prenatal visits (14091); HIV primary care management (13015); OAT assessment and management of induction and maintenance of OAT (13013, 13014, 00039). Submission must include a claim note record stating the service was provided via Telehealth.

Remember, any visit that you would have billed as a 0100 series or 0120 series when provided in-person should be billed as 13237 series or 13238 series.

Q: WHEN USING THE NEW AGE-ADJUSTED TELEHEALTH FEE CODES (13237 SERIES AND 13238 SERIES), DO I HAVE TO INCLUDE A CLAIM NOTE RECORD THAT THE SERVICE WAS PROVIDED BY TELEHEALTH?

A: No, the fee code already tells MSP that the service was provided by Telehealth.

Q: CAN I PROVIDE AND BILL A COMPLETE EXAMINATION (0101 SERIES) BY TELEHEALTH?

A: No. This requires an in-person physical examination.

Q: DO I HAVE TO SUBMIT START AND END TIMES WITH THE TELEHEALTH FEE CODES?

A: The 13237 series like the 0100 series does not require start end times. The 13238 series codes are counselling visits and must meet the same definition of counselling and time requirements as the 0120 series. For 13238 series billings start and end times must be submitted with the billing and noted in the medical record.

Q: IF I DETERMINE, AS A RESULT OF A TELEHEALTH VISIT, THAT I NEED TO SEE THE PATIENT IN-PERSON THE SAME DAY FOR A PHYSICAL EXAM, WHAT DO I BILL?

A: You bill either the age appropriate 13237 series for the telephone visit **OR** the appropriate in-person fee for the face-to-face visit. Telehealth and an in-person service are not billable on the same patient/same day *by the same physician*. The exceptions to this are the two new COVID-19 fees T13701 and T13702 (see below for more info on these new fees.)

Q: MY MULTI-PHYSICIAN CLINIC IS DIVIDING THE WORK LOAD DURING THE COVID-19 PANDEMIC. IF I PROVIDE A TELEHEALTH VISIT WITH MY PATIENT AND DETERMINE THEY NEED TO BE SEEN IN-PERSON THAT DAY AT OUR CLINIC BY A *DIFFERENT* PHYSICIAN, HOW DO WE BILL?

A: The age appropriate 13237 series code for the telephone visit is billable by the first physician, and the appropriate in-person fee for the service provided in-person is billable by the other physician.

Q: IF A COLLEAGUE DETERMINES VIA A TELEHEALTH VISIT THAT THE PATIENT REQUIRES A PHYSICAL EXAMINATION, AND I AM THE PHYSICIAN PROVIDING THE IN-PERSON ASSESSMENT, CAN I BILL A GP CONSULTATION (00110 SERIES)?

A: No. This does not meet the requirements for a GP Consultation (00110 series) as defined in the MSC Payment Schedule.

Q: I DELEGATE SOME PHONE CALLS TO MY OFFICE NURSE AND BILL 14076. CAN THESE NOW BE BILLED AS TELEHEALTH VISITS USING THE AGE APPROPRIATE 13237 SERIES?

A: No, Telehealth visits may not be delegated and billed to MSP. Use the new T13706 FP Delegated Patient Telehealth Management Fee in the amount of $20. See below in NEW FEES FOR THE COVID-19 PANDEMIC.

Q: WHAT ABOUT PRESCRIPTION RENEWALS BY PHONE?

A: If a Telehealth visit with the patient is necessary to determine if a prescription renewal is appropriate or a different prescription is necessary, then bill the age appropriate 13237 series code (as you would do for seeing the patient in person and billing the 0100 series.) If you are doing a prescription renewal without seeing the patient (either virtually or in person), you may now bill T13707 **FP Email/Text/Telephone Medical Advice Relay or ReRX Fee** in the amount of $7.

Q: I PROVIDE CONSULTATIONS BY REFERRAL FOR MY COLLEAGUES' PATIENTS - CAN I NOW DO THIS USING TELEHEALTH (VIDEO OR TELEPHONE) INSTEAD?

A: If you feel you could have provided an in-person consultation without a physical examination, then you may use Telehealth for the consultation without an examination and bill the age appropriate **Telehealth GP consultation fee** (13236 series). Continue to use your professional judgement to determine whether use of virtual technology is clinically appropriate, considering the circumstances of each patient.

Q: WHAT IS THE DIFFERENCE BETWEEN A TELEHEALTH VISIT 13237 SERIES AND A TELEHEALTH CONSULTATION 13236 SERIES?

A: Telehealth consultation fees are for consultation services provided by referral only and must meet the Preamble definition of a GP in-person consultation, excepting the requirement for physical examination. The Telehealth visit fees are the telehealth equivalent of office visits.

Q: CAN I PROVIDE GROUP MEDICAL VISITS BY TELEHEALTH?

A: Yes, if you are able to use a video platform or teleconference line that allows all patients to attend, bill the visit under the applicable Group Medical Visit code with a claim note record "service provided via Telehealth." Remember that GMVs require a 1:1 interaction between each patient and the attending physician.

Group counselling has its own specific Telehealth fee codes: 13041 and 13042.

Q: CAN I BILL THE AGE APPROPRIATE 13238 SERIES FOR ADVANCE CARE PLANNING AND GOALS OF CARE DISCUSSIONS IN LIGHT OF COVID-19?

A: The 13238 series must meet the same criteria as 0120 series. The General Preamble states: "*Counselling is defined as the discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress,…"*

Discussing advance care planning in the context of COVID is recognised as difficult by all physicians, and many patients will also be experiencing significant emotional distress. Some conversations about advance care planning, goals of care discussions, and Medical Orders for Scope of Treatment (MOST) designations will take 20 minutes or longer and can be billed using the age appropriate 13238 series codes. The visit must be a minimum of 20 minutes and start/end times are required to be recorded in the chart and submitted with the claim. Shorter visits should be billed using age appropriate 13237 series codes.

Other opportunities for advance care planning occur when creating a care plan as part of any GPSC planning visit (Complex Care 14033 and 14075, Mental Health 14043 and Palliative 14063.) During these visits, it is expected that advance care planning occurs (when clinically appropriate) and is documented in the care plan. Remember that the required face to face physician: patient planning time may now be provided by Telehealth during the COVID-19 pandemic.

Q: WHAT ABOUT THE CARE OF PATIENTS WHO NEED OPIOID AGONIST TREATMENT (OAT)? THESE PATIENTS STILL NEED CARE.

A: Bill 13013 for Assessment for Induction with claim note record "service provided by Telehealth." 13014 already allows service by Telehealth. The requirement for a once every 90 day in-person visit for 00039 can now be met by providing a Telehealth visit under the age appropriate 13237 series code.

Q: HOW DO I BILL A TELEHEALTH VISIT FOR A CHILD WHEN I AM TALKING TO THE PARENT?

A: Bill the age appropriate 13237 series code using the child's PHN. You may not bill an additional telehealth visit simply for talking to the parent about the child's condition. However, if the parent also has a medical problem that you address during the same encounter, then it would be appropriate to bill the age appropriate 13237 series code for the service to the parent.

Q: IF I PROVIDE TELEHEALTH VISITS OUTSIDE OF USUAL OFFICE HOURS OR ON WEEKENDS IS THERE AN OUT-OF-OFFICE HOURS FEE I CAN BILL IN ADDITION?

A: No

Q: IS THERE A DAILY LIMIT ON THE NUMBER OF TELEHEALTH VISITS I CAN PROVIDE?

A: Daily Volume Payment Limits have been suspended during the pandemic.

Q: I'VE HEARD THAT I HAVE TO INCLUDE A CLAIM NOTE RECORD WHEN SUBMITTING CLAIMS FOR SERVICES PROVIDED BY TELEHEALTH? WHAT DOES THAT MEAN?

A: When using the specific Telehealth fees (13237 series, 13238 series etc.), no claim note record is required because the fee code alerts MSP that the service was provided by Telehealth. However, if you are billing an in-person fee code because there is no specific Telehealth code for the service, you must include a claim note record that the service was provided via Telehealth. You must also note this in the medical record.

Q: WILL THE BUSINESS COST PREMIUM (BCP) APPLY TO TELEHEALTH BILLINGS?

A: The Business Cost Premium (BCP) will be temporarily expanded to apply to in-office telehealth fee items during the COVID-19 pandemic. This is effective May 1, 2020 (not retroactive). Read more here.

Q: HOW DO I SUBMIT MY TELEHEALTH BILLINGS TO ENSURE THAT THEY RECEIVE THE BCP?

A: Eligible BCP claims require submission of the unique facility number you received when you registered for the BCP as well as *location code A*, which identifies *Practitioner's office – in community*. The appropriate facility number and service location code is based on where the service would have been provided if it had been performed face-to-face.
Check your EMR to make sure the facility number and location code come up when telehealth fees are billed. If not, you or your MOA will have to manually add the codes for each billing or hold the billings until your EMR is updated.

Remember: In order to receive the BCP, physicians need to register their facility (clinic) and attach themselves as a practitioner of the facility.

You can read more about the BCP, including eligible fees, payment details and the registration process here.

Q: ARE TELEHEALTH FEES COVERED UNDER RECIPROCAL BILLING (WITH OTHER PROVINCES)?

A: Yes. If your patient has recently moved from another province and is not yet enrolled with MSP, bill Telehealth fees in the same way that you would bill in-person fees, using their previous out of province address and health number.

Note for physicians practicing in a border community:
From the CPSBC Practice Standard on Telemedicine: The requirements for treating patients via telemedicine vary by jurisdiction. Physicians must be aware of and comply with the licensing requirements in British Columbia, and in the province/territory where the patient is located. Some jurisdictions require physicians to hold a licence in order to treat a patient located in that jurisdiction.

TELEHEALTH SERVICES FOR PATIENTS IN LONG-TERM CARE (LTC) OR PALLIATIVE CARE FACILITIES

Q: CAN I PROVIDE TELEHEALTH SERVICES TO MY PATIENTS IN LTC FACILITIES? WHAT ABOUT PALLIATIVE CARE?

A: Yes. Effective March 20th, if the patient **is able to independently use a phone** and you feel the encounter could be appropriately provided by Telehealth (video or telephone), bill Long Term Care facility visit fee 00114 or Palliative Care Patient facility visit fee 00127 and include the claim note record "service provided via Telehealth."

If the patient **cannot independently use a phone** (e.g. due to debility, dementia, hearing loss etc.) or does not have their own phone, you may **review** the patient's medical status and any problems by telephone **with an RN/LPN** at the facility, and bill the visit using 00114 or 00127 and include the claim note record "Service provided via Telehealth with RN/LPN."

Q: WHAT IF THE REVIEW OF MY PATIENT IN LTC OR PALLIATIVE CARE TAKES LONGER THAN 8 MINUTES. CAN I BILL G14077 FP ALLIED CARE PROVIDER CONFERENCE FEE?

A: Telehealth fees, the 00114 **LTC facility visit** fee and the 00127 **Palliative Care Patient facility visit** fee are not time-based fees, so regardless of the time spent delivering a 00114 or 00127 visit by telephone, you will bill it as a 00114 or 00127 (not a 14077.) You are providing the visit by telephone in lieu of attending the patient in-person.

The rules for 14077 have not changed. 14077 may not be used for conversations with patients. Further, 14077 can not be used for conversations that are part of "routine rounds" simply because they take 8 or more minutes.

Q: CAN I BILL 00114 LTC FACILITY VISITSDONE BY TELEHEALTH MORE FREQUENTLY THAN EVERY 2 WEEKS?

A: The fee rules remain the same: billable up to once every 2 weeks for planned proactive care. Medically necessary visits more frequently require an electronic note outlining the reason for the extra visit.

Q: ARE THE 13334 AND 13338 FIRST VISIT OF THE DAY BONUSES BILLABLE WHEN 00114 OR 00127 SERVICES ARE PROVIDED BY TELEHEALTH? WHAT IF THE REVIEW OF MY PATIENT IN LTC OR PALLIATIVE CARE TAKES LONGER THAN 8 MINUTES?

A: No. The first visit of the day bonuses only apply to in-person visits. They recognize the travel time necessary for attending the facility.

Q: CAN I BILL A TELEHEALTH VISIT 13237 SERIES WHEN I SPEAK TO A PATIENT'S FAMILY MEMBER/MEDICAL REPRESENTATIVE TO UPDATE THEIR MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) FORM?

A: No, MSP has advised that in this case 14076 is the appropriate fee. If you delegate this telephone visit to a College Certified ACP employed by your practice, use T13706 instead.

MATERNITY/OBSTETRICAL BILLING

Q: MY HOSPITAL IS RESTRICTING THE NUMBER OF PEOPLE IN THE OR BECAUSE OF THE COVID-19 PANDEMIC. CAN I STILL BILL 14109 FOR MANAGEMENT OF LABOUR AND POSTNATAL CARE ASSOCIATED WITH EMERGENCY CAESAREAN SECTION IF THIS RESTRICTION PREVENTS ME FROM ATTENDING THE C-SECTION?

A: Yes

Q: CAN I PROVIDE AND BILL A 14090 PRENATAL VISIT – COMPLETE EXAMINATION BY TELEHEALTH WITHOUT DOING A PHYSICAL EXAMINATION?

A: No, 14090 requires a physical examination and, therefore, must be done in-person. Perinatal Services BC has created recommendations for the schedule of prenatal visits during the COVID-19 pandemic. While 14090 is often billed for the first prenatal visit, you can bill it at a subsequent prenatal visit, if that is when you see the patient in-person and conduct the physical examination.

Q. CAN I PROVIDE AND BILL A 14091 PRENATAL VISIT – SUBSEQUENT EXAMINATION BY TELEHEALTH WITHOUT DOING A PHYSICAL EXAMINATION?

A: Yes. Bill 14091 with a claim note record stating the service was provided by Telehealth. This is an example of a non procedural intervention for which there is no TH code. Do not use 13437 for prenatal visits provided by Telehealth.

WORKSAFEBC/ ICBC/ ROAD SAFETY BC

Q: WHAT ABOUT WORKSAFEBC SERVICES? CAN THEY BE PROVIDED BY TELEHEALTH?

A: Yes, effective March 20th, WorkSafeBC will allow Telehealth for any service **not requiring physical examination.** Use the appropriate Telehealth visit code (as of June 1st 13237 series, or 13238 series) identifying WorkSafeBC as the insurer. If there is no applicable Telehealth fee, then bill under the equivalent face-to-face fee with a claim note record stating the service was provided via Telehealth. Also document this on the Form 8/11 and bill the appropriate Form fee.

Q: WHAT ABOUT ICBC SERVICES? CAN THEY BE PROVIDED BY TELEHEALTH?

A: Yes, effective March 20th, use the appropriate Telehealth fee code (as of June 1st 13237 series, or 13238 series) and make a notation in the patient record that the service was provided by Telehealth.

As with MSP/WorkSafeBC, use the in-person fee code only if there is no equivalent Telehealth fee. Identify ICBC as the insurer when submitting through Teleplan.

In-person visits for the evaluation of new or recent injuries sustained by your patients may be scheduled in-clinic on an as-needed basis. However, in-person visits for the preparation of requested reports should be rescheduled in support of reducing non-essential in-person visits.

Q: I DON'T WANT MY VULNERABLE ELDERLY PATIENTS COMING TO THE OFFICE FOR DRIVER MEDICALS AT THIS TIME. WHAT CAN I DO?

A: RoadSafetyBC has suspended requesting Driver Medical Examination Reports (DMER), including any outstanding DMERs and other required medical exams, in response to the pressure on the medical community during the COVID-19 pandemic.

Road Safety BC surveyed physicians at the end of May to better understand their capacity to offer in-person drivers' assessments. They will take this into account as they plan next steps.

GPSC INCENTIVES AND TELEHEALTH

Q: I WANT TO KEEP PROVIDING GPSC PLANNING VISITS TO MY PATIENTS. CAN I DO THIS BY TELEHEALTH?

A: Effective March 23rd, all **face to face planning** required under the GPSC planning fees 14033 **Complex Care**, 14075 **Frailty**, 14043 **Mental Health**, and 14063 **Palliative Care** may now be provided by Telehealth: video or phone. Think of it as physician: patient planning.

All existing time requirements remain the same: total planning time (30 minutes) and physician: patient planning time (minimum 16 minutes).

Q: CAN I PROVIDE MENTAL HEALTH MANAGEMENT (14044, 14045, 14046, 14047, 14048) BY TELEHEALTH?

A: Mental Health Management fees currently allow videoconferencing. This has been expanded to include telephone counselling.

Q: CAN I BILL CHRONIC DISEASE MANAGEMENT INCENTIVE FEES (14050, 14051, 14052 AND 14053) IF THE TWO REQUIRED VISITS IN THE PREVIOUS 12 MONTHS WERE PROVIDED VIA TELEHEALTH?

A: Yes, **effective June 1, 2020** 0 CDM fees may be billed after one year of care has been provided including at least two visits.

Both of the two required visits may be a physician visit. Office, prenatal, home, long term care, or physician telehealth visits qualify.

Alternatively, one of the two required visits must be a physician visit while the second visit may be:

1. a telephone visit (14076) or
2. a group medical visit (13763-13781) or
3. an in-person visit with a college certified allied health provider (14029) working within the family physician's practice.

Q: HOW ABOUT IF I'M ON AN ALTERNATE PAYMENT/FUNDING MODEL? CAN I BILL CHRONIC DISEASE MANAGEMENT INCENTIVE FEES (14250, 14251, 14252, 14253) IF THE TWO REQUIRED VISITS IN THE PREVIOUS 12 MONTHS WERE PROVIDED VIA TELEHEALTH?

A: Yes, effective **June 1, 2020** CDM fees may be billed after one year of care has been provided including at least two visits.

Both of the two required visits may be a physician visit. Office, prenatal, home, long term care, or physician telehealth visits qualify.

Alternatively, one of the two required visits must be a physician visit while the second visit may be:
1. a telephone visit (14276) or
2. a group medical visit (13763-13781) or
3. an in-person visit with a college certified allied health provider(14029) working within the family physician's practice.

Q: CAN I BILL A TELEHEALTH SERVICE ON THE SAME DAY AS A GPSC INCENTIVE?

A: If a GPSC incentive already allows same-day billing of a visit service, then you may bill a same-day Telehealth fee.

Q: CAN I PROVIDE A 14066 PERSONAL HEALTH RISK ASSESSMENT INCENTIVE IF PROVIDED BY TELEHEALTH?

A: Yes, effective June 1, 2020, the required face-to-face visit to provide a personal health risk assessment can now be provided via telehealth. Physicians should include a note record when billing 14066 if the visit was provided to the patient via telehealth.

NEW FEES FOR THE COVID–19 PANDEMIC

For full details of the new fee codes, please see APPENDIX A.

FEES FOR CARE OF PATIENTS WITH SUSPECTED OR CONFIRMED COVID-19

Q: ARE THERE NEW FEES FOR IN-PERSON ASSESSMENT OF A PATIENT WITH SUSPECTED OR PROVEN COVID-19?

A: Yes, there are two new fees. Use diagnostic code **C19**.

- T13701 **Office Visit for COVID-19 with test**: $50
- T13702 **Office Visit for COVID-19 without test**: $40

Q: WHAT IF I, OR ANOTHER PHYSICIAN, HAVE ALREADY PROVIDED A TELEHEALTH VISIT TO THE PATIENT ON THE SAME DAY THEY HAVE THEIR IN-PERSON ASSESSMENT FOR COVID-19?

A: The T13701 or T13702 may be billed on the same day as a Telehealth fee whether the services are provided by the same physician or two different physicians.

Q: CAN I BILL T13702 FOR A TELEHEALTH VISIT WITH A PATIENT ABOUT COVID-19?

A: No, both T13701 and T13702 are payable only for in-person assessment. Use 13037 for a Telehealth visit for COVID-19 using diagnostic code **C19**.

Q: CAN I BILL T13701 AND T13702 FOR ASSESSING PATIENTS IN THE EMERGENCY ROOM? T

A: No, physicians working in the ER should continue to bill their usual patient assessment codes.

Q: WHAT IF I NEED TO SPEAK WITH A SPECIALIST OR ALLIED CARE PROVIDER ABOUT THE CARE OF A PATIENT WITH SUSPECTED OR CONFIRMED COVID-19? CAN I BILL FOR THAT?

A: Yes. You may use new fee T13708 **FP COVID-19 communication with specialist and/or allied care provider**. This fee replaces 14018 and 14077 for communication about care of patients with suspected or confirmed COVID-19. Use diagnostic code **C19**.

Q: CAN I BILL T13708 WHEN I CALL TO NOTIFY THE ER OR LOCAL COVID-19 ASSESSMENT CENTRE THAT A PATIENT NEEDS TO BE SEEN IN-PERSON BECAUSE OF COVID-19 SYMPTOMS?

A: No, this would be considered a communication that is part of regular work flow. See fee notes below in APPENDIX A.

FEES TO EXPAND CAPACITY DURING THE COVID–19 PANDEMIC

Q: BOTH 14076 AND 14078 HAVE LIMITS ON THE NUMBER BILLABLE PER CALENDAR YEAR. I AM GOING TO HAVE USED MY ALLOTTED NUMBER VERY SOON. IS THERE ANYTHING ELSE I CAN BILL?

A: Remember, phone visits **by physicians** should be billed under Telehealth codes (usually (13237 series, 13238 series). If you are delegating the work (as below), there are two new fees now available that should be used instead of 14076 and 14078.

- Use **T13706 FP Delegated Patient Telehealth Management Fee** in the amount of $20 when delegating phone calls to a College-certified allied care provider employed within your office.

- Use T13707 **FP Email/Text/Telephone Medical Advice Relay or ReRX Fee** in the amount of $7 when delegating relay of your medical advice to the patient by any allied care provider or MOA working in your office. T13707 may also be used to renew prescriptions when no patient visit (either by phone/video or in-person) is required.

Q: CAN I BILL T13707 WHEN FAXING A REPEAT PRESCRIPTION TO THE PHARMACY?

A: Yes, MSP has confirmed that this is acceptable.

Q: IS A CHART ENTRY REQUIRED WHEN BILLING T13707 FOR PRESCRIPTION RENEWAL?

A: There must be some auditable recording of the prescription renewal: chart entry; scan of a sent fax or other permanently retained method.

Q: IS T13707 BILLABLE IN ADDITION TO A VISIT SERVICE ON THE SAME DAY?

A: No.

Q: IS THERE A DAILY LIMIT ON THE NUMBER OF T13708 FEE CODES BILLABLE?

A: There is no daily limit per physician or per patient. Remember T13708 is for communication about a patient with suspected or active COVID-19 only and is not payable for communications which are part of regular workflow or routine rounds.

Q: CAN I BILL T13708 WHEN CALLING ER, THE UPCC, OR ANOTHER DESIGNATED TESTING SITE TO ADVISE I AM SENDING IN A PATIENT WITH SUSPECTED COVID-19 FOR TESTING?

A: No, this would be considered part of regular workflow

Q: CAN I STILL USE 14077 INSTEAD OF T13708?

A: 14077 is still billable for telehealth calls with other Specialists or Allied Care Providers (ACP) if they meet the criteria as defined in the fee rules (including minimum 15 min or better portion thereof). T13708 is only for telehealth discussions about a patient with suspected or active COVID-19 and has no minimum time requirement.

APPENDIX A: DETAILS OF NEW FEES FOR THE COVID–19 PANDEMIC

T13701 Office Visit for COVID-19 with test…….. $50.00
Notes:
i) Payable for patients with suspected or active COVID-19 symptoms only.
ii) COVID-19 testing must be performed.
iii) Not intended for providing general information on a viral infection, including COVID-19.
iv) Not payable in addition to any other office visits to the same physician to the same patient, same day.

T13702 Office Visit for COVID-19 without test ……..…. $40.00
Notes:
i) Payable for patients with suspected or active COVID-19 symptoms only.
ii) Not intended for providing general information on a viral infection, including COVID-19.
iii) Not payable in addition to any other office visits to the same physician for same patient, same day.

T13706 FP Delegated Patient Telehealth Management Fee ……..…….……$20.00
Notes:
i) For verbal, real-time telephone or video technology communication discussion between the patient or the patient's medical representative and a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed within a physician's practice. Not payable when the delegated representative is paid or funded by alternate means by a health authority or the Ministry of Health.
ii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.
iii) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
iv) Only one service payable per patient per day.
v) Not payable on the same calendar day as a visit or service fee by same physician for same patient.
vi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care

T13707 FP Email/Text/Telephone Medical Advice Relay or ReRX Fee…….…. $7.00

Notes:

i) Email/Text/Telephone Relay Medical Advice requires two-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.

ii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.

iii) Payable for prescription renewals without patient interaction.

iv) Not payable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

v) Only one service payable per patient per day.

vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient.

vii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

T13708 FP COVID-19 communication with specialist and/or allied care provider……. $40.00

Notes:

i) Payable to the Family Physician who participates in a 2 way telephone or videoconference communication with a specialist and/or allied care provider about a patient regarding COVID-19.

ii) T13708 FP COVID-19 communication with specialist and/or allied care provider can not be delegated. No claim may be made where communication is with a proxy for either provider.

iii) Payable in addition to any visit fee on the same day.

iv) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility, or communications which occur as part of regular work flow within a physician's community practice.

v) Not payable in addition to PG14018 or PG14077 on the same day for the same patient.

vi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

APPENDIX B: ADDITIONAL RESOURCES

1. DOCTORS TECHNOLOGY OFFICE

The Doctors Technology Office has created a number of resources to help physicians and clinics quickly get started with virtual care. You can find their materials here.

2. PATHWAYS

Pathways has curated a number of resources to help physicians respond to the COVID-19 pandemic.

These include:

- **COVID-19 NEWS BANNERS:** Pathways is creating VERY BRIEF up to date news banners with active links that are being pushed to every Division's homepage
- **COVID-19 PATIENT AND PHYSICIAN RESOURCES:** The Pathways Resource Committee has been meeting frequently and entering practical Physician Tools and Patient Info
- **NEW SPECIALTY OF COVID-19 CARE:** Physicians have been asking for a Central Repository of COVID-19 Assessment Centres. Pathways has entered close to 100 new clinic listings in the NEW Specialty of COVID Care and is continuing to gathering this data in collaboration with GPSC and Divisions of Family Practice.

You can find their materials here.