FACILITY PATIENT BILLING CODES – FAMILY MEDICINE

COMMUNITY FP PROVIDING HOSPITAL IN-PATIENT CARE

13109: **Acute Care Hospital Admission visit**

For provision of Admission History and Physical when community based FP is the MRP. Submitted in lieu of 13008 on the first in-patient day, for that patient.

13008: Community GP Hospital Visit

Bill 13008 for providing Most Responsible Physician (MRP) essential non-emergent visits to a patient in acute or sub-acute care facilities during one day. Billable daily for up to 30 days, then twice per week with no e-note.

Additional Medically Necessary Visits Same Patient-Same Day require:

Whenever a visit is the 2nd+ of the day for same patient, same fee code (e.g. 13008), please indicate "D" for duplicate and the time of the visit (must be at least 2 hours apart). A specific diagnostic code (not 780!) is required. If less than 2 hours apart use submission code D and an enote explaining the reason for the visit.

1. Indicate submission code "D";
2. Purpose for Additional visit;
3. Time of service: _____

Concurrent Care: When a specialist is MRP for admitting diagnosis but FP must provide concurrent active daily care for medical condition unrelated to purpose for admission, must use the diagnostic code for that unrelated condition.

1. Reason for concurrent care by FP in e-note for first visit billed using 13008;
2. Diagnostic code for medical condition requiring concurrent care to FP

Long Stay Hospitalization: Complex medical problems requiring hospitalization for >30 days can be billed for on a daily basis when documentation provided using an e-note. This requires description of concurrent or exacerbated illness in the e-note to bill for any medically necessary visits more frequently than twice weekly. Use appropriate Dx code.

Sub-Acute Care: When a patient has been transferred to a designated sub-acute care unit/bed for convalescence under the MRP status of the family physician following a stay in an acute care bed under the MRP care of a specialist (eg. Post-hip fracture, surgically stable but not medically fit to be discharged), the FP may bill 13008 for MRP care following the same billing rules as for concurrent care – up to daily for 30 days from date of admission then twice weekly without an electronic note. If more frequent care is required after this initial 30 days, must submit an e-note to bill for any medically necessary visits more frequently than twice weekly.

1. Reason for sub-acute care by FP in e-note for first visit billed using 13008;
2. Diagnostic code for medical condition requiring transfer for sub-acute care to FP

P13338: **First Facility Visit of the Day Bonus**

Bill in addition to 13008, 13028 or 00127 for the first in-patient visit of the day. One bonus payable per calendar day per physician.

00127: Palliative Care: Hospital visit for terminal care

Use for terminally ill patients with life expectancy of up to 6 months when focus of care is palliative. Payable daily for necessary visits up to 180 days prior to death. Under extenuating circumstances, for visits that exceed 180 days, a note record must be submitted. Billable in acute care, long-term care or hospice/palliative facilities. Does not require patient to be in designated "palliative bed."

Additional Medically Necessary Visits Same Patient-Same Day require:

1. Indicate submission code "D";
2. Purpose for Additional visit:
3. Time of service: _____

13028: Supportive care provided by Community MRP with active privileges
Use this code when providing supportive care when MRP care provided by Specialist. Payable daily for visits during the first 10 days of hospitalization and thereafter once every 7 days. If patient is subsequently transferred from Specialist to FP for MRP care (eg. post-surgery transfer to FP for MRP management of other medical condition prior to discharge from hospital) may bill 13008 from time of transfer.

If care of patient transferred from Specialist to GP for MRP care, claim must include:

1. Reason for transfer of MRP care to FP in e-note for first visit billed as MRP;
2. Diagnostic code for medical condition requiring transfer of MRP care to FP.

14088: GP Unassigned In-patient Care fee
FPs registered in a GPSC Unassigned In-patient Network or the Maternity Network may submit 14088 for each unassigned patient admitted under them as MRP. Billable once per admission in addition to the hospital visit or obstetric delivery fee as appropriate.

Out of Office Hours Premiums
Call out Charge
Billable when physician is called from outside the hospital, and must return to perform a service. Out of office hours surcharges are billed in addition to the service/consultation/visit fee (eg. out of office assessment, consult/procedure/surgery/delivery).

00112: Weekday day time (call placed and must immediately go in to see between 0800 and 1800 hours) – not billed in addition to visit fee. If called for surgery or obstetric delivery, only billable if call-in time and start time different.

01200: Evening (call placed between 1800 and 2300 hours)
01201: Night (call placed and service rendered between 2300 and 0800 hours)
01202: Saturday, Sunday or Stat Holiday (called placed between 0800 and 2300 hours)

Indicate time of service

Non-Operative Continuing Care Surcharges
Applicable when out of office hours service(s) is prolonged or are provided continuously with no "stand by" time between. Timing begins after the first 30 minutes and payment is based on one half hour of care or major portion thereof. The first surcharge is billable after 45 minutes of continuous care. If you leave the facility and get called back later, time clock restarts. Submit with **e-note: CCFPP** (continuing care from previous patient) in addition to out of office visit fee.

01205: Evening (service rendered between 1800 and 2300 hours, per half hour)
01206: Night (service rendered between 2300 and 0800 hours, per half hour)
01205: Saturday, Sunday or Stat Holiday (called placed between 0800 and 2300 hours)

Indicate start and end time of continuous care for each patient on whom surcharge is billed.

1. Start time of service: _____ 2. End time of service: _____

GP CONSULTATIONS WHERE PHYSICIAN IS NOT COMMUNITY MRP FOR PATIENT

00116: **Special in-hospital consultation**
For patients referred to a GP by a certified specialist for advice about and/or continuing care of complex problems (Eg. assessment of terminal illness, planning of activation or rehab programs, AIDS) require complicated management.

Claim must include explanation of medical complexity. Please provide this information:

1. Referring Doctor: _____ (MSP#)
2. Complex medical issue(s): _____

1X210: **GP Consultation – out of office**

Code	12210	13210	15210	16210	17210	18210
Age	< 2 yrs	2-49	50-59	60-69	70-79	>80

The service consists of a history and physical examination, review of x-rays and laboratory findings, prepare and render a written report including his/her findings, opinions and recommendations, to the referring practitioner.

RESIDENTIAL/LONG TERM CARE CODES

00114: **Long Term Care Facility visit**
One or multiple patients, billed for each patient seen. Billable up to once every 2 weeks for planned proactive care. Medically necessary visits more frequently require electronic note outlining reason for extra visit (including when providing follow-up of specially called visit < 2 weeks later).
P13334: **Community based GP, LTC Facility First Visit of the Day Bonus**

Bill in addition to 00114 for the first patient seen in a LTC facility that day. One bonus payable per calendar day per physician.

00115: Nursing Home Visit when specially called (7 days per week, 0800 – 2300 hrs)

Claim must include time and medical condition. Please provide this information:

1. Time, Start: _____ End: _____
2. Diagnosis requiring special visit

00127: Palliative Care: visit for terminal care
See p.1 for details. Bill 13338 in addition to 127 in LTC if it is the only facility visit that day. 13334 is NOT billable with 127.

CONFERENCING WITH OTHER HEALTH CARE PROFESSIONALS (INCLUDING SPECIALISTS)

Family Physicians who submit the GPSC Portal code 14070, may use 14077 for patient care conferences with allied care providers and other physicians:

14077: **GP Allied Care Provider Conference Fee $40.00 per 15 min or greater portion**
14077 is payable to community FP MRPs for two way collaborative conferencing with at least one other physician or allied care provider – by telephone or in-person - regardless of the location of the patient (in-patient, ER, community, other facility.) May be initiated by FP or allied care provider or other physician. Billable at any time during a patient's hospital stay for clinically indicated conferences.

Claim submission must include start and end times, which must also be recorded in the chart.

OTHER SERVICES

1X220: Counseling – individual - Up to 4 visits/patient/calendar year for a prolonged visit for counseling (minimum time 20 min)

Code	12220	13220	15220	16220	17220	18220
Age	< 2 yrs	2-49	50-59	60-69	70-79	>80

00081: Emergency Care – ½ Hour
Used for the evaluation, diagnosis and treatment immediate life threatening illness of a patient who requires constant bedside care by the physician. Bill 1 x 00081 for each ½ hour or major portion thereof. Not applicable during labour.

Claim submission must include start and end times, which must also be recorded in chart.
00082: Monitoring of critically ill patients – ½ Hour

For critically ill patients require continuous monitoring. Applicable when modification of care and active intervention for patient isn't necessary. Bill 1 x 00082 for each ½ hour or major portion thereof. Not applicable during labour.

Claim must include start and end times, which must also be recorded in chart.
00083: Crisis Intervention – ½ Hour

Physician provides continuous medical assistance at the exclusion of all other services in periods of personal or family crisis (e.g. rape, sudden bereavement, suicidal behavior). Bill 1 x 00083 for each ½ hour. Must bill a visit fee prior to 00083 with timing beginning after 1 hr if CPX or consult OR 30 min if regional exam or counselling.

1. **Claim must include start and end times, which must also be recorded in chart.**

Go to the Emergency tile of the Simplified guide to Fees for a handy Emergency Care Tracking sheet
https://sgp.bc.ca/fee-category/emergency/

Minor Diagnostic/Therapeutic Procedures:
With a *related* assessment/visit (not a consultation) either the visit or the procedure(s) may be claimed, unless noted with "Y". If one or more *unrelated* procedures are performed, the services may be billed in addition to the visit with the higher value service billed at 100% and the lesser value service(s) at 50%. IF providing procedural services in LTC and physician must bring in tray from office, it is appropriate to bill the related tray fee. Samples below:

13600	Biopsy of skin or mucosa (not to include punch or shave biopsy)
13611	Repair Minor laceration or foreign body (under 5 cm)
13620	Excision of tumor of skin
18	Blood Transfusion, Autologous ascitic infusion
Y00014	Intra-articular medications by injection (hip – initial injection) Same day visit same dx billable in addition for first injection only.

750	Lumbar Puncture – Patients 13 +
1156	Single injection: tendon sheath, ligament, trigger point
13605	Opening of superficial abscess
13612	Extensive lacerations (greater than 5 cm), 1 unit per cm
13621	Add'l excision of tumor (Max 6)
Y00012	Venepuncture (may be billed in addition to visit)
Y00015	Intra-articular medications by injection (tendons, bursae, all other joints) Same day visit same dx billable in addition for first injection only.
190	Cryotherapy
1157	Multiple injections: tendon sheath, ligaments, trigger points

COMMON DIAGNOSTIC CODES (ICD9)

303	Alcohol Withdrawal	**293**	Delirium	**410**	Myocardial infarction
285	Anemia	**290.1**	Dementia	**577**	Pancreatitis
493	Asthma	**311**	Depression	**486**	Pneumonia
427	Atrial Fibrillation	**250**	Diabetes	**415**	Pulmonary Embolism
724.4	Back Pain	**562**	Diverticulitis	**585**	Renal Failure
466	Bronchitis	**305**	Drug abuse	**518**	Respiratory Failure
799.4	Cachexia	**780.6**	Fever of Unknown Origin	**780.3**	Seizure
174.9	Cancer - Breast	**808**	Fracture # - hip	**38**	Sepsis
185	Cancer - Prostate	**807**	Fracture # - ribs	**786.1**	Shortness of Breath
162	Cancer-Lung	**558**	Gastroenteritis	**789**	Symptoms involving abdomen and pelvis
682	Cellulitis	**578**	GI bleed	**780.2**	Syncope & Collapse
436	Cerebrovascular Diseases - Acute	**401**	Hypertension	**599**	Urinary Tract Infection
491	Chronic Obstructive Pulmonary Disease	**959**	Injury and Trauma - unspecified site	**453**	Venous embolism and thrombosis (other)
428	Congestive Heart Failure	**592**	Kidney stones		