Long-term Care Billing Guide

Victoria and South Island Divisions of Family Practice
Long-term care Initiative
Updated February 2022

Contents

Questions about Billing Guide?
Feel free to contact Leanne – bulmero@gmail.com
-contact details also in Appendix A

Introduction

The following guide is meant to provide introductory information to family practitioners beginning to work in long-term care. It is specific to the fee for service billing codes that apply to long-term care. It is updated annually and as needed based on fee for service code changes.

Annually the provincial government updates the fee schedule both in terms of compensation and guidelines. The General Practice Services Committee (GPSC) also has incentive fees that are updated regularly.

The descriptions should not be fully interpreted without reference to the general preamble provided at the start of the Medical Services Plan (MSP) payment guide and General Practice Services Committee (GSPC) guide.

British Columbia Government – MSP and GPSC Payment Schedule website link:
https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/payment-schedules/msc-payment-schedule

Acronyms

ACP – Allied Care Provider (pharmacist, nurse, care team member – psychologist, dietitian, counselor, social worker, physiotherapist etc.)
CLFP – Community Longitudinal Family Physician
FP – Family Practitioner
GPSC – General Practice Services Committee
LTC – Long Term Care
MRP – Most Responsible Provider/Physician
MSP – Medical Services Plan
NP – Nurse Practitioner

Billing Codes in Long-term Care

Billing Code	Description	Amount	Details
Typical LTC Visit			
00114	LTC facility visit	36.54	One or multiple patients, per patient. Can be billed once every two weeks. Additional medically necessary visits can be billed before two weeks if a note is made when submitting claim. Include time if also doing a conference (14077)
13334	LTC first visit of day bonus	49.84	Billable for the first patient seen at the facility. One per FP per day. Must accompany a 00114 billing code.
GPSC			
14070	CLFP Portal Code	0.00	Annual code billed by FP with community practice to participate in GPSC incentive fees (14067, 14077, 14076, 14050, 14051, 14052, 14053). This is submitted annually as a mock bill to MSP with a mock PHN and patient name available on the GPSC website.
14072	Long Term Care Portal	0.00	Annual code billed by physicians providing focused LTC services to participate in GSPC incentive fees (14067, 14076/77, 14050, 14051, 14052, 14053). Billed as above.
Advice/Conferences			
13005	Advice about patient in community care - fax/call	18.28	Billable 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 given to families. May not be claimed in addition to patient visit that day. May be submitted same day as 14076.
14076	FP Telephone Management	20.12	Clinical discussion between patient or patient's medical representative or physician. Not billable on same day as visit but billable with 13005 same day. Limit 1500/year
14067	FP Brief Conference with ACP and/or Physician	18.22	*New Code Oct 2021* Fee for brief discussion (<8 min) with at least one ACP and/or physician. Time not required. Limit 1 per patient per day. Limit 150 per FP/year. Payable in addition to visit same day but time must be included for both items in this case.
14077	FP Conference with ACP and/or Physician	43.23	Fee for a patient conference with at least one ACP and/or Physician. Start and end time must be included for 15 min or > portion thereof. Can take place on phone. Payable up to 18 times per patient per year (4.5h). Only 2 allowable per patient per day (30 min) Payable in addition to a patient visit (00114 or 00127) but time must be included for both visit and conference.

Billing Code	Description	Amount	Details
14019	Consult with NP	43.23	Providing advice via telephone or in-person to NP. NP must be MRP for patient seen/discussed. FP consulting must be under GPSC portal 14070. Limit of 5 per FP per day, 6 total per patient per year. Not billable in addition to visit. NP billing number required.
14029	ACP visit	0.00	A college certified ACP can provide one of the visits for chronic care bonuses. This fee indicates in-person visit provided by ACP and MRP has accepted responsibility for the provision of that care.
14050-14053	Chronic Care Bonuses	50.31-125.78	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. One of the visits may also be with ACP (14029) For 14053 (COPD) a clinical action plan must be on file. For all, must include flow sheets and document providing care for same.
Special Call Visits			
00115	Special call LTC 0800-2300h	116.45	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 (13334) 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	54.20	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.
00083	Crisis Intervention	105.80	Applies to situations where the attending physician is called upon to provide continuous medical assistance at the exclusion of all other services in periods of personal or family crisis caused by rape, sudden bereavement, suicidal behaviour or acute psychosis - per 1/2 hour or major portion thereof
01201	Call out charge - night	101.86	Bill in addition to out of office consult (e.g. 18200), call out and visit between 2300-0800, document time
Out of Office Visits			
13200 - 18200	Out of office visit	41.87-57.09	For a visit that does not fall under parameters of routine LTC visit (00114). For example - seeing a patient with a new diagnosis or visit requires extensive assessment outside routine. Could accompany a call-out charge.

Billing Code	Description	Amount	Details
13201 (2-49), 15201 (50+), 16201 (60+), 17201 (70+),18201 (80+)	Complete exam out of office	92.20-125.74	For any condition seen requiring a complete physical examination and detailed history. A complete physical examination includes 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	102.48-139.76	FP consultations apply when a medical practitioner, or a health care practitioner (nurse practitioner; oral/dental surgeon etc.), 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 FP 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 FP or group of FPs within a six-month time frame.
Out of Office Counselling			
13220, 15220, 16220, 17220, 18220	Counselling out of office.	74.90-102.15	Applicable when extended counselling is necessary for the patient. Billable 4 times per patient per annum. Start and end time must be submitted with claim. 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	52.24	
13611	Repair Minor Laceration	66.76	(<5cm)
13620	Excision of tumor of skin	66.76	
00014	Intra-articular injection - hip	25.65	Initial injection only billable in addition to visit with same diagnostic code (i.e. 00114 + 00014 if injection done)
13605	Opening Superficial Abscess	44.76	

Billing Code	Description	Amount	Details
13612	Repair Major Laceration	13.40	(>5cm) – document the size of wound, fee is 13.32/cm, a 10 cm wound would be 10 x 13612
13621	Additional tumor excision	33.39	(6 max)
00015	Intra-articular injection (all other joints)	17.05	Initial injection only billable in addition to visit with same dx code
00190	Cryotherapy	31.72	Mini tray fee (if you bring your own liquid nitrogen)

Medical Assistance in Dying (MAiD)

In the event you are requested to provide an assessment for MAiD the following codes are appropriate:

Billing Code	Description	Amount	Details
13501	MAiD Assessment Fee – Assessor Prescriber	43.24	Includes all aspects of MAiD assessment – review of records, completion of MAiD Assessment Record (as prescriber). Can be provided in person or via video conference, billing amount is per 15 min or great portion thereof (maximum payable is 135 min or 9 units), start and end time must be included
13502	MAiD Assessment Fee - Assessor	43.24	Includes all aspects of MAiD assessment – review of records, completion of MAiD Assessment Record (as assessor). Can be provided in person or via video conference, billing amount is per 15 min or great portion thereof (maximum payable is 105 min or 7 units), start and end time must be included. FP cannot be both prescriber and assessor.
13503	Physician Witness to video-conference MAiD Assessment – patient encounter	43.24	Physician must be in attendance (via video is acceptable) for the duration of the patient encounter between Assessor Prescriber or Assessor. Billable only for time spent witnessing patient encounter, per 15 min or greater portion thereof (maximum payable is 105 min or 7 units), start and end time must be included for billing.
13504	MAiD Event Preparation and Procedure	283.85	Payable to Assessor Prescriber, includes all elements involved in procedure including establishment of I.V., administration of medications and pronouncement of death. Payable in addition to 13505 same day and out of office visit (18200 etc).
13505	MAiD Medication Pick-up and Return	125.94	Payable in addition to 13504 if there is not an on-site pharmacy where procedure will take place.

Specific details pertaining to the entire process of MAiD can be found at:
https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/end-of-life-care/medical-assistance-in-dying/information-for-providers

Island Health MAiD Contact:

250-727-4382 (Greater Victoria)
Toll Free: 1-877-370-8699
maid@islandhealth.ca

Forms and Non-insured Services

Forms – Billable to MSP

Billing Code	Description	Amount	Details
00199	Miscellaneous	FP assigns value	This code allows FP to assign a value but explanation must also accompany. There is a new form for LTC incapability assessment that it is suggested to bill using this code in the amount of 225.00 along with an explanation. Link to form: https://www2.gov.bc.ca/assets/gov/health/forms/3910fil.pdf

Non-insured Services – privately invoiced

Several services provided in LTC are not covered by MSP but require FP time and involvement for completion. In these situations, it is up to you as a FP to decide if you would like to invoice the patient or family privately. The fees listed below are the most common in LTC and pricing is updated annually. Each item has an associated 'code' but this is not required for invoicing. As FP the prices are a guideline only and you can bill what you feel appropriate based on the service provided.

The complete list of uninsured services and suggested fees can be found on the Doctors of BC website: https://www.doctorsofbc.ca/sites/default/files/uninsured_services1apr2020_327874.pdf

Code associated with form	Description	Amount	Details
A94533	Completion of Form for Public Trustee – opinion of incapability	380.00	Patient or family will in most cases provide form – information can be found here: https://www.trustee.bc.ca/reports-and-publications/Pages/certificate-of-incapability-guidelines.aspx Contact: Public Guardian and Trustee of British Columbia 604.660.4444
A00060	Written Certificate	46.40	includes Medical Certificate of Death, HandiDart form, SPARC parking form
A00069	Insurance company form to include review of records short	158.00	Completion of Disability Tax Credit forms falls into this category

If you are a member of BC Family Docs, they also provide a helpful guide: https://bcfamilydocs.ca/wp-content/uploads/2021/02/Billing-Tips-for-Uninsured-Services-022621.pdf

Billing Examples

Example 1: Scheduled Day –6 patient visits + Care Conference

You are scheduled to see 6 of your own patients for routine care and then have a care conference for a 7th patient with RN/Pharmacist (document the time of this to submit with billing). Later in the day you discuss a patient with the pharmacist (document time to submit with billing).

Billing for the day:
00114 + 13334 - for first patient of the day (36.54+49.84 =86.38)
00114 - for second patient of the day (36.54)
00114 - for third patient of the day (36.54)
00114 - for fourth patient of the day (36.54)
00114 - for fifth patient of the day (36.54)
00114 - for sixth patient of the day (36.54)
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) (86.46)
14077 - for call pertaining to patient lasting 10 minutes (43.23)
Time Commitment: ~2h total
Total Billing Amount: 398.77(MSP)/2h = 199.39/hr

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

Example 2: 10 patient visits + Care Conference

You are scheduled to see 10 of your own patients for routine care and then have a care conference for a 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 + 13334 - for first patient of the day (36.54+49.84 = 86.38)
00114 x 9 – for next 9 patients (36.54*9 = 328.86)
00114 - for 11th patient of the day (36.54) – 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 (86.46)
14077 – for call related to taking on new patient, discussion about health and hip fracture 1600-1615
Time Commitment: ~3h total
Total Billing Amount: 581.50(MSP= 193.83/hr)

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

Example 3: Weekend call

You are called at 10:00am to see a patient at the facility. While you are there at 12:00pm you are asked to see another patient 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 (116.45)
00114 - for second patient visit, make note of reason seen again (pneumonia f/u) as visit was within two-week time frame (36.54)
Time Commitment: ~ 1h
Total Billing Amount: 152.99/hr

Example 4: After hours' call

The nursing home calls at 9:00pm asking you to see a patient with CHF. You are there and see this patient and speak to allied health about a plan of care. You receive a call from a local FP to provide advice on one of his patients at the home whom you also examine. You combine these visits.

Billing for the special call:
00115– include time call came in 21:00, time of visit, 22:00-22:45 (116.45)
14077 – document time for speaking to ACP, 23:00-23:10 (if call is <8 min could use 14067 code)
18200 – out of office visit ages 80+, document time and FP who asked you to consult in notes, 57.09 (if complete physical needed can document 18201-physical for 80+ year old individual)
Time Commitment: ~ 1.5 h (considering time from call/travel)
Total Billing Amount: 216.77/1.5 = 144.51/hr.

Example 5: 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 has 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 or 14072 for the year to participate)

Billing for the day:
Patient A - 14077 (include time) + 00114 (include time) + 13334 (43.23+36.54+49.84)
Patient B - 14077 (include time) + 00114 (include time) (43.23+36.54)
Patient C - 14077 (include time) + 00127(include time) (Dx 428) (86.46+53.87)
Time Commitment: ~2h
Total Billing Amount: 334.43/2 = 167.22/hr

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

*for 14077 20 min duration equates to 1 unit, a 25 min duration would equate to 2 units

Example 6: MAiD Assessment

A patient of yours with terminal cancer has made the decision to proceed with medical assistance in dying. As MRP you are required to do a review of records and paperwork completion as the MAiD Assessor Prescriber. The full assessment and completion of paperwork takes 1.25h (5 units). The patient encounter takes 1.0h (4 units) to fully discuss the procedure. On the date chosen by the patient you have medications delivered to the care home, establish the I.V., administer medication and then pronounce the time of death for the patient (~3h). After this you provide the service of completing the death certificate for the family.

Billing:
13501 MAiD Assessment Fee (9 units allowed):

- you would bill for the initial assessment and review with times documented – 43.24 x 5 units
- you would also bill for the patient encounter with times documented which is – $43.24 x 4 units

13504 MAiD Event Preparation and Procedure time not required– 283.85
18200 – Out of office visit – 57.09 (applicable if appropriate visit completed on date of MAiD event)
A00060 – private invoice – completion of death certificate – it is your discretion if you wish to bill the family for the completion of the death certificate. - 46.40
Time Commitment: ~ 5.25h
Billing Amount: 389.16 + 283.85 + 57.09 = 730.1/5 =146.01/h

Example 7: Regular visits and Counselling

You arrive at the facility for a regular day of patient visits. You have 8 patient visits and in addition have a patient who has been newly diagnosed with diabetes. You speak with the pharmacist about the medication plan and then sit down with the patient to discuss the changes they will see based on this diagnosis which takes about 25 minutes.

Billing for the day:
00114 + P13334 - for first patient of the day (36.54+49.84 = 86.38)
00114 x 7 for the remaining patient visits (36.54 x 7 = 255.78)
14077 – discussion with pharmacist re: medication, include time (43.23)
18220 – counselling visit for diabetes discussion, include the time (102.15)
Total Time Commitment: ~ 3h
Total Billing: 487.54/3 = 162.51/hr.

Estimated Annual Remuneration

Below is an estimation of annual, monthly, and hourly remuneration based on being MRP to 30 patients in long-term care. In this scenario the physician may choose to see 15 patients each week or 30 patients every other week. This estimation has been compared with actual physician billing and the annual amount is accurate. The annual estimation does not include the CLFP payment or other incentive fees for LTC.

Hourly estimations are based on spending either 2 hours weekly at the facility or 3 hours weekly. This may be different if you choose to do 1 day weekly and see all patients. * If spending 2 hours on site weekly considering only routine care the hourly rate would be $298.97. ** If spending 2 hours on site weekly and including all the additional possible billing codes (conference calls, physicals etc.) the hourly rate is $710.43. The estimations of 10 annual faxes (13005) and telephone management calls (14076) are based on averages of actual care provided versus meeting the annual allowable maximums.

Estimation of Hourly/Monthly/Yearly Remuneration in Residential Care Facility
Based on being MRP for 30 patients - 30 (15 one week, 15 the next)

Estimated time on site weekly - 1h travel, 2-3h on site — 8h/month approx — 12h/month if spending more time

Billing Code	Description	Amount	Notes	Number per Year	Annual	Monthly	Hourly Based on 2h on site weekly	Hourly Based on 3h on site weekly	
P13334	First of Day	$ 49.84	1 per visit to home, estimate based on 1x weekly	48	$ 2,392.32	$ 199.36	$ 24.92	$ 16.61	
00114	Routine Visit	$ 36.54	every 2 weeks	720	$ 26,308.80	$ 2,192.40	$ 274.05	$ 182.70	
13201-18201	Complete Exam	92.20-124.74	1 per annum	30	$ 3,269.10	$ 272.43	$ 34.05	$ 22.70	
13005	Fax/Call	$ 18.28	not same day as visit	est. 10 per pt annually	$ 5,484.00	$ 457.00	$ 57.13	$ 38.08	
14076	Telephone Mgmt	$ 20.12	1500 per year	est. 10 per pt annually	$ 6,036.00	$ 503.00	$ 62.88	$ 41.92	
14077	Consult/Case Conf	$ 43.23	18/pt/yr - 15 min units	18 annually	$ 23,344.20	$ 1,945.35	$ 243.17	$ 162.11	
14067	Brief Consult/Conf	$ 18.22	limit 150 per year	75 annually	$ 1,366.50	$ 113.88	$ 14.23	$ 9.49	
				Estimates	**$ 68,200.92**	**$ 5,683.41**	**$ 298.97**	**$ 199.31**	*
							$ 710.43	**$ 473.62**	**

*Estimate for routine care 00114 and 13334

**Estimate including faxes/physicals/conferences

Not Accounted for in Estimate:

Code	Description	Amount	Notes
00115	Special Call	$ 116.45	cannot do 13334 also
00127	Palliative Care	$ 54.20	daily for up to 6 months
14050-14053	Chronic Care Bonus	$50.31-125.78	billable after 1 year
13220-18220	Out of Office Counselling	$74.90-102.15	>20min, 4/pt/year
14019	NP Consult	$ 43.23	include NP billing #

MSP Remittance Dates 2022

Month	Close-off	Remittance Available	Payment Date
January 2022	4th &19th	12th & 27th	14th & 31st
February 2022	3rd &15th	11th & 24th	15th & 28th
March 2022	3rd & 21st	11th & 29th	15th & 31st
April 2022	4th & 19th	12th & 27th	14th & 29th
May 2022	3rd & 18th	11th & 27th	13th & 31st
June 2022	3rd & 20th	13th & 28th	15th & 30th
July 2022	5th & 19th	13th & 27th	15th & 29th
August 2022	3rd & 19th	11th & 29th	15th & 31st
September 2022	2nd & 19th	13th & 27th	15th & 29th
October 2022	3rd & 19th	12th & 27th	14th & 31st
November 2022	2nd & 18th	10th & 28th	15th & 30th
December 2022	5th & 16th	13th & 28th	15th & 30th

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 for all patient conferences and special call visits

Correcting rejections

- Fix the error and resubmit (i.e. Add in the time, correct patient name etc.)
- Example Rejection Code: FV - ‘this service is included in a previously paid item’ – this code will appear if you submit a 14077 and 00114 on the same day without including time for both and references a small part of the description of 14077 from the GPSC: *viii) Payable in addition to any visit fee on the same day if medically required and does not take place during a time interval that overlaps with the patient conference (i.e. Visit time is separate from conference time).*
- 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 (i.e. 14050).
- Sometimes PWE codes just want to inform you of something (such as checking patient name to ensure spelled correctly etc.) and do not signify that the claim is not getting paid.

References

BC Family Doctors -Simplified Guide to Billing - Long-term care Billing: https://bcfamilydocs.ca/fee-category/long-term-care/ *Accessible to registered members only

Doctors of BC Fee Guide - https://www.doctorsofbc.ca/system/files/fee_guide_uploads/general_practice_id_145698_17.pdf *accessible to members

General Practice Services Committee (2021). Complete Billing Guide: http://www.gpscbc.ca/what-we-do/longitudinal-care/billing-guides

Government of BC – GPSC Payment Schedule (as of April 1, 2020): https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/gpsc-payment-schedule.pdf

Government of BC – MOA Billing Guide: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/reference-material/medical-office-assistant-billing-guide

Government of BC –Medical Services Commission Payment Schedule May 2021: https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/medical-services-plan/msc-payment-schedule-may-2021.pdf

**Link to source page for both MSP and GPSC payment guides: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/payment-schedules/msc-payment-schedule **

Appendix A – Billing Options

Claim Processing Programs

http://www.claimmanager.ca/features/
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)

Contractors

1. Leanne Bulmer RN BSN MBA
bulmero@gmail.com

Services Provided:

- Processing claims as received
- 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 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. (e.g. Annual fee of ~ $230.00 for software and ~$40.00 per month billing)

2. Ingrid Zaffino
Interior Medcom
interiormedcom@shaw.ca
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 nonpaid 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: please contact Ingrid directly for cost estimates

Appendix B – Commonly used ICD9 Diagnostic Codes

303 – alcohol dependence syndrome
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
3384 – chronic pain

Quick Reference Billing Guide

Billing Code	Description	Amount	Details
Typical Resident Care Visit			
00114	LTC facility visit	36.54	One per patient seen, billable once every two weeks, add note for additional visits.
13334	First visit of day bonus	49.84	Billable for first patient of the day in addition to visit.
GPSC Participation			
14070/14072	GPSC Portal Code	0	Annual code billed to participate in GPSC incentive program for full-service FP or LTC FP, allows billing of codes 14067, 14076, 14077, 14019, 14029, 14050-53
Advice/Conferences			
13005	Advice about patient in community care - fax/call	18.28	Use for short telephone interactions on patient care. Typical to LTC orders, any pt. in community care, 1 per day, billable same day as 14076, no annual limit
14076	Telephone Management Fee	20.12	Call with patient, patient's medical representative or physician, 1500 limit per year. Cannot be billed with 00114, can be billed with 13005
14067	FP Brief patient conference fee	18.22	No time needed, brief conference with ACP (<8min), limit 150 per FP per year
14077	FP patient conference fee	43.23	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 but include visit and conf times, can be a phone conversation
14019	Consult with NP	43.23	Providing advice to NP, 5pts/day, 6 total per pt./year, NP must be MRP for pt. not billable in addition to visit
Chronic Care Codes			
14029	Allied Care Provider Visit	0	Indicates in person visit was provided by ACP for chronic care
14050-14053	Chronic Care Bonuses	50.31-125.78	Billed annually for care of chronic diseases, 14050 (DM), 14051 (CHF), 14052 (HTN), 14053 (COPD), must see twice for same/yr., 1 visit can be call with ACP – see 14029
Special Call Visits			
00115	Special call long-term care 0800-2300h	116.45	One patient, must be called by facility, document time, must be within 24h of request
00127	Terminal care visit	54.20	For any pt. with end stage disease, billable daily up to 180 days when pt. is seen
01201	Call out charge - night	101.86	bill with out of office consult, call out and visit b/w 2300-0800, document time
Out of Office Visits (13xxx age 2-49, 15xxx age 50+, 16xxx age 60+, 17xxx age 70+, 18xxx age 80+)			
13200 - 18200	Visit out of office	41.87-57.09	For visit that does not fall under parameters of 00114, routine long-term care visit
13201-18201	Complete exam out of office	92.20-125.74	for condition requiring complete exam, exclusive of 00114
13220 - 18220	Counselling out of office	74.90-102.15	Must be greater than 20 min, 4 per pt./year