

Module 5: Facility Visit Fees for General Practitioners and Specialists

General Practitioners (GP)

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- 5.2 Community Based GP with Active Hospital Privileges
- 5.3 Community Based GP with Courtesy or Associate Hospital Privileges
- 5.4 Hospitalist (On Site)
- 5.5 Community Based GP- Doctor of the day
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Specialists

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Billing Rules for Facility Visits – General Practitioners

5.1 Acute Care Hospital Admission Visit (fee item 00109)

Fee item 00109 may be billed by:

- Community based GP with Active Hospital Privileges
- Hospitalist (On Site)
- Community based GP – Doctor of the Day

Fee item 00109 may not be billed by:

- Community based GP with Courtesy or Associate Privileges

Fee item 00109 may be billed when:

- A patient is admitted into an acute-care hospital for medical care rendered by a general practitioner;

Fee item 00109 should not be billed when:

- A patient is admitted for surgery;
- A patient is admitted under the care of a specialist;
- A patient has received a complete physical examination or a prior hospital admission examination within the previous week by the same physician;

- A patient is already an in-patient (i.e. fee item 00109 cannot be billed for transfer of care from one physician to another in the same hospital or same city).

5.2 Community Based GP with Active Hospital Privileges

Subsequent Hospital Visits (fee item 13008)

Subsequent hospital visits may be billed:

- When the patient is hospitalized primarily under the care of a general practitioner;
- Only when medically required, and only for those days when the physician sees the patient;
- Within the preceding guidelines, up to 30 days on a daily basis from the date of admission.

Tip: When more than one visit per day and/or more than 30 days of daily care are medically required, an explanation of the medical necessity for the extra visit(s) should be provided in your note record(s). Each case is given independent consideration.

Supportive Care (fee item 13028)

Supportive care visits should be billed:

- When a specialist is primarily responsible for the patient's care;
- Up to one visit for every day of hospitalization for the first ten days and one visit for every seven days thereafter;
- Only when the physician sees the patient.

Tip: Supportive care is not normally paid when the patient's care is primarily managed by another general practitioner. In some areas where a specialist is not available, and one general practitioner is acting, for all intents, as a specialist, billings for supportive care by a second general practitioner should be submitted with an explanation in the note record. MSP gives independent consideration to such cases.

Sub acute (Fee item 12148)

- Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred for sub-acute care.
- This may include sub-acute care in rehabilitation and convalescent care units where indicated.
- Payable 2 times per patient per week to a maximum of 90 days.
- In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

5.3 Community Based GP with Courtesy or Associate Hospital Privileges

13229 Community based GP: first hospital visit of the day
(courtesy/associate privileges)

13228 Community based GP: hospital visit (courtesy/associate
privileges)

- Payable once per calendar week per patient up to the first four weeks. Thereafter, this item is payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.
- Payable for patients in acute, sub-acute care or palliative care.
- A written record of the visit must appear in either patient's hospital or office chart.

5.4 Hospitalist (on Site)

Subsequent Hospital Visits (fee item 00108)

Subsequent hospital visits may be billed:

- When the patient is hospitalized primarily under the care of a general practitioner;
- Only when medically required, and only for those days when the physician sees the patient;
- Within the preceding guidelines, up to 30 days on a daily basis from the date of admission.

Tip: When more than one visit per day and/or more than 30 days of daily care are medically required, an explanation of the medical necessity for the extra visit(s) should be provided in your note record(s). Each case is given independent consideration.

Supportive Care (fee item 00128)

Supportive care visits should be billed:

- When a specialist is primarily responsible for the patient's care;
- Up to one visit for every day of hospitalization for the first ten days and one visit for every seven days thereafter;
- Only when the physician sees the patient.

Tip: Supportive care is not normally paid when the patient's care is primarily managed by another general practitioner. In some areas where a specialist is not available, and one general practitioner is acting, for all intents, as a specialist, billings for supportive care by a second general practitioner should be submitted with an explanation in the note record. MSP gives independent consideration to such cases.

Sub acute (Fee item 12148)

- Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred for sub-acute care.
- This may include sub-acute care in rehabilitation and convalescent care units where indicated.
- Payable 2 times per patient per week to a maximum of 90 days.
- In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

5.5 Community based GP – Doctor of the Day**Subsequent Hospital Visits (fee item 13008)**

Subsequent hospital visits may be billed:

- When the patient is hospitalized primarily under the care of a general practitioner;
- Only when medically required, and only for those days when the physician sees the patient;
- Within the preceding guidelines, up to 30 days on a daily basis from the date of admission.

Tip: When more than one visit per day and/or more than 30 days of daily care are medically required, an explanation of the medical necessity for the extra visit(s) should be provided in your note record(s). Each case is given independent consideration.

Supportive Care (fee item 13028)

Supportive care visits should be billed:

- When a specialist is primarily responsible for the patient's care;
- Up to one visit for every day of hospitalization for the first ten days and one visit for every seven days thereafter;
- Only when the physician sees the patient.

Tip: Supportive care is not normally paid when the patient's care is primarily managed by another general practitioner. In some areas where a specialist is not available, and one general practitioner is acting, for all intents, as a specialist, billings for supportive care by a second general practitioner should be submitted with an explanation in the note record. MSP gives independent consideration to such cases.

Sub acute (Fee item 12148)

- Payable only when provided to patients who have had an acute medical or surgical episode and have been transferred for sub-acute care.
- This may include sub-acute care in rehabilitation and convalescent care units where indicated.
- Payable 2 times per patient per week to a maximum of 90 days.
- In higher acuity situations, a note record explaining the medical necessity is required if additional visits are necessary.

5.6 First hospital visit of the day

Fee Item 13108 – first routine hospital visit of the day

Fee item 13128 – first supportive care hospital visit of the day

Fee item 13148 – first sub-acute hospital visit of the day

Fee item 13127 – first terminal care facility visit of the day (X-ref 5.8)

Fee items 13108, 13128, 13148 and 13127 may be billed by:

- Community based GP with Active Hospital Privileges
- Community based GP – Doctor of the Day

Fee items 13108, 13128, 13148 and 13127 may not be billed by:

- Community based GP with Courtesy or Associate Privileges
- Hospitalist (On Site)

These visits are payable for the first in-patient seen on any given day.

For example, the following four patients were seen in the following order on one day by the same doctor.

		<u>Fee Item</u>
Patient 1	Routine hospital visit to patient under the care of a community based GP with active privileges	13108
Patient 2	Follow-up post-operative visit	13028
Patient 3	Visit to a patient under the care of a specialist	13028
Patient 4	Palliative care visit to cancer patient	00127

Only the first patient seen on any given day is eligible for fee items 13108, 13128, 13127 or 13148 – depending upon the type of service provided.

5.7 Terminal Care

Fee item 13127 - First terminal care facility visit of the day

Fee item 13127 may be billed by:

- Community based GP with Active Hospital Privileges
- Community based GP – Doctor of the Day

Fee item 13127 may not be billed by:

- Community based GP with Courtesy or Associate Privileges
- Hospitalist (On Site)

Fee item 00127 - Terminal care facility visit

Fee item 00127 may be billed by:

- Community based GP with Active Hospital Privileges
- Hospitalist (On Site)
- Community based GP – Doctor of the Day

Fee item 00127 may not be billed by:

- Community based GP with Courtesy or Associate Privileges

Fee item 00127 may be billed:

- For visits rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure.
- When no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.
- This item may be billed for necessary visits rendered for a period not to exceed 180 days prior to death and is applicable to patients in an acute care hospital, nursing home or terminal care facility, whether or not the patient is in a palliative care unit.
- Under extenuating circumstances, for visits that exceed 180 days, a note record must be submitted.

Fee item 00127 may not be billed:

- When unexpected death occurs after a prolonged hospitalization;
- When admitted for a diagnosis unrelated to the cause of death;
- When aggressive treatment of the disease is taking place (e.g. chemotherapy).

5.8 Long-term Care Institution Visits (fee item 00114)

Fee item 00114 may be billed by:

- Community based GP with Active Hospital Privileges
- Community based GP with Associate/Courtesy Privileges
- Hospitalist (On Site)
- Community based GP – Doctor of the Day

Fee item 00114 may be billed up to once every two weeks for patients in a long-term care institution (such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities) under the following circumstances:

- The visit must be medically required;
- There must be a face-to-face patient/physician encounter (i.e. a visit cannot be billed for review of a patient's charts).

First Visit of the Day (fee item 13114)

Fee item 13114 may be billed by:

- Community based GP with Active Hospital Privileges
- Community based GP with Associate/Courtesy Privileges
- Community based GP – Doctor of the Day

Fee item 13114 is :

- Payable only for the first person seen on any calendar day regardless of number of long term care institutions attended.
- Not payable in addition to 00114
- See Preamble clause B.4.e.vii for long-stay patients
- This fee is payable to only to community based GP's.

Tips:

Fee item 00103 (Home visit) is not billed for visits to patients in long-term care institutions. This fee is only billed for visits to a patient's private residence. When additional institutional visits are medically required, bill fee item 00114 with the reason for the extra visits in a note record. When specially called during the day, fee item 00115 may be billed for the first patient seen on the special call. If additional patients are seen by request during the same call, bill under fee item 00114 with indication of medical necessity in a note record.

5.9 Special Calls to Nursing Home

Not Specially Called	Bill
<ul style="list-style-type: none"> Routine visit to nursing home-1st patient 	<ul style="list-style-type: none"> 13114-Long term care institution visit-First visit of the day Payable only for the first patient seen on any calendar day regardless of the number of institutions attended.
<ul style="list-style-type: none"> Routine visit to nursing home-subsequent patients 	<ul style="list-style-type: none"> 00114-Long term care institution visit-one or multiple patients, per patient
<ul style="list-style-type: none"> Extra nursing home visit due to patients medical condition-not specially called 	<ul style="list-style-type: none"> 00114--Long term care institution visit-one or multiple patients, per patient Include a note such as: “Extra visit due to (provide the medical reason for the extra visit)”
<ul style="list-style-type: none"> Procedure performed on same visit (unrelated diagnosis) 	<ul style="list-style-type: none"> Bill the fee with the higher \$ value at 100% and the lesser fee at 50%
<ul style="list-style-type: none"> Procedure performed on same visit (same diagnosis) 	<ul style="list-style-type: none"> If the purpose of the visit is to perform the procedure-bill the procedure only Otherwise, bill the larger fee only

Specially Called	Bill
<ul style="list-style-type: none"> Specially called and patient seen between 0800 and 2300 hours-Any day (Includes emergency visits) 	<ul style="list-style-type: none"> 00115-one patient, when specially called and patient seen between hours of 0800 hrs and 2300 hrs –any day
<ul style="list-style-type: none"> 2nd patient seen during same call out May be specially called or routine visit 	<ul style="list-style-type: none"> 00114- Long term care institution visit-one or multiple patients, per patient If specially called include a note such as: “specially called-2nd patient seen” If not specially called- note is not required
<ul style="list-style-type: none"> Night call out called between 2300hrs-0800hrs patient seen between 2300hrs and 0800hrs 	<ul style="list-style-type: none"> 01201-Call-out -charge + 12200,13200,15200, 16200,17200 or 18200 -out of office visit

General Practice Facility Visits – Billing Reference Guide

IN OFFICE VISITS

AGE RANGE	0 – 1	2 – 49	50 – 59	60 – 69	70 – 79	80+
Consultation	12110	00110	15310	16110	17110	18110
Complete Examination	12101	00101	15301	16101	17101	18101
Office Visit	12100	00100	15300	16100	17100	18100
Counselling	12120	00120	15320	16120	17120	18120

OUT OF OFFICE VISITS

AGE RANGE	0 – 1	2 – 49	50 – 59	60 – 69	70 – 79	80+
Consultation	12210	13210	15210	16210	17210	18210
Complete Examination	12201	13201	15201	16201	17201	18201
Out of Office Visit	12200	13200	15200	16200	17200	18200
Counselling	12220	13220	15220	16220	17220	18220
Home Visit (0800 – 2300hrs)	00103	00103	00103	00103	00103	00103

Notes: Call-out charges may be billed in conjunction with out of office visits (except 00103) if all the out-of-office hours premium criteria are met.
Home visits called before 2300 hrs but seen after 2300 hrs should be billed as out of office visit and 01200 call out.

EMERGENCY VISITS

Emergency Visit (0800 – 1800hrs)	00112
Emergency Home (or scene of accident)	00111

FACILITY/HOSPITAL VISITS

TYPE OF VISIT	COMMUNITY BASED GP WITH ACTIVE/FULL PRIVILEGES	COMMUNITY BASED GP WITH ASSOCIATE / COURTESY PRIVILEGES	HOSPITALIST (ON SITE)	COMMUNITY BASED GP-DOCTOR OF THE DAY
First Hospital (admit)	00109	N/A	00109	00109
Subsequent Hospital (first visit of the day)	13108	13229	00108	13108
Subsequent Hospital	13008	13228	00108	13008
Supportive Care (first visit of the day)	13128	13229	00128	13128
Supportive Care	13028	13228	00128	13028
Sub-Acute (first visit of the day)	13148	13229	12148	13148
Sub-Acute	12148	13228	12148	12148
Terminal Care (first visit of the day)	13127	13229	00127	13127
Terminal Care	00127	13228	00127	00127
Long Term Care (first visit of the day)	13114	13114	00114	13114
Long Term Care	00114	00114	00114	00114
Long Term Care (specially called) (0800 – 2300hrs)	00115	00115	00114	00114 if On-Site 00115 if Called In

ON-CALL ON-SITE EMERGENT HOSPITAL VISITS

Evening (1800 – 2300hrs)	00113
Night (2300 – 0800hrs)	00105
Saturday, Sunday or Statutory Holiday	00123

Billing Rules for Hospital and Institutional Visits – Specialists

The rules for billing hospital/institutional visits are complex. For more information on hospital/institutional visits, refer to Preamble B.4.e) and the specific fee items found in the *MSC Payment Schedule*. The following examples illustrate some common billing rules.

Note: The following examples refer to billing at specialist (referred) rates. For billing information for non-referred cases (where the specialist is acting as the patient's primary care physician), refer to the Hospital/Institutional Visits -General Practice module.

Daily visits are not paid after surgery if the hospital policy is to move the patient to a different ward. Post-operative care is the responsibility of the surgeon.

5.10 Subsequent Hospital Visits

Subsequent hospital visits may be billed:

- When the patient is hospitalized under the care of the specialist;
- Only when medically required, and only for those days when the physician sees the patient;
- Within the preceding guidelines, up to 30 days on a daily basis from the date of admission.

Tip: When more than one visit per day is medically required, and/or more than 30 days of daily care is medically required, an explanation of the medical necessity for the extra visit(s) should be provided in your note record(s). Each such case will be given independent consideration.

5.11 Long-stay Hospitalization over 30 days

For long stays over 30 days in an acute care hospital, claims for subsequent hospital visits are limited to two visits per patient per week.

Tip: Claims in excess of two visits per patient per week will be given independent consideration upon receipt of details of the medical indication for the extra visit(s). For long-stay hospital care, the first 30 days are calculated from the date of admission whether or not the patient's care is transferred from one physician to another.

5.12 Directive Care

Directive Care is billable up to two visits per week and is applicable when:

- Responsibility for the case rests with another physician (either a general practitioner or another specialist);
- As with other hospital visits, directive care may only be billed when medically required, and when there is direct patient/physician contact.

Tip: Some specialties have specific fee items for directive care visits, such as General Internal Medicine (fee item 00306). For those specialties such as Obstetrics and Gynaecology that do not have specific directive care fee items, bill under subsequent hospital visit fees (e.g. fee item 04008) up to twice per week.

5.13 Concurrent Care

For cases where the medical indications are of such complexity that daily visits by more than one physician are required to provide adequate care of a patient, subsequent visits may be claimed by each physician as required for that care.

Tip: Details of the medical necessity for daily care by more than one physician should be provided in your note record(s). Concurrent care may apply for ICU care, or when the patient has separate, multiple, serious medical conditions.

5.14 Long-term Care Institution Care

Medically required specialist visits to patients in long-term care institutions (such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities) should be billed under the appropriate subsequent hospital visit listings (e.g. 00308, 00608).

Tip: Home visit fees (e.g. 00309, 00609) are not applicable for visits to patients in long-term care institutions. These fees may only be billed for visits to a patient's private residence.