BCPS Children's Health Today Billing Questions and Answers

November 8, 2024

Presented by: Dr Odion Kalaci & Dr Tommy Gerschman
(BCPS Economics Committee)

Agenda

- Economics Update
- New Fees
- Questions & Answers

BCPS Economics Committee

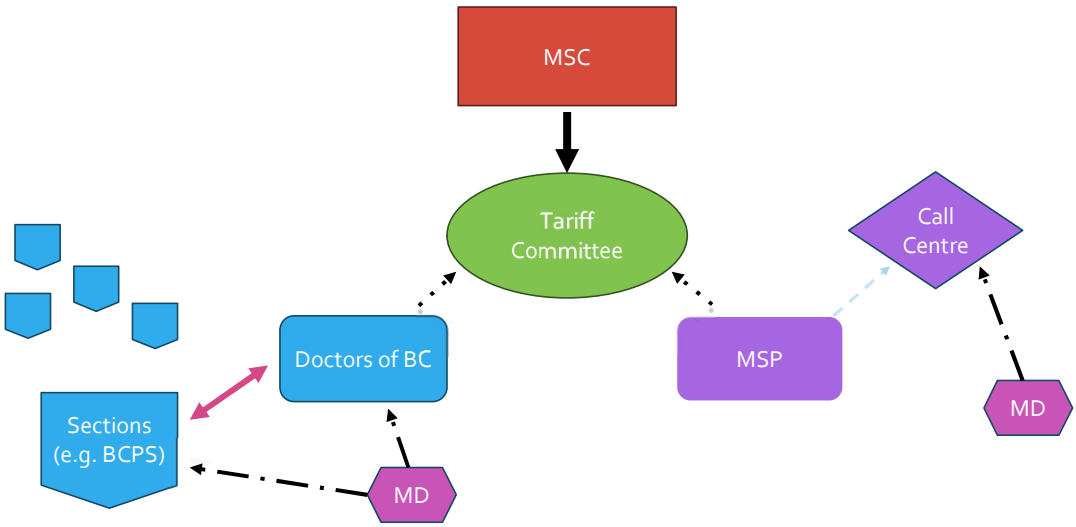
Who Are We?

- Tommy Gerschman (Chair)
- Odion Kalaci (President)
- Warda Toma
- Stephen Noseworthy
- Amieleena Chhabra
- Glen Ward

What do We Do?

- Create New Fees
- Implement Fee Funding
- Disparity Submissions
- Gender Disparity
- Liaise with MSP/Tariff
- Answer Fee/Billing Questions

Who Makes / Knows the Rules?



Common Questions Relating to a **Consult?**

Second Issues

- Patient asks about a new issue
- Pediatrician discovers a new unrelated issue
- Referring doctor's referral mentions multiple issues

Re-Referrals

- New issue requires new consult (any time)
- Implicit Re-Referral (after 6m)
  - July 1, 2023
- No limit on follow-up appointments once a consultation has been done

D. 2. Consultation
D. 2. 1. General

A consultation applies when a medical practitioner, or a health care practitioner*, in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a medical practitioner competent to give advice in this field.

Common Misunderstandings

- "**Face-to-Face**" Time is MD time
  - Not applicable for allied health
  - For residents/trainees – "total billings must not exceed the amount that a medical practitioner could bill in the same time period in the absence of other team members."
- Business Cost Premium (**BCP**) does not (yet) apply to HOSPITAL billings. BCP is for *community* offices only (ie cannot have a BCP for a hospital)
- Just because MSP pays for it, doesn't mean it's "allowed"
- If there is no pediatric fee for a service this does not mean that it can be charged privately

What if there is no pediatric fee for this?

- Generally restricted to billing from *fee schedule you have certification* (Royal College) in and the General Services / Procedures
  - Note procedures on same day as visit pays at 50% (unless done during Initial Visit) *if visit and procedure are unrelated*
  - May be eligible for a tray fee
- MSP covers medically necessary services
  - MSC may deem certain things non-insurable (e.g. IVF)
- Private pay is applicable only when it is a *non-insurable* service
  - See Doctors of BC fee schedule for suggested amounts – but you can decide whatever
  - Consider legal documentation requests "A00095 Review of paper or EMR records" ($117 per 15 minutes or portion thereof)
- Billing for items that *are* medically necessary but *not* on fee schedule
  - Ask for help! (599 – Miscellaneous Fee)

Pediatrics Miscellaneous Fee Code

- 00599 is the Pediatrics Miscellaneous fee code
- In the claim: The fee code 00599 is entered instead of 02457, in the note field you would enter "in equity with 02457 at 50% for in-office service"
- There are some instances where a fee code might be owned by a section but is commonly billed by other sections, these are billed using the regular fee code listed. The use of miscellaneous fee codes generally applies when there is no fee code at all to be billed.

C. 4. Miscellaneous Services

This section relates to services not listed in the MSC Payment Schedule that are:

- new medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature;
- unusually complex procedures, for established but infrequently performed procedures;
- for unlisted "team" procedures, or
- for any medically required service for which the medical practitioner desires independent consideration to be given by MSP

Claims under a miscellaneous fee code will be accepted for adjudication only if the following criteria are fulfilled:

- An estimate of an appropriate fee, with rational for the level of that fee
- Sufficient documentation of the services (such as the operative report) to substantiate the claim.

Some Useful Tips

- Billing multiple 508.
  - If you are asked to reassess a patient for a change in medical status (incl PM call)
  - Include MSP Note as to who called and why
- Billing Case Conference (545)
  - Needs ONE additional participant
    - "psychologists, counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry" [note technically surgeons and family doctors not listed!]
  - Must have pre-existing relationship with patient (18 years old or less)
  - Need *minimum* 15 minutes then "major portion thereof"
- Use MSP Notes for anything non-standard
- Schedule patients for Implicit Re-Referrals (*exception 511*)
- Use virtual health (telephone) visits

New Fees: A Focus on **Adolescents**

- Pediatricians can bill for patients up to the age of 19 years + 364 days
- 547: *Adolescent Care Modifier* (April 1, 2024) 12-19yo ($24.50)
  - Applies to consults only (not 511 / 50511)
  - Rebilling considerations
- 546: *Pediatric to Adult Transition Care and Communication* ($378)
  - For patients who need specific transition to adult care providers
  - It is for *both* the care association with transition *and* its communication
  - Requires Transition Summary (e.g. BCPS Transfer Summary Form)
  - If billed on SAME day as a visit then need to indicate times for BOTH (non-overlapping)

New Fees: Specialist Text Message Advice

- P78710 Specialist Text Message Advice – Initiated by a Specialist, Family Physician, or Allied Care Provider.
- Response within 7 days of initiating request..... $20.00
- Notes:
- i) Payable for two-way text message communication in response to request for patient management advice from another physician or allied care provider.
- ii) Not payable for advice rendered to allied care providers located in the same facility or clinic at the time the service is rendered.
- iii) Document date of request, date of the response, as well as advice given and to whom.
- iv) Include the practitioner number of the physician or allied care provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP, use practitioner number 99987).
- v) Limited to one service per patient per physician per day.
- vi) Limited to two services per patient per physician per week.
- vii) Limited to 100 services per physician per calendar year.)

Question 1

- Can you go over after hours billing codes? There is the non-operative and the pediatric surcharge but usually when I use the actual consult code gets rejected by MSP. I'm confused how to do this correctly...I use Dr Bill for billing.

Call Outs

- 1200: Evening, called 1800-2300 hrs ($77.52)
- 1201: Night, called 2300-0800 hrs ($108.87)
- 1202: Saturday, Sunday or Stat, 0800-2300 hrs ($77.52)

Continuing Care

- Timing begins after first 30 min of consult
- Billed per ½ hour or major portion thereof (so >15 min)
- Indicate CCFPP
- 1205: Evening, called 1800-2300 hrs ($71.27)
- 1206: Night, called 2300-0800 hrs ($97.46)
- 1207: Saturday, Sunday or Stat, 0800-2300 hrs ($71.27)

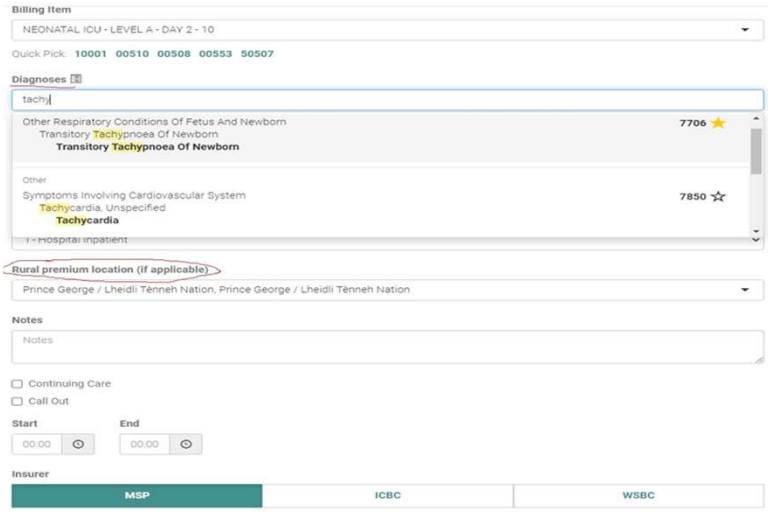
g) The non-operative continuing care surcharge applies to delivery only (not standby time or first stage of labour). State continuous time spent with the patient during second or third stages of labour only.

Surcharges

- 50571: Pediatric evening surcharge, 1800-2300 hrs ($36.35)
- 50572: Pediatric Saturday, Sunday, Stat surcharge, 0800-2300 hrs ($36.35)
- 50573: Pediatric night surcharge, 2300-0800 hrs ($112.11)

- Payable only in addition to in person consultation (not payable if called in to reassess an admitted patient)

Hospital Day – Dr Bill



Example: overnight call

1. Called in to see an unconsolable 3 month old, encounter at 2230-2320

   0510 + 1200 + 1206 (CC) + 50571

1. While in hospital, transfer arrived of a 2 yo with abdo pain and fever, seen 2340-0045

   0550 + 1206 x 2 (CCFPP) + 50573

1. Asked to “stick around’ for imminent Caesarean section of premature infant (34 weeks), delivery at 0125-0200

   1513 + 1200 + 50573

   1513 + 1206 (CCFPP) + 50573

Question 2

- How do you actually use the call out charges (1200, 1201, etc) and the p50571/71/73 etc? How are people billing when residents see patients (and then review with you, patient is seen by you etc)? What is correct to do?
  - For time-based fees: Technically it is YOUR face to face time with the patient.
  - For call-out charges: Stand-by times do NOT apply.
  - Don't overlap times.
  - You should have SOME interaction with the patient if you are billing.

Question 3

- NICU codes are 24hr however sometime we get called in the middle of the night for a deterioration or change in patient status. Can we bill anything? I've tried 508 but it gets rejected. I tried 505 and I think it also gets rejected.
  - All Critical Care codes are for FULL DAY. So you need to CHOOSE
  - Can bill a call-out code only (ie. 1200-2; no visit)

Included in these daily composite fees are the initial consultation or assessment, subsequent visits and examinations as required in any given day. Also included are: family counselling, emergency resuscitation, insertion of arterial, venous, Swan-Ganz, CVP or urinary catheters, intravenous lines, interpretation of blood gases, insertion of nasogastric tubes, infusion of pharmaceutical agents including TPN, endotracheal intubation and artificial ventilation and all other necessary respiratory support. Exchange transfusion is not included in these fees and not all infants requiring an exchange transfusion are critically ill.

Neonatal Codes

- For sick or preterm infants requiring intensive care
- Not applicable to stable patients admitted to NICU for observation or short course of prophylactic antibiotics
- No more than 28 days old (except if premature) (newborns may be in NICU > 28 days)
- Includes all care for the day billed
- If acuity changes (up or down), then day 2 rate applies (note needed)

Neonatal Codes

- NICU A: requiring ventilation, full intensive monitoring, TPN
  - 01511: Day 1 ($676.54)
  - 01521: Day 2-10 ($270.59)
  - 01531: Day 11+ ($180.44)
- NICU B: requiring full monitoring, IV therapy or TPN
  - 01512: Day 1 ($496.18)
  - 01522: Day 2-10 ($180.44)
  - 01532: Day 11+ ($134.63)
- NICU C: requiring oxygen and/or non-invasive monitoring, and/or NG feeding
  - 01513: Day 1 ($428.48)
  - 01523: Day 2-10 ($132.42)
  - 01533: Day 11+ ($114.91)

Emergency/Critical Care

- 00081: for evaluation, diagnosis, treatment of a critically ill patient who requires constant bedside care ($113.18)
  - Per ½ hour or major portion thereof (>15 min)
  - When a consult is also billed, it accounts for the first 30 min
  - A second or third MD can bill 00081
- 00082: monitoring of critically ill patients ($67.90)
  - Per ½ hour or major portion thereof (>15 min)
  - When modification of care and active intervention are not necessary
- Example: Sunday afternoon, teen in shock, managed in ER until transport team arrived

0510 + 1202 + 1207 (CCFPP) x 4 + 0081 + 0082 x 3

Question 4

- The question is about when we attend deliveries specifically in anticipation for resuscitation like meconium or placental abruption or maternal SSRI use. Usually we build a 510 (plus if any surcharge or call out etc) with the reason for consultation, being one of these factors. But then there are instances where you discover other issues unrelated to the initial problem, like antenatal hydronephrosis , and we have to organize ultrasounds that the midwives can't do or recently I had an abnormal NIPT and I had to figure out if the parents wanted to do any postnatal, genetic testing, etc.
  - You are billing for a newborn consult - that includes "discovering abnormalities" and having an obligation to follow-through with those (or making recommendations to referring doctor).
  - Some newborn consults take 5 minutes, some 45 minutes (if longer than 53 min can use 00550).

Question 5

- But if I have to go back and do other things, can I bill another 510? Or anything else ? It came up recently speaking with some Peds in the group as they noticed that if some OBs are consulted for suturing or vacuum, they bill strictly for this and don't look for anything else unless asked (ex HTN).

- First of all - remember YOU NEED A REFERRAL for every 510 you bill (except for implicit re-referrals 6 months later). So if you were referred for patient Issue X and then two days later Issue Y - then I think that is legit second consult (as long as you aren't providing continuing care and just discovering Issue Y on your own - then you are responsible for that).

Question 6

- How to use the 1000X codes?

Phone calls/Emails

- 10000: Urgent Specialist Advice on patient with previous visit/ service ($60.75)
  - Response within 2 hours, 1 claim per patient per MD per day
- 10001: Urgent Specialist Advice ($64.45)
  - Response within 2 hours, 1 claim per patient per MD per day
  - Not payable if a paid visit for same within previous 180 days
- 10002: Specialist Advice ($42.96 per 15 min)
  - Response within 7 days, limited to 1 claim per patient per MD per day and 2 per patient per week
- 10009: Specialist Advice on patient with previous visit/service ($40.50)
  - Response within 7 days, limited to 1 claim per patient per MD per day and 2 per patient per week

Phone calls/Emails

- 10003: Specialist Patient Management/Follow Up ($25.83)
  - Phone call to patient, must have billed 'face to face' within preceding 18 months, billed per 15 min
- 10005: Specialist Email Advice (to FP, specialist, or AHP) ($10.85)
  - Max 3 per patient per MD per day and 12 per year
- 10006: Specialist Email Patient Mgmt/FU ($10.85)
  - Max 3 per patient per MD per day and 12 per year, must have billed 'face to face' within preceding 18 months,
- 10007: Delegated (e.g. MOA) advice or Rx fax ($10.23)
- 10008: Phone advice re: COVID-19 (2 per day) ($60.75)

Question 7

- We cover emergency patient calls for Oncology and Diabetes when on call. i.e. they can page us directly without going through ED. What do I bill for those? some people bill 10001, some directive care, some a phone follow up. But none of this really represents the work we do. Suggestions?

- You cannot bill a pediatric code on a patient whom you haven't been referred.
- If you are serving in a "covering" capacity for a specific doctor who WAS referred that patient it would be ok. Maybe you could bill a VISIT?
- Definitely wouldn't be a 10001 - that's only for speaking with a DOCTOR. And then for 10003 it may get confusing for MSP if you yourself have not seen them (could make an MSP Note saying you are covering for Doctor X and their MSP)

Question 8

- How do I bill for an in-office procedure like tongue tie?

- Paid as a miscellaneous fee item in equity with 50% of 02457.
- Would not be paid in addition to an office visit if the only reason for the visit was the tongue tie.

- Current listing for 02457 Tongue tie, under general anesthesia - operation only fee is $83.98. ($41.99 is 50%)

Special Circumstances

- Twins, triplets
- Baby born to refugee parent (IFHP)
- Referring MD out of province or has no MSP number: generic MSP numbers exist for this
  - 99957 (retired, deceased, moved), 99992 (optometrist), 99994 (dentist), 99997 (primary care organization), 99998 (out of province physician)
  - Document MD name in “Notes” field

Good luck everyone!

- Let the BCPS Economics Committee know if you think of billing codes that should exist, but do not

- Email us:
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- tgerschman@gmail.com

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- Twins, triplets
- Referring MD out of province or has no MSP number: generic MSP numbers exist for this
  - 99957 (retired, deceased, moved), 99992 (optometrist), 99994 (dentist), 99997 (primary care organization), 99998 (out of province physician)
  - Document MD name in “Notes” field
- Care by trainees
- Call back to reassess patient already seen
- Private billing

New Billing Codes

- **P00547 Adolescent (12-19 years of age) care surcharge $24.50**

  Notes:
  i) Restricted to Pediatricians.
  ii) Payable only in addition to 00510, 00550, 00551, 50510, 50515, or 50516 on the same date of service.
  iii) Limited to one claim per patient per physician per day.

- Started April 1, 2024

New Billing Codes

- **00546 - Pediatric to Adult Transition Care and Communication $378**
- For patients 15-19 years of age transitioning from community pediatric care to adult services.
- Limited to one service per patient per year per physician.
- Limited to two services per patient per lifetime per physician.
- A written transition summary, for example the BC Pediatric Society Medical Transfer Summary form, must be recorded in the patient's chart.
- Provisional Fee – Monitored for 24 months! (estimated average 4 billings per year)
- Started November 1, 2023