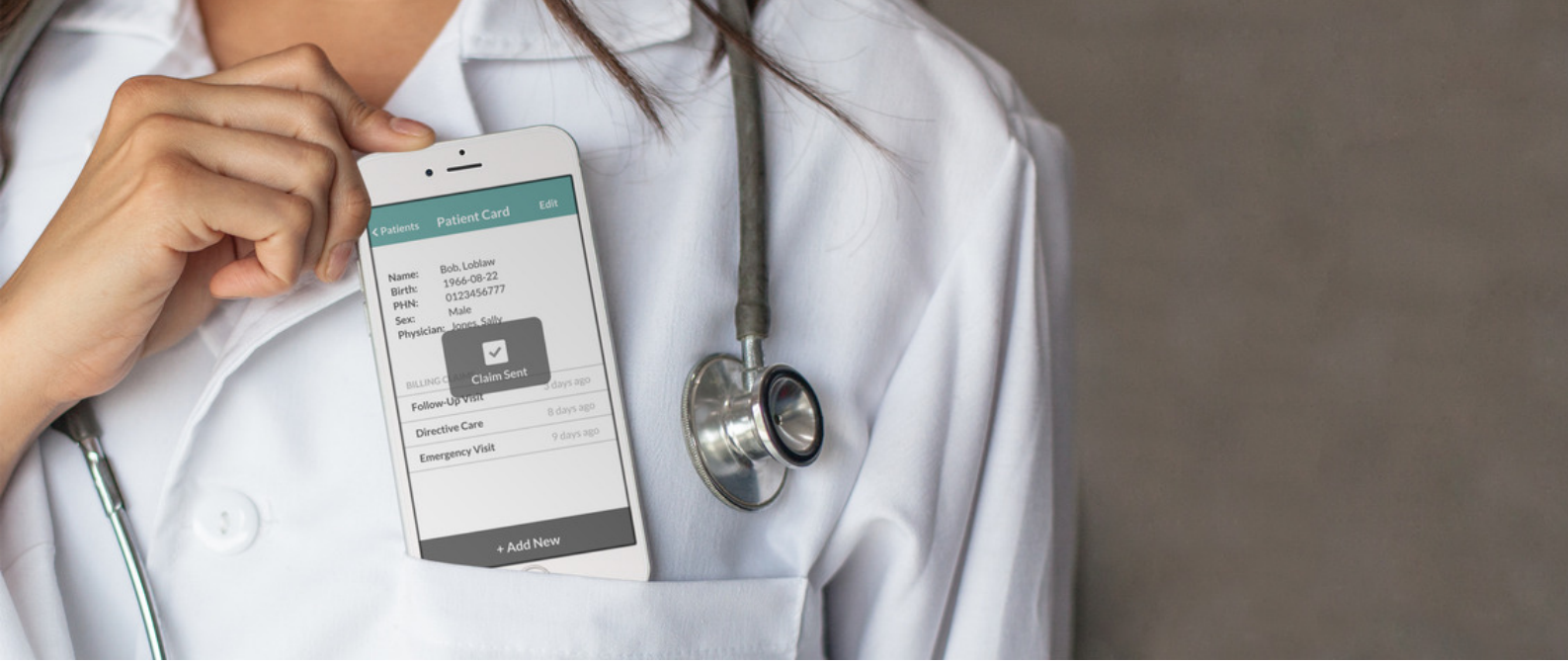
MSP Billing Guide for General Internal Medicine

How to

- Save time
- Earn more
- Bill better

DR.BILL



Billing Tips for GIM Practitioners

This guide will help you manage your billing, reduce rejections and maximize your return from MSP.

Consultations

MSP states that all new consultations require a written letter from the referring physician and that you (the attending) provide a written report on your findings to the referring physician within 2 weeks.

In practice this isn't used for day-to-day billing, but your documentation would be required if you were to be audited.

You can bill a new consultation on a patient if a new condition arrises during their stay. If you've already billed a new consult and a new condition arrises you should bill a **00310**.

However, if your patient meets the criteria for complex conditions, you can bill a **00311** (3 new conditions) or a **32312** (2 new conditions).

Consultations

00310 - New Consultation

Only paid once per 6 months, per diagnosis. That's across all physicians, so if another physician logged a New Consult (same billing code) for the same diagnosis (ICD9 code) in that 6 month interval you can't bill for it.

(Of course, you'll likely not know if this is the case, so it'll get rejected – resubmit as a **Limited Consult - 00312**)

If the patient develops a new condition/diagnosis within that 6 month interval you can log a new consultation. MSP matches the billing code to the ICD9 code logged on the claim to determine if it is valid.

Consultations

00312 - Repeat or Limited Consult

Log this when you're requested to do a consultation but a New Consultation has already been logged for that diagnosis in the past 6 months.

Also logged if the Consult isn't as comprehensive as a Full Consultation and it doesn't warrant the full fee (ex: it's less effort).

There's no specific written timing rule for how often you can log a Limited Consult, however in our experience it'll get rejected if another Limited Consult has been logged within the previous 42 days.

It's expected that a Limited Consult is logged as part of Continuing Care for a patient, but it must be requested.

Consultations

00311 - Complex Consult (3 Conditions)

Paid once per patient, per hospital admission/visit and doesn't have the 6 month requirement of a **00310**.

Patient must have 3 of the listed medical conditions. In some circumstances, they may have only 2 conditions from the list and a third not on the list. In this case you must provide an explanation of the medical necessity for the Complex fee code.

32312 - Complex Consult (2 Conditions)

Paid once per patient per 6 month period (unlike **00311** which is per admission).

Patient must have 2 of the conditions from the list provided.

Continuing Care

32308/32318 - Subsequent Hospital Visit (2 or 3 Conditions)

Requires that a **00311/32312** has been logged on the patient in the past 6 months.

You can only log these claims for the first 10 days of hospitalization, thereafter you need to log a **00308**.

You can see a patient multiple times (and bill for it) in a day if there's a medical necessity – you just need to indicate that.

00306 - Directive Care

You can only bill this twice per week (Sunday to Saturday). According to MSP, Directive Care is billable only when "visits rendered by a consultant in cases in which the responsibility for the case remains in the hands of the attending practitioner but for which a consultant is requested by the referring physician to give directive care in hospital during the acute phase."

This means that you bill **00306** instead of **00308** when you're not the MRP for the patient. If you need to see the patient more than twice in the week, you can bill a 00308 or other codes as appropriate – but you'll need to include an explanation of the necessity.

Continuing Care

32307/32317 - Sub Office Visit (2 or 3 Conditions)

Payable only if a 00311 has been logged in the past 6 months.

00308 Subsequent Hospital Visit

You can bill this code multiple times in a day if required, but you'll need to provide an explanation in the notes as to why the patient needed to be seen more than the initial visit.

After 30 days you can only bill this twice per week, unless you provide an explanation in the notes why the patient required the additional visits.

00305 Emergency Visit

These claims require a start & end time.

You cannot bill a Call Out or Continuing Care premium (see below for more on these fees) for these claims.

Call Out

You get paid a premium on top of your consultations/procedure fees anytime you're specially called out to render services after 6:00pm (weekdays) or on weekends.

You don't have to be at home when you're called, just not in the hospital.

This doesn't apply if you're scheduled for weekend or evening service as part of your hospital coverage. So if you're working on the weekend and saw patients, you can't bill these.

However, if you went home and were on call that evening and had to go back you can.

Other Fees

Here are some fees that are commonly billed by GIM specialists:

10001 - Telephone Call Specialist Advice

You can log this when you are called for a consultation/advice on a patient over the phone.

You can't log this when you initiate the call nor can you add Call Out or Continuing Care premiums to the claim.

This is not payable for booking an appointment, arranging a consultation or procedure, lab results, etc. Only for discussion about the care of the patient.

The call/conversion should be noted in the patient's chart (auditing purposes).

Other Fees

78720 Specialist Advance Care Planning Discussion Extra

You can bill this if you have a discussion with the patient and/or their family about future care of a patient as their health deteriorates.

A care plan template must be filled out with the consultation: **http://www.sscbc.ca/sites/default/files/ACP_Template.pdf**

00314 Internal Medicine Prolonged Visit for Counselling

MSP's definition:
"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, including the management of malignant disease. Counselling, to be claimed as such, must not be delegated and must last at least 20 minutes."

This is payable 4 times per year per patient.

Other Fees

78717 Specialist Discharge Care Plan for Complex Patients

Billed for patients who require community support upon discharge and are otherwise at risk of readmission.

A detailed care plan must be created for the patient.

Patient must have been admitted for 5 days or longer, not application for elective procedures, care plan must be included in the patient's medical record. You must be the MRP for this patient.

10003 Specialist Telephone Patient Management Follow-up

You can bill this if you have a phone call with the patient to discuss their care or condition.

You have to have seen the patient previously in the past 18 months and you cannot bill for this if you billed for other claims on this patient for the same day.

Helpful Resources

Here's some links to various documents that go into great detail about billing for these claims. We also have a billing code lookup on our site that you can use to quickly find out the rules around a specific billing code.

MSP Billing Code Lookup

Internal Medicine Fee Guide

Call Out & Continuing Care Fee Guide

Special Service Committee Guide

MSP Pre-amble

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