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Palliative Care MSP Billing Cheat Sheet

Knowing which codes are available within your specialty is essential in order to maximize your earning potential. Use this cheat sheet as a quick reference guide to the available codes in Palliative Care.

Palliative Care General Restrictions/Guidelines:

- You can use palliative care fee codes if your patient is in acute care hospitals, hospice facilities or other institutions - they are not restricted to patients who are in a palliative care unit.
- You cannot use palliative care fee codes if your patient unexpectedly dies from a diagnosis that is unrelated to the diagnosis that they were originally hospitalized for.
- All palliative care fee codes can be billed continuously once the patient is given a palliative status, for a period not to exceed 180 days prior to death. If you submit palliative care claims that go beyond 180 days, you need to leave a note in the MSP note field explaining why. MSP will then consider your reasons and either approve or reject it.

There are 5 palliative care fee codes. Read the guidelines below to make sure you know when you can and cannot use them.

1. 00127 Terminal care facility visit

Bill this with diagnosis V667.

After billing this fee code once, you'll only be able to bill it for necessary visits for a period not to exceed 180 days (6-month life expectancy). If your patient's condition changes for the better and you expect that their life expectancy will now exceed 180 days, you can go back to billing [00114](#). If you do this, just make sure you leave a note in the MSP note field explaining why. Something like this would do:

- Patient's condition has changed, life expectancy to exceed 180 days.

00127 Guidelines:



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- If you make essential non-emergent additional visits to a hospitalized patient (whether you're the attending physician or the replacement physician), you can bill them as 00127. The claim must include **the time of each visit** and a **statement of need** included in the MSP note field.
- For weekday **daytime emergency visit**, use fee item [00112](#). For additional emergency visits (on the same day for the same patient) **in the evening, at night or over the weekend**, when you're called back (whether your attending or the replacement) because your patient's condition has changed or for something that's unrelated to the hospitalization, bill **the following fee codes**:

- [12200](#) Visit - out of office (age 0 - 1)
- [13200](#) Visit - out of office (age 2 - 49)
- [15200](#) Visit - out of office (age 50 - 59)
- [16200](#) Visit - out of office (age 60 - 69)
- [17200](#) Visit - out of office (age 70 - 79)
- [18200](#) Visit - out of office (age 80 plus)

For additional visits, when you're on-site, use one of the following:

- [00113](#) On call, on site hospital visit (Evening).
- [00105](#) On call, on site hospital visit (Night).
- [00123](#) On call, on site hospital visit (Saturday, Sunday or Holidays).

Your claim must include **the time of service and an explanation for the visit** included in the MSP note field.

- Chemotherapy fee codes ([33581](#), [33582](#), [33583](#), [00578](#), [00579](#), and [00580](#)) may not be billed when palliative care patient facility visit fees are being billed.

2. 13338 First Facility Visit of the day Bonus

This is billable in addition to the [00127](#) for your first patient of the day.

13338 Guidelines:

- Paid only if [13008](#), [13028](#), [00127](#) are paid on the same day.



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- You can only use 13338 once a day, regardless of the number of facilities you need to attend.
- Not payable on the same day if you've already billed [13339](#).

3. 13228 Supportive visit

This is the fee code for supportive visits if you are not the primary palliative care doctor. You need to leave a note in the MSP note field briefly explaining what you did in order to justify the reason/show it's necessity.

13228 Guidelines:

- Payable **once per calendar week per patient**, up to the first four weeks. Thereafter, payable **once per two weeks** up to a maximum of 90 days. For visits over 90 days please you need to submit a MSP note record.
- Payable only for patients in acute, sub-acute care or palliative care.
- Not payable **with any other visit fee** including: [00108](#), [13008](#), [00109](#), [13109](#), [00114](#), [00115](#), [00113](#), [00105](#), [00123](#), [00127](#), [12200](#), [13200](#), [15200](#), [16200](#), [17200](#), [18200](#), [12201](#), [13201](#), [15201](#), [16201](#), [17201](#), [18201](#), [00128](#), [13028](#), [13015](#), [12220](#), [13220](#), [15220](#), [16220](#), [17220](#), [18220](#), [00121](#), [00122](#), [12210](#), [13210](#), [15210](#), [16210](#), [17210](#), [18210](#), [00116](#), [00112](#), [00111](#).
- If your on-site and called for **emergent care**, the following fee codes are billable:
[00113](#) On call, on site hospital visit (Evening).
[00105](#) On call, on site hospital visit (Night).
[00123](#) On call, on site hospital visit (Saturday, Sunday or Holidays).
- A written record of the visit must appear in either the patient's hospital or office chart.
- If your a hospitalist or a GP member of an Unassigned In-Patient Care Network, and you're providing GP care to the patient, you may bill [13228](#). This also applies to Community based GPs with active hospital privileges at a hospital other than the one to which the patient is admitted.



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4. 13005 Phone call (advice about patient in community care)

This fee may be claimed for advice by telephone, fax or in written form about a patient in community care in response to an enquiry **initiated by an allied health care worker** specifically assigned to the care of the patient.

Community Care comprises of residential, intermediate and extended care and includes patients receiving home nursing care, home support or palliative care at home.

Allied health care workers are defined as: home care coordinators, nurses, (registered, licensed practical, public health, and psychiatric), psychologists, mental health workers, physiotherapists, occupational therapists, respiratory therapists, social workers, ambulance paramedics, and pharmacists (including completion of faxed medication review with orders, up to twice per calendar year, but not for simple prescription renewal).

13005 Advice About a Patient in Community Care Guidelines:

- Claims should be submitted under the **personal health number of the patient** and should indicate **the time of day the request for advice was received**.
- When submitting 13005 make sure the dates of services are documented in the patient's record together with the name and position of the enquiring allied health care worker and a brief notation of the advice given. Alternatively, the original fax, or a copy of written advice, will suffice to document these services.
- You cannot claim this fee in addition to visits or other services provided on the same day for the same patient.
- This fee may be billed to a maximum of one per patient per physician per day.
- You cannot claim this fee for advice in response to enquiries from a patient or their family.
- You cannot claim this fee if your employed or are under contract to a facility in which your duties would otherwise include this type of care. Similarly, the fee does not cover advice provided by doctors who are on-site, on-duty in an emergency department, who are being paid at the time on a sessional basis, or who are working at the time as hospitalists.



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5. 14063 GP Palliative Care Planning fee

This is billed for the development and documentation for a **care plan** for your patient. This means that in your clinical judgement your patient has reached the palliative stage of a life-limiting disease or illness, and they now have a life expectancy of up to 6 months. The patient needs to consent to the focus of care now being palliative.

Remember that Palliative Care fee codes are available only if your patient suffers from:

- malignant disease or AIDS,
- end-stage respiratory, cardiac, liver and renal disease,
- end-stage dementia with life expectancy of up to 6 months.

Patient Eligibility

- Eligible patients must be living at home or in assisted living. *Patients in Acute and Long Term Care Facilities are not eligible.*
- Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and the patient's agreement to no longer seek treatment aimed at cure.
- The patient must be eligible for BC Palliative Care Benefits Program (even if they haven't applied for the palliative care benefits program, just as long as they are eligible).

14063 GP Palliative Care Planning Fee Guidelines:

- This fee requires a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision-maker, or legal health representative, must be consulted and asked to provide informed consent.
- Payable once per patient, once the patient is deemed palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.



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- Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face-to-face planning included under [14063](#).
- You must spend a minimum of 30 minutes on the care plan. 16 minutes of this must be face-to-face with your patient or their medical representative. The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and **may be delegated to College-certified allied care provider** (e.g.: nurse, nurse practitioner), working within the eligible physician practice. Chart documentation must include:
 1. the care plan;
 2. total planning time (minimum 30 minutes); and
 3. face-to-face planning time (minimum 16 minutes).
- 14063 is only payable if your a family physician who commits to providing the majority of your patient's longitudinal comprehensive care. The Care Plan requires documentation of the following in the patient's chart:
 - There has been a detailed review of the case/chart and of current therapies.
 - Name and contact information of the substitute decision-maker.
 - Documentation of eligible condition(s).
 - There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed.
 - Specifies a clinical plan for the patient's care.
 - Documentation of the patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive.
 - Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan.
 - Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate.
 - Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles.
 - Identifies an appropriate time frame for a re-evaluation of the plan.
 - Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally, or in writing, to other involved allied care providers as appropriate. The patient and/or their representative/family should leave the



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planning process knowing there is a plan for their care and what that plan is.

- [14077](#) is payable on the same day, for the same patient, if all criteria are met. (Time spent on conferencing does not apply to time requirement for [14063](#)).
- Not payable if [14033](#) or [14075](#) has been paid within 6 months.
- Not payable on same day as [14043](#) ,[14076](#) or [14078](#).
- [14050](#), [14051](#), [14052](#), [14053](#), [14033](#), [14066](#), [14075](#) not payable once Palliative Care Planning fee is billed and paid because the patient has been changed from active management of chronic disease and/or complex condition(s) to palliative management.
- The GPSC Mental Health Initiative Fees ([14043](#), [14044](#), [14045](#), [14046](#), [14047](#), [14048](#)), are still payable once [14063](#) has been billed, provided all requirements are met. However, they are not payable on the same day.
- Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.