PARA Transition to Practice Physician Billing

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Session Overview

- Things to think about as you start billing
  - Keeping Track of your billings and other services
  - Schedule Philosophy
- Consultations and Visits
- Procedure groupings
- Selected other services

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Things to think about as you start practice

- Apply for your Alberta Health PRACID (billing number) as soon you have your license
  - Contact Alberta Health to register as a new physician
  - See this link (Health professional business forms | Alberta.ca) for
    - Practitioner request form (PRACID)*
    - Facility registration form (new office)
    - Business Arrangement and Relationships (new or add a physician)*
      - Identifies billing software/agent and directs payment
    - Direct Deposit
  - You'll need to complete some or all of these forms to get a billing number and appropriately direct payments (*=required)

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Things to think about as you start practice

- Information you'll need to apply

  - Your Practice Permit issued by the College of Physicians and Surgeons of Ab (CPSA).
  - Your Registration, Understanding and Acknowledgement Letter (RUA) also issued by the CPSA
  - Copy of your Specialty Letter, issued by the CPSA.
  - When you have these documents you can complete the AHC11234 (PRACID request) and submit with the attachments
  - You may practice, but cannot submit any claims until your PRACID and Business Arrangement are in place (they can be backdated – request your first day of full licensure as start date)

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Things to think about as you start practice

- Keep track of what you do, where, and when
  - Write it down
- Know when you started and ended your day
  - There's a rule (2.3.6)
- Do your billings frequently so you don't forget what you did
- Use the AMA Fee Navigator to be sure you know the requirements
- Pay attention to your reconciliations and rejections – ask if you don't understand
- Know what's being claimed on your behalf!

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Starting Practice and Billing

Things to think about:

- Will you be in independent practice or join a group?
- If existing, what is their payment model?
  - Fee-for-service
  - Alternative compensation model
- Why is this important?
  - Payment schedule/certainty
  - FFS or Shadow Billing
  - Alternative payment arrangements are still required to submit billing codes to reflect services provided

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Starting Practice and Billing

- Will you do your own billing and reconciliation?
  - Clarity/control
  - Time commitment
  - Cost/benefit

vs.

- Hiring or contracting out
  - Ease
  - Maintain oversight
  - Software costs vs. cost of contracting

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Starting Practice and Billing

- Start billing and tracking your Statements of Assessment against what was claimed.
  - Are you being paid in full for your claims?
  - If not, what adjustments are required and made?
  - Do you understand why a claim hasn't been paid as submitted?
  - What does the explanatory code tell you?
  - Does it fit with the description, rules and notes related to the code?
  - If not – ask!

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Things to Think About…

- Understand your role in billing vs. that of your billing team
- You're responsible for determining what code to claim
  - Your billing team isn't in the room with you when you provide the service
- Your billing team is responsible for entering the claim, flagging any concerns

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Things to Think About…

- Be certain you know what your billing team is claiming on your behalf – how?
  - You decide what code, modifiers
- Know what's happening with reconciliations and resubmissions
  - Are they being done?
  - What's your resubmission rate – why?
  - Are invalid health insurance numbers being followed up?

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Things to Think About…

Uninsured Services:

- What will you charge for uninsured services?
- How will you let patients know?
- Do your partners have an existing rate guide?
- If not, are they willing to create one?

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Things to Think About…

Uninsured Services cont'd:

- AMA has resources for members
  - Uninsured Services Guide
  - Poster
- Determine what you'll charge
- Post your rates
- Educate your team
  - Remind patients at booking
  - You'll discuss questions/concerns with patients

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Things to Think About…

- What happens when you see a patient:
  - From outside Alberta?
  - Who can’t produce an AHCIP card?
  - Who doesn’t have Alberta insurance?
    - Opted out
    - Didn’t register
    - Has relocated or had a change in living situation
  - Who needs a form completed or other uninsured service?

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Schedule of Medical Benefits and Billing Basics

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Understanding the Schedule

- The Schedule pays for physicians' direct, in person, services to patients, except for:
  - Technical, delegated services, services by directly eyes-on supervised resident physician or medical student (MED 97)
  - Physician to physician, physician to other health provider communications (as described), and team or family conferences
  - Specified phone/other contact with patients, including virtual codes
- Determine the correct health service code – the EMR/billing software description is only part of the story – read:
  - Full description
  - Modifiers
  - Rules

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Not all services can be claimed or have a specific code

- Not every patient-related activity has a specific fee code and may be claimed; some are bundled into other services; others may be part of a service claimed on an earlier date, and no additional claim or time may be added
- For example, the following may not be claimed:
  - Reviewing diagnostic results on a day the patient isn't seen (part of insured basket)
  - Administrative work (practice management, billing, reconciliation)
- The following may be included in visit modifier time, if they occur on the same date as the patient is seen:
  - In-office pregnancy tests or urine dip/urinalysis interpretation
  - Impromptu meetings with members of your care team
- Remember that some codes have specific wording that requires a certain time commitment or that the service be scheduled in advance.
- Be sure your billings are consistent with what the Schedule describes and allows; that's your protection in the event of an AH audit
- Don't forget there's a rule requiring you to document time on a day you'll claim a time-based service. Use a convenient method, and track it!

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Stay up-to-date

- Read the AMA's Billing Corner and AH Bulletins
- Use the AMA Fee Navigator™

  www.albertadoctors.org/feenav

- Download and review the Schedule components:

  http://www.health.alberta.ca/professionals/SOMB.html

- Remember – Physicians decide what fee code, and how many, to bill!

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Need Help?

- Alberta Health Resources
  - Physician Resource Guide
  - Schedule of Medical Benefits Procedure List
- Alberta Health
  - 310-0000 780 422-1600 (not currently answered)
  - Email: Health.HCIPAProviderClaims@gov.ab.ca
- AMA – Physician Advocacy
  - 1-800-272-9680 780 482-2626
  - E-mail:
    billingadvice@albertadoctors.org
    norma.shipley@albertadoctors.org
    darcy.shade@albertadoctors.org
    marisa.bonuccelli@albertadoctors.org

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Verifying Coverage

Use the AH Physician's Resource Guide: Physician's resource guide - Open Government (alberta.ca)

- Netcare/IVR 1-888-422-6257
  - All new patients, those not seen recently, life change (young adult, change in marital status)
  - Check date of coverage and expiry date
  - For patients seen in AHS facilities who don't have health insurance, there is support to register: https://www.albertahealthservices.ca/about/Page13445.aspx

- Opted out
  - A few Albertans have formally opted out of health care insurance
  - Bill directly – not limited to Schedule rates

- **Revised good faith process for AB and Canadian patients (excluding Quebec) coming soon**

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Patients from other Provinces/Territories

Virtual visits are only claimable for AB patients, and then only when both physician and patient are within provincial boundaries.

- Reciprocal billing
  - All provinces participate except Quebec
    - Bill Quebec patients directly at AB rates
    - Submit claims for all other provinces/territories with patient health insurance number to AH
      - Include patient's address in home province (no punctuation)
  - Is the card in the current format?
    - https://www.alberta.ca/assets/documents/ahcip-valid-insured-health-services-plan-cards-reciprocal-billing.pdf
  - Check name and DOB against photo ID and scan all OOP health cards

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Some services may not be claimed for out-of-province patients

- Telemedicine, including virtual visits
- Team Conferences
- Evidence at a review Panel (08.11B)
- Services in the experimental/ developmental phase
- Third-party required/requested services
- Services to federal corrections patients

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Submission Deadlines (GR 2.7.4)

- Since March 31, 2020, claims must be submitted within:
  - 90 days of date of service, or
  - 90 days of date of last communication from AH
- The Minister may give special permission to submit after that, but it's rare:
  - Disasters (fire, flood, employee theft)
  - Infrequent, little/no flexibility

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Time-based Services (GR 2.3.6)

- Physicians must document time spent providing time-based services
- How?
  - Keep track of the start/end of your day each day – retain in chronological order
  - Use a note book, Excel, app in your electronic device, geolocation app
  - Exclude any time for breaks
  - Include any time you spent after office/clinic hours on work related to patients seen that day
  - Retain for 6 years

Your EMR may track the time at which individual patients' files are opened and closed, but is not good at tracking when the first was opened and last was closed on a given day.
AMA recommends you track time worked each day separately.

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Encounter – Definition (GR 1.14)

- Each separate and distinct time a physician provides services to a patient in a given day (defined as 0001 to 2400)
- Not continuation of an earlier service
- Examples:
  - Consultation time divided between 2 encounters on one date due to patient condition – one encounter, include all time under one consultation claim
  - Visit, treatment initiated, patient returns later same day or physician called to attend by hospital staff, problem worse or new problem = 2nd visit is encounter two
  - Start of encounter determines the surcharge/callback/date of visit, etc.
  - Virtual care
    - One virtual care service claimable per day
    - Not claimable same date as in-person service
  - Team conferences/family conferences claimed at a separate encounter

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Some services require supporting text

7.5 Health Service Codes that Require Supporting Text/Documentation

03.04Q	08.19H
08.19AA	08.19J
08.19BB	08.19K
08.19CC	13.99J
08.19D	13.99K
08.19F	

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Billing Specifics

Visits and Consultations

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Determining what visit or consultation

- The extent of physical examination (or psychiatric evaluation for psychiatry) determines the level of visit or consultation
  - Comprehensive visit/consultation – requires a full physical examination for all specialties except psychiatry and surgical specialties. They require a complete psychiatric examination or examination suited to the surgical specialty
  - Some visits and consultations have time extenders – specific to visit or consultation and specialty – no mixing and matching

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Consultations

- Used when a patient has been referred because the patient has an unusual or serious problem
- Typically intra-specialty consultations not appropriate unless the consultant has additional education, training and experience in treating the patient's problem
- There must be a verbal (and recorded in the patient record) or written request from the referring physician
- There must be formal communication to the referring physician from the consultant after the patient has been seen and evaluated

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Virtual Visits and Consultations

- Must be initiated by the patient and a formal appointment booked and reflected in the physician's schedule
- Record your patient contact start and end times
- Know what modifiers may be claimed with your visit or consultation
- There are specific codes for responding to patient initiated emails and others for physician-initiated emails and phone calls

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Visits vs. Consultations

- Consultations may only be claimed when ALL of the following criteria have been met:
  - Patient is examined by referring provider (full list G.R. 4.4.1)
  - Referring provider specifically requests (verbal or written) opinion and or advice of consultant who has additional training in the required area of practice
- Consultant performs:
  - full history and patient assessment (comprehensive, according to specialty) or problem-focused history and assessment (problem-focused) and
  - may order lab or diagnostics
  - discusses treatment and advice with the patient and in some cases the referring provider
  - provides referring provider with written report about recommendations, treatment, opinion (time required may be included in in-person consultation time)
- Criteria not met? **It's not a consultation**

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Consultation Referrals

Incorrect referral numbers or ineligible referring professional can cause explanatory code 45 rejection

4.4.1

In this Schedule "consultation" means that situation where a physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner after an appropriate examination of the patient, requests the opinion of a consultant physician, and the consultant does a history, an examination and a review of the diagnostic data and provides a written opinion with recommendations as to the treatment, to the referring physician, audiologist, midwife, chiropractor, podiatrist, dentist, optometrist, physical therapist or nurse practitioner. Consultations may not be claimed for the transfer of care alone.

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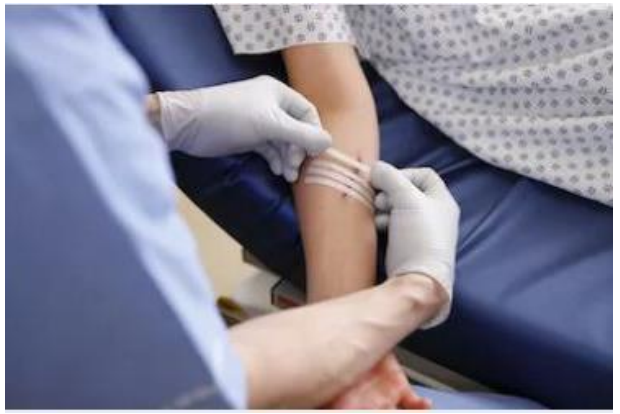
Procedures

Minor Procedures (M)
Minor Diagnostic Procedures (M+)



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Visits with Procedures

- Minor procedure (M) and office visit
  - Both payable only if unrelated reasons/diagnose
  - Procedure includes removal of sutures
    - Same physician
    - Same practice group
  - Local anesthetic infiltration included in the benefit

If doing an M category procedure that is eligible for a tray fee and visit at same encounter in the physician's office, claim procedure PLUS visit to be paid for the tray fee. AH will pay the full rate for the visit, and the tray fee for the procedure, unless has the note allowing it to be claimed with a visit. See next page for the list…

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Visit & Procedure Exceptions

10.16A	Pessary fitting
10.16B	Pessary removal, adjustment and/or reinsertion (not claimable with 10.16A)
81.8	IUD insertion
11.71A	Removal of intrauterine contraceptive device (IUD)
13.59A	IM or subcutaneous injections (insured injections only)
13.59O	Injections for Botulinum A Toxin for the prophylaxis of chronic migraine headaches (be aware of age and other requirements)
13.99BA	Periodic Papanicolaou smear
13.99BE	Pelvic examination using a speculum requiring swab(s) and/or sample(s) collection
13.99BD	Anal Papanicolaou smear

These procedures are payable on the same date as a visit if the physician sees and evaluates the patient.

13.59A may be claimed for insured injections given by the physician (excluding local anesthetic), and for flu/pneumococcal vaccinations under the physician's supervision.

The physician must complete and document the evaluation and history required for a visit.

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Visit & Procedure Exceptions

These procedures are claimable on the same date as a visit.

16.81A	Spinal tap
51.92A	Varicose vein injection
58.99F	Manual disimpaction of stool
79.22	Cautery of cervix
79.23A	Cryotherapy of cervix
93.91A	Joint injection, hip
93.91B	Joint injection, other joints
98.03A	I&D of abscess or hematoma, subcutaneous or submucous
98.12L	Rx of warts (insured warts only)
98.12C	Removal of sebaceous cyst
98.12J	Removal or excision (warts, keratoses)

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Diagnostic Surgical Procedures (+) (GR 6.6)

- Office
  - “+” and visit – both payable
  - “+” and consultation – both payable
- Hospital
  - “+” and visit – greater only
  - “+” and consultation – both payable

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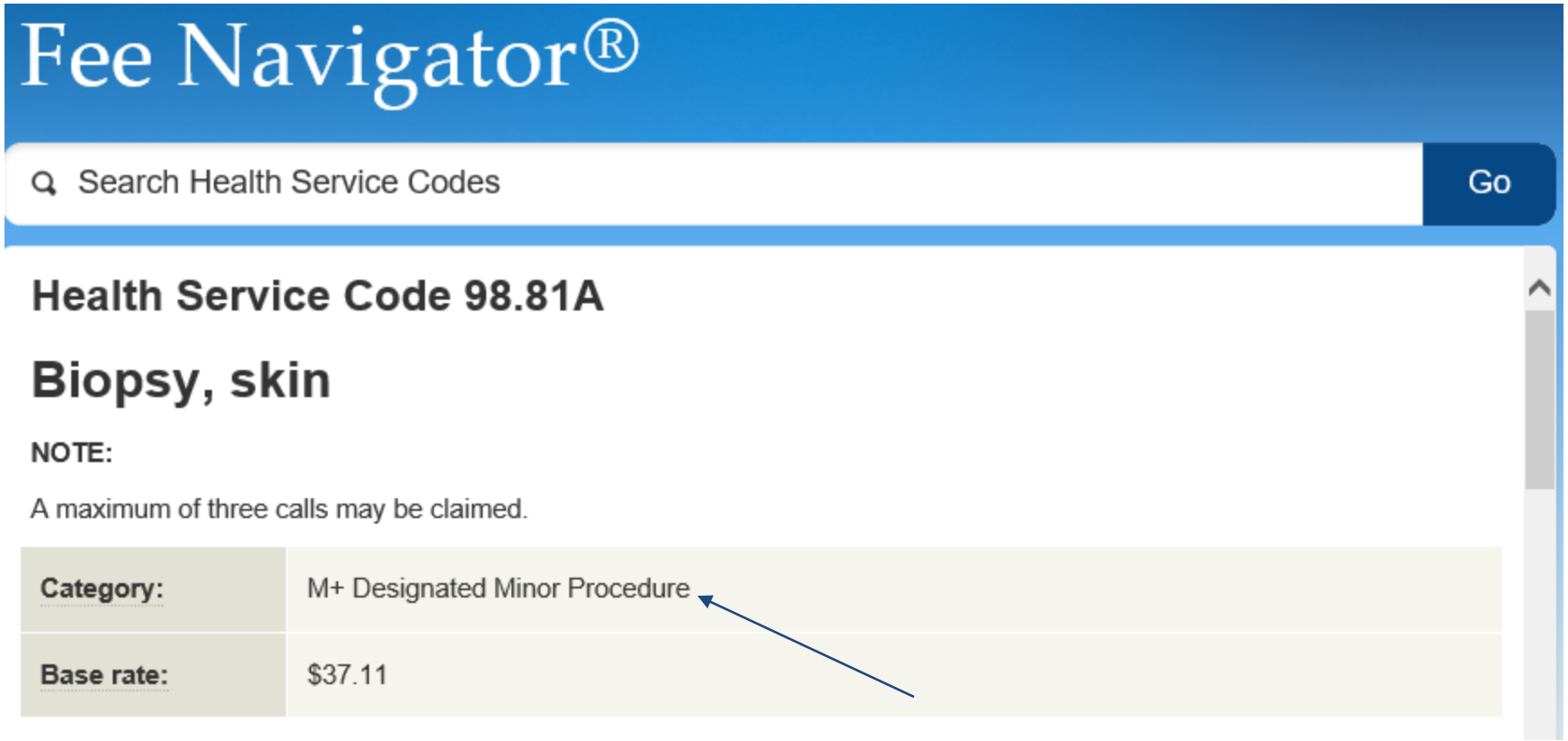
Diagnostic Surgical Procedures



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Major Procedures – pre- and post-Inclusive Care Periods

Category	*Pre-operative Period	Post-Operative Period
1	0 Days	14 Days
3	7 Days	7 Days
4	7 Days	14 Days
6	14 Days	14 Days
14	30 Days	14 Days
15	0 Days	7 Days
***Pre-operative consultation is always claimable in addition, except for M category procedures Category is listed in on AMA Fee Navigator ®		

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Billing Specifics

Telephone/other communication with physicians/other professions

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Family and Team Conferences

- Family Conferences
  - About the patient – patient not present
- Visits/consultations
  - With the patient (including need for translation services)
- Team conferences – typically more than physicians
  - Not for meeting with physician directed team
  - Independent health professionals (e.g., PT, OT, Social Worker)

Be aware of "formal, scheduled" wording for team and family conferences – it means the conference is scheduled in advance, with patient and attendees known

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Billing Considerations

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As you get started

- The AMA provides billing education to physician and resident groups
  - No charge to resident physicians and AMA members
  - Group sessions (by specialty grouping) are offered monthly
  - Private sessions for groups of 5+ in the same specialty
  - See Billing seminars | Alberta Medical Association (albertadoctors.org) for more information

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Resources

- AMA Fee Navigator®
  - www.albertadoctors.org/fee-navigator
- AMA Billing Advice
  - billingadvice@albertadoctors.org

- Alberta Health Bulletins
  - www.alberta.ca/bulletins-for-health-professionals.aspx
- Alberta Health Schedule of Medical Benefits
  - https://www.alberta.ca/fees-health-professionals.aspx

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Questions & Wrap-up

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