

Long-term Care Fee Code Summary

Overview

The GPSC [Long-term Care Initiative](#) (LTCI) supports divisions, or self-organizing groups of family physicians (FP) where no division exist, to design and implement local solutions that deliver dedicated FP most responsible physician/provider (MRP) services for patients in long-term care (LTC) facilities.

In addition to the initiative funding, there are a number fees available to support physicians who provide LTC services.

GPSC Fees for Patients in Long-term Care

Physicians who have submitted the [Community Longitudinal Family Physician \(CLFP\) Portal 14070 \(or 14071 for locums\)](#) at the beginning of every calendar year have access to the incentives and fee codes that are applicable to patients in LTC. Physicians who work in a focused practice in LTC and who do not work in a community-based longitudinal family practice may no longer meet the eligibility requirements of 14070 (or 14071). As such, they are eligible to submit the Long-term Care (LTC) Portal (14072) in order to access the fee codes listed below, for their patients that they are the MRP for.

14076 FP Patient Telephone Management Fee – payable for telephone management for any patient in any location, including LTC, and is billable by physicians who have submitted the CLFP Portal Code 14070 (or 14071 for locums), or the LTC Portal (14072). 14076 is not payable on the same day as a visit or service fee by same physician for same patient, with the exception of 14077, 14018, 14050-53, 13005. There is a maximum of 1500 services per physician per calendar year. **See the [Conferencing & Telephone Management Billing Guide](#) for more details.**

14077 FP Allied Care Provider and/or Physician Conference Fee – payable per 15 minutes or greater portion thereof (eight minutes), to a maximum of two units per calendar day and 18 units per calendar year per patient, for conferencing with at least one allied care professional/physician (telephone, videoconferencing, or in-person).

For physicians who have submitted the CLFP Portal Code 14070 (or 14071 for locums), or LTC Portal (14072), payable in addition to any visit fee provided the visit is done separate from the conference. **See the [Conferencing & Telephone Management Billing Guide](#) for more details.**

Chronic Disease Management Fees – for those patients where it is clinically appropriate to provide guideline-informed care for the covered conditions, the Chronic Disease Management fee codes also apply. These fee codes are available after one full year of guideline-informed care with at least two visits in that 12-month period. **See the [Chronic Disease Management Billing Guide](#) for more details.**

- **14050** CDM for patients with Diabetes
- **14051** CDM for patients with Heart Failure
- **14052** CDM for patients with Hypertension
- **14053** CDM for patients with COPD

One of the two visits must be in person by the physician while one may be:

1. a telephone visit (14076); or
2. a group medical visit (13763 – 13781); or
3. a telehealth visit (13017, 13018, 13037, 13038); or
4. an in-person visit with a College-certified allied health provider (14029) working within the physician's practice.

It is important to note that although 14075 FP Frailty Complex Care is behind the CLFP Portal, it is **not** applicable to patients in LTC.

MSP Fees in Long-term Care

When non-urgent/emergent visits are made to patients in LTC facilities (such as nursing homes, intermediate care, extended care units, rehabilitation, chronic care, convalescent care, and personal care), regardless of being situated on the campus of an acute care facility, claims may be made to a maximum of one visit every two weeks. It is not sufficient, however, for the physician to simply review the patient's chart; a face-to-face patient-physician encounter must be made. For acute inter-current illnesses or exacerbation of original illness requiring institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation in the note claim area.

Billing for Non-urgent/non-emergent visit (00114, 13334)

Literature supports that regular, longitudinal care (versus episodic care) for patients in LTC facilities improves patient care by decreasing unnecessary transfers to acute care. With the aging and increasing complexity of the population, visits may be provided and billed every two weeks, with the ability to provide extra medically necessary visits when a note record (e.g., "Extra visit required due to ____") is submitted with the billing. For physicians with a community-based office, the first visit to a LTC facility on any calendar day is subject to the community-based physician, LTC facility visit – first visit of the day bonus fee (13334) billed in addition to the visit fee (00114).

Billing for Patients in Long-term Care When Specially Called (00115)

For care of a patient in a nursing home (LTC) when especially called, 00115 may be claimed seven days per week between 0800 – 2300 provided the visit occurs within 24 hours of the time called. Start/end time must be submitted with the claim. The first visit of the day bonus (13334) is not applicable when specially called. Any additional patients seen during the same call may be claimed under 00114.

Billing for Patients in Long-term Care when Called to See at Night (01200/01201/01202 + 13200 series)

When especially called and for a visit with a patient in a nursing home (LTC) that occurs during the overnight time (2300 – 0759), the call-out fee is billable in addition to the out-of-office age appropriate visit fee. The call-out-fee used is dependent on when the physician was called. For calls before 2300 and patient visit is after 2300, must use either 01200 or 01202 as appropriate for day of week. When the physician is called and sees a nursing home (LTC) patient from 2300 - 0759 hours, the appropriate out-of-office visit fee (13200, 15200, 16200, 17200, or 18200), depending on the patients age, is billable in addition to the call-out charge (01201), if all of the out-of-office hours premium criteria are met. Start/end time of visit must be submitted with the claim. In the electronic note, indicate time called as well as time seen. Any additional patients seen during the same call may also be claimed using the out of office age differential fee codes (13200 series). *In addition, if the visit(s) meets the non-operative surcharge criteria, fee item 01205, 01206 or 01207 may be billed.*

Visits for Terminal Care (00127)

Once terminally ill patients with malignant disease, AIDS, end-stage respiratory, cardiac, liver and renal disease, neuromuscular degenerative disease and/or end-stage dementia are located in a LTC facility, patients are deemed to be palliative (in the last six months of life and eligible for the Palliative Care Benefits program whether applied for or not). It is appropriate to change to billing fee 00127 for their care, whether or not the patient is in a palliative care unit. These patients often require frequent visits for palliative care. Billing for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs. These fees may be billed on an ongoing basis, for medically necessary visits rendered for a period not to exceed 180 days from determination of palliative level of care to death. If a patient survives longer than 180 days from the time status is changed from active management to palliative management, visits may still be submitted with fee code 00127 for up to a further 90 days, but an electronic note must accompany the billing to outline why the patient has survived beyond the six months. If the patient survives longer than 270 days, claims may be submitted with electronic notes and are subject to individual adjudication. Chemotherapy fees may not be billed when terminal care visit fees are being billed. This fee is also subject to the “first visit of the day” bonus (13338) that may be billed only once per day, per physician regardless how many eligible facilities you visit.

Billing for Phone Advice about Patients in Long-term Care (13005)

When called/faxed for advice about a patient in a LTC facility, other than for medication re-orders, it is appropriate to bill the fee 13005, as long as all other criteria are met. This fee is not billable for advice to a patient’s family members.

This fee is not billable if a visit has also occurred on the same day and is limited to one fee billable per day per patient. Documentation of the concern and advice given must be kept in a patient's chart.

Minor Procedures and Related Tray Fees

A tray fee is billable in addition to the procedure fee when a physician brings a tray from their office to a LTC facility to perform minor procedures (e.g., laceration repair, lesion excision). When performed in addition to other procedure or visit, the rules regarding multiple services apply – bill the higher valued service at 100% and the lower valued service(s) at 50%. Note that punch or shave biopsies are to be billed as age-appropriate office visit (00100 series) only, and are not eligible for a tray fee. If biopsy is positive for carcinoma and the full lesion is removed at a later date, bill under appropriate excision fee (13622) for the later service.