Time-Based Services

Billing Information Sheet
Insured Services, Medical Services Branch

1.	GENERAL INFORMATION
a)	**Documentation Requirements:** Documentation is an integral and fundamental component of a medical service. An adequate record enhances quality and accountability, and provides protection for the physician, the beneficiary and the Ministry. For billing purposes, the physician is responsible for documenting and maintaining an adequate medical record that appropriately supports the service being provided and billed, regardless of method of reimbursement to physician (fee-for-service, contract/shadow biller, etc.). To be considered adequate, a medical record must be legible and contain the information specifically designated in the Physician Payment Schedule service codes depending on the classification of the service. The record must also establish that: 1. An insured service was provided; and, 2. The service for which the account is submitted is the service that was rendered; and, 3. The service was medically required. **All services billed to Medical Services Branch (MSB) are the sole responsibility of the physician rendering the service with respect to appropriate documentation and billing.**
b)	**Documentation Requirements for Time-based Services (in-person and virtual):** All time-based services require that the duration of the insured service is documented in the patient's medical record. If the medical record does not include this required information, the service is not eligible for time-based payment. Unless otherwise specified, the insured service is the time spent directly with the patient providing medically required care. For time-based procedures, the insured service is the time a physician spends performing the medically required procedure. Administrative tasks are not included in eligible billable time except where explicitly stated in the Payment Schedule. The key component associated with time-based services is the "time" and **it is mandatory to document both the start and stop times in the medical record** and ensure you are following the criteria as set out in the Payment Schedule. Start and stop times must be explicitly recorded in the patient record **using actual clock times** (e.g., "1:04 p.m. to 1:47 p.m."), rather than a duration only (e.g., "43 minutes"). Start and stop times must **reflect the actual duration of the clinical encounter and time a physician spends providing patient care** and must not be based on automatically generated EMR appointment times or booking templates.

c)	**<u>Times required on the claim</u>** While all time-based codes require start and stop times to be documented on the patient's medical record, **some time-based codes also require the physician to submit the start and stop times on the claim to fulfill Payment Schedule criteria and be eligible for payment.** The requirement for start and stop times to be entered on the claim will be explicitly stated in the service code descriptor or preamble. **Start and stop times must be entered in the *Start and Stop Times* fields** on the claim. When entering times in the *Start and Stop Times f*ields, **times should be rounded up or down to the nearest minute** as the claims system is not able to accept time in seconds.
2.	**SUBMITTING START AND STOP TIMES ON THE CLAIM**

a)	**<u>Time Thresholds:</u>**
	
	The total time billed must meet the requirements of the applicable code(s), including the correct application of time thresholds:
	
	• **Major Portion/Major Part Thereof:** At least half of the minimum time stated in the service code descriptor must have elapsed to be payable. For example:
	  ○ If the code states "15 minutes or major portion thereof", the minimum time that must be spent with the patient is 7 minutes and 30 seconds. When entering times on the claim, times should be rounded up or down to the nearest minute.
	  ○ If the code states "each subsequent 30 minutes or major part thereof", the minimum time that must be spent with the patient is 15 minutes and 30 seconds. When entering times on the claim, times should be rounded up or down to the nearest minute.
	
	• **Minimum required duration of time:** The minimum time stated in the code must be met to be payable. For example:
	  ○ If the code states "a minimum 30 minutes of direct patient care", the minimum time that must be spent with the patient is 30 minutes.
	  ○ If the code states "first complete 15 minutes", the minimum time that must be spent with the patient is 15 minutes.
	
	• **"Base" and "Add" codes**: For time-based service codes with a base and add component, the add code is only billable once the required time stated in the base code has been met.
	  ○ The add code is not billable without the corresponding base code and both must be submitted on the same claim.

- When entering times on the claim, the stop time of the base code must be the same as the start time of the add code. For example, if the stop time of the base code is 9:30 AM, then the start time of the add code must be 9:30 AM.

- **Number of units of service rendered**: For service codes billable in time increments or "units", the start and stop times must correspond to the number of units billed. If the number of units billed is over the maximum allowable units stated in the service code descriptor, the system will only pay up to the maximum allowable units.
  - If the code states "major portion thereof", all units except for the final unit must meet the full required time stated in the service code descriptor. The final unit is billable if it represents more than half the required time stated in the service code descriptor.
  - If the code states "each complete period", every unit – including the final unit – must represent the full required time stated in the service code descriptor.
  - If a service exceeds the maximum allowable time, the actual stop time and corresponding units must still be entered; however, the system will only pay up to the maximum allowable units stated in the service code descriptor.

b)

Billing Example

- 15C: Per **first complete 15-minute time period** for time spent directly with the child and/or relatives/caregivers counselling
- 16C: For **each additional 15-minute time period, or major portion thereof**, for time spent directly with the patient and/or relatives/caregivers counselling – **bill units (max 3)**

1) Physician sees a pediatric patient in-person for counselling. The physician spends 45 minutes assessing and counselling the patient from 9:00 – 9:45AM. The physician then spends 30 minutes discussing treatment options with the patient's father from 9:45-10:15AM. **Total time billable is 75 minutes.**

➢ Both service codes should be submitted on the same claim as follows:

Code	Units	Start Time	Stop Time
15C	1	9:00	9:15
16C	4	9:15	10:15

➢ **The stop time and units billed must still reflect the actual time spent; however, the number of units paid by the system will not exceed the maximum allowable units stated in the service code descriptor.**

➢ **Even though 60 minutes of additional time was spent, 16C is only payable to a maximum of 3 units (or a maximum of 45 additional minutes).**

3.	Chronic Disease Management (64B, 65B, 66B, 67B, 68B, 864B)
a)	**Payment Schedule Time Requirements:** • The CDM fee (both in-person & virtual) includes a patient visit that involves a minimum of 15 minutes of physician time. • CDM visits involving less than 15 minutes of physician to patient interaction in real-time, should be billed using appropriate in-person or virtual visit codes (e.g. 5B, 805B). • If the patient has more than one of the listed conditions, they will be dealt with at the same visit. • For in-person CDM visits, an approved patient CDM flow sheet must be completed for each condition and a minimum of 5 minutes of physician time per condition must be spent. • The base code (64B) is not billable alone. It must be billed with at least one of the add codes (65B-68B) and the total time spent must be a minimum of 15 minutes of physician time. • For virtual CDM visits, there is no requirement to complete a CDM flow sheet but a minimum of 15 minutes of direct physician to patient interaction in real-time discussing key aspects of chronic disease management is required. **64B** ➢ Considered the "base" code. ➢ Cannot be billed alone. Must be billed with at least one add code (65B-68B). **65B – 68B** ➢ Considered the "add" codes. ➢ Cannot be billed alone, must be billed in addition to the base code (64B). **864B** ➢ Can be billed alone. ➢ Must be preceded by at least one in-person CDM visit. ➢ No add codes are eligible but a minimum of 15 minutes of direct physician to patient interaction in real-time is still required.
b)	**For the purposes of submitting start and stop times on the claim:** ➢ The base code (64B) is equal to 10 minutes. ➢ Each add code (65B-68B) must be a minimum of 5 minutes. ➢ Start and stop times for each CDM code billed should be entered in chronological order by time seen and must begin with the start and stop time of the base code (64B) followed by the start and stop time of each applicable add code. ➢ When entering times on the claim, the stop time of the base code must be the same as the start time of the first add code. The stop time of the first add code must be the same as the start time of the second add code and so forth.

Billing Examples:

1) Physician sees their patient for an in-person CDM visit. The patient has diabetes, coronary artery disease, and COPD. The physician provides the necessary care and completes three CDM flowsheets. Total physician time spent was from 9:00 – 9:28 AM.

Total billable time is 28 minutes.

- All four billable service codes must be submitted on the same claim as follows:

Code	Start Time	Stop Time
64B	9:00	9:10
65B	9:10	9:15
68B	9:15	9:20
66B	9:20	9:28

- **When entering times on the claim, the stop time of the base code (64B) must be the same as the start time of the first add code (65B).**
- **Start and stop times must be entered in chronological order by time seen from earliest to latest.**

2) Physician calls their patient for virtual CDM visit over the phone. The patient has diabetes and COPD. The physician has a brief discussion with the patient about ordering further lab work and refilling chronic medications. Total physician time spent directly with the patient was from 9:00 – 9:10 AM.

Total billable time is 0 minutes for 864B.

- **Since the minimum time requirement for 864B was not met, only the appropriate virtual visit code (i.e., 805B) is billable.**
- **864B is only payable when 15 minutes of direct physician to patient interaction in real-time discussing key aspects of chronic disease management is spent.**
- **Since only the visit code (805B) is billable, start and stop times are not required to be entered on the claim.**

4. Psychiatry Consultations (9E, 10E, 12E, 13E, 809E, 810E, 812E, 813E)

a)

Payment Schedule Time Requirements:

- **9E, 10E, 809E, 810E** - Adult/Child Consultation (in person & virtual)
  - Minimum of 30 minutes of direct patient care.
- **12E, 13E, 812E, 813E**– Extended Adult/Child Consultation (in person & virtual)
  - Payable when consultation (9E or 10E) exceeds 55 minutes of direct patient care;
  - Each complete 15-minute period or major portion thereof of direct patient care is met.
  - Maximum of 8 units (or 120 minutes) payable.

- **Extended codes (12E/13E/812E/813E) are only billable in addition to the applicable consultation codes (9E/10E) <u>when</u>:**
  - The consultation (9E/10E/809E/810E) exceeds 55 minutes; <u>and</u>
  - The major portion of the extended code (12E/13E/812E/813E) is met (i.e., 62.5 minutes or more of direct patient care has been provided).

b)

<u>Billing Examples:</u>

1) Physician sees a referred adult patient for an in-person psychiatry consultation. The physician spent 90 minutes of direct time with the patient from 9:00 – 10:30 AM and then spends 7 minutes after the patient has left their office writing a letter with their recommendations back to the referring physician.
Total billable time is 90 minutes.

- Both service codes must be submitted on the same claim as follows:

Code	Units	Start Time	Stop Time
9E	1	9:00	9:55
12E	2	9:55	10:30

- **Only two units of the extended consultation are billable because the major portion of the time required to bill a third unit was not met.**
- **Only the time spent directly with the patient is billable.**

2) Physician sees a referred child patient for a virtual psychiatry consultation over the phone. The physician spends 60 minutes of direct time with the patient from 9:00-10:00 AM and then spends 10 minutes after the phone call to write their letter of recommendation back to the referring physician.
Total billable time is 60 minutes.

- Service code must be submitted as follows:

Code	Units	Start Time	Stop Time
810E	1	9:00	10:00

- **Although the consultation exceeded 55 minutes, the extended code is not billable in addition because the major portion of the time required to bill the first unit was not met.**
- **Start and stop times must still be entered on the claim and must represent the minimum required time (30 minutes) stated in the service code descriptor.**

5.	**Advanced Primary Health Care for Pediatric Patients – Psychiatric Care (163B, 164B)**

a)	**<u>Payment Schedule Time Requirements:</u>**
	• 163B - Advanced Primary Health Care for Pediatric Patients – Psychiatric Care, first 15 minutes
	  ○ First 15 minutes of direct patient care.
	• 164B - Advanced Primary Health Care for Pediatric Patients – Psychiatric Care, each subsequent 15 minutes (or major portion thereof)
	  ○ Add-on to 163B for each subsequent 15 minutes or major portion thereof.
	  ○ Maximum of 2 units (or 30 additional minutes) payable.
	  ○ Each subsequent, may be direct or indirect care.

b)	**<u>Billing Example:</u>** **1)** Physician sees a pediatric patient for an in-person psychiatric care. The physician spends 35 minutes of direct time with the patient from 9:00 – 9:35 AM and 20 minutes speaking with the child's social worker over the phone to collect collateral history from 9:35 – 9:55 AM. **Total billable time is 55 minutes.** ➢ Both codes must be submitted on the same claim as follows: <table><tr><th>Code</th><th>Units</th><th>Start Time</th><th>Stop Time</th></tr><tr><td>163B</td><td>1</td><td>9:00</td><td>9:15</td></tr><tr><td>164B</td><td>3</td><td>9:15</td><td>9:55</td></tr></table> ➢ **The stop time and units billed must still reflect the actual time spent; however, the number of units paid by the system will not exceed the maximum allowable units stated in the service code descriptor.** ➢ **Although 40 minutes of additional time was spent, 164B is only payable to a maximum of 2 units (or a maximum of 30 additional minutes).**
6.	**Extended Consultations (12L, 12M, 12N, 12P)**

a)	**<u>Payment Schedule Time Requirements</u>**
	• **12L & 12P - Extended Consultation**
	  ○ Each complete 15-minute period or major portion thereof of direct patient care.
	  ○ Billable when the corresponding consultation (9L/9P) exceeds 25 minutes of direct in-person patient care.
	  ○ A minimum of 32.5 minutes of direct in-person patient care is required to bill the consultation (9L/9P) with the first unit of the extended code (12L/12P).
	  ○ Maximum of 4 units (or 60 additional minutes) payable.
	• **12M & 12N – Extended Consultation**
	  ○ Each complete 15-minute period or major portion thereof of direct patient care.

- Billable when the corresponding consultation (9M/9N) exceeds 20 minutes of direct in-person patient care.
- A minimum of 27.5 minutes of direct in-person patient care is required to bill the consultation (9M/9N) with the first unit of the extended code (12M/12N).
- Maximum of 4 units (or 60 additional minutes) payable.

➢ ***If the above requirements are not met, only the consultation (9L/9P/9M/9N) is billable.***

- When billing an Extended Consultation, start and stop times must be entered in the *Start and Stop Times* field on the claim for **both** the consultation and the extended consultation.
- If only the consultation (9L,9M,9N,9P) is billed, start and stop times are not required to be entered on the claim.

b)

Billing Examples:

1) Physician sees a referred patient for an in-person general surgery consultation. The physician spent 95 minutes of direct time with the patient from 9:00 – 10:35 AM and 5 minutes after the patient has left their office writing a letter with their recommendations back to the referring physician.
Total billable time is 95 minutes.

➢ Both codes should be submitted on the same claim as follows:

Code	Units	Start Time	Stop Time
9L	1	9:00	9:25
12L	5	9:25	10:35

➢ **The stop time and units billed must still reflect the actual time spent; however, the number of units paid by the system will not exceed the maximum allowable units stated in the service code descriptor.**

➢ **Although 70 minutes of additional time was spent, 12L is only payable to a maximum of 4 units (or 60 additional minutes).**

2) Physician sees a referred patient for an in-person plastic surgery consultation. The physician spends 23 minutes of direct time with the patient from 9:00 – 9:23 AM and spends 6 minutes after the patient has left their office writing their recommendation back to the referring physician.
Total billable time is 0 minutes for 12N.

➢ **Since the minimum required time to bill 12N was not met, only the consultation (9N) is billable.**

➢ **A minimum of 27.5 minutes of direct in-person patient care is required to bill the first unit of the extended code (12N).**

➢ **Since only the consultation (9N) is billable, start and stop times are not required to be entered on the claim.**