Hospital Care – Psychiatrists

Billing Information Sheet

Insured Services, Medical Services Branch

1.	HOSPITAL DAY CARE (25E, 26E, 27E, 28E)
a)	**BASED ON "SPANS" OF DATES** • Claim must show the total number of days from the date you assumed the care as the most responsible physician (MRP), to the date you ceased to assume care (in spans according to the maximum days allowable under each service code. Generally speaking, hospital care codes are inclusive of all visits). • Do not bill hospital day care on multiple separate lines of service; bill in 'spans' as much as possible.
b)	**CALL-BACKS TO THE HOSPITAL** In the event of an urgent/emergent call back to the hospital outside of regular hospital rounds, the appropriate visit service PLUS the applicable surcharge (815A-839A) can be billed.
c)	**DAY OF ADMISSION** On day of admission to hospital: • hospital care is payable • A consultation/visit may be billed
d)	**DAY OF DISCHARGE** • Hospital Discharge (725A) can be billed by the physician most responsible for discharging the patient. It must be billed on the date of discharge and location 2 (hospital in-patient). • Only ONE (1) discharge is paid per patient per admission. • No visit services are payable to attend the patient and discharge them. This is included in the hospital day care (25-28B-T) and the 725A.
e)	**CONTINUOUS CARE** • *This means that more than one physician's hospital care follows another.* • Physicians in the same specialty must bill at the continuing care rates when following others; no restarts allowed within specialties no matter when you assumed the care. • The patient's care should be 'cost neutral' when other physicians are assuming care. • If you are the first physician in your specialty to assume care, you can start at day 1 (25B-T) no matter when the patient was admitted. • If your claim has failed for an analyst to review, they will adjust these spans appropriately if another physician has billed prior to you. They will use explanatory code "DT".

f)	**CONCURRENT CARE** • *More than one physician billing hospital care at the same time* • Requires that an explanation be provided to support why the concurrent care is medically necessary. • Generally speaking, we allow the GP and at least 1 specialist to bill concurrent care without question. • If your claim has failed for an analyst to review, if there is unexplained concurrent care within your specialty, they will reject the claim with explanatory code "DX". Please resubmit with a comment indicating why the concurrent care was necessary.
2.	**TRANSFERS OF CARE IN HOSPITAL**
a)	*A change of attending physician or when a physician has been asked to cover for another physician.* The billing should be as if there was a continuation of care under the same physician.
b)	The new attending/covering physician is not entitled to charge an assessment/consultation for the first patient contact.
c)	The new attending/covering physician should continue billing hospital care at the same point in the hospital care series.
d)	The only time we would expect to see a consultation/visit service on transfer is when there has been a change in service (ie: different specialty taking over) due to the complexity of the patient's condition.
3.	**PSYCHIATRIC VISIT SERVICES PROVIDED TO INPATIENTS**
a)	Because the services that psychiatrists provide to inpatients are unique and different than general medicine inpatients, we allow a slightly modified/different billing model.
b)	Generally, for medicine inpatient stays, only hospital day care codes are billable. Separate "visit" services are only payable when the physician is specially called out due to a medical urgency not related to the daily ward rounds.
c)	Because psychiatric inpatients may be receiving counseling, psychotherapy or other specialized psychiatric services during their inpatient stay, we allow psychiatrists to bill those services in lieu of

	hospital care codes. These include: • Group Psychotherapy (33E, 34E) • Family Psychotherapy (35E, 37E) • Individual Psychotherapy or Psychiatric Counseling (38E, 39E) • Psychiatric Care (40E, 41E) ***On the days when these services have not been provided, hospital care is billable.***
4.	**TIME-BASED SERVICE CODES**
a)	Some of the most commonly billed psychiatric service codes are time-based. • Group Psychotherapy (33E, 34E) • Family Psychotherapy (35E, 37E) • Individual Psychotherapy or Psychiatric Counseling (38E, 39E) • Psychiatric Care (40E, 41E)
b)	Watch for service codes that are for 'additional time units' that state: • **Major part thereof** • **Major portion thereof** ***This means: if the additional time unit is worth 15 minutes you need to provide the service for AT LEAST an additional 7.5 minutes in order to bill the additional time unit.***
5.	**ELECTROSHOCK THERAPY (42E)**
a)	This service is classified as "0" day surgical procedure.
b)	If you bill electroshock therapy on the same day as any visit service (including consultations and hospital care), then payment for the 42E will be reduced to 75% of the fee. This rule is found under explanatory code "FP" and the assessment rules found in the payment schedule for visit + procedure services.