Hospital Care – All Physicians (Excluding Psychiatry)

Billing Information Sheet

Insured Services, Medical Services Branch

1.	HOSPITAL DAY CARE (25 – 28B – T)
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)	**CALLBACKS 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, your claim will be adjusted according to the previously billed hospital care at the continuing care rate with 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. Comments indicating only "concurrent care" will not be considered an acceptable explanation. • Generally speaking, we allow the GP and at least 1 specialist to bill concurrent care without question. • If there is unexplained concurrent care within your specialty, your claim will be rejected 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 where a consultation/visit service on transfer is acceptable is when there has been a change in service (ie: different specialty taking over) due to the complexity of the patient's condition.