

Dr.Bill®

**AN
ANAESTHESIOLOGY
GUIDE TO BILLING
IN B.C.**

WHAT'S INSIDE

CHAPTER 1

Anaesthesiology Salary Expectations & MSP Billing Basics

- 1.1 Salary Components for Anaesthesiology
- 1.2 How Claim Submission Works
- 1.3 How to Register to Bill
- 1.4 Overage Claims
- 1.5 Other types of Billing

CHAPTER 2

Anaesthesiology Fee Code Breakdown

- 2.1 Anaesthesiology Cheat Sheet
- 2.2 Anaesthesia Billing Tutorial (Most Common Codes)
- 2.3 Anaesthesiology Diagnostic Codes
- 2.4 Telehealth Billing
- 2.5 Working as a Locum
- 2.6 Billing WCB for Surgeries

CHAPTER 3

Anesthesiologist Billing Tips & Common Mistakes

- 3.1 Billing Reminders
- 3.2 The Most Common Types of Rejections

CHAPTER 4

Test your knowledge

- 4.1 Anaesthesiology Quiz
- 4.2 Answers

CHAPTER

01

ANAESTHESIOLOGY SALARY EXPECTATIONS & MSP BILLING BASICS

Anesthesiologists are in high demand throughout BC. Most work under the fee-for-service model and need to bill the government for their time. Knowing how claim submission in BC works will ensure that you fully understand why your claims need to be submitted a particular way. This chapter covers the potential earnings for anesthesiologists, the claim submission process, how to register to bill, overage claims, and other types of billing.

- 1.1 Salary Components for Anaesthesiology
- 1.2 How Claim Submission works
- 1.3 How to Register to Bill
- 1.4 Overage Claims
- 1.5 Other types of Billing

Salary Components for Anaesthesiology

Anesthesiologists are some of the most in-demand physicians since they provide a necessary service to surgeons, emergency rooms, and obstetricians. Their value is reflected in their earnings, which is one of the highest among medical specialists in Canada. Anesthesiologists in Canada earn **an average of \$437,000**  – almost all through the fee-for-service model – which varies depending on location, the types of procedures performed, and how much time you spend consulting with patients vs being in surgery. Your salary will depend on a few variables:

Types of Consultations and Surgical Procedures

In Canada, anesthesiologist salaries come from a mix of consultations – including pre-operative services such as hospital and office visits, and assessments for chronic pain – and surgeries. Depending on the complexity of the surgical procedure, the circumstances involved, the patient's age, the diagnosis, and the amount of post-op pain management required, what you can bill will differ considerably, and determine how much you earn for your time.

Working in a specific setting like a long-term care home, a specialized surgical practice, or in a delivery room will ensure more predictable earnings. Research shows that anesthesiologists in these settings work consistently until the age of 65 and often bill for similar procedures daily. Working in a busy surgery or emergency setting, on the other hand, means having less control over the types of patients you treat and the amounts you can bill.

Days Worked

Anesthesiologists take advantage of being in high demand and short supply by working steady hours – an average of 50.3 a week, according to the CMA. So much demand means opportunities for working **locum positions** , taking on contracts, and working at multiple locations. Anesthesiologists earn almost exclusively through the fee-for-service model, giving them the flexibility of deciding when and where to work.

Location

There are contract premiums and incentives available to those who work in rural districts or travel to remote areas. The **Northern Health incentive**  offered in BC, for example, gives doctors an additional \$15,000–20,000 bonus on top of their salary (and covers their moving expenses). programs like these are good options for increasing earnings and work-life balance, while also allowing you to take on more responsibility – which can help the future of your career – and benefit the healthcare field overall.

Clinical Setting

Anesthesiologists work almost exclusively in a hospital setting which explains why at 13% they have some of the lowest overhead of all doctors. how much you earn depends a lot on the complexity of the procedures you perform and the kinds of patients you see. highly complex patients with advanced diseases or chronic pain, aging populations, children,

or patients in emergency situations make you eligible for premiums in addition to your regular billings.

Anesthesiologists are a necessary and in-demand component of the medical professional. Whether you work in a busy eR, delivery room, or dental clinic, there are a variety of positions available to provide you a steady and consistent salary.



How Claim Submission works

If you work under the fee-for-service model you'll have to submit claims to the Medical Services plan (MSP) explaining what you did and who you saw. MSP will reimburse you after reviewing and approving your claim.

Cancel Add Claim Save

Saunders, Kelly

Basic WSBC

BILLING CODE

IN OFFICE: (AGE 80+)-CONSULTAT... 18110 >

Amount \$115.17

Diagnoses 428 >

Location Practitioner's office - in community

Rural Premium Location (None) >

DATES & TIMES

Date of Service 23 Sep 2019

Start Time 11:00

End Time 11:25

Patient Adm. Date 20 Jan 2019

PREMIUMS

Call Out ☐

Cont. Care ☐

Apply +10% Premium ☐

Referring Physician Abbas, Ali >

Notes

MSP Required Information

Each claim you submit must include the following information:

- Fee Code
- Date of Service
- Diagnosis
- Referring Physician
- Service Location

If you aren't sure which code applies to your visit, you can check the MSP payment Schedule, which lists all insured medical services that can be billed in BC, and it's where you can find descriptions and dollar amounts for each fee code.

Looking through the lengthy payment schedule is time-consuming and sometimes hard to navigate. Using an electronic searchable database – **BC Medical Billing Fee Codes: Searchable Database** [↗](#) – will help you find the exact code you're looking for, saving you tons of time.

How to submit Claims

'Telepan' is the only way to securely submit claims in BC and requires a data centre number (government regulations demand strict privacy and security requirements to be met). It is possible to submit claims yourself, however most physicians use a 3rd party billing software (like **Dr. Bill** [↗](#)) so they can upload claims in bulk and review reports online.

Payment & Reports

Twice a month MSP processes claim submissions. Any claims submitted before 11am on the deadline date will show up on the next remittance. Using a [reminder calendar](#) can help keep you on track and avoid missing a deadline.

Once your claims are submitted, MSP will send two reports informing you of the status (approved, adjusted, rejected, or paid with adjustment). These reports are known as a 'MSP Remittance Advice (RA) Report' and an 'error Code Report'.

MSP Remittance Advice (RA) Report

You can find which claims were approved or paid with adjustment on your remittance report. An adjusted claim is paid but usually at a lower cost. The frequency of when you receive this

report will depend on the billing software you use. With Dr. Bill, you'll get an official RA Report twice per month, but can track the status of your claims at any time through your dashboard. You can also see how much you've earned each day via our daily reports.

Claims Error Report

Your rejected or refused MSP claims will appear on the Claims error Report. There are 706 reasons why claims can get turned down, each accompanied with an error code. You can search any error code using our [Explanatory Code Lookup](#) to get a description explaining the error.

If you're new to MSP billing, it's a good idea to review the payment schedule and choose your billing software so you can familiarize yourself with their backend and submit practice claims. Knowing how claim submission works means you'll get paid quicker and easier.

PAYMENT PROVINCE

British Columbia

AMOUNT PAID

\$329.65

Cheque Amount

EXPECTED PAYMENT DATE

FEB 28

Payment Breakdown

Direct link to the individual claim

Claim status at the time of this remittance

Claim	Status Change	Assessed Amount	Adjusted Amount
13334 for PHN ' ' on JAN 17, 2019	Paid	\$33.81	\$33.81
13338 for PHN ' ' on JAN 22, 2019	Paid With Adjustment	-\$37.82	-\$37.82
13338 for PHN ' ' on JAN 22, 2019	Paid	\$37.82	\$37.82
13338 for PHN ' ' on JAN 22, 2019	Paid	\$37.82	\$37.82
13334 for PHN ' ' on JAN 18, 2019	Rejected	\$0.00	\$0.00
00115 for PHN ' ' on JAN 18, 2019	Paid	\$114.29	\$114.29

How to Register to Bill

If you're new to billing in BC you'll need to apply for an MSP practitioner number. This 5 digit number enrolls you in MSP, stays with you throughout your practice, and is what colleagues will use as your referring practitioner number.

*Your MSP practitioner number is not the same as your CPSID number. Your practitioner number tells MSP who you are and where your claims are coming from, whereas your CPSID number is your ID that registers you with the College of Physicians and Surgeons.

The MSP Practitioner Number Application

When applying for your free registration, be sure to have the following information:

- Your Independent License # from the College of Physicians and Surgeons
- Application for MSP Billing number (physicians) (hLTh 2991) (PDF, 140KB) (you have to choose 'Opted-in' to bill MSP directly)

Mail the form to:

Medical Services Plan
PO Box 9480 Stn Prov Govt
Victoria, B.C. V8W 9E7

Important Note: If you're submitting claims with Dr. Bill, you can fill out this form electronically and send it directly to MSP.

Connect Your MSP Payee Number to a Data Centre

Once you have your MSP practitioner number you'll need to connect it to a data centre. Remember, all claims must have your billing number and a data centre number to tell MSP where and who the claims come from.

Depending on where you work you may need an additional payee number, however, sometimes it's possible to connect your practitioner number to MSP.

MSP Practitioner Number vs. Your MSP Payee Number

It's common to be confused about the difference between the MSP practitioner number and the MSP payee number. To help you better understand:

If you've never billed with MSP before, your MSP practitioner number acts as your payee number. You'll only have to apply to get a different payee number if you'll be billing at multiple locations at the same time. This is because a single payee number can only be used to bill with a single billing service/EMR.

Technically, a billing number has two numbers:

- **The practitioner number** – this explains the practitioner performing and taking responsibility for the service.
- **The payee number** – this explains where the claim is coming from and where to send payment for claims submitted under that number.

In the beginning, your practitioner number and billing number are the same number. Later, if you start working at different locations, you'll need to get additional payment numbers. You can have multiple different payee numbers under your practitioner number.

For example:

- 12345: MSP practitioner number
- 12345: Used when billing through your EMR
- 44467: Used when you use Dr. Bill to submit your In-Hospital claims



You'll always have the same practitioner number since that's what colleagues will use on their claims when you're the referring physician, but you may have several different payee numbers.

Accordingly, to connect your MSP number to your billing software you have to fill out one of the following forms – depending on where you work:

A) Teleplan Application

If you want to connect your existing payee number you'll have to fill this out. Your existing payee number is not to be used anywhere else.

For example:

- You're a new physician and haven't billed before. Fill out a Teleplan application using your MSP practitioner number (which acts as your payee number).
- Previously, you used 12345 to bill for locum work but now that you're no longer locuming you can use the Teleplan application to connect 12345 to your new billing software.

You can either print out and mail this form to MSP, or fill it out electronically through Dr. Bill:

Teleplan Application

B) New Payee Number

If you're billing with your current payee number somewhere else and need a new payee number, fill this out.

You can either print out and mail this form to MSP, or fill it out electronically through Dr. Bill:

New Payee Application

For a complete breakdown of MSP payee numbers see **Chapter 2** in our MSP Billing guide.

MSP requires that claims are submitted within 90 days of the date of service so you'll want to get in the habit of submitting claims on time to avoid them being refused with a BV explanatory code.

If you do have overage claims, you'll have to provide MSP with a valid reason for the delay. If you think you have a valid reason you can try submitting an overage claim request which costs \$75 to recover the funds.

With this in mind, it's best to try to remember to submit your claims within 90 days to avoid penalties.



More available eBooks and guides to help you navigate through the world of medical billing.

View Resources 

Other types of Billing

Some types of billing you may need to do aren't always covered directly by MSP. here is an overview of some such cases:

Out of Province

Patients who aren't covered in BC but have coverage from another province are directly billed through MSP. You just have to confirm that their patient card has the correct billing address and their health card. MSP will then sort it out through the province they're covered under. This is valid thanks to the reciprocal program which allows all provinces (except Quebec) to receive shared coverage throughout Canada.

Quebec

Patients from Quebec will need to be invoiced directly since their province doesn't participate in the reciprocal program.

Uninsured Patients

Patients who aren't insured (out-of-country or from Quebec) will need to be privately invoiced. With Dr. Bill, for example, you can create and print an invoice to send to your patient directly.

Work Safe BC & ICBC

You'll need to join Work Safe BC if you provide treatment to a patient who was hurt at work.

There is no formal process or contract required to work with WSBC so check with your billing service to learn how to submit WSBC claims. You might need to create an account directly with WSBC if your software program doesn't provide one.

With Dr. Bill, on the other hand, you simply create a claim like you normally would, but select "WSBC" instead of "MSP."

Register with ICBC

You'll need to register for a vendor number through ICBC to treat patients who were injured in automobile crashes. Then you have to submit a claim like you normally would to MSP (indicating ICBC on the claim) any time you treat someone, in addition to filling out an online form detailing the accident.

How to Get a Vendor number:

Apply for an ICBC vendor number online

How to get paid for ICBC claims:

1. Submit a 'CL489' claim report through ICBC's online portal. Learn which CL489 Report to send based on your specialty.
2. Submit a claim to MSP, (if you're billing with Dr. Bill simply choose ICBC instead of MSP).

RCMP/DND/Refugees/Prisoners

When privately invoicing an RCMP officer, DnD, refugee, or prisoner you'll have to add a specific number (every category has a specific identifier) to the patient card. With Dr. Bill, for example, if you see a prisoner, you add them using their correctional ID or CS number – usually 7-9 digits long – provided by the prison. Always check with your billing software for more information in these situations.



02

ANAESTHESIOLOGY FEE CODE BREAKDOWN

Working Fee-for-service can be time-consuming and overwhelming. You need to make sure you submit claims correctly in order to be reimbursed properly for your time. In addition to a busy workload, it can be stressful handling rejections and refusals. In this chapter, we've created an anaesthesiology 'cheat sheet' so you know where to find the codes you're looking for, a tutorial on the most commonly used fee codes, a tool to look up diagnostic codes, telehealth billing, some tips on locum paperwork, and billing WCB for surgeries.

- 2.1 Anaesthesiology Cheat Sheet
- 2.2 Anaesthesiology Billing Tutorial (Most Common Codes)
- 2.3 Anaesthesiology Diagnostic Codes
- 2.4 Telehealth Billing
- 2.5 Working as a Locum
- 2.6 Billing WCB for Surgeries

Anaesthesiology Cheat Sheet

It's easy to bill the right codes when you have a reference list on hand, especially when you're just starting out. While we have an [in-depth billing guide](#), it's a good idea to make your own cheat sheet to help you remember the fee codes you'll be using and their rules. Make sure to include the following:

Pre-Anesthetic Evaluation Fees:

- [01151](#): pre-anaesthetic evaluation – standard – Applicable to certified anesthesiologists only.
- [13052](#): Anaesthetic evaluation – non-certified anaesthetist
 - Used for in-patient visits where a separate visit prior to the anaesthetic is required. If you're performing a visit immediately prior to the anaesthetic, it will be paid using the anaesthetic intensity/complexity level of the procedure itself and 01151 – this code will not be paid in addition.
 - Can also be used for out-patient visits where a separate visit for an anaesthetic assessment is required (such as in a pre-anesthetic clinic).

Consultations:

- [01015](#): Consultation, anaesthesia – This code is used when a certified anaesthesiology specialist is requested for a patient assessment because of the complexity, obscurity, and/or seriousness of the case.
- [01115](#): Consultation – repeat/limited anaesthesia
 - This is used when a repeat consultation is necessary for the same condition within six months and done by the same consultant.
 - It is also used for a limited consultation when in the opinion of the consultant the problem does not warrant 01015.

- **01016** : Consultation, mgmt of complicated chronic pain – This code is used in consultations for complex diagnostic and/or therapeutic chronic pain management problems that need a comprehensive history and a physical examination.
- **01116** : Consultation – repeat or limited diagnostic/pain mgmt
 - Used when, in the opinion of the consultant, the diagnostic and/or therapeutic chronic pain management problem is of a more limited nature.
 - If the same physician sees a patient for a consultation within six months of billing 01016 for the same problem, then they would also use this code.
- **01107** : Office visit – anaesthesia
 - This fee code applies to patient visits conducted in a private office setting where the physician has an increased overhead.
- **01155** : Telehealth Anesthesiology Consultation:
 - This is used for telehealth sessions conducted by a certified specialist in Anesthesiology because of the complexity, obscurity and/or seriousness of the case. Includes appropriate history and an appropriate physical examination, as well as a review of pertinent radiological and laboratory findings and a written report.

Visit/Evaluation:

- **01107** : Office visit.
 - not paid with other listings.
- **01108** : hospital visit (weekday)
 - not paid with other listings.
 - Applies only on weekdays, excluding statutory holidays.
 - Out-of-Office hour premiums are not applicable.
- **01109** : hospital visit (Saturday, Sunday, or statutory holiday)
 - not paid with other listings
 - Applies only on Saturday, Sunday, or statutory holidays
 - Out-of-office hour premiums are not applicable

Call Outs & Continuing Care Premiums

A call out is a premium added when you are called from outside of the hospital to come and care for a patient. During weekdays the call must be placed prior to 8:00am or after 6:00pm. On weekends the call must be placed after 8:00am. however, if you're called during regular weekday hours **you'd bill an emergency visit instead** , which covers both the visit and the surcharge.



If you have logged a Call Out charge and then continue to see additional patients you would be entitled to bill continuing care surcharges for each 30 minutes after the initial 30 minutes you spent with the patient you were initially called to see.

If you see multiple patients in a 30 minute block you would only log the continuing care on the last patient in that block but for the entire 30 minute period. You must also note CCFpp in the MSP note field to tell MSP that these patients were seen following your initial call out to the hospital.

To apply these surcharges on Dr. Bill, log your consult or visit with the patient. On that claim toggle 'Call Out & Continuing Care'. Don't forget to enter the Call Time, Start Time & end Time for your encounter. Our app will automatically apply the correct Out of Office premiums to your claim. If you need to claim a call out on its own or aren't using Dr. Bill then use the following fee codes:

Call Out Fee codes:

- **01200** : evening (call placed between 6:00pm and 11:00pm and service rendered between 1800 hours and 0800 hours)
- **01200** : night (call placed and service rendered between 11:00pm hours and 8:00am)
- **01200** : Saturday, Sunday or Statutory holiday (call placed between 8:00am and 11:00pm)

Continuing Care Surcharge Fee Codes (nonoperative):

Billed in addition to visits and consultation fees.

- **01205** : evening (service rendered between 6:00pm and 11:00pm) – per half hour or major part thereof
- **01206** : night (service rendered between 11:00pm hours and 8:00am) – per half hour or major part thereof
- **01207** : Saturday, Sunday or Statutory holiday (Service rendered between 8:00am and 11:00pm) – per half hour or major part thereof

Intensity and Complexity Index Intensity/Complexity Fee:

Anaesthetic intensity level/complexity time units are also indicated in the listing – these represent the different degrees of complexity and intensity for each procedure. Fees for your time are allocated in accordance to this intensity/complexity.

For each 15 minute Level Code or part thereof.

- Level 2: **01172** 
- Level 3: **01173** 
- Level 4: **01174** 
- Level 5: **01175** 
- Level 6: **01176** 
- Level 7: **01177** 
- Level 8: **01178** 
- Level 9: **01179** 
- Level 10: **01180** 
- Level 11: **01181** 

Anesthetic Procedural Fee Modifiers:

These are fixed fees that are paid in addition to the basic anesthetic procedural fees – these give you additional compensation for performing anaesthesia in certain situations. They are not included in the anesthetic procedural fee for the application of 01080.

- **01059** : prone position
- **01065** : patients under 1 year of age
- note: not to be billed in addition to 01168.
- **01070** : Controlled hypotension in neurosurgical anesthetic to lower mean blood pressure to 60 mm hg or less, or the appropriate safe lower limit
- **01071** : Thoracic epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up

- **01072** : Lumbar epidural catheter insertion during anesthetic, to include initial injection and/or infusion set-up
 - **01077** : pulmonary artery catheterization
 - **01082** : Axillary catheter insertion during anesthetic, to include initial injection and/or infusion set-up
 - **01084** : Intrapleural catheter insertion during anesthetic, to include initial injection and/or infusion set-up
 - **01093** : Spinal cord monitoring (interpretation of S-Sep during anesthetic)
 - **01096** : Retrobulbar/peribulbar block administered by an anesthesiologist in conjunction with an anesthetic
 - **01164** : patients 70 – 79 years of age
 - **01165** : patients 80 years of age and over
 - **01166** : Sitting position where there is a danger of venous air embolism
 - **01168** : neonates (less than 42 gestational weeks and/or 4000 grams or less)
 - **01192** : Awake intubation by any means in the patient with a suspected or proven difficult airway – note: Applicable only when airway score is 3 or 4.
 - **01169**: BMI ≥ 35 per 15 minutes or part thereof
 - Restricted to certified specialists in anaesthesiology and payable only when fee items 01172, 01173, 01174, 01175, 01176, 01177, 01178, 01179, 01180, 01181, 01005, 01106, 01110, or 01111 are also payable.
 - Applicable to all patients ≥ 19 years of age with a BMI ≥ 35 and to all patients < 19 years of age with a BMI ≥ 97 th percentile adjusted for age and gender.
 - **01080** : In the following cases an additional 15% of the procedural fee will be paid:
 - All patients (except cardiac surgery patients) who have an incapacitating, systemic disease which is a constant threat to life, or who are not expected to survive for 24 hours, i.e. ASA 4 or 5.
 - Cardiac surgery patients who have emergency surgery, i.e. ASA 4e or 5e.
 - Cardiac or transplant surgery patients who require an IABp or mechanical assist device.
 - All cases where the surgical time as noted on the OR record is 8 hours or more. This includes cardiac surgery.
 - You must provide the patient's BMI in the claim note record and document it on the patient's anesthetic record.
- For a breakdown of all of these anesthesia-specific fee codes, see our searchable database:
- Anaesthesia Fee Code Database** 

Anesthesiology Billing Tutorial (Most Common Codes)

Scenario 1:

You are called at 8:00pm on a Wednesday night to do the anesthetic for 2 hours starting at 8:30pm for a 45 year old patient urgently.

You'd bill a:

- 01174 (or Anesthetic level code that matches the surgery/procedure billed) with start and end times of 20:30 to 22:30
- Call Out with call time of 20:00
- CCFPP

While at the hospital you are asked to perform the anesthetic for an 80 year old patient and attend the patient for an hour.

You would bill:

- 01174 (or Anesthetic level code that matches the surgery/procedure billed) with start and end times of 22:30-23:30
- CCFPP

Then create a new claim for:

- 01165 (patients 80 years of age and over)



More available eBooks and guides to help you navigate through the world of medical billing.

[View Resources](#) 

Scenario 2:

You are working in the hospital on a Saturday and perform anesthetic for 2 hours for a 35 year old patient who has a BMI of 38.9 from 1:15pm to 3:15pm.

You'd bill a:

- 01176 (or Anesthetic level code that matches the surgery/procedure billed) with start and end times of 13:15 to 15:15
- CCFPP

Then create a new claim for:

- 01169 with a note record stating "BMI 38.9"

Scenario 3:

You are working in the hospital on a Monday and perform the anesthetic for a Cardiac surgery patient who had to have emergency surgery at 10:30am and that lasted 4 hours.

You'd bill a:

- 01178 (or Anesthetic level code that matches the surgery/procedure billed) with start and end times of 10:30 to 14:30

Then create a new claim for:

- 01080 with start and end times that match the 01178 and a note stating "ASA 4e"

Scenario 4:

You're working in a hospital and see a patient at 9:00am for the pre-anesthetic evaluation for a scheduled 2 hour surgery starting at 10:00am but the surgery gets bumped to later that evening at 6:00pm.

You'd bill a:

- 01151 (pre-anesthetic evaluation) with times of 09:00-09:30

Then create a new claim for:

- 01174 (or Anesthetic level code that matches the surgery/procedure billed) with start and end times of 18:00-20:00
- CCFPP

Scenario 5:

You are working in a hospital on a Wednesday afternoon and are asked to perform a labor epidural insertion and monitoring at 4:00pm. The labor lasts until 8:45pm.

You'd bill a:

- 01102 (Insertion of epidural catheter) with times of 16:00 to 16:30

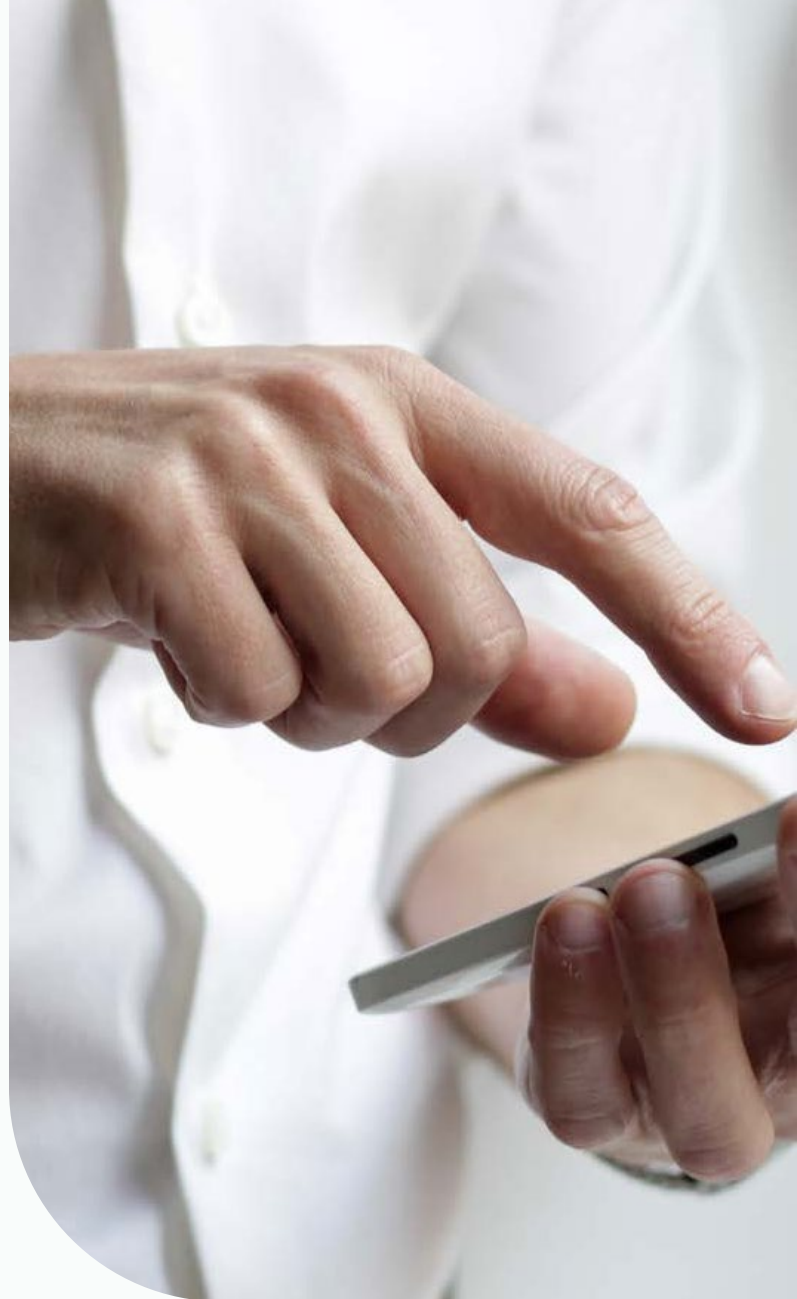
Then create a new claim for:

- 01047 (Medical Supervision of Labor epidural Analgesia: Daytime) with times of 16:30 to 20:30. 01047-01049 has a maximum of 48 units (4 hours).

While attending the first patient you are asked to monitor the epidural on another maternity patient starting at 6:30pm. The labor lasts until 11:30pm.

You'd bill a:

- 01048 (Medical Supervision of Labor epidural Analgesia: evening) with times of 18:30 to 22:30.



More available eBooks and guides to help you navigate through the world of medical billing.

[View Resources](#) 

Anaesthesiology Diagnostic Codes

Every claim you submit must have a diagnostic code. The generic diagnosis code for anaesthesia is 01Z (it stands for anaesthetic).

However, there might be times when you're doing a consultation or follow-up where that's not the same. We are currently putting together a searchable database of all MSP's diagnostic codes. To be notified when it's ready please email billingcoach@dr-bill.ca , otherwise, if you download the Dr. Bill app you can search all MSP diagnostic codes by keyword or fee code.

[MSP Billing Code Lookup \(Anaesthesia Telehealth\)](#) 



More available eBooks and guides to help you navigate through the world of medical billing.

[View Resources](#) 

Telehealth Billing

Billing for virtual visits is very similar to submitting a regular claim since MSP ensures all Telehealth services.

Simply create claims just like you would for a regular service, just make sure you select the Telehealth code listed in the **general preamble** [↗](#) for that service. They can also easily be searched in the Dr. Bill app by typing 'Telehealth' (the app syncs with MSP codes and is always up-to-date).

To look up any Anaesthesiology Telehealth billing code you can use our online searchable database, just scroll down to where it says 'Telehealth Services'.

MSP Billing Code Lookup (Anaesthesia Telehealth) [↗](#)

MSP has additionally introduced temporary billing changes to expand Telehealth services during the pandemic. Take a look at our **COVID-19 billing guide** [↗](#) for an overview of the changes.

General Virtual Care Billing Rules & Guidelines

- Similar to regular visits, you can only claim one Telehealth service on the same day for the same patient to be reimbursed by MSP
- You can be reimbursed for up to 4 services per patient per year
- Your patient has to be informed about virtual care, have a chance to agree to having a virtual visit, and have valid health insurance
- If you're not in an approved site (i.e. hospital or medical facility) you're responsible for the confidentiality and security of all records and transmissions related to the Telehealth service
- Both you and your patient have to attend the service
- Face-to-face encounters are required for services other than those designated as Telehealth services
- If you determine after providing a Telehealth consultation that your patient needs in-person examination, you would bill the subsequent visit as a limited consultation (given the visit meets the criteria and is 42 days post Telehealth consultation), unless it has been more than 6 months since the Telehealth consultation
- A Telehealth service is incomplete if it experiences technical failure and can't be recovered within a reasonable timeframe. In this case, you'll have to submit a claim for independent consideration using the appropriate **miscellaneous code** [↗](#)
- Rural Retention fee-for-service premiums are applicable to Telehealth services

Working as a Locum

Locuming is when you temporarily substitute, to either replace a specific physician (like a substitute teacher), or to help with patient overflow.

There are a lot of reasons why you should consider starting your career as a locum. Conventionally, locums are quite common for physicians who are in their first 5 years of practice, or for physicians who are near retirement. But this mindset is changing and many physicians are locuming for a better work-life balance. It's great for new families, offers more unique practice experiences and the ability to choose when and what type of work you'd like to do (and demand is high)!

Specifically, as a new grad, here are some of the best benefits:

It's the best way to trial out a practice before committing to a permanent position

You are a "freelance" doctor and have flexibility and control over your schedule. So you can be as busy or as free as you want to be. If you need 2 weeks off, you just block them off on your calendar!

Minimal administration – you do not have any of the responsibilities that come with running a practice (hiring/firing MOAs, ordering supplies, etc.).

It's a great way to see the country/travel while working

If you are starting out as a locum, follow along with our locum billing guide tutorial below – to make sure you've filled out all the paperwork for incentives and premiums and check out the list of locum specific incentives.



[VIDEO]

[View Resources](#) 

Billing WCB for Surgeries

Anesthesia for all expedited surgical procedures have to be billed electronically through Teleplan, except for nerve blocks and extensive spinal surgery.

Fee codes:

- the appropriate MSP fee code (Intensity & Complexity Index)
- 19507 – for expedited Anesthetic Service
- Note: This is a “time-based” fee code and can be used for 15 min. blocks.
- Apply MSP/WorkSafeBC Out-of-Office Surcharges as applicable.

Steps:

1. FAX a copy of the Record of Anesthesia to [604] 233-9777 or send it Toll Free to 1-888-922-8808. Be sure to include the claim number on all pages of the fax, otherwise it could result in “none payment”.
2. The anesthetic time has to include a preoperative assessment, in addition to exact start and stop times. (i.e., the time from induction up until the anesthesiologist is no longer present and the injured worker can be safely discharged for pAR). please note, if the pre-operative and pAR times are significantly longer than 30 minutes, then an explanatory note is required.
3. All WCB claim details have to be submitted.

Quick Reference

The Report must be faxed as noted above.

Anaesthesiology Billing	Fee code	Additional Person(s) Seen
MSP Level 3 for time of 3.5 hours	01173	Bill through Teleplan
WorkSafeBC Unique Fee Anaesthesia Time Based Block for time of 3.5 hours	19507	Bill through Teleplan
MSP Out-of-Office Surcharges(s)	Apply as required	Bill through Teleplan
WorkSafeBC Out-of-Office Surcharge	Apply as required	Bill through Teleplan



More available eBooks and guides to help you navigate through the world of medical billing.

[View Resources](#)

CHAPTER

03

ANESTHESIOLOGIST BILLING TIPS & COMMON MISTAKES

Whether you're just starting your career or an experienced anesthesiologist, MSP fee codes are confusing and mistakes are bound to happen.

Rejections can cause delayed payment or sometimes lost money and therefore, you'll want to avoid these mistakes as best you can. Reviewing the details of your claims can ensure your payment is on time and as expected.

This chapter covers common billing mistakes, the kinds of rejections you might get, and how to fix them.

3.1 Billing Reminders

3.2 The Most Common Types of Rejections

Billing Reminders



Billing correctly with MSP can be tricky. If you're new to billing it's common to see rejections, which are often fixable but cause you a delay in payment, or fewer earnings than you'd expected. Therefore, it's useful to **understand how to prevent rejections** [↗](#), mistakes, or missed opportunities to bill.

Data Capture

Capturing or inputting patient data incorrectly are the most common and time-consuming mistakes in MSP billing.

Wrong PHN

To avoid inputting the incorrect patient health number, or learning too late that they're uninsured, check with your billing provider to see if they have automatic data collection tools or insurance eligibility checks. With **Dr. Bill** [↗](#), for example, eligibility checks are automatically run on refused claims and anything that's eligible is resubmitted.

Forgetting a Referring Physician

Unless you're the first point of contact for a patient, a referring physician is usually required for consultations and visits. If you don't add a referring physician your claim will be rejected.

Failing to Meet Code Requirements

Your claim will be rejected if you use a code for a shorter visit than required. It's useful to know which **fee codes**  require a specific amount of time, such as fifteen minutes, to avoid breaking the rule.

Location of Fee Code Doesn't Match

If you bill a fee code in the wrong location (i.e. a radiology code in the eR), MSP will reject your claim.

Call Out/Continuing Care

Call outs and continuing care are one of the most complex aspects of MSP billing. It's helpful to know how they work so you don't make these common mistakes.

Call outs are premiums added to a claim if you get called in from outside of the hospital to care for a patient.

Continuing care is when you continue caring for patients after you've logged a call out charge.

It's useful to know the rules associated with these premiums since they can provide you additional income.

Call Outs:

- You can use call out premiums if you're called out to the hospital on an urgent, non-elective basis, using billing items (**01200** , **01201** , **01202** ).
- These premiums are based on the time you were called. During weekdays, if the call is between 6pm and 11pm you'd bill **01200**  for evenings. If the call is between 11pm and 8am you'd bill **01201**  for nights, and if you were called in over the weekend or on holidays you'd bill **01202** .
- If the call is during regular weekday hours, you would bill an emergency visit instead – which includes both the visit and the surcharge for the call.
- You have to provide 30 minutes of continuous care before you can use the call out premium – the timing for call outs starts after the first 30 minutes for consultations, visits, or anaesthetic evaluations. payment is based on one half hour of care, or the major part thereof (at least 15 minutes).
- These premiums cannot be used on routine visits or rounds – if you're scheduled to be there, you can't bill for these codes.

Continuous Care

- After you provide 45 minutes of continuous care, continuous care premiums are eligible – the initial 30 minute refractory period, plus the 15 minute major portion.
- After this 45 minute period, if you're still treating patients at the hospital, you can add the continuous care premium to your claims.
- Continuing care surcharges can be used (with codes [01205](#), [01206](#), [01207](#)) in addition to each half-hour of care that is provided, as long as the criteria for the fees are met (no routine visits or rounds).
- Continuing care premiums should be added to your claim along with a note 'CCFpp' (Continuing Care From previous patient); this tells MSP you did not leave the hospital or clinic between patients, otherwise you'll be deducted 30 minutes from your claim. Dr. Bill's software automatically adds this note for any claim you toggle continuing care.
- The continuous care premium is based on the total time you spend with the patient, not the number of patients you see – if you see 3 patients in a 30 minute time frame, then you would only add the continuing care premium on the last patient you see, using the entire 30 minute duration.

Your call out premium has to be in order for any continuing care premiums to be paid since

the premiums work together – if there are any problems with your call out claim, your claim for subsequent continuing care will also be refused.

Always review your call out claim to be sure the patient details are correct and that you've added a referring physician and start/end times. These premiums aren't meant to be used on routine rounds or for staying late, but for urgent or unexpected medical situations where you're called to another hospital to assist.

To log your consult or visit using Dr. Bill, toggle 'Call Out' or 'Continuing Care' to use these premiums.

Don't forget to input the call time, start and end time for the visit. Our software automatically applies the correct premiums. For your patient, use 'Call-Out' toggle and 'Cont.Care' for subsequent claims.

The most common mistakes with these premiums are forgetting to include 'CCFpp' in your notes, logging continuing care fees without a call out, and using the continuing care fees when you stay late but haven't been called in.

Consults & Visits

There are different rules and regulations for every fee code which makes billing complicated. The most common rejections are caused by the same errors:

Logging 3+ Directive Care Codes in a Week

You can claim a maximum of 2 direct care codes per patient per week. More than this will cause your claim to be rejected.

No Note for Multiple Visits on the Same Day/ Duplicate Claims

If you're billing for a consultation with multiple visits, make sure you add the times of the consults and the visits since duplicates aren't allowed. You don't need to do this when visits are billed independently, but when billed together you need to include it so MSP knows the visits aren't duplicate claims but happened at different times.

Incorrectly Billing Hospital vs. Directive Care

Directive care visits are visits from a consultant and show that you aren't the most responsible physician and were called in for your expertise. These visits pay more than hospital visits which can be billed daily and therefore can only be billed twice a week.

Keep in mind, it's possible to bill directive care visits or hospital daily visits, but not both. If doctors are expecting to see the patient enough times in a week they will sometimes choose to bill for hospital visits to make it worthwhile. This is allowed only if you don't bill two directive care visits and also try to claim hospital daily visits afterward.

Using Out of Office Premiums on Emergency Visits

When you bill for an emergency visit, your call out and continuing care premiums are included in the fee. If you bill them on top of these visits your claim will be rejected.

Same Day Visits and Procedures

As long as you use different diagnostic codes you can bill for a visit on the same day as a procedure. With the same diagnostic code, the lesser fee code will be reduced to 50%.

In order to get paid for all your hard work, it's important to fix mistakes on your claims. Double checking the details and reviewing the rules and regulations of MSP are good practices to avoid claim rejections.



The Most Common Types of Rejections

Fortunately, MSP claim rejections are avoidable, although they will cost you time and money. here are the most common billing mistakes and how you can fix them:

Rejection: Incorrect Diagnosis Code

If you bill a minor procedure for the same diagnosis on the same day you have a visit with a patient the lesser fee code will be paid 50%. If you use two different codes for different diagnoses you'll be paid in full.



Read more:

EMR Integration:
For Better and More
Effective Healthcare 

Rejection: Out of Office Premium

There are specific rules for out of office premiums – for example, a continuing care premium can't be billed without billing a call-out code first. Codes [01200](#), [01201](#), [01202](#) are billed for the initial call and if you stay at the hospital afterward, bill continuing care. Continuing care claims depend on you coming into the hospital and aren't paid until your call-out premiums are paid. Your continuing care premium will be refused if the call-out claim has any issues. Make sure to include a referring physician, start and end times to submit your claim correctly. You can always change the order and re-bill if you forget to bill a call-out premium before a continuing care premium.

Rejection: No Patient Insurance

Your patient (not you) will have to call MSP and ask to back-date their coverage if they have expired or outdated insurance. You can also reissue the claim as private  so either your patient or their insurer can make the payment.

Rejection: Using Directive Care Codes 3+ Times in a Week

Only 2 directive care codes per patient per week can be claimed. These codes pay more than regular hospital visit codes because they're meant to be used when you're called in for your expertise. If a third visit within a week is necessary, you can either bill a hospital visit, which can be billed daily, or include a note in the MSP notes section of your claim explaining why and try to resubmit.

Claims on Hold

Claims on hold are manually processed by someone from the MSP claims office. You'll know why the claim was on hold after it's finished processing, which could take 30 days or more depending on volume and staffing.

Rejections You Can't Recover

As best you can, avoid making these common mistakes that can't be fixed and resubmitted:

- MSP won't pay you for an identical claim already submitted by another doctor – whoever submits the claim first is the one who gets paid

- Certain codes can only be billed with a specific diagnosis. Diagnostic code descriptions (ICD-9) can be found here .
- If you've already resubmitted once you can't submit a rejection again
- There is a limit to when and how often each fee code can be claimed
- Charging twice for a service already included in another billed item would result in a rejection
- Certain fees can't be billed for a service provided at a funded facility – like a hospital, diagnostic and treatment centre, or psychiatric institution

Whether you make these mistakes as a new physician or a seasoned veteran, know you're not alone. Use them as a learning opportunity to avoid making the same mistake twice. MSP provides an error code and description of what the code means which you can find using a searchable database . Reviewing your error report will help you be more informed for future claims submissions.

Have you mastered billing? Test your skills with our general knowledge billing quiz to see how much you've learned.

CHAPTER

04

TEST YOUR
KNOWLEDGE

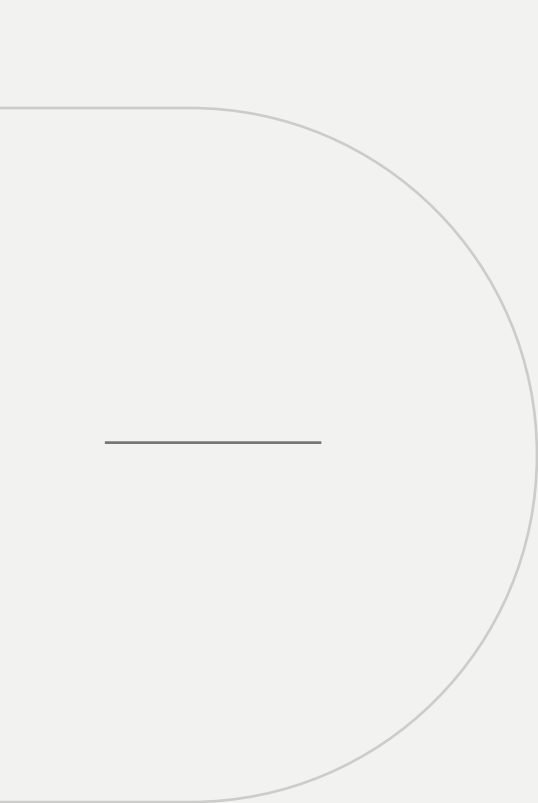
Think you're a billing expert?

Are you able to spot common
billing mistakes?

Try your hand at our
Anaesthesia quiz to see
how much you know about
Anaesthesia billing!

4.1 Anaesthesia Quiz

4.2 Answers



Anaesthesia Quiz

1. Is there a generic diagnosis code for Anaesthesia?
2. How is the Intensity and Complexity level code (01172-01181) determined?
3. The Pre-Anesthetic Evaluation (01151) is only eligible when a separate visit prior to anesthetic is required.

TRUE or FALSE

4. What extra information does the Body Mass Index surcharge (fee code 01169) require?

A) A note record containing BMI.

B) The patient's admission date needs to be added to the claim.
5. Does the surgical surcharge 01080 need a note?
6. You get called to the hospital and bill a call out, then decide to stay and treat more patients. On your second patient you bill 01206 with a note "Continuous care fee (CCS) starting 07:20 a.m. – 11:00 a.m."

Will your claim be rejected? **YES** or **NO**

7. Your patient has 3 different lacerations. You bill the following:
 - (3) separate 13611's billed without submission "D" and no note
 - (3) separate 13611 / 13610 / 13612 (more than 6 cm) billed without sub "D" / no note

Is this claim correct? **YES** or **NO**

8. Your patient has been seen more than 2 times a week in the hospital, for which you are the most responsible physician. You bill:

- **00306**  on June 2nd
- **32206**  on June 3rd
- **32206**  on June 6th

Is this correct? **YES** or **NO**

9. You stay late at the hospital one night and bill **01205**  because it was after 6pm. You add a continuing care fee to your claim.

Will your claim get rejected? **YES** or **NO**

10. You saw your patient earlier in the day at the maternity clinic, then seen later in the day at the hospital.

You bill:

- **14091**  (Prenatal visit) for the office visit.
- **13200**  (Out of office visit) for the hospital visit. In order to get both claims approved what does your note need to say:

- A)** A note on 13200 stating why you saw the patient for the second time.
- B)** A note stating the time that each claim took place.
- C)** A note on 14091 and 13200 with the time and reason for each claim.

11. Your patient was seen for Complex Consult earlier in the day, then seen later for hospital visit.

You bill:

- **00311**  (Consult)
- **32208**  (Hospital visit)

To get your claim approved you leave a note on both claims stating the time of each claim or the reason for seeing the patient twice in one day.

Is your claim correct? **YES** or **NO**

12. You're in the ER on a Saturday and billing the following for an emergency visit after being called in to the hospital. You bill the following: 01811 & 01207.

Will your claim get rejected? **YES** or **NO**

13. You have billed two directive visits for a patient but need to see the patient again and you bill a hospital visit.

Will this be paid by MSP? **YES** or **NO**

14. You saw the patient today and did a full work up and bill a consultation fee; you had seen the patient four months ago for this condition and billed a visit.

Will MSP pay the consultation? **YES** or **NO**

15. You see a patient for a visit and remove a haemangioma; you bill the visit and the minor procedure with the same diagnosis code.

Will MSP pay for this? **YES** or **NO**

1. **YES.** The generic diagnosis code for anaesthesia is 01Z.
2. The Intensity and Complexity level code is determined by anaesthetic level listed to the right of the surgical fee code in the MSC payment schedule.
3. **TRUE.** When the assessment is performed immediately prior to the anesthetic, the assessment will be paid using the anesthetic intensity/ complexity level of the anesthetic procedure itself and 01151 will not be paid in addition.
4. The BMI surcharge is only eligible for patients greater than 19 years of age with a BMI greater than 35. The BMI surcharge is only eligible for patients less than 19 years of age with a BMI greater than the 97th percentile adjusted for age and gender.
5. **YES.** The fee code 01080 does requires a note stating one of the following: “ASA 4”, “ASA 4e”, “ASA 5”, “ASA 5e”, “IABp”, “mechanical assist device” or “greater than 8 hours”
6. **YES.** 01205, 01206 and 01207 have to have a specific note which is just “CCFpp”
7. **NO.** MSP assumes this is one claim billed 3 times in error – should be billed with submission “D” and notes in each claim: 1st area, 2nd area & 3rd area (if 13612 note should include note 1 lac x ____ cm)
8. **NO.** MSP rules are limited to two directive care visits per patient per week (Sunday – Saturday).
9. **YES.** 01205, 01206, 01207 are only eligible if called in to attend an emergent patient and then attend subsequent patients without break. Continuing care is not to be used for overtime compensation.

10. **A)** – a note on 13200 stating why you saw the patient for the second time.
11. **YES.** Without adding a note, MSP assumes either claims are both billed at the same time because these claims on their own do not require start and end times therefore they think it was billed in error for example, wrong date of service.
12. MSP rules “Out of Office premiums” are not payable with emergency fees.
13. **NO.** MSP will only pay for directive care OR daily hospital visits. If you have billed two directive care visits MSP will not pay a daily visit even if you have to see the patient. have a look at how many times you will need to see this patient each week and decide if it would be worth more money to bill daily care vs directive.
14. **NO.** MSP will not pay the consultation fee because you had seen the patient previously for this same condition. If you have been following patient for this same condition MSP does not think that a consult at this point is required. You will need to add a note to explain the medical necessity to warrant a consultation or bill a visit.

When a consult is rejected there could be a couple of reasons why this could have happened: – Another consult provided within six months.

– Invalid referring doctor.

– You had been seeing the patient for the same issue recently.

15. **NO.** When you bill a visit and a minor procedure on the same day with the same diagnosis code, only the larger fee is paid. Try to bill the two fee codes with different diagnosis codes so that they will pay the second fee at 50%.



You wouldn't refer a torn ACL to a psychiatrist.

So why trust anyone but a billing expert for your medical billing?

Let's refer you to Dr.Bill:

Save Time: Submit claims in as little as 30 seconds

Human Support: Our billing experts provide ongoing support

More Accurate Payments: Rejected claims resubmitted on your behalf

Get a 45-day free trial¹ of Dr.Bill

¹ When you sign up for the Full-Serve plan with Dr. Bill ("Plan") for the first time, you will get access to the Plan at no cost for 45 days from creation of your Dr. Bill account (additional services are extra). One offer per person. Other conditions apply. Offer may be amended or withdrawn at any time. For full terms, visit dr-bill.ca/free-trial.

[®]Trademark of Royal Bank of Canada. Used under licence.



Got a question?

Email us at hello@dr-bill.ca

Our support team is available between 9AM and 5PM PST (Monday-Friday) and usually responds within 1 business day.

This eBook offers general information only and is not intended as legal, financial or other professional advice. A professional advisor should be consulted regarding your specific situation. While information presented is believed to be factual and current, its accuracy is not guaranteed and it should not be regarded as a complete analysis of the subject matter discussed. All expressions of opinion reflect the judgment of the author(s) as of the date of publication and are subject to change. No endorsement of any third parties or their advice, opinions, information, products or services is expressly given or implied by RBC Medical Billing Inc. or its affiliates