Enhancing Interprofessional Collaboration in Maternity Care:

TECHNICAL GUIDE FOR BILLING

Enhancing Interprofessional Collaboration in Maternity Care: Technical Guide for Billing

Principal Author: Tanya Momtazian, RM, MPH

Co-author: Lee Yeates, RM, MHM, CHE

Designer: Freyja Barnwell

Administrative Support: Raveena Garcha

With special thanks to the Subject Matter Experts for generously sharing their time, knowledge, experience, and expertise during the development of this technical guide:

Lee Saxell, RM

Cathy Clelland, MD

Sara Sandwith, MD

Alix Bacon, RM

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Shared Care Committee
A partnership of the Doctors of BC and the BC government

115 – 1665 West Broadway
Vancouver, BC
V6J 5A4

www.sharedcarebc.ca

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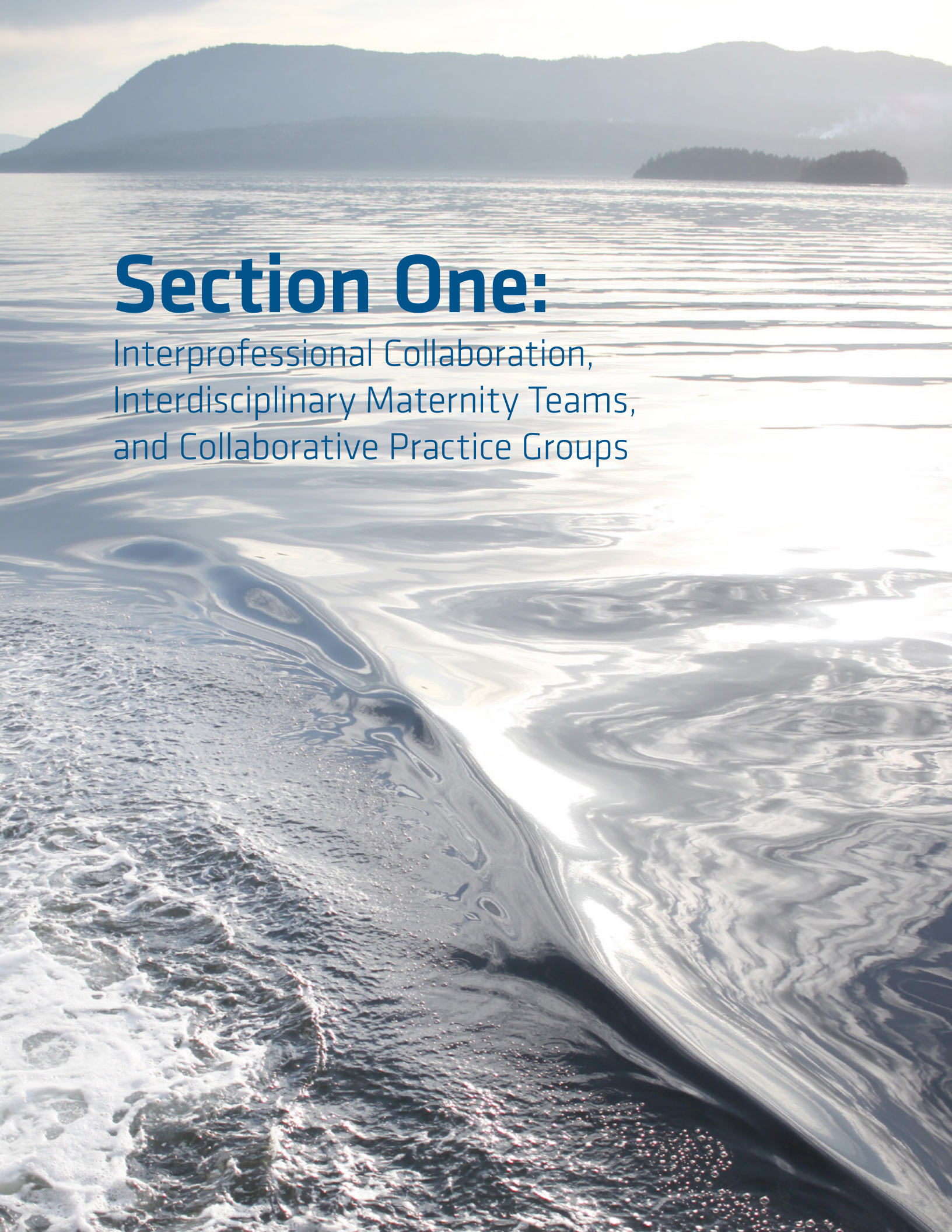

Section One:

Interprofessional Collaboration, Interdisciplinary Maternity Teams, and Collaborative Practice Groups

Section One

WHAT IS THE PURPOSE OF THE TECHNICAL GUIDE?

The aim of this technical guide is to provide an overview of physician and midwifery billing in British Columbia and to capture and share some examples of how providers are utilizing the current billing structure across a variety of interprofessional teams and collaborative practice arrangements around the province. To contextualize how the existing billing and payment structure is utilized in collaborative practice arrangements, a variety of scheduling possibilities and the role and responsibilities of team members are also described. Since clear communication, expectations, and decisions with regards to financial agreements are imperative for a well-functioning team, worksheets to aid team conversations and billing reference sheets for physicians and midwives are provided at the end of the technical guide.

In communities across British Columbia, interdisciplinary teams and collaborative practice groups adapt to innovatively meet local needs. Exploring team members' philosophy of care, vision, scope of practice, and limitations are an essential part of establishing a collaborative team. Information to support these conversations can be found in the Community Toolkit – Enhancing Interprofessional Collaboration in Maternity Care: Pathway to Positive Change.

WHO MIGHT BE PART OF AN INTERDISCIPLINARY MATERNITY CARE TEAM?

Interdisciplinary maternity care teams may include any of the following regulated and allied service providers and in some cases, other professionals too. The composition of the collaborative team depends on the team's goals and values and the social and financial resources available in each community.

REGULATED HEALTH PROFESSIONALS	ALLIED SERVICE PROVIDERS
Family Physicians (FPs)	**Doulas**
Registered Midwives (RMs)	**Childbirth Educators**
Registered Nurses (RNs)	**Community Family Groups**
Nurse Practitioners (NPs)	**Aboriginal Patient Navigators**
Pediatricians (Peds)	**Lactation Consultants** (LC)
Obstetricians (OBs)	
Social Workers (SWs)	
Psychologists (RPsych)	
Registered Clinical Counselors (RCCs)	
Licensed Practical Nurses (LPNs)	

Section One

WHAT ROLE DO NURSES HAVE ON COMMUNITY-BASED INTERDISCIPLINARY MATERNITY CARE TEAMS?

Nurses, whether they are RNs, NPs, LPNs, nurse educators, or psychiatric nurses play an important role within many collaborative practice arrangements. Some nurses may also be certified lactation consultants. There are no MSP fee schedules for nurses. Nursing positions may be salaried through a Health Authority, hospital, or agency, or the collaborative team might privately employ a nurse. If hired privately, the expense would be an overhead cost of the practice.

If a physician is to delegate aspects of the in-person care to an RN, the physician must also see the patient in person and provide a medically necessary component of the care in order for the physician to bill. However, the physician does not have to attend the entire appointment. Nurses who are employed privately within a practice group may also provide appropriate telephone care to patients without involving the physician. Physicians registered in a GPSC Maternity Network can bill for the RN telephone care using the relevant GPSC codes.

The midwife may also delegate some aspects of care to an RN or NP. Because midwives bill a course of care fee, they are required to see the patient in person during each billable segment of a course of care, not during an individual visit.

WHAT ARE SOME POTENTIAL AREAS FOR COLLABORATION?

While some interprofessional teams wish to work in collaborative practice groups having shared patients, call, and clinic across the continuum of perinatal care, other teams may choose to focus collaboration on particular areas of care or clinical interest. These may include:

- Shared on-call to support work/life integration
- Pregnancy and/or Postpartum Group Care
- Breastfeeding/Postpartum Care
- Perinatal Mood and Anxiety Care
- Adolescent/Youth Sexual and Reproductive Health
- Aboriginal Health and Wellness
- Refugee/New Immigrant Care
- Substance Use and Recovery Support

Collaborating on focused areas of care can build relationships and trust among interprofessional team members, in addition to responding to unique community needs.

WHAT IS INTERPROFESSIONAL COLLABORATION AND WHAT COULD AN INTERDISCIPLINARY MATERNITY CARE TEAM LOOK LIKE?

Interprofessional collaboration happens anywhere health care providers with different professional backgrounds are working together to influence policy and practice, and to deliver the highest quality of care across the continuum, while emphasizing patient-centred goals and values.
In addition to working collaboratively across the care continuum, some maternity care providers may want to formalize the structure of an interdisciplinary team to share specific aspects of patient care or the provision of on-call services. Building local collaborative teams can be a useful mechanism to address gaps of care in the community or to enhance sustainability in a call schedule. It can also provide an opportunity to slowly begin working together as a team, building relationships and trust.

Some examples of interdisciplinary maternity care team arrangements include:

- Sharing On-Call Responsibilities
- Sharing Prenatal Care
- Sharing Postpartum Care
- Sharing Connecting Pregnancy Group Care

Below are various scenarios of each of the above configurations of collaborative teams. The appendices contain worksheets to support discussions about team structure and remuneration.

Section One

Sharing On-Call Responsibilities

In many communities, especially rural and remote, the demands of hard call while balancing other clinical, administrative, and family responsibilities require increased collaboration across disciplines. In these examples, family physicians and registered midwives share 24/7 call to attend births and hospital assessments, as needed or through an established call schedule.

Scenario A

A rural community has three family doctors that work within a 1:3 maternity call schedule in addition to their other clinical responsibilities, including a full scope family practice. One of these family physicians has extended surgical skills (GPESS) and another has extended anaesthesia skills (GPA) to enable a local cesarean section service. The community also has two midwives providing 1:2 call coverage and NRP support at c-sections.

All prenatal and postpartum care is provided within their respective family practice or midwifery clinics. Call coverage is provided for each other's patients when providers are on leave for vacation, continuing professional development, illness, or emergencies. This enables call schedules to remain at a 1:3 and 1:2 respectively, reducing the strain on teams. No extra payment is provided to be on call for each other's patients. The care provider who is present at the birth bills accordingly and assessments are billed individually under their respective fee codes.

Scenario B

An urban center has a midwifery clinic with two midwives providing full scope midwifery care. Nearby, a family practice group has a team of three family doctors providing full scope family practice care, including maternity care for their patients.

Together, these five care providers share an established call schedule. Some physicians choose to work fewer call days than the midwives but enjoy continuing to provide excellent and supportive intrapartum care. The team decided that homebirths will not be provided when the family physicians are on call and postpartum home visits by midwives are incorporated into their clinic days.

All providers bill MSP for intrapartum care using their respective billing codes. These fees are pooled into a group account, and providers are paid from the pooled fees based on the number of call days they have worked, at the set, pre-determined daily rate decided by the team members. This enables a consistent and stable income for call days, enabling the family physicians to take time away from their community practice to provide extended intrapartum care and support.

Sharing Prenatal Care

Sharing prenatal care can create more flexibility for meeting the health and wellness needs of patients who require additional time and assistance. Family physicians and midwives working together can utilize their respective strengths, tailor their clinical interests, and maximize their scopes of practice for the provision of innovative and high-quality prenatal care.

Scenario A

A near-urban community has a physician that provides care for pregnant people with a history of, or current substance use. The physician is able to prescribe methadone and has developed good relationships with this population. At the same time, attending regularly scheduled prenatal appointments can be challenging for people in this demographic. A midwife works with the physician to provide drop-in, community outreach, and in-house prenatal care and support. The midwife also shares a midwifery practice with another midwife to care for low-risk women.

At the time of the delivery, the physician will attend the birth unless otherwise unavailable, at which point the midwifery practice will back up the physician. Intrapartum care is billed by the attending provider using their respective fee codes. Postpartum care is determined based on the patient's need and care plan and may include community health nursing and outreach services.

The midwife bills prenatal midwifery course of care fee codes for the prenatal care. The physician bills additional medically necessary visits, such as methadone prescribing and counselling. The billing is pooled and divided between the physician and midwife based on clinical hours provided.

Scenario B

An urban centre has a family physician and midwife, both with special interest and training in perinatal mental health. The physician is able to counsel, prescribe and monitor relevant medication and treat accordingly, but does not provide intrapartum care. The midwife has additional

training in counseling and cognitive behavior therapy. Patients with moderate perinatal mood disorders alternate to see the family physician and midwife throughout their prenatal care.

The intrapartum and immediate postpartum care is provided by the midwifery practice where the midwife works. Postpartum care at 2, 4, and 6 weeks is provided by the family physician and midwife to follow the patient's moods appropriately.

The midwife bills prenatal midwifery course of care fee codes for the prenatal care. The physician bills additional medical visits, such as monitoring or prescribing SSRIs/SNRIs. The prenatal care billing is pooled and divided between the physician and midwife based on clinical hours provided.

Sharing Postpartum Care

Excellent care and support in the early postpartum period can contribute to improved health outcomes related to breastfeeding success, secure attachment, and mental wellness. Having a collaborative approach to postpartum care can enable intensive support to those experiencing challenges with the transition to parenthood.

Scenario A

In an urban centre, a physician provides care primarily to new immigrant and refugee families that have numerous obstetrical risk factors. There is a midwifery clinic with a team of four midwives that provide midwifery care to the low-risk population.

The physician provides the prenatal and intrapartum care for their patients and bills accordingly. The physician then hands over the postpartum care to the midwifery call group. They can provide home visits, which are helpful to those with transportation challenges, 24-7 phone support, and lengthened clinic appointments in the early postpartum period. This enables more time for culturally sensitive care and support. The midwives bill for the postpartum course of care using their respective fee codes.

Scenario B

A near-urban community has a busy midwifery practice of six midwives working in two teams of three. The urban centre has a large Aboriginal population and there are a number of Aboriginal reserves in the local area.

The midwifery practice hires an Aboriginal Registered Nurse who is also a certified Lactation Consultant to provide home visits and conduct a Breastfeeding/Mental Health support group for the Aboriginal population. The RN works closely with the local Aboriginal Patient Navigator and collaborates with the other professionals and programs offering support and services for new Aboriginal parents.

The RN is paid primarily from of the midwives' postpartum billings, although they have received some small community seed grants to start the support group. The collaborative team is working with local First Nation Bands to explore the potential for additional funding and resources to expand the maternal/infant health and wellness services they offer and to grow their interprofessional team.

Sharing Connecting Pregnancy Group Care

Connecting Pregnancy group care is a model first established in the US, then adapted to the Canadian context for providing prenatal and/or postpartum care in groups. Families can choose to do the second half of pregnancy and sometimes their early postpartum care in a group setting with other families who have due dates around the same time. Short, individual 'belly checks' done by midwives or physicians are followed by facilitated group discussions and learning activities about pregnancy, birth, postpartum, newborn care, and the transition to parenthood. Parents welcome the ability to share and connect with other families, while care providers enjoy the stronger relationships with families and the depth of discussion compared to a standard clinic appointment.

Scenario A

In a rural setting, there is a family practice and midwifery group, each with two providers, and both practices serve a large population of youth and young parents.

Young, expectant parents are encouraged to attend group care where they can connect with other families. A family physician and registered midwife facilitate the group, and invite presentations from a lactation consultant, pediatrician, mental health worker, and nutritionist. Sometimes the group may be co-facilitated by one primary care provider and a childbirth educator.

Payment for the physician and midwife is generated through the physician group billing fees and midwifery 3rd trimester course of care fees. A small community grant provides funding to support administration and payment or

honorariums for guest speakers or co-facilitators. Intrapartum and postpartum care occurs within the providers' respective practice groups.

Scenario B

A rural community with a small hospital and health center does not offer planned deliveries. The closest facility with intrapartum obstetrics services is 2.5 hours away, in good weather conditions. There are approximately 100 pregnancies a year in the region and on average, 15 people have unplanned deliveries at the local hospital.

Two family physicians provide the majority of the prenatal care for local residents in an innovative group care model. Each group session is co-facilitated by one of the family physicians and the local Public Health Nurse. This enables the formation of strong relationships between patients and the PHN, who will later provide early postpartum care and do many of the well-baby checks when residents return to the community after delivery.

The family physician and nurse each receive a salary from the Health Authority.

WHAT DOES AN INTERDISCIPLINARY COLLABORATIVE PRACTICE GROUP LOOK LIKE?

In some communities, teams of providers will choose to create an interdisciplinary collaborative practice group where the provision of all primary maternity care (prenatal, intrapartum and postpartum care) is shared among the interprofessional team of health care providers. To provide comprehensive 24/7 care, team members have various roles and responsibilities.

The composition and roles on the interprofessional team vary based on the caseload volume of the practice group and interprofessional mix of providers. Practices with higher volumes (typically over 20 births/month) often need to assign specific clinical responsibilities to different team members whereas practices with lower volumes can group some of these responsibilities within different clinical roles. The tables below outline examples of how various on-call and in-clinic responsibilities can be distributed across the interprofessional team. This table does not include the Prenatal/Postpartum Group Facilitation, RN/LC support, or administrative support.

	HIGH VOLUME PRACTICE			LOW VOLUME PRACTICE		
ROLES/RESPONSIBILITIES	1st call	2nd call	Clinic	1st call	2nd call	Clinic
Manage all emergent calls	X			X		
Manage all non-emergent calls		X		X		
Labour assessment, attend birth and immediate postpartum care	X			X		
Conduct postpartum home visits		X		X		
Act as 2nd attendant at home birth (if offered)		X			X	
Provide prenatal care			X		X*	X
Review and manage all incoming labs			X			X
Provide postpartum care in clinic			X		X*	X

* often the provider on 2nd call also does clinic, since being called out to support the 1st call provider happens rarely with lower practice volumes

Section One

WHO PROVIDES ADMINISTRATIVE SERVICES FOR THE COLLABORATIVE PRACTICE GROUP AND CLINIC?

Collaborative practice groups have well trained Medical Office Administrators to assist with the day to day functioning of their clinics. However, some care providers within the clinic will also need to perform administrative oversight. Some larger collaborate practices have created the role of Administrative Director, whose responsibilities may include:

- Provider scheduling, billing, and payment (oversight or execution)
- Coordination and management of communication within the interprofessional team
- Hiring and management of administrative and support staff

Another piece to consider is the need for regular chart reviews. In busy practices, with a number of providers sharing patient care, it is important to ensure completeness and quality of the care and chart. This responsibility can be shared across the primary care team, however suitable. Some larger collaborative practices have created the role of Clinical Director, who may be a midwife or physician and whose responsibilities may include:

- Care quality and chart review (oversight, distribution, or execution)
- Recognizing where there may be need for and facilitating team discussions about philosophy of care, practice standards, and protocols
- Providing clinical expertise, support, and mentorship for complex care planning or critical patient safety event reviews (CPSER)

WHAT POSSIBILITIES EXIST FOR SCHEDULING IN COLLABORATIVE PRACTICES?

Across the province, collaborative practice groups are implementing a variety of scheduling and co-working arrangements based on projected volume and how the collaborative practice itself has been set-up. A useful way to begin conceptualizing and discussing scheduling is to use the idea of 'shifts,' establishing shifts for on-call and for clinic. Practice volume, the organization of roles, and the distribution of clinical responsibilities will inform to the team's discussion and decision-making about shift length in the context of sustainable and safe practice.

The table below provides some examples that have been implemented by collaborative practice groups in BC:

ROLE	LENGTH OF SHIFT			
	Higher volume practices		Lower volume practices	
1st on Call	12 h (day), 12h (night)	10h (day), 14h (night)	24h	24 – 48h
2nd on Call (availability)	24h	48h	Weekdays/Weekends	7d
	Length of 2nd on call shift varies considerably according to practice need and availabilities. The shift denotes time available on-call to the practice.			
Clinic	4h	6h	7h	8h
	Length of a clinic shift varies considerably according to practice volume, the length of appointments, and scheduling preferences (ie: full day or half day, other clinical responsibilities, etc.)			
CP Group	Hourly		4h (day/evening 2h group session + preparation and completion of charts)	

Section One

HOW IS BILLING AND PAYMENT ARRANGED IN COLLABORATIVE PRACTICES?

Thus far and in general, collaborative practice groups in BC are electing to combine midwife and physician billings in a shared practice group account. The distribution of finances and decisions about remuneration structure will be dependent on several factors including practice volume, overhead costs, and any other revenue, funding, or grants that may be available to the clinic or practice group. This enables the collaborative practice group to combine a variety of billing and funding sources into a functional structure for transparently and equitably covering practice overhead costs and paying providers for clinical and administrative duties. Remuneration to primary care providers for clinical care is dispersed monthly or bi-monthly, commonly based on units or hours of work, or shifts completed.

HOW IS AN MSP ACCOUNT CREATED FOR A COLLABORATIVE PRACTICE GROUP?

Collaborative practice groups must establish a group billing number for the practice. Physicians and midwives, using their individual MSP billing numbers are then attached to the practice's group billing number. Billings submitted for care provided under the umbrella of the collaborative practice group will contain both the individual provider's billing number and the group billing number for the practice. To achieve this, the following MSP forms must be completed:

FORM NO.	FORM NAME	FORM PURPOSE
HLTH 2976	Application for Additional Payment Number	To apply for a billing number for the collaborative practice group/clinic's MSP account
HLTH 2832	Application for Direct Bank Payment from MSP	To direct deposit MSP billings to the collaborative practice group's bank account
HLTH 2820	Application for Teleplan Service	To establish electronic billing through the collaborative practice group's EMR
HLTH 2870	Assignment of Payment	To have primary care provider billings assigned to collaborative practice group's MSP account
Note: Locum name (care provider), Principle Practitioner Name (Clinic Name). Effective date is maximum 5 years minus 1-day (after 5 years application but be resubmitted)		

HOW IS THE RATE OF PAY DETERMINED FOR CLINICAL WORK?

A variety of structures for care provider remuneration are being implemented in collaborative practice groups across the province. While the following table provides emerging examples, what is possible need not be limited to what has been presented. Commonly, collaborative practice groups are establishing remuneration structures based on a decided hourly rate, a rate of pay per unit of work, or by way of a calculating percentage of the overall work completed. The determined rate of pay varies by collaborative practice group and is usually calculated from what's available once projected overhead costs (rent, staff, supplies, etc.) are subtracted from projected revenue which combines MSP billings from anticipated clinical volume, with any other available grants, incentives, and funding sources. Aligning with the group's decided remuneration structure, funds are paid to team members from the shared practice bank account.

Section One

	HOURLY SESSIONAL RATE	UNIT RATE	PERCENTAGE OF WORK DONE
Description	Established hourly rate	Each shift type is assigned a number of units. A rate of pay per unit of work is established. The pay is the same regardless of amount or volume of work while on-call.	Combined billings and are split based on care provider's Full Time Equivalency (FTE) on the clinical team. The practice group retains a percentage of revenue for overhead costs.
Examples	Ranges $60 – 100/hr	**1st on call:** 7 units per shift **4h Clinic or CP group:** 2 units **2nd on call:** 1 unit per shift • The average rate for one unit ranges from $100 – 150	4 care providers – 2 work 1.0 FTE, and 2 others work a 0.75 FTE and an 0.5 FTE. 30% of billings are retained to cover overhead costs. Remaining revenue for the month is divided and distributed based on provider's FTE.
Advantages	• paid for amount of work completed • payment can include administrative/ non-clinical work at the same rate • extra work for clinic/ call can be easily compensated • easily adjustable if expenses/revenue changes	• useful in lower volume practices where 1st on call and clinic days aren't necessarily full or busy • provides an even and predictable amount of monthly income to each care provider regardless of the number of births for the clinic or individual (can be useful in lower volume practices where monthly practice volume may vary significantly) • easily adjustable if expenses/revenue change; only need to change the unit rate	• reflects the amount work done by each care provider • busy months with higher volumes requiring more work are rewarded with higher income • can be quicker to administer than structures requiring the tracking units or preparation of invoices
Disadvantages	• can be difficult to track every hour/work • requires detailed invoices to be submitted by each care provider • often assumes high volume practice (frequently working through duration of call shifts)	• establishing the unit rate can be challenging • the volume of work performed while on call may not reflect the income received in a particular shift (providers anticipate this will even or average out after an extended period of time) • it does not include non-clinical or administrative work, though groups may decide to assign units for certain administrative or leadership roles within the practice • is does not include additional time worked (staying beyond shift for a complex clinical case)	• monthly revenue from MSP billings does not always correspond to work done in that month because MSP submission cutoff is 2/3 way through the month and billings may held in review for prolonged periods of time • monthly revenue can vary significantly, and it can be hard to predict income • does not include non-clinical or administrative work, though groups may decide to incorporate structured remuneration for this work in the practice overhead costs

Section One

HOW DO YOU BILL MSP FOR CLINICAL CARE PROVIDED IN A COLLABORATIVE PRACTICE GROUP?

Registered midwives and family physicians bill MSP differently, either using a course of care or fee for service structure respectively. Collaborative practice groups are commonly choosing to bill the midwifery course of care fee codes for the prenatal and postpartum care provided by all team members. This can be done if a midwife member of the team has seen the patient at least once in every trimester and once in the postpartum period. This means that the physician DOES NOT bill a fee for service code for routine prenatal and postpartum care that is provided by a physician member of the team.

The advantage to billing midwifery course of care codes is that it simplifies the billing process by not requiring a billing submission for every clinic or out-patient appointment. It also allows more time for clinical care, based on the midwifery model of practice.

The disadvantages are that it can be difficult to 'share' a patient in small rural communities where patients may rotate between appointments with the family physician in their local community to care provided by a collaborative practice group in the community where they will deliver. Also, if it is a complicated pregnancy or complex care situation requiring multiple extra appointments, no further billing can be done.

For intrapartum care and the birth, the care provider that conducts the birth will bill MSP using their respective fee codes. These billings are also associated with the collaborative practice group and deposited into the group's shared bank account.

Billing reference guides have been prepared and included as an appendix to this technical guide. They provide a simple mechanism to track the complexities of physician and midwife prenatal intrapartum and postpartum care billing and ensure provider billing is comprehensive and inclusive of care rendered.

"Collaboration is the piece that continues, so that is why **collaboration is most important**. If people are collaborating better – then the other things, like equal access and standardization, and knowledge – will continue to improve BECAUSE there is better collaboration."

Section Two:

Frequently Asked Questions About Physician and Midwife Billing in Team-based Care Environments

Section Two

CAN A PHYSICIAN BILL FOR SPECIALIZED CARE OUTSIDE MIDWIFERY SCOPE?

If a physician is providing medically relevant perinatal care that is outside of midwifery scope, then a physician, as part of a collaborative practice group can bill in addition to the midwifery course of care codes. An easy illustration of this would be for the prescription and monitoring of thyroid medication during the perinatal period. However, a GP consult fee CANNOT be billed because the care providers work in the same practice. Billing codes for this purpose include:

- Age appropriate in-office visit for medical conditions (*if seen by a physician for that purpose*) – 00100 series
- Age appropriate in-office Counseling fee (00120 series)
- Group Medical Visit Codes (137XX series)
- Age appropriate out-of-office visit for medical conditions when seen in hospital outpatient/LDR assessment (*if seen by a physician for that purpose*) – 132XX series
- Hospital Inpatient fees (*care provided outside of normal intrapartum/postpartum care*) (13109, 13008,13028, 13338)
- Conferencing fee (*for complex patients for care/discharge plans*) – 14077

CAN A PHYSICIAN BILL A GP OR RM CONSULT FEE FOR COMPLICATED PATIENTS?

Physicians and midwives have consultation fee codes (0110 and 36079 to 36083 respectively). Consultation fee codes can be used when a physician or a midwife in independent practice (outside the collaborative practice group) requests the provision of care or service, relevant to the consultant's professional expertise. Consultation fees CANNOT be billed if the consulting and consultant physician and/or midwife share a practice and patients (ie: between members of the collaborative practice group).

CAN A PHYSICIAN BILL A MENTAL HEALTH PLANNING AND MANAGEMENT FEE?

Only the family physician of the patient can bill a Mental Health Planning and Management Fee (G14043) and the subsequent visits 14044 or 14045 (age dependent). This requires longitudinal mental health care provided by the physician. Physician's that are part of a maternity group or collaborative practice are able to bill the 00120 or 15320 counseling fee codes to a maximum of 4 counseling codes/yr/patient.

CAN PHYSICIAN GROUP MEDICAL VISIT CODES BE BILLED IN ADDITION TO RM COURSE OF CARE CODES?

Yes, group medical visits provide additional care and information beyond what is provided in individual prenatal and postpartum appointments. If a physician is present at the group medical visit and provides some 1:1 time with patients (ie: 'belly checks' in group prenatal care) a group medical visit billing code can be applied. Group medical visit billing codes are billed per 1/2-hour increments to a maximum of 1.5 hours. If there are two physicians participating in the group medical visit then the group is split into two for billing purposes, with each billing being appropriate for their share of patients.

Section Two

DOES A PHYSICIAN CONTINUE TO RECEIVE THE MATERNITY NETWORK FEE INCENTIVE?

Physicians who share call with a minimum of 3 other physicians or midwives may bill for the Maternity Network fee code (G14010). For groups of less than 4 primary care providers, a written request must be sent to the GPSC maternity Working Group for approval to bill for this network incentive. The Network fee is billable by each member of a maternity network through their individual billing number. Similar to pooling of delivery or other fees, the individual physician can bill the maternity network incentive with their billing number assigned to a group payment number. The provider and collaborative practice group should discuss and decide whether this billing will be included with combined revenue for the practice or retained by the physician.

CAN A PHYSICIAN BILL FOR A HOSPITAL ASSESSMENT IN ADDITION TO THE RM COURSE OF CARE FEE CODES BEING BILLED?

Any emergent assessments or outpatient care provided by a physician in the hospital setting (ie: NSTs, query rupture of membranes, management of hyperbilirubinemia) can be billed in addition to the midwifery course of care fee codes. This does not include the provision of routine postpartum care to patients or their newborns in either the hospital or community setting, as it is covered by the midwifery postpartum course of care fee billing.

CAN A PHYSICIAN BILL A CALL-OUT CODE TWICE ON THE SAME DAY FOR THE SAME PATIENT?

In general, only one call-out fee is billable per calendar day, per patient, unless there is an unusual medical reason to be called-out a second time. In such cases, the time must be at least 2 hours between services and an electronic note must be submitted with the billing. The weekday daytime call-out fee (00112) is considered to be inclusive of any assessment or procedure provided at that time and for the purpose of the call-out. It is not payable in addition to a delivery fee, if the physician is called in only to deliver the baby (vaginal or C/S). However, if the physician was called in to assess the patient who is not yet fully dilated and the baby does not deliver until several hours later, the 00112 daytime call-out fee can be applied.

CAN THE OUT OF OFFICE SURCHARGE CODES BE BILLED PRIOR TO THE START OF 2ND STAGE?

The 01205-01207 fee codes can be billed after a 30min wait time from the beginning of 2nd stage, when the physician is called in during 2nd stage. If the physician is called in prior to the patient starting 2nd stage, up to 30 minutes of the time before commencing 2nd stage can be billed as the wait time. A Continuing Care From Previous Patient (CCFPP) note must be included in the e-note with the billing. MSP will use the call-out fee time for the patient and consider it the previous patient. Detailed information is also required in the e-note including time of full dilation, delivery time, and end of 3rdstage (placenta delivery time).

DOES THE 'MAXIMUM 25 DELIVERIES/YEAR INCENTIVE' INCLUDE ALL MODES OF BIRTH?

Yes, the GPSC Delivery Incentive codes with a maximum of 25 deliveries/year include the combined vaginal (14004), emergency c-section (14009) and elective c-section (14008) births. Although there are four separate incentive fee codes (the above 3 plus one for management of labour and transfer to higher level of care facility 14005 – mostly rural), the maximum is 25 deliveries cumulatively between the four codes.

Section Two

CAN A PHYSICIAN BILL FOR A BIRTH ATTENDED AT HOME?

At this time there is no fee code for a physician attending an out of hospital birth as the primary care provider. There has been a request to MSP for the inclusion of fee code for this purpose, that will mirror the RM fee code for attendance at labour and delivery. A physician can attend an out of hospital birth with a midwife and the midwife can bill the birth fee in addition to the 2nd attendant fee for the physician's attendance.

CAN A PHYSICIAN BILL A PAP & TRAY FEE WITH A COMPLETE PHYSICAL?

PAP and tray fees are included in the Complete Physical billing code (14090) and CANNOT be billed separately.

IS THERE A SEPARATE FEE CODE FOR VACUUM DELIVERIES?

There is no fee code for vacuum deliveries, it is considered a vaginal birth. The 04000 Complicated Delivery code is NOT applicable in this case.

IS THERE A SEPARATE FEE CODE FOR A VBAC/TOLAC BIRTH?

The 04107 VBAC/TOLAC code is only used for physicians 'standing by' in case of needed intervention. The physician billing the labour and birth of a VBAC/TOLAC cannot bill the 04107. There are no additional fee codes for managing a VBAC/TOLAC (the complicated delivery fee does not apply). This is included in the delivery fee itself.

WHAT IS THE APPROPRIATE CODE FOR MANAGEMENT OF A POSTPARTUM HEMORRHAGE?

There is no specific code for management of PPH however, depending on severity, one of the Emergency Codes may be billed. The 00082 code is used when a critically ill patient requires continuous monitoring by the physician. The code 00081 is reserved for those with immediately life-threatening illness (ie: shock or severe hemodynamic instability) and does not include any 'stand-by' time for labs, etc. Start and end times must be included when billing an Emergency Code.

WHAT IS THE APPROPRIATE CODE FOR NEONATAL RESUSCITATION?

Similar to management of PPH, there is no specific code for NRP provided by family physicians. The Emergency Codes 00081 and 00082 can be used when this care is provided by the family physician instead of a pediatrician. Fee code 00081 is used when a resuscitation is underway, whereas 00082 can be used when the family physician is providing the post-resuscitation care and monitoring of a sick neonate.

SHOULD PROVIDERS BE TESTING URINE AT EVERY PRENATAL VISIT?

There is no evidence to routinely test for Protein and Glucose at every clinic visit (www.choosingwisely.org). The tests are not suitable to screen for pre-eclampsia or gestational diabetes and could lead to further unnecessary testing. Urine dipsticks can be used if risk factors are present (ie: elevated BP).

Appendix One:

Worksheets for Developing Interdisciplinary Maternity Care Teams

Appendix One:

SHARING ON-CALL RESPONSIBILITIES

Who are the primary people in the collaboration?

Who are your interdisciplinary champions? Will they co-lead or mentor the team?

Why does the team want to share call responsibilities with one another?

Will sharing call be on an ad-hoc or scheduled basis?

How is the philosophy and provision of intrapartum care similar among providers? How may it be different?

What are the potential benefits of sharing call?

What are the potential drawbacks of sharing call?

How will each care provider bill and be remunerated for their services?

Will labour assessments and intrapartum care be paid to the individual or billed to the group of providers sharing call?

If it is billed to the group, how is the rate of pay to the individual determined? How will payment be dispersed?

Will there be financial compensation for time spent being available on-call for one another's patients?

Appendix One:

SHARING POSTPARTUM CARE

Who are the primary people in the collaboration?

Who are your interdisciplinary champions? Will they co-lead or mentor the team?

Why does the team want to share postpartum care?

Will sharing postpartum care be on an ad-hoc or scheduled basis?

How is the philosophy and provision of postpartum care similar among providers? How may it be different?

What are the potential benefits of sharing postpartum care?

What are the potential drawbacks of sharing postpartum care?

How will each care provider bill and be remunerated for their services?

Will the postpartum care be billed to the individual or to the group of providers sharing postpartum care?

If it is billed to the group, how is the rate of pay to the individual determined? How will payment be dispersed?

Will there be financial compensation for time spent being available on-call for one another's patients?

Appendix One:

SHARING CONNECTING PREGNANCY (CP) GROUP CARE

Who are the primary people in the collaboration?

Who are your interdisciplinary champions? Will they co-lead or mentor the team?

Why does the team want to do CP groups with one another and for their patients?

What are the potential benefits of sharing CP group care?

What are the potential drawbacks of sharing CP group care?

How is the philosophy and provision of care similar among providers? How may it be different? What about teaching or facilitation style?

Will any care providers need education or training to provide CP group care? If so, how will this be achieved?

How will the CP group care be organized? Will your groups be facilitated by two providers, one provider and one nurse, or one provider and one childbirth educator? Will you have guest speakers?

How will the CP group care be billed? Are there any additional sources of funding or revenue to support the CP group?

How will you determine the individual's rate of pay for facilitation of CP group care? Will you pay or provide honorariums for guest speakers?

How will payment be dispersed?

Appendix Two:

Billing Reference Sheets

Midwifery Billing Reference Sheet

All dollar values are based on Jan 1st, 2018

DIAGNOSIS CODE – PRENATAL CARE: ☐ **30B**

MIDWIFERY PRENATAL CODES

☐	36010	1st Tri	**$ 259.12**
☐	36020	2nd Tri	**$ 259.12**
☐	36030	3rd Tri	**$ 518.34**

NOTE: a transfer in or out of each trimester or no care received in the 1st trimester are separate codes not included in this guide

MIDWIFERY INTRAPARTUM CODES

☐	36040	Attendance at Labour and Birth	**$ 1036.51**
☐	36031	Atten Labour and Birth in 2nd tri	**$ 518.34**
☐	36041	Atten and Transfer in Labour	**$ 414.61**
☐	36042	Receive & Atten at Labour & Birth	**$ 621.90**
☐	36045	2nd Attendant at Home Birth	**$ 357.75**

NAME: _____

MW C-SECTION CODES

DATE OF DELIVERY: _____ **TIME OF DELIVERY:** _____

☐	36048	Supportive Care at Elective C/S in OR		**$ 102.21**
☐	36049	Supportive Care at Elective C/S in PAR		**$ 102.21**
☐	36070	Surgical Assist C/S – Scheduled		**$ 187.83**
☐	36071	Surgical Assist C/S – Emergency		**$ 187.83**
☐	36073	First Surgical Assist of the Day		**$ 82.51**
☐	36072	Attendance at C-section for MRP of baby		**$ 89.42**
☐	36075	Call-out Eve	1800-2300	**$ 71.09**
☐	36076	Call-out Night	2300-0800	**$ 113.98**
☐	36077	Call-out W-E/Hol	0800-2300	**$ 71.09**
☐	36078	Emergency Call-out		**$ 111.74**

TIME: _____ (36075)
TIME: _____ (36076)
TIME: _____ (36077)
TIME: _____ (36078)

MIDWIFERY POSTPARTUM CODES

☐	36050	Postpartum Care (to 6wk pp)	**$ 1036.51**

NOTE: a transfer in or out of the postpartum period is a separate code and not included in this guide

CONSULTATIVE FEE CODES (Cannot be part of same practice)

☐ 36079 ☐ 36080 ☐ 36081 ☐ 36082 ☐ 36083 (max 3ser/d ~ 1hr) **$ 40.46**

Consultative Care and Assessment. START: _____ END: _____ REFERED BY: _____

☐ 36085 Call-out Day (0800-1800) CALLED: _____ SERVED: _____

☐ 36086 Call-out Night (1800-08:00) & W/E CALLED: _____ SERVED: _____

☐ 36084 Consultative Care & Assess by phone **$ 40.46** REASON: _____

Physician Intrapartum Care Billing Reference Sheet

PATIENT STICKER HERE:

All dollar values are based on April 1, 2018. Rates are updated regularly, please check the fee guide for most recent values

CALL-OUT CODES

					DATE	CALLED	TIME SERVICE RENDERED
☐	00112	Day (Urgent)	0800-1800	*$ 114.29*			
☐	01200	Evening	1800-2300	*$ 60.96*			
☐	01201	Night	2300-0800	*$ 85.62*			
☐	01202	WE/Holiday	0800-2300	*$ 60.96*			

LABOUR – DELIVERY

DATE: _____ TIME OF DEL: _____

☐	04118	Oxy IOL/Aug 1st Hr	*$ 41.58*	START: _____ END: _____
☐	04119	Oxy IOL/Aug Subse Hrs (up to 9h)	*$ 28.66*	START: _____ END: _____
☐	14104	Normal Del/PP care	*$ 577.54*	
☐	G14004	SVD Delivery Incentive	*$ 240.54*	(max 25 GPSC Del Incentives/yr/FP of any combination)
☐	14105	Mgmt of Labour & Transfer	*$ 240.52*	(trans to higher level care in active labour)
☐	G14005	Mgmt of Labour & Trans Incentive	*$ 120.26*	(max 25 GPSC Del Incentives/yr/FP of any combination)
☐	04000	Complicated Del	*$ 337.93*	(shoul dyst, PTL < 37wks) pd 50% c/ 14104)
☐	00082	PPH/Emerg monitor (per 1/2hr)	*$ 62.68*	START: _____ END: _____
☐	14199	Prolonged 2nd stage	*$ 41.58*	(ea ½ hr over 2hs) Cannot bill 04000+14199)

2ND STAGE START: _____ 2ND STAGE FINISH: _____

3RD STAGE START: _____ 3RD STAGE FINISH: _____

Out of Office Hours Srchr (per 30min, gen bill once reach 2nd stage +14199 if appl)

☐	01205	1800-2300	*$ 56.06*	START: _____ END: _____
☐	01206	2300-0800	*$ 76.64*	START: _____ END: _____
☐	01207	W-E/Holid	*$ 56.06*	START: _____ END: _____

DIAGNOSTIC CODES:

MATERNAL

- ☐ **644** EARLY LABOUR
- ☐ **650** UNCOMPLICATED LABOUR
- ☐ **642** HYPERTENSION
- ☐ **646** OTHER
- ☐ **652** MALPOSITION
- ☐ **660** COMPLIC OF LABOUR

C-SECTION

DATE: _____ TIME OF DEL: _____ C/S START: _____ C/S FINISH: _____

☐	14108	Elective C/S (pp care)	*$ 118.82*
☐	G14008	Elective C/S Del Incentive (max 25 GPSC Del Incentives/yr/FP of any combination)	*$ 240.54*
☐	14109	Mgmt of Labour & Emerg C/S	*$ 481.07*
☐	G14009	Emerg C/S Del Incentive (max 25 GPSC Del Incentives/yr/FP of any combination)	*$ 240.54*
☐	13194	1st Surgical Assist of the Day	*$ 87.07*
☐	00196	Surgical Assist (Elective C/S)	*$ 187.83*
☐	00197	Surgical Assist (Emergent C/S)	*$ 256.18*

☐	01210	Surg Surch Even	1800-2300	(38% of assis fee)
☐	01211	Surg Surch Night	2300-0800	(61% of assis fee)
☐	01212	Surg Surch W-E/Hol	1800-2300	(38% of assis fee)

DETAILED NOTES:

Physician Prenatal, Outpatient, and Postpartum Billing Reference Sheet

All dollar values are based on April 1, 2018. Rates are updated regularly, please check the fee guide for most recent values

PHYSICIAN PRENATAL OFFICE CODE

☐	15130	Urinalysis (chemicl, if appl)	*$ 2.15*
☐	15120	Pregnancy Urine Test (in office)	*$ 11.50*
☐	14090	Prenatal Visit Complete Exam	*$ 83.38*
☐	14091	Subsequent Prenatal Visit	*$ 31.23*
☐	00120	Counseling (min 20 minutes instead of pre/postnatal visit; max 4/yr/pt) *(15320 if 50+yrs)*	*$ 54.35*

FEE CODES APPLY TO PHYSICIANS BELONGING TO A MATERNITY NETWORK

☐	G14076	Telephone Mgmt c/ pt	*$ 20.00*
		REASON: _____	
☐	G14078	Email/Text/Phone Advice c/ pt	*$ 7.00*
		REASON: _____	
☐	G14019	GP Advice to NP/MW (not at same clinic)	*$ 40.00*
		REASON: _____	
☐	G14077	GP Allied Provid Conf (per 15min or greater, max 2 units/day)	*$ 40.00*
		REASON: _____	
☐	G14018	GP Urgent Phon Conf c/ Specialist	*$ 40.00*
		REASON: _____	

MATERNAL OUT-PATIENT/IN-PATIENT/POSTPARTUM VISITS

☐	P13109	Inpt Hosp ADMIS – MRP only (NOT labour, ie HTN)	*$ 101.25*
☐	P13008	Inpt Hosp FP MRP visit (NOT labour/pp)	*$ 53.20*
☐	13028	Inpt FP Supportive Care vis (NOT labour/pp)	*$ 35.34*
☐	P13338	First Facility Visit of the Day (c/ 13008 or 13028)	*$ 37.82*

Non-labour/delivery/pp maternal inpatient care:

START DATE: _____ END DATE: _____

REASON/DX: _____

☐	13200	Outpt Hospital Visit/Assess *(15200 if 50+ yrs)*	*$ 37.48*
☐	790	Interpretation of FH Monitoring (NST) *(NOT in labour)*	*$ 17.44*
☐	14094	Postnatal Office Visit (within 6wk pp)	*$ 31.23*

GROUP MEDICAL VISIT CODES *Apply to physician attending the group*

# OF PTS	CODE	AMOUNT
3	13763	*$25.55*
4	13764	*$20.64*
5	13765	*$17.73*
6	13766	*$15.78*
7	13767	*$14.39*
8	13768	*$13.36*
9	13769	*$12.52*
10	13770	*$11.87*
11	13771	*$10.40*
12	13772	*$9.78*
13	13773	*$9.05*
14	13774	*$8.89*
15	13775	*$8.53*
16	13776	*$8.28*
17	13777	*$7.94*
18	13778	*$7.76*
19	13779	*$7.48*
20	13780	*$7.30*
>20	13781	*$7.03*

NEWBORN CARE

☐	00119	Routine Newborn Care in Hosp	*$ 91.67*
☐	00118	Attendance of newborn at C/S	*$ 86.69*
☐	00081	NRP – active resusc (per ½ hr)	*$ 104.48*
		START: _____ END: _____	
☐	00082	NRP – post NRP surveillance (per ½ hr)	*$ 62.68*
		START: _____ END: _____	

Baby as in-patient (ie Jaundice)

START DATE: _____ END DATE: _____

☐	13008	Inpt FP MRP visit (not routine NB care)	*$ 53.20*
☐	13028	Inpt FP Supportive Care visit (MRP care by peds)	*$ 35.34*
☐	P13338	1st Hospital Visit of the Day Bonus	*$ 37.82*

Newborn inpatient care (not routine NB care):

START DATE: _____ END DATE: _____ REASON/DX: _____

☐	12100	Newborn/baby Office Visit	*$ 34.36*

COMMON DIAGNOSTIC CODES:

- ☐ **08A** HEALTHY
- ☐ **774** JAUNDICE
- ☐ **770** RESP. CONDITION
- ☐ **776** HEMOTOLOGIC DISORDER
- ☐ **779.3** FEEDING ISSUE
- ☐ **7706** TACHYPNEA
- ☐ **6563** FETAL DISTRESS
- ☐ **6568** MECONIUM
- ☐ **7756** NEONATAL HYPOGLYCEMIA
- ☐ **7741** PRENATAL JAUNDICE
- ☐ **642** HYPERTENSION
- ☐ **644** EARLY LABOUR

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115 – 1665 West Broadway
Vancouver, BC
V6J 5A4

www.sharedcarebc.ca