Module 4: MULTIPLE VISITS and PROCEDURES and VISIT

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4.1 Multiple and Duplicate Visits on the Same Day

Occasionally a patient will visit their doctor more than once in the same day. The following information will clarify when it is appropriate to bill more than one visit on the same day for the same patient. For a definition of '"visit" and included services please see Preamble B.4. in the *MSC Payment Schedule*

More than one visit may be billed for the same patient on the same day when:

- The patient is seen for a visit to assess one specific problem, and presents later in the day with a new condition;

- The patient is seen for a visit to assess one specific problem, and presents later in the day because the condition has worsened significantly and requires a new assessment.

More than one visit may not be billed for the same patient on the same day when:

- The patient returns to the office to receive additional information regarding their condition than could reasonably be expected to have been included in the initial visit. For example if a patient is asked to return for treatment advice and **does not require a new assessment**, a second visit would not be billable.

- The patient is seen for multiple problems during the same visit.

Billing Instructions

Duplicate visits are additional visits occurring on the same day for the same patient and billed under the same fee code (e.g. 00100)

To bill duplicate visits:

- Submit a claim for each visit on a separate line
- Use submission code "D" for the second visit
- Indicate the medical reason for the second visit in the note record (e.g. patient condition worsened; seen for new condition).

Note: Claims will be processed electronically if you include time.

Note: If a note record is included for the first visit, the note record for the second visit must be different from the first.

Multiple visits are visits occurring on the same day for the same patient and billed under different fee codes (e.g. 00100 for first visit and 00112 for second visit)

To bill multiple visits:

- Submit a claim for each visit on a separate line
- Indicate the medical reason for the second visit in a note record – must specify that the patient returned

Note: Claims will be processed electronically if you include time.

Tip: We recommend that you include a note record with all duplicate claims.

4.2 Submission Code D

Duplicate or Multiple Services

A duplicate claim is one for the same patient, service date, and fee item as identified in another claim. It may be for two or more visits on one day, or for multiple services performed at the same time under the same fee item.

If you bill for multiple visits on the same day for which the time between the visits exceeds two hours, the claims will be processed electronically if you provide the time for each service rendered. We recommend that you include a note record with all duplicate claim submissions.

Billing for a Duplicate Service

There are two methods of billing for duplicate services/procedures:

1. You can bill multiple procedures on one line. Submission code **D** is not required when you bill in this manner. Use submission code **0** (zero).

or

2. You can bill the service on separate lines, with submission code **0** (zero) for the first service and submission code **D** for the duplicate service.
   If you are billing for visit fee items such as 00100 or 13100, indicate the start time on both claims, as indicated in this example:

Service	**Fee Item**	**Amount**	**Submission Code**	**Time**	**Note**
First	00100	Full	0	0900	*n/a*
Second	00100	Full	D	1300	*n/a*

If you cannot include the start times on the visits because of system limitations, use submission code **D** on the duplicate service(s), and include a claim comment or note record indicating the start time of each service.

Note: Use submission code **0** (zero) for the original or first claim.
Use submission code **D** for all valid duplicates, regardless of the fee items, unless you are billing multiple services on one line.
Do not use submission code **D** on the original or first claim.

Not all duplicate services require a note. For services such as visit fees, provide the time on both claims and use submission code **D** on your second claim. If the visits are less than two hours apart, include a note or claim comment indicating the medical necessity of the second service.

4.3 Daily Volume Limits

Effective April 1, 2009 the following replaces all references to relative value calculations in the *MSC Payment Schedule*/General Practice Preamble:

Note: Daily Volume Payment rules applying to designated office codes

(i) The codes to which these rules apply are as follows:

Office visits: 12100, 00100, P15300, 16100, 17100, 18100
Office counselling: 12120, 00120, P15320, 16120, 17120, 18120
Office complete examinations: 12101, 00101, P15301, 16101, 17101, 18101

(ii) The total of all billings under the codes listed in i) that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. When such a daily total exceeds 50 the practitioner's payment on these codes for that day will be discounted. Moreover, when a daily total exceeds 65, a further payment discount will be made.

Daily Ranges *(for an individual practitioner for any single calendar day)*	**Discount Rate**	**Payment Rate**
0 to 50	0%	100%
51 to 65	50%	50%
66 and greater	100%	0%

iii. Payment discounts will not be applied to services rendered in communities that are/were receiving NIA premiums as of December 15, 2002.

iv. Payment discounts will not be applied to services designated by the physician as being the responsibility of ICBC, (designate by checking the MVA indicator on the claim), or services that are the responsibility of WCB.

v. Services will be assessed and payment/discounts will be applied to services in the order in which they are received and accepted for payment by MSP.

4.4 Procedure and Visit on the Same Day (Preamble B. 12. d.)

Minor Diagnostic/Therapeutic Procedures

If in the course of a visit for a specific complaint, one or more procedures are performed which are unrelated to the purpose of the visit (eg., URI and laceration repair), the service having the largest fee may be claimed in full and the remaining service(s) at 50 percent of the listed fee(s), unless otherwise specifically indicated in the Payment Schedule.

Examples:

Fee item 13611 in full for laceration	Paid
Fee item 00090 in full, tray fee for fee item 13611	Paid
Fee item 00100 @ 50% for laceration	Refused explanatory code KB
Fee item 13611 in full for laceration	Paid
Fee item 00090 in full, tray fee for fee item 13611	Paid
Fee item 00100 @ 100% for migraine headache	Paid @ 50% explanatory code KB
Fee item 00101 in full for abdominal pain	Paid
Fee item 14560 @ 50% for pap test	Refused explanatory code GG
Fee item 00044 in full, tray fee for fee item 14560	Refused
Fee item 00190 in full for wart removal	Paid
Fee item 00044 in full, tray fee for fee item 00190	Paid
Fee item 00100 in full for general symptoms	Refused explanatory code KB