doctorcare
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Palliative Care

Quick Reference Guide

This short guide will provide you with key information to bill for palliative care services

Read below for best practice recommendations on how to take advantage of the palliative care fee codes and maximize your billings

Challenge	DoctorCare Best Practices and Recommendations
What is Palliative Care?	• Palliative care services are for patients who in the family practice's clinical judgement have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to 6 months, and who consent to the focus of care being palliative.

What are the rules and guidelines to billing Palliative Care codes?	• Palliative care codes are only valid if you're visiting a patient that is terminally ill or suffering from:
	  ○ Malignant disease or AIDS
	  ○ End-stage respiratory, cardiac, liver and renal disease
	  ○ End-stage dementia with life expectancy of up to 6 months
	• Fee codes can be billed when there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.
	• Fee codes are not limited to patients who are in a palliative care unit, but are also available for patients that are in acute care hospitals, hospice facilities or other institutions.
	• Fee codes are invalid if the patient dies from an illness that they were not hospitalized for.
	• All palliative care fee codes can be billed continuously once the patient is given a palliative status, for a period not to exceed 180 days prior to death. If you submit palliative care claims that go beyond 180 days, you need to leave a note in the MSP note field explaining why. MSP will then consider your reasons and either approve or reject it.

Challenge	DoctorCare Best Practices and Recommendations
What are the codes you can bill for Palliative Care?	• **00127 – Palliative Care Patient Facility Visit - $53.87** This item is applicable to the visits for palliative care patients as defined in the previous section. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs. • **13338 – Community Based GP: First Facility Visit of the Day Bonus - $49.72** The bonus fee item is billed for the first facility visit of the day. This fee item is paid only if 13008, 13028, and 00127 is paid the same day. Regardless of the number of facilities attended, there is a limit of one payable for the same physician, same day. • **13228 - Community Based GP: Hospital Visit (courtesy/associate privileges) - $30.00** The hospital visit code is for physicians who are not the primary palliative care physicians. This is payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days, an explanation in the note record is required. • **13005 - Advice About a Patient in Community Care - $18.22** Fee item 13005 is claimed for advice by telephone, fax, or in written form about a patient in community care in response to an enquiry initiated by an allied health care worker specifically assigned to the care of the patient. This fee may be billed to a maximum of one per patient per physician per day. • **PG14063 - Palliative Care Planning Fee (Effective April 1, 2020) - $100.00** The FP Palliative Care Planning Fee is payable only to family physicians who have successfully submitted and met the requirements of the PG14070 or PG14071 in the same calendar year. It is payable once per patient once the patient is deemed to be palliative. The code is only eligible if the patients are living at home or in assisted living and they are not in acute and long term facilities.