Long-term care facility visits (fee items 00114 and 00115)

The roll-out of the GPSC Residential Care Initiative represents a major advance in delivering high-quality care to residential care residents in British Columbia. One of the expectations of the initiative is the provision of proactive visits. However, recent audits have identified some issues with the following long-term care fee items (00114 and 00115).

This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.

Common errors seen in audits

Fee item 00114 (one or multiple patients, per patient):

- Claims exceeding the maximum of one visit every 2 weeks. If the visits are beyond the limit of one every 2 weeks, a note stating the medical necessity is required.
- Billing out-of-office visits (not appropriate for day visits,* after hours only).
- Physician reviewing the chart and not seeing the patient. A face-to-face patient-doctor encounter must be made.

*The Preamble to the General Practice section of the *Doctors of BC Guide to Fees* states that out-of-office visit fees are applicable unless the circumstance of the service is specifically covered by the definition of fee item 00103, 00108, 13008, 00109, 00127, 00128, 13028, 00111, 00112, 00114, 00115, 00113, 00105, 00123, 13228, or one of the 01800 series.

Fee item 00115 (nursing home visit— one patient, when specially called):

- Visits appear to be on a set day or the physician's regular round day. The visit must take place within 24 hours of receiving the request from the nursing home.
- No evidence the physician was specially called. Documentation should include who called, the time called, and the medical necessity.

Refer to Preamble D.4.9. Long-Term-Care Institution Visits for more information.

—**Keith J. White, MD**
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