BRITISH COLUMBIA

# MEDICAL SERVICES COMMISSION

# MINUTE OF THE COMMISSION



**Amendment to the Medical Services Commission Payment Schedule**
**Section of General Practice**
**General Practice Services Committee Funded Fee Items**

15-067

Pursuant to the 2014 Physician Master Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

**Amendment:**

Effective August 1, 2015, the GPSC Initiated Listings Preamble is amended to:

Refer to Appendix 1 for detailed amendments.

## GPSC Initiated Listings

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

Unless otherwise identified in the individual fee description, physicians are eligible to participate in the incentive program if they are:

1. A general practitioner who has a valid BC MSP practitioner number;
2. Currently in general practice in BC as a full service family physician;
3. The most responsible general practitioner for the majority of the patient's longitudinal general practice care; and
4. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

Additional detailed eligibility requirements are identified in each section.

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

For the purposes of its incentives, GPSC defines Physicians working on Alternative Payment Program (APP) as those working under Health Authority paid APP contracts. Agreements to pool FFS billings and

pay out physicians in a mutually acceptable way (e.g. per day, per shift, per hour, etc.) are not considered APP by GPSC. If services supported and paid through GPSC incentives are already included in a sessional, salary or service contract then they are not billable in addition.

For the purpose of its incentives, GPSC defines a General Practitioner (GP) with specialty training as: "A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program".

For the purposes of its incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Specialist Physicians; GPs with Specialty Training; Nurses; Nurse Practitioners; Mental Health Workers; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.

**Amendment:**

Effective August 1, 2015, a preamble is added to Section 1. Expanded Full Service Family Practice Condition-based Payments and fee items G14050, G14051, G14052 and G14053 are amended to:

Refer to Appendix 2 for detailed amendments.

## 1. Expanded Full Service Family Practice Condition-based Payments

The GPSC Condition-based Payments compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full year. The goal is to improve provision of clinically appropriate care that considers both the patient's values and the impact of comorbidities. To confirm an ongoing doctor-patient relationship, there must be at least 2 visit fees (office; prenatal; home; long term care; only one of which can be a GPSC Telephone Visit (G14076, G14079) or Group Medical Visit (13763 -13781) billed on each qualifying patient in the 12 months prior to billing the CDM incentive. **Visits provided by a locum for the MRP GP are included; however, an electronic note indicating this must be submitted with the claim.** Patients in long-term care facilities are eligible. Clinical judgment must be used to determine the appropriateness of following clinical practice guidelines in all patients, particularly those with dementia or very limited life expectancy. Documentation of the provision of guideline-informed care for the specific condition is required in the medical record. Although use of the GPAC Chronic Care flow sheets is not mandatory, they are a useful tool for tracking care provided to patients over time. **Condition-based payments are no longer payable once G14063, the Palliative Planning Incentive has been billed and paid as patient has been changed from active management of chronic disease to palliative management**.

Patient self-management can be defined as the decisions and behaviors that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. An important part of this support is the provision of tools by the family physician that can enable patients to make appropriate choices and sustain healthy behaviors. There are a variety of tools publically available (e.g. health diaries/passports, etc.) to help build the skills and confidence patients need to improve management of their chronic conditions and potentially improve outcomes. Documentation in the patient chart of the provision of patient self-management supports as part of the patient's chronic disease management is expected.

When a new GP assumes the practice of another GP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fee is billable on its anniversary date provided the new GP has continued to provide guideline-informed care for these patient(s). To demonstrate continuity, if

some of the required visits have been provided by the previous GP, an electronic note indicating continuity of care over the full 12 months is required at the time of the initial submission of the CDM fee by the new GP.

| | | $ |
|---|---|---|
| G14050 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (diabetes mellitus) | 125.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.*

*iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14250.*

*v) Claim must include the ICD-9 code for diabetes (250).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Payable in addition to fee items G14051 or G14053 for same patient if eligible.*

*viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

*ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

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|---|---|---|
| G14051 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (heart failure) | 125.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.*

*iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14251.*

*v) Claim must include the ICD-9 code for heart failure (428).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Payable in addition to items G14050 or G14053 for the same patient if eligible.*

*viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

*ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

| | | $ |
|---|---|---|
| G14052 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (hypertension) | 50.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.*

*iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14252.*

*v) Claim must include the ICD-9 code for hypertension (401).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Not payable if G14050, G14250, G14051, G14251 paid within the previous 12 months.*

*viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

*ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

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|---|---|---|
| G14053 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (Chronic Obstructive Pulmonary Disease-COPD) | 125.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.*

*iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14253.*

*v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Payable in addition to fee items G14050, G14051 or G14052 for the same patient if eligible.*

*viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

*ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

Successful billing of the Annual Chronic Care incentive for COPD (G14053) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months.

**Amendment:**

Effective January 1, 2015, the following CDM fee items are added to Section 1. Expanded Full Service Family Practice Condition-based Payments:

Use the following CDM incentives if the required two visits were billed as an encounter record while working under salary, service contract or sessional arrangement. Post review will be performed within 2 years and recoveries made if encounter records were not submitted for the required visits.

| | | $ |
|---|---|---|
| G14250 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus) | 125.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.*

*iii) This item may only be billed after one year of care and at least two visits have been provided the patient in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.*

*v) Claim must include the ICD-9 code for diabetes (250).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Payable in addition to fee items G14051, G14250, G14053 or G14253 for same patient if eligible.*

*viii) Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*

*ix) A visit may be provided on the same date the incentive is billed.*

| | | |
|---|---|---|
| G14251 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (heart failure) | 125.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.*

*iii) This item may only be billed after one year of care and at least two visits have been provided in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice*

*as a requirement of their employment and submitted the requisite encounter code visits.*

v) *Claim must include the ICD-9 code for heart failure (428).*
vi) *Payable once per patient in a consecutive 12 month period.*
vii) *Payable in addition to items G14050, 14250,G14053 or G14253 for the same patient if eligible*
viii) *Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*
ix) *A visit may be provided on the same date the incentive is billed.*

| | | $ |
|---|---|---|
| G14252 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (hypertension) | 50.00 |

***Notes:***

i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*
ii) *Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.*
iii) *This item may only be billed after one year of care and at least two visits have been provided in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*
iv) *Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.*
v) *Claim must include the ICD-9 code for hypertension (401).*
vi) *Payable once per patient in a consecutive 12 month period.*
vii) *Not payable if G14050, G14250, G14051 or G14251 paid within the previous 12 months.*
viii) *Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*
ix) *A visit may be provided on the same date the incentive is billed.*

| | | |
|---|---|---|
| G14253 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD) | 125.00 |

***Notes:***

i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*
ii) *Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.*
iii) *This item may only be billed after one year of care and at least two visits have been provided in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*
iv) *Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice*

*as a requirement of their employment and submitted the requisite encounter code visits.*

v) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*
vi) *Payable once per patient in a consecutive 12 month period.*
vii) *Payable in addition to fee items G14050, G14250, G14051, G14251, G14052, G14252 for the same patient if eligible.*
viii) *Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*
ix) *A visit may be provided on the same date the incentive is billed.*

**Amendment:**

Effective August 1, 2015, fee items G14015, G14016, G14017 and G14018 under Section 2. Conference Fees are amended to:

Refer to Appendix 3 for detailed amendments.

**2. Conference Fees**

**Facility Patient Conference Fee**

| | | $ |
|---|---|---|
| G14015 | General Practice Facility Patient Conference: when requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient with complex supportive care needs in a facility can safely return to the community or transition to a supportive or long-term facility - per 15 minutes or greater portion thereof | 40.00 |

***Notes:***

i) *Refer to Table 1 (below) for eligible patient populations.*
ii) *Must be performed in the facility and results of the conference must be recorded in the patient chart.*
iii) *Payable only for patients in a facility. Facilities limited to: hospital, palliative care facility, LTC facility, rehab facility, sub-acute facility, psychiatric facility, detox/drug and alcohol facility).*
iv) *Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any allied care provider charged with coordinating discharge and follow-up planning.*
v) *Requires interdisciplinary team meeting of at least 2 allied care professionals in total, and will include family members when available.*
vi) *Fee includes:*
    a. *Where appropriate, interviewing of and conferencing with patient, family members, and other allied care providers of both the acute care facility and community.*
    b. *Review and organization of appropriate clinical information.*
    c. *The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*
    d. *The care plan must be recorded and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*vii) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*
*viii) Claim must state start and end times of the service. Start and end times must be documented in the patient chart.*
*ix) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*
*x) Not payable to physicians who are participating in the GPSC attachment initiative (G14070).*
*xi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
*xii) Not payable on the same day for the same patient fee item G14016, G14017, G14033, G14043, G14063, G14074, G14075, G14076 or G14077.*
*xiii) Visit payable in addition if medically required and does not take place concurrently with the patient conference. Medically required visits performed consecutive to the Facility Patient Conference are payable. (i.e. Visit is separate from conference time).*

**Community Patient Conference Fee**

| | | $ |
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| G14016 | General Practice Community Patient Conference Fee: Creation of a coordinated clinical action plan for the care of community-based patients with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other allied care providers is required (e.g. specialists, psychologists or counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers,) as well as with the patient and will include family members when available (as required due to the severity of the patient's condition) - per 15 minutes or greater portion thereof | 40.00 |

***Notes:***
*i) Refer to Table 1 (below) for eligible patient populations.*
*ii) Fee is billable for conferences that occur as a result of care provided in the following community locations for patients who are resident in the community:*
- *Community GP Office*
- *Patient Home*
- *Community placement agency*
- *Disease clinic (DEC, arthritis, CHF, Asthma, Cancer or other palliative diagnoses, etc.*
- *Assisted living*

*iii) Fee includes:*
*a. The interviewing of patient and family members as indicated and the conferencing with other allied care providers.*
*b. Review and organization of appropriate clinical information.*
*c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*
*d. The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*iv) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*

*v) Claim must state start and end times of service. Start and end times must be documented in the patient chart.*
*vi) Not payable to physicians who are participating in the GPSC attachment initiative (G14070).*
*vii) Not payable to the same patient on the same date of service as fee item G14015, G14017, G14074, G14075, G14076 or G14077.*
*viii) Not payable to physicians who are employed by, or who are under contract to a facility, who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
*ix) Visit payable in addition if medically required and does not take place concurrently with clinical action plan.*

**Acute Care Discharge Conference Fee**

| | | $ |
|---|---|---|
| G14017 | General Practice Acute Care Discharge Conference fee<br>In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to the most responsible GP for that patient following discharge from the acute care facility. This fee is billable when a Discharge Planning Conference is performed upon the request of either an Acute Care facility, or by the GP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.<br>- per 15 minutes or greater portion thereof | 40.00 |

***Notes:***
*i) Refer to Table 1 for eligible populations.*
*ii) Payable only for patients being discharged from an acute care facility to the community or to a different facility; another acute care facility, or a supportive care or Long Term Care facility.*
*iii) Must be performed in the acute care facility and results of the conference must be recorded in the patient's chart in the acute care facility and the receiving GP's office chart (or receiving facility's chart in the case of inter-facility transfer).*
*iv) Face-to-face conferencing is required; the only exception is if a patient is being discharged from an acute care facility in a different community, and a chart notation must be made to indicate this circumstance.*
*v) Requesting care providers limited to: Facility-affiliated physicians and nurses, GP assuming MRP status upon patient's discharge, care coordinators, liaison nurses, rehab consultants, social workers, and any allied care provider charged with coordinating discharge and follow-up planning.*
*vi) Requires interdisciplinary team meeting of the GP assuming MRP status upon discharge and a minimum of 2 other allied care professionals as enumerated above, and will include family members when appropriate.*
*vii) Fee includes:*
*a. Where appropriate, interviewing of and conferencing with patient, family members, and other allied care providers of both the acute care facility and community.*
*b. Review and organization of appropriate clinical information.*
*c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of degrees of intervention and end of life documentation as appropriate.*

d. *The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*
e. *This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses during the course of a patient's stay in the acute care facility.*
f. *Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*
g. *Claim must state start and end times of the service.*
h. *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*
i. *Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
j. *Medically required visits performed consecutive to the Acute Care Discharge Conference are payable (i.e. Visit is separate from conference time).*
k. *Submit the new fee item G14017 through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders.*
l. *Not payable to physicians who are participating in the GPSC attachment initiative (G14070).*
m. *Not payable to the same patient on the same date of service as fee item G14015, G14016, G14074, G14075, G14076 or G14077.*
n. *Not payable on the same day as any GPSC planning fees (G14033, G14075, G14043, G14063 (Palliative Planning Fee).*

*Table 1:* ***Eligible patient populations for the Facility Patient, Community Patient and Acute Care Discharge Conference Fees***

i. **Frail elderly (ICD-9 code V15)**

Patient over the age of 65 years with at least 3 out of the following factors:

- Unintentional weight loss (10 lbs in the past year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow gait speed (decreased balance and motility)
- Low levels of physical activity (slowed performance and relative inactivity)
- Incontinence
- Cognitive impairment

ii. **Palliative care (ICD-9 code V58)**

Patient of any age who:

- Is living at home ("Home" is defined as wherever the person is living, whether in their own home, living with family or friends, or living in an assisted living residence or hospice); and
- Has been diagnosed with a life-threatening illness or condition; and
- Has a life expectancy of up to six months; and
- Consents to the focus of care being palliative rather than treatment aimed at cure.

iii. **End of life (ICD-9 code V58)**

Patient of any age:

- Who has been told by their physician that they have less than six months to live; or
- With terminal disease who wish to discuss end of life, hospice or palliative care.

iv. **Mental illness**

Patient of any age with any of the following disorders is considered to have mental illness:

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Personality Disorders
- Sleep Disorders
- Developmentally Delayed, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders
- Sexual Dysfunction
- Dissociative Disorders
- Mental Disorders due to a General Medical Condition
- Factitious Disorder

*Definitions and the management of these mental disorders are defined in the Manual: Management of Mental Disorders, Canadian Edition, Volume One and Two, edited by Dr. Elliot Goldner, Mental Health Evaluation and Community Consultation Unit, University of British Columbia.*

*Definitions for Delirium, Dementia and Other Cognitive Disorders; Developmental Disabilities; Dissociative Disorders; Mental Disorders due to a General Medical Condition and Factitious Disorder are found in the Diagnostic and Statistical Manual of Mental Disorders - DSM-IVR.*

v. **Patients of any age with multiple medical needs or complex co-morbidity**

Patients of any age with multiple medical conditions or co-morbidities (two or more distinct but potentially interacting problems) where care needs to be coordinated over a period of time between several health disciplines. On your claim form use the code for one of the major disorders.

**General Practice Urgent Telephone Conference with a Specialist Fee**

The intent of this initiative is to improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers.

This fee is billable when the severity of the patient's condition justifies urgent conference with a specialist or GP with specialty training, for the development and implementation of a care plan within the next 24 hours to keep the patient stable in their current environment

This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

| | | $ |
|---|---|---|
| G14018 | General Practice Urgent Telephone Conference with a Specialist Fee: Conferencing on an urgent basis (within 2 hours of request for a telephone conference) with a specialist or GP with specialty training by telephone followed by the creation, documentation, and implementation of a clinical action plan for the care of patients with acute needs; i.e. requiring attention within the next 24 hours and communication of that plan to the patient or patient's representative | 40.00 |

***Notes:***

*i) Payable to the GP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or GP with specialty training regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.*

*ii) A GP with specialty training is defined as a GP who:*
- *a. Provides specialist services in a Health Authority setting and is acknowledged by the Health Authority as acting in a specialist capacity and providing specialist services;*
- *b. Has not billed another GPSC fee item on the patient in the previous 18 months; Telephone advice must be related to the field in which the GP has received specialty training.*

*iii) Conversation must take place within two hours of the GP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, e-mail).*

*iv) Fee includes:*
- *a. Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*
- *b. Developing, documenting and implementing a plan to manage the patient safely in their care setting.*
- *c. Communication of the plan to the patient or the patient's representative.*
- *d. The care plan must be recorded in the patient chart and must include patient identifiers, reason for the care plan, list of comorbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*v) Not payable to the same patient on the same date of service as fee items G14015, G14016, G14017 or G14077.*

*vi) Not payable to physicians who are employed by, or who are under a contract to a facility, who would otherwise have provided the service as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangement.*

*vii) Include start time in time fields when submitting claim.*

*viii) Not payable for situations where the primary purpose of the call is to:*
- *a. Book an appointment*
- *b. Arrange for transfer of care that occurs within 24 hours*
- *c. Arrange for an expedited consultation or procedure within 24 hours*
- *d. Arrange for laboratory or diagnostic investigations*
- *e. Inform the other physician of results of diagnostic investigations*
- *f. Arrange a hospital bed for the patient*
- *g. Obtain non-urgent advice for patient management (i.e. not required within the next 24 hours).*

*ix) Limited to one claim per patient per physician per day.*

*x) Out-of-Office Hours Premiums may not be claimed in addition.*

*xi) Maximum of 6 (six) services per patient, per practitioner per calendar year.*

*xii) Visit payable on same date of service if medically required and does not take place concurrently with the clinical action plan.*

**Amendment:**

Effective August 1, 2015, fee item G14079 under Section 2. Conference Fees is amended to:

Refer to Appendix 4 for detailed amendments.

**GP Telephone/E-mail follow-up Management Fee**

In order to encourage non-face-to-face communication with patients covered by some of the GPSC incentives, patients covered by one or more of the planning related incentives are eligible for five telephone/e-mail services per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.

| | | $ |
|---|---|---|
| G14079 | GP Telephone/Email Management Fee<br>This fee is payable for two-way communication with eligible patients, or the patient's medical representative, via telephone or email by the GP who has billed and been paid for at least one of the following GPSC incentives:<br>Complex Care Planning Fee (G14033)<br>Mental Health Planning Fee (G14043)<br>Annual Chronic Care Bonus for COPD (G14053)<br>Palliative Care Planning Fee (G14063)<br>Attachment Complex Care Management Fee (G14075)<br>This fee is billable for medical management of the conditions covered under the initial planning/Chronic Care fee. This fee is not to be billed for simple appointment reminders or referral notification.<br><br>***Notes:***<br>*i) Payable to a maximum of 5 times per patient per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.*<br>*ii) Telephone/Email Management requires two-way communication between the patient or the patient's medical representative and physician or medical office staff for the purpose of medical management of the relevant chronic condition(s); it is not payable for simple notification of office or laboratory appointments or of referrals.*<br>*iii) Payable only to the physician paid for the G14033, G14043, G14053, G14063 or G14075 unless that physician has agreed to share care with another delegated physician. To facilitate payment, a note record should be submitted by the delegated physician.*<br>*iv) G14077 or G14016 payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for G14077 or G14016.*<br>*v) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077 or G14016.*<br>*vi) Not payable on same day for same patient as G14076 GP Attachment Patient Telephone Management Fee.* | 15.00 |

Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

**Amendment:**

Effective August 1, 2015, Section 3. Complex Care Fees, including Preamble and fee item G14033, is amended to:

Refer to Appendix 5 for detailed amendments.

## 3. Complex Care Fees

The Complex Care Management Fee was developed to compensate GPs for the management of complex patients residing in the community, who have documented confirmed diagnoses of 2 chronic conditions from at least 2 of the 8 categories listed below. Community patients are those residing in their home or in assisted living. Patients in acute or long term care facilities are not eligible.

Having comorbidities does not necessarily make a patient complex and so to be eligible for the Complex Care Management Fee, the individual patient co-morbidities should be of sufficient severity and complexity to cause interference in activities of daily living and warrant the development of a management plan.

These items are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing calendar year.

***Eligible Complex Care Condition Categories:***

1) *Diabetes mellitus (type 1 and 2)*
2) *Chronic Kidney Disease*
3) *Heart failure*
4) *Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)*
5) *Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g. TIA, Migraine)*
6) *Ischemic heart disease, excluding the acute phase of myocardial infarct*
7) *Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.)*
8) *Chronic Liver Disease with evidence of hepatic dysfunction.*

If a patient has more than 2 of the qualifying conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

Successful billing of the Complex Care Management Fee (G14033) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months.

| | | $ |
|---|---|---|
| G14033 | GP Annual Complex Care Management Fee ..... | 315.00 |

The Complex Care Management Fee is advance payment for the complex work of caring for patients with two of the eligible conditions. It is payable upon the completion and documentation of a Complex Care Plan which includes Advance Care Planning when appropriate, as described below.
A Complex Care Plan requires documentation of the following elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies;
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;

3. Specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;
5. Outlines expected outcomes as a result of this plan, including end-of-life issues (advance care planning) when clinically appropriate;
6. Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles;
7. Identifies an appropriate time frame for re-evaluation of the plan;
8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as appropriate.

The development of the care plan is done jointly with the patient &/or the patient representative as appropriate. The patient &/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

***Notes:***

*i) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions.*
*ii) Refer to Table 1 for eligible diagnostic categories.*
*iii) Payable once per calendar year per patient on the date of the complex care planning visit.*
*iv) Documentation of the Complex Care Plan is required in patient's chart.*
*v) Minimum required time 30 minutes to review chart and create the care plan jointly with the patient and/or their medical representative. The majority of the time must be face-to-face. Documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required.*
*vi) Visit (in office or home) or CPx fee to indicate face-to-face interaction with patient same day must be billed for same date of service. Visit time does not count toward required planning time.*
*vii) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14033.*
*viii) G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.*
*ix) Not payable once G14063 has been billed and paid as patient has been changed from active management of complex chronic conditions to palliative management.*
*x) G14015, G14017, G14076 and G14079 not payable on the same day for the same patient.*
*xi) Maximum daily total of 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.*
*xii) G14075 is not payable in the same calendar year for same patient as G14033.*
*xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.*
*xiv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
*xv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Diagnostic codes submitted with 14033 billing must be from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

**Table 1: Complex Care Diagnostic codes**

| Diagnostic Code | Condition One | Condition Two |
|---|---|---|
| N519 | Chronic Neurodegenerative Disorder | Chronic Respiratory Condition |
| N414 | Chronic Neurodegenerative Disorder | Ischemic Heart Disease |
| N428 | Chronic Neurodegenerative Disorder | Heart Failure |
| N250 | Chronic Neurodegenerative Disorder | Diabetes |
| N430 | Chronic Neurodegenerative Disorder | Cerebrovascular Disease |
| N585 | Chronic Neurodegenerative Disorder | Chronic Kidney Disease |
| N573 | Chronic Neurodegenerative Disorder | Chronic Liver Disease |
| R414 | Chronic Respiratory Condition | Ischemic Heart Disease |
| R428 | Chronic Respiratory Condition | Heart Failure |
| R250 | Chronic Respiratory Condition | Diabetes |
| R430 | Chronic Respiratory Condition | Cerebrovascular Disease |
| R585 | Chronic Respiratory Condition | Chronic Kidney Disease |
| R573 | Chronic Respiratory Condition | Chronic Liver Disease |
| I428 | Ischemic Heart Disease | Heart Failure |
| I250 | Ischemic Heart Disease | Diabetes |
| I430 | Ischemic Heart Disease | Cerebrovascular Disease |
| I585 | Ischemic Heart Disease | Chronic Kidney Disease |
| I573 | Ischemic Heart Disease | Chronic Liver Disease |
| H250 | Heart Failure | Diabetes |
| H430 | Heart Failure | Cerebrovascular Disease |
| H585 | Heart Failure | Chronic Kidney Disease |
| H573 | Heart Failure | Chronic Liver Disease |
| D430 | Diabetes | Cerebrovascular Disease |
| D585 | Diabetes | Chronic Kidney Disease |
| D573 | Diabetes | Chronic Liver Disease |
| C585 | Cerebrovascular Disease | Chronic Kidney Disease |
| C573 | Cerebrovascular Disease | Chronic Liver Disease |
| K573 | Chronic Kidney Disease | Chronic Liver Disease |

**Amendment:**

Effective August 1, 2015, 4. Prevention Fees, fee item G14066, is amended to:

Refer to Appendix 6 for detailed amendments.

## 4. Prevention Fees

| | | $ |
|---|---|---|
| G14066 | Personal Health Risk Assessment<br>This fee is payable to the general practitioner who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, smoker, physically inactive, unhealthy eating). The GP is expected to develop a plan that recommends age and sex specific targeted | 50.00 |

clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative and the G14066 must be billed in addition to the age appropriate visit fee.

***Patient Eligibility:***

- *Eligible patients must be living at home or in assisted living. Patients in acute and long term care facilities are not eligible.*

***Notes:***

*i) Payable only for patients with one or more of the following risk factors: smoking, unhealthy eating, physical inactivity, medical obesity.*
*ii) Diagnostic code submitted with 14066 must be one of the following: Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783).*
*iii) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.*
*iv) Visit (office or home) or CPx fee to indicate face-to-face interaction with patient or patient's representative same day must be billed for same date of service.*
*v) G14016 or G14077 payable on same day for same patient if all criteria met.*
*vi) G14015, G14017, G14033, G14043, G14063, G14076 and G14079 not payable on the same day for the same patient.*
*vii) Payable to a maximum of 100 patients per calendar year, per physician.*
*viii) Payable once per calendar year per patient.*
*ix) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*
*x) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care;*
*xi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

**BC Lifetime Prevention Schedule Recommended Actions**

| Clinical Condition | | MEN | WOMEN |
|---|---|---|---|
| Colorectal Cancer Screening (Fecal Occult Blood Testing q1-2 years starting age 50) | | • | • |
| Mammography Screening (40-79 yrs, q 1-2 years) | | | • |
| Pap Smear Screening (sexually active until age 69, q 1 – 2 years) | | | • |
| Hypertension Screening | | • | • |
| Hyperlipidemia Screening ( Male 40 yr; Female 50 yr or postmenopausal; or sooner if at risk either sex) | | • | • |
| Diabetes Screening (Fasting Blood Sugar at least q 3 yrs age 40 yr or sooner if at risk either sex) | | • | • |
| Discussion of ASA use as clinically indicated (if high risk of Cardiovascular Disease or Stroke) | | • | • |
| Smoking Cessation | | • | • |
| Adult Immunization: | Influenza (Annually if at risk) | • | • |
| | Pneumococcal (if ↑Risk q 10 years) | • | • |
| | Tetanus /Diphtheria (q 10 years) | • | • |
| Immunizations for patients < 19 years of age as per age appropriate publically funded schedule | | • | • |
| Diet Modification (if Cardiovascular Disease Risk) | | • | • |
| Exercise Recommendation (if Cardiovascular Disease Risk) | | • | • |

**Amendment:**

Effective August 1, 2015 fee items G14043, G14044, G14045, G14076, G14077 and G14048 are amended to:

Refer to Appendix 7 for detailed amendments.

## 7. Mental Health Planning and Management Fees

| | | $ |
|---|---|---|
| G14043 | GP Mental Health Planning Fee ..... | 100.00 |

This fee is payable upon the completion and documentation of a Mental Health Plan for patients resident in the community (home or assisted living). Patients in acute or long term care facilities are not eligible. Patients must have a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan. This is not intended for patients with self-limited or short lived mental health symptoms *(e.g.: situational adjustment reaction, normal grief, life transitions*). The Mental Health Planning Fee requires a face-to-face visit with the patient and/or the patient's medical representative.

A Mental Health Plan requires documentation of the following elements in the patient's chart:

1. There has been a detailed review of the patient's chart/history and current therapies.
2. The patient's confirmed diagnosis, (DSM Axis 1), psychiatric history and current mental state.
3. The use of and results of validated assessment tools. Examples of validated assessment tools include:
   a) PHQ9, Beck Depression Inventory, Ham-D depression scale;
   b) MMSE;
   c) MDQ;
   d) GAD-7;
   e) Suicide Risk Assessment;
   f) Audit (Alcohol Use Disorders Identification Test CAGE; T-ACE).
4. Specifies a clinical plan for the care of that patient's psychiatric illness. Outlines linkages with other allied care professionals and community resources who will be involved in the patient's care, and their expected roles.
5. Identifies an appropriate time frame for follow up and re-evaluation of the patient's progress and Mental Health Plan.
6. Provides confirmation that the Mental Health plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other involved allied care professionals as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Following the successful billing of the Mental Health Planning fee, the GP will have access to 4 additional counselling equivalent mental health management fees per calendar year once the 4 MSP counselling fees have been billed. Successful billing of the Mental Health Planning fee G14043 allows access to 4 mental health management fees in that same calendar year which may be billed once the 4 MSP counselling fees (00120) have been utilised.

Successful billing of the mental health planning fee (G14043) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year in the subsequent 18 months.

***Patient Eligibility:***

- *Eligible patients must be living at home or in assisted living.*
- *Patients in Acute and Long Term Care Facilities are not eligible.*

***Notes:***

*i) Payable only for patients with documentation of a confirmed diagnosis of a DSM Axis 1 condition causing significant interference with activities of daily living. Not intended for patients with self-limited or short lived mental health symptoms.*

*ii) Payable once per calendar year per patient. Not intended as a routine annual fee unless the severity of the illness requires a comprehensive Mental Health Plan review and revision.*

*iii) Minimum required face to face time 30 minutes.*

*iv) Visit fee on same day only payable in addition if total time exceeds 39 minutes; counselling fee on same day only payable in addition if total time exceeds 49 minutes.*

*v) G14043 claim must state start and end times of the total service (planning plus any additional visit/counselling.) Start and end times must also be documented in the patient chart.*

*vi) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for 14043.*

*vii) G14015, G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14074, G14075, G14076 and G14079 not payable on the same day for the same patient.*

*viii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*ix) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | $ |
|---|---|---|
| G14044 | GP Mental Health Management Fee age 2 – 49 | 52.76 |
| G14045 | GP Mental Health Management Fee age 50 – 59 | 58.03 |
| G14046 | GP Mental Health Management Fee age 60 – 69 | 60.67 |
| G14047 | GP Mental Health Management Fee age 70 – 79 | 68.59 |
| G14048 | GP Mental Health Management Fee age 80+ | 79.14 |

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee 14043 has been successfully billed. The four MSP counselling fees (age-appropriate 00120) must first have been paid in the same calendar year.

***Notes:***

*i) Payable a maximum of 4 times per calendar year per patient.*

*ii) Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician.*

*iii) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note.*

*iv) Not payable unless the four age-appropriate 00120 fees have already been paid in the same calendar year.*

*v) Minimum time required is 20 minutes.*

vi) *Claim must include Start and End times. Start and end times must also be documented in the patient chart.*
vii) *G14016 or G14077, payable on same day for same patient if all criteria met.*
viii) *G14015, G14043 , G14076, G14079 not payable on same day for same patient.*
ix) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
x) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

The following list of diagnosis and acceptable ICD9 codes are applicable for the Mental Health Planning and Management Fee, fee items G14043, G14044 – G14048, and G14079:

| | DIAGNOSIS | ICD-9 |
|---|---|---|
| **Adjustment Disorders:** | | **309** |
| | Adjustment Disorder with Anxiety | 309 |
| | Adjustment Disorder with Depressed Mood | 309 |
| | Adjustment Disorder with Disturbance of Conduct | 309 |
| | Adjustment Disorder with Mixed Anxiety and Depressed Mood | 309 |
| | Adjustment Disorder with Mixed Disturbance of Conduct & Mood | 309 |
| | Adjustment Disorder NOS | 309 |
| **Anxiety Disorders:** | | **300** |
| | Acute Stress Disorder | 308 |
| | Agoraphobia | 300 |
| | Anxiety Disorder Due to a Medical Condition | 300 |
| | Anxiety Disorder NOS | 300 |
| | Generalized Anxiety disorder | 50B, 300 |
| | Obsessive-Compulsive Disorder | 300 |
| | Panic Attack | 300 |
| | Post-Traumatic Stress Disorder | 309 |
| | Social Phobia | 300 |
| | Specific Phobia | 300 |
| | Substance-Induced Anxiety disorder | 300 |
| **Attention Deficit Disorders:** | | |
| | Attention Deficit disorder | 314 |
| **Cognitive Disorders:** | | |
| | Amnestic Disorder | 294 |
| | Delirium | 293 |
| | Dementia | 290,331,331.0,331.2 |
| **Dissociative Disorders:** | | |
| | Depersonalization Disorder | 300 |
| | Dissociative Amnesia | 300 |

| | | |
|---|---|---|
| | Dissociative Fugue | 300 |
| | Dissociative Identity Disorder | 300 |
| | Dissociative Disorder NOS | 300 |
| **Eating Disorders:** | | |
| | Anorexia Nervosa | 307.1, 783.0, 307 |
| | Bulimia | 307 |
| | Eating Disorder NOS | 307 |
| **Factitious Disorders:** | | **300,312** |
| | Factitious Disorder; Physical & Psych Symptoms | 300,312 |
| | Factitious Disorder; Predom Physical Symptoms | 300,312 |
| | Factitious Disorder; Predominantly Psych Symptoms | 300,312 |
| **Impulse Control Disorders:** | | **312** |
| | Impulse Control Disorder NOS | 312 |
| | Intermittent Explosive Disorder | 312 |
| | Kleptomania | 312 |
| | Pathological Gambling | 312 |
| | Pyromania | 312 |
| | Trichotillomania | 312 |
| **Mental Disorders Due to a Medical Condition** | | |
| **Mood Disorders:** | | |
| | Bipolar Disorder | 296 |
| | Cyclothymic disorder | 301.1 |
| | Depression | 311 |
| | Dysthymic Disorder | 300.4 |
| | Mood Disorder due to a Medical Condition | 293.8 |
| | Substance-Induced Mood Disorder | 303, 304, 305 |
| **Schizophrenia and other Psychotic Disorders:** | | **295,296,297,298** |
| | Paranoid Type | 295,297,298 |
| | Disorganized Type | 295, 298 |
| | Catatonic Type | 295, 298 |
| | Undifferentiated Type | 295, 298 |
| | Residual Type | 295, 298 |
| | Brief Psychotic Disorder | 295, 298 |
| | Delusional Disorder | 295, 298 |
| | Psychotic Disorder due to Medical Condition | 293 |
| | Psychotic Disorder NOS | 295, 298 |
| | Schizoaffective Disorder | 295, 298 |
| | Schizophreniform Disorder | 295, 298 |
| | Substance-Induced Psychosis | 295, 298 |
| **Sexual and Gender Identity Disorder Paraphilias:** | | **302** |

| | | |
|---|---|---|
| | Exhibitionism | 302 |
| | Fetishism | 302 |
| | Frotteurism | 302 |
| | Pedophilia | 302 |
| | Sexual Masochism | 302 |
| | Sexual Sadism | 302 |
| | Transvestic Fetishism | 302 |
| | Voyeurism | 302 |
| | Paraphilia NOS | 302 |
| **Sexual Dysfunction:** | | **302** |
| | Hypoactive Sexual Desire Disorder | 302 |
| | Female Orgasmic Disorder | 302 |
| | Female Sexual Arousal Disorder | 302 |
| | Male Erectile Disorder | 302 |
| | Male Orgasmic Disorder | 302 |
| | Premature Ejaculation | 302 |
| | Sexual Aversion Disorder | 302 |
| | Sexual Dysfunction due to a Medical Disorder | 625 |
| | Sexual Dysfunction due to a Substance | 302 |
| **Sexual Pain Disorders:** | | |
| | Dyspareunia (not due to a Medical Condition) | 302 |
| | Vaginismus (not due to a Medical Condition) | 302 |
| **Sleep Disorders:** | | |
| | Primary Insomnia | 307 |
| | Primary Hypersomnia | 307 |
| | Narcolepsy | 347 |
| | Breathing-Related Sleep Disorder | 780.5 |
| | Circadian Rhythm Sleep Disorder | 307.4 |
| | Insomnia Related to Another Mental Disorder | 307.4 |
| | Nightmare Disorder (Dream Anxiety Disorder) | 307.4 |
| | Sleep Disorder Due to a Medical Condition | 780.5 |
| | Sleep Disorder Related to another Medical Condition | 780.5 |
| | Sleepwalking Disorder | 780.5 |
| | Substance-Induced Sleep Disorder | 780.5 |
| **Somatoform Disorders:** | | |
| | Somatization Disorder | 300.8 |
| | Conversion Disorder | 300.1 |
| | Pain Disorder | 307.8 |
| | Hypochondriasis | 300.7 |
| | Body Dysmorphic Disorder | 300.7 |
| **Substance - Related Disorders:** | | |

| | |
|---|---|
| Substance-Induced Anxiety Disorder | 303,304,305 |
| Substance-Induced Mood Disorder | 303,304,305 |
| Substance-Induced Psychosis | 292 |
| Substance-Induced Sleep Disorder | 303,304,305 |
| **Alcohol Dependence Syndrome** | 303 |
| **Drug Dependence Syndrome** | 304 |
| **Drug Abuse, Non-Dependent** | 305 |

**Amendment:**

Effective August 1 2015, Section 8. Palliative Care Planning Fee, fee item G14063, is amended to:

Refer to Appendix 8 for detailed amendments.

## 8. Palliative Care Planning Fee

| | | $ |
|---|---|---|
| G14063 | Palliative Care planning fee<br>This fee is payable upon the development and documentation of a Palliative Care Plan for patients who in your 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. Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy.<br><br>Eligible patients must be living at home or in assisted living. Patients in Acute and Facilities are not eligible.<br><br>The Palliative Care Plan requires documentation of the following in the patient's chart:<br><br>1. There has been a detailed review of the case/chart and of current therapies.<br>2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Palliative Care Planning Fee is billed.<br>3. Specifies a clinical plan for the patient's palliative care.<br>4. Incorporates the patient's values and beliefs in creation of the plan, Name and contact information for substitute decision maker.<br>5. Completion of a NO CPR FORM.<br>6. Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles.<br>7. Provides confirmation that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved allied care professionals as appropriate.<br><br>This fee requires a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.<br><br>***Notes:*** | 100.00 |

i) *Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.*
ii) *Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).*
iii) *Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.*
iv) *Payable in addition to a visit fee (home or office) billed on the same day.*
v) *Minimum required time 30 minutes face to face in addition to visit time same day.*
vi) *Claim must state start and end times of the service. Start and end times must also be documented in the patient chart.*
vii) *G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14063.*
viii) *Not payable if G14033 or G14075 has been paid within 6 months.*
ix) *Not payable on same day as G14015, G14017, G14043 ,G14074, G14076 or G14079 GP Telephone/e-mail Management fee.*
x) *G14050, G14051, G14052, G14053, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid as patient has been changed from active management of chronic disease and/or complex condition(s) to palliative management.*
xi) *G14043, G14044, G14045, G14046, G14047, G14048, the GPSC Mental Health Initiative Fees are still payable once G14063 has been billed provided all requirements are met, but are not payable on same day.*
xii) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
xiii) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Successful billing of the Palliative care planning fee (G14063) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year over the following 18 months.

**Amendment:**

Effective August 1, 2015, Section 9. GPSC Incentives for GPs with Specialty Training, fee items G14021, G14022 and G14023 are amended to:

Refer to Appendix 9 for detailed amendments.

## 9. GPSC Incentives for GPs with Specialty Training

**Eligibility:**

- Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- Service may be provided when physician is located in office or hospital. For the purpose of these telephone advice fee items GPSC has defined General Practitioner (GP) with specialty training as: A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program.
- Telephone advice must be related to the field in which the GP has received specialty training.

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|---|---|---|
| G14021 | GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Response within 2 hours | 60.00 |

***Notes:***

*i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.*

*ii) Conversation must take place within two hours of the initiating physician's request. Not payable for written communication (i.e. fax, letter, e-mail).*

*iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

*iv) Not payable for situations where the purpose of the call is to:*
- *a. book an appointment*
- *b. arrange for transfer of care that occurs within 24 hours*
- *c. arrange for an expedited consultation or procedure within 24 hours*
- *d. arrange for laboratory or diagnostic investigations*
- *e. inform the referring physician of results of diagnostic investigations*
- *f. arrange a hospital bed for the patient*

*v) Not payable to physician initiating call.*

*vi) No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).*

*vii) Limited to one claim per patient per physician per day.*

*viii) A chart entry, including advice given and to whom, is required.*

*ix) Include start and end times in time fields when submitting claim.*

*x) Not payable in addition to another service on the same day for the same patient by same practitioner.*

*xi) Out-of-Office Hours Premiums may not be claimed in addition.*

*xii) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

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| G14022 | GP with Specialty Training Telephone Patient Management - Initiated by a Specialist, General Practitioner or Allied Care Provider, Response in One Week – per 15 minutes or portion thereof | 40.00 |

***Notes:***

*i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.*

*ii) Conversation must take place within 7 days of initiating physician request. Initiation may be by phone or referral letter.*

*iii) If conversation is with an allied care provider include a note record specifying the type of provider.*

*iv) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

*v) Not payable for situations where the purpose of the call is to:*
- *a. book an appointment*
- *b. arrange for transfer of care that occurs within 24 hours*
- *c. arrange for an expedited consultation or procedure within 24 hours*
- *d. arrange for laboratory or diagnostic investigations*
- *e. inform the referring physician of results of diagnostic investigations*
- *f. arrange a hospital bed for the patient*

*vi) Not payable to physician initiating call.*

*vii) No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).*

*viii) Limited to two services per patient per physician per week.*
*ix) A chart entry, including advice given and to whom, is required.*
*x) Include start and end times in time fields when submitting claim.*
*xi) Not payable in addition to another service on the same day for the same patient by same practitioner.*
*xii) Out-of-Office Hours Premiums may not be claimed in addition.*
*xiii) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

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| G14023 | GP with Specialty Training Telephone Patient Management / Follow-Up – per 15 minutes or portion thereof | 20.00 |

***Notes:***

*i) This fee applies to two-way direct telephone communication (including other forms of electronic verbal communication) between the GP with specialty training and patient, or a patient's representative. Not payable for written communication (i.e. fax, letter, e-mail).*
*ii) This fee is only payable for scheduled telephone appointments with the patient.*
*iii) Access to this fee is restricted to patients having received a prior consultation, office visit, hospital visit, diagnostic procedure or surgical procedure from the same GP with Specialty training, within the 6 months preceding this service.*
*iv) Telephone management requires two-way communication between the patient and physician on a clinical level; the fee is not billable for administrative tasks such as appointment notification.*
*v) No claim may be made where communication is with a proxy for the physician (e.g.: nurse or assistant).*
*vi) Each physician may bill this service four (4) times per calendar year for each patient.*
*vii) This fee requires chart entry as well as ensuring that patient understands and acknowledges the information provided.*
*viii) Include start and end times in time fields when submitting claim.*
*ix) Not payable in addition to another service on the same day for the same patient by the same practitioner.*
*x) Out-of-Office Hours Premiums may not be claimed in addition.*
*xi) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

**Amendment:**

Effective August 1, 2015, Section 10. GPSC Incentives for A GP for Me/Attachment initiative including Overview and fee items G14070, G14071, G14074, G14075, G14076 and G14077 is amended to:

Refer to Appendix 10 for detailed amendments.

## 10. GPSC Incentives for A GP for Me/Attachment initiative

Overview:

The fee codes for the A GP for Me (Attachment) Initiative, are billable by family doctors who submit the fee G14070 'GP Attachment Participation Code', to MSP at the beginning of each calendar year. Once successfully submitted, the Attachment initiative suite of fees may be billed. Submitting G14070 signifies that:

- You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year.

- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'. Refer to A GP for Me – Frequently Asked Questions (FAQs) for details.

You have contacted your local division of family practice to share your contact information) and to indicate your desire to participate in the community-level Attachment initiative as you are able. Division contacts are available online at www.divisionsbc.ca.

- Refer to A GP for Me – FAQs for more information.

The standardized wording of the Family Physician-Patient 'Compact' states:

As your family doctor I, along with my practice team, agree to:
- Provide you with the best care that I can
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:
- Seek your health care from me and my team whenever possible and, in my absence,
- through my colleague(s), xxxxxx
- Name me as your family doctor if you have to visit an emergency facility or another
- provider
- Communicate with me honestly and openly so we can best address your health care needs

Locums working in an "Attachment Participating" family practice, are able to bill the fee codes for the "A GP for Me" initiative, once they have successfully submitted fee G14071 'GP Locum Attachment Participation Code', once at the beginning of each calendar year. The Locum and Attachment participating host FP should discuss and mutually agree on which of the GPSC Services, including the Attachment Initiative fees, may be provided and billed by the locum. However, locums have their own annual allotment of G14076 Attachment Telephone Management Fee. Submitting G14071 signifies that:

- You are providing full-service family practice services to the patients of the host physicians, and will continue to do so for the duration of any locum coverage for a family physician participating in the attachment incentive.

- You have contacted the Divisions of Family Practice central office to share your contact information (AGPforMe@doctorsofbc.ca) and to indicate your desire to participate as a locum in the community-level Attachment initiative as you are able. Refer to A GP for Me - FAQs for more information.

General Notes:

The Attachment incentives are billable for BC residents with valid MSP coverage only; Reciprocal claims for patients with out of province health insurance are excluded. Rural retention premiums do not apply.

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| G14070 | GP Attachment Participation Code<br>The GP Attachment Participation Code should be submitted at the beginning of each calendar year by Full Service Family Physicians (FSFP)'s who choose to participate in the GPSC Attachment Initiative. | $00 |

Once successfully processed by MSP, the FP may access the "Attachment participation" incentives (G14074, G14075, G14076, G14077).

Submit fee item G14070 GP Attachment Participation Code using the following "Patient" demographic information:

| | |
|---|---|
| PHN: | 9753035697 |
| Patient Surname: | Participation |
| First name: | Attachment |
| Date of Birth: | January 1, 2013 |
| ICD9 code: | 780 |

***Notes:***

*i) Bill once per calendar year to confirm participation in the Attachment initiative.*

*ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*

*iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

**GP Locum Attachment Participation Code**

| | | $ |
|---|---|---|
| G14071 | GP Locum Attachment Participation Code<br>The GP Locum Attachment Participation code may be submitted by the GP who provides locum coverage for Family Physicians participating in the Attachment initiative at the beginning of the calendar year or prior to the start of the first such locum in each calendar year. Once processed by MSP, the locum may access GP Attachment incentives for services provided while covering for the Attachment participating host FPs. | 0.00 |

Submit fee item G14071 GP Locum Attachment Participation Code using the following "Patient" demographic information:

| | |
|---|---|
| PHN: | 9753035697 |
| Patient Surname: | Participation |
| First name: | Attachment |
| Date of Birth: | January 1, 2013 |
| ICD9 code: | 780 |

***Notes:***

*i) Bill once per calendar year at the beginning of the year or prior to the first locum coverage for a family physician who is participating in the attachment initiative.*

*ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*

*iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | $ |
|---|---|---|
| G14074 | GP Unattached Complex/High Needs Patient Attachment Fee ..... | 200.00 |

The Unattached Complex/High Needs Patient Attachment fee compensates for the time, intensity and complexity of integrating a new patient with high needs into a family physician's practice: the longer initial meetings, organization of the medical record, and initiation of appropriate Clinical Action Plan(s) as discussed with the patient.

By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice.

This fee is paid in addition to the visit fee

Billing this incentive requires the accepting family physician to collate and review the relevant patient record to date and to meet with the patient to discuss this information and determine what supports will be needed to provide for the patient's ongoing medical needs, taking into account his/her personal goals of care. The patient populations eligible for this intake fee are:

- Frail in Care (CSHA Clinical Frailty Scale score of six or more in residential care – new admissions only with exceptions for extenuating circumstances such as sudden departure from practice of existing MRP FP)
- Frail in the Community (CSHA Clinical Frailty Scale score of six or more)
- Significant Cancer
- Moderate to High Needs Complex Chronic Conditions
- Severe Disability in the community
- Mental Health and/or Substance Use
- New Mother and Infant(s) (intake can occur at any time during pregnancy up to 18 months of age. Each mother/child (ren) dyad counts as one unit for the purpose of billing this fee code.)

When submitting G14074 for a new mother/baby dyad use the mother's PHN and diagnostic code 01N. For all other qualifying patients, use the diagnostic code for the most appropriate medical condition causing the complexity/high needs status.

***Notes:***

*i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.*

*ii) Payable only for unattached new patients who do not already have a family physician. Requests for attachment may come from: Acute Care (ER and Admitted); Mental Health-Substance Use workers/Clinics; Home and Community Care; BC Cancer Agency or Regional Centers; Public Health; Colleagues; Local Division. Only payable on patients who are changing family physician if: the patient moves to a different community; the patient moves into a residential care/Long term care facility where the current family physician will no longer be responsible for the care; or, the patient's family physician leaves practice and another GP takes on one or some of the more complex patients but not the entire practice.*

*iii) Source of request to attach the patient must be documented in the new patient chart.*
*iv) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.*
*v) Payable in addition to office visit, home visit or residential care visit same day.*
*vi) G14077 payable on same day for same patient if all criteria met.*
*vii) G14033, G14075, G14063 and G14043 not payable on same day for same patient.*
*viii) Maximum daily total of 5 of any combination of G14033 complex care, G14075) Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.*
*ix) Not payable for patients located in acute care.*
*x) G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.*
*xi) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
*xii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | $ |
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| G14075 | GP Attachment Complex Care Management Fee | 315.00 |

The GP Attachment Complex Care Management Fee is advance payment for the complex work of caring for patients with eligible conditions. It is payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) as described below.

This Complex Care fee encompasses those patients with a qualifying diagnosis of Frailty as defined by a Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale score of six or more, indicating the patient is Moderately or Severely Frail.

A complex care plan requires documentation of the following elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies.
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the GP Attachment Complex Care Management Fee is billed.
3. Specifies a clinical plan for the care of that patient's chronic condition(s).
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic condition(s).
5. Outlines expected outcomes as a result of this plan, including any advance care planning for end-of-life issues when clinically appropriate.
6. Outlines linkages with other allied care professionals that would be involved in the care, their expected roles.
7. Identifies an appropriate time frame for re-evaluation of the plan.
8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as indicated.

The development of the care plan is done jointly with the patient and/or the patient representative as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

***Notes:***

*i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.*
*ii) Payable only for patients with documentation of confirmed CHSA frailty level 6 (moderate) or 7 (severe).*
*iii) Claim must include the diagnostic code V15.*
*iv) Payable once per calendar year per patient on the date of the complex care planning visit.*
*v) Documentation of the Complex Care Plan is required in patient's chart.*
*vi) Minimum required time 30 minutes to review chart and create the care plan jointly with the patient and/or their medical representative. The majority of the time must be face-to-face. Documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required.*
*vii) Visit (in office or home) or CPx fee to indicate face-to-face interaction with patient same day must be billed for same date of service. Visit time does not count toward required planning time.*
*viii) G14077 payable on the same day for the same patient, for patients located in the community only as long term care facility patients are not eligible for 14075.*
*ix) Maximum daily total 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.*
*x) G14075 not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*
*xi) G14033 is not payable in the same calendar year for same patient as G14075.*
*xii) G14043, G14063, G14076, G14079 not payable on the same day for the same patient.*
*xiii) G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.*
*xiv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
*xv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

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| G14076 | GP Attachment Telephone Management Fee ..... | 15.00 |

***Notes:***
*i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.*
*ii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care professionals (e.g.: Nurse, Nurse Practitioner) employed within the eligible physician office.*
*iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.*
*iv) Not payable for simple prescription renewals, notification of office or laboratory appointments or of referrals.*
*v) Payable to a maximum of 1500 services per physician per calendar year.*
*vi) G14077 payable for same patient on same day if all criteria are met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14077.*

vii) *Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077.*
viii) *Not payable on the same calendar day as G14079.*
ix) *G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.*
x) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
xi) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | $ |
|---|---|---|
| G14077 | GP Attachment Patient Conference Fee - per 15 minutes or greater portion thereof | 40.00 |

***Notes:***

i) *Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.*
ii) *Payable only to the Family Physician who has accepted the responsibility of being the Most Responsible Physician for that patient's care.*
iii) *Payable for two-way collaborative conferencing, either by telephone or in person, between the family physician and at least one other allied care provider(s). Conferencing cannot be delegated. Details of the Conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.*
iv) *Conference to include the clinical and social circumstances relevant to the delivery of care.*
v) *Not payable for situations where the purpose of the call is to:*
   a. *book an appointment*
   b. *arrange for an expedited consultation or procedure*
   c. *arrange for laboratory or diagnostic investigations*
   d. *inform the referring physician of results of diagnostic investigations*
   e. *arrange a hospital bed for the patient*
vi) *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*
vii) *Payable in addition to any visit fee on the same day if medically required and does not take place concurrently with the patient conference. (i.e. Visit is separate from conference time).*
viii) *Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.*
ix) *The claim must state start and end times of the service.*
x) *Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.*
xi) *Not payable for simple advice to a non-physician allied care professional about a patient in a facility.*
xii) *Not payable in addition to G14015 G14016 or G14017 as these fees are replaced by G14077 for those Family Physicians who have submitted the GP Attachment Participation code.*
xiii) *Not payable to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have participated in the conference as a requirement of their employment.*
xiv) *Not payable to physicians who are working under salary, service contract or sessional arrangements who would otherwise have participated in the conference as a requirement of their employment.*

**Amendment:**

Effective August 1, 2015 , a preamble is added to Section 11. GPSC Incentives for In-Patient Care and fee items G14086 and G14088 are amended to:

Refer to Appendix 11 for detailed amendments.

## 11. GPSC Incentives for In-patient Care

The GPSC In-patient Initiative was developed to recognize and better support the continuous relationship with a family physician (FP) that can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. An important aspect of such continuous care is the coordination of care through the in-patient journey as well as in transitions between hospital and community FP offices. There are two separate levels of incentives aimed at better supporting and compensating FPs who provide this important aspect of care. This initiative will support family physicians who:

- Provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned In-patients); and may also
- As part of a network, provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned In-patients).

To participate in the GPSC In-patient Initiative, it is expected that these FPs agree to the following expectations:

A. They are members of the **active or equivalent medical staff** category and have hospital privileges in the identified acute care hospital.

B. That their on-call colleagues (Network) are also members of the active or equivalent medical staff category and have hospital privileges.

C. That they will:

- Coordinate and manage the care of hospitalized patients (assigned &/or unassigned), admitted under them as the MRP.
- Provide supportive care when their hospitalized patient is admitted under a specialist as MRP.
- See all acute patients under their MRP care on a daily basis and document a progress note in the medical record.
- Work with the interdisciplinary team, as appropriate, to develop a care plan and a plan for discharge.
- When care is transferred to another physician, ensure that this is documented in the medical record and ensure there is a verbal or written handover plan provided to the accepting physician.
- Ensure availability through their network to expedite discharges of patients daily during the normal working day which includes early morning, daytime, and early evening.
- On weekends ensure the covering physician is made aware of those discharges that could occur over the weekend.

- Provide a discharge note to an unassigned in-patient for their FP or communicate directly with the FP on discharge.
- Respond to requests from members of the interdisciplinary in-patient care team by phone as per hospital bylaws.
- The Network Call Group will accept responsibility for their newly admitted in-patients on a 24/7/365 basis. The MRP shall assess and examine the patient, document findings and issue applicable orders as soon as warranted by the patient's needs, but in any case no longer than 24 hours after accepting the transfer. Utilization needs within the facility may dictate that the patient must be seen sooner.

D. The non-clinical services include the already existing expectations of FPs as outlined in the Health Authority Medical Staff bylaws, rules and regulations, and policies. The health authority, the Department of Family Practice, the Division of Family Practice (where it exists) and the In-patient Care Networks could reasonably expect that all parties would participate in discussions which could include:

- The orderly transitions of MRP status between specialists and generalists.
- Participating in the orderly discharge planning of generally more complicated patients.
- Patient safety concerns that come up in local hospitals.
- Identifying and providing input into "local hassle factors" that would need to be examined and resolved at a local level between the local division of family practice and health authorities.
- Participate in utilization management within the hospital.
- Patient care improvement discussions that would reasonably be covered under the improved FP hospital care incentives.

| | | $ |
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| G14086 | GP Assigned Inpatient Care Network Initiative | 2100.00 |

**Eligibility:**
To be eligible to be a member of a GP Assigned Inpatient Care Network, you must meet the following criteria:

- Be a Family Physician in active practice in B.C.
- Have active hospital privileges.
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing inpatient care – see below).
- Submit a completed Assigned Inpatient Care Agreement Form.
- Submit a completed Assigned Inpatient Care Network Registration Form.
- Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.
- Each doctor must provide MRP care to at least 24 admitted patients over the course of a year; networks may average out this number across the number of members.

This network incentive is payable in addition to visit fees, but is inclusive of time spent in associated Quality Improvement activities necessary to maintain privileges such as M and M rounds as well as time spent on network administration, etc.

Exemptions for communities where it may be difficult to achieve the minimum volume of MRP inpatient cases will be considered by the GPSC Inpatient Care Working Group.

The GP Assigned In-patient Care Network Incentive is payable for participation in the network activities for the majority of the following calendar quarter (50% plus 1 day). Once your registration in the network has been confirmed, submit fee item G14086 GP Assigned in-patient care network fee using the following billing specifics:

Billing Schedule: First day of the month, per calendar quarter (January 1, April 1, July1, October 1) and is paid for the subsequent quarter
ICD9 code : 780

Your location will determine which PHN# to use:

Interior Health Authority:
PHN# 9752590587
Patient Surname: Assigned
First Name: IHA
Date of birth: January 1, 2013

Fraser Health Authority:
PHN# 9752590548
Patient Surname: Assigned
First Name: FHA
Date of birth: January 1, 2013

Vancouver Coastal Health Authority:
PHN# 9752590523
Patient Surname: Assigned
First Name: CVHA (note first name starts with 'C')
Date of birth: January 1, 2013

Vancouver Island Health Authority:
PHN# 9752590516
Patient Surname: Assigned
First Name: VIHA
Date of birth: January 1, 2013

Northern Health Authority:
PHN# 9752590509
Patient Surname: Assigned
First Name: NHA
Date of birth: January 1, 2013

| | | $ |
|---|---|---|
| G14088 | GP Unassigned Inpatient Care Fee ..... | 150.00 |

The term "Unassigned Inpatient" is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted.

The GP Unassigned Inpatient Care Fee is designed to provide an incentive for Family Physicians to accept Most Responsible Physician status for an unassigned patient's hospital stay. It is intended to compensate the Family Physician for the extra time and intensity required to evaluate an unfamiliar patient's clinical status and care needs when the patient is admitted and is only billable once per hospital admission.

This fee is restricted to Family Physicians actively participating in the GP Unassigned Inpatient Care or the GP Maternity Networks. This fee is billable through the MSP Teleplan system and is payable in addition to the hospital visit (00109, 13008, 00127) or delivery fee.

***Notes:***

*i) Payable only to Family Physicians who have submitted a completed GP Unassigned Inpatient Care Network Registration Form and/or a GP Maternity Network Registration Form.*

*ii) Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.*

*iii) Payable once per unassigned patient per in-hospital admission in addition to the hospital visit (00109, 13008, 00127) or delivery fee.*

*iv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*v) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Tom Vincent
Chair
Medical Services Commission

Dated this 30th day of July AD 2015.

**Appendix 1 –** GPSC Initiated Listings Preamble

Strikethrough is deleted; bold is added.

## GPSC Initiated Listings

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

Unless otherwise identified in the individual fee description, physicians are eligible to participate in the incentive program if they are:

1. A general practitioner who has a valid BC MSP practitioner number ~~(registered specialty 00). Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.~~
2. Currently in general practice in BC as a full service family physician;~~ and~~
3. **The most responsible general practitioner for the majority of** ~~Responsible for providing~~ the patient's longitudinal general practice care; **and.**~~**
4. **Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.**

Additional detailed eligibility requirements are identified in each section.

**GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.**

**For the purposes of its incentives, GPSC defines Physicians working on Alternative Payment Program (APP) as those working under Health Authority paid APP contracts. Agreements to pool FFS billings and pay out physicians in a mutually acceptable way (e.g. per day, per shift, per hour, etc.) are not considered APP by GPSC. If services supported and paid through GPSC incentives are already included in a sessional, salary or service contract then they are not billable in addition.**

**For the purpose of its incentives GPSC defines a General Practitioner (GP) with specialty training as: "A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program".**

**For the purposes of its incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Specialist Physicians; GPs with Specialty Training; Nurses; Nurse Practitioners; Mental Health Workers; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.**

**Appendix 2 –** Fee items G14050, G14051, G14052 and G14053

Strikethrough is deleted; bold is added.

## 1. Expanded Full Service Family Practice Condition-based Payments

The GPSC Condition-based Payments compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full year. The goal is to improve provision of clinically appropriate care that considers both the patient's values and the impact of co-morbidities. To confirm an ongoing doctor-patient relationship, there must be at least 2 visit fees (office; prenatal; home; long term care; only one of which can be 14076 Telephone Visit or 13763 – 13781 Group Medical Visit) billed on each qualifying patient in the 12 months prior to billing the CDM incentive. **Visits provided by a locum for the MRP GP are included; however, an electronic note indicating this must be submitted with the claim.** Patients in long-term care facilities are eligible. Clinical judgment must be used to determine the appropriateness of following clinical practice guidelines in all patients, particularly those with dementia or very limited life expectancy. Documentation of the provision of guideline-informed care for the specific condition is required in the medical record. Although use of the GPAC Chronic Care flow sheets is not mandatory, they are a useful tool for tracking care provided to patients over time. **Condition-based payments are no longer payable once G14063, the Palliative Planning Incentive has been billed and paid as patient has been changed from active management of chronic disease to palliative management**.

Patient self-management can be defined as the decisions and behaviors that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. An important part of this support is the provision of tools by the family physician that can enable patients to make appropriate choices and sustain healthy behaviors. There are a variety of tools publically available (e.g. health diaries/passports, etc.) to help build the skills and confidence patients need to improve management of their chronic conditions and potentially improve outcomes. Documentation in the patient chart of the provision of patient self-management supports as part of the patient's chronic disease management is expected.

When a new GP assumes the practice of another GP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fee is billable on its anniversary date provided the new GP has continued to provide guideline-informed care for these patient(s). To demonstrate continuity, if some of the required visits have been provided by the previous GP, an electronic note indicating continuity of care over the full 12 months is required at the time of the initial submission of the CDM fee by the new GP.

| | | $ |
|---|---|---|
| G14050 | Incentive for Full Service General Practitioner<br>- annual chronic care **incentive** ~~bonus~~ (diabetes mellitus) ..... | 125.00 |

***Notes:***

*~~xvi) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.~~*

*~~xvii)~~xvi) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*~~xviii)~~xvii) Applicable only for patients with **documentation of** a confirmed diagnosis of diabetes mellitus **and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.***

*~~xix)~~xviii) This item may only be billed after one year of care has been provided and the patient **has been provided at least two visits** ~~has been seen at least twice~~ in the preceding 12 months. Office, prenatal, home, long term care **visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit 13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.***

*~~xx)~~xix) **Iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14250.***

~~xxi)~~xx) Claim must include the ICD-9 code for diabetes (250).

~~xxii)~~xxi) ~~This item may only be claimed~~**Payable** once per patient in a consecutive 12 month period.

~~xxiii)~~xxii) **Payable in addition to fee items G14051, G14251 G14053 or G14253 for same patient if eligible.**~~Payable when other CDM items G14051 or G14053 have been paid on the same patient.~~

~~xxiv)~~xxiii) **Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.**

~~xxv)~~xxiv) If a visit is provided on the same date the **incentive**~~bonus~~ is billed; both services will be paid at the full fee.

G14051 Incentive for Full Service General Practitioner
- annual chronic care **incentive** ~~bonus~~ (heart failure) ..... 125.00

***Notes:***

~~i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.~~

~~ii)~~i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.

~~iii)~~ii) Applicable only for patients with **documentation of** a confirmed diagnosis of heart failure **and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.**

~~iv)~~iii) This item may only be billed after one year of care has been provided and the patient has **been provided at least two visits** ~~been seen face-to-face at least twice iiiiiii~~**in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit 13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.**

~~v)~~iv) **Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14251.**

~~vi)~~v) Claim must include the ICD-9 code for heart failure (428).

~~vii)~~vi) **Payable** ~~This item may only be claimed~~ once per patient in a consecutive 12 month period.

~~viii)~~vii) **Payable in addition to items G14050, G14250, G14053 or G14253 for the same patient if eligible**~~Payable when other CDM items G14050 or G14053 have been paid on the same patient..~~

viii) **Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.**

ix) If a visit is provided on the same date the **incentive** ~~bonus~~ is billed; both services will be paid at the full fee.

G14052 Incentive for Full Service General Practitioner
- annual chronic care **incentive**~~bonus~~ (hypertension)..... 50.00

***Notes:***

~~i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.~~

~~ii)~~i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.

~~iii)~~ii) Applicable only for patients with **documentation of** a confirmed diagnosis of hypertension **and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.**

~~iv)~~iii) This item may only be billed after one year of care has been provided and the patient has been **provided at least two visits** ~~seen face-to-face at least twice~~ **in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit 13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.**

~~v)~~iv) ***Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14252.***

~~vi)~~v) *Claim must include the ICD-9 code for hypertension (401).*

~~vii)~~vi) ~~*This item may only be claimed*~~***Payable*** *once per patient in a consecutive 12 month period.*

~~viii)~~vii) *Not payable if G14050,* ***G14250****, G14051* ***or G14251*** *paid ~~claimed~~ within the previous 12 months.*

viii) ***Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.***

ix) *If a visit is provided on the same date the* ***incentive***~~*bonus*~~ *is billed; both services will be paid at the full fee.*

G14053 Incentive for Full Service General Practitioner - annual chronic care **incentive**~~bonus~~ (Chronic Obstructive Pulmonary Disease- COPD) 125.00

***Notes:***

~~i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.~~

~~ii)~~i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

~~iii)~~ii) *Applicable only for patients with* ***documentation of*** *a confirmed diagnosis of COPD* ***and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.***

~~iv)~~iii) *This item may only be billed after one year of care has been provided and the patient has been* ***provided at least two visits*** ~~*seen face to face at least twice*~~ *in the preceding 12 months.* ***Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit 13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.***

~~v)~~iv) ***Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14253.***

~~vi)~~v) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*

~~vii)~~vi) ~~*This item may only be claimed*~~***Payable*** *once per patient in a consecutive 12 month period.*

~~viii)~~vii) ***Payable in addition to fee items G14050, G14051 or G14052 for the same patient if eligible.***~~*Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.*~~

viii) ***Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.***

ix) *If a visit is provided on the same date the* ***incentive***~~*bonus*~~ *is billed; both services will be paid at the full fee.*

Successful billing of the Annual Chronic Care Bonus for COPD (G14053) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months.

**Appendix 3 –** Fee items G14015, G14016, G14017 and G14018

Strikethrough is deleted; bold is added.

**2. Conference Fees**

**Facility Patient Conference Fee**

| | | $ |
|---|---|---|
| G14015 | General Practice Facility Patient Conference: when requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient **with complex supportive care needs** in a facility ~~with complex supportive care needs~~ can safely return to the community or transition to a supportive ~~care~~ or long-term facility<br>- per 15 minutes or greater portion thereof | 40.00 |

***Notes:***

*i) Refer to Table 1 (below) for eligible patient populations.*

*ii) Must be performed in the facility and results of the conference must be recorded in the patient chart.*

*iii) Payable only for patients in a facility. Facilities limited to: hospital, palliative care facility, LTC facility, rehab facility, sub-acute facility, psychiatric facility, detox/drug and alcohol facility).*

*iv) Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any ~~health~~ **allied** care provider charged with coordinating discharge and follow-up planning.*

*v) Requires interdisciplinary team meeting of at least 2 ~~health~~ **allied care** professionals in total, and will include family members when available.*

*vi) Fee includes:*

*a. Where appropriate, interviewing of and conferencing with patient, family members, and other health allied care providers of the facility.*

*b. Review and organization of appropriate clinical information.*

*c. The integration of relevant information into the formulation of an action plan for the care of the patient in the facility, including provision of Degrees of intervention and end of life documentation as appropriate.*

*d. The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*vii) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*

*viii) Claim must state start and end times of the service. Start and end times must also be documented in the patient chart.*

*ix) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

*x) **Not payable to physicians who are participating in the GPSC attachment initiative (G14070).***

*~~x)~~xi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

*~~xi)~~xii) Not payable on the same day for the same patient ~~as the Community Patient Conference Fee (~~**fee item** G14016,~~), Acute Care Discharge Planning Conference Fee~~ (G14017,~~), GP Attachment Conference Fee (G14077), Complex Care Fee~~ (G14033,~~) or GP Attachment Complex Care Fee~~ (**G14043, G14063, G14074, G14075, G14076 or G14077**~~)~~.*

*~~xii)~~xiii) Visit payable in addition if medically required and does not take place concurrently with the patient conference. Medically required visits performed consecutive to the Facility Patient Conference are payable. (i.e. Visit is separate from conference time).*

**Community Patient Conference Fee**

| | | $ |
|---|---|---|
| G14016 | General Practice Community Patient Conference Fee: Creation of a coordinated clinical action plan for the care of community-based patients with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other ~~health~~ **allied** care providers is required (e.g. specialists, psychologists or counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, ~~specialists in medicine or psychiatry~~) as well as with the patient and **will include family members when available** ~~possibly family members~~ (as required due to the severity of the patient's condition) - per 15 minutes or greater portion thereof | 40.00 |

***Notes:***

*i) Refer to Table 1 (below) for eligible patient populations.*

*ii) Fee is billable for conferences that occur as a result of care provided in the following community locations for patients who are resident in the community:*

- *Community GP Office*
- *Patient Home*
- *Community placement agency*
- *Disease clinic (DEC, arthritis, CHF, Asthma, Cancer or other palliative diagnoses, etc.*
- *Assisted living*

*iii) Fee includes:*

*a. Where appropriate, interviewing of and conferencing with patient, family members, and other **~~health~~ allied care** providers..*

*b. Review and organization of appropriate clinical information.*

*c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*

*d. The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

~~*a. The interviewing of patient and family members as indicated and the conferencing with other health allied care providers as described above – this does not require face-to-face interaction in all cases; and*~~

~~*b. As appropriate, interviewing of, and conferencing with patients, family members, and other community health allied care providers; organizing and reviewing appropriate laboratory and imaging investigations, administration of other types of testing as clinically indicated (e.g.: Beck Depression Inventory, MMSE, etc); provision of degrees of intervention or No CPR documentation. ; and*~~

~~*c. The communication of that plan to patient, other health allied care providers, and family members or others involved in the provision of care, as appropriate; and*~~

~~*d. The care plan must be recorded in the chart and include the following information:*~~

- ~~*1. Patient's Name*~~
- ~~*2. Date of Service*~~
- ~~*3. Diagnosis:*~~
  - ~~*a. V15 (Frail Elderly)*~~
  - ~~*b. V58 (Palliative/End of Life Care)*~~
  - ~~*c. Mental Illness (enter ICD-9 code of qualifying illness)*~~
  - ~~*d. Patients of any age with multiple medical needs or complex co-morbidity (enter ICD-9 code for one of the major disorders)*~~
- ~~*4. Reason for need of Clinical Action Plan*~~
- ~~*5. Health Allied care providers with whom you conferred & their role in provision of care*~~
- ~~*6. Clinical Plan determined, including tests ordered and/or administered.*~~
- ~~*7. Patient risks based on assessment of appropriate domains (list of co-morbidities and safety risks)*~~

~~8. List of priority interventions that reflect patient goals for treatment~~
~~9. What referrals will be made, what follow-up has been arranged (including timelines and contact information), as well as advanced planning information~~
~~10. Start and stop times of service.~~

iv) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).

iv) Claim must state start and end times of service.Start and end times must also be documented in the patient chart.

v) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

vi) **Not payable to physicians who are participating in the GPSC attachment initiative (G14070).**

~~vi)~~vii) Not payable to the same patient on the same date of service as ~~the Facility Patient Conference Fee~~ (fee item G14015)~~, Acute Care Discharge Planning Conference Fee~~ (G14017)~~, GP Attachment Conference Fee (G14077) or GP Attachment Complex Care Management Fee~~ (G14074, G14075, G14076 or G14077)~~.~~

~~vii)~~viii) Not payable to physicians who are employed by, or who are under contract to a facility, who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.

~~viii)~~ix) Visit payable in addition if medically required and does not take place concurrently with clinical action plan.

## Acute Care Discharge Conference Fee

$

G14017 General Practice Acute Care Discharge Conference fee
In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to the most responsible GP for that patient following discharge from the acute care facility. This fee is billable when a Discharge Planning Conference is performed upon the request of either an Acute Care facility, or by the GP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.
- per 15 minutes or greater portion thereof ..... 40.00

***Notes:***

*i) Refer to Table 1 for eligible populations.*

*ii)*

*iii) Payable only for patients being discharged from an acute care facility to the community or to a different facility; another acute care facility, or a supportive care or Long Term Care facility.*

*iv) Must be performed in the acute care facility and results of the conference must be recorded in the patient's chart in the acute care facility and the receiving GP's office chart (or receiving facility's chart in the case of inter-facility transfer).*

*v) Face-to-face conferencing is required; the only exception is if a patient is being discharged from an acute care facility in a different community, and a chart notation must be made to indicate this circumstance.*

*vi) Requesting care providers limited to: Facility-affiliated physicians and nurses, GP assuming MRP status upon patient's discharge, care coordinators, liaison nurses, rehab consultants, social workers, any ~~healthcare~~ allied care provider charged with coordinating discharge and follow-up planning.*

*vii) Requires interdisciplinary team meeting of the GP assuming MRP status upon discharge and a minimum of 2 other ~~health~~ allied care professionals as enumerated above, and will include family members when appropriate.*

*viii) Fee includes:*

- *a. Where appropriate, interviewing of and conferencing with patient, family members, and other ~~health~~ allied care providers of both the acute care facility and community.*
- *b. Review and organization of appropriate clinical information.*
- *c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*
- *d. The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*vii) This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses during the course of a patient's stay in the acute care facility.*

*viii) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*

*ix) Claim must state start and end times of the service.*

*x) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

*xi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

*xii) Medically required visits performed consecutive to the Acute Care Discharge Conference are payable. (i.e. Visit is separate from conference time).*

*xiii) Submit the new fee item G14017 through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders.*

xiv) **Not payable to physicians who are participating in the GPSC attachment initiative (G14070).**

xv) *Not payable to the same patient on the same date of service as ~~the Facility Patient Conference Fee~~ (fee item G14015~~)~~, ~~Community Patient Conference Fee~~ (G14016, G14074, G14075, G14076~~)~~ or ~~GP Attachment Conference Fee (G14077)~~.*

xvi) *Not payable on the same day as any GPSC planning fees (G14033, G14075, G14043, G14063 (Palliative Planning Fee).*

| | | $ |
|---|---|---|
| G14018 | General Practice Urgent Telephone Conference with a Specialist Fee: Conferencing on an urgent basis (within 2 hours of request for a telephone conference) with a specialist or GP with specialty training by telephone followed by the creation, documentation, and implementation of a clinical action plan for the care of patients with acute needs; i.e. requiring attention within the next 24 hours and communication of that plan to the patient or patient's representative | 40.00 |

***Notes:***

i) *Payable to the GP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or GP with specialty training regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.*

ii) *A GP with specialty training is defined as a GP who:*
   a. *Provides specialist services in a Health Authority setting and is acknowledged by the Health Authority as acting in a specialist capacity and providing specialist services;*
   b. *Has not billed another GPSC fee item on the patient in the previous 18 months; Telephone advice must be related to the field in which the GP has received specialty training.*

iii) *Conversation must take place within two hours of the GP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, e-mail).*

iv) ***Fee i**ncludes:*
   a. *Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*
   b. *Developing, documenting and implementing a plan to manage the patient safely in their care setting.*
   c. *Communication of the plan to the patient or the patient's representative.*
   d. ***The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.***

*~~v) The care plan must be recorded in the patients chart and include the following information:~~*
   *~~a. Patient's Name.~~*
   *~~b. Date of Service.~~*
   *~~c. Diagnosis.~~*
   *~~d. Reason for need of Clinical Action Plan.~~*
   *~~e. Name of specialist/GP with specialty training & their role in provision of care.~~*
   *~~f. Elements of the Clinical Action Plan determined.~~*
   *~~g. Patient risks based on assessment of appropriate domains (list of relevant co-morbidities and safety risks).~~*
   *~~h. What referral will be made, what follow-up has been arranged (including timelines), as well as advanced planning information if appropriate.~~*
   *~~i. Start times of service.~~*

vi) *Not payable to the same patient on the same date of service as ~~any other Patient Conference~~ (fee items G14015, G14016, G14017 **or G14077**~~)~~, ~~complex care, mental health or palliative care planning (G14033, G14043, G14063) or telephone fees~~.*

vii) *Not payable to physicians who are employed by, or who are under a contract to a facility, who would otherwise have provided the service as a requirement of*

*their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangement.*

viii) *Include start time in time fields when submitting claim.*

ix) *Not payable for situations where the primary purpose of the call is to:*
   a. *Book an appointment*
   b. *Arrange for transfer of care that occurs within 24 hours*
   c. *Arrange for an expedited consultation or procedure within 24 hours*
   d. *Arrange for laboratory or diagnostic investigations*
   e. *Inform the other physician of results of diagnostic investigations*
   f. *Arrange a hospital bed for the patient.*
   g. *Obtain non-urgent advice for patient management (i.e. not required within the next 24 hours).*

x) *Limited to one claim per patient per physician per day.*

xi) *Out-of-Office Hours Premiums ~~and Rural Retention Premiums~~ may not be claimed in addition.*

xii) *Maximum of 6 (six) services per patient, per practitioner per calendar year.*

xiii) *Visit payable on same date of service if medically required and does not take place concurrently with the clinical action plan.*

**Appendix 4 –** Fee item G14079

Strikethrough is deleted; bold is added.

**GP Telephone/E-mail follow-up Management Fee**

In order to encourage non-face-to-face communication with patients covered by some of the GPSC incentives, **patients covered by one or more of the planning related incentives are eligible for five telephone/e-mail services per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.** ~~the initial four separate telephone/e-mail follow-up fees have been simplified into a single code that will still apply to the planning incentives (Complex Care G14033, Mental Health G14043, Palliative Care G14063 & COPD G14053 which requires a COPD Action Plan). Patients covered by one or more of these incentives are eligible for five telephone/e-mail services over the 18 months following the billing of the qualifying incentive(s).~~

| | | $ |
|---|---|---|
| G14079 | GP Telephone/Email Management Fee ..... | 15.00 |

This fee is payable for two-way communication with eligible patients, or the patient's medical representative, via telephone or email by the GP who has billed and been paid for at least one of the following GPSC incentives:
Complex Care Planning Fee (G14033)
Mental Health Planning Fee (G14043)
Annual Chronic Care Bonus for COPD (G14053)
Palliative Care Planning Fee (G14063)
Attachment Complex Care Management Fee (G14075)
This fee is billable for medical management of the conditions covered under the initial planning/Chronic Care fee. This fee is not to be billed for simple appointment reminders or referral notification.

***Notes:***

*i) Payable to a maximum of 5 times per patient per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.*

*ii) Telephone/Email Management requires two-way communication between the patient or the patient's medical representative and physician or medical office staff for the purpose of medical management of the relevant chronic condition(s); it is not payable for simple notification of office or laboratory appointments or of referrals.*

*iii) Payable only to the physician paid for the G14033, G14043, G14053, G14063 or G14075 unless that physician has agreed to share care with another delegated physician. To facilitate payment, a note record should be submitted by the delegated physician.*

*iv) G14077 or G14016 ~~Community Patient Conferencing Fee~~ payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for ~~the~~ G14077 or G14016.*

*~~v) G14077 GP Attachment Patient Conference Fee payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count towards the time requirement for the G14077.~~*

*~~vi)~~v) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077 or G14016.*

*~~vii)~~vi) Not payable on same day for same patient as G14076 GP Attachment Patient Telephone Management Fee.*

Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

**Appendix 5** - Complex Care Fees

Strikethrough is deleted; bold is added.

## 3. Complex Care Fees

The Complex Care Management Fee was developed to compensate GPs for the management of complex patients **residing in the community, who have documented confirmed diagnoses of 2 chronic conditions from at least 2 of the 8 categories listed below. Community patients are those residing in their home or in assisted living. Patients in acute or long term care facilities are not eligible.**

**Having comorbidities does not necessarily make a patient complex and so to be eligible for the Complex Care Management Fee, the individual patient co-morbidities should be of sufficient severity and complexity to cause interference in activities of daily living and warrant the development of a management plan.**

**These items are payable only to the *family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care* for the ensuing calendar year.**~~who have chronic conditions from a least 2 of the 8 categories listed below. Providing the Complex Care planning visit and billing for the development of a care plan allows access to 5 telephone/e-mail fees (G14079) per calendar year during the following 18 months.~~

~~These items are payable only to the General Practitioner who accepts the role of being Most Responsible for the longitudinal, coordinated care of that patient; by billing this fee the practitioner accepts that responsibility for the ensuing calendar year.~~

~~The Most Responsible General Practitioner may bill this fee when providing care only to community patients; i.e. residing in their homes or in assisted living with two or more of the following chronic conditions:~~

***Eligible Complex Care Condition Categories:***

1) *Diabetes mellitus (type 1 and 2)*
2) *Chronic Kidney Disease*
3) *~~Congestive heart~~ **Heart** failure*
4) *Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)*
5) *Cerebrovascular disease, **excluding acute transient cerebrovascular conditions (e.g. TIA, Migraine)***
6) *Ischemic heart disease, excluding the acute phase of myocardial infarct*
7) *Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, ~~stroke or other~~ brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.)*
8) *Chronic Liver Disease with evidence of hepatic dysfunction.*

If a patient has more than 2 of the qualifying conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

Successful billing of the Complex Care Management Fee (G14033) allows access to 5 Telephone/E-mail follow- up fees (G14079) per calendar year over the following 18 months.

| | | |
|---|---|---|
| G14033 | GP Annual Complex Care Management Fee ..... The Complex Care Management Fee is advance payment for the **complex work**~~complexity~~ of caring for patients with two of the eligible conditions. It~~and~~ is payable upon the completion and documentation of a Complex Care Plan **which includes Advance Care Planning when appropriate, as described below.**~~for the management of the complex care patient until the complex care plan is reviewed and revised in the next calendar year~~. | 315.00 |

A Complex Care Plan requires documentation of the following elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies;
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
3. Specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;
5. Outlines expected outcomes as a result of this plan, including end-of-life issues (advance care planning) when clinically appropriate;
6. Outlines linkages with other ~~health~~ **allied** care professionals who would be involved in the patient's care, and their expected roles;
7. Identifies an appropriate time frame for re-evaluation of the plan;
8. **Provides confirmation**~~Confirms~~ that the care plan has been **created jointly and shared with the patient and/or the patient's medical representative and has been** communicated verbally or in writing to ~~the patient and/or the patient's medical representative, and to~~ other involved ~~health~~ **allied care** professionals as appropriate.

The development of the care plan is done jointly with the patient &/or the patient representative as appropriate. The patient &/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

***Notes:***

*i) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions.*

*ii) Refer to Table 1 for eligible diagnostic categories.*

*iii) Payable once per calendar year per patient* ***on the date of the complex care planning visit.***

*iv)* ***Documentation of the Complex Care Plan is required in patient's chart.***

*v) Minimum required time 30 minutes* ***to review chart and create the care plan jointly with the patient and/or their medical representative. The majority of the time must be face-to-face.*** *~~in addition to visit time.~~* ***Documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required.***

*vi) Visit* ***(in office or home)*** *or CPx fee to indicate face-to-face interaction with patient same day must* ***be billed for same date of service***~~*accompany billing*~~*.* ***Visit time does not count toward required planning time.***

*vii) G14016* ~~*Community Patient Conference Fee*~~ *or G14077 payable on same day for same patient if all criteria met.* ***Time spent on conferencing does not apply to time requirement for 14033.***

*viii) G14050/, G14051/, G14052/, G14053 payable on same day for same patient, if all other criteria met.*

*ix)* ***Not payable once G14063 has been billed and paid as patient has been changed from active management of complex chronic conditions to palliative management.***

~~*ix)*~~*x) G14015* ~~*Facility Patient Conference Fee*~~*, G14017,* ~~*Acute Care Discharge Planning Conference Fee*~~ ***G14076 and G14079 not payable on the same day for the same patient.***

~~*x)*~~*xi) Maximum* ***daily total of 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees*** ~~*of 5 complex care fees (G14033 and/or G14075) per day*~~ *per physician.*

~~*xi)*~~*xii) G14075*~~*, GP Attachment Complex Care Management Fee,*~~ *is not payable in the same calendar year for same patient as G14033*~~*, GP Annual Complex Care Management Fee.*~~

~~*xii)*~~*xiii)* ***Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.***

~~xiii)~~xiv) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

~~xiv)~~xv) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Diagnostic codes submitted with 14033 billing must be from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

**Table 1: Complex Care Diagnostic codes**

| Diagnostic Code | Condition One | Condition Two |
|---|---|---|
| N519 | Chronic Neurodegenerative Disorder | Chronic Respiratory Condition |
| N414 | Chronic Neurodegenerative Disorder | Ischemic Heart Disease |
| N428 | Chronic Neurodegenerative Disorder | ~~Congestive~~ Heart Failure |
| N250 | Chronic Neurodegenerative Disorder | Diabetes |
| N430 | Chronic Neurodegenerative Disorder | Cerebrovascular Disease |
| N585 | Chronic Neurodegenerative Disorder | Chronic Kidney Disease ~~(Renal Failure)~~ |
| N573 | Chronic Neurodegenerative Disorder | Chronic Liver Disease ~~(Hepatic Failure)~~ |
| R414 | Chronic Respiratory Condition | Ischemic Heart Disease |
| R428 | Chronic Respiratory Condition | ~~Congestive~~ Heart Failure |
| R250 | Chronic Respiratory Condition | Diabetes |
| R430 | Chronic Respiratory Condition | Cerebrovascular Disease |
| R585 | Chronic Respiratory Condition | Chronic Kidney Disease ~~(Renal Failure)~~ |
| R573 | Chronic Respiratory Condition | Chronic Liver Disease ~~(Hepatic Failure)~~ |
| I428 | Ischemic Heart Disease | ~~Congestive~~ Heart Failure |
| I250 | Ischemic Heart Disease | Diabetes |
| I430 | Ischemic Heart Disease | Cerebrovascular Disease |
| I585 | Ischemic Heart Disease | Chronic Kidney Disease ~~(Renal Failure)~~ |
| I573 | Ischemic Heart Disease | Chronic Liver Disease ~~(Hepatic Failure)~~ |
| H250 | ~~Congestive~~ Heart Failure | Diabetes |
| H430 | ~~Congestive~~ Heart Failure | Cerebrovascular Disease |
| H585 | ~~Congestive~~ Heart Failure | Chronic Kidney Disease ~~(Renal Failure)~~ |
| H573 | ~~Congestive~~ Heart Failure | Chronic Liver Disease ~~(Hepatic Failure)~~ |
| D430 | Diabetes | Cerebrovascular Disease |
| D585 | Diabetes | Chronic Kidney Disease ~~(Renal Failure)~~ |
| D573 | Diabetes | Chronic Liver Disease ~~(Hepatic Failure)~~ |
| C585 | Cerebrovascular Disease | Chronic Kidney Disease ~~(Renal Failure)~~ |
| C573 | Cerebrovascular Disease | Chronic Liver Disease ~~(Hepatic Failure)~~ |
| K573 | Chronic Kidney Disease ~~(Renal Failure)~~ | Chronic Liver Disease ~~(Hepatic Failure)~~ |

**Appendix 6** – 4. Prevention Fees, fee item G14066

Strikethrough is deleted; bold is added.

| | | $ |
|---|---|---|
| G14066 | Personal Health Risk Assessment<br>This fee is payable to the general practitioner who undertakes a Personal Health Risk Assessment with **a patient in** ~~their patients who belong to~~ one of the designated target populations (obese, smoker, physically inactive, unhealthy eating) ~~either as part of proactive care or in response to a request for preventative care from one of these patients~~. The GP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative **and the G14066** must be billed in addition to the age appropriate visit fee. | 50.00 |

***Patient Eligibility:***

- *Eligible patients ~~are community based, living in their home, with family, in supportive housing or assisted living. Facility based patients are not eligible.~~must be living at home or in assisted living. Patients in acute and long term care facilities are not eligible.*

***Notes:***

*i) Payable only for patients with one or more of the following risk factors: Smoking, unhealthy eating, physical inactivity, medical obesity.*

*ii) **Diagnostic code submitted with 14066 must be one of the following:**~~Only applicable to services submitted using one of the following diagnostic codes:~~ Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783).*

*iii) **The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.**~~Requires chart entry documenting discussion and preventative plan of action~~*

*iv) **Visit (office or home) or CPx fee to indicate face-to-face interaction with patient or patient's representative same day must be billed for same date of service.**~~Face to face visit required with patient or patient's medical representative on the same calendar day that the personal health risk assessment is billed.~~*

*~~v) Payable in addition to the office visit billed on the same day.~~*

*~~vi)~~v) **G14016 or G14077 payable on same day for same patient if all criteria met.***

*~~vii)~~vi) **G14015, G14017, G14033, G14043, G14063, G14076 and G14079 not payable on the same day for the same patient.**~~Not payable on the same day as fee items G14015, G14017, G14033, G14043, G14063.~~*

*~~viii)~~vii) Payable to a maximum of 100 patients per calendar year, per physician.*

*~~ix)~~viii) Payable once per calendar year per patient.*

*ix) **Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.***

*x) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care;*

*xi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

**BC Lifetime Prevention Schedule Recommended Actions**

| Clinical Condition | | MEN | WOMEN |
|---|---|---|---|
| Colorectal Cancer Screening (Fecal Occult Blood Testing q1-2 years starting age 50) | | • | • |
| Mammography Screening (40-79 yrs, q 1-2 years) | | | • |
| Pap Smear Screening (sexually active until age 69, q 1 – 2 years) | | | • |
| Hypertension Screening | | • | • |
| Hyperlipidemia Screening ( Male 40 yr; Female 50 yr or postmenopausal; or sooner if at risk either sex) | | • | • |
| Diabetes Screening (Fasting Blood Sugar at least q 3 yrs age 40 yr or sooner if at risk either sex) | | • | • |
| Discussion of ASA use as clinically indicated (if high risk of Cardiovascular Disease or Stroke) | | • | • |
| Smoking Cessation | | • | • |
| Adult Immunization: | Influenza (Annually if at risk) | • | • |
| | Pneumococcal (if ↑Risk q 10 years) | • | • |
| | Tetanus /Diphtheria (q 10 years) | • | • |
| Immunizations for patients < 19 years of age as per age appropriate publically funded schedule | | • | • |
| Diet Modification (if Cardiovascular Disease Risk) | | • | • |
| Exercise Recommendation (if Cardiovascular Disease Risk) | | • | • |

**Appendix 7 –** Fee items G14043, G14044, G14045, G14076, G14077 and G14048

Strikethrough is deleted; bold is added.

| | | $ |
|---|---|---|
| G14043 | GP Mental Health Planning Fee ..... | 100.00 |

This fee is payable upon the completion and documentation of a Mental Health Plan for patients resident in the community (home or assisted living ~~excluding care facilities~~). **Patients in acute or long term care facilities are not eligible. Patients must have**~~with~~ a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan. **This is not intended for patients with self-limited or short lived mental health symptoms *(e.g.: situational adjustment reaction, normal grief, life transitions*). The Mental Health Planning Fee requires a face-to-face visit with the patient and/or the patient's medical representative.**

~~This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM-IV diagnostic criteria. It requires a face-to-face visit with the patient and/or the patient's medical representative.~~

**A Mental Health Plan requires documentation of the following elements in the patient's chart:**~~From these activities (review, assessment, planning and documentation), a Mental Health Plan for that patient will be developed that documents in the patient's chart, the following:~~

1. There has been a detailed review of the patient's chart/history and current therapies;
2. **The patient's confirmed diagnosis, (DSM Axis 1), psychiatric history and current mental state.**~~The patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;~~
3. The use of and results of validated assessment tools. **Examples of validated assessment tools include:**~~The GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:~~
   a) PHQ9, Beck Depression Inventory, Ham-D **depression scale**~~for depression~~;
   b) MMSE ~~for cognitive impairment~~;
   c) MDQ ~~for bipolar illness~~
   d) GAD-7 ~~for anxiety~~
   e) Suicide Risk Assessment;
   f) Audit (Alcohol Use Disorders Identification Test CAGE; T-ACE) ~~for Alcohol Misuse~~;

~~4. Specifies a clinical plan for the care of that patient's psychiatric illness. DSM-IV Axis I confirmatory diagnostic criteria;~~

~~5. A summary of the condition and a specific plan for that patient's care;~~

~~6. An outline of expected outcomes~~

~~7.~~4. Outlines linkages with other ~~health~~ allied care professionals ~~(Including Community Mental Health Resources and Psychiatrists, as indicated and/or available)~~ and community resources who will be involved in the patient's care, and their expected roles.

~~8.~~5. **Identifies** ~~An~~ an appropriate time frame for follow up and re-evaluation of the patient's progress and Mental Health Plan;

~~9.~~6. **Provides confirmation that the Mental Health** ~~That the developed~~ plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other involved ~~health~~ allied care professionals as **appropriate**~~indicated~~. The patient and/or their

representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Following the successful billing of the Mental Health Planning fee, the GP will have access to 4 additional counselling equivalent mental health management fees per calendar year once the 4 MSP counselling fees have been billed. **Successful billing of the Mental Health Planning fee G14043 allows access to 4 mental health management fees in that same calendar year which may be billed once the 4 MSP counselling fees (00120) have been utilised.**

**Successful billing of the mental health planning fee (G14043) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year in the subsequent 18 months.**

***Patient Eligibility:***

- ***Eligible patients must be living at home or in assisted living.*** ~~*Eligible patients are community based, living in their home or assisted living.*~~
- ***Patients in Acute and Long Term Care Facilities are not eligible.*** ~~*Facility based patients are not eligible.*~~

***Notes:***

*i)* ***Payable only for patients with documentation of a confirmed diagnosis of a DSM Axis 1 condition causing significant interference with activities of daily living.*** ~~*Requires documentation of the patient's mental health status and diagnosis by means of psychiatric history, mental state examination, and confirmatory DSM IV diagnostic criteria. Confirmation of Axis I Diagnosis is required for patients eligible for the GP Mental Health Planning Fee.*~~ *Not intended for patients with self-limited or short lived mental health symptoms.* ~~*(e.g.: Brief situational adjustment reaction, normal grief, life transitions) for whom a plan for longer term mental health care is not necessary.*~~

*ii)* ***Payable once per calendar year per patient. Not intended as a routine annual fee unless the severity of the illness requires a comprehensive Mental Health Plan review and revision.***

~~*iii) Payable in addition to a visit fee billed same day.*~~

~~*iv)*~~*iii)* *Minimum required face to face time 30 minutes* ~~*in addition to visit time same day*~~*.*

~~*v)*~~*iv)* ***Visit fee on same day only payable in addition if total time exceeds 39 minutes; counselling fee on same day only payable in addition if total time exceeds 49 minutes.***

*x)* ***G14043 claim must state start and end times of the total service (planning plus any additional visit/counselling.) Start and end times must also be documented in the patient chart.***

~~*vi)*~~*v)*

~~*vii)*~~*vi)* *G14016* ~~*Community Patient Conferencing Fee*~~ *or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for 14043.*

~~*viii)*~~*vii)* *G14015* ~~*(Facility Patient Conferencing Fee)*~~*, G14044, G14045, G14046, G14047, G14048* ~~*(GP Mental Health Management Fees)*~~*, G14033, G14063, G14074, G14075, G14076 and G14079* ~~*GP telephone /e-mail management fee*~~ ***not payable on the same day for the same patient.***

~~*ix)*~~*viii)* *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

~~*x)*~~*ix)* *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | $ |
|---|---|---|
| G14044 | GP Mental Health Management Fee age 2 – 49 | 52.76 |
| G14045 | GP Mental Health Management Fee age 50 – 59 | 58.03 |
| G14046 | GP Mental Health Management Fee age 60 – 69 | 60.67 |
| G14047 | GP Mental Health Management Fee age 70 – 79 | 68.59 |
| G14048 | GP Mental Health Management Fee age 80+ | 79.14 |

**These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee 14043 has been successfully billed. The four MSP counselling fees (age-appropriate 00120) must first have been paid in the same calendar year.** ~~These fees are payable for GP Mental Health Management required beyond the four MSP counselling fees (age-appropriate 00120 fees billable under the MSC payment schedule) for patients with a chronic mental health condition on whom a Mental Health Plan has been created and billed.~~

***Notes:***

*i) Payable a maximum of 4 times per calendar year per patient.*

*ii) Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician.*

*iii) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician* ***must*** *~~should~~ submit an electronic note.*

*iv)* ***Not payable unless the four age-appropriate 00120 fees have already been paid in the same calendar year*** *~~Not payable unless the age-appropriate 00120 series has been fully utilized.~~*

*v) Minimum time required is 20 minutes.*

*~~vi) Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14079 GP telephone /e-mail management fee.~~*

*~~vii)~~vi)* ***Claim must include Start and End times. Start and end times must also be documented in the patient chart.***

*~~viii)~~vii) G14016 ~~(Community Patient Conferencing Fee)~~* ***or G14077****, payable on same day for same patient if all criteria met.*

*~~ix)~~viii) G14015 ~~(Facility Patient Conferencing Fee)~~, G14043 ~~(Mental Health Planning Fee)~~, G14076, G14079 ~~(GP Telephone/e-mail Management Fee)~~ not payable on same day for same patient.*

*~~x) CDM fees (G14050, G14051, G14052, G14053) payable if all criteria met.~~*

*~~xi)~~ix) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*~~xii)~~x) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

~~**Successful billing of the mental health planning fee (G14043) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year in the subsequent 18 months.**~~

The following list of diagnosis and acceptable ICD9 codes are applicable for the Mental Health Planning and Management Fee, fee items G14043, G14044 – G14048, and G14079:

| | DIAGNOSIS | ICD-9 |
|---|---|---|
| **Adjustment Disorders:** | | **309** |
| | Adjustment Disorder with Anxiety | 309 |
| | Adjustment Disorder with Depressed Mood | 309 |
| | Adjustment Disorder with Disturbance of Conduct | 309 |
| | Adjustment Disorder with Mixed Anxiety and Depressed Mood | 309 |
| | Adjustment Disorder with Mixed Disturbance of Conduct & Mood | 309 |
| | Adjustment Disorder NOS | 309 |
| **Anxiety Disorders:** | | **300** |
| | Acute Stress Disorder | 308 |
| | Agoraphobia | 300 |
| | Anxiety Disorder Due to a Medical Condition | 300 |
| | Anxiety Disorder NOS | 300 |
| | Generalized Anxiety disorder | 50B, 300 |
| | Obsessive-Compulsive Disorder | 300 |
| | Panic Attack | 300 |
| | Post-Traumatic Stress Disorder | 309 |
| | Social Phobia | 300 |
| | Specific Phobia | 300 |
| | Substance-Induced Anxiety disorder | 300 |
| **Attention Deficit Disorders:** | | |
| | Attention Deficit disorder | 314 |
| **Cognitive Disorders:** | | |
| | Amnestic Disorder | 294 |
| | Delirium | 293 |
| | Dementia | 290,331,331.0,331.2 |
| **Dissociative Disorders:** | | |
| | Depersonalization Disorder | 300 |
| | Dissociative Amnesia | 300 |
| | Dissociative Fugue | 300 |
| | Dissociative Identity Disorder | 300 |
| | Dissociative Disorder NOS | 300 |
| **Eating Disorders:** | | |
| | Anorexia Nervosa | 307.1, 783.0, 307 |
| | Bulimia | 307 |
| | Eating Disorder NOS | 307 |
| **Factitious Disorders**: | | **300,312** |
| | Factitious Disorder; Physical & Psych Symptoms | 300,312 |
| | Factitious Disorder; Predom Physical Symptoms | 300,312 |

| | | |
|---|---|---|
| | Factitious Disorder; Predominantly Psych Symptoms | 300,312 |
| **Impulse Control Disorders:** | | **312** |
| | Impulse Control Disorder NOS | 312 |
| | Intermittent Explosive Disorder | 312 |
| | Kleptomania | 312 |
| | Pathological Gambling | 312 |
| | Pyromania | 312 |
| | Trichotillomania | 312 |
| **Mental Disorders Due to a Medical Condition** | | |
| **Mood Disorders:** | | |
| | Bipolar Disorder | 296 |
| | Cyclothymic disorder | 301.1 |
| | Depression | 311 |
| | Dysthymic Disorder | 300.4 |
| | Mood Disorder due to a Medical Condition | 293.8 |
| | Substance-Induced Mood Disorder | 303, 304, 305 |
| **Schizophrenia and other Psychotic Disorders:** | | **295,296,297,298** |
| | Paranoid Type | 295,297,298 |
| | Disorganized Type | 295, 298 |
| | Catatonic Type | 295, 298 |
| | Undifferentiated Type | 295, 298 |
| | Residual Type | 295, 298 |
| | Brief Psychotic Disorder | 295, 298 |
| | Delusional Disorder | 295, 298 |
| | Psychotic Disorder due to Medical Condition | 293 |
| | Psychotic Disorder NOS | 295, 298 |
| | Schizoaffective Disorder | 295, 298 |
| | Schizophreniform Disorder | 295, 298 |
| | Substance-Induced Psychosis | 295, 298 |
| **Sexual and Gender Identity Disorder Paraphilias:** | | **302** |
| | Exhibitionism | 302 |
| | Fetishism | 302 |
| | Frotteurism | 302 |
| | Pedophilia | 302 |
| | Sexual Masochism | 302 |
| | Sexual Sadism | 302 |
| | Transvestic Fetishism | 302 |
| | Voyeurism | 302 |
| | Paraphilia NOS | 302 |
| **Sexual Dysfunction:** | | **302** |
| | Hypoactive Sexual Desire Disorder | 302 |
| | Female Orgasmic Disorder | 302 |
| | Female Sexual Arousal Disorder | 302 |
| | Male Erectile Disorder | 302 |

| | | |
|---|---|---|
| | Male Orgasmic Disorder | 302 |
| | Premature Ejaculation | 302 |
| | Sexual Aversion Disorder | 302 |
| | Sexual Dysfunction due to a Medical Disorder | 625 |
| | Sexual Dysfunction due to a Substance | 302 |
| **Sexual Pain Disorders:** | | |
| | Dyspareunia (not due to a Medical Condition) | 302 |
| | Vaginismus (not due to a Medical Condition) | 302 |
| **Sleep Disorders:** | | |
| | Primary Insomnia | 307 |
| | Primary Hypersomnia | 307 |
| | Narcolepsy | 347 |
| | Breathing-Related Sleep Disorder | 780.5 |
| | Circadian Rhythm Sleep Disorder | 307.4 |
| | Insomnia Related to Another Mental Disorder | 307.4 |
| | Nightmare Disorder (Dream Anxiety Disorder) | 307.4 |
| | Sleep Disorder Due to a Medical Condition | 780.5 |
| | Sleep Disorder Related to another Medical Condition | 780.5 |
| | Sleepwalking Disorder | 780.5 |
| | Substance-Induced Sleep Disorder | 780.5 |
| **Somatoform Disorders:** | | |
| | Somatization Disorder | 300.8 |
| | Conversion Disorder | 300.1 |
| | Pain Disorder | 307.8 |
| | Hypochondriasis | 300.7 |
| | Body Dysmorphic Disorder | 300.7 |
| **Substance - Related Disorders:** | | |
| | Substance-Induced Anxiety Disorder | 303,304,305 |
| | Substance-Induced Mood Disorder | 303,304,305 |
| | Substance-Induced Psychosis | 292 |
| | Substance-Induced Sleep Disorder | 303,304,305 |
| **Alcohol Dependence Syndrome** | | 303 |
| **Drug Dependence Syndrome** | | 304 |
| **Drug Abuse, Non-Dependent** | | 305 |

– Section 8. Palliative Care Planning Fee, fee item G14063

Strikethrough is deleted; bold is added.

## 8. Palliative Care Planning Fee

| | | $ |
|---|---|---|
| G14063 | Palliative Care planning fee<br>This fee is payable upon the development and documentation of a Palliative Care Plan for patients **who in your clinical judgement** have ~~been determined to 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. **Examples** ~~Medical Diagnoses~~ include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy.<br><br>**Eligible patients must be living at home or in assisted living. Patients in Acute and Facilities are not eligible.** ~~Eligible patients must be resident in the community; in a home or in assisted living or supportive housing. Facility resident patients are not eligible for this initiative.~~<br><br>**The Palliative Care Plan requires documentation of the following in the patient's chart:**<br><br>1. *There has been a detailed review of the case/chart and of current therapies.*<br>2. *There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Palliative Care Planning Fee is billed.*<br>3. *Specifies a clinical plan for the patient's palliative care.*<br>4. *Incorporates the patient's values and beliefs in creation of the plan Name and contact information for substitute decision maker.*<br>5. *Completion of a NO CPR FORM*<br>6. *Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles.*<br>7. *Provides confirmation that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved allied care professionals as appropriate.*<br><br>This fee requires ~~the GP to conduct a comprehensive review of the patient's chart/history and assessment of the patient's current diagnosis to determine if the patient has a life limiting condition that has become palliative and/or remains palliative. It requires~~ a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.<br><br>***Notes:***<br>*i) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.*<br>*ii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).*<br>*iii) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.*<br>*iv) Payable in addition to a visit fee (**home or office**) billed on the same day.*<br>*v) Minimum required time 30 minutes face to face in addition to visit time same day.* | 100.00 |

vi) ***Claim must state start and end times of the service. Start and end times must also be documented in the patient chart.***

vii) *G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14063.*

viii) ***Not payable if G14033 or G14075 has been paid within 6 months.***

~~viii)~~ix) *Not payable on same day as G14015 ~~facility patient conferencing fee~~, G14017 ~~acute care discharge planning fee~~, G14043 ~~Mental Health Planning fee,~~ G14074, G14076 or G14079 GP Telephone/e-mail Management fee.*

~~ix)~~x) *G14050, G14051, G14052, G14053, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid as patient has been changed ~~moved~~ from active management of chronic disease and/or complex condition(s) to palliative management.*

~~x)~~xi) *G14043, G14044, G14045, G14046, G14047, G14048, the GPSC Mental Health Initiative Fees are still payable once G14063 has been billed provided all requirements are met, but are not payable on same day.*

~~xi)~~xii) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

~~xii)~~xiii) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Successful billing of the Palliative care planning fee (G14063) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year over the following 18 months.

**Appendix 9** – Section 9. GPSC Incentives for GPs with Specialty Training

Strikethrough is deleted; bold is added.

## 9. GPSC Incentives for GPs with Specialty Training

**Eligibility:**

- Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- Service may be provided when physician is located in office or hospital. For the purpose of these telephone advice fee items **GPSC has defined** ~~a~~ General Practitioner (GP) with specialty training ~~who is defined~~ as: A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program.
- Telephone advice must be related to the field in which the GP has received specialty training.

G14021 GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Response within 2 hours ..... 60.00

***Notes:***

*i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.*

*ii) Conversation must take place within two hours of the initiating physician's request. Not payable for written communication (i.e. fax, letter, e-mail).*

*iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

*iv) Not payable for situations where the purpose of the call is to:*
- *a. book an appointment*
- *b. arrange for transfer of care that occurs within 24 hours*
- *c. arrange for an expedited consultation or procedure within 24 hours*
- *d. arrange for laboratory or diagnostic investigations*
- *e. inform the referring physician of results of diagnostic investigations*
- *f. arrange a hospital bed for the patient*

*v) Not payable to physician initiating call.*

*vi) No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).*

*vii) Limited to one claim per patient per physician per day.*

*viii) A chart entry, including advice given and to whom, is required.*

*ix) Include start and end times in time fields when submitting claim.*

*x) Not payable in addition to another service on the same day for the same patient by same practitioner.*

*xi) Out-of-Office Hours Premiums ~~and Rural Retention Premiums~~ may not be claimed in addition.*

*xii) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

**$**

G14022 GP with Specialty Training Telephone Patient Management - Initiated by a Specialist, General Practitioner **or Allied Care Provider**, Response in One Week – **per 15 minutes or portion thereof** ..... 40.00

***Notes:***

*i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.*

*ii) Conversation must take place within 7 days of initiating physician request. Initiation may be by phone or referral letter.*

~~ii)~~iii) ***If conversation is with an allied care provider include a note record specifying the type of provider.***

~~iii)~~iv) *Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*

~~iv)~~v) *Not payable for situations where the purpose of the call is to:*

- *g. book an appointment*
- *h. arrange for transfer of care that occurs within 24 hours*
- *i. arrange for an expedited consultation or procedure within 24 hours*
- *j. arrange for laboratory or diagnostic investigations*
- *k. inform the referring physician of results of diagnostic investigations*
- *l. arrange a hospital bed for the patient*

~~v)~~vi) *Not payable to physician initiating call.*

~~vi)~~vii) *No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).*

~~vii)~~viii) *Limited to ~~one-two claim~~ services per patient per physician per week.*

~~viii)~~ix) *A chart entry, including advice given and to whom, is required.*

~~ix)~~x) *Include start and end times in time fields when submitting claim.*

~~x)~~xi) *Not payable in addition to another service on the same day for the same patient by same practitioner.*

~~xi)~~xii) *Out-of-Office Hours Premiums ~~and Rural Retention Premiums~~ may not be claimed in addition.*

~~xii)~~xiii) *Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

| | | $ |
|---|---|---|
| G14023 | GP with Specialty Training Telephone Patient Management / Follow-Up – **per 15 minutes or portion thereof** | 20.00 |

***Notes:***

i) *This fee applies to two-way direct telephone communication (including other forms of electronic verbal communication) between the GP with specialty training and patient, or a patient's representative. Not payable for written communication (i.e. fax, letter, e-mail).*

ii) *This fee is only payable for scheduled telephone appointments with the patient.*

iii) *Access to this fee is restricted to patients having received a prior consultation, office visit, hospital visit, diagnostic procedure or surgical procedure from the same GP with Specialty training, within the 6 months preceding this service.*

iv) *Telephone management requires two-way communication between the patient and physician on a clinical level; the fee is not billable for administrative tasks such as appointment notification.*

v) *No claim may be made where communication is with a proxy for the physician (e.g.: nurse or assistant).*

vi) *Each physician may bill this service four (4) times per calendar year for each patient.*

vii) *This fee requires chart entry as well as ensuring that patient understands and acknowledges the information provided.*

viii) *Include start and end times in time fields when submitting claim.*

ix) *Not payable in addition to another service on the same day for the same patient by the same practitioner.*

x) *Out-of-Office Hours Premiums ~~and Rural Retention Premiums~~ may not be claimed in addition.*

xi) *Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

**Appendix 10**. GPSC Incentives for A GP for Me/Attachment initiative

Strikethrough is deleted; bold is added.

## 10. GPSC Incentives for A GP for Me/Attachment initiative

Overview:

The fee codes for the A GP for Me **(Attachment)** Initiative, ~~also known as the Attachment initiative, will be~~ **are billable** ~~available to~~ **by** all family doctors who submit the **MSP** ~~MSP~~ fee G14070 'GP Attachment Participation Code', ~~a zero-sum amount,~~ **to MSP** at the beginning of each calendar year. **Once successfully submitted,** ~~This will in turn open the door to the new~~ **the** Attachment initiative suite ~~of~~ **of** fees **may be billed.. Submitting G14070** ~~Billing the zero sum fee code~~ signifies that:

- You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year.
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'. Refer to A GP for Me – Frequently Asked Questions (FAQs) for details.

You have contacted your local division of family practice to share your contact information **(AGPforMe@doctorsofbc.ca)** and to indicate your desire to participate in the community-level Attachment initiative as you are able. Division contacts are available online at www.divisionsbc.ca.

- Refer to A GP for Me – FAQs for more information.

~~Prior to submitting the GP Attachment Participation Code, each participating family physician must register their intent to participate in A GP for Me with their local division, even if he/she is not a member of that local division. This will assist the local division to understand how many doctors in their area are prepared to support Attachment initiative efforts. Division contacts are available online at www.divisionsbc.ca.~~

The standardized wording of the Family Physician-Patient 'Compact' ~~was developed in consultation with the physicians of the three Attachment prototype communities and in consultation with members of the Patient Voices Network. The compact~~ states:

As your family doctor I, along with my practice team, agree to:

- Provide you with the best care that I can
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:

- Seek your health care from me and my team whenever possible and, in my absence,
- through my colleague(s), xxxxxx
- Name me as your family doctor if you have to visit an emergency facility or another
- provider
- Communicate with me honestly and openly so we can best address your health care needs

**Locums working** ~~**When providing services**~~ **in an "Attachment Participating" family practice,** ~~**locum physicians are also**~~ **are able to bill** ~~**access**~~ **the fee codes for the "A GP for Me" initiative, once they have successfully submitted** ~~**by submitting the**~~ **MSP fee G14071 'GP Locum Attachment Participation Code',** ~~**a zero-sum amount**~~**, once at the beginning of each calendar year. The Locum and Attachment participating host FP should** ~~**must**~~ **discuss and mutually agree on which of the**

GPSC Services, including the ~~ose covered through the~~ Attachment Initiative fees, may be provided and billed by the locum. However, locums have their own annual allotment of G14076 Attachment Telephone Management Fee. Submitting~~ssion of~~ G14071 ~~this code~~ signifies that:

- You are providing full-service family practice services to the patients of the host physicians, and will continue to do so for the duration of any locum coverage for a family physician participating in the attachment incentive.
- You have contacted the Divisions of Family Practice central office to share your contact information (AGPforMe@doctorsofbc.ca) and to indicate your desire to participate as a locum in the community-level Attachment initiative as you are able. Refer to A GP for Me - FAQs for more information.

General Notes:

The Attachment incentives are billable ~~available~~ for BC residents with valid MSP coverage only; Reciprocal claims for patients with out of province health insurance ~~numbers~~billing arrangements for ~~patients from other provinces/territories~~ are excluded. Rural retention premiums do not apply.

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|---|---|---|
| G14070 | GP Attachment Participation Code ..... The GP Attachment Participation Code should be submitted at the beginning of each calendar year by **Full Service** Family Physicians (FSFP)'s who choose to participate in the GPSC Attachment Initiative.<br><br>Once successfully processed by MSP, the FP may access the "Attachment participation" incentives (G14074, G14075, G14076, G14077).<br><br>Submit fee item G14070 GP Attachment Participation Code using the following "Patient" demographic information:<br><br>PHN: 9753035697<br>Patient Surname: Participation<br>First name: Attachment<br>Date of Birth: January 1, 2013<br>ICD9 code: 780 | $00 |

***Notes:***

*v) Bill once per calendar year to confirm participation in the Attachment initiative.*
*vi) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*
*vii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
*viii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

## GP Locum Attachment Participation Code

~~It is the intent of the General Practice Services Committee (GPSC) to make initiatives available to Family Physicians participating in the 'A GP for Me' program, also known as the Attachment initiative that would not otherwise be accessible. GPSC recognizes that when locums are working for a Family Physician who is participating in the attachment initiative they should also have the opportunity to provide the same services to those patients.~~

~~Therefore, the fee codes for the Attachment initiative will be available to all locum GP's who submit the MSP fee G14071 'GP Locum Attachment Participation Code', a zero-sum amount, when they are providing locum coverage in a family practice subject to the services allowed in the locum agreement~~

~~between the locum and the host family physician. In subsequent years, G14071 should be submitted at the beginning of the calendar year or prior to providing the first locum coverage for a family physician participating in the attachment initiative. Billing the zero sum fee code signifies that:~~

~~You are providing full service family practice services to the patients of the host physician, and will continue to do so for the duration of locum coverage for a family physician participating in the attachment incentive.~~

~~You have contacted the Divisions of Family Practice central office to share your contact information and to indicate your desire to participate as a locum in the community level Attachment initiative as you are able.~~

| | | $ |
|---|---|---|
| G14071 | GP Locum Attachment Participation Code | 0.00 |

The GP Locum Attachment Participation code ~~should~~ **may** be submitted by the GP who provides locum coverage for ~~a~~ Family Physicians participating in the Attachment initiative at the beginning of the calendar year or prior to the start of the first such locum in each calendar year. Once processed by MSP, the locum may access GP Attachment incentives for services provided while covering for the Attachment participating host FPs.

Submit fee item G14071 GP Locum Attachment Participation Code using the following "Patient" demographic information:

| | |
|---|---|
| PHN: | 9753035697 |
| Patient Surname: | Participation |
| First name: | Attachment |
| Date of Birth: | January 1, 2013 |
| ICD9 code: | 780 |

***Notes:***

*v) Bill once per calendar year at the beginning of the year or prior to the first locum coverage for a family physician who is participating in the attachment initiative.*

*vi) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*

*vii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*viii) **Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.***

| | | $ |
|---|---|---|
| G14074 | GP Unattached Complex/High Needs Patient Attachment Fee | 200.00 |

The Unattached Complex/High Needs Patient Attachment fee ~~is intended to compensate for the often time consuming and intensive process of integrating a new patient with higher needs into a family physician's practice. This fee is paid in addition to the visit fee, and covers the~~. **It is intended to offset compensates for the time, intensity and complexity of** integrating a new **patient with high needs into a family physician's practice : the** longer initial meetings, organization of ~~the~~**a** medical record, ~~and organization and enactment of~~ **and initiation of** appropriate Clinical Action Plan(s) as discussed with the patient.

By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice.

**This fee is paid in addition to the visit fee**

Billing this incentive requires the accepting family physician to collate and review the relevant patient record to date and to meet with the patient to discuss this information and determine what supports will be needed to provide for the patient's ongoing medical needs, taking into account his/her personal goals of care. ~~By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice.~~ The patient populations eligible for this intake fee are:

- Frail in Care (CSHA Clinical Frailty Scale score of six or more in residential care – new admissions only with exceptions for extenuating circumstances such as sudden departure from practice of existing MRP FP)
- Frail in the Community (CSHA Clinical Frailty Scale score of six or more)
- Significant Cancer
- Moderate to High Needs Complex Chronic Conditions
- Severe Disability in the community
- Mental Health and/or Substance Use
- New Mother and Infant(s) (intake can occur at any time during pregnancy up to 18 months of age. Each mother/child(ren) dyad counts as one unit for the purpose of billing this fee code.)

When submitting G14074 for a new mother/baby dyad use **the mother's PHN and** diagnostic code 01N. For all other qualifying patients, use the diagnostic code for the most appropriate medical condition causing the complexity/high needs status.

***Notes:***

*xiii) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 ~~on the same or a prior date in the same calendar year~~. or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.*

*xiv) Payable only for unattached new patients who do not already have a family physician. Requests for attachment may come from: Acute Care (ER and Admitted); Mental Health-Substance Use workers/Clinics; Home and Community Care; BC Cancer Agency or Regional ~~Centres~~ **Centers**; Public Health; Colleagues; Local Division. **Only payable on patients who ~~have a~~are changing family physician if: the patient moves to a different community; the patient moves into a residential care/Long term care facility where the** current **family physician will no longer be responsible for the care; or, the patient's family physician ~~retires~~**leaves **the** practice **and another GP takes on one or some of the more complex patients but not the entire practice.**~~Patients who are already attached to a Family Physician in the same community are not eligible (i.e. Not for transfers between FPs unless moving to a new community).~~*

*xv) Source of request to attach the patient must be documented in the new patient chart.*

*xvi) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.*

*xvii) Payable in addition to office visit, home visit or residential care visit same day.*

*xviii) G14077 ~~GP Attachment Conference Fee~~ payable on same day for same patient if all criteria met.*

*xix) G14033 ~~Complex Care Management Fee~~, G14075 ~~GP Attachment Complex Care Management Fee~~, G14063 ~~Palliative Care Planning Fee~~ and G14043 ~~Mental Health Planning Fee~~ not payable on same day for same patient.*

*xx) Maximum **daily total of 5 of any combination of G14033 complex care, G14075) Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees** ~~of 5 complex care fees G14033 and/or G14075) per day~~ per physician.*

*xxi) Not payable for patients located in acute care.*

*xxii) G14015 ~~Facility Patient Conference Fee~~, G14016 ~~Community Patient Conference Fee~~ and G14017 ~~Acute Care Discharge Planning Fee~~ not payable*

*in addition, as these fees have been replaced by G14077 for ~~not payable to~~ FPs who have submitted the GP Attachment Participation Code. ~~Instead, these physicians should use G14077 GP Attachment Conference Fee.~~*

*xxiii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*xxiv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | $ |
|---|---|---|
| G14075 | GP Attachment Complex Care Management Fee | 315.00 |

The GP Attachment Complex Care Management Fee is advance payment for the ~~complexity~~ **complex work** of caring for patients with eligible conditions. ~~and~~ **It** is payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) ~~for the management of the complex care patient during that calendar year~~**as described below**.

This ~~initial expansion of the~~ Complex Care fee encompasses those patients with a qualifying diagnosis of Frailty as defined by a Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale score of six or more, indicating the patient is Moderately or Severely Frail.

A complex care plan requires documentation of the following elements in the patient's chart:

9. There has been a detailed review of the case/chart and of current therapies.
10. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the GP Attachment Complex Care Management Fee is billed.
11. Specifies a clinical plan for the care of that patient's chronic condition(s).
12. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic condition(s).
13. Outlines expected outcomes as a result of this plan, including any advance care planning for end-of-life issues when clinically appropriate.
14. Outlines linkages with other ~~health~~ **allied** care professionals that would be involved in the care, their expected roles.
15. Identifies an appropriate time frame for re-evaluation of the plan.
16. ~~Confirms~~ **Provides confirmation** that the care plan has been **created jointly and shared with the patient and/or the patient's medical representative and has been** communicated verbally or in writing to ~~the patient and/or the patient's medical representative, and to~~ other involved ~~health~~ **allied care** professionals as indicated.

The development of the care plan is done jointly with the patient and/or the patient representative as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

***Notes:***

*xvi) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 **or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071** on the same or a prior date in the same calendar year.*

*xvii) **Payable only for patients with documentation of confirmed CHSA frailty level 6 (moderate) or 7 (severe)***

*xviii) Claim must include the diagnostic code V15.*

*xix) Payable once per calendar year per patient **on the date of the complex care planning visit.***

*xx) **Documentation of the Complex Care Plan is required in patient's chart.***

*~~xxi) Applicable only to services submitted with diagnostic code V15 for the eligible patient population of frailty.~~*

~~xxii)~~xxi) Minimum required time 30 minutes to review chart and create the care plan jointly with the patient and/or their medical representative. ~~must be document in patient chart~~. The majority of the time must be face-to-face. ~~in addition to visit time same day~~. Documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required.

~~xxiii)~~xxii) Visit (in office or home) or CPx fee to indicate face-to-face interaction with patient same day must be billed for same date of service. Visit time does not count toward required planning time.~~accompany billing.~~

~~xxiv) Payable in addition to office visit or home visit same day.~~

~~xxv)~~xxiii) G14077 ~~GP Attachment Patient Conference Fee~~ payable on the same day for the same patient, for patients located in the community only as long term care facility patients are not eligible for 14075.

~~xxvi)~~xxiv) Maximum daily total 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees ~~of 5 complex care fees (G14033 and/or G14075 )and/or GP unattached complex/high needs patient attachment fees (G14074) per day~~ per physician.

xxv) G14075 not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

~~xxvii)~~xxvi) G14033 ~~GP Annual Complex Care Management Fee~~ is not payable in the same calendar year for same patient as G14075 ~~GP Attachment Complex Care Fee~~.

~~xxviii)~~xxvii) ~~Mental health, palliative care planning (~~G14043, G14063~~) or GP telephone management fees (~~G14076, G14079~~)~~ not payable on the same day for the same patient.

~~xxix)xxviii) G14079 Telephone/e-mail follow-up fee and G14076 Attachment Patient Telephone Management Fee not payable on the same day for the same patient.~~

xiii) G14015 ~~Facility Patient Conference Fee~~, G14016 ~~Community Patient Conference Fee~~ and G14017 ~~Acute Care Discharge Planning Fee~~ not payable in addition, as these fees ~~not payable to~~have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code. ~~Instead, these physicians should use G14077 GP Attachment Conference Fee.~~

xiv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

xv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

| | | $ |
|---|---|---|
| G14076 | GP Attachment Telephone Management Fee | 15.00 |

**Notes:**

xii) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.

xiii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied ~~health~~ care professionals (e.g.: Nurse, Nurse Practitioner) ~~working~~ employed within the eligible physician office.

xiv) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

xv) Not payable for simple prescription renewals, notification of office or laboratory appointments or of referrals.

xvi) Payable to a maximum of 1500 services per physician per calendar year.

xvii) G14077 ~~GP Attachment Patient Conference Fee~~ payable for same patient on same day if all criteria are met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14077.

xviii)Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077.

xix) *Not payable on the same calendar day as ~~the GP Telephone/e-mail fee~~ G14079.*

xx) *G14015 ~~Facility Patient Conference Fee~~, G14016 ~~Community Patient Conference Fee~~ and G14017 ~~Acute Care Discharge Planning Fee~~ not payable in addition, as these fees ~~not payable to~~**have been replaced by G14077 for** FPs who have submitted the GP Attachment Participation Code. ~~Instead, these physicians should use G14077 GP Attachment Conference Fee.~~*

xxi) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

xxii) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | $ |
|---|---|---|
| G14077 | GP Attachment Patient Conference Fee - per 15 minutes or greater portion thereof | 40.00 |

***Notes:***

xv) *Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070* ***or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071*** *on the same or a prior date in the same calendar year.*

xvi) *Payable only to the Family Physician ~~that~~ **who** has accepted the responsibility of being the Most Responsible Physician for that patient's care.*

xvii) ***Payable for two-way collaborative conferencing, either by telephone or in person, between the family physician and at least one other allied care provider(s). Conferencing cannot be delegated.*** *Details of the ~~Care~~ Conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.*

xviii) *Conference to include the clinical and social circumstances relevant to the delivery of care.*

xix) *Not payable for situations where the purpose of the call is to:*

- *f. book an appointment*
- *g. arrange for an expedited consultation or procedure*
- *h. arrange for laboratory or diagnostic investigations*
- *i. inform the referring physician of results of diagnostic investigations*
- *j. arrange a hospital bed for the patient*

xx) *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

xxi) *Payable in addition to any visit fee on the same day if medically required and does not take place concurrently with the patient conference. (i.e. Visit is separate from conference time).*

xxii) *Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.*

xxiii) *The claim must state start and end times of the service.*

xxiv) *Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.*

xxv) *Not payable for simple advice to a non-physician allied ~~health~~ care professional about a patient in a facility.*

xxvi) *Not payable in addition to G14015 ~~GP Facility Patient Conference Fee~~, G14016 ~~Community Patient Conference Fee~~ or G14017 ~~Acute Care Discharge Planning Conference Fee~~ as these fees are replaced by G14077 for those Family Physicians who have submitted the GP Attachment Participation code.*

xxvii) ~~*These payments are not available*~~***Not payable*** *to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have participated in the conference as a requirement of their employment.*

xxviii) ~~*They are also not available*~~***Not payable*** *to physicians who are working under salary, service contract or sessional arrangements who would otherwise have participated in the conference as a requirement of their employment.*

**Appendix 11 –** Section 11. GPSC Incentives for In-Patient Care

Strikethrough is deleted; bold is added.

## 11. GPSC Incentives for In-patient Care

The GPSC In-patient Initiative was developed to recognize and better support the continuous relationship with a family physician (FP) that can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. An important aspect of such continuous care is the coordination of care through the in-patient journey as well as in transitions between hospital and community FP offices. There are two separate levels of incentives aimed at better supporting and compensating FPs who provide this important aspect of care. This initiative will support family physicians who:

- Provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned In-patients); and may also
- As part of a network, provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned In-patients).

To participate in the GPSC In-patient Initiative, it is expected that these FPs agree to the following expectations:

A. They are members of the active or equivalent medical staff category and have hospital privileges in the identified acute care hospital.

B. That their on-call colleagues (Network) are also members of the active or equivalent medical staff category and have hospital privileges.

C. That they will:

- Coordinate and manage the care of hospitalized patients (assigned &/or unassigned), admitted under them as the MRP.
- Provide supportive care when their hospitalized patient is admitted under a specialist as MRP.
- See all acute patients under their MRP care on a daily basis and document a progress note in the medical record.
- Work with the interdisciplinary team, as appropriate, to develop a care plan and a plan for discharge.
- When care is transferred to another physician, ensure that this is documented in the medical record and ensure there is a verbal or written handover plan provided to the accepting physician.
- Ensure availability through their network to expedite discharges of patients daily during the normal working day which includes early morning, daytime, and early evening.
- On weekends ensure the covering physician is made aware of those discharges that could occur over the weekend.
- Provide a discharge note to an unassigned in-patient for their FP or communicate directly with the FP on discharge.
- Respond to requests from members of the interdisciplinary in-patient care team by phone as per hospital bylaws.
- The Network Call Group will accept responsibility for their newly admitted in-patients on a 24/7/365 basis. The MRP shall assess and examine the patient, document findings and issue applicable orders as soon as warranted by the patient's needs, but in any case no longer than 24 hours after accepting the transfer. Utilization needs within the facility may dictate that the patient must be seen sooner.

D. The non-clinical services include the already existing expectations of FPs as outlined in the Health Authority Medical Staff bylaws, rules and regulations, and policies. The health authority, the

**Department of Family Practice, the Division of Family Practice (where it exists) and the In-patient Care Networks could reasonably expect that all parties would participate in discussions which could include:**

- **The orderly transitions of MRP status between specialists and generalists.**
- **Participating in the orderly discharge planning of generally more complicated patients.**
- **Patient safety concerns that come up in local hospitals.**
- **Identifying and providing input into "local hassle factors" that would need to be examined and resolved at a local level between the local division of family practice and health authorities.**
- **Participate in utilization management within the hospital.**
- **Patient care improvement discussions that would reasonably be covered under the improved FP hospital care incentives.**

G14086 GP Assigned Inpatient Care Network Initiative..... 2100.00

**Eligibility:**
To be eligible to be a member of ~~the a~~ GP Assigned Inpatient Care Network, you must meet the following criteria:

- Be a Family Physician in active practice in B.C.
- Have active hospital privileges.
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing inpatient care – see below).
- Submit a completed Assigned Inpatient Care Agreement Form.
- Submit a completed Assigned Inpatient Care Network Registration Form.
- Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.
- Each doctor must provide MRP care to at least 24 admitted patients over the course of a year; networks may average out this number across the number of members.

This network incentive is payable in addition to visit fees, ~~and~~ **but** is inclusive of ~~services for~~ time spent in associated Quality Improvement activities **necessary to maintain privileges** such as M and M rounds ~~necessary to maintain privileges~~ as well as time spent on network administration, etc.

Exemptions for communities where it may be difficult to achieve the minimum volume of MRP inpatient cases will be considered by the GPSC Inpatient Care Working Group.

**The GP Assigned In-patient Care Network Incentive is payable for participation in the network activities for the majority of the following calendar quarter (50% plus 1 day).** Once your registration in the network has been confirmed, submit fee item G14086 GP Assigned in-patient care network fee using the following billing specifics:

**Billing Schedule: First day of the month, per calendar quarter (January 1, April 1, July1, October 1) and is paid for the subsequent quarter**~~For date of service use: April 1, 2013, July 1, 2013, October 1, 2013, January 1, 2014 Billing Schedule: First day of the month, per calendar quarter~~
ICD9 code : 780

Your location will determine which PHN# to use:

Interior Health Authority:
PHN# 9752590587
Patient Surname: Assigned
First Name: IHA
Date of birth: January 1, 2013

Fraser Health Authority:
PHN# 9752590548
Patient Surname: Assigned
First Name: FHA
Date of birth: January 1, 2013

Vancouver Coastal Health Authority:
PHN# 9752590523
Patient Surname: Assigned
First Name: CVHA (note first name starts with 'C')
Date of birth: January 1, 2013

Vancouver Island Health Authority:
PHN# 9752590516
Patient Surname: Assigned
First Name: VIHA
Date of birth: January 1, 2013

Northern Health Authority:
PHN# 9752590509
Patient Surname: Assigned
First Name: NHA
Date of birth: January 1, 2013

| | | $ |
|---|---|---|
| G14088 | GP Unassigned Inpatient Care Fee ..... | 150.00 |

The term "Unassigned Inpatient" is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted.

The GP Unassigned Inpatient Care Fee is designed to provide an incentive for Family Physicians to accept Most Responsible Physician status for **an unassigned**~~that~~ patient's hospital stay**. It is intended** ~~, and~~ to compensate the Family Physician for the extra time and intensity **required to evaluate**~~necessary to evaluating~~ an unfamiliar patient's clinical status and care needs **when the patient is admitted and is only billable once per hospital admission**.

This fee is restricted to Family Physicians actively participating in the GP Unassigned Inpatient Care or the GP Maternity Networks. This fee is billable through the MSP Teleplan system **and is payable in addition to the hospital visit (00109, 13008, 00127) or delivery fee**.

***Notes:***

*i) Payable only to Family Physicians who have submitted a completed GP Unassigned Inpatient Care Network Registration Form and/or a GP Maternity Network Registration Form.*

*ii) Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.*

*iii) Payable once per unassigned patient per in-hospital ~~admissio~~**admission -in addition to the hospital visit (00109, 13008, 00127) or delivery fee.** ~~n~~*

*iv) ~~Payable in addition to hospital visit fee on same day.~~Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

v) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

BRITISH COLUMBIA

# MEDICAL SERVICES COMMISSION



17 - 136

**Amendment to the Medical Services Commission Payment Schedule**
**General Practice Services Committee Funded Fee Items**

Pursuant to the 2014 Physician Master Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

**Amendment:**
Clarification of living in the community is added to the GPSC preamble (bold type) effective July 1, 2017.

GPSC Initiated Listings
The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

Unless otherwise identified in the individual fee description, physicians are eligible to participate in the incentive program if they are:

A general practitioner who has a valid BC MSP practitioner number;
Currently in general practice in BC as a full service family physician;
The most responsible general practitioner for the majority of the patient's longitudinal general practice care; and
Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

Additional detailed eligibility requirements are identified in each section.

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g.: Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

For the purposes of its incentives, GPSC defines Physicians working on Alternative Payment Program (APP) as those working under Health Authority paid APP contracts. Agreements to pool FFS billings and pay out physicians in a mutually acceptable way (e.g.: per day, per shift, per hour, etc.) are not considered APP by GPSC. If services supported and paid through GPSC incentives are already included in a sessional, salary or service contract then they are not billable in addition.

For the purpose of its incentives, GPSC defines a General Practitioner (GP) with specialty training as: "A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program".

For the purposes of its incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Physicians; Nurses; Nurse Practitioners; Mental Health Workers; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.

For the purpose of its incentives, GPSC defines Patient's Medical Representative as outlined in the "Health Care (Consent) and Care Facility (Admission) Act"

Representative means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative.

Temporary Substitute decision makers (Alternate Representative) in listed order, of the following who is available and qualifies under subsection 16(2):

(a) the adult's spouse
(b) the adult's child
(c) the adult's parent
(d) the adult's brother or sister
(d.1) the adult's grandparent
(d.2) the adult's grandchild
(e) anyone else related by birth or adoption to the adult
(f) a close friend of the adult
(g) a person immediately related to the adult by marriage

For the purpose of its incentives when referring to assisted living, GPSC utilizes the ministry definition as found at:
http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living

**For the purpose of its incentives, GPSC considers patients living in group homes to be living in community.**

**Amendment:**
GPSC fee items G14074 and G14079 are cancelled as of September 30, 2017.

~~G14074 GP Unattached Complex/High Needs Patient Attachment Fee ..... 200.00~~
~~The Unattached Complex/High Needs Patient Attachment fee compensates for the time, intensity and complexity of integrating a new patient with high needs into a family physician's practice: the longer initial meetings, organization of the medical record, and initiation of appropriate Clinical Action Plan(s) as discussed with the patient.~~

~~By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice. Once accepted into the practice, patients become eligible for other GPSC incentives provided they meet all eligibility criteria.~~

~~This fee is paid in addition to the visit fee~~

~~Billing this incentive requires the accepting family physician to collate and review the relevant patient record to date and to meet with the patient to discuss this information and determine what supports will be needed to provide for the patient's ongoing medical needs, taking into account his/her personal goals of care. The patient populations eligible for this intake fee are:~~

~~o Frail in Care (Moderate or severe frailty in residential care – new admissions only with exceptions for extenuating circumstances such as sudden~~

departure from practice of existing MRP FP)
- Frail in the Community (Moderate or severe frailty)
- Significant Cancer
- Moderate to High Needs Complex Chronic Conditions
- Severe Disability in the community
- Mental Health and Substance Use
- New Mother and Infant(s) (intake can occur at any time during pregnancy up to 18 months of age. Each mother/child(ren) dyad counts as one unit for the purpose of billing this fee code.

When submitting G14074 for a new mother/baby dyad use the mother's PHN and diagnostic code 01N. For all other qualifying patients, use the diagnostic code for the most appropriate medical condition causing the complexity/high needs status.

***Notes:***

*i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.*

*ii) Payable only for unattached new patients who do not already have a family physician. Requests for attachment may come from: Acute Care (ER and Admitted); Mental Health-Substance Use workers/Clinics; Home and Community Care; BC Cancer Agency or Regional Centers; Public Health; Colleagues; Local Division. Only payable on patients who are changing family physician if: the patient moves to a different community; the patient moves into a residential care/Long term care facility where the current family physician will no longer be responsible for the care; or, the patient's family physician leaves practice and another GP takes on one or some of the more complex patients but not the entire practice.*

*iii) Source of request to attach the patient must be documented in the new patient chart.*

*iv) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.*

*v) Payable in addition to office visit, home visit or residential care visit same day.*

*vi) G14077 payable on same day for same patient if all criteria met.*

*vii) G14033, G14075, G14063 and G14043 not payable on same day for same patient.*

*viii) Maximum daily total of 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.*

*ix) Not payable for patients located in acute care.*

*x) G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.*

*xi) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*xii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

**GP Telephone/Email follow-up Management Fee**

In order to encourage non-face-to-face communication with patients covered by some of the GPSC incentives, patients covered by one or more of the planning related incentives are eligible for five telephone/email services per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.

G14079 GP Telephone/Email Management Fee ..... 15.00
This fee is payable for two-way communication with eligible patients, or the patient's medical representative, via telephone or email by the GP who has billed and been paid for at least one of the following GPSC incentives:
Complex Care Planning Fee (G14033)

~~Mental Health Planning Fee (G14043)~~
~~Annual Chronic Care Bonus for COPD (G14053)~~
~~Palliative Care Planning Fee (G14063)~~
~~Attachment Complex Care Management Fee (G14075)~~
~~This fee is billable for medical management of the conditions covered under the initial planning/Chronic Care fee. This fee is not to be billed for simple appointment reminders or referral notification.~~

~~***Notes:***~~

~~*i) Payable to a maximum of 5 times per patient per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.*~~

~~*ii) Telephone/Email Management requires two-way communication between the patient or the patient's medical representative and physician or medical office staff for the purpose of medical management of the relevant chronic condition(s); it is not payable for simple notification of office or laboratory appointments or of referrals.*~~

~~*iii) Payable only to the physician paid for the G14033, G14043, G14053, G14063 or G14075 unless that physician has agreed to share care with another delegated physician. To facilitate payment, a note record should be submitted by the delegated physician.*~~

~~*iv) G14077 or G14016 payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for G14077 or G14016.*~~

~~*v)* Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077 or G14016.~~

~~*vi) Not payable on same day for same patient as G14076 GP Attachment Patient Telephone Management Fee.*~~

~~Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.~~

**Amendment:**
New fee items, description changes (bold type), deletions (strikethrough) and note renumbering are effective October 1, 2017.

**1. Expanded Full Service Family Practice Condition-based Payments**

The GPSC Condition-based Payments compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full year. The goal is to improve provision of clinically appropriate care that considers both the patient's values and the impact of comorbidities. To confirm an ongoing doctor-patient relationship, there must be at least 2 visit**s**~~. fees (office; prenatal; home; long term care; only~~ **Office, prenatal, home, long term care visits qualify**. Oone of ~~which can~~ **the two visits may** be a GPSC Telephone Visit (G14076, G14079 **prior to October 2017**),~~ or~~ Group Medical Visit (13763 -13781) **or an in person visit with a college certified allied health provider working within the family physicians practice (G14029)** billed on each qualifying patient in the 12 months prior to billing the CDM incentive. Visits provided by a locum **or colleague covering** for the MRP GP are included; however, an electronic note indicating this must be submitted with the claim. Patients in long-term care facilities are eligible. Clinical judgment must be used to determine the appropriateness of following clinical practice guidelines in all patients, particularly those with dementia or very limited life expectancy. Documentation of the provision of guideline-informed care for the specific condition is required in the medical record. Although use of the GPAC Chronic Care flow sheets is not mandatory, they are a useful tool for tracking care provided to patients over time. Condition-based payments are no longer payable once G14063, the Palliative Planning Incentive has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

Patient self-management can be defined as the decisions and behaviors that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. An important part of this support is the provision of tools by the family physician that can enable patients to make appropriate choices and sustain healthy behaviors. There are a variety of tools publically available (e.g.: health diaries/passports, etc.) to help build the skills and confidence patients need to improve management of their chronic conditions and potentially improve outcomes. Documentation in the patient chart of the provision of patient self-management supports as part of the patient's chronic disease management is expected.

When a new GP assumes the practice of another GP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fee is billable on its anniversary date provided the new GP has continued to provide guideline-informed care for these patient(s). To demonstrate continuity, if some of the required visits have been provided by the previous GP, an electronic note indicating continuity of care over the full 12 months is required at the time of the initial submission of the CDM fee by the new GP.

| | | **Total Fee $** |
|---|---|---|
| G14050 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (diabetes mellitus)..... | 125.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.*

*iii) This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076, G14079 -prior to October 2017) or*
2. *a group medical visit (13763-13781) **or***
3. ***an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*** *~~This visit requirement excludes procedures, laboratory and X-ray services.~~*

*iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14250.*

*v) Claim must include the ICD-9 code for diabetes (250).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Payable in addition to fee items G14051 or G14053 for same patient if eligible.*

*viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

*ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

| | | **Total Fee $** |
|---|---|---|
| G14051 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (heart failure)..... | 125.00 |

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.*

iii) *This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*
   1. *a telephone visit (G14076, G14079**-prior to October 2017**) or*
   2. *a group medical visit (13763-13781) **or***
   3. ***an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*** *~~This visit requirement excludes procedures, laboratory and X-ray services.~~*

iv) *Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14251.*

v) *Claim must include the ICD-9 code for heart failure (428).*

vi) *Payable once per patient in a consecutive 12 month period.*

vii) *Payable in addition to items G14050 or G14053 for the same patient if eligible.*

viii) *Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

ix) *If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

G14052 Incentive for Full Service General Practitioner
- annual chronic care incentive (hypertension)..... 50.00

***Notes:***

i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

ii) *Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.*

iii) *This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*
   1. *a telephone visit (G14076, G14079**-prior to October 2017**) or*
   2. *a group medical visit (13763-13781) **or***
   3. ***an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*** *~~This visit requirement excludes procedures, laboratory and X-ray services.~~*

iv) *Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14252.*

v) *Claim must include the ICD-9 code for hypertension (401).*

vi) *Payable once per patient in a consecutive 12 month period.*

vii) *Not payable if G14050, G14250, G14051, G14251 paid within the previous 12 months.*

viii) *Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

ix) *If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

**Total Fee $**

G14053 Incentive for Full Service General Practitioner
- annual chronic care incentive (Chronic Obstructive Pulmonary Disease-COPD)..... 125.00

***Notes:***

i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

ii) *Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.*

iii) *This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076, G14079-**prior to October 2017**) or*
2. *a group medical visit (13763-13781) **or***
3. ***an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.** ~~This visit requirement excludes procedures, laboratory and X-ray services.~~*

iv) *Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14253.*

v) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*

vi) *Payable once per patient in a consecutive 12 month period.*

vii) *Payable in addition to fee items G14050, G14051 or G14052 for the same patient if eligible.*

viii) *Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

ix) *If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

~~Successful billing of the Annual Chronic Care Bonus for COPD (G14053) allows access to 5 Telephone/Email follow-up fees (G14079) per calendar year over the following 18 months.~~

**Allied Care Provider Code**

**Chronic Care Incentives – Practitioners under Alternate Payment Program**

Use the following CDM incentives if the required two visits were billed as an encounter record while working under salary, service contract or sessional arrangement. Post review will be performed within 2 years and recoveries made if encounter records were not submitted for the required visits.

G14250 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus) ..... 125.00

***Notes:***

i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

ii) *Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.*

iii) *This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076, G14079-**prior to October 2017**) or*
2. *a group medical visit (13763-13781) **or***
3. ***an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.** ~~This visit requirement excludes procedures, laboratory and X-ray services.~~*

iv) *Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.*

v) *Claim must include the ICD-9 code for diabetes (250).*

vi) *Payable once per patient in a consecutive 12 month period.*

vii) *Payable in addition to fee items G14051, G14251~~0~~, G14053 or G14253 for same patient if eligible.*

*viii) Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*
*ix) A visit may be provided on the same date the incentive is billed.*

**Total Fee $**

G14251 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (heart failure) ..... 125.00

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*
*ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.*
*iii) This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*
    *1. a telephone visit (G14076, G14079-**prior to October 2017**) or*
    *2. a group medical visit (13763-13781) **or***
    ***3. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*** *~~This visit requirement excludes procedures, laboratory and X-ray services.~~*
*iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.*
*v) Claim must include the ICD-9 code for heart failure (428).*
*vi) Payable once per patient in a consecutive 12 month period.*
*vii) Payable in addition to items G14050, 14250,G14053 or G14253 for the same patient if eligible*
*viii) Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*
*ix) A visit may be provided on the same date the incentive is billed.*

G14252 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (hypertension)..... 50.00

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*
*ii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.*
*iii) This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*
    *1. a telephone visit (G14076, G14079-**prior to October 2017**) or*
    *2. a group medical visit (13763-13781) **or***
    ***3. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*** *~~This visit requirement excludes procedures, laboratory and X-ray services.~~*
*iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.*

v) *Claim must include the ICD-9 code for hypertension (401).*
vi) *Payable once per patient in a consecutive 12 month period.*
vii) *Not payable if G14050, G14250, G14051 or G14251 paid within the previous 12 months.*
viii) *Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*
ix) *A visit may be provided on the same date the incentive is billed.*

| | | Total Fee $ |
|---|---|---|
| G14253 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD) | 125.00 |

***Notes:***

i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*
ii) *Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.*
iii) *This item may only be billed after one year of care has been provided ~~and the patient has been provided~~ including at least two visits. ~~in the preceding 12 months.~~ Office, prenatal, home, long term care visits qualify. One of the two visits may be:*
    1. *a telephone visit (G14076, G14079-**prior to October 2017**) or*
    2. *a group medical visit (13763-13781) **or***
    3. ***an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*** *~~This visit requirement excludes procedures, laboratory and X-ray services.~~*
iv) *Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.*
v) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*
vi) *Payable once per patient in a consecutive 12 month period.*
vii) *Payable in addition to fee items G14050, G14250, G14051, G14251, G14052, G14252 for the same patient if eligible.*
viii) *Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.*
ix) *A visit may be provided on the same date the incentive is billed.*

**Allied Care Provider Code**

**To support team based care Allied Care Providers may provide one of the visits required for GPSC chronic disease management. Submission of this $0.00 code by the FP indicates an in person visit was provided by a college certified Allied Care Provider.**

**G14029 Allied Care Provider Practice Code ..... 0.00**

***Notes:***

i) ***Only billable by the family physician who has submitted Code G14070/G14071 and who is most responsible for the majority of the patient's longitudinal general practice care.***
ii) ***Applicable only for in-person medical services (office, home or LTC) provided by a college certified allied care provider working within the family physician's practice where the family physician has accepted responsibility for the provision of the care.***

*iii) **Not billable when the patient has had a service provided and billed by the family physician.***

*iv) **Billable on patients receiving guideline informed care who will be eligible for one of the chronic disease management incentives (CDM's).***

## 2. Conference Fees

### Facility Patient Conference Fee

G14015 General Practice Facility Patient Conference: when requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient with complex supportive care needs in a facility can safely return to the community or transition to a supportive or long-term facility - per 15 minutes or greater portion thereof ..... 40.00

***Notes:***

*i) Refer to Table 1 (below) for eligible patient populations.*

*ii) Must be performed in the facility and results of the conference must be recorded in the patient chart.*

*iii) Payable only for patients in a facility. Facilities limited to: hospital, palliative care facility, LTC facility, rehab facility, sub-acute facility, psychiatric facility, detox/drug and alcohol facility).*

*iv) Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any allied care provider charged with coordinating discharge and follow-up planning.*

*v) Requires interdisciplinary team meeting of at least 2 allied care **providers** ~~professionals~~ in total, and will include family members when available.*

*vi) Fee includes:*

- *a. Where appropriate, interviewing of and conferencing with patient, family members, and other allied care providers of both the acute care facility and community.*
- *b. Review and organization of appropriate clinical information.*
- *c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*
- *d. The care plan must be recorded and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*vii) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*

*viii) **Start and end times must be included with the claim and documented in the patient chart**. ~~Claim must state start and end times of the service. Start and end times must be documented in the patient chart.~~*

*ix) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

*~~x)~~ x)Not payable to physicians who **have submitted G14070 or G14071.** ~~are participating in the GPSC attachment initiative (G14070).~~*

*xi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

*xii) Not payable on the same day for the same patient **as** fee item G14016, G14017, **G14018,** G14033, G14043, G14063, ~~G14074,~~ G14075, G14076 ,~~or~~ G14077 **or G14078**.*

*xiii) Visit payable in addition if medically required and does not take place concurrently with the patient conference. Medically required visits performed consecutive to the Facility Patient Conference are payable. (i.e. Visit is separate from conference time).*

**Total Fee $**

**Community Patient Conference Fee**

G14016 General Practice Community Patient Conference Fee - per 15 minutes or greater portion thereof ..... 40.00

Payable for two-way collaborative conferencing about the care of the community- based patients with more complex needs, either by telephone or in person, between the family physician and at least one other ~~health~~ allied care provider.

***Notes:***

*i) Refer to Table 1 (below) for eligible patient populations.*

*ii) Fee is billable for conferences that occur as a result of care provided in the following community locations for patients who are resident in the community:*

- *Community GP Office*
- *Patient Home*
- *Community placement agency*
- *Disease clinic (DEC, arthritis, CHF, Asthma, Cancer or other palliative diagnoses, etc.*
- *Assisted living*

*iii) Fee includes:*

*a. Two-way collaborative conferencing, either by telephone or in person, between the family physician and at least one other allied care provider(s). Conferencing cannot be delegated.*

*b. Review and organization of appropriate clinical information.*

*c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient **in the community** ~~upon discharge from the acute care facility~~, including provision of Degrees of intervention and end of life documentation as appropriate.*

*d. The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*iv) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*

*v) **Start and end times must be included with the claim and documented in the patient chart.** ~~Claim must state start and end times of service. Start and end times must be documented in the patient chart.~~*

*vi) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

*vii) Not payable to physicians who ~~are participating in the GPSC attachment initiative~~ **have submitted** ~~(G14070)~~ **or G14071**.*

*viii) Not payable to the same patient on the same date of service as fee item G14015, G14017,**G14018,** ~~G14074,~~ G14075, G14076 ~~or~~ G14077 **or G14078**.*

*ix) Not payable to physicians who are employed by, or who are under contract to a facility, who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

*x) Visit payable in addition if medically required and does not take place concurrently with clinical action plan.*

**Total Fee $**

**Acute Care Discharge Conference Fee**

G14017 General Practice Acute Care Discharge Conference fee - per 15 minutes or greater portion thereof ..... 40.00

In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to the most responsible GP for that patient following discharge from the acute care facility. This fee is billable when a Discharge Planning Conference is performed upon the request of either an Acute Care facility, or by the GP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.

***Notes:***

*i) Refer to Table 1 for eligible populations.*

*ii) Payable only for patients being discharged from an acute care facility to the community or to a different facility; another acute care facility, or a supportive care or Long Term Care facility.*

*iii) Must be performed in the acute care facility and results of the conference must be recorded in the patient's chart in the acute care facility and the receiving GP's office chart (or receiving facility's chart in the case of inter-facility transfer).*

*iv) Face-to-face conferencing is required; the only exception is if a patient is being discharged from an acute care facility in a different community, and a chart notation must be made to indicate this circumstance.*

*v) Requesting care providers limited to: Facility-affiliated physicians and nurses, GP assuming MRP status upon patient's discharge, care coordinators, liaison nurses, rehab consultants, social workers, and any allied care provider charged with coordinating discharge and follow-up planning.*

*vi) Requires interdisciplinary team meeting of the GP assuming MRP status upon discharge and a minimum of 2 other allied care ~~professionals~~ **providers** as enumerated above, and will include family members when appropriate.*

*vii) Fee includes:*

- *a. Where appropriate, interviewing of and conferencing with patient, family members, and other allied care providers of both the acute care facility and community.*
- *b. Review and organization of appropriate clinical information.*
- *c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of degrees of intervention and end of life documentation as appropriate.*
- *d. The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*viii) This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses during the course of a patient's stay in the acute care facility.*

*ix) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*

*x) **Start and end times must be included with the claim and documented in the patient chart.** ~~Claim must state start and end times of the service. Start and end times must be documented in the patient chart.~~*

*xi) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

*xii) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

*xiii) Medically required visits performed consecutive to the Acute Care Discharge Conference are payable (i.e. Visit is separate from conference time).*

*xiv) Submit fee item G14017 through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders.*

*xv) Not payable to physicians who **have submitted G14070 or G14071.** ~~are participating in the GPSC attachment initiative (G14070).~~*

*xvi) Not payable to the same patient on the same date of service as fee item G14015, G14016, **G14018,** ~~G14074,~~ G14076, ~~or~~ G14077 **or G14078** .*

*xvii) Not payable on the same day as any GPSC planning fees (G14033, G14075, G14043, G14063.*

*Table 1:* ***Eligible patient populations for the Facility Patient, Community Patient and Acute Care Discharge Conference Fees***

i. **Frail elderly (ICD-9 code V15)**

Patient over the age of 65 years with at least 3 out of the following factors:

- Unintentional weight loss (10 lbs in the past year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow gait speed (decreased balance and motility)
- Low levels of physical activity (slowed performance and relative inactivity)
- Incontinence
- Cognitive impairment

ii. **Palliative care (ICD-9 code V58)**

Patient of any age who:

- Is living at home ("Home" is defined as wherever the person is living, whether in their own home, living with family or friends, or living in an assisted living residence or hospice); and
- Has been diagnosed with a life-threatening illness or condition; and
- Has a life expectancy of up to six months; and
- Consents to the focus of care being palliative rather than treatment aimed at cure.

iii. **End of life (ICD-9 code V58)**

Patient of any age:

- Who has been told by their physician that they have less than six months to live; or
- With terminal disease who wish to discuss end of life, hospice or palliative care.

iv. **Mental illness**

Patient of any age with any of the following disorders is considered to have mental illness:

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Personality Disorders
- Sleep Disorders
- Developmentally Delayed, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders
- Sexual Dysfunction
- Dissociative Disorders
- Mental Disorders due to a General Medical Condition
- Factitious Disorder

*Definitions and the management of these mental disorders are defined in the Manual: Management of Mental Disorders, Canadian Edition, Volume One and Two, edited by Dr. Elliot Goldner, Mental Health*

*Evaluation and Community Consultation Unit, University of British Columbia.*

*Definitions for Delirium, Dementia and Other Cognitive Disorders; Developmental Disabilities; Dissociative Disorders; Mental Disorders due to a General Medical Condition and Factitious Disorder are found in the Diagnostic and Statistical Manual of Mental Disorders - DSM-IVR.*

**v. Patients of any age with multiple medical needs or complex co-morbidity**

Patients of any age with multiple medical conditions or co-morbidities (two or more distinct but potentially interacting problems) where care needs to be coordinated over a period of time between several health disciplines. On your claim form use the code for one of the major disorders.

**General Practice Urgent Telephone Conference with a Specialist Fee**

The intent of this initiative is to improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers.

This fee is billable when the severity of the patient's condition justifies urgent conference with a specialist or GP with specialty training, for the development and implementation of a care plan within the next 24 hours to keep the patient stable in their current environment

This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

| | | Total Fee $ |
|---|---|---|
| G14018 | General Practice Urgent Telephone Conference with a Specialist Fee: Conferencing on an urgent basis (within 2 hours of request for a telephone conference) with a specialist or GP with specialty training by telephone followed by the creation, documentation, and implementation of a clinical action plan for the care of patients with acute needs; i.e. requiring attention within the next 24 hours and communication of that plan to the patient or patient's representative | 40.00 |

***Notes:***

*i) Payable to the GP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or GP with specialty training regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.*

*ii) A GP with specialty training is defined as a GP who:*
- *a. Provides specialist services in a Health Authority setting and is acknowledged by the Health Authority as acting in a specialist capacity and providing specialist services;*
- *b. Has not billed another GPSC fee item on the patient in the previous 18 months; Telephone advice must be related to the field in which the GP has received specialty training.*

*iii) Conversation must take place within two hours of the GP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, email).*

*iv) Fee includes:*
- *a. Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*
- *b. Developing, documenting and implementing a plan to manage the patient safely in their care setting.*
- *c. Communication of the plan to the patient or the patient's representative.*
- *d. The care plan must be recorded in the patient chart and must include patient identifiers, reason for the care plan, list of comorbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

*v) Not payable to the same patient on the same date of service as fee items G14015, G14016, G14017 or G14077.*

vi) *Not payable to physicians who are employed by, or who are under a contract to a facility, who would otherwise have provided the service as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangement.*
vii) *Include start time in time fields when submitting claim.*
viii) *Not payable for situations where the primary purpose of the call is to:*
   a. *Book an appointment*
   b. *Arrange for transfer of care that occurs within 24 hours*
   c. *Arrange for an expedited consultation or procedure within 24 hours*
   d. *Arrange for laboratory or diagnostic investigations*
   e. *~~Inform the other physician of~~* ***Convey the*** *results of diagnostic investigations*
   f. *Arrange a hospital bed for the patient*
   g. *Obtain non-urgent advice for patient management (i.e. not required within the next 24 hours).*
ix) *Limited to one claim per patient per physician per day.*
x) *Out-of-Office Hours Premiums may not be claimed in addition.*
xi) *Maximum of 6 (six) services per patient, per practitioner per calendar year.*
xii) *Payable in addition to a visit on the same day.*

**GP – Advice to Nurse Practitioner Fee**

The intent of this fee is to support collaboration between nurse practitioners and community family physicians. This fee is billable when providing advice by telephone or in person to a Nurse Practitioner who is an independent practitioner providing care to patients under his/her MRP care. This fee is not billable when the patient is attached to a GP.

| | | **Total Fee $** |
|---|---|---|
| G14019 | GP - Advice fee to a Nurse Practitioner – Telephone or In Person ..... | 40.00 |

***Notes:***

i) *Payable for advice by telephone or in person, in response to request from a Nurse Practitioner (NP) in independent practice on patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care.*
ii) *Excludes advice to an NP about patients who are attached to the GP.*
iii) *Payable for advice regarding assessment and management by the NP and without the responding physician seeing the patient.*
iv) *Not payable for written communication (i.e. fax, letter, email).*
v) *A chart entry, including advice given and to whom, is required.*
vi) *NP Practitioner number required in referring practitioner field when submitting fee through teleplan.*
vii) *Not payable for situations where the purpose of the call is to:*
   a. *book an appointment*
   b. *arrange for transfer of care that occurs within 24 hours*
   c. *arrange for an expedited consultation or procedure within 24 hours*
   d. *arrange for laboratory or diagnostic investigations*
   e. *~~inform the referring physician of~~* ***Convey the*** *results of diagnostic investigations*
   f. *arrange a hospital bed for the patient*
viii) *Limited to one claim per patient per day with a maximum of 6 claims per patient per calendar year.*
ix) *Limit of five (5) G14019 may be billed by a GP on any calendar day.*
x) *Not payable in addition to another service on the same day for the same patient by same GP.*
xi) *Out-of-Office Hours Premiums may not be claimed in addition.*
xii) *Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.*
xiii) *Not payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment.*

| | | Total Fee $ |
|---|---|---|
| G14077 | GP ~~Attachment Patient~~ **Allied Care Provider** Conference Fee - per 15 minutes or greater portion thereof | 40.00 |

***Notes:***

*i) Payable only to Family Physicians who have successfully:*
- *a) Submitted ~~the GP Attachment Participation Code~~ G14070 or on behalf of Locum Family Physicians who have successfully submitted ~~the GP Locum Attachment Participation Code~~ G14071 on the same or a prior date in the same calendar year; or*
- *b) Registered in a Maternity Network or GP unassigned In-patient network on a prior date.*

*ii) Payable only to the Family Physician who has accepted the responsibility of being the Most Responsible Physician for that patient's care.*

*iii) Payable for two-way collaborative conferencing, either by telephone, **videoconferencing** or in person, between the family physician and at least one other ~~physician or~~ allied care provider(s). Conferencing cannot be delegated. Details of the Conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference,role(s) in care, and information on clinical discussion and decisions made.*

*iv) Conference to include the clinical and social circumstances relevant to the delivery of care.*

*v) Not payable for situations where the purpose of the call is to:*
- *a. book an appointment*
- *b. arrange for an expedited consultation or procedure*
- *c .arrange for laboratory or diagnostic investigations*
- *d. ~~inform the referring physician of~~ **Convey the** results of diagnostic investigations*
- *e. arrange a hospital bed for the patient*

*vi) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*

*vii) Payable in addition to any visit fee on the same day if medically required and does not take place concurrently with the patient conference. (i.e. Visit is separate from conference time).*

*viii) Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.*

*ix) **Start and end times must be included with the claim and documented in the patient chart.** ~~The claim must state start and end times of the service. Start and end timesmust also be documented in the patient chart.~~*

*x) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.*

*xi) Not payable for simple advice to a non-physician allied care **provider** ~~professional~~ about a patient in a facility.*

*xii) Not payable in addition to G14015, G14016, ~~or~~ G14017, or **G14018.** ~~as these fees are replaced by G14077 for those Family Physicians who have submitted. the GP Attachment Participation code.~~*

*xiii) Not payable to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have participated in the conference as a requirement of their employment.*

*xiv) Not payable to physicians who are working under salary, service contract or sessional arrangements who would otherwise have participated in the conference as a requirement of their employment.*

**GP Email/Text/Telephone Medical Advice To Patients Fees**

| | | Total Fee $ |
|---|---|---|
| G14076 | GP ~~Attachment~~ **Patient** Telephone Management Fee ..... | **20.00**~~15.00~~ |

***Notes:***

*i) Payable only to Family Physicians who have successfully:*
- *a) Submitted ~~the GP Attachment Participation Code~~ G14070 or on behalf of Locum Family Physicians who have successfully submitted ~~the GP Locum Attachment Participation Code~~ G14071 on the same or a prior date in the same calendar year; or*
- *b) Registered in a Maternity Network or GP unassigned In-patient network on a prior date.*

*ii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care **provider** ~~professionals~~ (e.g.: Nurse, Nurse Practitioner) employed within the eligible physician **practice** ~~office~~.*

*iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.*

*iv) Not payable for ~~simple~~ prescription renewals, **anti-coagulation therapy by telephone (00043) or** notification of ~~office or laboratory~~ appointments or ~~of~~ referrals.*

*v) Payable to a maximum of 1500 services per physician per calendar year.*

*~~vi) G14077 payable for same patient on same day if all criteria are met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14077.~~*

*~~vii)~~ vi)Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077.*

*~~viii) Not payable on the same calendar day as G140789.~~*

*~~ix) G14015, G14016 and G14017 not payable in addition. , as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.~~*

*~~x)~~vii)Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*~~xi)~~viii)Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | Total Fee $ |
|---|---|
| **G14078 GP Email/Text/Telephone Medical Advice Relay Fee.....** | **7.00** |

This fee is payable for 2-way communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone relay.
This fee is not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

***Notes:***

i) Payable only to Family Physicians who have successfully:
- a. Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; or
- b. Registered in a Maternity Network or GP Unassigned In-patient Network on a prior date.

ii) Email/Text/Telephone Relay Medical Advice requires two-way communication between the patient or the patient's medical representative and physician or medical office staff.
iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.
iv)Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
v) Payable to a maximum of 200 services per physician per calendar year.
vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077.

**3. Complex Care Fees**

The Complex Care **Planning and** Management Fee was developed to compensate GPs for the management of complex patients living in their home or assisted living, who have documented confirmed diagnoses of 2 chronic conditions from at least 2 of the 8 categories listed below. Patients in acute or long term care facilities are not eligible.

Having comorbidities does not necessarily make a patient complex. To be eligible for the Complex Care **Planning and** Management Fee, G14033; the patient's co-morbidities should be of sufficient severity and complexity to warrant the development of a management plan. In other words, eligibility is not based solely on the individual diagnoses. Consideration should be given to the over-all clinical impact of the diagnosis, and the burden of illness the patient experiences.

These items are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing calendar year.

***Eligible Complex Care Condition Categories:***
1) *Diabetes mellitus (type 1 and 2)*
2) *Chronic Kidney Disease*
3) *Heart failure*
4) *Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)*
5) *Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g.: TIA, Migraine)*
6) *Ischemic heart disease, excluding the acute phase of myocardial infarct*
7) *Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.)*
8) *Chronic Liver Disease with evidence of hepatic dysfunction.*

If a patient has more than 2 of the qualifying conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

~~Successful billing of the Complex Care Management Fee (G14033) allows access to 5 Telephone/Email follow-up fees (G14079) per calendar year over the following 18 months~~

| | | **Total Fee $** |
|---|---|---|
| G14033 | GP ~~Annual~~ Complex Care **Planning and** Management Fee **(2 diagnoses)** ..... The Complex Care **Planning and** Management Fee is **payment for the creation of a care plan and** advance payment for the complex work of caring for patients with ~~two of the~~ eligible conditions. It is payable upon the completion and documentation of a ~~Complex~~ Care Plan which includes Advance Care Planning when appropriate, as described below. | 315.00 |

**The Complex Care Planning and Management fee (2 diagnoses) is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing year.**

A ~~Complex~~ Care Plan requires documentation of the following **core** elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies;
2. **Name and contact information for substitute decision maker;**
3. **Documentation of eligible condition(s);**
4. **There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;**
5. **Specifies a clinical plan for the patient's care;**
6. **Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;**
7. **Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;**
8. **Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;**
9. **Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;**
10. **Identifies an appropriate time frame for re-evaluation of the plan;**
11. **Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.**

~~2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;~~
~~3. Specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;~~
~~4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;~~
~~5. Outlines expected outcomes as a result of this plan, including end-of-life issues (advance care planning) when clinically appropriate;~~
~~6. Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles;~~
~~7. Identifies an appropriate time frame for re-evaluation of the plan;~~
~~8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as appropriate.~~

*Patient Eligibility:*

- ***Eligible patients must be living at home or in assisted living.***
- ***Patients in Acute and Long Term Care Facilities are not eligible.***

~~The development of the care plan is done jointly with the patient &/or the patient representative as appropriate. The patient &/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.~~

***Notes:***

*i) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions.*

*ii) Refer to Table 1 for eligible diagnostic categories.*

*iii) Payable once per calendar year per patient on the date of the complex care planning visit.*

*iv)* ***Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning included under G14033.*** *~~Documentation of the Complex Care Plan is required in the patient's chart.~~*

*v)* ***Minimum required total planning time 30 minutes. The majority of the planning time must be face- to- face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care provider(s) (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.*** *~~A medical visit (in office or home) or CPx fee must be billed for same date of service. Visit time does not count toward required planning time.~~*

*vi) Chart documentation must include:*

1. *the care plan;*
2. *total planning time (minimum 30 minutes); and*
3. *face to face planning time (minimum 16 minutes).* *~~Minimum required planning time 30 minutes, to review chart and create the care plan collaboratively with the patient and/or their medical representative. The majority of the planning time must be face- to- face. Chart review does not need to be on same day as face-to-face planning.~~*

*~~Chart documentation must include total work time (min35 minutes) and total face-to- face time (min. 20 minutes.) Total work time includes the combination of: chart review, face- to- face planning and same day medical visit. Total face- to face-time includes: face- to- face planning time plus the same day medical visit.~~*

*vii) G14016, G14018 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14033.*

*viii) G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.*

*ix) Not payable once G14063 has been billed and paid as patient has been changed from active management of complex chronic conditions to palliative management.*

*x) G14015, G14017, G14043, G14063, G14076 and G14078~~9~~ not payable on the same day for the same patient.*

*xi) Maximum daily total of 5 of any combination of G14033* ***and*** *~~complex care~~, G14075 ~~Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees~~ per physician.*

*xii) G14075 is not payable in the same calendar year for same patient as G14033.*

*xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.*

*xiv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*xv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Diagnostic codes submitted with 14033 billing must be from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

**Table 1: Complex Care Diagnostic codes**

| Diagnostic Code | Condition One | Condition Two |
|---|---|---|
| N519 | Chronic Neurodegenerative Disorder | Chronic Respiratory Condition |
| N414 | Chronic Neurodegenerative Disorder | Ischemic Heart Disease |
| N428 | Chronic Neurodegenerative Disorder | Heart Failure |
| N250 | Chronic Neurodegenerative Disorder | Diabetes |
| N430 | Chronic Neurodegenerative Disorder | Cerebrovascular Disease |
| N585 | Chronic Neurodegenerative Disorder | Chronic Kidney Disease |
| N573 | Chronic Neurodegenerative Disorder | Chronic Liver Disease |
| R414 | Chronic Respiratory Condition | Ischemic Heart Disease |
| R428 | Chronic Respiratory Condition | Heart Failure |
| R250 | Chronic Respiratory Condition | Diabetes |
| R430 | Chronic Respiratory Condition | Cerebrovascular Disease |
| R585 | Chronic Respiratory Condition | Chronic Kidney Disease |
| R573 | Chronic Respiratory Condition | Chronic Liver Disease |
| I428 | Ischemic Heart Disease | Heart Failure |
| I250 | Ischemic Heart Disease | Diabetes |
| I430 | Ischemic Heart Disease | Cerebrovascular Disease |
| I585 | Ischemic Heart Disease | Chronic Kidney Disease |
| I573 | Ischemic Heart Disease | Chronic Liver Disease |
| H250 | Heart Failure | Diabetes |
| H430 | Heart Failure | Cerebrovascular Disease |
| H585 | Heart Failure | Chronic Kidney Disease |
| H573 | Heart Failure | Chronic Liver Disease |
| D430 | Diabetes | Cerebrovascular Disease |
| D585 | Diabetes | Chronic Kidney Disease |
| D573 | Diabetes | Chronic Liver Disease |
| C585 | Cerebrovascular Disease | Chronic Kidney Disease |
| C573 | Cerebrovascular Disease | Chronic Liver Disease |
| K573 | Chronic Kidney Disease | Chronic Liver Disease |

**Total Fee $**

G14075 GP ~~Attachment~~ **Frailty** Complex Care **Planning and** Management Fee ..... 315.00

The GP ~~Attachment~~ **Frailty** Complex Care **Planning and** Management Fee is **payment for the creation of a care plan and a**dvance payment for the complex work of caring for **eligible** patients. ~~with eligible conditions.~~ It is payable upon the completion and documentation of the ~~Complex~~ Care Plan~~/Advance Care Plan (ACP)~~ **which includes Advance Care Planning when appropriate,** as described below. The GP ~~Attachment~~ **Frailty** Complex Care **Planning and** Management fee is payable only to the ~~General Practitioner~~ **family physician who commits to providing** ~~is the most responsible general practitioner for~~ the majority of the patient's longitudinal general practice care for the ensuing year.

~~This Complex Care fee encompasses those patients with a qualifying diagnosis of Moderate or Severe Frailty as defined as defined in the GPAC Guideline "Frailty in Older Adults – Early Identification and Management" (2012).~~ **Patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for G14075.**

| **Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community** | **Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care** |
|---|---|
| Meal preparation | Mobility in bed |
| Ordinary housework | Transfers |
| Managing finances | Locomotion inside and outside the home |
| Managing medications | Dressing upper and lower body |
| Phone use | Eating |
| Shopping | Toilet use |
| Transportation | Personal hygiene |
| | Bathing |

A ~~complex~~ care plan requires documentation of the following **core** elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies.
2. **Name and contact information of substitute decision maker.**
3. **Documentation of eligible conditions.**
4. ~~2.~~There has been a face-to-face **planning** visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the ~~GP-Attachment-Complex~~ Care **Planning Incentive** code ~~Management Fee~~ is billed.
5. ~~3.~~Specifies a clinical plan for the ~~care of that~~ patient's ~~chronic condition(s)~~ care. ~~for the next year.~~
6. **Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive.**
7. ~~4.~~Incorporates the patient's values, **beliefs** and personal health goals in the **creation of the** care plan. ~~with respect to the chronic condition(s).~~
8. ~~5.~~Outlines expected outcomes as a result of this plan, including ~~any~~ advance care planning ~~for end-of-life issues~~ when clinically appropriate.
9. ~~6.~~Outlines linkages with other allied care ~~professionals~~ **providers** that would be involved in the care~~,~~ **and** their expected roles.
10. ~~7.~~Identifies an appropriate time frame for re-evaluation of the plan.
11. ~~8.~~Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care **providers** ~~professionals~~ as ~~indicated~~ **appropriate. The patient and /or their representative /family should leave the planning process knowing there is a plan for their care and what that plan is.**

~~The development of the care plan is done jointly with the patient and/or the patient representative as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.~~

Patient Eligibility:

Eligible patients must be living at home or in assisted living
Patients in Acute and long term Care Facilities are not eligible.

***Notes:***

*i) Payable only to Family Physicians who have successfully submitted ~~the GP Attachment Participation Code~~ G14070 or on behalf of Locum Family Physicians who have successfully submitted ~~the GP Locum Attachment~~*

~~Participation Code~~ G14071 on the same or a prior date in the same calendar year.

ii) Payable only for patients **who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living** ~~with documentation of moderate or severe frailty.~~

iii) Claim must include the diagnostic code V15.

iv) Payable once per calendar year per patient on the date of the complex care planning visit.

v) **Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning included under G14075.** ~~Documentation of the Complex Care Plan is required in patient's chart.~~

vi) **Minimum required total planning time 30 minutes. The majority of the planning time must be face- to- face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.** ~~A medical visit (in office or home) or CPx fee must be billed for same date of service. Visit time does not count toward required planning time.~~

vii) **Chart documentation must include:** ~~Minimum required planning time 30 minutes, to review chart and create the care plan collaboratively with the patient and/or their medical representative.~~
~~The majority of the planning time must be face- to- face. Chart review does not need to be on same day as face-to-face planning.~~:

1. **the care plan;**
2. **total planning time (minimum 30 minutes); and**
3. **face to face planning time (minimum 16 minutes).**

viii) **G14018 or G14077 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for G14075.** ~~Chart documentation must include total work time (min. 35 minutes) and total face- to- face time (min. 20 minutes.) Total work time includes the combination of: chart review, face- to- face planning and same day medical visit. Total face- to face- time includes: face- to- face planning time plus the same day medical visit.~~

ix) **Maximum daily total 5 of any combination of G14033 and G14075 per physician.** ~~G14018 or G14077 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for G14075.~~

x) **G14075 not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.** ~~Maximum daily total 5 of any combination of G14033 complex care, and G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.~~

xi) **G14033 is not payable in the same calendar year for same patient as G14075.** ~~G14075 not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.~~

xii) **G14043, G14063, G14076, G140789 not payable on the same day for the same patient.** ~~G14033 is not payable in the same calendar year for same patient as G14075.~~

xiii) **G14015, G14016 and G14017 not payable in addition.** ~~G14043, G14063, G14076, G140789 not payable on the same day for the same patient.~~

xiv) **Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.** ~~G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.~~

xv) **Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.** ~~Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.~~

xvi) ***Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*** ~~*Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*~~

xvii) ~~*Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*~~

| | | Total Fee $ |
|---|---|---|
| | **4. Prevention Fees** | |
| G14066 | Personal Health Risk Assessment..... This fee is payable to the general practitioner who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, smoker, physically inactive, unhealthy eating). The GP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative and the G14066 must be billed in addition to the age appropriate visit fee. | 50.00 |

***Patient Eligibility:***

Eligible patients must be living at home or in assisted living. Patients in acute and long term care facilities are not eligible.

***Notes:***

i) *Payable only for patients with one or more of the following risk factors: smoking, unhealthy eating, physical inactivity, medical obesity.*

ii) *Diagnostic code submitted with 14066 must be one of the following: Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783).*

iii) *The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.*

iv) *Visit (office or home) or CPx fee to indicate face-to-face interaction with patient or patient's representative same day must be billed for same date of service.*

v) *G14016 or G14077 payable on same day for same patient if all criteria met.*

vi) *G14015, G14017, G14033, G14043, G14063, G14076 and G140789 not payable on the same day for the same patient.*

vii) *Payable to a maximum of 100 patients per calendar year, per physician.*

viii) *Payable once per calendar year per patient.*

ix) *Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

x) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care;*

xi) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

**The Ministry of Health website contains:**
**The current Lifetime Prevention Schedule "Establishing Priorities among Effective Clinical Prevention Services in British Columbia: 2016 Update" :**
**http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-report_2016.pdf**

A "Lifetime Prevention Schedule Tool" which allows identification of the recommended interventions at a glance. (When viewed online, there are embedded links to more details for each specific recommendation.): http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-graphic-tool.pdf

BC Prevention Guidelines:
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

**~~BC Lifetime Prevention Schedule Recommended Actions~~**

| ~~Clinical Condition~~ | | ~~MEN~~ | ~~WOMEN~~ |
|---|---|---|---|
| ~~Colorectal Cancer Screening (Fecal Occult Blood Testing q1-2 years starting age 50)~~ | | * | * |
| ~~Mammography Screening (40-79 yrs, q 1-2 years)~~ | | | * |
| ~~Pap Smear Screening (sexually active until age 69, q 1 – 2 years)~~ | | | * |
| ~~Hypertension Screening~~ | | * | * |
| ~~Hyperlipidemia Screening ( Male 40 yr; Female 50 yr or postmenopausal; or sooner if at risk either sex)~~ | | * | * |
| ~~Diabetes Screening (Fasting Blood Sugar at least q 3 yrs age 40 yr or sooner if at risk either sex)~~ | | * | * |
| ~~Discussion of ASA use as clinically indicated (if high risk of Cardiovascular Disease or Stroke)~~ | | * | * |
| ~~Smoking Cessation~~ | | * | * |
| ~~Adult Immunization:~~ | ~~Influenza (Annually if at risk)~~ | * | * |
| | ~~Pneumococcal (if †Risk q 10 years)~~ | * | * |
| | ~~Tetanus /Diphtheria (q 10 years)~~ | * | * |
| ~~Immunizations for patients < 19 years of age as per age appropriate publically funded schedule~~ | | * | * |
| ~~Diet Modification (if Cardiovascular Disease Risk)~~ | | * | * |
| ~~Exercise Recommendation (if Cardiovascular Disease Risk)~~ | | * | * |

## 147. Mental Health Planning and Management Fees

G14043 GP Mental Health Planning Fee ..... 100.00
This fee is payable upon the completion and documentation of a ~~Mental Health~~ **Care** Plan for patients **with** ~~living at home or in assisted living. Patients in acute or long term care facilities are not eligible. Patients must have~~ a confirmed eligible mental health diagnosis of sufficient severity **to** ~~and~~ warrant the development of a ~~management~~ **care** plan. This is not intended for patients with self-limited or short lived mental health symptoms *(e.g.: situational adjustment reaction, normal grief, life transitions*). The Mental Health Planning Fee requires a face-to-face visit with the patient and/or the patient's medical representative. **The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing year.**

A ~~Mental Health~~ **Care** Plan requires documentation of the following **core** elements in the patient's chart:

1. There has been a detailed review of the patient's chart/history and current therapies.
2. **Documentation of eligible condition(s).**

3. **Name and contact information for substitute decision maker.**
4. **There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed.**
5. **Specifies a clinical plan for the patient's care for the next year.**
6. **Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive.**
7. **Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan.**
8. **Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate.**

~~2The patient's confirmed eligible mental health diagnosis, psychiatric history and current mental state.~~

~~3The use of and results of validated assessment tools. Examples of validated assessment tools include:~~

~~a) PHQ9, Beck Depression Inventory, Ham-D depression scale;~~
~~b) MMSE;~~
~~c) MDQ;~~
~~d) GAD-7;~~
~~e) Suicide Risk Assessment;~~
~~f) Audit (Alcohol Use Disorders Identification Test CAGE; T-ACE).~~

9. ~~Specifies a clinical plan for the care of that patient's psychiatric illness.~~ Outlines linkages with other allied care ~~professionals~~ **providers** and community resources who will be involved in the patient's care, and their expected roles.
10. Identifies an appropriate time frame for ~~follow up and~~ re-evaluation of the ~~patient's progress and Mental Health~~ Plan.
11. Provides confirmation that the ~~Mental Health~~ care plan **has been created jointly and shared with the patient and /or the patient's medical representative and has been** communicated verbally or in writing to ~~the patient and/or the patient's Medical Representative, and to~~ other involved allied care ~~professionals~~ **providers** as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Successful billing of the Mental Health Planning fee G14043 allows access to 4 counselling equivalent mental health management fees in that same calendar year which may be billed once the 4 MSP counselling fees (**any combination of** 00120 **age differential or telehealth counselling codes**) have been utilized.

~~Successful billing of the mental health planning fee (G14043) allows access to 5 Telephone/email follow-up fees (G14079) per calendar year in the subsequent 18 months.~~

***Patient Eligibility:***

- *Eligible patients must be living at home or in assisted living.*
- *Patients in acute or long term care facilities are not eligible.*

***Notes:***

*i) Payable only for patients with documentation of a confirmed eligible mental health diagnosis of sufficient severity to warrant the development of a management plan. Not intended for patients with self-limited or short lived mental health symptoms.*

*ii) Payable once per calendar year per patient. Not intended as a routine annual fee.*

*iii)* ***Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning included under G14043.*** ~~*Minimum required face-to-face time 30 minutes.*~~

*iv)* ***Minimum required total planning time 30 minutes. The majority of the planning time must be face- to- face to create the care plan collaboratively with the patient and/or their medical representative***

***(minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.*** *~~Visit fee on same day only payable in addition if total time exceeds 39 minutes; counselling fee on same day only payable in addition if total time exceeds 49 minutes.~~*

v) *Chart documentation must include:*
   1. *the care plan;*
   2. *total planning time (minimum 30 minutes); and*
   3. *face to face planning time (minimum 16 minutes)* *~~G14043 claim must state start and end times of the total service (planning plus any additional visit/counselling .) Start and end times must also be documented in the patient chart.~~*

vi) *G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for G14043.*

vii) *G14015, G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14074, G14075, G14076 and G140789 not payable on the same day for the same patient.*

viii) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

ix) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

| | | Total Fee $ |
|---|---|---|
| G14044 | GP Mental Health Management Fee age 2 – 49 | 53.80 |
| G14045 | GP Mental Health Management Fee age 50 - 59 | 59.18 |
| G14046 | GP Mental Health Management Fee age 60 - 69 | 61.86 |
| G14047 | GP Mental Health Management Fee age 70 - 79 | 69.93 |
| G14048 | GP Mental Health Management Fee age 80+ | 80.70 |

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee G14043 has been successfully billed. The four MSP counselling fees **(any combination of** age-appropriate 00120 **or telehealth counselling)** must first have been paid in the same calendar year.

***Notes:***

i) *Payable a maximum of 4 times per calendar year per patient.*

ii) *Payable only when* *~~if the Mental Health Planning Fee (G14043) has been previously billed and~~* *paid in the same calendar year.* *~~by the same physician.~~*

iii) *Payable only to the physician paid for the GP Mental Health Planning Fee* *~~(G14043)~~*, *unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note.*

iv) *Not payable unless the four age-appropriate 00120* ***or telehealth counselling (13018, 13038)*** *fees have already been paid in the same calendar year.*

v) *Minimum time required is 20 minutes.*

vi) ***Start and end times must be included with the claim and documented in the patient chart.*** *~~Claim must include Start and End times. Start and end times must also be documented in the patient chart.~~*

vii) ***Counselling may be provided face-to-face or by videoconferencing.***

viii) *G14016 or G14077, payable on same day for same patient if all criteria met.*

ix) *G14015, G14043, G14076, G140789 not payable on same day for same patient.*

x) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

xi) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

The following list of diagnosis and acceptable ICD9 codes are applicable for the Mental Health Planning and Management Fee, fee items G14043, G14044 – G14048, and G14079:

| | DIAGNOSIS | ICD-9 |
|---|---|---|
| **Adjustment Disorders:** | | **309** |
| | Adjustment Disorder with Anxiety | 309 |
| | Adjustment Disorder with Depressed Mood | 309 |
| | Adjustment Disorder with Disturbance of Conduct | 309 |
| | Adjustment Disorder with Mixed Anxiety and Depressed Mood | 309 |
| | Adjustment Disorder with Mixed Disturbance of Conduct & Mood | 309 |
| | Adjustment Disorder NOS | 309 |
| **Anxiety Disorders:** | | **300** |
| | Acute Stress Disorder | 308 |
| | Agoraphobia | 300 |
| | Anxiety Disorder Due to a Medical Condition | 300 |
| | Anxiety Disorder NOS | 300 |
| | Generalized Anxiety disorder | 50B, 300 |
| | Obsessive-Compulsive Disorder | 300 |
| | Panic Attack | 300 |
| | Post-Traumatic Stress Disorder | 309 |
| | Social Phobia | 300 |
| | Specific Phobia | 300 |
| | Substance-Induced Anxiety disorder | 300 |
| **Attention Deficit Disorders:** | | |
| | Attention Deficit disorder | **314** |
| **Autism Spectrum Disorder:** | **Autistic Disorder** | **299.0** |
| | **Asperger Syndrome** | **299.0** |
| | **Pervasive Development Disorder Not Otherwise Specified** | **299.0** |
| **Cognitive Disorders:** | | |
| | Amnestic Disorder | 294 |
| | Delirium | 293 |
| | Dementia | 290,331,331.0,331.2 |
| **Dissociative Disorders:** | | |
| | Depersonalization Disorder | 300 |
| | Dissociative Amnesia | 300 |
| | Dissociative Fugue | 300 |
| | Dissociative Identity Disorder | 300 |
| | Dissociative Disorder NOS | 300 |
| **Eating Disorders:** | | |

| | | |
|---|---|---|
| | Anorexia Nervosa | 307.1, 783.0, 307 |
| | Bulimia | 307 |
| | Eating Disorder NOS | 307 |
| **Factitious Disorders:** | | **300,312** |
| | Factitious Disorder; Physical & Psych Symptoms | 300,312 |
| | Factitious Disorder; Predom Physical Symptoms | 300,312 |
| | Factitious Disorder; Predominantly Psych Symptoms | 300,312 |
| **Impulse Control Disorders:** | | **312** |
| | Impulse Control Disorder NOS | 312 |
| | Intermittent Explosive Disorder | 312 |
| | Kleptomania | 312 |
| | Pathological Gambling | 312 |
| | Pyromania | 312 |
| | Trichotillomania | 312 |
| ~~**Mental Disorders Due to a Medical Condition**~~ | | |
| **Mood Disorders:** | | |
| | Bipolar Disorder | 296 |
| | Cyclothymic disorder | 301.1 |
| | Depression | 311 |
| | Dysthymic Disorder | 300.4 |
| | Mood Disorder due to a Medical Condition | 293.8 |
| | Substance-Induced Mood Disorder | 303, 304, 305 |
| **Schizophrenia and other Psychotic Disorders:** | | 295,296,297,298 |
| | Paranoid Type | 295,297,298 |
| | Disorganized Type | 295, 298 |
| | Catatonic Type | 295, 298 |
| | Undifferentiated Type | 295, 298 |
| | Residual Type | 295, 298 |
| | Brief Psychotic Disorder | 295, 298 |
| | Delusional Disorder | 295, 298 |
| | Psychotic Disorder due to Medical Condition | 293 |
| | Psychotic Disorder NOS | 295, 298 |
| | Schizoaffective Disorder | 295, 298 |
| | Schizophreniform Disorder | 295, 298 |
| | Substance-Induced Psychosis | 295, 298 |
| **Sexual and Gender Identity Disorder Paraphilias:** | | **302** |
| | Exhibitionism | 302 |
| | Fetishism | 302 |
| | Frotteurism | 302 |
| | Pedophlia | 302 |
| | Sexual Masochism | 302 |
| | Sexual Sadism | 302 |
| | Transvestic Fetishism | 302 |
| | Voyeurism | 302 |
| | Paraphilia NOS | 302 |

| | | |
|---|---|---|
| **Sexual Dysfunction:** | | **302** |
| | Hypoactive Sexual Desire Disorder | 302 |
| | Female Orgasmic Disorder | 302 |
| | Female Sexual Arousal Disorder | 302 |
| | Male Erectile Disorder | 302 |
| | Male Orgasmic Disorder | 302 |
| | Premature Ejacualation | 302 |
| | Sexual Aversion Disorder | 302 |
| | Sexual Dysfunction due to a Medical Disorder | 625 |
| | Sexual Dysfunction due to a Substance | 302 |
| **Sexual Pain Disorders:** | | |
| | Dyspareunia (not due to a Medical Condition) | 302 |
| | Vaginismus (not due to a Medical Condition) | 302 |
| **Sleep Disorders:** | | |
| | Primary Insomnia | 307 |
| | Primary Hypersomnia | 307 |
| | Narcolepsy | 347 |
| | Breathing-Related Sleep Disorder | 780.5 |
| | Circadian Rhythm Sleep Disorder | 307.4 |
| | Insomnia Related to Another Mental Disorder | 307.4 |
| | Nightmare Disorder (Dream Anxiety Disorder) | 307.4 |
| | Sleep Disorder Due to a Medical Condition | 780.5 |
| | Sleep Disorder Related to another Medical Condition | 780.5 |
| | Sleepwalking Disorder | 780.5 |
| | Substance-Induced Sleep Disorder | 780.5 |
| **Somatoform Disorders:** | | |
| | Somatization Disorder | 300.8 |
| | Conversion Disorder | 300.1 |
| | Pain Disorder | 307.8 |
| | Hypochondriasis | 300.7 |
| | Body Dysmorphic Disorder | 300.7 |
| **Substance - Related Disorders:** | | |
| | Substance-Induced Anxiety Disorder | 303,304,305 |
| | Substance-Induced Mood Disorder | 303,304,305 |
| | Substance-Induced Psychosis | 292 |
| | Substance-Induced Sleep Disorder | 303,304,305 |
| **Alcohol Dependence Syndrome** | | 303 |
| **Drug Dependence Syndrome** | | 304 |
| **Drug Abuse, Non-Dependent** | | 305 |

**Total Fee $**

## 8. Palliative Care Planning Fee

G14063 **GP** Palliative Care **P**~~p~~lanning fee ..... 100.00

This fee is payable upon the development and documentation of a ~~Palliative~~ Care Plan for patients who in your 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. Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy**. This fee requires a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent. The GP Palliative Planning and Management fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the patient.**

~~Eligible patients must be living at home or in assisted living. Patients in Acute and Facilities are not eligible.~~

The ~~Palliative~~ Care Plan requires documentation of the following in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies.
2. **Name and contact information for substitute decision maker.**~~.;There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Palliative Care Planning Fee is billed.~~
3. **Documentation of eligible condition(s).**~~Specifies a clinical plan for the patient's palliative care.~~
4. **There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed.** ~~Incorporates the patient's values and beliefs in creation of the plan,~~
   ~~Name and contact information for substitute decision maker.~~
5. **Specifies a clinical plan for the patient's care.** ~~Completion of a NO CPR FORM.~~
6. **Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive.** ~~Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles.~~
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan. ~~Provides confirmation that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved allied care professionals as appropriate.~~
8. **Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate.**
9. **Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles.**
10. **Identifies an appropriate time frame for re-evaluation of the plan.**
11. **Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.**

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

~~This fee requires a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent. The~~

~~patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.~~

***Notes:***

*i) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.*

*ii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).*

*iii) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.*

***iv) Payable in addition to a visit fee (home or office) ~~billed~~ on the same day if medically required and does not take place concurrently with the face to face planning included under G14063.***

***v) Minimum required total planning time 30 minutes. The majority of the planning time must be face- to- face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.***

***vi) Chart documentation must include:***

1. ***the care plan;***
2. ***total planning time (minimum 30 minutes); and***
3. ***face to face planning time (minimum 16 minutes).***

~~*vii) Minimum required time 30 minutes face-to-face in addition to visit time same day.*~~

~~*viii) Claim must state start and end times of the service. Start and end times must also be documented in the patient chart.*~~

*vii) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14063.*

*viii) Not payable if G14033 or G14075 has been paid within 6 months.*

*ix) Not payable on same day as G14015, G14017, G14043, ~~G14074~~, G14076 or G14078~~.9 GP Telephone/email Management fee~~.*

*x) G14050, G14051, G14052, G14053, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid as patient has been changed from active management of chronic disease and/or complex condition(s) to palliative management.*

*xi) G14043, G14044, G14045, G14046, G14047, G14048, the GPSC Mental Health Initiative Fees are still payable once G14063 has been billed provided all requirements are met, but are not payable on same day.*

*xii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*xiii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

~~Successful billing of the Palliative care planning fee (G14063) allows access to 5 Telephone/email follow-up fees (G14079) per calendar year over the following 18 months.~~

## 10. GPSC Portal Fees ~~for A GP for Me/Attachment Initiative~~

**The "GPSC Portal" Codes provides access to the following incentive fee codes:**

- **G14075 GP Frailty Complex Care Planning and Management Fee**
- **G14076 GP-Patient Telephone Management Fee**
- **G14077 GP-Allied Care Provider Conference Fee**
- **G14078 GP Email/Text/Telephone Medical Advice Relay Fee**

- **G14029 GP Allied Care Provider Practice Code ($0.00)**

~~Overview:~~

~~The fee codes for the A GP for Me (Attachment) initiative are billable by family doctors who submit the MSP fee G14070 'GP Attachment Participation Code' to MSP at the beginning of each calendar year. Once successfully submitted, the Attachment initiative suite of fees may be billed.~~
Submitting G14070 signifies that:

- You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year.

- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'. ~~Refer to A GP for Me – Frequently asked questions Q6 for details.~~

- ~~You have contacted your local division of family practice to share your contact information and to indicate your desire to participate in the community-level Attachment initiative as you are able. Division contacts are available online at www.divisionbc.ca.~~

The standardized wording of the Family Physician-Patient 'Compact' ~~states:~~ **was developed in consultation with the physicians of the three attachment prototype communities and in consultation with members of the patient voices network. The GPSC continues to believe this compact appropriately describes the relationship between a full service family physician and his/her parents. The compact states:**

As your family doctor I, along with my practice team, agree to:
- Provide you with the best care that I can
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:
- Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s), xxxxxx
- Name me as your family doctor if you have to visit an emergency facility or another provider
- Communicate with me honestly and openly so we can best address your health care Needs

Locums working in **host practices where G14070 has been submitted are able to access the same fee codes** ~~an "Attachment Participating" family practice, are able to bill the fee codes for the "A GP for ME" Initiative,~~ once they have successfully submitted ~~MSP fee~~ G14071 **"GPSC Locum Portal Code"** ~~"GP Locum Attachment Participation Code~~", once at the beginning of each calendar year. The Locum and ~~Attachment participating~~ host FP should discuss and mutually agree on which of the GPSC Services, including the ~~Attachment Initiative~~ fees**, accessed through the GPSC Portal codes,** may be provided and billed by the locum. However, locums have their own annual allotment of G14076 ~~Attachment~~ **GP Patient** Telephone Management Fee **and G14078 GP Patient Email/Text/Telephone Medical Advice Relay Fee.** Submitting G14071 signifies that:

- You are providing full-service family practice services to the patients of the host physicians, and will continue to do so for the duration of any locum coverage for a family physician **who has submitted G14070.**~~participating in the attachment incentive.~~

- ~~You have contacted the Divisions of Family Practice central office to share your contact information (AGPforMe@doctorsofbc.ca) and to indicate your desire to participate as a locum in the community-level Attachment initiative as you are able. Refer to A GP for Me - FAQs for more information.~~

~~General Notes:~~

**Total Fee $**

~~The Attachment incentives are billable for BC residents with valid MSP coverage only; Reciprocal claims for patients with out of province health insurance are excluded. Rural retention premiums do not apply.~~

G14070 GP**SC** ~~Attachment Participation~~ **Portal** Code ..... 0.00

The GP**SC** ~~Attachment Participation~~ **Portal** Code should be submitted at the beginning of each calendar year by Full Service Family Physicians (FSFP)~~'s~~ to access G14075, G14076, G14077, G14078 and G14029 during the calendar year. ~~who choose to participate in the GPSC Attachment Initiative~~.

~~Once successfully processed by MSP, the FP may access the "Attachment participation" incentives (G14074, G14075, G14076, G14077).~~

Submit fee item G14070 GP**SC Portal** ~~Attachment Participation~~ Code using the following "Patient" demographic information:

| | |
|---|---|
| PHN: | 9753035697 |
| Patient Surname: | Participation |
| First name: | Attachment |
| Date of Birth: | January 1, 2013 |
| ICD9 code: | 780 |

**Submission of this code signifies that:**

- **You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year.**
- **You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'.**

***Notes:***

*i) ~~Bill~~ **Submit** once per calendar year.~~ to confirm participation in the Attachment initiative.~~*

*ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*

*iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

**Total Fee $**

**GPSC Locum Portal ~~Attachment Participation~~ Code**

G14071 GP**SC** Locum **Portal** ~~Attachment Participation~~ Code ..... 0.00

The GP**SC Portal** ~~Locum Attachment Participation~~ code may be submitted by the GP who provides locum coverage for Family Physicians **who have submitted G14070.** ~~participating in the Attachment initiative~~ **G14071 should be submitted** at the beginning of the calendar year or prior to the start of the first such locum in each calendar year. Once processed by MSP, the locum may access G14075, G14076, G14077, G14078 and G14029 ~~GP Attachment incentives~~ for services provided while covering for the ~~Attachment participating~~ host FPs.

Submit fee item G14071 GP**SC** Locum **Portal** ~~Attachment Participation~~ Code using the following "Patient" demographic information:

| | |
|---|---|
| PHN: | 9753035697 |
| Patient Surname: | Participation |
| First name: | Attachment |
| Date of Birth: | January 1, 2013 |
| **ICD9 code:** | **780** |

**Submission of this code signifies that:**

- **You are providing full-service family practice services to the patients of the host physician who has submitted G14070 and will continue to do so for the duration of locum coverage.**

***Notes:***

*i) ~~Bill~~ Submit once per calendar year at the beginning of the year or prior to the first locum ~~coverage~~ for a family physician who has submitted G14070 in the same calendar year. ~~is participating in the attachment initiative~~.*

*ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*

*iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*

*iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

**Amendment:**
**GPSC fee items G14015, G14016 and G14017 are cancelled as of December 31, 2017.**

G14015 General Practice Facility Patient Conference: when requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient with complex supportive care needs in a facility can safely return to the community or transition to a supportive or long-term facility - per 15 minutes or greater portion thereof ..... 40.00

G14016 General Practice Community Patient Conference Fee - per 15 minutes or greater portion thereof ..... 40.00

G14017 General Practice Acute Care Discharge Conference fee - per 15 minutes or greater portion thereof ..... 40.00

**GPSC fee items G14070 & G14071 will have a change in name of the "portal patient" effective January 1, 2018.**

| | |
|---|---|
| PHN: | 9753035697 |
| Patient Surname: | **Portal** ~~Participation~~ |
| First name: | **GPSC** ~~Attachment~~ |
| Date of Birth: | January 1, 2013 |
| **ICD9 code:** | **780** |

Dr. Robert Halpenny
Chair
Medical Services Commission

Dated this 24th day of October AD 2017.

# BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD):2018-04-01**
**CANCEL DATE (CCYYMMDD): 2018-04-15 TARGET TYPE: SP**
**TARGET KEY: 00 COPY MESSAGE FROM**

**BROADCAST TITLE: GPSC CDM fees and G14043 note changes**
**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

Effective February 15, 2018 note iii listed under fee items G14050, G14051, G14052, G14053, G14250, G14251, G14252 and G14253 was amended to:
Notes:
iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 - prior to October 2017) or
2. a group medical visit (13763 -13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4.an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

Effective February 15, 2018 note vii for fee item G14043 was amended to:
Notes:
vii) G14015, G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14075, G14076 and G14078 not payable on the same day for the same patient.

**INITIATED BY: MoH**

**Copy to BCMA __yes_____**

**AUTHORIZED BY_____**

| IF TARGET TYPE IS | THEN TARGET KEY IS |
|---|---|
| **PY**-PAYEES | PAYEE NO. |
| **PR**- PRACTITIONER | PRACTITIONER NO. |
| **SP**-SPECIALTY | SPECIALTY CODE |
| **AI**-ASSOCIATION IDENTIFIER | MD – BC MEDICAL ASSOCIATION |
| **A** -ALL | LEAVE TARGET KEY BLANK |
| **PS**-PAYEE STATUS | **C** - VESTED INTEREST LAB |
| | **F** PRIMARY CARE |
| | **H** - HOSPITAL |
| | **I** - INACTIVE PAYEE |

**L** - LABORATORY
**M** - ACTIVE PAYEE
**V** - 3RD PARTY- OUT OF PROVINCE
**Y** – ALTERNATIVE PAYMENTS PROGRAM

ADD:
CHANGE: X

**MSP CLAIMS FEE SCHEDULE**
**FEE ITEM PROFILE**

**ITG #:**_____

**FEE ITEM:** 14050

**TITLE:**

---------- **FEE ITEM PAYMENT INFORMATION** ----------

prefix 2: prefix 1:
eff dt: fee sched amnt: pvc applicable?:
can dt: amnt less pvc: $ _____ allowed # srvcs:
version number: 00 alternate amnt: $ _____ adjdctn # srvcs:
valid version?: Y minimum amount: $ _____ submit exact amnt?:
permutation?: surcharge : % _____

-- PATIENT RESTRICTIONS --- YY MM DD --------- SERVICE RESTRICTIONS ---------
nmbr srvcs: interval: location:
gender: min age: allow rcp?: out of country only?:
max age: pre-approval rqrd?: apb indicator:

---------- CLAIM PROCESSING INDICATORS ----------
routine block: sort key: type:
service code: high use: msclns item?:
time rqrd?: interval: : (H:M) portion?:
referral rqrd?: non-refer fee item: overage cutoff date:
anaesth units: anaes intensity: anatomical area rqrd?: N
hospital visit: documentation rqrd?: N page #: _____ _____ _____

**DESCRIPTION:**

Incentive for Full Service General Practitioner
- annual chronic care bonus (diabetes mellitus)

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of diabetes mellitus.

iv) Care provided must be consistent with the BC clinical guideline recommendations for Diabetes Mellitus and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.

v) Claim must include the ICD-9 code for diabetes (250).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vii) Payable when other CDM items G14051 or G14053 have been paid on the same patient.

viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

**BILLABLE RULE:** EFFECTIVE DATE:
CANCELLATION DATE:

**REQUIRED SPECIALTY:** EFFECTIVE DATE:
CANCELLATION DATE:

**DAY OF WEEK CODE:** EMERGENCY FROM TIME: __.__ EMERGENCY TO TIME: __.__
EFFECTIVE DATE:
CANCELLATION DATE:

**APPROVAL CATEGORY:** EFFECTIVE DATE:
CANCELLATION DATE:

APPROVED BY: Betty Louie DATE: April 27, 2010
UPDATED BY: DATE:
PER MOC: 10-047. Changes to the notes in the description.

ADD:
CHANGE:X

**MSP CLAIMS FEE SCHEDULE**
**FEE ITEM PROFILE**

**ITG #:**_____

**FEE ITEM:**14050

**TITLE:** GP Annual Chronic Care Incentive-(diabetes mellitus)

---------- **FEE ITEM PAYMENT INFORMATION** ----------

prefix 2: prefix 1:
eff dt: fee sched amnt: pvc applicable?:
can dt: amnt less pvc: $ _____ allowed # srvcs:
version number: 00 alternate amnt: $ _____ adjdctn # srvcs:
valid version?: Y minimum amount: $ _____ submit exact amnt?:
permutation?: surcharge : % _____

-- PATIENT RESTRICTIONS --- YY MM DD --------- SERVICE RESTRICTIONS ---------

nmbr srvcs: interval: location:
gender: min age: allow rcp?: out of country only?:
max age: pre-approval rqrd?: apb indicator:

---------- CLAIM PROCESSING INDICATORS ----------

routine block: sort key: type: INS code
service code: high use: msclns item?:
time rqrd?: interval: : (H:M) portion?:
referral rqrd?: non-refer fee item: overage cutoff date:
anaesth units: anaes intensity: anatomical area rqrd?: N
hospital visit: documentation rqrd?: N page #: _____ _____ _____

**DESCRIPTION:**

Incentive for Full Service General Practitioner - annual chronic care incentive (diabetes mellitus)

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.*

*iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14250.*

*v) Claim must include the ICD-9 code for diabetes (250).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Payable in addition to fee items G14051 or G14053 for same patient if eligible.*

*viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

*ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

**BILLABLE RULE:** EFFECTIVE DATE:
CANCELLATION DATE:

**REQUIRED SPECIALTY:** EFFECTIVE DATE:

CANCELLATION DATE:

**DAY OF WEEK CODE:** EMERGENCY FROM TIME: __.__ EMERGENCY TO TIME: __.__
EFFECTIVE DATE:
CANCELLATION DATE:

**APPROVAL CATEGORY:** EFFECTIVE DATE:
CANCELLATION DATE:

APPROVED BY: Sakya Newman DATE: August 14, 2015
UPDATED BY: DATE:
PER MOC: 15-067

ADD:
CHANGE: X

**MSP CLAIMS FEE SCHEDULE**
**FEE ITEM PROFILE**

**ITG #:**_____

**FEE ITEM:** 14052

**TITLE:**

---------- **FEE ITEM PAYMENT INFORMATION** ----------

prefix 2: prefix 1:
eff dt: fee sched amnt: pvc applicable?:
can dt: amnt less pvc: $ _____ allowed # srvcs:
version number: 00 alternate amnt: $ _____ adjdctn # srvcs:
valid version?: Y minimum amount: $ _____ submit exact amnt?:
permutation?: surcharge : % _____

-- PATIENT RESTRICTIONS --- YY MM DD --------- SERVICE RESTRICTIONS ---------
nmbr srvcs: interval: location:
gender: min age: allow rcp?: out of country only?:
max age: pre-approval rqrd?: apb indicator:

---------- CLAIM PROCESSING INDICATORS ----------
routine block: sort key: type:
service code: high use: msclns item?:
time rqrd?: interval: : (H:M) portion?:
referral rqrd?: non-refer fee item: overage cutoff date:
anaesth units: anaes intensity: anatomical area rqrd?: N
hospital visit: documentation rqrd?: N page #: _____ _____ _____

**DESCRIPTION:**

Incentive for Full Service General Practitioner
- annual chronic care bonus (hypertension)

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of hypertension.

iv) Care provided must be consistent with the BC clinical guideline recommendations for Hypertension and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their flow sheet in order to facilitate patient self management.

v) Claim must include the ICD-9 code for hypertension (401).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vii) Not payable if G14050 or G14051 claimed within the previous 12 months.

viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

**BILLABLE RULE:** EFFECTIVE DATE:
CANCELLATION DATE:

**REQUIRED SPECIALTY:** EFFECTIVE DATE:
CANCELLATION DATE:

**DAY OF WEEK CODE:** EMERGENCY FROM TIME: __.__ EMERGENCY TO TIME: __.__
EFFECTIVE DATE:
CANCELLATION DATE:

**APPROVAL CATEGORY:** EFFECTIVE DATE:
CANCELLATION DATE:

APPROVED BY: Betty Louie DATE: April 27, 2010
UPDATED BY: DATE:
PER MOC: 10-047. Changes to the notes in the description.

ADD:
CHANGE:X

**MSP CLAIMS FEE SCHEDULE**
**FEE ITEM PROFILE**

**ITG #:**_____

**FEE ITEM:**14052

**TITLE:** GP Annual Chronic Care Incentive-(hypertension)

---------- **FEE ITEM PAYMENT INFORMATION** ----------

prefix 2: prefix 1:
eff dt: fee sched amnt: pvc applicable?:
can dt: amnt less pvc: $ _____ allowed # srvcs:
version number: 00 alternate amnt: $ _____ adjdctn # srvcs:
valid version?: Y minimum amount: $ _____ submit exact amnt?:
permutation?: surcharge : % _____

-- PATIENT RESTRICTIONS --- YY MM DD --------- SERVICE RESTRICTIONS ---------

nmbr srvcs: interval: location:
gender: min age: allow rcp?: out of country only?:
max age: pre-approval rqrd?: apb indicator:

---------- CLAIM PROCESSING INDICATORS ----------

routine block: sort key: type: INS code
service code: high use: msclns item?:
time rqrd?: interval: : (H:M) portion?:
referral rqrd?: non-refer fee item: overage cutoff date:
anaesth units: anaes intensity: anatomical area rqrd?: N
hospital visit: documentation rqrd?: N page #: _____ _____ _____

**DESCRIPTION:**

Incentive for Full Service General Practitioner - annual chronic care incentive (hypertension)

***Notes:***

*i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.*

*ii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.*

*iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.*

*iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14252.*

*v) Claim must include the ICD-9 code for hypertension (401).*

*vi) Payable once per patient in a consecutive 12 month period.*

*vii) Not payable if G14050, G14250, G14051, G14251 paid within the previous 12 months.*

*viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*

*ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

**BILLABLE RULE:** EFFECTIVE DATE:
CANCELLATION DATE:

**REQUIRED SPECIALTY:** EFFECTIVE DATE:
CANCELLATION DATE:

**DAY OF WEEK CODE:** EMERGENCY FROM TIME: __.__ EMERGENCY TO TIME: __.__
EFFECTIVE DATE:
CANCELLATION DATE:

**APPROVAL CATEGORY:** EFFECTIVE DATE:
CANCELLATION DATE:

APPROVED BY: Sakya Newman DATE: August 17, 2015
UPDATED BY: DATE:
PER MOC: 15-067

# BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD):2009-10-01**
**CANCEL DATE (CCYYMMDD): 2009-10-15** **TARGET TYPE: SP**
**TARGET KEY: 00-General Practice** **COPY MESSAGE FROM**

**BROADCAST TITLE: AMENDMENT TO DESCRIPTION FOR 14050, 14051, 14052**

**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

Effective September 15, 2009 the notes following fee items G14050, G14051, G14052 have been updated to remove reference to cancelled fee item 13050 and add the criteria for two visits in the preceding 12 months.

G14050 Incentive for Full Service General Practitioner
- annual chronic care bonus (diabetes mellitus)

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of diabetes mellitus.

iv) Care provided must be consistent with the BC clinical guideline recommendations for diabetes mellitus and may only be billed after 2 columns of the flow sheet have been completed and the patient has been seen at least twice in the preceding 12 months.

v) Claim must include the ICD-9 code for diabetes (250).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

G14051 Incentive for Full Service General Practitioner
- annual chronic care bonus (congestive heart failure)

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty
consultation fee within the preceding 12 months are not eligible.
ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline- based care.
iii) Applicable only for patients with confirmed diagnosis of congestive heart failure.
iv) Care provided must be consistent with the BC clinical guideline recommendations for congestive heart failure and may be billed once the Goals Column, Initial Review (baseline) Column and subsequent column (visit intervals to be determined by physician) have been completed and the patient has been seen at least twice in the preceding 12 months.
v) Claim must include the ICD-9 code for congestive heart failure (4280).
vi) This item may only be claimed once per patient in a consecutive 12 month period.
vii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

G14052 Incentive for Full Service General Practitioner
- annual chronic care bonus (hypertension)

Notes:
i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.
ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline-based care.
iii) Applicable only for patients with confirmed diagnosis of hypertension who do not also have a diagnosis of diabetes mellitus and/or congestive heart failure.
iv) Care provided must be consistent with the BC clinical guideline recommendations for hypertension.
v) May only be billed after the patient has been provided guideline based care for one year and the patient has been seen at least twice in the

preceding 12 months. The patient must be given a copy of their flow sheet.

vi) Claim must include the ICD-9 code for hypertension (401).

vii) This item may only be claimed once per patient in a consecutive 12 month period.

viii) Not payable if 14050 or 14051 claimed within the previous 12 months.

ix) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

**INITIATED BY: Val Johnson**

**Copy to BCMA _____**

| **IF TARGET TYPE IS** | **THEN TARGET KEY IS** |
|---|---|
| **PY**-PAYEES | PAYEE NO. |
| **PR**- PRACTITIONER | PRACTITIONER NO. |
| **SP**-SPECIALTY | SPECIALTY CODE |
| **AI**-ASSOCIATION IDENTIFIER | MD – BC MEDICAL ASSOCIATION |
| **A** -ALL | LEAVE TARGET KEY BLANK |
| **PS**-PAYEE STATUS | **C** - VESTED INTEREST LAB |
| | **V** PRIMARY CARE |
| | **H** - HOSPITAL |
| | **I** - INACTIVE PAYEE |
| | **L** - LABORATORY |
| | **M** - ACTIVE PAYEE |
| | **V** - 3RD PARTY- OUT OF PROVINCE |

# BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD):2014-11-01**
**CANCEL DATE (CCYYMMDD): 2014-11-15** **TARGET TYPE: SP**
**TARGET KEY: 00-General Practice** **COPY MESSAGE FROM**

**BROADCAST TITLE: Enforcing minimum visit requirements on CDM fees**
**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

The following note is listed under the General Practice Services Committee (GPSC) Chronic Disease Management fee items G14050, G14051, G14052 and G14053:
"This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months."

Effective immediately MSP will be refusing claims for GPSC chronic disease management fee items 14050, 14051, 14052 and 14053 with explanatory code RV if there has not been two face-to-face visits within the previous 12 months.

MSP will be checking for two visits by the General Practitioner (GP) who bills the CDM fee item. If there are not two visits by this GP, MSP will check for visits by another GP. Include a note record on your billing for the CDM item if a locum or associated GP has provided visits to your patient in your absence and you want this visit(s) counted towards the two face-to-face visit minimum requirement.

**Explanatory code RV-** "The patient has not been seen face-to face at least twice in the preceding 12 months. (This visit requirement excludes procedures, laboratory and x-rays)".

**INITIATED BY: Val Johnson**

**Copy to BCMA _____**

**AUTHORIZED BY_____**

| **IF TARGET TYPE IS** | **THEN TARGET KEY IS** |
|---|---|
| **PY**-PAYEES | PAYEE NO. |
| **PR**- PRACTITIONER | PRACTITIONER NO. |
| **SP**-SPECIALTY | SPECIALTY CODE |

**AI**-ASSOCIATION IDENTIFIER---------- ----MD – BC MEDICAL ASSOCIATION
**A** -ALL ---------- ---- ----------LEAVE TARGET KEY BLANK
**PS**-PAYEE STATUS ---------- ----------**C** - VESTED INTEREST LAB
**F** PRIMARY CARE
**H** - HOSPITAL
**I** - INACTIVE PAYEE
**L** - LABORATORY
**M** - ACTIVE PAYEE
**V** - 3RD PARTY- OUT OF PROVINCE
**Y** – ALTERNATIVE PAYMENTS PROGRAM

# BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD):2009-12-15**
**CANCEL DATE (CCYYMMDD): 2009-12-31** **TARGET TYPE: SP**
**TARGET KEY: 00 – General Practice** **COPY MESSAGE FROM**

**BROADCAST TITLE: REVISIONS TO CDM INCENTIVES**

**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

## EFFECTIVE JANUARY 1, 2010:

The previous note stating that billings may be submitted after 2 columns of the flow sheet have been completed has been deleted and replaced with the requisite that cdm incentives may only be billed after one year of care has been provided.

Notes ii) and iv) under fee items G14050, G14051 have been amended as follows:

G14050 Incentive for Full Service General Practitioner
- Annual Chronic Care Bonus – Diabetes Mellitus
Notes:

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.

iv) Care provided must be consistent with the BC clinical guideline recommendations for Diabetes Mellitus and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. While it is not mandatory that patients must be provided a copy of their flow sheet, this is encouraged in order to facilitate patient self management.

G14051 Incentive for Full Service General Practitioner
- Annual Chronic Care Bonus – Congestive Heart Failure
Notes:

ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.

iv) Care provided must be consistent with the BC clinical guideline recommendations for Congestive Heart failure and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.

Note ii) has been amended and note iv) and v) have been combined for the new note iv) and the remaining notes have been renumbered for fee item G14052.

G14052 Incentive for Full Service General Practitioner
- Annual Chronic Care Bonus – Hypertension
Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.
ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.
iii) Applicable only for patients with confirmed diagnosis of hypertension.
iv) Care provided must be consistent with the BC clinical guideline recommendations for Hypertension and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their flow sheet in order to facilitate patient self management.
v) Claim must include the ICD-9 code for hypertension (401).
vi) This item may only be claimed once per patient in a consecutive 12 month period.
vii) Not payable if G14050 or G14051 claimed within the previous 12 months.
viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

**INITIATED BY: Val Johnson**

**Copy to BCMA _____**

| IF TARGET TYPE IS | THEN TARGET KEY IS |
|---|---|
| **PY**-PAYEES | PAYEE NO. |
| **PR**- PRACTITIONER | PRACTITIONER NO. |
| **SP**-SPECIALTY | SPECIALTY CODE |
| **AI**-ASSOCIATION IDENTIFIER | MD – BC MEDICAL ASSOCIATION |
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| **PS**-PAYEE STATUS | **C** - VESTED INTEREST LAB |
| | **V** PRIMARY CARE |
| | **H** - HOSPITAL |
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| | **L** - LABORATORY |
| | **M** - ACTIVE PAYEE |
| | **V** - 3RD PARTY- OUT OF PROVINCE |

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# MEDICAL SERVICES COMMISSION

# MINUTE OF THE COMMISSION

09 - 125



**Amendment to the Medical Services Commission Payment Schedule**
**Section of General Practice**

Pursuant to the 2006 Letter of Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

**Amendments:**

The following amendments are effective September 15, 2009:

Note iv) is amended and Note vii) is deleted. Therefore, Note viii) will become note vii):

G14050 Incentive for Full Service General Practitioner
- annual chronic care bonus (diabetes mellitus) ..... 125.00

***Notes:***

*i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*

*ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline-based care.*

*iii) Applicable only for patients with confirmed diagnosis of diabetes mellitus.*

*iv) Care provided must be consistent with the BC clinical guideline recommendations for diabetes mellitus and may only be billed after 2 columns of the flow sheet have been completed and the patient has been seen at least twice in the preceding 12 months.*

*v) Claim must include the ICD-9 code for diabetes (250).*

*vi) This item may only be claimed once per patient in a consecutive 12 month period.*

*vii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

Note iv) is amended and Note vii) is deleted. Therefore, Note viii) will become note vii):

G14051 Incentive for Full Service General Practitioner
- annual chronic care bonus (congestive heart failure)

***Notes:***

*i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*

*ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline- based care.*

*iii) Applicable only for patients with confirmed diagnosis of congestive heart failure.*

*iv) Care provided must be consistent with the BC clinical guideline recommendations for congestive heart failure and may be billed once the Goals Column, Initial Review (baseline) Column and subsequent column (visit intervals to be determined by physician) have been completed and the patient has been seen at least twice in the preceding 12 months.*

*v) Claim must include the ICD-9 code for congestive heart failure (4280).*

*vi) This item may only be claimed once per patient in a consecutive 12 month period.*

*vii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

Note v) and viii) are amended:

G14052 Incentive for Full Service General Practitioner
- annual chronic care bonus (hypertension)

***Notes:***

*i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*

*ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided an adequate level of guideline-based care.*

# MINUTE OF THE COMMISSION



iii) *Applicable only for patients with confirmed diagnosis of hypertension who do not also have a diagnosis of diabetes mellitus and/or congestive heart failure.*
iv) *Care provided must be consistent with the BC clinical guideline recommendations for hypertension.*
v) *May only be billed after the patient has been provided guideline based care for one year and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their flow sheet.*
vi) *Claim must include the ICD-9 code for hypertension (401).*
vii) *This item may only be claimed once per patient in a consecutive 12 month period.*
viii) *Not payable if 14050 or 14051 claimed within the previous 12 months.*
ix) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

Bob de Faye
Chair
Medical Services Commission

Dated this 14th day of September AD 20 09.

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# MEDICAL SERVICES COMMISSION

# MINUTE OF THE COMMISSION



**Amendment to the Medical Services Commission Payment Schedule**
**Section of General Practice**

10-047

Pursuant to the 2006 Letter of Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

**Amendment:**

The following notes are amended effective, January 1, 2010:

G14050 Incentive for Full Service General Practitioner
- annual chronic care bonus (diabetes mellitus) ..... $125.00

***Notes:***

*i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*

*ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.*

*iii) Applicable only for patients with confirmed diagnosis of diabetes mellitus.*

*iv) Care provided must be consistent with the BC clinical guideline recommendations for Diabetes Mellitus and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.*

*v) Claim must include the ICD-9 code for diabetes (250).*

*vi) This item may only be claimed once per patient in a consecutive 12 month period.*

*vii) Payable when other CDM items G14051 or G14053 have been paid on the same patient.*

*viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14051 Incentive for Full Service General Practitioner
- annual chronic care bonus (congestive heart failure) ..... $125.00

***Notes:***

*i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*

*ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.*

*iii) Applicable only for patients with confirmed diagnosis of congestive heart failure.*

*iv) Care provided must be consistent with the BC clinical guideline recommendations for Congestive Heart failure and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.*

*v) Claim must include the ICD-9 code for congestive heart failure (428).*

*vi) This item may only be claimed once per patient in a consecutive 12 month period.*

*vii) Payable when other CDM items G14050 or G14053 have been paid on the same patient.*

*viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14052 Incentive for Full Service General Practitioner
- annual chronic care bonus (hypertension) ..... $50.00

***Notes:***

*i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*

*ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.*

*iii) Applicable only for patients with confirmed diagnosis of hypertension.*

*iv) Care provided must be consistent with the BC clinical guideline recommendations for Hypertension and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their flow sheet in order to facilitate patient self management.*

*v) Claim must include the ICD-9 code for hypertension (401).*

*vi) This item may only be claimed once per patient in a consecutive 12 month period.*

*vii) Not payable if G14050 or G14051 claimed within the previous 12 months.*

*viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

# MINUTE OF THE COMMISSION



G14053 Incentive for Full Service General Practitioner
- annual chronic care bonus (Chronic Obstructive Pulmonary Disease-COPD) ..... $125.00

***Notes:***

*i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*

*ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline-based care.*

*iii) Applicable only for patients with confirmed diagnosis of COPD.*

*iv) Care provided must be consistent with the BC clinical guideline recommendations for COPD and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their personalized COPD care plan in order to facilitate patient self management.*

*v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*

vi) *This item may only be claimed once per patient in a consecutive 12 month period.*

*vii) Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.*

*ix) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

**Amendment:**

The following fee item is increased effective the quarter ending December 31, 2009:

G14010 Maternity Care Network Initiative Payment ..... $2100.00

Bob de Faye
Chair
Medical Services Commission

Dated this 8th day of April AD 20 10.

BRITISH COLUMBIA

# MEDICAL SERVICES COMMISSION



18 - 044

**Amendment to the Medical Services Commission Payment Schedule**
**Section of General Practice**
**General Practice Services Committee Funded Fee Items**

Pursuant to the 2014 Physician Master Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

**Amendment:**
Fee item notes are amended to include reference to Telehealth visits. These changes are effective February 15, 2018 (deletions in strikethrough, changes in bold type).

G14050 Incentive for Full Service General Practitioner
- annual chronic care incentive (diabetes mellitus)
***Notes:***
iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 -prior to October 2017) or
2. a group medical visit (13763-13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

G14051 Incentive for Full Service General Practitioner
- annual chronic care incentive (heart failure)
***Notes:***
iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 -prior to October 2017) or
2. a group medical visit (13763-13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

G14052 Incentive for Full Service General Practitioner
- annual chronic care incentive (hypertension)
***Notes:***
iii) This item may only be billed after one year of care has been provided

including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 -prior to October 2017) or
2. a group medical visit (13763-13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

G14053 Incentive for Full Service General Practitioner
- annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD)
***Notes:***
iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 -prior to October 2017) or
2. a group medical visit (13763-13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

G14250 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus)
***Notes:***
iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 -prior to October 2017) or
2. a group medical visit (13763-13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

G14251 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (heart failure)
***Notes:***
iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 - prior to October 2017) or
2. a group medical visit (13763 -13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

G14252 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (hypertension)
***Notes:***
iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 - prior to October 2017) or
2. a group medical visit (13763 -13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

G14253 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive
(Chronic Obstructive Pulmonary Disease- COPD)
***Notes:***

iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076, G14079 - prior to October 2017) or
2. a group medical visit (13763 -13781) or
3. **a telehealth visit (13017, 13018, 13037, 13038) or**
4. ~~3.~~ an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

The change to fee item G14043, note vii) is effective October 1, 2017:

G14043 GP Mental Health Planning Fee
Notes:

vii) G14015, G14044, G14045, G14046, G14047, G14048, G14033, G14063, ~~G14074~~, G14075, G14076 and G14078 not payable on the same day for the same patient.

Dr. Robert Halpenny
Chair
Medical Services Commission

Dated this 4th day of April AD 20 18.

# BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD):2006-10-16**
**CANCEL DATE (CCYYMMDD): 2006-10-31** **TARGET TYPE: SP**
**TARGET KEY: 00-GENERAL PRACTICE** **COPY MESSAGE FROM**

**BROADCAST TITLE: FEE ITEM 14050/14051-REMINDER TO RESUBMIT**

**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

Fee item 13050-annual chronic care bonus diabetes or congestive heart failure -$75.00 was retroactively cancelled March 31, 2006. It was replaced with the following fee items at an increased rate:
14050-incentive for full service GP annual chronic care bonus-diabetes-$125.00
14051- incentive for full service GP annual chronic care bonus-congestive heart failure.-$125.00

Most claims for fee item 13050 submitted between May 5 and June 6, 2006 were paid under the new fee items at the increased fee. However, many claims were already paid for April/May 2006 dates of service under fee item 13050-$75.00.

Please resubmit under fee item 14050 or 14051 if you were paid under fee item 13050 for services provided in April or May 2006. Use submission code A and submit before December 23, 2006.

**INITIATED BY: Val Johnson**

**Copy to BCMA _____**

**AUTHORIZED BY: Janet van Klaveren**

| **IF TARGET TYPE IS** | **THEN TARGET KEY IS** |
|---|---|
| **PY**-PAYEES | PAYEE NO. |
| **PR**- PRACTITIONER | PRACTITIONER NO. |
| **SP**-SPECIALTY | SPECIALTY CODE |
| **AI**-ASSOCIATION IDENTIFIER | MD – BC MEDICAL ASSOCIATION |
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| | **M** - ACTIVE PAYEE |
| | **V** - 3RD PARTY- OUT OF PROVINCE |

# BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD): 2006-05-16**

**CANCEL DATE (CCYYMMDD): 2006-05-31** **TARGET TYPE: SP__**

**TARGET KEY: 00 –GENERAL PRACTITIONER** **COPY MESSAGE FROM:**
**_____**

**BROADCAST TITLE: GENERAL PRACTICE ONE TIME INCENTIVE PAYMENTS (14020)**

**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

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General practitioners who, as of April 1, 2006, have provided care, are eligible to bill and have billed 13050 for at least ten patients with diabetes or congestive heart failure by completing the patient flow sheets since the inception of the program in 2003, and/or have performed at least five deliveries (fee codes 14104 or 14109) in the preceding 12 months, will receive a one time payment of $2500. Any physician who has been paid a specialist consult fee since the inception of this program in 2003 is not eligible for this payment.

If you meet all of the criteria submit your claim as follows:
In the fee item field: 14020
Claim amount: $2,500.00
In the patients PHN field: 9812530133
In the Last name field: Gpbonus
In the First initial field: T
If you require a date of birth, use: March 6, 1990
For Date of service use: April 1, 2006
Report the Diagnosis as: V68

V68 is the ICD-9 code for “encounters for administrative purposes”.

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In addition:
General practitioners who, as of June 30, 2006, have provided care, are eligible to bill and have billed 13050, 14050, 14051 or 14052 for at least ten patients with diabetes, congestive heart failure or hypertension by completing a CDM patient flow sheet and /or have performed at least five deliveries (fee codes 14104 or 14109) in the preceding 12 months, will receive a one time payment of $7500. Any physician who has been paid a specialist consult fee since the inception of this program in 2003 is not eligible for this payment.

When submitting your claim use the same information as indicated above except:
Claim amount: $7500.00
For date of service use: June 30, 2006

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Note: Claims submitted before the date of service will be refused.

More information about the General Practice One Time Incentive Payment is available at: http://www.health.gov.bc.ca/cdm/practitioners/index.html

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**INITIATED BY**:

Copy to BCMA _____

**AUTHORIZED BY: Janet van Klaveren**

| **IF TARGET TYPE IS** | | **THEN TARGET KEY IS** |
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# BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD):2006-05-16**
**CANCEL DATE (CCYYMMDD): 2006-05-31** **TARGET TYPE: SP**
**TARGET KEY: 00-GENERAL PRACTITIONER** **COPY MESSAGE FROM**

**BROADCAST TITLE: GP-ANNUAL CHRONIC CARE BONUS FEE ITEM CHANGES**

**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

Fee item 13050 –incentive for full service gp-annual chronic care bonus (diabetes and congestive heart failure) is cancelled March 31, 2006 and replaced with the following fee items effective April 1, 2006:

14050- incentive for full service gp-annual chronic care bonus (diabetes)-$125.00
Notes:
i.General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.
ii.Payable to the general practice full service family physician who has provided the majority of the patients longitudinal general practice care over the preceding year and who has provided an adequate level of guideline based care.
iii.Applicable only for patients with confirmed diagnosis of diabetes mellitus
iv.Care provided must be consistent with the BC clinical guideline recommendations for diabetes mellitus and may only be billed after 2 columns of the flow sheet have been completed.
v.Claim must include the ICD_9 code for diabetes (250)
vi.This item may only be claimed once per patient in a consecutive 12 month period
vii.Not payable if 13050 claimed within the previous 12 months for the same diagnosis.
viii.If a visit is provided on the same date the bonus is billed both services will be paid at the full fee.

14051- incentive for full service gp-annual chronic care bonus (congestive heart failure)-$125.00
Notes:
i. General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii. Payable to the general practice full service family physician who has provided the majority of the patients longitudinal general practice care over the preceding year and who has provided an adequate level of guideline based care.
iii. Applicable only for patients with confirmed diagnosis of congestive heart failure.
iv. Care provided must be consistent with the BC clinical guideline recommendations for congestive heart failure and may be billed once the Goals Column, Initial Review (baseline) Column and subsequent column (visit intervals to be determined by physician) have been completed.
v. Claim must include the ICD_9 code for congestive heart failure (4280)
vi. This item may only be claimed once per patient in a consecutive 12 month period.
vii. Not payable if 13050 claimed within the previous 12 months for the same diagnosis.
viii. If a visit is provided on the same date the bonus is billed both services will be paid at the full fee.

If you previously submitted and were paid under fee item 13050-$75.00 for dates of service commencing April 1, 2006 please send an electronic debit request to withdraw the payment and resubmit under fee item14050 or 14051. Claims for April or May 2006 service dates submitted under fee item 13050 after May 4, 2006 and before June 7, 2006 will be paid as 14050 or 14051 at $125.00.
Claims submitted on May 18, 2006 for fee item 13050 for April and May 2006 service dates were inadvertently refused with explanatory code VG. Please do not resubmit as these claims will be reprocessed for payment under the new fee items.

**INITIATED BY: Val Johnson**

**Copy to BCMA _____**

**AUTHORIZED BY: Janet van Klaveren**

| **IF TARGET TYPE IS** | **THEN TARGET KEY IS** |
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## BROADCAST MESSAGES

**EFFEC. DATE (CCYYMMDD):2009-09-01**
**CANCEL DATE (CCYYMMDD): 2009- 09-15 TARGET TYPE: SP**
**TARGET KEY: 00-GP COPY MESSAGE FROM**

**BROADCAST TITLE: New GPSC fees-COPD**

**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**
The following new General Practices Services Committee (GPSC) chronic disease management fees for Chronic obstructive pulmonary disease (COPD) are effective September 15, 2009 and may be submitted commencing September 22, 2009.

Eligibility:
These payments are available to all general practitioners who have a valid B.C. Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months, and:

- Whose majority professional activity is in full service family practice as described in the introduction, and
- Who have provided the patient the majority of their longitudinal general practice care over the preceding year, and

- Have provided the requisite level of guideline-based care

G14053 Annual Chronic Care Bonus (Chronic Obstructive Pulmonary Disease- COPD)…….. ..... $125.00
Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.
ii) Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the

preceding year and who has provided the requisite level of guideline-based care.

iii) Applicable only for patients with confirmed diagnosis of COPD.

iv) Care provided must be consistent with the BC clinical guideline recommendations for COPD and may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months. The patient must be given a copy of their personalized COPD care plan.

v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492) bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).

vi) This item may only be claimed once per patient in a consecutive 12 month period.

vi) Payable when other CDM items 14050, 14051 or 14052 have been paid on the same patient.

viii) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

G14073 – COPD Telephone/Email Management Fee…….$15.00
This fee is payable for 2-way communication with eligible patients via telephone or email for the
provision of clinical follow-up management of a patient's COPD by the GP who has billed and been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

i. Payable to a maximum of 4 times per patient in the 12 months following the successful billing of the GPSC Annual Chronic Care Bonus for COPD (G14053)

ii. Not payable unless the GP/FP is eligible for and has been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053

iii. Telephone/Email Management requires 2-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office or laboratory appointments or of referrals

iv. Payable only to the physician paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) unless that physician has agreed to share care with another delegated physician
v. G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14016
vi. Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016
vii. Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed

Additional information regarding these new items is/will be available on the following websites:
http://www.primaryhealthcarebc.ca/phc/gpsc_incentive.html
https://www.bcma.org/gpsc-gp-services-committee-incentive-update

The COPD and other guidelines are posted at :
www.bcguidelines.ca

**INITIATED BY: Val Johnson**

**Copy to BCMA _____**

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BRITISH COLUMBIA

# MEDICAL SERVICES COMMISSION

# MINUTE OF THE COMMISSION



18 - 141

**Amendment to the Medical Services Commission Payment Schedule**
**Section of General Practice**
**General Practice Services Committee Funded Fee Items**

Pursuant to the 2014 Physician Master Agreement, the Medical Services Commission supports access and improvement to full service family practice by recognizing the following fee items initiated by the General Practice Services Committee.

**Amendment:**

The following wording is amended (strikethrough deleted), effective September 30, 2018:

| | Total Fee $ |
|---|---|

**1. Expanded Full Service Family Practice Condition-based Payments**

The GPSC Condition-based Payments compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full year. The goal is to improve provision of clinically appropriate care that considers both the patient's values and the impact of comorbidities. To confirm an ongoing doctor-patient relationship, there must be at least 2 visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC Telephone Visit (G14076~~, G14079 prior to October 2017~~), Group Medical Visit (13763 -13781) or an in person visit with a college certified allied health provider working within the family physicians practice (G14029) billed on each qualifying patient in the 12 months prior to billing the CDM incentive. Visits provided by a locum or colleague covering for the MRP GP are included; however, an electronic note indicating this must be submitted with the claim. Patients in long-term care facilities are eligible. Clinical judgment must be used to determine the appropriateness of following clinical practice guidelines in all patients, particularly those with dementia or very limited life expectancy. Documentation of the provision of guideline-informed care for the specific condition is required in the medical record. Although use of the GPAC Chronic Care flow sheets is not mandatory, they are a useful tool for tracking care provided to patients over time. Condition-based payments are no longer payable once G14063, the Palliative Planning Incentive has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

**Amendment:**

The following wording is amended (strikethrough deleted) for the indicated fee items, effective September 30, 2017:

| | | Total Fee $ |
|---|---|---|
| G14050 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (diabetes mellitus) | 125.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 prior to October 2017~~) or*
2. *a group medical visit (13763-13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

| | | |
|---|---|---|
| G14051 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (heart failure) | 125.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 prior to October 2017~~) or*
2. *a group medical visit (13763-13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

| | | |
|---|---|---|
| G14052 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (hypertension) | 50.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 prior to October 2017~~) or*
2. *a group medical visit (13763-13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

| | | |
|---|---|---|
| G14053 | Incentive for Full Service General Practitioner<br>- annual chronic care incentive (Chronic Obstructive Pulmonary Disease-COPD) | 125.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 prior to October 2017~~) or*
2. *a group medical visit (13763-13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

| | | Total Fee $ |
|---|---|---|
| G14250 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus) | 125.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 - prior to October 2017~~) or*
2. *a group medical visit (13763-13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

| | | |
|---|---|---|
| G14251 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (heart failure) | 125.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 - prior to October 2017~~) or*
2. *a group medical visit (13763 -13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

| | | |
|---|---|---|
| G14252 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (hypertension) | 50.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 - prior to October 2017~~) or*
2. *a group medical visit (13763 -13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

| | | |
|---|---|---|
| G14253 | Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD) | 125.00 |

***Notes:***

*iii) This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:*

1. *a telephone visit (G14076~~, G14079 - prior to October 2017~~) or*
2. *a group medical visit (13763 -13781) or*
3. *a telehealth visit (13017, 13018, 13037, 13038) or*
4. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

# MINUTE OF THE COMMISSION



| | | Total Fee $ |
|---|---|---|
| G14044 | GP Mental Health Management Fee age 2 – 49 | 54.35 |
| G14045 | GP Mental Health Management Fee age 50 - 59 | 59.78 |
| G14046 | GP Mental Health Management Fee age 60 - 69 | 62.49 |
| G14047 | GP Mental Health Management Fee age 70 - 79 | 70.64 |
| G14048 | GP Mental Health Management Fee age 80+ | 81.51 |

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee G14043 has been successfully billed. The four MSP counselling fees (any combination of age-appropriate 00120 or telehealth counselling) must first have been paid in the same calendar year.

The following list of diagnosis and acceptable ICD9 codes are applicable for the Mental Health Planning and Management Fee, fee items G14043, G14044 – G14048~~, and G14079~~:

Dr. Robert Halpenny
Chair
Medical Services Commission

Dated this 4th day of December AD 2018