GP SERVICES COMMITTEE

Attachment INITIATIVE

2017

GPSC General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP Society of General Practitioners of BC

Attachment Codes

GPSC Incentives for Attachment

While the "A GP for Me" initiative formally ended March 31, 2016, until further discussion and a decision by the GPSC has been made, the Attachment fee codes will continue to be available to all family doctors who submit the MSP fee G14070 'GP Attachment Participation Code', a zero-sum amount, at the beginning of the calendar year. This will in turn open the door to the Attachment suite of fees. 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'.
- 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.

Prior to submitting the initial GP Attachment Participation Code, each participating Family Physician must be registered as "participating" with their local division, even if he/she is not a member of that 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

When providing services in an "Attachment Participating" family practice, locum physicians are also able to access the fee codes 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 must discuss and mutually agree on which of the GPSC Services including those covered through the Attachment Initiative may be provided and billed by the locum. Submission of this 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.

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

1. Attachment Participation

G14070 GP Attachment Participation Code $0.00

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

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

PHN#: 975 303 5697
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'.
- 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.

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.

(See FAQ #1.11 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14070 - GP Attachment Participation Code:

1.1 How do I submit the GP Attachment Participation code (G14070)?

The Attachment Initiative requires participating FPs to notify their local Division of Family Practice (if one exists) of their willingness to participate as they are able. Once the DoFP has been notified the, the FP must submit the GP Attachment Participating Code G14070 in order to then have access to the additional Attachment Fee supports.

In subsequent years, in order to continue to access the Attachment fee supports G14074, G14075, G14076 & G14077, at the beginning of each calendar year, participating FPs must re-submit fee item G14070 GP Attachment Participation Code indicating their intention to continue to participate in the program.

To submit code G14070 use diagnostic code **780** and the following program "Patient" demographic information:

PHN#: 975 303 5697
Patient Surname: Participation
First name: Attachment
Date of Birth: January 1, 2013

Once processed by MSP, this will then allow access to the other Attachment Portal fees for the balance of that calendar year.

1.2 What are the new incentive fees is available to family doctors who participate?

The new attachment fees that are available to family physician as of April 1, 2013, include:

- **G14074 GP Unattached Complex/High Needs Patient Attachment Fee**
- **G14075 GP Attachment Complex Care Management Fee**
- **G14076 GP Attachment Telephone Management Fee**
- **G14077 GP Attachment Patient Conferencing Fee**

These fee codes for the Attachment initiative will be available to all family doctors who submit through MSP the GP Attachment Participation code (G14070) at the beginning of each calendar year, which will in turn open the door to the new Attachment initiative suite of fees. Billing the zero sum fee code G14070 also signifies to the division that you, as a physician, are willing to participate in the community-level Attachment initiative to the degree that you are able.

1.3 Will the billing of this trigger any indication that the physician is now taking new Patients?

The submission of code G14070, the GP Attachment Participation Code, will NOT trigger anything regarding the FP taking on new patients. The ability and willingness of individual FPs to accept new patients is voluntary and as they are able. The GPSC is hopeful that with the Attachment supports (Practice, Divisional and System level); participating FPs will take on some of the unattached patients in the target population under the Unattached Complex/High-needs Patient Attachment initiative (G14074).

1.4 Are we expected to take on new patients?

No, participation in the Attachment initiative is voluntary. If you choose to participate you will not be forced to take on patients that you do not want; the commitment states you must participate at the community level "as you are able".

However, the program is designed to help create capacity within the existing system:

- The telephone visits available through the Attachment initiative suite of fee codes have been shown in other jurisdictions to increase efficiency and therefore practice capacity.
- The new Attachment incentives related to patients with complex, chronic conditions are designed to support you if you do choose to take on these individuals.
- The three Attachment prototype communities have demonstrated that community-level planning through local divisions has created capacity.

So, you may find that participation in the Attachment initiative does create capacity in your practice, enabling you to take on more patients if you wish.

1.5 Are Family Physicians working in focused practices eligible to participate in the Attachment Initiative and access the Attachment and other GPSC fees?

The intent of the Attachment Initiative and its incentives is to facilitate the attachment of currently unattached complex/high-needs patients as well as support the relationship between patients (both already attached and newly attached) and their personal Family Physician. It is this longitudinal relationship and the provision of the broad spectrum of services of Family Medicine (Prevention, Acute needs and Chronic Disease management, etc.) as opposed to focused practices organizing the care around a specific area – HIV, Addictions, Mental Health, etc. that all the GPSC incentives (except the GP with Specialty Training) were developed to support. If a Family Physician is committing to the provision of this broad spectrum of services and not just the services focused on a specific condition for patients who are attached to the FP, regardless of location of the provision of these services (ie. whether in own community FP office or through a focused practice clinic) then that FP is eligible to participate in the Attachment Initiative and can the access the Attachment (and other) GPSC incentives for those patients for whom he/she is the community MRP FP.

GPSC cautions FPs to remember the intent and mandate of the focused practice area as these have often been developed to provide enhanced services to a broader population specifically around the relevant conditions, and by taking patients into the longitudinal FP practice, there may be the unintended consequence of reducing capacity for providing these focused services.

1.6 How do Full Service Family Physicians providing longitudinal comprehensive care in a shared group setting participate in the Attachment Initiative?

The intent of the Attachment Initiative and its incentives is to facilitate the attachment of currently unattached complex/high-needs patients as well as support the relationship between patients (both already attached and newly attached) and their personal Family Physician. It is this longitudinal relationship and the provision of the broad spectrum of services of Family Medicine (Prevention, Acute needs and Chronic Disease management) that all the GPSC incentives (except the GP with Specialty Training) were developed to support.

Being in a shared practice does not remove the need to have a FP who is still responsible for this coordinating role. Therefore, while there is no requirement to submit an attachment code to MSP indicating which FP any patient is attached or assigned to, in the patient record there must be a specific FP who is committing to the provision of this broad spectrum of services and taking on the overall responsibility of the coordination of the care needs for the patient even if the care is shared with others. This could be done based on who saw a new patient for intake, or for existing patients, assigned to the FP who provided the majority of services or, if there is no identifiable individual “Most Responsible Family Physician” (MRP), then assigned under some sharing agreement across the FPs in the group practice. Previously groups such as these have been given permission to bill for GPSC incentives provided they assign each patient to one member of the group as the MRP FP, preferably the one who is the Majority Source of Care provider.

1.7 I provide longitudinal care but my practice is already full. So a new doctor can access these new fees and reap economic benefits, as can doctors that haven’t previously been providing longitudinal care. Why can’t I?

Several of the attachment fees are aimed at rewarding longitudinal care that is already being provided by family doctors. These include fees for telephone consultations and an expanded scope of complex care fees for your existing patients. GPSC believes that

these fee codes make it possible for physicians to work in more flexible ways, enabling patients to talk to you on the phone for matters that don't require an in-person visit. Expansion of patient eligibility for complex care enables doctors to include more patients in this billing category as well.
You do not need to take on new patients to benefit. However, if these other measures help you increase efficiency in your practice and you choose to take on new patients at some point in the future, you will also have access to the new patient fees.

1.8 How will participating in this initiative help doctors?

Through this initiative, family physicians will be provided with both practice-level and community-level supports. New fees will improve practice efficiencies through telephone 'visits', and family physicians will be better compensated and supported for the time required to provide longitudinal care to more complex patients.

Community-level efficiencies can be developed by local divisions, again increasing the capacity of primary care in the community in which you work.

Family doctors will also have opportunities for input – through Divisions of Family Practice – into primary care planning at the community level, aimed at coordinating and, if needed, enhancing access to services.

Finally, family doctors will be positioned at the centre of primary care delivery, and awareness of their important role will be built through focused communication and enhanced patient relationships.

1.9 I want to participate, but I don't have a local division that is participating. What can I do?

While over 95% of Family Physicians now have access to a local division, there are still some communities that do not have one. If you do not have a local division, you should consult your local colleagues to see if there is interest in participating. If there is, contact us through www.divisionsbc.ca to indicate your interest and you will receive assistance in establishing either a division or an alternate process if forming a full division is not feasible.

You are entitled to submit the Attachment participation code as long as you meet all requirements, and then also to access the Attachment fees.

1.10 What is meant by my needing to 'confirm your doctor-patient relationship with your existing patients'?

Doctors and patients participated in the drafting of an informal doctor-patient conversation (sometimes referred to as a 'Compact') that is being used to confirm patient attachment.

The three prototype Attachment communities helped develop wording for this doctor-patient conversation and, more recently, focus groups were held to test the language of the compact. Here is the resulting wording:

As your family doctor, my practice team and I will:

- *Provide you with the best care that we can*
- *Coordinate any specialty care that you need*
- *Offer you timely access to care within the best of our ability*
- *Maintain an ongoing record of your health*
- *Keep you up-to-date on any changes to the services offered at our office*
- *Communicate with you honestly and openly to address your health care needs.*

As my patient, I ask that you:

- *Seek your health care from me and my team whenever possible*

- *Identify me as your doctor if you have to visit an emergency facility or other health care provider, so they can provide me with information about your treatment for your medical record*
- *Communicate with me honestly and openly so that we can best address your health care needs.*

You do not need to call in your patients to discuss this or mail information individually. Materials have been created that provide this information to patients; you may choose to use these materials in your office and offer them to your patients. You can download the materials from the GPSC website (gpscbc.ca/attachment-initiative).

1.11 How does GPSC define Alternately Paid Physicians "APP" for any of its incentives?

For the purposes of GPSC incentives, including both the Attachment and In-patient Initiative incentives, the GPSC is referring to physicians who are working under MoH or Health Authority paid APP contracts. Local group decisions to pool FFS billings and pay out in a mutually agreeable way (eg. per day, per shift, per hour, etc) are not considered APP by GPSC. If the services that are supported through the GPSC incentives are already included within the time for which a physician is paid under the contract, then it is not appropriate to also bill for the GPSC incentives.

G14071 GP Locum Attachment Participation Code $0.00

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.

Submit fee item G14071 GP Attachment Locum Participation Code use diagnostic code 780 and the following "Patient" demographic information each year:

PHN#: 975 303 5697
Patient Surname: Participation
First name: Attachment
Date of Birth: January 1, 2013

Submission of this 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.
-

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.

(See FAQ #1.11 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14071 GP Locum Attachment Participation Code:

Which of the Attachment Incentive fees, if any, can a locum bill when working in an Attachment Participating Practice?

There needs to be a discussion between the host FP and the locum as to the provision of any service that is covered by any GPSC incentive regardless if the host FP is participating in the Attachment Initiative. Many of the GPSC incentives are for services or care that goes beyond the individual visit. For example, both Complex Care incentives include planning visit and pre-payment for time, intensity and complexity in the coming year, not just for the duration of the locum.

Since the host FP is responsible for the follow-up management of the care incented through the initiatives, it must be agreed that it would be appropriate for the service to be provided by the locum. There are also implications in how the provision of these services and the resulting billing of the incentive fees will be treated in the locum agreement for fee splitting/payment. The host FP and locum must come to an agreement on this issue prior to any GPSC incentives being billed on behalf of services provided by locums. (See Appendix 1. For SGP Locum checklist)

The following are the Attachment Incentive codes that can be billed on behalf of locums:

1. **G14071 – GP Locum Attachment Participation Code**

   Since locums have no longitudinal practice of their own, they do not need to bill the G14070 Attachment participation code. However, in order to facilitate the billing for services provided by the locum covering in an Attachment participating practice, the GPSC has developed the GP Locum Attachment Participation Code G14071 which will remove the need to submit any e-notes when billing any of the Attachment Incentive fee codes. Fee item should be submitted at the beginning of each calendar year or prior to providing the first locum coverage for a family physician participating in the attachment initiative. To submit code G14071 use diagnostic code **780** and the following program "Patient" demographic information:

   PHN#: 975 303 5697
   Patient Surname: Participation
   First name: Attachment
   Date of Birth: January 1, 2013

2. **G14074 – Complex/High-needs Unattached Patient Attachment Fee**

   If the host FP is agreeable to the locum seeing a new patient to provide the review of past history and discuss the needs of the patient in planning for care into the future, then this service is billable with fee code G14074 Complex/High-needs Unattached Patient Attachment Fee for the provision of this intake service by the locum, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

3. **G14075 – Attachment Patient Complex Care Fee – Moderate or severe frailty**

   If the host FP is agreeable to the locum seeing a patient eligible for the Attachment Complex Care incentive to provide the planning visit as per fee description, then this service is billable with fee code G14075 Attachment Patient Complex Care Fee for the provision of this service by the locum, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

4. **G14076 – Attachment Patient Telephone Fee**

   Locum physicians are eligible to have the G14076 Attachment Patient Telephone Fee billed for telephone calls provided to patients when covering an Attachment participating host FP. Each locum will still have the same 1500 telephone call fees per calendar year

available, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

Note: An electronic note "Dr. A covering/locuming for Dr. B pract #XXXXX" is still required in order to bill G14079 – GP Telephone/e-mail follow-up management fees for patients on whom the host FP has been paid one of the portal planning related fees 14033, 14043, 14053, 14063 or 14075.

5. G14077 – Attachment Patient Conference Fee

Locum physicians are eligible to have the G14077 Attachment Patient Conference Fee billed for conferencing with allied care professionals when covering an Attachment participating host FP, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

2. GP Unattached Complex/High Needs Patient Attachment Incentive

G14074 GP Unattached Complex/High Needs Patient Attachment Fee $200

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. 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 (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/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.*

(See FAQ #1.11 for the definition used by GPSC regarding physicians under APP)

Frequently Asked Questions about G14074 GP Unattached Complex/High Needs Patient Attachment Fee:

2.1 What is required to bill for the GP Unattached Complex/High Needs Patient Attachment Fee (G14074)?

GPSC has decided to focus initially on higher needs unattached patients (see fee description above for target population) who would most benefit from being attached to an FP for their ongoing care needs. The Unattached Complex/High Needs Patient Intake fee is intended to compensate for the often time consuming and intensive process of integrating a new patient with higher needs into a full service Family Physician's practice. This fee will be paid in addition to appropriate visit fee, and will cover the initial meeting, organization of a medical record, organization and enactment of appropriate Clinical Action Plan(s) as discussed with the patient. Billing this incentive requires a review of the relevant patient record to date and meeting with the patient and/or the patient's medical representative to discuss this information and determine what other 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.

In order to facilitate the identification of eligible patients, it is expected that there will be a request to attach the patient from a separate source. The initial source and process for these requests can be found in the fee specific background information. The request does not need to come from a physician but can be provided by Care Provider working within the requesting center provided they have the capability to determine/confirm that the patient meets the target population requirements.

2.2 Why is a request required and is a formal referral either using a referral form or by submitting anything through MSP required in order to bill fee item G14074 Complex/High-needs Unattached Patient Attachment Fee for accepting these patients into a Full Service Family Practice?

The requirement of a request to attach is to embed a vetting/triaging process to ensure that patients being accepted into a Community longitudinal family physician's practice meet the requirements/intent of the incentive. It can be a written request (paper, fax, secure e-mail) or it can be a verbal request. Once the request to take on the patient has been accepted, the new FP must document in the chart who requested that the patient be taken into the practice and what the patient's qualifying conditions are, followed by the usual Allergies, Medications, Past Medical Hx, Family History and then the review of conditions and the plan for management that has developed jointly with the patient. The requesting physician or agency does not need to document the request in their chart/file for the patient. There is no need for a formal referral to be submitted through Teleplan or to the local division.

2.3 What specific diagnoses qualify in the various broad categories of eligible patients for the GP Unattached Complex/High Needs Patient Attachment Fee (G14074)?

Evaluation of the GPSC incentives has shown that the best return on investment in terms of both outcomes and overall costs is in higher-needs patients regardless of diagnosis. This is due in large part from the greater the benefit of attachment of these patients to a Family Physician. Rather than developing an extensive list that will always be incomplete, the intent of the "Complex/High-needs Unattached Patient Attachment Incentive" is to attach those patients who will most benefit from being in a strong FP – patient relationship over time. As such, ***the intended target population are to have medical conditions that are of sufficient severity and potential for poor outcomes that ongoing monitoring and management through the planned proactive care that is found within the Full Service Family Physician – Patient relationship will benefit both their quality of life and improve outcomes.*** Having a specific diagnosis or co-morbidities does not necessarily equate to being "Complex" or high-needs. It is expected that Family Physicians participating in the Attachment Initiative will use their clinical judgment to ensure that patients who are accepted under the Unattached Complex/High-needs Patient Attachment fee G14074 in fact do meet the criteria and require the level of time, intensity and complexity as indicated above.

2.4 Will G14074 GP Unattached Complex/High Needs Patient Attachment Fee be applicable for patients of an FP who is retiring or leaving practice for other reason?

If there is a new FP taking over a practice of a doc retiring/leaving, the new FP is not eligible to bill G14074 GP Unattached Complex/High Needs Patient Attachment Fee on any existing patients of practice as all practice infrastructure in existence it is a transition only. New patients accepted into the practice through the process that is developed locally will be eligible for G14074 GP Unattached Complex/High Needs Patient Attachment Fee.

If there is no FP to take over a practice of a doc retiring/leaving and the leaving FP asks other colleagues (in same clinic or other location) to take on these complex patients, GPSC has agreed that this is an acceptable request so the FP accepting transfer of these patients will be able to bill the G14074 GP Unattached Complex/High Needs Patient Attachment Fee for eligible patients. Alternatively, the locally determined unattached patient attachment process can be the source that requests the patients be attached to the accepting FPs.

2.5 How do I bill for taking on a new Complex/High-needs patient in residential care/long term care?

When an unattached Complex/High-needs patient is being admitted to residential/long term care and an Attachment Participating FP has been asked to accept the patient into their longitudinal practice, this fulfills the "request to attach" requirement in order to bill G14074 Unattached Complex/High-needs Patient Attachment fee. The FP will have been advised of the date of admission of the patient and will have been asked to specially come to see the patient to undertake the admission history and physical examination and completion of all required documentation. The resulting assessment visit, if provided between 0800 and 2300 hr any day of the week and within 24 hours of being contacted, can be billed using the 00115 "Nursing Home Visit when Specially Called" in addition to the G14074 Unattached Complex/High-needs Patient Attachment fee for the provision of this intake service. When the patient is seen more than 24 hours from the day of the call/request (eg. Called Monday about a new patient being admitted Friday and patient then seen on day of admission) you must use the date and time seen as Date of Service/Time of Service. A note must be included in the patient chart “FP contacted DD/MM/YY by LTC staff for request to accept new patient”.

If the FP is called at night (2300 - 0800) to see the patient for an urgent issues prior to seeing the patient for the intake service, and the FP decides to complete the intake process at that time rather than returning later in the day, the call out fee 01201 (2300 - 0800 hr physician called and patient seen) plus the out of office age differential visit (13200, 15200, 16200, 17200, 18200) or CPX if medically indicated (13201, 15201, 16201, 17201, 18201) is billable indicating the face-to-face visit has occurred in addition to the G14074. In addition to the time seen, the out-of-office visit/CPX code must be submitted with location code “C” to indicate the location is Residential/ Long Term Care.

2.6 What happens if an FP retires or leaves after working on service contract or sessional agreement with the Health Authority as the MRP physician in a Long Term Care facility and who over the years has taken on a significant number of patients as many office FPs have not wanted to continue to follow patients in LTC?

If the retiring FP asks or the HA/facility staff request an accepting FP to take on these patients, this would be acceptable and these patients are eligible to have the G14074 GP Unattached Complex/High Needs Patient Attachment Fee billed on the day the accepting FP sees the patient to review history, current status and plan for care under the new FP.

2.7 If one of my patients asks me to take on a family member who has recently moved to town or recently become unattached, how can the patient be referred?

A “request” or confirmation from a colleague qualifies. Many FPs work in groups, and showing the chart to your colleague to show that the patient has those qualifying diagnoses and has moved from out of town should be able to result in that colleague saying "Yes, that qualifies from my perspective". The requesting doctor (or Division) does not need to see the patient, or send away for corroborating diagnostic information (e.g. spirometry from the hospital where they used to live). The requesting doctor

simply needs to be given enough information that they would feel comfortable that this patient actually meets the complex/high-needs eligibility requirement.

Alternately, contacting the previous doctor to confirm medical issues, and the fact the patient is moving and so changing doctors would qualify as a request to attach. The receiving FP needs to make a chart entry that the patient has no local physician, has diagnoses with complexity/high-needs and that your colleague Dr ABC requested he/she be accepted into your practice on this basis.

2.8 In a multi-doctor clinic with a Walk In Clinic component, if the WIC doc sees a frail/complex/high-needs patient can he/she request attachment of this person to a regular doc in the longitudinal side of the clinic?

Walk In Clinics can be a source of request to attach for these patients, but only if the accepting physician has submitted the Attachment participation code G14070 and as such is committing to provide ongoing longitudinal care to his/her patients, regardless if the FP practice is co-located with the WIC making the request.

2.9 If an Attachment Participating FP also works in one of the request source locations (eg. ER, Mental Health, WIC, etc) and has identified his/her willingness to accept patients through the local request to attach process, how would the patient seen through the source program then be attached?

Requests to attach do not have to come from another physician but the physician accepting a Complex/High Needs patient MUST have the qualification criteria confirmed before billing the fee. The confirmation can come from an allied care professional in one of the requesting sources identified in the fee details. A family physician cannot bill the fee simply by unilaterally identifying. Physician colleagues or Allied Care Professionals located at the requesting source may initiate/confirm the request to attach.

2.10 What happens when an FP who is participating in the Unassigned In-patient Network initiative and has been caring for an unassigned patient in hospital who is also unattached in the community and agrees upon discharge to accept them into their practice?

Physician colleagues or Allied Care Professionals within the hospital (eg. Discharge Planning Coordinator) may initiate/confirm the request to attach the patient to the FP's community practice.

2.11 For Maternity patients referred from WIC for maternity/obstetric care to an Attachment Participating FP who subsequently agrees to take the mom (and baby) into his/her longitudinal practice, how is the request to attach done?

The G14074 GP Unattached Complex/High Needs Patient Attachment Fee is billable for Mother/baby dyads at any time during pregnancy to 18 months of age of baby. Therefore, if an unattached pregnant patient is referred to a FP who does OB and the request is to include attachment as well as prenatal care/delivery then the G14074 GP Unattached Complex/High Needs Patient Attachment Fee would be billable with the 14090. If the patient was referred only for the prenatal care/delivery, but then later during the pregnancy, a physician colleague or Allied Care Professional located at the primary OB clinic or at the hospital may initiate/confirm the request to attach for the FP agreeing to take the patient into the practice.

When accepting a new pregnant patient or mother/baby dyad, submit fee code G14074 GP Unattached Complex/High Needs Patient Attachment Fee with Diagnostic code 01N.

2.12 Can a Midwife be the source for a request to attach for an Unattached Mom and Baby dyad?

Yes. One of the target populations for the Unattached Complex/High-needs Patient Attachment initiative (G14074) is unattached new moms/babes and the request to attach can be made at any point in the pregnancy up to 18 months of age of the infant. These moms and babes can be identified by the local primary obstetrical providers, whether individual FPs, Midwives or Primary OB clinics (FP and/or midwife). The mother/baby dyad counts as one unit, so the G14074 GP Unattached Complex/High Needs Patient Attachment Fee is to be billed on the mom's PHN. When accepting a new pregnant patient or mother/baby dyad, submit fee code G14074 GP Unattached Complex/High Needs Patient Attachment Fee with Diagnostic code 01N.

2.13 New people to community who are or subsequently become pregnant call around to see who will take them on. In smaller communities, there is no WIC to act as a source for the request to attach. How can we prevent the requirement of a request to attach from creating a barrier to attaching these patients?

Most people who have moved to a new community will contact the local hospital to see if anyone is taking on new patients. If the local Division/Group of FPs decides to participate in the Attachment Initiative, they can determine what the local process would be to attach these patients. As an example, this could be through the hospital or through a locally advertised contact number to facilitate this request (eg. a Divisional website link, "hot-line" number, etc).

2.14 What happens if there is a sudden shut down of an office due to loss of FP (death, leaving for personal reasons – retirement with no replacement found) with no provision for transition leaving patients unattached? How can a Division or community try and get them linked when a request to attach is required as this will add a step that may slow the process down?

The request to attach does not need to come from a physician. The community/division can agree to a process whereby the MOA of the previous physician can connect the patients to accepting FPs in the community. The request to attach may be made by the local Division process or even their clinic colleague if there is sufficient information that the Division/colleague will feel comfortable that the patients qualify as complex/high-needs.

2.15 In rural and remote communities patients are often cared for by a group of FPs who rotate through the community. None of the patients are specifically attached to one physician, but instead to the group of physicians in the clinic. How do we attach a patient to these groups?

The intent of the Attachment Initiative and its incentives is to facilitate the attachment of currently unattached complex/high-needs patients as well as support the relationship between patients and their personal Family Physician. It is this longitudinal relationship and the provision of the broad spectrum of services of Family Medicine (Prevention, Acute needs and Chronic Disease management) that all the GPSC incentives (except the GP with Specialty Training) were developed to support.

Therefore, while there is no requirement to submit an attachment fee for every patient in a practice, all patients must be attached/assigned within the practice (as indicated on the patient chart) to a specific FP who is committing to the provision of this broad spectrum of services and taking on the overall responsibility of the coordination of the care needs for the patient. Being in a shared practice does not remove the need to have a FP who is still responsible for this coordinating role.

Eligible new patients will need to be assigned to a physician in order to bill the G14074 GP Unattached Complex/High Needs Patient Attachment Fee. The care over the year would be shared between the group of physicians, similar to the manner in which FPs in group/shared practice currently manage the CDM incentives. This could occur based on who saw the patient for the initial intake assessment and setting up of the chart.

2.16 Since the G14074 GP Unattached Complex/High Needs Patient Attachment Fee applies to frail patients in residential care, are palliative patients (Level 7 Frailty) admitted to a free standing hospice or one that is part of a long term care facility, who do not have an FP who can care for them there considered Unassigned and eligible for the G14088 Unassigned In-patient Care Fee or Unattached and eligible for G14074 GP Unattached Complex/High Needs Patient Attachment Fee?

Hospice care is provided in several settings; as part of an acute care hospital, as a free-standing facility, or as part of a long term care facility. At this point in time, FPs providing care for unassigned palliative patients in hospices that are NOT attached to or part of an acute care hospital are not yet eligible for the Unassigned In-patient Network fee and these patients are not eligible for the G14088 Unassigned In-Patient Care fee until GPSC assesses the number and types of hospices around the province to ensure sustainability of the initiative. Patients who are admitted to a hospice that is attached to or part of an acute care hospital and who do not have an FP that will care for them while admitted qualify for the G14088, Unassigned In-patient Care Fee of $150 when accepted under MRP care by members of an Unassigned In-patient Network.

While some patients admitted to hospice are not discharged, other patients may be discharged back into the community following a respite or for symptom control. If that patient has no FP in their community to continue to provide care, they also qualify for the G14074 Unattached Complex/High-Needs Patient Attachment fee when accepted into the community practice of an Attachment participating FP.

If a patient is admitted into Long Term Care/Residential Care with no plan to return to the community setting, and the patient's community MRFP is unable to provide care within the facility, this patient is considered "unattached" within the facility and would be eligible for the G14074 Unattached Complex/High-Needs Patient Attachment fee.

Due to the short term nature of most patients admitted to hospice, any patients who are unattached in this location are not eligible for 14074.

2.17 How long is the FP expected to care for patients he/she has accepted into the practice under fee code G14074 Unattached Complex/High-Needs Patient Attachment fee?

The intent is for these patients to be taken into the practice with a commitment to provide ongoing longitudinal care, in the same manner as any new patient would be accepted.

2.18 What role will the patient have in agreeing to the attachment process? What if the patient doesn't "like" the doc he/she is assigned to?

The patient compact includes the expectations from the patient in the FP/Patient relationship. While there is no requirement that the patient must stay with the FP who has agreed to take him/her on, the incentive will only be billable once unless the patient moves to a different community and is therefore once again "unattached". Therefore if the patient leaves the new practice, any other doctor who is in the same community that agrees to take on the patient will not be able to bill the G14074 GP Unattached Complex/High Needs Patient Attachment Fee. In order to minimize the impact of

multiple phone calls to accepting FPs, the GPSC feels a process that is community developed to streamline and triage the intake of these patients be used and why "self-referral" is not allowed.

2.19 Will we be allowed to end the Patient-Physician Relationship or are we committed to these new patients forever by the attachment program?

The intent of the Unattached Complex/High-needs Patient Attachment incentive is to accept patients who would most benefit from being attached into your ongoing longitudinal practice. Just as there is always the ability of a patient to leave an FPs practice if they so wish, doctors will still be able to end the Patient-Physician Relationship for appropriate reasons, as long as they adhere to the College of Physicians and Surgeons of BC policies found at:
www.cpsbc.ca/files/pdf/PSG-Ending-the-Patient-Physician-Relationship.pdf

2.20 What about people who move from other provinces – for the complex/high-needs patients that the incentive is targeting as it is often not appropriate or desirable to have to wait for 3 months for their MSP to come into effect?

The GP complex/High-needs Unattached Patient Attachment initiative is restricted to patients with valid BC MSP coverage. Patients who are new to BC are therefore not eligible until they have valid BC MSP coverage.

2.21 Do locums have access to the G14074 Complex/High-needs Unattached Patient Attachment Fee?

If the host FP is agreeable to the locum seeing a new patient to provide the review of past history and discuss the needs of the patient in planning for care into the future, then this service is billable with fee code G14074 GP Unattached Complex/High Needs Patient Attachment Fee for the provision of this intake service by the locum, provided the G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

2.22 Is there a limit to the number of G14074 Complex/High-needs Unattached Patient Attachment Fees that can be billed on a calendar day?

While there is no minimum time requirement included in the rules for billing the Complex/High-needs Unattached Patient Attachment code, the amount of work and time needed to meet with patient and review all past history, medications, develop a plan for management, is similar if not identical to the Complex Care Planning visit. As such, GPSC has included the G14074 GP Unattached Complex/High Needs Patient Attachment Fee with the two complex care codes G14033 (Original) Complex Care Management fee & G14075 Attachment Complex Care Management fee in the maximum of 5 services of any combination of the three per calendar day.

3. GP Attachment Complex Care Management Incentive

G14075 GP Attachment Complex Care Management Fee $315

The GPSC has stated that the initial G14033 Complex Care fee will remain outside the Attachment Participation Portal, while the G14075 Attachment Complex Care fee encompassing those patients with a qualifying diagnosis of Frailty as defined in the GPAC Guideline "Frailty in Older Adults – Early Identification and Management" (2012) with Moderate or Severe Frailty who do not otherwise qualify under the dual diagnostic eligibility for G14033 Complex Care Management Fee, will remain inside the Attachment Participation Portal. Patients will qualify only for one of the Complex Care Management Fees, not both. The details and FAQs for both Complex Care Fees G14033 and G14075 can be found in the GPSC Complex Care Billing Guide.

4. GP Attachment Telephone Management Expansion

G14076 GP Attachment Telephone Management Fee $15

Telephone and other non-face-to-face 'visits' or 'touches' are a standard component of workflow in other jurisdictions. They have been shown to significantly improve efficiency of care and therefore practice capacity.

The expansion of telephone 'visits' as part of the Attachment Initiative is seen as an important component of improving practice capacity.

The details and FAQs for G14076, GP Attachment Telephone Management Fee can be found in the GPSC Conferencing and Telephone Management Billing Guide.

5. GP Attachment Patient Conference Fee

The GPSC has simplified as well as expanded the applicability of conferencing through the Attachment Patient Conference fee in order to support improved collaborative care between participating FPs and other health care providers. ***The Attachment Patient Conference fee replaces all three of the original conference codes (G14015, G14016 & G14017)*** as well as removes a number of other identified barriers that were present in order to bill these codes. The details and FAQs for G14077, GP Attachment Patient Conference Fee can be found in the GPSC Conferencing and Telephone Management Billing Guide.

Attachment Fees

G14070	**Attachment Participation Code**	**$0**
G14071	**Locum Attachment Participation Code**	**$0**
G14074	**Unattached Complex/High-Needs Patient Attachment Fee**	**$200**
G14075	**Attachment Patient Complex Care Management Fee (Frailty Level 6 or 7)**	**$315**
G14076	**Attachment Patient Telephone Fee**	**$15**
G14077	**Attachment Conferencing Fee**	**$40 per 15 minutes or greater portion**

Billing Examples:

Mr. B is a 79 year old unattached patient with diabetes (Metformin 500 mg once a day X 5 years), heart failure and severe osteoarthritis of the spine. As a result of his comorbidities, he is classified as having a moderate level of frailty. He lives alone in a seniors complex (not assisted living) with minimal supports other than home-making services funded by DVA and some care and ADL support provided by his adult children. You are asked to take him on as a new patient through your local divisional process and see him in the company of his daughter for an intake visit/review. He arrives with his medications, and you set up a chart for him. He is feeling tired but has no other specific complaints. You note he has not had any blood work done in the past several years as he has been attending a walk-in-clinic for prescription refills only. A glucometer check in your office shows a random blood sugar of 10.2. You develop a short term plan, including arranging for your local seniors outreach program to assess his home situation (10 minute conference call with RN at 1400 hr and 5 min call with pharmacists at 1500 hr – to confirm his medication history) but they are unable to see him for 2 – 3 weeks. You give Mr. B a requisition for some basic bloodwork, including a HgB A1C and arrange for him to come to see you in 3 - 4 weeks after the outreach assessment and lab work is completed for a CPx and Complex Care Planning Session.

Mr. B returns for the follow-up appointment in 4 weeks, at which time you spend 20 minutes doing his complete physical examination. Following this, you ask him to dress and then he asks you to bring his daughter in for the planning visit. During the 25 min planning visit, you review the findings of your examination, his investigations (A1C of 12.3 and Hgb of 135) and the assessment feedback from the outreach nurse. You discuss his goals in life, the stage and impact of his co-morbidities on his life as well as discuss his personal advance care plan choices and note that he has decided he would not want CPR but does want full medical treatment of acute illnesses. His daughter is in full agreement with his decisions at this time. You write a prescription for an increased dose of Metformin and advise you will phone him in one week at 1700 hr to see how he is tolerating the higher dose. You recommend he and his family utilize the “My Voice” tool to develop a formal Advance Directive with documentation of his Medical Representative and ask that a copy be sent back to the office for your files. After finishing the planning visit, you spend another 10 minutes completing the chart documentation of his complex care plan including his advance care decision and noting the follow-up timeline. Later in the day at 1600 hr you spend 15 minutes conferencing with the outreach nurse about Mr. B’s Complex Care Plan and Advance Care decisions and revise the community management plan for their follow-up.

Billing:
Initial Intake Visit:

14074	Review of history, medications and documentation of short term plan in new chart
17100	
15100	(Glucometer testing in office)
14077 X 1 unit	Start time 1400 hr, end time 1415 hr

CPX and Complex Care Planning visit 4 weeks Later:

17101	
14075	Documentation: Total time 55 minutes including face-to-face of 45 minutes.
14077 X 1 unit	Start time 1600 hr, end time 1615 hr

Telephone Call 1 week later

14076	Start time 1700 hr

Appendix 1.

Locum/Host Check List:

- ☐ Length of locum & daily hours?
- ☐ On-call obligations and arrangements?
- ☐ Hospital work & obtaining privileges?
- ☐ Obstetrics?
- ☐ Office staffing?
- ☐ Specialty backup?
- ☐ Review daily office bookings & billings procedure
- ☐ Place to stay?
- ☐ Income percentage split? Office vs. Out-of-office (e.g. Obstetrics, hospital care)
- ☐ What if the host doc is not FFS? Can you receive host doc's APP bonuses?
- ☐ Guaranteed minimum income?
- ☐ Billing for uninsured services?
- ☐ Which GPSC incentives can be billed for services provided by locum? Some GPSC incentives cover more than a single service (e.g. CDMs and Complex Care – covers 1 year period) and if included in locum services, need to mutually agree on any adjustment to calculations for income percentage split to reflect this.
    - Attachment Practice
        - Yes
        - No
    - Complex/high-needs Unattached Patient Attachment (Intake assessment and planning visit)
    - Complex Care Planning
    - Mental Health Planning
    - Palliative Planning
    - Prevention
    - Conferencing
    - Patient Telephone Calls
    - Chronic Disease Management annual bonuses

(See SGP website www.sgp.bc.ca for Locum Contract Template)