GP SERVICES COMMITTEE
CHRONIC DISEASE MANAGEMENT INCENTIVES

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GPSC General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP Society of General Practitioners of BC

Expanded Full Service Family Practice Condition-based Payments

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.

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 or G14079 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 heath 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 (eg. 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.

The Condition-based incentives are payable in recognition of work that has been done and are not payable in advance – in other words, they are to be billed after provision of one year of care. Currently, there are annual payments for four conditions: Diabetes, Heart Failure, Hypertension and Chronic Obstructive Pulmonary Disease. 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.**

The Condition-based incentives remain outside the "Attachment Initiative" portal and are available to any Full Service Family Physician (FSFP) to support the management of their patients with eligible conditions. Please also refer to the Attachment Section of the GPSC Billing Guide for further details of this initiative and the relevant fee incentives.

In order to encourage non-face-to-face communication with patients covered by some of the GPSC incentives, the GP Telephone/E-mail Follow-up Management fee is available 5 times per patient per calendar year for patients on whom one or more of the portal planning incentives (G14033 Complex Care Planning, G14043 Mental Health Planning, G14053 COPD CDM with a COPD Action Plan, G14063 Palliative Planning or G14075 (Attachment Patient Complex Care Planning) has been successfully billed within the previous 18 months. In addition, FSFPs who are participating in the "GP for Me" or

Attachment Initiative have access to additional telephone visit fees to support the ongoing provision of care for any patient in their practice through the Attachment Patient Telephone Management fee G14076.

Eligibility:

Physicians are eligible to participate in the GPSC incentive programs if they are:

1. A general practitioner who has a valid BC MSP practitioner number (registered specialty 00).
2. Currently in general practice in BC as a full service family physician;
3. 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.

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 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.

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

Chronic Care Incentives – Fee-For-Service Practitioners

G14050 Incentive for Full Service General Practitioner - 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 been provided at least two visits. 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) in the preceding 12 months. 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.

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

G14051 Incentive for Full Service General Practitioner - Annual Chronic Care Incentive (Heart Failure) $125.00

Notes:

i) Payable to the family physician who is 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 seen 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 congestive 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.

viii) 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 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 or G14051 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.

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

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 audit 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 in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GSPC telephone or group medical visit. 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 G14251 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) If a visit is provided on the same date the incentive is billed; both services will be paid at the full 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 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. 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 G14250 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) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

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. 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 G14250 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) If a visit is provided on the same date the bonus is billed; both services will be paid at the full 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 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. 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 G14250, G14251 or 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) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

FLOW SHEETS & ACTION PLANS

All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient's longitudinal general practice care over the preceding year (12 months). *Chronic Care flow sheets can be a useful tool for tracking care provided to patients over time. The GPSC requires physicians to track and document adequately the care provided to their patients to ensure they are providing guideline informed care. While it is not mandatory to utilize official GPAC flow sheets, if you use a different flow sheet to document your provision of guideline-informed care, all essential elements from the GPAC guideline must be included. Effective July 1, 2015, there is no longer a requirement to share a flow sheet or action plan with patients, however, self-management support is the help given to patients with chronic conditions that enables them to manage their heath 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 (eg. 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.*

FREQUENTLY ASKED QUESTIONS

1. How do I claim the condition-based payments?

The incentive payments are payable if the patient has **a confirmed diagnosis** of diabetes mellitus *(please note this incentive payment is **not payable for pre diabetes** patients)*, heart failure, hypertension or chronic obstructive pulmonary disease.

Effective July 1, 2015, there are 2 different sets of Condition Based Payments, depending on the payment mechanism the eligible family physician works under. If the physician is paid by regular Fee-For-Service, the codes are still:

G14050 Annual Chronic Care Bonus (Diabetes)
G14051 Annual Chronic Care Bonus (Heart Failure)
G14052 Annual Chronic Care Bonus (Hypertension)
G14053 Annual Chronic Care Bonus (COPD)

If the physician is paid under an alternate payment program (APP = Salary, service contract or sessional arrangement) and the required two visits were billed as an encounter record, use the following new CDM incentive codes:

G14250 Annual Chronic Care Bonus for (Diabetes)
G14251 Annual Chronic Care Bonus (Heart Failure)
G14252 Annual Chronic Care Bonus (Hypertension)
G14253 Annual Chronic Care Bonus (COPD)

Post audit will be performed within 2 years and recoveries will be made if encounter records were not submitted for the required visits.

Only one payment per diagnosis is payable per patient per year. The bonus 14052 (hypertension) is not payable if a bonus payment 14050 (diabetes mellitus) or 14051 (heart failure) has been paid for the patient in the preceding year. 14052 (hypertension) is payable in addition to 14053 for those patients who also have COPD but not diabetes or heart failure.

Condition-based bonus claims are submitted through the MSP Claims system the same way you would submit a MSP fee-for service claim. The submission must include the relevant ICD 9 codes:

Diabetes mellitus – 250;
Heart failure - 428;
Hypertension – 401;
COPD – 491 or 492 or 494 or 496.

2. Is it possible to claim all Chronic Disease Management fees in the same patient?
If a patient has any of the three conditions diabetes mellitus, heart failure, and/or COPD and criteria are met for each condition, each annual incentive bonuses may be billed separately. If a patient has hypertension, the 14052 cannot be billed in addition to Diabetes or Heart Failure, as management of hypertension is included in the guideline for these 2 conditions. If the patient has hypertension and COPD without Diabetes or Heart Failure, then both the 14052 and 14053 may be billed on the same patient if all criteria are met.

CDM Allowable Combinations in Single Patient

	14050	14051	14052	14053
14050		Yes	No	Yes
14051	Yes		No	Yes
14052	No	No		Yes
14053	Yes	Yes	Yes	

3. When should the incentive bonus be billed?
All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient's longitudinal general practice care over the preceding year. The Chronic Care Incentive bonus fees may be billed once the patient has been provided guideline informed care for one year for that particular condition. To confirm an ongoing doctor-patient relationship, there must be at least 2 visit fees billed (office; prenatal; home; long term care; only one of which can be 14076 or 14079 Telephone Visit or 13763 – 13781 Group Medical Visit) or 2 patient encounter records provided on each qualifying patient in the 12 months prior to billing the CDM incentive. Post audit of APP physicians will be performed within 2 years and recoveries will be made if encounter records were not submitted for the required visits. **Visits provided by a locum for the MRP GP are included; however an electronic note indicating this must be submitted with the claim.**

Once successfully billed, the CDM incentives may be billed on or about the anniversary date of the initial billing, provided guideline informed care has continued to be provided in the intervening 12 months.

4. Does obstructive sleep apnea qualify for the COPD CDM (G14053)?
No. COPD and obstructive sleep apnea are two different conditions. Criteria for the diagnosis of COPD are included in the COPD fee description.

5. Will payment item G14050, G14051, G14052 and G14053 replace the usual MSP visit fees for those patients who have diabetes, heart failure, hypertension or COPD?
No. Billing for office visits should continue as usual. This bonus is billed *in addition to* any other fees incurred by usual patient care.

6. Do I have to see the patient on the same day to bill the payment?
You will have to see the patient to provide the necessary clinical care over the year, but you do not have to see the patient on the day of billing the payment. Effective July 1, 2015, for physicians paid through FFS, there must be at least 2 visits provided to each CDM patient in the 12 months prior to billing the Condition-based incentive. See FAQ 3 above for further details.

7. Do I have to provide all follow up care to the patient face to face?
At least one of the required 2 visits in the 12 months prior to submitting a claim for the CDM incentives **MUST BE** Face-to-Face.

After successfully billing the G14053 for COPD, some follow up management may be provided to patients by telephone or e-mail, for which you can bill the G14079 GP Telephone/e-mail fee up to 5 times per calendar year provided the G14053 (or other portal fee) has been paid in the previous 18 months.

Family Physicians participating in the GPSC Attachment Initiative also have access to telephone management fee G14076 for any patient in their practice. The restriction for this fee incentive is 500 X 14076 per family physician per calendar year, not a restriction per patient. However, it is recommended that for patients who are eligible for G14079, these should be utilized first (5 over the 18 months following the provision and billing of the eligible planning fees) before using the G14076 GP Attachment Telephone Management fees due to the limited number per participating FP (1500 per calendar year).

As per FAQ 3 only one of these phone visits may be used toward the 2 visit requirement for the CDM incentives.

8. How does my locum or colleague bill for telephone follow up on my COPD patients when I billed the G14053?

In order to facilitate processing of any claims for G14079 GP telephone/e-mail advice fees by a locum of colleague who has been designated to provide this service, an electronic note should be entered stating "locum for Dr. X billing number YYYYY".

Locums who are participating in the Attachment initiative (and have submitted the G14071 GP Locum Attachment Participation Code earlier in the same calendar year) also each have the same 500 X G 14076, Telephone Management fee per calendar year. Similarly, any colleague who is also participating in attachment and has submitted G14070 GP attachment Participation Code earlier in the same year also has access to 1500 X G 14076, Telephone Management fee per calendar year. If all 5 of the G14079 have been used for any specific patient, G14076 could still be used if the locum (or host FP or other covering colleague) has not reached the maximum of 1500 in that calendar year.

9. Can I still bill if the patient is in a long-term care facility?

Patients in long-term care facilities are eligible; however clinical judgment is needed in determining the appropriateness of following clinical practice guidelines in patients with dementia or very limited life expectancy.

10. Where can I find the clinical guidelines and flow sheets?

The full Diabetes Care, Heart Failure Care, and the Treatment of Essential Hypertension guidelines along with available GPAC Flow Sheets, are found on the Guidelines and Protocols web site, along with all other current guidelines.
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

11. What supports are available for assisting my patients with COPD who are still smoking to quit?

Patients may be referred to a number of support groups and programs that are available within local communities. Programs such as those at local recreation centers, weight-loss management programs, disease specific self-management programs, or telephone support such as HealthlinkBC or QuitNowBC.

On September 30, 2011, the B.C. government introduced the BC Smoking Cessation Program that is intended to help eligible B.C residents stop smoking or stop using other tobacco products by assisting them with the cost of smoking cessation aids. The program offers coverage for two treatment options: prescription smoking cessation drugs or non-prescription nicotine replacement therapy (NRT) products. The program is open to eligible B.C. residents who wish to stop using tobacco.

Resources on the B.C. Smoking Cessation Program

Patients may not know about the B.C. Smoking Cessation Program. If patients want to learn about the program, you can refer them to:

- the B.C. Smoking Cessation Program Patient Information Sheet (PDF 202K), an easy-to-print downloadable document that provides a high-level overview of the program
- detailed smoking cessation program information for patients on the PharmaCare website, including information on eligibility, coverage and registration procedures for the nicotine replacement therapy gums and patches
- HealthLink BC (phone 8 1 1 and ask for the smoking cessation program)

Resources to help patients plan and manage their stop-smoking activities including the QuitNow.ca website has a wide range of resources for patients on planning and managing their smoking cessation activities, including:

- information, tips, tools and techniques posted in the QuitNow Tools & ResourcesSupport services such as a quit plan tool, a free 3-month text support that provides helpful quit smoking tips and motivational support, a trained Quit Coach available by free by phone, chat or group phone support.
- the Quit Now Online community of peer-to-peer support groups

You can also use Quit Now's fax referral program to connect patients with counselors.

Medications covered under the Smoking Cessation program

PharmaCare covers only the following products as part of the Smoking Cessation Program:

1. bupropion (Zyban®, the brand name version for smoking cessation)
2. varenicline (Champix®)
3. Thrive™ NRT chewing gum in two strengths
4. Habitrol® NRT patches in three strengths

Patients are eligible for coverage of one single continuous course of treatment, lasting up to 12 consecutive weeks (84 consecutive days) with either one NRT product or one prescription drug per calendar year. A Special Authority Form is NOT required for the initial prescription in any given year. Under exceptional and compelling circumstances, PharmaCare may provide additional coverage. To request additional coverage, physicians are asked to submit a Special Authority request (using the General Special Authority Request form) for exceptional case-by-case consideration.

12. Can I bill the payment even if the clinical or laboratory objectives have not been met?
The payment is provided for the provision of guideline-informed clinically appropriate care which takes account of patient's values and co-morbidities. It is not required that a patient meet any specific clinical outcome target as individual goals/targets are determined through a conversation about how recommendations are relevant to each patient. It is NOT a payment simply because the patient has a diagnosis of diabetes, heart failure, hypertension or COPD.

13. Can I bill for patients covered by other provinces?
Patients covered by other provincial health plans, who are temporarily living in BC are not eligible. In border communities where a BC physician provides the majority of care for an Alberta or Yukon patient, those patients will be eligible.

14. I have assumed/taken over the practice of another GP within the last 12 months. May I still bill for patients' Chronic Disease Management fees?
When a new GP assumes the practice of another GP who has been providing guideline-informed care (see bullet 3 in this section) 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) as the transition from the old to the new GP is considered a shared year. ***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.*** You may not bill the Chronic Disease Management fees if a patient did not receive the requisite level of care, or a chronic disease management fee code has been billed for the patient in the preceding 12 months.

15. Are the payments eligible for the rural premiums?
Yes.

16. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the chronic care bonus payments?
Yes, provided this is not already specified in their contract. Please refer to FAQ 1 for more details on the specific codes that these physicians must now use.

CDM Fee Values

G14050/G14250	**Annual Chronic Care Bonus – Diabetes Mellitus**	**$125.00**
G14051/G14251	**Annual Chronic Care Bonus – Heart Failure**	**$125.00**
G14052/G14252	**Annual Chronic Care Bonus – Hypertension**	**$50.00**
G14053/G14253	**Annual Chronic Care Bonus – Chronic Obstructive Pulmonary Disease**	**$125.00**

Billing Scenario

Mr. William S is a 76 year old former smoker who has a past history of Diabetes, hypertension and COPD. You have been his family physician for the past 12 years. When the initial GPSC CDM incentive program began, you had pulled all your charts for eligible patients including Mr. S, and started utilizing the CDM flow sheets for following the care of his diabetes. You see have also been undertaking the complex care management planning visits with Mr. S and find he is due for a CPX as per the guideline recommendations. Mr. S was seen in February for follow up of his diabetes. The Complex Care Management Planning visit was provided in April of this calendar year. Mr. S has seen you in June and returns in September for his planned CPX in the same month as the anniversary date of his Diabetes CDM. You review his complex care plan including self-management of his diabetes COPD especially for the coming winter. He returns in November for his annual seasonal flu shot given by your office nurse. You do not see him at that time as there was no medical indication for a visit with you. Later that month, after a visit with his daughter and grandchildren he phones the office with some increased shortness of breath and a change in his sputum but no fever. You advise him on the management of his COPD as per the complex care plan. You follow up with him at an office visit 2 weeks later. The billings for his management for this calendar year are:

Date	Service Description	Fee Code	Diagnostic Code
Feb	Office Visit	17100	250
April	Complex Care Management Planning Visit	14033 17100	R250 496
June	Office Visit	17100	250
September	CPX plus CDM review Diabetes CDM COPD CDM	17101 14050 14053	250 250 496
November	Seasonal Flu shot by office nurse (not seen by FP)	00010	33A
November	Phone Follow up of COPD (separate day from flu shot)	14079	496
December	Office Follow up of COPD	17100	496