GP SERVICES COMMITTEE
CHRONIC DISEASE MANAGEMENT INCENTIVES

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

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

When a new GP <u>assumes</u> 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, provided the new GP has seen the patient to at least once in the transitional 12 month CDM period, **if one of the required two 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.

Chronic Care Incentives – Practitioners under Fee-for-Service

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:

1. *a telephone visit (G14076, G14079 prior to October 2017); or*
2. *a group medical visit (13763 – 13781); or*
3. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice*

iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14250.
v) Claim must include the ICD-9 code for diabetes (250).
vi) Payable once per patient in a consecutive 12 month period.
vii) Payable in addition to fee items G14051 or G14053 for same patient if eligible.
viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.
ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
    1. a telephone (G14076, G14079 prior to October 2017); or
    2. a group medical visit (13763 – 13781); or
    3. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice
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.
ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

G14052 Incentive for Full Service General Practitioner - Annual Chronic Care Incentive (Hypertension)
$50.00

Notes:

i) Payable to the family physician who is 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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
    1. a telephone visit (G14076, G14079 prior to October 2017); or
    2. a group medical visit (13763 – 13781);or
    3. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
    1. a telephone visit (G14076, G14079 prior to October 2017); or
    2. A group medical visit (13763 – 13781); or
    3. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice
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.

Chronic Care Incentives – Practitioners under Alternate Payment Program

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

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

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.
ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.

iii) This item may only be billed after one year of care including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:

1. *a GSPC telephone visit (G14076, G14079 prior to October 2017); or*
2. *a group medical visit (13763-13781); or*
3. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.*

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:

1. *a GPSC telephone visit (G14076, G14079 prior to October 2017); or*
2. *a group medical visit (13763-13781); or*
3. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice*

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:

1. *a GPSC telephone visit (G14076, G14079 prior to October 2017); or*
2. *a group medical visit (13763-13781); or*
3. *an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice*

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:

1. *a GPSC telephone visit (G14076, G14079 prior to October 2017); or*
2. *a group medical visit (13763-13781); or*
3. *an in-person visit with a college certified allied health provider G14029) working within the family physician's practice*

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. While there is no requirement to share a flow sheet or action plan with patients, 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.*

Allied Care Provider Code - Effective October 1, 2017

To support team based care Allied Care Providers may provide one of the visits required for GPSC chronic disease management. Submission of this $0.00 code by the FP indicates an in person visit was provided by a college certified Allied Care Provider.

G14029 Allied Care Provider Practice Code $0.00

Notes:

i) *Only billable by the family physician who has submitted Code G14070/G14071 and who is most responsible for the majority of the patient's longitudinal general practice care.*
ii) *Applicable only for in-person medical services (office, home or LTC) provided by a college certified allied care provider working within the family physician's practice where the family physician has accepted responsibility for the provision of the care.*
iii) *Not billable when the patient has had a same day service provided and billed by the family physician.*
iv) *Billable on patients receiving guideline informed care who will be eligible for one of the chronic disease management incentives (CDM).*

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.

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 review 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 G14052 (hypertension) is not payable if a bonus payment G14050 (diabetes mellitus) or G14051 (heart failure) has been paid for the patient in the preceding year. G14052 (hypertension) is payable in addition to G14053 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 G14052 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 G14052 and G14053 may be billed on the same patient if all criteria are met.

CDM Allowable Combinations in Single Patient

	G14050	G14051	G14052	G14053
G14050		Yes	No	Yes
G14051	Yes		No	Yes
G14052	No	No		Yes
G14053	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) or 2 patient encounter records provided on each qualifying patient in the 12 months prior to billing the CDM incentive. Post review of APP physicians will be performed within 2 years and recoveries will be made if encounter records were not submitted for the required visits. One of the two required visits may be:

- ✓ A GPSC telephone visit (G14076 if FFS); or,
- ✓ a Group Medical Visit (13763 – 13781 if FFS); or
- ✓ an in-person visit with a college certified allied health provider (G14029 if FFS) working within the family physician's practice

Visits provided by a locum or other FP colleague covering 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. 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** provided by the physician Face-to-Face with the patient.

Family Physicians who have submitted G14070 (or locums who have submitted G14071 when covering) have access to telephone management fee G14076 for any patient in their practice. The restriction for this fee incentive is 1500 X 14076 per family physician per calendar year, not a restriction per patient.

As per FAQ 3, phone visits may be used toward only 1 of the 2 visits required for the CDM incentives.

8. Can I still bill the CDM codes 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.

9. 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

10. 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. For more details, please go to the Ministry BC Smoking Cessation Program website:

http://www2.gov.bc.ca/gov/content/health/health-drug-coverage/pharmacare-for-bc-residents/what-we-cover/drug-coverage/bc-smoking-cessation-program

11. 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.

12. 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.

13. 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, provided the new GP has seen the patient to at least once in the transitional 12 month CDM period, if one of the required two 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.

14. Are the Chronic Disease Management payments eligible for the rural premiums?
Yes.

15. 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.

16. Which College-certified allied care providers (ACP) working within the eligible physician practice qualify for providing services to be eligible for the G14029 Allied Care Provider Practice Code to be submitted?
G14029 will be applicable for services provided to eligible patients by college certified allied care providers working within the family physician's practice, whether employed directly by the Full Service Family Practice or who are embedded within the practice through a Health Authority agreement where the family physician has accepted responsibility for the provision of care to patients of the FP by that ACP. This includes nurses, NP, LPN, dieticians, social workers, etc. but excludes the Medical Office Assistant as they do not have a clinical scope of practice. To be considered working within her/his scope of practice, the ACP must maintain his/her certification with their professional college, and maintain medical legal coverage to do so.

17. Does the College certified allied care provider have to see my patients in the office in order for me to submit G14029?
While these College certified allied care providers are working within your practice, it is not required that they only support your patients within the office. You may have a nurse who is able to do home visits with those patients who have chronic conditions who are home bound. Submitting G14029 will allow the ability to track services provided by ACPs to your patients in the most appropriate location. As an example, a patient with severe COPD and Heart Failure may be home-bound and between you seeing the patient in person once per year to review their management plans and renew any prescriptions and your nurse seeing them as appropriate to support their chronic condition management in between, you will still be eligible to submit G14051 and G14053 on the anniversary date just as if you had provided all the visits in person yourself.

Incentive 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**
G14029	**Allied Care Provider Practice Code**	**$0.00**

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. You have a nurse in your practice who provides chronic disease management support for your patients and has been supporting your care of Mr. S.. On the days of the visits with the nurse, you are seeing other patients in your office due to the increased capacity this has enabled. You have been utilizing the electronic CDM flow sheets within your EMR for following the care of his diabetes. When undertaking the complex care planning visit with Mr. S you find he is due for a CPX as per the guideline recommendations. Immediately following the care planning, you check Mr. S' chest as he is complaining of increased cough. Mr. S was seen by your RN in February for follow up of his diabetes. The Complex Care Planning visit was provided in April of this calendar year. Mr. S has seen your nurse in June and returns in September to see you 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 and 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 his 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	Visit with office nurse for review of diabetes (not seen by FP)	G14029	250
April	Complex Care Management Planning Visit	14033 17100	R250 496
June	Visit with office nurse for review of diabetes (not seen by FP)	G14029	250
September	CPX plus CDM review Diabetes CDM COPD CDM	17101 G14050 G14053	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)	14076	496
December	Office Follow up of COPD	17100	496