GP SERVICES COMMITTEE
Complex Care INCENTIVES

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GPSC General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP Society of General Practitioners of BC

Complex Care Planning and Management Fees

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.

These items are ***payable only to the General Practitioner who is the most responsible general practitioner for the majority of the patient's longitudinal general practice care for the ensuing year.***

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

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.

Restrictions

- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;
- 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;
  Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

Complex Care Planning and Management Fees (G14033, G14075)

There are currently two Complex Care Planning and Management Incentives G14033 and G14075. Only Family Physicians who have submitted G14070 or G14071, have access to both complex care fees. Those who have not submitted G14070/71 only have access to the original Complex Care Planning and Management Fee (2 diagnoses) G14033.

The Complex Care Planning and Management Fee (2 diagnoses) G14033 was developed to compensate GPs for the management of complex patients living in their home or assisted living, who have documented confirmed diagnoses of 2 chronic conditions from at least 2 of the 8 categories listed below. Patients in acute or long term care facilities are not eligible.

Having comorbidities does not necessarily make a patient complex. To be eligible for the Complex Care Planning and Management Fee, G14033, the patient's co-morbidities should be of sufficient severity and complexity to warrant the development of a management plan. In other words, eligibility is not based solely on the individual diagnoses. Consideration should be given to the over- all clinical impact of the diagnoses, and the burden of illness the patient experiences.

G14033 Eligibility: Complex Care Condition Categories:

1) *Diabetes mellitus (type 1 and 2)*
2) *Chronic Kidney Disease (see FAQ #9)*
3) *Heart failure*

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

If a patient has more than 2 of the qualifying conditions, when submitting G14033, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

The GP Frailty Complex Care Planning and Management Fee (G14075) encompasses those patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL).

Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community	**Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care**
Meal preparation	Mobility in bed
Ordinary housework	Transfers
Managing finances	Locomotion inside and outside the home
Managing medications	Dressing upper and lower body
Phone use	Eating
Shopping	Toilet use
Transportation	Personal hygiene
	Bathing

Patients may only have one of the Complex Care Planning and Management Fees submitted in any given calendar year, not both. If a patient already qualifies for G14033 there is no need or benefit to change to the GP Frailty Complex Care Planning and Management fee G14075 even if the patient has the required level of frailty. For new patients who qualify under both complex care fees, FSFPs who have submitted G14070 should choose the complex care fee (G14033 or G14075) that best reflects the cause of complexity.

Both Complex Care Planning and Management Fees are advance payment for the complexity of caring for patients with eligible conditions during that calendar year and have the same basic rules:

- ✓ Community Based patients = Living at home or in Assisted Living (excludes those patients living in Residential or Long Term Care where there is 24 hour nursing care available)
- ✓ Payable once at any time in a calendar year per patient
- ✓ *Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning*.
- ✓ *Minimum required total planning time 30 minutes. The majority of the planning time must be face-to- face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.*
- ✓ Maximum of five complex care fees of either category (G14033 or G14075) payable per day per physician

- ✓ Payable on the day the Care Plan was developed collaboratively with the patient and/or the patient's medical representative when appropriate for the management of the complex care patient during that calendar year.

The GPSC strongly recommends accurate ICD-9 Diagnostic Coding when billing for care of these patients throughout the year. ICD-9 diagnostic codes can be downloaded from the Ministry of Health Website at: http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/diagnostic-code-descriptions-icd-9

Consent Legislation:

With the 2011 changes to "Health Care (Consent) and Care Facility (Admission) Act" and other Acts, patients with complex health conditions also need to know the potential impact of these changes on their care. Advance Care Planning (ACP) is an essential part of the management of all patients, and should be included in Complex Care Plan when clinically appropriate

Advance care planning is the process whereby a capable adult discusses their beliefs, values, wishes or instructions for future health care with trusted family and health care providers. Advance care planning may lead to a written Advance Care Plan (ACP). An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on conversations with trusted family/friend and health care provider. The ACP is to be used by a Substitute Decision Maker (SDM) to make health care decisions for the adult when incapable and this may include consent or refusal for treatment. The decisions are to be based on a healthcare provider's offer of medically appropriate care. An Advance Directive is a legal document consenting to or refusing specific treatment options and may or may not be included in the ACP. If it is, then health care providers are legally bound by consent refusals in the advance directive.
On September 1, 2011 changes to the *"Health Care (Consent) and Care Facility (Admission) Act" and other Acts*[1] come into effect. The following changes will impact all healthcare providers. Complex Care Patients will also need to know the potential impact on their care. Advance Care Planning is an essential part of the management of Complex Care Patients, and should be included at the time of the Complex Care Planning visit when clinically appropriate.

- Advance directives gain legal status
- Health Organizations, physicians, nurse practitioners, nurses & other regulated health care providers plus Emergency medical assistants (EMAs) are legally bound by consent refusals in an advance directive
- The list of people eligible to be chosen as temporary substitute decision makers is broadened
- The rules are tightened about who can be named as a representative, while at the same time a capable adult may name their representative without having to visit a lawyer or notary public
- A process is set out for making an application to court to resolve health care consent disputes

Advance Care Planning:

- Advance care planning is the **process** whereby a capable adult discusses their beliefs, values, wishes or instructions for future health care with trusted family and health care providers.
- Advance care planning **may** lead to a written **Advance Care Plan** (ACP). An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on **conversations** with trusted family/friend and health care provider. The ACP is to be used by a **Substitute Decision Maker** (SDM) to make health care decisions for the adult when incapable and this may include consent or refusal for treatment. The decisions are to be based on a healthcare provider's offer of medically appropriate care.
- An **Advance Directive may or may not be included in the ACP**. If it is, then health care providers are legally bound by consent refusals in the advance directive. Some exceptions do apply – see the Health Care Providers 'Guide to Consent to Health Care for further information.
- There are four options for Advance Care Plans & "Who Decides":
  Temporary Substitute Decision Makers decides
  Representative decides

[1] Representation Agreement Act, Power of Attorney Act, Adult Guardianship Act

Representative decides using the Advance Directive
Advance Directive – the adult decides in advance what should be done

Advance Directives:

- Must be made and signed by a capable adult and be witnessed by two witnesses or one witness who is a lawyer or notary public in good standing with the Society of Notaries Public. A witness cannot be a person who provides personal care, health care or financial services to the adult for compensation, nor the spouse, child, parent, employee or agent of such a person.
- When an Advance Directive is in place, Temporary Substitute Decision maker **is not** sought unless an exception applies
- If there is a legal representative, then decisions are based on the instructions in the Advance Directive. The adult may have instructed through the Representative Agreement that the AD may be followed independent of the representative.
- Must state that the adult knows that:
  – a health care provider may not provide to the adult any health care for which the adult refuses consent in the advance directive; and
  – a person may not be chosen to make decisions on behalf of the adult in respect of any health care for which the adult has given or refused consent in the advance directive

G14033 GP Complex Care Planning and Management Fee (2 Diagnoses) $315

The Complex Care Planning and Management Fee is payment for the creation of a care plan and advance payment for the complex work of caring for patients with eligible conditions. It is payable upon the completion and documentation of a Care Plan which includes Advance Care Planning when appropriate, as described below. **The Complex Care Planning and Management Fee (2 Diagnoses) is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing year.**

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

1. There has been a detailed review of the case/chart and of current therapies therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. **The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.**

Patient Eligibility:

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

Notes:

i) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions.
ii) Refer to Table 1 for eligible diagnostic categories.
iii) Payable once per calendar year per patient on the date of the complex care planning visit.
iv) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning included under G14033.
v) Minimum required total planning time 30 minutes. The majority of the planning time must be face- to- face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.
vi) Chart documentation must include:
    1. the care plan;
    2. total planning time (minimum 30 minutes); and
    3. face to face planning time (minimum 16 minutes).
vii) G14016, G14018 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14033.
viii) G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.
ix) Not payable once G14063 has been billed and paid as patient has been changed from active management of complex chronic conditions to palliative management.
x) G14015, G14017, G14043, G14063, G14076 and G14078not payable on the same day for the same patient.
xi) Maximum daily total of 5 of any combination of G14033 and G14075 per physician.
xii) G14075 is not payable in the same calendar year for same patient as G14033.
xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.
xiv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
xv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

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

G14075 GP Frailty Complex Care Planning and Management Fee $315

The GP Frailty Complex Care Planning and Management Fee is payment for the creation of a care plan and advance payment for the complex work of caring for eligible patients. It is payable upon the completion and documentation of the Care Plan which includes Advance Care Planning when appropriate, as described below. **The GP Frailty Complex Care Planning and Management fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing year.**

Patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for G14075.

Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the	**Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to**

community	**personal care**
Meal preparation	Mobility in bed
Ordinary housework	Transfers
Managing finances	Locomotion inside and outside the home
Managing medications	Dressing upper and lower body
Phone use	Eating
Shopping	Toilet use
Transportation	Personal hygiene
	Bathing

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

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Care Planning Incentive code is billed.
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers that would be involved in the care, their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. **The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.**

Patient Eligibility:

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

Notes:

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

ii) Payable only for patients who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living

iii) Claim must include the diagnostic code V15.

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

v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning included under G14075.

vi) Minimum required total planning time 30 minutes. The majority of the planning time must be face- to- face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.

vii) Chart documentation must include:

1. *the care plan;*
2. *total planning time (minimum 30 minutes); and*
3. *face to face planning time (minimum 16 minutes).*

viii) *G14018 or G14077 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for G14075.*
ix) *Daily total 5 of any combination of G14033and G14075 per physician.*
x) *G14075 not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.*
xi) *G14033 is not payable in the same calendar year for same patient as G14075.*
xii) *G14043, G14063, G14076, G14078 not payable on the same day for the same patient.*
xiii) *G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted G14070 or G14071.*
xiv) *Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.*
xv) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
xvi) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

HOW TO BILL

Have a face-to-face visit with the eligible patient, and/or the patient's medical representative if appropriate;

- Review the patient's history/chart and create a Care Plan including the elements itemized above, which is billable only on the day of a face-to-face planning visit;
- Over the rest of the calendar year, conduct a review of the Complex Care Plan and provide other follow ups as clinically indicated. Follow-up may be face-to-face or by telephone/e-mail as appropriate, with the appropriate fee being payable.

Step 1. Create a Care Plan **G14033 or G 14075 - $315**

The Complex Care Planning and Management Fees acknowledge that eligible patients require medical management that is more time intense and complex. This fee compensates the GP/FP for the creation of a care plan (including Advance Care Planning when appropriate) jointly with the patient as described above, and for the additional complexity of managing these patients over the balance of the calendar year.

The initial service shall be the development of a Care Plan for a patient residing in their home or assisted living (excluding care facilities) with the eligible condition(s). G14033 requires two or more chronic conditions from two different eligible categories, while G14075 is for patients with who require assistance in at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL). The creation of a care plan requires fulfillment of the itemized elements of service and documentation of these as specified in the fee item above. ***The patient & or their representative or family should leave the planning process knowing there is a plan for their care and what that plan is.***

The diagnostic code for the GP Complex Care Planning and Management Fee (G14033) must be one of the codes from Table 1 below. If the patient has multiple co-morbidities, the submitted diagnostic code should reflect the two conditions creating the most complexity of care;

The diagnostic code for the GP Frailty Complex Care Fee (G14075) must be V15 regardless of the age of the patient.

Step 2. Provide Follow-up Visits

Visits for the rest of the year are billable under the appropriate MSP fee and with the ICD-9 code of the presenting complaint. Table 1 Complex Care Dual Diagnostic codes should not be used for follow-up services; Table 1 codes were created for billing only the Complex Care Management Fee (G14033).

Follow-up care may also be provided by telephone, and if the family physician has submitted G14070 (or G14071 if a locum), this is billable using G14076 GP-Patient Telephone Management fee. Additionally, FPs who have submitted G14070 (or G14071) also have access to G14078 GP Email/Text/Telephone Medical Advice Relay fee for medical advice provided to eligible patients, or the patient's medical representative, via email/text or telephone relay. Neither of these fees are payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals. See GPSC Conferencing and Telephone Advice Billing Guide for more details.

Step 3. Using the Diagnostic Code(s) as appropriate to the patient's eligible condition(s)

Many software programs in use in B.C. do not allow capture of more than one diagnostic code per billing. Diagnostic codes have therefore been developed to cover all combinations of any two of the chronic condition categories covered under the G14033 complex care fee. These codes are listed below, and should be used only when submitting the GP Complex Care Planning and Management Fee (G14033). All follow-up fees should use 'real' ICD-9 codes. When a patient has co-morbidities from more than two categories, the submitted diagnostic code should reflect the two conditions creating the most complexity of care.

The diagnostic code for the GP Frailty Complex Care Fee (G14075) must be V15 regardless of the age of the patient or the underlying cause of the frailty.

Table 1: Complex Care Diagnostic codes (G14033)

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

1. Frequently Asked Questions (General):

1.1. What is the purpose of the Complex Care Planning and Management Fees?

The Complex Care Planning and Management Fees have been created to provide recognition that those patients with co-morbid conditions or patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL), who require more time and effort to provide quality care, and to remove the financial barrier to providing this care as opposed to seeing more patients of a simpler clinical condition.

1.2. What is a Care Plan?

The initial service allowing access to the complex care planning and management fees shall be the development of a Care Plan for eligible patients residing in their home or assisted living (excluding care facilities). This plan should be reviewed and revised as clinically indicated.
A care plan requires documentation of the following core elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Care Planning Incentive code is billed.
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers that would be involved in the care, their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. **The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.**

1.3. How much time is required for billing the Complex Care Planning and Management Incentives and how should the time spent face-to-face with the patient and in non-face-to-face review of the patient information be documented?

Both Complex Care fees require you to spend at least 30 minutes on the planning process, the majority of it face to face with the patient. Therefore, chart documentation of the planning process must include **total work time** (minimum 30 minutes) and **total face-to-face time** (minimum 16 minutes). The time of any visit billed in addition to planning does not count toward planning time. Total planning time includes the combination of face- to-face planning with the patient and non-face-to-face planning, including chart review, review of relevant consultation recommendations, medication reconciliation, etc. Non-face-to-face planning activities may be delegated to a college certified allied care provider with the scope of practice to undertake this component (eg. RN, NP, etc). **There is no requirement to document or submit start/end times.** Any conferencing with an allied care provider that results from the complex care planning proves is billable separately using conferencing fees. The time for this conferencing does not count toward the Complex Care Planning time and the time for planning does not count toward conferencing.

Eg. 18 minutes spent face-to-face with the patient collaboratively creating a plan for their care and 20 minutes doing a physical exam. You and/or your ACP spend 15 minutes on non-face-to-face planning work (chart and current plan review, medication reconciliation, etc) that day or another day.

Documentation: "Total planning time = 33 min; face to face planning time = 18 min".

1.4. What is the difference between "assisted living" and "care facilities"?

There are a wide range of living facilities currently available. Some, referred to under the terms of this initiative as 'assisted living' facilities, provide only basic supports such as meals and housecleaning, and do not provide their residents with nursing and other health support. A "care facility" on the other hand, is defined under the terms of this initiative as being a facility that does provide supervision and support from other health professionals such as nurses.

1.5. Why is this incentive limited to patients living in their homes or assisted living?

While there may be exceptions, patients residing in a Long Term Care Facility or hospital usually have a resident team of health care providers available to share in the organization and provision of care and therefore, Complex Care Planning and Management Fees are not applicable. Patients residing in their homes or in assisted living usually do not have such a team, so the organization and supervision of care is usually more complex and time consuming for the GP.

1.6. Why are there restrictions excluding physicians "who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care" or to "physicians working under salary, service, or sessional arrangements?"

The current Fee-for-Service payment schedule tends to encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.

If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

1.7. What are the differences and similarities between the G14075 GP Frailty Complex Care Planning and Management Fee and the original G14033 GP Complex Care Management Fee?

The original Complex Care Fee G14033 applies to patients with two eligible co-morbidities (see Eligble Condition Table). The G14075 GP Frailty Complex Care Planning and Management Fee applies to patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL). FPs who have submitted G14070 (or G14071 if a locum) have access to both G14033 & G14075 complex care planning and management incentives. Regardless of diagnoses or frailty, an individual patient is eligible for only one complex care planning and management fee (14033 or 14075.) see FAQ 1.8

Both Complex Care fees have the same basic rules:

- ✓ Community Based patients = Living at home or in Assisted Living (excludes those patients living in Residential or Long Term Care where there is 24 hour nursing care available)
- ✓ Payable once at any time in a calendar year per patient
- ✓ *Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning*.
- ✓ *Minimum required total planning time 30 minutes. The majority of the planning time must be face- to-face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.*
- ✓ Maximum of five complex care fees of either category (G14033 or G14075) payable per day per physician
- ✓ Payable on the day the Care Plan was developed collaboratively with the patient and/or the patient's medical representative when appropriate for the management of the complex care patient during that calendar year.

1.8. What do I do if my patient has more than two of the eligible conditions for the original GP Complex Care Planning and Management Fee G14033 or would also qualify under the patient eligibility for the GP Frailty Complex Care Planning and Management Fee G14075?

When billing the Complex Care Management fee (G14033) use the diagnostic code from Table 1 that indicates the two conditions causing the most complexity for the patient. If a patient already is qualified under the initial dual-diagnosis G14033 there is no need or benefit to change to the GP Frailty Complex Care Planning and Management fee G14075 even if the patient meets the eligibility criteria. For new patients who would qualify under either of the complex care fees, FSFPs who have submitted G14070 (or G14071 if a locum) should choose the one that most reflects the cause of complexity. All subsequent visits/services should use the ICD-9 code for the condition requiring the visit/service.

1.9. Why did GPSC create "fake" diagnostic codes for the original GP Complex Care Planning and Management Fee G14033?

TelePlan requires software in order to capture more than one diagnostic code, but many versions of software currently used do not support this. To get around this barrier without requiring modification of current software, GPSC created different diagnostic codes to indicate different combinations of two eligible criteria.

1.10. How do the complex care planning and management incentives impact the Palliative Planning fee G14063?

Not all palliative patients are at the End-of-Life, and it is these "non-EOL" palliative patients who will require ongoing management beyond 6 months that would be appropriate for the either of the G14033 or G14075. Once they are at End-of-Life (life expectancy 6 months or less and eligible for palliative benefits plan – even if not applied for), the G14063 can be billed for Palliative Planning visit provided the G14075 or G14033 has not been billed in the previous 6 months. If a patient is determined to be in the last 6 months of life and it is decided to provide and bill for the Palliative Planning Visit through fee G14063, the complex care fees G14075 & G14033 as well as the CDM fees G14050, G14051, G14052 & G14053 are no longer billable.

1.11. Am I eligible to bill for the GP Allied Care Provider Conferencing Fee (G14077) or the GP Community Patient Conferencing Fee (G14016) in addition to receiving the Complex Care Planning and Management payment(s)?

If the physician needs to conference with allied care professionals about the care plan and any changes, then the services provided in conferencing with other allied care professionals is payable over and above the Complex Care Planning and Management fees (G14033, G14075), provided that the all criteria for the Conferencing fee are met. The time spent conferencing with allied care providers does not count toward the total time billed for the complex care fees (and vice versa). FSFPs who have submitted G14070 (or G14071 if a locum) should use the GP Allied Care Provider Conferencing Fee (G14077) while FSFPs who have not submitted G14070 should use the GP Community Patient Conferencing Fee (G14016).

1.12. What is the difference between the GP Patient Telephone Management Fee (G14076) and the GP Allied Care Provider Conferencing Fee (G14077) or the GP Community Patient Conferencing Fee (G14016)?

The Telephone Management payment (G14076) relate to services provided to the patient or the patient's medical representative as indicated. Both the GP-Allied Care Provider Conference Fee (G14077) and the GP Community Patient Conference Fee (G14016) relate to services spent conferencing with other allied care providers in a 2-way discussion on the provision of care to benefit the patient.

1.13. Am I eligible to bill for the Chronic Disease Management Fee(s) (G14050/G14051/G14052/G14053) in addition to receiving the Complex Care Planning and Management payment(s)?

Yes. The Chronic Disease Management Fees (G14050, G14051, G14052 and G14053) are independent of the Complex Care Planning and Management fees, and are payable on the same patient as long as the criteria for those fees are met.

1.14. Do locums have access to billing the Complex Care Planning and Management fees?

Many of the GPSC incentives are for services or care that goes beyond the individual visit. Both Complex Care Planning and Management 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, there must be agreement 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. Therefore, before either of the Complex Care Planning and Management Incentives can be billed on behalf of services provided by Locums, the locum and host FP need to discuss the appropriateness and acceptability of this planning process to be provided by the locum.

Specifically with respect to the GP Frailty Complex Care Planning and Management incentive, if the host FP is agreeable to the locum seeing patients eligible for this incentive to provide the planning visit as per fee description, then fee code G14075 for the provision of this service is payable, provided G14071 has been submitted on behalf of the locum earlier in the same calendar year.

1.15. Are the payments eligible for the rural premiums?
G14033 is eligible for the Rural Retention Premium. G14075 is not eligible for the rural retention premium.

1.16. I am planning to leave practice/retire – can I still bill the Complex Care incentives G14033 and G14075?
Because both Complex Care Planning and Management incentives (G14033 & G14075) include funding not only for the planning visit itself, but also prepayment for the time, intensity and complexity of caring for eligible patients over the rest of the calendar year, you should only bill them if you will be providing care to that patient for the majority of the ensuing calendar year.

2. Frequently Asked Questions (Clinical/Diagnostic):

2.1 What level of complexity is required in order to undertake and bill for the Complex Care Planning and Management incentives?
The Complex Care Planning and Management Incentives are intended to compensate for the "time, intensity and complexity" of caring for patients with multiple co-morbidities over the following year or so following the Complex Care Planning visit.

Having a specific diagnosis does not necessarily make a patient complex and so to be eligible for either of the Complex Care Planning and Management Fees, the individual patient conditions should be of sufficient severity and complexity to cause interference in their daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and warrant the development of a management plan. It is not the individual diagnosis itself, but the clinical impact of the diagnosis that is necessary for eligibility for the Complex Care Planning and Management fees.

Family Physicians are expected to use their clinical judgment when reviewing the impact of medical conditions on any given patient to determine if a patient with any given eligible diagnosis is of a level of complexity that will require a significant time and intensity of management over the following year or so to warrant undertaking a complex care planning visit.

2.2. If when managing a patient's medical condition, measurable testing (eg. eGFR, HgBA1C, PFTs, echocardiogram, etc) improves, does the patient still qualify for complex care G14033?
Eligibility is not simply about the medical diagnosis, but the clinical impact of that diagnosis that is important. If a person's measurements for their medical co-morbidities improve with management, the underlying condition has not been cured, but is being appropriately managed to prevent further progression of the condition. Those conditions that improve because they are transient or self-limited would not qualify as chronic and complex, and so are not eligible for G14033 or G14075.

2.3 What are instrumental and non-instrumental activities of daily living (IADL & NIADL) for determining patient eligibility for G14075?

Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community:

- Meal preparation
- Ordinary housework
- Managing finances
- Managing medications
- Phone use
- Shopping
- Transportation

Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care:

- Mobility in bed
- Transfers
- Locomotion inside and outside the home
- Dressing upper and lower body
- Eating
- Toilet use
- Personal hygiene
- Bathing

Patients who require assistance for at least one ADL from each category are eligible for G14075.

2.4. Does Sleep Apnea qualify as an eligible condition for Complex Care G14033?

Sleep Apnea is considered a sleep disorder, not a respiratory disorder and as such, it does not qualify.

2.5. What is the level of abnormal laboratory testing that will qualify my chronic liver patients as having "hepatic dysfunction"?

For the Complex Care Fee, Chronic Liver Disease with hepatic dysfunction will be defined as:

1) 'Chronic' refers to liver disease/dysfunction present for a period of at least six months;
2) 'Chronic Liver Disease with Hepatic Dysfunction' is defined as hepatic disease with evidence of liver dysfunction. Conditions that are not eligible include:
   a. Self-limiting conditions (e.g. Acute Hepatitis A or B, mononucleosis, CMV, etc.);
   b. Hepatitis carrier states with normal liver function tests;
   c. Benign conditions with elevation of liver function tests (e.g Gilbert's Syndrome, isolated elevation of a liver enzyme without other evidence of hepatic dysfunction)
3) Conditions that may be eligible but that require additional consideration of the bigger clinical picture to determine the clinical impact of the condition include:
   a. Fatty liver disease with increased liver enzymes: Fatty liver is the result of the excess fat in liver cells. Fatty tissue slowly builds up in the liver when a person's diet exceeds the amount of fat his or her body can handle. A person has a fatty liver when fat makes up at least 5% of the liver. ***Simple fatty liver can be a completely benign condition and usually does not lead to liver damage***. However, once there is a buildup of fat, the liver becomes vulnerable to further injury, which may result in inflammation and scarring of the liver.

   b. Alcoholic hepatitis with increased liver enzymes: Alcoholic hepatitis is hepatitis (inflammation of the liver) due to excessive intake of alcohol. It is usually found in association with fatty liver, an early stage of alcoholic liver disease, and may contribute to the progression of fibrosis, leading to cirrhosis.

For a detailed outline of liver enzyme abnormalities and their connection to ongoing liver disease vs temporary/reversible non-chronic conditions if the underlying cause is addressed, the GPAC Guideline "Abnormal Liver Chemistry" can be found at:

http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/abnormal-liver-chemistry

2.6. What is required to confirm a diagnosis of Chronic Kidney Disease?

The presence of CKD should be established, based on presence of kidney damage and level of kidney function (estimated glomerular filtration rate [eGFR]), irrespective of diagnosis. All individuals with eGFR

<60 for 3 months are classified as having chronic kidney disease, irrespective of the presence or absence of kidney damage. The rationale for including these individuals is that reduction in kidney function to this level or lower represents loss of half or more of the adult level of normal kidney function, which may be associated with a number of complications.

All individuals with kidney damage (defined as structural or functional abnormalities of the kidney based on abnormalities in the blood or urine [ACR at least 3.0 mg/mmol] or abnormalities in imaging tests) are classified as having chronic kidney disease, irrespective of the level of eGFR. The rationale for including individuals with eGFR 60 is that eGFR may be sustained at normal or increased levels despite substantial kidney damage and that patients with kidney damage are at increased risk of the two major outcomes of chronic kidney disease: loss of kidney function and development of cardiovascular disease.

Decreased eGFR may be acute or chronic. An acute decrease in eGFR does not necessarily indicate the presence of kidney damage/disease. For example, it is well known that a brief period of mildly decreased blood flow to the kidneys or transient partial obstruction of the urinary tract may cause decreased eGFR without kidney damage. However, a sustained decrease in blood flow or prolonged obstruction is often associated with kidney damage. Chronically decreased eGFR is more often associated with kidney damage. Decreased eGFR without recognized markers of kidney damage is very frequent in infants and older adults, and is usually considered to be "normal for age." Other causes of chronically decreased eGFR without kidney damage/disease in adults include vegetarian diets, unilateral nephrectomy, extracellular fluid volume depletion, and systemic illnesses associated with reduced kidney perfusion, such as heart failure and cirrhosis. It is not certain whether individuals with chronically decreased eGFR in the range of 60 to 89 mL/min/1.73 m2 without other evidence of kidney damage are at increased risk for adverse outcomes, such as toxicity from drugs excreted by the kidney or acute kidney failure. As a result, there is insufficient evidence to label individuals with eGFR 60 to 89 mL/min/1.73 m2, but without markers of kidney damage, as having chronic kidney disease. In clinical practice, it may be difficult to determine whether individuals with decreased eGFR alone have chronic kidney disease.

Misclassification is possible, and family physicians should carefully consider all aspects of the patient's clinical presentation when interpreting test results and determining evaluation and ongoing management. ***If the initial diagnosis of CKD was confirmed through more than just an abnormal eGFR, then while lab work may improve with good management, the underlying medical problem does not disappear. In order to reduce the risk of complications in the future, ongoing management must continue and as such, the complexity of caring for these patients continues.***

2.7. What is included under Neurodegenerative Disease as an eligible condition for G14033?
Neurodegenerative Disease is the umbrella term for the progressive loss of structure or function of neurons, including death of neurons. Examples of Chronic Neurodegenerative conditions include those degenerative disorders such as Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.

2.8. Does Epilepsy or seizure disorder qualify as a Chronic Neurodegenerative Disease?
Epilepsy/seizure disorder in and of itself is not a condition with an ongoing progressive loss of structure or function of neurons. Seizures may be a symptom of an underlying chronic neurodegenerative disorder that may qualify but as a stand-alone diagnosis, Epilepsy/Seizure Disorder does not qualify.

2.9. Does Downs Syndrome or other such genetic conditions qualify for G14033?
Chromosomal abnormalities are not chronic neurodegenerative disorders as these do not result in a progressive loss of structure or function of neurons, therefore this diagnosis is not eligible for 14033. However, ***depending on the level of disability, these patients may qualify for G14075*** if they require assistance with at least one task in each of the IADL & NIALD lists.

2.10. Does Mental Retardation or other cognitive impairment qualify for G14033?
Mental Retardation or other cognitive impairment is a functional diagnosis that in most cases does not result in a progressive loss of structure or function of neurons. If cognitive impairment is the symptom of an underlying eligible condition, then it is that underlying condition that would qualify, not the symptom. Therefore, depending on the underlying cause, this diagnosis is most likely not eligible for 14033. However,

depending on the level of disability, these patients may qualify for G14075 if they fulfill require assistance with at least one task in each of the IADL & NIALD)

2.11 Does evidence of multiple lacunar infarcts or cerebrovascular disease on CT scan without known event qualify under Cerebrovascular Disease for G14033?
Evidence of multiple lacunar infarcts or cerebrovascular disease on CT scan ***with symptoms that are of sufficient severity and complexity to cause interference in their daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and warrant the development of a management plan*** would be an eligible condition. It is not simply about a diagnosis made on a CT scan, but the clinical impact of that diagnosis that is necessary for eligibility for the Complex Care Planning and Management fee G14033**.**

2.12. Does diastolic heart dysfunction qualify under Ischemic Heart Disease for G14033?
Diastolic heart dysfunction is a functional diagnosis that **may** be the result of underlying ischemic heart disease. ***If it is due to underlying ischemic heart disease, and is clinically of sufficient severity and complexity to cause interference in their daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and and warrant the development of a management plan,*** then yes it would qualify. ***If the patient has heart failure as a result of diastolic heart dysfunction,*** then it is the heart failure that would be a qualifying diagnosis for the purpose of G14033. It is not simply the medical diagnosis, but the clinical impact of that diagnosis that is important.

2.13. Does Cor Pulmonale qualify under Ischemic Heart Disease for G14033?
Cor pulmonale is a condition that causes the right side of the heart to fail. Long-term high blood pressure in the arteries of the lung and right ventricle of the heart can lead to cor pulmonale. It is not usually due to ischemic heart disease, therefore would not be eligible unless it is a symptom due to underlying ischemic heart disease. However**, *if the patient has heart failure as a result of cor pulmonale, then it is the heart failure that would be a qualifying diagnosis*** for the purpose of G14033, not the diagnosis of cor pulmonale. If either underlying ischemic heart disease and/or resultant heart failure is present then the patient would qualify using one of these diagnoses, not both.

Complex Care Management Fees

G14033	**GP Complex Care Planning and Management Fee** (Table 1 Diagnoses)	**$315**
G14075	**GP Frailty Complex Care Planning and Management Fee**	**$315**

Complex Care Billing Example

You are a family physician who has submitted G14070. Mrs. J. is a 68 year old lady with diabetes, asthma and Parkinson's disease. While she lives in her own home, she requires assistance in at least one area of

each of Instrumental and Non-Instrumental Activities of Daily Living. The local Home Care nurse visits her on a monthly basis. She has made an appointment to see you in January for review of her care plan that was set up the previous year. Prior to seeing Mrs. J, you spend 10 minutes reviewing her chart and you note that her frailty in large part due to her Parkinson's disease, is causing more of her complexity than are her other medical co-morbidities. When you see Mrs. J, you review her current medications, most recent lab tests as well as her peak flow chart and her diabetes flow sheet. You then spend the next 20 minutes discussing her personal goals, advance care wishes and resulting complex care plan for the remainder of the year and set up an appointment for her to have her complete checkup in March when it is due. She also complains of a dry cough at night and you examine her to determine if there is any cause for concern. You also note that her Diabetes CDM (14050) anniversary is coming up at the end of January.

In February, Mrs. J calls when you are on call to advise that her peak flow has suddenly dropped into her low yellow zone after visiting her daughter who has a cat. She tells you that her maintenance dose of inhaled steroids has been 1 inhalation twice daily, so you ask her to increase to 2 inhalations twice daily and to come in to the office to see you the following day. When you see her, you determine she has had a flare of her asthma but that there is no sign of acute infection, and so advise to continue with the increased inhaled steroids. You contact the home care nurse to review the community plan for her management (15 minute conference), and she agrees to see her early the following week and follows up with you by teleconference (10 minute conference). You see Mrs. J again 2 days after the home care nurse has visited and her peak flows have improved. You advise her to stay on this higher dose for the next 2 weeks, and that you will have your office nurse call to check on her.

When contacted by phone in early March, her peak flows have stayed stable and she is advised to go back to her maintenance dose. You see her again in March for her CPX and over the rest of the year for follow up of her complex conditions she is seen in July, October for planned proactive care of her Diabetes and Parkinson's disease and in December twice due to a flare of her asthma. In addition, in September, she is seen by you for a bladder infection and treated appropriately.

The billings for this calendar year for Mrs. J. are:

Month	Service	Fee Code	Dx Code
Jan.	Frailty Complex Care Planning Documentation: *Total planning time 30 minutes including face-to-face planning time of 20 minutes.* Same Day Medical Visit Diabetes CDM Anniversary	14075 16100 14050	V15 786 250
Feb.	Phone call by GP Office Visit – Asthma flare Conference call with home care nurse at time of visit Conference call with home care nurse prior to next visit Office visit – Asthma flare follow up	14076 16100 14077 X 1 14077 X 1 16100	493 493 493 493 493
March	Phone call follow-up by office nurse CPX	14076 16101	493 250
July	Office Visit – proactive follow up	16100	250
Sept.	UTI Office Visit	16100 15130	595 01L
Oct.	Office Visit – proactive follow up	16100	332
Dec.	Office Visit – Asthma flare Office Visit – Asthma flare	16100 16100	493 493