GP SERVICES COMMITTEE
Conferencing and Telephone Management
INCENTIVES

Revised
July 2017

General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP
Society of General Practitioners of BC

Conference & Telephone Fees (G14077, G14015, G14016, G14017, G14018, G14019, G14021, G14022, G14023, G14076, G14079)

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.

Conferencing with Allied Care Professionals

There are two ways for conferencing to be supported. For those Full Service Family Physicians who have submitted G14070/71, the billing for conferencing with allied care professionals (including specialists and GPs with specialty training) will be through the use of G14077 which replaced the original conference codes (G14015, G14016 & G14017) for FPs. G14076 and G14076 are also available to those family physicians who are members of a GP Maternity Network or a GP Unassigned Inpatient Network and who provide care to patients who are not attached to them in the community, but who may be cared for in a shared care manner with the patient's community Family Physician.

For FPs who have not submitted G14070/71, there will still be access to the initial three conference incentive fees (G14015, G14016 & G14017) that are for case conferencing for eligible patients who are facility based, community based or ready for discharge from a hospital. These codes are limited to the care of BC patients (out of province patients are not eligible) who fall into five categories:

- Frail elderly: use diagnostic code V15
- Palliative care: use diagnostic code V58
- End of life: use diagnostic code V58
- Mental illness: use appropriate mental health diagnostic code.
- Patients of any age with multiple medical needs or complex co-morbidity (two or more distinct but potentially interacting problems) where care needs to be coordinated over time between at least one (or more depending on fee specific requirements) health disciplines: Pregnancy qualifies as one diagnosis. Use the diagnostic code for one of the major disorders but at some future date, both will be required.

See table 1 below for a more complete description of the eligible patient populations for G14015, G14016 & G14017.

All four conference payments (G14077, G14015, G14016 & G14017) are payable at a rate of $40 per 15 minutes or greater portion thereof. They are payable in addition to payment for a medically required visit if the conferencing requirements are done on the same day provided the visit occurs before or after the conference.

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

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

> Representative means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative.
>
> Temporary Substitute decision makers (Alternate Representative) in listed order, of the following who is available and qualifies under subsection 16(2):
>
> (a) the adult's spouse
> (b) the adult's child
> (c) the adult's parent

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

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

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

G14018 Urgent Telephone Advice from a Specialist or GP with Specialty Training is also still available to all Full Service Family Physicians as it remains outside the G14070/71 portal and does not have a minimum time requirement. It is to be used for brief urgent telephone calls (response within 2 hours) needed to keep a patient safe in their current location, whereas the other 4 conferencing codes as described above have a "per 15 minute or greater portion thereof" time requirement. G14018 also does not have any patient diagnostic requirements and provides some additional flexibility compared to the original 3 conference codes G14015, G14016 & G14017.

G14019 GP Advice to a Nurse Practitioner – Telephone or In Person became available January 1, 2015. This fee is to be used when a Nurse Practitioner (NP) in independent practice (ie. Not employed as staff in a FP practice) has contacted a GP for advice regarding patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care. This is not for conferencing with an NP about patients who are attached to the FP. It is outside the G14070/71 portal and does not have a minimum time requirement. This can be used to support those NPs who become the MRP for patients involved in a multidisciplinary team model providing care for specific populations who would otherwise be hard to integrate into a standard family practice.

GPSC Conference/Advice Incentives G14077, G14015, G14016, G14017, G14018, G14019

Eligibility
These incentive payments to improve patient care and continuity are available to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00). Practitioners who have billed any specialty fee in the previous 12 months are not eligible; and
- Whose majority professional activity is in **full service family practice**; and
- Is considered the most responsible FP for that patient at the time of service.

GPSC defines "Full Service Family Physician" as the FP who has a ***longitudinal ongoing relationship with his/her patients and has committed to the provision of the broad spectrum of services and the overall responsibility of the coordination of the 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 (eg. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care with the patient's family physician.

If you are billing for a medically necessary visit as well as the care conference, submit the visit fee for the same date but do not put in a time if it is a weekday daytime visit. If using an out-of-office hour's visit fee code, make sure the time is either before or after the conferencing fee, not the same time. Details of Care Conference must be documented in the patients chart (in office or facility as appropriate). See template for charting at the end of this document.

All four patient conferencing fees (G14077, G14015, G14016 & G14017) are payable at the same rate of $40.00 per 15 min or greater portion thereof to a maximum of 2 units per calendar day per patient. Time spent must be noted in patient chart located in office or facility as appropriate. The claims must state start and end times of the conferencing service.

G14077 has a maximum of 18 units payable per calendar year per patient across all locations and scenarios.

The initial conference codes G14015, G14016 & G14017 each have a maximum of 6 units per calendar year per eligible patient in each specifically defined setting.

For G14077, use the diagnostic code for the patient's most significant condition that caused the need for the conference to occur. For G14015, G14016 & G14017, the claim must include one of the appropriate diagnostic codes V15, V58, the code for one of the major psychiatric disorders or one of the major medical conditions (see table 1 below).

Restrictions
These payments are not available to physicians who are employed by or who are under contract to a facility or health authority ***who would otherwise have attended the conference as a requirement of their employment***. They are also not available to physicians who are working under salary, service contract or sessional arrangements ***who would otherwise have attended the conference as a requirement of their employment***.

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

1. GP Attachment Patient Conference Fee

The GPSC has received feedback about the complexity of the initial Patient Conferencing incentives. As part of the Attachment Initiative, these concerns have been addressed through a significant simplification as well as expansion of the Attachment Patient Conference fee in order to support improved collaborative care between participating FPs and other health care providers. ***The Attachment Patient Conference fee replaces all three of the original conference codes (G14015, G14016 & G14017)*** as well as removes a number of other identified barriers that were present in order to bill these codes.

G14077 GP Attachment Patient Conference Fee $40.00

Notes:

i. *Payable only to Family Physicians who have successfully:*
   a. *Submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year; or*
   b. *Registered in a Maternity Network or GP Unassigned In-patient network on a prior date.*

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

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

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

v. *Not payable for situations where the purpose of the call is to:*
   a. *book an appointment*
   b. *arrange for an expedited consultation or procedure*
   c. *arrange for laboratory or diagnostic investigations*
   d. *inform the referring physician of results of diagnostic investigations;*
   e. *arrange a hospital bed for a patient*

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

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

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

ix. *The claim must state start and end times of the service. Start and end times must also be documented in the patient chart.*

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

xi. *Not payable for simple advice to a non-physician allied care professional about a patient in a facility.*

xii. *Not payable in addition to G14015, G14016, or G14017 as these fees are replaced by G14077 for those Family Physicians who have submitted the GP Attachment Participation code.*

xiii. *Not payable to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have participated in the conference as a requirement of their employment.*

xiv. *Not payable to physicians who are working under salary, service contract or sessional arrangements who would otherwise have participated in the conference as a requirement of their employment.*

FREQUENTLY ASKED QUESTIONS about G14077 GP Attachment Patient Conference Fee

1.1. What is the difference between the G14077 GP Attachment Patient Conference Fee and the original G14015 GP Facility Patient Conference, G14016 GP Community Patient Conference and G14017 GP Acute Care Discharge Planning Conference fees?

GPSC received significant feedback on the barriers of the original Conference fees (G14015, G14016 & G14017). The G14077 GP Attachment patient Conference fee essentially amalgamates the original conference fees G14015 (Facility Patient Conference Fee), G14016 (Community Patient Conference Fee) & G14017 (Acute Care Discharge Planning Conference fee) and also removes the barriers that existed with these initial ones. FPs participating in the Attachment Initiative will never again have to remember the original codes and the requirements for billing them.

Now, there is a single code, G14077, with a total of 18 units per calendar year and 2 units per calendar day (same as the combined totals for the original fees) but with much more flexibility in when, where and how they can be accessed:

- Can be used when the patient is located in the community, acute care, sub-acute care, assisted living, long-term or intermediate care facilities, detox units, mental health units, etc. etc.
- Can be provided/requested at any stage of admission to a facility from ER through stay to discharge)
- Need to conference with at least 1 Allied Care Professional (including physicians) regardless of location.
- Can be done in person or by telephone.
- Can be initiated by either the FP or the Allied Care Professional.

1.2. Is G14077 GP Attachment Patient Conference Fee billable for patients in acute care? Is the phrase "not billable for simple advice given to a health care professional about a Patient in a facility" only intended to cover that specific instance and a case of a call for other than simple advice (for example) is billable even if the patient is in a facility?

The Attachment Patient Conference Fee (14077) is much more flexible than the three conference codes it is replacing (14015, 14016, 14017). FPs participating in the GPSC Attachment Initiative will no longer bill the original codes. They will only bill the 14077 for conferences that occur for any patient in their practice (there are no diagnostic requirements with the 14077 unlike with the original conference codes which were restricted to Frail elderly, Palliative/End-of-Life, Multiple Co-morbidities, Mental Health). There is also no patient location restriction for this new conference fee. So patients may be in the community or in a facility (any facility including acute care and even in ER). All of the conferencing codes have the same time requirements – billed per 15 minutes or greater portion thereof, requires start and end time.

Simple/brief advice to a non-physician allied care practitioner is covered using 13005 for patients in community "care" (eg. home health, palliative care, and public health services provided in the home) or any facility except acute care.

1.3. What "Allied Care Professionals" are included in order to bill G14077 GP Attachment Patient Conference Fee?

G14077 Attachment Conferencing Fee is intended as compensation when the FP participating in attachment undertakes a conference with any allied care provider. The FP component of conferencing cannot be delegated to a non-physician.

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

1.4. Can G14077 be billed when a family physician conferences with Allied Care providers working within a practice, either employed by the physicians or employed by a Health Authority (or other agency) and embedded within the practice?

Conversations for brief advice or update about a patient, between GP and an allied care provider that is located in the GP office, are part of the normal medical office work flow and would not be eligible for G14077 as this does not meet the criteria. True case conferences that meet the requirements of G14077, whether scheduled or occurring due to an important change in patient status are not part of normal daily work flow, and would be eligible for G14077, regardless who the employer of the allied care provider is. This is similar to the hospital or long term care based patients, where G14077 is not billable for conversations with allied care providers when on routine rounds but is billable for care conferences, discharge planning conferences, medication reviews (not when only for prescription renewals), etc.

1.5. If a hospital has a multidisciplinary team potentially that meets to discuss the needs of inpatients with respect to issues such as placement, nutritional support, physio or rehab, and the condition of the patient determines that there is the necessity of a physician meeting with the group, will this team meeting be eligible for billing G14077 GP Attachment Patient Conference Fee?

Yes, FP conferencing with this group of Allied Care Professionals (either in person or by teleconference) would qualify for the use of the new Attachment Patient Conference fee G14077 regardless of the underlying patient medical condition that requires the conference to occur. There is a limit of 2 units (30 minutes) per calendar day per patient, and with the 18 units per calendar year, there is increased flexibility for using this fee across locations/scenarios of conferencing. Conversations that are part of the normal clinical hospital rounds would not be eligible for G14077 as this does not meet the criteria or intent of the conferencing fees.

1.6. Are locums able to access the G14077 GP Attachment Patient Conferencing Fee when covering in an Attachment Participating practice?

Yes. Locum physicians are eligible to have the G14077 billed for conferencing with allied care professionals when covering an Attachment participating host FP, provided G14071 GP Locum

Attachment Participation Code has been submitted earlier in the same calendar year. The number of units available are patient specific (18 per calendar year), not provider specific (host vs. locum FP).

1.7. In a multi-doctor Attachment participating clinic, is G14077 GP Attachment Patient Conference Fee billable for conferencing services provided by one of the clinic FPs covering for a patient's FP when their own FP is not available (eg. Holiday or out of hours coverage)?

If all FPs in the clinic group participate in attachment and the patient in question is attached to one of them, then conferencing is appropriate. If the covering doc is conferencing for a patient that does not belong to the group (ie. either another non-group FP or patient is unattached), then none of the conferencing fees would be appropriate, as these are restricted to the FP who provides the community MRP care for the patient on an ongoing longitudinal basis. When covering for a colleague in the absence of a locum, these patients may be booked or may be a walk-in/fit-in on any given day. Some of these conferences could occur on the weekend or in the evenings by the doc "on-call" for the group.

The important point is about the underlying relationship with the FP and the fact that in multi-doctor clinics, while the majority of the care is provided by the FP the patient is attached to, there are situations where the other docs must cover not only out of office hours but also during office time. How each group of docs arranges this coverage is variable. It is not about where in the clinic the patient is care for. It's about the status of patient (attached or not) and well as whether or not the treating physician is participating in attachment and has submitted code G14070 or G14071 in the case of a locum at the clinic.

1.8. Am I eligible to bill for the Attachment Patient Conferencing Fee (G14077) in addition to receiving the Complex Care Management payment(s)?

Yes. If the physician needs to conference with allied care professions about the care plan and any changes, then the services provided in conferencing with other allied care professionals and billed using the Attachment Patient Conferencing Fee (G14077) is payable over and above the Complex Care 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 complex care fees (and vice versa).

1.9 Can FPs who are in "Focused Practice" Obstetrics access the G14077 GP Attachment Patient Conference Fee?

Effective January 1, 2016, family physicians who provide care through a GP Maternity Network or a GP Unassigned Inpatient Network to patients who are not attached to them in the community are eligible to access G14077 for conferencing with allied care providers about these patients.

1.10. If I am part of a maternity network or unassigned in-patient network and I see a complex patient for whom I need to conference with their family physician, are we both able to bill for this conference?

Yes, each of the FP in a maternity or unassigned network and the patient's family physician who has submitted G14070 in the same calendar year, may bill 1 unit of G14077 for this conference. If the patient's GP has not submitted G14070 in the same calendar year, 1 unit of G14016 may be billed provided the patient is in one of the eligible categories, while the FP in a maternity or unassigned network may submit 1 unit of G14077.

1.11. How do I document the time spent conferencing about an individual patient for G14077 if the conferencing takes place over several time intervals on the same day, but cumulatively adds up to the greater part of 15 min?

G14077 can be billed for conferencing with allied care providers in person or by telephone. When conferencing with multiple providers over the course of a day, you should add up the total time spent conferencing and as well as documenting in the chart which providers you spoke to and when. When submitting the start/end time, use the start time of the first conversation and set the end time as the time it would have been if all the conversations had been done consecutively. eg. Chart

documentation: Specialist X at 1100 – 1105 hr, home care RN at 1400 – 1410 hr for total time spent conferencing 15 min. Start time 1100 end time 1115 in fee submitted.

1.12. Is this payment eligible for rural premiums?

No, currently none of the Attachment incentive fees are eligible for rural premiums.

2. G14015 FACILITY PATIENT CONFERENCE FEE

The Facility Patient Conference fee is billable by FPs who have not submitted G14070/71 but who are still providing longitudinal comprehensive care to the patients in their practice. It is billable when the family physician or locum is requested by the facility in which the patient is residing (permanently or temporarily) to review ongoing management of the patient in that facility or to determine whether a patient in a facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility. The conference is an interdisciplinary team meeting of at least two allied care providers and will include family members when available. Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any allied care provider charged with coordinating discharge and follow-up planning.

The conference must be performed in the facility (**in-person attendance by FP is required** except under extraordinary circumstance) and results of the conference must be recorded in the patient's chart. (See chart documentation template in Appendix i) Facilities are limited to:

- Palliative Care facility
- LTC facility
- Rehab facility
- Sub-Acute care facility
- Psychiatric facility
- Detox/Drug and Alcohol facility
- Acute Care (Long stay or complex patient)

Restrictions

- If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
- This payment does not cover routine discharge planning from an acute care facility, nor is this fee payable for conferencing with acute care nurses on the patient's ward.
- This incentive payment is not payable on the same day for the same patient as the community patient conference fee (G14016) or the acute care discharge planning conferencing fee (G14017).
- This incentive payment is not payable for FPs who have submitted G14070/71.

G14015 General Practice Facility Patient Conference $40.00

Payable when requested by a facility to review on-going management of the patient in that facility or to determine whether a patient with complex supportive care needs in a facility can safely return to the community or transition to a supportive or long-term facility - per 15 minutes or greater portion thereof

Notes:

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

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

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

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

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

vi) Fee includes:

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

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

FREQUENTLY ASKED QUESTIONS about G14015 GP Facility Patient Conference fee:

2.1. How do I claim the Facility Patient Conference Fee payments?
Submit the fee item 14015 (value $40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).

2.2. What is the maximum number of payments allowed per patient?
There is a maximum of two units (30 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year per patient.

2.3. Is this payment eligible for rural premiums?
Yes.

2.4. Are there circumstances where payment will be allowed even if the care conference did not occur in a face-to-face meeting in the facility?
Face to face meetings are expected. Only under exceptional circumstances will care conferences by teleconference will be payable. For audit purposes, when this occurs, a chart entry is required to indicate that you were not physically present and the circumstances that prevented it.

2.5. If more than one patient is discussed at the same case management conference is the fee billable for each patient discussed?
Yes. The fee is billable under the PHN of each of the patients discussed, for the length of time that each patient's care was discussed. If you attend a care conference and two patients are discussed over the course of an hour the total time billed must not exceed one hour (max of 2 units per patient per calendar year).

2.6. Is the Facility Patient Conference Fee billable by physicians who are employed or under contract to a facility and would have attended the conference as a requirement of their employment or contract with the facility?

No.

2.7. Is the Facility Patient Conference Fee billable by physicians working in a or physicians working under salary, service contract or sessional arrangements?

No. When provision of this service is included as a part of the contract for physicians working under these, funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.

2.8. Can this fee be billed if I also submitted a Community Patient, Acute Care Discharge Planning or Attachment Patient Conference Fee on the same day?

No. It is not payable on the same day of service for the same patient as the Community Patient Conference Fee or the Acute Care Discharge Planning Conference Fee. The Community Patient Conference Fee is intended for patients living in the community while the Facility Patient Conference Fee is intended for patients residing in a facility. The Acute Care Discharge planning fee is to be used when the patient is in an acute care facility and the complexity of their condition requires a multi-disciplinary care conference to ensure a smooth transition back to the community other acute care or long term care facility.

If a Community Patient Conference Fee or an Acute Care Discharge Planning Conference fee was billed and the patient is subsequently admitted to a facility included in the list as above, and a patient management conference is requested by that facility on a separate day, fee item 14015 may be billed. Conversely, if a Facility Patient Conference Fee is billed and the patient is subsequently discharged from the facility and additional clinical action planning is required, fee item 14016 may be billed once the patient has been discharged. If the facility patient is admitted to acute care, and subsequently requires a discharge planning conference prior to return to the initial facility, then the fee item 14017 may be billed for the acute care discharge planning conference. They may not, however, be billed on the same calendar day.

G14077 has replaced all three of the original conferencing codes for Family Physicians who are participating in the Attachment Initiative.

2.9. Are locums able to bill this incentive?

Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.

2.10. Can I bill for patients covered by other provinces?

No. this service is not covered under the reciprocal agreement with other provinces.

2.11. Is this fee billable by hospitalists or on behalf of hospitalists?

No. Refer to bullet ix. under the fee description above. Hospitalists are under contract to a facility and would have attended the conference as part of their duties.

2.12. Can a community-based GP bill this fee for the discharge planning of a patient from an acute-care hospital?

No. If the FP is participating in the Attachment Initiative then the discharge planning conferences are to be billed under G14077 Attachment Patient conference fee. If the FP is not participating in the Attachment Initiative, then this would be billed using the Acute Care Discharge Planning Fee (14017).

2.13. Can FPs who are in "Focused Practice" Obstetrics access the G14015 Facility Patient Conference Fee?

FPs in focused practice obstetrics cannot access G14015 Facility Patient Conference fee unless they are not in a maternity network and are the community MRP for the patient's ongoing longitudinal care but have not submitted G14070 to participate in Attachment. However, effective January 1, 2016, family physicians who provide care through a GP Maternity Network or a GP Unassigned Inpatient Network to patients who are not attached to them in the community are eligible to access G14077 for conferencing with allied care providers about these patients. G14077 is appropriate for eligible physicians when conferencing with allied care providers about patients located in facilities.

3. G14016 COMMUNITY PATIENT CONFERENCING FEE

The Community Patient Conference fee G14016 is billable by Family Physicians who are not participating in the GPSC Attachment Initiative when there is a need for the communication of a coordinated clinical action plan developed (or revised) for the care of **community-based patients** with more complex needs. It is payable only when coordination of care and ***two-way collaborative conferencing with at least one other allied care providers*** is required (e.g., physicians, psychologists or counselors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers). This conference with allied care providers may include, but does not require, the participation of the patient and possibly family members as required due to the severity of the patient's condition.

This planning/conferencing payment is billable when the complex patient's condition requires contacting other allied care professionals and developing a plan for care to keep the patient stable in their community environment. Included in this is: the interviewing of, and conferencing with other community allied care providers; organizing and reviewing appropriate laboratory and imaging investigations, administration of other types of testing as clinically indicated (e.g., Beck Depression Inventory, MMSE, etc); provision of degrees of intervention or No CPR documentation; and the communication of that plan to patient, other allied care providers, and family members or others involved in the provision of care, as appropriate; and if a telephone call to discuss management strategies while the patient is awaiting an assessment by a consultant is required, then this fee is applicable.

The community patient conferencing fee is billable for conferences that occur as a result of care provided in the following community locations for patients who are resident in the community:

- Community GP Office
- Patient Home
- Community placement agency
- Disease clinic (DEC, arthritis, HF, Asthma, Cancer or other palliative diagnoses, etc.)

The care plan must be recorded in the chart and include the following information:

- *Patient's Name*
- *Date(s) and time(s) of Service*
- *Diagnosis*
- *Reason for need of Clinical Action Plan*
- *Health Care Providers with whom you conferred & their role in provision of care*
- *Clinical Plan Determined, including tests ordered and/or administered*
- *Patient risks based on assessment of appropriate domains (list of co-morbidities and safety risks)*
- *List of priority interventions that reflect patient goals for treatment;*
- *What referrals will be made, what following about has been arranged (including timelines and contact information), as well as advanced planning information*

Restrictions

- This incentive payment is not payable on the same day for the same patient as the facility patient conference fee (14015) the acute care discharge planning conferencing fee (14017).
- This payment is not for referrals to the emergency room or to consultants when only a referral letter is required for an acute illness.
- This incentive payment is not payable for FPs participating in the GPSC Attachment Initiative as it has been replaced by G14077 Attachment Patient Conference Fee.

G14016 General Practice Community Patient Conference Fee **- per 15 minutes or greater portion thereof 40.00**
Payable for two-way collaborative conferencing about the care of the community- based patients with more complex needs, either by telephone or in person, between the family physician and at least one other health care provider.
Notes:
i) Refer to Table 1 (below) for eligible patient populations.

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

iii) Fee includes:
- *a. Two -way collaborative conferencing, either by telephone or in person, between the family physician and at least one other allied care provider(s). Conferencing cannot be delegated.*
- *b. Review and organization of appropriate clinical information.*
- *c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*
- *d. The care plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

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

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

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

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

viii) Not payable to the same patient on the same date of service as fee item G14015, G14017, G14074, G14075, G14076 or G14077.

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

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

FREQUENTLY ASKED QUESTIONS about G14016 GP Community Patient Conference fee:

3.1. How do I claim the Community Patient Conferencing Fee payments?
Submit the fee item 14016 (value $40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).

3.2. What is the maximum number of payments allowed per patient?
There is a maximum of two units (30 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year per patient.

3.3. Is G14016 billable for a Community Patient Conference on the same day as a Facility Patient Conferencing Fee or Acute Care Discharge Planning Conferencing Fee for conferences provided in two separate locations for the patient on the same day?
No. If the FP is not participating in the Attachment Initiative, then conferencing is billable only in one location as only one of G14015, G14016 or G1407 is billable on any calendar day. However, if the FP

is participating in the Attachment Initiative then the patient conferences in any setting, community, facility (care conferences) and acute care (including discharge planning conferences) can be cumulative to a maximum of 2 units per calendar day (eg. 15 – 20 minutes in one location early in day and 15 – 20 minutes later in the day in the second location) and are to be billed under G14077 Attachment Patient conference fee.

3.4. Is this payment eligible for rural premiums?
Yes.

3.5. Are locums able to bill this incentive?
Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.

3.6. Can I bill for patients covered by other provinces?
No.

3.7. Is the Community Patient Conferencing Fee billable by physicians working under salary, service contract or sessional arrangements?
No. Physicians working under these funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.

3.8. When I undertake a phone consultation/conferencing with a specialist about a patient who fulfills the criteria, can I bill the community patient conferencing 14016?
For a FP not participating in the GPSC Attachment Initiative, if any of the qualifying patients where a medical situation requires conferencing/consulting with a specialist or physician with specialized training, in order to create a plan to keep the patient safe in the community, the community patient conferencing fee is applicable provided the other requirements are also met. Included in the time required for billing the 14016 (15 minutes or major portion thereof) is the time spent on the phone with the specialist, the documentation of the recommendation, any additional calls needed to implement the recommendations (eg. Contacting home & community care, etc) and the time advising the patient or the patient's representative of the recommendations/plan.

3.9. Am I eligible to bill this fee when I refer an acutely-ill patient and discuss the case with an Emergency Room Physician/Specialist/Emergency Department nurse?
No. This fee covers the two-way collaborative conferencing with other providers in the development of a clinical action plan to keep the patient safely in the community. The transmission of information in a referral process does not qualify.

3.10. Can FPs who are in "Focused Practice" Obstetrics access the G14016 Community Patient Conference Fee?
FPs in focused practice obstetrics cannot access G14016 Community Patient Conference fee unless they are not in a maternity network and are the community MRP for the patient's ongoing longitudinal care but have not submitted G14070 to participate in Attachment. However, effective January 1, 2016, family physicians who provide care through a GP Maternity Network or a GP Unassigned Inpatient Network to patients who are not attached to them in the community are eligible to access G14077 for conferencing with allied care providers about these patients. G14077 is appropriate for eligible physicians when conferencing with allied care providers about patients located in in the community.

3.11. How do I document the time spent conferencing about an individual patient for G14016 if the conferencing takes place over several time intervals on the same day, but cumulatively adds up to the greater part of 15 min?
G14016 can be billed for conferencing with allied care providers in person or by telephone. When conferencing with multiple providers over the course of a day, you should add up the total time spent conferencing and as well as documenting in the chart which providers you spoke to and when. When submitting the start/end time, use the start time of the first conversation and set the end time as the time it would have been if all the conversations had been done consecutively. eg. Chart

documentation: Specialist X at 1100 – 1105 hr, home care RN at 1400 – 1410 hr for total time spent conferencing 15 min. Start time 1100 end time 1115 in fee submitted.

4. G14017 Acute Care Discharge Planning Conferencing fee

The general practice acute care discharge planning conference fee is billable by Family Physicians who are not participating in the GPSC Attachment Initiative when a Discharge Planning Conference is performed by the community based FP upon the request of either an Acute Care facility, or by the FP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.

It is payable only for patients being discharged from an acute care facility to the community or to a different facility; another acute care facility, or a supportive care or Long Term Care facility and must be performed in the acute care facility with results of the conference must be recorded in the patient's chart in the acute care facility and the receiving GP's office chart (or receiving facility's chart in the case of inter-facility transfer). Face-to-face conferencing is required with the only exception allowed if a patient is being discharged from an acute care facility in a different community, and a chart notation must be made to indicate this circumstance. The requesting care providers are limited to Facility-affiliated physicians and nurses, GP assuming MRP status upon patient's discharge, care coordinators, liaison nurses, rehab consultants, social workers, and any allied care provider charged with coordinating discharge and follow-up planning. This requires an interdisciplinary team meeting of the GP assuming MRP status upon discharge and a minimum of 2 other allied care professionals as enumerated above, and will include family members when appropriate.

This fee includes:

- Interviewing of and conferencing with other allied care providers of both the acute care facility and community and may in addition include where appropriate, the patient and/or family members.
- Review and organization of appropriate clinical information;
- The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of Intervention and end of life documentation as appropriate;
- The care plan must be recorded and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged

Restrictions

- This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses during the course of a patient's stay in the acute care facility;
- If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
- Not billable on the same day as Facility Patient or Community Patient Conferencing Fees (G14015 or G14016);
- This incentive payment is not payable for FPs participating in the GPSC Attachment Initiative as it has been replaced by G14077 Attachment Patient Conference Fee;
- Not billable on the same day as any GPSC planning fees (G14075, G14033, G14043, G14063).

G14017 GP Acute Care Discharge Conference fee $40.00

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

facility, or a supportive care or long-term care facility.
- per 15 minutes or greater portion thereof

Notes:

i) Refer to Table 1 for eligible populations.

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

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

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

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

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

vii) Fee includes:

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

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

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

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

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

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

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

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

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

xvi) Not payable to the same patient on the same date of service as fee item G14015, G14016, G14074, G14076 or G14077.

xvii) Not payable on the same day as any GPSC planning fees (G14033, G14075, G14043, G14063

FREQUENTLY ASKED QUESTIONS about G14017 Acute Care Discharge Planning Conference Fee:

4.1. How do I claim the Acute Care Discharge Planning Conference Fee payments?
Submit fee item 14017 (value $40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).

4.2. What is the maximum number of payments allowed per patient?
There is a maximum of two units (30 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year per patient.

4.3. Is this payment eligible for rural premiums?
Yes.

4.4. Are there circumstances where payment will be allowed even if the care conference did not occur in a face-to-face meeting in the facility?
Face to face meetings are expected. Only under exceptional circumstances will care conferences by teleconference be payable. For audit purposes, when this occurs, a chart entry is required to indicate that you were not physically present and the circumstances that prevented it**.**

4.5. If more than one patient is discussed at the same case management conference is the fee billable for each patient discussed?
Yes. The fee is billable under the PHN of each of the patients discussed, for the length of time that each patient's care was discussed. If you attend a care conference and two patients are discussed over the course of an hour the total time billed must not exceed one hour (max of 2 units per patient per calendar day).

4.6. Is the Acute Care Discharge Planning Conference Fee billable by physicians who are employed or under contract to a facility and would have attended the conference as a requirement of their employment or contract with the facility?
No.

4.7. Is the Acute Care Discharge Planning Conference Fee billable by physicians working in a or physicians working under salary, service contract or sessional arrangements?
No. When provision of this service is included as a part of the contract for physicians working under these, funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.

4.8. Can this fee be billed if I also submitted a Community Patient or Facility Patient Conference Fee on the same day?
No. The Acute Care Discharge Planning Conference fee (G14017) is not payable on the same day of service for the same patient as the Community Patient Conference Fee (G14016) or the Facility Patient Conference Fee (G14015). The Community Patient Conference Fee is intended for patients living in the community and the Facility Patient Conference Fee is intended for patients residing in a facility. The Acute Care Discharge planning fee is to be used when the patient is in an acute care facility and the complexity of their condition requires a multi-disciplinary care conference to ensure a smooth transition back to the community other acute care or long term care facility.

If a Community Patient Conference Fee (G14016) or a Facility Patient Conference fee (G14015) was billed and the patient is subsequently admitted to an acute care facility, and a discharge planning conference is deemed to be needed, fee item G14017 may be billed but not on the same day as

G14015 or G14016. Conversely, if a Facility Patient Conference Fee (G14045) is billed and the patient is subsequently admitted to acute care, and subsequently requires a discharge planning conference prior to return to the initial facility, then the fee item G14017 may be billed for the acute care discharge planning conference. They may not, however, be billed on the same calendar day.

4.9. Are locums able to bill this incentive?
Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.

4.10. Can I bill for patients covered by other provinces?
No. This service is not covered under the reciprocal agreement with other provinces.

4.11. Is this fee billable by hospitalists or on behalf of hospitalists?
No. Refer to bullet ix. under the fee description above. Hospitalists are under contract to a facility and would have attended the conference as part of their duties.

4.10. Can FPs who are in "Focused Practice" Obstetrics access the G14017 Acute Care Discharge Planning Conference Fee?
FPs in focused practice obstetrics cannot access G14017 Acute Care Discharge Planning Conference fee unless they are not in a maternity network and are the community MRP for the patient's ongoing longitudinal care but have not submitted G14070 to participate in Attachment. However, effective January 1, 2016, family physicians who provide care through a GP Maternity Network or a GP Unassigned Inpatient Network to patients who are not attached to them in the community are eligible to access G14077 for conferencing with allied care providers about these patients. G14077 is appropriate for eligible physicians when discharge planning conference about patients located in acute care.

5. G14018 General Practice Urgent Telephone Conference with a Specialist (or GP with Specialty Training) Fee

The intent of this initiative is to improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers. This fee is billable when the patient's condition requires urgent conferencing with a specialist or GP with specialty training, and the development and implementation of a care plan within the next 24 hours to keep the patient stable in their current environment. This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

Eligibility:
This incentive payment is available to improve patient care to:

- All General Practitioners who have a valid B.C. MSP practitioner number (registered specialty 00), except those with access to any specialty consultation fee.
- Is considered the most responsible general practitioner for that patient at the time of service.
- Where the severity of the patient's condition justifies urgent conference with a specialist by telephone for the development of a clinical action plan to keep the patient safely in their location.

G14018 General Practice Urgent Telephone Conference with a Specialist/GP with Specialty Training Fee

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

Notes:

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

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

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

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

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

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

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

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

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

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

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

xii) *Payable in addition to a visit on the same date.*

Frequently Asked Questions about G14018 General Practice Urgent Telephone Conference with a Specialist/GP with Specialty Training Fee

1. What is the difference between G14018 General Practice Urgent Telephone Conference with a Specialist/GP with Specialty Training Fee and the other conferencing fees (G14077, G14015, G14016, G14017)?

The G14018 requires there be a patient acuity that determines the need for response from the specialist or GP with specialty training within 2 hours. There are no such response time restrictions for the other conferencing fees. In addition, the G14018 is not a time based fee (per 15 minutes or greater portion) and therefor has no minimum total time for the telephone advice/conferencing.

2. Are all telephone conversation responses from the Rapid Access to Specialty Expertise (RACE) line billable with G14018?

No, unless the 2 hour urgency due to patient condition is present, G14018 may not be billed for the RACE line response. If all requirements for the other conferencing fees are met for these conversations, one of these may be applicable instead.

6. GP – Advice to Nurse Practitioner Fee

The intent of this fee is to support collaboration between nurse practitioners and community family physicians. This fee is billable when providing advice by telephone or in person when a Nurse Practitioner (NP) in independent practice (ie. Not employed as staff in a FP practice) has contacted a GP for advice regarding patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care. This is not for conferencing with an NP about patients who are attached to the FP. It is outside the G14070/71 portal and does not have a minimum time requirement. This incentive can be used to support those NPs who become the MRP for patients involved in a multidisciplinary team model providing care for specific populations who would otherwise be "hard to attach". It is also an appropriate support in situations where an NP has a practice that is not formally connected with other providers, but when he/she feels having a virtual connection to local GPs would be beneficial for sustainability.

Eligibility

These incentive payments to improve patient care and are available to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00). Practitioners who have billed any specialty fee in the previous 12 months are not eligible; and
- Whose majority professional activity is in full service family practice;
- Patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care

G14019 GP -Advice to a Nurse Practitioner – Telephone or In Person $40.00

Notes:

i) Payable for advice by telephone or in person, in response to request from a Nurse Practitioner (NP) in independent practice on patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care.

ii) Excludes advice to an NP about patients who are attached to the GP.

iii) Payable for advice regarding assessment and management by the NP and without the responding physician seeing the patient.

iv) Not payable for written communication (i.e. fax, letter, e-mail).

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

vi) NP Practitioner number required in referring practitioner field when submitting fee through teleplan.

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

- *a. book an appointment*
- *b. arrange for transfer of care that occurs within 24 hours*
- *c. arrange for an expedited consultation or procedure within 24 hours*
- *d. arrange for laboratory or diagnostic investigations*
- *e. inform the referring physician of results of diagnostic investigations*
- *f. arrange a hospital bed for the patient*

viii) Limited to one claim per patient per day with a maximum of 6 claims per patient per calendar year.

ix) Limit of five (5) G14019 may be billed by a GP on any calendar day.

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

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

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

xiii) Not payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment.

Frequently Asked Questions about G14019 GP -Advice to a Nurse Practitioner – Telephone or In Person

6.1. If our local Division has collaborated with the Health Authority to start up a multi-disciplinary clinic for complex, high-needs patients who cannot be attached to a usual FSFP practice, can GPs supporting this approach bill this incentive when responding asked for advice about a patient who is attached to the NP in this model?
Yes, provided the NP is the MRP for that patient, if a GP is asked for advice about a patient without the FP seeing the patient, then G14019 is billable.

6.2. Can a GP bill this incentive when responding to a phone call by an NP who is providing MRP care for patients living in a Long Term Care Facility?

Yes, provided the NP is the MRP for that patient, if a GP is called for advice about a patient without the FP seeing the patient, then G14019 is billable.

6.3. What is the maximum number of payments allowed per patient or per physician?
There is a maximum of one claim per day, per patient with a maximum of 6 claims per calendar year per patient. There is also a limit of 5 G14019 billed by any GP on any calendar day.

6.4. Is this payment eligible for rural premiums?
No.

General Practitioners with Specialty Training Telephone Advice Fees (G14021, G14022, G14023)

GP with Specialty Training Telephone Advice fees (G14021, G14022, G14023) have been developed to support teleconferencing between GPs with specialty training and other Family Physicians, Specialists or Allied Care Providers, for the purpose of improving patient care

Eligibility:

- Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- Service may be provided when physician is located in office or hospital.
- For the purpose of these telephone advice fee items the GPSC has defined a General Practitioner (GP) with specialty training as: **"A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program".**
- Telephone advice must be related to the field in which the GP has received specialty training.
- **When advice is requested by an Allied Care Provider not registered with MSP use the generic practitioner number 99987: Advice requested by an allied care provider. (Not applicable to referred case fee items such as consultations.)**

G14021 GP with Specialty Training Telephone Advice for Patient Management - Initiated by a Specialist. General Practitioner, or Allied Care Provider, Response within 2 hours **$60.00**

Notes:

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

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

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

iv) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.
v) Not payable for situations where the purpose of the call is to:
a. book an appointment
b. arrange for transfer of care that occurs within 24 hours
c. arrange for an expedited consultation or procedure within 24 hours
d. arrange for laboratory or diagnostic investigations
e. inform the referring provider of results of diagnostic investigations
f. arrange a hospital bed for the patient
vi) Not payable to provider initiating call.
vii) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).
viii) Limited to one claim per patient per physician per day.
ix) A chart entry, including advice given and to whom, is required.
x) Include start and end times in time fields when submitting claim.
xi) Not payable in addition to another service on the same day for the same patient by same practitioner.
xii) Out-of-Office Hours Premiums may not be claimed in addition.
xiii) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.
xiv) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987).

G14022 GP with Specialty Training Telephone Advice for Patient Management - Initiated by a Specialist, General Practitioner or other Allied Care Provider, response within one week – per 15 minutes or portion thereof **$40.00**

Notes:

i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.
ii) Conversation must take place within 7 days of initiating provider's request. Initiation may be by phone or referral letter.
iii) If conversation is with an allied care provider include a note record specifying the type of provider.
iv) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.
v) Not payable for situations where the purpose of the call is to:
a. book an appointment
b. arrange for transfer of care that occurs within 24 hours
c. arrange for an expedited consultation or procedure within 24 hours
d. arrange for laboratory or diagnostic investigations
e. inform the referring provider of results of diagnostic investigations
f. arrange a hospital bed for the patient
vi) Not payable to provider initiating call.
vii) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).
viii) Limited to two services per patient per physician per week.
ix) A chart entry, including advice given and to whom, is required.
x) Include start and end times in time fields when submitting claim. Start and end times must also be recorded in patient chart.
xi) Not payable in addition to another service on the same day for the same patient by same practitioner.
xii) Out-of-Office Hours Premiums may not be claimed in addition.

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

xiv) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987).

G14023 GP with Speciality Training-Patient Telephone Management / Follow-Up $20.00

Notes:

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

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

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

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

v) No claim may be made where communication is with a proxy for the GP with Specialty Training (e.g.: office support staff).

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

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

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

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

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

Frequently Asked Questions about GP with Specialty Training Fees

1. Can both the patient's GP and a GP with Specialty Training bill for these fees on the same patient?

Yes, for urgent (less than 2 hours) telephone conferencing, the patient's FP would bill the G14018 as the requesting the telephone conferencing and the resulting GP for the development and implementation of the clinical action plan, while the GP with specialty training would bill G14021 (the FRCP Specialist would bill G10001) for providing the advice within 2 hours of the request for this advice.

For less urgent telephone conferencing, the GP with specialty training may bill the G14022 (FRCP Specialist would bill G10002) but the requesting GP cannot bill the G14018. If the FP has submitted G14070/71, he/she may bill the G14077 GP Patient Conference fee provided the conference lasts 15 minutes or greater portion thereof.

However, if the FP has not submitted G14070/71 and this less urgent teleconferencing is for a patient covered by the community patient conferencing fee (G14016) and fulfills the requirements outlined in this fee, then the appropriate units of G14016 may be billed by the patient's GP.

2. Are there any restrictions on the patient underlying medical conditions?

No, unlike the other Original Patient Conferencing fees for FPs have not submitted G14071 (G14015, G14016, G14017) there are no specific medical condition requirements for these new fees. The intent of this initiative is to improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers. If a patient's condition is severe enough to warrant the telephone conferencing and the patient is not seen the same day by the specialist/GP with Specialty training, then the fees are billable.

3. **Does the patient have to be seen in the office to be eligible for these new fees?**
   No, patient location in the community is not a requirement for these new fees. The patient could be in a community hospital and the teleconference with a specialist or GP with specialty training could be at a regional or tertiary care hospital. The main requirements for these new fees are based on the timing of the teleconferencing.

4. **Are fee items G14018, G14021, G14022 and G14023 eligible for the rural retention premiums?**
   Yes these fee items are eligible for rural retention premiums.

5. **Can any of these fees be billed in addition to a visit or other service on the same day?**
   Only the G14018 is billable in addition to a visit or service on the same day. The fee items G14021, G14022 & G14023 are not payable in addition to another service on the same day by the same physician for the same patient.

6. **What is the maximum number of G14018 payments allowed per patient?**
   There is a maximum of 6 units of 14018 per calendar year per patient. There is no restriction on the number of 14021, 14022 or 14023 fees per patient.

GPSC CONFERENCE/TELEPHONE ADVICE FEES

G14077	*Attachment Patient Conference Fee*
G14015	*Facility Patient Conference Fee*
G14016	*Community Patient Conference Fee*
G14017	*Acute Care Discharge Planning Conference Fee*
G14018	*GP Urgent Telephone Conference with a Specialist (or GP with Specialty Training) Fee*
G14019	*GP Advice to a Nurse Practitioner Fee – Telephone or In-person*
G14021	*GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Urgent (less than 2 hour response time)*
G14022	*GP with Specialty Training Telephone Patient Management - Initiated by a Specialist or General Practitioner, One Week*
G14023	*GP with Specialty Training Telephone Patient Management / Follow-Up*

BILLING EXAMPLES (14077 if FP has submitted G14070/71or G14015, G14016 & G14017 if FP has not submitted G14070/71)

Example #1: You have been asked to attend care conferences on 3 of your patients at the local LTC facility. This is arranged for 0830 hr on a Thursday. You arrive for the care conferences which are attended by the nursing staff, a pharmacist, the OT and PT for the ward. You discuss your first 2 patients (Mr. A and Mr. B) for 20 minutes each. Your third patient, Mrs. C, has her daughter attending the care conference due to concerns about her mother's shortness of breath. After reviewing her current status and discussion plans to manage the issues, the care conference ends after 35 minutes. You then go and see each of your patients, as you have not seen them for > 2 weeks. Mr. A's main diagnosis is severe arthritis as well as general frailty. Br. B's main diagnosis is diabetes with peripheral vascular disease and amputation of the right leg. Mrs. C's main diagnosis is severe COPD, hypertension and acute upper respiratory infection.

Your billings would be:

Patient	Time	# of Services	Fee code	Diagnostic Code
Mr. A	0800 – 0820	1	14077 or 14015	V15
Mr. A		1	00114 plus 13334	781
Mr. B	0820 – 0840	1	14077 or 14015	V15
Mr. B		1	00114	250
Mrs. C	0840 – 0915	2	14077 or 14015	V15
Mrs. C		1	00114	460

Example #2: Mr. B, 73 years old, arrives for his office visit accompanied by his two children AT 11:00. They are concerned that, since his wife's death a year ago, he has deteriorated significantly. The house is dirty and his personal hygiene has slipped. He is not eating and has lost weight, and is drinking more than he used to. He is no longer as interested in his family's activities and, on occasion, he has forgotten the names of his grandchildren. You initially meet with all three, and then you excuse the daughters and meet alone with Mr. B. He is unkempt, his clothes hang on his body, and he doesn't engage in conversation with you as he did in the past. He admits to drinking 'at least' a bottle of wine per day, and frequently comments that he wished he had died before his wife. You perform a full physical examination, without significant findings. You order laboratory investigations. At this point (11:30) you also personally administer a Beck Depression Inventory and a Mini-Mental Status Examination, which reveals severe depression and mild cognitive impairment. Then with Mr. B's permission, his children rejoin you to discuss your findings and plan; Mr. B tells you to follow up with his children as his memory "hasn't been so good." Following this you conference with (depending on your community) the Quick Response Team/ Geriatric Outreach/ Home Care Nurse to arrange for a home visit assessment, and also conference with a psychiatrist to discuss initiation of treatment and arrange for him to be seen. Shortly after, you phone his pharmacist to prescribe the antidepressant agreed upon during the telephone conference with the psychiatrist and to arrange for all his medications to be blister-packed as he has been forgetting to take them. You then phone his daughter to advise her of the steps taken and the appointments you have made for him, and arrange a follow-up office visit in two weeks. All total, you have spent 50 minutes conferencing with the AHP and family.

Billing: *You are eligible in this case to bill 17101 for the full physical examination. You are also eligible to bill the appropriate units of 14077 or 14016 for the time following the examination spent administering the Beck and MMSE, and organizing the care plan with other health care providers.*

Your billings would be:

Date	Time	# of Services	Fee code	Diagnostic Code
MM/DD/YY			17101	V15
MM/DD/YY	1130 – 1220	2	14077 or 14016	V15

Example #3*:*

New complex patient to your practice – On taking history you find out the 78 year old patient (Mrs. D.) suffers from osteoporosis with previous compression fractures of the spine, recurrent TIAs and hypertension. She is in an adult day program at a local LTC facility, requires blister packaging of her meds, and has ongoing monitoring by the elderly outreach team through your local home care department at the public health unit. After taking a detailed history, including obtaining a list of medications, and noting her BP of 185/80, you and the patient agree that as their level of stability varies, it would be appropriate for the elderly outreach team to go out and reassess safety issues in the home, have the home care nurse monitor her BP at home, and that all other care providers need to be involved in understanding some change to their level of needs. You follow this by contacting the elderly outreach team member involved and the pharmacy the patient deals with on the same day. In addition to the visit, the conferencing takes you

15 minutes immediately following the visit at 1600hr. The next day you contact the day program manager and then the patient's daughter/son to discuss these issues and make a plan for ongoing monitoring and reporting lines. You spend 10 minutes conferencing on the second day at 1330 hr followed by the patient/family follow-up phone call at 1345 hr. You see the patient in 3 weeks for a CPX and to review her BP measures from home care. Over the course of the next year, you see Mrs. D twice more for planned proactive care and undertake a follow up 20 minute conferencing call with the elder outreach team immediately after the second visit (1430 hr). 1 year after taking over her care, can bill for the hypertension CDM.

Billing: *You are eligible in this case to bill 17100 for the office visit in addition to the Unattached Patient Attachment code if you submitted G14070. You are also eligible to bill the appropriate units of 14077 or 14016 for the time following the examination for conferencing with other health care providers on both days. If you have submitted G14070, you can also bill for the follow-up telephone call with the patient and family about the care plan on the second day.*

Your billings would be:

Date	Time	# of Services	Fee code	Diagnostic Code
MM/#1/YY			17100	V15
(MM/#1/YY			14074	V15)
MM/#1/YY	1600 – 1615	1	14077 or 14016	V15
MM/#2/YY	1330 – 1340	1	14077 or 14016	V15
(MM/#2/YY	1345	1	14076	V15)
MM/#3/YY			17101	401
MM/#4/YY			17100	401
MM/#5/YY			17100	401
MM/#5/YY	1430 – 1450	1	14077 or 14016	V15
MM/#6/YY			14052	401

If the pharmacy calls you to renew a prescription or the patient asks you to call in a prescription renewal, this is not covered under the conferencing fee as this is a simple renewal.

Example #4*:*

Mrs. J, an 82 year old patient who lives in assisted living has fallen and suffered fractured ribs with a pneumothorax. She was taken to your local hospital where she was stabilized and treated. She has diabetes with decreased vision and suffered a CVA 2 years ago. On day 3 you get a call asking you to come to a discharge planning conference at 0800 hr the next day in efforts to arrange a safe discharge in the next few days. At the conference, there is the nursing staff, respiratory and physio therapists as well as OT. Arrangements are made for some additional support in her assisted living apartment until an assessment of her long term needs can be made in the community. The conference is 25 min. She is discharged 2 days later. You have been her MRP and visited her daily for the full 6 days (first patient seen).

Your billings would be:

Date	Time	# of Services	Fee code	Diagnostic Code
MM/#1-#6/YY		6	13008 (+ 13338)	786
MM/#4/YY	0800 – 0825	2	14077 or 14017	V15

Example #5:

Mrs. V. is a 38 year old maternity patient, G2 P0 at 32 weeks gestation. Her prenatal care has to date been relatively uneventful with normal SIPS testing and normal 1 hour 50 gm GTT. At this visit, her BP is 140/90 on 3 readings, including after lying in the left lateral position. Her reflexes are normal, and she has no signs of pre-eclampsia. You advise her that she needs to have some blood work undertaken and give her a requisition for a PIH panel, put her on bedrest at home, and put a call in to your local obstetrician for a telephone consultation.

When Dr. J calls you back at 1600 hr you discuss the case, he advises home BP monitoring and a recheck in your office later the same week. He advises that if her BW is normal, and her home BP settles with bed rest, she only requires closer conservative management. If her BP does not settle he advises you on starting medication and arranging an office consultation in the near future. You then contact home care to arrange the home BP monitoring and follow up by phone with the patient. Total time spent in the telephone consultation, recording and implementation of recommendations as well as advising the patient is 30 minutes.

Your billings would be:

Date	Time	# of Services	Fee code	Diagnostic Code
MM/DD/YY			14091	642
MM/DD/YY	1600-1630	2	14077 or 14016	642

Example #6:

Mr. S is a patient with a past history of ulcerative colitis. The patient has at your office arrived febrile with significant bloody diarrhea. Your initial workup has revealed there is no acute surgical concern, but you feel you need to discuss the management of this case urgently. You place a page to the Gastroenterologist on call with a request for an urgent phone conference. You get the return call within 30 minutes and discuss the case in more detail. You are given appropriate advice on urgent management and agree to follow up with the patient within 48 hours, earlier if symptoms worsen. The patient's condition does improve, and you send a note to the specialist asking for a follow up in the office on a less urgent basis, as it has come to your attention that the patient has not undergone colonoscopy in over 5 years. This is then arranged between your separate office staff.

Billings:

Community GP	G14018
Specialist	G10001 (Specialist Physician to Physician Urgent Telephone Advice fee)

Example #7:

Ms. C is a palliative patient who is being managed in her home. You have been called in to see the patient due to worsening respiratory distress. After your assessment, you page the Palliative Care Physician on call (a GP with specialty training), requesting urgent phone advice. You receive the call within 20 minutes and discuss the case. After review, you are provided with advice on managing the patient's distress and then document the plan and effect the recommendations with good benefit for the patient.

Billings:

Community GP	00103
	G14018
GP with Specialty Training	G14021

Example #8:

Mr. H is a 85 year old frail patient who is finding more difficulty with walking steadily. Your examination reveals no acute neurologic, respiratory or cardiology concerns. You place a call to the local geriatrician who has seen the patient in the past requesting a call back within the next few days. The geriatrician calls you later the next day and you discuss the patient's condition and findings. Recommendations were made for further investigations and home care assessments. After the telephone conferencing with the specialist, you document the plan, contact the home care nurse and home care pharmacist to further refine the plan and agree that after the in home assessment, the nurse will call you to report on her findings. In total you have spent 30 minutes on day 2. You then contact the patient's daughter to discuss the plan. The home care nurse calls you 2 days later and after a 15 minute conversation, further recommendations are agreed to and implemented.

Billings:

Community GP	Day 1: 18100
	Day 2: 14077 or 14016 X 2 units
	Day 4: 14077 or 14016 X 1 unit
Specialist	Day 2: G10002 (Specialist Physician to Physician Patient Management Telephone Advice fee)

Example #9

Mr. J is a 77 year old patient with Heart Failure and numerous other co-morbidities. You saw him in the office with some increased shortness of breath. On exam, his weight had increased 2 kg from the previous visit but his chest was clear to auscultation. You discussed his diet and medications and he agreed to some modifications. Despite these changes, he went to the ER 2 days later, complaining of worsening dyspnea with orthopnea. The ERP calls you to discuss your findings from the visit 2 days earlier as it may help in the decision to admit or discharge with further changes to management. After discussing the patient, a change of management plan is agreed to and Mr. J is sent home and a follow-up visit to the office was arranged for the a few days later. Total time in conferencing with ERP 15 minutes.

Billings:

Community GP – if you have submitted G14070/71 you can bill 1 unit 14077

Community GP – if you have not submitted G14070/71, you cannot bill any fee as none of 14015, 14016 or 14017 is applicable for this conferencing.

ER Physician – there is no fee billable currently for this conferencing.

Table 1: Eligible patients populations for the G14015 Facility Patient Conference Fee, G14016 Community Patient Conference Fee and G14017 Acute Care Discharge Planning Conference Fee

i. Frail elderly (ICD-9 code V15)

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

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

ii. Palliative care (ICD-9 code V58)

Patient of any age who:

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

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

Patients of any age:

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

iv. Mental illness

Patients of any age with any of the following disorders are considered to have mental illness.

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

Definitions and the management of these mental disorders are defined in the Manual: Management of Mental Disorders, Canadian Edition, Volume One and Two, edited by Dr. Elliot Goldner, Mental Health Evaluation and Community Consultation Unit, University of British Columbia. Definitions for Delerium, Dementia and Other Cognitive Disorders; Developmental Disabilities; Dissociative Disorders; Mental Disorders due to a General Medical Condition and Factitious Disorder are found in the Diagnostic and Statistical Manual of Mental Disorders - DSM-IVR

v. Patients of any age with multiple medical needs or complex co-morbidity (ICD-9 code XXX)

Patient of any age with multiple medical conditions or co-morbidities (two or more distinct but potentially interacting problems) where care needs to be coordinated over a period of time between at least one (or more depending on fee specific requirements) health disciplines. Pregnancy qualifies as one of the two conditions. On your claim form use the code for one of the major disorders.

Template Chart Documentation for 14077/14015/14016/14017

Date: _____ Location: _____

Start/Stop Time of Service:_____ Unit(s)[1] _____

Family Members Involved: _____

_____

Other Health Professionals & their role in provision of care:_____

_____

_____

_____

_____

Requirement for Facility/Community Patient Conference/Care Plan: Frail Elderly / Palliative or End of Life / Mental illness / Complex

Risks/Problems (list of co-morbidities/safety risks):_____

_____

_____

_____

_____

_____

_____

_____

_____

Prioritized Interventions/Referrals/Follow-ups[2] (Patient Goals for Treatment):

1._____

2._____

3._____

4._____

5._____

6._____

Planned Date of Follow-up: _____

[1] $40/unit; 1 unit = 15 minutes; 2unit maximum/day

[2] Follow-ups should include timelines/contact information

Telephone/e-mail Fees (G14079 & G14076)

Telephone and Two-way e-mail visits with Patients

Telephone and other non-face-to-face 'visits' or 'touches' are a standard component of workflow in other jurisdictions. They have been shown to significantly improve efficiency of care and therefore practice capacity. When expanding patient care to include non-face-to-face care, whether by telephone or e-mail, you must always determine if you have enough information to be confident appropriate advice is given. You documentation in the patient chart must indicate not only the nature of the patient request, but also the advice given.

In this context, **G14076** expanded telephone 'visits' as part of the Attachment Initiative as it is seen as an important component of improving practice capacity. The intent is to avert the need for a patient to be physically seen in the practice in order to increase access for other patients and/or to address urgent problems to avert a patient visit to an urgent care facility or Emergency Department. G14076 can be used at the discretion of the Family Physician for any patient for whom that Family Physician has assumed the Most Responsible Physician role for any clinical reason that addresses the intent above. Each Attachment participating FP (and locum – see Attachment Section of Billing Guide) has access to 1500 G14076 fees per calendar year. G14076 is also available for those family physicians who are members of a GP Maternity Network or a GP Unassigned Inpatient Network and who provide care to patients who are not attached to them in the community, but who may be cared for in a shared care manner with the patient's community Family Physician.

G14079 the GP Telephone/E-mail fee (which replaced the original separate Telephone/E-mail fees G14039, G14049, G14059 & G14069 effective January 1, 2012) is also available for patients on whom a Full Service FP has assumed MRP status and has billed a GPSC planning fee (Complex Care, COPD, Mental Health, and Palliative Care) will remain intact outside the Attachment portal and will therefore not be dependent upon an FP submitting an Attachment Portal Fee. Fee item G14079 can still be billed up to 5 times in the 18 months after the successful billing of one or more of the following fees: 14033; 14043; 14063; 14053; 14075. When implementing E-mail Management as part of patient care, security and patient confidentiality must be maintained and guarded in the same way that paper records are protected. The Canadian Medical Protective Association (CMPA) recommendations regarding the use of email indicate:

- **Three major areas of potential liability:**
  - Confidentiality/privacy/security
  - Timeliness of Response
  - Clarity of Communication
- **Document Consent** – preferably written
  - CMPA template consent form for email communication www.cmpa-acpm.ca
- **Document Discussion & Advice** – all manners of communication

The BC College of Physicians and Surgeons has also developed guidelines regarding emailing of patient information:

- Obtain express and informed consent before transmitting patient information electronically (see CMPA Template)
- Confidential & sensitive information should be encrypted or at a minimum, password protected. Send password or cryptographic key separately.
- Email addresses need to be double checked.
- Consider the sensitivity before emailing (eg. Ca Dx)Develop clear, written policies around use of e-mail in your practice and ensure they are consistently followed.

1. G14079 GP Telephone/E-mail Follow-up Management Fee

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

G14079 GP Telephone/Email Management Fee $15.00

This fee is payable for 2-way communication with eligible patients, or the patient's medical representative, via telephone or email by the GP who has billed and been paid for at least one of the following GPSC incentives:

- Complex Care Planning Fee (G14033)
- Mental Health Planning Fee (G14043)
- Annual Chronic Care Incentive for COPD (G14053)
- Palliative Care Planning Fee (G14063)
- Attachment Complex Care Management Fee (G14075)

This fee is billable for medical management of the conditions covered under the initial planning/Chronic Care fee. This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

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

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

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

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

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

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

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

Frequently Asked Questions for G14079 GP Telephone/E-mail Management Fee

1. Why has the GPSC condensed the initial 4 telephone/e-mail follow-up management fees (G14039, G14049, G14069 & G14073) into a single fee?

The GPSC has frequently heard that the billing system is getting very complicated. Having 4 different codes billable for non-face-to-face services for these patient populations created challenges as the code used had to directly relate back to the original incentive billed if more than one incentive had been billed on any single patient. For example, a complex care patient who also suffers an axis 1 mental health condition could have had both the G14033 and the G14043 billed, and then depending on the telephone/e-mail service offered, either the G14039 or G14049 had to be billed. Now, regardless which condition(s) are reviewed in these visits, the same fee (G14079) is billed.

2. How many non-face-to-face services can I bill for per patient?

There is a limit of 5 non-face-to-face services per calendar year per patient, regardless how many eligible portal incentives were billed. In an average year with 1 planning visit and 2 – 3 in-office follow-up visits, the use of 5 non-face-to-face visits supports services every 1 – 2 months.

3. Do the telephone/e-mail follow-up services count toward the 2 visit requirement in the 12 months prior to billing the CDM incentives?

Yes, effective August 1, 2015, to confirm an ongoing doctor-patient relationship, there must be at least 2 visit fees billed one of which can be 14076 or 14079 Telephone Visit or 13763 – 13781 Group Medical Visit)

4. Why is the GP Telephone/Email Follow-Up Management Fee (G14079) restricted to the GP that has been paid for one or more of the planning portal incentives (G14033, G14075 G14043, G14053 or G14063)?

This fee is designed to allow greater flexibility in providing follow-up to a plan that has been created. The GP that has been paid for the one of the planning incentives (the Original Dual-diagnosis Complex Care Management, Attachment Complex Care Management, Mental Health Management or Palliative Care Management) or the COPD CDM (which requires the use of a COPD Action Plan) in the previous 18 months has also accepted the responsibility of being the Most Responsible GP (MRGP) for that patient's care for these conditions. The planning visits require work, the shouldering of responsibility, and the co-ordination of care. It has considerable value. This fee is therefore restricted to the FP who has created the plan.

5. If the GP Telephone/Email Follow-Up Management Fee is restricted to the GP who has been paid for the eligible portal incentive (G14033, G14075, G14043, G14053 or G14063), what do group practices do when they share the care of the patient or when a locum is covering?

An exception has been made, allowing another GP to bill for these fees with the approval of the Most Responsible GP (MRGP). This allows flexibility in situations when patient care is shared between GPs. In order to facilitate processing of any claims for telephone/e-mail advice fees by a locum or colleague who has been designated to provide this service, an electronic note should be entered stating "locum/covering for Dr. X billing number YYYYY".

If a disagreement arises about the billing of this service, the GP Services Committee will adjudicate based upon whether the Most Responsible GP, i.e the GP paid for the Annual Complex Care Fee, approved or did not approve the service provided. The GP Services Committee feels that this provides the maximum flexibility while still maintaining responsibility.

6. What about shared practices where both physicians share the same patients over the year?

In a shared practice, if only one physician has billed any of the "portal fees" and the other provides some of the phone management, then use same recommendations as in Q. 5 above. If each physician has billed one of the portal fees (eg. GP A did the complex care planning visit and billed 14033, but the COPD CDM 14053 is billed under GP B) then they can bill the 14079 for the telephone/e-mail management they provide without any need for a note. It is important to remember that the limit is 5 telephone/e-mail management fees per patient per calendar year, whether it is one or two GPs who have provided the service and billed for these.

7. What diagnostic code should I use when billing the G14079?

When billing the G14079, you should use the same diagnostic code as the "portal incentive". For example, if the portal incentive was G14033 for complex care with Dx H250 then this is the diagnostic code to use for the telephone/e-mail services provided for that complex care patient. If the portal incentive was G14043 for mental health planning with a Dx of 311, then this is the diagnostic code to use for the G14079. If both the G14033 (Dx H250) and G14043 (Dx 311) were billed on a patient and a telephone/e-mail service was subsequently provided, use either of the two diagnostic codes submitted with the portal fee, as appropriate to the actual content of the service.

8. Can I bill the Follow-up Management fees if I have billed for one of the eligible portal incentives (G14033, G14075, G14043, G14053 or G14063) but have not yet been paid?

Adjudication of this will depend upon whether the GP is eventually paid for the portal incentive. For example, if a GP bills the Annual Complex Care Management Fee (G14033) then provides—and bills for—a follow-up service under G14079 prior to receiving payment for G14033, payment for G14079 will made only if G14033 is subsequently paid to that GP. Until that time it will show as "BH' on the remittance.

9. Can I bill for patients covered by other provinces?

No. This service is not covered under the reciprocal agreement with other provinces.

10. Is this fee billable by hospitalists or on behalf of hospitalists?
No. Refer to bullet ix. under the fee description above. Hospitalists are under contract to a facility and would have attended the conference as part of their duties.

11. Is this payment eligible for the rural premiums?
No.

2. G14076 GP Telephone Management Expansion

Telephone and other non-face-to-face 'visits' or 'touches' are a standard component of workflow in other jurisdictions. They have been shown to significantly improve efficiency of care and therefore practice capacity. While GPSC has already introduced a limited number of these virtual services for specific targeted populations, MSP has not funded their general introduction for the fear that it could push utilization without providing value. In this context, the expansion of telephone 'visits' as part of the Attachment Initiative is seen as an important component of improving practice capacity. The intent is to avert the need for a patient to be physically seen in the practice in order to increase access for other patients and/or to address urgent problems to avert a patient visit to an urgent care facility or Emergency Department.

They can be used at the discretion of the Family Physician for any patient for whom that Family Physician has assumed the Most Responsible Physician role for any clinical reason that addresses the intent above. Effective January 1, 2016, this has been expanded to include those family physicians who are members of a GP Maternity Network or a GP Unassigned Inpatient Network and who provide care to patients who are not attached to them in the community, but who may be cared for in a shared care manner with the patients community Family Physician.

The current GPSC telephone fee (G14079) available for patients on whom a FP has assumed MRP status and has billed a GPSC planning fee (Complex Care, COPD, Mental Health, and Palliative Care) will remain intact outside the portal and will not be dependent upon an FP submitting an Attachment Portal Fee. It is recommended that for patients who are eligible for G14079, these should be utilized first (5 over the 18 months following the provision and billing of the eligible planning fees) before using the G14076 GP Attachment Telephone Management fees due to the limited number per participating FP (1500 per calendar year).

G14076 GP Attachment Telephone Management Fee $15

Notes:

i) Payable only to Family Physicians who have successfully:
   a. *Submitted GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year; or*
   b. *Registered in a Maternity Network or GP Unassigned In-patient network on a prior date.*

ii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care professionals (eg. Nurse, Nurse Practitioner) employed within the eligible physician office.

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

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

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

vi) G14077 payable for same patient on same day if all criteria are met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14077.

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

viii) Not payable on the same calendar day as G14079.

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

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

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

Frequently Asked Questions about G14076 GP Attachment Telephone Management Fee

1. What is the difference between the G14076 GP Attachment Telephone Management Fee and the original G14079 GP Telephone/e-mail Management Fee?

The new G14076 GP Attachment Telephone Management Fee has no specific patient diagnostic criteria and has no restrictions on the number of telephone visits that can be billed per patient per year. This new fee is only for telephone management, not e-mail communication. In the prototyping phase for this new non-face-to-face incentive, there will be a cap of 1500 telephone fees per participating FP per year. Any patient for whom the FP is the Community MRP FP is eligible to have this code submitted for telephone visits provided by participating FPs.

The original G14079 GP Telephone/e-mail Management Fee is restricted to those patients on whom one of the Planning related fees (G14033 Complex Care; G14043 Mental Health; GP14053 COPD; 14063 Palliative Care; G14075 Attachment Complex Care) has been paid in the previous 18 months. There is a limit of 5 G14079 Telephone/e-mail fees per calendar year per patient. .

However, patients who are eligible for the original G14079 GP Telephone/e-mail Management Fee are also eligible for additional new G14076 GP Attachment Telephone Management fees if their FP is participating in a GP for Me (attachment). FPs are encouraged to think about how they would spread the restricted number of new Telephone fees they will have access to in this prototyping phase when providing telephone follow-up to patients who would also be eligible under the original telephone/e-mail fee.

Therefore, if a Family Physician thinks he/she will make a lot of these telephone calls, and any of them are for patients who are eligible for the 14076, it would be best to use all 5 of the 14079 for these patients first before using the new 14076. This way, you leave the "arrows in the quiver" for other patients who do not qualify for the 14079 unless you have used all 5 of the 14079 already, then you can use 14076 if you still have any left of your 1500 in that calendar year.

2. If when making a phone call to the patient there is no answer and a message is left on voice mail, can G14076 GP Attachment Telephone Management Fee be billed?

No, G14076 requires a two-way telephone conversation with the patient.

3. Are locums able to provide telephone calls in an Attachment Participating Practice and have G14076 GP Attachment Telephone Management Fee billed?

Locum physicians are eligible to have the G14076 billed for telephone calls provided to patients when covering an Attachment participating host FP. Each locum will still have the same 1500 telephone call fees per calendar year available, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

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

4. Telephone Management requires "a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care professionals working within the eligible physician office". Which college certified AHPs qualify for making these calls to be eligible for the G14076 GP Attachment Telephone Management Fee to be billed?

14076 Attachment Patient Telephone Call fee - is billable when the telephone call is made by the staff member of the FP office providing she/he is a member of a college certified allied care profession - nurse, NP, LPN, etc. This excludes the Medical Office Assistant. When an RN, LPN or NP is working within her/his scope of practice and is the employee of the FP, these calls are covered. If the AHP has not kept up his/her certification, they would not be working within their scope of practice in the office so

would not be eligible. To work within scope of practice and maintain medical legal coverage to do so, all allied care professionals must maintain certification.
Note: G14079 GP Telephone/e-mail follow-up management fee is payable when the telephone call is provided by the office staff, RN or MOA, when under the direction of the FP, so these calls would be okay for this RN who has not maintained certification and is working as an MOA.

5. **If the telephone call with the patient is only about a WorkSafeBC covered injury, can G14076 GP Attachment Telephone Management Fee be billed?**
When providing a service to a patient regarding an injury that is covered by WorkSafeBC (WSBC), it is not appropriate to bill for these services to MSP or GPSC. However, WSBC has indicated they will consider payment for these calls billed under code 14076 on an individual basis when submitted with WSBC as the insurer. Calls submitted with WSBC as the insurer will not count toward the 1500 per calendar year limit submitted under MSP as the insurer. To submit to WSBC for consideration, ensure "W" is listed in the insurer section of the fee submitted through Teleplan.

6. **Is the use of Text Messaging acceptable in order to bill G14076 Attachment Patient Telephone fee?**
No. G14076, the Attachment Telephone Management fee requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care professionals working within the eligible physician office. While the G14079 GP Telephone/e-mail follow-up management fee is applicable to two-way e-mails, the G14076 Attachment Patient Telephone fee is only for telephone advice and is not payable for any form of electronic communication including test messages.

7. **Can FPs who are in "Focused Practice" Obstetrics, or who provide Unassigned Inpatient care (previously referred to as "Doctor of the Day") access the G14076 GP Attachment Patient Telephone Fee?**
Effective January 1, 2016, family physicians who provide care through a GP Maternity Network or a GP Unassigned Inpatient Network to patients who are not attached to them in the community are eligible to access G14076 for telephone visits with these patients.

8. **Is this payment eligible for rural premiums?**
No, currently none of the Attachment incentive fees are eligible for rural premiums.

GP PATIENT TELEPHONE/E-MAIL FEES

G14079 GP Patient Telephone/e-mail (2-way) Fee

G14076 Attachment Patient Telephone Management Fee