

GP SERVICES COMMITTEE
Hospital Inpatient INCENTIVES

Revised
April 2017

Hospital Inpatient Initiative

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

The GPSC In-patient Initiative was developed to recognize and better support the continuous relationship with a family physician (FP) that can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. An important aspect of such continuous care is the coordination of care through the in-patient journey as well as in transitions between hospital and community FP offices. There are two separate levels of incentives aimed at better supporting and compensating FPs who provide this important aspect of care. This initiative will support family physicians who:

- Provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned In-patients); and may also
- As part of a network, provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned In-patients);

To participate in the GPSC In-patient Initiative, it is expected that these FPs agree to the following expectations:

A. They are members of the **active or equivalent medical staff** category and have hospital privileges in the identified acute care hospital.

B. That their on-call colleagues (Network) will also be members of the active or equivalent medical staff category and have hospital privileges.

C. That they will:

- Coordinate and manage the care of the hospitalized patients (assigned &/or unassigned), either as admitted under them as the MRP. or
- Provide in a supportive care role when their hospitalized patient is admitted under a specialist as MRP.
- See all acute patients under their MRP care on a daily basis and document a progress note in the medical record.
- Work with the interdisciplinary team, as appropriate, to develop a care plan and a plan for discharge.
- When care is transferred to another physician, ensure that this is documented in the medical record and ensure there is a verbal or written handover plan provided to the accepting physician.
- Ensure availability through their network to expedite discharges of patients daily during the normal working day which includes early morning, daytime, and early evening.
- On weekends ensure the covering physician is made aware of those discharges that could occur over the weekend.
- Provide a discharge note to an unassigned in-patient for their FP or communicate directly with the FP on discharge.
- Respond to requests from members of the interdisciplinary in-patient care team by phone as per hospital bylaws.
- The Network Call Group will accept responsibility for their newly admitted in-patients on a 24/7/365 basis. The MRP shall assess and examine the patient, document findings and issue applicable orders as soon as warranted by the patient's needs, but in any case no longer than 24 hours after accepting the transfer. Utilization needs within the facility may dictate that the patient must be seen sooner.

D. The non-clinical services include the already existing expectations of FPs as outlined in the Health Authority Medical Staff bylaws, rules and regulations, and policies. The health authority, the Department of

Family Practice, the Division of Family Practice (where it exists) and the In-patient Care Networks could reasonably expect that all parties would participate in discussions which could include:

- The orderly transitions of MRP status between specialists and generalists.
- Participating in the orderly discharge planning of generally more complicated patients.
- Patient safety concerns that come up in local hospitals.
- Identifying and providing input into “local hassle factors” that would need to be examined and resolved at a local level between the local division of family practice and health authorities.
- Participate in utilization management within the hospital.

Patient care improvement discussions that would reasonably be covered under the improved FP hospital care incentives.

Any inquiries/concerns regarding GPSC Assigned and Unassigned Networks should be sent by mail to: GPSCregistration@gov.bc.ca or by facsimile to: 250-952-1417.

Frequently Asked Questions: IN-PATIENT INCENTIVE GENERAL INFORMATION

1.1 If a community has any outstanding issues regarding the GPSC in-patient care incentives where do they get more information?

100% of communities which were eligible participated in the initiative. For any outstanding issues, please contact inpatientcare@doctorsofbc.ca.

1.2 Is there financial support for Divisions of Family Practice or family physician groups that will be administering the in-patient care incentives?

There was one-time financial support is available to Divisions of Family Practice and family physician groups during the first year of administration only. There is no administrative support beyond that first year.

2. GPSC Incentives for Assigned Inpatient Care

GP14086 GP Assigned Inpatient Care Network Initiative \$2100.00 per quarter

The GP Assigned Inpatient Care Network initiative was designed to support Community Family Physicians who continue to accept Most Responsible Physician (MRP) status to provide care to their own patients who have been admitted to hospital. The Assigned In-patient Network payment is for FPs who provide in-patient care services for their own and colleagues’ patients (assigned). Maternity patients are not included under the Assigned In-patient Network if the FP is also participating in a GPSC Maternity Care Network because those patients are counted as part of that incentive.

Eligibility:

To be eligible to be a member of a GP Assigned Inpatient Care Network, you must meet the following criteria:

- Be a Family Physician in active practice in B.C.
- Have active hospital privileges.
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing inpatient care – see below).
- Submit a completed Assigned Inpatient Care Network Registration Form (Appendix 1)
- Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.

- Each doctor must provide MRP care to at least 24 admitted patients over the course of a year; networks may average out this number across the number of members.

This network incentive is payable in addition to visit fees, but is inclusive of time spent in associated Quality Improvement activities necessary to maintain privileges such as Morbidity and Mortality rounds as well as time spent on network administration, etc.

Exemptions for communities where it may be difficult to achieve the minimum volume of MRP inpatient cases will be considered by the GPSC Inpatient Care Working Group.

The GP Assigned In-patient Care Network is payable for participation in the network activities for the majority of the following calendar quarter (50% plus 1 day). Once your registration in the network has been confirmed, submit fee item G14086 GP Assigned in-patient care network fee on a quarterly basis with Date of Service the first day of the calendar quarter using the following demographic patient information. Your location will determine which PHN# to use.

Billing Schedule: First day of the month, per calendar quarter (January 1, April 1, July1, October 1) and is paid for the subsequent quarter.

ICD9 code: 780

Fraser Health Authority: PHN# 9752 590 548 Patient Surname: Assigned First Name: FHA Date of birth: January 1, 2013	Interior Health Authority: PHN# 9752 590 587 Patient Surname: Assigned First Name: IHA Date of birth: January 1, 2013
Northern Health Authority: PHN# 9752 590 509 Patient Surname: Assigned First Name: NHA Date of birth: January 1, 2013	Vancouver Coastal Health Authority: PHN# 9752 590 523 Patient Surname: Assigned First Name: CVHA (note first name starts with 'C') Date of birth: January 1, 2013
Vancouver Island Health Authority: PHN# 9752 590 516 Patient Surname: Assigned First Name: VIHA Date of birth: January 1, 2013	

Frequently Asked Questions: ASSIGNED IN-PATIENT CARE INITIATIVE

2.1 What if an Assigned In-patient Care Network is less than four FP members?

The intention of setting the minimum number of FPs at four is to encourage FPs to collaborate in the delivery of in-patient care services. In communities with less than four FPs delivering in-patient care, exemptions can be requested through the GPSC In-patient Care Incentive Working Group.

2.2 If a community has more than four FPs but less than four in the network, do the FPs need to combine or join call groups?

In communities with multiple call groups or solo providers, combining to form one network does not mean FPs have to change actual call group coverage functions. FPs are encouraged to collaborate on how to best cover the in-patient care needs of their community, which may still mean multiple call groups.

2.3 What if an FP does not meet the minimum number of in-patients?

The minimum number of 24 in-patient cases defined in the criteria section is across the network of FPs; there should be very few cases where the minimum number cannot be met. However, there are some smaller communities or other circumstances where the minimum cannot reasonably be met. Because of that, exemptions will be considered by the GPSC In-patient Care Incentive Working Group.

2.4 Do maternity patients count towards the minimum number of in-patient cases?

Maternity patients over 20 weeks are not included under either the Assigned or Unassigned In-patient Network if the FP is also participating in a GPSC Maternity Care Network because those patients are counted as part of that incentive. Under 20 weeks, patients are often admitted to a non-maternity ward bed if there are complications. These In-patient cases are eligible *if the FP is not also part of a Maternity Network*.

2.5 Am I eligible to be in both a Maternity Network and an Assigned Inpatient Network?

The Maternity Network payment is for FPs who provide obstetric services for both assigned and unassigned maternity patients. The Assigned In-patient Network payment is for FPs who provide in-patient care services for their own and colleagues' non-obstetric patients (assigned) while the Unassigned In-patient Network payment is for FPs who provide in-patient care services for unassigned non-obstetric patients. Maternity patients are not included under either the Assigned or Unassigned In-patient Network if the FP is also participating in a GPSC Maternity Care Network because those patients are counted as part of that incentive. Therefore in order to participate in both a Maternity Network and an Unassigned Inpatient Network, you must be providing in-patient care for both pregnant and non-pregnant patients.

2.6 What if there is no Division of Family Practice near a hospital?

Family physicians in communities where there is no Division of Family Practice may wish to explore the creation of a division to better support community-based initiatives such as this. More information can be found at www.divisionsbc.ca. In communities where FPs do not wish to form a division, they will need to self-organize to claim the incentives.

2.7 What if there are multiple hospitals near where an FP practices?

In some urban areas, there can be multiple hospitals in the community where an FP's patient could be admitted. An FP is only required to maintain active privileges at one local hospital to claim the incentive.

2.8 What if there is no hospital in the local community?

The Assigned In-patient Care Network Incentive is intended to support community FPs who deliver in-patient care for their own patients. If it is not practical for an FP to deliver in-patient care to his or her own patients, this incentive is not applicable.

2.9 If an FP does not belong to the local division, can they still claim the Assigned In-patient Care Network Incentive?

Yes. The process for the FP to claim the incentive would be the same as documented for communities without a Division of Family Practice.

2.10 Will Rural Retention Premiums be applied to the Assigned In-patient Care Network Incentive?

No.

2.11 What's the relationship between a Division and a Department of Family Practice?

Both Divisions of Family Practice and Departments of Family Practice have a role in the delivery of in-patient care at a local level in some communities. It will be important for each community to work through the roles and responsibilities of each body to avoid working at cross-purposes.

2.12 Can hospitalists claim the Assigned In-patient Care Network Incentive?

Full-time hospitalists without a current community practice cannot claim the Assigned In-patient Care Network Incentive. Part-time hospitalists - where most of their work is in a community general practice *and* who meet the incentive's criteria as outlined - can claim the incentive. See [Physician Overview of the In-Patient Care Initiative](#) document for detailed criteria.

2.13 Can physicians on Alternate Payment Program (APP) contracts claim the incentive?

No.

2.14 Does participating in the Assigned In-patient Care Network Incentive mean being on call for the entire hospital?

No. While the eligibility criteria requires cooperation within the group of FPs to ensure one member is always available to their admitted in-patients, participating in this program does not require an FP to be on call for patients outside their group. The Unassigned In-patient Care Incentives are intended to address this broader function.

2.15 Does the Assigned In-patient Care Network Incentive contribute towards the dollars used to calculate FP benefits?

Yes.

2.16 What other information is needed in order to bill the Assigned In-patient Care Network Incentive G14086?

The Teleplan system requires a Personal Health Number (PHN) on every claim, even though the Assigned In-patient Care Network Incentive is not patient-specific. To manage this limitation of the Teleplan system, a generic PHN has been created for each Health Authority to use when claiming the incentive. Once registration in the network has been confirmed, submit for the G14086 FP Assigned In-patient Care Network fee using the following demographic patient information. An FP's location will determine which PHN# to use:

<p>Fraser Health Authority: PHN# 9752 590 548 Patient Surname: Assigned First Name: FHA Date of birth: January 1, 2013 For date of service use: April 1, 201x, July 1, 201x, October 1, 201x, January 1, 201x Billing Schedule: First day of the month, per calendar quarter ICD9 code:780</p>	<p>Interior Health Authority: PHN# 9752 590 587 Patient Surname: Assigned First Name: IHA Date of birth: January 1, 2013 For date of service use: April 1, 201x, July 1, 201x, October 1, 201x, January 1, 201x Billing Schedule: First day of the month, per calendar quarter ICD9 code:780</p>
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<p>Vancouver Island Health Authority: PHN# 9752 590 516 Patient Surname: Assigned First Name: VIHA Date of birth: January 1, 2013 For date of service use: April 1, 201x, July 1, 201x, October 1, 201x, January 1, 201x Billing Schedule: First day of the month, per calendar quarter ICD9 code:780</p>	

2.17 Are there certain medical staff categories which are not eligible for the Assigned In-patient Care Network Incentive?

The Assigned In-patient Care Incentive is intended to be available for family physicians with active or equivalent medical staff privileges. The FP must have a level of privileging that allows them to assume MRP responsibility for a patient admitted to an acute care hospital. In some cases there may be medical staff categories such as locum which can be eligible if the FP registers as part of an Assigned In-patient Care Network. In the case of locums, they must be a member and increase the capacity of the network for an entire quarter, or replace the billing for the doctor for whom the locum is working. Shorter-term locums will need to make private arrangements with the doctor that they are covering.

FPs who are members of the following medical staff categories are not eligible for this incentive: associate, consulting, and honorary.

2.18 Are locums eligible for the Assigned In-patient Care Network Incentive?

Yes, if they meet the eligibility criteria. The locum will only bill for the quarters that they will be doing the work required under the network incentive for at least 50% of that quarter. The locum must register with at least one network that is their 'home' network, where they provide the majority of their in-patient care network services.

2.19 Are FPs eligible to also bill the \$250 MOCAP call back fee in addition to receiving the Assigned In-patient Care Network Incentive?

No.

2.20 Can population-based funding practices claim the Assigned In-patient Care Network Incentive?

Yes, unless the physician(s) is/are remunerated under a service contract with the Health Authority that does not fluctuate directly with the population-based funding received from the Ministry.

3. GPSC Incentives for Unassigned Inpatient Care

GP Unassigned Inpatient Care Network Initiative – Paid per quarter to Division or Physician Network Account via adjustment code 'GU'

The GPSC Unassigned Inpatient Care Network Fee is a lump sum incentive based on the annual volume of unassigned inpatients and is available for each hospital with a community GP run unassigned inpatient care model.

This incentive for Unassigned Inpatient Care is not available for hospitals which have a Hospitalist model. This payment will be made to participating Divisions of Family Practice (DoFP), or where there is no Division or the local Division decides not to provide the oversight, to the Network group (either directly through a common payment mechanism or through the Regional Health Authority as determined by the Network Group) on behalf of eligible general practitioners on a quarterly basis for each quarter beginning April 1, July 1, October 1, and January 1 and is intended to support the following functions:

- 1) Recognition of delivering the service.
- 2) On-call services.
- 3) Non-clinical services as outlined in the Assigned Inpatient Care Network Initiative.

To be eligible to be a member of the Unassigned Inpatient Care Network, you must meet the following criteria:

- Be a Family Physician in active practice in B.C.
- Have active hospital privileges.
- Submit a completed Unassigned Inpatient Care Network Registration Form. (Appendix 2)
- Also be a member of the Assigned Inpatient Care Network unless an exemption is granted by the DoFP or the GPSC Inpatient Care Working Group as indicated under the specifics of the Assigned Inpatient Care Network Incentive.

- Cooperate with other members of the network so that one member is always available to care for patients of the unassigned inpatient network.

This network incentive is inclusive of services for direct patient care as well as time spent in associated Quality improvement activities such as M and M rounds, network organization, etc.

G14088GP Unassigned Inpatient Care Fee

\$150

The term "Unassigned Inpatient" is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted. The GP Unassigned Inpatient Care fee is designed to provide an incentive for Family Physicians to accept Most Responsible Physician status for an unassigned patient's hospital stay. It is intended to compensate the Family Physician for the extra time and intensity required to evaluate an unfamiliar patient's clinical status and care needs when the patient is admitted and is only billable once per hospital admission.

This fee is restricted to Family Physicians actively participating in the GP Unassigned Inpatient Care or the GP Maternity Networks. This fee is billable through the MSP Teleplan system and is payable in addition to the visit (13109, 13008, 00127) or delivery fee.

Notes:

- Payable only to Family Physicians who have submitted a completed GP Unassigned Inpatient Care Network Registration Form and /or a GP Maternity Network Registration Form.
- Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.
- Payable once per unassigned patient per in-hospital admission in addition to the hospital visit (13109, 13008, 00127) or delivery fee.
- Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

Frequently Asked Questions: UNASSIGNED IN-PATIENT CARE INITIATIVE

3.1 How was the Unassigned In-patient Care Network Incentive calculated?

The following methodology was used to calculate the Unassigned In-patient Care Network Incentive for the communities that do not have a hospitalist model in place to care for Unassigned In-patients.

The high end of the sliding scale assumes a maximum rate of \$600/day for hospitals with more than 1,000 Unassigned In-patients per year. For the purposes of this calculation, these are Unassigned In-patients where a specialist was not involved as MRP. For each 200 fewer Unassigned In-patients, the daily amount is reduced \$100/day. Below 600 Unassigned Inpatients, there is an additional \$10/day for each decreased increment of 200 Unassigned Inpatients to help reflect a fixed component in smaller locations.

Annual Volume	Daily payment	Annual Rate
>1,000	\$600	\$219,000
800-999	\$500	\$182,500
600-799	\$400	\$146,000
400-599	\$310	\$113,150
200-399	\$220	\$80,300
100-199	\$130	\$47,450
<100	\$90	\$32,850

The table at the end of this document shows the funding level for each hospital. The calculations for 2013/14 are based on hospital statistics from 2011/12, since hospital data does not become available until six months after the end of a fiscal year. As GPSC In-patient Care Incentive data becomes available starting in 2013/14, the GPSC will refine this formula and revisit the unassigned in-patient care volumes & applicable annual rate for each hospital.

3.2 Will Rural Retention Premiums be applied to the Unassigned In-patient Care Network Incentive?

No.

3.3 What is the relationship between these GPSC incentives and MOCAP Doctor of the Day (DOD), MoH Service Agreements and other HA funded agreements for In-patient care?

The combination of the four GPSC incentives for In-patient care is intended to replace the older DOD, MoH In-patient Care Service Agreements and other HA funded agreements for In-patient care, excluding hospitalists. MOCAP and other agreements related to urgent care centres and facilities that don't accept In-patient care cases are not included within this scope.

3.4 Can a community choose a mix of new and old In-patient care incentives?

No. The new GPSC incentives are designed to work together holistically. Considering the four incentives collectively, all communities are better off financially using the new incentives.

3.5 Can an FP assume MRP for Unassigned In-patients in a community that has hospitalists and claim the \$150 per Unassigned In-patient Care Fee?

No. As a general rule, community-based FPs are not able to access the G14088 for unassigned in-patients where a hospitalist model is in place. The GPSC seeks to avoid hybrid models wherever possible as it fragments the unassigned in-patient care model.

3.6 Do maternity In-patients qualify for the \$150 Unassigned In-patient Care Fee?

Yes, in most cases. Factors to be aware of include:

- The Unassigned In-patient Care fee (G14088) would be paid to an FP who is part of a Maternity Network with privileges to provide primary obstetric in-patient care and who is providing the MRP care for unassigned pregnant women admitted to the local hospital.
 - Unassigned pregnant patients may be: visiting the community; transferred from another community; or may have no FP in the community able to care for them in the hospital (whether no care at all/unattached, care by an FP who does not have obstetric privileges and who has not yet transferred the patient to a provider for delivery or care under a midwife).
- If the patient delivers during the admission, the mother and baby are considered a dyad: one unit.
- If a pregnant woman admitted with an obstetrician as MRP, then delivers and remains under the specialist's MRP care, because the mother and child are considered a dyad, the baby alone does not qualify for the G14088 (even if admitted under the MRP care of an FP participating in the Maternity Network or the Unassigned In-patient Network).
- Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned.
- Accepting patients referred for prenatal care and possible delivery is a requirement of the Maternity Care *Network* Initiative. Accepting these maternity patients for the prenatal/delivery /six weeks post-partum period is considered a sharing of care with the referring FP, and these patients are therefore not unassigned. They are assigned to the FP or group of FPs in the call group/clinic/network. Therefore the G14088 fee is not appropriate for these referred patients.

3.7 Do maternity patients who were cared for by a midwife and subsequently transferred care to the FP OB qualify for the \$150 Unassigned In-patient Care Fee?

Yes. A midwife patient who is later admitted under an FP for MRP care qualifies for the \$150 Unassigned In-patient Care Fee. If the patient delivers during the admission, the mother and baby are considered a dyad:

one unit. If admitted under the specialist OB then the patient does not qualify even if FP is involved in the delivery (e.g. assists at C/S) as the FP is not the MRP.

A midwife patient does not qualify for the incentive when the midwife and FPs are practicing in a multi-disciplinary care clinic but the FP ends up doing the delivery. The patient is assigned to the care providers of the multi-disciplinary care clinic pre-admission and is therefore not unassigned.

3.8 Do Newborns qualify as an Unassigned In-patient?

During the delivery and immediate in-hospital post-partum period, the baby and the mother are considered a dyad: one unit. If the mother was an unassigned in-patient, then the newborn is also considered unassigned and together they would qualify as a unit for the \$150 Unassigned In-patient Care Fee. If the mother was assigned, then the newborn is also considered assigned. When eligible, the Unassigned In-patient Care Fee G14088 is to be billed under the mother's PHN to cover the mother/baby dyad.

If an unassigned baby is discharged from hospital after the usual newborn post-delivery period and subsequently readmitted for management of a medical condition such as jaundice, the baby would qualify independently for the G14088 as a new admission if admitted under a GP participating in either the Maternity Network or the Unassigned In-patient Network (depending on the local admission process).

3.9 Can hospitalists claim this incentive?

No.

3.10 Can physicians on Alternate Payment Program (APP) contracts claim this incentive?

No.

3.11 If an FP takes over a MRP role from a specialist, are they eligible to claim the \$150 per Unassigned In-patient Fee?

As outlined in the [Physician Overview of the In-Patient Care Initiative](#), the fee is only payable where the MRP care provided by an FP is due to a significant medical issue that is not within the scope of the specialist's practice and is unrelated to the purpose of admission.

3.12 Do the Unassigned In-patient Care Incentives contribute towards the dollars used to calculate FP benefits?

The Unassigned In-patient Care Network Incentive is not part of the benefits calculation as it is made to a group of FPs rather than individuals.

The \$150 per Unassigned In-patient Care Fee (G14088) is part of the benefits calculation.

3.13 Do Divisions need to continue submitting 14081–14084 encounter records?

Once divisions transition from their MoH In-patient Care Service Agreements, these encounter records are no longer required.

3.14 Are patients admitted to a free standing hospice who do not have an FP who can care for them there considered Unassigned and eligible for the 14088 or Unattached and eligible for 14074?

G14088 GP Unassigned In-patient Care Fee

FPs providing care for unassigned palliative patients in hospices NOT attached to or part of an acute care hospital are not eligible for the Unassigned In-patient Network fee. The GPSC will assess the number and type of hospices around the province to determine the sustainability of including these in the initiative. Until then, patients outside acute care hospital hospices will not be eligible for 14088.

Patients admitted to a hospice that is attached to or part of an acute care hospital, and who do not have an FP that will care for them while admitted, qualify for the G14088 Unassigned In-patient Care Fee of \$150 when accepted for MRP care by members of an Unassigned In-patient Network.

G14074 Unattached Complex/High Needs Patient Attachment Fee

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

If a patient is admitted into long term care/residential care with no plan to return to the community setting, and the patient's community MRP is unable to provide care within the facility, this patient is considered "unattached" within the facility and would be eligible for the G14074 Unattached Complex/High-Needs Patient Attachment Fee.

3.15 Are there certain medical staff categories which are not eligible for the \$150 Unassigned In-patient Care Fee?

The Unassigned In-patient Care Fee is intended to be available for Family Physicians (FPs) with active or equivalent medical staff privileges. The FP must have a level of privileging that allows them to assume MRP responsibility for a patient admitted to an acute care hospital. In some cases, there may be medical staff categories such as locum which can be eligible if the FP registers as part of an Unassigned In-patient Care Network. In the case of locums, the locum must be a member and increase the capacity of the network for an entire quarter, or replace the billing for the doctor for whom the locum is working. Shorter-term locums will need to make private arrangements with the doctor that they are covering.

FPs who are members of the following medical staff categories are not eligible for this incentive: associate, consulting and honorary.

3.16 Are locums eligible for the \$150 Unassigned In-patient Care Fee?

Yes, if they meet the criteria for the incentive. However, in order for the locum to bill the fee, they must be registered as part of an Unassigned In-patient Care Network or Maternity Care Network.

3.17 Are FPs eligible to also bill the \$250 MOCAP call back fee in addition to receiving the Unassigned In-patient Care Incentives?

No.

3.18 Do out of Province unassigned in-patients qualify for the G14088 Unassigned In-patient Care Fee of \$150 in addition to the hospital visit fee?

All patients with valid medical coverage from any Canadian province or territory, with the exception of Quebec, are eligible for the G14088 billed in addition to the hospital visit fee when admitted as an unassigned in-patient to a hospital in BC under the MRP care of the eligible FP.

Patients from Quebec, out of country or those without valid medical coverage from another Canadian jurisdiction as outlined are to be treated as uninsured patients and billed directly for all services provided when admitted to a hospital in BC. All MSP and GPSC fees have a recommended uninsured (BCMA) rate but it is up to the discretion of the treating physician which fees and at which rate these "private" paying patients should be billed. As such it would be acceptable for the treating MRP FP to bill the private rate for the 13109 (First Visit in hospital for the admission history and physical examination) plus the G14088 at the BCMA recommended uninsured rates, followed by the BCMA recommended rates for 13008 (+/- 13338 if the patient is the first patient seen on the day subsequent to the admission date when 13109 is billable). If patients have private insurance coverage when visiting Canada, you should always contact the insurance carrier to inquire if they will pay you directly or if the patient is expected to pay first and then submit the receipt to the company for reimbursement.

3.19 Can a Family Physician who does not have a community practice (eg. Retired FP or FP who works in some other focused capacity) be a member of an Unassigned In-patient Network?

While the GPSC designed the In-patient initiative to support community based Family Physicians, it is recognized that, particularly in smaller communities, disallowing Unassigned In-patient Care Network participation by local FPs who do not have a community based practice could create an increased burden based on the number of GPs available to care for unassigned in-patients.

If a community is taking responsibility for the delivery of in-patient care for the hospital and the vast majority of the in-patient care service (80%+) is delivered by community based GPs, then it continues to be reasonable to grant limited exemptions as they come up. GPSC will continue to support requests for exemptions if the vast majority principle is met for the community.

3.20 What scenarios involving FP/specialist shared care for an unassigned in-patient qualify for the G14088 Unassigned In-patient Care Fee to be billed by a participant of the Unassigned In-patient Network?

1. **Transfers from a higher level hospital to a community acute care hospital**
Regardless of who was providing MRP care in the tertiary care hospital, once a patient is discharged from the higher level of care hospital and transferred to the community hospital and admitted under the Unassigned In-patient Network with an FP as MRP, the patient qualifies for the G14088. This is considered a separate hospitalization and the admission time clock begins anew.
2. **Directive care by a specialist**
Patients admitted with an FP as MRP, with a specialist involved to provide guidance to the FP (even if the specialist saw the patient in ER or shortly after admission and before the FP caught up with the patient on his/her list), qualify for the 14088.
 - Directive care refers to subsequent hospital visits by a consultant where responsibility for the case remains in the hands of the attending practitioner but for which a consultant is requested by the referring physician to give directive care in hospital during the acute phase.
 - Payments for directive care are limited to two visits per patient per week (Sunday to Saturday), even when there is no interval between visits, for each consultant.
3. **Concurrent Care with a specialist**
Patients who are admitted with a specialist as MRP and require an FP to be involved in concurrent MRP care for an unrelated condition, qualify for the FP to bill daily visits as well as the G14088 for unassigned patients.
 - For medical cases which are of such complexity that the concurrent services of more than one medical practitioner are required for the adequate care of the patient, subsequent visits should be claimed by each medical practitioner required to provide for that care.
 - For surgical cases where there is a medical diagnosis unrelated to the purpose for admission and requires the concurrent services of more than one medical practitioner for the adequate care of patient, subsequent visits should be claimed by each medical practitioner as required for that care using the appropriate diagnostic code for that medical condition.
 - To facilitate payment, claims should be accompanied by an electronic note record, and independent consideration will be given. For patients in I.C.U. or C.C.U. this information in itself is sufficient.
4. **Transfer of care from a specialist to an FP after concurrent care in ICU**
FPs may bill for concurrent care and the unassigned in-patient care fee in the following circumstance: when a patient is admitted to intensive care with a specialist as MRP who will not provide ongoing care after the patient is moved to a ward (and transferred to the MRP care of the FP). If the FP has been providing concurrent care (see point 3) from the start of the admission, they are eligible to bill 13008 while the patient is in ICU as they need to be involved in and aware of the course of care to prepare for the patient's transfer to a ward where they will take over as MRP (specialist/GP functioning as the MRP team). Upon transfer, the patient would qualify for G14088.
5. **FP as Attending/MRP**
Unassigned patients who are admitted under the MRP care of the GP to provide all care during admission are eligible for 14088.
6. **FP providing supportive care for patients admitted with a specialist as MRP**
Where a case has been referred and the referring medical practitioner no longer is in charge of the patient's care (and is not required to provide concurrent care) but for which continued liaison with the family and/or reassurance of the patient is necessary while the patient is hospitalized, supportive care may be claimed by the referring medical practitioner.
Patients admitted with a specialist as MRP, with the FP only providing supportive care during the acute phase, even if they are transferred to the FP's care for convalescence (i.e. concurrent care during acute phase is not applicable and patient does not need acute care management by FP) do not qualify for G14088.

3.21 Some hospitals have a hospitalist model for the majority of unassigned in-patients, but the hospitalists do not cover specific services, such as rehab ward care or palliative care. Are family physicians covering these wards/patients eligible for the unassigned in-patient fee G14088?

Hospitals with a hospitalist model for unassigned in-patient coverage are not eligible to have an Unassigned In-patient Network. As a result, hospital-based palliative, sub-acute and rehab patients who are cared for by community FPs at these hospitals are not eligible for the G14088.

3.22 If a hospital has unassigned in-patients managed by an alternately paid family practice model can this be converted to the GPSC unassigned in-patient model under Fee-for-Service (FFS)?

Yes, converting from an FP Alternate Payment Program (APP) model of unassigned in-patient care to the GPSC supported model would be acceptable provided there is agreement between all participating family physicians and all the criteria of the in-patient initiative, both assigned and unassigned, are met.

4. Enhanced clinical fees for select in-patient MRP services

The General Practice Services Committee is providing funding to increase these fees an additional 25 per cent through a bonus that will be applied directly to the MSP fee codes 13008 and 00127. Where applicable for the community, Rural Retention Premiums will be applied to the fee increases.

FREQUENTLY ASKED QUESTIONS AND ANSWERS FOR THE 25% LIFT ON ENHANCED CLINICAL FEES FOR SELECT INPATIENT MRP SERVICES

4.1 Will Rural Retention Premiums (RRP) be applied to the 25% increase on the 13008 and 00127 Fees?

The 13008 and 00127 fee items are eligible for RRP. The lift will be applied to the RRP where the community is eligible for RRP.

4.2 Does the 25% lift on select In-patient Care fee items contribute towards the dollars used to calculate FP benefits?

Yes.

4.3 How will the 25% lift on the 13008 and 00127 fee items be handled for population based funding practices?

The 13008 and 00127 fee items are associated with core fee items and will remain part of the core basket. The population based funding (PBF) practices will see this incentive through their ACG payments only.

5. Funding for the Unassigned In-patient Care Network Incentive by Hospital

The following table outlines the estimated Unassigned In-patient Care Network Incentive by hospital based on 2011/12 statistics. Updated calculations will be provided in the fall of each year.

HA	DOFP or Community Name	Unassigned model	Hospital	Total Cases	GP Cases	SP Cases	Est. # GP Assigned Cases	Est. # GP Unassigned cases	Est. Unassigned Cases / day	Unassigned Network Incentive
FHA	Abbotsford	DOFP	609 Abbotsford Regional Hospital and Cancer Cer	17,803	8,823	8,980	2,971	5,852	16.0	\$219,000
FHA	Abbotsford		603 Matsqui-Sumas-Abbotsford General Hospital	379	377	2	132	245	0.7	
FHA	Burnaby	Hospitalist	130 Burnaby Hospital	15,453	5,125	10,328	133	4,992	13.7	
FHA	Chilliwack	DOFP	601 Chilliwack General Hospital	8,444	4,822	3,622	2,839	1,983	5.4	\$219,000
FHA	Chilliwack		606 Fraser Canyon Hospital	499	499		414	85	0.2	\$32,850
FHA	Delta	Hospitalist	134 Delta Hospital	3,427	2,079	1,348	277	1,802	4.9	
FHA	Fraser Northwest	Hospitalist	109 Royal Columbian Hospital	23,354	7,051	16,303	209	6,842	18.7	
FHA	Fraser Northwest	Hospitalist	136 Eagle Ridge Hospital	5,774	3,415	2,359	494	2,921	8.0	
FHA	Fraser Northwest		135 Queen's Park Hospital	1,034	987	47	20	967	2.6	
FHA	Langley	Hospitalist	115 Langley Memorial Hospital	11,506	6,293	5,213	1,846	4,447	12.2	
FHA	Mission	DOFP	602 Mission Memorial Hospital	1,220	1,216	4	808	408	1.1	\$113,150
FHA	Ridge Meadows	Hospitalist	604 Ridge Meadows Hospital and Health Care Cen	6,955	3,444	3,511	693	2,751	7.5	
FHA	Surrey N Delta	Hospitalist	116 Surrey Memorial Hospital	25,066	10,656	14,410	1,886	8,770	24.0	
FHA	White Rock / S Surrey	Hosp / DOFP	131 Peace Arch District Hospital	9,384	5,917	3,467	2,467	3,450	9.5	\$219,000
IHA	Central Interior Rural	DOD	406 Cariboo Memorial Hospital	2,518	1,717	801	1,142	575	1.6	\$113,150
IHA	Central Interior Rural		708 One Hundred Mile District General Hospital	834	833	1	615	218	0.6	\$80,300
IHA	Central Okanagan	Hospitalist	302 Kelowna General Hospital	21,316	9,374	11,942	3,649	5,725	15.7	
IHA	East Kootenay	Orp. Care Pr	756 East Kootenay Regional Hospital	5,103	1,991	3,112	1,051	940	2.6	\$182,500
IHA	East Kootenay		753 Elk Valley Hospital	1,057	1,032	25	531	501	1.4	\$113,150
IHA	East Kootenay		654 Creston Valley Hospital	1,035	954	81	797	157	0.4	\$47,450
IHA	Kootenay Boundary	Hospitalist	801 Kootenay Boundary Regional Hospital	4,552	2,231	2,321	941	1,290	3.5	
IHA	Kootenay Boundary		651 Kootenay Lake Hospital	2,073	1,567	506	880	687	1.9	\$146,000
IHA	Kootenay Boundary		803 Boundary Hospital	563	542	21	356	186	0.5	\$47,450
IHA	Kootenay Boundary		655 Arrow Lakes Hospital	213	207	6	168	39	0.1	\$32,850
IHA	S Okanagan Similkameen	DOFP	303 Penticton Regional Hospital	7,942	3,244	4,698	1,709	1,535	4.2	\$219,000
IHA	S Okanagan Similkameen		309 South Okanagan General Hospital	1,161	1,159	2	815	344	0.9	\$80,300
IHA	S Okanagan Similkameen		305 Princeton General Hospital	205	205		164	41	0.1	\$32,850
IHA	Shuswap N Okanagan	DOFP	301 Vernon Jubilee Hospital	10,167	5,316	4,851	2,896	2,420	6.6	\$219,000
IHA	Shuswap N Okanagan	DOD	404 Shuswap Lake General Hospital	2,920	2,527	393	1,588	939	2.6	\$182,500
IHA	Thompson Region	Hospitalist	401 Royal Inland Hospital	13,350	4,494	8,856	2,197	2,297	6.3	
IHA			403 Nicola Valley Health Centre	550	550		420	130	0.4	\$47,450
IHA			755 Invermere and District Hospital	537	537		420	117	0.3	\$47,450
IHA			409 Golden and District Hospital	560	532	28	415	117	0.3	\$47,450
IHA			419 Dr. Helmcken Memorial Hospital	229	210	19	94	116	0.3	\$47,450
IHA			402 Queen Victoria Hospital	513	423	90	315	108	0.3	\$47,450
IHA			417 Lillooet Hospital and Health Centre	276	273	3	208	65	0.2	\$32,850
NHA	Northern Interior Rural		701 Fort St. John General Hospital	2,845	2,431	414	1,768	663	1.8	\$146,000
NHA	Northern Interior Rural		702 St. John Hospital	1,336	1,286	50	1,030	256	0.7	\$80,300
NHA	Northern Interior Rural		707 Burns Lake and District Hospital	482	482		375	107	0.3	\$47,450
NHA	Northern Interior Rural	APP	715 MacKenzie and District Hospital	179	179		115	64	0.2	
NHA	Prince George	DOFP	703 The University Hospital of Northern British Co	10,889	4,027	6,862	2,514	1,513	4.1	\$219,000
NHA			704 Dawson Creek and District Hospital	2,380	1,380	1,000	836	544	1.5	\$113,150
NHA			903 Bulkley Valley District Hospital	1,459	1,227	232	773	454	1.2	\$113,150
NHA			902 Prince Rupert Regional Hospital	1,996	1,517	479	1,073	444	1.2	\$113,150

HA	DOFP or Community Name	Unassigned model	Hospital	Total Cases	GP Cases	SP Cases	Est. # GP Assigned Cases	Est. # GP Unassigned cases	Unassigned Cases / day	Est. Unassigned Network Incentive
NHA			902 Prince Rupert Regional Hospital	1,996	1,517	479	1,073	444	1.2	\$113,150
NHA			912 Mills Memorial Hospital	2,466	1,291	1,175	861	430	1.2	\$113,150
NHA			705 G.R. Baker Memorial Hospital	2,070	1,635	435	1,283	352	1.0	\$80,300
NHA			714 Fort Nelson General Hospital	625	625		421	204	0.6	\$80,300
NHA		APP	907 Queen Charlotte Islands General Hospital	279	243	36	41	202	0.6	
NHA		APP	918 Northern Haida Gwaii Hospital and Health Ce	213	213		36	177	0.5	
NHA		APP	901 Wrinch Memorial Hospital	537	537		372	165	0.5	
NHA			917 Kitimat General Hospital	1,206	974	232	818	156	0.4	\$47,450
NHA			716 Chetwynd General Hospital	352	352		218	134	0.4	\$47,450
NHA			717 Stuart Lake Hospital	249	249		207	42	0.1	\$32,850
NHA			713 McBride and District Hospital	98	97	1	62	35	0.1	\$32,850
PHSA		DOD	104 B.C. Women's Hospital	14,822	4,201	10,621	-	4,201	11.5	\$113,150
PHSA			105 B.C. Children's Hospital	7,267	-	7,267	-	-	0.0	
PHSA			929 Riverview Hospital	107	24	83	-	24	0.1	
PHSA			107 B.C. Cancer Agency	872	2	870	-	2	0.0	
PHSA			114 Sunny Hill Hospital for Children	237		237	-	-	0.0	
VCHA	North Shore	Hospitalist	112 Lions Gate Hospital	15,301	5,479	9,822	793	4,686	12.8	
VCHA	Powell River		111 Powell River General Hospital	1,754	1,311	443	1,092	219	0.6	\$80,300
VCHA	Richmond	Hospitalist	121 Richmond Hospital	13,231	3,932	9,299	630	3,302	9.0	
VCHA	Sunshine Coast		113 St. Mary's Hospital	2,271	2,067	204	1,551	516	1.4	\$113,150
VCHA	Vancouver	Hospitalist	101 Vancouver General Hospital	29,400	3,122	26,278	-	3,122	8.6	
VCHA	Vancouver	APP	102 St. Paul's Hospital	18,370	1,433	16,937	20	1,413	3.9	
VCHA	Vancouver		106 Mount Saint Joseph Hospital	3,466	685	2,781	1	684	1.9	\$146,000
VCHA	Vancouver		118 Holy Family Hospital	508	507	1	-	507	1.4	
VCHA	Vancouver	APP	119 G.F. Strong Rehab Centre	507	224	283	-	224	0.6	
VCHA	Vancouver	APP	123 UBC Health Sciences Centre	3,848	1	3,847	0	1	0.0	
VCHA			128 Squamish General Hospital	1,317	1,095	222	470	625	1.7	\$146,000
VCHA		APP	904 R.W. Large Memorial Hospital	198	198		-	198	0.5	
VCHA		APP	906 Bella Coola General Hospital	307	307		174	133	0.4	
VIHA	Comox Valley	DOFP	502 St. Joseph's General Hospital	5,733	2,713	3,020	1,531	1,182	3.2	\$219,000
VIHA	Cowichan Valley	DOFP	203 Cowichan District Hospital	6,783	4,156	2,627	2,339	1,817	5.0	\$219,000
VIHA	Nanaimo	Hospitalist	501 Nanaimo Regional General Hospital	14,810	5,696	9,114	1,848	3,848	10.5	
VIHA	Rural and Remote		511 Port McNeill and District Hospital	353	352	1	258	94	0.3	\$32,850
VIHA	Rural and Remote		510 Port Hardy Hospital	423	420	3	343	77	0.2	\$32,850
VIHA	Rural and Remote		507 Cormorant Island Health Centre	122	122		100	22	0.1	\$32,850
VIHA	South Island	DOFP	217 Saanich Peninsula Hospital	1,881	1,587	294	783	804	2.2	\$182,500
VIHA	Victoria	Hospitalist	202 Victoria General Hospital	18,441	7,574	10,867	738	6,836	18.7	
VIHA	Victoria	Hospitalist	201 Royal Jubilee Hospital	16,741	3,964	12,777	673	3,291	9.0	
VIHA	Victoria		204 Queen Alexandra Centre for Children's Health	104		104	-	-	0.0	
VIHA		DOD	508 Campbell River and District General Hospital	3,714	2,053	1,661	1,185	868	2.4	\$182,500
VIHA			206 Lady Minto / Gulf Islands Hospital	672	582	90	382	200	0.5	\$80,300
VIHA			851 West Coast General Hospital	2,709	930	1,779	750	180	0.5	\$47,450
VIHA			854 Tofino General Hospital	281	266	15	202	64	0.2	\$32,850
				424,183	174,370	249,813	65,225	109,145		\$5,496,900

6. Conference Fees (G14077) and Relationship to Unassigned Inpatient Networks

The GPSC introduced fee incentives for conferencing with allied care professionals (including Specialist Physicians and GPs with specialty training) in order to support improved collaborative care between participating FPs and other health care providers.

Effective January 1, 2016, the Attachment Conferencing (G14077) Incentive has been expanded to include those family physicians who are members of 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. Please also refer to the Attachment Section of the GPSC Billing Guide for further details of this initiative and the relevant fee incentives.

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.

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.

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

6.1. 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.

6.2. 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.

6.3. 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.

6.4. 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.

6.5. 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.

6.6. 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).

6.7. 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.

6.8. 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).

6.9 Can FPs who are providing in-hospital care to unassigned patients access the G14077 GP Attachment Patient Conference Fee?

Effective January 1, 2016, family physicians who provide care through 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.

6.10. If I am part of an 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 an 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.

6.11. Is this payment eligible for rural premiums?

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

7. Patient Telephone Fees (G14076) and Relationship to Unassigned Inpatient Networks

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. Your documentation in the patient chart must indicate not only the nature of the patient request, but also the advice given. Fee incentives have been developed to encourage non-face-to-face follow-up with patients to support expansion of GP capacity to provide care for patients.

Effective January 1, 2016, the Patient Telephone (G14076) Incentive has been expanded to include those family physicians who are members of 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. Please also refer to the Attachment Section of the GPSC Billing Guide for further details of this initiative and the relevant fee incentives.

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

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

The 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 and is only payable to the Community MRP GP who billed the portal planning fee. G14076 is only for telephone management, not e-mail communication. The 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, but is restricted to 1500 per physician per calendar year.

7.2. 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.

7.3. 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.

7.4. 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.

7.5. 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.

7.6. 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 text messages.

7.7. 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.

7.8. Is this payment eligible for rural premiums?

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

GP CONFERENCING AND PATIENT TELEPHONE FEES

G14077 Attachment Patient Conference Fee

G14076 Attachment Patient Telephone Management Fee

 General Practice Services Committee	 BRITISH COLUMBIA	 doctors of bc	 Society of General Practitioners of British Columbia	Unassigned In-patient Care Network Registration form Last revised: February 2, 2016
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The term “Unassigned In-patient” is used in this context to denote those patients whose family physician (FP) does not have admitting privileges in the acute care facility in which the patient has been admitted.

The General Practice Services Committee (GPSC) Unassigned In-patient Care Incentives are applicable to FPs with a community practice who are delivering unassigned in-patient care services and meet the criteria outlined on the GPSC web site at: www.gpsc.bc.ca. In order to register for the Unassigned In-patient Care Incentives, each FP must be listed on this form and a new form must be submitted if membership in the network below changes. In addition, each FP must have completed and signed the Unassigned In-patient Care Service Verification form.

Division of Family Practice (if applicable):	
City/Town/Community of the network:	
Hospital the network is associated with:	
MSP billing/payee number for the quarterly unassigned network incentive (if applicable):	
Who will bill the Unassigned In-patient Care Fee of \$150 (G14088)? Tick only one box.	DoFP/FP group: <input type="checkbox"/> Individual FPs: <input type="checkbox"/>

For each FP participating in unassigned in-patient care for the hospital, please complete the following information. If completing this form electronically, expand this table to as many rows as is required. If completing this form non-electronically, please complete additional pages as required to list all the network associates.

Name of the network associate (please print legibly)	MSP practitioner number	MSP payee/billing number	Email or fax

Date submitted:	
Network Contact name:	
Network Contact phone number:	
Network Contact email:	

Submit to: GPSC In-patient Care Incentives coordinator at Divisions Central at: divisions@doctorsofbc.ca

Appendix 3

GPSC In-Patient Initiative Preamble from Guide to Fees

The GPSC In-patient Initiative was developed to recognize and better support the continuous relationship with a family physician (FP) that can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. An important aspect of such continuous care is the coordination care through the in-patient journey as well as in transitions between hospital and community FP offices. There are two separate levels of incentives aimed at better supporting and compensating FPs who provide this important aspect of care. This initiative will support family physicians who:

- Provide care to their own patients (Accepted most responsible physician (MRP) status for their care while resident in the community) when they are in hospitals (Assigned In-patients); and
- Provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned In-patients);

To participate in the GPSC In-patient Initiative, it is expected that these FPs agree to the following expectations:

A. They are members of the **active or equivalent medical staff** category and have hospital privileges in the identified acute care hospital.

B. That their on-call colleagues (Network) will also be members of the active or equivalent medical staff category and have hospital privileges.

C. That they will:

- Coordinate and manage the care of the patients (assigned &/or unassigned), either as the MRP or in a supportive care role.
- See all acute patients on a daily basis and document a progress note in the medical record.
- Work with the interdisciplinary team, as appropriate, to develop a care plan and a plan for discharge.
- When care is transferred to another physician, ensure that this is documented in the medical record and ensure there is a verbal or written handover plan provided to the accepting physician.
- Ensure availability to expedite discharges of patients daily during the normal working day which includes early morning, daytime, and early evening.
- On weekends ensure the covering physician is made aware of those discharges that could occur over the weekend.
- Provide a discharge note to an unassigned in-patient for their FP or communicated directly with the FP on discharge.
- Respond to requests from members of the interdisciplinary in-patient care team by phone as per hospital bylaws.
- The Network Call Group will accept responsibility for their newly admitted in-patients on a 24/7/365 basis. The MRP shall assess and examine the patient, document findings and issue applicable orders as soon as warranted by the patient's needs, but in any case no longer than 24 hours after accepting the transfer. Utilization needs within the facility may dictate that the patient must be seen sooner.

D. The non-clinical services include the already existing expectations of FPs as outlined in the Health Authority Medical Staff bylaws, rules and regulations, and policies. The health authority, the Department of Family Practice, the Division of Family Practice (where it exists) and the In-patient Care Networks could reasonably expect that all parties would participate in discussions which could include:

- The orderly transitions of MRP status between specialists and generalists.
- Participating in the orderly discharge planning of generally more complicated patients.
- Patient safety concerns that come up in local hospitals.
- Identifying and providing input into "local hassle factors" that would need to be examined and resolved at a local level between the local division of family practice and health authorities.
- Participate in utilization management within the hospital.
- Patient care improvement discussions that would reasonably be covered under the improved FP hospital care incentives.