GP SERVICES COMMITTEE
Hospital Inpatient INCENTIVES

Revised
January 2018

General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP Society of General Practitioners of BC

January 2018

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 are 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

G14086 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:

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**	**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**
Northern Health Authority: **PHN# 9752 590 509** **Patient Surname: Assigned** **First Name: NHA** **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**	**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** **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**
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**	

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:

i) 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.

ii) Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.

iii) Payable once per unassigned patient per in-hospital admission in addition to the hospital visit (13109, 13008, 00127) or delivery fee.

iv) 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.

v) 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 *Net*work 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?

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.

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 13109, 13008 and 00127 Fees?

The 13109, 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 13109, 13008 and 00127 fee items be handled for population based funding practices?

The 13109, 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

Funding levels for the Unassigned In-patient Care Network Incentive are calculated for each hospital based on the previous fiscal year data. Updated calculations will be provided in the fall of each year.

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

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

The GP-Allied Care Provider Conferencing (G14077) Incentive is available to 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.

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-Allied Care Provider Conference Fee $40.00

Notes:

- *i. Payable only to Family Physicians who have successfully:*
  - *a. Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; or*
  - *b. Registered in a Maternity Network or GP Unassigned In-patient network on a prior date.*
- *ii. Payable only to the Family Physician who 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, videoconferencing 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. convey the 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. Start and end times must be included on the claim and 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 provider about a patient in a facility.*
- *xii. Not payable in addition to G14018.*
- *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-Allied Care Provider Conference Fee

6.1. When is it appropriate to submit the G14077 GP Allied Care Provider Conference Fee?

G14077 is billable by physicians who have submitted G14070/71 or who are members of a GP Maternity or a GP Unassigned Inpatient Network. G14077, with a total of 18 units per calendar year and 2 units per calendar day has significant 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 Provider (including physicians) regardless of location.
- Can be done in person or by telephone.
- Can be initiated by either the FP or the Allied Care Provider.

6.2. Is G14077 GP-Allied Care Provider Conference Fee billable for patients in acute care? Is the phrase "not billable for simple advice given to an allied care provider 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?

FPs who have submitted G14070/71 may bill G14077 for conferences that occur for any patient in their practice (there are no diagnostic requirements with the G14077). There is also no patient location restriction for G14077. Patients may be in the community or in a facility (any facility including acute care and even in ER). The time of per 15 minutes or greater portion thereof to a maximum of 2 unites per calendar day and 18 units per calendar year per patient, requires start and end time to be documented in the patient chart and fee submission.

Simple/brief advice to a non-physician allied care provider 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 Providers" are included in order to bill G14077?

G14077 is intended as compensation when the eligible FP 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?

Yes, FP conferencing with this group of Allied Care Providers (either in person or by teleconference or videoconference) would qualify for the use of 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 when covering in an eligible practice?

Yes. Locum physicians are eligible to have the G14077 billed for conferencing with allied care providers when covering an eligible host FP, provided G14071 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 clinic, is G14077 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 have submitted G14070 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 family physicians 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 has submitted code G14070 or G14071 in the case of a locum at the clinic.

6.8. Am I eligible to bill G14077 in addition to receiving the Complex Care Planning and Management payment(s)?

Yes. If the physician needs to conference with allied care providers about the care plan and any changes, then the services provided in conferencing with other allied care providers and billed using 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 G14077?

Yes, 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, then there is nothing (s)he can bill, while the FP in a maternity or unassigned network may submit up to 2 units of G14077 if the time requirements are met.

6.11. Do FPs participating in a Residential Care Network but who do not have a separate community practice qualify to submit G14070 and access the additional codes available through the GPSC portal?

Yes, FPs who do not have a community practice but who are participating in a Residential Care Network are considered to have a community "practice" in the residential care site. As such, they are eligible to submit G14070 in order to access codes G14076 GP Patient Telephone Management, G14077 FP Allied Care Provider Conferencing & G14078 GP Email/Text/Telephone Medical Advice Relay, for the patients for whom they are MRP (or covering for the MRP). It is important to note that G14075 GP Frailty Complex Care is not applicable to patients in residential care.

6.12. Is this payment eligible for rural premiums?

No, G14077 is not eligible for rural premiums.

7. Non-face-to-face Fees 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, text or email, 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.

G14076 the GP-Patient Telephone Management Incentive and as of October 1, 2017, G14078 the GP Email/Text/Telephone Medical Advice Relay fee are available for 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.

G14076 GP-Patient Telephone Management Fee $15

Notes:

i) *Payable only to Family Physicians who have successfully:*
   a. *Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; 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 providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.*

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 prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.*

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

vi) *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 G14018.*

vii) *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.*

viii) *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 Patient Telephone Management Fee

1. What is the difference between the G14076 GP Patient Telephone Management Fee and the new G14078 GP /Text/Telephone Relay Fee?

G14076 GP-Patient Telephone Management Fee is for telephone management, not email or text message communication. There is 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 new GP-Patient Email/Text/Telephone Relay Fee is payable for 2-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone that may be made on behalf of the physician by a College Certified Allied Care Provider or MOA working within the physician practice. There is a cap of 200 Email/Text/Telephone Relay fees (G14078) per physician 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 be billed?
No, G14076 requires a two-way telephone conversation with the patient. See G14078 Email, Text, Telephone Relay Fee.

3. Are locums able to provide telephone calls and have G14076 billed?
Locum physicians are eligible to have the G14076 billed for telephone calls provided to patients when covering a host FP who has submitted G14070. Each locum will still have the same 1500 telephone call fees per calendar year available, provided G14071 has been submitted earlier in the same calendar year.

4. Telephone Management requires "a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care providers (ACP) working within the eligible physician practice". Which college certified ACPs qualify for making these calls to be eligible for the G14076 to be billed?
G14076 is billable when the telephone call is made by the Allied Care Provider staff member of the FP practice 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 ACP has not kept up his/her certification, they would not be working within their scope of practice, so would not be eligible. To work within scope of practice and maintain medical legal coverage to do so, all allied care providers must maintain certification.

5. If the telephone call with the patient is only about a WorkSafeBC covered injury, can G14076 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?
No. G14076, requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care providers working within the eligible physician practice. The use of two way text messaging is covered under the G14078 GP Patient Email/Text/Telephone Relay Fee

7. Can FPs who are in "Focused Practice" Obstetrics, or who provide Unassigned Inpatient care (previously referred to as "Doctor of the Day") access G14076?
Yes, 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 G14076 eligible for rural premiums?
No, G14076 is not eligible for rural premiums.

2. GP Email/Text/Telephone Medical Advice Relay Incentive

G14078 GP Email/Text/Telephone Medical Advice Relay Fee $7.00

This fee is payable for 2-way communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone relay.
This fee is not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

Notes:

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

ii) Email/Text/Telephone Relay Medical Advice requires two-way communication between the patient or the patient's medical representative and physician or medical office staff.

iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.

iv) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

v) Payable to a maximum of 200 services per physician per calendar year.

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

Frequently Asked Questions about G14078 GP Email/Text/Telephone Medical Advice Relay Fee

1. What is the difference between G14078 GP Email/Text/Telephone Medical Advice Relay Fee and G14076 GP-Patient Telephone Management Fee?

G14078 is for relay of medical advice from the physician to the patient or patient's medical representative and may be delegated to a College-certified allied care provider or a Medical Office Assistant (MOA). An example could be letting the patient know that a urine culture shows a bacterial resistance to the antibiotic prescribed and the need to change medications. The resulting replacement Rx could either be picked up by the patient without seeing the FP or faxed to a pharmacy of the patient's choice. G14076 is for medical management by telephone and requires a clinical telephone discussion between the patient or the patient's medical representative and physician or may be delegated only to a College-certified allied care provider (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice. It may help to think of the G14076 as a telephone visit rather than simple relay of advice.

2. Can I use G14078 to send out reminders that a specific follow-up or other service id now due (eg. Pap test reminders, flu shot notices, etc.)?

No, this is the same as a notification of appointment and neither G14076 nor G14078 are billable.

3. Is G14028 billable for notifying patients of normal results from lab or other diagnostic tests?

The routine notification of normal results would not be covered by G14028. However, it would be appropriate to submit G14028 in cases where relaying or notifying a patient of a normal or more correctly "negative" test result would impact care due to the clinical implication of that negative result. Examples of when it would be appropriate to submit G14028 include (but are not limited to):

i. Someone who has had a biopsy of a lesion, letting them know there is no cancer is an important and acceptable use. In some cases, it would be more appropriate for the physician or college-certified ACP to do this by telephone (G14076) as there will likely be other questions to answer.
ii. Letting a mother know about a child's negative throat swab so no need to start (or no need to continue) antibiotics.

iii. Letting a patient who has been on iron for anemia know their hemoglobin has improved to a normal level, so they can decrease their iron intake from 300 mg a day to 150 mg a day for another few weeks before stopping to build up their iron stores.

In these cases there is a clinical reason for relaying the negative results as opposed to just a notification of normal results.

4. **If a phone call to the patient is made but there is no answer and a message is left on voice mail, can G14078 be billed?**
   Provided the patient returns the call to confirm the message has been recieved, yes, G14078 may be billed for this relay of medical advice from the physician.

5. **Are locums able to authorize relay of advice by email/text/telephone and have G14078 GP Email/Text/Telephone Medical Advice Relay Fee billed?**
   Locum physicians are eligible to have the G14078 billed for medical advice relayed to patients when covering a host FP who has submitted G14070. Each locum will still have the same 200 telephone call fees per calendar year available, provided G14071 has been submitted earlier in the same calendar year.

6. **Can FPs who are in "Focused Practice" Obstetrics, or who provide Unassigned Inpatient care (previously referred to as "Doctor of the Day") access the G14078 GP Email/Text/Telephone Medical Advice Relay Fee?**
   Yes, 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. **Do FPs participating in a Residential Care Network but who do not have a separate community practice qualify to submit G14070 and access the additional codes available through the GPSC portal?**
   Yes, FPs who do not have a community practice but who are participating in a Residential Care Network are considered to have a community "practice" in the residential care site. As such, they are eligible to submit G14070 in order to access codes G14076 GP Patient Telephone Management, G14077 FP Allied Care Provider Conferencing & G14078 GP Email/Text/Telephone Medical Advice Relay, for the patients for whom they are MRP (or covering for the MRP). It is important to note that G14075 GP Frailty Complex Care is not applicable to patients in residential care.

8. **Is G14078 eligible for rural premiums?**
   No, G14078 is not eligible for rural premiums.

GP CONFERENCING AND PATIENT TELEPHONE FEES

G14077 GP Allied Care Provider Conference Fee
G14076 GP Patient Telephone Management Fee
G14078 GP Email/Text/Telephone Medical Advice Relay Fee

Appendix 1.

Assigned In-patient Care Network Registration form

Last revised: October, 2016

The term "Assigned In-patient" is used in this context to denote those patients whose family physician (FP) has:

- Accepted most responsible physician (MRP) status for their care while resident in the community, and
- Active privileges at the acute care facility in which the patient has been admitted and follows the rules and by-laws of the health authority.

The General Practice Services Committee (GPSC) Assigned In-patient Care Network Incentive is applicable to FPs with a community practice who are delivering assigned in-patient care services and meet the criteria outlined on the GPSC web site at: www.gpscbc.ca . In order to register for the Assigned In-patient Care Network Incentive, each FP must be listed on this form and a new form must be submitted if membership in the network below changes.

Division of Family Practice (if applicable):	
City/Town/Community of the network:	
Hospital the network is associated with:	
Who will bill the Assigned In-patient Care Network Incentive (G14086)? Tick only one box.	DoFP/FP group: ☐ Individual FPs: ☐
DoFP or FP group payee/billing number (if applicable):	

For each FP participating in assigned 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 2.

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

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.gpscbc.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: ☐ Individual FPs: ☐

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.