GP SERVICES COMMITTEE
Palliative Care INCENTIVES

Revised
April 2017

GPSC General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP Society of General Practitioners of BC

GPSC Palliative Care Planning and Management Fees

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

Eligibility:

Physicians are eligible to participate in the GPSC incentive programs if they are:

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

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

GPSC Palliative Care Initiative

The *"Health Care (Consent) and Care Facility (Admission) Act" and the "Representation Agreement Act, Power of Attorney Act, Adult Guardianship Act"* provides the legal requirements with respect to consent and is applicable to all healthcare providers:

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

The GPSC Palliative Care Incentive is intended to enhance the planning and coordination of end-of-life care for patients. Preparation and advance care planning are critical once it has been determined that a patient's condition is palliative. The GPSC Palliative Care Incentive supports family physicians to take the time needed to work through the various decisions and plans that need to be determined to ensure the best possible quality of life for dying patients and their families. The "Palliative Care Planning fee" will compensate the family physician for undertaking and documenting an Advance Care Plan for patients who have been determined to be palliative. The development of the ACP is done jointly with the patient &/or the patient representative as appropriate and requires a minimum of 30 minutes face-to-face. There must also be a visit fee (home or office) billed in addition to G14063. You must enter total start and end times when submitting face-to-face time based fees (eg. 30 minutes for planning plus 10 minutes for the medical visit for total 40 minutes), and this must also be documented in the patient chart. ***The patient & or their representative/family should leave the planning process/visit knowing there is a plan for their care and what that plan is.***

In addition, the Family Physician or practice group will be able to access up to 5 phone/e-mail follow- up management fees provided the planning process has been completed and the planning fee successfully billed within the previous 18 months.

Eligibility

- Eligible patients are community based (living in their home, with family or assisted living).
- Payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for longitudinal coordinated care of the patient for that calendar year;
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;

- Not payable to physicians who are employed by a health authority or agency or who are under contract whose duties would otherwise include the provision of this care;
- Not payable to physicians working under a salary, service contract or sessional arrangements and whose duties would otherwise include the provision of this care.

G14063 Palliative Care Planning incentive remains outside the "Attachment Initiative" portal and is available to any Full Service Family Physician (FSFP) to support the provision of end-of-life and palliative care services.

G14063 Palliative Care planning fee $100

This fee is payable upon the development and documentation of an Advance (Palliative) Care Plan for patients who in your clinical judgment have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to 6 months, and who consent to the focus of care being palliative rather than treatment aimed at cure. Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy.

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

The Palliative Care Plan requires documentation of the following in the patient's chart:

1. *There has been a detailed review of the case/chart and of current therapies.*
2. *There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Palliative Care Planning Fee is billed.*
3. *Specifies a clinical plan for the patient's palliative care.*
4. *Incorporates the patient's values and beliefs in creation of the plan*
   Name and contact information for substitute decision maker.
5. *Completion of a NO CPR FORM*
6. *Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles.*
7. *Provides confirmation that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved allied care professionals as appropriate.*

This fee requires a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Notes:

i) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.

ii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).

iii) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.

iv) Payable in addition to a visit fee (home or office) billed on the same day.

v) Minimum required time 30 minutes face to face in addition to visit time same day.

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

vii) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14063.

viii) Not payable if G14033 or G14075 has been paid within 6 months.

ix) *Not payable on same day as G14015, G14017, G14043, G14074, G14076 or G14079 GP Telephone/e-mail Management fee.*

x) *G14050, G14051, G14052, G14053, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid as patient has been changed from active management of chronic disease and/or complex condition(s) to palliative management.*

xi) *G14043, G14044, G14045, G14046, G14047, G14048, the GPSC Mental Health Initiative Fees are still payable once G14063 has been billed provided all requirements are met, but are not payable on same day.*

xii) *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.*

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

Successful billing of the Palliative care planning fee (G14063) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year over the following 18 months.

Frequently Asked Questions

1. What is the purpose of the Palliative Care Planning and Management Fees?

Family Physicians provide care to patients and their families across the full spectrum of life. Preparation and advance care planning are a critical first step once it has been determined that a patient's malignancy, AIDS or end-stage medical condition is terminal. With the GPSC Palliative Care Incentive payment, family physicians will be encouraged to take the time needed to work through the various decisions and plans that need to be determined to ensure the best possible quality of life for dying patients and their families. The "Palliative Care Planning fee" will compensate the family physician for undertaking and documenting a care plan.

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

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

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

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

4. When can I bill the Palliative Care Planning Fee (14063)?

This fee is payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient. The patient must be eligible for BC Palliative Care Benefits Program although it is not necessary to have applied for palliative care benefits program prior to undertaking the palliative care planning process. You must have determined that the patient has become palliative, and must confirm the patient's agreement to no longer seek treatment aimed at cure.

5. What is an Advance Directive?

An AD provides written consent or refusal to health care by the adult to a health care provider, in advance of a decision being required about that health care:

- Advance Directives must be written, signed by a capable adult and be witnessed by two witnesses or one witness who is a lawyer or notary public in good standing with the Society of Notaries Public. A witness cannot be a person who provides personal care, health care or financial services to the adult for compensation, nor the spouse, child, parent, employee or agent of such a person.

- The Ministry of Health has developed an Advance Directive form for individuals to use when undertaking advance care planning, but the use of this specific form is optional. This form can be found within the My Voice Advance Care Planning Guide located on the Ministry Website at: http://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf
- When an Advance Directive is in place, a Temporary Substitute Decision maker is not required unless an exception applies.
- If there is a legal representative, then decisions must be based on the instructions in the Advance Directive. An adult may also provide in a Representation Agreement that a health care provider may act in accordance with instructions in the adult's Advance Directive without the consent of the adult's Representative.
- If a Personal Guardian has been appointed by the courts, he/she may withdraw consent given by an adult when capable or by way of an Advance Directive, or by a Representative or Temporary Substitute Decision maker (TSDM). The Advance Directive document is not binding on the decisions of a Personal Guardian.
- The AD must state that the adult knows that:
  – a health care provider may not provide to the adult any health care for which the adult refuses consent in the advance directive; and
  – a person may not be chosen to make decisions on behalf of the adult in respect of any health care for which the adult has given or refused consent in the advance directive

6. What is an Advance Care Plan?

Advance care planning is the **process** whereby a capable adult discusses their beliefs, values, wishes or instructions for future health care with trusted family and health care providers. Advance care planning may lead to a written **Advance Care Plan** (ACP). An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on **conversations** with trusted family/friend and health care provider. The ACP is to be used by a **Substitute Decision Maker** (SDM) to make health care decisions for the adult when incapable and this may include consent or refusal for treatment. The decisions are to be based on a healthcare provider's offer of medically appropriate care. An Advance Care Plan will include the following components:

- A statement of the patient's primary medical diagnosis;
- A statement that the patient is medically palliative based on the physician's medical diagnosis AND the patient's agreement to no longer seek treatment aimed at cure;
- A list of the potential health care needs and the plan for managing these needs. As an example this may include Home and Community Care support services such as home support, home nursing care, personal care, after-hours palliative care, respite and/or hospice care; access to palliative medications, and supplies and equipment through the Provincial Palliative Benefits Program;
- A detailed, current plan for symptom management, including completing the application form and process to access the Palliative Benefits Program when appropriate;
- A list of the clinical indicators on when referral/access to specialist palliative care services may be needed;
- A copy of the patient's most current Advance Directive if available; and
- Completion and retention of forms to support a planned natural home death when this is part of the patient goal (Notification of a Planned Home Death; No CPR form, etc.).
- Physicians and patients are encouraged to ensure these documents will be available to the local emergency room in the event of patient attendance there.

7. How much time is required for billing the Palliative Care Planning Incentives and how should the time be documented?

The Palliative Care fee (G14063) require a minimum of 30 minutes face-to-face for the planning component. This time is in addition to the medical visit component. ***Start and end times must be documented in the patient chart and are also required to be submitted with the fee to MSP.***

Eg. Patient seen at 1600 hr for 5 minutes to review current status, then 30 minutes face-to-face planning that includes components of the Palliative (Advance) Care Plan as per FAQ 6. Document in chart and submit with G14063 claim to MSP start time 1600 hr, end time 1635 hr.

8. When can I bill the GP Telephone/Email Management fee (14079)?

The follow-up of patients with a palliative condition does not always need to be face-to-face or by the physician. This fee is payable for 2-way clinical interaction provided between the GP or delegated practice staff (e.g. office RN or MOA) in follow-up on the Palliative Care Planning Fee (G14063). This fee is payable only if the GP or practice has billed and been paid for the Palliative Care Planning Fee (G14063). In order to facilitate processing of any claims for telephone/e-mail advice fees by a locum or colleague who has been designated to provide this service, an electronic note should be entered stating "locum/covering for Dr. X billing number YYYYY".

Family Physicians participating in the GPSC Attachment Initiative also have access to telephone management fee G14076 for any patient in their practice. The restriction for this fee incentive is 1500 X 14076 per family physician per calendar year, not a restriction per patient. However, it is recommended that for patients who are eligible for G14079, these should be utilized first (5 over the 18 months following the provision and billing of the eligible planning fees) before using the G14076 GP Attachment Telephone Management fees due to the limited number per participating FP (1500 per calendar year).

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

This incentive has been designed to remove the disincentive that exists under current fee for service payments to provide more time-consuming complex care to a patient, instead of choosing to see a greater number of patients of a simpler clinical nature. The physician's time is considered to be already compensated if he/she is under a contract "whose duties would otherwise include provision of this care", or is being compensated by a salary, service, or sessional arrangement.

10. Am I eligible to bill for the Attachment Patient Conferencing Fee (G14077) or the Community Patient Conferencing Fee (G14016) in addition to receiving the Palliative Care payment(s)?

Yes. The palliative care planning payment(s) relates to services provided to the patient. Much of Palliative Care is provided in an interdisciplinary manner with the use of teams including community nurses, pharmacists, palliative specialists and other allied care professionals. If as a result of the Palliative Care Planning visit (G14063), or as a result of telephone calls billed with either the GP Telephone/Email Management (G14079) or Attachment Patient Telephone Management fee (G14076), the physician needs to conference with allied care professions about the care plan and any changes, then the services provided in conferencing with other health care professionals is payable over and above the palliative care payments. It is payable on the same day as long as all criteria are met. The time spent on the phone or e-mail with the patient for the non-face-to-face complex care management does not count toward the total time billed under the community patient conferencing fee. FSFPs who are participating in the Attachment Initiative should use the Attachment Patient Conferencing Fee (G14077) while FSFPs who are not participating should use the Community Patient Conferencing Fee (G14016).

11. Am I eligible to bill for the Chronic Disease Management, Complex Care or Prevention Fee(s) (G14050, G14051, G14052, G14053, G14033, G14075, G14066) in addition to these Palliative Care Initiative fees?

No. The G14050, G14051, G14052, G14053, G14033, G14066 are not payable once Palliative Care Planning fee is billed as patient has been changed from active management of chronic disease(s) to palliative.

However, not all palliative patients are at the End-of-Life, and it is these "non-EOL" palliative patients who will require ongoing management beyond 6 months that would be appropriate for the G14075. Once they are at End-of-Life (life expectancy 6 months or less and eligible for palliative benefits plan – even if not applied for), the 14063 can be billed for palliative Planning visit provided the G14075 has not been billed in the previous 6 months. If a patient is determined to be in the last 6 months of life and it is decided to provide and bill for the Palliative Planning Visit through fee G14063, the complex care fees G14075 & G14033 as well as the CDM fees G14050, G14051, G14052 & G14053 are no longer billable.

Both 14075 & 14063 open the door to the GP Telephone/e-mail follow-up management fee (14079) and this is complemented by the additional Attachment telephone fee (14076) but family physicians should use all 5 of the 14079 first before using the limited 14076 (1500 per FP per calendar year).

12. Is the Palliative Care Planning fee eligible for the Rural Retention Premium?
Yes, the Palliative Care Planning fee is eligible for the Rural Retention Premium.

Palliative Care Fee

G14063 Palliative Care Planning Fee $100

Billing Scenario

Mr A. is a 65 patient with metastatic Lung Cancer. He has just come to his GP's office to review the feedback from the local cancer clinic. He has been advised by the oncologist that there is no further active management of his cancer that is aimed at cure available. He understands that he is now palliative and he and his wife want to discuss his options for care and make plans for his management in his home with community support. He is your last appointment of the day. You spend time reviewing his diagnosis, treatment, community care options and complete all forms needed for a planned natural home death as that is he and his wife's goal. In total this **Advance Care (Palliative) Planning visit takes 45 minutes**.

The next day you **contact the local home hospice program to discuss the plan** for Mr. A in the community as well as follow **up with the pharmacists** around his medications. **In total this community conferencing takes 25 minutes.** Over the next 3 weeks, you see him **once for counseling** and **once for a follow up visit in the office**, provide **three telephone follow up visits** with Mr. A., and then determine that home visits are the best course of planned care. Over the next 2 months, you **see him 4 times at home** and **conference with community care twice for 15 minutes each time** as well as **5 brief phone calls with the home hospice worker to provide advice about management**.

As his condition progresses it becomes apparent that despite increased home support, his family need some respite, so you arrange for his admission to the local hospice facility. He is admitted to the local hospice unit and on the day after admission you attend a **30 minute care conference** to review his management. You see him every second day for the first 2 weeks, then daily for the last 4 days prior to his death for a **total of 11 visits in the hospice unit**. You have no other patients in hospice so Mr. A. is your first and only patient seen each day. Total of 3 ½ months from time of change to palliative status.

Billings for Mr. A

Service	Fee Code	Value*
Palliative Care Planning Visit – 45 min	14063	$100.00
Palliative Care Planning Visit – 45 min	16100	
Community Patient Conferencing	14077 or 14016 X2	$80.00
Counseling Visit	16120	
Telephone follow up management #1	14079 or 14076	$15.00
Office Visit for follow up	16100	
Telephone follow up management #2	14079 or 14076	$15.00
Telephone follow up management #3	14079 or 14076	$15.00
Planned Home visit #1	00103	

Community Patient Conferencing	14077 or 14016 X1	$40.00
Advice about patient in care #1	13005	
Planned Home visit #2	00103	
Planned Home visit #2	00103	
Advice about patient in care #2	13005	
Planned Home visit #3	00103	
Community Patient Conferencing	14077 or 14016 X1	$40.00
Advice about patient in care #3	13005	
Advice about patient in care #4	13005	
Planned Home visit #4	00103	
Advice about patient in care #5	13005	
Facility Patient conferencing – 30 min	14077 or 14015 X2	$80.00
Palliative Visits in hospice** (first or only pt seen – note must submit billing each day separately, do not block bill in order to facilitate processing of 1st patient bonus)	00127 X11 + 13338 X 11	

* Only GPSC values included as MSP values are subject to change every April 1.

** Visits to palliative patients in facilities are billable on an ongoing basis for up to 180 days of care once the patient care has been deemed to be palliative. You can bill this day by day, or batch together as provided (eg. by week, month or course of care).