# GP SERVICES COMMITTEE
# Palliative Care INCENTIVES

**Revised**
**January 2018**

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 ***effective October 1, 2017, requires a minimum of 30 minutes total planning time, the majority of which must be face-to-face. A visit fee (home or office) may be billed in addition to G14063, when medically appropriate. As a result, there will be no requirement to submit/document start and end times for G14063. However, the total planning time and face-to-face planning time must still 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.

**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 G14070/71 portal and is available to any Full Service Family Physician (FSFP) to support the provision of end-of-life and palliative care services.

## G14063 GP Palliative Care Planning Fee $100

The GP Palliative Care Planning fee is payable upon the development and documentation of a 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. 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 GP Palliative Planning and Management fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the patient.**

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

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

***Patient Eligibility:***

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

***Notes:***

*i) 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) on the same day if medically required and does not take place concurrently with the face to face planning included under G14063.*

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

vi) *Chart documentation must include:*
   1. *the care plan;*
   2. *total planning time (minimum 30 minutes); and*
   3. *face to face planning time (minimum 16 minutes).*

vii) *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 G14043, G14076 or G14078.*

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.*

## Frequently Asked Questions

**1. What is the purpose of the Palliative Care Planning Fee?**

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 should include the following components that are in addition to the GPSC Care Plan core elements described above:

- 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 Incentive and how should the time be documented?**

The Palliative Care Planning fee (G14063) require a minimum total planning time of 30 minutes, the majority of which must be face-to-face planning with the patient and/or the patient's medical representative. This time is in addition to any medical visit that may also be provided. **Effective October 1, 2017, *Start and end times are no longer required to be documented in the patient chart and submitted with the fee to MSP. However, the total planning time and face-to-face planning time must still be documented in the patient chart.***

Eg. The day before a Palliative Planning visit, the FP reviews the chart, previous care plans and relevant consultation information for 15 minutes. On the day of the planning visit, the patient is seen to review current needs and other issues, then 20 minutes of face-to-face planning that includes the core elements outlined above as well as components of the Advance Care Planning as per FAQ 6. Documentation in chart "Total planning time 35 minutes, Face-to-face planning time 20 minutes".

**8. 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.

**9. Am I eligible to bill for the GP-Allied Care Provider Conferencing Fee (G14077) in addition to receiving the Palliative Care payment(s)?**

FSFPs who have submitted G14070 (or G14071 if a locum) may submit the GP Allied Care Provider Conferencing Fee (G14077) while FSFPs who have not submitted the GPSC Portal code G14070/71 will not be able to bill for these conferences. 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 other visits (office home, hospice, hospital) including telephone calls billed with GP Patient Telephone Management fee (G14076), the physician needs to conference with allied care professionals 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 visit (in-person or by phone) does not count toward the total time billed under the conferencing fee.

**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 likely be appropriate for the G14075 Frailty Complex Care Planning and Management Fee. 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.

**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 Planning Fee

| | | |
|---|---|---|
| **G14063** | **Palliative Care Planning Fee** | **$100** |

## Billing Scenario

Mr A. is a 65 patient with metastatic Lung Cancer. He and his wife visit 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. This first day, you spend 30 minutes with them 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. He also has a cough and you check him for any signs of acute illness that may need additional management. In total this **Care Planning visit takes 40 minutes – 30 minutes face-to-face planning and 10 minutes for your review of relevant information prior to the planning visit**.

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, all on separate days**.

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*** |
|---|---|---|
| Visit #1: Palliative Care Planning Visit – document 40 min total planning time, 30 minutes face-to-face planning time<br>Visit #1: Same Day Medical visit for cough | 14063<br><br>16100 | $100.00 |
| Conference #1 with allied care providers (next day) | 14077 X2 or | $80.00 |
| Visit #2: Counseling Visit | 16120 | |
| Telephone follow up management #1 | 14076 | $15.00 |
| Visit #3: Office Visit for follow up | 16100 | |
| Telephone follow up management #2 | 14076 | $15.00 |
| Telephone follow up management #3 | 14076 | $15.00 |
| Planned Home visit #1 | 00103 | |
| Conference #2 with allied care providers | 14077 X1 or | $40.00 |
| Advice about patient in care #1 | 13005 | |
| Planned Home visit #2 | 00103 | |
| Advice about patient in care #2 | 13005 | |
| Planned Home visit #3 | 00103 | |
| Conference #3 with allied care providers | 14077 X 1 or | $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 | |
| Conference #4 with allied care providers in Facility – 30 min | 14077 or | $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<br>+ 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).