

GP SERVICES COMMITTEE
Patient Conferencing INCENTIVES

Revised
January 2011



Society of
General
Practitioners

Conferencing Fees (14015, 14016, 14017, 14018, 14021, 14022, 14023)

The newest of the conferencing fees (14018, 14021, 14022, 14023) available September 1, 2010, have been developed to support teleconferencing with specialists and GPs with specialty training with a purpose of improving patient care. These new fees are to ensure both the requesting GP and the specialist/GP with specialized training are compensated for the service. These fees are not restricted to specific patient conditions and are available for patients who are facility or community based. These fees are not time based but have flat rates set depending on acuity of the requested teleconference. See details below.

The initial three of these payments (14015, 14016 & 14017) are for case conferencing for complex patients who are facility based, community based or ready for discharge from a hospital. They are limited to the care of BC patients (out of province patients are not eligible) who fall into five categories:

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

See table 1 below for a more complete description of the eligible patient populations for 14015, 14016 & 14017.

These three payments are payable at a rate of \$40 per 15 minutes or greater portion thereof. They are payable in addition to payment for a medically required visit if the conferencing requirements are done on the same day provided the visit occurs before or after the conference. There is a maximum of 6 units (90 minutes) payable **per calendar year** per patient, with a maximum of 4 units (1 hour) on any single day. The claim must state start and end times of the service. Details of Care Conference must be documented in the patients chart (in office or facility as appropriate). See template for charting at the end of this document.

Eligibility

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

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

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**.

HOW TO BILL 14015, 14016 & 14017

Submit the patient conferencing fees through the MSP claim system under the patient's PHN. The claim must include one of the appropriate diagnostic codes V15, V58, the code for one of the major psychiatric disorders or one of the major medical conditions (see table 1 below). You must put a start and end time in the claim for the conferencing fee only.

If you are billing for a medically necessary visit as well, submit the visit fee for the same date but do not put in a time if it is a weekday daytime visit. If using an out-of-office hour's visit fee code, make sure the time is either before or after the conferencing fee, not the same time.

All three patient conferencing fees (14015, 14016, 14017) pay at the same rate of \$40.00 per 15 min or greater portion thereof. Time spent must be noted in patient chart located in office or facility as appropriate.

1. G14015 FACILITY PATIENT CONFERENCE FEE

The general practice facility patient conference fee is billable when the family physician or locum is requested by the facility that the patient is residing in (permanently or temporarily) to review ongoing management of the patient in that facility or to determine whether a patient in a facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility. The conference is an interdisciplinary team meeting of at least two health professionals and will include family members when available. Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any healthcare provider charged with coordinating discharge and follow-up planning.

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

- Palliative Care facility
- LTC facility
- Rehab facility
- Sub-Acute care facility
- Psychiatric facility
- Detox/Drug and Alcohol facility

Effective January 1, 2010, Community Placement Facility and Disease Clinic have been moved under Community Patient Conferencing (14016) as these are outpatient/community programs not inpatient programs.

Restrictions

- If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
- This payment does not cover routine discharge planning from an acute care facility, nor is this fee payable for conferencing with acute care nurses on the patient's ward.
- This incentive payment is not payable on the same day for the same patient as the community patient conference fee (14016) or the acute care discharge planning conferencing fee (14017).

FREQUENTLY ASKED QUESTIONS:

1. How do I claim the Facility Patient Conference Fee payments?

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

2. What is the maximum number of payments allowed per patient?

There is a maximum of four units (60 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year per patient.

3. Is this payment eligible for rural premiums?

No.

4. Are there circumstances where payment will be allowed even if the care conference did not occur in a face-to-face meeting in the facility?

Face to face meetings are expected. Only under exceptional circumstances will care conferences by teleconference will be payable. For audit purposes, when this occurs, a chart entry is required to indicate that you were not physically present and the circumstances that prevented it.

5. If more than one patient is discussed at the same case management conference is the fee billable for each patient discussed?

Yes. The fee is billable under the PHN of each of the patients discussed, for the length of time that each patient's care was discussed. Concurrent billing for more than one patient is not permitted. That is, if you attend a care conference and two patients are discussed over the course of an hour the total time billed must not exceed one hour.

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

No.

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

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

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

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

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

9. Are locums able to bill this bonus?

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

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

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

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

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

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

No. Effective June 1, 2009, these are to be billed under the Acute Care Discharge Planning Fee (14017).

2. G14016 COMMUNITY PATIENT CONFERENCING FEE

The general practice community patient conferencing fee is for the communication of a coordinated clinical action plan developed (or revised) for the care of **community-based patients** with more complex needs. It is payable only when coordination of care and ***two-way collaborative conferencing with at least one other health care providers*** is required (e.g., Specialists, psychologists or counselors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry), as well as with the patient and possibly family members (as required due to the severity of the patients condition).

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

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

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

Effective January 1, 2010, the later 2 locations have been moved from the facility patient conferencing fee as these are community/out-patient clinics that patients attend while resident in the community.

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

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

Restrictions

- This incentive payment is not payable on the same day for the same patient as the facility patient conference fee (14015) or the acute care discharge planning conferencing fee (14017).
- This payment is not for referrals to the emergency room or to consultants when only a referral letter is required for an acute illness.

FREQUENTLY ASKED QUESTIONS:

1. How do I claim the Community Patient Conferencing Fee payments?

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

2. What is the maximum number of payments allowed per patient?

There is a maximum of four units (60 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year per patient.

3. Is this fee billable if a claim for the Facility Patient Conferencing Fee or Acute Care Discharge Planning Conferencing Fee was also made for the patient on the same day?

No.

4. Is this payment eligible for rural premiums?

No.

5. Are locums able to bill this bonus?

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

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

No.

7. Is the Community Patient Conferencing Fee billable by physicians working under salary, service contract or sessional arrangements?

No. Physicians working under these funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.

8. When I undertake a phone consultation/conferencing with a specialist about a patient who fulfills the criteria, can I bill the community patient conferencing 14016?

In any of the qualifying patients where a medical situation requires conferencing/consulting with a specialist or physician with specialized training, in order to create a plan to keep the patient safe in the community, the community patient conferencing fee is applicable provided the other requirements are also met. Included in the time required for billing the 14016 (15 minutes or major portion thereof) is the time spent on the phone with the specialist, the documentation of the recommendation, any additional calls needed to implement the recommendations (eg. Contacting home & community care, etc) and the time advising the patient or the patient's representative of the recommendations/plan.

9. Am I eligible to bill this fee when I refer an acutely-ill patient and discuss the case with an Emergency Room Physician/Specialist/Emergency Department nurse?

No. This fee covers the two-way collaborative conferencing with other providers in the development of a clinical action plan to keep the patient safely in the community. The transmission of information in a referral process does not qualify.

3. G14017 Acute Care Discharge Planning Conferencing fee

The general practice acute care discharge planning conference fee is billable when a Discharge Planning Conference is performed by the family physician upon the request of either an Acute Care facility, or by the GP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.

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

This fee includes:

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

Restrictions

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

FREQUENTLY ASKED QUESTIONS:

1. How do I claim the Acute Care Discharge Planning Conference Fee payments?

Submit the new fee item 14017 (value \$40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).

2. What is the maximum number of payments allowed per patient?

There is a maximum of four units (60 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year per patient.

3. Is this payment eligible for rural premiums?

No.

4. Are there circumstances where payment will be allowed even if the care conference did not occur in a face-to-face meeting in the facility?

Face to face meetings are expected. Only under exceptional circumstances will care conferences by teleconference be payable. For audit purposes, when this occurs, a chart entry is required to indicate that you were not physically present and the circumstances that prevented it.

5. If more than one patient is discussed at the same case management conference is the fee billable for each patient discussed?

Yes. The fee is billable under the PHN of each of the patients discussed, for the length of time that each patient's care was discussed. Concurrent billing for more than one patient is not permitted. That is, if you attend a care conference and two patients are discussed over the course of an hour the total time billed must not exceed one hour.

6. Is the Acute Care Discharge Planning Conference Fee billable by physicians who are employed or under contract to a facility and would have attended the conference as a requirement of their employment or contract with the facility?

No.

7. Is the Acute Care Discharge Planning Conference Fee billable by physicians working in a or physicians working under salary, service contract or sessional arrangements?

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

8. Can this fee be billed if I also submitted a Community Patient or Facility Patient Conference Fee on the same day?

No. The Acute Care Discharge Planning Conference fee (14017) is not payable on the same day of service for the same patient as the Community Patient Conference Fee (14016) or the Facility Patient Conference Fee (14015). The Community Patient Conference Fee is intended for patients living in the community and the Facility Patient Conference Fee is intended for patients residing in a facility. The Acute Care Discharge planning fee is to be used when the patient is in an acute care facility and the complexity of their condition requires a multi-disciplinary care conference to ensure a smooth transition back to the community other acute care or long term care facility.

If a Community Patient Conference Fee or a Facility Patient Conference fee was billed and the patient is subsequently admitted to an acute care facility, and a patient management conference is deemed to be needed, fee item 14017 may be billed. Conversely, if a Facility Patient Conference Fee is billed and the patient is subsequently admitted to acute care, and subsequently requires a discharge planning conference

prior to return to the initial facility, then the fee item 14017 may be billed for the acute care discharge planning conference. They may not, however, be billed on the same calendar day.

9. Are locums able to bill this bonus?

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

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

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

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

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

4. Telephone Conferencing with Specialist and Specialty Trained General Practitioners

Effective September 1, 2010, 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.

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

The intent of this initiative is to improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers.

This fee is billable when the patient's condition requires urgent conferencing with a specialist or GP with specialty training, and the development and implementation of a care plan within the next 24 hours to keep the patient stable in their current environment.

This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

Eligibility:

This incentive payment is available to improve patient care to:

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

G14018 General Practice Urgent Telephone Conference with a Specialist Fee

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

\$40.00

Notes:

- i) *Payable to the GP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or GP with specialty training regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.*
- ii) *A GP with specialty training is defined as a GP who:*
 - a. *Provides specialist services in a Health Authority setting and is acknowledged by the Health Authority as acting in a specialist capacity and providing specialist services;*

- b. *Has not billed another GPSC fee item on the patient in the previous 18 months; Telephone advice must be related to the field in which the GP has received specialty training.*
- iii) *Conversation must take place within two hours of the GP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, e-mail).*
- iv) *Includes:*
 - a. *Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*
 - b. *Developing, documenting and implementing a plan to manage the patient safely in their care setting.*
 - c. *Communication of the plan to the patient or the patient's representative.*
- v) *The care plan must be recorded in the patients chart and include the following information:*
 - a. *Patient's Name.*
 - b. *Date of Service.*
 - c. *Diagnosis.*
 - d. *Reason for need of Clinical Action Plan.*
 - e. *Name of specialist/GP with specialty training & their role in provision of care.*
 - f. *Elements of the Clinical Action Plan determined.*
 - g. *Patient risks based on assessment of appropriate domains (list of relevant co-morbidities and safety risks).*
 - h. *What referral will be made, what follow-up has been arranged (including timelines), as well as advanced planning information if appropriate.*
 - i. *Start times of service.*
- vi) *Not payable to the same patient on the same date of service as any other Patient Conference (fee items G14015, G14016, G14017), complex care, mental health or palliative care planning (G14033, G14043, G14063) or telephone fees.*
- vii) *Not payable to physicians who are employed by, or who are under a contract to a facility, who would otherwise have provided the service as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangement.*
- viii) *Include start time in time fields when submitting claim.*
- ix) *Not payable for situations where the primary purpose of the call is to:*
 - a. *book an appointment*
 - b. *arrange for transfer of care that occurs within 24 hours*
 - c. *arrange for an expedited consultation or procedure within 24 hours*
 - d. *arrange for laboratory or diagnostic investigations*
 - e. *inform the other physician of results of diagnostic investigations*
 - f. *arrange a hospital bed for the patient.*
 - g. *obtain non-urgent advice for patient management (i.e. not required within the next 24 hours).*
- x) *Limited to one claim per patient per physician per day.*
- xi) *Out-of-Office Hours Premiums and Rural Retention Premiums may not be claimed in addition.*
- xii) *Maximum of 6 (six) services per patient, per practitioner per calendar year.*
- xiii) *Visit payable on same date of service if medically required and does not take place concurrently with the clinical action plan.*

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

Eligibility:

- Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- Service may be provided when physician is located in office or hospital.

- For the purpose of these telephone advice fee items the GPSC has defined a General Practitioner (GP) with specialty training as: **"A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program"**.
- Telephone advice must be related to the field in which the GP has received specialty training.

G14021 GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Urgent \$60.00

Notes:

- i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.
- ii) Conversation must take place within two hours of the initiating physician's request. Not payable for written communication (i.e. fax, letter, e-mail).
- iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.
- iv) Not payable for situations where the purpose of the call is to:
 - a. book an appointment
 - b. arrange for transfer of care that occurs within 24 hours
 - c. arrange for an expedited consultation or procedure within 24 hours
 - d. arrange for laboratory or diagnostic investigations
 - e. inform the referring physician of results of diagnostic investigations
 - f. arrange a hospital bed for the patient
- v) Not payable to physician initiating call.
- vi) No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).
- vii) Limited to one claim per patient per physician per day.
- viii) A chart entry, including advice given and to whom, is required.
- ix) Include start and end times in time fields when submitting claim.
- x) Not payable in addition to another service on the same day for the same patient by same practitioner.
- xi) Out-of-Office Hours Premiums and Rural Retention Premiums may not be claimed in addition.
- xii) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.

G14022 GP with Specialty Training Telephone Patient Management - Initiated by a Specialist or General Practitioner, One Week \$40.00

Notes:

- i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.
- ii) Conversation must take place within 7 days of initiating physician's request. Initiation may be by phone or referral letter.
- iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.
- iv) Not payable for situations where the purpose of the call is to:
 - a. book an appointment
 - b. arrange for transfer of care that occurs within 24 hours
 - c. arrange for an expedited consultation or procedure within 24 hours
 - d. arrange for laboratory or diagnostic investigations
 - e. inform the referring physician of results of diagnostic investigations
 - f. arrange a hospital bed for the patient

- v) *Not payable to physician initiating call.*
- vi) *No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).*
- vii) *Limited to one claim per patient per physician per week.*
- viii) *A chart entry, including advice given and to whom, is required.*
- ix) *Include start and end times in time fields when submitting claim.*
- x) *Not payable in addition to another service on the same day for the same patient by same practitioner.*
- xi) *Out-of-Office Hours Premiums and Rural Retention Premiums may not be claimed in addition.*
- xii) *Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

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

Notes:

- i) *This fee applies to two-way direct telephone communication (including other forms of electronic verbal communication) between the GP with specialty training and patient, or a patient's representative. Not payable for written communication (i.e. fax, letter, e-mail).*
- ii) *This fee is only payable for scheduled telephone appointments with the patient.*
- iii) *Access to this fee is restricted to patients having received a consultation, visit, diagnostic procedure or surgical procedure from the same GP with specialty training, within the 6 months preceding this service.*
- iv) *Telephone management requires two-way communication between the patient and physician on a clinical level; the fee is not billable for administrative tasks such as appointment notification.*
- v) *No claim may be made where communication is with a proxy for the physician (e.g.: nurse or assistant).*
- vi) *Each physician may bill this service four (4) times per calendar year for each patient.*
- vii) *This fee requires chart entry as well as ensuring that patient understands and acknowledges the information provided.*
- viii) *Include start and end times in time fields when submitting claim.*
- ix) *Not payable in addition to another service on the same day for the same patient by the same practitioner.*
- x) *Out-of-Office Hours Premiums and Rural Retention Premiums may not be claimed in addition.*
- xi) *Cannot be billed simultaneously with salary, sessional, or service contract arrangements.*

Frequently Asked Questions

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

Yes, for urgent (less than 2 hours) telephone conferencing, the patient's GP (the requesting GP) would bill the G14018 for their part in the telephone conferencing and the resulting development and implementation of the clinical action plan, while the GP with specialty training would bill the G14021. For less urgent telephone conferencing, the GP with specialty training may bill the G14022 but the requesting GP cannot bill the G14018. However, if this less urgent teleconferencing is for a patient covered by the community patient conferencing fee (G14016) and fulfills the requirements outlined in this fee, then the appropriate units of G14016 may be billed by the patient's GP.

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

No, unlike the other GPSC patient conferencing fees (G14015, G14016, G14017) there are no specific medical condition requirements for these new fees. The intent of this initiative is to improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers. If a patient's condition

is severe enough to warrant the telephone conferencing and the patient is not seen the same day by the specialist/GP with Specialty training, then the fees are billable.

3. Does the patient have to be seen in the office to be eligible for these new fees?

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

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

No these fee items are not eligible for rural retention premiums.

5. Can any of these fees be billed in addition to a visit or other service on the same day?

Only the G14018 is billable in addition to a visit or service on the same day. The fee items G14021, G14022 & G14023 are not payable in addition to another service on the same day by the same physician for the same patient.

6. What is the maximum number of payments allowed per patient?

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

GP CONFERENCING FEES

<i>G14015</i>	<i>Facility Patient Conferencing Fee</i>
<i>G14016</i>	<i>Community Patient Conferencing Fee</i>
<i>G14017</i>	<i>Acute Care Discharge Planning Conferencing Fee</i>
<i>G14018</i>	<i>GP Urgent Telephone Conference with a Specialist (or GP with Specialty Training) Fee</i>
<i>G14021</i>	<i>GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Urgent (less than 2 hour response time)</i>
<i>G14022</i>	<i>GP with Specialty Training Telephone Patient Management - Initiated by a Specialist or General Practitioner, One Week</i>
<i>G14023</i>	<i>GP with Specialty Training Telephone Patient Management / Follow-Up</i>

BILLING EXAMPLES

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

Your billings would be:

Patient	Time	# of Services	Fee code	Diagnostic Code
Mr. A	0800 – 0820	1	14015	V15
Mr. A		1	13114	781
Mr. B	0820 – 0840	1	14015	V15
Mr. B		1	00114	250
Mrs. C	0840 – 0915	2	14015	V15
Mrs. C		1	00114	460

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

Billing: You are eligible in this case to bill 17101 for the full physical examination. You are also eligible to bill the appropriate units of 14016 for the time following the examination spent administering the Beck and MMSE, and organizing the care plan with other health care providers and with the patient and family. If you did not speak with the daughter until the following day and you did not speak with an allied health professional on that same day, the family discussion would not be billed as 14016.

Your billings would be:

<u>Date</u>	<u>Time</u>	<u># of Services</u>	<u>Fee code</u>	<u>Diagnostic Code</u>
MM/DD/YY			17101	V15
MM/DD/YY	1130 – 1220	3	14016	V15

Example #3:

New complex patient to your practice – On taking history you find out the 78 year old patient (Mrs. D.) suffers from osteoporosis with previous compression fractures of the spine, recurrent TIAs and hypertension. She is in an adult day program at a local LTC facility, requires blister packaging of her meds, and has ongoing monitoring by the elderly outreach team through your local home care department at the public health unit. After taking a detailed history, including obtaining a list of medications, and noting her BP of 185/80, you and the patient agree that as their level of stability varies, it would be appropriate for the elderly outreach team to go out and reassess safety issues in the home, have the home care nurse monitor her BP at home, and that all other care providers need to be involved in understanding some change to their level of needs. You follow this by contacting the elderly outreach team member involved and the pharmacy the patient deals with on the same day. In addition to the visit, the conferencing takes you 15 minutes immediately following the visit at 1600hr. The next day you contact the day program manager and the patient's daughter/son to discuss these issues and make a plan for ongoing monitoring and reporting lines. This takes 10 minutes the second day at 1330. You see the patient in 3 weeks for a CPX and to review her BP measures from home care. Over the course of the next year, you see Mrs. D twice more for planned proactive care and undertake a follow up 20 minute conferencing call with the elder outreach team immediately after the second visit (1430 hr). 1 year after taking over her care, can bill for the hypertension CDM.

Billing: You are eligible in this case to bill 17100 for the office visit. You are also eligible to bill the appropriate units of 14016 for the time following the examination spent organizing the care plan with other health care providers and with the patient and family on both days as an AHP was contacted each day.

Your billings would be:

<u>Date</u>	<u>Time</u>	<u># of Services</u>	<u>Fee code</u>	<u>Diagnostic Code</u>
MM/#1/YY			17100	401
MM/#1/YY	1600 – 1615	1	14016	V15
MM/#2/YY	1330 – 1340	1	14016	V15
MM/#3/YY			17101	401
MM/#4/YY			17100	401
MM/#5/YY			17100	401

MM/#5/YY	1430 – 1450	1	14016	V15
MM/#6/YY			14052	401

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

Example #4:

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

Your billings would be:

<u>Date</u>	<u>Time</u>	<u># of Services</u>	<u>Fee code</u>	<u>Diagnostic Code</u>
MM/#1-#6/YY		6	13108	786
MM/#4/YY	0800 – 0825	2	14017	V15

Example #5:

Mrs. V. is a 38 year old maternity patient, G2 P0 at 32 weeks gestation. Her prenatal care has to date been relatively uneventful with normal SIPS testing and normal 1 hour 50 gm GTT. She at this visit, her BP is 140/90 on 3 readings, including after lying in the left lateral position. Her reflexes are normal, and she has no signs of pre-eclampsia. You advise her that she needs to have some blood work undertaken and give her a requisition for a PIH panel, put her on bedrest at home, and put a call in to your local obstetrician for a telephone consultation. When Dr. J calls you back at 1600 hr you discuss the case, he advises home BP monitoring and a recheck in your office later the same week. He advises that if her BW is normal, and her home BP settles with bed rest, she only requires closer conservative management. If her BP does not settle he advises you on starting medication and arranging an office consultation in the near future. You then contact home care to arrange the home BP monitoring and follow up by phone with the patient. Total time spent in the telephone consultation, recording and implementation of recommendations as well as advising the patient is 30 minutes.

Your billings would be:

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

Example #6:

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

Billings:

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

Example #7:

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

Billings:
Community GP 00103
G14018
GP with Specialty Training G14021

Example #8:

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

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

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

i. Frail elderly (ICD-9 code V15)

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

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

ii. Palliative care (ICD-9 code V58)

Patient of any age who:

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

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

Patients of any age:

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

iv. Mental illness

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

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

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

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

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

Template Chart Documentation for 14015/14016/14017

Date: _____ Location: _____

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

Family Members Involved: _____

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

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

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

Prioritized Interventions/Referrals/Follow-ups² (Patient Goals for Treatment):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Planned Date of Follow-up: _____

¹ \$40/unit; 1 unit = 15 minutes; 6 unit maximum/year; 4 unit maximum/day

² Follow-ups should include timelines/contact information