GP SERVICES COMMITTEE INCENTIVES

Revised
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BILLING WORKBOOK

Table of Contents

1. Chronic Disease Management Fees

1.1 Diabetes (G14050)
1.2 Congestive Heart Failure (G14051)
1.3 Hypertension (G14052)
1.4 Chronic Obstructive Pulmonary Disease (G14053)
1.5 Flow Sheets
1.6 Frequent Asked Questions
1.7 CDM Fees (G14050, G14051, G14052, G14053)
1.8 Billing Scenario

2. Conferencing Fees

Eligibility
Restrictions
How to Bill
2.1 Facility Patient Conferencing Fee (G14015)
Restrictions
2.1.1 Frequently Asked Questions
2.2 Community Patient Conferencing Fee (G14016)
Restrictions
2.2.1 Frequently Asked Questions
2.3 Acute Care Discharge Planning Conference Fee (G14017)
Restrictions
2.3.1 Frequently Asked Questions
2.4 GP Telephone/E-mail Follow-up Management Fee (G14079)
2.4.1 Frequently Asked Questions
2.5 Conferencing between GP and Specialist/GP with Specialty Training Fees (G14018, G14021, G14022, G14023)
2.5.1 General Practice Urgent Telephone Conference with a Specialist (or GP with Specialty Training) Fee (G14018)
2.5.2 General Practitioners with Specialty Training Telephone Advice Fees (G14021, G14022, G14023)
2.5.3 Frequently Asked Questions
2.6 Billing Scenarios

3. Complex Care Management Fees (G14033)

Eligibility
Restrictions
3.1 G14033 – Annual Complex Care Planning Fee
3.2 How to Bill
3.3 Frequently Asked Questions
3.4 Complex Care Management Fees (G14033)
3.5 Billing Scenario

4. Prevention
- 4.1 Personal Health Risk Assessment Fee (G14034)
- 4.2 Frequently Asked Questions
- 4.3 Billing Scenario

5. GP Obstetrical Delivery Bonuses (G14004, G14005, G14008, G14009)
- 5.1 Obstetric delivery bonus associated with vaginal delivery and postnatal care
- 5.2 Obstetric delivery bonus associated with Management of labour and transfer for delivery to a higher level of care facility
- 5.3 Obstetric delivery bonus associated with attendance at delivery and postnatal care associated with elective caesarean section
- 5.4 Obstetric delivery bonus associated with attendance at delivery and postnatal care associated with emergency caesarean section

Eligibility
- 5.5 Frequently Asked Questions
- 5.6 GP Obstetrical Delivery Bonus fees (G14004, G14005, G14008, G14009)

6. Maternity Network (G14010)

Eligibility
- 6.1 Frequently Asked Questions

7. Mental Health Fees

Eligibility
- 7.1 Mental Health Planning Fee (G14043)
- 7.2 Mental Health Management Fees (G14044, G14045, G414046, G14047, G14048)
- 7.3 Frequently Asked Questions
- 7.4 Mental Health Fees (G14043,G14044, G14045, G14046, G14047, G14048)
- 7.5 Billing Scenario

8. Palliative Care Fees

Eligibility
- 8.1 Palliative Care Planning Fee (G14063)
- 8.2 Frequently Asked Questions
- 8.3 Palliative Care Fees (G14063)
- 8.4 Billing Scenario

All GPSC incentive information and updates can be found on the GPSC website (www.gpscbc.ca) as well as the SGP website (www.sgp.bc.ca)

1. Chronic Disease Management (CDM) Payments

The program payments recognize the additional work, beyond the office visit, of providing guideline informed care to patients over a year. The goal is to improve provision of clinically appropriate patient care that considers both the patient's values and the impact of co-morbidities. Effective January 1, 2009, there must be at least 2 visits billed on each CDM patient in the 12 months prior to billing the CDM incentive.

They are payable in recognition of work that has been done and are not payable in advance – in other words, they are to be billed after provision of one year of care. Currently, there are CDM annual payments for four conditions: Diabetes, Congestive Heart Failure, Hypertension and Chronic Obstructive Pulmonary Disease.

Effective January 1, 2012 the GPSC has streamlined the initial 4 telephone/e-mail follow up management fees into a single fee billable up to 5 times in the 18 months following the successful billing of one (or more) of the following incentives: 14053 (COPD CDM); 14033 (Complex Care Planning); 14043 (Mental Health Planning); or 14063 (Palliative Planning).

Eligibility:
These payments are available to:
All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months; and:

- Whose majority professional activity is in full service family practice as described in the introduction, and
- Who has provided the majority of the patient's longitudinal general practice care over the preceding year, and
- Has provided a clinically appropriate level of guideline-informed care.

1.1 G14050 GP Annual Chronic Care Bonus – Diabetes Mellitus

Notes:

i) *General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
ii) ***Payable to the family physician who has provided the majority of the patient's longitudinal general practice care and a clinically appropriate level of guideline--informed care for diabetes in the preceding year.***
iii) *Applicable only for patients with confirmed diagnosis of diabetes mellitus.*
iv) ***This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
v) *Claim must include the ICD-9 code for diabetes (250).*
vi) *This item may only be claimed once per patient in a consecutive 12 month period.*
vii) *Payable when other CDM items G14051 or G14053 have been paid on the same patient.*
viii) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

1.2 G14051 GP Annual Chronic Care Bonus – Congestive Heart Failure

Notes:

i) *General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
ii) ***Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care and a clinically appropriate level of guideline-–informed care for congestive heart failure in the preceding year.***
iii) *Applicable only for patients with confirmed diagnosis of congestive heart failure.*
iv) ***This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
v) *Claim must include the ICD-9 code for congestive heart failure (428).*
vi) *This item may only be claimed once per patient in a consecutive 12 month period.*
vii) *Payable when other CDM items G14050 or G14053 have been paid on the same patient.*
viii) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

1.3 G14052 GP Annual Chronic Care Bonus – Hypertension

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) ***Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care and a clinically appropriate level of guideline--informed care over the preceding year.***

iii) Applicable only for patients with confirmed diagnosis of hypertension.

iv) ***This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***

v) ***The patient must be given a copy of the Hypertension flow sheet in order to facilitate patient self-management.***

vi) Claim must include the ICD-9 code for hypertension (401).

vii) This item may only be claimed once per patient in a consecutive 12 month period.

viii) Not payable if G14050 or G14051 claimed within the previous 12 months.

ix) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

1.4 G14053 GP Annual Chronic Care Bonus – Chronic Obstructive Pulmonary Disease- COPD

Notes:

i) General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.

ii) ***Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care and provided a clinically appropriate level of guideline-informed care.***

iii) Applicable only for patients with confirmed diagnosis of COPD.

iv) ***This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***

v) ***The patient must be given a copy of their personalized COPD care plan in order to facilitate patient self-management.***

vi) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).

vii) This item may only be claimed once per patient in a consecutive 12 month period.

viii) Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.

ix) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

Successful billing of the Annual Chronic Care Bonus for COPD (G14053) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months.

1.5 FLOW SHEETS & ACTION PLANS

All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient's longitudinal general practice care over the preceding year. *Chronic Care flow sheets are a useful tool for tracking care provided to patients over time. The GPSC requires physicians to track and document adequately the care provided to their patients to ensure they are providing guideline informed care. While it is not mandatory to utilize official GPAC flow sheets, if you use a different flow sheet, all essential elements from the GPAC guideline must be included. There are other requirements that are incentive specific as outlined below:*

- ***Diabetes Patient Care Flow Sheet***
  Fee item 14050 may be billed after the patient has been provided guideline informed care for one year. Although you are not required to give the patient a copy of the flow sheet, the patient may find it helpful for self-management.
- ***Congestive Heart Failure Care Flow Sheet***
  Fee item 14051 may be billed after the patient has been provided guideline informed care for one year. Although you are not required to give the patient a copy of the flow sheet, the patient may find it helpful for self-management.

- ***Hypertension Care Flow Sheet***
  Fee item 14052 may be billed after the patient has been provided guideline informed care for one year. To assist in patient self-management the patient ***must*** be given a copy of their flow sheet for the year.
- ***COPD Patient Action Plan***
  Fee item 14053 may be billed after the patient has been provided guideline informed care for one year. There is no flow sheet for the 14053, however, to facilitate self-management, the patient must be provided with their COPD Action plan, jointly developed with their GP, and reviewed and updated regularly.

1.6 FREQUENTLY ASKED QUESTIONS

1. How do I claim the condition-based payments?

The incentive payments are payable if the patient has a confirmed diagnosis of diabetes mellitus *(please note this incentive payment is not payable for pre diabetes patients)*, congestive heart failure, hypertension or chronic obstructive pulmonary disease. Only one payment per diagnosis is payable per patient per year. The bonus 14052 (hypertension) is not payable if a bonus payment 14050 (diabetes mellitus) or 14051 (congestive heart failure) has been paid for the patient in the preceding year. 14052 (hypertension) is payable in addition to 14053 for those patients who also have COPD.
Condition-based bonus claims are submitted through the MSP Claims system the same way you would submit a MSP fee-for service claim. The submission must include the relevant ICD 9 codes:

Congestive heart failure - 428;
Diabetes mellitus – 250;
Hypertension – 401;
COPD – 491 or 492 or 494 or 496.

2. Is it possible to claim all Chronic Disease Management fees in the same patient?

If a patient has any of the three conditions diabetes mellitus, congestive heart failure, and/or COPD and criteria are met for each condition, each annual incentive bonuses may be billed separately. If a patient has hypertension, the 14052 cannot be billed in addition to Diabetes or CHF, as management of hypertension is included in the guideline for these 2 conditions. If the patient has hypertension and COPD without diabetes or CHF, then both the 14052 and 14053 may be billed on the same patient if all criteria are met.

CDM Allowable Combinations in Single Patient

	14050	14051	14052	14053
14050		Yes	No	Yes
14051	Yes		No	Yes
14052	No	No		Yes
14053	Yes	Yes	Yes	

3. When should the incentive bonus be billed?

All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient's longitudinal general practice care over the preceding year. The Chronic Care Incentive bonus fees may be billed once the patient has been provided guideline informed care for one year for that particular condition.

Once successfully billed, the CDM incentives may be billed on or about the anniversary date of the initial billing, provided guideline informed care has continued to be provided in the intervening 12 months.

4. Does obstructive sleep apnea qualify for the COPD CDM (G14053)?

No. COPD and obstructive sleep apnea are two different conditions. Criteria for the diagnosis of COPD are included in the COPD fee description.

5. Will payment item G14050, G14051, G14052 and G14053 replace the usual visit fees for those patients who have diabetes, congestive heart failure, hypertension or COPD?

No. Billing for office visits should continue as usual. This bonus is billed *in addition to* any other fees incurred by usual patient care.

6. Do I have to see the patient on the same day to bill the payment?
You will have to see the patient to provide the necessary clinical care over the year, but you do not have to see the patient on the day of billing the payment. Effective January 1, 2009, there must be at least 2 visits billed on each CDM patient in the 12 months prior to billing the CDM incentive.

7. Do I have to provide all follow up care to the patient face to face?
After successfully billing the G14053 for COPD, some follow up management may be provided to patients by telephone or e-mail, for which you can bill the G14079 GP Telephone/e-mail fee up to 5 times in the following 18 months (in addition to at least 2 face to face visits per 12 months).

8. How does my locum or colleague bill for telephone follow up on my COPD patients when I billed the G14053?
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".

9. Can I still bill if the patient is in a long-term care facility?
Patients in long-term care facilities are eligible; however clinical judgment may be needed about the appropriateness of following clinical practice guidelines in patients with dementia or very limited life expectancy. If the COPD incentive (14053) is billed for a resident in a long-term care facility a personalized Clinical Action plan must be entered in the patient's chart.

10. Where can I find the clinical guidelines and flow sheets?
The full Diabetes Care, Heart Failure Care, and the Treatment of Essential Hypertension guidelines are found on the Guidelines and Protocols page of the Medical Services Plan web site, along with all other current guidelines. http://www.bcguidelines.cahttp://www.healthservices.gov.bc.ca/msp/protoguides/gps/index.html A link is also provided on the BCMA web site, https://www.bcma.org/gpsc-chronic-disease-management
The link to information about the flow sheets is also found on the same site. Should you wish to receive a pad of pre-printed flow sheets, please fax your request at the following toll-free fax number 1-800-952-2895.

11. Will other flow sheets be admissible for the bonus?
Other flow sheets can be used if they are consistent with the BC clinical guidelines for diabetes, heart failure, and/or essential hypertension management. It is a requirement to give hypertension patients a copy of their flow sheet as an aid to patient self-management. This program is to the usual process of random audit through the Ministry of Health's Billing Integrity Program. Therefore, it is important that you keep all of your completed patient flow sheets on file.

12. Where can I find the COPD Action Plan template?
As part of the patient self-management handout, a COPD Care plan template can be found at the end of this document.

13. What supports are available for assisting my patients with COPD who are still smoking to quit?
On September 30, 2011, the B.C. government introduced the BC Smoking Cessation Program that is intended to help eligible B.C residents stop smoking or stop using other tobacco products by assisting them with the cost of smoking cessation aids. The program offers coverage for two treatment options: prescription smoking cessation drugs or non-prescription nicotine replacement therapy (NRT) products. The program is open to eligible B.C. residents who wish to stop using tobacco.

Resources on the B.C. Smoking Cessation Program
Patients may not know about the B.C. Smoking Cessation Program. If patients want to learn about the program, you can refer them to:

- the B.C. Smoking Cessation Program Patient Information Sheet (PDF 488K), an easy-to-print downloadable document that provides a high-level overview of the program
- detailed smoking cessation program information for patients on the PharmaCare website, including information on eligibility, coverage and registration procedures for the nicotine replacement therapy gums and patches
- HealthLink BC (phone 8-1-1 and ask for the smoking cessation program)

Resources to help patients plan and manage their stop-smoking activities:
The QuitNow.ca website has a wide range of resources for patients on planning and managing their smoking cessation activities, including:

- information, tips, tools and techniques posted in the QuitNow library
- access to trained CareCoaches®. A phone consultation can be booked at any time of day or night by phoning 8-1-1. More information on CareCoaches® is available online at QuitNow by Phone, a free telephone service offering advice, information and support about quitting smoking. The Quitnow Helpline is staffed from 10am to 6pm. After hours and on weekends, callers are invited to leave a message and a Quit Specialist will return the call during service hours.
- the Quit Now Online community of peer-to-peer support groups
- QuitNow By TXT, a 14-week mobile texting service that provides helpful quit smoking tips and motivational support
- Demonstration videos on how to use nicotine gum and patches

You can also use Quit Now's fax referral program to connect patients with counsellors.

Medications covered under the Smoking Cessation program
PharmaCare covers only the following products as part of the Smoking Cessation Program:

1. bupropion (Zyban®, the brand name version for smoking cessation)
2. varenicline (Champix®)
3. Thrive™ NRT chewing gum in two strengths
4. Habitrol® NRT patches in three strengths

Patients are eligible for coverage of one single continuous course of treatment, lasting up to 12 consecutive weeks (84 consecutive days) with either one NRT product or one prescription drug per calendar year. ***A Special Authority Form is NOT required for the initial prescription in any given year.*** *Under exceptional and compelling circumstances, PharmaCare may provide additional coverage. To request additional coverage, physicians are asked to submit a Special Authority request (using the General Special Authority Request form) (PDF 133K) for exceptional case-by-case consideration.*

14. Can I bill the payment even if the clinical or laboratory objectives have not been met?
The payment is provided for the provision of guideline-informed clinically appropriate care which takes account of patient's values and comorbitidites. It is NOT a payment simply because the patient has a diagnosis of diabetes, congestive heart failure, hypertension or COPD.

15. Can I bill for patients covered by other provinces?
Patients covered by other provincial health plans, who are temporarily living in BC are not eligible. In border communities where a BC physician provides the majority of care for an Alberta or Yukon patient, those patients will be eligible.

16. I have assumed the practice of another GP within the last 12 months. May I still bill for patients' Chronic Disease Management fees?
If the practice you assumed has provided the requisite care to the patient (see bullet 3 in this section) you may bill the Chronic Disease Management payment on its anniversary date. You may not bill the Chronic Disease Management fees if a patient did not receive the requisite level of care, or a chronic disease management fee code has been billed for the patient in the preceding 12 months.

16. Are the payments eligible for the rural premiums?
No.

17. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the chronic care bonus payments?
Yes.

1.7 CDM Fee Values

G14050	**Annual Chronic Care Bonus – Diabetes Mellitus**	**$125.00**
G14051	**Annual Chronic Care Bonus – Congestive Heart Failure**	**$125.00**
G14052	**Annual Chronic Care Bonus – Hypertension**	**$50.00**
G14053	**Annual Chronic Care Bonus – Chronic Obstructive Pulmonary Disease**	**$125.00**

1.8 Billing Scenario

Mr. William S is a 76 year old former smoker who has a past history of Diabetes, hypertension and COPD. You have been his family physician for the past 12 years. When the initial GPSC CDM incentive program began, you had pulled all your charts for eligible patients including Mr. S, and started utilizing the CDM flow sheets for following the care of his diabetes. You see have also been undertaking the complex care management planning visits with Mr. S and find he is due for a CPX as per the guideline recommendations. Mr. S was seen in February for follow up of his diabetes. The Complex Care Management Planning visit was provided in April of this calendar year. Mr. S has seen you in June and returns in September for his planned CPX in the same month as the anniversary date of his Diabetes CDM. You review his complex care plan and his diabetes management. As well, you provide him with a COPD Action plan for the coming winter. He returns in November for his annual seasonal flu shot given by your office nurse. Later that month, after a visit with his daughter and grandchildren he phones the office with some increased shortness of breath and a change in his sputum but no fever. You advise him on the management of his COPD according to his COPD action plan. You follow up with him at an office visit 2 weeks later. The billings for his management for this calendar year are:

Date	Service Description	Fee Code	Diagnostic Code
Feb	Office Visit	17100	250
April	Complex Care Management Planning Visit	14033 17100	R250 496
June	Office Visit	17100	250
September	CPX plus CDM review and COPD Action Plan update Diabetes CDM COPD CDM	17101 14050 14053	250 250 496
November	Seasonal Flu shot by office nurse	00010	33A
November	Phone Follow up of COPD	14079	496
December	Office Follow up of COPD	17100	496

2. Conferencing Fees (14015, 14016, 14017, 14079, 14018, 14021, 14022, 14023)

As of January 1, 2012, after hearing feedback from practicing family physicians, the GPSC streamlined the patient telephone/e-mail follow up fees into a single code that would still be applicable for the same patient population. Fee item 14079 can now be billed up to 5 times in the 18 months after the successful billing of one or more of the following fees: 14033; 14043; 14063; 14053. This will join the other conferencing fees (14018, 14021, 14022, 14023) that have been developed to support teleconferencing with specialists and GPs with specialty training with a purpose of improving patient care, in addition to the original fees to support care conferencing with other allied health professionals for specific patient populations. 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 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.

2.1 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

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).

G14015 GP Facility Patient Conference: when requested by a facility to review on going 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 facility - per 15 minutes or greater portion thereof 40.00

Notes:

i) *Refer to Table 1 (below) for eligible patient populations.*
ii) *Must be performed in the facility and results of the conference must be recorded in the patient chart.*
iii) *Payable only for patients in a facility. Facilities limited to: hospital, palliative care facility, LTC facility, rehab facility, sub-acute facility, psychiatric facility, detox/drug and alcohol facility).*
iv) *Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any health care provider charged with coordinating discharge and follow-up planning.*
v) *Requires interdisciplinary team meeting of at least 2 health professionals in total, and will include family members when available.*
vi) *Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.*
vii) *Claim must state start and end times of the service.*
viii) *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*
ix) *Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
x) *Not payable on the same day for the same patient as the Community Patient Conference Fee (G14016) or Acute Care Discharge Planning Conference fee (G14017).*
xi) *Visit payable in addition if medically required and does not take place concurrently with the patient conference. Medically required visits performed consecutive to the Facility Patient Conference are payable.*

2.1.1 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).

2.2 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.

G14016 GP Community Patient Conference Fee: Creation of a coordinated clinical action plan for the care of community-based patients with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other health care providers is required to develop a clinical action plan due to the severity of the patient's condition (e.g.

specialists, psychologists or counsellors, 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 patient's condition)
- per 15 minutes or greater portion thereof... 40.00

Notes:

i) *Refer to Table 1 (below) for eligible patient populations.*
ii) *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.)*
   - *Assisted living*

iii) *Fee includes:*
   a. *The interviewing of patient and family members as indicated and the conferencing with other health care providers as described above - this does not require face-to-face interaction in all cases and;*
   b. *As appropriate, 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*
   c. *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*
   d. *The care plan must be recorded in the chart and include the following information:*
      1., *Patient's Name*
      2. *Date of Service*
      3. *Diagnosis:*
         a. *V15 (Frail Elderly)*
         b. *V58 (Palliative/End of Life Care)*
         c. *Mental Illness (enter ICD-9 code of qualifying illness)*
         d. *Patients of any age with multiple medical needs or complex co-morbidity (enter ICD-9 code for one of the major disorders)*
      4. *Reason for need of Clinical Action Plan*
      5. *Health care providers with whom you conferred & their role in provision of care*
      6. *Cinical Plan determined, including tests ordered and/or administered.*
      7. *Patient risks based on assessment of appropriate domains (list of co-morbidities and safety risks)*
      8. *List of priority interventions that reflect patient goals for treatment*
      9. *What referrals will be made, what follow-up has been arranged (including timelines and contact information), as well as advanced planning information*
      10. *Start and stop times of service.*

iii) *Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.*
iv) *Claim must state start and end times of service.*
v) *Not payable to the same patient on the same date of service as the Facility Patient Conference fee (fee item G14015) or Acute Care Discharge Planning Conference fee (G14017).*
vi) *Not payable to physicians who are employed by, or who are under contract to a facility, who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
vii) *Visit payable in addition if medically required and does not take place concurrently with clinical action plan.*

2.2.1 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.

2.3 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).

G14017 GP Acute Care Discharge Conference fee

In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to the most responsible GP for that patient following discharge from the acute care facility. This fee is billable when a Discharge Planning Conference is performed 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.

\- per 15 minutes or greater portion thereof..40.00

Notes:

i) Refer to Table 1 for eligible populations.

ii) 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.

iii) Must be performed in the acute care facility and 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).

iv) Face-to-face conferencing is required; the only exception is 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.

v) Requesting care providers 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.

vi) Requires 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.

vii) Fee includes:

a) Where appropriate, interviewing of and conferencing with patient, family members, and other health providers of both the acute care facility and community.

b) Review and organization of appropriate clinical information.

c) 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.

d) 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.

viii) 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.

ix) Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.

x) Claim must state start and end times of the service.

xi) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

xii) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.

xiii) Medically required visits performed consecutive to the Acute Care Discharge Conference are payable.
xiv) Submit the new fee item G14017 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.
xv) Not billable on the same day as Facility Patient or Community Patient Conferencing Fees (G14015 or G14016).
xvi) Not billable on the same day as any GPSC planning fees (G14033, G14043,G14063 (Palliative Planning Fee).

2.3.1 FREQUENTLY ASKED QUESTIONS:

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

2.4 GP Telephone/E-mail Follow-up Management Fee

In order to encourage non-face-to-face communication with patients covered by some of the GPSC incentives, the initial 4 separate telephone/e-mail follow up fees have been simplified into a single code that will still apply to the planning incentives (Complex Care 14033, Mental Health 14043, Palliative Care 14063 & COPD 14053 which requires a COPD Action Plan). Patients covered by one or more of these incentives are eligible for 5 telephone/e-mail services over the 18 months following the billing of the qualifying incentive(s).

G14079 GP Telephone/Email Management Fee $15.00
This fee is payable for 2-way communication with eligible patients, <u>or the patient's medical representative,</u> via telephone or email by the GP who has billed and been paid for at least one of the following GPSC incentives:

- Complex Care Planning Fee (G14033)
- Mental Health Planning Fee (G14043)
- Annual Chronic Care Bonus for COPD (G14053)
- Palliative Care Planning Fee (G14063)

This fee is billable for medical management of the conditions covered under the initial planning/Chronic Care fee. This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

- *i. Payable to a maximum of 5 times per patient per calendar year following the successful billing of G14033, G14043, G14053, or G14063 within the previous 18 months.*
- *ii. Telephone/Email Management requires two-way communication between the patient <u>or the patient's medical representative</u> and physician or medical office staff for the purpose of medical management of the relevant chronic condition(s); it is not payable for simple notification of office or laboratory appointments or of referrals.*
- *iii. Payable only to the physician paid for the G14033, G14043, G14053, or G14063 unless that physician has agreed to share care with another delegated physician. To facilitate payment, a note record should be submitted by the delegated physician.*
- *iv. G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14016.*
- *v. Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016.*

Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

2.4.1 Frequently Asked Questions

1. Why has the GPSC condensed the initial 4 telephone/e-mail follow-up management fees (G14039, G14049, G14069 & G14073) into a single fee?
The GPSC has frequently heard that the billing system is getting very complicated. Having 4 different codes billable for non-face-to-face services for these patient populations created challenges as the code used had to directly relate back to the original incentive billed if more than one incentive had been billed on any single patient. For example, a complex care patient who also suffers an axis 1 mental health condition could have both the 14033 and the 14043 billed, and then depending on the telephone/e-mail service offered, either the 14039 or 14049 had to be billed. Now, regardless which condition(s) are reviewed in these visits, the same fee (14079) is billed.

2. How many non-face-to-face services can I bill for per patient?
There is a limit of 5 non-face-to-face services per calendar year per patient, regardless how many eligible portal incentives were billed. In an average year with 1 planning visit and 2 – 3 in-office follow-up visits, the use of 5 non-face-to-face visits supports services every 1 – 2 months.

3. Do the telephone/e-mail follow-up services count toward the 2 visit requirement in the 12 months prior to billing the CDM incentives?
No. As with the previous telephone/e-mail follow-up fees, these services do not count toward the required visits for the CDM incentives. The CDM incentives require 2 face-to-face visits in the 12 months prior to billing.

4. Why is the GP Telephone/Email Follow-Up Management Fee (G14079) restricted to the GP that has been paid for one or more of the portal incentives (G14033, G14043, G14053 or G14063)?
This fee is designed to allow greater flexibility in providing follow-up to a plan that has been created. The GP that has been paid for the one of the planning incentives (Complex Care Planning, Mental Health Planning or Palliative Care Planning) or the COPD CDM (which requires the use of a COPD Action Plan) in the previous 18 months has also accepted the responsibility of being the Most Responsible GP (MRGP) for that patient's care for these conditions. The planning visits require work, the shouldering of responsibility, and the co-ordination of care. It has considerable value. This fee is therefore restricted to the GP that has created the plan.

5. If the GP Telephone/Email Follow-Up Management Fee is restricted to the GP who has been paid for the eligible portal incentive (G14033, G14043, G14053 or G14063), what do group practices do when they share the care of the patient or when a locum is covering?
An exception has been made, allowing another GP to bill for these fees with the approval of the Most Responsible GP (MRGP). This allows flexibility in situations when patient care is shared between GPs. 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".

If a disagreement arises about the billing of this service, the GP Services Committee will adjudicate based upon whether the Most Responsible GP, i.e the GP paid for the Annual Complex Care Fee, approved or did not approve the service provided. The GP Services Committee feels that this provides the maximum flexibility while still maintaining responsibility.

6. What diagnostic code should I use when billing the G14079?
When billing the G14079, you should use the same diagnostic code as the "portal incentive". For example, if the portal incentive was G14033 for complex care with Dx H250 then this is the diagnostic code to use for the telephone/e-mail services provided for that complex care patient. If the portal incentive was G14043 for mental health planning with a Dx of 311, then this is the diagnostic code to use for the G14079. If both the G14033 (Dx H250) and G14043 (Dx 311) were billed on a patient and a telephone/e-mail service was subsequently provided, use either of the two diagnostic codes submitted with the portal fee, as appropriate to the actual content of the service.

7. Can I bill the Follow-up Management fees if I have billed for one of the eligible portal incentives (G14033, G14043, G14053 or G14063) but have not yet been paid?
Adjudication of this will depend upon whether the GP is eventually paid for the portal incentive. For example, if a GP bills the Annual Complex Care Management Fee (G14033) then provides—and bills for—a follow-up service under G14079 prior to receiving payment for G14033, payment for G14079 will made only if G14033 is subsequently paid to that GP. Until that time it will show as "BH' on the remittance.

8. Can I bill for patients covered by other provinces?
No. This service is not covered under the reciprocal agreement with other provinces.

9. 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.

10. Is this payment eligible for the rural premiums?
No.

2.5 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.

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

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.

2.5.2 G14021, G14022, G14023 – General Practitioners with Specialty Training Telephone Advice Fees

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.*

2.5.3 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

G14015 Facility Patient Conferencing Fee

G14016 Community Patient Conferencing Fee

G14017 Acute Care Discharge Planning Conferencing Fee

G14079 GP Telephone/E-mail Follow-up Management Fee

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

G14021 GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Urgent (less than 2 hour response time)

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

G14023 GP with Specialty Training Telephone Patient Management / Follow-Up

2.6 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:

Date	Time	# of Services	Fee code	Diagnostic Code
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:

Date	Time	# of Services	Fee code	Diagnostic Code
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:

Date	Time	# of Services	Fee code	Diagnostic Code
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:

Date	Time	# of Services	Fee code	Diagnostic Code
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 Facility Patient Conference Fee, the Community Patient Conference Fee and the 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, group home 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 Delerium, 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 specifics) health disciplines. Pregnancy is included as a qualifying condition for this fee. On your claim form use the code for one of the major disorders.

3. Complex Care Management Fees

The GP Services Committee (GPSC) has revised the conditions that are eligible for the Complex Care Incentive, with the following changes effective January 1, 2011:

In recognition of the need to monitor the impact on co-morbidities of those patients with chronic renal conditions (> 6 months duration) who have an eGFR that is not < 60, the "Chronic Kidney Disease" category has been **revised to include those patients with Chronic Glomerulonephritis (greater than 6 months), Polycystic Kidney Disease or Nephrotic Syndrome in addition to those patients with Chronic Renal Failure stages 3, 4 or 5 (eGFR < 60).** Patients who develop an acute but self-limited kidney condition, such as acute Glomerulonephritis, are not eligible for inclusion under the complex care management fees.

The Complex Care Management Fee was developed to compensate GPs for the management of complex patients who have chronic conditions from a least 2 of the 8 categories listed below. There are also fees for up to 5 non-face-to-face encounters during the 18 months following the billing of the complex care management fee. These items are ***payable only to the General Practitioner that accepts the role of being Most Responsible for the longitudinal, coordinated care of that patient; by billing this fee the practitioner accepts that responsibility for the ensuing calendar year.*** The Most Responsible General Practitioner may bill these fees when providing care only to community patients; i.e. residing in their homes or in assisted living/group home with two or more of the following chronic conditions:

1) ***Diabetes Mellitus (type 1 and 2)***
2) ***Chronic Kidney Disease***
3) ***Congestive Heart Failure***
4) ***Chronic Respiratory Condition (asthma, COPD, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)***
5) ***Cerebrovascular disease***
6) ***Ischemic Heart Disease, excluding the acute phase of myocardial infarct***
7) ***Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.)***
8) ***Chronic Liver Disease with evidence of hepatic dysfunction (see FAQ #7)***

On September 1, 2011 changes to the *"Health Care (Consent) and Care Facility (Admission) Act" and other Acts*[1] come into effect. The following changes will impact all healthcare providers. Complex Care Patients will also need to know the potential impact on their care. Advance Care Planning is an essential part of the management of Complex Care Patients, and should be included at the time of the Complex Care Planning visit when clinically appropriate.

- 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

Advance Care Planning:

- 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.

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[1] Representation Agreement Act, Power of Attorney Act, Adult Guardianship Act

- An **Advance Directive may or may not be included in the ACP**. If it is, then health care providers are legally bound by consent refusals in the advance directive. Some exceptions do apply – see the Health Care Providers 'Guide to Consent to Health Care for further information.
- There are four options for Advance Care Plans & "Who Decides":
  Temporary Substitute Decision Makers decides
  Representative decides
  Representative decides using the Advance Directive
  Advance Directive – the adult decides in advance what should be done

Advance Directives:

- Must be made and 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.
- When an Advance Directive is in place, Temporary Substitute Decision maker **is not** sought unless an exception applies
- If there is a legal representative, then decisions are based on the instructions in the Advance Directive. The adult may have instructed through the Representative Agreement that the AD may be followed independent of the representative.
- 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

Billing Eligibility

These payments are available to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months; and:
- Whose majority professional activity is in full service family practice, and
- Who has provided the patient the majority of their longitudinal general practice care over the preceding year, and
- Is the General Practitioner that is most responsible for the ongoing care of the patient over the ensuing calendar year.

Restrictions

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

The Complex Care Management Visit can be provided and billed once at any time in the calendar year. The development of the care plan is done jointly with the patient &/or the patient representative 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.

If a patient has more than 2 of the qualifying conditions, when billing the Complex Care Management Fee the submitted diagnostic code from Table 1 (below) should represent the two conditions creating the most complexity.

Successful billing of the Complex Care Management Fee (G14033) allows access to 5 GP Telephone/email Follow-up fees (G14079) over the following 18 months. Once the Complex Care plan is reviewed and revised in the subsequent calendar year, the allowable G14079 resets to 4 over the following 18 months.

The GPSC strongly recommends accurate ICD-9 Diagnostic Coding when billing for care of these patients throughout the year. ICD-9 diagnostic codes can be downloaded from the Ministry of Health Website at:

http://www.health.gov.bc.ca/msp/infoprac/diagcodes/index.html

3.1 G14033 Annual Complex Care Management Fee $315

The Complex Care Management Fee is advance payment for the complexity of caring for patients with two of the eligible conditions and is payable upon the completion and documentation of the Complex Care Plan for the management of the complex care patient during that calendar year.

A complex care plan requires documentation of the following elements in the patient's chart that:

- there has been a detailed review of the case/chart and of current therapies;
- 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 Complex Care Management Fee is billed;
- specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
- incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;
- outlines expected outcomes as a result of this plan, including any advance care planning for end-of-life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care, their expected roles;
- identifies an appropriate time frame for re-evaluation of the plan;
- confirms 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 health professionals as indicated.

The development of the care plan is done jointly with the patient &/or the patient representative 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.*** See care plan template at end of document.

Notes:

i) Payable once per calendar year;
ii) Payable in addition to office visits or home visits same day;
iii) Visit or CPx fee to indicate face-to-face interaction with patient same day must accompany billing;
iv) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met;
v) G14015, facility patient conferencing fee, not payable on the same day for the same patient, as facility patients not eligible;
vi) G14017, acute care discharge planning conferencing fee, not payable on the same day for the same patient, as facility patients not eligible;
vii) CDM fees G14050/G14051/G14052/G14053 payable on same day for same patient, if all other criteria met;
viii) Minimum required time 30 minutes in addition to visit time same day;
ix) Maximum of 5 complex care fees per day per physician.
x) G14079 – Telephone/e-mail follow up fee is not payable on the same day.
xi) Not payable for patients seen in locations other than the office, home or assisted living residence where no professional staff on site;
xii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

The diagnostic code submitted with 14033 billing must be from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care;

3.2 HOW TO BILL

Have a face-to-face visit with the eligible patient, and/or the patient's medical representative if appropriate;

- Review the patient's history/chart and create a Complex Care Plan including the elements itemized above, which is billable only on the day of a face-to-face visit;

- Over the rest of the calendar year, conduct a review of the Complex Care Plan and provide other follow ups as clinically indicated. Follow-up may be face-to-face or by telephone/e-mail as appropriate, with the appropriate fee being payable.

Step 1. Create a Complex Care Plan G14033- $315

The Complex Care Management Fee acknowledges that eligible patients require medical management that is more time intense and complex. This fee compensates the GP/FP for the creation of a clinical action plan (including Advance Care Planning when appropriate) for the patient as described above, and for the additional complexity of managing these patients for the calendar year in which the Complex Care Plan is billed.

The initial service allowing access shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excluding care facilities) with two or more chronic conditions from two different eligible categories. This requires fulfillment of the itemized elements of service and documentation of these as specified in the fee item above. ***The patient & or their representative or family should leave the planning process knowing there is a plan for their care and what that plan is.***See Complex Care Plan Template below.

The diagnostic code for the Complex Care Management Fee (G14033) must be one of the codes from Table 1 below. If the patient has multiple co-morbidities, the submitted diagnostic code should reflect the two conditions creating the most complexity of care;

Step 2. Provide Office Visit Follow-Up

Visits for the rest of the year are billable under the appropriate MSP fee and with the ICD-9 code of the presenting complaint. Table 1 ICD-9 diagnostic codes should not be used for follow-up services; Table 1 codes were created for billing only the Complex Care Management Fee (G14033).

Step 3. Provide Follow-Up Telephone/Email Management G14079 - $15

These fees allow medical management through 2-way telephone or e-mail communication with the patient and/or the patient's medical representative. These non-face-to-face services are payable to a maximum of 5 times in the 18 months following the successful billing of the 14033. These services will also be applied toward the majority source of care calculation for these patients. ***The Dual Diagnostic codes used when submitting the 14033 submitting the Telephone/Email Management fees must also be used for the follow-up fees.***

Step 4. Using the Diagnostic Codes listed in Table 1

Many software programs in use in B.C. do not allow capture of more than one diagnostic code per billing. Diagnostic codes have therefore been developed to cover all combinations of any two of the chronic condition categories covered under the complex care fees. These codes are listed below, and should be used only when submitting the Complex Care Management Fee (G14033). All follow-up fees should use 'real' ICD-9 codes. When a patient has co-morbidities from more than two categories, the submitted diagnostic code should reflect the two conditions creating the most complexity of care.

Table 1: Complex Care Diagnostic codes

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Congestive Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease (Renal Failure)
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Failure)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Congestive Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease (Renal Failure)
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Failure)
I428	Ischemic Heart Disease	Congestive Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease (Renal Failure)
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Failure)
H250	Congestive Heart Failure	Diabetes
H430	Congestive Heart Failure	Cerebrovascular Disease
H585	Congestive Heart Failure	Chronic Kidney Disease (Renal Failure)
H573	Congestive Heart Failure	Chronic Liver Disease (Hepatic Failure)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease (Renal Failure)
D573	Diabetes	Chronic Liver Disease (Hepatic Failure)
C585	Cerebrovascular Disease	Chronic Kidney Disease (Renal Failure)
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Failure)
K573	Chronic Kidney Disease	Chronic Liver Disease (Hepatic Failure)

3.3 Frequently Asked Questions:

1. What is the purpose of the Complex Care Management Fees?

The Complex Care Management Fees have been created to provide recognition that patients with co-morbid conditions require more time and effort to provide quality care, and to remove the financial barrier to providing this care as opposed to seeing more patients of a simpler clinical condition.

2. What is a Complex Care Plan?

The initial service allowing "portal" access to the complex care fees shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excluding care facilities) with two or more of the above chronic conditions. This plan should be reviewed and revised as clinically indicated. It is essentially an expansion of the SOAP formula for chart documentation. ***The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.***

A complex care plan requires documentation in the patient's chart that:

- there has been a detailed review of the case/chart and of current therapies;
- 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 Complex Care Management Fee is billed;
- specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
- incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the Complex Care Management Fee;
- outlines expected outcomes as a result of this plan, including Advance Care Planning for end-of-life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care, their expected roles;
- identifies an appropriate time frame for re-evaluation of the plan;
- confirms 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 health professionals as indicated.

3. 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.

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

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

5. 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?"

The current Fee-for-Service payment schedule tends to encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.

If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

6. There are many co-morbidities that result in complexity of care. Why is this incentive limited to a list of eight categories of conditions?

Compiling the list of eligible conditions has been difficult, and has required a careful balance. It is apparent that many additional conditions create complexities in providing care, but at the same time the GPSC is contractually required to remain within its budget.

After feedback from the FSFP GPs of BC, effective January 1, 2010, the GP Services Committee's revision of the Complex Care initiative has expanded the number of eligible patients. While asthma and COPD have been combined into a single "Chronic Respiratory Condition", this category has also been expanded to include other chronic respiratory diseases such as Cystic Fibrosis and restrictive airways diseases such as fibrosing alveolitis and pulmonary fibrosis. Also, GPSC has added 2 new disease categories: Chronic Neurodegenerative Disorders and Chronic Liver Disease (with hepatic dysfunction). While there are other conditions that add to complexity, this expansion to 8 categories covers a significant number of the medical co-morbidities that are seen in the population of BC. This list will undergo ongoing review and potential modification in the future.

7. What is the level of abnormal laboratory testing that will qualify my chronic lever patients as having "hepatic dysfunction"?

For the Complex Care Fee, Chronic Liver Disease with hepatic dysfunction will be defined as:

1) 'Chronic' refers to liver disease/dysfunction present for a period of at least six months;
2) 'Chronic Liver Disease with Hepatic Dysfunction' is defined as hepatic disease with evidence of liver dysfunction with the exception of:
    a. Self limiting conditions (e.g. Acute Hepatitis A or B, mononucleosis, CMV, etc.);
    b. Hepatitis carrier states with normal liver function tests;
    c. Benign conditions with elevation of liver function tests (e.g Gilbert's Syndrome, isolated elevation of a liver enzyme without other evidence of hepatic dysfunction)

8. Why did GPSC create "fake" diagnostic codes for the Complex Care Management Fee?

TelePlan requires software to be able to capture more than one diagnostic code, but many versions of software currently used do not support this. To get around this barrier without requiring that many GPs modify their current software, GPSC created different diagnostic codes to indicate different combinations of two eligible criteria. These dual diagnostic codes have been revised this year to reflect the changes and additions to the categories. You will need to review and revise your patient diagnostic code to align with the revisions. Effective January 1, 2010, the new diagnostic codes for these patients must be utilized.

9. What do I do if my patient has more than two of the eligible conditions?
When billing the Complex Care Management fee (14033) use the diagnostic code from Table 1 that indicates the two conditions causing the most complexity. All subsequent visits/services should use the ICD-9 code for the condition requiring the visit/service

10. Am I eligible to bill for the Community Patient Conferencing Fee (G14016) in addition to receiving the Complex Care Management payment(s)?
Yes. If the physician needs to conference with allied health 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 Complex Care Management Payments, provided that the all criteria for the Conferencing fee 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.

11. What is the difference between the GP Telephone/Email Follow-Up Management Fee (G14079) and the Community Patient Conferencing Fee (G14016)?
The GP Telephone/Email Follow-Up Management payment relates to services provided to the patient or the patient's medical representative as indicated. The Community Patient Conferencing Fee relates to services spent conferencing with other health care providers in a 2-way discussion on the provision of care to benefit the patient.

12. Am I eligible to bill for the Chronic Disease Management Fee(s) (G14050/G14051/G14052/G14053) in addition to receiving the Complex Care payment(s)?
Yes. The Chronic Disease Management Fees (G14050, G14051, G14052 and G14053) are independent of the Complex Care fees, and are payable on the same patient as long as the criteria for those fees are met.

13. Are the payments eligible for the rural premiums?
No.

3.4 Complex Care Fees

G14033	**Complex Care Annual Management Fee**	**$315**

3.5 Complex Care Billing Example

Mrs. J. is a 68 year old lady with diabetes, asthma and Parkinson's disease. She has made an appointment to see you in January for her annual review of her care plan that was set up the previous year. You note that the two conditions causing the most complexity are diabetes and asthma, as her Parkinson's is well controlled with medication. You note that her new Dual Diagnostic code is R250. You review her medications and most recent lab tests as well as her peak flow chart. After also checking her diabetes flow sheet, you discuss with her the complex care plan for the remainder of the year and set up an appointment for her to have her complete check up in March when it is due. You also note that her Diabetes CDM (14050) anniversary is coming up at the end of January.

In February, Mrs. J calls when you are on call to advise that her peak flow has suddenly dropped into her low yellow zone after visiting her daughter who has a cat. She tells you that her maintenance dose of Flovent has been 125 mcg twice daily, so you ask her to increase to 250 mcg twice daily and to come in to the office to see you the following day. When you see her, you determine she has had a flare of her asthma but that there is no sign of acute infection, and so advise to continue with the increased Flovent.

You see her again 7 days later and her peak flows have improved. You advise her to stay on this higher dose for the next 2 weeks, and that you will have your office nurse call to check on her.

When contacted in early March, her peak flows have stayed stable and she is advised to go back to her maintenance dose. You see her again in March for her CPX and over the rest of the year for follow up of her complex conditions she is seen in July, October for planned proactive care of her complex conditions and December twice due to a flare of her asthma. In addition, in September, she is seen by you for a bladder infection and treated appropriately. Mrs. J's Diagnostic Code for her Complex Care Management under all options is R250.

The billings for this calendar year for Mrs. J. are:

Month	Service	Fee Code	Dx Code
Jan.	Complex Care Management Planning Visit	14033	R250
		16100	R250
	Diabetes CDM Anniversary	14050	250
Feb.	Phone call	14079	R250
	Office Visit – Asthma flare	16100	493
	Office visit – Asthma flare follow up	16100	493
March	Phone call	14079	R250
	CPX	16101	250
July	Office Visit – proactive follow up	16100	250
Sept.	UTI Office Visit	16100	595
		15130	01L
Oct.	Office Visit – proactive follow up	16100	250
Dec.	Office Visit – Asthma flare	16100	493
	Office Visit – Asthma flare	16100	493

4.0 Prevention

4.1 <u>GPSC Personal Health Risk Assessment Initiative</u>

The Family Physician (FP) is uniquely placed to fit the available health promotion and disease prevention possibilities to the individual patient, based on the FP's knowledge of each patient's personal medical condition, family history, and social, lifestyle and work circumstances. It is also considered that personal customized health plans for patients will be taken a great deal more seriously if they are recommended by a familiar and trusted FP.

Not all actions that may come from an assessment of an individual's risk factors need to be addressed directly by the Family Physician. Many activities that will modify an individual's risk factors can be undertaken with the access of other health care providers. Patient self management has been targeted through the PSP process for chronic diseases, and in fact is necessary for any life style modification to be successful. Support from other providers such as dieticians, advanced practice nurses, nurse practitioners, physician assistants and personal coaches (professional and possible lay coaches as part of behaviour modification processes) can be very beneficial to patients provided the overall coordinator of care is the Family Physician.

In December 2009, the BC the Clinical Prevention Policy Review Committee 2009 report "*A Lifetime of Prevention"* commented that while there has been improvement since the BC Screening report in 2006, there continues to be no comprehensive provincial process that systematically supports the benefit of a number of clinical preventive actions, these ideally being tailored to patients according to age, sex, lifestyle factors, motivation, etc. The BCMA paper *Partners in Prevention: Implementing a Lifetime Prevention Plan* recommended that "the provincial government should fund the lifetime prevention plan primarily through the GP Services Committee, the Specialist Services Committee, and the Shared Care Committee where appropriate." The BCMA paper also recommended that "the Ministry of Health Services should recognize the GP as the primary clinician responsible for the delivery of clinical prevention services offered under the lifetime prevention plan where appropriate" and that "the Ministry of Health Services should recognize the GP as the coordinator of the lifetime prevention plan."

In September, 2010, BC's Provincial Health Officer released the paper "Investing in Prevention Improving Health & Creating Sustainability". In order to reduce the burden of disease on families and communities, the need for health care services, and the impact of disease, disability and premature death on the economy, this report advocates for strengthened provincial strategy for and investment in prevention. The report raises concerns about the increasing prevalence of obesity and weight-related illnesses, such as high blood pressure (hypertension) and Type 2 diabetes across the population. One of the recommendations of this paper was to "Continue to work with the British Columbia Medical Association and other health professional organizations to build a primary care system that will effectively deliver evidence-based lifetime preventive services and integrate prevention into chronic disease management." The BC Guidelines and Protocols Committee (GPAC) will also be releasing a revised "Obesity Guideline" in the near future.

In response to recommendations stemming from the above stated reports a new GPSC prevention initiative will come into effect on January 1, 2011This new initiative will replace the initial prevention incentive that was narrowly focused on Cardiovascular Risk Assessment. The new Personal Health Risk Assessment Incentive will be available to patient populations with the one or more of following risk factors:

* Smoking
* Unhealthy eating
* Physical inactivity
* Medical Obesity

Under this initiative, Family Physicians would initiate Personal Health Risk Assessment visits with these "at risk" patient populations as part of proactive care, or in response to patient request for preventive care from the patient in one of these target populations. The FP is expected to recommend age- and sex-specific targeted clinical preventive actions of proven benefit, consistent with the Lifetime Prevention Schedule (see chart outlining recommended actions) and includes but is not limited to recommendations found in the revised GPAC Obesity Guideline (when available) and Cardiovascular Disease – Primary Prevention Guideline. These lifestyle modification services should be provided in partnership with other community services such as access to appropriate nutritional and exercise programs, counselling or support. The use of patient self-management tools in addition to supportive lifestyle modification services would likely increase the success rate for sustained behavioural change.

G14066 Personal Health Risk Assessment $50.00

This fee is payable to the general practitioner who undertakes a Personal Health Risk Assessment with their patients who belong to one of the designated target populations (obese, smoker, physically inactive, unhealthy eating) either as part of proactive care or in response to a request for preventative care from one of these patients. The GP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative and must be billed in addition to the age appropriate visit fee.

Eligibility:

- Eligible patients are community based, living in their home, with family, in supportive housing or assisted living. Facility based patients are not eligible.
- Payable only to the General Practitioner that accepts the role of being Most Responsible for the 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 or who are under contract to a facility and whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

Notes:

i. Payable only for patients with one or more of the following risk factors: Smoking, unhealthy eating, physically inactive, medical obesity.

ii. Only applicable to services submitted using one of the following diagnostic codes:
Smoking (786), Unhealthy Eating (783), physically inactive (785), Medical Obesity (783)

iii. Requires chart entry documenting discussion and preventative plan of action.

iv. Face to face visit required with patient or patient's medical representative on the same calendar day that the personal health risk assessment is billed.

v. Payable in addition to the office visit billed on the same day.

vi. Not payable on the same day as fee items G14015, G14017, G14033, G14043, G14063.

vii. Payable to a maximum of 100 patients per calendar year, per physician.

viii. Payable once per calendar year per patient.

BC Lifetime Prevention Schedule Recommended Actions

<table>
<tr><th colspan="2">Clinical Condition</th><th>MEN</th><th>WOMEN</th></tr>
<tr><td colspan="2">Colorectal Cancer Screening (Fecal Occult Blood Testing q1-2 years starting age 50)</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Mammography Screening (40-79 yrs, q 1-2 years)</td><td></td><td>•</td></tr>
<tr><td colspan="2">Pap Smear Screening (sexually active until age 69, q 1 – 2 years)</td><td></td><td>•</td></tr>
<tr><td colspan="2">Hypertension Screening</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Hyperlipidemia Screening (Male 40 yr; Female 50 yr or postmenopausal; or sooner if at risk either sex)</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Diabetes Screening (Fasting Blood Sugar at least q 3 yrs age 40 yr or sooner if at risk either sex)</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Discussion of ASA use as clinically indicated (if high risk of Cardiovascular Disease or Stroke)</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Smoking Cessation</td><td>•</td><td>•</td></tr>
<tr><td rowspan="3">Adult Immunization:</td><td>Influenza (Annually if at risk)</td><td>•</td><td>•</td></tr>
<tr><td>Pneumococcal (if ↑Risk q 10 years)</td><td>•</td><td>•</td></tr>
<tr><td>Tetanus /Diphtheria (q 10 years)</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Immunizations for patients < 19 years of age as per age appropriate publically funded schedule</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Diet Modification (if Cardiovascular Disease Risk)</td><td>•</td><td>•</td></tr>
<tr><td colspan="2">Exercise Recommendation (if Cardiovascular Disease Risk)</td><td>•</td><td>•</td></tr>
</table>

4.2 Frequently Asked Questions

1. **Why was the initial prevention fee (cardiovascular risk assessment fee) replaced by the new Personal Health Risk Evaluation fee?**
   In reviewing the various prevention papers that have been released over the past year, the GPSC felt it needed to broaden the prevention target population. The BC Guidelines and Protocols Committee (GPAC) will also be releasing the revised "Obesity Guideline" in the near future. (See Appendix B for links to background documents and resources)

2. **Are there any age restrictions for this new incentive?**
   No, it was felt that due to the broad nature of the target patient population, it would be appropriate to be inclusive of children and adolescents in addition to the adult population, with age appropriate prevention recommendations (eg. Immunization review; diet; exercise; and smoking discussions).

3. **Am I eligible to bill for an office visit, procedure, or conference fee on the same day?**
   Yes. In fact, the incentive must be performed in a face-to-face individual visit with the patient or the patient's medical representative, and as such the age appropriate 00100 must be billed in addition to the G14066.

4. **Is this fee billable in a group medical visit setting?**
   No. The Personal Health Risk Evaluation fee requires a one-on-one personal evaluation of health risks with the patient or the patient's medical representative. It requires the development of a personalized plan of action to address any risks identified. However, medically necessary follow-up of the plan of action may be undertaken in a group medical visit setting.

5. **Why is this fee payable only to the "General Practitioner that accepts the role of being most responsible for the longitudinal coordinated care of the patient for that calendar year"?**
   The mandate of the GP Services Committee is to support and enhance Full Service Family Practice, and this style of practice routinely accepts responsibility for longitudinal, coordinated care of a patient. Also, just as important as the risk evaluation is what is done with that evaluation over the course of time, and that full value is derived from having an ongoing relationship with the patient over time. While the GPSC acknowledges that individual Family Physicians may practice in many different settings, including group practices, the key attributes of primary care indicate that having an individual family Physician who is the main coordinator of care provides the most efficient and effective form of primary health care. It has been shown that it is the Family Physician who is MRP that has the most impact on a patient's willingness to undertake changes in their lifestyle choices and is key to the success and sustainability of those changes.

6. **Is this billable by a locum in my office?**
   Yes. In your absence the locum is providing part of the continuity of care. Locums also have access to 100 prevention incentives per year. This means they must track how many have been billed, so that the total over the year does not exceed 100. The incentives billed by the locum do not count toward the host FP limit, but the host FP must have a conversation with the locum about the circumstances they should be billing this for and what the expectations are from this prevention planning process.

7. **Am I able to bill this on the same patient every year or is there a recommended frequency?**
   In high risk patients a review every year may be appropriate and so this may be billed on the same patient every year. If in your clinical judgment, risk assessments every two or three years would be appropriate, this would free up additional Personal Health Risk Evaluation fees over the 2 – 3 year time period.

8. **If I find a patient at higher risk is willing to make changes, is there any information on where I can refer them for further support?**
   Patients may be referred to a number of support groups and programs that are available within local communities. Programs such as those at local recreation centers, weight-loss management programs, disease specific self-management programs, or telephone support such as HealthlinkBC or QuitNowBC.

   On September 30, 2011, the B.C. government introduced the BC Smoking Cessation Program that is intended to help eligible B.C residents stop smoking or stop using other tobacco products by assisting them with the cost of smoking cessation aids. The program offers coverage for two treatment options: prescription smoking cessation drugs or non-prescription nicotine replacement therapy (NRT) products. The program is open to eligible B.C. residents who wish to stop using tobacco.

Resources on the B.C. Smoking Cessation Program

Patients may not know about the B.C. Smoking Cessation Program. If patients want to learn about the program, you can refer them to:

- the B.C. Smoking Cessation Program Patient Information Sheet(PDF 488K), an easy-to-print downloadable document that provides a high-level overview of the program
- detailed smoking cessation program information for patients on the PharmaCare website, including information on eligibility, coverage and registration procedures for the nicotine replacement therapy gums and patches
- HealthLink BC (phone 8 1 1 and ask for the smoking cessation program)

Resources to help patients plan and manage their stop-smoking activities:

The QuitNow.ca website has a wide range of resources for patients on planning and managing their smoking cessation activities, including:

- information, tips, tools and techniques posted in the QuitNow library
- access to trained CareCoaches®. A phone consultation can be booked at any time of day or night by phoning 8 1 1. More information on CareCoaches® is available online at QuitNow by Phone, a free telephone service offering advice, information and support about quitting smoking. The Quitnow Helpline is staffed from 10am to 6pm. After hours and on weekends, callers are invited to leave a message and a Quit Specialist will return the call during service hours.
- the Quit Now Online community of peer-to-peer support groups
- QuitNow By TXT, a 14-week mobile texting service that provides helpful quit smoking tips and motivational support
- Demonstration videos on how to use nicotine gum and patches

You can also use Quit Now's fax referral program to connect patients with counselors.

Medications covered under the Smoking Cessation program

PharmaCare covers only the following products as part of the Smoking Cessation Program:

1. bupropion (Zyban®, the brand name version for smoking cessation)
2. varenicline (Champix®)
3. Thrive™ NRT chewing gum in two strengths
4. Habitrol® NRT patches in three strengths

Patients are eligible for coverage of one single continuous course of treatment, lasting up to 12 consecutive weeks (84 consecutive days) with either one NRT product or one prescription drug per calendar year. A Special Authority Form is NOT required for the initial prescription in any given year. Under exceptional and compelling circumstances, PharmaCare may provide additional coverage. To request additional coverage, physicians are asked to submit a Special Authority request (using the General Special Authority Request form) (PDF 133K) for exceptional case-by-case consideration.

9. Why does this initiative exclude "physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care"?

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 in lieu of seeing more patients of a simpler clinical condition. 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. Is there any plan to expand this in the future to other patient populations and areas of prevention?

The Clinical Prevention Policy Review Committee 2009 report "*A Lifetime of Prevention*" outlined a proposed mechanism to ensure the specific services recommended in a lifetime prevention schedule remain current with the evidence. As such, the specific recommendations will change over time, and the new initiative has the flexibility to accommodate these changes as additional funding becomes available. While the target population for this new fee is focused on those with one or more of the specified conditions, the GPSC will continue to monitor the effectiveness of the initiative, and as additional funding

becomes available, consideration of expansion into other populations will be discussed at the GP Services Committee.

11. When undertaking a personal health risk assessment, am I to restrict my discussions with the patient to the specific risk factors that made them eligible for the incentive?

No, *the intention of the new personal health risk assessment initiative is to review the prevention interventions recommended in the Lifetime Prevention Schedule as age and sex appropriate for patients in these 4 risk groups*. While the issues that put them into these risk groups are part of the schedule, the incentive is intended to compensate the Family Physician for taking the time to review all appropriate recommendations for that particular patient (eg. Stool testing for Occult Blood, Immunization status, etc) see the table above outlining specific recommended actions from the BC Lifetime Prevention Schedule.

12. Must I use a flow sheet or paper Risk Scoring Sheet?

While there is no specific flow sheet or risk scoring sheet that is required for the personal health risk assessment, there are a number of tools available to use as a template when providing this service. See Appendix B for links to these resources.

13. Are the payments eligible for the rural premiums?

No.

Appendix A – Resources for Additional Patient Support

1. Hypertension GPAC Guideline Lifestyle Change recommendations
bcguidelines.ca/gpac/pdf/hypertension_appendix_d.pdf

2. Quit Now
quitnow.ca/
or
bc.lung.ca/smoking_and_tobacco/quit_now.html

3. BC Healthy Living Guide for patients
bcguidelines.ca/gpac/pdf/healthy_active_pg.pdf

4. ActNow including:
- **i. Health Eating**
- **ii. Physical Activities**
- **iii. Seniors**
- **iv. Health Schools**

actnowbc.ca/

5. Aboriginal ActNow BC
aboriginalactnow.ca/

6. Healthy choices in Pregnancy (Component of Act Now Platform)
hcip-bc.org/

7. Dietician Services at HealthLink (formerly Dial-a-dietician)
healthlinkbc.ca/dietitian/

8. BC Recreation and Parks Association Walking programs (in partnership with ActNow)
bcrpa.bc.ca/walking/

9. Walk BC
walkbc.ca/activities-programs

10. BC Heart and Stroke Foundation – Health Living
heartandstroke.bc.ca/site/c.kpIPKXOyFmG/b.3644425/k.94E9/Healthy_Living.htm

11. Screening Mammography Program
http://www.bccancer.bc.ca/PPI/Screening/Breast/default.htm

Appendix B – Background Documents and Resources

1. Lifetime Prevention Schedule
health.gov.bc.ca/library/publications/year/2009/CPPR_Lifetime_of_Prevention_Report.pdf

2. BCMA "Partners in Prevention: Implementing a Lifetime Prevention Plan"
bcma.org/files/Prevention_Jun2010.pdf

3. GPAC Guidelines

- **i. Cardiovascular Disease Primary Prevention**
  bcguidelines.ca/gpac/guideline_cvd.html

- **ii. Preventative Health**
  bcguidelines.ca/gpac/submenu_preventative.html

- **iii. Revised Obesity Guideline – TBA**
- **iv. Detection of Colorectal Neoplasms in Asymptomatic Patients**
  http://www.bcguidelines.ca/gpac/pdf/colorectal_det.pdf
- **v. Mammography**
  http://www.bcguidelines.ca/gpac/pdf/mammo.pdf

4. Revised WHO Child Growth Standards (2010)
dietitians.ca/growthcharts

5. College of Family Physicians of Canada Preventive Care including:

- **i. Greig Health Record (ages 6 – 17)**
- **ii. Pan-Canadian physical activity strategy**
- **iii. Preventive Care Checklist Forms**
- **iv. Preventive Medicine**
- **v. Rourke Baby Record**

http://www.cfpc.ca/HealthProfessionalResources/?filter=139

6. SGP Chronic Disease Prevention Flow Sheet (SGP Members sign in to access)
http://www.sgp.bc.ca/billing.php

7. BC Childhood Immunization Schedule

i. SGP Immunizations patients 18 and younger billing information (SGP Members sign in to access)
http://www.sgp.bc.ca/billing.php
ii. MOH/HealthLink BC
http://www.healthlinkbc.ca/immunization.stm

8. Other Flow Sheets
impactbc.ca/files/documents/Flowsheet_-_Prevention.pdf

4.3 Billing Scenarios

Case 1. Miss K is a 16 year old patient who has come in to see you due to severe dysmenorrhea. Her periods are very regular at 28 – 30 days. She has not tried any over the counter medications but is thinking she might want to start the birth control pill as her best friend went on it for this reason and has had a great decrease in the cramps. She is 5 ft 3 inches with a weight of 180 lbs which calculates to a BMI of. She does not smoke. She does not participate in any formal exercise program but does like to swim and has in fact passed her bronze cross in swimming. Miss K has no past medical history of illnesses or surgery. There is a family history of diabetes in her mother and maternal grandmother but no other significant family history. In asking further questions, you find she does not have a boyfriend and has not yet been sexually active. She did not have the HPV vaccine in school as her mom was not sure of this. Her other immunizations are up to date. You review the pro's and con's of HPV and give her some information to take home for her parents to read and encourage them to come in to discuss this further if they feel it is appropriate for her to be immunized. You are aware that her family does have extended benefits so this would be covered if they chose to go ahead with it.

On examination, her BP is 115/70. You discuss the pro's and con's of oral contraceptives for dysmenorrhea. You also discuss with her the concern of further weight gain from the pill and she admits she wants to try and lose some weight that has accumulated since puberty. After reviewing her options, she agrees to try naproxen 220 mg for the dysmenorrheal and to start swimming three times per week. Since here friend also likes to swim, she will see if they can do this together. You advise her to return after the next two menstrual cycles to see if the naproxen is working and to weigh her again.

When seen 2 ½ months later with her mother, she finds that the naprosyn has worked very well for her cramps. She has been swimming 3 – 4 times per week at the local pool as there is a lower rate for students under a local program aimed at increasing youth activity and fitness. She has lost 8 lbs and has also been following a more balanced. She feels great. Her mom notes that they have decided to undertake the HPV vaccination after reading the literature. You advise her that since this is now outside the provincially funded ages, it is an uninsured service. She agrees to fill a prescription and return for the injection after school the next Friday. No other service is provided at that time.

The billings for Ms. K are:

Service #	Service	Fee Code	Dx Code
1	Office Visit Personal Health Risk Assessment	00100 14066	783 783
2	Office visit	00100	626
3	Uninsured Visit for HPV immunization – no other service	00010 – private rate	33A

Case 2. Mr. D is a 36 year old patient who presents to your office in March with concerns about his health as he is a smoker and has a body weight above ideal (BMI 35). He and his wife have just had newborn twins and he knows that he needs to make some changes in his lifestyle to ensure he sees them grow up. He has a family history of Coronary Artery Disease with both his father and a paternal uncle having had heart attacks before they were 60. His Past History is negative for any medical conditions and his only surgical history is that of an appendectomy at age 10, but he has not seen you for the past 5 years. He has not had a tetanus shot since becoming and adult and has never had the flu shot either. You discuss the need to update his Tetanus immunization but also the recommendation that he should have the flu shot annually in the fall due to the presence of infant children in the home. He agrees to have the Tetanus shot that same day, which you provide for him. He feels he is ready to seriously consider stopping smoking as he has read about the impact on childhood asthma and other illnesses if there are smokers in the home.

On examination, Mr. D's BP at this time is 170/95 and his pulse is 88 and regular. He has no history of chest pain or dyspnea. You review his status send him for blood work including a CBC, Fasting Blood Sugar, Lipid profile, Creatinine, Electrolytes and TSH. You advise him to do home BP checks and to write them down in a notebook and return to see you for a complete physical examination. You discuss with him the various options for stopping smoking and refer him to the QuitNow program for more information.

When Mr. D returns 2 weeks later for his physical examination, you review his BP readings at different times during the day, and find his systolic levels range from 150 – 180 and diastolic from 90 – 105 (Mostly ~ 165/100). His BP at the time of his CPX is 170/100 and pulse is 82. The rest of the examination of all systems is unremarkable. You advise him to dress and when you return, you review your findings and his efforts to stop smoking. His labs are as follows:

FBS	5.2
Total Cholesterol	6.8
HDL Cholesterol	0.88
LDL Cholesterol	4.1
Triglycerides	1.80
Creatinine	105
Lytes, CBC, TSH	Normal

After advising Mr. D of the limitations of the Framingham Risk Scoring sheet, you calculate that his Total points are 9. This gives him an estimated 10 year CHD risk of 20%. With the low 10 year CHD risk for the population of 3%, his relative risk is 7 times that of the low 10 year population risk. You discuss this relative risk and the areas that he can change through lifestyle interventions. He has checked out the information on the QuitNow website and is preparing to stop smoking. He also agrees to undertake some exercise and diet changes, including reducing his salt intake. At this visit you give him a copy of your BP management sheet which has space for him to track his home BP. After the visit, you enter him in your CDM registry as he fulfills the criteria for hypertension.

He returns for follow up of his lifestyle interventions in 3 months, and his BP has only decreased to 155/95 at home on an average. You undertake a BP true reading and find his average is 155/100 today. He has been cigarette free for 4 weeks. He has lost 10 lbs and is walking every day. You discuss the risks and benefits of using medication for his hypertension given his family history. He agrees to start medication. You reassess him in 3 monthly intervals until his BP is at an acceptable level (home readings averaging 125/80), by which time he has lost another 15 lbs. This has taken almost 10 months from the diagnosis of his hypertension. You provide his flu shot in the fall. At this time you advise him it is appropriate to repeat his laboratory testing before his next visit. At that follow-up exam, his BP is 120/80, and his lipids have also improved. You encourage him to maintain his new lifestyle choices, and follow his hypertension every 3 – 6 months as clinically indicated. Since it has been 1 year since the diagnosis of hypertension, you are eligible to bill the hypertension CDM.

The billings for Mr. D are:

Service #	Service	Fee Code	Dx Code
1	Office Visit Personal Health Risk Assessment	00100 14066	786 786
2	CPX for hypertension	00101	401
3	Office Visit	00100	401
4	Office Visit	00100	401
5	Office Visit	00100	401
6 (2nd Calendar year)	Office Visit Hypertension CDM	00100 14052	401 401

5. GP Obstetrical Delivery Bonuses

This program is a continuation and expansion of the Full Service Family Practice Obstetrical Care Incentive Program introduced in 2003. It provides a 50% bonus on the MSC Payment Schedule delivery fee codes 14104, 14105, 14108 and 14109. The purpose of the payment is to encourage full service family practitioners to continue to provide obstetrical care, giving women the benefit of choice and longitudinal care.

5.1 GP Obstetric delivery bonus associated with vaginal delivery and postnatal care (G14004)

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care
ii) Payable only when fee item 14104 billed in conjunction
iii) Maximum of one bonus per patient delivered
iv) Maximum of 25 bonuses per calendar year under fee item 14004, 14005, 14008, 14009 or a combination of these items.

5.2 GP Obstetric delivery bonus associated with Management of labour and transfer for delivery to a higher level of care facility (G14005)

Notes:

ii) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care
ii) Payable only when fee item 14105 billed in conjunction
iii) Maximum of one bonus per patient delivered
iv) Maximum of 25 bonuses per calendar year under fee item 14004, 14005, 14008, 14009 or a combination of these items.

5.3 GP Obstetric delivery bonus associated with post natal care after an elective c-section (G14008)

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care
ii) Payable only when fee item 14108 billed in conjunction
iii) Maximum of one bonus per patient delivered
iv) Maximum of 25 bonuses per calendar year under fee item 14004, 14005, 14008, 14009 or a combination of these items.

5.4 GP Obstetric delivery bonus associated with attendance at delivery and postnatal care associated with emergency caesarean section (G14009)

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care
ii) Payable only when fee item 14109 billed in conjunction
iii) Maximum of one bonus per patient delivered
iv) Maximum of 25 bonuses per calendar year under fee item 14004, 14005, 14008, 14009 or a combination of these items

Eligibility:

The incentive payments are available to all general practitioners in B.C. who:

- in addition to being paid the delivery fee items 14104, 14108 and 14109 for the patient,
- provides the maternity care and is also responsible, or share responsibility, for providing the patient's general practice medical care.

Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

5.5 FREQUENTLY ASKED QUESTIONS

1. When I submit a claim for the bonus payment on fee items 14104, 14108 or 14109, what is the exact amount of the payment?

The obstetrical care bonus payment is to be claimed using specific fee codes:

- Fee code 14004 with item 14104
- Fee code 14005 with item 14105
- Fee code 14008 with item 14108
- Fee code 14009 with item 14109

Each will be paid at 50% of the appropriate delivery fee code.

A maximum of twenty five (25) services under fee item 14004, 14005, 14008 or 14009 may be claimed in a calendar year. Multiple incentives may now be billed on any given day, provided the annual maximum of 25 is not exceeded.

2. How is the bonus billed?
In addition to billing 14104 (Delivery and post-natal care) a 14004 would be billed. If billing 14105 (Management of labour and transfer for delivery to higher level of care facility) a 14005 would be billed. If billing a 14108 (GP elective C-section and post partum care (not the surgical assist fee) a 14008 would be billed. If billing 14109 (Delivery and postnatal care associated with emergency caesarean section) a 14009 would be billed, with the appropriate three-digit ICD-9 code, in order to receive the bonus. The maximum number of bonuses payable per calendar year is 25. They may be claimed under fee item 14004, 14008 or 14009 or a combination of these items but the combined total must not exceed 25.

3. How many bonuses may I bill in each calendar year?
You may bill bonuses for up to 25 deliveries in each calendar year. This is for any combination of 14004, 14005, 14008 and 14009. (eg. 20 X 14004 + 5 X 14009 = 25 bonuses total)

4. Is the delivery bonus for the first 25 deliveries of the year?
No. It is for any combination of deliveries up to a maximum of 25 in a year. It is up to the individual GP to decide which deliveries to bill the bonuses on, provided the combined total of all bonuses does not exceed 25 in a calendar year.

5. Am I able to claim this new bonus for post-natal care following an elective C-Section in addition to the 25 delivery bonuses per year?
No. Any individual GP may bill up to 25 bonuses per year in total. These can be any combination of 14004, 14008 and 14009, but the combined total of all bonuses cannot exceed the annual maximum of 25 per year. It is up to the individual GP to decide which deliveries to bill the bonuses on, provided the combined total of all bonuses does not exceed 25 in a calendar year.

6. If I am limited to a total of 25 bonuses per year, why would I choose to bill the smaller 14008?
Most GPs providing obstetrics do not deliver more than 25 patients per year, so the 14008 allows them to bonus all their deliveries, regardless of type or number in any one day, to a maximum of 25 per calendar year. A physician may choose whether to bill the 14008 or to wait for a future delivery to bill the higher 14004 or 14009.

7. What happens if I have billed for 14008, and later go over my limit of 25 bonuses per calendar year so I 'miss out' on billing the higher 14004 or 14009?
You can submit an electronic debit request to reverse the payment on a 14008, then subsequently bill the 14004 or 14009 if you qualify.

8. Are locums able to bill this bonus?
Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.

9. In practice situations where a patient's care may be shared amongst partners is the bonus still applicable? If so, who bills it?
The physician performing the delivery (14104), attendance at labour and transfer for delivery to a higher level of care facility due to complications of labour (14105) or attendance at delivery and post natal care associated with a c-section (14109) may bill fee item 14004, 14005 or 14009. Practice groups providing on call patient coverage or access to patient records are considered to be sharing the responsibility of that patient's care and are eligible to bill one bonus for the patient. Fee item 14008 is payable to the physician who provides the maternity care_and is responsible for or shares the responsibility for providing the patients general practice medical care and who provides post natal care after an elective c-section (fee item 14108).

10. If a GP refers a patient to me for only the maternity care, am I eligible to bill the bonus?
Yes. GPs specializing in general practice/obstetrics who receive referrals from other GPs for maternity care are considered to share in the general practice medical care of the patient, and so are eligible for this bonus even if the patient returns to the referring GP after the postpartum care.

11. Is the bonus billable if a delivery is performed during an on-call shift for a partner's patient?
Yes. This is considered shared care and eligible for one bonus per patient.

12. How is the bonus applied to multiple births?
Multiple births are considered one delivery, and thus eligible for one bonus.

13. Can I bill for delivering mothers covered by other provinces?
Yes. B.C. has a reciprocal billing agreement with other provinces except Quebec. Treat patients from other provinces (except Quebec) who have their babies in B.C. as though they were B.C. residents.

14. Can I still bill the payment if another doctor helps me with complications?
As long as you attend the delivery of the baby (or are prepared to until the need for an emergency c-section) and submit a claim for fee item 14104 or 14109 you may bill for the obstetrical bonus.. If another doctor helps by performing a forceps rotation, emergency c-section, or other additional procedure you are still eligible.

15. Can I still bill the payment 14005 if a doctor in another facility does the delivery?
As long as you attended the labouring patient and was prepared to do the delivery until the need for transfer to another facility of higher level of care (i.e. From facility without C/S capability to facility with C/S capability) and submit a claim for fee item 14105 you may bill for the obstetrical bonus 14005. If another doctor has performed a forceps rotation, emergency c-section, or other additional procedure you are still eligible.

16. Is this payment eligible for rural premiums?
Yes.

17. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the obstetrical premium payments?
Yes. When claiming for the obstetrical delivery bonus associated with vaginal delivery and post natal care, submit an encounter record for the vaginal delivery (14104) along with a fee for service claim for the obstetrical delivery incentive bonus (14004). When claiming for the obstetrical delivery bonus associated with attendance at delivery and post natal care for an emergency c-section (14109), submit an encounter record for 14109 along with a fee for service claim for the obstetrical delivery bonus (14009). When claiming for the GP elective c-section and postpartum care (14108), submit an encounter record for 14108 along with a fee for service claim for the obstetrical delivery bonus (14008). If a fee for service claim is submitted for 14104, 14108 or 14109, it will be refused or withdrawn as this service is funded through the alternative payment arrangement.

18. Are Emergency Room physicians eligible for this payment?
No. Emergency room physicians who happen to be on duty and deliver a baby have not shared the general practice maternity care.

5.6 GP Obstetrical Bonus Fees

G14004 GP Obstetric delivery bonus - vaginal delivery and postnatal care — 50% value 14104
G14005 GP Obstetric delivery bonus - Management of labour and transfer for delivery to a higher level of care facility — 50% value 14105
G14008 GP Obstetric delivery bonus - post natal care after an elective c-section — 50% value 14108
G14009 GP Obstetric delivery bonus - attendance at delivery and postnatal care associated with emergency caesarean section — 50% value 14109

6. Maternity Network Incentive (G14010)

Eligible general practitioners can receive a quarterly payment each quarter ending March 31, June 30, September 30 & December 31 (which includes additional CMPA subsidy with an approximate value of $650 per year) to cover the costs of group/network activities for their shared care of obstetric patients. Effective December 31, 2009, the maternity network payment has been increased to $2100 each quarter.

Eligibility:
To be eligible to be a member of the network, you must, for the complete three-month period up to the payment date:

- Be a general practitioner in active practice in B.C.;
- Have hospital privileges to provide obstetrical care;
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care – see below). Refer to the Maternity Network Registration Form included in this workbook;
- Cooperate with other members of the network so that one member is always available for deliveries;
- Make patients aware of the members of the network and the support specialists available for complicated cases;
- Accept a reasonable number of referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy; the referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care);
- Share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic prenatal record; and
- Each doctor must schedule at least four deliveries in each six month period of time.

6.1 Frequently Asked Questions

1. How do I register as a maternity network?

Please complete the Maternity Network Registration Form (see copy at end of this document). Additional copies are available at: https://www.bcma.org/gpsc-maternity-network-initiative or http://www.health.gov.bc.ca/cdm/practitioners/index.html.

Registering as a member of a maternity care network provides opportunities for enhanced communication and dialogue among B.C.'s GPs providing this important service. If desired, GPs registering as a network will receive pertinent updates from the GP Services Committee and other organizations on maternity care supports, resources, and CME opportunities available in the province.

2. How do I claim payments?

After a quarter in which you have met the eligibility criteria, submit a claim along with your usual claims through TelePlan. (Only payable to registered members of a maternity network.). Effective December 31, 2006 use the following values in the claim:

- In the Fee item field: 14010 Claim amount: $2,100.00 as of December 31, 2009
- In the patient's PHN field: 9824870522
- In the Last name field: Maternity
- In the First initial field G
- If you require a date of birth, use: 2 November 1989
- For Date of service use: last day in a quarter
- Report the Diagnosis as: V26 (ICD-9 code for "procreative management")

Notes:

- Claims received for processing before the date of service, or with a date of service other than the last day in a quarter will be refused.

3. What if I cannot find three other doctors to form a network?

If fewer than four general practitioners deliver babies at your hospital or, if there are other extenuating

circumstances, request an exemption by faxing to: Administrator, Maternity Care Network Initiative, 1-800-952-2895 (toll free). Exemptions may be granted for up to one year.

4. Does participating in this program mean the network members are on call for obstetrics for the community?

No. This is not an on call program. Although one eligibility criterion requires cooperation within the network to ensure that one member is always available for deliveries, participating in this program does not require you to be on call for patients outside your group.

5. Is the payment per doctor or per group?

As of June 30, 2006 the quarterly payment was initially set at $1,250. Effective December 31, 2009, the payment was increased to $2,100 per doctor.

6. Do we have to advertise that we accept referrals?

No, word of mouth is sufficient.

7. What if a doctor delivers 5 babies in one month, then none in the next seven months?

The condition of scheduling at least four deliveries in every six-month period seemed reasonable in ensuring a doctor was in active obstetrical practice. If this situation arises during the program, let the administrator know and the GP Services Committee will review the situation.

8. Is this payment eligible for rural premiums?

No.

9. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the maternity network payments?

Yes.

7. COMMUNITY-BASED MENTAL HEALTH INITIATIVE

Family physicians will identify their high-risk patients living in the community (i.e. home, assisted living or group home) who meet the following criteria:

i) Axis I diagnosis confirmed by DSM IV criteria;
ii) Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan to maintain the patient safely in the community would be appropriate

Additional factors that increase risk include drug or alcohol addiction, cognitive impairment, poor nutritional status, and socioeconomic factors such as homelessness. Given these factors, the approach to be encouraged is to manage the whole patient, not the disease.

The physician will need to accept the role of being Most Responsible for the longitudinal, coordinated care of that patient for the ensuing calendar year.

The Mental Health Planning Fee and resulting access to an increased number of billable GP management/counseling fees is intended to recognize the significant investment in time and skill such clients/patients require in General Practice. These Fee items are intended to acknowledge the vital role of the GP in supporting patients with mental illness and addictions to remain safely in their home community. Once the Mental Health Plan is developed, GPs are encouraged to collaborate with community mental health resources, in providing longitudinal mental health support for these patients across the spectrum of care needs. This networking is complementary to and eligible for the Community Patient Conferencing Fee (14016) if all other requirements are met.

The initial GP/FP service providing 'Portal' access to the mental health care management fees shall be the development of a Mental Health Care Plan for a patient with significant mental health conditions residing in their home or assisted living (excluding care facilities).

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

From these activities (review, assessment, planning and documentation) a Mental Health Care Plan for that patient will be developed that documents in the patient's chart (see care mental health plan template in Appendix 1):

- that there has been a detailed review of the patient's chart/history and current therapies;
- the patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- the use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
    - i) PHQ9, Beck Inventory, Ham-D for depression;
    - ii) MMSE for cognitive impairment;
    - iii) MDQ for bipolar illness;
    - iv) GAD-7 for anxiety;
    - v) Suicide Risk Assessment;
    - v) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
- DSM-IV Axis 1 confirmatory diagnostic criteria;
- a summary of the condition and a specific plan for that patient's care;
- an outline of expected outcomes;
- outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists) as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- an appropriate time frame for re-evaluation of the Mental Health Plan;

- that the developed plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other health professionals as indicated. ***The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.***

Once the Mental Health Plan has been created, the General Practitioner or practice group can access two additional supports:

1) GP Mental Health Management Fees, an additional four (4) visit fees equivalent to the current age differential 00120 series. These fees are billable after the current 4 Counselling Visit per year (00120 fees per MSP guide to fees) have been billed.

2) GP Telephone/Email Management Fees (G14079); access to telephone/email follow-up fees to allow flexibility in providing non-face-to-face management/follow-up for these patients. These telephone/email follow-up services may be provided by the physician or other medical professionals that are directly under the family physician or practice group's supervision (e.g. MOA or Office nurse). The telephone follow up care fee is to be used for providing clinical management such as medication, symptom, and clinical status monitoring. It is not for simple appointment reminder or referral notification. The telephone management fee may be billed up to a maximum of 5 times in the 18 months following the successful billing of the 14043, for either physician-initiated or patient-initiated follow up.

   The GP Telephone/Email Management Fee may be billed on the same day as the community patient conferencing fee (14016) provided all other criteria are met, but the time spent with the patient on the telephone does not count toward the time requirement of the conferencing fee.

Access to these supportive fees is restricted to the GP that has been paid for the Mental Health Planning Fee (G14043) and is therefore Most Responsible GP (MRGP) for the care of that patient for the submitted Axis 1 condition. The only exception would be if the billing GP has the approval of the Most Responsible GP (eg. locum or shared coverage), and this must be documented as a note entry accompanying the billing.

Eligibility

- Eligible patients must be community based, (living in their home or assisted living). Facility based patients are not eligible.
- Payable only to the General Practitioner who accepts the role of being Most Responsible for the 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 or who are under contract whose duties would otherwise include provision of this care;
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

7.1 GP Mental Health Planning Fee (G14043)

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients resident in the community (home, assisted living or group home, excluding care facilities) with a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan. This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- that there has been a detailed review of the patient's chart/history and current therapies;

- the patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- the use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
  - i) PHQ9, Beck Inventory, Ham-D for depression;
  - ii) MMSE for cognitive impairment;
  - iii) MDQ for bipolar illness;
  - iv) GAD-7 for anxiety;
  - v) Suicide Risk Assessment;
  - v) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
- DSM-IV Axis 1 confirmatory diagnostic criteria;
- a summary of the condition and a specific plan for that patient's care (template in Appendix 1);
- an outline of expected outcomes;
- outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists) as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- an appropriate time frame for re-evaluation of the Mental Health Plan;
- that the developed plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other health professionals as indicated. ***The patient & 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 mental health status and diagnosis by means of psychiatric history, mental state examination, and confirmatory DSM IV diagnostic criteria. Confirmation of Axis 1 Diagnosis is required for patients eligible for the GP Mental Health Planning Fee. *Not intended for patients with self limiting or transient mental health symptoms (e.g. Brief situational adjustment reaction, normal grief, life transitions) for whom a plan for longer term mental health care is not necessary.*
  - ii) Payable once per calendar year per patient;
  - iii) Payable in addition to a visit fee billed same day;
  - iv) Minimum required time 30 minutes. This time does not count towards visit fee same day;
  - v) G14016, community conferencing fee payable on same day for same patient, if all criteria met;
  - vi) Not payable on the same day as G14044, G14045, G14046, G14047, G14048 (GP Mental Health Management Fees);
  - vii) Not payable on the same day as G14079 (GP Telephone/Email Management fee)
  - viii) Not intended as a routine annual fee if the patient does not require ongoing Mental Health Plan review and revision;
  - ix) G14015, Facility Patient Conferencing Fee, not payable on same day for same patient as facility patients are not eligible.

7.2 GP Mental Health Management Fees

GP Mental Health Management Fee age 2–49 (G14044)
GP Mental Health Management Fee age 50–59 (G14045)
GP Mental Health Management Fee age 60–69 (G14046)
GP Mental Health Management Fee age 70–79 (G14047)
GP Mental Health Management Fee age 80+ (G14048)

These fees are payable for GP Mental Health Management required beyond the four (4) MSP counselling fees (age-appropriate 00120 fees billable under the MSP guide to fees) for patients with a chronic mental health condition on whom a Mental Health Plan has been created and billed. Access to this fee is restricted to the GP that has been paid for the Mental Health Planning Fee (G14043) and is therefore Most Responsible GP (MRGP)

for the care of that patient for the submitted Axis 1 condition. The only exception would be if the billing GP has the approval of the Most Responsible GP, and this must be documented as a note entry accompanying the billing.

Notes:

i. Payable a maximum of 4 times per calendar year per patient;
ii. Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician;
iii. Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician;
iv. Not payable unless the age-appropriate 00120 series has been fully utilized;
v. Minimum time required is 20 minutes; this time does not count towards GP Mental Health Planning Fee if performed same day;
vi. Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14079 (GP Telephone/Email Management Fee);
vii. G14016 (Community Patient Conferencing Fee) payable on same day or same patient if all criteria met;
viii. G14015 (Facility Patient Conferencing Fee) not payable on same day as facility patients not eligible;
ix. CDM fees (G14050, G14051, G14052, G14053) payable if all criteria met.

7.3 Frequently Asked Questions:

1. What is the purpose of the Mental Health Initiative Fees?

Family Physicians provide the majority of mental care in BC. This is time consuming and is often not adequately compensated, so the Mental Health fees have been created to provide compensation for the provision of this care. Additionally, there is known benefit from having a longer planning visit with patients suffering from chronic mental health conditions and this initiative was developed to remove the financial barrier to providing this care, as opposed to seeing a greater number of patients with simpler clinical conditions.

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 are unable to provide their residents with nursing and other health support. Group homes are also classified as a form of assisted living. 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, in assisted living or group home?

While there may be exceptions, patients resident in a facility such as a Psychiatric 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. Patients residing in their homes or in assisted living/group home 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 Mental Health Planning Fee (14043)?

This fee is payable once per calendar year per patient. The GP may bill this fee upon:

1) confirmation through DSM IV criteria that a patient has an Axis I disorder;
2) determined that the severity and acuity level of this Axis I disorder is causing sufficient interference in activities of daily living that developing a management plan to maintain the patient safely in the community would be appropriate, and
3) creation of a Mental Health Plan for that patient that includes all of the elements outlined in fee G14043

5. What is a Mental Health Plan?

The initial service allowing access to the mental health care fees shall be the development of a Mental Health Plan for a patient residing in their home, assisted living or group home (excludes care facilities) with a diagnosed Axis One mental health condition. This plan should be reviewed and revised as clinically indicated. Creation of a Mental Health Plan requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric

history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria (See information following FAQs). It requires a face-to-face visit with the patient, with or without the patient's medical representative. ***The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.***

From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- that there has been a detailed review of the patient's chart/history and current therapies;
- the patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- the use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
    - i) PHQ9, Beck Inventory, Ham-D for depression;
    - ii) MMSE for cognitive impairment;
    - iii) MDQ for bipolar illness;
    - iv) GAD-7 for anxiety;
    - v) Suicide Risk Assessment;
    - vi) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
- DSM-IV Axis 1 confirmatory diagnostic criteria;
- a summary of the condition and a specific plan for that patient's care;
- an outline of expected outcomes;
- outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists) as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- an appropriate time frame for re-evaluation of the Mental Health Plan;
- that the developed plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other health professionals as indicated.

6. When can I bill the Mental Health Management Fees (14044-14048)?
The MSP counselling fees (the 00120 series) are limited to 4 visits per patient per calendar year. Managing patients with a significant mental health diagnosis, however, may require more than 4 counselling visits per year. The GPSC Mental Health Management fees provide an additional 4 counselling visits per calendar year to provide counselling to these patients. They are payable only after all 4 MSP counselling fees of the 00120 series have been utilized and only if the GP has billed and been paid for the Mental Health Care Planning Fee. They are payable to a maximum of 4 times per calendar year, at the same rate as the age-appropriate 00120 series counselling fee.

7. When can I bill the GP Telephone/Email Management fee?
There is evidence that the follow-up of patients with significant mental illness does not always need to be face-to-face or by the physician. This new fee (**14079**) 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 Mental Health Planning Fee (G14043). This fee is payable only if the GP or practice has billed and been paid for at least one of the portal GPSC incentives, including the Mental Health Planning Fee (G14043).

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 Community Patient Conferencing Fee (G14016) in addition to receiving the Mental Health Care payment(s)?

Yes. The mental health care payment(s) relates to services provided to the patient. The new "Mental Health Management Fees" (G14044-14048) for non-face-to-face care still relates to the services provided to the patient. If it is appropriate for some of this care to be provided by phone, then the physician is compensated for this. If as a result of the Mental Health Planning visit (G14043), follow up Mental Health Management visit (G14044-14048) or as a result of the GP Telephone/Email Management (G14079), the physician needs to conference with allied health 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 mental health care payments. It is payable on the same day as long as all criteria are met. The time spent on the phone with the patient for the GP Telephone/Email Management (G14079) does not count toward the total time billed under the Community Patient Conferencing Fee (G14016).

10. Am I eligible to bill for the Chronic Disease Management Fee(s) (G14050, G14051, G14052, G14053) in addition to these Mental Health Initiative fees?

Yes. Patients with mental health diagnoses still often have co-existing medical conditions. For those patients with Diabetes (G14050), Congestive Heart Failure (G14051), Hypertension (G14052) or COPD (G14053), the appropriate CDM payment(s) are payable in addition to the Mental Health Care payment(s). See CDM section for rules for billing of CDM incentives for patients with multiple comorbid conditions.

11. If the GP Mental Health Management fees (G14044-14048) are restricted to the GP who has been paid for the Mental Health Planning Fee (G14043), what do group practices do when they share the care of the patient, or when a locum is covering?

An exception has been made, allowing another GP to bill for these fees with the approval of the Most Responsible GP (MRGP). This allows flexibility in situations when patient care is shared between GPs. 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".

If a disagreement arises about the billing of this service, the GP Services Committee will adjudicate based upon whether the Most Responsible GP, i.e the GP paid for the Annual Complex Care Fee, approved or did not approve the service provided. The GP Services Committee feels that this provides the maximum flexibility while still maintaining responsibility.

12. Can I access the Mental Health Management fees if I have billed for the Mental Health Planning fee but have not yet been paid for it?

Adjudication of any billings for Mental Health Management fees will depend upon whether the GP is eventually paid for the Mental Health Care Planning Fee. In other words, if a GP bills for the Mental Health Planning Fee (G14043) and provides—and bills for— a follow-up Management service under G14044, G14045, G14046, G14047, G14048 or G14079 prior to receiving payment for G14043, payment for those follow-up Management billings will be made only if G14043 is subsequently paid to that GP. Until that time any follow-up services will show as "BH" on the remittance.

14. Does "Chronic Pain" qualify as an Axis I diagnosis for the GPSC Mental Health Planning Fee (14043)?

Chronic Pain qualifies as an Axis I diagnosis only when it is present in association with a psychological condition (DSM 307.80, 307.89). When chronic pain is present due only to a physical condition and without associated psychological condition(s), it is an Axis III diagnosis and does not qualify for the GPSC Mental Health Planning Fee (14043).

In addition, if the Mental Health Planning Fee (14043) is billed for a patient who does have an associated psychological condition, all other criteria of the 14043 Planning Fee must be met. These include:

- The billing physician must be the GP who accepts responsibility for the ongoing longitudinal care for that patient
- A full assessment that includes:
  - A detailed review of the chart, history, and current therapies

- Psychiatric history and mental state examination
  - The use of and results of validated assessment tools for the psychological disorder and, in this case, the pain disorder
  - DSM-IV Axis I confirmatory diagnostic criteria
  - A summary of the condition and a specific plan for that patient's care
  - An outline of expected outcomes
  - Linkages with other health care professionals as appropriate
  - A time frame for re-evaluation of the Mental Health Plan
- Communication of the plan to the patient and/or patient's medical representative, and to other health professionals as indicated

15. Does Substance Abuse and/or Addictions qualify as an Axis I diagnosis for the GPSC Mental Health Planning Fee (14043)?

Both Alcohol Dependency (303) and Substance Abuse (non-nicotine) (304) qualify as Axis I diagnoses. If the Mental Health Planning Fee (14043) is billed for a patient with either Alcohol or Substance abuse issues, all other criteria of the 14043 Planning Fee must be met. These include:

- The billing physician must be the GP who accepts responsibility for the ongoing longitudinal care for that patient
- A full assessment that includes:
  - A detailed review of the chart, history, and current therapies
  - Psychiatric history and mental state examination
  - The use of and results of validated assessment tools for the psychological disorder and, in this case, the alcohol and/or substance disorder
  - DSM-IV Axis I confirmatory diagnostic criteria
  - A summary of the condition and a specific plan for that patient's care
  - An outline of expected outcomes
  - Linkages with other health care professionals as appropriate
  - A time frame for re-evaluation of the Mental Health Plan
- Communication of the plan to the patient and/or patient's medical representative, and to other health professionals as indicated

16. Are any of the Mental Health Incentive fees eligible for the Rural Retention Premium?

Only the follow-up Management service under G14045, G14046, G14047 and G14048 are eligible as these have MSP equivalents (00120, 15320, 16120, 17120, 18120).

7.4 GP MENTAL HEALTH FEES

G14043	**GP Mental Health Planning Fee**	**$100**
G14044	**GP Mental Health Management Fee age 2–49**	**=00120**
G14045	**GP Mental Health Management Fee age 50–59**	**=15320**
G14046	**GP Mental Health Management Fee age 60–69**	**=16120**
G14047	**GP Mental Health Management Fee age 70–79**	**=17120**
G14048	**GP Mental Health Management Fee age 80+**	**=18120**

7.5 GP MENTAL HEALTH BILLING EXAMPLE

A long time patient of yours comes in with her 35 year old brother John, who has just moved from another city. He has brought his clinical records with him and needs a prescription refill. His past history includes Bipolar Disorder with situational anxiety, managed with Lithium, an anti-depressant and an anxiolytic. He advises you he has not had a lithium level in the past 6 months, and with the stress of moving is worried about his mental health. You confirm he is not at risk of harm currently and he is staying with his sister until he finds

a place of his own. You send him for some baseline bloodwork including a lithium level, arrange for him to come in for a 30 minute mental health planning session in 2 weeks and ask him to complete a take home risk assessment questionnaire to bring to that appointment.

He returns at the scheduled time, your last appointment of the day, and you undertake a review of his Axis 1 diagnosis of Bipolar Disorder, review his risk assessment and develop a plan for management of his mental health condition. He agrees to come to see you on a monthly basis for the next 3 months, and that at that third visit, you will review the direction of the plan for the following time. His Lithium level was low, so you adjust his medication dose. Jointly you agree that he also needs referral to the local mental health team as he is having some adjustment anxiety with his recent move. You advise him that you will contact mental health directly to discuss the management plan you have jointly developed and that your office will call him in 3 days to follow up on how he is tolerating this change as well as to discuss any feedback from the mental health worker. The mental health planning visit has taken 30 minutes to complete but the total time spent is 40 minutes. The following day you contact the mental health team and spend 10 minutes discussing the case and management plan for the patient. They will see him the following week, and when you contact the patient as agreed 2 days later, you advise him of this information, plus review his status.

Over the course of the year, John sees you on a planned pro-active basis monthly for the next 3 months, then every 2 months for the last 6 months of the year. The first three visits were counseling sessions of at least 20 minutes but the other 2 were regular visits. In addition there were 2 crisis intervention counseling sessions of at least 20 minutes, each with one follow up phone call management. He is also attending at the local mental health clinic on a regular basis and you have had 2 more telephone conversations with his therapist around his management plan related to the acute crisis intervention, each one lasting 10 – 15 minutes.

Billings for John include utilizing the 4 MSP counseling fees (00120) followed by access to the GPSC mental health management fees (counseling equivalent) once the Mental Health Planning visit has been successfully billed. As well, mental health conditions are one of the qualifying categories for community patient conferencing fees. If John would have had any chronic disease conditions (eg. Hypertension) after one year of care, you would have been eligible to bill the appropriate CDM fee.

Service#	**Type of Visit**	**Fee Code**	**Diagnostic Code**
1	Office Visit	00100	296
2	Mental Health Planning Visit Office visit	14043 00100	296 296
3	Community Patient Conferencing	14016 X 1	296
4	Telephone Follow Up	14079	296
5	Counseling (#1 MSP)	00120	296
6	Counseling (#2 MSP)	00120	296
7	Counseling (#3 MSP)	00120	296
8	Office Visit	00100	296
9	Counseling (Acute Crisis - #4 MSP)	00120	296
10	Community Patient Conferencing	14016 X 1	296
11	Telephone Follow Up	14079	296
12	Counseling (Acute Crisis - # 1 GPSC)	14044	296
13	Community Patient Conferencing	14016 X 1	296
14	Telephone Follow Up	14079	296
15	Office Visit	00100	296

8.0 GPSC Palliative Care Planning and Management Fees

On September 1, 2011 changes to the *"Health Care (Consent) and Care Facility (Admission) Act" and the "Representation Agreement Act, Power of Attorney Act, Adult Guardianship Act"* come into effect. The following changes will impact 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. ***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, once the planning process has been completed and the planning fee successfully billed, the Family Physician or practice group will be able to access up to 5 phone/e-mail follow- up management fees

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.

8.1 G14063 Palliative Care planning fee

This fee is payable upon the development and documentation of an Advance (Palliative) Care Plan for patients who have been determined to 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. Medical Diagnoses include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy.

Eligible patients must be resident in the community; in a home or in assisted living or supportive housing. Facility-resident patients are not eligible for this initiative.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history and assessment of the patient's current diagnosis to determine if the patient has a life-limiting condition that has become palliative and/or remains palliative. It 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.

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 billed on the same day;
iv) Minimum required time 30 minutes in addition to visit time same day;
v) G14016, community patient conferencing fee payable on same day for same patient if all criteria met;
vi) Not payable on same day as G14015, facility patient conferencing fee;
vii) Not payable on same day as G14017, acute care discharge planning;
viii) Not payable on the same day as G14079 (GP Telephone/E-mail management fee)
ix) G14050, G14051, G14052, G14053, G14033, G14034 not payable once Palliative Care Planning fee is billed as patient has moved from active management of chronic disease to palliative.
x) 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.

8.2 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 are unable to 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. 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 may be will be available after September 1, 2011
- 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. 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 new 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 of the Palliative Care Planning Fee (G14063). This fee is payable only if the GP 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".

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 Community Patient Conferencing Fee (G14016) in addition to receiving the Palliative Care payment(s)?
Yes. The palliative care 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 health professionals. If as a result of the Palliative Care Planning visit (G14063), or as a result of the GP Telephone/Email Management (G14079), the physician needs to conference with allied health 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 with the patient for the GP Telephone/Email Management (G14079) does not count toward the total time billed under the Community Patient Conferencing Fee (G14016).

10. Am I eligible to bill for the Chronic Disease Management, Complex Care or Prevention Fee(s) (G14050, G14051, G14052, G14053, G14033, 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 moved from active management of chronic disease to palliative.

11. Are any of the Palliative Care Incentive fees eligible for the Rural Retention Premium?
No.

8.4 GP Palliative Care Fees

G14063 Palliative Care Planning Fee $100

8.5 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 **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. There has been a 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	14016 X2	$80.00
Counseling Visit	16120	
Telephone follow up management #1	14079	$15.00
Office Visit for follow up	16100	
Telephone follow up management #2	14079	$15.00
Telephone follow up management #3	14079	$15.00
Planned Home visit #1	00103	
Community Patient Conferencing	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	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	14015 X2	$80.00
Palliative Visits in hospice** (first or only pt seen)	13127 X11	

* Only GPSC values included as MSP values are subject to increase every April 1.
** Effective April 1, 2009, 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.