

GP Services Committee Initiatives Update August 2010

1. Expanded Full Service Family Practice Condition Based Payments

This program is a continuation of the Full Service Family Practice Condition Payment introduced in 2003. The program payments recognize that additional work, beyond the office visit payments, of providing guideline informed care to patients over a year. The Condition Based Payments for Chronic Disease Management can be submitted on the anniversary date annually if guideline informed care has been provided for the year. The purpose of the condition based payments is to improve patient care. They are payable in recognition of the work that has been done and are not payable in advance of the work being done. **Effective January 1, 2009, there must have been at least 2 visits/encounters billed in the previous 12 months to bill and be paid for the CDM initiatives.** These fees are intended for the GP who has taken on the responsibility for the ongoing care for the patient over the previous 12 months. The codes for claiming the condition-based bonuses are as follows:

G14050 Diabetes mellitus	\$125.00
G14051 Congestive heart failure	\$125.00
G14052 Hypertension – requires GP give copy of flow sheet to patient	\$50.00
G14053 COPD (value \$125.00) – requires GP to give copy of COPD Action Plan to patient.	\$125.00
G14073 COPD Telephone follow up management –up to 4 times in the 12 months after successful billing of the G14053	\$15.00

2. Patient Conferencing & GP/Specialist Telephone Consultation Fees

The 3 conferencing fees are limited to use in BC patients (Out of province patients not eligible) who fall into 5 categories:

1. Frail Elderly; Diagnostic Code V15
2. Palliative Care; Diagnostic Code V58
3. End of Life; Diagnostic Code V58
4. Mental Illness; Appropriate Mental Health Diagnostic Codes see Appendix 2
5. 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 several health disciplines).

The Telephone consultation fees (coming soon) are not limited to specific diagnoses or locations, but are related to urgency of call.

2.A. FACILITY PATIENT CONFERENCE FEE:

General Practice Facility Patient Conference is to be billed when the GP is requested by facility 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. This fee is for patient care conferences taking place in a facility with at least 2 other health care providers.

G14015 - General Practice Facility Patient Conference per 15 minutes or greater portion thereof.....\$40.00

2.B. COMMUNITY PATIENT CONFERENCING FEE

General Practice Community Patient Conferencing Fee is for the 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 at least one other health care providers is required e.g., Specialists, psychologists or counselors (including school 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 fee is intended to be a case conferencing fee for complex patients who are community based rather than facility based. This fee is also billable for telephone consultations with specialists and the time required will include actual phone consultation, documentation and implementation of recommendations and communication of recommendations to the patient or patient representative.*

G14016 - General Practice Community Patient Conferencing Fee per 15 minutes or greater portion thereof..... \$40.00

2.C. ACUTE CARE DISCHARGE PLANNING CONFERENCING FEE

This conferencing fee is for billable for the Community GP attendance at an acute care discharge planning conference with at least 2 other health care providers to assist in safe transition from acute care to community care for same patient population. Discharge planning conference may be requested by the Community GP or by the acute care facility.

G14017 - General Practice Acute Care Discharge Planning Conferencing Fee per 15 minutes or greater portion thereof... \$40.00

NEW 2.D. GENERAL PRACTICE URGENT TELEPHONE CONSULTATION AND CLINICAL ACTION PLAN FEE Starting September 1, 2010

This new fee is billable for conferencing with a specialist or GP with specialty training, 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.

G14018- General Practice Urgent Telephone Consultation with a Specialist Fee \$40.00

***NEW* 2.E. GP WITH SPECIALTY TRAINING TELEPHONE ADVICE FEES Starting September 1, 2010**

These three new fees are to allow GPs with Specialty training to access the same fees as developed by the Specialist Services Committee for FRCP certified specialists. For the purpose of these telephone advice fee items a General Practitioner (GP) with specialty training who is defined as a GP with specialty training must provide specialist services in a health authority setting and be acknowledged by the health authority to act in a specialist capacity and provide specialist services. These fees are payable 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.

G14021 GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Urgent \$60.00
Conversation must take place within two hours of the initiating physician's request. Not payable for written communication.

G14022 GP with Specialty Training Telephone Patient Management - Initiated by a Specialist or General Practitioner, One Week \$40.00
Conversation must take place within 7 days of initiating physician's request. Initiation may be by phone or referral letter.

G14023 GP with Specialty Training Telephone Patient Management / Follow-Up \$20.00
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. This fee is only payable for **scheduled telephone appointments** with the patient. Access to this fee is restricted to patients having received a consultation, diagnostic procedure or surgical procedure from the same GP with specialty training, within the 6 months preceding this service.

3. Complex Care Fee

The GP Services Committee (GPSC) has revised the conditions that are eligible for the Complex Care Incentive effective January 1, 2010. Asthma and COPD have been incorporated in a single category of "Chronic Respiratory Conditions". This category has also been expanded to include other chronic respiratory diseases such as Cystic Fibrosis and restrictive conditions such as pulmonary fibrosis and fibrosing alveolitis. Two new disease categories have also been added: Chronic Neurodegenerative Disorders and Chronic Liver Disease (with hepatic dysfunction). 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. Please note this expansion has resulted in a revision of the dual diagnostic codes. Those patients with respiratory conditions in particular have had their dual diagnostic code changed. The revised dual diagnostic codes are listed below. 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. There are also fees for up to 4 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 or practice group that accepts the role of being Most Responsible for the longitudinal, coordinated care of that patient; by billing this fee the practitioner or practice accepts that responsibility for the ensuing calendar year. Eligible patients are community based; i.e. residing in their homes or in assisted living with two or more of the following chronic conditions (**See below for revised Dual Diagnostic Codes**):

- 1) Diabetes mellitus (type 1 and 2)
- 2) Chronic renal failure with eGFR values less than 60
- 3) Congestive heart failure
- 4) Chronic respiratory Condition (asthma, 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.

G14033 Annual Complex Care Management Fee \$315.00

This fee provides compensation for the creation of a Complex Care Plan for eligible patients; those with two qualifying co-morbidities. Minimum time requirement is 30 minutes. This fee is payable once per calendar year for the provision and monitoring of the Complex Care Plan during that calendar year;

Provision of care for eligible patients will be billed throughout the year on a standard fee-for-service basis for all visits whether dealing with the complex care issues or other conditions. Face-to-face visits between the GP and patient are required using the appropriate MSP fee code. Unlike the Condition Based Payments, the Complex Care Management fee does not have to be billed on an anniversary date. The Complex Care Planning visit can be provided at anytime once in each calendar year, depending on clinical need. The Complex Care Management Visit can be provided and billed once at anytime 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.** Due to the time (minimum 30 minutes), intensity and complexity of creating the complex care plan, GPSC has determined that a maximum of five (5) Complex Care Management Fees can be billed by a GP per calendar day.

G14039 Complex Care Telephone/Email Follow-Up Management fee \$15.00

Additionally, once a GP/FP or practice has determined a patient is eligible for a Complex Care Plan and has created and has successfully billed for this plan, they may access a new Complex Care Follow-Up Management fee under Fee Item G14039. These fees compensate the GP/FP or practice for 2-way telephone or email communication with the patient or the patient's medical representative. These fees are paid at \$15 for up to a maximum of 4 services over the 18 months following the successful billing of the 14033.

4. Prevention Fee – Cardiovascular Risk Assessment

Due to limited funding, the GPSC developed a narrow prevention focus in the form of a *C-V RISK ASSESSMENT FEE*. While the target population will still be men age 40-49 and women age 50-59, **effective June 1, 2009, any adult under 70 years of age for whom a cardiovascular risk assessment is deemed medically appropriate may be assessed under this incentive.** Billing will still be done on an individual patient basis for a **maximum of 30 such payments** per physician and is billable in addition to the office visit fee. The assessment parameters will include age, sex, smoking status, fasting blood sugar, B.P., lipid profile at a minimum*; more detailed assessment parameters could include family history, waist circumference, diet, alcohol use, exercise and stress levels. This assessment is intended to assure that major guideline recommended measurements are made for appropriate age groups; a specific % 10 yr. M.I. risk assessment is not required **; the essence of the activity is that the doctor discusses with the patient the major risk factors and their presence or absence. The number of visits required to complete the assessment will be left to the practitioner and patient. The assessment outcome/action planning should be determined by reference to specific guidelines (eg. diabetes, hypertension, lipids) and the new C-V Disease Primary Prevention guideline whose algorithm recognizes importance of major individual disease specific guidelines and the critical importance of appropriate life style modifications for all patients. Chart records will include the six specific parameters; evidence of an appropriate response to major high risk findings is required eg. prescriptions, counseling, referrals.

G14034 – GP Cardiovascular Risk Assessment/Prevention Fee \$100.00

5. GP MENTAL HEALTH INITIATIVE

Family physicians provide the majority of mental health care in their offices. With this new initiative, they will identify their high-risk patients living in the community (i.e. home or assisted living) 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 would be appropriate

G14043 – GP Mental Health Planning Fee (minimum 30 min.) \$100.00

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 30 minutes face-to-face with the patient. If the time is longer, an office visit (total time up to 50 min) or counseling fee (total time more than 50 min) may be billed.

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

- G14044 – GP Mental Health Management Fee age 2–49 years (minimum 20 min.)** (= 00120 value)
- G14045 – GP Mental Health Management Fee age 50–59 years (minimum 20 min.)** (= 15320 value)
- G14046 – GP Mental Health Management Fee age 60–69 years (minimum 20 min.)** (= 16120 value)
- G14047 – GP Mental Health Management Fee age 70–79 years (minimum 20 min.)** (= 17120 value)
- G14048 – GP Mental Health Management Fee age 80+ years (minimum 20 min.)** (= 18120 value)

GP Mental Health Management Fees, an additional four (4) visit fees (minimum 20 min.) equivalent to the current age differential 00120 series. These fees are billable after the current 4 MSP counseling visits per year (00120 fees) have been billed.

G14049 – GP Mental Health Telephone/Email Management Fee \$15.00

GP Mental Health Telephone/Email Management Fees; access to telephone/email follow-up fees to allow flexibility in providing non-face-to-face management/follow-up for these patients. 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.

6. GP Delivery Bonus Program

This is a continuation of the Full Service Family Practice Obstetrical Care Incentive Program introduced in 2003. On July 1, 2008, it was further expanded to include the new "Management of labour and transfer for delivery to a higher level of care facility" in order to better support rural GP obstetrics. 50% bonus on the MSC Payment Schedule delivery fee codes 14104, 14105, 14108 and 14109 and is payable to the general practitioner who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care. 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. **Max of 25 bonuses (any combo of 14004, 14005, 14008 &/or 14009) per calendar year.**

The Fee codes are: **14004/14005/14009/14008**

7. Maternity Network Initiative

Eligible general practitioners can bill **14010** for a quarterly payment (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 quarterly payment rate is \$2,100. 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; 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; 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.

8. Palliative Care Initiative

GPSC has developed a new "Palliative Care Planning" fee and telephone/e-mail follow up fee that is available June 1, 2009. The planning fee is payable upon the development and documentation of a patient's 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. Patients may be living at home and in home-like settings including assisted living and supportive housing, with family or friends. This requires the GP to conduct a comprehensive review of the patient's chart/history, and assessment of the patient's current diagnosis. It requires a face-to-face visit and assessment of the patient to determine if the patient has a life-limiting condition that has become palliative and/or remains palliative. 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. Once the planning fee has been successfully billed, the GP is eligible to bill for up to 5 telephone/e-mail follow up management fees. If the patient transfers to another community after the initial palliative care planning fee has been billed, a new planning visit may be provided and billed by the new GP who is assuming ongoing palliative care for the patient.

G14063 Palliative Care planning fee \$100.00

Requires documentation of the patient's medical diagnosis and determination that the patient has become palliative; The patient must be eligible for BC Palliative Care Benefits Program but it is not required to have applied; 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; Payable in addition to a visit fee billed on the same day; Minimum required time 30 minutes in addition to visit time same day; G14016, community patient conferencing fee payable on same day for same patient if all criteria met; Not payable on same day as G14015, facility patient conferencing fee; Not payable on same day as G14017, acute care discharge planning; Not payable on the same day as 14069 (Palliative Care Telephone/E-mail management fee); G14050, G14051, G14052, G14053 not payable once Palliative Care Planning fee is billed as patient has moved from active management of chronic disease to palliative.

G14069 Palliative Care Telephone/E-mail follow up management fee \$15.00

Additionally, once a GP/FP or practice has determined a patient is eligible for a Palliative Care Plan and has created and has successfully billed for this plan, they may access the Palliative Care Follow-Up Management fee. These fees compensate the GP/FP or practice for 2-way telephone or email communication with the patient or the patient's medical representative. These fees are paid at \$15 for up to a maximum of 5 services following the successful billing of the 14069.

GPSC Diagnostic Codes

CDM Fees

14050 Diabetes	250	14053 COPD	491
14051 Congestive Heart Failure	428	(choose one of 4 Dx Code options)	492
14052 Hypertension	401		494
			496

Complex Care Fees: 14033, 14039

Neurodegenerative + Respiratory	N519	Ischemic Heart Disease + CHF	I428
Neurodegenerative + Ischemic Heart Dis.	N414	Ischemic Heart Disease + Diabetes	I250
Neurodegenerative + CHF	N428	Ischemic Heart Disease + CVD	I430
Neurodegenerative + Diabetes	N250	Ischemic Heart Disease + CKD	I585
Neurodegenerative + CVD	N430	Ischemic Heart Disease + COPD	I573
Neurodegenerative + CKD	N585	CHF + Diabetes	H250
Neurodegenerative + COPD	N573	CHF + CVD	H430

Complex Care Diagnostic codes continued

Respiratory + Ischemic Heart Dis.	R414	CHF + CKD	H585
Respiratory + CHF	R428	CHF + Chronic Liver Disease	H573
Respiratory + Diabetes	R250	Diabetes + CVD	D430
Respiratory + CVD	R430	Diabetes + CKD	D585
Respiratory + CKD	R585	Diabetes + Chronic Liver Disease	D573
Respiratory + Chronic Liver Disease	R573	CVD + CKD	C585
CKD + Chronic Liver Disease	K573	CVD + Chronic Liver Disease	C573

Facility and Community Patient Conferencing Fees: 14015, 14016

Frail Elderly	V15
Palliative Care	V58
End of Life	V58
Mental Illness	Use appropriate mental health diagnostic code (see below)
Multiple Medical Needs/Complex Co-morbidities (2 or more)	Use one of the complex medical condition diagnostic codes

Community GP Mental Health Initiative: 14043, 14044, 14045, 14046, 14047, 14048, 14049

Adjustment Disorder	Adjustment Disorder with Anxiety/ Depressed Mood/ Disturbance of Conduct/ Mixed Anxiety and Depressed Mood/ Mixed Disturbance of Conduct& Mood/NOS	309
Anxiety Disorders	Acute Stress Disorder	308
	Agoraphobia/ Anxiety Disorder Due to a Medical Condition/ Anxiety Disorder NOS/ Obsessive-Compulsive Disorder/ Panic Attack/ Social Phobia/ Specific Phobia/ Substance-Induced Anxiety disorder	300
	Generalized Anxiety disorder	50B, 300
	Post-Traumatic Stress Disorder	309
Attention Deficit Disorders	Attention Deficit disorder	315
Cognitive Disorders	Amnesic Disorder	294
	Delirium	293
	Dementia	290,331,331.0,331.2
Dissociative Disorders	Depersonalization Disorder/ Dissociative Amnesia/ Dissociative Fugue/ Dissociative Identity Disorder/ Dissociative Disorder NOS	300
Eating Disorders	Anorexia Nervosa	307.1, 783.0, 307
	Bulimia	307
	Eating Disorder NOS	307
Factitious Disorders	Factitious Disorder; Physical &/or Psych Symptoms	300,312
Impulse Control Disorders	Impulse Control Disorder NOS/ Intermittent Explosive Disorder/ Kleptomania/ Pathological Gambling/ Pyromania/ Trichotillomania	312
Mood Disorders	Bipolar Disorder	296
	Cyclothymic disorder	301.1
	Depression	311
	Dysthymic Disorder	300.4
	Mood Disorder due to a Medical Condition	293.8
	Substance-Induced Mood Disorder	303, 304, 305
Schizophrenia and Psychotic Disorders	Paranoid Type	295,297,298
	Disorganized Type/ Catatonic Type/ Undifferentiated Type/ Residual Type/ Brief Psychotic Disorder/ Delusional Disorder/ Psychotic Disorder NOS/ Schizoaffective Disorder/ Schizophreniform Disorder/ Substance-Induced Psychosis	295, 298
	Psychotic Disorder due to Medical Condition	293
Sexual and Gender Identity Disorder		302

Paraphilias	Exhibitionism/ Fetishism/ Frotteurism/ Pedophilia/ Sexual Masochism/ Sexual Sadism/ Transvestic Fetishism/ Voyeurism/ Paraphilia NOS	302
Sexual Dysfunction	Hypoactive Sexual Desire Disorder/ Female Orgasmic or Sexual Arousal Disorder/ Male Erectile/Orgasmic Disorder or Premature Ejaculation/ Sexual Aversion Disorder/ Sexual Dysfunction due to a Substance	302
Sexual Pain Disorder	Sexual Dysfunction due to a Medical Disorder Dyspareunia or Vaginismus (not due to a Medical Cond.)	625 302
Sleep Disorders	Primary Insomnia or Hypersomnia Narcolepsy Breathing-Related Sleep Disorder Circadian Rhythm Sleep Disorder/ Insomnia Related to Another Mental Disorder/ Nightmare Disorder (Dream Anxiety Disorder) Sleep Disorder Due/Related to a Medical Condition/ Sleepwalking Disorder/ Substance-Induced Sleep Disorder	307 347 780.5 307.4 780.5
Somatoform Disorders	Somatization Disorder Conversion Disorder Pain Disorder Hypochondriasis/ Body Dysmorphic Disorder	300.8 300.1 307.8 300.7
Substance -Related Disorders	Substance-Induced Anxiety, Mood or Sleep Disorder Substance-Induced Psychosis	303, 304, 305 292
Alcohol Dependence Syndrome		303
Drug Dependence Syndrome		304
Drug Abuse, Non-Dependent		305

Maternity Codes

14010 Maternity Network Payment	Dx V26 – Procreative Management
14004/14005/14008/14009 – Delivery Bonus – Delivery Diagnostic Codes:	
NORMAL DELIVERY	650
ANTEPARTUM HEMORRHAGE	641
PIH	642
PROLONGED PREGNANCY	645
MULTIPLE GESTATION	651
MALPRESENTATION	652
DISPROPORTION	653
FETAL/PLACENTAL PROBLEM	656
POLYHYDRAMNIOS	657
PREM. RUPTURE MEMB	658.1
OBSTRUCTED LABOUR	660
PROLONGED LABOUR	662
COMPLICATED LABOUR	646