

GPSC Initiated Listings – Revisions Effective January 1, 2012

GPSC Full Service Family Practice Incentives

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.

Physicians are eligible to participate in the incentive program if they are:

1. A general practitioner who has a valid BC MSP practitioner number (registered specialty 00). Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.
2. Currently in general practice in BC as a full service family physician; and
3. Responsible for providing the patient's longitudinal general practice care.

Additional detailed eligibility requirements are identified in each section.

1. Expanded Full Service Family Practice Condition-based Payments

G14050 GP annual chronic care bonus (diabetes mellitus).....125.00

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.*

G14051 GP annual chronic care bonus (congestive heart failure)125.00

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.*

		Total Fee \$
G14052	GP annual chronic care bonus (hypertension)	50.00
Notes:		
i) <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.</i>		
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) <i>Applicable only for patients with confirmed diagnosis of hypertension.</i>		
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) <i>Claim must include the ICD-9 code for hypertension (401).</i>		
vii) <i>This item may only be claimed once per patient in a consecutive 12 month period.</i>		
viii) <i>Not payable if G14050 or G14051 claimed within the previous 12 months.</i>		
ix) <i>If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.</i>		

G14053	GP annual chronic care bonus (Chronic Obstructive Pulmonary Disease-COPD)	125.00
Notes:		
i) <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.</i>		
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) <i>Applicable only for patients with confirmed diagnosis of COPD.</i>		
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) <i>Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).</i>		
vii) <i>This item may only be claimed once per patient in a consecutive 12 month period.</i>		
viii) <i>Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.</i>		
ix) <i>If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.</i>		

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.

2. Conference Fees

Facility Patient Conference Fee

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
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**Total
Fee \$**

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.

Community Patient Conference Fee

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.*

Acute Care Discharge Conference Fee

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-

**Total
Fee \$**

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)).

Table 1: Eligible patient populations for the Facility Patient, Community Patient and Acute Care Discharge Conference Fees

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 an assisted living residence or hospice); and
- Have been diagnosed with a life-threatening illness or condition; and
- Have a life expectancy of up to six months; and
- Consent to the focus of care being palliative rather than treatment aimed at cure.

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

Patients of any age:

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

iv. Mental illness

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

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Personality Disorders
- Sleep 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

Patients 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 several health disciplines. On your claim form use the code for one of the major disorders.

**Total
Fee \$**

GP Urgent Telephone Conference with a Specialist 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 severity of the patient's condition justifies urgent conference with a specialist or GP with specialty training, for 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.

G14018 GP 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 representative40.00

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

- 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.*

**Total
Fee \$**

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, or the patient's medical representative, 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.

**Total
Fee \$**

- ii. Telephone/Email Management requires two-way communication between the patient or the patient's medical representative 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.

3. Complex Care Incentive

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. Providing the Complex Care planning visit and billing for the development of a care plan allows access to 5 telephone/e-mail fees (G14079) during the following 18 months.

These items are payable only to the General Practitioner who 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 this fee when providing care only to community patients; i.e. residing in their homes or in assisted living 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, 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.*

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 should represent the two conditions creating the most complexity.

Successful billing of the Complex Care Management Fee (G14033) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months.

G14033 GP Annual Complex Care Management Fee315.00

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 a Complex Care Plan for the management of the complex care patient until the complex care plan is reviewed and revised in the next calendar year.

A Complex Care Plan requires documentation of the following elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies;
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
3. Specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
4. 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;
5. Outlines expected outcomes as a result of this plan, including end-of-life Issues (advance care planning) when clinically appropriate;
6. Outlines linkages with other health care professionals that would be involved in the care, their expected roles;
7. Identifies an appropriate time frame for re-evaluation of the plan;
8. 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.

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

Diagnostic codes submitted with 14033 billing must be from Table 1. If the patient has multiple comorbidities, the submitted diagnostic code should represent 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 (Renal Failure)	Chronic Liver Disease (Hepatic Failure)

4. Prevention Fees

- G14066** GP Personal Health Risk Assessment50.00
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.

**Total
Fee \$**

Patient Eligibility:

- *Eligible patients are community based, living in their home, with family, in supportive housing or assisted living. Facility based patients are not eligible*

Notes:

- Payable only for patients with one or more of the following risk factors: Smoking, unhealthy eating, physically inactive, medical obesity.*
- Only applicable to services submitted using one of the following diagnostic codes: Smoking (786), Unhealthy Eating (783), physically inactive (785), Medical Obesity (783).*
- Requires chart entry documenting discussion and preventative plan of action.*
- 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.*
- Payable in addition to the office visit billed on the same day.*
- Not payable on the same day as fee items G14015, G14017, G14033, G14043, G14063.*
- Payable to a maximum of 100 patients per calendar year, per physician.*
- Payable once per calendar year per patient.*
- 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.*

BC Lifetime Prevention Schedule Recommended Actions

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

5. Maternity Network Initiative

G14010 GP Maternity Care Network Initiative Payment2100.00

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 BC;
- 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). Refer to the Maternity Network Registration Form;
- 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 (April to September, October to March) .

Billing Information for Maternity Care Network Initiative Payment:

PHN:	9824870522
Patient Last name:	Maternity
Patient First name/initial:	G
Date of Birth:	November 2, 1989
Diagnostic code:	V26
For Date of service use:	Last day in a calendar quarter
Billing Schedule:	Last day of the month, per calendar quarter

**Total
Fee \$**

6. General Practitioner Obstetrical Premium

G14004 GP - Obstetric Delivery bonus associated with vaginal delivery and postnatal care 275.28

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 under fee item G14004, G14008, G14009 per patient delivered.
- iv) Maximum of 25 bonuses per calendar year under fee item G14004, G14005, G14008, G14009 or a combination of these items.

G14005 GP - Obstetric delivery bonus associated with management of labour and transfer to a higher level of care facility for delivery114.64

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 14105 billed in conjunction.

- iii) Maximum of one bonus under fee item G14004, G14008, G14009 per patient delivered.
- iv) Maximum of 25 bonuses per calendar year under fee item G14004, G14005, G14008, G14009 or a combination of these items.

**Total
Fee \$**

- v) If claimed by a different GP in a different location, G14005 may be paid on the same patient delivered in addition to G14004, G14008 or G14009 paid to the GP attending delivery.

G14009 GP - Obstetric Delivery bonus related to attendance at delivery and postnatal care associated with emergency caesarean section229.29

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 under fee item G14004, G14008, G14009 per patient delivered.
- iv) Maximum of 25 bonuses per calendar year under fee item G14004, G14005, G14008, G14009 or a combination of these items.

G14008 GP – Obstetric Delivery bonus associated with postnatal care after an elective C-section56.63

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 under fee item G14004, G14008, G14009 per patient delivered.
- iv) Maximum of 25 bonuses per calendar year under fee item G 14004, G14005, G14008, G14009 or a combination of these items.

7. Mental Health Planning and Management Fees

G14043 GP Mental Health Planning Fee100.00

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients resident in the community (home or assisted living, 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 and/or 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, the following:

1. That there has been a detailed review of the patient's chart/history and current therapies;
2. The patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;

3. The use of and results of validated assessment tools. The 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:
 - a) PHQ9, Beck Inventory, Ham-D for depression;
 - b) MMSE for cognitive impairment;
 - c) MDQ for bipolar illness;
 - d) GAD-7 for anxiety;
 - e) Suicide Risk Assessment;
 - f) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
4. DSM-IV Axis I confirmatory diagnostic criteria;
5. A summary of the condition and a specific plan for that patient's care;
6. An outline of expected outcomes;
7. 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;
8. An appropriate time frame for re-evaluation of the Mental Health Plan;
9. 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 and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Following the successful billing of the Mental Health Planning fee, the GP will have access to 4 additional counselling equivalent mental health management fees per calendar year once the 4 MSP counselling fees have been billed.

Patient Eligibility:

- *Eligible patients are community based, living in their home or assisted living. Facility based patients are not eligible.*

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 I 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 in addition to visit time 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) *G14079 GP telephone /e-mail management fee is not payable on the same day.*
- viii) *Not intended as a routine annual fee if the patient does not require on-going 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.*
- x) *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;*
- xi) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

		Total Fee \$
G14044	GP Mental Health Management Fee age 2 – 49.....	51.84

G14045	GP Mental Health Management Fee age 50 - 59.....	57.03
G14046	GP Mental Health Management Fee age 60 - 69.....	59.62
G14047	GP Mental Health Management Fee age 70 - 79.....	67.40
G14048	GP Mental Health Management Fee age 80+.....	77.77

These fees are payable for GP Mental Health Management required beyond the four MSP counselling fees (age-appropriate 00120 fees billable under the MSC payment schedule) for patients with a chronic mental health condition on whom a Mental Health Plan has been created and billed.

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. To facilitate payment, the delegated physician should submit an electronic note;
- iv) Not payable unless the age-appropriate 00120 series has been fully utilized;
- v) Minimum time required is 20 minutes;
- vi) Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14079 GP telephone /e-mail management fee.
- vii) G14016 (Community Patient Conferencing Fee) payable on same day for same patient if all criteria met;
- viii) G14015 (Facility Patient Conferencing Fee) not payable on same day as facility patients not eligible;
- i) CDM fees (G14050, G14051, G14052, G14053) payable if all criteria met.
- ii) 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;
- iii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

Successful billing of the mental health planning fee (G14043) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year over the following 18 months.

The following list of diagnosis and acceptable ICD9 codes are applicable for the Mental Health Planning and Management Fee, fee items G14043, G14044 – G14048, and G14079:

	<u>DIAGNOSIS</u>	<u>ICD-9</u>
Adjustment Disorders:		309
	Adjustment Disorder with Anxiety	309
	Adjustment Disorder with Depressed Mood	309
	Adjustment Disorder with Disturbance of Conduct	309
	Adjustment Disorder with Mixed Anxiety and Depressed Mood	309
	Adjustment Disorder with Mixed Disturbance of Conduct & Mood	309
	Adjustment Disorder NOS	309
		300
Anxiety Disorders:	Acute Stress Disorder	308
	Agoraphobia	300
	Anxiety Disorder Due to a Medical Condition	300
	Anxiety Disorder NOS	300
	Generalized Anxiety disorder	50B, 300
	Obsessive-Compulsive Disorder	300
	Panic Attack	300
	Post-Traumatic Stress Disorder	309

	Social Phobia	300
	Specific Phobia	300
	Substance-Induced Anxiety disorder	300
	<u>DIAGNOSIS</u>	<u>ICD-9</u>
Attention Deficit Disorders:		
	Attention Deficit disorder	314
Cognitive Disorders:		
	Amnestic Disorder	294
	Delirium	293
	Dementia	290,331,331.0,331.2
Dissociative Disorders:		
	Depersonalization Disorder	300
	Dissociative Amnesia	300
	Dissociative Fugue	300
	Dissociative Identity Disorder	300
	Dissociative Disorder NOS	300
Eating Disorders:		
	Anorexia Nervosa	307.1, 783.0, 307
	Bulimia	307
	Eating Disorder NOS	307
Factitious Disorders:		300,312
	Factitious Disorder; Physical & Psych Symptoms	300,312
	Factitious Disorder; Predom Physical Symptoms	300,312
	Factitious Disorder; Predominantly Psych Symptoms	300,312
Impulse Control Disorders:		312
	Impulse Control Disorder NOS	312
	Intermittent Explosive Disorder	312
	Kleptomania	312
	Pathological Gambling	312
	Pyromania	312
	Trichotillomania	312
Mental Disorders Due to a Medical Condition		
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 other Psychotic Disorders:		295,296,297,298
	Paranoid Type	295,297,298
	Disorganized Type	295, 298
	Catatonic Type	295, 298
	Undifferentiated Type	295, 298

Residual Type	295, 298
Brief Psychotic Disorder	295, 298
Delusional Disorder	295, 298
<u>DIAGNOSIS</u>	<u>ICD-9</u>
Psychotic Disorder due to Medical Condition	293
Psychotic Disorder NOS	295, 298
Schizoaffective Disorder	295, 298
Schizophreniform Disorder	295, 298
Substance-Induced Psychosis	295, 298
Sexual and Gender Identity Disorder Paraphilias:	302
Exhibitionism	302
Fetishism	302
Frotteurism	302
Pedophilia	302
Sexual Masochism	302
Sexual Sadism	302
Transvestic Fetishism	302
Voyeurism	302
Paraphilia NOS	302
Sexual Dysfunction:	302
Hypoactive Sexual Desire Disorder	302
Female Orgasmic Disorder	302
Female Sexual Arousal Disorder	302
Male Erectile Disorder	302
Male Orgasmic Disorder	302
Premature Ejaculation	302
Sexual Aversion Disorder	302
Sexual Dysfunction due to a Medical Disorder	625
<u>DIAGNOSIS</u>	<u>ICD-9</u>
Sexual Dysfunction due to a Substance	302
Sexual Pain Disorders:	
Dyspareunia (not due to a Medical Condition)	302
Vaginismus (not due to a Medical Condition)	302
Sleep Disorders:	
Primary Insomnia	307
Primary Hypersomnia	307
Narcolepsy	347
Breathing-Related Sleep Disorder	780.5
Circadian Rhythm Sleep Disorder	307.4
Insomnia Related to Another Mental Disorder	307.4
Nightmare Disorder (Dream Anxiety Disorder)	307.4
Sleep Disorder Due to a Medical Condition	780.5
Sleep Disorder Related to another Medical Condition	780.5
Sleepwalking Disorder	780.5
Substance-Induced Sleep Disorder	780.5
Somatoform Disorders:	

Somatization Disorder	300.8
Conversion Disorder	300.1
Pain Disorder	307.8
DIAGNOSIS	ICD-9
Hypochondriasis	300.7
Body Dysmorphic Disorder	300.7

Substance - Related Disorders:

Substance-Induced Anxiety Disorder	303,304,305
Substance-Induced Mood Disorder	303,304,305
Substance-Induced Psychosis	292
Substance-Induced Sleep Disorder	303,304,305

Alcohol Dependence Syndrome

303

Drug Dependence Syndrome

304

Drug Abuse, Non-Dependent

305

**Total
Fee \$**

8. Palliative Care Planning Fee

G14063 GP Palliative Care planning fee.....100.00

This fee is payable upon the development and documentation of a 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. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Notes:

- i) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.
- ii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).
- iii) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.

- iv) Payable in addition to a visit fee billed on the same day.
- v) Minimum required time 30 minutes in addition to visit time same day.
- vi) G14016, community patient conferencing fee payable on same day for same patient if all criteria met.
- vii) Not payable on same day as G14015, facility patient conferencing fee.
- viii) Not payable on same day as G14017, acute care discharge planning.
- ix) G14079 GP Telephone/e-mail management fee is not payable on the same day.
- x) G14050, G14051, G14052, G14053, G14033, G14066 not payable once Palliative Care Planning fee is billed as patient has moved from active management of chronic disease to palliative.
- xi) G14043, G14044, G14045, G14046, G14047, G14048, the GPSC Mental Health Initiative Fees are still payable once G14063 has been billed provided all requirements are met, but are not payable on same day.
- xii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care;
- xiii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

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

**Total
Fee \$**

GPSC Incentives for GPs with Specialty Training

1. 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 a General Practitioner (GP) with specialty training who is defined as: **“A GP who has specialty training and who provides services in that specialty area though 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, Response within 2 hours60.00

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, Response in 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.

**Total
Fee \$**

- 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 Specialty Training Telephone Patient Management / Follow-Up20.00

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 prior consultation, office visit, hospital visit, diagnostic procedure or surgical procedure from the same GP with Specialty training, within the 18 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.*