

## Module 9: GPSC Initiated Fees

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### 9.1 Background and Update – GPSC Initiated Fees

The General Practice Services Committee (GPSC) was established in 2002 as a vehicle for the Ministry of Health, the BC Medical Association and the Society of General Practitioners of BC to work in partnership to develop innovative solutions to support and sustain full service family practice in B.C.

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 family physician, and
3. Responsible for providing the patient's longitudinal general practice care.

The following initiatives are available for eligible patients through the *Full Service Family Practice Incentive Program*:

The annual **Chronic Care Bonus Payment** supports family doctors in providing evidence-based BC Guidelines recommended care for their patients with diabetes (fee code G14050) and/or congestive heart failure (fee code G14051), hypertension (fee code G14052) and chronic obstructive pulmonary disease/COPD (fee items G14053 and G14073).

To help ensure that women have access to maternity care in their communities, GPs providing this vital service are eligible to receive the **Obstetric Care Premium** (fee codes G14004, G14005, G14008, G14009) which provides a 50% bonus on the current value of GP fee-for-service delivery and attendance at emergency and elective C-section billable in addition to fee items 14104, 14105, 14109 and 14108. The **Maternity Care Network Payment** (fee code G14010 - \$2100. per quarter) is also available in recognition, and support of GPs working within a group practice approach to maternity care that ensures that a GP is always available to deliver their patients.

GPs caring for the frail elderly, people with complex chronic illness, chronic mental illness and/or addictions, and those requiring end of life/palliative care often need to case conference with other health care providers and families about their patients who are residing in a facility. In

addition, many complex patients live in the community and need a clinical care plan to help ensure they receive appropriate care, from the appropriate health care provider, in a timely manner. In response, the **Facility Patient Conferencing Fee**, (fee G14015) the **Community Patient Conferencing Fee** (fee G14016) and the **Acute Care Discharge Planning Fee** (fee G14107) , respectively, are available to support GPs for the time they spend in coordinating their patient's care and in collaborative planning.

Effective June 1, 2009 the **Palliative Care Incentive** (fee G14063) is a new payment initiative that is intended to compliment the existing conferencing component of end-of-life care when sharing care with other health care professionals.

Care of patients living with more than two chronic illnesses is often complex and demanding. People living with more than two chronic illnesses often have a poor quality of life due to their illness, and face significant challenges in navigating the health system to effectively meet their health needs. To better support thoughtful treatment planning based on patient goals and improved care coordination, the *Full Service Family Practice Incentive Program* now includes the **Complex Care Payment** (fees G14033 and G14039) to better enable GPs:

- to take time to reflect on the needs of their complex patients,
- develop treatment plans in collaboration with the patient and their support network,
- and where needed, coordinate and/or become an active member of a broader care team focused on assisting the patient to manage their multiple conditions.

Approximately half of B.C.'s population is at risk for and/or been tested for a chronic illness. Many diseases, such as diabetes and cardiovascular disease, have common risk factors (unhealthy eating, sedentary lifestyle, tobacco and alcohol use), that if addressed early could prevent the onset of chronic illness. Family physicians want to provide preventative care to their patients, and most can readily identify those individuals in need of intervention. In response, the *Full Service Family Practice Incentive Program* now includes a **Prevention Fee** that supports GPs in conducting a cardiovascular risk assessment (fee code G14034) and patient follow-up. Men and women between 18 and 69 years of age, are eligible to receive a cardiovascular risk assessment based on minimum age, gender, smoking status, fasting blood sugar, blood pressure, and lipid profile.

The **Mental Health Initiative** has been implemented to encourage better access to primary care for people with mental illness, and to improve the quality of that care, with special attention to coordination of care planning and continuity of information and to encourage a shared care model of management where possible. The ultimate goal of these improved care processes is to improve the health outcomes of the patients in terms of both better quality of life and reduced mortality and morbidity.

For more information on the *Full Service Family Practice Incentive Program*:

[www.primaryhealthcarebc.ca](http://www.primaryhealthcarebc.ca)  
[www.bcma.org/PracticeSupportProgram.htm](http://www.bcma.org/PracticeSupportProgram.htm)  
[www.bcma.org/PracticeSupportProgram.htm](http://www.bcma.org/PracticeSupportProgram.htm)  
[www.gpscbc.ca](http://www.gpscbc.ca)

## 9.2 Expanded Full Service Family Practice Condition Based Payments

This incentive program is aimed at supporting high quality management of congestive heart failure, diabetes, and hypertension. Physicians will now receive an annual payment of \$125 for each patient with diabetes and/or congestive heart failure whose clinical management is consistent with recommendations in the B.C. Clinical Practice Guidelines. In addition, an annual \$50 incentive payment is now available for BC Clinical Practice Guidelines treatment of hypertension where this care is not part of treating diabetes or congestive heart failure.

### Fee Item Information

**G14050** Incentive for full service 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 general practice full service family physician who has provided the majority of the patient's longitudinal general practice care over the preceding year and who has provided the requisite level of guideline based care.
- iii) Applicable only for patients with confirmed diagnosis of diabetes mellitus
- iv) Care provided must be consistent with the BC clinical guideline recommendations for diabetes mellitus and 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 ICD9 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 an 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** Incentive for full service 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 over the preceding year and who has provided the requisite level of guideline based care.
- iii) Applicable only for patients with confirmed diagnosis of congestive heart failure.
- iv) Care provided must be consistent with the BC clinical guideline recommendations for congestive heart failure and 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 ICD9 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 and 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.

**G14052** Incentive for Full Service 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 over the preceding year and who has provided the requisite level of guideline based care.
- iii) Applicable only for patients with confirmed diagnosis of hypertension.
- iv) Care provided must be consistent with the BC clinical guideline recommendations for hypertension and 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. The patient must be given a copy of their flow sheet in order to facilitate patient self management.
- v) Claim must include the ICD9 code for hypertension (401)
- vi) This item may only be claimed once per patient in a consecutive 12 month period
- vii) Not payable if G14050 or G14051 claimed within the previous 12 months.
- viii) If a visit is provided on the same date the bonus is billed, both services will be paid at the full fee.

**G14053** Incentive for Full Service 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 over the preceding year and who has provided the requisite level of guideline-based care.
- iii) Applicable only for patients with confirmed diagnosis of COPD.
- iv) Care provided must be consistent with the BC clinical guideline recommendations for COPD and 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. The patient must be given a copy of their personalized COPD care plan in order to facilitate patient self management.
- v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).
- vi) This item may only be claimed once per patient in a consecutive 12 month period.

- vii) Payable when other CDM items G14050, G14051 or G14052 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.

**G14073** COPD Telephone/Email Management Fee

This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management of a patient's COPD by the GP who has billed and been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053). This fee is not to be billed for simple appointment reminders or referral notification.

**Notes:**

- i) Payable to a maximum of 4 times per patient in the 12 months following the successful billing of the GPSC Annual Chronic Care Bonus for COPD (G14053).
- ii) Not payable unless the GP/FP is eligible for and has been paid for the GPSC Annual Chronic Care Bonus for COPD (G14053).
- iii) Telephone/Email Management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office or laboratory appointments or of referrals.
- iv) Payable only to the physician paid for the GPSC Annual Chronic Care Bonus for COPD (G14053) unless that physician has agreed to share care with another delegated physician.
- v) 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.
- vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016.
- vii) 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.

Further information about the annual chronic care bonus items, the clinical guidelines and the flow sheets is available at:

<http://www.bcguidelines.ca/gpac/>

<http://www.health.gov.bc.ca/cdm/practitioners/index.html>

## Frequently Asked Questions:

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

Effective September 15, 2009, in addition to the existing codes for diabetes (14050) congestive heart failure (14051) and hypertension (14052), code 14053 has been added for COPD.

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. 14052 (hypertension) is only billable for patients with hypertension who do not also have a diagnosis of diabetes mellitus and/or congestive heart failure.

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.

### 3. When should the incentive bonus be billed?

The Chronic Care Incentive bonus fees may be billed once continuity of monitoring the patients' course of care according to BC Clinical Guidelines has been established. This is considered to be established once the minimum requirements outlined below have been completed.

#### *i) Diabetes Patient Care Flow Sheet*

Although it is not required that the patient be given a copy of their flow sheet, this is highly recommended by the GP Services Committee.

#### *ii) Congestive Heart Failure Care Flow Sheet*

It is an annual payment that may be billed if all conditions have been met for the previous 12 months. Although it is not required that the patient be given a copy of their flow sheet, this is highly recommended by the GP Services Committee.

*iii) Hypertension*

Fee item 14052 may be billed after the patient has been provided guideline based care for one year. The patient must be given a copy of their flow sheet for the year. Flow sheets may be completed retroactively if guideline criteria have been met.

*iv) Chronic Obstructive Pulmonary Disease*

Fee item 14053 may be billed after the patient has been provided guideline based care for one year. There will be no flow sheet for the COPD CDM, but patients must be given a copy of their COPD Action Plan as developed jointly with the patient.

**4. Will payment item 14050, 14051, 14052 and 14053 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. It is a management bonus, intended to compensate for the time taken to maintain patient care plans in accordance with the BC clinical guidelines.

**5. Do I have to see the patient to bill the payment?**

You will have to see the patient to provide care according to the guidelines, but you do not have to see the patient to fill in the flow sheet or on the day of billing the payment. However, 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.

**6. Do I have to provide all follow up care to the patient face to face?**

After successfully billing the G14053, some follow up management may be provided to patients by telephone or e-mail, for which you can bill the G14073 COPD up to 4 times in the following 12 months.

**7. 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 these guidelines in patients with dementia or very limited life expectancy. If the COPD incentive (14053) is billed for resident in a long-term care facility a personalized Clinical Action plan must be entered in the patient's chart.

**8. 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.ca> A link is also provided on the BCMA web site, <http://www.bcma.org/public/CDM/CDMIncentivePaymentInfo.htm>. 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.

**9. 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, and contain the same information

included in the patient flow sheets that are part of the BC clinical guideline. It is a requirement to give hypertension patients a copy of their flow sheet as an aid to patient self management. Physicians are not required to submit the completed flow sheets to the Ministry of Health in order to receive the incentive payment. Instead, this program will be subject 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.

**10. 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 following the CDM FAQs.

**11. 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-based care, and is NOT a payment simply because the patient has a diagnosis of diabetes, congestive heart failure, or hypertension. However, you may still claim for the payment if you have attempted to provide guideline based care but for some reason care objectives have not been met. If this is the case, however, for audit purposes you must have clear chart entries that show that you attempted to provide the recommended level of care and did not achieve targets, or you explicitly established different targets based on the unique circumstances of your patient.

**12. Can I bill for patients covered by other provinces?**

Patients covered by other provinces who are temporarily in BC are not eligible as their regular physician is in the other province. If they stay in BC and obtain coverage under the Medical Services Plan then they become eligible for the program. In a few border communities a BC physician may provide the majority of care for an Alberta or Yukon patient, and these patients will be eligible.

**13. 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, without having to wait a full 12 months from the time you assumed responsibility for the practice. 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.

**14. Are the payments eligible for the rural premiums?**

No.

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

Yes.



### 9.3 Full Service Family Practice Incentive Program – General Practitioner

#### 1. General Practitioner Obstetrical Delivery Bonuses

##### Eligibility:

The incentive payments are available to all general practitioners in BC who, in addition to being paid the delivery fee items 14104, 14105, 14108, and 14109 for the patient, provide the maternity care and are also responsible, or share responsibility, for providing the patient's general practice medical care.

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

General practitioners specializing in general practice or obstetrics who receive referrals from other general practitioners for maternity care are considered to share in the general practice medical care of the patient. General practitioners who are paid by service contract, sessional, or salary payments are eligible to receive the obstetrical premium payments.

*Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible. Emergency room physicians who happen to be on duty and deliver a baby have not shared the general practice maternity care and are not eligible.*

The following GP obstetrical fee items provide a 50 % bonus on the delivery fee items 14104, 14105, 14108, 14109.

**G14004** Incentive for Full Service GP – Obstetric Delivery Bonus associated with Vaginal Delivery and Postnatal Care

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** Incentive for Full Service GP – Obstetric Delivery Bonus associated with management of labour and transfer to a higher level of care facility for delivery.

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.
- 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.

**G14008** Incentive for Full Service GP -Obstetrics Delivery Bonus associated with post natal care after an elective c-section

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 G14004, G14005, G14008, G14009 or a combination of these items.

**G14009** Incentive for Full Service GP – Obstetric Delivery Bonus related to attendance at Delivery and Postnatal Care associated with Emergency Caesarean Section

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.

Note: There is no restriction to the number of bonuses billed per day providing all of the other criteria is met. However, the combined total of all bonuses (G14004, G14005, G14008 and G14009) within a calendar year cannot exceed the maximum of 25.

## Frequently Asked Questions:

### 1. When I submit a claim for the bonus payment on fee items 14104, 14105, 14108 or 14109 what is the exact amount of the payment?

The obstetrical care bonus payment is to be claimed using specific fee codes (paid at 50% of the appropriate delivery code):

- Fee code G14004 with item 14104
- Fee code G14005 with item 14105
- Fee code G14008 with item 14108
- Fee code G14009 with item 14109

A maximum of twenty five (25) services under fee item G14008, G14009, **G14005** or G14004 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?

Vaginal delivery:

Bill 14104 (Vaginal Delivery and post-natal care) and G14004 –bonus associated with vaginal delivery

Elective C-Section:

Bill 14108 (GP elective C-section and post partum care (not the surgical assist fee) and G14008 –bonus associated with elective C-Section

Emergency C-Section:

Bill 14109 (Attendance at Delivery and postnatal care associated with emergency caesarean section) and G14009 –bonus associated with Attendance at Delivery and postnatal care associated with emergency caesarean section

Management of labour and transfer to higher level of care facility for delivery

Bill 14105 (Management of labour and transfer to higher level of care facility for delivery) and G14005 – bonus associated with management of labour and transfer to a higher level of care facility for delivery.

Remember: The maximum number of bonuses payable per calendar year is 25. They may be claimed under fee item G14004, G14005, G14008 or G14009 or a combination of these items but the combined total must not exceed 25. Include the appropriate ICD-9 code on your claims.

### 3. How many bonuses may I bill in each calendar year?

You may bill for up to 25 deliveries in each calendar year under fee item G14004, G14005, G14008 or G14009 or a combination of these items.

**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. You 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 the bonus for post-natal care following an elective C-Section in addition to the 25 delivery bonuses per year?**

No. You may bill up to 25 bonuses per year in total. These can be any combination of G14004, G14005, G14008 and G14009, but the combined total of all bonuses cannot exceed the annual maximum of 25 per year. You 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 G14008?**

Most GP's providing obstetrics do not deliver more than 25 patients per year, so the G14008 allows them to bonus all their deliveries, regardless of type or number in any one day. Physicians who deliver more than 25 patients per year may choose which patients to bill the bonuses on. You may choose to bill fee item G14008 or wait for a future delivery to bill the higher priced bonus fee items G14004 or G14009.

**7. What happens if I have claimed a bonus G14008 for an elective c-section and later in the year deliver my 26<sup>th</sup> patient by vaginal delivery or emergency c-section . Can I claim for the higher priced bonus on this patient and withdraw the previous obstetrical bonus payment under fee item G14008?**

Yes. Send an electronic debit request to withdraw the lesser priced 14008 claimed earlier in the year and then subsequently bill the G14004 and G14009 if you qualify.

**8. What if I chose not to bill a G14008 on an elective c-section and later in the year realized I would not exceed 25 deliveries? Can I go back and bill the G14008?**

Claims must be submitted within 90 days of the date of service. If you are not sure whether you will deliver more than 25 patients in the calendar year submit a claim for the elective c-section bonus under fee item G14008. You can submit an electronic debit for this service at a later date if you exceed 25 deliveries.

**9. Are locums able to bill this bonus?**

Yes. Locum coverage is considered part of the usual care provided by the host general practitioner. The locum is also limited to 25 bonuses in total, but these are separate from the GP bonus allowance.

**10. 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) or attendance at delivery and post natal care associated with a c-section (14109) may bill fee item G14004 or G14009. 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 G14008 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).

**11. 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.

**12. Is the bonus billable if a delivery is performed during an on-call shift for a partners patient?**

Yes. This is considered shared care and eligible for one bonus per patient.

**13. How is the bonus applied to multiple births?**

Multiple births are considered one delivery, and thus eligible for one bonus.

**14. 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.

**15. 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.

**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 (G14004). 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 (G14009). 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 (G14008). When claiming for the Management of Labour and transfer to a higher level of care facility (14105) submit with obstetric delivery bonus (G14005). 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.

**19. Will MSP automatically refuse my claims for the obstetrical bonus if I submit more than 25 bonuses or the calendar year?**

No. You should keep track of the number of obstetrical bonuses you claim. These items are subject to audit and recovery.

## 2. Maternity Network Initiative

As part of the most recent agreement the maternity care network initiative payment under fee item 14010 has been continued for eligible general practitioners. Eligible practitioners can receive a \$2100.00 quarterly payment to support a group practice approach to GP provision of obstetrical care. Under the Maternity Care Network Initiative- G14010, doctors forming their own shared care networks will work as a team so that at least one physician is always available to deliver their patients.

### Fee Item G14010 – Maternity Network Initiative

#### 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 – 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)

## Frequently Asked Questions:

### 1. How do I submit a claim for payment?

If you are registered with a maternity care network and meet all of the criteria submit your next claim as follows:

In the fee item field:	14010
Claim amount:	\$2100.00
In the patients PHN field	9824 870 522
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 date in a calendar quarter
Report the Diagnosis as:	V26 (V26 is the ICD-9 code for procreative management)

#### Notes:

Only payable to registered members of a network.

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.

Future claims may be billed on the last day of each calendar quarter (e.g. **March 31, 2010, June 30, 2010, September 30, 2010 and December 31, 2010**)

### 2. How do I register as a maternity network?

Please complete the [Maternity Network Registration Form](#).

Registration forms and information about the Maternity Care Network are available at:

<http://www.health.gov.bc.ca/cdm/practitioners/index.html> or:

<http://www.bcma.org/public/CDMincentivePaymentInfo.htm>

### 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?**

The quarterly maternity network payment is \$2100 per practitioner.

**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 GPSC 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.

**10. Are locums eligible for the maternity network payment?**

Yes, provided the locum participates and registers in a maternity network and schedules 4 deliveries in a 6 month period.

**9.4 Fee items G14015, G14016 and G141017 – Facility Patient Conference Fee, Community Patient Conference Fee and Acute Care Discharge Planning Conferencing Fee**

**Facility Patient Conference Fee:**

Fee item and description:

**G14015** General Practice Facility Patient Conference: when requested by a 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 per 15 minutes or greater portion thereof.

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

**Notes:**

- i) Refer to Table 1 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: palliative care facility LTC facility, rehab facility, assisted living, sub-acute facility, psychiatric facility, detox/drug and alcohol facility, community placement agency, disease clinic (DEC, arthritis, CHF, asthma, cancer or other palliative diagnoses etc.)
- 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 healthcare 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 the 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.

This fee is for patient care conferences taking place in a facility.

**Eligibility:**

This incentive payment is available to improve patient care to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00). Practitioners who have billed any specialty 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.
- This payment is billable for the groups of patients identified in Table 1.

**Frequently Asked Questions :****1. How do I claim the Facility Patient Conference Fee payments?**

Submit the fee item G14015 (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?**

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

**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 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 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. These physicians do have comparable encounter record fees.

- 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 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, fee item G14015 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 G14016 may be billed. 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 G14017 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 (G14017).

## Community Patient Conference Fee

G14016 General Practice 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 (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 patients condition).

- per 15 minutes or greater portion thereof

### Notes:

- i) Refer to Table 1 for eligible patient populations.
- ii) 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 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) Clinical 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 following about 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.

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.)

### **Eligibility:**

This incentive payment is available to improve patient care to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00), except those with access to any specialty consultation fee; and
- Whose majority professional activity is in full service family practice as described in the introduction;
- is considered the most responsible general practitioners for that patient at the time of service; and
- Where the severity of the patient's condition justifies the development of a clinical action plan.

This new fee is intended to be a case conferencing fee for complex patients who are community based rather than facility based. The full Fee Code description is attached in Appendix 1. Under the 2006 agreement is limited to use in BC patients (put 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); Diagnostic Code of one of the major disorders but on at some point, both will be required.

This fee is time based, and payable per 15 minutes or greater portion thereof. It is payable in addition to the actual visit fee code if the action plan conferencing requirements are done on the same day as a visit. A face to face visit is not required to bill this fee. While the visit fee does not need start/end times, the clinical action plan fee does require start and stop times. There is a maximum of 6 units (90 minutes) payable per calendar year per patient, with a maximum of 4 units (one hour) on any single day. This fee is available to those GPs in BC whose practice is primarily to provide longitudinal, comprehensive care to the patient, and who is considered the “Most Responsible Physician” for the patient at that time (including locums or partners in absence of the practitioner at the time the service is required). This fee is not available to physicians who are employed by or who are under contract with a facility or health authority who would otherwise have attended the conference as a requirement of their employment or contract. It is also not available for physicians working under salary, service contract or sessional arrangements.

This planning/conferencing fee is used 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 administration of a Beck Depression Inventory, MMSE, etc. as well as reviewing and documenting Levels of Intervention and No CPR documentation as appropriate. It is not for referrals to the emergency room or to consultants when only a referral letter is required for an acute illness. 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.

When charting information to support this fee, one must include the date(s) of service, the diagnosis, the reason for the clinical action plan including risk factors, which other health care professionals were contacted in developing and implementing the plan, what tests (if any) were ordered and undertaken, what the details of the plan are, when the patient will be reassessed, along with the start and stop time(s) of the conferencing/planning. There are times where the development of the plan and the involvement of other health care providers may require time over two days, and each day would then have the fee billed with a different date and time of service, along with documentation of this in the chart.

### **Frequently Asked Questions**

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

Submit the fee item G14016 (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?**

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



- 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. These physicians do have comparable encounter record fees.

- 8. 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. The transmission of information in a referral process does not qualify.

## **Acute Care Discharge Planning Conferencing Fee - Effective June 1, 2009**

**G14017** General Practice Acute Care Discharge Conference Fee: 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

### **Eligible Patient Population (refer to Table 1 for details)**

- Frail elderly (ICD-9 code V15)
- Palliative care (ICD-9 code V58)
- End of life (ICD-9 code V58)
- Mental illness
- Patients of any age with multiple medical needs or complex co-morbidity

### **Eligible Physician Population**

In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to all General Practitioners who:

- Have a valid B.C. Medical Service Plan practitioner number (registered specialty 00) (practitioners who have billed any specialty 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 following discharge from the acute care facility

### **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)).

**Frequently Asked Questions:****1. How do I claim the Acute Care Discharge Planning Conference Fee payments?**

Submit the new fee item G14017 (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?**

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

**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 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. These physicians do have comparable encounter record fees.

**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 (G14017) is not payable on the same day of service for the same patient as the Community Patient Conference Fee (G14016) or the Facility Patient Conference Fee (G14015). 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 G14017 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 G14017 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 xii under the fee description above. Hospitalists are under contract to a facility and would have attended the conference as part of their duties.

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

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

Patients of any age:

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

#### iv. *Mental illness*

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

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

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

#### v. *Patients of any age with multiple medical needs or complex co-morbidity*

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

## 9.5 Palliative Care Planning and Management Fee – Effective June 1, 2009

The Palliative Care Incentive is a payment initiative intended to compliment the existing conferencing component of end-of-life care when sharing care with other health care professionals. To date, the GPSC has developed the community and facility patient conferencing fees which appropriately compensate the family physician for their role in conferencing with other team members in supporting the care needs for these patients.

Preparation and advance care planning are a critical first step once it has been determined that a patient's 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. A new "Palliative Care Planning fee" will compensate the family physician for undertaking and documenting a care plan that 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.

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.

### **G14063 Palliative Care Planning Fee**

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) Not payable on the same day as G14069 (Palliative Care Telephone/E-mail management fee)
- x) 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.
- xi) G14043, G14044, G14045, G14046, G14047, G14048, G14049 the GPSC Mental Health Initiative Fees are payable once G14063 has been billed provided all requirements are met, but are not payable on same day.

**G14069 Palliative Care Telephone/E-mail Follow-up Management Fee**

This fee is payable for 2-way communication with eligible patients via telephone or e-mail for the provision of clinical follow-up management by the GP who has created and billed for the Palliative Care Planning fee (G14063). This fee is not to be billed for simple appointment reminders or referral notification.

**Notes:**

- i) Payable to a maximum of 5 times following successful billing of Palliative Care Planning fee G14063;



- ii) Telephone/e- mail Management requires 2-way communication between the patient and physician or medical staff on a clinical level; it is not payable for simple notification of office appointments;
- iii) Payable only to the physician paid for the Palliative Care Planning fee (G14063) unless that physician has agreed to share care with another delegated physician;
- iv) Not payable on the same day as a visit fee;
- v) Not payable on the same day as G14063, Palliative care planning fee
- vi) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement of G14016;
- vii) Not payable on same day as any of G14043, G14044, G14045, G14046, G14047, G14048 or G14049, GPSC Mental Health Initiative fees.
- viii) Not payable on same day as G14015, Facility Patient Conferencing Fee;
- ix) Not payable on same day as G14017, Acute Care Discharge Planning Conferencing Fee;
- x) 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.

### **Eligibility for G14063 and G14069**

- Eligible patients are community based (living in their home, with family or assisted living where there isn't onsite medical support).
- 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.

## 9.6 Complex Care Fees

### Introduction

#### Complex Care Fees amended effective January 1, 2010:

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 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.

The Most Responsible General Practitioner or practice group may bill these fees 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 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.*

### 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 patient the majority of their longitudinal general practice care over the preceding year, and
- Are the General Practitioner or practice group that is most responsible for the ongoing care of the patient.

### 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.

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 4 Telephone/email Follow-up fees (G14039) over the following 18 months. Once the Complex Care plan is reviewed and revised in the subsequent calendar year, the allowable G14039 resets to 4 over the following 18 months.

### **G14033 – Annual Complex Care Management Fee**

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:

- 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 when clinically appropriate;
- 6) outlines linkages with other health care professionals that would be involved in the care and their expected roles;
- 7) identifies an appropriate time frame for re-evaluation of the plan; and
- 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) *Not payable for patients seen in locations other than the office, home or assisted living residence where no professional staff on site.*

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.

### **G14039 – Complex Care Telephone/Email Follow-Up Management Fee**

Complex Care Telephone/Email Follow-Up Management fee  
 This fee is payable for follow-up management, via 2-way telephone or email communication, of patients for whom a Complex Care Management Fee (G14033) has been paid. Access to this fee is restricted to the GP that has been paid for the Complex Care Management Fee (G14033) within the preceding 18 months and is therefore Most Responsible GP (MRGP) for the care of that patient for the submitted chronic conditions. 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. As with all clinical services, dates of services under this item should be documented in the patient record together with the name of the person who communicated with the patient or patient's medical representative as well as a brief notation on the content of the communication.

#### Notes:

- i) Payable a maximum of four times per patient in the 18 months following the successful billing of G14033;
- ii) Not payable unless the GP/FP is eligible for and has been paid for the GP Annual Complex Care Management Fee (G14033) within the previous 18 months;
- iii) Telephone or e-mail management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not billable for simple notification of office appointments;
- iv) Payable only to the physician that has successfully billed for the Annual Complex Care Management Fee (G14033) unless the billing physician has the approval of the GP

responsible for the Annual Complex Care Management Fee (G14033) and a note entry is submitted indicating this;

- v) G14016, Community Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;
- vi) G14015, Facility Patient Conferencing Fee, not payable on the same day for the same patient as facility patients not eligible;
- vii) G14017, Acute Care Discharge Planning Conferencing Fee, not payable on the same day for the same patient as facility patients not eligible;
- viii) Not payable on the same calendar day as a visit fee by the same physician for the same patient.
- ix) Chart entry requires the capture of the name of the person who communicated with the patient or patient's representative as well as capture of the elements of care discussed

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**

<b>Diagnostic Code</b>	<b>Condition One</b>	<b>Condition Two</b>
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)

## 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.

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 end-of-life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care and 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. How do I bill the Complex Care Fees?

The first service must be the creation of a Complex Care Plan (see Question 2 above for details) in consultation with your eligible patient. You may then bill fee code 14033 (Annual Complex Care Management Fee) as well as the appropriate visit fee. The visit fee can be a standard in-office or out-of-office visit, a CPx, home visit, or prolonged counselling visit as appropriate

**Note:**

- a. A visit fee code **MUST** accompany the billing for the Annual Complex Care Management Fee (G14033)
- b. Fee item G14033 **MUST** be dated the same date of service as the date of the patient visit in which the Complex Care Plan was discussed.

- c. It is strongly recommended that your chart entry include the time spent in preparing the Complex Care Plan and, if a Prolonged Counselling visit is billed, the time spent on the face-to-face visit;
- d. Time spent on preparation of the Complex Care plan does not count towards the time requirement for a prolonged counselling visit

#### **4. Must I spend at least 30 minutes with the patient to bill the Annual Complex Care Management Fee?**

The complex care fee compensates for the time taken to review the chart, prepare a preliminary plan, discuss and finalize the plan with a face-to-face visit with the patient and/or the patient's medical representative, and to document the plan. It does not have to be done as a single 30-minute block, but as an aggregate amount of time spent. In most cases, GPs are reviewing the charts in advance, then meeting with the patient and/or representative, then subsequent to the meeting preparing the documentation of the final plan. It is strongly recommended, however, that your chart record include the time that has been spent in this process.

**Note:** As in Question 4 above, the date of service for the Annual Complex Care Management Fee **MUST** be the same as the date of service for the office visit in which the plan was discussed and finalized with the patient.

#### **5. 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.

#### **6. 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.

#### **7. 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. These physicians do have comparable encounter record fees.

**8. There are many co-morbidities that result in complexity of care. Why is this incentive limited to a list of seven conditions?**

According to Ministry of Health data, patients living with two or more of the eligible conditions are among the most chronically ill in the province and high users of the acute care system. As a result, the GP Services Committee has elected to introduce incentives on a smaller scale. As this revision shows, they can and will be modified depending upon the outcomes the incentive creates.

Compiling the list of eligible conditions has been a difficult task, and it has required a careful balance. It is apparent that many additional conditions create complexities in providing care, but at the same time, the 2006 Letter of Agreement stipulated a budget for all the activities of the GP Services Committee and requires that the GP Services Committee remain within that budget.

**9. My software only captures one diagnostic code per billing. How do I indicate that the patient has two?**

This has been a problem. While Teleplan requires that eligible software has the ability to enter more than one diagnostic code, many versions of software currently used do not support this. Also, vendors are currently so occupied with the Physician Information Technology Office (PITO) qualification process that we cannot realistically expect them to modify current versions.

To get around this barrier without requiring that many GPs modify their current software, the GP Services Committee created a number of different diagnostic codes to indicate different combinations of two eligible criteria.

**10. What do I do if my patient has more than two of the eligible conditions?**

Choose which two of the patient's eligible conditions to submit. Review the list of diagnostic codes provided and choose the one that reflects the two eligible conditions you wish to submit. Since the revised Complex Care payment involves the advance payment for the planning and "complexity" of the complex care conditions, but the care provided is billable on a fee-for-services basis, all patient care services are compensated as they occur regardless of the diagnoses.

**11. 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 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.

**12. What is the difference between the Complex Care Telephone/Email Follow-Up Management Fee (G14039) and the Community Patient Conferencing Fee (G14016)?**

The Complex Care Follow-Up Telephone/Email 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 two-way discussion on the provision of care to benefit the patient.

**13. 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, 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.

**14. Why is the Complex Care Telephone/Email Follow-Up Management Fee (G14039) restricted to the GP that has been paid for the Annual Complex Care Fee (G14033)?**

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 Annual Complex Care Management Fee has also accepted the responsibility of being the MRGP for that patient's care for the two submitted chronic illnesses for that calendar year. The Annual Complex Care Management Plan requires 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 clinical action plan.

**15. If the Complex Care Telephone/Email Follow-Up Management Fee is restricted to the GP who has been paid for the Annual Complex Care Management Fee, what do group practices do when they share the care of the patient?**

An exception has been made, allowing another GP to bill for this fee with the approval of the MRGP. This allows flexibility in situations when patient care is shared between GPs. In this circumstance, the alternate GP must submit the claim with a note record indicating he/she is in the group of the MRGP and is sharing the care of the patient.

If a disagreement arises about the billing of this service, the GP Services Committee will adjudicate based upon whether the MRGP, 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.

**16. Can I bill the Follow-up Management fees if I have billed for the Annual Complex Care Fee, but have not yet been paid?**

Adjudication of this will depend upon whether the GP is eventually paid for the Annual Complex Care Fee. In other words, if a GP bills the Annual Complex Care Management Fee (G14033) then provides—and bills for—a follow-up service under G14039 prior to receiving payment for G14033, payment for G14039 will be made only if G14033 is subsequently paid to that GP. Until that time it will show as “BH” on the remittance.

**Billing Tips**

- CDM fees 14050/14051/14052/14053 are payable on the same day for the same patient if all other criteria are met.
- Community conferencing fee 14016 payable on the same day for the same patient if all other criteria are met.
- Facility conferencing fee 14015 only payable on the same day for the same patient if a community-based patient is temporarily in a facility (e.g., sub-acute care unit) when both the complex care planning and conferencing occur and if all other criteria are met.
- Cardiovascular risk assessment fee 14034 payable on the same day for the same patient if all other criteria are met for complex patients who live at home or in an assisted-living facility (excluding long-term care facilities).
- Out-of-office fees can be billed in addition (provided criteria have been met)

**Example:**

Month	Service	Bill	
Jan	Major Complex Care Planning Visit	14033	\$315.00
		16100	\$32.08
Feb	Phone call Complex Care Office Visit  Complex Care Office visit	14039	\$15.00
		16100	\$32.08
		16100	\$32.08
March	Phone call CPX	14039 16101	\$15.00
			\$71.34
July	Complex Care Office Visit	16100	\$32.08
Sept	UTI Office Visit	16100	\$32.08
		15130	\$1.96
Oct	Complex Care Office Visit – Minor Care Plan review	16100	\$32.08
Dec	Complex Care Office Visit  Office visit for asthma flare	16100	\$32.08
		16100	\$32.08
Total			\$674.94

## 9.7 Preventative Fee

The GPSC has developed the following initiative to improve disease prevention.

### **G 14034 Cardiovascular Risk Assessment Fee:**

Effective June 1, 2009, the patient age range eligible for the GPSC cardiac risk assessment fee item G14034 has been expanded to 18-69 years, inclusive provided all other fee item criteria are met. Therefore the following note listed beneath fee item G14034 has been amended:

*i) The eligible population will be males or females between 18 and 69 years of age, inclusive.*

Reminder: The maximum calendar year limit per physician is 30 services

This fee is payable on the completion of cardiovascular risk assessment of an individual using the parameters of age, gender, smoking status, fasting blood sugar, blood pressure, and lipid profile as a minimum. More detailed assessment parameters could include family history, waist circumference, diet, alcohol use, exercise levels, and stress levels.

Notes:

- i) the eligible population will be males or females between 18 and 69 years of age, inclusive.
- ii) a chart record is required that includes the minimum parameters above and evidence of an appropriate response to major high risk findings, including interventions, prescriptions, referrals to appropriate health care professional and/or linkages with community supports;
- iii) interventions should be aligned with the current guidelines published by the Guideline and Protocol Advisory Committee (GPAC); e.g. Diabetes, hypertension, lipids;
- iv) payable for a maximum of 30 patients per physician per calendar year;
- v) Payable in addition to office visit fee(s) billed same day
- vi) Payable once per calendar year per patient.

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 optional. The essence of the activity is that the family physician discusses with the patient the major risk factors and their presence or absence.

### **Eligibility**

- Payable only to the General Practitioner or practice group 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.

## **Rationale**

### **Person/Population Focus**

Over one million people in British Columbia currently live with one to three chronic diseases. Almost half of the population is at risk for and/or has been tested for a chronic disease. A key response to the demographic and disease trends towards an increasingly older population with more chronic diseases is to invest in strategies that will prevent or delay the onset of chronic diseases. There is growing evidence that this is possible. According to the World Health Organization, 80% of the cases of some chronic diseases such as Type 2 diabetes can be prevented. Research has found that moderate exercise and diet control among overweight people with pre-diabetes (impaired glucose tolerance) reduces the likelihood of developing diabetes by more than 50%. Many chronic diseases such as diabetes and cardiovascular disease have similar risk factors. Addressing these common risk factors, reducing tobacco and alcohol use, eating healthily and being active underlies the logic for the cross-government ActNow initiative. However, despite the evidence, for many people understanding and making healthy choices remain elusive. People are faced with life-time habits, lack of resources or family/social supports, or life's pressures that make "adding something else" impossible. Personal change needs the same support as professional change i.e.:

- to receive and understand personal data to show the outcome of remaining with the status quo;
- to learn evidence-based approaches that have worked for many other people
- to put those approaches into action with others (buddy, group, family)
- to measure results and be accountable for these results to others

### **Physician Focus**

Family physicians want to provide their patients with preventative care. The role of the family physician in prevention is twofold: (a) very influential health professional and (b) facilitator. Most physicians can already identify these patients in their practices. The family physician can use a variety of tools to assess risk of chronic diseases – and share these data with the patient. The focus of this initiative is to more formally introduce the process of cardiovascular risk assessment and follow up to family practice.

### **Health System Focus**

The current health system is not linked to community resources in a way that supports health improvement for the majority of the population. Most communities have infrastructure, services and resources that can provide support to people who want to quit smoking, reduce alcohol intake, improve their diet and increase their activity levels. However, these resources are not often linked together and are very rarely formally linked to primary health care. Family physicians and their patients are not going to succeed at very difficult life changes for health if supports and expertise are not readily available. To this end GPSC has linked with Health Authorities and the BC Healthy Living Alliance – responsible for creating an effective infrastructure in communities to supply people, identified as being at risk of developing chronic disease, with tools, supports, and opportunities for healthy change.

Community infrastructure for overall health must be clearly identifiable to family physicians and their patients. Therefore, regional change teams put into place through GPSC non-compensation funding will be required to provide physicians with direct facilitation support and/or referral information for each community. In addition, family physicians wishing to take on the direct facilitation role with their patients will also be supported and trained in group patient visits.

### **Principles for the Prevention Payment**

- Focus on the patients at greater risk for the onset of chronic disease
- Achieve equity of access to improved health status for patients. Horizontal equity refers to similar public funding for patients with similar needs. Vertical equity refers to more support given for patients with greater need;
- Reward the intervention and knowledge of the family physician with direct facilitation and/or referral to information and community-based services
- Retain and encourage family physicians already providing preventative care and encourage general practitioners currently targeting patients who have relatively straight forward clinical needs to take on their greater share of at risk patients.
- The 2007 GPSC approach to prevention is experimental. It is understood that not all higher risk patients will be identified through this initiative. GPSC will work closely with Family Physicians to determine the effectiveness of this incentive from the perspectives of patient, provider, and system, and retains the right and authority to modify this incentive based on results. It is anticipated that future initiatives in preventative care will evolve through ongoing input from Family Physicians

## Frequently Asked Questions

**1. Why is the prevention fee limited to cardiovascular risk assessment, rather than allowing a broader range of choices?**

The funding for prevention is only 5% of the new funds allocated to GP Services in the 2006 Letter of Agreement. The GP Services Committee is also charged under the 2006 agreement with evaluating and reporting on the outcomes of any initiatives it introduces. The committee therefore felt that it would be more likely to see a measurable difference with a more focused initiative at this time.

**2. Why is the age range restricted to men ages 40-49 and women ages 50-59?**

Effective June 1, 2009 the patient age range eligible for the GPSC cardiac risk assessment fee item G14034 has been expanded to 18-69 years, inclusive provided all other fee item criteria are met.

**3. Am I able to do the Cardiovascular Risk Assessment on any person in those age ranges?**

Yes. At the same time it is also hoped that GPs will use discretion in using this initiative just as they use discretion in using other fees, and will focus on their patients who are at higher risk.

**4. Am I eligible to bill for an office visit, procedure, or conference fee on the same day?**

Yes.

**5. Why is it payable for only 30 patients per year?**

This decision was made for financial reasons. First, the prevention budget as noted above is limited. Second, as this is a trial entry into the field of prevention initiatives, the GP Services Committee decided to take a more limited ‘first step’ in order to see what the outcomes of this initiative would be.

A GP is always permitted to do a cardiovascular risk assessment on more than 30 patients per year, but our budget limits the payment to only 30. It is conceivable, too, that the time and effort needed to perform this risk assessment and subsequent patient counselling will become easier and less time-consuming as it is done more often.

**6. Why is this fee payable only to the “General Practitioner or practice group 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 assessment 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.

**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 are appropriate and so this may be billed on the same patient every year. If in your clinical judgement, risk assessments every two years would be appropriate, this would free up additional Cardiovascular Risk Assessment fees in alternate years.

**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. Programs such as Healthy Hearts, Canadian Lung Association, Canadian Heart and Stroke Foundation, etc. have patient support materials available.

**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. These physicians do have comparable encounter record fees.

**10. Is there any plan to expand this in the future to other conditions?**

While this area of prevention care is a first step, expansion into other areas has been discussed at GPSC and will be revisited in the future depending on the feedback and assessment of this initiative.

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

No. A paper risk scoring sheet has been provided for patient education if the physician wishes to use it. Some physicians may decide use an electronic risk calculator when educating their patients. Use of these tools is completely optional.

**12. Will MSP automatically refuse my claims for the Cardiovascular risk assessment fee if I submit more than 30 claims in the calendar year?**

No. You should keep track of the number of risk assessments you have billed. These items are subject to audit and recovery.

**13. Is this prevention fee billable during group clinical visits?**

No.



## 9.8 Mental Health Initiative

### Introduction

The current health system designed for episodic care can create a substantial burden on both patients living with mental illness and the family physicians who provide the bulk of their care. British Columbians, through the Conversation on Health process, have identified mental health and addictions as a major concern of the health system. The inability of the current system to respond to serious mental illness results in very high burden to patients and their families and, in terms of health system costs because of unnecessary emergency department, hospitalizations and re-hospitalizations. In addition, studies of regional variation in expenditure for specialist services have demonstrated that greater specialist inputs do not produce better outcomes. International and inter-jurisdictional studies have shown that populations that have better access to primary care have better health outcomes. For example, in the Downtown Eastside of Vancouver, 70% of the population living with mental illness and addictions do not have access to primary health care. The purpose of the mental health initiative is to encourage better access to primary care for people with mental illness, and to improve the quality of that care, with special attention to coordination of care planning and continuity of information and to encourage a shared care model of management where possible. The ultimate goal of these improved care processes is to improve the health outcomes of the patients in terms of both better quality of life and reduced mortality and morbidity.

### Mental Health Initiative

Family physicians 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.

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 – or practice – will need to accept the role of being Most Responsible for the longitudinal, co-ordinated care of that patient for that calendar year

The Mental Health Planning Fee and resulting access to an increased number of billable GP management/counselling 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 (G14016) 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, and/or 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:

- 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 I 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.

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 visit fees equivalent to the current age differential 00120 series. These fees are billable after the current four counselling visits per year (00120 fees per *MSC Payment Schedule*) have been billed.

- 2) 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. 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 five times per calendar year, for either physician-initiated or patient-initiated follow up.

The Mental Health Telephone/Email Management Fee may be billed on the same day as the community patient conferencing fee (G14016) 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.

### **G14043 GP Mental Health Planning Fee**

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:

- 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. 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 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 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) Not payable on the same day as G14049 (GP Mental Health 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.

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

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;
- 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 G14049 (GP Mental Health Telephone/Email 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;
- ix) CDM fees (G14050, G14051, G14052, G14053) payable if all criteria met.

**G14049 GP Mental Health Telephone/Email Management Fee**

This fee is payable for two-way communication with eligible patients via telephone or email for the provision of clinical follow-up management by the GP who has created and billed for the GP Mental Health Planning Fee (G14043). This fee is not to be billed for simple appointment reminders or referral notification.

## Notes:

- i) Payable to a maximum of five times within 18 months following the successful billing of G14043;
- ii) Not payable unless the GP/FP is eligible for and has been paid for the GP Mental Health Planning Fee (G14043) within the previous 18 months;
- iii) Telephone/Email Management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office appointments;
- iv) 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;
- v) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;
- vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;
- vii) 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;

**Eligibility for G14043, G14044, G14045, G14046, G14047, G14048, G14049**

- Eligible patients are community based, living in their home or assisted living. Facility based patients are not eligible.
- Payable only to the GP or practice group 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 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.

## 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.

This initiative is designed to focus on those patients with greater need and those that require more time of the community General Practitioner (GP), so the eligible patient population is restricted to patients living in the community (their own homes or assisted living) who:

- Have an Axis I diagnosis confirmed by DSM IV criteria, with
- Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan would be appropriate.

### 2) 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 his/her home or assisted living (excludes care facilities) with a diagnosed DSM IV Axis I 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. It requires a face-to-face visit with the patient, with or without the patient's medical representative. The patient and/or their representative/family should leave the planning process knowing there is a plan for 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. GP Services Committee 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 I 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.

### 3) How do I bill the Mental Health Fees?

The first service must be the creation of a Mental Health Plan as described in Question 2 above. This acts as a "portal" to access the other Mental Health Management Fees. The GP Mental Health Planning Fee (G14043) may be billed once per calendar year per patient upon:

- i) confirming that the patient is living in his/her own home or in assisted living;
- ii) confirming through DSM IV criteria that the patient has an Axis I disorder;
- iii) determining 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
- iv) creating a Mental Health Plan for that patient that includes all of the elements outlined in fee G14043 (See Question 2 above).

#### Note:

- (a) A visit fee code **MAY** accompany the billing for the GP Mental Health Planning Fee (G14043), but this is not a requirement. The first 30 minutes of time is the requirement of the GP Mental Health Planning Fee (G14043); additional time past the first 30 minutes counts towards the visit fee that may be billed in addition to G14043;
- (b) this visit may be a standard office or out-of-office visit, a CPx, home visit, or a Prolonged Counselling visit as appropriate;
- (c) Fee item G14043 **MUST** be dated the same date as the patient visit in which the Mental Health Plan was discussed/confirmed;

- (d) It is strongly recommended that your chart entry include the time spent in preparing the Mental Health Plan and, if a visit is also billed, the amount of time spent with the patient in addition to the minimum 30 minutes required to bill G14043;
  - (e) Time spent on preparation of the Mental Health plan does not count towards the time requirement for a Prolonged Counselling visit.
- 4) **Must I spend a single block of at least 30 minutes with the patient to bill the Mental Health Planning Fee (G14043)?**

Unlike the Complex Care Fee, the Mental Health Planning Fee does require a minimum block of 30 consecutive minutes in face-to-face interaction with the patient. Provision of quality mental health care through assessment, development of a plan, and discussion with the patient and/or patient's medical representative does require more face-to-face time than a regular office visit.

A block of 30 minutes in face-to-face contact with the patient is therefore required to bill the GP Mental Health Planning Fee G14043. Time spent in addition to 30 minutes counts towards the visit fee that may be billed on the same day. It is strongly recommended that your chart entry include the time spent in preparing the Mental Health Plan and, if a visit is also billed, the amount of time spent with the patient in addition to the minimum 30 minutes required to bill G14043.

- 5) **May I bill the Mental Health Planning Fee (G14043) on every patient I have with a qualifying diagnosis?**

The fee requires **both**:

- a qualifying Axis I diagnosis, and
- that this diagnosis has “a Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan would be appropriate.”

Many patients with an Axis I diagnosis are stable, or of a lower severity/acuity level so that extra time is not required to provide their care. It would not be appropriate to bill for these patients. The Mental Health Management Fee (G14043) is designed to remove the disincentive to providing the time to those qualifying patients who truly need it.

While it may be billed once in a calendar year, it is not intended to be an annual fee, as not all patients require a mental health plan each year; many people with depression remain stable or in remission for years. The need for a mental health plan would depend upon the acuity of the patient's condition.

Whether the patient needs an annual plan or not is left to your professional judgement and to trust. If the annual Mental Health Management Fee is billed for all Axis I patients, the GP Services Committee will have fewer funds to allocate for other areas requiring support.

- 6) **When can I bill the Mental Health Management Fees (G14044-G14048)?**

The MSP counselling fees (the 00120 series) are limited to four visits per patient per calendar year. Managing patients with a significant mental health diagnosis, however, may require



more than four counselling visits per year. The GPSC Mental Health Management fees provide an additional four counselling visits per calendar year to provide counselling to these patients. They are payable only after all four 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.

**Notes:**

This fee is payable only if the GP or practice has billed and been paid for the Mental Health Planning Fee (G14043). (*A note record is required if billed by another physician sharing care with the MRGP – see # 8 and #15 below.*)

- i. These fees are payable only after the standard MSP 00120 series has been fully utilized;
- ii. Payable to a maximum 4 times per year per patient.

**7) When can I bill the Mental Health 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 is payable for two-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).

**Notes:**

- i. Payable to a maximum of five times within 18 months following the successful billing of G14043;
- ii. Not payable unless the GP/FP is eligible for and has been paid for the GP Mental Health Planning Fee (G14043) within the previous 18 months;
- iii. Telephone/Email Management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office appointments;
- iv. 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;
- v. G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;
- vi. Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;
- vii. 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;

**8) How would our group practice arrange to be able to 'share' these Mental Health Management Fees?**

To make these fees as flexible as possible in the variety of practice styles found in the province, GPSC decided that no specific steps should need to be taken. We will become involved only if a GP who has billed and been paid for the 'portal' fee - the GP Mental Health Planning Fee (G14043) – lodges a complaint with GPSC. In that case, we will adjudicate based upon which GP has been paid for fee item G14043.

**9) What is the difference between “assisted living” and “care facilities”?**

There is a wide range of living facilities available. Some, referred to under the terms of this initiative as ‘assisted living’ facilities, provide basic supports, such as meals and housecleaning, and are unable to provide 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 provides supervision and support from other health professionals such as nurses.

**10) Why is this incentive limited to patients living in their homes or in assisted living?**

While there may be exceptions, residents 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 usually do not have such a team, and the organization and supervision of care is usually more complex and time consuming for the GP.

**11) 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. These physicians do have comparable encounter record fees.

**12) 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-G14048) 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-G14048) or as a result of the Mental Health Telephone/Email Management (G14049), 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 Mental Health Telephone/Email Management (G14049) does not count toward the total time billed under the Community Patient Conferencing Fee (G14016).

**13) 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 and/or Congestive Heart Failure, the CDM payment(s) G14050/G14051 are payable in addition to the Mental Health Care payment(s). Additionally, if the patient does not have Diabetes and or CHF, but does have hypertension, the CDM payment for this (G14052) is payable in addition to the Mental Health Initiative payment(s). These are payable on the same day as long as all criteria are met.

**14) Why is the Mental Health Telephone/Email Management Fee (G14049) restricted to the GP that has been paid for the Mental Health Planning Fee (G14043)?**

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 Mental Health Planning Fee has also accepted the responsibility of being Most Responsible for that patient's care for mental health diagnoses for that calendar year. The Mental Health Plan requires work, the shouldering of responsibility, and has considerable value. This fee is therefore restricted to the GP that has created the mental health plan.

**15) If the GP Mental Health Management fees (G14044-G14048) and the GP Mental Health Telephone/Email Management fees (G14049) 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?**

An exception has been made, allowing another GP to bill for this fee with the approval of the Most Responsible GP (MRGP). This allows flexibility in situations when patient care is shared between GPs. In this circumstance, the alternate GP must submit the claim with a note record indicating he/she is in the group of the MRGP and is sharing the care of the patient. If a disagreement arises about the billing of this service, GP Services will adjudicate based upon whether the Most Responsible GP, i.e. the GP paid for the Annual Mental Health Planning Fee, approved or did not approve the service provided. GP Services feels that this provides the maximum flexibility while still maintaining responsibility.

**16) 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 G14049 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.

**17) Are any of the Mental Health fee items eligible for rural premiums (RRP)?**

The Mental Health Management fee items (G14044 – G14048) are eligible for RRP.