SPECIALIST SERVICES COMMITTEE INITIATED LISTINGS

The following Specialist Services Committee (SSC) fee items are available to BC specialist physicians who are a certificant or fellow of the Royal College of Physicians and Surgeons of Canada.

The objective of the SSC fees is to facilitate improved care for patients by avoiding unnecessary face to face encounters, being seen by the most appropriate physician, and receiving faster access to specialist advice and addressing care gaps.

1. G10001, G10002, G10003, G10004 please refer to section D. 1. (Telehealth Services) of the General Preamble.

2. G10002, G10004, G10005 A non-exclusive list of allied care providers is included below:

   Nurses, Nurse Practitioners, Mental Health Workers, Dieticians, Physiotherapists, Occupational Therapists, School counsellors, Pharmacist, Social worker, Substance use worker, Patient navigators, audiologist, Psychologist, Physiologist, Kinesiologist, Optometrist, Orthotist, Orthoptist, Perfusionist, Respiratory therapist, Speech-Language pathologist, Home Care Coordinator, Educators, Midwives, Long-term care coordinators/managers, Registered Counsellor, Prosthetist, Behavior interventionist, Behavior consultant, All other registered and regulated professionals.

3. Electronic communication as part of patient care must ensure that security and patient confidentiality are maintained and guarded in the same way that paper records are protected. The Canadian Medical Protective Association (CMPA) and the College of Physicians and Surgeons of British Columbia (CPSBC) recommendations regarding the use of electronic communications indicate:

   - Three major areas of potential liability:
     - Confidentiality/privacy/security
     - Timeliness of Response
     - Clarity of Communication
   - Physician should document consent, preferably written. Obtain express and informed consent before transmitting patient information electronically. Refer to the CMPA Template for consent to use electronic communications: https://www.cmpa-acpm.ca/
   - Physician should document discussion & advice for all manners of communication. The email record should be included in the patient record.
   - Consider sensitivity before emailing (e.g.: Ca Dx). Develop clear, written policies around use of email in your practice and ensure they are consistently followed.
   - Communication between providers should clearly identify the MRP (most responsible physician).
   - Confidential & sensitive information should be encrypted as an attachment or at a minimum, password protected. Send password or cryptographic key separately.
   - Physicians are encouraged to use secure communication modalities (i.e.health authority email addresses) if possible.
   - Email addresses need to be double checked.

4. SSC fees are not eligible for communication by text/short message service (SMS) modality.

5. SSC fees are not payable to physicians for services provided within time periods when working under salary, service contract or sessional arrangement.

6. G10001, G10002, G10005 may not be delegated to resident physicians.

7. No claim may be made where communication or service is with a proxy for the physician.

8. SSC fees are not payable for situations where the sole purpose of the communication is to:
    a) book an appointment
    b) arrange for transfer of care that occurs within 24 hours
    c) arrange for an expedited consultation or procedure within 24 hours
    d) arrange for laboratory or diagnostic investigations
    e) inform the referring physician of results of diagnostic investigations
    f) arrange a hospital bed for the patient
    g) renew prescriptions with a pharmacist

9. The SSC reserves the right to reduce, suspend or cancel these fee items.

10. Out-of-Office Hours Premiums may not be claimed in addition to SSC fees.

11. G10001, G10002, G10004 and G10005 are not payable to the same patient on the same date of service if adult and pediatric critical care team fees have been paid by any practitioner/same site.

12. When advice is requested by an Allied Care Provider not registered with MSP use the generic practitioner number 99987: Advice requested by an allied care provider. (Not applicable to referred case fee items such as consultations or specialist visits).

Fees will be monitored to ensure that the overall expenditures do not exceed the funds available. Changes may be made to the fees to ensure financial accountability and effectiveness.

G10001 Urgent Specialist Advice - Initiated by a Specialist or General Practitioner, Response within 2 hours 60.00

The purpose of this fee is for the specialist to provide urgent real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.

Notes:

i) Payable to Specialist Physicians for urgent real-time advice (including telephone, video technology or face to face communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Conversation must take place within two hours of the initiating physician's request. Not payable for written communication (i.e. fax, letter, email).

iii) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iv) An Adequate medical record/chart entry, including time of initiating request and time of response as well as advice given and to who, is required.

v) Include the practitioner number of the physician requesting advice in the "referred by" field when submitting claim.

vi) Limited to one claim per patient per physician per day.

vii) Not payable to physician initiating communication.

viii) Not payable in addition to another service on the same day for the same patient by same practitioner.

ix) The specialist is responsible for the confidentiality and security of all records and transmissions related to video technology.

x) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 180 days.

G10002 Specialist Advice for Patient Management - Initiated by a Specialist, General Practitioner or Allied Care Provider, Response in one week – per 15 minutes or portion thereof 40.00

The purpose of this fee is for the specialist to provide real-time advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.

Notes:

i) Payable to Specialist Physicians for real-time advice (including telephone, video technology or face to face communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Conversation must take place within 7 days of initiating request.

iii) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iv) An adequate medical record/chart entry, including time of initiating request as well as advice given and to whom, is required.

v) Include the practitioner number of the physician or allied care provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987).

vi) Include start and end times in the patient's chart/medical record and time fields when submitting claim.

vii) Limited to two services per patient per physician per week.

viii) Not payable to physician initiating communication.

ix) Not payable in addition to another service on the same day, for the same patient by same practitioner.

x) The specialist is responsible for the confidentiality and security of all records and transmissions related to video technology.

xi) Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 30 days.

G10005 Specialist Email Advice for Patient Management - Initiated by a Specialist, General Practitioner or Allied Care Provider, Response in one week.....10.10

The purpose of this fee is for the specialist to provide email advice when the intent of communication is to replace the need for the specialist to see the patient in person. The consulting specialist is responsible for ensuring that an appropriate communication modality is used to meet the medical needs of the patient.

Notes:

i) Payable to Specialist Physicians for email communication regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Communication must take place within 7 days of the initiating request.

iii) Includes discussion of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iv) An adequate medical record/chart entry, including time of initiating request as well as advice given and to whom, is required.

v) Include the referring practitioner number of the physician or allied care provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987).

vi) Limited to three services per patient per physician per day.

vii) Limited to maximum of 12 services per patient per physician per year.

viii) Not payable to physician initiating communication.

ix) Not payable in addition to another service on the same day, for the

same patient by same practitioner.

x) Not payable if patient was seen (visit, consult or procedure) in previous 30 days.

G10004 Multidisciplinary Conferencing for Complex Patients

A scheduled meeting to discuss and plan medical management of patients with serious and complex problems under extraordinary circumstances where the patient is too complex for the specialists to deal with on his/her own. Payable only when coordination of care is required via a collaborative conference with at least two of the following: other specialists, GPs, allied health providers and/or coordinators of the patient's care.

Per 15 minutes or major portion thereof.....46.23

Notes:

i) Includes scheduled face to face, telephone or video technology communication regarding assessment, clinical coordination and management of a complex patient.

ii) Patient must have one of the following:

- *a. Multiple medical needs or complex 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. Please use the ICD9 code for one of the major disorders when submitting your billing.*
- *b. Diagnosis of malignancy (excluding non-melanoma skin cancer). Please use the ICD9 code for one of the major disorders when submitting your billing.*
- *c. One morbidity plus a minimum of one of the following non-medical conditions: poor socioeconomic status, unstable home environment, dependency on family/caregiver for daily living tasks, accessibility/mobility issues, under care of MCFD Protection Services, received Tertiary or Acute level of care related to psychiatric condition within the previous 6 Months, frail elderly, >75 years old, BMI > 35 or high readmission rate. Please use the following code M04 when submitting your billing.*

iii) All specialists involved in the conference may each independently bill for this fee.

iv) Not payable to the same patient on the same date of service as 00545, 00645, 60645, G33445, G10001, G10002, G10003, G10005, G10006, G78717 when claimed by the same practitioner.

v) Not payable to the same patient on the same date of service if adult and pediatric critical care team fees have been paid to the same practitioner or a practitioner who belongs to the same critical care team.

vi) Each specialist involved in the case conference must document their contribution to the discussion and its effect on the patient's overall care in the medical record/chart along with the start and end times of the conference, and the names and job titles of the other participants at the meeting.

vii) Claim must state start and end times for the service.

viii) Maximum of 4 services may be claimed per patient per physician per day.

ix) Maximum of 16 services per patient per physician per calendar year.

x) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods and services are to be claimed under the PHN of each patient for the specific time period.

Specialist Group Medical Visits

Referred Cases

A Group Medical Visit provides medical care in a group setting. A requirement of a GMV is a 1:1 interaction between each patient and the attending physician. Because this is a time based fee, concurrent billing for other services during the time of the GMV is not permitted. The physician must be physically present at the GMV for the majority of each time interval billed. While portions of the GMV may be delegated to a non-physician staff member, the specialist must be present for a majority of the GMV and assumes clinical responsibility for the patients in attendance.

Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction. Physicians can also benefit by reducing the need to repeat the same information many times and free up time for other patients. Appropriate patient privacy is always maintained and typically these benefits result in improved satisfaction for both patients and physicians. The Group Medical Visit is not appropriate for advice relating to a single patient. It applies only when all members of the group are receiving medically required treatment (i.e. each member of the group is a patient). The Group Medical Visits are not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns other than in the context of the individual medical condition.

		Total Fee $
Fee per patient, per 1/2 hour		
G78763	Three patients	47.16
G78764	Four patients	37.67
G78765	Five patients	32.75
G78766	Six patients	29.13
G78767	Seven patients	26.58
G78768	Eight patients	24.66
G78769	Nine patients	23.15
G78770	Ten patients	21.90
G78771	Eleven patients	19.19
G78772	Twelve patients	18.05
G78773	Thirteen patients	16.71
G78774	Fourteen patients	16.41
G78775	Fifteen patients	15.75
G78776	Sixteen patients	15.27
G78777	Seventeen patients	14.64
G78778	Eighteen patients	14.41
G78779	Nineteen patients	13.80
G78780	Twenty patients	13.47
G78781	Greater than 20 patients (per patient)	13.01

Notes:

i) A separate claim must be submitted for each patient.

ii) An active referral is required by a medical practitioner or a health care practitioner for each patient.

iii) Claim must state start and end times for the service.

iv) Service is not payable with other services, for the same patient, on the same day.

v) Where two physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate per patient for the reduced group size. Each claim should also indicate "group medical visit" and also identify the other physician.

vi) *This fee is not intended for providing group psychotherapy (00663, 00664, 00665, 00666, 00667, 00668, 00669, 00670, 00671, 00672, 00673, 00674, 00675, 00676, 00677, 00678, 00679, 00680, 00681).*