

Preamble - General Practice Services Committee (GPSC) Initiated Listings

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. These fees were previously administered by the General Practice Services Committee (GPSC). Note that the GPSC Preamble governs the GPSC initiated listings in this section, however, the GPSC Preamble does not apply to the rest of the MSP fee listings.

Unless otherwise identified in the individual fee description, physicians are eligible to bill the following incentive payments if they are:

1. A Family Physician who has a valid BC MSP practitioner number;
2. Currently in family practice in BC as a community longitudinal family physician;
3. The most responsible physician/provider for the majority of their patients' longitudinal primary medical care.

Unless otherwise identified in the individual fee description, physicians are NOT eligible to bill GPSC Incentives if:

1. They are working under an Alternate Payment/Funding model as defined below and their duties would otherwise include provision of this care; and
2. They have billed any specialty consultation fee in the previous 12 months.

Additional detailed eligibility requirements are identified in each section.

Definitions in GPSC Initiated Listings:

(1) Physicians

Community Longitudinal Family Physician (CLFP)

For the purpose of GPSC incentives, a family physician is working as a "Community Longitudinal Family Physician" (CLFP) when they do all of the following:

- Assume the role of Most Responsible Physician/Provider (MRP) for a known panel of patients.
- Confirm patient-physician relationship with their patients through a standardized conversation or "compact", as outlined in PG14070.
- Provide, or coordinate delivery of, longitudinal full scope family medicine primary care services to a patient panel that is inclusive of patients of diverse demographics and medical needs.
- Work in community settings such as physician offices or health care clinics where patients are seen in person. CLFP may also provide some virtual services to their patient panel via telephone, video or other virtual care modality. CLFP may also provide some services to patient panel in facility settings such as hospitals, long term care, hospices, assisted living, or group homes.
- Maintain the comprehensive longitudinal medical records of each patient on patient panel.

A family physician is not considered to be working as a CLFP while they are working solely in one or more of the following health care settings:

- Episodic care settings such as (but not limited to) walk-in clinics, urgent care centres, and hospitals, where physician does not assume the role of MRP for patients.
- Virtual care settings where patient care is delivered via telephone, video, or other virtual care modalities.

- Focused practices serving a specific patient population or providing sub-specialty services such as (but not limited to) maternity care, palliative care, sports medicine, chronic pain, and addiction care.
- Facility settings such as (but not limited to) hospitals, long term care, hospices, assisted living, or group homes.

Family Physician with Consultative Expertise

GPSC defines a Family Physician with Consultative Expertise as: “A family physician who has consultative expertise and provides consultative services or support to colleagues through a health authority supported or approved program. Examples of health authority supported programs include (but are not limited to) mental health, addictions, palliative, chronic pain, and emergency medicine.

Locum Tenens

For the purpose of its incentives, GPSC defines a locum tenens as a physician with appropriate accreditation who substitutes on a temporary basis for another physician who is away from practice.

Most Responsible Physician/Provider (MRP)

For the purpose of its incentives, the GPSC defines “Most Responsible Physician/Provider” (MRP) as a physician who takes responsibility for directing and coordinating the ongoing care and management of a patient. This includes coordinating clinical services delegated to other providers, ensuring cross coverage when MRP is unavailable, and coordinating referrals to specialty care when needed.

(2) Allied Care Providers

Allied Care Provider

For the purposes of incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Nurses; Nurse Practitioners; Mental Health Workers; Midwives; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dietitians; Physiotherapists; Occupational Therapists; and Pharmacists etc.

Note: *Not all allied care providers are College-certified.*

College-certified Allied Care Provider

Allied Care Providers who are College-certified are governed by a provincial regulatory college or body. Specific GPSC incentives may require ACPs to be College-certified for the delegation of tasks, whereas other GPSC incentives may not require ACPs to be College-certified to undertake delegated tasks. Fee notes will clearly indicate whether the ACP must be College-certified to be delegated tasks.

Allied Care Provider “Employed by” a Physician Practice

For the purposes of its incentives, GPSC defines Allied Care Providers (ACPs) “employed by” a physician practice as ACPs who are employed by a physician practice and paid out of practice earnings to work directly within the practice team, with no cost recovery either directly or indirectly from a third party (e.g.: Health Authority, Division of Family Practice, Ministry of Health, etc.), unless otherwise specified.

Allied Care Provider “Working Within” a Physician Practice Team

For the purpose of its incentives, GPSC defines Allied Care Providers (ACPs) “working within” a physician practice team as ACPs who work as part of an FP practice’s team to support the ongoing care of its patients. The costs of an ACP “working within” the practice team may be paid either by the physician practice or by a third party (directly or indirectly). ACPs employed by a Health Authority are considered to be “working within” the practice team if they are assigned to work with an FP practice to support the longitudinal care of its patients. By contrast, ACPs not assigned to work with an FP practice and who provide episodic services to patients on a referral basis such as through Specialized Health Authority

Programs or in stand-alone chronic disease clinics are not considered to be “working within” the physician practice team.

(3) Payment Models

Alternative Payment/Funding Model:

For the purposes of these fees Alternative Payment/Funding Model means an Alternative Payment Arrangement or Alternative Funding contract between an entity (e.g.: Ministry of Health, Health Authority or other organization) and an individual physician or physician clinic. An Alternative Payment Arrangement or Alternative Funding contract may or may not be governed by the Physician Master Agreement. If services supported and paid through GPSC incentives are already included in an Alternative Payment/Funding Model contract, GPSC incentives are not billable in addition. Private agreements between physicians to pool FFS billings and pay out physicians in a mutually acceptable way (e.g.: per day, per shift, per hour, etc.) are not considered as an Alternative Payment/Funding Model.

(4) Miscellaneous

Assisted Living:

For the purpose of its incentives when referring to assisted living, GPSC utilizes the ministry definition as found at: <https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living>

Care Plan

For the purpose of its incentives, when referring to a care plan, GPSC requires documentation of the following core elements in the patient’s chart, as follows:

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face to face planning visit with the patient, or the patient’s medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient’s care;
6. Documentation of patient’s current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient’s values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient’s care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient’s medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. 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.

Face to Face

For the purpose of its incentives, GPSC defines “face to face” to mean in in-person.

Living in Community

For the purpose of its incentives, GPSC considers patients living in group homes to be living in community.

Patient's Medical Representative:

For the purpose of its incentives, GPSC defines Patient's Medical Representative as outlined in the "Health Care (Consent) and Care Facility (Admission) Act".

Representative means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative.

Temporary Substitute decision makers (Alternate Representative) in listed order, of the following who is available and qualifies under subsection 16(2):

- (a) the adult's spouse
- (b) the adult's child
- (c) the adult's parent
- (d) the adult's brother or sister
 - (d.1) the adult's grandparent
 - (d.2) the adult's grandchild
- (e) anyone else related by birth or adoption to the adult
- (f) a close friend of the adult
- (g) a person immediately related to the adult by marriage

Patient self-management

Patient self-management can be defined as the decisions and behaviours that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. There are a variety of publicly available tools that FPs can provide to patients, to help build the patients' skills and confidence to manage their chronic conditions.

Patient Panel

For the purpose of its incentives, the GPSC defines a "patient panel" as the group of patients for which a family physician has assumed the role of MRP, and has confirmed their ongoing patient-physician relationship.

1. Community Longitudinal Family Physician Portals (PG14070, PG14071)

Submitting code PG14070 provides access to the following fee codes:

- PG14075 FP Frailty Complex Care Planning and Management Fee
- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee

In addition to the fees below:

- PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Fees (Behind portal as of April 1, 2020)
- PG14033 Complex Care Planning & Management (Behind portal as of April 1, 2020)
- PG14043 Mental Health Planning fee (Behind portal as of April 1, 2020)

- PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management fees (Behind portal as of April 1, 2020)
- PG14063 Palliative Care Planning (Behind portal as of April 1, 2020)
- PG14066 Prevention/Personal Health Risk Assessment (Behind portal as of April 1, 2020)

Submitting PG14070 signifies that:

- You are a community longitudinal family physician (as defined in the GPSC Preamble), with an office from which you provide in-person medical services to a known panel of patients;
- You are the MRP for the majority of the patient’s longitudinal primary medical care, providing continuous comprehensive coordinated family practice services to your patients, and will continue to do so for the duration of that calendar year;
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or ‘compact’; and
- You are able to produce a list of active patients for whom you are the MRP.

Family Physician-Patient ‘Compact’

The standardized wording of the Family Physician-Patient ‘Compact’ was developed in consultation with physicians and members of the Patient Voices Network. The GPSC believes this compact appropriately describes the relationship between a FP and their patients. The compact states:

As your family doctor I, along with my practice team, agree to:

- Provide you with the best care that I can
- Coordinate any specialty care you may need
- Offer you timely access to care, to the best of my ability
- Maintain an ongoing record of your health
- Keep you updated on any changes to services offered at my clinic
- Communicate with you honestly and openly so we can best address your health care needs

As my patient I ask that you:

- Seek your health care from me and my team whenever possible and, in my absence, through my colleague(s)
- Name me as your family doctor if you have to visit an emergency facility or another provider
- Communicate with me honestly and openly so we can best address your health care needs

**Total
Fee \$**

PG14070 Community Longitudinal Family Physician Portal Code.....0.00
 The Community Longitudinal Family Physician Portal should be submitted once at the beginning of each calendar year by CLFP who maintain a comprehensive longitudinal practice OR at any time during the year when the CLFP begins their comprehensive longitudinal practice. Successful submission of PG14070 allows access to fees listed in the notes below during the calendar year.

Submit fee item PG14070 Community Longitudinal Family Physician Portal Code using the following "Patient" demographic information:

PHN: 9753035697
Patient Surname: Portal
First name: GPSC
Date of Birth: January 1, 2013
ICD-9 code: 780

Notes:

- i) *Submit once per calendar year per physician.*
- ii) *Submission provides access to the following fee codes:*
 - *PG14075 FP Frailty Complex Care Planning and Management Fee*
 - *PG14076 FP Patient Telephone Management Fee*
 - *PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
 - *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
 - *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees*
 - *PG14033, PG14075 Complex Care Planning & Management Fees*
 - *PG14043 Mental Health Planning fee*
 - *PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management fees*
 - *PG14063 Palliative Care Planning Fee; and*
 - *PG14066 Personal Health Risk Assessment (Prevention) Fee.*
- iii) *Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*
- iv) *Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

Locum Community Longitudinal Family Physician Portal

The Locum Community Longitudinal Family Physician Portal Code (PG14071) provides access to the following incentive fee codes:

- PG14075 FP Frailty Complex Care Planning and Management Fee
- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
- PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees (Behind portal as of April 1, 2020)
- PG14033 Complex Care Planning & Management Fee – 2 Diagnoses (Behind portal as of April 1, 2020)
- PG14043, PG14044, PG14045, PG14046, PG14047, PG14048 Mental Health Planning & Management fees (Behind portal as of April 1, 2020)
- PG14063 Palliative Care Planning (Behind portal as of April 1, 2020)
- PG14066 Personal Health Risk Assessment/Prevention (Behind portal as of April 1, 2020)

These fees are accessible by a locum tenens when working on a temporary basis for a CLFP who is away from practice. As per the GPSC Preamble, a locum tenens is defined as a physician with appropriate credentials who substitutes on a temporary basis for another physician who is away from practice.

The host CLFP must have submitted PG14070 in the same calendar year. The locum tenens and host FP should discuss and mutually agree which of the services accessed through the Community Longitudinal Family Physician Portal may be provided and billed by the locum. However, locums have their own annual allotment of PG14076 (FP Patient Telephone Management Fee) and PG14078 (FP Patient Email/Text/Telephone Medical Advice Relay Fee).

Submitting PG14071 signifies that:

- You are providing community longitudinal family practice services to the patients of host physicians, and will continue to do so for the duration of any locum coverage for a family physician who has submitted PG14070.

		Total Fee \$
PG14071	Locum Community Longitudinal Family Physician Portal Code.....	0.00
<p>The Locum Community Longitudinal Family Physician Portal Code may be submitted by the FP who provides locum coverage for Family Physicians who have submitted PG14070. PG14071 should be submitted once at the beginning of the calendar year or prior to the start of the first locum for a host FP who has submitted PG14070 in the same calendar year. Once processed by MSP, the locum may access the fees listed in note ii) below.</p>		

Submit fee item PG14071 Locum Community Longitudinal Family Physician Portal Code using the following "Patient" demographic information:

PHN:	9753035697
Patient Surname:	Portal
First name:	GPSC
Date of Birth:	January 1, 2013
ICD-9 code:	780

Submission of this code signifies that:

- You are providing continuous comprehensive coordinated family practice services to the patients of the host physician who has submitted PG14070 and will continue to do so for the duration of locum coverage.

Notes:

- i) *Submit once per calendar year at the beginning of the year or prior to the first locum for a family physician who has submitted PG14070 in the same calendar year.*
- ii) *Submission provides access to the following incentive fee codes:*
 - *PG14075 FP Frailty Complex Care Planning and Management Fee*
 - *PG14076 FP Patient Telephone Management Fee*
 - *PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
 - *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
 - *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees*
 - *PG14033, PG14075 Complex Care Planning & Management Fees*
 - *PG14043, PG14044, PG14045, PG14046, PG14047, PG14048 Mental Health Planning & Management fees*
 - *PG14063 Palliative Care Planning Fee; and*
 - *PG14066 Personal Health Risk Assessment (Prevention).*
- iii) *Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*
- iv) *Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

2. Long Term Care Portal

Effective January 1, 2021, family physicians who have a focused practice in long term care facilities and are not working as a Community Longitudinal Family Physician (as defined in the GPSC Preamble) in a community-based physician office or clinic will not be eligible to submit the Community Longitudinal Family Physician Portals (PG14070, PG14071).

They may submit the Long Term Care Portal Code (PG14072) to access the following fee codes:

- PG14076 FP Patient Telephone Management Fee
- PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- PG14078 FP Email/Text/Telephone Medical Advice Relay Fee
- PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Fees

Total
Fee \$

PG14072 Long Term Care Portal Code.....0.00

The Long Term Care Portal Code should be submitted once at the beginning of each calendar year by family physicians who have a focused practice in long term care facilities and is not working as a Community Longitudinal Family Physician (as defined in the GPSC Preamble) in a community-based physician office or clinic.

When a family physician first begins a long term care focused practice, the Long Term Care Portal Code should be submitted when the focused practice begins. Successful submission of PG14072 allows access to fees listed in the notes below during the calendar year.

Submit fee item PG14072 Long Term Care Portal Code using the following “Patient” demographic information:

PHN:	9753035697
Patient Surname:	Portal
First name:	GPSC
Date of Birth:	January 1, 2013
ICD-9 code:	780

Notes:

- i) *Submit once per calendar year per physician.*
- ii) *Submission provides access to the following fee codes:*
 - *PG14076 FP Patient Telephone Management Fee*
 - *PG14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof*
 - *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
 - *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Fees*
- iii) *Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.*
- iv) *Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

3. Chronic Disease Management Incentives-Fee For Service (PG14050, PG14051, PG14052, PG14053, PG14029)

The GPSC Chronic Disease Management Incentives compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full twelve-month period. Guideline-informed care includes consideration of the patient’s goals, values and comorbidities.

To confirm an ongoing doctor-patient relationship, there must be at least 2 visits billed over the previous 12 months. Visits provided by a locum or colleague covering for the MRP FP may be counted toward these 2 visits however, an electronic note indicating the locum or colleague coverage must be submitted with the claim. Patients in long-term care facilities are eligible when active chronic disease management is clinically appropriate.

When a new FP assumes the practice of another FP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fees are billable on the anniversary date of the previous billing, provided the new FP has continued to provide guideline-informed care for these patients. To demonstrate continuity, if some of the required visits have been provided by the previous FP, an electronic note should be submitted at the time of the CDM submission by the new FP, indicating they have taken over the practice of the previous FP and there has been continuity of care over 12 months. Documentation in the patient chart of the provision of patient self-management supports as part of the patient’s chronic disease management is expected.

PG14050, PG14051, PG14052, PG14053 are payable to MRP FPs who have submitted PG14070 or PG14071, or FP’s who have submitted PG14072.

		Total Fee \$
PG14050	Incentive for MRP Family Physicians - - annual chronic care incentive (diabetes mellitus)	125.00
	Notes:	
	i) Payable to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.	
	ii) Payable to Family Physicians who have successfully submitted PG14072.	
	iii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.	
	iv) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be:	
	1. a telephone visit (PG14076) or	
	2. a group medical visit (13763-13781) or	
	3. an in-person visit with a College-certified allied care provider working within the family physician’s practice team (PG14029). (See Preamble definition of “working within” and “College-certified ACP”).	
	v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.	
	vi) Claim must include the ICD-9 code for diabetes (250).	
	vii) Payable once per patient in a consecutive 12 month period.	
	viii) Payable in addition to fee items PG14051 or PG14053 for same patient if eligible.	
	ix) Not payable once PG14063 has been billed and paid.	
	x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.	

**Total
Fee \$**

PG14051 Incentive for MRP Family Physicians
- annual chronic care incentive (heart failure)125.00

Notes:

- i) Payable to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.
- ii) Payable to Family Physicians who have successfully submitted PG14072.
- iii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.
- iv) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be:
 - 1. a telephone visit (PG14076) or
 - 2. a group medical visit (13763-13781) or
 - 3. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
- v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.
- vi) Claim must include the ICD-9 code for congestive heart failure (428).
- vii) Payable once per patient in a consecutive 12 month period.
- viii) Payable in addition to items PG14050 or PG14053 for the same patient if eligible.
- ix) Not payable once PG14063 has been billed and paid.
- x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

PG14052 Incentive for MRP Family Physicians
- annual chronic care incentive (hypertension).....50.00

Notes:

- i) Payable to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.
- ii) Payable to Family Physicians who have successfully submitted PG14072.
- iii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.
- iv) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be:
 - 1. a telephone visit (PG14076) or
 - 2. a group medical visit (13763-13781) or
 - 3. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
- v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.
- vi) Claim must include the ICD-9 code for hypertension (401).
- vii) Payable once per patient in a consecutive 12 month period.
- viii) Not payable if PG14050 or PG14051 paid within the previous 12 months.
- ix) Not payable once PG14063 has been billed and paid.
- x) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

**Total
Fee \$**

PG14053 Incentive for MRP Family Physicians
- annual chronic care incentive (Chronic Obstructive Pulmonary Disease-
COPD)125.00

Notes:

- i) Payable to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year.
- ii) Payable to Family Physicians who have successfully submitted PG14072.
- iii) Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.
- iv) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be:
 - 1. a telephone visit (PG14076) or
 - 2. a group medical visit (13763-13781) or
 - 3. an in-person visit with a College-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
- v) Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble.
- vi) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).
- vii) Payable once per patient in a consecutive 12 month period.
- viii) Payable in addition to fee items PG14050, PG14051 or PG14052 for the same patient if eligible.
- ix) Not payable once PG14063 has been billed and paid
- x) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

Allied Care Provider Code (PG14029)

To support team based care, College-certified Allied Care Providers (ACPs) may provide one of the two visits required for billing GPSC chronic disease management incentives. Visits provided by the College-certified ACP can be in person (PG14029) or by telephone (PG14076).

PG14029 Allied Care Provider Practice Code0.00

Notes:

- i) Applicable only for in-person medical services (office, home or LTC) provided by a College-certified allied care provider working within the family physician's practice team where the family physician has accepted responsibility for the provision of the care. (See Preamble definition of "working within" and "College-certified ACP").
- ii) Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14077.
- iii) Billable on patients receiving guideline informed care who will be eligible for one of the chronic disease management incentives (CDM).

4. Chronic Disease Management Incentives – MRP Family Physicians under Alternate Payment/Funding Model Programs (PG14250, PG14251, PG14252, PG14253, PG14276)

Use the following CDM incentive fee codes if the required two visits were billed as an encounter record while working under sessional, salary, service or independent contractor contracts. Post review will be performed within 2 years and recoveries made if encounter records were not submitted for the required visits.

A new telephone management encounter code (PG14276) is billable for physicians on alternate payment/funding models.

		Total Fee \$
PG14250	Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus)	125.00
	Notes:	
	<ul style="list-style-type: none"> i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care. ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year. iii) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be: <ul style="list-style-type: none"> 1. a telephone visit (PG14276); or 2. a group medical visit (13763-13781), or 3. an in-person visit with a College-certified allied care provider working within the family physician's practice team. (PG14029). (See Preamble definition of "working within" and "College-certified ACP"). iv) Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the GPSC Preamble. v) Claim must include the ICD-9 code for diabetes (250). vi) Payable once per patient in a consecutive 12 month period. vii) Payable in addition to fee items PG14251 or PG14253 for same patient if eligible. viii) Not payable once PG14063 has been billed and paid. ix) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee. 	
PG14251	Incentive for MRP Family Physician (who bill encounter record visits) - annual chronic care incentive (heart failure)	125.00
	Notes:	
	<ul style="list-style-type: none"> i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care. ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year. iii) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be: <ul style="list-style-type: none"> 1. a telephone visit (PG14276); or 2. a group medical visit (13763-13781), or 3. an in-person visit with a College-certified allied care provider working within the family physician's practice team. (PG14029). (See Preamble definition of "working within" and "College-certified ACP"). 	

- iv) Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble.
- v) Claim must include the ICD-9 code for heart failure (428).
- vi) Payable once per patient in a consecutive 12 month period.
- vii) Payable in addition to items PG14250 or PG14253 for the same patient if eligible.
- viii) Not payable once PG14063 has been billed and paid.
- ix) If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.

	Total Fee \$
PG14252 Incentive for MRP Family Physician (who bill encounter record visits) - annual chronic care incentive (hypertension).....	50.00

Notes:

- i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.
- ii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.
- iii) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be:
 1. a telephone visit (PG14276); or
 2. a group medical visit (13763-13781), or
 3. an in-person visit with a College-certified allied care provider working within the family physician's practice team. (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
- iv) Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble.
- v) Claim must include the ICD-9 code for hypertension (401).
- vi) Payable once per patient in a consecutive 12 month period.
- vii) Not payable if PG14250 or PG14251 paid within the previous 12 months.
- viii) Not payable once PG14063 has been billed and paid.
- ix) If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.

PG14253 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD)	125.00
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Notes:

- i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.
- ii) Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.
- iii) This item may only be billed after one year of care has been provided including at least two visits: Both of the two required visits may be a physician visit. Office, prenatal, home, long term care or physician telehealth visits qualify. Alternatively, one of the two required visits must be a physician visit, while the second visit may be:
 1. a telephone visit (PG14276); or
 2. a group medical visit (13763-13781), or
 3. an in-person visit with a College-certified allied care provider working within the family physician's practice team. (PG14029). (See Preamble definition of "working within" and "College-certified ACP").
- iv) Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble.

- 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) Payable once per patient in a consecutive 12 month period.
- vii) Payable in addition to fee items PG14250, PG14251 or PG14252 for the same patient if eligible.
- viii) Not payable once PG14063 has been billed and paid.
- ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

		Total Fee \$
PG14276	Patient Telephone Management encounter code for MRP Family Physicians on alternate payment/funding models providing chronic disease management	0.00
Notes:		
i) Billable only by MRP Family Physicians who are employed or under contract to a facility or working under an alternate payment/funding model to demonstrate one of the two required visits as per fees PG14250, PG14251, PG14252, and/or PG14253.		
ii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician. Alternatively, telephone management may be billed when delegated to or a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed by the eligible physician practice (see GPSC Preamble for definition of allied care provider "employed by" a physician practice and "College-certified ACP").		
iii) 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.		
iv) Not billable for prescription renewal alone.		
v) Not billable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.		
vi) Billable to a maximum of 1500 services per physician per calendar year.		
vii) Not billable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14250, PG14251, PG14252, PG14253.		

5. Complex Care Planning and Management Fees (PG14033, PG14075)

There are two Complex Care Planning and Management Incentives: PG14033 and PG14075.

Both PG14033 and PG14075 are available only to MRP Family Physicians who have submitted PG14070 or PG14071. PG14033 and PG14075 are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing calendar year.

Only one Complex Care Planning and Management Incentive may be billed for an individual patient in any given calendar year, even if the patient meets eligibility requirements for both PG14033 and PG14075. When patients meet eligibility requirements for both Complex Care Incentives, choose either PG14033 or PG14075 - whichever best reflects the cause of their medical complexity.

To be eligible for either of the Complex Care Planning and Management Fees, the effects of the patient's condition(s) should be significant enough to warrant the development of a management plan. In other words, eligibility is not based solely on the individual diagnoses. Consideration should be given to the overall clinical impact of the diagnoses on the patient.

**Total
Fee \$**

PG14033 Complex Care Planning and Management Fee - 2 Diagnoses315.00
The Complex Care Planning and Management Fee is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions. It is payable upon the completion and documentation of a care plan in the patient's chart.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

PG14033 Complex Care Planning & Management Fee- 2 Diagnoses

The Complex Care Planning and Management Fee-2 Diagnoses was developed to compensate FPs for the management of complex patients living in their home or assisted living, who have documented confirmed diagnoses of 2 eligible conditions from at least 2 of the 8 categories listed below.

Eligible Complex Care Condition Categories:

- 1) Diabetes mellitus (type 1 and 2)
- 2) Chronic Kidney Disease
- 3) Heart failure
- 4) Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)
- 5) Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g.: TIA, Migraine)
- 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, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.)
- 8) Chronic Liver Disease with evidence of hepatic dysfunction.

If a patient has more than 2 of the eligible conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

Notes:

- i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.
- ii) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions as listed in Table 1.
- iii) Payable once per calendar year per patient on the date of the complex care planning visit.
- iv) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14033.
- v) Minimum required total planning time 30 minutes. The majority of the planning time must be spent face to face between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates,

may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of “working within” and “College-certified ACP”).

- vi) Chart documentation must include:
 1. the care plan;
 2. total planning time (minimum 30 minutes); and
 3. physician face to face planning time (minimum 16 minutes).
- vii) PG14018 or PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14033.
- viii) PG14050, PG14051, PG14052, PG14053 payable on same day for same patient, if all other criteria met.
- ix) Not payable once PG14063 has been billed and paid.
- x) PG14043, PG14063, PG14076 and PG14078 not payable on the same day for the same patient.
- xi) Maximum daily total of 5 of any combination of PG14033 and PG14075 per physician.
- xii) PG14075 is not payable in the same calendar year for same patient as PG14033.
- xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.
- xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Diagnostic codes submitted with PG14033 billing must be from Table 1. If the patient has multiple comorbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

Table 1: Complex Care Diagnostic codes (PG14033)

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Dysfunction)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Dysfunction)
I428	Ischemic Heart Disease	Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Dysfunction)
H250	Heart Failure	Diabetes

H430	Heart Failure	Cerebrovascular Disease
H585	Heart Failure	Chronic Kidney Disease
H573	Heart Failure	Chronic Liver Disease (Hepatic Dysfunction)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease
D573	Diabetes	Chronic Liver Disease (Hepatic Dysfunction)
C585	Cerebrovascular Disease	Chronic Kidney Disease
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Dysfunction)
K573	Chronic Kidney Disease	Chronic Liver Disease (Hepatic Dysfunction)

**Total
Fee \$**

PG14075 Complex Care Planning and Management Fee - Frailty315.00
 The Complex Care Planning and Management Fee- Frailty is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for eligible patients of any age with documented frailty from any cause. Frailty is defined as requiring assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL). The effect of the frailty on the patient must be significant enough to warrant the development of a management plan.

Patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for PG14075.

Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community	Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care
Meal preparation	Mobility in bed
Ordinary housework	Transfers
Managing finances	Locomotion inside and outside the home
Managing medications	Dressing upper and lower body
Phone use	Eating
Shopping	Toilet use
Transportation	Personal hygiene
	Bathing

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

Notes:

- Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.*
- Payable only for patients who require assistance with at least one ADL from*

each of the instrumental and non-instrumental activities of daily living, the effects of which are significant enough to warrant the development of a management plan.

- iii) Claim must include the diagnostic code V15.
- iv) Payable once per calendar year per patient on the date of the complex care planning visit.
- v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14075.
- vi) Minimum required total planning time 30 minutes. The majority of the planning time must be face to face between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, be on different dates and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").
- vii) Chart documentation must include:
 - 1. the care plan;
 - 2. total planning time (minimum 30 minutes); and
 - 3. physician face to face planning time (minimum 16 minutes).
- viii) PG14018 or PG14077 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for PG14075.
- ix) Maximum daily total 5 of any combination of PG14033 and PG14075 per physician.
- x) PG14075 not payable once PG14063 has been billed.
- xi) PG14033 is not payable in the same calendar year for same patient as PG14075.
- xii) PG14043, PG14063, PG14076, PG14078 not payable on the same day for the same patient.
- xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.
- xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

**Total
Fee \$**

6. Prevention Fee (PG14066)

PG14066	Personal Health Risk Assessment (Prevention).....	50.00
	<p>This fee is payable to the family physician who is most responsible for the majority of the patient's longitudinal primary medical care and who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, tobacco use, physically inactive, unhealthy eating). The FP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative.</p>	

PG14066 is payable only to MRP Family Physicians who have submitted PG14070 or PG14071.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

The Ministry of Health website contains: The current Lifetime Prevention Schedule and the BC Prevention Guidelines.

Notes:

- i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.
- ii) Payable only for patients with one or more of the following risk factors: Tobacco Use/Smoking, unhealthy eating, physical inactivity, medical obesity.
- iii) Diagnostic code submitted with PG14066 must be one of the following: Tobacco use/Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783).
- iv) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.
- v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under PG14066.
- vi) PG14077 payable on same day for same patient if all criteria met.
- vii) PG14033, PG14043, PG14063, PG14076 and PG14078 not payable on the same day for the same patient.
- viii) Payable to a maximum of 100 patients per calendar year, per physician.
- ix) Payable once per calendar year per patient.
- x) Not payable once PG14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.
- xi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

7. Mental Health Planning Fee (PG14043)

This fee is payable upon the completion and documentation of a care plan (as defined in the GPSC Preamble) in the patient's chart for patients with a confirmed eligible mental health diagnosis when the effect on the patient is significant enough to warrant the development of a care plan. This is not intended for patients with short-lived mental health symptoms (e.g.: normal grief, life transitions).

The Mental Health Planning Fee requires a face to face visit with the patient and/or the patient's medical representative and the physician.

PG14043 is payable only to Family Physicians who have submitted PG14070 or PG14071. The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing year.

Successful billing of the Mental Health Planning fee PG14043 allows access to four counselling equivalent mental health management fees in that same calendar year which may be billed once the four MSP counselling fees (any combination of 00120 age differential or telehealth counselling codes) have been utilized.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

**Total
Fee \$**

PG14043 FP Mental Health Planning Fee100.00

Notes:

- i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.
- ii) Payable only for patients with documentation of a confirmed eligible mental health diagnosis the effects of which are significant enough to warrant the development of a care plan. Eligible diagnoses are listed in Table 1. Not intended for patients with short lived mental health symptoms.
- iii) Payable once per calendar year per patient. Not intended as a routine annual fee.
- iv) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face to face planning included under PG14043.
- v) Minimum required total planning time 30 minutes. The majority of the planning time must be face to face between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) or another physician working within the eligible physician practice team. See Preamble definition of "working within" and "College-certified ACP").
- vi) Chart documentation must include:
 - 1. The care plan;
 - 2. Total planning time (minimum 30 minutes); and
 - 3. Physician face to face planning time (minimum 16 minutes).
- vii) PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for PG14043.
- viii) PG14044, PG14045, PG14046, PG14047, PG14048, PG14033, PG14063, PG14075, PG14076 and PG14078 not payable on the same day for the same patient.
- ix) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Table 1

The following list of eligible diagnoses and ICD-9 codes is to be used when billing the Mental Health Planning and Management Fees, PG14043, PG14044 – PG14048:

CATEGORY	DIAGNOSIS	ICD-9
Anxiety Disorders	Anxiety Disorders	300, 308, 50B
Bipolar and Related Disorders	Bipolar	296
	Cyclothymia	301.13
Depressive Disorders	Depressive disorders	311

CATEGORY	DIAGNOSIS	ICD-9
Dissociative Disorder	Dissociative Disorders	300
Eating Disorders	Eating Disorders	307, 307.1
Gender Dysphoria	Gender Dysphoria	302
Impulse Control Disorders	Impulse Control Disorders	312
Neurocognitive Disorders	Delirium	293
	Dementia	290, 331, 331.0, 331.2
Neurodevelopmental disorders	Attention Deficit Disorder	314
	Autism Spectrum Disorder	299.0
	Pervasive Developmental Disorder	299.0
Obsessive-Compulsive & Related Disorders	Obsessive-Compulsive Disorder	300
	Body Dysmorphic Disorder	300.7
Schizophrenia and other Psychotic Disorders	Schizophrenia and other Psychotic Disorders	293, 295, 297, 298
Sexual Dysfunction	Sexual Dysfunction	302
Sleep Disorders	Sleep wake disorders: Insomnia/ hypersomnolence/ narcolepsy	307.4, 347
	Parasomnias	307.4
	Breathing-Related Sleep Disorders	780.5
Somatic Symptom & Related Disorders	Factitious Disorder	300, 312
	Pain Disorder with Affective Symptoms	338
	Somatic Symptom Disorder	300.8
	Conversion Disorder	300.1
Substance Use Disorders	Substance Use Disorder: Alcohol	303
	Substance Use Disorder: Drugs	304
Trauma and stressor related disorders	Adjustment Disorders	309
	Post-Traumatic Stress Disorder	309

8. Mental Health Management Fees (PG14044, PG14045, PG14046, PG14047, PG14048)

	Total Fee \$
PG14044 FP Mental Health Management Fee age 2 - 49	56.41
PG14045 FP Mental Health Management Fee age 50 - 59	62.05
PG14046 FP Mental Health Management Fee age 60 - 69	64.86
PG14047 FP Mental Health Management Fee age 70 - 79	73.32
PG14048 FP Mental Health Management Fee age 80+	84.60

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee PG14043 has been successfully billed. The four MSP counselling fees (any combination of age-appropriate 00120 or telehealth counselling) must first have been paid in the same calendar year.

Notes:

- i) Payable only to the physician who has previously billed and been paid the Mental Health Planning fee (PG14043) in the same calendar year, unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note.
- ii) Payable a maximum of 4 times per calendar year per patient.
- iii) Not payable unless the four age-appropriate 00120 or telehealth counselling fees have already been paid in the same calendar year in any combination.
- iv) Minimum time required is 20 minutes.
- v) Start and end times must be included with the claim and documented in the patient chart.
- vi) Counselling may be provided face to face or by videoconferencing.
- vii) PG14077, payable on same day for same patient if all criteria met.
- viii) PG14043, PG14076, PG14078 not payable on same day for same patient.
- ix) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.
- x) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

9. Palliative Care Planning Fee (PG 14063)

This fee is payable upon the development and documentation of a care plan as described in the GPSC Preamble, for patients who in the FP's clinical judgement 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.

Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy. This fee 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.

PG14063 is payable only to Family Physicians who have submitted PG14070 or PG14071 in the same calendar year.

This fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the patient.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

**Total
Fee \$**

PG14063 FP Palliative Care Planning Fee.....100.00

Notes:

- i) Payable only to Family Physicians who have successfully submitted and met the requirements for PG14070. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year.
- ii) 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.
- iii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).
- iv) 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 FP who is assuming the ongoing palliative care for the patient.
- v) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the face to face planning included under PG14063.
- vi) Minimum required total planning time 30 minutes. The majority of the planning time must be spent face to face between physician and patient (or patient’s medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of “working within” and “College-certified ACP”).
- vii) Chart documentation must include:
 - 1. the care plan;
 - 2. total planning time (minimum 30 minutes); and
 - 3. physician face to face planning time (minimum 16 minutes).
- viii) PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14063.
- ix) Not payable if PG14033 or PG14075 has been paid within 6 months.
- x) Not payable on same day as PG14043, PG14076 or PG14078.
- xi) PG14050, PG14051, PG14052, PG14053, PG14250, PG14251, PG14252, PG14253, PG14033, PG14066, PG14075 not payable once Palliative Care Planning fee is billed and paid.
- xii) The GPSC Mental Health Initiative Fees (PG14043, PG14044, PG14045, PG14046, PG14047, PG14048) are still payable once PG14063 has been billed provided all requirements are met, but are not payable on same day.
- xiii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

10. FP Email, Text & Telephone Fees: Medical Advice to Patients (PG14076, PG14078)

PG14076 FP Patient Telephone Management Fee20.00

Notes:

- i) Payable only to:
 - a. MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or

- b. *Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or*
- c. *Family Physicians who have successfully submitted and met the requirements for PG14072 in the same calendar year; or*
- d. *Family Physicians Registered in a Maternity Network, or FP Unassigned In-patient network on a prior date.*
- ii) *Telephone Management requires a clinical telephone discussion between the patient or the patient’s medical representative and physician. Alternatively, this fee may be billed when delegated to or a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed by the eligible physician practice (see GPSC Preamble for definition of allied care provider “employed by” a physician practice and “College-certified ACP”).*
- iii) *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.*
- iv) *Not payable for prescription renewal alone.*
- v) *Not payable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.*
- vi) *Payable to a maximum of 1500 services per physician per calendar year.*
- vii) *Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14077, PG14018, PG14050, PG14051, PG14052, PG14053, 13005.*
- viii) *Not payable to physicians who are employed or under contract to a facility or working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

**Total
Fee \$**

PG14078 FP Email/Text/Telephone Medical Advice Relay7.00

PG14078 is payable for 2-way communication of medical advice from the MRP Family Physician to eligible patients, or the patient’s medical representative, via email/text or telephone relay. This fee is not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

Notes:

- i) *Payable only to:*
 - a. *MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or*
 - b. *Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or*
 - c. *Family Physicians who have successfully submitted and met the requirements for PG14072 in the same calendar year; or*
 - d. *Family Physicians Registered in a Maternity Network, or FP Unassigned In-patient network on a prior date.*
- ii) *Email/Text/Telephone Relay Medical Advice requires 2-way relay/ communication of medical advice from the physician to eligible patients, or the patient’s medical representative, via email/text or telephone. Alternatively, the task of relaying the physician’s advice may be delegated to any allied care provider or MOA working within the physician practice (see GPSC Preamble for definition of allied care provider “working within” a physician practice team).*

- iii) *Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.*
- iv) *Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.*
- v) *Payable to a maximum of 200 services per physician per calendar year.*
- vi) *Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of PG14077.*

11. Conferencing and Advice Fees (PG14077, PG14018, PG14019)

FP Conference with Allied Care Provider and/or Physician - per 15 minutes or greater portion thereof

PG14077 pays for two-way case conferencing about a patient with at least one allied care provider or physician. The fee is billable regardless of where the patient is located or how the conference occurs (in-person, by phone). Time spent talking to the patient or family member does not count towards conferencing time under PG14077.

As start and end times must be submitted, consider:

- a) If conferencing takes place as a series of separate phone calls, use the start time of the first call and calculate the "end time" based on total time spent conferencing.
- b) If billing a same day out-of-office hour's visit fee code (which also requires start/end times), the time submitted must either be before or after the PG14077 start/end time.

	Total Fee \$
PG14077 FP Conference with Allied Care Provider and/or Physician - per 15 minutes or greater portion thereof.....	40.00

Notes:

- i) *Payable only to:*
 - a. *MRP Family Physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or*
 - b. *Locum Family Physicians who are covering for a MRP FP when using this fee code, and have successfully submitted and met the requirements for PG14071 on the same or a prior date in the same calendar year; or*
 - c. *Family Physicians who have successfully submitted and met the requirements for PG14072 in the same calendar year; or*
 - d. *Family Physicians registered in a Maternity Network, or FP Unassigned In-patient network on a prior date.*
- ii) *Payable for two-way collaborative conferencing, either by telephone, videoconferencing or in-person, between the Family Physician and an allied care provider and/or a physician.*
- iii) *Conferencing cannot be delegated. No claim may be made where communication is with a proxy for either provider.*
- iv) *Details of care conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.*
- v) *Conference to include the clinical and social circumstances relevant to the delivery of care.*
- vi) *Not payable for situations where the purpose of the call is to:*
 - a. *Book an appointment*

- b. *Arrange for an expedited consultation or procedure*
- c. *Arrange for laboratory or diagnostic investigations*
- d. *Convey the results of diagnostic investigations*
- e. *Arrange a hospital bed for a patient.*
- vii) *If multiple patients are discussed, the billings must be for consecutive, non-overlapping time periods.*
- viii) *Payable in addition to any visit fee on the same day if medically required and does not take place during a time interval that overlaps with the patient conference (i.e. Visit time is separate from conference time).*
- ix) *Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.*
- x) *Start and end times must be included with the claim and documented in the patient chart.*
- xi) *Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility, or communications which occur as part of regular work flow within a physician's community practice.*
- xii) *Not payable for simple advice to a non-physician allied care provider about a patient in a facility.*
- xiii) *Not payable in addition to PG14018.*
- xiv) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

FP Urgent Telephone Advice from a Physician with Consultative Expertise

PG14018 is billable when the severity of the patient's condition justifies urgent advice (within 2 hours of request) from a Specialist or Physician with Consultative Expertise (as defined in the GPSC Preamble), in order to develop and implement a plan to keep the patient stable in their current environment. The intent of PG14018 is to improve the management of patients with acute needs, and reduce unnecessary ER or hospital admissions/transfers. This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

		Total Fee \$
PG14018	FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise..... 14018 is payment for telephone advice that is needed on an urgent basis (within 2 hours of request) from a Specialist or Family Physician with Consultative Expertise (as defined in the Preamble). Includes the creation, documentation, and implementation of a plan for the care of patients with acute needs (i.e. requiring attention within the next 24 hours) and communication of that plan to the patient or patient's representative. Notes: i) <i>Payable to the FP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or family physician with consultative expertise (as defined in the GPSC Preamble) regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.</i> ii) <i>Conversation must take place within two hours of the FP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, email).</i> iii) <i>Fee Includes:</i> a. <i>Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.</i> b. <i>Developing, documenting and implementing a plan to manage the patient safely in their care setting.</i>	40.00

- c. *Communication of the plan to the patient or the patient's representative.*
- d. *The plan must be recorded in patient chart 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.*
- iv) *Not payable to the same patient on the same date of service as fee item PG14077.*
- v) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*
- vi) *Include start time in time fields when submitting claim.*
- vii) *Not payable for situations where the primary purpose of the call is to:*
 - a. *Book an appointment*
 - b. *Arrange for transfer of care that occurs within 24 hours*
 - c. *Arrange for an expedited consultation or procedure within 24 hours*
 - d. *Arrange for laboratory or diagnostic investigations*
 - e. *Convey the results of diagnostic investigations*
 - f. *Arrange a hospital bed for the patient*
 - g. *Obtain non-urgent advice for patient management (i.e. advice that is not required within the next 2 hours).*
- viii) *Limited to one claim per patient per physician per day.*
- ix) *Out-of-Office Hours Premiums may not be claimed in addition.*
- x) *Maximum of 6 (six) services per patient, per practitioner, per calendar year.*
- xi) *Payable in addition to a visit on the same date.*

FP – Advice to Nurse Practitioner/Registered Midwife Fee

The intent of PG14019 is to support collaboration between nurse practitioners, registered midwives and community family physicians. This fee is billable when providing advice by telephone or in person to a Nurse Practitioner who is an independent practitioner providing care to patients under their MRP care. This fee is not billable for providing advice to a NP when the patient is attached to a FP. This fee is also billable when providing advice by telephone or in person to a Registered Midwife who is an independent practitioner providing maternity care to patients under their MRP care.

		Total Fee \$
PG14019	FP Advice to a Nurse Practitioner/Registered Midwife Fee—Telephone or In Person	40.00

Notes:

- i) *Payable to:*
 - a. *the FP who provides advice by telephone or in person in response to a request from a Nurse Practitioner (NP) in independent practice on patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care; or*
 - b. *the FP who provides advice by telephone or in-person in response to a request from a Registered Midwife in independent practice on patients for whom the Midwife has accepted the responsibility of being the Most Responsible Provider for that patient's maternity care.*
- ii) *Excludes advice to an NP about patients who are attached to the FP; excludes advice to a Registered Midwife about patients being cared for in a shared care model with a FP.*
- iii) *Payable for advice regarding assessment and management by the NP/midwife and without the responding physician seeing the patient.*
- iv) *Not payable for written communication (i.e. fax, letter, email).*
- v) *A chart entry, including advice given and to whom, is required.*
- vi) *NP/Midwife Practitioner number required in referring practitioner field when submitting fee through Teleplan.*
- vii) *Not payable for situations where the purpose of the call is to:*
 - a. *Book an appointment*

- b. Arrange for transfer of care that occurs within 24 hours
- c. Arrange for an expedited consultation or procedure within 24 hours
- d. Arrange for laboratory or diagnostic investigations
- e. Convey the results of diagnostic investigations
- f. Arrange a hospital bed for the patient.
- viii) Limited to 1 (one) claim per patient per day with a maximum of 6 (six) claims per patient per calendar year.
- ix) Limit of 5 (five) PG14019 units may be billed by a FP on any calendar day.
- x) Not payable in addition to another service on the same day for the same patient by same FP.
- xi) Out-of-Office Hours Premiums may not be claimed in addition.
- xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

12. Family Physicians with Consultative Expertise Fees (PG14021, PG14022, PG14023)

FP with Consultative Expertise Telephone Advice Fees (PG14021, PG14022, PG14023) support tele/videoconferencing between FP's with Consultative Expertise and other Family Physicians, Specialists or Allied Care Providers for the purpose of improving patient care.

The GPSC Preamble defines Family Physicians with Consultative Expertise as:

GPSC defines a Physician with Consultative Expertise as: "A family physician who has consultative expertise and provides consultative services or support to colleagues through a health authority supported or approved program". Examples of health authority supported programs include (but are not limited to) mental health, addictions, palliative, chronic pain and emergency medicine.

Eligibility for FP with Consultative Expertise Telephone Advice Fees:

In addition to meeting the definition of FP with Consultative Expertise listed above and in the GPSC Preamble, the following criteria must be met:

- a. Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- b. Service may be provided when physician is located in office or hospital.
- c. Telephone advice must be related to the field in which the FP provides consultative services or support.

	Total Fee \$
PG14021 FP with Consultative Expertise Telephone/video Advice - Initiated by a Specialist, Family Physician, or Allied Care Provider, Response within 2 hours	60.00
Notes:	
i) Payable to a FP with consultative expertise (as defined in the GPSC Preamble) for two-way telephone/video 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 provider'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) Not payable for situations where the purpose of the call is to:	
a. Book an appointment	
b. Arrange for transfer of care that occurs within 24 hours	

- c. Arrange for an expedited consultation or procedure within 24 hours
- d. Arrange for laboratory or diagnostic investigations
- e. Convey the results of diagnostic investigations
- f. Arrange a hospital bed for the patient.
- v) Not payable to provider initiating call.
- vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).
- vii) Limited to one claim per patient per physician per day.
- viii) A chart entry including advice given and to whom, is required.
- ix) Start times must be included with the claim and documented in the patient chart.
- x) Not payable in addition to another service on the same day for the same patient by same physician.
- xi) Out-of-Office Hours Premiums may not be claimed in addition.
- xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.
- xiii) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note record specifying the type of provider).

**Total
Fee \$**

PG14022 FP with Consultative Expertise Telephone/video Advice - Initiated by a Specialist, Family Physician or Allied Care Provider, response within one week – per 15 minutes or portion thereof40.00

Notes:

- i) Payable to a FP with Consultative Expertise (as defined in the GPSC Preamble) for two-way telephone/video 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 provider's request. Initiation may be by phone or referral letter.
- iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.
- iv) Not payable for situations where the purpose of the call is to:
 - a. Book an appointment
 - b. Arrange for transfer of care that occurs within 24 hours
 - c. Arrange for an expedited consultation or procedure within 24 hours
 - d. Arrange for laboratory or diagnostic investigations
 - e. Convey the results of diagnostic investigations
 - f. Arrange a hospital bed for the patient.
- v) Not payable to provider initiating call.
- vi) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).
- vii) Limited to two services per patient per physician per week.
- viii) A chart entry, including advice given and to whom, is required.
- ix) Start and end times must be included with the claim and documented in the patient chart.
- x) Not payable in addition to another service on the same day for the same patient by same physician.
- xi) Out-of-Office Hours Premiums may not be claimed in addition.
- xii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.
- xiii) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987 and include a note record specifying the type of provider.)

		Total Fee \$
PG14023	FP with Consultative Expertise - Patient Telephone/video Management/Follow-Up	20.00

Notes:

- i) *This fee applies to two-way telephone/video communication between the FP with Consultative Expertise (as defined in the GPSC Preamble) and patient, or a patient's representative. Not payable for written communication (i.e. fax, letter, email).*
- ii) *Access to this fee is restricted to patients having received a prior consultation, office visit, hospital or ER visit, diagnostic procedure or surgical procedure from the same physician, within the 6 months preceding this service.*
- iii) *Telephone/video management requires two-way communication between the patient and physician on a clinical level; the fee is not billable for administrative tasks such as appointment notification.*
- iv) *No claim may be made where communication is with a proxy for the physician (e.g.: office support staff).*
- v) *Each physician may bill this service 4 (four) times per calendar year for each patient.*
- vi) *This fee requires chart entry as well as ensuring that patient understands and acknowledges the information provided.*
- vii) *Not payable in addition to another service on the same day for the same patient by the same physician.*
- viii) *Out-of-Office Hours Premiums may not be claimed in addition.*
- ix) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

13. Family Physician Obstetrical Premiums (PG14004, PG14005, PG14008, PG14009)

The following fees are payable to B.C.'s eligible family physicians. The purpose of the payment is to encourage family physicians to continue to provide obstetrical care, giving women the benefit of choice and longitudinal care. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

PG14004, PG14005, PG14008, and PG14009 are payable only to Family Physicians who have submitted PG14070 or PG14071 in the same calendar year, or who are registered in a Maternity Network.

PG14004	Obstetric Delivery Incentive for Family Physicians– associated with vaginal delivery and postnatal care.....	375.40
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Notes:

- i) *Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:*
 - a. *Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or*
 - b. *Registered in a Maternity Network on a prior date.*
- ii) *Payable only when fee item 14104 billed in conjunction.*
- iii) *Maximum of one incentive under fee time PG14004, PG14008, PG14009 per patient delivered.*
- iv) *Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.*

PG14005 Obstetric Delivery Incentive for Family Physicians – associated with management of labour and transfer for delivery to a higher level of care facility 156.34

Notes:

- i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:
 - a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
 - b. Registered in a Maternity Network on a prior date.
- ii) Payable only when fee item 14105 billed in conjunction.
- iii) Payable in addition to PG14004 or PG14009 when billed and paid to a different GP attending delivery in the receiving hospital.
- iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

PG14008 Obstetric Delivery Incentive for Family Physicians– associated with postnatal care after elective caesarean-section.....77.23

Notes:

- i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:
 - a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
 - b. Registered in a Maternity Network on a prior date.
- ii) Payable only when fee item 14108 billed in conjunction.
- iii) Maximum of one incentive under fee item PG14004, PG14008, PG14009 per patient delivered.
- iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

PG14009 Obstetric Delivery Incentive for Family Physicians – associated with attendance at delivery and postnatal care associated with emergency caesarean section 312.70

Notes:

- i) Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully:
 - a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or
 - b. Registered in a Maternity Network on a prior date.
- ii) Payable only when fee item 14109 billed in conjunction.
- iii) Maximum of one incentive under fee item PG14004, PG14008, PG14009 per patient delivered.
- iv) Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.

14. Maternity Network Initiative (H14010)

Eligible family physicians can receive a quarterly payment each quarter ending March 31, June 30, September 30 & December 31, to cover the costs of group/network activities for their shared care of obstetric patients (both assigned and unassigned obstetric patients).

To support conferencing with other health care providers and communication with patients, registration in a Maternity Network allows access to FP Conferencing Incentive PG14077 and FP Patient telephone/advice Incentives PG14076 and PG14078. As part of the GPSC In-patient Initiative, members of Maternity Networks are eligible to bill the Unassigned In-patient Care fee H14088 for unassigned pregnant patients for whom they are the Most Responsible Physician (MRP). Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned.

Note: 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.

Registration in a Maternity Network provides access to the Obstetrical Delivery Incentives for Family Physicians (PG14004, PG14005, PG14008, and PG14009).

		Total Fee \$
H14010	Maternity Care Network Initiative Payment	2100.00 per quarter

Eligibility:

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

- Be a family physician in active practice in BC;
- Have hospital privileges to provide obstetrical care;
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care). Refer to the Maternity Network Registration Form found on the GPSC website at gpscbc.ca;
- Co-operate 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;
- Each doctor must schedule at least four deliveries in each six month period of time (April to September, October to March); and
- The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day).

Billing Information for Maternity Care Network Initiative Payment:

PHN: 9824870522
 Patient Last name: Maternity
 Patient First name/initial: G

Date of Birth:	November 2, 1989
Diagnostic code:	V26
For Date of service use:	Last day in a calendar quarter
Billing Schedule:	Last day of the month, per calendar quarter

15. GPSC Incentives for In-patient Care (H14086, H14088)

The GPSC In-patient Initiative was developed to recognize and better support the continuous relationship with a family physician (FP) that can improve patient health outcomes and ease the burden on hospitals by reducing repeat hospitalizations and emergency room visits. An important aspect of such continuous care is the coordination of care through the in-patient journey as well as in transitions between hospital and community FP offices. There are two separate levels of incentives aimed at better supporting and compensating FPs who provide this important aspect of care. This initiative will support family physicians who:

- a. Provide Most Responsible Provider (MRP) care to their own patients when they are admitted to the identified acute care hospital in their community (Assigned In-patients); and may also
- b. As part of a network, provide care for patients admitted to hospital without an FP, whose FP does not have hospital privileges, or who are from out-of-town (Unassigned In-patients).

To participate in the GPSC In-patient Initiative, it is expected that these FPs agree to the following expectations:

A. They are members of the active or equivalent medical staff category and have hospital privileges in the identified acute care hospital.

B. That their on-call colleagues (Network) are also members of the active or equivalent medical staff category and have hospital privileges.

C. That they will:

- Coordinate and manage the care of hospitalized patients (assigned and/or unassigned), admitted under them as the MRP.
- Provide supportive care when their hospitalized patient is admitted under a specialist as MRP.
- See all acute patients under their MRP care on a daily basis and document a progress note in the medical record.
- Work with the interdisciplinary team, as appropriate, to develop a care plan and a plan for discharge.
- When care is transferred to another physician, ensure that this is documented in the medical record and ensure there is a verbal or written handover plan provided to the accepting physician.
- Ensure availability through their network to expedite discharges of patients daily during the normal working day which includes early morning, daytime, and early evening.
- On weekends ensure the covering physician is made aware of those discharges that could occur over the weekend.
- Provide a discharge note to an unassigned in-patient for their FP or communicate directly with the FP on discharge.

- Respond to requests from members of the interdisciplinary in-patient care team by phone as per hospital bylaws.
- The Network Call Group will accept responsibility for their newly admitted in-patients on a 24/7/365 basis. The MRP shall assess and examine the patient, document findings and issue applicable orders as soon as warranted by the patient's needs, but in any case no longer than 24 hours after accepting the transfer. Utilization needs within the facility may dictate that the patient must be seen sooner.

D. The non-clinical services include the already existing expectations of FPs as outlined in the Health Authority Medical Staff bylaws, rules and regulations, and policies. The health authority, the Department of Family Practice, the Division of Family Practice (where it exists) and the In-patient Care Networks could reasonably expect that all parties would participate in discussions which could include:

- The orderly transitions of MRP status between specialists and generalists.
- Participating in the orderly discharge planning of generally more complicated patients.
- Patient safety concerns that come up in local hospitals.
- Identifying and providing input into "local hassle factors" that would need to be examined and resolved at a local level between the local division of family practice and health authorities.
- Participate in utilization management within the hospital.
- Patient care improvement discussions that would reasonably be covered under the improved FP hospital care incentives.

FP Assigned Inpatient Care Network (H14086)

The FP Assigned Inpatient Care Network initiative was designed to support community Family Physicians who continue to accept Most Responsible Physician (MRP) status to provide care to their own patients who have been admitted to hospital. The Assigned In-patient Network payment is for FPs who provide in-patient care services for their own and colleagues' patients (assigned). Maternity patients are not included under the Assigned In-patient Network if the FP is also participating in a GPSC Maternity Care Network because those patients are counted as part of that incentive.

		Total Fee \$
H14086	FP Assigned Inpatient Care Network Initiative	2100.00

Eligibility:

To be eligible to be a member of a FP Assigned Inpatient Care Network, you must meet the following criteria:

- Be a Family Physician in active practice in B.C.*
- Have active hospital privileges.*
- 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 inpatient care – see below).*
- Submit a completed Assigned Inpatient Care Network Registration Form.*
- Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.*
- Each doctor must provide MRP care to at least 24 admitted patients over the course of a year; networks may average out this number across the number of members.*

This network incentive is payable in addition to visit fees, but is inclusive of time spent in associated Quality Improvement activities necessary to maintain privileges such as M and M rounds as well as time spent on network administration, etc.

Exemptions for communities where it may be difficult to achieve the minimum volume of MRP inpatient cases will be considered by the GPSC Inpatient Care Working Group.

The FP Assigned In-patient Care Network Incentive is payable for participation in the network activities for the majority of the following calendar quarter (50% plus 1 day). Once your registration in the network has been confirmed, submit fee item H14086 FP Assigned in-patient care network fee using the following billing specifics:

Billing Schedule: First day of the month, per calendar quarter (i.e. January 1, April 1, July 1, October 1) and is paid for the subsequent quarter ICD-9 code: 780

Your location will determine which PHN# to use:

Fraser Health Authority PHN# 9752 590 548 Patient Surname: Assigned First Name: FHA Date of birth: January 1, 2013	Interior Health Authority PHN# 9752 590 587 Patient Surname: Assigned First Name: IHA Date of birth: January 1, 2013
Northern Health Authority PHN# 9752 590 509 Patient Surname: Assigned First Name: NHA Date of birth: January 1, 2013	Vancouver Coastal Health Authority PHN# 9752 590 523 Patient Surname: Assigned First Name: CVHA Date of birth: January 1, 2013
Vancouver Island Health Authority PHN# 9752 590 516 Patient Surname: Assigned First Name: VIHA Date of birth: January 1, 2013	

FP Unassigned Inpatient Care Fee (H14088)

The term “Unassigned Inpatient” is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted.

The FP Unassigned Inpatient Care Fee is designed to provide an incentive for Family Physicians to accept Most Responsible Physician (MRP) status for an unassigned patient’s hospital stay. It is intended to compensate the Family Physician for the extra time and intensity required to evaluate an unfamiliar patient’s clinical status and care needs when the patient is admitted and is only billable once per hospital admission.

This fee is restricted to Family Physicians actively participating in an FP Unassigned Inpatient Care Network or an FP Maternity Network. This fee is billable through the MSP Teleplan system and is payable in addition to the hospital visit (00109, 13109, 13008, 00127) or delivery fee.

**Total
Fee \$**

H14088 FP Unassigned Inpatient Care Fee150.00

Notes:

- i) *Payable only to Family Physicians who have submitted a completed FP Unassigned Inpatient Care Network Registration Form and/or an FP Maternity Network Registration Form.*
- ii) *Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.*
- iii) *Payable once per unassigned patient per in-hospital admission in addition to the hospital visit (00109, 13109, 13008, 00127) or delivery fee.*
- iv) *Not payable to physicians who are employed or under contract to a facility or working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*