MINISTRY OF HEALTH

MEDICAL SERVICES COMMISSION

LONGITUDINAL FAMILY PHYSICIAN

PAYMENT SCHEDULE

NOVEMBER 21, 2023

MEDICAL SERVICES COMMISSION
LONGITUDINAL FAMILY PHYSICIAN PAYMENT SCHEDULE

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PART I: INTRODUCTION

1. Purpose

This is a Payment Schedule under Section 26 of the *Medicare Protection Act.* A physician who meets the eligibility criteria for the Longitudinal Family Physician (LFP) Payment Model can enrol and be compensated in accordance with this LFP Payment Schedule. This document sets out the eligibility criteria, enrolment steps and billing rules for this payment model, acting as a roadmap for its application and interpretation.

2. Definitions

Capitalized terms have the meaning given to them in the Definitions at Appendix A, unless otherwise provided in this Payment Schedule. Unless context requires otherwise, definitions expressed in the singular include the plural and *vice versa*.

3. Description of the LFP Payment Model

The LFP Payment Model is a compensation option for family physicians who provide longitudinal, relationship-based, family medicine care to a known panel of patients, aligned with the attributes of a Patient Medical Home. It is an alternative to Fee-For-Service and the Alternative Payments Program. The LFP Payment Model is a blended payment model which compensates a physician for:

(a) physician time;

(b) physician-patient interactions; and

(c) the size and complexity of a physician's patient panel.

Appendix B outlines how physician time, physician-patient interactions, and the patient panel together generate the total compensation for a physician enrolled in the LFP Payment Model. It also describes the background and principles for the LFP Payment Model, including the Patient Medical Home.

Rural physicians who practice in a Rural Practice Subsidiary Agreement (RSA) community are eligible to receive rural premiums on LFP Payment Model payments, in accordance with the RSA. These rural premiums can be found in the RSA Guide under the Rural Retention Program.

PART II: ELIGIBILITY, REQUIRED SERVICES, ENROLMENT AND WITHDRAWAL

4. Initial Eligibility for the LFP Payment Model

To be eligible for the LFP Payment Model, a physician must:

(a) commit to provide all of the Required Services, except the physician is not required to meet the requirement in Section 6(g) [ensure that Non-panel Services are no more than 30% of the total LFP Practice Services and Non-panel Services]:

(i) until March 31, 2024, if the physician is actively transitioning their practice to meet the requirement in Section 6(g) and submits the Transition Code; or

(ii) until March 31, 2024 or such time as the LFP Payment Model is amended for rural communities, if the physician is practicing at an LFP Clinic in a rural community that was receiving Northern Isolation Allowance (NIA) premiums as of December 15, 2002.

(b) contribute either directly or indirectly to the rent, lease, or ownership costs, as well as other operating costs (such as staffing, equipment and supplies) of the clinic(s) that will be their LFP Clinic;

(c) have not withdrawn from the LFP Payment Model within the past 12 months, unless the Medical Services Commission provides written approval that the physician is eligible to re-enrol; and

(d) not be Deemed Ineligible by the Medical Services Commission, unless the Medical Services Commission provides written approval that the physician is eligible to re-enrol.

("**Initial Eligibility Criteria**")

Notwithstanding the Initial Eligibility Criteria, a physician may be eligible for the LFP Payment Model as an LFP Locum if they meet the criteria in Section 10.

5. Ongoing Eligibility in the LFP Payment Model

Once a physician is enrolled in the LFP Payment Model, the physician must do the following to maintain eligibility:

(a) meet the Initial Eligibility Criteria on an ongoing basis;

(b) submit the Registration Code to Health Insurance BC (HIBC) via Teleplan between January 1 and March 31 of each calendar year, to confirm that they meet the Initial Eligibility Criteria; and

(c) confirm their list of Empanelled Patients each calendar year, as required.

("**Ongoing Eligibility Criteria**")

6. Required Services

A physician enrolled in the LFP Payment Model must:

(a) provide Longitudinal Family Physician Services, aligned with the attributes of a Patient Medical Home;

(b) provide timely, accessible, comprehensive, and relationship-based care to patients by working and collaborating with other physicians and healthcare providers when appropriate;

(c) develop and submit an accurate list of Empanelled Patients by October 31, 2023 or within three months of enrolling in the LFP Payment Model, whichever is later;

(d) **participate in the Provincial Attachment System by providing information in the Panel Registry and working with clinic medical directors/delegates to update information in the Clinic and Provider Registry as directed;**

(e) have at least 250 Empanelled Patients within four months of enrolling in the LFP Payment Model;

(f) provide LFP Practice Services for a minimum of one day per week, distributed equitably over the course of a year. This minimum is based on the physician's usual work arrangement. It does not include temporary absences or decreases in days worked related to illness, vacation, parental leave, caregiving, military deployment or other reasons;

(g) ensure that Non-panel Services are no more than 30% of the total of LFP Practice Services and Non-panel Services provided in one calendar year;

(h) provide patient care consistent with any interim or permanent guidance on the appropriate use of virtual care in physician practices endorsed and/or issued by the College of Physicians and Surgeons of BC. Unless CPSBC guidance on the appropriate use of virtual care states otherwise, the physician must provide both in-person and virtual visits to patients in their LFP Clinic;

(i) encourage patients to participate in a provincially administered patient survey about primary care experiences;

(j) create and maintain Adequate Medical Records; and

(k) agree to the audit and assessment authority of the Medical Services Commission as set out in the *Medicare Protection Ac*t.

(the "**Required Services**")

7. Enrolment and Annual Registration Code

(a) **How to Enrol** – A physician who meets the Initial Eligibility Criteria enrols in the LFP Payment Model by submitting the Registration Code to HIBC via Teleplan, unless the physician does not yet meet Section 6(g) [ensure that Non-panel Services are no more than 30% of the total LFP Practice Services and Non-panel Services].

A physician who meets the Initial Eligibility Criteria but does not yet meet Section 6(g) enrols for the LFP Payment Model by submitting both the Registration Code and the Transition Code.

For clarity, a physician practicing in a rural community that was receiving NIA premiums as of December 15, 2002 does not need to submit the Transition Code in addition to the Registration Code.

(b) **Enrolment Effective Date - A physician's enrolment is effective on the first day that the physician bills a Time Code. After this day, the physician cannot claim under Fee-for-Service for services covered under the LFP Payment Schedule. Physicians cannot bill for services under the LFP Payment Model for dates of service prior to this date. A physician's enrolment effective date cannot be earlier than the day they submitted the Registration Code.**

(c) **How to Continue Enrolment –** To continue enrolment, a physician who meets the Ongoing Eligibility Criteria must submit the Registration Code annually between January 1 and March 31. If the Registration Code is not submitted by March 31 of a given calendar year, no

subsequent payments will occur under the LFP Payment Model until the Registration Code is submitted.

(d) **Registration Code** – The "**Registration Code**" is as follows:

98000 Longitudinal Family Physician Payment Model Registration Code…….....**0.00**

A longitudinal family physician who meets the Eligibility Criteria submits this code to enrol or continue enrolment in the LFP Payment Model.

By submitting 98000, the physician confirms that they meet the Eligibility Criteria or Locum Eligibility Criteria as outlined in this Longitudinal Family Physician Payment Schedule. The physician agrees to only claim for payment in relation to services in accordance with the terms contained in this LFP Payment Schedule, including that they cannot claim under Fee-for-Service for services covered under the LFP Payment Schedule.

a) Submit once per calendar year per physician.
b) For physicians who meet the Eligibility Criteria, submission provides access to the LFP Panel Payment and the following Time Codes and Patient Interaction Codes until the end of the calendar year:
   - 98010 LFP Direct Patient Care Time
   - 98011 LFP Indirect Patient Care Time
   - 98012 LFP Clinical Administration Time
   - 98020 LFP In-person Interaction with an Advanced Procedure
   - 98021 LFP In-person Interaction with a Standard Procedure
   - 98022 LFP Minor Procedure or Diagnostic Test Provided with an In-person Interaction
   - 98030 LFP Consultation
   - 98031 LFP In-person Interaction in a Clinic
   - 98032 LFP Virtual Interaction by Phone or Video
   - 98033 LFP In-person Interaction in the Patient's Home
   - 98034 LFP In-person or Video Group Interaction

(e) **How to submit the Registration Code** – A physician submits the Registration Code using their MSP Practitioner Number and the following "patient" demographic information:

- PHN: 9694105066
- Patient Surname: Portal
- First name: LFP
- Date of Birth: January 1, 2023
- ICD-9 code: L23

(f) **Transition Code –** The "Transition Code" is as follows:

98001 Longitudinal Family Physician Payment Model Transition Code…….... 0.00

A longitudinal family physician submits this code after the Registration Code to indicate that they do not yet meet Section 6(g) [ensure that Non-panel Services are no more than 30% of the total of LFP Practice Services and Non-panel Services].

By submitting this code, the physician confirms that they are actively transitioning their practice to meet the requirement in Section 6(g) by March 31, 2024.

(g) **How to submit the Transition Code –** A physician submits the Transition Code after the Registration Code using their MSP Practitioner Number and the following "patient" demographic information:

- PHN: 9753035697
- Patient Surname: Portal
- First name: GPSC
- Date of Birth: January 1, 2013
- ICD-9 code: L23

The Transition Code must be submitted using the MSP Facility Number associated with the LFP Clinic. If a physician practices at multiple LFP Clinic locations, submit a separate Transition Code with the associated MSP Facility Number of each LFP Clinic location where they meet the eligibility criteria and provide the Required Services.

8. Withdrawal and Removal from the LFP Payment Model

(a) **Voluntary Withdrawal** – A physician can voluntarily withdraw from the LFP Payment Model and transition to another payment model at any time, but a physician who withdraws may not re-enrol in the LFP Payment Model for a period of 12 months unless approved in writing by the Medical Services Commission.

(b) **Withdrawal due to Ineligibility** – A physician who does not meet the Ongoing Eligibility Criteria must promptly withdraw from the LFP Payment Model.

(c) **Method of Withdrawal** – A physician withdraws from the LFP Payment Model by providing written notice to the Ministry of Health. To do so, complete and submit form 2981 LFP Payment Model – Withdrawal to:

Mailing Address:	LFP Payment Schedule PO Box 9649 Stn Prov Govt Victoria, B.C. V8W 9P4
Fax:	(250) 952-1417

(d) **Deemed Ineligible** – Notwithstanding any other provision in this LFP Payment Schedule, the Medical Services Commission may determine that a physician is ineligible for the LFP Payment Model on the basis that:

(i) the physician is not providing the Required Services;

(ii) the physician is claiming for payment contrary to this LFP Payment Schedule, or in an unjustifiable departure from the patterns of practice or billing of other physicians in this category; or

(iii) it would be in the public interest that the physician not be entitled to participate in the LFP Payment Model.

("**Deemed Ineligible**").

Prior to determining that a physician is Deemed Ineligible for the LFP Payment Model, the Medical Services Commission will provide:

(i) written notice to the physician identifying the reason(s) why the Medical Services Commission is considering making the physician ineligible;

(ii) the records the Medical Services Commission intends to consider in determining the physician's eligibility (if any); and

(iii) an opportunity for the physician to provide a written response for consideration within 21 days from delivery of the written response.

For clarity, a finding by the Medical Services Commission that a physician is Deemed Ineligible does not otherwise impact the physician's enrolment in MSP. As such, the physician may continue to provide services and make claims for payment under Fee-for-Service, subject to the other requirements and processes of the *Medicare Protection Act*.

Please see Appendix E in relation to billing Fee-for-Service after withdrawing from the LFP Payment Model.

PART III: LOCUMS

9. Locum Services in the LFP Payment Model

The LFP Payment Model is a compensation option for locum physicians who provide care on behalf of longitudinal family physicians. An "**LFP Locum**" means a physician who meets the Locum Eligibility Criteria and provides LFP Locum Services on behalf of a Host Physician.

An LFP Locum must only bill under the LFP Payment Model when providing LFP Locum Services for one or more Host Physicians at the Host Physician's longitudinal family medicine clinic. An LFP Locum may provide LFP Locum Services at the same time as a Host Physician is providing care or while they are away from practice.

An LFP Locum may bill Locum Time Codes and Locum Patient Interaction Codes for LFP Locum Services at a Host Physician's longitudinal family medicine clinic. An LFP Locum must not bill the Time Codes or Patient Interaction Codes for such services. LFP Locums are not eligible to receive a panel payment directly from the Medical Services Commission.

The terms "**Host Physician**" and "**LFP Locum Services**" are defined in Appendix A [*Definitions*]. For reference:

- "**Host Physician**" means a physician who provides Longitudinal Family Physician Services, is having an LFP Locum provide services on their behalf, and is:
    i) enrolled in the LFP Payment Model; or

ii) remunerated under Fee-for-Service and has submitted 14070 in the same calendar year; or
iii) remunerated under the Group Contract for Practicing Full-Service Family Physicians or the Individual Contract for New-to-Practice Family Physicians.

- "**LFP Locum Services**" means LFP Practice Services, Non-panel Services, and Maternity Services provided by an LFP Locum on behalf of a Host Physician.

For clarity, a physician who is enrolled under the LFP Payment Model and providing Longitudinal Family Physician Services may also provide LFP Locum Services. When they provide LFP Locum Services, they must bill Locum Time Codes and Locum Patient Interaction Codes.

10. Locum Eligibility

To be eligible as an LFP Locum under the LFP Payment Model, a physician must:

(a) commit to provide LFP Locum Services on behalf of one or more Host Physicians;

(b) commit to provide all Required Locum Services;

(c) submit both the 98000 Registration Code and the 98005 Locum Registration Code;

(d) submit an LFP Locum registration form each calendar year; and

(e) not be Deemed Ineligible by the Medical Services Commission, unless the Medical Services Commission provides written approval that the physician is eligible to re-enrol.

("Locum Eligibility Criteria")

11. Required Locum Services

An LFP Locum enrolled in the LFP Payment Model must:

(a) provide LFP Practice Services, with or without Non-panel Services and/or Maternity Services, when providing LFP Locum Services for a Host Physician;

(b) provide timely, accessible, comprehensive, and relationship-based care to patients by working and collaborating with other physicians and healthcare providers when appropriate;

(c) ensure that Non-panel Services are no more than 30% of the total of LFP Practice Services and Non-panel Services provided in one calendar year at each clinic where LFP Locum Services are provided. **The physician is not required to meet this requirement until March 31, 2024 or such time as the LFP Payment Model is amended for rural communities, when the physician is practicing at an LFP Clinic in a rural community that was receiving Northern Isolation Allowance (NIA) premiums as of December 15, 2002;**

(d) provide patient care consistent with any interim or permanent guidance on the appropriate use of virtual care in physician practices endorsed and/or issued by the College of Physicians and Surgeons of BC. An LFP Locum must not provide exclusively virtual care;

(e) create and maintain Adequate Medical Records; and

(f) agree to the audit and assessment authority of the Medical Services Commission as set out in the Medicare Protection Act.

("Required Locum Services")

12. Locum Enrolment and Annual Registration ~~Code~~

(a) **How to Enrol –** A physician who meets the Locum Eligibility Criteria may enrol in the LFP Payment Model as an LFP Locum by:

i) submitting both the 98000 Registration Code and 98005 Locum Registration Code to HIBC via Teleplan; and

ii) submitting an LFP Locum registration form.

(b) How to Continue Enrolment – To continue enrolment, an LFP Locum who meets the Locum Eligibility Criteria must do the following between January 1 and March 31 in each calendar year they provide LFP Locum Services:

iii) submit the 98000 Registration Code and the 98005 Locum Registration Code; and

iv) submit an LFP Locum registration form.

If the Registration Code, Locum Registration Code, and LFP Locum registration form are not submitted by March 31 of a given calendar year, no subsequent payments will occur under the LFP Payment Model until they are submitted.

(c) **LFP Locum Registration Code –** The "Locum Registration Code" is as follows:

98005 Longitudinal Family Physician Payment Model Locum Registration Code……0.00

A family physician who meets the Locum Eligibility Criteria submits this code to enrol or continue enrolment in the LFP Payment Model to provide LFP Locum Services. By submitting 98005, the physician confirms that they meet the Locum Eligibility Criteria.

The physician agrees to only claim for payment in relation to services in accordance with the terms contained in this LFP Payment Schedule, including that that they can only bill Locum Time Codes and Locum Patient Interaction Codes when they provide LFP Locum Services.

a) Submit once per calendar year

b) Submission provides access to the following Locum Time Codes and Locum Patient Interaction Codes until the end of the calendar year:

- 98040 LFP Locum Direct Patient Care Time
- 98041 LFP Locum Indirect Patient Care Time
- 98042 LFP Locum Clinical Administration Time
- 98050 LFP Locum In-person Interaction with an Advanced Procedure
- 98051 LFP Locum In-person Interaction with a Standard Procedure
- 98052 LFP Locum Minor Procedure or Diagnostic Test Provided with an In-person Interaction
- 98060 LFP Locum Consultation
- 98061 LFP Locum In-person Interaction in a Clinic
- 98062 LFP Locum Virtual Interaction by Phone or Video
- 98063 LFP Locum In-person Interaction in the Patient's Home
- 98064 LFP Locum In-person or Video Group Interaction

(d) **How to submit the Locum Registration Code** – A physician submits the Locum Registration Code using their MSP Practitioner Number and the following "patient" demographic information:

- PHN: 9753035697
- Patient Surname: Portal
- First name: GPSC
- Date of Birth: January 1, 2013
- ICD-9 code: L23

PART IV: INCLUDED AND EXCLUDED SERVICES

13. Included Services

The following services are included under the LFP Payment Model:

(a) LFP Practice Services;

(b) Non-panel Services; and

(c) Maternity Services

except for services that fall under Section 14.

~~For clarity, Non-panel Services are part of the LFP Payment Model; therefore, they cannot be billed under Fee-for-Service and must be claimed under the LFP Payment Model. Non-panel Services can be no more than 30% of the total of LFP Practice Services and Non-panel Services~~.

The terms "**LFP Clinic,**" "**LFP Practice Service,**" "**Maternity Service,**" and "**Non-panel Service**" are defined in Appendix A [*Definitions*]. For reference:

- "**LFP Clinic"** means a medical clinic in which a physician enrolled in the LFP Payment Model provides Longitudinal Family Physician Services.

- "**LFP Practice Service**" means Direct Patient Care and Indirect Patient Care that a physician provides to a patient on: (i) the physician's panel; or (ii) the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:

  (a) at the physician's LFP Clinic;

  (b) as a virtual care service associated with the physician's LFP Clinic, except if the physician provides successive services to patients located in a Facility; or

  (c) to a patient in their Home Setting (but not in a Facility).

- "**Maternity Service**" means maternity care provided by a physician to a patient who is not on: (i) the physician's panel; or (ii) the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:
  (a) at the physician's LFP Clinic;
  (b) as a virtual care service associated with the physician's LFP Clinic, except if the physician provides successive services to patients located in a Facility; or
  (c) to a patient in their Home Setting (but not in a Facility).

- "**Non-panel Service**" means Direct Patient Care and Indirect Patient Care that a physician provides to a patient who is not: (i) on the physician's panel; (ii) on the panel of another longitudinal physician**/**nurse practitioner who works at the same LFP Clinic as the physician; or (iii) receiving Maternity Services, if the service is provided:
  (a) at the physician's LFP Clinic;
  (b) as a virtual care service associated with the LFP Clinic, except if the physician provides successive services to patients located in a Facility; or
  (c) to a patient in their Home Setting (but not in a Facility).

For clarity, Non-panel Services are part of the LFP Payment Model; therefore, they cannot be billed under Fee-for-Service and must be claimed under the LFP Payment Model. Non-panel Services can be no more than 30% of the total of LFP Practice Services and Non-panel Services. This 30% limit does not apply to Maternity Services.

14. Excluded Services

The following services are excluded and not payable under the LFP Payment Model:

(a) Services at a Facility

Services in which the patient is located at a Facility are excluded from the LFP Payment Model. The term "Facility" is defined in Appendix A [*Definitions*]. For reference, it means an acute care, hospice, palliative care or long-term care facility, including but not limited to hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.

Physicians must claim for these services under a different compensation model, including using fees contained in Fee-for-Service or an alternative payment model, as applicable.

For clarity, if a physician provides Indirect Patient Care for a patient located at a Facility while the physician is between patient interactions in the course of their workday at an LFP Clinic, this Indirect Patient Care time is payable under the LFP Payment Model.

(b) Surgical Procedures Not Listed at Appendix D

Surgical procedures not listed in Appendix D are excluded from the LFP Payment Model. Physicians must claim for surgical procedures not listed in Appendix D under a different compensation model, including fees contained in Fee-for-Service or an alternative payment model, as applicable. If Fee-for-

Service or the applicable alternative payment model includes services associated with the surgical procedure, that service or time is excluded under the LFP Payment Model.

When a physician provides a consultation and surgical procedure not listed in Appendix D to the same patient on the same day:

- Direct Patient Care time is payable for the time spent on the consultation, but not the surgical procedure.
- An LFP Consultation (98030) or LFP Locum Consultation (98060) Patient Interaction Code is payable in addition to the surgical procedure.
- No other Patient Interaction Codes are payable **for the same patient** on the same day.

(c) Medical Assistance in Dying

Medical assistance in dying services are excluded from the LFP Payment Model. Physicians must claim for services related to assessment and provision of medical assistance in dying (any location) under a different compensation model, including fees contained in Fee-for-Service or an alternative payment model as applicable.

(d) Services to Residents of Other Provinces and Territories

Services to residents of other provinces and territories are excluded from the LFP Payment Model. MSP-insured services for out-of-province patients are claimed under Fee-for-Service, except for residents of Quebec. All Provinces and Territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid provincial health card. Physicians charge services for Quebec residents directly to the patient.

C. 11 (Reciprocal Claims) of the General Preamble to the Fee-for-Service Payment Schedule lists services that are excluded from the inter-provincial agreements. Physicians charge these services directly to the patient.

(e) Services to Residents of Other Countries and Non-beneficiaries

Services provided to patients who are not beneficiaries under the *Medicare Protection Act* are excluded from the LFP Payment Model, including out-of-country patients and patients who do not meet minimum residency requirements (but excluding patients who fall under Section **14**~~10~~(d)). These services are not insured under MSP and can be charged to the patient or third-party insurance.

(f) Motor Vehicle Accident and WorkSafeBC Services

Patient care relating to a motor vehicle accident and WorkSafeBC services cannot be claimed under the LFP Payment Model.

All patient care directly relating to a motor vehicle accident (ICBC) must be billed in accordance with C. 17 (Motor Vehicle Accident Billing Guidelines) of the General Preamble to the Fee-for-Service Payment Schedule.

All patient care directly relating to WorkSafeBC services must be billed to WorkSafeBC. A detailed description of WorkSafeBC fees, preamble, and policies is contained in the Physicians and Surgeons WorkSafeBC Services Agreement.

When a physician provides both MSP-insured services and WorkSafeBC/ICBC-related care during a single patient interaction:

- Time Codes and Locum Time Codes are not payable under the LFP Payment Schedule for any of the time during the patient interaction.
- A Patient Interaction Code or Locum Patient Interaction Code is payable in full for the MSP-insured service under the LFP Payment Model.
- Start and end times for the patient interaction must be entered on the codes billed for WorkSafeBC/ICBC-related care.

(g) Services Not Insured by MSP

The following services are not insured by MSP and therefore are not payable under the LFP Payment Model:

- Services that are not benefits under the *Medicare Protection Act*.
- Services requested or required by a third party for reasons other than medical requirements.
- Services provided solely in association with other services not insured under MSP, including patient consultations, pre-operative examinations, and laboratory investigations.
- Medical services which are provided solely for the purposes of research or experimentation.
- Cosmetic procedures solely to alter or restore appearance.
- Charges for missed appointments.
- Services provided by a physician to their family and household members as follows:
    - spouse,
    - child or stepchild,
    - parent or stepparent,
    - parent of a spouse,
    - grandparent,
    - grandchild,
    - sibling,
    - person living in their household, or
    - spouse of a person referred to in the above list

("**Services Not Insured by MSP"**)

Physicians can charge these services to the third party or directly to the patient as appropriate.

(h) Services Provided under Health Authority Contract

Services provided under a contract (e.g. service contract, sessional contract and salary agreement) between a physician and a health authority (including Provincial Health Services Authority, Providence Health Care Society and First Nations Health Authority) are excluded from the LFP Payment Model.

(i) Services Insured by Legislation other than the Medicare Protection Act

Services in which a patient is eligible for and entitled to under the following legislation are not payable under the LFP Payment Model:

- the *Aeronautics Act* (Canada),
- the *Civilian War-related Benefits Act*,
- the *Government Employees Compensation Act* (Canada),
- the *Merchant Seaman Compensation Act* (Canada),
- the *National Defence Act* (Canada),
- the *Pension Act* (Canada),
- the *Royal Canadian Mounted Police Pension Continuation Act* (Canada),
- the *Royal Canadian Mounted Police Superannuation Act* (Canada),
- the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*,
- the *Department of Veterans Affairs Act*,
- the *Corrections and Conditional Release Act* (Canada),
- the *Workers Compensation Act*, or
- the *Hospital Insurance Act*.

PART V: BILLING FOR TIME

15. Included and Excluded Time

A physician may claim for their work time on a daily basis using Time Codes or Locum Time Codes for Direct Patient Care, Indirect Patient Care, and Clinical Administration.

Patient care provided by non-physicians (e.g., nurses, nurse practitioners, allied care providers, nonclinical staff) is not payable under the LFP Payment Model. A physician may claim Indirect Patient Care for time spent communicating, care planning, and conferencing about a specific patient or patients.

The amount of time a physician may claim per calendar day is equal to the amount of time the physician spends providing Direct Patient Care, Indirect Patient Care, and Clinical Administration services that are included under the LFP Payment Model, subject to Section 16.

Physicians must not claim for time spent on Excluded Services. This includes:

- WorkSafeBC and ICBC-related services
- Services for patients who are not BC residents
- After-hours coverage (on call) time when not providing patient care
- Breaks

Physicians must ensure that medical records and other documentation support time claimed under the Time Codes or Locum Time Codes (Direct Patient Care, Indirect Patient Care, and Clinical Administration). In the event of an audit, a medical inspector (who will ordinarily be a family physician) must be able to independently determine the services provided in any given block of time.

Documentation of time claimed must be made available upon request, in accordance with the terms of the *Medicare Protection Act*.

Time spent on care provided under other payment models (e.g. Fee for Service, Alternate Payment Program) must be clearly documented and demonstrate there is no overlap with time claimed under the LFP Payment Model.

16. Limits on Payment for Time

Time codes are subject to the following limits:

(a) **Maximum Daily Time –** The maximum amount of time payable under the LFP Payment Model is 14 hours in a single calendar day.

(b) **Maximum Two-Week Time –** The maximum amount of time payable under the LFP Payment Model is 120 hours in any 14-day period.

(c) **Maximum Clinical Administration Time** – The maximum amount of time billable as Clinical Administration time (98012, 98042) is 10% of the total amount of time claimed by the physician in a calendar year for Direct Patient Care (98010, 98040) and Indirect Patient Care (98011, 98041) and Clinical Administration (98012, 98042). It is anticipated that Clinical Administration time for most physicians will be in the range of 5% of the time claimed under the Time Codes and Locum Time Codes.

Claims for Time Codes and Locum Time Codes that exceed typical hours by peer family physicians are more likely to result in a review and/or audit.

17. How to Claim for Time Codes and Locum Time Codes

Claims for Time Codes and Locum Time Codes are submitted on a daily basis for Direct Patient Care, Indirect Patient Care, and Clinical Administration. One or more claims may be submitted for each Time Code each day. There is no requirement to separately claim for the time spent with each individual patient.

Start and end times on each block of time must be entered on the billing claim. Only one Time Code or Locum Time Code at a time is payable. This means that start and end times for each code must not overlap.

Time Codes and Locum Time Codes are billed in 15-minute increments. The number of 15-minute units of time providing Clinic-based Services is totaled over the whole day and entered as the number of services on the claim. A physician must work the full 15 minutes to bill for that 15-minute increment. For example, if a physician provides 50 minutes of Direct Patient Care, they are entitled to claim 3 units of “98010 LFP Direct Patient Care Time – per 15 minutes”.

Time Codes and Locum Time Codes are submitted using the personal health number (PHN) and demographic information of the first or last patient of the day for whom Direct Patient Care or Indirect Patient Care is provided under the LFP Payment Model. On a day when only Clinical Administration is provided, use the information of the last LFP patient for whom Direct Patient Care or Indirect Patient Care was provided. The following fields are required for each Time Code and Locum Time Code submitted to HIBC via Teleplan:

- MSP Payee Number,
- Practitioner Number,
- Date of service
- Time Code or Locum Time Code (using the fee item field in Teleplan)
- Start time (for each block of time),
- End time (for each block of time),
- Time units – the number of 15-minute time units
- ICD-9 diagnostic code: L23
- Location Code, and
- MSP Facility Number
- *Referred by (The MSP Practitioner number of the Host Physician is required on all Locum Time Codes. When an LFP Locum is providing care on behalf of more than one Host Physician at the same longitudinal clinic, use the MSP practitioner number of one of the Host Physicians.)*

18. Time Codes

The "**Time Codes**", as explained in detail below, are the following:

- 98010 LFP Direct Patient Care Time – per 15 minutes
- 98011 LFP Indirect Patient Care Time – per 15 minutes
- 98012 LFP Clinical Administration Time – per 15 minutes

Each type of patient care must be billed using the appropriate Time Code. An LFP Locum can only bill Locum Time Codes and must not bill the Time Codes.

The Time Codes are as follows:

98010 **LFP Direct Patient Care Time – per 15 minutes……$32.50**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.

b) Payable for time spent providing Direct Patient Care, which means the following Clinic-based Services with a patient present:
   - In-person care, including home visits
   - Synchronous virtual care (phone, video)
   - Clinical teaching provided concurrently with patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students, and midwives/midwifery students.

c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is included under 98010.

d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.

e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include time spent on:
   - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
   - After-hours coverage (on call) time when not providing patient care
   - Breaks

f) Start and end times must be entered on the billing claim.

98011 **LFP Indirect Patient Care Time – per 15 minutes ……$32.50**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.

b) Payable for time spent on Indirect Patient Care, which is patient-specific services provided when the patient is not present. This means:
   - Documentation of patient interactions and charting
   - Review of results: labs, imaging, consultations, and other reports
   - Preparing referrals and requisitions
   - Chart review
   - Asynchronous virtual care (email, text, messaging via EMR)
   - Care coordination, care planning, and prescription refills done without the patient present
   - Conferencing, consulting, and meeting with other physicians and/or other health professionals for a specific patient or patients
   - Conferencing and meeting with family members**, caregivers,** and/or patient medical representatives
   - Travel time required to see a patient in their Home Setting
   - Clinical teaching arising from direct patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students
   - Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g. investigating particular diagnostic and therapeutic interventions)
   - Completion of clinically required forms, reports and medical certificates of death. This excludes services requested or required by a third party for other than medical requirements, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial examinations, and physical fitness examinations for school/camp.

c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is excluded, as it is included under 98010.

d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.

e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
   - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
   - After-hours coverage (on call) time when not providing patient care
   - Breaks

f) Start and end times must be entered on the billing claim.

98012 **LFP Clinical Administration Time – per 15 minutes ……..…….……$32.50**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.

b) Payable for time spent on clinical administration, which are activities that may not be patient-specific but require the professional expertise of a physician for management of the patient panel and practice. Examples include the following services:
   - Proactive patient panel management and review for screening interventions, disease management, and provision of data-informed care (e.g. mammograms, colon cancer screening, immunizations, diabetes management).
   - Electronic Medical Record (EMR) updating and management that requires physician expertise.

- Medical director responsibilities to ensure standards of medical care in the primary care practice as required by the College of Physicians and Surgeons of British Columbia.
- Privacy officer responsibilities for establishing and maintaining a privacy management program as required by privacy and other legislation, including the *Personal Information Protection Act*, the *Freedom of Information and Protection of Privacy Act* and *E-Health Act*.

c) Not payable for non-clinical administration related to clinic management that does not require the professional expertise of a physician for management of the patient panel and practice. This includes, but is not limited to, management of employees, finance and accounting responsibilities, ordering supplies and equipment, and clinic infrastructure services such as leasing and insurance.
d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.
e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
   - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
   - After-hours coverage (on call) time when not providing patient care
   - Breaks
f) Start and end times must be entered on the billing claim.
g) The maximum amount of time payable as clinical administration is 10% of the total hours paid as 98010, 98011, and 98012 per calendar year.

19. Locum Time Codes

The Locum Time Codes, as explained in detail below, are the following:

- 98040 LFP Locum Direct Patient Care Time – per 15 minutes
- 98041 LFP Locum Indirect Patient Care Time – per 15 minutes
- 98042 LFP Locum Clinical Administration Time – per 15 minutes

Each type of patient care provided by an LFP Locum must be billed using the appropriate Locum Time Code.

The Locum Time Codes are as follows:

98040 **LFP Locum Direct Patient Care Time– per 15 minutes……..…$32.50**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for time spent providing Direct Patient Care, which means the following Clinic-based Services with a patient present:
   - In-person care, including home visits
   - Synchronous virtual care (phone, video)
   - Clinical teaching provided concurrently with patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students, and midwives/midwifery students.
c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is included under 98040.
d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.

e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include time spent on:
   - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
   - After-hours coverage (on call) time when not providing patient care
   - Breaks

f) Start and end times must be entered on the billing claim.

g) The MSP practitioner number of the Host Physician must be entered in the "Referred by" field on the billing claim.

98041 LFP Locum Indirect Patient Care Time – per 15 minutes ……$32.50

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.

b) Payable for time spent on Indirect Patient Care, which is patient-specific services provided when the patient is not present. This means:
   - Documentation of patient interactions and charting
   - Review of results: labs, imaging, consultations, and other reports
   - Preparing referrals and requisitions
   - Chart review
   - Asynchronous virtual care (email, text, messaging via EMR)
   - Care coordination, care planning, and prescription refills done without the patient present
   - Conferencing, consulting, and meeting with other physicians and/or other health professionals for a specific patient or patients
   - Conferencing and meeting with family members**, caregivers,** and/or patient medical representatives
   - Travel time required to see a patient in their Home Setting
   - Clinical teaching arising from direct patient care for the following learners: medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students
   - Reviewing and analyzing clinically related information/research directly related to the needs of a particular patient (e.g. investigating particular diagnostic and therapeutic interventions)
   - Completion of clinically required forms, reports and medical certificates of death. This excludes services requested or required by a third party for other than medical requirements, such as insurance forms and reports, medical-legal letters and reports, insurance/industrial examinations, and physical fitness examinations for school/camp.

c) Time spent on indirect patient care provided between patient interactions in the course of a clinic day is excluded, as it is included under 98040.

d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.

e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
   - Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
   - After-hours coverage (on call) time when not providing patient care
   - Breaks

f) Start and end times must be entered on the billing claim.

g) The MSP practitioner number of the Host Physician must be entered in the "Referred by" field on the billing claim.

98042 **LFP Locum Clinical Administration Time – per 15 minutes ……..……$32.50**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and the 98005 Locum Registration Code.

b) Payable for time spent on clinical administration, which are activities that may not be patient-specific but require the professional expertise of a physician for management of the patient panel and practice. Examples include the following services:
- Proactive patient panel management and review for screening interventions, disease management, and provision of data-informed care (e.g. mammograms, colon cancer screening, immunizations, diabetes management).
- Electronic Medical Record (EMR) updating and management that requires physician expertise.
- Medical director responsibilities to ensure standards of medical care in the primary care practice as required by the College of Physicians and Surgeons of British Columbia.
- Privacy officer responsibilities for establishing and maintaining a privacy management program as required by privacy and other legislation, including the *Personal Information Protection Act*, the *Freedom of Information and Protection of Privacy Act* and *E-Health Act*.

c) Not payable for non-clinical administration related to clinic management that does not require the professional expertise of a physician for management of the patient panel and practice. This includes, but is not limited to, management of employees, finance and accounting responsibilities, ordering supplies and equipment, and clinic infrastructure services such as leasing and insurance.

d) Time Codes are billed in 15-minute increments. Physicians must work the full 15 minutes to bill for that 15-minute increment.

e) The number of 15-minute units is totaled over the day or block of time worked and entered as the number of services on the claim. The total number of units submitted must not include:
- Excluded Services, including WorkSafeBC and ICBC-related services, services for patients who are not BC residents, and services billable to third parties (insurance, employers etc.)
- After-hours coverage (on call) time when not providing patient care
- Breaks

f) Start and end times must be entered on the billing claim.

g) The maximum amount of time payable as clinical administration is 10% of the total hours paid as 98040, 98041, and 98042 per calendar year.

h) The MSP practitioner number of the Host Physician must be entered in the “Referred by” field on the billing claim.

PART VI: BILLING FOR PHYSICIAN-PATIENT INTERACTIONS

20. Physician-Patient Interaction Codes

In addition to billing Time Codes or Locum Time Codes, a physician also bills for physician-patient interactions included in the LFP Payment Model using a Patient Interaction Code or Locum Patient Interaction Code.

Fee-For-Service codes, such as tray fees and diagnostic tests, are not payable in addition to Patient Interaction Codes or Locum Patient Interaction Codes in relation to services included in the LFP Payment Model.

21. Limits on Payment for Physician-Patient Interactions

Patient Interaction Codes and Locum Patient Interaction Codes are subject to the following limits:

(a) **Maximum Interactions Paid Daily** – The maximum number of Patient Interaction Codes and Locum Patient Interaction Codes payable in a single calendar day is 50. This maximum applies to all Patient Interaction Codes and Locum Patient Interaction Codes, except 98022 and 98052. This maximum does not apply to services provided in communities that were receiving NIA premiums as of December 15, 2002.

(b) **Maximum Payment for Services to Patients not on Panel** – A physician cannot claim more than 30% of their Patient Interaction Codes for Non-panel Services in one calendar year, unless they meet the exception criteria in Section 4(a)(i) or (ii). A physician is not entitled to payments in excess of the 30% limit. If a physician exceeds this 30% limit, they cannot bill Fee-for-Service for additional Clinic-based Services.

An LFP Locum cannot claim more than 30% of their Locum Patient Interaction Codes for Non-panel Services in one calendar year at each clinic where LFP Locum Services are provided.

For the purposes of Section 21(b), the terms "Patient Interaction Codes," “Locum Patient Interaction Codes,” and "Clinic-based Services" exclude Maternity Services.

Claims for Patient Interaction Codes and Locum Patient Interaction Codes that exceed typical numbers by peer family physicians are more likely to result in a review and/or audit.

22. How to Bill Patient Interaction Codes and Locum Patient Interaction Codes

The following fields are required for each Patient Interaction Code and Locum Patient Interaction Codes submitted to HIBC via Teleplan (items in italics are required for referrals and consultations only):

- MSP Payee Number
- Practitioner Number
- Patient Personal Health Number (PHN)
- Patient Name
- Patient Date of Birth
- Date of service
- Patient Interaction Code or Locum Patient Interaction Code (fee item)
- ICD-9 Diagnostic Codes (1 code mandatory, 3 maximum)
- Location Code
- MSP Facility Number
- *Referred by (Notify MSP that a referral has been made to you by including the MSP practitioner number of the referring physician in the “Referred by Field.”)*

- *Referred to (Notify MSP of a referral by including the MSP practitioner number of the physician being referred to in the "Referred to Field." If no Patient Interaction Code or Locum Patient Interaction Code is being submitted, a claim record for a "no charge referral" may be submitted to MSP under fee item 03333 with a zero-dollar amount.)*

23. Patient Interaction Codes

The "**Patient Interaction Codes**", as explained in detail below, are the following:

- 98031 LFP In-person Interaction in a Clinic
- 98032 LFP Virtual Interaction by Phone or Video
- 98022 LFP Minor Procedure or Diagnostic Test Provided with an In-person Interaction
- 98021 LFP In-person Interaction with a Standard Procedure
- 98020 LFP In-person Interaction with an Advanced Procedure
- 98033 LFP In-person Interaction in the Patient's Home
- 98030 LFP Consultation
- 98034 LFP In-person or Video Group Interaction

Seven Patient Interaction Codes are stand-alone fee codes, inclusive of all services provided during the physician-patient interaction. For these services, only one Patient Interaction Code is billable for each patient interaction. When the patient is seen for multiple issues during the same patient interaction, the applicable Patient Interaction Code with the highest value should be billed and additional Patient Interaction Codes are not payable.

The eighth Patient Interaction Code is "98022 LFP Minor Procedure or Diagnostic Test Provided with an In-person Interaction." When minor procedures or diagnostic tests are provided during an in-person interaction, these are billed via an add-on code that can be billed in addition to other in-person interaction codes.

Appendix D outlines the procedures and diagnostic tests that are payable under the three procedure Patient Interaction Codes (98020, 98021, 98022). Procedures and diagnostic tests not outlined in Appendix D cannot be claimed under these Patient Interaction Codes and are included in the appropriate in-person Patient Interaction Code (98030, 98031, 98033, 98034). They cannot be claimed under Fee-For-Service or by any alternative payment model, unless it is an Excluded Service.

The Patient Interaction Codes are as follows:

98031 **LFP In-person Interaction in Clinic…… ……..…….…..…$25**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.
b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for an in-person interaction provided in an LFP Clinic.
d) Not payable in addition to 98020, 98021, 98030, 98032, 98033, or 98034.

98032 **LFP Virtual Interaction by Phone or Video ……...…….. $25**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.

b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for a virtual interaction provided by phone or video.
d) Not payable in addition to 98020, 98021, 98022, 98030, 98031, 98033, or 98034.

98022 LFP Minor Procedure or Diagnostic Test Provided in addition to an In-person Interaction……$10

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.
b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of a minor procedure or diagnostic test to the patient.
c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
d) Payable for a maximum of two of the services from the following list. Only one of each type of minor procedure or diagnostic test listed below is payable per patient per day.
    - Cryotherapy to any or multiple parts of the body
    - Injection of a medically necessary drug, allergy serum, or vaccine (with the exception of a vaccine for the indication of travel)
    - Urinalysis by dipstick
    - Urine pregnancy test
    - Urine screening for opioid agonist treatment
    - Urine screening for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone
    - Peak flow testing
    - Venipuncture
e) Payable on the same day in addition to 98020, 98021, 98030, 98031, or 98033.
f) Not payable in addition to 98032 and 98034.

98021 LFP In-person Interaction with a Standard Procedure ……..……$60

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.
b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
d) Payable for the following procedures:
    - Gynecologic examination that includes the use of a speculum
    - Cervical cancer screening
    - IUD removal
    - Cervical polypectomy
    - Anoscopy
    - Trigger point injection
    - Injection or aspiration of tendon or bursa
    - Intra-articular injection or aspiration

- Varicose vein injection

e) Not payable in addition to 98020, 98030, 98031, 98032, 98033, or 98034.

98020 LFP In-person Interaction with an Advanced Procedure ……..…..…. $110

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.
b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
d) Only payable for procedures named in Appendix D.
e) Not payable for procedural pain management that is required to be performed in a facility accredited by the Non-Hospital Medical and Surgical Facilities Accreditation Program Committee of the College of Physicians and Surgeons of BC.
f) Not payable in addition to 98021, 98030, 98031, 98032, 98033, or 98034.

98033 LFP In-person Interaction in the Patient's Home ……..……..….$100

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.
b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for an in-person interaction provided to a patient in their Home Setting as deemed appropriate by the physician. This excludes patients in acute care facilities and long-term care facilities such as hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.
d) Not payable in addition to 98020, 98021, 98030, 98031, 98032, or 98034.
e) Time spent during the in-person interaction in the patient's home is payable as 98010. Travel time required to see a patient in their Home Setting is payable as 98011.

98030 LFP Consultation…….. $60

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.
b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for consultations provided in-person or virtually as is clinically appropriate for the presenting concern.
d) A consultation applies when a physician, nurse practitioner, or other health care practitioner requests the opinion of a family physician who has specialized expertise to provide consultative services. "Health care practitioner" in this context is limited to a:
    - midwife for maternity care or pediatric care,
    - registered nurse or registered psychiatric nurse for substance use care.
e) A consultation must not be billed without a written request for consultation and the provision of a written report to the referring practitioner. It is expected that a written report will be generated by the physician providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable.

f) The consultation service includes the initial services necessary to enable the consultant to prepare a written report to the referring practitioner, including their findings, opinions and recommendations.
g) A consultation for the same diagnosis is not payable as an LFP Consultation unless an interval of at least six months has passed since the consultant has last billed an LFP Consultation for the patient. A new and unrelated diagnosis can be billed as an LFP Consultation without a six-month interval.
h) Not payable for transfer of care within a group of physicians who work together to provide care and coverage to patients.
i) Not payable in addition to 98020, 98021, 98031, 98032, 98033, or 98034.

98034 LFP In-person or Video Group Interaction ……. $25/patient

Notes:

a) Payable only to physicians who have billed 98000 Registration Code.
b) Payable for a documented interaction between a group of patients and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for an in-person or video group medical visit or group counselling visit for groups of two or more patients that provides 1:1 interaction between each patient and the physician.
d) A minimum of thirty minutes must be spent for the group interaction.
e) While the length of the group interaction and the number of patients in the group interaction may vary, this is only payable for a maximum of:
    - 3 patients for a 30 minute In-person or Video Group Interaction
    - 5 patients for a 45 minute In-person or Video Group Interaction
    - 6 patients for a 60 minute In-person or Video Group Interaction
    - 8 patients for a 75 minute In-person or Video Group Interaction
    - 9 patients for a 90 minute or longer In-person or Video Group Interaction
f) Start and end times for the group interaction must be entered on the billing claim.
g) Not payable in addition to 98020, 98021, 98022, 98030, 98031, 98032, or 98033.

24. Locum Patient Interaction Codes

The “Locum Patient Interaction Codes”, as explained in detail below, are the following:

- 98061 LFP Locum In-person Interaction in a Clinic
- 98062 LFP Locum Virtual Interaction by Phone or Video
- 98052 LFP Locum Minor Procedure or Diagnostic Test Provided with an In-person Interaction
- 98051 LFP Locum In-person Interaction with a Standard Procedure
- 98050 LFP Locum In-person Interaction with an Advanced Procedure
- 98063 LFP Locum In-person Interaction in the Patient’s Home
- 98060 LFP Locum Consultation
- 98064 LFP Locum In-person or Video Group Interaction

An LFP Locum can only bill Locum Patient Interaction Codes and must not bill the Patient Interaction Codes.

Seven Locum Patient Interaction Codes are stand-alone fee codes, inclusive of all services provided during the physician-patient interaction. For these services, only one Locum Patient Interaction Code is billable for each patient interaction. When the patient is seen for multiple issues during the same patient interaction, the applicable Locum Patient Interaction Code with the highest value should be billed and additional Locum Patient Interaction Codes are not payable.

The eighth Locum Patient Interaction Code is “98052 LFP Locum Minor Procedure or Diagnostic Test Provided with an In-person Interaction.” When minor procedures or diagnostic tests are provided during an in-person interaction, these are billed via an add-on code that can be billed in addition to other in-person interaction codes.

Appendix D outlines the procedures and diagnostic tests that are payable under the three procedure Locum Patient Interaction Codes (98050, 98051, 98052). Procedures and diagnostic tests not outlined in Appendix D cannot be claimed under these Locum Patient Interaction Codes and are included in the appropriate in-person Locum Patient Interaction Code (98060, 98061, 98063, 98064). They cannot be claimed under Fee-For-Service or by any alternative payment model, unless it is an Excluded Service.

98061 **LFP Locum In-person Interaction in Clinic……..……..…$25**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for an in-person interaction provided in an LFP Clinic.
d) Not payable in addition to 98050, 98051, 98060, 98062, 98063, or 98064.

98062 **LFP Locum Virtual Interaction by Phone or Video ……..….. $25**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for a virtual interaction provided by phone or video.
d) Not payable in addition to 98050, 98051, 98052, 98060, 98061, 98063, or 98064.

98052 **LFP Locum Minor Procedure or Diagnostic Test Provided in addition to an In-person Interaction……$10**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of a minor procedure or diagnostic test to the patient.
c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
d) Payable for a maximum of two of the services from the following list. Only one of each type of minor procedure or diagnostic test listed below is payable per patient per day.
    - Cryotherapy to any or multiple parts of the body
    - Injection of a medically necessary drug, allergy serum, or vaccine (with the exception of a vaccine for the indication of travel)
    - Urinalysis by dipstick
    - Urine pregnancy test

- Urine screening for opioid agonist treatment
- Urine screening for amphetamines, benzodiazepines, buprenorphine/naloxone, cocaine metabolites, methadone metabolites, opioids and oxycodone
- Peak flow testing
- Venipuncture

e) Payable on the same day in addition to 98050, 98051, 98060, 98061, or 98063.
f) Not payable in addition to 98062 and 98064.

98051 LFP Locum In-person Interaction with a Standard Procedure ……..……$60

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
d) Payable for the following procedures:
    - Gynecologic examination that includes the use of a speculum
    - Cervical cancer screening
    - IUD removal
    - Cervical polypectomy
    - Anoscopy
    - Trigger point injection
    - Injection or aspiration of tendon or bursa
    - Intra-articular injection or aspiration
    - Varicose vein injection
e) Not payable in addition to 98050, 98060, 98061, 98062, 98063, or 98064.

98050 LFP Locum In-person Interaction with an Advanced Procedure ……..…. $110

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented in-person interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for medically necessary services generally considered to be accepted standards of care in the medical community currently and not considered experimental in nature. Cosmetic procedures solely to alter or restore appearance are not considered medically necessary.
d) Only payable for procedures named in Appendix D.
e) Not payable for procedural pain management that is required to be performed in a facility accredited by the Non-Hospital Medical and Surgical Facilities Accreditation Program Committee of the College of Physicians and Surgeons of BC.
f) Not payable in addition to 98051, 98060, 98061, 98062, 98063, or 98064.

98063 **LFP Locum In-person Interaction in the Patient's Home ……..….$100**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for an in-person interaction provided to a patient in their Home Setting as deemed appropriate by the physician. This excludes patients in acute care facilities and long-term care facilities such as hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.
d) Not payable in addition to 98050, 98051, 98060, 98061, 98062, or 98064.
e) Time spent during the in-person interaction in the patient's home is payable as 98040. Travel time required to see a patient in their Home Setting is payable as 98041.

98060 **LFP Locum Consultation…….. $60**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented interaction between a patient and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.
c) Payable for consultations provided in-person or virtually as is clinically appropriate for the presenting concern.
d) A consultation applies when a physician, nurse practitioner, or other health care practitioner requests the opinion of a family physician who has specialized expertise to provide consultative services. "Health care practitioner" in this context is limited to a:
    - midwife for maternity care or pediatric care,
    - registered nurse or registered psychiatric nurse for substance use care.
e) A consultation must not be billed without a written request for consultation and the provision of a written report to the referring practitioner. It is expected that a written report will be generated by the physician providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable.
f) The consultation service includes the initial services necessary to enable the consultant to prepare a written report to the referring practitioner, including their findings, opinions and recommendations.
g) A consultation for the same diagnosis is not payable as an LFP Consultation unless an interval of at least six months has passed since the consultant has last billed an LFP Consultation for the patient. A new and unrelated diagnosis can be billed as an LFP Consultation without a six-month interval.
h) Not payable for transfer of care within a group of physicians who work together to provide care and coverage to patients.
i) Not payable in addition to 98050, 98051, 98061, 98062, 98063, or 98064.

98064 **LFP Locum In-person or Video Group Interaction …..……. $25/patient**

Notes:

a) Payable only to physicians who have billed 98000 Registration Code and 98005 Locum Registration Code.
b) Payable for a documented interaction between a group of patients and a physician who exercises their independent clinical judgment in the provision of services to the patient, including the following components (as clinically appropriate): history, appropriate examination, review of symptoms, discussion of management, and provision of support.

c) Payable for an in-person or video group medical visit or group counselling visit for groups of two or more patients that provides 1:1 interaction between each patient and the physician.
d) A minimum of thirty minutes must be spent for the group interaction.
e) While the length of the group interaction and the number of patients in the group interaction may vary, this is only payable for a maximum of:
    - 3 patients for a 30 minute In-person or Video Group Interaction
    - 5 patients for a 45 minute In-person or Video Group Interaction
    - 6 patients for a 60 minute In-person or Video Group Interaction
    - 8 patients for a 75 minute In-person or Video Group Interaction
    - 9 patients for a 90 minute or longer In-person or Video Group Interaction
f) Start and end times for the group interaction must be entered on the billing claim.
g) Not payable in addition to 98050, 98051, 98052, 98060, 98061, 98062, or 98063.

PART VII: THE PANEL PAYMENT

25. Panel Payment

In addition to billing for time and patient interactions, a physician enrolled in the LFP Payment Model who is not an LFP Locum receives a panel payment based on the size and complexity of their patient panel. The panel payment is the component of the LFP Payment Model that recognizes relational continuity – the ongoing, trusting, therapeutic relationship between a patient and their family physician.

In 2023, the panel payment will be based on an interim methodology adapted from the Community Longitudinal Family Physician (CLFP) Payment to estimate the size and complexity of a longitudinal family physician's patient panel. In this interim methodology, the number of patients is estimated using the Majority Source of Care (MSOC) methodology and complexity is measured using the Adjusted Clinical Group (ACG) system.

~~Once a provincial system to identify a physician's Empanelled Patients is in place, the panel payment will be calculated based on the number of Empanelled Patients and the complexity of those patients.~~

Once the Provincial Attachment System is fully established for identifying physicians' Empanelled Patients, the panel payment will be calculated based on the number of Empanelled Patients and the complexity of those patients.

The panel payment is designed to be paid out four times per year on a quarterly installment schedule. An eligible physician must submit a claim form once per calendar year to claim the panel payment instalments for the calendar year. Submitting the claim form will confirm the physician's eligibility for the panel payment and their MSP Payee Number.

PART VIII: SPECIAL SITUATIONS

26. Multiple Visits by the Same Patient in One Day

Occasionally, a patient will visit a physician more than once on the same day. When this occurs:

(a) Direct Patient Care Time (98010) or Locum Direct Patient Care Time (98040) is billable; and

(b) a second Patient Interaction Code or Locum Patient Interaction Code is not billable, unless the second visit is:

(iii) for a new condition; or

(ii) because the condition has worsened significantly and requires a new assessment.

To bill more than one Patient Interaction Code or Locum Patient Interaction Code for the same patient on the same calendar day:

- provide the time for each interaction in the time field for each Patient Interaction Code or Locum Patient Interaction Code;
- provide a note record indicating the reason for the second interaction; and
- use submission code "D" for the second Patient Interaction Code or Locum Patient Interaction Code.

27. Clinical Teaching

For the purposes of payment for clinical teaching, "**Clinical Learners"** are medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students.

Time Codes and Locum Time Codes are payable to physicians providing clinical teaching to Clinical Learners in relation to Clinic-Based Services as follows:

a) Direct Patient Care time

- Time spent providing clinical teaching concurrent with patient care is payable as Direct Patient Care Time (98010) or Locum Direct Patient Care Time (98040).
- The physician must be present in-person in order for the Direct Patient Care Time (98010) or Locum Direct Patient Care Time (98040) to be payable for clinical teaching concurrent with in-person patient care.
- For clinical teaching concurrent with virtual patient care, the physician can be present in-person, by telephone, or by videoconference.

b) Indirect Patient Care time

- Time spent providing clinical teaching arising from Direct Patient Care is payable as Indirect Patient Care Time (98011) or Locum Indirect Patient Care Time (98041).

Time Codes and Locum Time Codes are not payable for the Clinical Learner's time.

28. Services provided by Students, Residents and Trainees

Patient Interaction Codes and Locum Patient Interaction Codes for Clinic-based Services are payable to supervising physicians for patient interactions provided by students, residents, and trainees as follows:

- When patient care is provided in-person, the supervising physician must be present in-person at the LFP Clinic.
- When patient care is provided virtually by phone or video, the supervising physician must be available in-person, by telephone, or by videoconference in a timely manner appropriate to the acuity of the service being supervised.
- The maximum number of Patient Interaction Codes and Locum Patient Interaction Codes payable in a single calendar day is 50. This maximum applies to all Patient Interaction Codes and Locum Patient Interaction Codes except 98022 and 98052.
- The physician must review the patient interaction and sign off the medical record or other auditable document by the end of the next workday.

PART IX: ADMINISTRATION AND CLAIMS SUBMISSION

29. Audit Authority

Physicians receiving payment through the LFP Payment Model are subject to the auditing authority of the Medical Services Commission under the *Medicare Protection Act.*

Physicians are responsible for all claims submitted under their MSP practitioner number, even if they receive support from others.

30. Adequate Medical Records

All claims must be supported by an Adequate Medical Record. An "**Adequate Medical Record**" is a record that contains sufficient information to enable a family physician, without being familiar with the patient or the physician, to readily determine the following:

(a) Date and location of the service.
(b) Identification of the patient and the physician.
(c) Presenting concern(s) and presenting symptoms and signs, including their history.
(d) All pertinent previous history including pertinent family history.
(e) The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient's problem(s).
(f) Identification of the extent of the physical examination including pertinent positive and negative findings.
(g) Results of any investigations carried out during the interaction.
(h) Summation of the problem and plan of management.

A service for which an Adequate Medical Record has not been recorded and retained is not a benefit under MSP.

31. MSP Facility Number

An MSP Facility Number is required to submit claims under the LFP Payment Model. A physician can obtain the MSP Facility Number from the physician responsible for administration of the clinic.

If a clinic does not have an MSP Facility Number, the physician responsible for administration of the clinic (the "**Facility Administrator**") must apply for a number by submitting an *Application for MSP Facility Number* via online application or printable form.

If there are any changes to the information for the facility after the application for MSP Facility Number has been submitted, the Facility Administrator must submit an *Application to Cancel or Change Details for Facilities with an MSP Facility Number* via online application or printable form.

Each clinic location must obtain a unique MSP Facility Number. Only one MSP Facility Number is required per clinic.

32. Billing the LFP Payment Model on the Same Day as Fee-for-Service, ICBC Services, or WorkSafeBC Services

If a physician provides LFP Clinic-based Services and Fee-for-Service services on the same day, start and end times must be entered on each Fee-for-Service claim. This is required for all Fee-for Service claims, regardless of whether the service is provided at the LFP Clinic, in a Facility, or at another location.

For an individual service~~s~~, a physician~~s~~ must enter the actual start and end time on the Fee-for-Service claim. For multiple services provided back-to-back under Fee-for-Service (a block of services), a physician~~s~~ must enter the start and end times of the block of services on each Fee-for-Service claim. Actual start and end times for each service provided during a continuous block of services are not required.

In addition, if a physician provides LFP Clinic-based Services and WorkSafeBC/ICBC-related services on the same day, start and end times must be entered on the codes billed for WorkSafeBC/ICBC-related care.

33. Claims Submission

Physicians billing under the LFP Payment Model must submit claims for Time Codes, Locum Time Codes, Patient Interaction Codes, and Locum Patient Interaction Codes to HIBC via Teleplan within 90 days of the date of service, subject to limited exceptions.

Please see Appendix C for detailed information about submitting claims more than 90 days after the date of service and submitting claims for newborns.

34. Reviewing and Resubmitting Claims

A physician should carefully review their remittance statements issued by MSP to reconcile all claims and payments made.

In certain circumstances, MSP may hold, reduce, or refuse claims submitted by a physician. In each case, explanatory codes explain the reason for the claim not being paid in full.

If a physician does not agree with MSP's payment of a claim, the physician should resubmit the claim to MSP with a note record explaining the circumstances.

35. Contact Information

Health Insurance BC (HIBC) Practitioner & Professional Resources

Phone

Vancouver: (604) 456-6950
Elsewhere in B.C.: 1-866-456-6950

Fax

Billing Support
Fax: (250) 405-3593

- Assists with Practitioner billing; payment schedule/fee item questions; handles adjudication disputes and overage claims.

Provider Services
Fax: (250) 405-3592

- Responsible for practitioner registration, opting-in/out, assignment of payment, electronic claims submission, direct bank deposit, locum programs, northern and rural programs.

Mail

Medical Services Plan
PO Box 9480 Stn Prov Govt
Victoria, B.C. V8W 9E7

APPENDICES

Appendix A: Definitions

Appendix B: Background and Principles of the LFP Payment Model

Appendix C: Claim Submission and Payment

Appendix D: Procedures and Diagnostic Tests Payable Under 98020, 98021, 98022, 98050, 98051, and 98052

Appendix E: Billing Fee-for-Service After Withdrawing from the LFP Payment Model

Appendix A – Definitions

In this Payment Schedule, unless the context otherwise requires:

(a) "**Adequate Medical Record**" has the meaning given to it in Section 30 [*Adequate Medical Records*].

(b) "**Clinic-based Services**" means LFP Practice Services, Non-panel Services and Maternity Services.

(c) **"Clinical Administration"** means Clinical Administration as described in Time Code 98012 LFP Clinical Administration – per 15 minutes at Section 18 [*Time Codes*], including item (b) of that Time Code and excluding time described in item (c).

(d) **"CPSBC"** means the College of Physicians and Surgeons of BC.

(e) **"Deemed Ineligible"** has the meaning given to it in Section 8(d) [*Withdrawal and Removal from the LFP Payment Model*].

(f) **"Direct Patient Care"** means direct patient care as described in Time Code 98010 LFP Direct Patient Care Time– per 15 minutes at Section 18 [*Time Codes*], including item (b) of that Time Code.

(g) **"Eligibility Criteria"** means, for a physician not currently enrolled in the LFP Payment Model, the Initial Eligibility Criteria; for a physician enrolled in the LFP Payment Model, the Ongoing Eligibility Criteria.

(h) **"Empanelled Patient"** means an individual for whom a family physician has accepted responsibility to provide and coordinate longitudinal, relationship-based, comprehensive, family medicine care.

(i) **"Excluded Services"** means all of the services and circumstances described in Section 14 [*Excluded Services*] as being excluded from the LFP Payment Model.

(j) **"Facility"** means an acute care, palliative care, or long-term care facility, including but not limited to hospitals, hospice, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.

(k) **"Fee-for-Service"** means a Payment Schedule titled the "Medical Services Commission Payment Schedule" that contains a "General Preamble" and separate schedules for different sections of physicians, as amended from time-to-time, which is sometimes referred to as "fee-for-service". For clarity, it is a Payment Schedule that is not this LFP Payment Schedule.

(l) "**Home Setting**" means a setting where a patient lives – including a home, assisted living or another setting where a person lives – but excluding a Facility.

(m) **"Host Physician**" means a physician who provides Longitudinal Family Physician Services, is having an LFP Locum provide services on their behalf, and is:

i. enrolled in the LFP Payment Model;

ii. remunerated under Fee-for-Service and has submitted 14070 in the same calendar year; or

iii. remunerated under the Group Contract for Practicing Full-Service Family Physicians or the Individual Contract for New-to-Practice Family Physicians.

(n) "**Indirect Patient Care**" means indirect patient care as described in Time Code 98011 LFP Indirect Patient Care Time– per 15 minutes at Section 18 [*Time Codes*], including item (b) of that Time Code.

(o) **"Initial Eligibility Criteria**" means the initial eligibility criteria for the LFP Payment Model defined in Section 4 [*Initial Eligibility for the LFP Payment Model*].

(p) "**LFP Clinic"** means a medical clinic in which a physician enrolled in the LFP Payment Model provides Longitudinal Family Physician Services.

(q) **"LFP Locum"** means a physician who meets the Locum Eligibility Criteria and provides LFP Locum Services on behalf of a Host Physician.

(r) **"LFP Locum Patient Interaction Codes"** has the meaning given to it in Section 24 [*Locum Patient Interaction Codes*].

(s) **"LFP Locum Services"** means LFP Practice Services, Non-panel Services, and Maternity Services provided by an LFP Locum on behalf of a Host Physician.

(t) **"LFP Locum Time Code"** or **"LFP Locum Time Codes"** means, as context requires, one or more of: LFP Locum Direct Patient Care Time (98040), LFP Locum Indirect Patient Care Time (98041), and LFP Locum Clinical Administration Time (98042).

(u) "**LFP Payment Schedule"** means this Payment Schedule.

(v) "**LFP Practice Service**" means Direct Patient Care and Indirect Patient Care that a physician provides to a patient on: (i) the physician's panel; or (ii) the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:

i. at the physician's LFP Clinic;

ii. as a virtual care service associated with the physician's LFP Clinic, except if the physician provides successive services to patients located in a Facility; or

iii. to a patient in their Home Setting (but not in a Facility).

(w) **"Locum Eligibility Criteria"** means the eligibility criteria for the LFP Payment Model defined in Section 10 [*Locum Eligibility*].

(x) **"Locum Registration Code"** means 98005 Longitudinal Family Physician Payment Model Locum Registration Code, as defined in Section 12 [*Locum Enrolment and Annual Registration*].

(y) **"Longitudinal Family Physician Payment Model**" or **"LFP Payment Model**" means the compensation model set out in this LFP Payment Schedule.

(z) **"Longitudinal Family Physician Services"** means the types of services typically provided by a family physician who provides longitudinal, relationship-based, comprehensive, family medicine care in a community-based setting (including medically required services to beneficiaries), aligned with the attributes of a Patient Medical Home.

(aa) **"Maternity Service"** means maternity care provided by a physician to a patient who is not on: (i) the physician's panel; or (ii) the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician, if the service is provided:

i. at the physician's LFP Clinic;

ii. as a virtual care service associated with the physician's LFP Clinic, except if the physician provides successive services to patients located in a Facility; or

iii. to a patient in their Home Setting (but not in a Facility).

(bb) **"MSP"** means the Medical Services Plan, which is continued under the Medicare Protection Act.

(cc) "**Non-panel Services**" means Direct Patient Care and Indirect Patient Care that a physician provides to a patient who is not: (i) on the physician's panel; (ii) on the panel of another longitudinal physician/nurse practitioner who works at the same LFP Clinic as the physician; or (iii) receiving Maternity Services, if the service is provided:

i. at the physician's LFP Clinic;

ii. as a virtual care service associated with the LFP Clinic, except if the physician provides successive services to patients located in a Facility; or

iii. to a patient in their Home Setting (but not in a Facility).

(dd) "**Ongoing Eligibility Criteria"** has the meaning given to it in Section 5 [*Ongoing Eligibility in the LFP Payment Model*].

(ee) **"Patient"** means an individual who is a beneficiary under the Medical Services Plan.

(ff) **"Patient Interaction Code"** has the meaning given to it in Section 23 [*Patient Interaction Codes*].

(gg) **"Patient Medical Home"** or **"PMH"** means the description of Patient Medical Home specified in Section 4 of Appendix B.

(hh) **"Payment Schedule"** means a payment schedule established by the Medical Services Commission under Section 26 of the Medicare Protection Act.

(ii) "**Provincial Attachment System**" **means British Columbia's IT-enabled attachment system that connects patients who do not have a family doctor with physicians who are able to take on new patients. The system also provides data to measure system progress and capacity.**

(jj) **"Registration Code"** means 98000 Longitudinal Family Physician Payment Model Registration Code, as defined in Section 7(d) [*Registration Code*].

(kk) **“Required Locum Services”** means the services specified in Section 11 [*Required Locum Services*].

(ll) **“Required Services”** means the services specified in Section 6 [*Required Services*].

(mm) **“Time Code”** or **"Time Codes”** means, as context requires, one or more of: LFP Direct Patient Care Time (98010), LFP Indirect Patient Care Time (98011), and LFP Clinical Administration Time (98012).

(nn) **“Transition Code**” means 98001 Longitudinal Family Physician Payment Model Transition Code, as defined in Section 7(f) [*Transition Code*].

Appendix B – Background and Principles of the LFP Payment Model

The Longitudinal Family Physician (LFP) Payment Model was developed by the BC Ministry of Health in consultation with BC Family Doctors and Doctors of BC. It is a compensation option for family physicians who provide longitudinal, relationship-based, family medicine care to a known panel of patients, aligned with the attributes of a Patient Medical Home. It is grounded in a commitment to increase patient access to community-based, longitudinal family medicine care, and expand primary care capacity across British Columbia.

To reflect the comprehensive and continuous nature of family medicine, it is a blended payment model that compensates physicians for time, patient interactions, and their overall patient panel. It was developed to:

- Recognize the complexity of longitudinal care
- Value the time spent with patients
- Resource family medicine clinics as critical healthcare infrastructure
- Acknowledge the value of indirect care and clinical administrative services
- Support physician agency and flexibility in practice

1. LFP PAYMENT MODEL PRINCIPLES

The LFP Payment Model is guided by a set of principles that govern the payment model and this payment guide. These principles outline what the payment model seeks to support and achieve for patients, physicians, and the healthcare system:

1. **Quality and Safety:** Supporting the provision of safe, high-quality care as defined in the BC Health Quality Matrix.
2. **Health Equity:** Facilitating the provision of care that supports health equity and provides all British Columbians with fair opportunity to reach their fullest health potential.
3. **Patient Medical Home**: Strengthening the ability of family physicians and family medicine clinics to act as Patient Medical Homes, enabling team-based care delivery for clinics who choose.
4. **Physician Health and Well-being:** Promoting family medicine clinics and care environments that support physicians' needs as health care providers and as human beings.
5. **Equitable Payment:** Providing equitable payment for family physician services, with an emphasis on valuing the critical role of longitudinal family medicine as the foundation of our healthcare system.
6. **Professional Agency:** Recognizing the professional agency and clinical judgement of family physicians as an enabler of patient care while maintaining accountability to the health system.
7. **Simplicity of Administration:** Offering a payment mechanism that is simple to access and administer for both physicians and the healthcare system.

The LFP Payment Model is structured to empower family physicians to provide accessible, high-quality, comprehensive, and continuous care that is adaptive to the needs of their patients and communities. It recognizes family medicine as the cornerstone of an integrated system of care and family practice clinics as hubs of access and coordination. It recognizes the important role of family medicine in an integrated system of care, and that family practice clinics are hubs of access and coordination.

2. LFP PAYMENT MODEL COMPONENTS

The LFP Payment Model is a blended payment model which compensates a physician for:

(a) physician time;

(b) physician-patient interactions; and

(c) the size and complexity of a physician's patient panel.

In the development of this payment model, the concept of a "full-time equivalent" physician was considered, while acknowledging that there is significant variation in how family physicians work. This concept was used to determine how the above payment mechanisms together generate the total compensation for a physician being paid under the LFP Payment Schedule.

A "full-time equivalent" is described as a family physician who, as part of the LFP Payment Model, provides:

- 1680 hours of patient care per year, inclusive of time spent on Direct Patient Care, Indirect Patient Care, and Clinical Administration;
- 5000 physician-patient interactions per year; and
- care to a patient panel that is the equivalent of 1250 Empanelled Patients of average complexity.

A family physician must work a minimum of 0.2 of a full-time equivalent in order to be eligible for the LFP Payment Model. This requires a family physician, as part of the LFP Payment Model, to:

- provide LFP Practice Services a minimum of one day per week, distributed equitably over the course of the year; and
- have a minimum patient panel of at least 250 Empanelled Patients.

3. FAMILY MEDICINE ATTRIBUTES

Family physicians embody within their professional practice the Four Principles of Family Medicine articulated by the College of Family Physicians of Canada:

- The family physician is a skilled clinician
- Family medicine is a community-based discipline
- The patient-physician relationship is central to the family physician's role
- The family physician is a resource to a defined practice population

Through these principles and a broad professional profile, family physicians collectively provide a system of front-line health care that is accessible, comprehensive, and continuous. Individually, they take responsibility for the coordinated medical care of patients, by providing relational continuity and a commitment to responsive and proactive patient care.

Care provided by family physicians may include, but is not limited to, the following primary care services:

- Health promotion and illness prevention services
- Primary care for minor or episodic illnesses

- Chronic disease management
- Reproductive and sexual care, including maternity care
- Mental health and substance use care
- Palliative care
- Care coordination and planning of patient care across the spectrum of primary, secondary and tertiary care
- Advocacy and outreach to ensure patients have timely and appropriate access to care
- Clinical teaching

4. PATIENT MEDICAL HOME

The Patient Medical Home (PMH) is the foundation and cornerstone of an integrated system of care in BC. As such, it is fundamental to the LFP Payment Model. The PMH is a family medicine clinic that provides longitudinal family medicine services, operating as a central hub for patients' healthcare needs. The goal is patient-centred, whole person-care in which care is easily navigated and centered on the needs of the patient, family, and community.

A PMH has a number of key attributes that define how the clinic supports patients:

a) Service Attributes

(i) **Commitment:** Patients are attached to a defined practice and primary care provider who will be the most responsible provider of their medical care. Family physicians accept responsibility for a panel of longitudinal patients.

(ii) **Contact:** Patients are able to access timely care through the PMH, including linking to after-hours services.

(iii) **Comprehensive:** Care is provided within the PMH throughout the patients' lifecycle, supplemented by services in care settings or through providers outside the PMH as needed.

(iv) **Continuity of care:** Longitudinal relationships between patients, the physician, and the team within the PMH are the foundation of care, supported through informational continuity and clinical networks of care outside the practice.

(v) **Coordination:** The PMH is the hub for coordination of care with simple and clear pathways to support patients as they transition to and from acute care, specialized services, or other community health services.

b) Relational enablers of care

(i) **Team-based care**: The PMH is supported by an inter-professional team within and/or linked to the practice.

(ii) **Family physician networks supporting practice**: Family physicians and associated teams are part of a clinical network of providers responding to the comprehensive care needs of the patients, including access to after hours care and cross coverage with other PMHs.

(iii) **PMH networks supporting communities**: Family physicians and associated teams are supported through partnerships as part of a broader network of care encompassing Divisions of Family Practice, health authority services, consultant specialist care, and other health care services.

c) Structural enablers of care

(i) **Information technology enabled:** Physicians and staff in the PMH are IT-enabled, including optimized EMR use, virtual care, and data collection methods to inform quality improvements in patient care and practice workflow.

(ii) **Education, training and research:** Physicians within the PMH are active participants in medical student and resident education, mentoring of new-to-practice physicians, primary care research, and/or interprofessional education.
(iii) **Evaluation and quality improvements:** Robust data and information sharing safeguards allow for active participation in quality improvement activities and evaluation of patient experience, contributing to regional and provincial understanding of the value and quality of primary care services.
(iv) **Internal and external supports:** The PMH has a business model supporting longitudinal team-based primary care, with linkages with the broader health care system.

Appendix C – Claims Submission and Payment

1. Claims Submission Period

Physicians billing under the LFP Payment Model must submit claims for Time Codes, Locum Time Codes, Patient Interaction Codes, and Locum Patient Interaction Codes to HIBC via Teleplan within 90 days of the date of service, which is the period of time for submission of claims under Section 27 of the *Medicare Protection Act* as prescribed by Section 33 of the Medical and Health Care Services Regulation

Notwithstanding the claims period above, the Medical Services Commission will pay claims submitted more than 90 days after the date of service in special circumstances. The following information provides an overview of how to bill claims more than 90 days after the date of service using submission codes C, X, I, W, and A:

SUBMISSION CODE C

- The patient did not have active coverage at the time the service was rendered.
- Coverage has been reinstated, but the claim is now over 90 days from the date of service.
- Note record required: “coverage reinstated”

SUBMISSION CODE X

- The physician disagrees with the adjudication of the claim. It is now over 90 days from the date of service.
- A note record with additional information is required to assist in re-adjudication of the claim.
- The claim must be resubmitted within 90 days from the remittance date of the original claim.
- See below for information about resubmitting claims for reassessment of payment.

SUBMISSION CODE I

- The claim has been either refused or accepted by ICBC since originally submitted. It is now over 90 days from the date of service.
- The claim must be submitted within 90 days of being advised of ICBC decision.

SUBMISSION CODE W

- The claim has been either refused or accepted by WorkSafe BC (WSBC) since originally submitted. It is now over 90 days from the date of service.
- The claim must be submitted within 90 days of being advised of WSBC decision.

SUBMISSION CODE A

- If the claim does not meet the criteria for the other submission codes (C, X, I and W), a physician can submit a written request to use submission code A to submit or resubmit claims more than 90 days after the date of service.
- Fax a *Practitioner Request for Approval of Over-age Claims* form to MSP billing support to (250) 405-3593.
- Requests must include the date range of the claims, number of claims, value of claims and the fee items involved.

- Requests must include detailed explanation for late submission. Administrative issues such as staffing problems, clerical errors, lost or forgotten claims, system or service bureau problems do not qualify for exemption.
- If the written request for use of submission code A is approved, the approval applies only to the exemption to the 90-day submission limit and does not guarantee payment. All claims billed are subject to the usual processing and adjudication rules and regulations.

2. Submitting Claims for Newborns

Services for newborns can be billed under the mother's personal health number (PHN), if the mother has valid MSP coverage. The maximum period that MSP will cover an unregistered baby under the mother's PHN is the month of birth plus the following two calendar months. After that, all services must be billed under the baby's own PHN.

When a baby has been provided with a PHN by the hospital, the family must still register the baby with MSP before that PHN can be used to submit claims.

To submit a claim for a newborn, use the mother's PHN with a dependent number of '66'. Some electronic medical record (EMR) systems have a different mechanism for billing a newborn patient.

Appendix D – Procedures and Diagnostic Tests Payable Under 98020, 98021, 98022, 98050, 98051, 98052

The following Patient Interaction Codes and Locum Patient Interaction Codes are payable only for the listed procedures and diagnostic tests.

Associated Fee-for-Service codes are provided for reference to assist physicians transitioning from Fee-for-Service. The General Preamble, billing rules, and fee notes of the listed Fee-for-Service codes do not apply to procedures and diagnostic tests billed under the LFP Payment Model, unless specifically noted in the LFP Payment Schedule.

98022 – LFP Minor Procedure or Diagnostic Test in addition to an In-person Interaction
98052 – LFP Locum Minor Procedure or Diagnostic Test in addition to an In-person Interaction

Procedures and Diagnostic Tests Payable as 98022 and 98052	Fee-for-Service Code
Cryotherapy	00190
Injection of a medically necessary drug, allergy serum, or vaccine (with the exception of a vaccine for the indication of travel)	00010 00011 00013 00016 00030 00034 10010 to 10030 **10040** **10041**
Urinalysis by dipstick	15130
Urine pregnancy test	15120
Urine screening for opioid agonist treatment	15039
Urine screening for amphetamines, benzodiazepines, etc.	15040
Peak flow testing	00930
Venipuncture	00012

98021 – LFP In-person Interaction with a Standard Procedure
98051 – LFP Locum In-person Interaction with a Standard Procedure

Procedures Payable as 98021 and 98051	Fee-for-Service Code
Gynecologic examination that includes the use of a speculum Cervical cancer screening	~~14560~~ **14562**
IUD removal	~~14541~~ **14562**
Cervical polypectomy	04509
Anoscopy	10710
Trigger point injection	01156 01157
Injection or aspiration of tendon or bursa	00014 00015 51039 51040
Intra-articular injection or aspiration	00811 52405 52410 53405 53410 54405

98021 – LFP In-person Interaction with a Standard Procedure
98051 – LFP Locum In-person Interaction with a Standard Procedure

Procedures Payable as 98021 and 98051	Fee-for-Service Code
Intra-articular injection or aspiration	00811 52405 52410 53405 53410 54405 54410 55405 55410 56405 56410 57405 57410
Varicose vein injection	77045

98020 – LFP In-person Interaction with an Advanced Procedure
98050 – LFP Locum In-person Interaction with an Advanced Procedure

COMMONLY PERFORMED IN FAMILY MEDICINE CLINICS	
Procedures Payable as 98020 and 98050	**Fee-for-Service Code**
Biopsy of skin or mucosa	13600 13601
Abscess, superficial opening	13605
Laceration or foreign body, Minor	13610 13611 13612
Excision of tumour of skin, subcutaneous tissue or scar	13620 13621 13622 13623 13624
Paronychia	13630
Nail removal	13631 13632
Wedge excision or Vandenbos procedure of one nail	13633
Hemorrhoid Thrombotic, Enucleation	13650
Insertion of IUD	14540
Insertion or removal of subdermal contraceptive implant	14542 14543
Cautery or excision of genital wart(s)	04305
Cervix punch biopsy	00784
Endometrial biopsy	00785
Proctosigmoidoscopy, rigid, diagnostic	10714
Abscess – perianal, I & D, superficial	07678

LESS COMMONLY PERFORMED IN FAMILY MEDICINE CLINICS	
Procedures Payable as 98020 and 98050	**Fee-for-Service Code**
Venesection for polycythaemia or phlebotomy	00019
Curettage and electrosurgery of skin carcinoma	00218 00219
Direct laryngoscopy	00701
Sigmoidoscopy with or without biopsy	00715 00716 00718
Chest Aspiration Paracentesis	00759
Paracentesis Abdominal	00760
Scratch test, per antigen Note: Only applicable if a minimum of 15 antigens are used.	00762 00763 00765
Endoscopic Examination of the Nose and Nasopharynx	00907
Nerve block paravertebral sympathetic	01042
Peripheral nerve block, single or double	01124 01125
Chalazion Excision	02150
Aural polyp removal or debridement, foreign body removal	02221
Myringotomy unilateral or bilateral - with insertion of aerating tube	02254 02274
Cauterization of septum, electric	02303
Posterior nasal packing	02341 02346
Nasal fracture - simple reduction or with reduction and splinting	02364 02365
Direct or indirect laryngoscopy with foreign body removal	02419
Incision of peritonsillar abscess – under local anesthetic	02447
Muscle Biopsy	03211
Biopsy of vulva, excisional lesion	04032 04317
Bartholin's cyst excision	04301
Amputation, Finger	06219
Aspiration: abdomen or chest	07041
Vasectomy – bilateral	08345
Esophagogastroduodenoscopy, including collection of specimens	10761
Application of Cast	51016 to 51025
Fine Needle aspiration of solid or cystic lesion	70041 70042
Removal of tumour (including intraoral) or scar revision – 2 to 5 cm	70116
Hemorrhoid(s); (e.g. band ligation) to include proctoscopy	71689
Compression sclerotherapy initial or repeat	77050 77060
Removal of totally implantable access device (e.g.: portacath),	77142

Appendix E – Billing Fee-For-Service After Withdrawing from the LFP Payment Model

Longitudinal family physicians transitioning **from the LFP Payment Model** to Fee-for-Service are reminded to submit the Community Longitudinal Family Physician Portal Code (14070) if they will be continuing to provide care as a longitudinal family physician and meet the criteria for the portal code.

14070 provides access to the following Fee-for-Service codes if individual fee criteria are met:

- *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*
- *PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician*
- *PG14078 FP Email/Text/Telephone Medical Advice Relay Fee*
- *PG14050, PG14051, PG14052, PG14053 Chronic Disease Management Incentive Fees*
- *PG14033 Complex Care Planning & Management Fee – 2 Diagnoses*
- *PG14043 Mental Health Planning fee*
- *PG14044, PG14045, PG14046, PG14047 and PG14048 Mental Health Management Fees*
- *PG14063 Palliative Care Planning Fee*
- *PG14066 Personal Health Risk Assessment (Prevention) Fee*
- *PH14041 CLFP New Patient Intake Fee*
- *PH14002 Maternity Care Risk Assessment*

Fee codes that will be affected by the transition from the LFP Payment Model are as follows:

- Chronic Disease Management (CDM) fees (14050, 14051, 14052, 14053)
    - These fees compensate for the additional work, beyond the office visit, of providing guideline-informed care to patients with eligible conditions over a full twelve-month period.
    - These fees are not payable for eligible patients who are living in their home or assisted living for 12 months after a physician transitions from the LFP Payment Model to Fee-for-Service.
    - There must be at least 2 visits billed via Fee-for-Service in the 12 months prior to billing a CDM fee. Further details about the two visits can be found in the fee details.

- Complex Care Planning and Management Fees (14033, 14075)
    - These fees are payment for the creation of a care plan (as defined in the FPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions (14033) or frailty (14075) who are living in their home or assisted living.
    - These fees are payable for eligible patients after a physician transitions from the LFP Payment Model to Fee-for-Service, if the care meets the requirements of the fee notes. However, if a physician switches back to the LFP Payment Model within the calendar year of billing Complex Care Planning and Management Fees, payments for those fees will be recovered for that calendar year.