MSC Longitudinal Family Physician (LFP) Payment Schedule
Summary of Changes – July 1, 2025

1) Transition Code (98001)

The LFP Clinic-based Services Transition Code 98001 has been extended to March 31, 2026.
See Section 37(c) [Exceptions to the Limit on Clinic Non-panel Services].

2) Changes related to Fee-for-Service fee item updates

Section 13 [FPSC Network Payments] has been deleted as the related fee items are expired. Section numbers and references throughout the Payment Schedule have been updated accordingly.

Section 14 [Hospital at Home Services] of III. Excluded Services has been updated to reflect changes to fee-for-service Hospital at Home fee items.

MINISTRY OF HEALTH

MEDICAL SERVICES COMMISSION

LONGITUDINAL FAMILY PHYSICIAN

PAYMENT SCHEDULE

JULY 1, 2025

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I. INTRODUCTION

1. The LFP Payment Schedule

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 LFP Payment Schedule. Unless context requires otherwise, definitions expressed in the singular include the plural and vice versa.

3. Overview of the LFP Payment Model

(a) Purpose

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 grounded in a commitment to increase patient access to community-based, longitudinal family medicine care, and expand primary care capacity across British Columbia.

The background and principles of the LFP Payment Model are described in Appendix B.

(b) Description

The LFP Payment Model is designed as a comprehensive payment model for longitudinal family physicians, incorporating several aspects of family medicine care. It includes clinic-based services that are provided via longitudinal family physician clinics, pregnancy & newborn clinics, and patients' home settings. It also includes facility-based care in long-term care facilities and palliative care facilities, as well as inpatient care and pregnancy & newborn care in hospital.

(c) How it works

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

(a) physician time;
(b) interactions; and
(c) the size and complexity of a physician's patient panel.

A physician bills for the total daily time they spend providing care, including time spent on direct care, indirect care and clinical administration. They also bill for each patient interaction and conferencing/communication. In addition, they receive a quarterly panel payment based on the number of patients on their panel and the complexity of those patients.

II. ADMINISTRATION

4. 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 Medical Services Plan (MSP) practitioner number, even if they receive support from others. Claims that exceed typical patterns of practice by peer family physicians are more likely to result in a review and/or audit.

Physicians are responsible for billing in accordance with the LFP Payment Schedule, including the time code and interaction code notes as well as identified limits. Claims submitted in contravention of the LFP Payment Schedule may be refused and/or recovered.

5. 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 positive and negative, 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.

6. Documentation

Physicians must ensure that medical records and other documentation support time claimed under the time codes and services claimed under interaction codes. 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 time period.

Documentation 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, Alternative Payment Program) must be clearly documented and demonstrate there is no overlap with time claimed under the LFP Payment Model.

7. Clinical Teaching

Clinical teaching is recognized as an enabler of care, with physicians actively participating in medical student and resident education, mentoring of new-to-practice physicians, and/or interprofessional education. 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.

Physicians providing clinical teaching to Clinical Learners are paid for their clinical teaching time as follows:

(a) Direct Patient Care time

- When clinical teaching is provided concurrent with patient care, time is payable as Direct Patient Care Time.
- When patient care is provided in-person, the physician must be present in person.
- When patient care is provided virtually by phone or video, the physician can provide clinical teaching to the Clinical Learner in-person, by telephone, or by videoconference.

(b) Indirect Patient Care time

When patient-specific clinical teaching arises from Direct Patient Care, time is payable as Indirect Patient Care Time. Teaching that that is unrelated to Direct Patient Care is not payable as Indirect Patient Care Time.

8. Services provided by Students, Residents and Trainees

Interaction codes 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 location where the care is provided (e.g., LFP Clinic, Pregnancy & Newborn Clinic, Facility, Home Setting, Home Birth Setting).
- 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 physician must review the patient interaction and sign off the medical record or other auditable document by the end of the next workday.

Time codes are not payable for a student, resident, trainee, or other Clinical Learner's time.

9. MSP Facility Number

An MSP Facility Number is required on all claims submitted under the LFP Payment Model for "**LFP Clinic-based Services**" and "**LFP Facility-based Services**."

- LFP Clinic-based Services must be billed using the MSP Facility Number of the LFP Clinic or Pregnancy & Newborn Clinic where the service is provided.
- LFP Facility-based Services must be billed using the MSP Facility Number of an LFP Clinic.

- Longitudinal family physicians must use the MSP Facility Number associated with their LFP Clinic.
- LFP Locum physicians must use the MSP Facility Number associated with their Host Physician's longitudinal family medicine clinic.

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.

10. Rural Practice Subsidiary Agreement Communities

Rural physicians who practice in a Rural Practice Subsidiary Agreement (RSA) community are eligible to receive Rural Retention Program (RRP) fee premiums on LFP Payment Model payments, in accordance with the RSA Rural Practice Subsidiary Agreement. Information about RRP fee premiums can be found in the Rural Practice Subsidiary Agreement Community Designation & Rural Retention Program Point List.

III. EXCLUDED SERVICES

The services listed in this section are excluded and not payable under the LFP Payment Model. Physicians must claim for these services under a different compensation model or may charge these services to a third party/patient if they are not covered by MSP, as applicable.

Further details about how to bill for Excluded Services are noted in Section 22 [*Billing the LFP Payment Model on the Same Day as Excluded Services*].

11. Services at a Facility

Services at a Facility are Excluded Services unless a physician has registered to bill for LFP Facility-based Services provided in an applicable Facility setting:

- Long-term Care and Palliative Facility Services
- Inpatient Facility Services
- Pregnancy & Newborn Facility Services

Physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment (e.g. ventilatory support, haemodynamic support including vasoactive medications, or prolonged resuscitation) can bill critical care Fee-for-Service codes as appropriate.

LFP Facility-based Services for which the physician has not registered are excluded from the LFP Payment Model. In addition, all other types of facility-based services are excluded from the LFP Payment Model (e.g. surgery, surgical assists unrelated to pregnancy).

The term "**Facility**" is defined in Appendix A [*Definitions*]. For reference, it means an acute care, hospice, palliative care, or long-term care facility. This includes but is not limited to hospitals, nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities, and personal care facilities.

12. Services Provided under Health Authority Contract

Services provided under an Alternative Payments Subsidiary Agreement (APSA) contract (e.g., service contract, sessional contract, 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.

~~13. FPSC Network Payments~~

~~The following Family Practice Services Committee (FPSC) network payments are excluded from the LFP Payment Model. They can be billed using the applicable alternative payment model or Fee-for-Service codes:~~

- ~~FP Assigned Inpatient Care Network (14086)~~
- ~~Maternity Care Network Initiative Payment (14010)~~

13. Medical Assistance in Dying

The following medical assistance in dying services in all settings are excluded from the LFP Payment Model. They can be billed using an alternative payment model or applicable Fee-for-Service codes:

- MAiD Assessment (Prescriber) (13501)
- MAiD Assessment (Assessor) (13502)
- Physician witness to video conference MAiD Assessment – Patient Encounter (13503)
- MAiD Event Preparation and Procedure (13504)
- MAiD Medication Pick-up and Return (13505)
- MAiD Expert Case Review (13506)
- MAiD Waiver of Final Consent (13507)
- Oral MAiD extension (13508)

Other palliative care (e.g. care planning, end of life visits) can be billed under the LFP Payment Model for applicable services and settings.

14. Hospital at Home Services

Hospital at Home allows eligible patients to receive hospital-level care in their homes rather than in a hospital. Patients receive care at home from an interdisciplinary team led by a physician with hospital admitting privileges.

Services provided to patients admitted to a Hospital at Home program are excluded from the LFP Payment Model. They can be billed using an alternative payment model or applicable Fee-for-Service codes when billed by physicians working in a health authority-operated Hospital at Home program.

This includes the following fee-for-service codes:

- Hospital at Home Virtual Visit (13010)
- Hospital at Home In-Person Visit (13011)
- Hospital at Home FP Conference with Allied Care Provider and/or Physician (13012)
- Emergency visit (call placed between hours of 0800 and 1800 hours) – weekdays (00112)
- Visit - out of office (12200, 13200, 15200, 16200, 17200, 18200)
- Call-Out Charges (01200, 01201, 01202)
- Continuing Care Surcharges (01205, 01206, 01207)
- ~~Telehealth FP Visit (13237, 13437, 13537, 13637, 13737, 13837)~~
- ~~Telehealth FP Individual counselling for a prolonged visit for counselling (13238, 13438, 13538, 13638, 13738, 13838~~
- Fee-for-service codes for procedures noted in Appendix D

For physicians who have registered to bill LFP Inpatient Facility Services: Services provided to the patient while the physician and patient are on site at the hospital should be billed under the LFP Payment Model using Inpatient Facility Services time and interaction codes.

15. Surgical Procedures not Listed in 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 follow-up services associated with the surgical procedure, that follow-up service is excluded for payment under the LFP Payment Model.

When a physician provides a consultation and a 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 interaction code is payable in addition to the surgical procedure.
- No other interaction codes are payable for the same patient on the same day.

16. Motor Vehicle Accidents

Services related to motor vehicle accidents (ICBC-related services) are excluded from the LFP Payment Model. These services must be billed under Fee-for-Service, in accordance with the Fee-for-Service Payment Schedule (General Preamble C. 17 Motor Vehicle Accident Billing Guidelines).

17. WorkSafeBC Services

Services related to WorkSafeBC services are excluded from the LFP Payment Model. These services must be billed using Fee-for-Service codes with WorkSafeBC identified as the payor. A detailed description of WorkSafeBC fees, preamble, and policies is contained in the Physicians and Surgeons' WorkSafeBC Services Agreement.

18. 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 billed under Fee-for-Service, except for residents of Quebec. Physicians can charge services for Quebec residents directly to the patient.

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. There are some services that are excluded from these interprovincial agreements, as identified in the Fee-for-Service Payment Schedule (General Preamble C. 11 Reciprocal Claims). Physicians can charge these services directly to the patient.

19. 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. This includes out-of-country patients and patients who do not meet minimum residency requirements (with the exception of residents of other provinces and territories with a valid provincial health card).

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

20. Services Not Insured by MSP

Services that are not insured by MSP 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 requested or required by provincial government ministries other than the Ministry of Health for reasons other than medical requirements, including RoadSafetyBC forms and Ministry of Social Development and Poverty Reduction forms (e.g. Persons with Disabilities (PWD) Designation Application).
- 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.

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

21. Services Insured by Legislation other than the Medicare Protection Act

Services are not payable under the LFP Payment Model if the patient is eligible for and entitled to them under the following legislation:

- 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*.

22. Billing the LFP Payment Model on the Same Day as Excluded Services

Some Excluded Services are billable using Fee-for-Service codes that are submitted through Teleplan:

- Services at a facility (unless a physician has registered to bill LFP Facility-based Services in an applicable Facility setting)
- Medical assistance in dying
- Hospital at Home Services

- Surgical procedures not listed in Appendix D
- Motor vehicle accidents (ICBC-related services)
- WorkSafeBC-related services
- Services to Residents of Other Provinces and Territories, except Quebec

When a physician provides an Excluded Service payable under Fee-for-Service during the same patient interaction as a service payable under the LFP Payment Model:

- The appropriate Fee-for-Service code(s) should be billed for the Excluded Service.
- An interaction code should be billed for the service payable under the LFP Payment Model.
- An LFP time code cannot be submitted for any of the time during the patient interaction.

Start and end times must be entered on Fee-for-Service codes when billed on the same day as LFP Payment Model time and interaction codes.

- This is required for all Fee-for-Service codes, including those billed for ICBC-related Services, RoadSafetyBC services, and WorkSafeBC-related services.
- This is required for services billed in all settings, including an LFP Clinic, Pregnancy & Newborn Clinic**,** Facility, or another location.

When a single patient interaction is billed under Fee-for-Service, the actual start and end time must be entered on the Fee-for-Service claim. When multiple, back-to-back interactions (a block of services) are billed under Fee-for-Service, the start and end times for each individual service are not required. Instead, the start and end times of the block of services must be entered on each Fee-for-Service claim.

When start and end times are not entered on Fee-for-Service codes for MSP-payable services, the Fee-for-Service claims will be refused. When start and end times are not entered on codes related to ICBC-related and WorkSafe-BC related services, the LFP interaction codes will be refused.

IV. ELIGIBILITY AND ENROLMENT FOR LONGITUDINAL FAMILY PHYSICIANS

23. Initial Eligibility Criteria 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;

(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.

24. Ongoing Eligibility Criteria 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 Enrolment Code annually 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.

25. 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 within three months of enrolling in the LFP Payment Model;

(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 Clinic-based 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 Clinic Non-panel Services are no more than 30% of LFP Clinic-based Services provided in one calendar year (Exceptions to this requirement are described in Section 37 [*Exceptions to the Limit on Clinic Non-panel Services*]);

(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 (CPSBC). 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.

26. Enrolment and Annual Re-enrolment

(a) How to Enrol in the LFP Payment Model

A physician who meets all the Initial Eligibility Criteria enrols in the LFP Payment Model by submitting the Enrolment Code to HIBC via Teleplan.

By submitting the Enrolment Code, the physician confirms that they meet the Eligibility Criteria as outlined in this LFP Payment Schedule. A physician's enrolment is effective the day they submit the Enrolment Code and cannot be made effective for an earlier date.

(b) How to Continue Enrolment

To continue enrolment, a physician who meets the Ongoing Eligibility Criteria must re-submit the Enrolment Code annually between January 1 and March 31. If the Enrolment Code is not submitted by March 31 of a given calendar year, no subsequent payments will occur under the LFP Payment Model until the Enrolment Code is submitted.

(c) Enrolment Code

98000 **Longitudinal Family Physician Payment Model Enrolment 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 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. Enrolment is effective on the first day that the physician bills a time code following submission of 98000.

a) Submit once per calendar year per physician.
b) For physicians who meet the Eligibility Criteria, submission provides access to the LFP time codes, interaction codes, and panel payment until the end of the calendar year.

(d) How to submit the Enrolment Code

A physician submits the Enrolment 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

27. Registration to Bill Services under the LFP Payment Model

(a) How to Register to bill Clinic-based and Facility-based Services

A physician who is enrolled in the LFP Payment Model is eligible to bill LFP Clinic-based Services and LFP Facility-based Services for the following settings:

- LFP Clinic-based Services,
- Long-term Care and Palliative Facility Services
- Inpatient Facility Services
- Pregnancy & Newborn Facility Services

A physician is not required to register and bill under the LFP Payment Model for all settings or locations in which they provide care.

A physician may choose to bill either the LFP Payment Model, Fee-for-Service, or an alternative payment model for each facility-based setting:

- Long-term Care and Palliative Facility Services,
- Inpatient Facility Services, and
- Pregnancy & Newborn Facility Services

Physicians are encouraged to bill under the LFP Payment Model for multiple settings as it is designed as a comprehensive payment model.

A physician is not required to bill under the LFP Payment Model at all clinics, hospitals, and facility locations where they provide care.

- If they plan to bill under different payment models at different clinic/hospital/facility locations, they must put the full name of the clinic/hospital/facility where they will be billing under the LFP Payment Model in the claim note record of the Setting Registration Code. (Do not use abbreviations as multiple locations may share the same abbreviation.)
- Once a physician has started to bill under the LFP Payment Model at a specific location, they must continue billing under that payment model at that location until they withdraw from the LFP Payment Model.

All physicians and locum physicians must register for each type of service that they wish to bill under the LFP Payment Model. This is done by submitting a Setting Registration Code to HIBC via Teleplan.

By submitting the Setting Registration Code, the physician agrees to only claim for payment in accordance with the terms contained in this LFP Payment Schedule, including that they cannot claim under Fee-for-Service or alternative payment model for the services in that setting (with the exception of Excluded Services).

(b) Setting Registration Effective Date

A physician's setting registration is effective on the first day that the physician bills a time code associated with that setting. After this day, the physician cannot claim under Fee-for-Service for services in that setting (with the exception of Excluded Services).

A physician cannot bill for services under the LFP Payment Model for dates of service prior to this date.

All physicians and locum physicians are required to submit both the Enrolment Code and the applicable Setting Registration code(s) at the time of initial enrolment and annually between January 1 and March 31 of each calendar year.

(c) Setting Registration Codes

98002 LFP Clinic-based Services Registration Code…….....**0.00**

A family physician submits this code to register to bill under the LFP Payment Model for Clinic-based Services.

By submitting 98002, the physician agrees to only claim for payment in accordance with the terms contained in this LFP Payment Schedule, including that they cannot claim under Fee-for-Service for clinic-based services covered under the LFP Payment Schedule. Registration is effective on the first day that the physician bills a Clinic-based Services time code following submission of 98002.

98003 LFP Long-term Care and Palliative Care Facility Services Registration Code...**0.00**

A family physician submits this code to register to bill under the LFP Payment Model for Long-term Care and Palliative Care Facility Services.

By submitting 98003, the physician agrees to only claim for payment in accordance with the terms contained in this LFP Payment Schedule, including that they cannot claim under Fee-for-Service for long-term care and palliative care facility services covered under the LFP Payment Schedule. Registration is effective on the first day that the physician bills a Long-term Care and Palliative Care time code following submission of 98003.

98004 LFP Inpatient Services Registration Code…….....**0.00**

A family physician submits this code to register to bill under the LFP Payment Model for Inpatient Services.

By submitting 98004, the physician agrees to only claim for payment in accordance with the terms contained in this LFP Payment Schedule, including that they cannot claim under Fee-for-Service for inpatient services covered under the LFP Payment Schedule. Registration is effective on the first day that the physician bills an Inpatient Services time code following submission of 98004.

98006 LFP Pregnancy & Newborn Services Registration Code….....**0.00**

A family physician submits this code to register to bill under the LFP Payment Model for Facility-based Pregnancy & Newborn Services.

By submitting 98006, the physician agrees to only claim for payment in accordance with the terms contained in this LFP Payment Schedule, including that they cannot claim under Fee-for-Service for facility-based pregnancy & newborn services covered under the LFP Payment Schedule. Registration is effective on the first day that the physician bills a Pregnancy & Newborn Services time code following submission of 98006.

(d) How to submit a Setting Registration Code

A physician submits a Setting 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

A longitudinal family physician must use the MSP Facility Number associated with their LFP Clinic for their Setting Registration Code(s).

- If they plan to bill under different payment models at different clinic/hospital/facility locations, they must put the full name of the clinic/hospital/facility where they will be billing under the LFP Payment Model in the claim note record of the Setting Registration Code. (Do not use abbreviations as multiple locations may share the same abbreviation.)

A locum physician must use an MSP Facility Number associated with the longitudinal family medicine clinic of any of their host physicians for their Setting Registration Code(s).

- They are not required to indicate the name of each clinic/hospital/facility locations where they will be billing under the LFP Payment Model as services may be provided at many clinics/hospitals/facilities.

V. WITHDRAWAL AND REMOVAL FROM THE LFP PAYMENT MODEL

28. Withdrawal from the LFP Payment Model

(a) Withdrawal

A physician must submit the withdrawal form 2981 LFP Payment Model – Withdrawal to the Ministry of Health when:

- they no longer meet the Ongoing Eligibility Requirements
- they choose to voluntarily withdraw from the LFP Payment Model
- they choose to voluntarily withdraw from billing under the LFP Payment Model for a specific setting.

Submission of a withdrawal form is required when a physician transitions to another payment model, leaves practice in BC, or other circumstance where there is no longer an intention to bill for services under the LFP Payment Model.

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.

Not completing the annual requirement to resubmit the Enrolment Code by March 31 will not result in automatic withdrawal from the payment model. More information about the requirement for annual re-enrolment can be found in Section 26 [*Enrolment and Annual Re-enrolment*].

Please see Appendix F for information about billing Fee-for-Service after withdrawing from the LFP Payment Model.

(b) 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

29. Removal from the LFP Payment Model

Notwithstanding any other provision in this LFP Payment Schedule, the Medical Services Commission may determine that a physician is Deemed 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.

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 notice.

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*.

VI. BILLING FOR TIME

30. Overview of Time Codes

A physician may claim for the time that they provide patient services by using 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.

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.

A physician must not claim for time spent on Excluded Services, as noted in Sections 11 through 22 [*Excluded Services*]. This includes:

- Services at a Facility (unless a physician has registered to bill LFP Facility-based Services in an applicable Facility setting)
- Services Provided under Health Authority Contract
- Medical Assistance in Dying
- Hospital at Home Services
- Surgical Procedures not Listed in Appendix D
- Motor Vehicle Accidents
- WorkSafeBC Services
- Services to Residents of Other Provinces and Territories
- Services to Residents of Other Countries and Non-beneficiaries
- Services Not Insured by MSP
- Services Insured by Legislation other than the Medicare Protection Act

In addition, time is not payable for breaks or on call/availability time.

31. How to Bill Time Codes

(a) How to Calculate Time Codes

Time codes are claimed on a cumulative basis per day. Cumulative time is calculated by adding the total time spent providing services for each time code. Time codes should not be calculated for each individual patient.

A physician must work a full 15 minutes to bill for a 15-minute unit. For example, if a physician provides 50 minutes of Direct Patient Care, they are entitled to claim 3 units of *98010 LFP Clinic-based Direct Patient Care Time – per 15 minutes*.

(b) How to Bill Time Codes Across Settings

When a physician and a patient are in the same setting, all services should be billed using time codes and interaction codes applicable to that setting.

When a physician is clinically required to provide services to patients in more than one setting during the same time period, the physician should bill the higher value Direct Patient Care time code. Once the physician is no longer clinically required to provide care to patients in more than one setting, they should bill the Direct Patient Care time code for the single setting in which they continue to provide care. The applicable interaction code is also payable.

For example, when a physician is clinically required to be on site at a hospital providing care for a patient in the second stage of labour, they may need to provide a phone visit for a clinic-based patient. They can bill a Pregnancy & Newborn Direct Patient Care time code for the time during the phone visit, as they are providing care for both the patient in labour and the clinic-based patient.

(c) **How to submit time codes**

Claims for time codes are submitted for each date of service. For each date of service, all time codes must be submitted on a single personal health number (PHN) for each clinic or Facility setting.

Time codes are submitted using the PHN and demographic information of the first patient of the day for whom an interaction code was billed in each clinic or Facility setting. On a day when only Indirect Patient Care or Clinical Administration is provided, use the information of the last LFP patient for whom an interaction code was billed in that setting.

- Start and end times must be entered on the billing claim for each time code.
- Start and end times for each time code must not overlap.
- Only one time code is payable for the same time period.

One or more claims may be submitted for each time code each day. If more than one submission of the same time code is required, submission code “D” must be entered on the billing claim(s) to avoid a claim refusal on subsequent time code claims.

The following fields are required for each time code submitted to HIBC via Teleplan (items in italics are optional):

- MSP Payee Number,
- Practitioner Number,
- Date of service,
- Time code (using the fee item field in Teleplan),
- Start time (for each time code),
- End time (for each time code),
- Time units – the number of 15-minute time units,
- ICD-9 diagnostic code: L23,
- Location Code, and
- MSP Facility Number
- *RRP code - for rural physicians who practice in a Rural Practice Subsidiary Agreement (RSA) community*.

For locum time codes, the MSP practitioner number of the Host Physician must be entered in the “Referred by” field on the billing claim. When an LFP Locum is providing care on behalf of more than

one Host Physician at the same clinic, use the MSP practitioner number of one of the Host Physicians.

VII. BILLING FOR INTERACTIONS

32. Overview of Interaction Codes

In addition to billing time codes, a physician also bills for physician-patient interactions, conferencing, and communication using interaction codes.

Fee-For-Service codes are not payable in addition to interaction codes for services included in the LFP Payment Model. This includes items such as tray fees and diagnostic tests.

33. Multiple Services for the Same Patient on the Same Day

(a) How to bill multiple services for the same patient on the same day

In some circumstances, a physician will need to provide more than one service for the same patient on the same day.

When this occurs, Direct Patient Care time is billable.

An interaction code is only billable when the subsequent interaction is:

- for a new condition;
- in a new setting; or
- because the condition has changed significantly and requires a new assessment, management, or procedure.

Conferencing and communication codes for LFP Facility-based Services (98158/98258, 98159/98259, 98169/98269, 98035/98235, 98036/98236, 98037/98237) are billable in addition to interaction codes for patient interactions.

(b) How to submit more than one interaction code for the same patient on the same day

To submit more than one interaction code for the same patient on the same calendar day:

- provide the time for each interaction in the time field for each interaction code;
- provide a note record indicating the reason for the subsequent service; and
- if the subsequent interaction code is the same interaction code, use submission code “D”.

34. How to Bill Interaction Codes

The following fields are required for each interaction code submitted to HIBC via Teleplan (items in italics are required only for specific circumstances):

- MSP Payee Number
- Practitioner Number

- Patient Personal Health Number (PHN)
- Patient Name
- Patient Date of Birth
- Date of service
- Interaction Code (fee item)
- ICD-9 Diagnostic Codes (1 code mandatory, 3 maximum)
- Location Code
- MSP Facility Number
- *RRP code - for rural physicians who practice in a Rural Practice Subsidiary Agreement (RSA) community*
- *Referred by (Notify MSP that a referral was 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 an interaction code is not being submitted, a claim record for a "no charge referral" may be submitted to MSP under fee item 03333 with a zero-dollar amount.)*

VIII. INCLUDED SERVICES: CLINIC-BASED SERVICES

35. Overview of Clinic-based Services

The Patient Medical Home (PMH) is fundamental to the LFP Payment Model, operating as a central hub for patients' healthcare needs. Appendix B describes the background and principles for the LFP Payment Model, including the Patient Medical Home.

In the context of the LFP Payment Model, the PMH is known as an "**LFP Clinic**," meaning a medical clinic in which a physician enrolled in the LFP Payment Model provides Longitudinal Family Physician Services. The services provided via LFP Clinics and Pregnancy & Newborn Clinics can be billed using clinic-based time codes and interaction codes.

"LFP Clinic-based Service" means care that a physician provides to a patient:

(a) at the physician's LFP Clinic;

(b) at a Pregnancy & Newborn Clinic;

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

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

A physician can provide an occasional virtual visit associated with the physician's LFP Clinic to a patient located in a Facility. However, successive services to patients located in Facilities are not payable.

Services may be provided to patients who are:

- on the physician's panel;
- on the panel of another longitudinal physician or nurse practitioner who works at the same LFP Clinic as the physician; or

- not on the panel of any longitudinal physician or nurse practitioner who works at the same LFP Clinic as the physician.

36. Clinic-based Services for Non-panel Patients

A physician may choose to provide services for patients who are not on the panel of any longitudinal physician or nurse practitioner who works at the same LFP Clinic. They must ensure that "**Clinic Non-panel Services**" are no more than 30% of LFP Clinic-based Services.

"Clinic Non-panel Service" means LFP Clinic-based Services that a physician provides to a patient who is not:

(a) on the physician's panel; or

(b) on the panel of another longitudinal physician or nurse practitioner who works at the same LFP Clinic as the physician.

For clarity, Clinic Non-panel Services cannot be billed under Fee-for-Service and must be claimed under the LFP Payment Model.

37. Exceptions to the Limit on Clinic Non-panel Services

(a) Rural Communities

In recognition of the unique challenges of practicing in a rural community, the 30% limit on Clinic Non-panel Services does not apply to physicians practicing in some rural communities. This applies only to rural communities that were receiving Northern Isolation Allowance (NIA) premiums as of December 15, 2002.

(b) Clinic-based Pregnancy & Newborn Services and Complex Contraception Services

The 30% limit on Clinic Non-panel Services does not apply to Clinic-based Pregnancy & Newborn Services and Complex Contraception Services if the service is identified with one of the specified ICD-9 codes.

- **"Clinic-based Pregnancy & Newborn Service"** means prenatal care, postnatal care, lactation support, care of newborns up to six weeks of age, and medical abortion care.

- **"Complex Contraception Service"** means care related to contraceptive procedures and surgeries (e.g. intrauterine devices, contraceptive implants, vasectomies, tubal ligations), as well as the use of contraceptive methods for medically and socially complex patients, care resulting from a referral or recommendation from a physician or allied care provider, and gender-affirming care.

To identify an interaction code as a Clinic-based Pregnancy & Newborn Service, a physician must submit one of the following ICD-9 codes:

- V20 Health Supervision of Infant or Child – for care of newborns up to six weeks of age
- V22 Normal Pregnancy – for care during a pregnancy, including medical abortion

- V24 Postpartum Care and Examination – for postnatal care and lactation support

To identify an interaction code as a Complex Contraception Service, a physician must submit the following ICD-9 code:

- V25 Contraceptive Management

If the patient care provided is not fully reflected by one of the specified ICD-9 codes, use one of the specified ICD-9 codes to identify the interaction code as a Clinic-based Pregnancy & Newborn Service or Complex Contraception Service and up to two additional ICD-9 codes to describe the care provided during the interaction.

Please see Appendix E for detailed information about using ICD-9 codes when billing under the LFP Payment Model.

(c) Transition Code and Transition Form

A physician is not required to meet the requirement in Section 25(g) [*ensure that Clinic Non-panel Services are no more than 30% of LFP Clinic-based Services]* until ~~September 30, 2025~~ March 31, 2026, if they are actively transitioning their clinic-based services to meet this requirement and submit:

- an LFP Clinic-based Services Transition Code (98001) ~~on or after September 1, 2024~~; and
- an LFP Clinic-based Services Transition Form ~~on or after September 1, 2024~~.

If the period required for a physician to transition their clinic-based services extends past December 31, 2025, the physician should resubmit the LFP Clinic-based Services Transition Code (98001) and LFP Clinic-based Services Transition Form between January 1 and March 31, 2026.

If both the Transition Code and Transition Form are not submitted, a physician enrolled in the LFP Payment Model must ensure that Clinic Non-panel Services are no more than 30% of LFP Clinic-based Services, except for physicians practicing in rural communities that were receiving Northern Isolation Allowance (NIA) premiums as of December 15, 2002.

For information about locum physicians, please see Section 51 [*Required Locum Services*].

98001 Longitudinal Family Physician Clinic-based Services Transition Code..... 0.00

A longitudinal family physician submits this code after the Enrolment Code to indicate that they do not yet meet Section 25(g) [ensure that Clinic Non-panel Services are no more than 30% of LFP Clinic-based Services].

By submitting this code, the physician confirms that they are actively transitioning their practice to meet the requirement in Section 25(g) by ~~September 30, 2025~~ March 31, 2026.

A physician submits the Transition Code (98001) after the Enrolment Code (98000) and the LFP Clinic-based Services Registration Code (98002) 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, they should 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.

38. Limits on Payment for Clinic-based Services

(a) Limits for Clinic-based Time Codes

Physicians are responsible for ensuring they do not exceed the following limits:

- **Maximum Daily Time -** A maximum of 14 hours of clinic-based time codes (98010/98040, 98011/98041, 98012/98042) is payable in a single calendar day.

- **Maximum Two-Week Time -** A maximum of 120 hours of clinic-based time codes (98010/98040, 98011/98041, 98012/98042) is payable in any 14-day period.

- **Maximum Clinical Administration Time** - The maximum amount of Clinical Administration time (98012 or 98042) payable is 10% of the total amount of clinic-based time codes (98010/98040 98011/98041, 98012/98042) paid to a physician in a calendar year. It is anticipated that Clinical Administration time for most physicians will be in the range of 5% of the time claimed under the clinic-based time codes.

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

(b) Limits for Clinic-based Interaction Codes

Physicians are responsible for ensuring they do not exceed the following limits:

- **Maximum Interactions Paid Daily -** A maximum of 50 clinic-based interaction codes is payable in a single calendar day. This maximum applies to all clinic-based interaction codes, except 98022/98052. This maximum does not apply to services provided in communities that were receiving NIA premiums as of December 15, 2002.

- **Maximum Payment for Services to Patients not on Panel -** A physician cannot claim more than 30% of their interaction codes for Clinic Non-panel Services in one calendar year, unless they have submitted both the Transition Code and Transition Form. This maximum applies to all clinic-based interaction codes, except 98022/98052. 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 Non-panel Services.

Patient interactions provided by students, residents, and trainees are included in the above limits for clinic-based interaction codes.

Claims for clinic-based interaction codes that exceed typical numbers by peer family physicians are more likely to result in a review and/or audit.

IX. INCLUDED SERVICES: LONG-TERM CARE AND PALLIATIVE FACILITY SERVICES

39. Overview of Long-term Care Facility Services

Long-term care supports people who can no longer live safely or independently at home due to their care needs. Their care is supported by 24-hour nursing supervision, personal care assistance, and other therapeutic/support services.

The Family Practice Services Committee (FPSC) created the Long-Term Care Initiative (LTCI) to improve the quality of care in long-term care facilities. It enables Divisions of Family Practice to develop local solutions to improve the care of patients receiving long-term care services.

The LTCI promotes three system level outcomes:

- Reduced unnecessary or inappropriate hospital transfers
- Improved patient and provider experience
- Reduced cost per patient as a result of a higher quality of care

The five LTCI Best Practice Expectations are fundamental to the LFP Payment Model:

- Proactive visits to residents
- Meaningful medication reviews
- Completed documentation
- Attendance at interdisciplinary care conferences
- 24/7 availability and on-site attendance when required

Together, the LTCI and the LFP Payment Model provide an opportunity to improve long-term care, retain and attract physicians, and prepare for the expected increase in patients residing in long-term care in the coming years.

40. Overview of Palliative Facility Services

Palliative care helps people with a serious illness and their family manage end-of-life choices, the process of dying, as well as coping with loss and grief. It addresses people's physical, psychological, social, and spiritual needs, with the aim of improving the quality of living and dying.

People can receive palliative care in various settings as suited to their needs and the available community resources. In the context of the LFP Payment Model, palliative care may be billed for services provided in Home Settings, clinic, hospital, long-term care, and palliative care facilities.

- Services in palliative care facilities, such as hospices, should be billed using Long-term Care and Palliative Facility Services time codes and interaction codes.
- Palliative care services provided in other settings should be billed using the time codes and interaction codes applicable to that care setting (e.g., clinic-based codes should be used for palliative care in a Home Setting).

41. Limits on Payment for Long-term Care and Palliative Facility Services

(a) Limits for Long-term Care and Palliative Facility Services Time Codes

Physicians are responsible for ensuring they do not exceed the following limits:

- **Maximum Daily Time -** A maximum of 14 hours of Long-term Care and Palliative Facility Services time codes (98120/98220, 98121/98221, 98122/98222, 98123/98223) is payable in a single calendar day.

- **Maximum Two-Week Time -** A maximum of 120 hours of Long-term Care and Palliative Facility Services time codes (98120/98220, 98121/98221, 98122/98222, 98123/98223) is payable in any 14-day period

- **Maximum Clinical Administration Time** - The maximum amount of Clinical Administration time (98012/98042) payable for Long-term Care and Palliative Facility Services is 10% of the total amount of the following time codes paid to a physician in a calendar year:
    - Long-term Care or Palliative Care Direct Patient Care Time (98120/98220, 98121/98221, 98122/98222, 98123/98223);
    - Indirect Patient Care Time (98011/98041); and
    - Clinical Administration Time (98012/98042).

(b) Limits for Long-term Care and Palliative Facility Services Interaction Codes

Physicians are responsible for ensuring they do not exceed the following limits:

- **Maximum Interactions Paid Daily -** A maximum of 50 Long-term Care and Palliative Facility Services interaction codes is payable in a single calendar day. This maximum applies to all Long-term Care and Palliative Facility Services interaction codes, except Team Communication (98035/98235). This maximum does not apply to services provided in communities that were receiving NIA premiums as of December 15, 2002.

X. INCLUDED SERVICES: INPATIENT FACILITY SERVICES

42. Overview of Inpatient Facility Services

Inpatient care supports patients who require assessment and/or treatment in an acute care hospital. Family physicians provide inpatient care in hospitals as admitting physicians and/or consultant physicians. In the context of the LFP Payment Model, Inpatient Facility Services can only be billed for services provided by physicians who have privileges to provide care in a health authority-operated or affiliated hospital.

Physicians providing direct bedside care to critically ill and unstable patients who are in need of intensive treatment (e.g. ventilatory support, haemodynamic support including vasoactive medications, or prolonged resuscitation) can bill critical care Fee-for-Service codes as appropriate. These services are excluded from the LFP Payment Model.

Longitudinal family physicians often provide coordination of care and supportive care for their hospitalized patients. If a physician does not have health authority privileges, these services should be billed using the time codes and/or interaction codes applicable to the setting in which they provide care to the patient (e.g. clinic, long-term care)

43. Limits on Payment for Inpatient Facility Services

(a) Limits for Inpatient Facility Services Time Codes

Physicians are responsible for ensuring they do not exceed the following limits:

- **Maximum Daily Time -** A maximum of 24 hours of Inpatient Facility Services time codes (98124/98224, 98125/98225, 98126/98226, 98127/98227), Indirect Patient Care Time (98011/98041), and Clinical Administration Time (98012/98042) is payable in a single calendar day.

- **Maximum Clinical Administration Time** - The maximum amount of Clinical Administration time (98012/98042) payable for Inpatient Facility Services is 10% of the total amount of the following time codes paid to a physician in a calendar year:
    - Inpatient Care Direct Patient Care Time (98124/98224, 98125/98225, 98126/98226, 98127/98227);
    - Indirect Patient Care Time (98011/98041); and
    - Clinical Administration Time (98012/98042).

(b) Limits for Inpatient Facility Services Interaction Codes

Inpatient Facility Services interaction codes are structured to enable family physicians to provide accessible, high-quality, comprehensive, and continuous inpatient care. As such, a daily limit does not apply in recognition of the varying needs of patients and communities.

XI. INCLUDED SERVICES: PREGNANCY & NEWBORN FACILITY SERVICES

44. Overview of Pregnancy & Newborn Facility Services

Pregnancy & Newborn Facility Services encompass the patient journey from pregnancy to labour and birth to postpartum and newborn care. People can receive this care in various settings as suited to their needs and the available community resources.

Pregnancy & Newborn Facility Services can only be billed for services provided by physicians who have privileges to provide family medicine obstetrics care in a health authority-operated or affiliated hospital.

These acute care services, including labour and birth in Home Birth Settings, should be billed using Pregnancy & Newborn Facility Services time codes and interaction codes. Services provided in an

LFP Clinic, Pregnancy & Newborn Clinic, or Home Setting should be billed using time codes and interaction codes for Clinic-based Services.

45. Limits on Payment for Pregnancy & Newborn Facility Services

(a) Limits for Pregnancy & Newborn Facility Services Time Codes

Physicians are responsible for ensuring they do not exceed the following limits:

- **Maximum Daily Time -** A maximum of 24 hours of Pregnancy & Newborn Facility Services time codes (98128/98228, 98129/98229, 98130/98230, 98131/98231), Indirect Patient Care Time (98011/98041), and Clinical Administration Time (98012/98042) is payable in a single calendar day.

- **Maximum Clinical Administration Time** - The maximum amount of Clinical Administration time (98012/98042) payable for Pregnancy & Newborn Facility Services is 10% of the total amount of the following time codes paid to a physician in a calendar year:
    - Pregnancy and Newborn Direct Patient Care Time (98128/98228, 98129/98229, 98130/98230, 98131/98231);
    - Indirect Patient Care Time (98011/98041); and
    - Clinical Administration Time (98012/98042).

(b) Limits for Pregnancy & Newborn Facility Services Interaction Codes

Pregnancy & Newborn Facility Services interaction codes are structured to enable family physicians to provide accessible, high-quality, comprehensive, and continuous care for pregnant people and newborns. As such, a daily limit does not apply in recognition of the varying needs of patients and communities.

XII. THE PANEL PAYMENT

46. Overview of the Panel Payment

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 addition to billing for time and interactions, a physician who is enrolled in the LFP Payment Model and registered to bill Clinic-based Services receives a panel payment based on the size and complexity of their patient panel, unless they are enrolled only as an LFP Locum.

47. Panel Payment Methodology

Currently, the panel payment is based on an interim methodology 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 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.

48. Panel Payment Logistics

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.

XIII. LOCUM SERVICES

49. 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. 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 must bill locum time codes and locum interaction codes for LFP Locum Services. Physicians providing only LFP Locum Services 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 one or more of the following:

  i) enrolled in the LFP Payment Model;

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

  iii) remunerated under the Individual Contract for New-to-Practice Family Physicians; or

  iv) remunerated under Alternative Payments Subsidiary Agreement (APSA) contracts under the following practice categories:

  - General Practice – Full Scope (Rural) – Area A, B, C
  - General Practice – Full Scope (Non-JSC Community)

• General Practice – Defined Scope B (Student Health Centres) until June 30, 2027

• "**LFP Locum Services**" means services provided by an LFP Locum on behalf of a Host Physician in one or more of the following settings:

i) LFP Clinic-based Services

ii) Long-term Care and Palliative Facility Services

iii) Inpatient Facility Services, and

iii) Pregnancy & Newborn Facility Services

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 interaction codes.

50. Locum Eligibility Criteria

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) 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.

51. Required Locum Services

An LFP Locum enrolled in the LFP Payment Model must:

(a) provide LFP Clinic-based Services, and/or LFP Facility-based 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 Clinic Non-panel Services are no more than 30% of LFP Clinic-based Services provided in one calendar year at each clinic where LFP Locum Services are provided (Exceptions to this requirement are described in Section 37 [*Exceptions to the Limit on Clinic Non-panel Services*]);

(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.

52. Locum Enrolment and Annual Re-enrolment

(a) How to Enrol as an LFP Locum

A physician who meets the Locum Eligibility Criteria may enrol in the LFP Payment Model as an LFP Locum by submitting:

- 98005 Locum Enrolment Code to HIBC via Teleplan
- Applicable Setting Registration Codes to HIBC via Teleplan (98002, 98003, 98004, 98006)
- An LFP Locum registration form.

An LFP Locum is eligible to bill LFP Locum Clinic-based Services and LFP Locum Facility-based Services for the following:

- LFP Clinic-based Services,
- Long-term Care and Palliative Facility Services,
- Inpatient Facility Services, and
- Pregnancy & Newborn Facility Services

An LFP Locum is required to submit both the Enrolment Code and the applicable Setting Registration code(s) at the time of initial enrolment

Please see Section 27(c) [*Setting Registration Codes*] for information on how to submit each registration code.

(b) How to Continue Enrolment as an LFP Locum

To continue enrolment, an LFP Locum who meets the Locum Eligibility Criteria must submit the following between January 1 and March 31 in each calendar year they provide LFP Locum Services:

- 98005 Locum Enrolment Code to HIBC via Teleplan
- Applicable Setting Registration Codes to HIBC via Teleplan (98002, 98003, 98004, 98006); and
- an LFP Locum registration form.

If the Locum Enrolment 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.

A physician who wishes to withdraw from the LFP Payment Model must submit a withdrawal form as noted in Section 28(a) [*Withdrawal from the LFP Payment Model*].

(c) LFP Locum Enrolment Code

98005 Longitudinal Family Physician Payment Model Locum Enrolment 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 interaction codes when they provide LFP Locum Services. Enrolment is effective on the first day that the physician bills a locum time code following submission of 98005.

a) Submit once per calendar year.
b) Submission provides access to locum time codes and locum interaction codes for clinic and facility-based services until the end of the calendar year.

(d) **How to submit the Locum Enrolment Code**

A physician submits the Locum Enrolment 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

53. Locum Registration to bill Services under the LFP Payment Model

Locum physicians must submit a setting registration code for each type of service that they wish to bill as an LFP Locum under the LFP Payment Model, as noted in Section 27 [*Registration to Bill Services under the LFP Payment Model*].

A locum physician is not required to bill under the LFP Payment Model for all settings in which they provide care on behalf of longitudinal family physicians. A locum physician may choose to bill either the LFP Payment Model, Fee-for-Service, or an alternative payment model for each setting or location.

54. Locum Withdrawal and Removal from the LFP Payment Model

A physician who wishes to withdraw from the LFP Payment Model must submit a withdrawal form as noted in Section 28 [*Withdrawal from the LFP Payment Model*].

Notwithstanding any other provision in this LFP Payment Schedule, the Medical Services Commission may determine that a physician is Deemed Ineligible for the LFP Payment Model, as noted in Section 29 [*Removal from the LFP Payment Model*].

XIV. BILLING CODES

55. Billing Codes for LFP Clinic-based Services

(a) Clinic-based Time Codes

Clinic-based time codes are only payable to physicians who have billed:

- 98000/98005 Enrolment Code and
- 98002 Clinic-based Services Registration Code.

For locum time codes, the MSP practitioner number of the Host Physician must be entered in the "Referred by" field on the billing claim.

LFP 98010 **Locum 98040** **LFP Clinic-based Direct Patient Care Time – per 15 minutes……$32.50**

Notes:

(a) Payable for time spent providing Clinic-based Direct Patient Care, which means the following services with a patient present:
- In-person care, excluding any facility settings.
- Synchronous virtual care (phone, video).
- Clinical teaching provided concurrently with patient care.

(b) Indirect patient care provided between patient interactions in the course of a clinic day.

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

LFP 98011 **Locum 98041** **LFP Indirect Patient Care Time – per 15 minutes ……...$32.50**

Notes:

(a) Payable for time spent on Indirect Patient Care for clinic-based and facility-based care, which means the following patient-specific services provided when the patient is not present:
- Documentation of patient interactions and charting.
- Review of results: labs, imaging, consultations, and other reports.
- Preparing referrals and requisitions.
- Chart review.
- Asynchronous virtual care (e.g., fax, email, text, messaging via EMR/EHR).
- 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.
- Clinical teaching arising from direct patient care.
- 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.

(b) Not payable for time spent on travel.

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

LFP 98012 **Locum 98042** **LFP Clinical Administration Time – per 15 minutes ……$32.50**

Notes:

(a) Payable for time spent on clinical administration for clinic-based and facility-based care, 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 preventative health, disease management, and provision of data-informed care (e.g., fall prevention, immunizations, cancer screening, diabetes management, deprescribing).
- Electronic Medical Record (EMR) and Electronic Health Record (EHR) updating and management that requires physician expertise.
- Evaluation of the efficiency, quality, and delivery of the services provided in a Facility (e.g., medical audits, peer and interdisciplinary reviews, and incident report reviews) when not payable through other means.
- Clinic 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. (Not applicable to health authority-operated clinics).
- Clinic 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*. (Not applicable to health authority-operated clinics).

(b) 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.
- Medical leadership responsibilities for health authority funded leadership positions.
- Time spent on travel.

(c) The maximum amount of time payable as clinical administration in each LFP Clinic or Facility setting is 10% of the total hours paid as Time Codes per setting by the physician in a calendar year.

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

LFP 98119 **Locum 98219** **LFP Travel Time – per 15 minutes ……$32.50**

Notes:

(a) Payable for time spent on travel for the most direct route between patient care sites, including Clinic settings, Facility settings, Home Settings, and Home Birth Settings.

(b) The maximum amount of Travel Time payable on a single day is 60 minutes of travel.

(c) Physicians must take all reasonable and clinically appropriate steps to reduce the amount of travel time where possible.

(d) The start and destination sites must be documented in the patient's chart.

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

(b) Clinic-based Interaction Codes

Clinic-based interaction codes are only payable to physicians who have billed:

- 98000/98005 Enrolment Code and

- 98002 Clinic-based Services Registration Code.

Generally, only one interaction code is payable per patient per physician per day, except for 98022/98052. Additional interaction codes are not payable unless the services meet the conditions of Section 33 [*Multiple Services for the Same Patient on the Same Day*].

When the patient is seen for multiple issues during the same patient interaction, the applicable interaction code with the highest value should be billed.

An interaction code is only 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.
- 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.

LFP	Locum	**LFP Clinic-based In-person Visit in Clinic……..……$25**
98031	**98061**	***Notes:*** (a) Payable for an in-person visit with direct patient interaction provided in an LFP Clinic or Pregnancy & Newborn Clinic.

LFP	Locum	**LFP Clinic-based Virtual Visit by Phone or Video……...$25**
98032	**98062**	***Notes:*** (a) Payable for a phone or video visit with direct patient interaction associated with an LFP Clinic or Pregnancy & Newborn Clinic.

LFP	Locum	**LFP Clinic-based Minor Procedure or Diagnostic Test Provided in addition to an In-person Visit……..…$10**
98022	**98052**	***Notes:*** (a) Payable for an in-person minor procedure or diagnostic test that is provided for a patient in an LFP Clinic, Pregnancy & Newborn Clinic, or patient's Home Setting. (b) Payable only for procedures named under 98022/98052 in Appendix D. (c) Details of the procedure must be documented in a procedure note in the patient's chart. (d) Payable for a maximum of two of the services from the list named under 98022/98062 in Appendix D. (e) Only one of each type of minor procedure or diagnostic test is payable per patient per day. (f) Not payable in addition to 98032/98062 and 98034/98064.

LFP	Locum	**LFP Clinic-based Standard Procedure……..$60**
98021	**98051**	***Notes:*** (a) Payable for an in-person standard procedure that is provided for a patient in an LFP Clinic, Pregnancy & Newborn Clinic, or patient's Home Setting. (b) Payable only for procedures named under 98021/98051 in Appendix D. (c) Details of the procedure must be documented in a procedure note in the patient's chart.

LFP 98020 **Locum 98050** **LFP Clinic-based Advanced Procedure……..…….$110**

Notes:

(a) Payable for an in-person advanced procedure that is provided for a patient in an LFP Clinic, Pregnancy & Newborn Clinic, or patient's Home Setting.
(b) Payable only for procedures named under 98020/98050 in Appendix D.
(c) Details of the procedure must be documented in a procedure note in the patient's chart.
(d) 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.

LFP 98033 **Locum 98063** **LFP In-person Visit in the Patient's Home……..……..$100**

Notes:

(a) Payable for an in-person visit with direct patient interaction provided by a physician in-person to a patient in their Home Setting as deemed appropriate by the physician.

LFP 98030 **Locum 98060** **LFP Clinic-based Consultation…….…….$60**

Notes:

(a) Payable for a consultation with direct patient interaction provided in-person or by phone/video for a patient in in an LFP Clinic, Pregnancy & Newborn Clinic, or Patient's Home Setting.
(b) 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 pregnancy, postpartum, or pediatric care,
    - Registered nurse or registered psychiatric nurse for substance use care.
(c) 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.
(d) 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.
(e) A consultation for the same diagnosis is not payable as 98030/98060 unless an interval of at least six months has passed since the consultant has last billed a consultation for the patient. A new and unrelated diagnosis can be billed as an LFP Consultation without a six-month interval.
(f) Not payable for:
    - A transfer of patient care between physicians; or
    - Follow-up visits after a consultation.

LFP 98034 **Locum 98064** **LFP Clinic-based Group Visit…….$25/patient**

Notes:

(a) Payable for an in-person or video group visit associated with an LFP Clinic or Pregnancy & Newborn Clinic.
(b) The group visit must have:
    - A minimum duration of thirty minutes,
    - A group of two or more patients,

- 1:1 interaction between each patient and the physician.

(c) While the length of the group interaction and the number of patients in the group visit may vary, this is only payable for a maximum of:
- 3 patients for a 30 minute In-person or Video Group Visit,
- 5 patients for a 45 minute In-person or Video Group Visit,
- 6 patients for a 60 minute In-person or Video Group Visit,
- 8 patients for a 75 minute In-person or Video Group Visit,
- 9 patients for a 90 minute or longer In-person or Video Group Interaction.

(d) Start and end times for the group visit must be entered on the billing claim.

56. Billing Codes for Long-term Care and Palliative Facility Services

(a) Long-term Care and Palliative Facility Services Time Codes

Long-term Care or Palliative Care Direct Patient Care time codes are only payable to physicians who have billed:

- 98000/98005 Enrolment Code,
- 98003 Long-term Care and Palliative Care Facility Registration Code.

Direct Patient Care time codes are only payable when the physician is:

- providing direct patient care on site or
- clinically required to be on site at the Long-term Care or Palliative Care Facility

In addition, 98011/98041 and 98012/98042 are payable for services provided for patients in a Long-term Care or Palliative Care Facility.

For locum time codes, the MSP practitioner number of the Host Physician must be entered in the "Referred by" field on the billing claim.

LFP	Locum	LFP Long-term Care or Palliative Care Direct Patient Care Time – per 15 minutes
98120	**98220**	**Weekday (between 0800 hours and 1800 hours) $42.50**
98121	**98221**	**Evening (between 1800 hours and 2300 hours) $48.75**
98122	**98222**	**Saturday, Sunday, or Statutory Holiday (between 0800 and 2300 hours.....$48.75**
98123	**98223**	**Night (between 2300 hours and 0800 hours) $51.25**

Notes:

(a) Payable for time spent providing Long-term Care or Palliative Care Facility Direct Patient Care, which means the following services:
- In-person care with a patient present.
- Indirect patient care.
- Clinical teaching arising from direct patient care.

(b) Payable only when the physician is providing direct patient care or clinically required to be at the Long-term Care or Palliative Care Facility.

(c) All Long-term Care or Palliative Care Facility Direct Patient Care time must have appropriate clinical documentation in the patient's chart.

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

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

98011 **98041** ***Notes:***

(a) Payable for time spent on Indirect Patient Care for clinic-based and facility-based care, which means the following patient-specific services provided when the patient is not present:
- Documentation of patient interactions and charting.
- Review of results: labs, imaging, consultations, and other reports.
- Preparing referrals and requisitions.
- Chart review.
- Asynchronous virtual care (e.g., fax, email, text, messaging via EMR/EHR).
- 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.
- Clinical teaching arising from direct patient care.
- 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.

(b) Not payable for time spent on travel.

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

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

98012 **98042** ***Notes:***

(a) Payable for time spent on clinical administration for clinic-based and facility-based care, 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 preventative health, disease management, and provision of data-informed care (e.g., fall prevention, immunizations, cancer screening, diabetes management, deprescribing).
- Electronic Medical Record (EMR) and Electronic Health Record (EHR) updating and management that requires physician expertise.
- Evaluation of the efficiency, quality, and delivery of the services provided in a Facility (e.g., medical audits, peer and interdisciplinary reviews, and incident report reviews) when not payable through other means.
- Clinic 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. (Not applicable to health authority-operated clinics).
- Clinic 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*. (Not applicable to health authority-operated clinics).

(b) 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.

- Medical leadership responsibilities for health authority funded leadership positions.
- Time spent on travel.

(c) The maximum amount of time payable as clinical administration in each LFP Clinic or Facility setting is 10% of the total hours paid as Time Codes per setting by the physician in a calendar year.
(d) Start and end times must be entered on the billing claim.

LFP 98119	**Locum 98219**	**LFP Travel Time – per 15 minutes ……..…$32.50** ***Notes:*** (a) Payable for time spent on travel for the most direct route between patient care sites, including Clinic settings, Facility settings, Home Settings, and Home Birth Settings. (b) The maximum amount of Travel Time payable on a single day is 60 minutes of travel. (c) Physicians must take all reasonable and clinically appropriate steps to reduce the amount of travel time where possible. (d) The start and destination sites must be documented in the patient's chart. (e) Start and end times must be entered on the billing claim.

(b) Long-term Care and Palliative Facility Services Interaction Codes

Long-term Care and Palliative Facility Services interaction codes are only payable to physicians who have billed:

- 98000/98005 Enrolment Code and
- 98003 Long-term Care and Palliative Care Facility Registration Code.

Generally, only one interaction code is payable per patient per physician per day, except for 98035/98235. Additional interaction codes are not payable unless the services meet the conditions of Section 33 [*Multiple Services for the Same Patient on the Same Day*].

This does not apply to conferencing and communication codes (98158/98258, 98159/98259, 98035/98235) for Long-term Care and Palliative Facility Services.

When the patient is seen for multiple services during the same patient interaction, the applicable interaction code with the highest value should be billed.

The LFP Payment Model supports the provision of safe, high-quality care to patients with attention paid to best practices. For care provided in long-term care and palliative care facilities, this may include the following (as clinically appropriate):

- Medication reconciliation
- Goals of care discussions
- Care planning, such as discharge planning and end-of-life planning
- FPSC LTCI Best Practice Expectations, as noted in Section 39 [*Overview of Long-term Care Facility Services*]

An interaction code is only 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.

- 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.

An interaction code is not payable for:

- Review of a patient's chart without direct patient interaction.
- On-site interaction with the care team without direct patient interaction, except for an Interdisciplinary Care Conference

LFP 98150 **Locum 98250** **LFP Long-term Care or Palliative Care In-person Visit.....$25**

Notes:

(a) Payable for an in-person visit with direct patient interaction provided for a patient admitted to a Long-term Care or Palliative Care Facility, including any procedures not payable as 98155/98255, 98156/98256.

LFP 98151 **Locum 98251** **LFP Long-term Care or Palliative Care Urgent Assessment.....$90**

Notes:

(a) Payable for an in-person urgent assessment with direct patient interaction provided for a patient admitted to a Long-term Care or Palliative Care Facility.
(b) Payable when a physician must leave immediately from an off-site location to provide an assessment that is urgently and clinically required for an acute medical event or significant change in the patient's condition due to:
    - Being contacted by care staff; or
    - Results of investigations that require urgent attention.
(c) Details must be documented in the patient's chart, including the person who contacts the physician, time of contact, time of attendance to patient, and reason for urgency.

LFP 98152 **Locum 98252** **LFP Long-term Care or Palliative Care Admission.....$90**

Notes:

(a) Payable for an in-person admission visit with direct patient interaction for a patient who is being admitted to a Long-term Care or Palliative Care Facility under the care of a family physician.
(b) Payable once per patient per facility admission.

LFP 98153 **Locum 98253** **LFP Long-term Care or Palliative Care Discharge $60**

Notes:

(a) Payable for an in-person discharge visit with direct patient interaction provided for a patient admitted to a Long-term Care or Palliative Care Facility who is being discharged to another facility, a hospital, or a home setting.
(b) Requires the creation of a discharge summary, review of necessary medications, and written direction to the patient regarding follow up care.
(c) Payable once per patient per facility discharge.
(d) Not payable for paperwork for a patient who has died.

LFP 98154 **Locum 98254** **LFP Long-term Care or Palliative Care End of Life Visit.....$60**

Notes:

(a) Payable for an in-person end of life visit with direct patient interaction provided to a patient in a Long-term Care or Palliative Care Facility who has a documented:

- Medical Orders for Scope of Treatment (MOST) status of M1; and
- Palliative Performance Scale score of 20% or less.

(b) Payable once per calendar day per patient.
(c) Not payable for follow-up visits after a consultation (bill these as 98150/98250).

LFP 98155 **Locum 98255** **LFP Long-term Care or Palliative Care Procedure...…..….....$60**

Notes:

(a) Payable for an in-person procedure that is provided for a patient admitted to Long-term Care or Palliative Care Facility when the physician provides a procedure named under 98155/98255 in Appendix D.
(b) Details of the procedure must be documented in a procedure note in the patient's chart.
(c) 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.

LFP 98156 **Locum 98256** **LFP Long-term Care or Palliative Care Advanced Procedure with Physician-provided Supplies……..$110**

Notes:

(a) Payable for an in-person procedure that is provided for a patient admitted to Long-term Care or Palliative Care Facility when the physician provides an Advanced Procedure named under 98156/98256 in Appendix D and the physician provides the supplies.
(b) Details of the procedure must be documented in a procedure note in the patient's chart, including supplies provided by the physician.
(c) 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.

LFP 98157 **Locum 98257** **LFP Long-term Care or Palliative Care Consultation....…….$60**

Notes:

(a) Payable for a consultation with direct patient interaction provided in-person or by phone/video for a patient admitted to a Long-term Care or Palliative Care Facility.
(b) 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 pregnancy-related care or pediatric care; or
    - Registered nurse or registered psychiatric nurse for substance use care.
(c) 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.
(d) 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.
(e) A consultation for the same diagnosis is not payable as 98157/98257 unless an interval of at least six months has passed since the consultant has last billed a consultation for the patient. A new and unrelated diagnosis can be billed as 98157/98257 without a six-month interval.
(f) Not payable for:
    - A transfer of patient care; or

- Follow-up visits after a consultation (bill these as 98150/98250).

LFP **Locum** **LFP Long-term Care or Palliative Care Interdisciplinary Care Conference……$30**

98158 **98258** ***Notes:***

(a) Payable for in-person or phone/video participation at a care conference for a patient admitted to a Long-term Care or Palliative Care Facility.
(b) Payable when a physician participates in a care conference with an allied care provider and/or a physician to develop and review a patient's care plan, such as an Interdisciplinary Care Conference or a Meaningful Medication Review.
(c) Only payable when the conference is a minimum of 10 minutes.
(d) Payable to a maximum of 4 conferences per 60 minutes.
(e) Details of the care conference must be documented in the patient's chart, including the participants, their roles, information about the discussion, and decisions made.
(f) Payable in addition to a patient visit on the same day if clinically required, provided that the visit does not take place concurrently with the care conference (i.e. The visit time must be separate from the care conference time).
(g) Not payable for communication that occurs as a part of the performance of routine rounds on the patient.
(h) Start and end times must be documented in the patient's chart and entered on the billing claim.

LFP **Locum** **LFP Long-term Care or Palliative Care Family Conference……..…$30**

98159 **98259** ***Notes:***

(a) Payable for in-person or phone/video participation in a family conference for a patient admitted to a Long-term Care or Palliative Care Facility.
(b) Payable when a physician participates in a family conference with one or more family members/representatives for the purpose of:
    - Obtaining informed consent for care related to an acute medical event or a significant change in the patient's condition; or
    - Developing and reviewing the patient's documented Care Plan that identifies the goals of care, management plan, and supports for activities of daily living as clinically appropriate.
(c) Only payable when the conference is a minimum of 15 minutes.
(d) Details of the family conference must be documented in the patient's chart, including the participants, their roles, information about the discussion, and decisions made.
(e) Payable in addition to a patient visit on the same day if clinically required, provided that the visit does not take place concurrently with the family conference (i.e. The visit time must be separate from the family conference time).
(f) Not payable when:
    - Communication occurs as a part of routine communication with the family; or
    - Consent is not required for an acute medical event or a significant change in the patient's condition.
(g) Start and end times must be documented in the patient's chart and entered on the billing claim.

LFP **Locum** **LFP Long-term Care or Palliative Care Team Communication…….$15**

98035 **98235** ***Notes:***

(a) Payable for physician phone/video communication with an allied care provider or another physician for a patient admitted to a Long-term Care or Palliative Care Facility when a physician is required to communicate about patient care, including provision or receipt of advice, medication orders, or a response for an acute medical event.
(b) Only payable when the physician is not on site providing LFP Facility-based Care.
(c) Only payable when:

- The care staff contacts the physician; or
- The physician contacts the care staff as a result of investigations that require urgent attention.

(d) Only payable when the communication is a minimum of 5 minutes.
(e) Details of the communication must be documented in the patient's chart, including the participants, their roles, information about the discussion, and decisions made.
(f) Payable in addition to a patient visit on the same day if clinically required, provided that the visit does not take place concurrently with the care team communication (i.e., The visit time must be separate from the team communication time).
(g) Payable once per patient per physician per calendar day.
(h) Only payable in addition to time codes 98010/98040, 98011/98041, and 98012/98042.
(i) Not payable for communication that does not require the professional expertise of a physician, such as:
- Booking an appointment;
- Arranging for laboratory or diagnostic investigations; or
- Arranging a hospital bed, consult, or additional non-emergent care.

(j) Start and end times must be documented in the patient's chart and entered on the billing claim.

57. Billing Codes for Inpatient Facility Services

(a) Inpatient Facility Services Time Codes

Inpatient Care Direct Patient Care time codes are only payable to physicians who:

- have privileges to provide care in a health authority-operated or affiliated hospital,
- have billed 98000/98005 Enrolment Code, and
- have billed 98004 Inpatient Services Registration Code

Direct Patient Care time codes are only payable when the physician is:

- providing direct patient care on site, or
- clinically required to be on site at the hospital.

In addition, 98011/98041 LFP Indirect Patient Care Time and 98012/98042 LFP Clinical Administration Time are payable for Inpatient Facility Services provided for patients admitted to a hospital.

For locum time codes, the MSP practitioner number of the Host Physician must be entered in the "Referred by" field on the billing claim.

LFP	Locum	LFP Inpatient Care Direct Patient Care Time – per 15 minutes
98124	**98224**	**Weekday (between 0800 hours and 1800 hours) $42.50**
98125	**98225**	**Evening (between 1800 hours and 2300 hours) $48.75**
98126	**98226**	**Saturday, Sunday, or Statutory Holiday (between 0800 and 2300 hours) $48.75**
98127	**98227**	**Night (between 2300 hours and 0800 hours) $51.25**
		Notes:

(a) Payable for time spent providing Inpatient Direct Patient Care, which means the following services:
- In-person care with a patient present.
- Indirect patient care.
- Clinical teaching arising from direct patient care.

(b) Payable only when the physician is providing direct patient care or clinically required to be at the hospital.
(c) All Inpatient Direct Patient Care time must have appropriate clinical documentation in the patient's chart.
(d) Start and end times must be entered on the billing claim

LFP 98011 **Locum 98041** **LFP Indirect Patient Care Time – per 15 minutes ……..…$32.50**

Notes:

(a) Payable for time spent on Indirect Patient Care for clinic-based and facility-based care, which means the following patient-specific services provided when the patient is not present:
- Documentation of patient interactions and charting.
- Review of results: labs, imaging, consultations, and other reports.
- Preparing referrals and requisitions.
- Chart review.
- Asynchronous virtual care (e.g., fax, email, text, messaging via EMR/EHR).
- 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.
- Clinical teaching arising from direct patient care.
- 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.

(b) Not payable for time spent on travel.
(c) Start and end times must be entered on the billing claim.

LFP 98012 **Locum 98042** **LFP Clinical Administration Time – per 15 minutes ……..…$32.50**

Notes:

(a) Payable for time spent on clinical administration for clinic-based and facility-based care, 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 preventative health, disease management, and provision of data-informed care (e.g., fall prevention, immunizations, cancer screening, diabetes management, deprescribing).
- Electronic Medical Record (EMR) and Electronic Health Record (EHR) updating and management that requires physician expertise.
- Evaluation of the efficiency, quality, and delivery of the services provided in a Facility (e.g., medical audits, peer and interdisciplinary reviews, and incident report reviews) when not payable through other means.
- Clinic 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. (Not applicable to health authority-operated clinics).
- Clinic 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*. (Not applicable to health authority-operated clinics).

(b) 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.
- Medical leadership responsibilities for health authority funded leadership positions.
- Time spent on travel.

(c) The maximum amount of time payable as clinical administration in each LFP Clinic or Facility setting is 10% of the total hours paid as time codes per setting by the physician in a calendar year.
(d) Start and end times must be entered on the billing claim.

LFP 98119 **Locum 98219** **LFP Travel Time – per 15 minutes ……...…$32.50**

Notes:
(a) Payable for time spent on travel for the most direct route between patient care sites, including Clinic settings, Facility settings, Home Settings, and Home Birth Settings.
(b) The maximum amount of Travel Time payable on a single day is 60 minutes of travel.
(c) Physicians must take all reasonable and clinically appropriate steps to reduce the amount of travel time where possible.
(d) The start and destination sites must be documented in the patient's chart.
(e) Start and end times must be entered on the billing claim.

(b) Inpatient Facility Services Interaction Codes

Inpatient Facility Services interaction codes are only payable to physicians who:

- have privileges to provide care in a health authority-operated or affiliated hospital,
- have billed 98000/98005 Enrolment Code, and
- have billed 98004 Inpatient Services Registration Code.

Generally, only one interaction code is payable per patient per physician per day, except for 98036/98236. Additional interaction codes are not payable unless the services meet the conditions of Section 33 [*Multiple Services for the Same Patient on the Same Day*].

This does not apply to conferencing and communication codes (98169/98269, 98036/98236) for Inpatient Facility Services.

When the patient is seen for multiple issues during the same patient interaction, the applicable interaction code with the highest value should be billed.

The LFP Payment Model supports the provision of safe, high-quality care to patients with attention paid to best practices. For Inpatient Facility Services, this may include the following (as clinically appropriate):

- Medication reconciliation
- Goals of care discussions
- Care planning, such as discharge planning and end-of-life planning

An interaction code is only 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.
- 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.

An interaction code is not payable for:

- Review of a patient's chart without direct patient interaction.
- On-site interaction with the care team without direct patient interaction

LFP 98160 **Locum 98260** **LFP Inpatient In-person Visit ……$30**

Notes:

(a) Payable for an in-person visit with direct patient interaction for a patient admitted to a hospital, including any procedures not payable as 98166/98266.

LFP 98161 **Locum 98261** **LFP Inpatient Urgent Assessment ……..……$90**

Notes:

(a) Payable for an in-person urgent assessment with direct patient interaction provided for a patient admitted to a hospital.
(b) Payable when a physician must leave immediately from an off-site location to provide an assessment that is urgently and clinically required for an acute medical event or significant change in the patient's condition due to:
    - Being contacted by care staff; or
    - Results of investigations that require urgent attention.
(c) Details must be documented in the patient's chart, including the person who contacts the physician, time of contact, time of attendance to the patient, and reason for urgency.

LFP 98162 **Locum 98262** **LFP Inpatient Admission ……$90**

Notes:

(a) Payable for an in-person admission visit with direct patient interaction for a patient who is being admitted to a hospital by an admitting family physician.
(b) Payable once per patient per hospitalization.

LFP 98163 **Locum 98263** **LFP Inpatient Transfer of Care from another Physician/Service ……....$60**

Notes:

(a) Payable for an in-person visit for a patient admitted to a hospital whose care is being transferred to the responsibility of a physician/service with a different expertise in the same hospital, including documented review of medications, goals of care, and care planning.
(b) Payable to the physician who is receiving the patient and accepting responsibility for their care.
(c) Not payable for a handover of patient care and responsibility between physicians who work together to provide on-call/availability coverage or when different expertise is not required.

LFP 98164 **Locum 98264** **LFP Inpatient Discharge ……$60**

Notes:

(a) Payable for an in-person discharge visit with direct patient interaction provided for a patient admitted to a hospital who is being discharged to another hospital, facility, or a home setting.
(b) Requires the creation of a discharge summary, review of necessary medications, and written direction to the patient regarding follow up care.
(c) Payable once per patient per hospitalization.
(d) Not payable for paperwork for a patient who has died.

LFP 98165 **Locum 98265** **LFP Inpatient End of Life Visit ……..…$60**

Notes:

(a) Payable for an in-person end of life visit provided by the attending physician to a patient in a hospital who has a documented:
- Medical Orders for Scope of Treatment (MOST) status of M1; and
- Palliative Performance Scale score of 20% or less.

(b) Payable once per calendar day per patient.
(c) Not payable for follow-up visits after a consultation (bill these as 98160/98260).

LFP 98166 **Locum 98266** **LFP Inpatient Procedure ……$60**

Notes:

(a) Payable for an in-person procedure named under 98166/98266 in Appendix D that is provided for a patient admitted to a hospital.
(b) Details of the procedure must be documented in a procedure note in the patient's chart.

LFP 98167 **Locum 98267** **LFP Inpatient Resuscitation ……$60**

Notes:

(a) Payable for in-person treatment of an acute life-threatening or limb/organ saving emergency provided for a patient admitted to a hospital.
(b) Payable when a physician must provide care and/or procedures that are necessary to resuscitation. This includes:
- Emergent airway management, including endotracheal intubation, removal of foreign bodies, and insertion of airway devices.
- Cricothyrotomy.
- Chest compressions.
- Cardiac defibrillation, cardioversion, and pacing.
- Vascular access, including central venous catheter or intraosseous.
- Invasive monitoring.
- Chest tube drainage.

(c) Details of the resuscitation must be documented in the patient's chart, including the process, events, and outcome of resuscitation.

LFP 98168 **Locum 98268** **LFP Inpatient Consultation ……$60**

Notes:

(a) Payable for a consultation with direct patient interaction provided in-person or by phone/video for a patient admitted to a hospital.

(b) 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 pregnancy-related care or pediatric care; or
- Registered nurse or registered psychiatric nurse for substance use care.

(c) 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 written documentation and recommendations will be generated by the physician providing the consultation within 48 hours of the date of service.

(d) 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.

(e) Payable for one consultation per physician per hospitalization.

(f) Not payable for:

- A transfer of patient care between physicians; or
- Follow-up visits after a consultation (bill these as 98160/98260).

LFP 98169 **Locum 98269** **LFP Inpatient Family Conference……$30**

Notes:

(a) Payable for in-person or phone/video participation in a family conference for a patient admitted to a hospital.

(b) Payable when a physician participates in a family conference with one or more family members/representatives for the purpose of:

- Obtaining informed consent for care related to an acute medical event or a significant change in the patient’s condition; or
- Developing and reviewing the patient’s documented Care Plan that identifies the goals of care, management plan, and supports for activities of daily living as clinically appropriate.

(c) Only payable when the conference is a minimum of 15 minutes.

(d) Details of the family conference must be documented in the patient’s chart, including the participants, their roles, information about the discussion, and decisions made.

(e) Payable in addition to a patient visit on the same day if clinically required, provided that the visit does not take place concurrently with the family conference (i.e. The visit time must be separate from the family conference time).

(f) Not payable when:

- Communication occurs as a part of routine communication with the family; or
- Consent is not required for an acute medical event or a significant change in the patient’s condition.

(g) Start and end times must be documented in the patient’s chart and entered on the billing claim.

LFP 98036 **Locum 98236** **LFP Inpatient Team Communication ……..……$15**

Notes:

(a) Payable for physician phone/video communication with an allied care provider or another physician for a patient admitted to a hospital when a physician is required to communicate about patient care, including provision or receipt of advice, medication orders, or a response for an acute medical event.

(b) Only payable when the physician is not on site providing LFP Facility-based Care.

(c) Only payable when:

- the care staff contacts the physician; or

- the physician contacts the care staff as a result of investigations that require urgent attention.

(d) Only payable when the communication is a minimum of 5 minutes.
(e) Details of the communication must be documented in the patient's chart, including the participants, their roles, information about the discussion, and decisions made.
(f) Payable in addition to a patient visit on the same day if clinically required, provided that the visit does not take place concurrently with the care team communication (i.e., The visit time must be separate from the team communication time).
(g) Payable once per patient per physician per calendar day.
(h) Only payable in addition to time codes 98010/98040, 98011/98041, and 98012/98042.
(i) Not payable for communication that does not require the professional expertise of a physician, such as:
- booking an appointment;
- arranging for laboratory or diagnostic investigations; or
- arranging a hospital bed, consult, or additional non-emergent care.

(j) Start and end times must be documented on the patient's chart and entered on the billing claim.

58. Billing Codes for Pregnancy & Newborn Facility Services

(a) Pregnancy & Newborn Facility Services Time Codes

Pregnancy and Newborn Direct Patient Care time codes are only payable to physicians who:

- have privileges to provide family medicine obstetrics care in a health authority-operated or affiliated hospital,
- have billed 98000/98005 Enrolment Code, and
- have billed 98006 Pregnancy & Newborn Services Registration Code.

Direct Patient Care is only payable when the physician is:

- providing direct patient care on site, or
- clinically required to be on site at the hospital or Home Birth setting providing care for Pregnancy & Newborn Care patients.

In addition, 98011/98041 LFP Indirect Patient Care Time and 98012/98042 LFP Clinical Administration Time are payable for Pregnancy & Newborn Facility Services provided for patients in a hospital or Home Birth Setting.

For Locum time codes, the MSP practitioner number of the Host Physician must be entered in the "Referred by" field on the billing claim.

LFP	Locum	LFP Pregnancy and Newborn Direct Patient Care Time – per 15 minutes
98128	**98228**	**Weekday (between 0800 hours and 1800 hours) $57.50**
98129	**98229**	**Evening (between 1800 hours and 2300 hours) $63.75**
98130	**98230**	**Saturday, Sunday or Statutory Holiday (between 0800 and 2300 hours) $63.75**
98131	**98231**	**Night (between 2300 hours and 0800 hours) $66.25**

Notes:

(a) Payable for time spent providing Pregnancy and Newborn Direct Patient Care for a patient:
- in an acute care setting of a hospital for pregnancy-related or newborn care concerns,
- in a Home Birth Setting for labour/birth, or
- in a Home Birth Setting for postpartum/newborn care in the 5 days after birth.

(b) The following services are payable as Pregnancy and Newborn Direct Patient Care Time when the physician is on site at the hospital or Home Birth setting providing care for Pregnancy and Newborn Care patients:
- In-person care with a patient present.
- Management of the first stage of labour when the physician is clinically required to be in attendance.
- Management of the second and third stage of labour.
- Transition between consecutive patient interactions.
- Indirect patient care.
- Clinical teaching arising from direct patient care.

(c) Payable only when the physician is providing clinically required Pregnancy and Newborn Direct Patient Care and documents the clinical indication that requires attendance at the hospital or Home Birth Setting.

(d) All Pregnancy and Newborn Direct Patient Care time must have appropriate clinical documentation in the patient's chart.

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

LFP 98011 **Locum 98041** **LFP Indirect Patient Time – per 15 minutes ……..…$32.50**

Notes:

(a) Payable for time spent on Indirect Patient Care for clinic-based and facility-based care, which means the following patient-specific services provided when the patient is not present:
- Documentation of patient interactions and charting.
- Review of results: labs, imaging, consultations, and other reports.
- Preparing referrals and requisitions.
- Chart review.
- Asynchronous virtual care (e.g., fax, email, text, messaging via EMR/EHR).
- 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.
- Clinical teaching arising from direct patient care.
- 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.

(b) Not payable for time spent on travel.

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

LFP 98012 **Locum 98042** **LFP Clinical Administration Time – per 15 minutes ……..……$32.50**

Notes:

(a) Payable for time spent on clinical administration for clinic-based and facility-based care, 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 preventative health, disease management, and provision of data-informed care (e.g., fall prevention, immunizations, cancer screening, diabetes management, deprescribing).
- Electronic Medical Record (EMR) and Electronic Health Record (EHR) updating and management that requires physician expertise.
- Evaluation of the efficiency, quality, and delivery of the services provided in a Facility (e.g., medical audits, peer and interdisciplinary reviews, and incident report reviews) when not payable through other means.
- Clinic 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. (Not applicable to health authority-operated clinics).
- Clinic 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*. (Not applicable to health authority-operated clinics).

(b) 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.
- Medical leadership responsibilities for health authority funded leadership positions.
- Time spent on travel.

(c) The maximum amount of time payable as clinical administration in each LFP Clinic or Facility setting is 10% of the total hours paid as Time Codes per setting by the physician in a calendar year.

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

LFP	**Locum**	**LFP Travel Time – per 15 minutes ……$32.50**
98119	**98219**	***Notes:***

(a) Payable for time spent on travel for the most direct route between patient care sites, including Clinic settings, Facility settings, and patients' Home Settings.

(b) The maximum amount of Travel Time payable on a single day is 60 minutes of travel.

(c) Physicians must take all reasonable and clinically appropriate steps to reduce the amount of travel time where possible.

(d) The start and destination sites must be documented in the patient's chart.

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

(b) Pregnancy & Newborn Facility Services Interaction Codes

Pregnancy & Newborn Facility Services interaction codes are only payable to physicians who:

- have privileges to provide family medicine obstetrics care in a health authority-operated or affiliated hospital,

- have billed 98000/98005 Enrolment Code, and
- have billed 98006 Pregnancy & Newborn Services Registration Code.

Generally, only one interaction code is payable per patient per physician per day, except for 98037/98237. Additional interaction codes are not payable unless the services meet the conditions of Section 33 [*Multiple Services for the Same Patient on the Same Day*].

This does not apply to conferencing and communication codes (98037/98237) for Pregnancy & Newborn Facility Services.

When the patient is seen for multiple issues during the same patient interaction, the applicable interaction code with the highest value should be billed.

An interaction code is only 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.
- 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.

An interaction code is not payable for:

- Review of a patient's chart without direct patient interaction.
- On-site interaction with the care team without direct patient interaction.

LFP 98170 **Locum 98270** **LFP Pregnancy-related In-person Acute Care Visit ……..……...…$30**

Notes:

(a) Payable for an in-person visit with direct patient interaction for a pregnant or postpartum patient in:
- an acute care setting of a hospital for pregnancy-related concerns.
- a Home Birth Setting for labour, birth, and postpartum care in the 5 days after birth.

LFP 98171 **Locum 98271** **LFP Newborn In-person Acute Care Visit...……..……..……..……...…$30**

Notes:

(a) Payable for an in-person visit with direct patient interaction for a newborn patient in:
- an acute care setting of a hospital for newborn-related concerns in the 10 days after birth.
- a Home Birth Setting for newborn care in the 5 days after birth.

LFP 98172 **Locum 98272** **LFP Newborn Resuscitation……..……..……..……..……..……..……..…$60**

Notes:

(a) Payable for in-person treatment with direct patient interaction for a newborn patient who requires positive pressure ventilation, chest compressions, laryngeal mask, and/or endotracheal intubation in:
- an acute care setting of a hospital.
- a Home Birth Setting.

LFP 98173 **Locum 98273** **LFP Birth …….....……$270**

Notes:

(a) Payable for in-person management of one of the following types of births in any setting:
- Spontaneous vaginal birth.
- Vacuum-assisted birth.
- Forceps-assisted birth.
- Emergency caesarean section birth.
- Pregnancy losses from 16+0 weeks gestational age.

(b) Payable to the physician who is:
- Responsible for managing a birth,
- Responsible for co-managing a birth with an obstetrician or a family physician who has privileges to provide enhanced surgical skills for operative delivery, or
- The second attendant at a Home Birth

(c) Payable once per patient per pregnancy.

LFP 98174 **Locum 98274** **LFP Pregnancy-related Surgical Assist …...…..…....…..……..…..…$150**

Notes:

(a) Payable for in-person surgical assistance provided in hospital for one of the following:
- Elective caesarean section birth.
- Emergency caesarean section surgical assist for a patient whose labour and birth are being managed by another physician or midwife.
- Surgical assist for an obstetrical surgery provided separately from a birth.

(b) Not payable in addition to 98173/98273 LFP Birth to the same physician for the same pregnancy, except when a surgical assist is required for an obstetrical surgery provided separately from a birth.

LFP 98175 **Locum 98275** **LFP Pregnancy & Newborn Care Consultation ……..…..…$60**

Notes:

(a) Payable for a consultation with direct patient interaction provided in-person or by phone/video for a patient admitted to a hospital for pregnancy-related or newborn care concerns.

(b) 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 pregnancy-related care or pediatric care,
- Registered nurse or registered psychiatric nurse for substance use care.

(c) 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 documentation and recommendations report will be generated by the physician providing the consultation within 48 hours of the date-of-service.

(d) 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.

(e) A consultation for the same diagnosis is not payable as 98175/98275 unless an interval of at least six months has passed since the consultant has last billed a consultation for the patient. A new and unrelated diagnosis can be billed as 98175/98275 without a six-month interval.

(f) Not payable for:
- A transfer of patient care between physicians, or

- Follow-up visits after a consultation (bill these as 98170/98270 or 98171/98271).

LFP 98037 **Locum 98237** **LFP Pregnancy-related Acute Care Team Communication……$15**

Notes:

(a) Payable for physician phone/video communication with an allied care provider or another physician for a patient admitted to a hospital when a physician is required to communicate about patient care, including provision or receipt of advice, medication orders, or a response for an acute medical event.

(b) Only payable when the physician is not on site providing LFP Facility-based Care.

(c) Only payable when:
- The care staff contacts the physician; or
- The physician contacts the care staff as a result of investigations that require urgent attention.

(d) Only payable when the communication is a minimum of 5 minutes.

(e) Details of the communication must be documented in the patient's chart, including the participants, their roles, information about the discussion, and decisions made.

(f) Payable in addition to a patient visit on the same day if clinically required, provided that the visit does not take place concurrently with the care team communication (i.e., The visit time must be separate from the team communication time).

(g) Payable once per patient per physician per calendar day.

(h) Only payable in addition to time codes 98010/98040, 98011/98041, and 98012/98042.

(i) Not payable for communication that does not require the professional expertise of a physician, such as:
- Booking an appointment;
- Arranging for laboratory or diagnostic investigations; or
- Arranging a hospital bed, consult, or additional non-emergent care.

(j) Start and end times must be documented on the patient's chart and entered on the billing claim.

XV. APPENDICES

Appendix A – Definitions

In this LFP Payment Schedule, unless the context otherwise requires:

(a) "**Adequate Medical Record**" has the meaning given to it in Section 5 [*Adequate Medical Records*].

(b) **"Clinical Administration"** means Clinical Administration as described in time code 98012/98042 LFP Clinical Administration – per 15 minutes.

(d) "**Clinical Learner**" means medical students, residents, Practice Ready Assessment (PRA-BC) physicians, nurses/nursing students, nurse practitioners/nurse practitioner students and midwives/midwifery students.

(e) **"Clinic-based Pregnancy & Newborn Service"** means prenatal care, postnatal care, lactation support, care of newborns up to six weeks of age, and medical abortion care.

(f) "**Clinic Non-panel Service**" means LFP Clinic-based Services that a physician provides to a patient who is not:

(i) on the physician's panel; or

(ii) on the panel of another longitudinal physician or nurse practitioner who works at the same LFP Clinic as the physician.

(g) **"Complex Contraception Service"** means care related to contraceptive procedures and surgeries (e.g. intrauterine devices, contraceptive implants, vasectomies, tubal ligations), as well as the use of contraceptive methods for medically and socially complex patients, care resulting from a referral or recommendation from a physician or allied care provider, and gender-affirming care.

(h) **"Deemed Ineligible"** has the meaning given to it in Section 29 [*Removal from the LFP Payment Model*].

(i) **"Direct Patient Care"** means direct patient care as described in one of the Direct Patient Care time codes: 98010/98040, 98120/98220, 98121/98221, 98123/98223, 98124/98224, 98125/98225, 98126/98226, 98127/98227, 98128/98228, 98129/98229, 98130/98230, 98131/98231.

(j) **"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.

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

(l) **"Enrolment Code"** means 98000 Longitudinal Family Physician Payment Model Registration Code.

(m) **"Excluded Services"** means all of the services and circumstances described as being excluded from the LFP Payment Model in Sections 11 to 21 [*Excluded Services*].

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

(o) **"Pregnancy & Newborn Facility Service"** means care that a physician provides for a patient:
- (i) in an acute care setting of a hospital for pregnancy-related or newborn care concerns,
- (ii) in a Home Birth Setting for labour/birth, or
- (iii) in a Home Birth Setting for postpartum/newborn care in the 5 days after birth.

(p) **"Fee-for-Service"** means the 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".

(q) "**Home Birth Setting**" means an out-of-hospital setting where a patient labours and/or gives birth.

(r) "**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.

(s) **"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;
- (iii) remunerated under the Individual Contract for New-to-Practice Family Physicians; or
- (iv) Remunerated under Alternative Payments Subsidiary Agreement (APSA) contracts under the following practice categories:
  - General Practice – Full Scope (Rural) – Area A, B, C
  - General Practice – Full Scope (Non-JSC Community)
  - General Practice – Defined Scope B (Student Health Centres) until June 30, 2027

(t) "**Indirect Patient Care**" means indirect patient care as described in time code 98011/98041 LFP Indirect Patient Care Time– per 15 minutes.

(u) **"Initial Eligibility Criteria**" means the initial eligibility criteria for the LFP Payment Model defined in Section 23 [*Initial Eligibility Criteria for the LFP Payment Model*].

(v) **"Inpatient Facility Service"** means care that a physician provides to a patient in an acute care setting of a hospital, except for:

(i) Care provided in an acute care setting of a hospital for pregnancy-related or newborn care concerns,
(ii) Direct bedside care provided to critically ill and unstable patients who are in need of intensive treatment such as ventilatory support, haemodynamic support including vasoactive medications or prolonged resuscitation.

(w) **"Interdisciplinary Care Conference"** means an interdisciplinary discussion with the physician, nurse, other staff, and the patient/family (if available and appropriate) to discuss how best to care for a patient, including review of a patient's care plan that identifies the goals of care, management plan, and supports for activities of daily living as clinically appropriate. It is one of the FPSC Long-term Care Initiative's Best Practice Expectations

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

(y) "**LFP Clinic-based Service**" **means** care that a physician provides to a patient:
(i) at the physician's LFP Clinic;
(ii) at a Pregnancy & Newborn Clinic;
(iii) as a virtual visit associated with the physician's LFP Clinic, except if the physician provides successive services to patients located in a Facility; or
(iv) to a patient in their Home Setting (but not in a Facility).

(z) **"LFP Facility-based Service"** means care that a physician provides to a patient in an applicable Facility setting:
(i) Long-term Care and Palliative Facility Services
(ii) Inpatient Facility Services
(iii) Pregnancy & Newborn Facility Services

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

(bb) **"LFP Locum Services"** means services provided by an LFP Locum on behalf of a Host Physician in an LFP Clinic-based setting and/or in any of the following LFP Facility-based settings:
• Long-term Care and Palliative Facility Services,
• Inpatient Facility Services, and
• Pregnancy & Newborn Facility Services.

(cc) **"Locum Eligibility Criteria"** means the eligibility criteria for the LFP Payment Model defined in Section 50 [*Locum Eligibility Criteria*].

(dd) **"Locum Enrolment Code"** means 98005 Longitudinal Family Physician Payment Model Locum Enrolment Code, as defined in Section 52 [*Locum Enrolment and Annual Re-enrolment*].

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

(ff) **"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.

(gg) **"Long-term Care and Palliative Facility Service"** means care that a physician provides to a patient in a Long-term Care or Palliative Care Facility.

(hh) **"Meaningful Medication Review"** means an interdisciplinary discussion with the physician, pharmacist, and nurse to discuss to assess the appropriateness, dose, route, and/or dispensing schedule of each medication used by a patient as well as reducing/stopping medications when safe to do so. It is one of the FPSC Long-term Care Initiative's Best Practice Expectations.

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

(jj) "**Ongoing Eligibility Criteria"** has the meaning given to it in Section 24 [*Ongoing Eligibility Criteria in the LFP Payment Model*].

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

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

(mm) **"Pregnancy & Newborn Clinic"** means a medical clinic in which a physician enrolled in the LFP Payment Model provides Pregnancy & Newborn Services.

(nn) **"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.

(oo) **"Required Services"** means the services specified in Section 25 [*Required Services*].

(pp) **"Setting Registration Code"** means 98002 LFP Clinic-based Services Registration Code, 98003 LFP Long-term Care and Palliative Care Facility Services Registration Code, 98004 LFP Inpatient Services Registration Code, or 98006 LFP Pregnancy & Newborn Services Registration Code, as defined in Section 27 [*Registration to Bill Services under the LFP Payment Model*].

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, 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 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 medicine 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) 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 for LFP Clinic-based Services, 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 clinic-based compensation for a physician being paid under the LFP Payment Schedule.

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

- 1680 hours of clinic-based 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 to be eligible for the LFP Payment Model. This requires a family physician, as part of the LFP Payment Model, to:

- provide LFP Clinic-based 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 pregnancy-related 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 – Claim Submission and Payment

1. Claims Submission Period

Physicians billing under the LFP Payment Model must submit claims for time codes and 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. 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.

3. 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.

4. 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

Appendix D – Procedures and Diagnostic Tests

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

Associated Fee-for-Service codes are provided for reference to assist physicians. 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.

1. Clinic Procedures

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

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 Clinic-based Standard Procedure
98051 – LFP Locum Clinic-based Standard Procedure

Procedures Payable as 98021 and 98051	Fee-for-Service Code
Gynecologic examination and cervix screening that includes the use of a speculum	14562
IUD removal	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 54410 55405 55410 56405 56410 57405 57410
Varicose vein injection	77045

98020 – LFP Clinic-based Advanced Procedure
98050 – LFP Locum Clinic-based 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

2. Long-term Care or Palliative Care Facility Procedures

98155 – LFP Long-term Care or Palliative Care Procedure
98255 – LFP Locum Long-term Care or Palliative Care Procedure

Note: If the physician provides the supplies for an Advanced Procedure, bill 98156 or 98256.

COMMONLY PERFORMED IN LONG-TERM CARE AND PALLIATIVE CARE FACILITIES	
Procedures Payable as 98155 and 98255	**Fee-for-Service Code**
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 54410 55405 55410 56405 56410 57405 57410
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

LESS COMMONLY PERFORMED IN LONG-TERM CARE AND PALLIATIVE CARE FACILITIES	
Procedures Payable as 98155 and 98255	**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
Insertion of IUD	14540
Insertion or removal of subdermal contraceptive implant	14542 14543
Gynecologic examination and cervix screening that includes the use of a speculum	14562
IUD removal	14562
Cervical polypectomy	04509
Cautery or excision of genital wart(s)	04305
Cervix punch biopsy	00784
Endometrial biopsy	00785
Proctosigmoidoscopy, rigid, diagnostic	10714
Anoscopy	10710
Abscess – perianal, I & D, superficial	07678
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

98156 – LFP Long-term Care or Palliative Care Advanced Procedure with Physician-provided Supplies
98256 – LFP Locum Long-term Care or Palliative Care Advanced Procedure with Physician-provided Supplies

Note: If the Long-term Care or Palliative Care Facility provides the supplies, bill 98155 or 98255.

COMMONLY PERFORMED IN LONG-TERM CARE AND PALLIATIVE CARE FACILITIES	
Procedures Payable as 98156 and 98256	**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

LESS COMMONLY PERFORMED IN LONG-TERM CARE AND PALLIATIVE CARE FACILITIES	
Procedures Payable as 98156 and 98256	**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	00762

Note: Only applicable if a minimum of 15 antigens are used.	00763 00765
Endoscopic Examination of the Nose and Nasopharynx	00907
Nerve block paravertebral sympathetic	01042
Peripheral nerve block, single or double	01124 01125
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
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

3. Inpatient Procedures

98166 – LFP Inpatient Procedure
98266 – LFP Locum Inpatient Procedure

Procedures Payable as 98166 and 98266	Fee-for-Service Code
Gynecologic examination and cervix screening that includes the use of a speculum	14562
IUD removal	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 54410 55405 55410 56405 56410 57405 57410
Varicose vein injection	77045
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
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
Insertion, revision, or removal of totally implantable access device (e.g., portacath),	07142, 77142, 07143
Closure of complicated lacerations of scalp, cheek, or neck	06077
Minor burn dressing or debridement	06078, 06079, 06080
Lumbar puncture for diagnostic purposes	SY00750, SY00570
Removal foreign body from nose, complicated	02301
Pilonidal abscess/sinus incision and drainage	70084
Dislocation closed reduction without general anesthesia – temporo-mandibular joint, patella, toe, shoulder, elbow, or hip	01860, 01861, 01862, 52721, 53751, 55711
Dislocation closed reduction without general anesthesia –metatarsophalangeal, metacarpophalangeal, or interphalangeal joint	57771, 57791 06236
Fracture reduction – metacarpal or finger phalanx	06222, 06223
Fracture reduction without general anesthesia – metatarsal, radius, ulna, carpus, ankle (malleolus), hindfoot/midfoot/Lisfranc, talus, tarsus, toe phalanx	13660 53761, 54701, 54721 57711, 57721, 57741, 57751, 57781
Nerve root block – cervical, thoracic, lumbar	01140, 01141, 01142, 00143, 01144, 01145
Epidural block – lumbar, thoracic, cervical, caudal	01135, 01136, 01137, 01138
Stricture of urethra dilatation	S08264, S08265
Insertion of central venous pressure catheter	00017
Breast biopsy, needle core	70469
Removal of anal tag or polyp	71684, 71686
Peripheral or subcutaneous lymph node biopsy	S00745
Simple screening spirometry with FVC, FEV(i), and FEV(i)/FVC ratio using a portable apparatus with or without bronchodilators	S00928, S00929
Intrathecal medications by injection	00016
Repair of torn earlobe for complete tear of lobe through margin	06027
Temporal artery biopsy	07025
PICC line insertions - simple	10323
Reinsertion of peritoneal catheter (for acute peritoneal dialysis)	33756
Peritoneal lavage	SY00789
Stomach lavage and gavage	00040
Closed drainage of chest	S32031
Parietal pleural needle biopsy	00749
Repair of complicated fingertip injury	06238
Deep abscess (complex, subfascial, and/or multilocular) incision and drainage with local or regional anesthesia	07059
Insertion or removal of Broviac catheter	07139, 07140, 01741
Intra osseous access	07145
Cystostomy by trochar	08202
Dorsal slit, isolated procedure	08301
Cardioversion	33025
Fracture reduction – femur shaft, tibial shaft	55780, 56751

Appendix E – Using ICD-9 Codes when Billing Under the LFP Payment Model

All claims submitted by physicians to the Medical Services Plan (MSP) must include an ICD-9 code. Each claim submitted to Teleplan can accommodate up to three ICD-9 codes. The ICD-9 codes submitted should reflect the care provided during the patient interaction.

The ICD-9 field in Teleplan only accepts alphanumeric characters. As special characters like decimal points are invalid, ICD-9 codes should be entered without decimal points (e.g., V10.4 is entered as V104, 102.51 is entered as 10251).

The diagnostic codes used by MSP are based on the ninth revision of the International Classification of Diseases developed by the World Health Organization, commonly referred to as ICD-9. MSP's Index and Guide to 3-Digit and 4-Digit Diagnostic Code Descriptions provides a list of ICD-9 codes listed by topic area.

1. Clinic-based Pregnancy & Newborn Services and Complex Contraception Services for Non-panel Patients

A physician cannot claim more than 30% of their interaction codes for Clinic Non-panel Services in one calendar year. This limit does not apply to Clinic-based Pregnancy & Newborn Services and Complex Contraception Services for non-panel patients if the service is:

(i) provided at the physician's LFP Clinic, at a Pregnancy and & Newborn Clinic, as a virtual care service associated with the physician's LFP Clinic or Pregnancy and & Newborn Clinic (except if the physician provides successive services to patients located in a Facility), or to a patient in their Home Setting (but not in a Facility); and
(ii) identified with one of the specified ICD-9 codes.

To identify an interaction code as a Clinic-based Pregnancy and Newborn Service, a physician must submit one of the following ICD-9 codes:

- V20 Health Supervision of Infant or Child – for care of newborns up to six weeks of age
- V22 Normal Pregnancy – for care during a pregnancy, including medical abortion
- V24 Postpartum Care and Examination – for postnatal care and lactation support

To identify an interaction code as a Complex Contraception Service, a physician must submit the following ICD-9 code:

- V25 Contraceptive Management

"Clinic-based Pregnancy and Newborn Service" means prenatal care, postnatal care, lactation support, care of newborns up to six weeks of age, and medical abortion care.

"Complex Contraception Service" means care related to contraceptive procedures and surgeries (e.g. intrauterine devices, contraceptive implants, vasectomies, tubal ligations), as well as the use of contraceptive methods for medically and socially complex patients, care resulting from a referral or recommendation from a physician or allied care provider, and gender-affirming care.

If the patient care provided is not fully reflected by one of the specified ICD-9 codes, use one of the specified ICD-9 codes to identify the interaction code as a Clinic-based Pregnancy and Newborn

Service or Complex Contraception Service, and up to two additional ICD-9 codes to describe the care provided during the interaction.

2. Enrolment Codes

The Enrolment Code and Locum Enrolment Code must be submitted using ICD-9 code L23.

3. Time Codes

All time codes must be submitted using ICD-9 code L23.

4. Panel Payment

Currently, the panel payment is 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.

All ICD-9 codes submitted to Teleplan are considered by the ACG system to estimate patient complexity.

Appendix F – 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 withdraws from the LFP Payment Model and moves 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 withdraws from the LFP Payment Model and moves to Fee-for-Service, if the care meets the requirements of the fee notes. However, if a physician receives permission and proceeds to re-enrol in 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.