



The following amendments to the MSC Payment Schedule have been approved on a temporary basis to support the Province's response to the COVID-19 pandemic. The cancellation date will be determined by the Provincial Health Officer.

General Preamble amendment effective March 13, 2020 on a temporary basis

The first paragraph of Preamble D. 1. is amended to the following (strikethrough deleted and bold added):

"Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient ~~via live image transmission of those images to a receiving medical practitioner at another approved site,~~ through the use of video technology **or telephone**. "Video technology" means the recording, reproducing and broadcasting of live visual images utilizing a direct interactive video link with a patient. ~~If the sending and/or receiving medical practitioner are not in a Health Authority approved site, the medical practitioner is responsible for the confidentiality and security of all records and transmissions related to the telehealth service. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those sServices which are designated as telehealth services are payable by MSP. Other services/procedures require face-to-face encounters.~~ **Consultations, office visits, and non-procedural interventions where there is no telehealth fee may be claimed under the face-to-face fee with a claim note record that the service was provided via telehealth.** Telehealth services do not include teleradiology or tele-ultrasound, which are regulated by their specific Sectional Preambles.

Section of General Practice Preamble amendment effective March 13, 2020 on a temporary basis

The following wording is deleted from the Section of General Practice Preamble (strikethrough deleted):

Note: ~~Daily Volume Payment Rules Applying to Designated Office Codes~~

(i) ~~The codes to which these rules apply are as follows:~~

~~Office visits: 12100, 00100, 15300, 16100, 17100, 18100
Office counselling: 12120, 00120, 15320, 16120, 17120, 18120
Office complete examinations: 12101, 00101, 15301, 16101, 17101, 18101~~

(ii) ~~The total of all billings under the codes listed in i) that are accepted for payment by MSP will be calculated for each practitioner for each calendar day. When such a daily total exceeds 50 the practitioner's payment on these codes for that day will be discounted. Moreover, when a daily total exceeds 65, a further payment discount will be made.~~

Daily Ranges **Discount Rate** **Payment Rate**
*(for an individual practitioner
for any single calendar day)*

0 to 50	0%	100%
51 to 65	50%	50%
66 and greater	100%	0%

- ~~(iii) — Payment discounts will not be applied to services rendered in communities that are/were receiving NIA premiums as of December 15, 2002.~~
- ~~(iv) — Payment discounts will not be applied to services designated by the physician as being the responsibility of ICBC, (designate by checking the MVA indicator on the claim), or services that are the responsibility of Worksafe BC.~~
- ~~(v) — Services will be assessed and payment/discounts will be applied to services in the order in which they are received and accepted for payment by MSP.~~

New Fee items effective March 17, 2020 on a temporary basis

T13701 Office Visit for COVID-19 with test\$50.00

Notes:

- i) Payable for patients with suspected or active COVID-19 symptoms only.*
- ii) COVID-19 testing must be performed.*
- iii) Not intended for providing general information on a viral infection, including COVID-19.*
- iv) Not payable in addition to any other office visits to the same physician for same patient, same day.*

T13702 Office Visit for COVID-19 without test\$40.00

Notes:

- i) Payable for patients with suspected or active COVID-19 symptoms only.*
- ii) Not intended for providing general information on a viral infection, including COVID-19.*
- iii) Not payable in addition to any other office visits to the same physician for same patient, same day.*

Section of General Practice New Fee items effective March 27, 2020 on a temporary basis

T13706 FP Delegated Patient Telehealth Management Fee\$20.00

Notes:

- i) For verbal, real-time telephone or video technology communication discussion between the patient or the patient’s medical representative and a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed within a physician’s practice. Not payable when the delegated representative is paid or funded by alternate means by a health authority or the Ministry of Health.*
- ii) Chart entry must record the name of the person who communicated with the*

patient or patient's medical representative, as well as capture the elements of care discussed.

- iii) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
- iv) Only one service payable per patient per day.
- v) Not payable on the same calendar day as a visit or service fee by same physician for same patient.
- vi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

T13707 FP Email/Text/Telephone Medical Advice Relay or ReRX Fee\$7.00

Notes:

- i) Email/Text/Telephone Relay Medical Advice requires two-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.
- ii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.
- iii) Payable for prescription renewals without patient interaction.
- iv) Not payable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.
- v) Only one service payable per patient per day.
- vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient.
- vii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

T13708 FP COVID-19 communication with specialist and/or allied care provider\$40.00

Notes:

- i) Payable to the Family Physician who participates in a 2 way telephone or videoconference communication with a specialist and/or allied care provider about a patient regarding COVID-19.
- ii) T13708 FP COVID-19 communication with specialist and/or allied care provider can not be delegated. No claim may be made where communication is with a proxy for either provider.
- iii) Payable in addition to any visit fee on the same day.
- iv) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility, or communications which occur as part of regular work flow within a physician's community practice.
- v) Not payable in addition to PG14018 or PG14077 on the same day for the same patient.
- vi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Specialist New Fee items effective March 27, 2020 on a temporary basis

T10007 Specialist Email/Text/Telephone Medical Advice Relay or ReRX Fee\$10.10

Notes:

- i) Email/Text/Telephone Relay Medical Advice requires two-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.

- ii) *Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.*
- iii) *Payable for prescription renewals without patient interaction.*
- iv) *Not payable for notification of appointments or referrals.*
- v) *Only one service payable per patient per day.*
- vi) *Not payable on the same calendar day as a visit or service fee by same physician for same patient.*
- vii) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

T10008 Urgent Specialist COVID-19 Advice – Initiated by a Specialist, General Practitioner or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request.....\$60.00

Notes:

- i) *Payable for telephone, video technology or face to face communication only about a patient regarding COVID-19. Not payable for written communication (i.e. fax, letter, email).*
- ii) *Document time of initiating request, time of response, as well as advice given and to whom.*
- iii) *Include the practitioner number of the physician or Health Care Practitioner requesting the advice in the "referred by" field when submitting claim.*
- iv) *Not payable in addition to another service on the same day for the same patient by same practitioner.*
- v) *Limited to two claims per patient per physician per day.*
- vi) *Not payable in addition to G10001 on the same day for the same patient.*

Specialist New Fee items effective April 15, 2020 on a temporary basis

T10000 Urgent Specialist Advice on patient with previous visit/service – Initiated by a Specialist, General Practitioner or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request\$60.00

Notes:

- i) *Payable for telephone, video technology or face to face communication only. Not payable for written communication (i.e. fax, letter, email).*
- ii) *Document time of initiating request, time of response, as well as advice given and to whom.*
- iii) *Include the practitioner number of the physician or Health Care Practitioner requesting the advice in the "referred by" field when submitting claim.*
- iv) *Not payable in addition to another service on the same day for the same patient by same practitioner.*
- v) *Limited to one claim per patient per physician per day.*

T10009 Specialist Advice for Patient Management on patient with previous visit/service – Initiated by a Specialist, General Practitioner, Allied Care Provider, or coordinator of the patient's care. Verbal real-time response within 7 days of initiating request\$40.00

Notes:

- i) *Payable for telephone, video technology or face to face communication only. Not payable for written communication (i.e. fax, letter, email).*
- ii) *Document date of initiating request, date of the response, as well as advice given and to whom.*
- iii) *Include the practitioner number of the physician or Allied Care Provider requesting advice in the "referred by" field when submitting claim. (For Allied*

- Care Providers not registered with MSP use practitioner number 99987.)
- iv) *Not payable in addition to another service on the same day for the same patient by the same practitioner.*
 - v) *Limited to one claim per patient per physician per day and two services per patient per physician per week.*

Section of Diagnostic Ultrasound Preamble amendment effective April 17, 2020 on a temporary basis

The following wording is deleted from the Section of Diagnostic Ultrasound Preamble (strikethrough deleted):

Preamble: ~~Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.~~

Diagnostic Ultrasound Telemetry

Definition: *The electronic transmission of diagnostic ultrasound images from one site to another for interpretation.*

For diagnostic ultrasound telemetry services to be considered as benefits under the Medical Services Plan:

- the transmitting and receiving sites must be located within ~~Medical Services Commission approved and~~ Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients
- the services are billed in accordance with the Telemetry Billing Guidelines as follows:

Telemetry Billing Guidelines:

- a) Services must be billed by the facility where the image was taken using the practitioner number of the physician who did the interpretation
- b) Facility number field – the facility number of the diagnostic facility where the image was taken
- c) Sub-Facility field
 - the facility number of the diagnostic facility where the image was interpreted
 - zeros if interpreted at the same site where the image was taken
- d) Service charges (fee items 01200 – 01202) are only billable when a physician is required to travel from home to hospital in order to perform a telemetry service for an outpatient and when the *MSC Payment Schedule* criteria are met.
- e) The original site should ensure that only one interpretation is billed to MSP.
- f) In those rare cases when a second radiological opinion is requested by the referring physician, a radiologist may bill for the service using fee item 08628, provided written radiological report is sent to the referring physician

Real time ultrasound fees may only be claimed for studies performed by telemetry when:

- the facility currently holds a remote site designation from the Medical Services Commission. (Facilities should recognize that once the volume of services justifies full-time radiologist's coverage remote site designation may be removed.); and,
- the use of telemetry will not negatively affect the existing on-site visit schedules of the radiologists; and,
- the majority of scans will continue to be scheduled when the visiting radiologist is on-site for the purpose of ultrasound supervision.

Section of Diagnostic Radiology Preamble amendment effective April 17, 2020 on a temporary basis

The following wording is deleted from the Section of Diagnostic Radiology Preamble (strikethrough deleted):

Diagnostic Radiology Telemetry

Definition: *The electronic transmission of radiological images from one site to another for interpretation.*

For diagnostic radiology telemetry services to be considered as benefits under the Medical Services Plan:

- the transmitting and receiving sites must be located within ~~Medical Services Commission approved~~ and Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients
- the services are billed in accordance with the Telemetry Billing Guidelines as follows.

Telemetry Billing Guidelines:

- a) Services must be billed by the facility where the image was taken using the practitioner number of the physician who did the interpretation
- b) Facility number field – the facility number of the diagnostic facility where the image was taken
- c) Sub-Facility field
 - the facility number of the diagnostic facility where the image was interpreted
 - zeros if interpreted at the same site where the image was taken
- d) Service charges (fee items 01200 – 01202) are only billable when a physician is required to travel from home to hospital in order to perform a telemetry service for an outpatient and when the *MSC Payment Schedule* criteria are met.
- e) The original site should ensure that only one interpretation is billed to MSP.
- f) In those rare cases when a second radiological opinion is requested by the referring physician, a radiologist may bill for the service using fee item 08628, provided written radiological report is sent to the referring physician.

General Preamble amendment effective May 1, 2020 on a temporary basis

The following description and list of fees have been added temporarily to C. 27. Business Cost Premium

C. 27. Business Cost Premium

Effective May 1, 2020 on a temporary basis

The BCP list of eligible fees has been temporarily amended to include telehealth fee items during Covid-19 pandemic to ensure BCP is paid given the majority of these services would have otherwise been provided to patients face-to-face at eligible physician offices.

Eligible BCP claims require a registered facility number and a community-based office service location code. While telehealth services do not need to be provided by the physician in their office, the appropriate facility number and service location code that should be entered on the claim is based on where the service would have been provided if it had been performed face-to-face.

Temporary list of eligible Telehealth fee items:

00470	00471	00477	01155	01470	01472	01770	01772	01777	03310
03312	03317	04070	04072	04077	08070	08072	08077	13036	13037
13038	13041	13042	20207	20210	20214	22007	22010	22011	30070
30071	30072	30077	31107	31110	31112	32107	32110	32112	32114
32270	32271	32272	32277	32370	32372	33107	33110	33112	33114
33260	33262	33267	33270	33272	33277	33360	33362	33367	33421
33422	33423	33424	33427	33470	33472	33473	33474	33477	33570
33572	33577	33630	33632	33637	33730	33732	33737	50507	50510
50511	50512	50514	50515	50516	50517	50518	50519	60607	60610
60613	60614	60622	60625	60626	60630	60631	60632	60633	60635
60636	60638	60639	66007	66010	66012	70070	70072	70077	70080
70087	77707	77710	77712	78007	78010	78012	79207	79210	79212
83070	94070	94072	94077						

General Preamble amendment effective March 13, 2020 on a temporary basis

The following wording is deleted from General Preamble D. 3. 3. (strikethrough deleted):

D. 3. 3. Counselling

Counselling is defined as the discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress, including the management of malignant disease. Counselling, to be claimed as such, must not be delegated and must last at least 20 minutes.

Counselling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the

counselling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counselling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns. Nor are the counselling codes generally applicable to the explanation of the results of diagnostic tests or approved laboratory facility services.

Not only must the condition be recognized as difficult by the medical profession, but the medical practitioner's intervention must of necessity be over and above the advice which would normally be appropriate for that condition. For example, a medical practitioner may have to use considerable professional skill counselling a patient (or a patient's parent) who has been newly diagnosed as having juvenile diabetes, in order for the family to understand, accept and cope with the implications and emotional problems of this disease and its treatment. In contrast, if simple education alone including group educational sessions (e.g.: asthma, cardiac rehabilitation and diabetic education) is required, such service could not appropriately be claimed under the counselling listings even though the duration of the service was 20 minutes or longer. It would be appropriate to apply for sessional payments for group educational sessions. Unless the patient is having significant difficulty coping, the counselling listings normally would not be applicable to subsequent visits in the treatment of this disease.

Other examples of appropriate claims under the counselling listings are Psychiatric Care, the counselling that may be necessary to treat a significant grief reaction, and conjoint therapy and/or family therapy for significant behavioural problems.

MSP payment of counselling under the counselling listings is limited to four sessions per year per patient unless otherwise specified. Subsequent counselling is payable under the other visit listings. ~~Counselling by telephone is not a benefit under MSP.~~

Section on General Practice temporary amendments, effective date as indicated:

New Fee Items:

The following new fee items have been approved on a temporary basis, effective June 1, 2020. The cancellation date will be determined by the Provincial Health Officer and will be reflected in subsequent MOC's.

Telehealth Service with Direct Interactive Video Link with the Patient:

These fee items cannot be interpreted without reference to the Preamble D. 1.

		\$
T13236	Telehealth GP Consultation (age 0-1)	84.87
T13436	Telehealth GP Consultation (age 2-49)	77.15
T13536	Telehealth GP Consultation (age 50-59)	84.87
T13636	Telehealth GP Consultation (age 60-69)	88.73
T13736	Telehealth GP Consultation (age 70-79)	100.29
T13836	Telehealth GP Consultation (age 80+)	115.75
T13237	Telehealth GP Visit (age 0-1)	34.79
T13437	Telehealth GP Visit (age 2-49)	31.62
T13537	Telehealth GP Visit (age 50-59)	34.79
T13637	Telehealth GP Visit (age 60-69)	36.36
T13737	Telehealth GP Visit (age 70-79)	41.10
T13837	Telehealth GP Visit (age 80+)	47.44
		\$

T13238	Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 0-1)	62.05
T13438	Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 2-49)	56.41
T13538	Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 50-59)	62.05
T13638	Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 60-69)	64.86
T13738	Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 70-79)	73.32
T13838	Telehealth GP Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) (age 80+)	84.60

Notes:

- i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth) per patient per year (see Preamble D. 3. 3.).
- ii) Start and end time must be entered into both the billing claims and patient's chart.
- iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

Amendment

The following description under the heading Counselling – Individual will be amended by the deletion of 13018 and 13038 (shown by strikethrough), effective May 31, 2020.

Counselling - Individual

For a prolonged visit for counselling (minimum time per visit – 20 minutes)

Notes:

- i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth ~~13018 and 13038~~) per patient per year (see Preamble D. 3. 3.).
- ii) Start and end time must be entered in both the billing claims and patient's chart.
- iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

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Deleted Fee Items

The following fee items, headings and wording is temporarily deleted effective May 31, 2020:

In-Office

P13036	Telehealth GP in-office Consultation.....	82.43
P13037	Telehealth GP in-office Visit	34.44
P13038	Telehealth GP in-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes).....	58.90

\$

Notes:

- i) *MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) per patient per year (see Preamble D. 3. 3.).*
- ii) *Start and end time must be entered into both the billing claims and patient's chart.*
- iii) *Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.*

Out-of-Office

For the billing of the GP Telehealth out-of-office fees 13016, 13017, 13018, 13021 and 13022, out-of-office shall mean that the physician providing the service is physically present in a Health Authority approved facility. The name of the facility and the results of the Telehealth service must be recorded in the patient chart.

P13016	Telehealth GP out-of-office Consultation	109.02
P13017	Telehealth GP out-of-office	41.10
P13018	Telehealth GP out-of-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes).....	75.32

Notes:

- i) *MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) per patient per year (see Preamble D. 3. 3.).*
- ii) *Start and end time must be entered into both the billing claims and patient's chart.*
- iii) *Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.*

General Preamble C. 27. (Business Cost Premium) amendment effective June 1, 2020 on a temporary basis

Amendment:

The Section of General Practice has temporarily deleted three Telehealth fee items and added eighteen Telehealth fee items to the General Preamble C. 27. (Business Cost Premium {BCP}) List of eligible BCP fee items. The cancellation date will be determined by the Provincial Health Officer and will be reflected in subsequent MOC's.

Deletions

13036, 13037 and 13038

Additions

13236, 13436, 13536, 13636, 13736, 13836
13237, 13437, 13537, 13637, 13737, 13837
13238, 13438, 13538, 13638, 13738, 13838

Section of General Practice amendment effective June 1, 2020 on a temporary basis

Amendment:

Note iii of the indicated fee items has been amended on a temporary basis, effective June 1, 2020 (strikethrough is deleted). The end date will be reflected on a subsequent MOC.

\$

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

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

Notes:

- i) Payable only to the physician who has previously billed and been paid the Mental Health Planning fee (PG14043) in the same calendar year, unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note.
- ii) Payable a maximum of 4 times per calendar year per patient.
- iii) Not payable unless the four age-appropriate 00120 or telehealth counselling (~~13018, 13038~~) fees have already been paid in the same calendar year in any combination.
- iv) Minimum time required is 20 minutes.
- v) Start and end times must be included with the claim and documented in the patient chart.
- vi) Counselling may be provided face to face or by videoconferencing.
- vii) PG14077, payable on same day for same patient if all criteria met.
- viii) PG14043, PG14076, PG14078 not payable on same day for same patient.
- ix) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.
- x) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Section of General Practice amendment effective June 1, 2020 on a temporary basis

Amendment:

Note iii of the indicated fee items has been amended to the following on a temporary basis (strikethrough deleted and bold added). The effective date of the temporary amendment will be June 1, 2020 with the end date to be reflected on a subsequent MOC.

\$

Chronic Disease Management Incentives-Fee For Service

PG14050	Incentive for MRP Family Physicians - - annual chronic care incentive (diabetes mellitus)	125.00
PG14051	Incentive for MRP Family Physicians - annual chronic care incentive (heart failure)	125.00
PG14052	Incentive for MRP Family Physicians - annual chronic care incentive (hypertension).....	50.00

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

- iii) *This item may only be billed after one year of care has been provided including at least two visits. : **Both of the two required visits may be a physician visit.** Office, prenatal, home, long term care or **physician telehealth** visits qualify. **Alternatively, ☉ one of the two required visits must be a physician visit, while the second visit may be:***
 1. a telephone visit (PG14076) or
 2. a group medical visit (13763-13781) or
 3. a telehealth visit (13017, 13018, 13037, 13038) or
 4. an in-person visit with a College-certified allied care provider working within the family physician’s practice team (PG14029).
(See Preamble definition of “working within” and “College-certified ACP”).

Chronic Disease Management Incentives – MRP Family Physicians under Alternate Payment/Funding Model Programs

PG14250	Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus)	125.00
PG14251	Incentive for MRP Family Physician (who bill encounter record visits) - annual chronic care incentive (heart failure)	125.00
PG14252	Incentive for MRP Family Physician (who bill encounter record visits) - annual chronic care incentive (hypertension).....	50.00
PG14253	Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD)	125.00

Notes:

- iii) *This item may only be billed after one year of care **has been provided** including at least two visits. : **Both of the two required visits may be a physician visit.** Office, prenatal, home, long term care **or physician telehealth** visits qualify. **Alternatively, ☉ one of the two required visits must be a physician visit, while the second visit may be:***
 1. a ~~GPSC~~ telephone visit (PG14276); or
 2. a group medical visit (**13763-13781**), or
 3. a telehealth visit or
 4. an in-person visit with a College-certified allied care provider working within the family physician’s practice team. (PG14029).
(See Preamble definition of “working within” and “College-certified ACP”).

General Preamble C. 27. (Business Cost Premium) amendment effective August 1, 2020 on a temporary basis

Amendment:

Fee item 32377 (General Internal Medicine, Telehealth Subsequent office visit) is temporarily added to General Preamble C. 27. Business Cost Premium (BCP), List of BCP eligible fee items. The end date will be reflected on a subsequent MOC.

Section of General Practice amendment effective July 23, 2020 on a temporary basis

Amendment:

Notes ii and iii of the indicated fee item have been amended on a temporary basis, effective July 23, 2020 (bold is added). The end date will be reflected on a subsequent MOC.

P00039	Management of Maintenance Opioid Agonist Treatment (OAT) for Opioid Use Disorder.....	23.60	\$
	Management of ongoing maintenance Opioid Agonist Treatment for Opioid Use Disorder		

Notes:

- i) *The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.*
- ii) *00039 is **not** the only fee payable for any medically necessary service associated with maintenance opioid agonist treatment for opioid use disorder. This includes but is not limited to the following:*
 - a) *At least one visit (in-person, telephone or video conference) per month with the patient after induction/stabilization on opioid agonist treatment is complete.*
 - b) *At least one in-person visit with the patient every 90 days. Exceptions to this criterion will be considered on an individual basis.*
 - c) *Supervised urine drug screening and interpretation of results.*
 - d) *Simple advice/communication with other allied care providers involved in the patients OAT.*
- iii) *Claims for treatment of co-morbid medical conditions, including psychiatric diagnoses other than substance use disorder, are billable using the applicable visit of service fees. Counselling and visit fees related only to substance use disorder are not payable in addition **with the exception of visits required to support Substance Use Risk Mitigation in the context of COVID-19 (claim note record must indicate “COVID-19 risk mitigation”)**.*
- iv) *This fee is payable once per week per patient regardless of the number of services per week for management of OAT maintenance.*
- v) *This fee is not payable with out of office hours premiums.*
- vi) *Eligibility to submit claims for this fee item is limited to physicians who are actively supervising the patient’s continuing use of opioid agonist medications for treatment of opioid use disorder.*
- vii) *This payment stops when the patient stops opioid agonist treatment.*