



MINISTRY OF HEALTH

SUMMARY OF CHANGES MEDICAL SERVICES COMMISSION PAYMENT SCHEDULE

February 1, 2026 – May 31, 2026

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INTRODUCTION

The purpose of this document is to summarize changes to the Medical Services Commission (MSC) Payment Schedule that occurred between November 1, 2025, and January 31, 2026 (additions in **bold**, deletions ~~struck through~~).

For full understanding and interpretation of fees listed in this document, and how to bill for them, refer to the complete [MSC Payment Schedule](#).

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FAMILY MEDICINE

Amendment effective February 4, 2026:

Note: Daily Volume Payment Rules Applying to Designated Office Codes

(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.

WorkSafeBC and ICBC Services

In cases where a visit or procedure was occasioned by more than one condition, the dominant purpose must be related to an MVA or WorkSafeBC issue to code it as such. If medically necessary, an assessment of an unrelated condition can also be billed to MSP by Family Physicians.

Amendments effective March 1, 2026:

3. ~~Chronic Disease Management Incentives Fee For Service (G14050, G14051, G14052, G14053, G14029)~~

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

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

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

~~G14050, G14051, G14052, G14053 are payable to MRP-FPs who have submitted G14070 or G14071, or FP's who have submitted G14072.~~

3. Chronic Disease Management Fees (G14050, G14051, G14052, G14053, G14029)

Chronic Disease Management (CDM) fees compensate for the work of providing guideline-informed care to a patient with an eligible condition, including consideration of the patient's goals, values and comorbidities. Patients in long-term care facilities are eligible when active chronic disease management is clinically appropriate.

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To confirm an ongoing doctor-patient relationship, there must be at least 2 visits billed over the previous 12 months.

- Visits provided by a locum or colleague covering for the MRP FP may be counted toward these 2 visits. A claim note record indicating the locum or colleague coverage must be submitted with the claim.

When a new family physician (FP) takes over patient care from another FP, CDM fees can be billed on the anniversary of the previous billing if both FPs provided guideline-informed care.

- If one or more of the required visits were done by the previous FP, the new FP should include a claim note record when submitting the CDM fee.
- The claim note record should indicate that they've assumed responsibility for the patient's care, and the previous FP's name.

Care provision must be documented in the patient's chart, including support provided to help build the patient's skills and confidence to manage their chronic condition.

CDM fees G14050, G14051, G14052, G14053, and G14029 are payable to MRP Family Physicians billing under Fee-For-Service who have submitted G14070, G14071, or G14072.

G14050 ~~Incentive for MRP Family Physicians—annual chronic care incentive~~
Annual chronic disease management fee (diabetes mellitus)

Notes:

- Payable only to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.*
- Payable to Family Physicians who have successfully submitted G14072.*
- Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.*
- This item may only be billed after one year of care has been provided including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.*
 - Only one of the qualifying visits may be a group medical visit.*
 - At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (See FPSC Preamble definition of "working within" and "College-certified ACP").*
- Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.*
- Claim must include the ICD-9 code for diabetes (250).*
- Payable once per patient in a consecutive 12 month period.*
- Payable in addition to items G14051 or G14053 for the same patient if eligible.*
- Not payable once G14063 has been billed and paid.*
- If a visit is provided on the same date the incentive is billed, both services will be paid at the full fee.*

G14051 ~~Incentive for MRP Family Physicians—annual chronic care incentive~~
Annual chronic disease management fee (heart failure)

Notes:

- Payable only to Family Physicians who have successfully submitted P14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.*
- Payable to Family Physicians who have successfully submitted G14072.*

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- iii) *Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.*
- iv) *This item may only be billed after one year of care has been provided including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.*
 - 1. *Only one of the qualifying visits may be a group medical visit.*
 - 2. *At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (See FPSC Preamble definition of "working within" and "College-certified ACP").*
- v) *Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.*
- vi) *Claim must include the ICD-9 code for congestive heart failure (428).*
- vii) *Payable once per patient in a consecutive 12 month period.*
- viii) *Payable in addition to items G14050 or G14053 for the same patient if eligible.*
- ix) *Not payable once G14063 has been billed and paid.*
- x) *If a visit is provided on the same date the incentive is billed, both services will be paid at the full fee.*

G14052 ~~Incentive for MRP Family Physicians – annual chronic care incentive~~
Annual chronic disease management fee (hypertension)

Notes:

- i) *Payable only to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.*
- ii) *Payable to Family Physicians who have successfully submitted G14072.*
- iii) *Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.*
- iv) *This item may only be billed after one year of care has been provided including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.*
 - 1. *Only one of the qualifying visits may be a group medical visit.*
 - 2. *At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team (See FPSC Preamble definition of "working within" and "College-certified ACP").*
- v) *Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.*
- vi) *Claim must include the ICD-9 code for hypertension (401).*
- vii) *Payable once per patient in a consecutive 12 month period.*
- viii) *Not payable if G14050 or G14051 paid within the previous 12 months.*
- ix) *Not payable once G14063 has been billed and paid.*
- x) *If a visit is provided on the same date the incentive is billed, both services will be paid at the full fee.*

G14053 ~~Incentive for MRP Family Physicians – annual chronic care incentive~~
Annual chronic disease management fee (Chronic Obstructive Pulmonary Disease-COPD)

Notes:

- i) *Payable only to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.*
- ii) *Payable to Family Physicians who have successfully submitted G14072.*

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- iii) *Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.*
- iv) *This item may only be billed after one year of care has been provided including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.*
 - 1. *Only one of the qualifying visits may be a group medical visit.*
 - 2. *At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician's practice team. (See FPSC Preamble definition of "working within" and "College-certified ACP").*
- v) *Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.*
- vi) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*
- vii) *Payable once per patient in a consecutive 12 month period.*
- viii) *Payable in addition to fee items G14050, G14051 or G14052 for the same patient if eligible.*
- ix) *Not payable once G14063 has been billed and paid.*
- x) *If a visit is provided on the same date the incentive is billed, both services will be paid at the full fee.*

Allied Care Provider Code (~~G14029~~)

~~To support team based care, College-certified Allied Care Providers (ACPs) may provide one of the two visits required for billing FPSC chronic disease management incentives. Visits provided by the College-certified ACP can be in person (G14029) or by telephone (G14076).~~

G14029 Allied Care Provider Practice Code

Notes:

- i) ~~Applicable *only* for medical services (office, **prenatal**, home or **LTC long-term care**) provided by a College-certified allied care provider working within the family physician's practice team where the family physician has accepted responsibility for the provision of the care. (See **FPSC** Preamble definition of "working within" and "College-certified ACP").~~
- ii) ~~Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of G14077 or H14067.~~
- iii) ~~Billable on patients receiving guideline-informed care who will be eligible for one of the chronic disease management incentives (CDM).~~
- ii) **A College-certified allied care provider may provide one of the two visits required for billing chronic disease management fees.**
- iii) **Visits may be provided in-person or by telehealth (G14029, G14076).**
- iv) **Payable for care provided to a patient with a condition eligible for one of the chronic disease management fees.**
- v) **Not payable in addition to a visit fee on the same day to the same physician for the same patient, except for H14067 or G14077.**
- vi) *Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.*

4. Chronic Disease Management Incentives — MRP Family Physicians under Alternate Payment/Funding Model Programs (PG14250, PG14251, PG14252, PG14253, PG14276) Chronic Disease Management fees for MRP Family Physicians billing under Alternate Payment/Funding Model Programs (G14250, G14251, G14252, G14253, G14276)

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

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

G14250, G14251, G14252, and G14253 are payable to FPs billing under sessional, salary, service or independent contractor contracts when the required two visits are billed as an encounter record. Post-adjudication monitoring will be performed within 2 years. If encounter records were not submitted for the required two visits, funds will be recovered.

G14250 ~~Incentive for MRP Family Physicians (who bill encounter record visits)~~
~~annual chronic care incentive (diabetes mellitus)~~

Annual chronic disease management fee (diabetes mellitus) for MRP FPs on alternate payment/funding models

Notes:

- i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.
- ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.
- iii) This item may only be billed after one year of care including at least two visits (**in-person or telehealth**). Office, prenatal, home, long-term care, **group medical, or telehealth** visits qualify.
 1. **Only one of the qualifying visits may be a group medical visit.**
 2. **At least one of the two required visits must be a physician visit, while the other visit may be:**
 1. ~~an FPSC telephone visit (G14276) or~~
 2. ~~a group medical visit, or~~
 3. ~~a telehealth visit or~~
 4. **a physician visit or a in-person visit with a College-certified allied care provider working within the family physician's **Family Physician's** practice team (G14029). (See FPSC Preamble definition of "working within" and "College-certified ACP").**
- iv) Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.
- v) Not payable to physicians remunerated under the LFP Payment Model.
- vi) Claim must include the ICD-9 code for diabetes (250).
- vii) Payable once per patient in a consecutive 12 month period.
- viii) Payable in addition to fee items G14251 or G14253 for same patient if eligible.
- ix) Not payable once G14063 has been billed and paid.
- x) If a visit is provided on the same date the incentive is billed, both services will be paid at the full fee.

G14251 ~~Incentive for MRP Family Physician (who bill encounter record visits)~~
~~annual chronic care incentive (heart failure)~~

Annual chronic disease management fee (heart failure) for MRP FPs on alternate payment/funding models

Notes:

- i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.
- ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.

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- iii) *This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.*
 - 1. **Only one of the qualifying visits may be a group medical visit.**
 - 2. **At least one of the two required visits must be a physician visit, while the other visit may be:**
 - 1. ~~an FPSC telephone visit (G14276) or~~
 - 2. ~~a group medical visit, or~~
 - 3. ~~a telehealth visit or~~
 - 4. **a physician visit or a an in-person visit with a College-certified allied care provider working within the family physician's Family Physician's practice team (G14029).** (See **FPSC Preamble** definition of "working within" and "College-certified ACP").
- iv) *Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.*
- v) *Not payable to physicians remunerated under the LFP Payment Model.*
- vi) *Claim must include the ICD-9 code for heart failure (428).*
- vii) *Payable once per patient in a consecutive 12 month period.*
- viii) *Payable in addition to fee items G14250 or G14253 for same patient if eligible.*
- ix) *Not payable once G14063 has been billed and paid.*
- x) *If a visit is provided on the same date the incentive is billed, both services will be paid at the full fee.*

G14252 ~~Incentive for MRP Family Physician (who bill encounter record visits) annual chronic care incentive (hypertension)~~

Annual chronic disease management fee (hypertension) for MRP FPs on alternate payment/funding models

Notes:

- i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.*
- ii) *Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.*
- iii) *This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.*
 - 1. **Only one of the qualifying visits may be a group medical visit.**
 - 2. **At least one of the two required visits must be a physician visit, while the other visit may be:**
 - 1. ~~an FPSC telephone visit (G14276) or~~
 - 2. ~~a group medical visit, or~~
 - 3. ~~a telehealth visit or~~
 - 4. **a physician visit or a an in-person visit with a College-certified allied care provider working within the family physician's Family Physician's practice team (G14029).** (See **FPSC Preamble** definition of "working within" and "College-certified ACP").
- iv) *Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.*
- v) *Not payable to physicians remunerated under the LFP Payment Model.*
- vi) *Claim must include the ICD-9 code for hypertension (401).*
- vii) *Payable once per patient in a consecutive 12 month period.*
- viii) *Not payable if G14250 or G14251 paid within the previous 12 months.*
- ix) *Not payable once G14063 has been billed and paid.*
- x) *If a visit is provided on the same date the bonus is billed, both services will be paid at the full fee.*

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G14253 ~~Incentive for MRP Family Physicians (who bill encounter record visits) annual chronic care incentive (Chronic Obstructive Pulmonary Disease - COPD)~~

Annual chronic disease management fee (Chronic Obstructive Pulmonary Disease - COPD) for MRP FPs on alternate payment/funding models

Notes:

- i) *Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care.*
- ii) *Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.*
- iii) *This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.*
 1. **Only one of the qualifying visits may be a group medical visit.**
 2. **At least one of the two required visits must be a physician visit, while the other visit may be:**
 1. ~~an FPSC telephone visit (G14276) or~~
 2. ~~a group medical visit, or~~
 3. ~~a telehealth visit or~~
 4. **a physician visit or a an in-person visit with a College-certified allied care provider working within the family physician's Family Physician's practice team (G14029). (See FPSC Preamble definition of "working within" and "College-certified ACP").**
- iv) *Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the FPSC Preamble.*
- v) *Not payable to physicians remunerated under the LFP Payment Model.*
- vi) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*
- vii) *Payable once per patient in a consecutive 12 month period.*
- viii) *Payable in addition to fee items G14250, G14251 or G14252 for the same patient if eligible.*
- ix) *Not payable once G14063 has been billed and paid.*
- x) *If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.*

Community Based FP Hospital Visits

The following eligibility rules apply to all community based FP hospital visit fees.

Physician Eligibility:

- Payable only to FPs who maintain an active family practice in the community, accepting the role of being Most Responsible Physician (MRP) for the longitudinal coordinated care of their patients.
- Not payable to physicians who have been paid for ~~any specialty~~ **a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).**
- Not payable to physicians who are employed by, or who are under contract, whose duties would otherwise include provision of this care.
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

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Family Practice Services Committee (FPSC) Initiated Listings

Preamble

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

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

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

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

- They are working under an Alternate Payment/Funding model as defined below and their duties would otherwise include provision of this care; and
- They have billed any specialty **been paid for a Specialist** consultation fee in the previous 12 months, **with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).**

Additional detailed eligibility requirements are identified in each section.

1. Community Longitudinal Family Physician Portals (G14070, G14071)

Submitting code G14070 provides access to the following fee codes:

- G14075 FP Frailty Complex Care Planning and Management Fee
- G14076 FP Patient Telephone Management Fee
- G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
- H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
- G14078 FP Email/Text/Telephone Medical Advice Relay Fee

~~In addition to the fees below:~~

- G14050, G14051, G14052, G14053 Chronic Disease Management Fees (~~Behind portal as of April 1, 2020~~)
- G14033 Complex Care Planning & Management Fee – 2 Diagnoses (~~Behind portal as of April 1, 2020~~)
- **G14075 Complex Care Planning and Management Fee - Frailty**
- G14043 Mental Health Planning fee (~~Behind portal as of April 1, 2020~~)
- G14044, G14045, G14046, G14047 and G14048 Mental Health Management Fees (~~Behind portal as of April 1, 2020~~)
- G14063 Palliative Care Planning (~~Behind portal as of April 1, 2020~~)
- G14066 Prevention/Personal Health Risk Assessment (~~Behind portal as of April 1, 2020~~)
- H14041 CLFP New Patient Intake Fee (~~Behind portal as of April 1, 2020~~)
- **H14002 Maternity Care Risk Assessment**
- **G14004, G14005, G14008 and G14009 FP Obstetrical Premiums**

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Submitting G14070 signifies that:

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

Family Physician-Patient 'Compact'

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

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

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

As my patient I ask that you:

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

G14070 Community Longitudinal Family Physician Portal Code
The Community Longitudinal Family Physician Portal should be submitted once at the beginning of each calendar year by CLFP who maintain a comprehensive longitudinal practice OR at any time during the year when the CLFP begins their comprehensive longitudinal practice. Successful submission of G14070 allows access to fees listed in the notes below during the calendar year.

Submit fee item G14070 Community Longitudinal Family Physician Portal Code using the following "Patient" demographic information:

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

Notes:

- Submit once per calendar year per physician.*
- Submission provides access to the following fee codes:*
 - ~~• G14075 FP Frailty Complex Care Planning and Management Fee~~
 - G14076 FP Patient Telephone Management Fee
 - G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof
 - H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician

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- G14078 FP Email/Text/Telephone Medical Advice Relay Fee
 - G14050, G14051, G14052, G14053 Chronic Disease Management ~~Incentive~~ Fees
 - G14033 Complex Care Planning & Management Fee – 2 Diagnoses
 - **G14075 Complex Care Planning and Management Fee - Frailty**
 - G14043 Mental Health Planning fee
 - G14044, G14045, G14046, G14047 and G14048 Mental Health Management Fees
 - G14063 Palliative Care Planning Fee
 - G14066 Personal Health Risk Assessment (Prevention) Fee
 - H14041 CLFP New Patient Intake Fee
 - **H14002 Maternity Risk Assessment Fee**
 - **G14004, G14005, G14008 and G14009 FP Obstetrical Premiums**
- iii) Not payable to ~~any a~~ physician who has billed and been paid for ~~any specialist a~~ **Specialist** consultation fee in the previous 12 months, **with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).**
- iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

G14071 Locum Community Longitudinal Family Physician Portal Code
The Locum Community Longitudinal Family Physician Portal Code may be submitted by the FP who provides locum coverage for Family Physicians who have submitted G14070. G14071 should be submitted once at the beginning of the calendar year or prior to the start of the first locum for a host FP who has submitted G14070 in the same calendar year. Once processed by MSP, the locum may access the fees listed in note ii) below.

Submit fee item G14071 Locum Community Longitudinal Family Physician Portal Code using the following "Patient" demographic information:

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

Submission of this code signifies that:

- You are providing continuous comprehensive coordinated family practice services to the patients of the host physician who has submitted G14070 and will continue to do so for the duration of locum coverage.

Notes:

- i) *Submit once per calendar year at the beginning of the year or prior to the first locum for a family physician who has submitted G14070 in the same calendar year.*
- ii) *Submission provides access to the following fee codes:*
- ~~G14075 FP Frailty Complex Care Planning and Management Fee~~
 - G14076 FP Patient Telephone Management Fee
 - G14077 FP Conference with Allied Care Provider and/or physician - per 15 minutes or greater portion thereof

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- H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
 - G14078 FP Email/Text/Telephone Medical Advice Relay Fee
 - G14050, G14051, G14052, G14053 Chronic Disease Management Incentive Fees
 - G14033, G14075 Complex Care Planning & Management Fees
 - G14043, G14044, G14045, G14046, G14074, G14048 Mental Health Planning and Management Fees
 - G14063 Palliative Care Planning Fee; and
 - G14066 Personal Health Risk Assessment (Prevention)
- iii) Not payable to ~~any~~ a physician who has ~~billed and~~ been paid for ~~any specialist~~ a **Specialist** consultation fee in the previous 12 months, **with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).**
- iv) Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

2. Long-Term Care Portal

G14072 Long-Term Care Portal Code

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

When a family physician first begins a long-term care focused practice, the Long-Term Care Portal Code should be submitted when the focused practice begins. Successful submission of G14072 allows access to fees listed in the notes below during the calendar year.

Submit fee item G14072 Long-Term Care Portal Code using the following "Patient" demographic information:

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

Notes:

- i) *Submit once per calendar year per physician.*
- ii) *Submission provides access to the following fee codes:*
 - G14076 FP Patient Telephone Management Fee
 - G14077 FP Conference with Allied Care Provider and/or physician – per 15 minutes or greater portion thereof
 - H14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician
 - G14078 FP Email/Text/Telephone Medical Advice Relay Fee
 - G14050, G14051, G14052, G14053 Chronic Disease Management Fees

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- iii) *Not payable to ~~any~~ a physician who has ~~billed and~~ been paid for ~~any specialist~~ a **Specialist** consultation fee in the previous 12 months, **with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).***
- iv) *Not billable by physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

11. Conferencing and Advice Fees (G14077, H14067, G14018, G14019)

G14018 FP Urgent Telephone Advice from a Specialist or FP with Consultative Expertise

14018 is payment for telephone advice that is needed on an urgent basis (within 2 hours of request) from a Specialist or Family Physician with Consultative Expertise (as defined in the Preamble). Includes the creation, documentation, and implementation of a plan for the care of patients with acute needs (i.e. requiring attention within the next 24 hours) and communication of that plan to the patient or patient's representative.

Notes:

- i) *Payable to the FP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or family physician with consultative expertise (as defined in the FPSC Preamble) regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.*
- ii) *Conversation must take place within two hours of the FP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, email).*
- iii) *Fee Includes:*
 - a. *Discussion with the specialist of pertinent family/patient history, history of presenting complaint, and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.*
 - b. *Developing, documenting and implementing a plan to manage the patient safely in their care setting.*
 - c. *Communication of the plan to the patient or the patient's representative.*
 - d. *The plan must be recorded in patient chart and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*
- iv) *Include start time in time fields when submitting claim.*
- v) *Payable for only one service per patient per physician per day.*
- vi) *Payable for a maximum of 6 services per patient per physician per calendar year.*
- vii) *Payable in addition to a visit on the same date.*
- viii) *Not payable for situations where the primary purpose of the call is to:*
 - a. *Book an appointment*
 - b. *Arrange for transfer of care that occurs within 24 hours*
 - c. *Arrange for an expedited consultation or procedure within 24 hours*
 - d. *Arrange for laboratory or diagnostic investigations*
 - e. *Convey the results of diagnostic investigations*
 - f. *Arrange a hospital bed for the patient*
 - g. *Obtain non-urgent advice for patient management (i.e. advice that is not required within the next 2 hours).*
- ix) *Not payable in addition to 14067 or 14077 on the same day to the same physician for the same patient.*
- x) *Out-of-Office Hours Premiums are not payable in addition.*

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- x) ~~Not payable if the~~ **to a physician who has billed any specialty been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).**
- xii) ~~Not payable for a patient admitted under a Hospital at Home program.~~
- xiii) ~~Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.~~

13. Family Physician Obstetrical Premiums (G14004, G14005, G14008, G14009) and Maternity Care Risk Assessment (H14002)

The following fees are payable to B.C.'s eligible family physicians. The purpose of the payment is to encourage family physicians to continue to provide obstetrical care, giving women the benefit of choice and longitudinal care. ~~Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.~~ **These fees are not payable to physicians who have been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).**

Deletion of Fee Item effective February 28, 2026:

- 13075 Assessment of an unrelated condition(s) in association with an ICBC
service 20.06
- Notes:**
- i) *Paid only when services are provided for an unrelated illness occurring in conjunction with an ICBC insured service.*
 - ii) *Unrelated service must be initiated by patient.*
 - iii) *The unrelated condition(s) must justify a stand-alone visit.*
 - iv) *Only paid once per patient per day, per insurer, and includes all other unrelated problems.*
 - v) *Not paid if a procedure for the same or related condition is paid for same patient on same day, same practitioner.*
- i) *The visit for each payer must be fully and adequately documented in chart.*
 - ii) *Paid only to Family Physicians.*
 - iii) *May be provided in-person or by telehealth.*

GASTROENTEROLOGY

New Fee Items effective April 1, 2026:

Transient Elastography (TE)		
T33395	- professional fee	25.00
T33396	- technical fee	25.00

- Notes:**
- i) *Payable only to physicians with completion of additional recognized training in Transient Elastography interpretation and performance.*
 - ii) *Requires an elevated pre-test probability of hepatic fibrosis, based on identifiable risk factors or clinical indicators.*
 - iii) *Interpretation of clinical findings and their application to the patient's care plan must be clearly documented in the patient's chart.*
 - iv) *Payable once per patient in a consecutive 12-month period. Additional claims within this period will be given independent consideration when submitted with an explanatory note record.*

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GENERAL PREAMBLE

Amendment effective February 4, 2026:

C. 16. Payment for Specialist Consultations/Visits and specialty-restricted items

To be paid by MSP, ICBC or WorkSafeBC for specialist consultations, visit items and/or other specialty-restricted fee items listed in the specialty sections of the Payment Schedule, one must be a Certificant or a Fellow of the Royal College of Physicians and Surgeons of Canada and/or be so recognized by the College of Physicians and Surgeons of British Columbia in that particular specialty.

A specialist recognized in more than one specialty by the College of Physicians and Surgeons of British Columbia should bill consultation and referred items under the specialty most appropriate for the condition being diagnosed and/or treated for that referral/treatment period.

C. 17. Motor Vehicle Accident (MVA) Billing Guidelines

- ~~1. All cases directly relating to an MVA which ICBC Insurance coverage applies should be identified as such by a "yes" code in the Teleplan MVA field.~~
- ~~2. All such cases should be coded "MVA" regardless of whether seen in an office visit, emergency, diagnostic, lab or x-ray facility. Surgery or procedures performed in regard to these cases should also be identified.~~
- ~~3. Where possible, please attach an ICBC claim number to each coded MVA in your Teleplan billing.~~
- ~~4. In cases where a visit or procedure was occasioned by more than one condition, the dominant purpose must be related to an MVA to code it as such.~~
- ~~5. If the patient is from another province, use the normal out-of-province billing process.~~
- ~~6. In those instances in which the patient has no MSP coverage, the medical practitioner should bill the patient or ICBC directly. Medical practitioners have the choice of either billing the uninsured patient directly at the Doctors of BC recommended rate and having the patient recover the costs from ICBC (see Doctors of BC Fee Guide), or billing ICBC for the MSP amount.~~
- ~~7. If the MVA is work-related, WorkSafeBC (WSBC) should be billed under their procedures.~~
- ~~8. Medical Practitioners are accountable for proper MVA identification and are subject to audit.~~
- 1. Services related to motor vehicle accidents (e.g. visits, procedures, counselling, consultations) are no longer the responsibility of Insurance Corporation of BC (ICBC).**
- 2. ICBC-related physician reports remain billable to ICBC via report or invoice using the applicable ICBC fee codes (see Doctors of BC ICBC Fee Guide).**
- 3. ICBC claim numbers and a "yes" code in the Teleplan MVA field are not required.**
- 4. If the patient is from another province, use the normal out-of-province billing process as noted in C. 11. Reciprocal Claims.**
- 5. When the patient has no MSP coverage, the medical practitioner should bill the patient directly.**
- 6. If the MVA is work-related, WorkSafeBC (WSBC) should be billed under their procedures.**

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GENERAL SURGERY

Amendment effective March 1, 2026:

- V07074 Tenotomy - resection
Notes:
i) **Payable only when performed in an Operating Room (Service Location Code G, I, or P).**
ii) **Not payable for percutaneous procedures.**
iii) *For operative section of transverse carpal ligament - bill under 06258*

Amendment effective March 5, 2026:

Mastectomy:

For malignant breast disease or invasive melanoma the following procedures when performed by the same surgeon will be paid at 100% for the greater procedure, lesser procedures will be paid at 100% for the second, 75% for the third, and 50% for the remaining.

(NOTE: This does not apply to procedures that are inclusive of others (e.g., oncoplastic breast-conserving procedures – see notes under 07481, 07482, 07483).

Mastectomy: 07472, 07473, 07498, 07481, 07482, 07483

Axillary dissection: 07474, 07475

Sentinel lymph node biopsy: 07479

Tumours or scars: 70116, 70125, 70126

NEUROLOGY

Amendment effective April 1, 2025:

Note ii under 00452 will be amended as follows (additions in **bold**):

P00452 Neurology in-hospital consultation – extra25.00

Notes:

- i) *Not for patients seen within the last 6 months by the same physician for the same or related condition.*
- ii) *Payable in addition to 00410, 00441, **00485** and 40441.*
- iii) *Not payable for hospital outpatients, or for patients located in transient ischemic attack (TIA) or rapid access neurology clinics.*
- iv) *Daily maximum of 5 claims per day per Neurologist.*

OBSTETRICS AND GYNECOLOGY

Amendment effective February 1, 2026:

04605 Vault prolapse—abdominal approach **Abdominal sacrocolpopexy – open**
(includes oophorectomy when applicable)

Laparoscopic Operations

Note: The following fee items for individual laparoscopic procedures are billable in addition to fee item 04001.

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04001	Laparoscopy (operation only)	306.88	
	Note: Not paid with 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048.		
P04662	Laparoscopic removal of intrapertoneal foreign body (operation only) 162.42	422.37	
P04664	Laparoscopic management of Ectopic pregnancy, removal via scope	363.29	603.15
P04034	Laparoscopic salpingolysis via laparoscope : - unilateral (operation only).....	126.17	389.75
P04035	- bilateral (operation only) 225.00	225.00	505.77
P04036	Laparoscopic salpingostomy via laparoscope - unilateral (operation only) 252.50	252.50	503.44
P04037	Laparoscopic salpingostomy via laparoscope - bilateral	470.65	699.78
P04040	Laparoscopic cautery of endometriosis (operation only) 90.83	90.83	357.94
P04041	Laparoscopic oophorectomy and/or salpingectomy, including for sterilization – unilateral (operation only) 194.82	194.82	451.53
P04042	Laparoscopic oophorectomy and/or salpingectomy, including for sterilization – bilateral	385.63	623.26
P04043	Laparoscopic ovarian cystectomy – unilateral	309.35	554.61
P04044	Laparoscopic ovarian cystectomy – bilateral	576.59	795.12
P04045	Laparoscopic ventral suspension of uterus (operation only) 160.45	160.45	420.60
P04047	Laparoscopic excision of extensive peritoneal endometriosis including pelvic sidewall dissection and unilateral ureterolysis	450.97	682.07
P04048	Laparoscopic removal of complicated pelvic disease	618.41	832.76
	Notes:		
	<i>i) Fee items 04047 and 04048 are composite fees.</i>		
	<i>ii) When performed together, the fee items for laparoscopic procedures are billable at 100%, except for composite fees, and subject to iii) and iv) below.</i>		
	<i>iii) When more than one laparoscopic procedure is performed, fee item 04001 is payable once only at 100%.</i>		
	<i>iv) Maximum billable for multiple laparoscopic operations (listed above) is up to the rate payable for 04229.</i>		

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DIAGNOSTIC AND SELECTED THERAPEUTIC PROCEDURES

(g) Gynecological

S00815 Laparoscopically directed biopsies and/or lysis of adhesions – extra.....66.09

Note: Not paid with 04662, 04664, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048.

P04720 Body Mass Index Surgical Surcharge payable at 25% of listed fee for surgery or procedure performed for patients with a BMI of 35 or greater.

Notes:

- i) Payable only to Obstetricians and Gynecologists.
- ii) Patient's BMI must be provided in the claim note record and documented in the patient's chart and/or operative report.
- iii) Maximum of one surcharge per operation unless two obstetricians or gynecologists perform two synchronous surgeries that are both eligible for the surcharge.
- iv) When multiple procedures are performed during the same operation, the surcharge applies to all eligible procedures based on the prorated value according to the applicable preamble(s).
- v) The surcharge does not apply to surgical fee modifiers 04715, 04716 or 04719, but may be paid in addition.
- vi) Not payable if 04708 or 04714 is billed with the surgery or procedure.
- vii) Out-of-Office Hours operative surcharges (01210, 01211 and 01212) are not to be paid on the BMI surcharge.
- viii) The surcharge is excluded from the calculation of total operative fee(s) for which surgical assist fees are based.
- ix) Payable when the following Obstetrics and Gynecology fee items are performed for patients with a BMI of 35 or greater:
00770, 00775, 00776, 00787, 00794, 00807, 00808, 00815, 00819, 04000, 04001, 04003, 04011, 04014, 04017, 04018, 04022, 04023, 04024, 04025, 04026, 04029, 04032, 04033, 04034, 04035, 04036, 04037, 04040, 04041, 04042, 04043, 04044, 04045, 04047, 04048, 04049, 04050, 04052, 04080, 04085, 04106, 04110, 04111, 04114, 04116, 04141, 04142, 04201, 04202, 04203, 04204, 04206, 04208, 04212, 04216, 04217, 04218, 04219, 04220, 04221, 04222, 04223, 04224, 04225, 04227, 04228, 04229, 04230, 04232, 04233, 04250, 04300, 04301, 04303, 04304, 04305, 04306, 04307, 04309, 04311, 04312, 04316, 04318, 04320, 04322, 04330, 04331, 04401, 04405, 04406, 04408, 04410, 04411, 04421, 04422, 04424, 04427, 04429, 04500, 04502, 04503, 04508, 04510, 04512, 04515, 04516, 04517, 04530, 04531, 04536, 04551, 04602, 04605, 04616, 04617, 04620, 04621, 04622, 04623, 04624, 04628, 04630, 04631, 04632, 04633, 04640, 04641, ~~04660~~, 04662, 04664, 04680, 04701, 04702, 04703, 04704, 04705, 04706, 04707, 04709, 04728, 04729.

C04709 Laparoscopic total or supracervical hysterectomy, and/or laparoscopic assisted vaginal hysterectomy (LAVH) (includes oophorectomy and/or salpingectomy)

Notes:

- i) Fee items 00815, 04001, 04003, 04041, 04042, 04048, 04202, 04228, 04229, 04232 and 04233 are not paid in addition.
- ii) Fee items 04043, 04044, 04047, ~~04660~~, and 04662 are payable in addition, but the maximum payable under these items shall not exceed the value of fee item 04229.
- iii) Other items listed under laparoscopic operations are not payable in addition to this item.
- iv) In cases where conversion to open surgery is necessary, 04001 paid at 50%, plus open procedure.

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- v) G04708 will apply after 2 hours.
- vi) Restricted to Obstetrics and Gynecology specialists.

Deletion of Fee Item effective February 1, 2026:

Deleted Fee Item:

04660 Tubal interruption (sterilization) (operation only).....306.88

Amendment effective March 1, 2026:

V07771 ~~Picking operation; metastatic neck nodes for thyroid carcinoma~~
Central neck dissection for confirmed and/or potential extrathyroidal metastatic thyroid cancer (with operative report)
Note: Payable for comprehensive removal of all resectable pathologic tissue between trachea and carotid from the innominate artery (inferiorly) to the hyoid bone superiorly with dissection of recurrent laryngeal nerve.

OTOLARYNGOLOGY

Amendment effective January 19, 2026:

- 02354 Complete rhinoplasty with S.M.R. to include nasal hump removal, nasal refracture, and/or reconstruction of nasal tip, without skin grafting **via closed approach.**
- 02355 Complete rhinoplasty with SMR to include nasal hump removal, nasal refracture and/or ~~external~~ reconstruction of nasal tip without skin grafting **via open (or external) approach.**
Note: To include a columellar incision with marginal incisions

Amendment effective February 1, 2026:

- T25316 Comprehensive aeration of a complex frontal sinus-without drilling (unilateral)
Includes comprehensive removal of all septations within the frontal recess – resulting in a maximally expanded frontal sinus outflow tract bounded by the orbit, frontal beak, posterior table of the frontal sinus (including identification of the anterior ethmoid artery) and middle turbinate (or septum, if the middle turbinate is removed).
Notes:
- i) *Either a) or b) must apply:*
 - a. *Frontal sinus with complex frontal recess cellularity as defined by the IFAC classification.*
 - b. *For revision surgery, frontal sinus with complicated frontal recess anatomy (such as scarring following previous frontal sinus surgery).*
 - ii) *Requires direct visualization of the top of the frontal sinus with an angled endoscope.*
 - iii) *Frontal sinus disease must be present to bill this item.*
 - iv) *Not to be billed in uncomplicated anterior ethmoidotomy.*
 - v) *Payable at 100% with one of 02359, 02360, 02361, 02362 or 02363.*
 - vi) *Payable at 150% if done bilaterally.*
 - vii) *Not payable with 25318.*
 - viii) *Not payable with 25315 or 25317 on same side.*
 - ix) *Payable at 50% if repeated on same side within six months.*
 - x) *Payable at 50% if done within six months of 25318.*
 - xi) *Payable at 50% if done within six months of 25315 or 25317 on same side.*

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T25317 Comprehensive aeration of a complex frontal sinus-with drilling (unilateral)
Frontal recess must have chronic inflammation, scarring or narrow anatomy (usually because of a prominent bony frontal beak resulting in a poor AP diameter to the frontal recess) and where the bone/scar tissue in the frontal recess is firm enough to necessitate use of a drill. Includes comprehensive removal of all septations within the frontal recess – resulting in a maximally expanded frontal sinus outflow tract bounded by the orbit, frontal beak, posterior table of the frontal sinus (including identification of the anterior ethmoid artery) and middle turbinate (or septum, if the middle turbinate is removed).

Notes:

- i) *Requires direct visualization of the top of the frontal sinus with an angled endoscope.*
- ii) *Frontal sinus disease must be present to bill this item.*
- iii) *Not to be billed in uncomplicated anterior ethmoidotomy.*
- iv) *Payable at 100% with one of 02359, 02360, 02361, 02362, or 02363.*
- v) *Payable at 150% if done bilaterally.*
- vi) *Not payable with 25318.*
- vii) *Not payable with 25315 or 25316 on same side.*
- viii) *Payable at 50% if repeated on same side within six months.*
- ix) *Payable at 50% if done within six months of 25318.*

T25318 Modified endoscopic Lothrop procedure (Draf III) Requires the drilling of the entire floor of both frontal sinuses, the frontal intersinus septum and an anterior/superior nasal septectomy (unilateral or bilateral)

Notes:

- i) *Restricted to Otolaryngologists.*
- ii) *Requires direct visualization of frontal sinus recess/ostium.*
- iii) *Frontal sinus disease must be present to bill this item.*
- iv) *Not to be billed in uncomplicated anterior ethmoidotomy.*
- v) *Payable at 100% with one of 02359, 02360, 02361, 02362, or 02363.*
- vi) *Includes fee items 25315, 25316 or 25317.*
- vii) *Payable at 50% if repeated within six months.*
- viii) *Payable at 100% within six months of 25315, 25316 or 02531.*

PALLIATIVE MEDICINE

Amendments effective May 1, 2026:

Complete understanding of the following paragraphs is essential to appropriate billing of the palliative medicine fees. Not payable to physicians for services when working under salary, service contract, or sessional arrangement.

Preamble

These listings are applicable for referred services to a palliative medicine physician.

Palliative medicine fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

The palliative medicine fees are comprehensive time-based fees.

- Applicable only for palliative care patients and diagnostic code V66.7 must be submitted on the claim.
- Start and end times are for direct face-to-face time with the patient and include all services provided within those times.

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- **Travel time is not billable in addition.**
- Documentation which occurs outside of the direct face-to-face times is not billable in addition and is compensated through the rate set for the palliative medicine fees.

When a referral from a physician is not available, referrals from a registered nurse for specialist palliative care can be accepted by indicating the practitioner number of the requesting nurse in the “referred by” field when submitting claims. For registered nurses not registered with MSP, use practitioner number 99987. The name of the referring registered nurse should be documented in the note field of the claim and in the patient’s clinical record.

These listings cannot be correctly interpreted without reference to the Preamble

Referred Cases

	\$
P43000	
Consultation: To consist of examination, review of history, laboratory and imaging findings, and written report – per 15 minutes, or greater portion thereof	75.75

Notes:

- i) *Paid to a maximum of 4-6 units.*
- ii) *Start and end times must be included with the claim and documented in the patient chart.*
- iii) *Not billable by or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

P43100	
Consultation in patient’s home: To consist of examination, review of history, laboratory and imaging findings, and written report – first 15 minutes or greater portion thereof	175.75
P43101	
– each additional 15 minutes or greater portion thereof (extra)	75.75

Notes:

- i) *Paid to a maximum of 6 units (43100 and 43101 combined).*
- ii) *Start and end times must be included with the claim and documented in the patient chart.*
- iii) *Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement. See Palliative Medicine preamble.*
- iv) *Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

Continuing care by consultant

P43001	
Subsequent office or home visit – per 15 minutes, or greater portion thereof	50.50

Notes:

- i) *Paid to a maximum of 2 units. **Submit an explanatory note record for additional units claimed beyond the maximum.***
- ii) *Start and end times must be included with the claim and documented in the patient chart.*
- iii) *Not billable by or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

P43002	
Subsequent hospital or facility visit – per 15 minutes, or greater portion thereof	50.50

Notes:

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- i) *Paid to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum.*
- ii) *Start and end times must be included with the claim and documented in the patient chart.*
- iii) *Not billable by or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

Subsequent visit in patient’s home

P43200	– first 15 minutes or greater portion thereof	150.50
P43201	– each additional 15 minutes or greater portion thereof (extra)	50.50

Notes:

- i) *Paid to a maximum of 4 units (43200 and 43201 combined). Submit an explanatory note record for additional units claimed beyond the maximum.*
- ii) *Start and end times must be included with the claim and documented in the patient chart.*
- iii) *Palliative Medicine fee items are payable only for direct, face-to-face patient interactions. Travel time is not eligible for reimbursement. See Palliative Medicine preamble.*
- iv) *Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

Complex End-of-Life Visits

Complex end-of-life visit in hospital or facility (extra)

P43006	– per 15 minutes, or greater portion thereof	75.75
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Notes:

- i) *Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient’s family, notifying other healthcare providers or services.*
- ii) *Payable only in addition to 43002.*
- iii) *Paid once per patient to a maximum of 2 units. Submit an explanatory note record for additional units claimed beyond the maximum.*
- iv) *Start and end times must be included with the claim and documented in the patient chart.*
- v) *Not payable in addition to out-of-office-hours premiums.*
- vi) *Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

Complex end-of-life visit in patient’s home (extra)

P43007	– per 15 minutes, or greater portion thereof	75.75
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Notes:

- i) *Payable for the final clinical encounter with the patient to the physician with primary responsibility for performing end-of-life duties. These may include: completing a death certificate, finalizing discharge documentation, communicating with and supporting the patient’s family, notifying other healthcare providers or services.*
- ii) *Payable only in addition to 43200 and 43201.*
- iii) *Paid once per patient to a maximum of 4 units. Submit an explanatory note record for additional units claimed beyond the maximum.*
- iv) *Start and end times must be included with the claim and documented in the patient chart.*
- v) *Not payable in addition to out-of-office-hours premiums*

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- vi) **Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.**

Telehealth Service:

Telehealth Consultation: To consist of examination, review of history, laboratory and imaging findings, and written report
P43010 – per 15 minutes, or greater portion thereof75.75

Notes:

- i) *Paid to a maximum of 4-6 units.*
- ii) *Start and end times must be included with the claim and documented in the patient chart.*
- iii) *Not billable by or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

Telehealth subsequent visit
P43011 – per 15 minutes, or greater portion thereof50.50

Notes:

- i) *Paid to a maximum of 2 units. **Submit an explanatory note record for additional units claimed beyond the maximum***
- ii) *Start and end times must be included with the claim and documented in the patient chart.*
- iii) *Not billable by or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

Miscellaneous

P43008 **First palliative hospital or facility visit of the day bonus (extra).....100.00**

Notes:

- i) *Paid only if 43002 paid the same day.*
- ii) *Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended.*
- iii) *Not payable same day for same physician as 13338 or 13339.*

P43009 **First palliative home visit of the day bonus (extra).....200.00**

Notes:

- i) *Paid only if 43200 paid the same day.*
- ii) *Limit of one 43008 or 43009 payable for the same physician, same day, regardless of the number of patient homes or facilities attended.*
- iii) *Not payable same day for same physician as 13338 or 13339.*

P43003 **Palliative hospital or facility admission examination**
– per 15 minutes, or greater portion thereof75.75 **80.00**

Notes:

- i) *Paid to a maximum of 4-6 units. **Submit an explanatory note record for additional units claimed beyond the maximum.***
- ii) *Start and end times must be included with the claim and documented in the patient chart. **Start and end times must not be concurrent with another service.***
- iii) ***Not payable with a consultation or visit (43000, 43001, 43002, 43010, 43011, 43100, 43101, 43200 or 43201).***
- iv) *Not billable by or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

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P43004 **Palliative Family Conference (planning for patient)**
 – per 15 minutes or greater portion thereof.....43.99 **75.75**

Notes:

- i) *Restricted to Palliative Medicine.*
- ii) *Paid to a maximum of 4 units per patient, per sitting. **Submit an explanatory note record for additional units claimed beyond the maximum.***
- iii) *Annual maximum of 8-12 units per patient.*
- iv) *Start and end times must be included with the claim and documented in the patient chart. **Start and end times must not be concurrent with another service.***
- v) *One or more family members/representatives must be present.*
- vi) *Service may be provided face-to-face, telephone, or video technology.*
- vii) *The results of the conference, as well as the names and roles of those who participated in the meeting must be documented in the patient's chart, and result communicated to the Family Physician, Specialist and/or appropriate Allied Care Provider involved in the care of the patient.*
- ~~viii) *Claim must state start and end times of this service.*~~
- ix) *Visit paid in addition, if medically required and does not take place concurrently with the conference. ~~Not payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.~~*
- x) *Not ~~billable~~ or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

P43005 **Palliative Interdisciplinary Conference with Allied Care Provider and/or Physician**
 – per 15 minutes or greater portion thereof.....75.75

Notes:

- i) *Restricted to Palliative Medicine.*
- ii) *Paid to a maximum of 2 units per sitting. **Submit an explanatory note record for additional units claimed beyond the maximum.***
- iii) *Start and end times must be included with the claim and documented in the patient chart. **Start and end times must not be concurrent with another service.***
- iv) *Service may be provided face-to-face, telephone, or video technology.*
- v) *Payable for two-way collaborative conferencing with another physician and/or an allied care provider.*
- vi) *Details of care conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, roles(s) in care, and information on clinical discussion and decisions made.*
- vii) *Not ~~billable by~~ or payable to physicians for services when working under salary, service contract, or if clinical service is covered by a sessional arrangement.*

UROLOGY

New Fee Item effective April 1, 2026:

Bladder

PC08355 Tensor fascia lata or abdominal rectus fascia harvest..... ~~818.40~~ **1,072.76 2**
~~Operation for urinary incontinence or urinary tract reconstruction. To include operation for urinary incontinence or urinary tract reconstruction and harvest of tensor fascia lata or abdominal rectus fascia for use as a bladder neck sling.~~

Notes:

- i) *Restricted to Urologists and approved Urogynecologists.*

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- ii) ~~Paid only in addition to fee items~~ **Not payable with fee item 08283, 08255, 08259, 08317, 08268, 04227, 81153, or 81154; the lesser procedure will be paid at 75%.**
- iii) Includes cystoscopy.