GENERAL PRACTICE

These listings cannot be correctly interpreted without reference to the Preamble.

Note: Cosmetic Surgery - Physicians should be familiar with the Guidelines for Cosmetic Surgery in the Preamble prior to referring patients for surgery for alteration of appearance. Where it is clear at the time of referral that the proposed surgery for alteration of appearance would not qualify for coverage under MSP, the consultation also would not be covered.

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

Billing For In-Office and Out-of-Office Visits

The following definitions must be adhered to when preparing MSP billings for consultation, complete examination, office visit and individual counselling services (both in and out-of-office listing).

IN-OFFICE FEE ITEMS: 12110, 00110, 15310, 16110, 17110, 18110, 12100, 00100, 15300, 16100, 17100, 18100, 12101, 00101, 15301, 16101, 17101, 18101, 12120, 00120, 15320,16120, 17120, and 18120 apply to consultation, visit, complete examination and counselling services provided in offices, clinics, outpatient areas of hospitals, diagnostic treatment centers and similar locations.

OUT-OF-OFFICE FEE ITEMS: 12210, 13210, 15210, 16210, 17210, 18210, 12200, 13200, 15200, 16200, 17200, 18200, 12201, 13201, 15201, 16201, 17201, 18201, 12220, 13220, 15220, 16220, 17220, and 18220 apply to consultation, visit, complete examination and counselling services provided in either a patient's home, at the scene of an illness or accident, in a hospital in-patient area, palliative care facility, long term care institution or in a hospital emergency department, unless the circumstance of the service is specifically covered by the definition of either fee item 00103, 00108, 00109, 00127, 00128, 13028, 00111, 00112, 00114, 00115, 00113, 00105, 00123, 13228 or one of the 01800 series.

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 General Practitioners.

		$	Anes. Level

Consultations

GP Consultations apply when a medical practitioner (GP or Specialist), or a health care practitioner (midwife, for obstetrical or neonatal related consultations; nurse practitioner; oral/dental surgeon, for diseases of mastication), in the light of his/her professional knowledge of the patient and because of the complexity, obscurity or seriousness of the case, requests the opinion of a general practitioner competent to give advice in this field. A consultation must not be claimed unless it was specifically requested by the attending practitioner. The service consists of the initial services of GP consultant, including a history and physical examination, review of x-rays and laboratory findings, necessary to enable him/her to prepare and render a written report, including his/her findings, opinions and recommendations, to the referring practitioner. Consultations will not apply if the referred patient has been attended by the consulting general practitioner or another general practitioner in the same group during the preceding six months

12110	Consultation - in office: (age 0-1)	81.38	
00110	Consultation - in office: (age 2 - 49)	73.98	
15310	Consultation – in office (age 50 - 59)	81.38	
16110	Consultation - in office: (age 60 - 69)	85.07	
17110	Consultation - in office: (age 70 - 79)	96.17	
18110	Consultation - in office: (age 80+)	110.97	

00116	Special in-hospital consultation	157.13	

Notes:

i) This item applies to consultations on in-hospital patients of an acute or extended care (or when the patient is in the ER with a complex problem as described below and a decision has been made to admit), who are referred to a general practitioner by a certified specialist for advice about and/or the continuing care of complex problems for which the management is complicated and requires extra consideration. Examples of such problems include (but are not restricted to) the assessment of terminal illness, the planning of activation/rehabilitation programs and the management of patients with AIDS.

ii) This item is not applicable to the transfer of care in uncomplicated cases. It also will not apply if the referred patient has been attended by the consulting general practitioner or another general practitioner in the same group during the preceding six months.

12210	Consultation – out of office (age 0 – 1)	97.66	
13210	Consultation – out of office (age 2 - 49)	88.78	
15210	Consultation – out of office (age 50 - 59)	97.66	
16210	Consultation – out of office (age 60 - 69)	102.10	
17210	Consultation – out of office (age 70 - 79)	115.41	
18210	Consultation – out of office (age 80+)	133.17	

Complete Examinations

For any condition seen requiring a complete physical examination and detailed history (to include tonometry and biomicroscopy when performed).

Notes:

i) A complete physical examination shall include a complete detailed history and detailed physical examination of all parts and systems with special

attention to local examination where clinically indicated, adequate recording of findings and if necessary, discussion with patient. The above should include complaints, history of present and past illness, family history, personal history, functional inquiry, physical examination, differential diagnosis, and provisional diagnosis.

ii) Routine or periodic physical examination (check-up) is not a benefit under MSP. This includes any associated diagnostic or laboratory procedures unless significant pathology is found. Advise laboratory of patient's responsibility for payment.

iii) Complete examination fee codes are not to be charged for in-hospital admission examinations. Fee code 00109 may apply in this circumstance. See Preamble and listing restrictions.

12101	Complete examination - in office (age 0-1)	74.04
00101	Complete examination - in office (age 2-49)	67.31
15301	Complete examination – in office (age 50 – 59)	74.04
16101	Complete examination - in office (age 60-69)	77.41
17101	Complete examination - in office (age 70-79)	87.73
18101	Complete examination - in office (age 80+)	100.97

Note: *Items 12101, 00101, 15301, 16101, 17101 and 18101 are subject to the daily volume payment rules described earlier in this section.*

12201	Complete examination - out of office (age 0-1)	88.85
13201	Complete examination - out of office (age 2-49)	80.78
15201	Complete examination - out of office (age 50-59)	88.85
16201	Complete examination - out of office (age 60-69)	92.89
17201	Complete examination - out of office (age 70-79)	105.28
18201	Complete examination - out of office (age 80+)	121.16

Visits

For any condition(s) requiring partial or regional examination and history - includes both initial and subsequent examination for same or related condition(s).

Note*: Visit fee codes are not to be charged for in-hospital admission examinations. Fee code 00109 may apply in this circumstance. See Preamble and listing restrictions.*

12100	Visit - in office (age 0-1)	33.35
00100	Visit - in office (age 2-49)	30.32
15300	Visit – in office (age 50-59)	33.35
16100	Visit - in office (age 60-69)	34.87
17100	Visit - in office (age 70-79)	39.42
18100	Visit - in office (age 80+)	45.48

Note: *Fee items 12100, 00100,15300, 16100, 17100, and 18100 are subject to the daily volume payment rules described earlier in this section.*

		$	Anes. Level
P13070	In office assessment of an unrelated condition(s) in association with a WorkSafe BC service	15.76	

Notes:

i) Paid only when services are provided for an unrelated illness occurring in conjunction with a WorkSafeBC 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.
vi) The visit for each payer must be fully and adequately documented in chart.
vii) Paid only to General Practitioners.

P13075	In office assessment of an unrelated condition(s) in association with an ICBC service	15.76	

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.
vi) The visit for each payer must be fully and adequately documented in chart.
vii) Paid only to General Practitioners.

12200	Visit - out of office (age 0-1)	40.02	
13200	Visit - out of office (age 2-49)	36.38	
15200	Visit – out of office (age 50-59)	40.02	
16200	Visit - out of office (age 60-69)	41.84	
17200	Visit - out of office (age 70-79)	47.30	
18200	Visit - out of office (age 80+)	54.58	

***Note**: For fee items 12200, 13200, 15200, 16200, 17200 and 18200, see notes following fee item 00108.*

General Practice Group Medical Visit

A Group Medical Visit provides 1:1 patient care in a group setting. Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction. Physicians can also benefit by reducing the need to repeat the same information many times and free up time for other patients. Appropriate patient privacy is always maintained and typically these benefits result in improved satisfaction for both patients and physicians.

The Group Medical Visit is not appropriate for advice relating to a single patient. It applies only when all members of the group are receiving medically required treatment (i.e. each member of the group is a patient). The GP Group Medical Visits are not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns other than in the context of the individual medical condition.

		$	Anes. Level
	Fee per patient, per 1/2 hour or major portion thereof:		
P13763	Three patients	24.80	
P13764	Four patients	20.04	
P13765	Five patients	17.21	
P13766	Six patients	15.32	
P13767	Seven patients	13.97	
P13768	Eight patients	12.96	
P13769	Nine patients	12.16	
P13770	Ten patients	11.52	
P13771	Eleven patients	10.09	
P13772	Twelve patients	9.49	
P13773	Thirteen patients	8.79	
P13774	Fourteen patients	8.63	
P13775	Fifteen patients	8.28	
P13776	Sixteen patients	8.03	
P13777	Seventeen patients	7.70	
P13778	Eighteen patients	7.52	
P13779	Nineteen patients	7.26	
P13780	Twenty patients	7.09	
P13781	Greater than 20 patients (per patient)	6.83	

Notes:

i) A separate claim must be submitted for each patient.

ii) When a patient attends a group visit, it should be noted in his or her chart, along with the start and end times.

iii) A separate file should be maintained which documents all participants in each group visit.

iv) Claim must include start and end times.

v) Not payable to physicians working under salary, service contract or sessional arrangements, and whose duties would otherwise include provision of care.

vi) A minimum of a full thirty (30) minute period and a maximum of ninety (90) minutes may be claimed per patient per day.

vii) Where group medical visits with a patient extend beyond two and one-half (2 ½) hours in any seven (7) day period, a note-record is required.

viii) Service is not payable with other consultation, visit or complete examination services, for the same patient, on the same day.

ix) Where two physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate per patient for the reduced group size. Each claim should indicate "Group medical visit" and also identify the other physician.

Counselling - Individual

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

Notes:

i) MSP will pay for up to four (4) such visits 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.

12120	Individual counselling - in office (age 0-1)	58.03	
00120	Individual counselling - in office (age 2-49)	52.76	
15320	Individual counselling – in office (age 50-59)	58.03	
16120	Individual counselling - in office (age 60-69)	60.67	
17120	Individual counselling - in office (age 70-79)	68.59	
18120	Individual counselling - in office (age 80+)	79.14	

Note: *Items 12120, 00120, 15320, 16120, 17120 and 18120 are subject to the daily volume payment rules described earlier in this section.*

		$	Anes. Level
12220	Individual counselling - out of office (age 0-1)	69.64	
13220	Individual counselling - out of office (age 2-49)	63.31	
15220	Individual counselling – out of office (age 50 – 59)	69.64	
16220	Individual counselling - out of office (age 60-69)	72.80	
17220	Individual counselling - out of office (age 70-79)	82.31	
18220	Individual counselling - out of office (age 80+)	94.97	

Counselling - Group

For groups of two or more patients.

00121	- first full hour	85.77	
00122	- second hour, per 1/2 hour or major portion thereof	42.92	

Telehealth Service with Direct Interactive Video Link with the Patient

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

In-Office

P13036	Telehealth GP in-office Consultation	80.37	
P13037	Telehealth GP in-office Visit	33.56	
P13038	Telehealth GP in-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) ***Note:*** *MSP will pay for up to four (4) such visits per patient per year (see Preamble D. 3. 3.)*	57.42	
	Telehealth GP in-office Group Counselling For groups of two or more patients		
P13041	- First full hour	84.75	
P13042	- Second hour, per ½ hour or major portion thereof	42.41	

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	106.92	
P13017	Telehealth GP out-of-office Visit	40.31	
P13018	Telehealth GP out-of-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes) ***Note:*** *MSP will pay for up to four (4) such visits per patient per year (see Preamble D. 3. 3.)*	73.87	
	Telehealth GP out-of-office Group Counselling For groups of two or more patients		
P13021	- First full hour	85.77	

		$	Anes. Level
P13022	- Second hour, per ½ hour or major portion thereof	42.92	
13020	Telehealth General Practitioner Assistant – Physical Assessment as requested by receiving specialist: - for each 15 minutes or major portion thereof	30.32	

Notes:

i) Applicable only if general practitioner is required at the referring end to assist with essential physical assessment, without which the specialist service would be ineffective.

ii) Applies only to period spent during consultation with specialist.

Miscellaneous Visits

13015	HIV/AIDS Primary Care Management – in or out of office - per half hour or major portion thereof	83.78	

Notes:

i) When performed in conjunction with visit, counselling, consultations or complete examinations, only the larger fee is billable.

ii) Only applicable to services submitted under diagnostic codes 042, 043 and 044.

iii) Services that are less than 15 minutes duration should be billed under the appropriate visit fee item.

Home Visits

00103	Home visit (service rendered between 0800 and 2300 hours – any day) - any day	110.97	

Note: *Additional patients seen during same house call are to be billed under the applicable out of office visit fee items (12200, 13200, 15200, 16200, 17200, 18200)*

GP Facility Visit Fees

Please read the entire facility listings as some visits are restricted to community based GP's with active or associate/courtesy hospital privileges.

00109	Acute care hospital admission visit	80.04	

Notes:

i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a GP with active hospital privileges. It is not applicable when a patient has been admitted for surgery or for "continuing care" by a certified specialist

ii) This item is intended to apply in lieu of fee item 00108, 13008 on the first in-patient day, for that patient.

iii) Fee item 00109 is not applicable if fee item 12101, 00101, 15301, 16101,17101, 18101, 12201, 13201, 15201, 16201, 17201, or 18201 has been billed by the same physician within the week preceding the patient's admission.

iv) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.

v) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

		$	Anes. Level
00108	Hospital visit	31.31	

Notes:

i) Billable by GP's with active hospital privileges for daily attendance on the patients they have most responsibility for.

ii) Essential emergent or non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108. The claim must include the time of each visit and a statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record. This note is not applicable to hospitalists.

00128	Supportive care hospital visit	26.51	

Notes:

i) Referring physician may charge one supportive care hospital visit for each day hospitalized during the first ten days of hospitalization and thereafter one visit for every seven days hospitalized {Preamble D. 4. 7.}.

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening,night time or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

00127	Terminal care facility visit	51.80	

Notes:

i) This item is applicable to the visits for palliative care rendered to terminally ill patients suffering from malignant disease or AIDS or end-stage respiratory, cardiac, liver and renal disease and end-stage dementia with life expectancy of up to 6 months and the focus of care is palliative rather than treatment aimed at cure. Billings for this item will only apply where there is no aggressive treatment of the underlying disease process and care is directed to maintaining the comfort of the patient until death occurs.

ii) This item may be billed for necessary visits rendered for a period not to exceed 180 days prior to death and is applicable to patients in an acute care hospital, nursing home or terminal care facility, whether or not the patient is in a palliative care unit. Under extenuating circumstances, for visits that exceed 180 days, a note record must be submitted.

iii) Terminal care visit fees do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death.

iv) The chemotherapy listings (33581, 33582, 33583, 00578, 00579, and 00580) may not be billed when terminal care facility visit fees are being billed.

v) Essential non-emergent additional terminal care facility visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00127. The claim must include the time of each visit and a statement of need included in a note record.

vi) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent terminal care facility visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

Community Based GP Hospital Visits

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

Physician Eligibility:

- Payable only to the GP or practice group that accepts the role of being Most Responsible Physician (MRP) for the longitudinal coordinated care of his/her/their patient.
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months.
- 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.

Community Based GP with Active Hospital Privileges

Active privileges signify the physician has the authority to write orders, whereas courtesy/associate privileges permit the GP to write progress notes in charts, but not orders.

P13338 Community based GP, first facility visit of the day bonus, extra (active hospital privileges) (for routine, supportive or terminal care) 36.18

Notes:

i) Paid only if 13008, 13028, 00127 paid the same day.

ii) Limit of one payable for the same physician, same day, regardless of the number of facilities attended.

iii) Not payable same day for same physician as P13339.

13008 Community based GP: hospital visit (active hospital privileges) 51.80

Notes:

i) Additional visits are not payable on same day to same physician for the same patient, except as set out in the notes ii) and iii).

ii) Essential non-emergent additional visits to a hospitalized patient by the attending or replacement physician during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included a note record.

iii) For weekday daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

		$	Anes. Level
13028	Community based GP: supportive care hospital visit (active hospital privileges)	34.71	

Notes:

i) Referring physician may charge one hospital visit for each day hospitalized during the first ten days of hospitalization and thereafter one visit for every seven days hospitalized (Preamble D. 4. 7).

ii) Essential non-emergent additional visits to a hospitalized patient by the physician providing supportive care for diagnosis unrelated to the admission diagnosis, during one day are to be billed under fee item 00108 or 13008. The claim must include the time of each visit and a statement of need included in a note record.

iii) For weekday, daytime emergency visit, see fee item 00112. Fee items 12200, 13200, 15200, 16200, 17200, 18200 may be billed for additional evening, night time, or weekend emergent hospital visits same day, same patient when the attending physician or replacement physician is specially called back as the patient's condition has changed, requiring the physician's attendance or due to a condition unrelated to the hospitalization. If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable. The claim must include the time of service and an explanation for the visit included in the note record.

Community Based GP with Courtesy or Associate Hospital Privileges

P13339	Community based GP, first facility visit of the day bonus, extra, (courtesy/associate privileges)	28.76	

Notes:

i) Only payable if 13228 paid the same day.

ii) Limit of one payable for the same physician, same day, regardless of the number of facilities attended.

iii) Not payable same day for same physician as P13338.

13228	Community based GP: hospital visit (courtesy/associate privileges)	28.76	

Notes:

i) Payable once per calendar week per patient up to the first four weeks. Thereafter, payable once per two weeks up to a maximum of 90 days. For visits over 90 days please submit note record.

ii) Payable for patients in acute, sub-acute care or palliative care.

iii) Not payable with G14015 or any other visit fee including 00108, 13008, 00109, 00114, 00115, 00113, 00105, 00123, 00127, 12200, 13200, 15200, 16200, 17200, 18200, 12201, 13201, 15201, 16201, 17201, 18201, 00128, 13028, 13015, 12220, 13220, 15220, 16220, 17220, 18220, 00121, 00122, 12210, 13210, 15210, 16210, 17210, 18210, 00116, 00112, 00111.

iv) If physician is on-site and called for emergent care, fee items 00113, 00105 or 00123 are billable.

v) A written record of the visit must appear in either patient's hospital or office chart.

vi) If a hospitalist is providing GP care to the patient, the community based GP with courtesy or associate hospital privileges may bill 13228.

		$	Anes. Level

On-call On-site Hospital Visits

These listings should be used when a physician, located in the hospital or Emergency Department, is called to see a patient in either the Emergency Department or elsewhere in the hospital.

00113	Evening (between 1800 hours and 2300 hours)	49.62	
00105	Night (between 2300 hours and 0800 hours)	69.79	
00123	Saturday, Sunday or Statutory Holiday	49.62	

Note: *For services rendered between 0800 hours and 1800 hours weekdays bill appropriate visit or procedure fee. Out-of-office hours premiums are not chargeable in addition to emergency department fees. Claim must state time call placed.*

Long-Term Care Facility Visits

00114	One or multiple patients, per patient	33.03	
P13334	Community based GP, long term care facility visit - first visit of the day bonus, extra	32.81	

Notes:

i) Paid only if 00114 paid the same day.

ii) Limit of one payable for the same physician, same day, regardless of the number of long term care facilities attended.

00115	Nursing home visit – one patient, when specially called and patient seen between hours of 0800 hrs and 2300 hrs – any day. The visit must take place within 24 hours of receiving the request from the Nursing home. (*See Preamble Clause D. 4. 9., for long-stay patients).*	110.97	

Emergency Visits

00112	Emergency visit (call placed between hours of 0800 and 1800 hours) – weekdays	110.97	

Notes:

i) This item to be charged only when one must immediately leave home, office, or hospital to render immediate care. Call to hospital emergency department while at hospital, bill under appropriate on-call on-site hospital visit listings or procedure.

ii) Claim must state time service rendered.

The following are examples of situations explaining when it would be appropriate to bill under fee item 00112:

Example 1: *Physician is called by patient with non-urgent condition. Physician agrees to meet the patient later in the day at the hospital.*

Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

Example 2*: Physician is called to assess a patient at the hospital. Due to the urgent nature of the patient's condition, the physician must leave his/her office immediately.*

Fee item 00112 is applicable, as all the criteria are met.

Example 3*: Physician is visiting patients at the hospital during the daytime. She/he is called to attend a patient in the emergency ward. Due to the urgent nature of the patient's condition, the physician must attend the patient immediately.*

Fee item 00112 is not applicable, as the physician remained at the same site.

Example 4*: The physician is called at home regarding a patient. She/he asks the patient to meet him/her at the office later in the day for assessment.*

Fee item 00112 is not applicable, as the physician was not required to immediately leave home, office or hospital to render immediate care.

00111 An emergency home (or scene of accident) visit for an acutely ill or injured patient immediately followed by a trip to hospital to arrange for emergency admission and to include immediate associated hospital visit 112.92

Telephone Advice

13000 Telephone advice to a Community Health Representative in First Nation's Communities.....15.14

Notes:

i) Applicable only to medically required calls to physician for medical advice initiated by and provided to Community Health Representative.

ii) Not billable if a Community Health Nurse is available in the Community.

13005 Advice about a patient in Community Care 15.16

Notes:

i) This fee may be claimed for advice by telephone, fax or in written form about a patient in community care in response to an enquiry initiated by an allied health care worker specifically assigned to the care of the patient.

ii) Community Care comprises Residential, Intermediate and Extended care and includes patients receiving Home Nursing care, Home support or Palliative care at home.

iii) Allied health care workers are defined as: home care coordinators, nurses, (registered, licensed practical, public health, and psychiatric), psychologists, mental health workers, physiotherapists, occupational therapists, respiratory therapists, social workers, ambulance paramedics, and pharmacists (not intended for prescription renewal).

iv) Claims should be submitted under the personal health number of the patient and should indicate the time of day the request for advice was received.

v) Dates of services under this item should be documented in the patient's record together with the name and position of the enquiring allied health care worker and a brief notation of the advice given. Alternatively the original of a fax or a copy of written advice will suffice to document these services.

vi) This fee may <u>not</u> be claimed in addition to visits or other services provided on the same day by the same physician for the same patient.

vii) This fee may be billed to a maximum of one per patient per physician per day.

viii) This fee may not be claimed for advice in response to enquiries from a patient or their family.

ix) This fee may not be claimed by physicians who are on third party call to a facility or applicable to calls about doctor of the day patients to a physician who is on-call for doctor of the day at the time of the request for advice. Similarly the fee does not cover advice provided by doctors who are on-site, on-duty in an emergency department, who are being paid at the time on a sessional basis, or who are working at the time as hospitalists.

x) This fee item is not billable by physicians receiving non fee-for-service compensation to provide coverage at continuing care facilities during normal business hours.

		$	Anes. Level

Pregnancy and Confinement

14090 Prenatal visit - complete examination 80.95

14091 - subsequent examination 30.32

Notes:

i) Uncomplicated pre-natal care usually includes a complete examination followed by monthly visits to 32 weeks, then visits every second week to 36 weeks, and weekly visits thereafter to delivery. In complicated pregnancies, charges for additional visits will be given independent consideration upon explanation.

ii) Where a patient transfers her total on-going uncomplicated pre-natal care to another physician, the second physician also may charge a complete examination (item 14090) and subsequent examinations, as rendered. To facilitate payment the reason for transfer should be stated with the claim. Temporary substitution of one physician for another during days off, annual vacation, etcetera, should not be considered as a patient transfer.

iii) Other than during pre-natal or post-natal visits, it is proper to charge separately for all visits (including counselling) for conditions unrelated to the pregnancy, under appropriate fee items listed elsewhere. The reason for the charges should be clearly spelled out when submitting claim.

iv) Other than procedures, services for the care of unrelated conditions, during a pre-natal or post-natal visit are included in the pre-natal (14091) or post-natal visit fee (P14094), and are not to be billed under fee item 04007. Procedures rendered for unrelated conditions are chargeable as set out in Preamble D. 8. d..

P14094 Post-natal office visit 30.32

Notes:

i) P14094 may be billed in the six weeks following delivery (vaginal or Caesarean Section).

ii) Not payable to physician performing Caesarean Section.

14199 Management of prolonged 2nd stage of labour, per 30 minutes or major portion thereof. 81.41

Notes:

i) This item is billable in addition to the delivery fee only when the second stage of labour exceeds two hours in length.

ii) Not payable with 04000, 04014, 04017, or 04018.

iii) Timing ends when constant personal attendance ends, or at the time of delivery.

14104 Delivery and post-natal care (1-14 days in-hospital) 560.50

Notes:

i) Care of newborn in hospital (see item 00119).

ii) Repair of cervix is not included in fee item14104. Charge 50% of listed fee when done on same day as delivery.

iii) When medically necessary additional post-partum office visit(s) are payable under fee item P14094.

14105 Management of labour and transfer to higher level of care facility for delivery 233.42

Notes:

i) This fee includes all usual hospital care associated with the confinement and provided by the referring physician.

		$	Anes. Level

ii) May be claimed by the referring physician when the referring physician intended to conduct the delivery providing the following conditions are met:
- *a) The referring physician attended the patient during active labour and provided assessment of the progress of labour, both initial and on-going.*
- *b) Active labour is defined as:"regular painful contractions, occurring at least once in five minutes, lasting at least 40 seconds, accompanied by either spontaneous rupture of the membranes, or full cervical effacement and dilatation of at least two centimeters."*
- *c) There is a documented complication warranting the referral such as foetal distress or dysfunctional labour (failure to progress).*
- *d) Where the referring physician must transfer the patient to another facility.*

iii) Not payable with assessment or visit fee or 14104, 14109 and generally 14199 (provide details if claiming for 14199 in addition).

iv) OOOHP Continuing Care Surcharges do not apply to maternity services in the first stage of labour only.

v) When medically necessary additional post-partum office visit (s) are payable under fee item P14094.

14108 Post-natal care after elective caesarean section(1-14 days in-hospital).....115.31
Note: *When medically necessary additional post-partum office visit(s) are payable under fee item P14094.*

14109 Primary management of labour and attendance at delivery and post-natal care associated with emergency caesarean section (1-14 days in-hospital) 466.87
Notes*:*
- *i) Surgical assistant is extra to fee items 14108 and 14109.*
- *ii) When medically necessary additional post-partum office visit(s) are payable under fee item P14094.*

T14545 Medical abortion 158.11
Note: *Includes all associated services rendered on the same day as the abortion, including the consultation whenever rendered, required components of Rh factor, associated services including counselling rendered on the day of the procedure, and any medically necessary clinical imaging.*

15120 Pregnancy test, immunologic - urine 11.14

Infant Care

00118 Attendance at caesarian section (if specifically requested by surgeon for care of baby only) 87.04
Note: *Not payable if a pediatrician is present at the caesarean section to care for the baby.*

00119 Routine care of newborn in hospital 88.98

Gynecology

14540 Insertion of intrauterine contraceptive device (operation only).....41.35 2
Note*: Includes Pap smear if required.*

14560 Routine pelvic examination including Papanicolaou smear (no charge when done as a pre and post-natal service) 30.32
Note: *Services billed under this code must include both a pelvic examination and Pap smear.*

		$	Anes. Level

Urology

Y13655 GP vasectomy bonus associated with bilateral vasectomy 20.56

Notes:

i) Restricted to General Practitioners
ii) Maximum of 25 bonuses per calendar year per physician
iii) Payable only when fee item S08345 billed in conjunction
iv) Maximum of one bonus per vasectomy per patient.

Surgical Assistance

13194 First Surgical Assist of the Day 81.53

Notes:

i) Restricted to General Practitioners
ii) Maximum, of one per day per physician, payable in addition to 00195,00196, 00197 or 00193.

Total operative fee(s) for procedure(s):

00195 - less than $317.00 inclusive 131.64
00196 - $317.01 to 529.00 inclusive 185.59
00197 - over $529.00 ..... 245.47
00198 Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof 27.80

Notes:

i) In those rare situations where an assistant is required for minor surgery a detailed explanation of need must accompany the account to the Plan.
ii) Where an assistant at surgery assists at two operations in different areas performed by the same or different surgeon(s) under one anesthesic, s/he may charge a separate assistant fee for each operation, except for bilateral procedures, procedures within the same body cavity or procedures on the same limb.
iii) Visit fees are not payable with surgical assistance listings on the same day, unless each service is performed at a distinct/separate time. In these instances, each claim must state time service was rendered.

Open Heart Surgery:

00193 Non-CVT-certified surgical assistance at open-heart surgery, per quarter hour or major portion thereof 28.39

Note: *The same fee applies equally to all assistants (first, second, etc.).*

Anesthesia

13052 Anesthetic evaluation - non-certified anesthesiologist 39.42

Note: *See Anesthesia Preamble regarding Pre-Anesthetic Evaluation Fees.*

Minor Procedures

00190 Forms of treatment other than excision, X-ray, or Grenz ray; such as removal of haemangiomas and warts with electrosurgery, cryotherapy, etc.- per visit (operation only) 29.99

Notes:

i) Payable to non-dermatologists only.
ii) The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."

		$	Anes. Level
13660	Metatarsal bone - closed reduction (operation only)	50.58	2
13600	Biopsy of skin or mucosa (operation only)	49.77	2
13601	Biopsy of facial area (operation only)	49.77	2
	Note: *Punch or shave biopsies not to be charged under fee items 13600 or 13601.*		
13605	Opening superficial abscess, including furuncle - operation only	42.63	2
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	34.15	
	Notes: *i) Intended for primary treatment of injury. ii) Not applicable to dressing changes or removal of sutures. iii) Applicable for steri-strips or glue to repair a primary laceration.*		
13611	Minor laceration or foreign body - requiring anesthesia - operation only	63.59	2
13612	Extensive laceration greater than 5 cm (maximum charge 35 cm) - operation only - per cm	12.75	2
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	63.59	2
13621	- additional lesions removed at the same sitting (maximum per sitting, five) each (operation only)	31.80	
	Note: *The treatment of benign skin lesions for cosmetic reasons, including common warts (verrucae) is not a benefit of the Plan. Refer to Preamble D. 9. 2. 4. a. and b. "Surgery for the Alteration of Appearance."*		
13622	Localized carcinoma of skin proven histopathologically (operation only)	70.25	2
13630	Paronychia - operation only	34.06	2
13631	Removal of nail - simple operation only	34.06	2
13632	- with destruction of nail bed (operation only)	68.91	2
13633	Wedge excision of one nail (operation only)	60.80	2
13650	Enucleation or excision of external thrombotic hemorrhoid (operation only)	49.96	2
Y10710	In office Anoscopy	7.60	
	Notes: *i) Anoscopy is the examination of the anus and anal sphincter, for evaluating patients with anal and/or peri-anal symptoms (pain or bleeding), or used as an adjunct to the DRE. ii) Not payable in addition to 00715, 00716, 00718, 10714, 10731, 10732 or 10733. iii) Restricted to General Practitioners.*		

Total Fee $

Laboratory Services

The following tests, when performed in physicians' offices, are accepted for payment by the Medical Services Plan of British Columbia. These tests are not payable to laboratories, vested interest laboratories and/or hospitals.

00012 Venepuncture and dispatch of specimen to laboratory, when no other blood work performed 5.71
Notes:
i) This is the only fee applicable for taking blood specimens and is to apply in those situations where a single bloodwork service is provided by an unassociated facility or person.
ii) Where a blood specimen is taken by physician's office and dispatched to another unassociated physician's office or diagnostic facility, the original physcian's office may charge 00012 only when it does not perform another laboratory procedure using blood collected at the same time. (See Preamble Clause C. 21.)
iii) When billed with another service such as an office visit, 00012 may be billed at 100%.

15132 Candida Culture 6.54
15133 Examination for eosinophils in secretions, excretions and other body fluids 7.01
P15134 Examination for pinworm ova 5.76
15136 Fungus, direct examination, KOH preparation 8.23
15100 Glucose - semiquantitative (dipstick analysed visually or by reflectance meter) 3.59
15137 Hemoglobin cyanmethemoglobin method and/or haematocrit. 3.07
15000 Hemoglobin - other methods 1.57
***Note**: 15137 and 15000 - see Laboratory Medicine Preamble for hematology protocol.*

15110 Occult blood – feces 5.21
***Note:** Applies only to guaiac methods.*
15120 Pregnancy test, immunologic - urine 11.14
30015 Secretion smear for eosinophils 7.15
15138 Sedimentation rate 2.46
15139 Sperm, Seminal examination for presence or absence 14.49
P15140 Stained smear 7.25
P15141 Trichomonas and/or Candida direct examination 5.52
15130 Urinalysis - Chemical or any part of (screening) 2.08
15131 Urinalysis - Microscopic examination of centrifuged deposit 4.02
15142 Urinalysis - Complete diagnostic, semi-quant and micro 5.40
15143 White cell count only (see hematology protocol) 6.35

The following test is payable to laboratories, vested interest laboratories, hospitals and physicians' offices:
93120 E.C.G. tracing, without interpretation, (technical fee) 16.32

Investigation

00117 Interpretation of electrocardiogram by non-internist 9.95

No Charge Referral

03333 Use this code when submitting a claim for a "no charge referral."

Total Fee $

GPSC Initiated Listings

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

Unless otherwise identified in the individual fee description, physicians are eligible to participate in the incentive program if they are:

1. A general practitioner who has a valid BC MSP practitioner number;
2. Currently in general practice in BC as a full service family physician;
3. The most responsible general practitioner for the majority of the patient's longitudinal general practice care; and
4. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

Additional detailed eligibility requirements are identified in each section.

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

For the purposes of its incentives, GPSC defines Physicians working on Alternative Payment Program (APP) as those working under Health Authority paid APP contracts. Agreements to pool FFS billings and pay out physicians in a mutually acceptable way (e.g. per day, per shift, per hour, etc.) are not considered APP by GPSC. If services supported and paid through GPSC incentives are already included in a sessional, salary or service contract then they are not billable in addition.

For the purpose of its incentives, GPSC defines a General Practitioner (GP) with specialty training as: "A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program".

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

1. Expanded Full Service Family Practice Condition-based Payments

The GPSC Condition-based Payments 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 year. The goal is to improve provision of clinically appropriate care that considers both the patient's values and the impact of comorbidities. To confirm an ongoing doctor-patient relationship, there must be at least 2 visit fees (office; prenatal; home; long term care; only one of which can be a GPSC Telephone Visit (G14076, G14079) or Group Medical Visit (13763 -13781) billed on each qualifying patient in the 12 months prior to billing the CDM incentive. **Visits provided by a locum for the MRP GP are included; however, an electronic note indicating this must be submitted with the claim.** Patients in long-term care facilities are eligible. Clinical judgment must be used to determine the appropriateness of following clinical practice guidelines in all patients, particularly those with dementia or very limited life expectancy. Documentation of the

provision of guideline-informed care for the specific condition is required in the medical record. Although use of the GPAC Chronic Care flow sheets is not mandatory, they are a useful tool for tracking care provided to patients over time. **Condition-based payments are no longer payable once G14063, the Palliative Planning Incentive has been billed and paid as patient has been changed from active management of chronic disease to palliative management**.

Patient self-management can be defined as the decisions and behaviors that patients with chronic illness engage in that affect their health. Self-management support is the help given to patients with chronic conditions that enables them to manage their health on a day to day basis. An important part of this support is the provision of tools by the family physician that can enable patients to make appropriate choices and sustain healthy behaviors. There are a variety of tools publically available (e.g. health diaries/passports, etc.) to help build the skills and confidence patients need to improve management of their chronic conditions and potentially improve outcomes. Documentation in the patient chart of the provision of patient self-management supports as part of the patient's chronic disease management is expected.

When a new GP assumes the practice of another GP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fee is billable on its anniversary date provided the new GP has continued to provide guideline-informed care for these patient(s). To demonstrate continuity, if some of the required visits have been provided by the previous GP, an electronic note indicating continuity of care over the full 12 months is required at the time of the initial submission of the CDM fee by the new GP.

		Total Fee $
G14050	Incentive for Full Service General Practitioner - annual chronic care incentive (diabetes mellitus)	125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.

ii) Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year.

iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.

iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14250.

v) Claim must include the ICD-9 code for diabetes (250).

vi) Payable once per patient in a consecutive 12 month period.

vii) Payable in addition to fee items G14051 or G14053 for same patient if eligible.

viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

ix) 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 Full Service General Practitioner - annual chronic care incentive (heart failure)	125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.

ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.

iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.

iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14251.

v) Claim must include the ICD-9 code for heart failure (428).

vi) Payable once per patient in a consecutive 12 month period.

vii) Payable in addition to items G14050 or G14053 for the same patient if eligible.

viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

Total Fee $

G14052 Incentive for Full Service General Practitioner - annual chronic care incentive (hypertension).....50.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.

ii) Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year.

iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.

iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14252.

v) Claim must include the ICD-9 code for hypertension (401).

vi) Payable once per patient in a consecutive 12 month period.

vii) Not payable if G14050, G14250, G14051, G14251 paid within the previous 12 months.

viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

ix) 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 Full Service General Practitioner - annual chronic care incentive (Chronic Obstructive Pulmonary Disease-COPD) 125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.

ii) Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year.

iii) This item may only be billed after one year of care has been provided and the patient has been provided at least two visits in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (G14076, G14079) or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.

iv) Not payable if the required two visits were provided while working under salary, service contract or sessional arrangement. If applicable, bill your incentive under fee item G14253.
v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).
vi) Payable once per patient in a consecutive 12 month period.
vii) Payable in addition to fee items G14050, G14051 or G14052 for the same patient if eligible.
viii) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.
ix) If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.

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

Total Fee $

G14250 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus) 125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice 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 and at least two visits have been provided the patient in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.
iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.
v) Claim must include the ICD-9 code for diabetes (250).
vi) Payable once per patient in a consecutive 12 month period.
vii) Payable in addition to fee items G14051, G14250, G14053 or G14253 for same patient if eligible.
viii) Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.
ix) A visit may be provided on the same date the incentive is billed.

G14251 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (heart failure) 125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice care.
ii) Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year.
iii) This item may only be billed after one year of care and at least two visits have been provided in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.

iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.
v) Claim must include the ICD-9 code for heart failure (428).
vi) Payable once per patient in a consecutive 12 month period.
vii) Payable in addition to items G14050, 14250,G14053 or G14253 for the same patient if eligible
viii) Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.
ix) A visit may be provided on the same date the incentive is billed.

Total Fee $

G14252 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (hypertension) 50.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice 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 and at least two visits have been provided in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.
iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment and submitted the requisite encounter code visits.
v) Claim must include the ICD-9 code for hypertension (401).
vi) Payable once per patient in a consecutive 12 month period.
vii) Not payable if G14050, G14250, G14051 or G14251 paid within the previous 12 months.
viii) Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.
ix) A visit may be provided on the same date the incentive is billed.

G14253 Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD).....125.00

Notes:

i) Payable to the family physician who is the most responsible for the majority of the patient's longitudinal general practice 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 and at least two visits have been provided in the preceding 12 months. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC telephone or group medical visit (13763-13781).This visit requirement excludes procedures, laboratory and X-ray services.
iv) Only payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the

advice as a requirement of their employment and submitted the requisite encounter code visits.

v) Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).

vi) Payable once per patient in a consecutive 12 month period.

vii) Payable in addition to fee items G14050, G14250, G14051, G14251, G14052, G14252 for the same patient if eligible.

viii) Not payable once a palliative care planning code has been claimed as the patient has changed from active management of chronic disease to palliative management.

ix) A visit may be provided on the same date the incentive is billed.

Total Fee $

Successful billing of the Annual Chronic Care Bonus for COPD (G14053) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months.

2. Conference Fees

Facility Patient Conference Fee

G14015 General Practice Facility Patient Conference: when requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient with complex supportive care needs in a facility can safely return to the community or transition to a supportive or long-term facility - per 15 minutes or greater portion thereof 40.00

Notes:

i) Refer to Table 1 (below) for eligible patient populations.

ii) Must be performed in the facility and results of the conference must be recorded in the patient chart.

iii) Payable only for patients in a facility. Facilities limited to: hospital, palliative care facility, LTC facility, rehab facility, sub-acute facility, psychiatric facility, detox/drug and alcohol facility).

iv) Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any allied care provider charged with coordinating discharge and follow-up planning.

v) Requires interdisciplinary team meeting of at least 2 allied care professionals in total, and will include family members when available.

vi) Fee includes:

- *a. Where appropriate, interviewing of and conferencing with patient, family members, and other allied care providers of both the acute care facility and community.*
- *b. Review and organization of appropriate clinical information.*
- *c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*
- *d. The care plan must be recorded 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.*

vii) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).

viii) Claim must state start and end times of the service. Start and end times must be documented in the patient chart.

ix) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

x) Not payable to physicians who are participating in the GPSC attachment initiative (G14070).

xi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.

xii) Not payable on the same day for the same patient fee item G14016, G14017, G14033, G14043, G14063, G14074, G14075, G14076 or G14077.

xiii) Visit payable in addition if medically required and does not take place concurrently with the patient conference. Medically required visits performed consecutive to the Facility Patient Conference are payable. (i.e. Visit is separate from conference time).

Total Fee $

Community Patient Conference Fee

G14016 General Practice Community Patient Conference Fee: Creation of a coordinated clinical action plan for the care of community-based patients with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other allied care providers is required (e.g. specialists, psychologists or counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers,) as well as with the patient and will include family members when available (as required due to the severity of the patient's condition)

- per 15 minutes or greater portion thereof.....40.00

Notes:

i) Refer to Table 1 (below) for eligible patient populations.

ii) Fee is billable for conferences that occur as a result of care provided in the following community locations for patients who are resident in the community:
- *Community GP Office*
- *Patient Home*
- *Community placement agency*
- *Disease clinic (DEC, arthritis, CHF, Asthma, Cancer or other palliative diagnoses, etc.*
- *Assisted living*

iii) Fee includes:
- *a. The interviewing of patient and family members as indicated and the conferencing with other allied care providers.*
- *b. Review and organization of appropriate clinical information.*
- *c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of intervention and end of life documentation as appropriate.*
- *d. The care 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) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).

v) Claim must state start and end times of service. Start and end times must be documented in the patient chart.

vi) Not payable to physicians who are participating in the GPSC attachment initiative (G14070).

vii) Not payable to the same patient on the same date of service as fee item G14015, G14017, G14074, G14075, G14076 or G14077.

viii) Not payable to physicians who are employed by, or who are under contract to a facility, who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.

ix) Visit payable in addition if medically required and does not take place concurrently with clinical action plan.

Total Fee $

Acute Care Discharge Conference Fee

G14017 General Practice Acute Care Discharge Conference fee
In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to the most responsible GP for that patient following discharge from the acute care facility. This fee is billable when a Discharge Planning Conference is performed upon the request of either an Acute Care facility, or by the GP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.
- per 15 minutes or greater portion thereof.....40.00

Notes:

i) Refer to Table 1 for eligible populations.

ii) Payable only for patients being discharged from an acute care facility to the community or to a different facility; another acute care facility, or a supportive care or Long Term Care facility.

iii) Must be performed in the acute care facility and results of the conference must be recorded in the patient's chart in the acute care facility and the receiving GP's office chart (or receiving facility's chart in the case of inter-facility transfer).

iv) Face-to-face conferencing is required; the only exception is if a patient is being discharged from an acute care facility in a different community, and a chart notation must be made to indicate this circumstance.

v) Requesting care providers limited to: Facility-affiliated physicians and nurses, GP assuming MRP status upon patient's discharge, care coordinators, liaison nurses, rehab consultants, social workers, and any allied care provider charged with coordinating discharge and follow-up planning.

vi) Requires interdisciplinary team meeting of the GP assuming MRP status upon discharge and a minimum of 2 other allied care professionals as enumerated above, and will include family members when appropriate.

vii) Fee includes:

- *a. Where appropriate, interviewing of and conferencing with patient, family members, and other allied care providers of both the acute care facility and community.*
- *b. Review and organization of appropriate clinical information.*
- *c. The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of degrees of intervention and end of life documentation as appropriate.*
- *d. The care 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.*
- *e. This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses during the course of a patient's stay in the acute care facility.*
- *f. Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units).*
- *g. Claim must state start and end times of the service.*
- *h. If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*
- *i. Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*

j. Medically required visits performed consecutive to the Acute Care Discharge Conference are payable (i.e. Visit is separate from conference time).

k. Submit the new fee item G14017 through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders.

l. Not payable to physicians who are participating in the GPSC attachment initiative (G14070).

m. Not payable to the same patient on the same date of service as fee item G14015, G14016, G14074, G14075, G14076 or G14077.

n. Not payable on the same day as any GPSC planning fees (G14033, G14075, G14043, G14063 (Palliative Planning Fee).

Table 1: ***Eligible patient populations for the Facility Patient, Community Patient and Acute Care Discharge Conference Fees***

i. Frail elderly (ICD-9 code V15)

Patient over the age of 65 years with at least 3 out of the following factors:

- Unintentional weight loss (10 lbs in the past year)
- General feeling of exhaustion
- Weakness (as measured by grip strength)
- Slow gait speed (decreased balance and motility)
- Low levels of physical activity (slowed performance and relative inactivity)
- Incontinence
- Cognitive impairment

ii. Palliative care (ICD-9 code V58)

Patient of any age who:

- Is living at home ("Home" is defined as wherever the person is living, whether in their own home, living with family or friends, or living in an assisted living residence or hospice); and
- Has been diagnosed with a life-threatening illness or condition; and
- Has a life expectancy of up to six months; and
- Consents to the focus of care being palliative rather than treatment aimed at cure.

iii. End of life (ICD-9 code V58)

Patient of any age:

- Who has been told by their physician that they have less than six months to live; or
- With terminal disease who wish to discuss end of life, hospice or palliative care.

iv. Mental illness

Patient of any age with any of the following disorders is considered to have mental illness:

- Mood Disorders
- Anxiety and Somatoform Disorders
- Schizophrenia and other Psychotic Disorders
- Eating Disorders
- Substance Use Disorders
- Infant, Child and Adolescent Disorders
- Delirium, Dementia and Other Cognitive Disorders
- Personality Disorders
- Sleep Disorders

- Developmentally Delayed, Fetal Alcohol Spectrum Disorders and Autism Spectrum Disorders
- Sexual Dysfunction
- Dissociative Disorders
- Mental Disorders due to a General Medical Condition
- Factitious Disorder

Definitions and the management of these mental disorders are defined in the Manual: Management of Mental Disorders, Canadian Edition, Volume One and Two, edited by Dr. Elliot Goldner, Mental Health Evaluation and Community Consultation Unit, University of British Columbia.

Definitions for Delirium, Dementia and Other Cognitive Disorders; Developmental Disabilities; Dissociative Disorders; Mental Disorders due to a General Medical Condition and Factitious Disorder are found in the Diagnostic and Statistical Manual of Mental Disorders - DSM-IVR.

v. Patients of any age with multiple medical needs or complex co-morbidity

Patients of any age with multiple medical conditions or co-morbidities (two or more distinct but potentially interacting problems) where care needs to be coordinated over a period of time between several health disciplines. On your claim form use the code for one of the major disorders.

Total Fee $

General Practice Urgent Telephone Conference with a Specialist Fee

The intent of this initiative is to improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers.

This fee is billable when the severity of the patient's condition justifies urgent conference with a specialist or GP with specialty training, for the development and implementation of a care plan within the next 24 hours to keep the patient stable in their current environment

This fee is not restricted by diagnosis or location of the patient, but by the urgency of the need for care.

Total Fee $

G14018 General Practice Urgent Telephone Conference with a Specialist Fee: Conferencing on an urgent basis (within 2 hours of request for a telephone conference) with a specialist or GP with specialty training by telephone followed by the creation, documentation, and implementation of a clinical action 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.....40.00

Notes:

i) Payable to the GP who initiates a two-way telephone communication (including other forms of electronic verbal communication) with a specialist or GP with specialty training regarding the urgent assessment and management of a patient but without the responding physician seeing the patient.

ii) A GP with specialty training is defined as a GP who:

a. Provides specialist services in a Health Authority setting and is acknowledged by the Health Authority as acting in a specialist capacity and providing specialist services;

b. Has not billed another GPSC fee item on the patient in the previous 18 months; Telephone advice must be related to the field in which the GP has received specialty training.

iii) Conversation must take place within two hours of the GP's request and must be physician to physician. Not payable for written communication (i.e. fax, letter, e-mail).

iv) 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 care plan must be recorded in the patient chart and must include patient identifiers, reason for the care plan, list of comorbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged.*

v) Not payable to the same patient on the same date of service as fee items G14015, G14016, G14017 or G14077.
vi) Not payable to physicians who are employed by, or who are under a contract to a facility, who would otherwise have provided the service as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangement.
vii) Include start time in time fields when submitting claim.
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. Inform the other physician of results of diagnostic investigations*
- *f. Arrange a hospital bed for the patient*
- *g. Obtain non-urgent advice for patient management (i.e. not required within the next 24 hours).*

ix) Limited to one claim per patient per physician per day.
x) Out-of-Office Hours Premiums may not be claimed in addition.
xi) Maximum of 6 (six) services per patient, per practitioner per calendar year.
xii) Visit payable on same date of service if medically required and does not take place concurrently with the clinical action plan.

GP – Advice to Nurse Practitioner Fee

The intent of this fee is to support collaboration between nurse practitioners and community family physicians. This fee is billable when providing advice by telephone or in person to a Nurse Practitioner who is an independent practitioner providing care to patients under his/her MRP care. This fee is not billable when the patient is attached to a GP.

		Total Fee $
G14019	GP - Advice fee to a Nurse Practitioner – Telephone or In Person	40.00

Notes:
i) Payable for advice by telephone or in person, in response to request from a Nurse Practitioner (NP) in independent practice on patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care.
ii) Excludes advice to an NP about patients who are attached to the GP.
iii) Payable for advice regarding assessment and management by the NP and without the responding physician seeing the patient.
iv) Not payable for written communication (i.e. fax, letter, e-mail).
v) A chart entry, including advice given and to whom, is required.
vi) NP Practitioner number required in referring practitioner field when submitting fee through teleplan.
vii) Not payable for situations where the purpose of the call is to:
- *a. book an appointment*
- *b. arrange for transfer of care that occurs within 24 hours*
- *c. arrange for an expedited consultation or procedure within 24 hours*
- *d. arrange for laboratory or diagnostic investigations*
- *e. inform the referring physician of results of diagnostic investigations*
- *f. arrange a hospital bed for the patient*

viii) Limited to one claim per patient per day with a maximum of 6 claims per patient per calendar year.
ix) Limit of five (5) G14019 may be billed by a GP on any calendar day.
x) Not payable in addition to another service on the same day for the same patient by same GP.
xi) Out-of-Office Hours Premiums may not be claimed in addition.
xii) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.
xiii) Not payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment.

GP Telephone/E-mail follow-up Management Fee

In order to encourage non-face-to-face communication with patients covered by some of the GPSC incentives, patients covered by one or more of the planning related incentives are eligible for five telephone/e-mail services per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.

G14079 GP Telephone/Email Management Fee 15.00
This fee is payable for two-way communication with eligible patients, or the patient's medical representative, via telephone or email by the GP who has billed and been paid for at least one of the following GPSC incentives:
Complex Care Planning Fee (G14033)
Mental Health Planning Fee (G14043)
Annual Chronic Care Bonus for COPD (G14053)
Palliative Care Planning Fee (G14063)
Attachment Complex Care Management Fee (G14075)
This fee is billable for medical management of the conditions covered under the initial planning/Chronic Care fee. This fee is not to be billed for simple appointment reminders or referral notification.
Notes:
i) Payable to a maximum of 5 times per patient per calendar year following the successful billing of G14033, G14043, G14053, G14063 or G14075 within the previous 18 months.
ii) Telephone/Email Management requires two-way communication between the patient or the patient's medical representative and physician or medical office staff for the purpose of medical management of the relevant chronic condition(s); it is not payable for simple notification of office or laboratory appointments or of referrals.
iii) Payable only to the physician paid for the G14033, G14043, G14053, G14063 or G14075 unless that physician has agreed to share care with another delegated physician. To facilitate payment, a note record should be submitted by the delegated physician.
iv) G14077 or G14016 payable on same day for same patient if all criteria met. Time spent on telephone with patient under this fee does not count toward the time requirement for G14077 or G14016.
v) 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 G14016.
vi) Not payable on same day for same patient as G14076 GP Attachment Patient Telephone Management Fee.

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.

3. Complex Care Fees

The Complex Care Management Fee was developed to compensate GPs for the management of complex patients residing in the community, who have documented confirmed diagnoses of 2 chronic conditions

from at least 2 of the 8 categories listed below. Community patients are those residing in their home or in assisted living. Patients in acute or long term care facilities are not eligible.

Having comorbidities does not necessarily make a patient complex and so to be eligible for the Complex Care Management Fee, the individual patient co-morbidities should be of sufficient severity and complexity to cause interference in activities of daily living and warrant the development of a management plan.

These items are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing calendar year.

Eligible Complex Care Condition Categories:

1) Diabetes mellitus (type 1 and 2)
2) Chronic Kidney Disease
3) Heart failure
4) Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)
5) Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g. TIA, Migraine)
6) Ischemic heart disease, excluding the acute phase of myocardial infarct
7) Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.)
8) Chronic Liver Disease with evidence of hepatic dysfunction.

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

Successful billing of the Complex Care Management Fee (G14033) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months

		Total Fee $
G14033	GP Annual Complex Care Management Fee	315.00

The Complex Care Management Fee is advance payment for the complex work of caring for patients with two of the eligible conditions. It is payable upon the completion and documentation of a Complex Care Plan which includes Advance Care Planning when appropriate, as described below.
A Complex Care Plan requires documentation of the following elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies;
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
3. Specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;
5. Outlines expected outcomes as a result of this plan, including end-of-life issues (advance care planning) when clinically appropriate;
6. Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles;
7. Identifies an appropriate time frame for re-evaluation of the plan;
8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as appropriate.

The development of the care plan is done jointly with the patient &/or the patient representative as appropriate. The patient &/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Notes:

i) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions.
ii) Refer to Table 1 for eligible diagnostic categories.
iii) Payable once per calendar year per patient on the date of the complex care planning visit.
iv) Documentation of the Complex Care Plan is required in patient's chart.
v) Minimum required time 30 minutes to review chart and create the care plan jointly with the patient and/or their medical representative. The majority of the time must be face-to-face. Documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required.
vi) Visit (in office or home) or CPx fee to indicate face-to-face interaction with patient same day must be billed for same date of service. Visit time does not count toward required planning time.
vii) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14033.
viii) G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.
ix) Not payable once G14063 has been billed and paid as patient has been changed from active management of complex chronic conditions to palliative management.
x) G14015, G14017, G14076 and G14079 not payable on the same day for the same patient.
xi) Maximum daily total of 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.
xii) G14075 is not payable in the same calendar year for same patient as G14033.
xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.
xiv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
xv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

Diagnostic codes submitted with 14033 billing must be from Table 1. If the patient has multiple co-morbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

Total Fee $

Table 1: Complex Care Diagnostic codes

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Heart Failure

R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease
R573	Chronic Respiratory Condition	Chronic Liver Disease
I428	Ischemic Heart Disease	Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease
I573	Ischemic Heart Disease	Chronic Liver Disease
H250	Heart Failure	Diabetes
H430	Heart Failure	Cerebrovascular Disease
H585	Heart Failure	Chronic Kidney Disease
H573	Heart Failure	Chronic Liver Disease
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease
D573	Diabetes	Chronic Liver Disease
C585	Cerebrovascular Disease	Chronic Kidney Disease
C573	Cerebrovascular Disease	Chronic Liver Disease
K573	Chronic Kidney Disease	Chronic Liver Disease

Total Fee $

4. Prevention Fees

G14066 Personal Health Risk Assessment 50.00
This fee is payable to the general practitioner who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, smoker, physically inactive, unhealthy eating). The GP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative and the G14066 must be billed in addition to the age appropriate visit fee.

Patient Eligibility:

Eligible patients must be living at home or in assisted living. Patients in acute and long term care facilities are not eligible.

Notes:

i) Payable only for patients with one or more of the following risk factors: smoking, unhealthy eating, physical inactivity, medical obesity.
ii) Diagnostic code submitted with 14066 must be one of the following: Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783).
iii) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.
iv) Visit (office or home) or CPx fee to indicate face-to-face interaction with patient or patient's representative same day must be billed for same date of service.
v) G14016 or G14077 payable on same day for same patient if all criteria met.
vi) G14015, G14017, G14033, G14043, G14063, G14076 and G14079 not payable on the same day for the same patient.
vii) Payable to a maximum of 100 patients per calendar year, per physician.
viii) Payable once per calendar year per patient.

ix) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

x) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care;

xi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

BC Lifetime Prevention Schedule Recommended Actions

Clinical Condition		MEN	WOMEN
Colorectal Cancer Screening (Fecal Occult Blood Testing q1-2 years starting age 50)		•	•
Mammography Screening (40-79 yrs, q 1-2 years)			•
Pap Smear Screening (sexually active until age 69, q 1 – 2 years)			•
Hypertension Screening		•	•
Hyperlipidemia Screening (Male 40 yr; Female 50 yr or postmenopausal; or sooner if at risk either sex)		•	•
Diabetes Screening (Fasting Blood Sugar at least q 3 yrs age 40 yr or sooner if at risk either sex)		•	•
Discussion of ASA use as clinically indicated (if high risk of Cardiovascular Disease or Stroke)		•	•
Smoking Cessation		•	•
Adult Immunization:	Influenza (Annually if at risk)	•	•
	Pneumococcal (if ↑Risk q 10 years)	•	•
	Tetanus /Diphtheria (q 10 years)	•	•
Immunizations for patients < 19 years of age as per age appropriate publically funded schedule		•	•
Diet Modification (if Cardiovascular Disease Risk)		•	•
Exercise Recommendation (if Cardiovascular Disease Risk)		•	•

5. Maternity Network Initiative

Total Fee $

G14010 Maternity Care Network Initiative Payment 2100.00

Eligibility:

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

- *Be a general practitioner in active practice in BC;*
- *Have hospital privileges to provide obstetrical care;*
- *Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care). Refer to the Maternity Network Registration Form;*
- *Cooperate with other members of the network so that one member is always available for deliveries;*
- *Make patients aware of the members of the network and the support specialists available for complicated cases;*
- *Accept a reasonable number of referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy; the referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care);*

- *Share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic prenatal record; and*
- *Each doctor must schedule at least four deliveries in each six month period of time (April to September, October to March) .*

Billing Information for Maternity Care Network Initiative Payment:

PHN:	9824870522
Patient Last name:	Maternity
Patient First name/initial:	G
Date of Birth:	November 2, 1989
Diagnostic code:	V26
For Date of service use:	Last day in a calendar quarter
Billing Schedule:	Last day of the month, per calendar quarter

6. General Practitioner Obstetrical Premium

G14004 Obstetric Delivery Incentive for Full Service General Practitioner - associated with vaginal delivery and postnatal care 280.25

***Notes*:**

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care.

ii) Payable only when fee item 14104 billed in conjunction.

iii) Maximum of one incentive under fee item G14004, G14008, G14009 per patient delivered.

iv) Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.

Total Fee $

G14005 Obstetric delivery Incentive for Full Service General Practitioner - associated with management of labour and transfer to a higher level of care facility for delivery 116.71

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care.

ii) Payable only when fee item 14105 billed in conjunction.

iii) Payable in addition to G14004 or G14009 when billed and paid to a different GP attending delivery in the receiving hospital.

iv) Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.

G14009 Obstetric Delivery Incentive for Full Service General Practitioner - related to attendance at delivery and postnatal care associated with emergency caesarean section 233.44

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care.

ii) Payable only when fee item 14109 billed in conjunction.

iii) Maximum of one incentive under fee item G14004, G14008, G14009 per patient delivered.

iv) Maximum of 25 incentives per calendar per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.

G14008 Obstetric Delivery Incentive for Full Service General Practitioner – associated with postnatal care after an elective C-section.....57.66

Notes:

i) Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care.
ii) Payable only when fee item 14108 billed in conjunction.
iii) Maximum of one incentive under fee item G14004, G14008, G14009 per patient delivered.
iv) Maximum of 25 incentives per calendar per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.

7. Mental Health Planning and Management Fees

G14043 GP Mental Health Planning Fee.....100.00

This fee is payable upon the completion and documentation of a Mental Health Plan for patients resident in the community (home or assisted living). Patients in acute or long term care facilities are not eligible. Patients must have a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan. This is not intended for patients with self-limited or short lived mental health symptoms *(e.g.: situational adjustment reaction, normal grief, life transitions*). The Mental Health Planning Fee requires a face-to-face visit with the patient and/or the patient's medical representative.

. A Mental Health Plan requires documentation of the following elements in the patient's\chart:

1. There has been a detailed review of the patient's chart/history and current therapies.
2. The patient's confirmed diagnosis, (DSM Axis 1), psychiatric history and current mental state.
3. The use of and results of validated assessment tools. Examples of validated assessment tools include:
   a) PHQ9, Beck Depression Inventory, Ham-D depression scale;
   b) MMSE;
   c) MDQ;
   d) GAD-7;
   e) Suicide Risk Assessment;
   f) Audit (Alcohol Use Disorders Identification Test CAGE; T-ACE).
4. Specifies a clinical plan for the care of that patient's psychiatric illness. Outlines linkages with other allied care professionals and community resources who will be involved in the patient's care, and their expected roles.
5. Identifies an appropriate time frame for follow up and re-evaluation of the patient's progress and Mental Health Plan.
6. Provides confirmation that the Mental Health plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other involved allied care professionals as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Following the successful billing of the Mental Health Planning fee, the GP will have access to 4 additional counselling equivalent mental health management fees per calendar year once the 4 MSP counselling fees have been billed. Successful billing of the Mental Health Planning fee G14043 allows access to 4 mental health management fees in that same calendar year which may be billed once the 4 MSP

counselling fees (00120) have been utilised.

Successful billing of the mental health planning fee (G14043) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year in the subsequent 18 months.

Patient Eligibility:

- *Eligible patients must be living at home or in assisted living.*
- *Patients in acute or long term care facilities are not eligible.*

Notes:

i) Payable only for patients with documentation of a confirmed diagnosis of a DSM Axis 1 condition causing significant interference with activities of daily living. Not intended for patients with self-limited or short lived mental health symptoms.

ii) Payable once per calendar year per patient. Not intended as a routine annual fee unless the severity of the illness requires a comprehensive Mental Health Plan review and revision.

iii) Minimum required face to face time 30 minutes.

iv) Visit fee on same day only payable in addition if total time exceeds 39 minutes; counselling fee on same day only payable in addition if total time exceeds 49 minutes.

v) G14043 claim must state start and end times of the total service (planning plus any additional visit/counselling.) Start and end times must also be documented in the patient chart.

vi) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for 14043.

vii) G14015, G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14074, G14075, G14076 and G14079 not payable on the same day for the same patient.

viii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

ix) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

		Total Fee $
G14044	GP Mental Health Management Fee age 2 – 49	52.76
G14045	GP Mental Health Management Fee age 50 - 59	58.03
G14046	GP Mental Health Management Fee age 60 - 69	60.67
G14047	GP Mental Health Management Fee age 70 - 79	68.59
G14048	GP Mental Health Management Fee age 80+	79.14

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee G14043 has been successfully billed. The four MSP counselling fees (age-appropriate 00120) must first have been paid in the same calendar year.

Notes:

i) Payable a maximum of 4 times per calendar year per patient.

ii) Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician.

iii) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note.

iv) Not payable unless the four age-appropriate 00120 fees have already been paid in the same calendar year.

v) Minimum time required is 20 minutes.

vi) Claim must include Start and End times. Start and end times must also be documented in the patient chart.

vii) G14016 or G14077, payable on same day for same patient if all criteria met.
viii) G14015, G14043 , G14076, G14079 not payable on same day for same patient.
ix) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
x) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

The following list of diagnosis and acceptable ICD9 codes are applicable for the Mental Health Planning and Management Fee, fee items G14043, G14044 – G14048, and G14079:

	DIAGNOSIS	**ICD-9**
Adjustment Disorders:		**309**
	Adjustment Disorder with Anxiety	309
	Adjustment Disorder with Depressed Mood	309
	Adjustment Disorder with Disturbance of Conduct	309
	Adjustment Disorder with Mixed Anxiety and Depressed Mood	309
	Adjustment Disorder with Mixed Disturbance of Conduct & Mood	309
	Adjustment Disorder NOS	309
Anxiety Disorders:		**300**
	Acute Stress Disorder	308
	Agoraphobia	300
	Anxiety Disorder Due to a Medical Condition	300
	Anxiety Disorder NOS	300
	Generalized Anxiety disorder	50B, 300
	Obsessive-Compulsive Disorder	300
	Panic Attack	300
	Post-Traumatic Stress Disorder	309
	Social Phobia	300
	Specific Phobia	300
	Substance-Induced Anxiety disorder	300
Attention Deficit Disorders:		
	Attention Deficit disorder	**314**
Cognitive Disorders:		
	Amnestic Disorder	**294**
	Delirium	293
	Dementia	290,331,331.0,331.2
Dissociative Disorders:		
	Depersonalization Disorder	300
	Dissociative Amnesia	300
	Dissociative Fugue	300
	Dissociative Identity Disorder	300
	Dissociative Disorder NOS	300
Eating Disorders:		
	Anorexia Nervosa	307.1, 783.0, 307
	Bulimia	307

	Eating Disorder NOS	307
Factitious Disorders:		**300,312**
	Factitious Disorder; Physical & Psych Symptoms	300,312
	Factitious Disorder; Predom Physical Symptoms	300,312
	Factitious Disorder; Predominantly Psych Symptoms	300,312
Impulse Control Disorders:		**312**
	Impulse Control Disorder NOS	312
	Intermittent Explosive Disorder	312
	Kleptomania	312
	Pathological Gambling	312
	Pyromania	312
	Trichotillomania	312
Mental Disorders Due to a Medical Condition		
Mood Disorders:		
	Bipolar Disorder	296
	Cyclothymic disorder	301.1
	Depression	311
	Dysthymic Disorder	300.4
	Mood Disorder due to a Medical Condition	293.8
	Substance-Induced Mood Disorder	303, 304, 305
Schizophrenia and other Psychotic Disorders:		**295,296,297,298**
	Paranoid Type	295,297,298
	Disorganized Type	295, 298
	Catatonic Type	295, 298
	Undifferentiated Type	295, 298
	Residual Type	295, 298
	Brief Psychotic Disorder	295, 298
	Delusional Disorder	295, 298
	Psychotic Disorder due to Medical Condition	293
	Psychotic Disorder NOS	295, 298
	Schizoaffective Disorder	295, 298
	Schizophreniform Disorder	295, 298
	Substance-Induced Psychosis	295, 298
Sexual and Gender Identity Disorder Paraphilias:		**302**
	Exhibitionism	302
	Fetishism	302
	Frotteurism	302
	Pedophlia	302
	Sexual Masochism	302
	Sexual Sadism	302
	Transvestic Fetishism	302
	Voyeurism	302
	Paraphilia NOS	302
Sexual Dysfunction:		**302**

	Hypoactive Sexual Desire Disorder	302
	Female Orgasmic Disorder	302
	Female Sexual Arousal Disorder	302
	Male Erectile Disorder	302
	Male Orgasmic Disorder	302
	Premature Ejacualation	302
	Sexual Aversion Disorder	302
	Sexual Dysfunction due to a Medical Disorder	625
	Sexual Dysfunction due to a Substance	302
Sexual Pain Disorders:		
	Dyspareunia (not due to a Medical Condition)	302
	Vaginismus (not due to a Medical Condition)	302
Sleep Disorders:		
	Primary Insomnia	307
	Primary Hypersomnia	307
	Narcolepsy	347
	Breathing-Related Sleep Disorder	780.5
	Circadian Rhythm Sleep Disorder	307.4
	Insomnia Related to Another Mental Disorder	307.4
	Nightmare Disorder (Dream Anxiety Disorder)	307.4
	Sleep Disorder Due to a Medical Condition	780.5
	Sleep Disorder Related to another Medical Condition	780.5
	Sleepwalking Disorder	780.5
	Substance-Induced Sleep Disorder	780.5
Somatoform Disorders:		
	Somatization Disorder	300.8
	Conversion Disorder	300.1
	Pain Disorder	307.8
	Hypochondriasis	300.7
	Body Dysmorphic Disorder	300.7
Substance - Related Disorders:		
	Substance-Induced Anxiety Disorder	303,304,305
	Substance-Induced Mood Disorder	303,304,305
	Substance-Induced Psychosis	292
	Substance-Induced Sleep Disorder	303,304,305
Alcohol Dependence Syndrome		303
Drug Dependence Syndrome		304
Drug Abuse, Non-Dependent		305

Total Fee $

8. Palliative Care Planning Fee

G14063 Palliative Care planning fee.....100.00

This fee is payable upon the development and documentation of a Palliative Care Plan for patients who in your clinical judgement have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to 6 months, and who consent to the focus of care being palliative. Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy.

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

The Palliative Care Plan requires documentation of the following in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies.
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Palliative Care Planning Fee is billed.
3. Specifies a clinical plan for the patient's palliative care.
4. Incorporates the patient's values and beliefs in creation of the plan,
   Name and contact information for substitute decision maker.
5. Completion of a NO CPR FORM.
6. Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles.
7. Provides confirmation that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved allied care professionals as appropriate.

This fee requires a face-to-face visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Notes:

i) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.
ii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).
iii) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new GP who is assuming the ongoing palliative care for the patient.
iv) Payable in addition to a visit fee (home or office) billed on the same day.
v) Minimum required time 30 minutes face to face in addition to visit time same day.
vi) Claim must state start and end times of the service. Start and end times must also be documented in the patient chart.
vii) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14063.
viii) Not payable if G14033 or G14075 has been paid within 6 months.
ix) Not payable on same day as G14015, G14017, G14043 ,G14074, G14076 or G14079 GP Telephone/e-mail Management fee.
x) G14050, G14051, G14052, G14053, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid as patient has been changed from active management of chronic disease and/or complex condition(s) to palliative management.
xi) G14043, G14044, G14045, G14046, G14047, G14048, the GPSC Mental Health Initiative Fees are still payable once G14063 has been billed provided all requirements are met, but are not payable on same day.
xii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
xiii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

Successful billing of the Palliative care planning fee (G14063) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year over the following 18 months.

$

9. GPSC Incentives for GPs with Specialty Training

Eligibility:

- Must not have billed another GPSC fee item on the specific patient in the previous 18 months.
- Service may be provided when physician is located in office or hospital. For the purpose of these telephone advice fee items GPSC has defined General Practitioner (GP) with specialty training as: A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program.

- Telephone advice must be related to the field in which the GP has received specialty training

G14021 GP with Specialty Training Telephone Advice - Initiated by a Specialist or General Practitioner, Response within 2 hours 60.00

Notes:

i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Conversation must take place within two hours of the initiating physician's request. Not payable for written communication (i.e. fax, letter, e-mail).

iii) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

iv) Not payable for situations where the purpose of the call is to:

- *a. book an appointment*
- *b. arrange for transfer of care that occurs within 24 hours*
- *c. arrange for an expedited consultation or procedure within 24 hours*
- *d. arrange for laboratory or diagnostic investigations*
- *e. inform the referring physician of results of diagnostic investigations*
- *f. arrange a hospital bed for the patient*

v) Not payable to physician initiating call.

vi) No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).

vii) Limited to one claim per patient per physician per day.

viii) A chart entry, including advice given and to whom, is required.

ix) Include start and end times in time fields when submitting claim.

x) Not payable in addition to another service on the same day for the same patient by same practitioner.

xi) Out-of-Office Hours Premiums may not be claimed in addition.

xii) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.

G14022 GP with Specialty Training Telephone Patient Management - Initiated by a Specialist or General Practitioner or Allied Care Provider, Response in One Week – per 15 minutes or portion thereof 40.00

Notes:

i) Payable to a GP with specialty training for two-way telephone communication (including other forms of electronic verbal communication) regarding assessment and management of a patient but without the consulting physician seeing the patient.

ii) Conversation must take place within 7 days of initiating physician request. Initiation may be by phone or referral letter.

iii) If conversation is with an allied care provider include a note record specifying the type of provider.

iv) Includes discussion of pertinent family/patient history, history of presenting complaint and discussion of the patient's condition and management after reviewing laboratory and other data where indicated.

v) Not payable for situations where the purpose of the call is to:

- *a. book an appointment*
- *b. arrange for transfer of care that occurs within 24 hours*
- *c. arrange for an expedited consultation or procedure within 24 hours*
- *d. arrange for laboratory or diagnostic investigations*
- *e. inform the referring physician of results of diagnostic investigations*
- *f. arrange a hospital bed for the patient*

vi) Not payable to physician initiating call.

vii) No claim may be made where communication is with a proxy for either physician (e.g.: nurse or assistant).

viii) Limited to two services per patient per physician per week.

ix) A chart entry, including advice given and to whom, is required.

x) Include start and end times in time fields when submitting claim.

xi) Not payable in addition to another service on the same day for the same patient by same practitioner.

xii) Out-of-Office Hours Premiums may not be claimed in addition.

xiii) Cannot be billed simultaneously with salary, sessional*, or service contract arrangements.*

G14023 GP with Specialty Training Telephone Patient Management / Follow-Up
- per 15 minutes or portion thereof 20.00

Notes:

i) This fee applies to two-way direct telephone communication (including other forms of electronic verbal communication) between the GP with specialty training and patient, or a patient's representative. Not payable for written communication (i.e. fax, letter, e-mail).

ii) This fee is only payable for scheduled telephone appointments with the patient.

iii) Access to this fee is restricted to patients having received a prior consultation, office visit, hospital visit, diagnostic procedure or surgical procedure from the same GP with Specialty training, within the 6 months preceding this service.

iv) Telephone management requires two-way communication between the patient and physician on a clinical level; the fee is not billable for administrative tasks such as appointment notification.

v) No claim may be made where communication is with a proxy for the physician (e.g.: nurse or assistant).

vi) Each physician may bill this service four (4) times per calendar year for each patient.

vii) This fee requires chart entry as well as ensuring that patient understands and acknowledges the information provided.

viii) Include start and end times in time fields when submitting claim.

ix) Not payable in addition to another service on the same day for the same patient by the same practitioner.

x) Out-of-Office Hours Premiums may not be claimed in addition.

xi) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.

10. GPSC Incentives for A GP for Me/Attachment initiative

Overview:

The fee codes for the A GP for Me (Attachment) initiative are billable by family doctors who submit the MSP fee G14070 'GP Attachment Participation Code' to MSP at the beginning of each calendar year. Once successfully submitted, the Attachment initiative suite of fees may be billed. Submitting G14070 signifies that:

- You are providing full-service 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'. Refer to A GP for Me –Frequently asked questions Q6 for details.
- You have contacted your local division of family practice to share your contact information and to indicate your desire to participate in the community-level Attachment initiative as you are able. Division contacts are available online at www.divisionbc.ca.

The standardized wording of the Family Physician-Patient '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), xxxxxx
- 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

Locums working in an "Attachment Participating" family practice, are able to bill the fee codes for the "A GP for ME" Initiative, once they have successfully submitted MSP fee G14071 "GP Locum Attachment Participation Code", once at the beginning of each calendar year. The Locum and Attachment participating host FP should discuss and mutually agree on which of the GPSC Services, including the Attachment Initiative fees, may be provided and billed by the locum. However, locums have their own annual allotment of G14076 Attachment Telephone Management Fee. Submitting G14071 signifies that:

- You are providing full-service family practice services to the patients of the host physicians, and will continue to do so for the duration of any locum coverage for a family physician participating in the attachment incentive.

- You have contacted the Divisions of Family Practice central office to share your contact information (AGPforMe@doctorsofbc.ca) and to indicate your desire to participate as a locum in the community-level Attachment initiative as you are able. Refer to A GP for Me - FAQs for more information.

General Notes:

The Attachment incentives are billable for BC residents with valid MSP coverage only; Reciprocal claims for patients with out of province heath insurance are excluded. Rural retention premiums do not apply.

G14070 GP Attachment Participation Code.....0.00

The GP Attachment Participation Code should be submitted at the beginning of each calendar year by Full Service Family Physicians (FSFP)'s who choose to participate in the GPSC Attachment Initiative.

Once successfully processed by MSP, the FP may access the "Attachment participation" incentives (G14074, G14075, G14076, G14077).

Submit fee item G14070 GP Attachment Participation Code using the following "Patient" demographic information:

PHN:	9753035697
Patient Surname:	Participation
First name:	Attachment
Date of Birth:	January 1, 2013
ICD9 code:	780

Notes:

i) Bill once per calendar year to confirm participation in the Attachment initiative.

ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.

iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

GP Locum Attachment Participation Code

G14071 GP Locum Attachment Participation Code 0.00

The GP Locum Attachment Participation code may be submitted by the GP who provides locum coverage for Family Physicians participating in the Attachment initiative at the beginning of the calendar year or prior to the start of the first such locum in each calendar year. Once processed by MSP, the locum may access GP Attachment incentives for services provided while covering for the Attachment participating host FPs.

Submit fee item G14071 GP Locum Attachment Participation Code using the following "Patient" demographic information:

PHN:	9753035697
Patient Surname:	Participation
First name:	Attachment
Date of Birth:	January 1, 2013

Notes:
i) Bill once per calendar year at the beginning of the year or prior to the first locum coverage for a family physician who is participating in the attachment initiative.
ii) Not payable to any physician who has billed and been paid for any specialist consultation in the previous 12 months.
iii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.
iv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

G14074 GP Unattached Complex/High Needs Patient Attachment Fee 200.00
The Unattached Complex/High Needs Patient Attachment fee compensates for the time, intensity and complexity of integrating a new patient with high needs into a family physician's practice: the longer initial meetings, organization of the medical record, and initiation of appropriate Clinical Action Plan(s) as discussed with the patient.

By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice.

This fee is paid in addition to the visit fee

Billing this incentive requires the accepting family physician to collate and review the relevant patient record to date and to meet with the patient to discuss this information and determine what supports will be needed to provide for the patient's ongoing medical needs, taking into account his/her personal goals of care. The patient populations eligible for this intake fee are:

- Frail in Care (CSHA Clinical Frailty Scale score of six or more in residential care – new admissions only with exceptions for extenuating circumstances such as sudden departure from practice of existing MRP FP)
- Frail in the Community (CSHA Clinical Frailty Scale score of six or more)
- Significant Cancer
- Moderate to High Needs Complex Chronic Conditions

- Severe Disability in the community
- Mental Health and Substance Use
- New Mother and Infant(s) (intake can occur at any time during pregnancy up to 18 months of age. Each mother/child(ren) dyad counts as one unit for the purpose of billing this fee code.

When submitting G14074 for a new mother/baby dyad use the mother's PHN and diagnostic code 01N. For all other qualifying patients, use the diagnostic code for the most appropriate medical condition causing the complexity/high needs status.

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.

ii) Payable only for unattached new patients who do not already have a family physician. Requests for attachment may come from: Acute Care (ER and Admitted); Mental Health-Substance Use workers/Clinics; Home and Community Care; BC Cancer Agency or Regional Centers; Public Health; Colleagues; Local Division. Only payable on patients who are changing family physician if: the patient moves to a different community; the patient moves into a residential care/Long term care facility where the current family physician will no longer be responsible for the care; or, the patient's family physician leaves practice and another GP takes on one or some of the more complex patients but not the entire practice.

iii) Source of request to attach the patient must be documented in the new patient chart.

iv) Visit fee to indicate face-to-face interaction with patient same day must accompany billing.

v) Payable in addition to office visit, home visit or residential care visit same day.

vi) G14077 payable on same day for same patient if all criteria met.

vii) G14033, G14075, G14063 and G14043 not payable on same day for same patient.

viii) Maximum daily total of 5 of any combination of G14033 complex care, G14075) Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.

ix) Not payable for patients located in acute care.

x) G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.

xi) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

xii) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

G14075 GP Attachment Complex Care Management Fee.....315.00

The GP Attachment Complex Care Management Fee is advance payment for the complex work of caring for patients with eligible conditions. It is payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) as described below.

This Complex Care fee encompasses those patients with a qualifying diagnosis of Frailty as defined by a Canadian Study of Health and Aging (CSHA) Clinical Frailty Scale score of six or more, indicating the patient is Moderately or Severely Frail.

A complex care plan requires documentation of the following elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies.

2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the GP Attachment Complex Care Management Fee is billed.
3. Specifies a clinical plan for the care of that patient's chronic condition(s).
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic condition(s).
5. Outlines expected outcomes as a result of this plan, including any advance care planning for end-of-life issues when clinically appropriate.
6. Outlines linkages with other allied care professionals that would be involved in the care, their expected roles.
7. Identifies an appropriate time frame for re-evaluation of the plan.
8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as indicated.

The development of the care plan is done jointly with the patient and/or the patient representative as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.

ii) Payable only for patients with documentation of confirmed CHSA frailty level 6 (moderate) or 7 (severe).

iii) Claim must include the diagnostic code V15.

iv) Payable once per calendar year per patient on the date of the complex care planning visit.

v) Documentation of the Complex Care Plan is required in patient's chart.

vi) Minimum required time 30 minutes to review chart and create the care plan jointly with the patient and/or their medical representative. The majority of the time must be face-to-face. Documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required.

vii) Visit (in office or home) or CPx fee to indicate face-to-face interaction with patient same day must be billed for same date of service. Visit time does not count toward required planning time.

viii) G14077 payable on the same day for the same patient, for patients located in the community only as long term care facility patients are not eligible for 14075.

ix) Maximum daily total 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.

x) G14075 not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

xi) G14033 is not payable in the same calendar year for same patient as G14075.

xii) G14043, G14063, G14076, G14079 not payable on the same day for the same patient.

xiii) G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.

xiv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

xv) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

G14076 GP Attachment Telephone Management Fee.....15.00

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family

Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.

ii) Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care professionals (e.g.: Nurse, Nurse Practitioner) employed within the eligible physician office.

iii) Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed.

iv) Not payable for simple prescription renewals, notification of office or laboratory appointments or of referrals.

v) Payable to a maximum of 1500 services per physician per calendar year.

vi) G14077 payable for same patient on same day if all criteria are met. Time spent on telephone with patient under this fee does not count toward the time requirement for the G14077.

vii) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077.

viii) Not payable on the same calendar day as G14079.

ix) G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.

x) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

xi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

G14077 GP Attachment Patient Conference Fee - per 15 minutes or greater portion thereof.....40.00

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.

ii) Payable only to the Family Physician who has accepted the responsibility of being the Most Responsible Physician for that patient's care.

iii) Payable for two-way collaborative conferencing, either by telephone or in person, between the family physician and at least one other allied care provider(s). Conferencing cannot be delegated. Details of the Conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made.

iv) Conference to include the clinical and social circumstances relevant to the delivery of care.

v) Not payable for situations where the purpose of the call is to:
   a. book an appointment
   b. arrange for an expedited consultation or procedure
   c. arrange for laboratory or diagnostic investigations
   d. inform the referring physician of results of diagnostic investigations
   e. arrange a hospital bed for the patient

vi) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.

vii) Payable in addition to any visit fee on the same day if medically required and does not take place concurrently with the patient conference. (i.e. Visit is separate from conference time).

viii) Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day.

ix) The claim must state start and end times of the service.

x) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility.

xi) Not payable for simple advice to a non-physician allied care professional about a patient in a facility.

xii) Not payable in addition to G14015 G14016 or G14017 as these fees are replaced by G14077 for those Family Physicians who have submitted the GP Attachment Participation code.

xiii) Not payable to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have participated in the conference as a requirement of their employment.

xiv) Not payable to physicians who are working under salary, service contract or sessional arrangements who would otherwise have participated in the conference as a requirement of their employment.

11. GPSC Incentives for In-patient Care

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

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

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

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

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

C. That they will:

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

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

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

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

		Total Fee $
G14086	GP Assigned Inpatient Care Network Initiative	2100.00

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

- Be a Family Physician in active practice in B.C.
- Have active hospital privileges.
- Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing inpatient care – see below).
- Submit a completed Assigned Inpatient Care Network Registration Form.
- Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.
- Each doctor must provide MRP care to at least 24 admitted patients over the course of a year; networks may average out this number across the number of members.

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

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

The GP Assigned In-patient Care Network Incentive is payable for participation in the network activities for the majority of the following calendar quarter (50% plus 1 day). Once your registration in the network has been

confirmed, submit fee item G14086 GP Assigned in-patient care network fee using the following billing specifics:

Billing Schedule: First day of the month, per calendar quarter (January 1, April 1, July1, October 1) and is paid for the subsequent quarter
ICD9 code : 780

Your location will determine which PHN# to use:

Interior Health Authority:
PHN# 9752590587
Patient Surname: Assigned
First Name: IHA
Date of birth: January 1, 2013

Fraser Health Authority:
PHN# 9752590548
Patient Surname: Assigned
First Name: FHA
Date of birth: January 1, 2013

Vancouver Coastal Health Authority:
PHN# 9752590523
Patient Surname: Assigned
First Name: CVHA (note first name starts with 'C')
Date of birth: January 1, 2013

Vancouver Island Health Authority:
PHN# 9752590516
Patient Surname: Assigned
First Name: VIHA
Date of birth: January 1, 2013

Northern Health Authority:
PHN# 9752590509
Patient Surname: Assigned
First Name: NHA
Date of birth: January 1, 2013

G14088 GP Unassigned Inpatient Care Fee 150.00
The term "Unassigned Inpatient" is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted.

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

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

Notes:

i) Payable only to Family Physicians who have submitted a completed GP Unassigned Inpatient Care Network Registration Form and/or a GP Maternity Network Registration Form.

ii) Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission.

iii) Payable once per unassigned patient per in-hospital admission in addition to the hospital visit (00109, 13008, 00127) or delivery fee.

iv) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

v) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.