CHRONIC DISEASE MANAGEMENT

14050

GP - 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 been provided at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be a telephone (14076, 14079) or group medical visit (13763 – 13781) in the preceding 12 months. **Visits provided by a locum for the MRP GP are included; however an electronic note indicating this must be submitted with the claim.**

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

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

vi) Payable in addition to fee items 14051 or 14053 for same patient if eligible.

vii) Not payable once 14063 have been billed and paid as patient has been changed from active management of chronic disease to palliative management.

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

14051

GP - Annual Chronic Care Incentive (Heart Failure)..... $125.00

Notes:

i) Payable to the family physician who is 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 seen 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 (14076, 14079) or group medical visit (13763 – 13781). **Visits provided by a locum for the MRP GP are included; however an electronic note indicating this must be submitted with the claim.**

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

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

vi) Payable in addition to items 14050 or 14053 for the same patient if eligible

vii) Not payable once 14063 have been billed and paid as patient has been changed from active management of chronic disease to palliative management.

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

14052

GP - Annual Chronic Care Incentive (Hypertension) $50.00

Notes:

i) Payable to the family physician who is 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 (14076, 14079) or group medical visit (13763 – 13781). **Visits provided by a locum for the MRP GP are included; however an electronic note indicating this must be submitted with the claim.**

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

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

vi) Not payable if 14050 or 14051 paid within the previous 12 months.

vii) Not payable once 14063 have been billed and paid as patient has been changed from active management of chronic disease to palliative management.

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

14053

GP -Chronic Obstructive Pulmonary Disease – COPD…… $125.00

Notes:

i) Payable to the family physician who is 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). **Visits provided by a locum for the MRP GP are included; however an electronic note indicating this must be submitted with the claim.**

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

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

vi) Payable in addition to fee items 14050, 14051 or 14052 for the same patient if eligible.

vii) Not payable once 14063 have been billed and paid as patient has been changed from active management of chronic disease to palliative management.

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

ix) Successful billing of the Annual Chronic Care Bonus for COPD (14053) allows access to 5 Telephone/ E-mail follow -up fees (14079) per calendar year over the following 18 months.

FLOW SHEETS & ACTION PLANS

The GPSC requires physicians to track and document adequately the care provided to their patients to ensure they are providing guideline informed care. While it is not mandatory to utilize official GPAC flow sheets, if you use a different flow sheet to document your provision of guideline-informed care, all essential elements from the GPAC guideline must be included.

Effective July 1, 2015, there is no longer a requirement to share a flow sheet or action plan with patients. Documentation in the patient chart of the provision of patient self-management supports as part of the patient's chronic disease management is expected.

CDM Allowable Combinations in Single Patient

	14050	**14051**	**14052**	**14053**
14050		Yes	No	Yes
14051	Yes		No	Yes
14052	No	No		Yes
14053	Yes	Yes	Yes	

G14043 GP Mental Health Planning Fee $100

To access, FPs will identify their high-risk patients living in the community (i.e. home or assisted living) who meet the following criteria:

i) Axis I diagnosis confirmed by DSM IV criteria;

ii) Severity and Acuity level causing sufficient interference in activities of daily living that developing a management plan to maintain the patient safely in the community would be appropriate.
Additional factors that increase risk include drug or alcohol addiction, cognitive impairment, poor nutritional status, and socioeconomic factors such as homelessness.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of diagnosis through DSM IV diagnostic criteria.

It requires a face-to-face visit with the patient, with or without the patient's medical representative requiring a minimum of 30 minutes face-to-face. If the planning process goes longer than 30 minutes face to face, or there is an additional medical condition managed outside the 30 minutes, the office visit is billable in addition to 14043. If the planning session includes counseling and the total time is 50 minutes or more, the office counseling visit is billable in addition to 14043. Beginning August 1, 2015, **you must enter total start and end times** when submitting face-to-face time based fees, and this **must also be documented in the patient chart**.

Once the Mental Health Plan has been created, can access:

1) GP Mental Health Management Fees (14044, 14045, 14046, 14047, G14048) are an additional four (4) visit fees equivalent to the current age differential 00120 series. These fees are billable after the current 4 counselling Visit per year (age appropriate 00120 fees per MSP guide to fees) have been billed.
   Requiring a minimum of 20 minutes face-to-face counseling and must fulfill the same requirements from the preamble to fees as the MSP counseling fees.
2) GP Telephone/Email Management Fees (14079); access to telephone/email follow-up fees to allow flexibility in providing non-face-to-face management/follow-up for these patients. These telephone/email follow-up services may be provided by the physician or other medical professionals that are directly under the family physician or practice group's supervision (e.g. MOA or Office nurse).

   The telephone follow up care fee is to be used for providing clinical management such as medication, symptom, and clinical status monitoring. It is not for simple appointment reminder or referral notification.
   Billed up to a maximum of 5 times in the 18 months following the successful billing of the 14043, for either physician-initiated or patient-initiated follow up.
   Access to these supportive fees is restricted to the GP who has been paid for the Mental Health Planning Fee (14043) and is therefore Most Responsible GP (MRGP) for the care of that patient for the submitted Axis 1 condition. The only exception would be if the billing GP has the approval of the Most Responsible GP (eg. locum or shared coverage), and this must be documented as an electronic note entry accompanying the billing.

FPs who are participating in the "GP for Me" or Attachment Initiative have access to additional telephone visit fees to support the ongoing provision of care for any patient in their practice through the Attachment Patient Telephone Management fee 14076. Both of the fees for telephone management (14079 & 14076) may be billed on the same day as the conferencing fees (Attachment Patient Conference fee (14077) or Community Patient Conferencing fee (14016) provided the patient has not been seen and had any visit or other service code billed and all other criteria are met. The time spent with the patient on the telephone is compensated through one of the telephone fees and therefore does not count toward the time requirement of the conferencing fee.

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) 14043 claims 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 patient chart.
vi) 14016 or 14077 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) 14015, 14044, 14045, 14046, 14047, 14048, 14033, 14063, 14074, 14075, 14076 and 14079 not payable on the same day for the same patient.

GP Mental Health Management Fees: 14044 age 2–49
14045 age 50–59
14046 age 60–69
14047 age 70–79
14048 age 80+

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 (14043) 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 (14043), 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 patient chart.
vii) 14016 or 14077, payable on same day for same patient if all criteria met.
viii) 14015, 14043, 14076, 14079 not payable on same day for same patient.

How much time is required for billing the Mental Health Planning Incentives and how should the time be documented?

Require a minimum of 30 minutes face-to-face for the planning component. If the time goes beyond 39 minutes (due to the mental health plan or other medical reason) then an age differential office visit fee (00100) may be billed in addition to the 14043.

If the time goes beyond 49 minutes and the preamble requirements for counseling are fulfilled, the age differential MSP counseling fee (00120) may be billed in addition**. Start and end times for the total service time provided must be documented in the patient chart and are also required to be submitted with the fee to MSP**.

When can I bill the Mental Health Management Fees (14044-14048)
Payable only after all 4 MSP counselling fees of the 00120 series have been utilized and only if the GP has billed and been paid for the Mental Health Care Planning Fee.

Require a minimum of 20 minutes and must meet the criteria found in the preamble to fees regarding counseling. **Require start and end time documented in the patient chart and included when submitting the claim to MSP.**

When can I bill the GP Telephone/Email Management fee (14079)?
Payable for 2-way clinical interaction provided between the GP or delegated practice staff (e.g. office RN or MOA) in follow-up on the Mental Health Planning Fee (14043).
Payable only if the GP or practice has billed and been paid for at least one of the portal GPSC incentives, including the Mental Health Planning Fee (14043).

When can I bill the Attachment Patient Telephone Management fee (14076)?
Patients who are eligible for the original 14079 GP Telephone/e-mail Management Fee are also eligible for additional new 14076 GP Attachment Telephone Management fees if their FP is participating in a GP for Me (attachment).

Am I eligible to bill for the Chronic Disease Management Fee(s) (14050, 14051, 14052, 14053) in addition to these Mental Health Initiative fees? Yes. Patients with mental health diagnoses still often have co-existing medical conditions. For those patients with Diabetes (14050), CHF (14051), Hypertension (14052) or COPD (14053), the appropriate CDM payment(s) are payable in addition to the Mental Health Care payment(s).