Complex Care Management Fees

Complex Care Management Fee (14033) 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**.

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.

Eligible Complex Care Condition Categories:
1) Diabetes mellitus (type 1 and 2)
2) Chronic Kidney Disease (see FAQ #9)
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 (eg. 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. (see FAQ #8)

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.

14033 Annual Complex Care Management Fee $315

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) 14016 or 14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for 14033.

viii) 14050, 14051, 14052, 14053 payable on same day for same patient, if all other criteria met.

ix) Not payable once 14063 has been billed and paid as patient has been changed from active management of complex chronic conditions to palliative management.

x) 14015, 14017, 14076 and 14079 not payable on the same day for the same patient.

xi) Maximum daily total of 5 of any combination of 14033 complex care, 14075 Attachment Complex Care or 14074 GP unattached complex/high needs patient attachment fees per physician.

xii) 14075 is not payable in the same calendar year for same patient as 14033.

xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.

14070
The Attachment incentives are available for BC residents with valid MSP coverage only; Reciprocal claims for patients with out of province health numbers are excluded.

14070 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 (14074, 14075, 14076, and 14077).

Submit fee item 14070 GP Attachment Participation Code using the following "Patient" demographic information: PHN#: 975 303 5697
Patient Surname: Participation
First name: Attachment
Date of Birth: January 1, 2013
ICD9 code: 780

Submission of this code 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'.
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.

Notes: **i)** Bill <u>once per calendar year</u> 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.

**In subsequent years, in order to continue to access the Attachment fee supports 14074, 14075, 14076 & 14077, <u>at the beginning of each calendar year</u>, participating FPs must re-submit fee item 14070 GP Attachment Participation Code indicating their intention to continue to participate in the program.

14074
GP Unattached Complex/High Needs Patient Attachment Incentive $200

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. Once accepted into the practice, patients become eligible for other GPSC incentives provided they meet all eligibility criteria. **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.

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

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/or 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 14074 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 14070

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) 14077 payable on same day for same patient if all criteria met.

vii) 14033, 14075, 14063 and 14043 not payable on same day for same patient.

viii) Maximum daily total of 5 of any combination of 14033 complex care, 14075 Attachment Complex Care or 14074 GP Unattached complex/high needs patient attachment fees per physician.

ix) Not payable for patients located in acute care.

x) 14015, 14016 and 14017 not payable in addition, as these fees have been replaced by 14077 for FPs who have submitted the GP Attachment Participation Code.

Billing this incentive requires a review of the relevant patient record to date and meeting with the patient and/or the patient's medical representative to discuss this information and determine what other supports will be needed to provide for the patient's ongoing medical needs, taking into account his/her personal goals of care. By billing this incentive, the FP commits to providing ongoing longitudinal care for the patient accepted into the FSFP practice.

In order to facilitate the identification of eligible patients, it is expected that there will be a request to attach the patient from a separate source. The initial source and process for these requests can be found in the fee specific background information. The request does not need to come from a physician but can be provided by Care Provider working within the requesting center provided they have the capability to determine/confirm that the patient meets the target population requirements.

FAQ:

Why is a request required and is a formal referral either using a referral form or by submitting anything through MSP required in order to bill fee item 14074 Complex/High-needs Unattached Patient Attachment Fee for accepting these patients into a Full Service Family Practice?
The requirement of a request to attach is to embed a vetting/triaging process to ensure that patients being accepted into a Community longitudinal family physician's practice meet the requirements/intent of the incentive. It can be a written request (paper, fax, secure e-mail) or it can be a verbal request.

Once the request to take on the patient has been accepted, the new FP must document in the chart who requested that the patient be taken into the practice and what the patient's qualifying conditions are, followed by the usual Allergies, Medications, Past Medical Hx, Family History and then the review of conditions and the plan for management that has developed jointly with the patient. The requesting physician or agency does not need to document the request in their chart/file for the patient. There is no need for a formal referral to be submitted through Teleplan or to the local division.

What specific diagnoses qualify in the various broad categories of eligible patients for the GP Unattached Complex/High Needs Patient Attachment Fee (14074)?
Rather than developing an extensive list that will always be incomplete, the intent of the "Complex/High-needs Unattached Patient Attachment Incentive" is to attach those patients who will most benefit from being in a strong FP – patient relationship over time. As such, the intended target population are to have medical conditions that are of sufficient severity and potential for poor outcomes that ongoing monitoring and management through the planned proactive care that is found within the Full Service Family Physician – Patient relationship will benefit both their quality of life, improve outcomes and lessen the impact of their condition on activities of daily living. Having a specific diagnosis or co-morbidities does not necessarily equate to being "Complex" or highneeds. It is expected that Family Physicians participating in the Attachment Initiative will use their clinical judgment to ensure that patients who are accepted under the Unattached Complex/High-needs Patient Attachment fee 14074 in fact do meet the criteria and require the level of time, intensity and complexity as indicated above.

Will 14074 GP Unattached Complex/High Needs Patient Attachment Fee be applicable for patients of an FP who is retiring or leaving practice for other reason?
If there is a new FP taking over a practice of a doc retiring/leaving, the new FP is not eligible to bill 14074 GP Unattached Complex/High Needs Patient Attachment Fee on any existing patients of practice as all practice infrastructure in existence it is a transition only. New patients accepted into the practice through the process that is developed locally will be eligible for 14074 GP Unattached Complex/High Needs Patient Attachment Fee. If there is no FP to take over a practice of a doc retiring/leaving and the leaving FP asks other colleagues (in same clinic or other location) to take on these complex patients, GPSC has agreed that this is an acceptable request so the FP accepting transfer of these patients will be able to bill the 14074 GP Unattached Complex/High Needs Patient Attachment Fee for eligible patients. Alternatively, the locally determined unattached patient attachment process can be the source that requests the patients be attached to the accepting FPs.

14075 GP Attachment Complex Care Management Fee

GPSC has received feedback that the initial dual diagnosis-based complex care fee excludes many patients who are also very time and resource intense. The initial expansion of the 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 Moderately or Severely Frail) who do not otherwise qualify under the dual diagnostic eligibility for 14033 Complex Care Management Fee. Patients will qualify only for one of the Complex Care Management Fees, not both.

Effective Aug 1, 2015, documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required. There is no requirement to submit start/end times with claim for the complex care incentive as the 30 minute planning time is not required to be all face to face and the physician review may be on same or different day.

CSHA Clinical Frailty Scale*
1) Very Fit: robust, active, energetic, well-motivated and fit
2) Well: without active disease, but less fit than people in Category 1
3) Well, with treated comorbid disease: symptoms are well controlled
4) Apparently Vulnerable: although not frankly dependent, these people commonly complain of being "slowed up" or have disease symptoms
5) Mildly Frail: with limited dependence on others for instrumental activities of daily living
6) Moderately Frail: help is needed with both instrumental and non-instrumental activities of daily living
7) Severely Frail: completely dependent on others for the activities of daily living, or terminally ill guidelines.

Advance care planning is the process whereby a capable adult discusses their beliefs, values, wishes or instructions for future health care with trusted family and health care providers. Advance care planning may lead to a written Advance Care Plan (ACP). An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on conversations with trusted family/friend and health care provider. The ACP is to be used by a Substitute Decision Maker (SDM) to make health care decisions for the adult when incapable and this may include consent or refusal for treatment. The decisions are to be based on a healthcare provider's offer of medically appropriate care. An Advance Directive is a legal document consenting to or refusing specific treatment options and may or may not be included in the ACP. If it is, then health care providers are legally bound by consent refusals in the advance directive.

14075 GP Attachment Complex Care Management Fee $315

It is payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) as described below.
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 14070 GP
- **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)** 14077 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, 14075 Attachment Complex Care or 14074 GP unattached complex/high needs patient attachment fees per physician.
- **x)** 14075 not payable once 14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.
- **xi)** 14033 is not payable in the same calendar year for same patient as 14075.
- **xii)** 14043, 14063, 14076, 14079 not payable on the same day for the same patient.
- **xiii)** 14015, 14016 and 14017 not payable in addition, as these fees have been replaced by 14077 for FPs who have submitted the GP Attachment Participation Code.

FAQ:

What are instrumental and non-instrumental activities of daily living?

Instrumental Activities of Daily Living = Activities that are required to live in the community:
• Meal preparation • Ordinary housework • Managing finances • Managing medications • Phone use •Shopping • Transportation

Non-Instrumental Activities of Daily Living= Activities that are related to personal care:
• Mobility in bed • Transfers • Locomotion inside and outside the home • Dressing upper and lower body • Eating • Toilet use • Personal hygiene • Bathing

Patients who require assistance for at least one ADL from each category are defined as Level 6 Frailty.

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.

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) 14016 or 14077 payable on same day for same patient if all criteria met.

vi) 14015, 14017, 14033, 14043, 14063, 14076 and 14079 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 14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

FAQs:

Are there any age restrictions for this new incentive? No, it was felt that due to the broad nature of the target patient population, it would be appropriate to be inclusive of children and adolescents in addition to the adult population, with age appropriate prevention recommendations (eg. Immunization review; chronic illness & cancer screening; diet; exercise; and smoking discussions).

Am I eligible to bill for an office visit, procedure, or conference fee on the same day? Yes. In fact, the incentive must be performed in a face-to-face individual visit with the patient or the patient's medical representative, and as such **the age appropriate 00100 must be billed in addition to the 14066**.

Is this fee billable in a group medical visit setting? No.

Can I provide a follow-up by telephone to the patient to review the progress of their personal prevention plan? If you are participating in the "A GP for Me"/Attachment Initiative and have submitted the 14070 earlier in the calendar year, then the provision of follow-up by telephone can be billed using the G14076 Attachment Patient Telephone fee.

GP Attachment Telephone Management Expansion Telephone and other non-face-to-face 'visits' or 'touches' are a standard component of workflow in other jurisdictions. They have been shown to significantly improve efficiency of care and therefore practice capacity.

In this context, the expansion of telephone 'visits' as part of the Attachment Initiative is seen as an important component of improving practice capacity. The intent is to avert the need for a patient to be physically seen in the practice in order to increase access for other patients and/or to address urgent problems to avert a patient visit to an urgent care facility or Emergency Department.

They can be used at the discretion of the Family Physician for any patient for whom that Family Physician has assumed the Most Responsible Physician role for any clinical reason that addresses the intent above. The current GPSC telephone fee (14079) available for patients on whom a FP has assumed MRP status and has billed a GPSC planning fee (Complex Care, COPD, Mental Health, and Palliative Care) will remain intact outside the portal and will not be dependent upon an FP submitting an Attachment Portal Fee. It is recommended that for patients who are eligible for 14079, these should be utilized first (**5 over the 18 months following the provision and billing of the eligible planning fees)** before using the 14076 GP Attachment Telephone Management fees due to the limited number per participating FP (1500 per calendar year).

14076 GP Attachment Telephone Management Fee $15

Notes:

- **i)** Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code 14070
- **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 (eg. 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)** 14077 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 theG14077.
- **vii)** **Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of 14077.**
- **viii)** Not payable on the same calendar day as the GP Telephone/e-mail fee 14079.
- **ix)** 14015 , 14016 and 14017 not payable in addition, as these fees have been replaced by 14077 for FPs who have submitted the GP Attachment Participation Code.

FAQs:

What is the difference between the 14076 GP Attachment Telephone Management Fee and the original 14079 GP Telephone/e-mail Management Fee? The new 14076 GP Attachment Telephone Management Fee has no specific patient diagnostic criteria and has no restrictions on the number of telephone visits that can be billed per patient per year. This new fee is only for telephone management, not e-mail communication. In the prototyping phase for this new non-face-to-face incentive, there will be a cap of 1500 telephone fees per participating FP per year.

Any patient for whom the FP is the Community MRP FP is eligible to have this code submitted for telephone visits provided by participating FPs. The originalG14079 GP Telephone/e-mail Management Fee is restricted to those patients on whom one of the Planning related fees (14033 Complex Care;

14043 Mental Health; GP14053 COPD CDM – requires a COPD Action Plan; 14063 Palliative Care; 14075 Attachment Complex Care) has been claimed and is restricted to 5 Telephone/e-mail in the 18 months following the successful billing for one of these portal . This is reset each time the portal fee is billed in the subsequent year whether all 5 have been used or not (do not accumulate).

However, patients who are eligible for the original G14079 GP Telephone/e-mail Management Fee are also eligible for additional new G14076 GP Attachment Telephone Management fees if their FP is participating in a GP for Me (attachment). FPs are encouraged to think about how they would spread the restricted number of new Telephone fees they will have access to in this prototyping phase when providing telephone follow-up to patients who would also be eligible under the original telephone/e-mail fee. Therefore, if a Family Physician thinks he/she will make a lot of these telephone calls, and any of them are for patients who are eligible for the 14076, it would be best to use all 5 of the 14079 for these patients first before using the new 14076. This way, you leave the "arrows in the quiver" for other patients who do not qualify for the 14079 unless you have used all 5 of the 14079 already, then you can use 14076 if you still have any left of your 1500 in that calendar year.

If when making a phone call to the patient there is no answer and a message is left on voice mail, can G14076 GP Attachment Telephone Management Fee be billed? No, 14076 requires a two-way telephone conversation with the patient.

Telephone Management requires “a clinical telephone discussion between the patient or the patient’s medical representative and physician or College certified allied care professionals working within the eligible physician office”. **Which college certified AHPs qualify for making these calls to be eligible for the G14076 GP Attachment Telephone Management Fee to be billed?** 14076 Attachment Patient Telephone Call fee is billable when the telephone call is made by the staff member of the FP office providing she/he is a member of a college certified allied care profession - nurse, NP, LPN, etc. This excludes the Medical Office Assistant. When an RN, LPN or NP is working within her/his scope of practice and is the employee of the FP, these calls are covered

If the telephone call with the patient is only about a WorkSafeBC covered injury, can G14076 GP Attachment Telephone Management Fee be billed? When providing a service to a patient regarding an injury that is covered by WorkSafeBC it is not appropriate to bill for these services to MSP. However, WorkSafeBC has indicated they will consider payment for these calls billed under code 14076 on an individual basis when submitted with WSBC as the insurer. Calls submitted with WSBC as the insurer will not count toward the 1500 per calendar year limit submitted under MSP as the insurer. To submit to WSBC for consideration, **ensure “W” is listed in the insurer section of the fee submitted** through Teleplan.

GP Attachment Patient Conference Fee The GPSC has received feedback about the complexity of the initial Patient Conferencing incentives. As part of the Attachment Initiative, these concerns have been addressed through a significant simplification as well as expansion of the Attachment Patient Conference fee in order to support improved collaborative care between participating FPs and other health care providers.

The Attachment Patient Conference fee replaces all three of the original conference codes (14015, 14016 & 14017) as well as removes a number of other identified barriers that were present in order to bill these codes.

14077 GP Attachment Patient Conference Fee $40.00 per 15 min or greater portion thereof

Notes:

- **i)** Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code
- **ii)** Payable only to the Family Physician who has accepted the responsibility of being the MRP 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 Care 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, nonoverlapping 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)** **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 14015, 14016 or 14017 as these fees are replaced by 14077 for those Family Physicians who have submitted the GP Attachment Participation code.

What is the difference between the 14077 GP Attachment Patient Conference Fee and the original 14015 GP Facility Patient Conference, 14016 GP Community Patient Conference and 14017 GP Acute Care Discharge Planning Conference fees?

The 14077 GP Attachment patient Conference fee essentially amalgamates the original conference fees 14015 (Facility Patient Conference Fee), 14016 (Community Patient Conference Fee) & 14017 (Acute Care Discharge Planning Conference fee) and also removes the barriers that existed with these initial ones. FPs participating in the Attachment Initiative will never again have to remember the original codes and the requirements for billing them. Now, there is a single code, 14077, with a total of 18 units per

calendar year and 2 units per calendar day (same as the combined totals for the original fees) but with much more flexibility in when, where and how they can be accessed:

- Can be used when the patient is located in the community, acute care, sub-acute care, assisted living, long-term or intermediate care facilities, detox units, mental health units, etc. etc.
- Can be provided/requested at any stage of admission to a facility from ER through stay to discharge)
- Need to conference with at least 1 allied care professional (including physicians) regardless of location.
- Can be done in person or by telephone.
- Can be initiated by either the FP or the Allied care Professional.

Is 14077 GP Attachment Patient Conference Fee billable for patients in acute care?
FP bill the 14077 for conferences that occur for any patient in their practice (there are no diagnostic requirements with the 14077 unlike with the original conference codes which were restricted to Frail elderly, Palliative/End-of-Life, Multiple Co-morbidities, Mental Health). There is also no patient location restriction for this new conference fee. So patients may be in the community or in a facility (any facility including acute care and even in ER). All of the conferencing codes have the same time requirements – billed per 15 minutes or greater portion thereof, requires start and end time. Simple/brief advice to a non-physician allied care practitioner is covered using 13005 for patients in community "care" (eg. home health, palliative care, and public health services provided in the home) or any facility except acute care.

What "Allied care Professionals" are included in order to bill 14077 GP Attachment Patient Conference Fee? 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.

If a hospital has a multidisciplinary team potentially that meets to discuss the needs of inpatients with respect to issues such as placement, nutritional support, physio or rehab, and the condition of the patient determines that there is the necessity of a physician meeting with the group, will this team meeting be eligible for billing 14077 GP Attachment Patient Conference Fee? Yes, FP conferencing with this group of Allied care Professionals (either in person or by teleconference) would qualify for the use of the new Attachment Patient Conference fee 14077 regardless of the underlying patient medical condition that requires the conference to occur. There is a limit of 2 units (30 minutes) per calendar day per patient, and with the 18 units per calendar year, there is increased flexibility for using this fee across locations/scenarios of conferencing. Conversations that are part of the normal clinical hospital rounds would not be eligible for 14077 as this does not meet the criteria or intent of the conferencing fees.

G14015 General Practice Facility Patient Conference $40.00

Payable when requested by a facility to review on-going 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

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 the facility.

b. Review and organization of appropriate clinical information.

c. The integration of relevant information into the formulation of an action plan for the care of the patient in the 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.

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 also be documented in patient chart.

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

FAQs:

How do I claim the Facility Patient Conference Fee payments? Submit the fee item 14015 (value $40 for each 15 minute unit or major portion thereof) 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

14016 GP Community Patient Conference Fee $40.00 per 15 minutes or greater portion thereof
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 to develop a clinical action plan due to the severity of the patient's condition (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)

Notes:

i) 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

ii) Fee includes:
a. Where appropriate, interviewing of and conferencing with patient, family members, and 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 in the community, 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.

iii) Maximum payable per patient is 90 minutes (6 units) per calendar year.

iv) 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 also be documented in the patient chart.

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

vii) Not payable to physicians who are participating in the GPSC attachment initiative (14070).

viii) Not payable to the same patient on the same date of service as fee item 14015, 14017, 14074, 14075, 14076 or 14077.

14017 Acute Care Discharge Planning Conferencing fee $40.00 - per 15 minutes or greater portion thereof

It is 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 and must be performed in the acute care facility with 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).

This fee includes:
• Interviewing of and conferencing with other allied care providers of both the acute care facility and community and may in addition include where appropriate, the patient and/or family members. • Review and organization of appropriate clinical information;
• 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;

• 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 Restrictions
• 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;
• If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.
• Not billable on the same day as Facility Patient or Community Patient Conferencing Fees (14015 or 14016);
• This incentive payment is not payable for FPs participating in the GPSC Attachment Initiative as it has been replaced by 14077 Attachment Patient Conference Fee;
• Not billable on the same day as any GPSC planning fees (14075, 14033, 14043, 14063)

Notes:

i) 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.

ii) 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 interfacility transfer).

iii) 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.

iv) 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, any allied care provider charged with coordinating discharge and follow-up planning.

v) 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.

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 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.

vii) 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.

viii) Maximum payable per patient is 90 minutes (6 units) per calendar year. Maximum payable on any one day is 30 minutes (2 units). x) Claim must state start and end times of the service. Start and end times must also be documented in the patient chart. xi) If multiple patients are discussed, the billings shall be for consecutive, nonoverlapping time periods. xii) 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) Medically required visits performed consecutive to the Acute Care Discharge Conference are payable. (i.e. Visit is separate from conference time).

x) 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.

xi) Not payable to physicians who are participating in the GPSC attachment initiative (14070).

xii) Not payable to the same patient on the same date of service as fee item 14015, 14016, 14074, 14075, 14076 or 14077.

xiii) Not payable on the same day as any GPSC planning fees (14033, 14075, 14043, 14063 (Palliative Planning Fee).

14018 General Practice Urgent Telephone Conference with a Specialist/GP with Specialty Training Fee $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, email). 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 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) Not payable to the same patient on the same date of service as fee items 14015, 14016, 14017 or 14077,

v) **Include start time in time fields when submitting claim**.

vi) 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).

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

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

ix) **Maximum of 6 (six) services per patient, per practitioner per calendar year**.

x) Visit payable on same date of service if medically required and does not take place concurrently with the clinical action plan.

14063 Palliative Care planning fee **$100**

Payable upon the development and documentation of an Advance (Palliative) Care Plan for patients who in your clinical judgment 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 rather than treatment aimed at cure. Patients in Acute and Long-term Care 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) 14016 or 14077 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 14033 or 14075 has been paid within 6 months.

ix) Not payable on same day as 14015, 14017, 14043, 14074, 14076 or 14079 GP Telephone/e-mail Management fee.

x) 14050, 14051, 14052, 14053, 14033, 14066, 14075 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) 14043, 14044, 14045, 14046, 14047, 14048, the GPSC Mental Health Initiative Fees are still payable once 14063 has been billed provided all requirements are met, but are not payable on same day.

Successful billing of the Palliative care planning fee (14063) allows access to 5 Telephone/e-mail follow-up fees (14079) per calendar year over the following 18 months