SGP www.sgp.bc.ca

GPSC FEE CODE SUMMARY

Society of General Practitioners

GPSC Fees: **GPSC fees are payable to the FP who accepts the role of being Most Responsible for the longitudinal, coordinated care of the pt.**

Fee Code	$	Notes
14050 Annual Chronic Care Bonus - Diabetes **Dx code: 250**	125.00	INTENT: Chronic Care fees are management bonuses are for the provision of a clinically appropriate level of guideline-informed care for each specific condition. It is acknowledged that patent's values & comorbidities, as well as applicability of guideline recommendations to the patient's particular clinical context that should be taken into account when planning for their care. **BILLABLE: YEARLY ON THE ANNIVERSARY** of the initial billing date. Billed after 12 months of care for the specific condition and must have at billed/submitted for at least 2 visits/encounters with the patient in the 12 months prior to billing any of the CDM Bonus codes. NOTES: * Diabetes, CHF and COPD Condition Based payments are all billable together on the same patient. Hypertension CDM fee code is not billable if also billing for Diabetes and/or CHF, but is billable with COPD CDM. GPs on APP eligible to bill CDM incentives as these are for the overall management of patients with these conditions, not for an individual service. * Use of flow sheets is recommended as a tool for tracking care, but it is not mandatory to use the "official" GPAC flow sheet, as long as all the required information is included in the method you use. (Many EMRs have built in flow sheets) * For 14052 (BP) Pts to be given copy of flow sheet for the yr re: self-management. For (Do not need to give DM or CHF flow sheet to pt) * For 14053 (COPD) Patients must be given a copy of the COPD action plan during the first year for which this Chronic Care management bonus is billed. The COPD Action plan should be reviewed on an annual basis. * 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.
14051 Annual Chronic Care Bonus - CHF **Dx code: 428**	125.00	
14052 Annual Chronic Care Bonus - Hypertension **Dx code: 401**	50.00	
14053 Annual Chronic Care Bonus - COPD **Dx code: 491, 492, 494 or 496**	125.00	
14033 Annual Complex Care Fee CVD = Cerebrovascular Dz IHD = Ischemic Heart Dz Neuro + Resp N519 / IHD + CHF I428 Neuro + IHD N414 / IHD +DM I250 Neuro + IHD N414 / IHD +CVD I430 Neuro + CHF N428 / IHD +CKD I585 Neuro + DM N250 / IHD +CLD I573 Neuro + CVD N430 / CHF + DM H250 Neuro + CKD N585 / CHF + CVD H430 Neuro + Liver N573 / CHF + CKD H585 Resp + IHD R414 / CHF + CLD H573 Resp + CHF R428 / DM + CVD D430 Respi + DM R252 / DM + CKD D585 Resp + CVD R430 / DM + CLD D573 Resp + CKD R585 / CVD + CKD C585 Resp + CLD R573 / CVD + CLD C573 CKD + CLD K573	315.00	INTENT: To compensate GPs in advance for the management of complex patients living in the community (residing in their homes or assisted living – excludes care facilities) who have chronic conditions from a least 2 of the 8 categories: DM; CKD; CHF; Chronic Respiratory; Cerebrovascular; IHD; Neurodegenerative; and Chronic Liver Disease with evidence of hepatic dysfunction. BILLABLE: Once per calendar year at any time in the year. On the day of the planning visit, bill 14033, PLUS the visit (0100, 00101 or 00103) Continue to bill as usual for care provided over rest of calendar year. Note: Chronic Care Fees payable in addition when indicated. TIME: Minimum 30 min spent on complex care planning process encompassing: i)Review of the Complex Conditions and current treatment (not necessarily face-to-face) ii)Development of a care plan in collaboration with the patient &/or the patient representative as appropriate. The pt &/or their representative should leave the planning process with the knowledge that there is a plan for their care and what that plan is. PORTAL to (14079) telephone/e-mail follow-up. Once 14033 has been successfully billed – over the next 18 months GP can access up to 5 phone/e-mail follow- up management fees with patient or their family. NOTE: Attachment participating and non-participating FPs have access to G14033 (Note: 14075 & 14033 may not be billed on same pt in same calendar year)
14063 Palliative Care Planning Fee	100.00	INTENT: To Compensate for the development and documentation of a Palliative Care Plan for patients living in the community (see above) who 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. Requires minimum of 30 minutes face-to-face. PORTAL to (14079) telephone calls. Once 14063 billed, over the next 18 mos can access up to 5 phone/e-mail follow-ups with pt or family.
14043 Mental Health (MH) Planning Fee	100.00	INTENT: To Compensate for the development and documentation of a Mental Health Plan for patients living in the community (see above) with a confirmed Axis I diagnosis of sufficient severity and acuity to warrant the development of a management plan. TIME: Must be 30 min face to face. If longer than 30 min, may also bill 00100 or 00120 (if over 50 min and fulfills preamble req for counseling) PORTAL to (14079) telephone/e-mail follow-up. Also portal to (14044, 14045, 14046, 14047, 14048), once 14043 has been billed.
14044 MH Care Mgmt fee (ages <50) **14045 MH Care Mgmt fee (ages 50-59)** **14046 MH Care Mgmt fee (age 60 - 69)** **14047 MH Care Mgmt fee (age 70 - 79)** **14048 MH Care Mgmt fee (age 80+)**	=00120 =15320 =16120 =17120 =18120	BILLABLE: Once 14043 has been successfully billed, **AND** once a patient's four MSP 00120's for the calendar year have been used up, these 4 additional counselling visits can be billed over the duration of the calendar year. This means that in total, a patient may have eight 20 min counselling visits in a calendar year, along with a 30 min Mental Health planning visit.
14079 GP Patient Telephone/E-mail Follow-up Management fee	**15.00**	INTENT: To compensate for 2-way communication (FP or office staff) 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 GPSC portal fees. Not for simple appointment reminders or RX renewals. BILLABLE: Once any portal fee (14033, 14043, 14053, 14063, 14075) has been successfully billed – over the next 18 months GP may access up to 5 phone/e-mail follow up fees .
14018 GP Telephone Urgent Telephone Conference with a Specialist/GP with Specialty Training	**40.00**	INTENT: To improve management of the patient with acute needs, and reduce unnecessary ER or hospital admissions/transfers. Conversation must take place within two hours of the GP's request for the development and implementation of a care plan within the next 24 hours to keep the patient stable in their current environment. Must be physician to physician communication. Not payable for written communication (i.e. fax, letter, e-mail).

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GPSC Fees: Valuing the care of complex patients. . . Supporting longitudinal continuity & ongoing coordination of patient care. . . Valuing being someone's doctor. . .		
GPSC Conferencing fees **14015, 14016, 14017**		INTENT: Compensate the GP when conferencing with other health care professionals in a variety of circumstances and locations. A care plan must be recorded in the chart and include the following information: Documentation: Reason for Care conference, Health Care Providers with whom you conferred & their role; Start & stop time. **Eligible patient populations for these three conferencing fees: Frail elderly (ICD-9 V15); Palliative/End-of-Life (ICD-9 V58); Complex Mental Illness (Use Dx appropriate ICD-9); or, Complex comorbidity (Use ICD-9 for one of comorbidities.** Payable Per 15 minutes or greater portion thereof, Max of 2 units per calendar day, 6 units per calendar year per patient, per code.
14015 Facility Patient Conferencing Fee	**40.00**	ELIGIBLE Facilities: LTC, Rehab, Palliative, Sub-acute, Psychiatric (as in-pt), Detox/drug& alc (as in-pt), Hospital (complex or long stay pt) BILLABLE when requested by facility to attend care conferences with at least 2 other health care providers for patients in a care facility. Requires in person attendance at care conference.
14016 Community Pt Conferencing Fee	**40.00**	INTENT: Compensate the GP when conferencing with at least one other health care professional for the creation of a coordinated clinical action plan for the care of patients with more complex needs who are living in the community (see above for definition of community)
14017 Acute Care DC Planning Conf Fee	**40.00**	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. Requires in person attendance at conference with at least 2 other health care providers for eiligible patients in acute care.
14066 Personal Health Risk Assessment **Eligible population – must have one of four risks:** **Smoking Dx786** / **Obesity (BMI >30) Dx 783** **Unhealthy Eating Dx783** / **Inadequate Exercise Dx 785**	**50.00**	INTENT: Risk assessment & planning visit both for identified risks & to review relevant recommended prevention services based on age, sex and gender (eg. Pap, mammogram, stool OB, immunizations, etc.) BILLABLE for a maximum of 100 patients per physician per calendar year. Physician must track total #. Payable once per pt per yr. NOTE: Locums can bill but discuss with host FP 1st – locum physician has 100 max per year. (Cannot bill on pt already billed for the yr)

ATTACHMENT: The goals of this initiative are to: support and strengthen enduring doctor-patient relationships, better support the needs of vulnerable patients, provide access to family doctors for those British Columbians who want one, and increase the capacity of the primary health care system. Divisions of Family Practice will also have access to funding to assess the needs of the doctors and patients of their community and to improve supports to meet those needs. Read the details of the attachment initiative at: http://www.gpscbc.ca/attachment-initiative

To bill the Attachment Fee Codes listed below, once notification of intention to participate in Attachment has been sent to local Division of Family Practice (not needed if no Division locally available) MD must first submit Attachment Participation Code 14070 (zero sum fee code). Billing 14077 (once per year) 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'. See Q6 in FAQ for details.
- You have contacted your local division of family practice to share your contact info & to indicate your desire to participate in the community-level Attachment initiative, as you are able.

Attachment Fee Codes	$	Notes: To bill Attachment Fee Codes, MD must first choose to participate in Attachment & submit Participation Code 14070
14077 NEW Attachment Conference fee* **(REPLACES: 14015, 14016 & 14017 with ONE simpler, streamlined alternative for FPs participating in GPSC Attachment Initiative)**	**40.00**	INTENT: 2 way case conference with at least one other health professional. (Specialist or allied health professional) IMPROVEMENTS: Simplified SINGLE code, 14077, no matter where or how the conference occurs or who the patient is. •Only ONE fee code to remember for all case conferencing. •Can be telephone or in-person conference. Requirement of attending in–person has been removed. Anyone can initiate. •Conference does not need to be with 2 other health professionals, can now be with only 1 other health professional. DOCUMENT: Care plan must be recorded in the chart and include the following information: DX:, Reason for need of Clinical Action Plan, Health Care Providers with whom you conferred & their role, Clinical Plan, Pt risks, goals, refs& F/U, start & stop time. BILLABLE: On any patient for whom FP is community MRP. Not just applicable to specific target populations BILLABLE: $40 per 15 minutes or greater portion thereof BILLABLE: up to max 18/calendar year per patient. Max 2/day
14076 NEW Attachment Telephone Patient Management Visit	**15.00**	INTENT: Telephone clinical discussion with pt or family. Fee is NOT for: Rx refill, or notification of appointments & referrals. BILLABLE: Max 500/ MD per yr BILLABLE: IN ADDITION to 14079 for eligible patients – not on same day. ALL patients eligible, not just those with specific diagnoses. Call made by FP or or College-certified allied health professionals working within the eligible FP office
14075 Attachment Complex Care fee	**315.00**	Expansion of Complex Care to patients with the single diagnosis of significant 'Frailty'(Can Study of Health & Aging Levels 6 & 7) Level 6 = Moderately Frail: Help is needed with both instrumental and non-instrumental activities of daily living Level 7 = Severely Frail: Completely dependent on others for the activities of daily living Same requirements for planning, time as 14033. Also will be PORTAL to (14079) telephone/e-mail follow-up. BILLABLE: MDs billing this fee can still access 14033, but cannot bill 14033 & 14075 on the same patients.
14074 Unattached Complex Pt Attachment fee **Target Populations:** **Complex/high needs** / **Mother/Baby dyad (= 1)** **High needs chronic conditions** **Frail in community & res care** **Mental health & substance use** **Cancer patients** **Severe disability** **May be accepted into longitudinal practice at any time during pregnancy up to child aged 18 months**	200.00	INTENT: An incentive to support the attachment to an FP of unattached high needs patients who do not have a family doctor. This fee acknowledges the work of intake chart review. NOTE: Must commit to provide ongoing, longitudinal continuity of care for at least one year NOTE: Patient must be referred. Referral Sources: Acute Care, ER and Admitted, Mental Health/Substance Use Workers/Clinics, Home and Community Care, BCCA, Public Health, Colleagues (in specific circumstances), Local Division. Pts cannot self-identify BILLABLE: in addition to visits, and G14077 conference code on same day. All complex care codes and chronic care codes are applicable after patient has been accepted into practice and all requirements have been met.

GPSC FEE CODE SUMMARY

Comparison of Some Conferencing & Telephone Fee Codes — *** Indicates start and stop time must be submitted @ billing**

Fee Code	$	Who with?	Urgency	How	Eligible Patient Pop	Notes
14018 GP Telephone Conference with a Specialist or GP with Specialty Training	40.00	Specialist or GP with Specialty training	Urgent (<2 hrs)	2-way telephone call. GP initiates.	Severity of pt's condition must justify urgent conference for dev of plan to keep the pt safely in current location. No age, DX or loc'n reqs.	Payable to the GP who initiates communication regarding urgent assessment and management of patient and without the responding physician seeing the patient.
14077 NEW Attachment Conference fee	40.00	Specialist or allied health. (At least 1)	Non-urgent	2-way tel call or in-person. Anyone initiate.	ALL patients eligible	Max 18/yr/pt. Max 2/day. Anyone can initiate $40 per 15 minutes or greater portion thereof. Care plan must be recorded in chart as above.
14076 NEW Attachment Telephone Patient Management Visit	15.00	Patient or family	Non-urgent	2-way tel call	ALL patients eligible	Max 500/ MD per yr Billable in addition to 14079. Calls by FP or College-certified allied health professionals working within the eligible FP office
14079 GP Patient Telephone/E-mail Follow-up Management	15.00	Patient or family	Non-urgent	2-way tel call or e-mail.	Complex care pts (14033 or 14075), MH Plan (14043), COPD (14053) Palliative (14063)	Billable 5/yr/qualifying patient Calls/e-mail response by FP or office staff.
13005 Advice about a patient in Community Care **(MSP fee)**	15.05	Allied health incl: RN, LPN, PT, OT, RT psychologists, mental health, home care, paramedics, & pharmacists	Non-urgent	Asynchronous, by tel or fax. Response to allied health worker assigned to the care of the pt.	Patient in community care. This includes: Residential, Intermediate & Extended care & patients receiving Home Nursing care, Home support or Palliative care at home	BILLABLE: max 1 per pt per physician per day. NOT BILLABLE: on same day as other services by the same physician for the same patient NOT BILLABLE: by MD on-call to a facility or on-site, being paid at the time on a sessional basis, or working at the time as hospitalists. Not for RX refill.