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, 13109, 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)	84.45	
00110	Consultation - in office: (age 2 - 49)	76.77	
15310	Consultation – in office (age 50 - 59)	84.45	
16110	Consultation - in office: (age 60 - 69)	88.29	
17110	Consultation - in office: (age 70 - 79)	99.79	
18110	Consultation - in office: (age 80+)	115.17	
00116	Special in-hospital consultation	163.12	

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)	101.34	
13210	Consultation – out of office (age 2 - 49)	92.13	
15210	Consultation – out of office (age 50 - 59)	101.34	
16210	Consultation – out of office (age 60 - 69)	105.95	
17210	Consultation – out of office (age 70 - 79)	119.75	
18210	Consultation – out of office (age 80+)	138.21	

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

		$	Anes. Level

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 the diagnostic or approved laboratory facility of patient's responsibility for payment.

iii) Complete examination fee codes are not to be charged for in-hospital admission examinations. Fee code 00109 or 13109 may apply in this circumstance. See Preamble and listing restrictions.

12101	Complete examination - in office (age 0-1)	76.83	
00101	Complete examination - in office (age 2-49)	69.85	
15301	Complete examination – in office (age 50 – 59)	76.83	
16101	Complete examination - in office (age 60-69)	80.32	
17101	Complete examination - in office (age 70-79)	90.80	
18101	Complete examination - in office (age 80+)	104.79	

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)	92.20	
13201	Complete examination - out of office (age 2-49)	83.82	
15201	Complete examination - out of office (age 50-59)	92.20	
16201	Complete examination - out of office (age 60-69)	96.39	
17201	Complete examination - out of office (age 70-79)	108.95	
18201	Complete examination - out of office (age 80+)	125.74	

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 or 13109 may apply in this circumstance. See Preamble and listing restrictions.*

12100	Visit - in office (age 0-1)	34.62	
00100	Visit - in office (age 2-49)	31.46	
15300	Visit – in office (age 50-59)	34.62	
16100	Visit - in office (age 60-69)	36.18	
17100	Visit - in office (age 70-79)	40.90	
18100	Visit - in office (age 80+)	47.20	

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
13070	In office assessment of an unrelated condition(s) in association with a WorkSafe BC service	16.36	

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.

13075	In office assessment of an unrelated condition(s) in association with an ICBC service	16.36	

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)	41.53	
13200	Visit - out of office (age 2-49)	37.76	
15200	Visit – out of office (age 50-59)	41.53	
16200	Visit - out of office (age 60-69)	43.42	
17200	Visit - out of office (age 70-79)	49.08	
18200	Visit - out of office (age 80+)	56.63	

***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 medical care in a group setting. A requirement of a GMV is a 1:1 interaction between each patient and the attending physician. While portions of the GMV may be delegated to other allied health providers, the physician must be physically present at the GMV for the majority of each time interval billed and assumes clinical responsibility for the patients in attendance. Because this is a time based fee, concurrent billing for other services during the time intervals billed for GMV is not permitted.

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:		
13763	Three patients	25.74	
13764	Four patients	20.79	
13765	Five patients	17.86	
13766	Six patients	15.90	
13767	Seven patients	14.50	
13768	Eight patients	13.46	
13769	Nine patients	12.61	
13770	Ten patients	11.96	
13771	Eleven patients	10.48	
13772	Twelve patients	9.85	
13773	Thirteen patients	9.12	
13774	Fourteen patients	8.96	
13775	Fifteen patients	8.59	
13776	Sixteen patients	8.34	
13777	Seventeen patients	8.00	
13778	Eighteen patients	7.82	
13779	Nineteen patients	7.54	
13780	Twenty patients	7.35	
13781	Greater than 20 patients (per patient)	7.08	

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) Concurrent billings for any other MSP services for any patient during the time interval for which the GMV fee is billed will not be paid.

x) 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) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) 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.

iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

		$	Anes. Level
12120	Individual counselling - in office (age 0-1)	60.23	
00120	Individual counselling - in office (age 2-49)	54.76	
15320	Individual counselling – in office (age 50-59)	60.23	
16120	Individual counselling - in office (age 60-69)	62.96	
17120	Individual counselling - in office (age 70-79)	71.17	
18120	Individual counselling - in office (age 80+)	82.12	

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

12220	Individual counselling - out of office (age 0-1)	72.26	
13220	Individual counselling - out of office (age 2-49)	65.69	
15220	Individual counselling – out of office (age 50 – 59)	72.26	
16220	Individual counselling - out of office (age 60-69)	75.55	
17220	Individual counselling - out of office (age 70-79)	85.41	
18220	Individual counselling - out of office (age 80+)	98.55	

Counselling - Group

For groups of two or more patients.

00121	- first full hour	88.00	
00122	- second hour, per 1/2 hour or major portion thereof	44.02	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

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	82.43	
P13037	Telehealth GP in-office Visit	34.44	
P13038	Telehealth GP in-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes)	58.90	

Notes:

i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) per patient per year (see Preamble D. 3. 3.)

ii) Start and end time must be entered into both the billing claims and patient's chart.

iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

		$	Anes. Level
	Telehealth GP in-office Group Counselling For groups of two or more patients		
P13041	- First full hour	86.94	
P13042	- Second hour, per ½ hour or major portion thereof	43.50	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

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	109.02	
P13017	Telehealth GP out-of-office Visit	41.10	
P13018	Telehealth GP out-of-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes)	75.32	

Notes:

i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office, and telehealth 13018 and 13038) per patient per year (see Preamble D. 3. 3.)

ii) Start and end time must be entered into both the billing claims and patient's chart.

iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

	Telehealth GP out-of-office Group Counselling For groups of two or more patients		
P13021	- First full hour	87.46	
P13022	- Second hour, per ½ hour or major portion thereof	43.76	

Note: *Start and end times must be entered in both the billing claims and the patient's chart.*

13020	Telehealth General Practitioner Assistant – Physical Assessment as requested by receiving specialist: - for each 15 minutes or major portion thereof	31.46	

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.

iii) Start and end times must be entered in both the billing claims and the patient's chart.

Miscellaneous Visits

P13501	MAiD Assessment Fee – Assessor Prescriber Includes all requirements of a MAiD assessment, including review of medical records, patient encounter and completion of the MAiD Assessment Record (Prescriber). The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof	42.97	

Notes:

i) Maximum payable is 135 minutes (9 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.

ii) Start and end time for the assessment must be entered in both the billing claim and patient's chart.
iii) Additionally, start and end time for the patient encounter must be entered in the patient's chart.
iv) Only one service for 13501 or 13502 may be performed by video conference.

		$	Anes. Level
P13502	MAiD Assessment Fee – Assessor Includes all requirements of a MAiD assessment, including review of medical records, patient encounter and completion of the MAiD Assessment Record (Assessor). The assessment may be provided either in-person or by video conference – per 15 minutes or greater portion thereof	42.97	

Notes:
i) Maximum payable is 105 minutes (7 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.
ii) Start and end time for the assessment must be entered in both the billing claim and patient's chart.
iii) Additionally, start and end time for the patient encounter must be entered in the patient's chart.
iv) Not payable with 13501 by same physician.
v) Only one service for 13501 or 13502 may be performed by video conference.

P13503	Physician witness to video conference MAiD Assessment – Patient Encounter Physician must be in personal attendance with the patient for the duration of the patient encounter with the Assessor or Assessor Prescriber. Billable only for time spent witnessing the patient – Assessor encounter. Includes completion of any required documentation – per 15 minutes or greater portion thereof	42.97	

Notes:
i) Maximum payable is 105 minutes (7 units). Services which exceed the maximum will be given independent consideration with an explanatory letter.
ii) Start and end time for the witnessed encounter must be entered in both the billing claim and patient's chart.
iii) Not payable with 13501 or 13502 by same physician.

P13504	MAiD Event Preparation and Procedure	282.10	

Notes:
i) Payable only to Assessor Prescriber.
ii) Includes all necessary elements: establishment of IV, administration of meds, pronouncement of death.
iii) Includes pharmacy visits for procedures provided in facilities with on-site pharmacies.
iv) Fee 13505 billable in addition for procedures provided in facilities with no on-site pharmacy.
v) A same day visit fee is payable in full in addition under fee item 00103 (home) or out of office visit fee items 12200, 13200, 15200, 16200, 17200, and 18200 (all other locations). Fee items 00108, 13008, 00127 and 00114 are not payable.

P13505	MAiD Medication Pick-up and Return	125.94	

Notes:
i) Paid only in addition to 13504.
ii) Payable only when MAiD procedure takes place in a location where there is no on-site pharmacy.
iii) Not payable when time for medication pick-up and return has been compensated under a different payment modality.

		$	Anes. Level
13015	HIV/AIDS Primary Care Management – in or out of office - per half hour or major portion thereof	85.95	

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.

iv) Start and end times must be entered in both the billing claims and the patient's chart.

Home Visits

00103	Home visit (service rendered between 0800 and 2300 hours – any day) - any day	115.15	

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 examination	81.61	

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 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. 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.

vi) Limit of one hospital admission (00109 or 13109) payable per patient per hospitalization.

00108	Hospital visit	31.93	

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.

		$	Anes. Level
00128	Supportive care hospital visit	27.52	

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	Palliative care patient facility visit	53.60	

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 palliative care patient 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) Palliative care patient 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 palliative care patient facility visit fees are being billed.

v) Essential non-emergent additional palllative care patient 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 palliative care patient 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 GPs who maintain an active family practice in the community, accepting the role of being Most Responsible Physician (MRP) for the longitudinal coordinated care of their patients.
- Not payable to physicians who have been paid for any specialty 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.

	$	Anes. Level

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.

13109 Community based GP: Acute care hospital admission examination.....102.01

Notes:

i) This item applies when a patient is admitted to an acute care hospital for medical care rendered by a community based 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 13008 on the first in-patient day, for that patient.

iii) Fee item 13109 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 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.

vi) Limit of one hospital admission (00109 or 13109) payable per patient per hospitalization.

		$	Anes. Level
P13338	Community based GP, first facility visit of the day bonus, extra (active hospital privileges) (for routine, supportive or palliative care)	38.10	

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)	53.60	

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.

13028	Community based GP: supportive care hospital visit (active hospital privileges)	35.61	

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

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)	29.85	

Notes:

i) Only payable if P13228 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.

		$	Anes. Level
P13228	Community based GP: hospital visit (courtesy/associate privileges)	29.85	

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 any other visit fee including 00108, 13008, 00109, 13109, 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 or GP member of an Unassigned In-Patient Care Network, is providing GP care to the patient, the community based GP with courtesy or associate hospital privileges may bill 13228.

vii) Note vi) also applies to Community based GPs with active hospital privileges at a hospital other than the one to which the patient is admitted.

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)	51.51
00105	Night (between 2300 hours and 0800 hours)	71.59
00123	Saturday, Sunday or Statutory Holiday	51.51

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	36.13
P13334	Community based GP, long term care facility visit - first visit of the day bonus, extra	34.06

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).*	115.15

Emergency Visits

00112	Emergency visit (call placed between hours of 0800 and 1800 hours) – weekdays	115.15

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.

		$	**Anes. Level**
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	116.52	

Telephone Advice

13000 Telephone advice to a Community Health Representative in First Nation's Communities 15.72

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 15.72

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 (including completion of faxed medication review with orders, up to twice per calendar year, but not for simple 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 not 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) 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. Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care. 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.

		$	Anes. Level

Pregnancy and Confinement

14090 Prenatal visit - complete examination 84.01
14091 - subsequent examination 31.46

Notes:

i) Uncomplicated prenatal 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 prenatal 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 prenatal or postnatal 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 prenatal or postnatal visit are included in the prenatal (14091) or postnatal 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 Postnatal office visit 31.46

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 second stage of labour, per 30 minutes or major portion thereof. 84.52

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, 04018, or 04085.
iii) Timing ends when constant personal attendance ends, or at the time of delivery.
iv) Start and end times must be entered in both the billing claims and the patient's chart.

		$	Anes. Level
14104	Delivery and postnatal care (1-14 days in-hospital) ***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.*	581.87	
14105	Management of labour and transfer to higher level of care facility for delivery ***Notes:*** *i) This fee includes all usual hospital care associated with the confinement and provided by the referring physician.* *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.*	242.32	
14108	Postnatal care after elective caesarean section(1-14 days in-hospital) ***Note***: *When medically necessary additional post-partum office visit(s) are payable under fee item P14094.*	119.71	
14109	Primary management of labour and attendance at delivery and postnatal care associated with emergency caesarean section (1-14 days in-hospital) ***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.*	484.68	
14545	Medical abortion ***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.*	164.14	
15120	Pregnancy test, immunologic - urine	11.59	

Infant Care

00118	Attendance at caesarian section (if specifically requested by surgeon for care of baby only) ***Note:*** *Not payable if a pediatrician is present at the caesarean section to care for the baby.*	90.36	
00119	Routine care of newborn in hospital	92.36	

		$	Anes. Level
Gynecology			
14540	Insertion of intrauterine contraceptive device (operation only) ***Note**: Includes Pap smear if required.*	42.94	2
14541	Removal of intrauterine device (IUD) -operation only ***Note**: Not payable with a pap smear (14560) or IUD insertion (14540).*	31.46	
14560	Routine pelvic examination including Papanicolaou smear (no charge when done as a pre and postnatal service) ***Note:** Services billed under this code must include both a pelvic examination and Pap smear.*	31.46	
Urology			
Y13655	GP vasectomy bonus associated with bilateral vasectomy ***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.*	21.33	
Surgical Assistance			
13194	First Surgical Assist of the Day ***Notes:*** *i) Restricted to General Practitioners* *ii) Maximum, of one per day per physician, payable in addition to 00195,00196, 00197 or 00193.*	87.72	
	Total operative fee(s) for procedure(s):		
00195	- less than $317.00 inclusive	134.22	
00196	- $317.01 to 529.00 inclusive	189.24	
00197	- over $529.00	258.10	
00198	Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof ***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.*	28.52	
	Open Heart Surgery:		
00193	Non-CVT-certified surgical assistance at open-heart surgery, per quarter hour or major portion thereof ***Notes:*** *i) The same fee applies equally to all assistants (first, second, etc.).* *ii) Start and end times must be entered in both the billing claims and the patient's chart.*	29.58	
Anesthesia			
13052	Anesthetic evaluation - non-certified anesthesiologist ***Note:** See Anesthesia Preamble regarding Pre-Anesthetic Evaluation Fees.*	46.75	

		$	Anes. Level

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)	31.46	
	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."*		
13660	Metatarsal bone - closed reduction (operation only)	52.52	2
13600	Biopsy of skin or mucosa (operation only)	51.66	2
13601	Biopsy of facial area (operation only)	51.66	2
	Note: *Punch or shave biopsies not to be charged under fee items 13600 or 13601.*		
13605	Opening superficial abscess, including furuncle - operation only	44.26	2
13610	Minor laceration or foreign body - not requiring anesthesia - operation only	35.44	
	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	66.02	2
13612	Extensive laceration greater than 5 cm (maximum charge 35 cm) - operation only - per cm	13.25	2
	Note: *Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13620	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - up to 5 cm (operation only)	66.02	2
13621	- additional lesions removed at the same sitting (maximum per sitting, five) each (operation only)	33.01	
	Notes: *i) 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."* *ii) Fee items 13620 and 13621 are not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13623	Excision of tumour of skin or subcutaneous tissue or small scar under local anesthetic - face (operation only)	89.04	
	Note: *i) Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13624	Removal of extensive scars – 5 cm or more – per cm over 5 cm (in addition to 13623 or 13620)	8.53	
	Notes: *i) Payment for scar revision based on length of scar, not length of incision.* *ii) A note record is required for scars >30 cm.* *iii) Not billable by Plastic Surgery, Orthopedics or Otolaryngology.*		
13622	Localized carcinoma of skin proven histopathologically (operation only)	72.94	2
13630	Paronychia - operation only	35.35	2
13631	Removal of nail - simple operation only	35.35	2

		$	Anes. Level
13632	- with destruction of nail bed (operation only)	71.53	2
13633	Wedge excision of one nail (operation only)	63.12	2
13650	Enucleation or excision of external thrombotic hemorrhoid (operation only)	51.86	2
Y10710	In office Anoscopy	7.90	

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 $

Tests Performed in a Physician's Office

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 an approved laboratory facility, when no other blood work performed	5.92
	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 a medical practitioner.	
	ii) Where a blood specimen is taken by physician's office and dispatched to another unassociated physician's office or to an approved laboratory 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	6.67
15133	Examination for eosinophils in secretions, excretions and other body fluids	7.14
15134	Examination for pinworm ova	5.85
15136	Fungus, direct microscopic examination, KOH preparation	8.39
15100	Glucose - semiquantitative (dipstick analysed visually or by reflectance meter)	3.68
15137	Hemoglobin cyanmethemoglobin method and/or haematocrit.	3.12
15000	Hemoglobin - other methods	1.62
	***Note**: 15137 and 15000 - see the Laboratory Services Payment Schedule for additional hematology information.*	
15110	Occult blood – feces	5.31
	***Note:** Applies only to guaiac methods.*	
15120	Pregnancy test, immunologic - urine	11.59
30015	Secretion smear for eosinophils	7.29
15138	Sedimentation rate	2.51
15139	Sperm, Seminal examination for presence or absence	14.78
15140	Stained smear	7.40
15141	Trichomonas and/or Candida and/or Bacterial Vaginosis direct microscopic examination	5.62
15130	Urinalysis - Chemical or any part of (screening)	2.17
15131	Urinalysis - Microscopic examination of centrifuged deposit	4.10
15142	Urinalysis - Complete diagnostic, semi-quant and micro	5.59
15143	White cell count only (see the Laboratory Services Payment Schedule for additional information)	6.48
	The following test is payable in a physician's office (when performed on their own patients) and/or on a referral basis:	
93120	E.C.G. tracing, without interpretation, (technical fee)	16.70

Investigation

00117	Interpretation of electrocardiogram by non-internist	10.33

No Charge Referral

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

General Practice Services Committee (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.

Definitions In GPSC Initiated Listings:

Full Service Family Physician:
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.

General Practitioner with specialty training:
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".

Allied Care Provider:
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: Physicians; Nurses; Nurse Practitioners; Mental Health Workers; Midwives; Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.

Note: *Not all allied care providers are College-certified. Allied Care Providers who are College-certified are governed by a provincial regulatory college or body. Specific GPSC incentives may require ACPs to be College-certified for the delegation of tasks, whereas other GPSC incentives may not require ACPs to be College-certified to undertake delegated tasks. Fee notes will clearly indicate whether the ACP must be College-certified to be delegated tasks.*

Allied Care Provider "Employed Within" a Physician Practice:
For the purposes of its incentives, GPSC defines Allied Care Providers (ACPs) "employed within" a physician practice as ACPs who are employed by and work directly within a FP practice team, with no cost recovery either directly or indirectly from a third party (e.g.: Health Authority, Division of Family Practice, Ministry of Health, etc.).

Allied Care Provider "Working Within" a Physician Practice:
For the purpose of its incentives, GPSC defines Allied Care Providers (ACPs) "working within" a physician practice as ACPs who work directly within an FP practice team with ACP costs paid by the physician practice or a third party (directly or indirectly). For example, ACPs employed by a Health Authority, and assigned to work with a FP practice to support ongoing care of its patients are considered working within the practice team. ACPs not assigned to work with an FP practice, but who provide services to patients on a referral basis in stand-alone Health Authority Specialized Services Programs such as Chronic Disease Clinics, Mental Health Teams, Home & Community Care Teams, and Palliative Care Teams are not considered to be "working within" the physician practice team.

Alternate Payment Program:
For the purposes of its incentives, GPSC defines Physicians working on an 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 GPSC services are not billable in addition.

Patient's Medical Representative:
For the purpose of its incentives, GPSC defines Patient's Medical Representative as outlined in the "Health Care (Consent) and Care Facility (Admission) Act"

Representative means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative.

Temporary Substitute decision makers (Alternate Representative) in listed order, of the following who is available and qualifies under subsection 16(2):

(a) the adult's spouse
(b) the adult's child
(c) the adult's parent
(d) the adult's brother or sister
(d.1) the adult's grandparent
(d.2) the adult's grandchild
(e) anyone else related by birth or adoption to the adult
(f) a close friend of the adult
(g) a person immediately related to the adult by marriage

For the purpose of its incentives when referring to assisted living, GPSC utilizes the ministry definition as found at:
http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living

For the purpose of its incentives, GPSC considers patients living in group homes to be living in community.

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 visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be a GPSC Telephone Visit (G14076), Group Medical Visit (13763 -13781) or an in person visit with a college certified allied health provider working within the family physicians practice (G14029) billed on each qualifying patient in the 12 months prior to billing the CDM incentive. Visits provided by a locum or colleague covering 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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763-13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763-13781) or

3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763-13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.
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 including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763-13781) or

3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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.

Chronic Care Incentives – Practitioners under Alternate Payment Program

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 has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763-13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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, G14251, 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.

Total Fee $

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 has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763 -13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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, G14250,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.

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 has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763 -13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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.

Total Fee $

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 has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be:
1. a telephone visit (G14076) or
2. a group medical visit (13763 -13781) or
3. a telehealth visit (13017, 13018, 13037, 13038) or
4. an in-person visit with a college certified allied health provider (G14029) working within the family physician's practice.

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.

Allied Care Provider Code

To support team based care Allied Care Providers may provide one of the visits required for GPSC chronic disease management. Submission of this $0.00 code by the FP indicates an in person visit was provided by a college certified Allied Care Provider.

G14029 Allied Care Provider Practice Code.....0.00

Notes:

i) Only billable by the family physician who has submitted Code G14070/G14071 and who is most responsible for the majority of the patient's longitudinal general practice care.

ii) Applicable only for in-person medical services (office, home or LTC) provided by a college certified allied care provider working within the family physician's practice where the family physician has accepted responsibility for the provision of the care.

iii) Not billable when the patient has had a service provided and billed by the family physician.

iv) Billable on patients receiving guideline informed care who will be eligible for one of the chronic disease management incentives (CDM's).

2. Conference Fees

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 comorbidity

Patients of any age with multiple medical conditions or comorbidities (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.

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, email).

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 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. convey the 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) Payable in addition to a visit on the same day.

GP – Advice to Nurse Practitioner/Registered Midwife Fee

The intent of this fee is to support collaboration between nurse practitioners, registered midwives 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 for providing advice to a NP when the patient is attached to a GP. This fee is billable when providing advice by telephone or in person to a Registered Midwife who is an independent practitioner providing maternity care to patients under his/her MRP care.

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

Notes:
i) Payable for advice by telephone or in person, in response to a 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 OR in response to a request from a Registered Midwife in independent practice on patients for whom the Midwife has accepted the responsibility of being the Most Responsible Provider for that patient's maternity care.
ii) Excludes advice to a NP about patients who are attached to the GP; excludes advice to a Registered Midwife about patients being cared for in a shared care model with a GP.
iii) Payable for advice regarding assessment and management by the NP/Midwife and without the responding physician seeing the patient.
iv) Not payable for written communication (i.e. fax, letter, email).
v) A chart entry, including advice given and to whom, is required.
vi) NP/Midwife 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. convey the 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.

3. Complex Care Fees

The Complex Care Planning and Management Fee was developed to compensate GPs for the management of complex patients living in their home or assisted living, who have documented confirmed diagnoses of 2 chronic conditions from at least 2 of the 8 categories listed below. Patients in acute or long term care facilities are not eligible.

Having comorbidities does not necessarily make a patient complex. To be eligible for the Complex Care Planning and Management Fee, G14033; the patient's comorbidities should be of sufficient severity and complexity to warrant the development of a management plan. In other words, eligibility is not based solely on the individual diagnoses. Consideration should be given to the over-all clinical impact of the diagnosis, and the burden of illness the patient experiences.

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.

		Total Fee $
G14033	GP Complex Care Planning and Management Fee (2 diagnoses) ..... The Complex Care Planning and Management Fee is payment for the creation of a care plan and advance payment for the complex work of caring for patients with eligible conditions. It is payable upon the completion and documentation of a Care Plan which includes Advance Care Planning when appropriate, as described below. The Complex Care Planning and Management fee (2 diagnoses) is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing year.	315.00

A Care Plan requires documentation of the following core elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. 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 providers 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.

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 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) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face-to-face planning included under G14033.

v) Minimum required total planning time 30 minutes. The majority of the planning time must be face-to-face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice.

vi) Chart documentation must include:
   1. the care plan;
   2. total planning time (minimum 30 minutes); and
   3. face-to-face planning time (minimum 16 minutes).

vii) G14018 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) *G14043, G14063, G14076 and G14078 not payable on the same day for the same patient.*
xi) *Maximum daily total of 5 of any combination of G14033 and G14075 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 comorbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

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 $

G14075 GP Frailty Complex Care Planning and Management Fee 315.00

The GP Frailty Complex Care Planning and Management Fee is payment for the creation of a care plan and advance payment for the complex work of caring for eligible patients. It is payable upon the completion and documentation of the Care Plan which includes Advance Care Planning when appropriate, as described below. The GP Frailty Complex Care Planning and Management fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal general practice care for the ensuing year.

Patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for G14075.

Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community	**Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care**
Meal preparation	Mobility in bed
Ordinary housework	Transfers
Managing finances	Locomotion inside and outside the home
Managing medications	Dressing upper and lower body
Phone use	Eating
Shopping	Toilet use
Transportation	Personal hygiene
	Bathing

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

1. There has been a detailed review of the case/chart and of current therapies.
2. Name and contact information of substitute decision maker.
3. Documentation of eligible condition(s).
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Care Planning Incentive code is billed.
5. Specifies a clinical plan for the patient's care.
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive.
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan.
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate.
9. Outlines linkages with other allied care providers that would be involved in the care and their expected roles.
10. Identifies an appropriate time frame for re-evaluation of the plan.
11. 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 providers 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.

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 to Family Physicians who have successfully submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year.

ii) Payable only for patients who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living.

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) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face-to-face planning included under G14075.

vi) Minimum required total planning time 30 minutes. The majority of the planning time must be face-to-face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice.

vii) Chart documentation must include:

1. the care plan;

2. total planning time (minimum 30 minutes); and

3. face-to-face planning time (minimum 16 minutes).

viii) G14018 or G14077 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for G14075.

ix) Maximum daily total 5 of any combination of G14033 and G14075 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, G14078 not payable on the same day for the same patient.

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.

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.

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) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face-to-face planning included under G14066.

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

vi) G14033, G14043, G14063, G14076 and G14078 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.

The Ministry of Health website contains:

The current Lifetime Prevention Schedule "Establishing Priorities among Effective Clinical Prevention Services in British Columbia: 2016 Update" :

http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-report_2016.pdf

A "Lifetime Prevention Schedule Tool" which allows identification of the recommended interventions at a glance. (When viewed online, there are embedded links to more details for each specific recommendation.):

http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/lps-graphic-tool.pdf

BC Prevention Guidelines:

http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

5. Maternity Network Initiative

		Total Fee $
G14010	Maternity Care Network Initiative Payment	2,100.00

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;*
- *Each doctor must schedule at least four deliveries in each six month period of time (April to September, October to March); and*
- *The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day).*

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

Total Fee $

6. General Practitioner Obstetrical Premium

G14004 Obstetric Delivery Incentive for Full Service General Practitioner - associated with vaginal delivery and postnatal care 288.77

***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.

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 120.26

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 240.54

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.

Total Fee $

G14008 Obstetric Delivery Incentive for Full Service General Practitioner – associated with postnatal care after an elective C-section.....59.41

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 Care Plan for patients with a confirmed eligible mental health diagnosis of sufficient severity to warrant the development of a care 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. The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing year.

A Care Plan requires documentation of the following core elements in the patient's chart:

1. There has been a detailed review of the patient's chart/history and current therapies.
2. Documentation of eligible condition(s).
3. Name and contact information for substitute decision maker.
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed.
5. Specifies a clinical plan for the patient's care for the next year.
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive.
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan.
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate.
9. Outlines linkages with other allied care providers and community resources who will be involved in the patient's care, and their expected roles.
10. Identifies an appropriate time frame for re-evaluation of the Plan.

11. 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 providers 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.

Successful billing of the Mental Health Planning fee G14043 allows access to four counselling equivalent mental health management fees in that same calendar year which may be billed once the four MSP counselling fees (any combination of 00120 age differential or telehealth counselling codes) have been utilized.

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 documentation of a confirmed eligible mental health diagnosis of sufficient severity to warrant the development of a care plan. 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.

iii) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face-to-face planning included under G14043.

iv) Minimum required total planning time 30 minutes. The majority of the planning time must be face-to-face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice.

v) Chart documentation must include:
   1. the care plan;
   2. total planning time (minimum 30 minutes); and
   3. face-to-face planning time (minimum 16 minutes).

vi) 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 G14043.

vii) G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14075, G14076 and G14078 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	54.35
G14045	GP Mental Health Management Fee age 50 - 59	59.78
G14046	GP Mental Health Management Fee age 60 - 69	62.49
G14047	GP Mental Health Management Fee age 70 - 79	70.64
G14048	GP Mental Health Management Fee age 80+	81.51

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 (any combination of

age-appropriate 00120 or telehealth counselling) 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 when G14043 has been paid in the same calendar year.
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 or telehealth counselling (13018,13038) fees have already been paid in the same calendar year.
v) Minimum time required is 20 minutes.
vi) Start and end times must be included with the claim and documented in the patient chart.
vii) Counselling may be provided face-to-face or by videoconferencing.
viii) G14077, payable on same day for same patient if all criteria met.
ix) G14043 , G14076, G14078 not payable on same day for same patient.
x) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.
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.

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

	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**

Autism Spectrum Disorder:		
	Autistic Disorder	299.0
	Asperger Syndrome	299.0
	Pervasive Development Disorder Not Otherwise Specified	299.0
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
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 GP Palliative Care Planning Fee 100.00

This fee is payable upon the development and documentation of a 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. 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 GP Palliative Planning and Management fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the patient.

The 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. Name and contact information for substitute decision maker.
3. Documentation of eligible condition(s).
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed.
5. Specifies a clinical plan for the patient's care.
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive.
7. Incorportates the patient's values, beliefs and personal health goals in the creation of the care plan.
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate.

9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles.
10. Identifies an appropriate time frame for re-evaluation of the plan.
11. 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 providers 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.

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) 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) on the same day if medically required and does not take place concurrently with the face-to-face planning included under G14063.

v) Minimum required total planning time 30 minutes. The majority of the planning time must be face-to-face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice.

vi) Chart documentation must include:
   1. the care plan;
   2. total planning time (minimum 30 minutes); and
   3. face-to-face planning time (minimum 16 minutes).

vii) G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14063.

viii) Not payable if G14033 or G14075 has been paid within 6 months.

ix) Not payable on same day as G14043 ,G14076 or G14078.

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.

9. General Practitioners with Specialty Training Telephone Advice Fees

GP with Specialty Training Telephone Advice Fees (G14021, G14022, G14023) have been developed to support teleconferencing between GP's with Specialty Training and other Family Physicians, Specialists or Allied Care Providers for the purpose of improving patient care.

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.
- When advice is requested by an Allied Care Provider not registered with MSP use the generic practitioner number 99987: Advice requested by an allied care provider. (Not applicable to referred case fee items such as consultations.)

		Total Fee $
G14021	GP with Specialty Training Telephone Advice - Initiated by a Specialist, General Practitioner or Allied Care Provider, 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 provider's request. Not payable for written communication (i.e. fax, letter, email).

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. convey the results of diagnostic investigations*
- *f. arrange a hospital bed for the patient.*

vi) Not payable to provider initiating call.

vii) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).

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

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

x) Start and end times must be included with the claim and documented in the patient chart.

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

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

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

xiv) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987).

Total Fee $

G14022 GP with Specialty Training Telephone Advice for Patient Management - Initiated by a Specialist, 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 provider's 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. convey the results of diagnostic investigations*
- *f. arrange a hospital bed for the patient.*

vi) Not payable to provider initiating call.

vii) No claim may be made where communication is with a proxy for either provider (e.g.: office support staff).

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

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

x) Start and end times must be included with the claim and documented in the patient chart.

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

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

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

xiv) Include the practitioner number of the provider requesting advice in the "referred by" field when submitting claim. (For allied care providers not registered with MSP use practitioner number 99987).

G14023 GP with Specialty Training Telephone Patient Management/ Follow-Up.....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, email).

ii) 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.

iii) 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.

iv) No claim may be made where communication is with a proxy for the physician (e.g.: office support staff).

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

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

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

viii) Out-of-Office Hours Premiums may not be claimed in addition.
ix) Cannot be billed simultaneously with salary, sessional, or service contract arrangements.

10. GPSC Portal Fees

The "GPSC Portal" Codes provides access to the following incentive fee codes:

- G14075 GP Frailty Complex Care Planning and Management Fee
- G14076 GP-Patient Telephone Management Fee
- G14077 GP-Allied Care Provider Conference Fee
- G14078 GP Email/Text/Telephone Medical Advice Relay Fee
- G14029 GP Allied Care Provider Practice Code ($0.00)

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'.

The standardized wording of the Family Physician-Patient 'Compact' was developed in consultation with the physicians of the three attachment prototype communities and in consultation with members of the patient voices network. The GPSC continues to believe this compact appropriately describes the relationship between a full service family physician and his/her patients. The compact states:

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

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

Locums working in host practices where G14070 has been submitted are able to access the same fee codes once they have successfully submitted G14071 "GPSC Locum Portal Code", once at the beginning of each calendar year. The Locum and host FP should discuss and mutually agree on which of the GPSC Services, including the fees, accessed through the GPSC Portal codes, may be provided and billed by the locum. However, locums have their own annual allotment of G14076 GP Patient Telephone Management Fee and G14078 GP Patient Email/Text/Telephone Medical Advice Relay 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 who has submitted G14070.

Total Fee $

G14070 GPSC Portal Code 0.00

The GPSC Portal Code should be submitted at the beginning of each calendar year by Full Service Family Physicians (FSFP) to access G14075, G14076, G14077, G14078 and G14029 during the calendar year.

Submit fee item G14070 GPSC Portal Code using the following "Patient" demographic information:

PHN:	9753035697
Patient Surname:	Portal
First name:	GPSC
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'.

Notes:

i) Submit once per calendar year.

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

GPSC Locum Portal Code

G14071 GPSC Locum Portal Code.....0.00

The GPSC Portal code may be submitted by the GP who provides locum coverage for Family Physicians who have submitted G14070. G14071 should be submitted 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 G14075, G14076, G14077, G14078 and G14029.

Submit fee item G14071 GPSC Locum Portal Code using the following "Patient" demographic information:

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

Submission of this code signifies that:

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

Notes:

i) Submit once per calendar year at the beginning of the year or prior to the first locum for a family physician who has submitted G14070 in the same calendar year.

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

11. GP Email/Text/Telephone Medical Advice To Patients Fees

		Total Fee $
G14076	GP PatientTelephone Management Fee	20.00

Notes:

i) Payable only to Family Physicians who have successfully :

a. Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted Code G14071 on the same or a prior date in the same calendar year; or

b. Registered in a Maternity Network or GP unassigned In-patient network on a prior date.

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

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 prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

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

vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077, G14018, G14050, G14051, G14052, G14053, G14250, G14251, G14252, G14253.

vii) 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.

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

G14078 GP Email/Text/Telephone Medical Advice Relay Fee 7.00

This fee is payable for 2-way communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone relay.

This fee is not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

Notes:

i) Payable only to Family Physicians who have successfully:

a. Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; or

b. Registered in a Maternity Network or GP Unassigned In-patient Network on a prior date.

ii) Email/Text/Telephone Relay Medical Advice requires two-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.

iii) Chart entry must record the name of the person who communicated with the

patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received.

iv) Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals.

v) Payable to a maximum of 200 services per physician per calendar year.

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

Total Fee $

G14077 GP Allied Care Provider Conference Fee - per 15 minutes or greater portion thereof.....40.00

Notes:

i) Payable only to Family Physicians who have successfully:
- *a) Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; or*
- *b) Registered in a Maternity Network or GP unassigned In-patient network on a prior date.*

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 videoconferencing 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. convey the 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) Start and end times must be included with the claim and documented in the patient chart.

x) Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility or communications which occur as part of regular work flow within a physician's community practice.

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

xii) Not payable in addition to G14018.

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.

12. 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 and/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 2,100.00

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

- o Be a Family Physician in active practice in B.C.
- o Have active hospital privileges.
- o 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).
- o Submit a completed Assigned Inpatient Care Network Registration Form.
- o Co-operate with other members of the network so that one member is always available to care for patients of the assigned inpatient network.
- o 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

		Total Fee $
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, 13109, 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, 13109, 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.