GP SERVICES COMMITTEE
Complex Care INCENTIVES

Revised
2010

BRITISH COLUMBIA MEDICAL ASSOCIATION

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Complex Care Management Fees

The GP Services Committee (GPSC) has revised the conditions that are eligible for the Complex Care Incentive, with the following changes effective January 1, 2010:

Asthma and COPD have been incorporated in a single category of "Chronic Respiratory Conditions". This category has also been expanded to include other chronic respiratory diseases such as Cystic Fibrosis and restrictive conditions such as pulmonary fibrosis and fibrosing alveolitis.

Two new disease categories are added: Chronic Neurodegenerative Disorders and Chronic Liver Disease (with hepatic dysfunction).

The Complex Care Management Fee was developed to compensate GPs for the management of complex patients who have chronic conditions from a least 2 of the 8 categories listed below. There are also fees for up to 4 non-face-to-face encounters during the 18 months following the billing of the complex care management fee. These items are ***payable only to the General Practitioner or practice group that accepts the role of being Most Responsible for the longitudinal, coordinated care of that patient; by billing this fee the practitioner or practice accepts that responsibility for the ensuing calendar year.*** The Most Responsible General Practitioner or practice group may bill these fees when providing care only to community patients; i.e. residing in their homes or in assisted living with two or more of the following chronic conditions:

1) ***Diabetes mellitus (type 1 and 2)***
2) ***Chronic renal failure with eGFR values less than 60***
3) ***Congestive heart failure***
4) ***Chronic respiratory Condition (asthma, COPD, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)***
5) ***Cerebrovascular disease***
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, stroke or other brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.)***
8) ***Chronic Liver Disease with evidence of hepatic dysfunction (see FAQ #7)***

Eligibility

These payments are available to:

- All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months; and:
- Whose majority professional activity is in full service family practice as described in the introduction, and
- Who has provided the patient the majority of their longitudinal general practice care over the preceding year, and
- Are the General Practitioner or practice group that is most responsible for the ongoing care of the patient.

Restrictions

- 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 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.

The Complex Care Management Visit can be provided and billed once at anytime in the calendar year. The development of the care plan is done jointly with the patient &/or the patient representative as appropriate. ***The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.***

If a patient has more than 2 of the qualifying conditions, when billing the Complex Care Management Fee the submitted diagnostic code from Table 1 (below) should represent the two conditions creating the most complexity.

Successful billing of the Complex Care Management Fee (G14033) allows access to 4 Telephone/email Follow-up fees (G14039) over the following 18 months. Once the Complex Care plan is reviewed and revised in the subsequent calendar year, the allowable G14039 resets to 4 over the following 18 months.

The GPSC strongly recommends accurate ICD-9 Diagnostic Coding when billing for care of these patients throughout the year. ICD-9 diagnostic codes can be downloaded from the Ministry of Health Website at:

http://www.health.gov.bc.ca/msp/infoprac/diagcodes/index.html

G14033 Annual Complex Care Management Fee $315

The Complex Care Management Fee is advance payment for the complexity of caring for patients with two of the eligible conditions and is payable upon the completion and documentation of the Complex Care Plan for the management of the complex care patient during that calendar year.

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

- there has been a detailed review of the case/chart and of current therapies;
- there has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
- specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
- incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;
- outlines expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care, their expected roles;
- identifies an appropriate time frame for re-evaluation of the plan;
- confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

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

Notes:

i) Payable once per calendar year;
ii) Payable in addition to office visits or home visits same day;
iii) Visit or CPx fee to indicate face-to-face interaction with patient same day must accompany billing;
iv) G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met;
v) G14015, facility patient conferencing fee, not payable on the same day for the same patient, as facility patients not eligible;
vi) G14017, acute care discharge planning conferencing fee, not payable on the same day for the same patient, as facility patients not eligible;
vii) CDM fees G14050/G14051/G14052/G14053 payable on same day for same patient, if all other criteria met;
viii) Minimum required time 30 minutes in addition to visit time same day;
ix) Maximum of 5 complex care fees per day per physician.
x) Not payable for patients seen in locations other than the office, home or assisted living residence where no professional staff on site;

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

G14039 Complex Care Telephone/Email Follow-Up Management fee $15.00

This fee is payable for follow-up management, via 2-way telephone or email communication, of patients for whom a Complex Care Management Fee (G14033) has been paid. Access to this fee is restricted to the GP that has been paid for the Complex Care Management Fee (G14033) within the preceding 18 months and is therefore Most Responsible GP (MRGP) for the care of that patient for the submitted chronic conditions. The only exception would be if the billing GP has the approval of the Most Responsible GP, and this must be documented as a note entry accompanying the billing. As with all clinical services, dates of services under this item should be documented in the patient record together with the name of the person who communicated with the patient or patient's medical representative as well as a brief notation on the content of the communication.

Notes:

i) Payable a maximum of 4 times per patient in the 18 months following the successful billing of the 14033;

ii) Not payable unless the GP/FP is eligible for and has been paid for the Annual Complex Care Management Fee (G14033) within the previous 18 months;

iii) Telephone or e-mail management requires two-way communication between the patient and physician or medical office staff on a clinical level; it is not billable for simple notification of office appointments;

iv) Payable only to the physician that has successfully billed for the Annual Complex Care Management Fee (G14033) unless the billing physician has the approval of the GP responsible for the Annual Complex Care Management Fee (G14033) and a note entry is submitted indicating this;

v) G14016, Community Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;

vi) G14015, facility patient conferencing fee, not payable on the same day for the same patient as facility patients not eligible;

vii) G14017, acute care discharge planning conferencing fee, not payable on the same day for the same patient, as facility patients not eligible;

viii) Not payable on the same calendar day as a visit fee by the same physician for the same patient.

ix) Chart entry requires the capture of the name of the person who communicated with the patient or patient's representative as well as capture of the elements of care discussed;

HOW TO BILL

Have a face-to-face visit with the eligible patient, and/or the patient's medical representative if appropriate;

- Review the patient's history/chart and create a Complex Care Plan including the elements itemized above, which is billable only on the day of a face-to-face visit;
- Over the rest of the calendar year, conduct a review of the Complex Care Plan and provide other follow ups as clinically indicated. Follow-up may be face-to-face or by telephone/e-mail as appropriate, with the appropriate fee being payable.

Step 1. Create a Complex Care Plan G14033- $315

The Complex Care Management Fee acknowledges that eligible patients require medical management that is more time intense and complex. This fee compensates the GP/FP for the creation of a clinical action plan for the patient as described above, and for the additional complexity of managing these patients for the calendar year in which the Complex Care Plan is billed.

The initial service allowing access shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excluding care facilities) with two or more chronic conditions from two different eligible categories. This requires fulfillment of the itemized elements of service and documentation of these as specified in the fee item above. ***The patient & or their representative or family should leave the planning process knowing there is a plan for their care and what that plan is.***See Complex Care Plan Template below.

The diagnostic code for the Complex Care Management Fee (G14033) must be one of the codes from Table 1 below. If the patient has multiple co-morbidities, the submitted diagnostic code should reflect the two conditions creating the most complexity of care;

Step 2. Provide Office Visit Follow-Up

Visits for the rest of the year are billable under the appropriate MSP fee and with the ICD-9 code of the presenting complaint. Table 1 ICD-9 diagnostic codes should not be used for follow-up services; Table 1 codes were created for billing only the Complex Care Management Fee (G14033).

Step 3. Provide Follow-Up Telephone/Email Management G14039 - $15

These fees allow medical management through 2-way telephone or e-mail communication with the patient and/or the patient's medical representative. These non-face-to-face services are payable to a maximum of 4 times in the 18 months following the successful billing of the 14033. These services will also be applied toward the majority source of care calculation for these patients. As with the office visit follow-up, ICD-9 codes used in submitting the Telephone/Email Management fees should reflect the most appropriate condition requiring this service. Table 1 diagnostic codes should not be used, as these were created for billing the Complex Care Management Fee (G14033) only.

Step 4. Using the Diagnostic Codes listed in Table 1

Many software programs in use in B.C. do not allow capture of more than one diagnostic code per billing. Diagnostic codes have therefore been developed to cover all combinations of any two of the chronic condition categories covered under the complex care fees. These codes are listed below, and should be used only when submitting the Complex Care Management Fee (G14033). All follow-up fees should use 'real' ICD-9 codes. When a patient has co-morbidities from more than two categories, the submitted diagnostic code should reflect 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	Congestive Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease (Renal Failure)
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Failure)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Congestive Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease (Renal Failure)
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Failure)
I428	Ischemic Heart Disease	Congestive Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease (Renal Failure)
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Failure)
H250	Congestive Heart Failure	Diabetes
H430	Congestive Heart Failure	Cerebrovascular Disease
H585	Congestive Heart Failure	Chronic Kidney Disease (Renal Failure)
H573	Congestive Heart Failure	Chronic Liver Disease (Hepatic Failure)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease (Renal Failure)
D573	Diabetes	Chronic Liver Disease (Hepatic Failure)
C585	Cerebrovascular Disease	Chronic Kidney Disease (Renal Failure)
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Failure)
K573	Chronic Kidney Disease (Renal Failure)	Chronic Liver Disease (Hepatic Failure)

New diagnostic codes highlighted.

Frequently Asked Questions:

1. What is the purpose of the Complex Care Management Fees?
The Complex Care Management Fees have been created to provide recognition that patients with co-morbid conditions require more time and effort to provide quality care, and to remove the financial barrier to providing this care as opposed to seeing more patients of a simpler clinical condition.

2. What is a Complex Care Plan?
The initial service allowing "portal" access to the complex care fees shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excluding care facilities) with two or more of the above chronic conditions. This plan should be reviewed and revised as clinically indicated. It is essentially an expansion of the SOAP formula for chart documentation. ***The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.***

A complex care plan requires documentation in the patient's chart that:

- there has been a detailed review of the case/chart and of current therapies;
- there has been a face-to-face visit with the patient – or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
- specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
- incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the Complex Care Management Fee;
- outlines expected outcomes as a result of this plan, including end-of-life issues when clinically appropriate;
- outlines linkages with other health care professionals that would be involved in the care, their expected roles;
- identifies an appropriate time frame for re-evaluation of the plan;
- confirms that the care plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other involved health professionals as indicated.

3. What is the difference between "assisted living" and "care facilities"?
There are a wide range of living facilities currently available. Some, referred to under the terms of this initiative as 'assisted living' facilities, provide only basic supports such as meals and housecleaning, and do not provide their residents with nursing and other health support. A "care facility" on the other hand, is defined under the terms of this initiative as being a facility that does provide supervision and support from other health professionals such as nurses.

4. Why is this incentive limited to patients living in their homes or assisted living?
While there may be exceptions, patients residing in a Long Term Care Facility or hospital usually have a resident team of health care providers available to share in the organization and provision of care. Patients residing in their homes or in assisted living usually do not have such a team, so the organization and supervision of care is usually more complex and time consuming for the GP.

5. Why are there restrictions excluding physicians "who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care" or to "physicians working under salary, service, or sessional arrangements?"
The current Fee-for-Service payment schedule tends to encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.

If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

6. There are many co-morbidities that result in complexity of care. Why is this incentive limited to a list of eight categories of conditions?
Compiling the list of eligible conditions has been difficult, and has required a careful balance. It is apparent that many additional conditions create complexities in providing care, but at the same time the GPSC is contractually required to remain within its budget.

After feedback from the FSFP GPs of BC, effective January 1, 2010, the GP Services Committee's revision of the Complex Care initiative has expanded the number of eligible patients. While asthma and COPD have been combined into a single "Chronic Respiratory Condition", this category has also been expanded to include other chronic respiratory diseases such as Cystic Fibrosis and restrictive airways diseases such as fibrosing alveolitis and pulmonary fibrosis. Also, GPSC has added 2 new disease categories: Chronic Neurodegenerative Disorders and Chronic Liver Disease (with hepatic dysfunction). While there are other conditions that add to complexity, this expansion to 8 categories covers a significant number of the medical co-morbidities that are seen in the population of BC. This list will undergo ongoing review and potential modification in the future.

7. What is the level of abnormal laboratory testing that will qualify my chronic lever patients as having "hepatic dysfunction"?

For the Complex Care Fee, Chronic Liver Disease with hepatic dysfunction will be defined as:

1) 'Chronic' refers to liver disease/dysfunction present for a period of at least six months;
2) 'Chronic Liver Disease with Hepatic Dysfunction' is defined as hepatic disease with evidence of liver dysfunction with the exception of:
    a. Self limiting conditions (e.g. Acute Hepatitis A or B, mononucleosis, CMV, etc.);
    b. Hepatitis carrier states with normal liver function tests;
    c. Benign conditions with elevation of liver function tests (e.g Gilbert's Syndrome, isolated elevation of a liver enzyme without other evidence of hepatic dysfunction)

8. Why did GPSC create "fake" diagnostic codes for the Complex Care Management Fee?

TelePlan requires software to be able to capture more than one diagnostic code, but many versions of software currently used do not support this. To get around this barrier without requiring that many GPs modify their current software, GPSC created different diagnostic codes to indicate different combinations of two eligible criteria. These dual diagnostic codes have been revised this year to reflect the changes and additions to the categories. You will need to review and revise your patient diagnostic code to align with the revisions. Effective January 1, 2010, the new diagnostic codes for these patients must be utilized.

9. What do I do if my patient has more than two of the eligible conditions?

When billing the Complex Care Management fee (14033) use the diagnostic code from Table 1 that indicates the two conditions causing the most complexity. All subsequent visits/services should use the ICD-9 code for the condition requiring the visit/service

10. Am I eligible to bill for the Community Patient Conferencing Fee (G14016) in addition to receiving the Complex Care Management payment(s)?

Yes. If the physician needs to conference with allied health professions about the care plan and any changes, then the services provided in conferencing with other health care professionals is payable over and above the Complex Care Management Payments, provided that the all criteria for the Conferencing fee are met. The time spent on the phone or e-mail with the patient for the non-face-to-face complex care management does not count toward the total time billed under the community patient conferencing fee.

11. What is the difference between the Complex Care Telephone/Email Follow-Up Management Fee (G14039) and the Community Patient Conferencing Fee (G14016)?

The Complex Care Follow-Up Telephone/Email Management payment relates to services provided to the patient or the patient's medical representative as indicated. The Community Patient Conferencing Fee relates to services spent conferencing with other health care providers in a 2-way discussion on the provision of care to benefit the patient.

12. Am I eligible to bill for the Chronic Disease Management Fee(s) (G14050/G14051/G14052/G14053) in addition to receiving the Complex Care payment(s)?

Yes. The Chronic Disease Management Fees (G14050, G14051, G14052 and G14053) are independent of the Complex Care fees, and are payable on the same patient as long as the criteria for those fees are met.

13. Why is the Complex Care Telephone/Email Follow-Up Management Fee (G14039) restricted to the GP that has been paid for the Annual Complex Care Fee (G14033)?

This fee is designed to allow greater flexibility in providing follow-up to a plan that has been created. The GP that has been paid for the Annual Complex Care Management Fee in the previous 18 months has also

accepted the responsibility of being the Most Responsible GP (MRGP) for that patient's care for the two submitted chronic illnesses. The Annual Complex Care Management Plan requires work, the shouldering of responsibility, and the co-ordination of care. It has considerable value. This fee is therefore restricted to the GP that has created the clinical action plan.

14. If the Complex Care Telephone/Email Follow-Up Management Fee is restricted to the GP who has been paid for the Annual Complex Care Management Fee, what do group practices do when they share the care of the patient?

An exception has been made, allowing another GP to bill for this fee with the approval of the Most Responsible GP (MRGP). This allows flexibility in situations when patient care is shared between GPs. In this circumstance, the alternate GP must submit the claim with a note record indicating he/she is in the group of the MRGP and is sharing the care of the patient.

If a disagreement arises about the billing of this service, the GP Services Committee will adjudicate based upon whether the Most Responsible GP, i.e the GP paid for the Annual Complex Care Fee, approved or did not approve the service provided. The GP Services Committee feels that this provides the maximum flexibility while still maintaining responsibility.

15. Can I bill the Follow-up Management fees if I have billed for the Annual Complex Care Fee, but have not yet been paid?

Adjudication of this will depend upon whether the GP is eventually paid for the Annual Complex Care Fee. In other words, if a GP bills the Annual Complex Care Management Fee (G14033) then provides—and bills for—a follow-up service under G14039 prior to receiving payment for G14033, payment for G14039 will made only if G14033 is subsequently paid to that GP. Until that time it will show as "BH' on the remittance.

16. Are the payments eligible for the rural premiums?

No.

Complex Care Fees

G14033	**Complex Care Annual Management Fee**	**$315**
G14039	**Complex Care Telephone/E-mail Follow-up Management Fee**	**$15**

Complex Care Billing Example

Mrs. J. is a 68 year old lady with diabetes, asthma and Parkinson's disease. She has made an appointment to see you in January for her annual review of her care plan that was set up the previous year. You note that the two conditions causing the most complexity are diabetes and asthma, as her Parkinson's is well controlled with medication. You note that her new Dual Diagnostic code is R250. You review her medications and most recent lab tests as well as her peak flow chart. After also checking her diabetes flow sheet, you discuss with her the complex care plan for the remainder of the year and set up an appointment for her to have her complete check up in March when it is due. You also note that her Diabetes CDM (14050) anniversary is coming up at the end of January.

In February, Mrs. J calls when you are on call to advise that her peak flow has suddenly dropped into her low yellow zone after visiting her daughter who has a cat. She tells you that her maintenance dose of Flovent has been 125 mcg twice daily, so you ask her to increase to 250 mcg twice daily and to come in to the office to see you the following day. When you see her, you determine she has had a flare of her asthma but that there is no sign of acute infection, and so advise to continue with the increased Flovent.

You see her again 7 days later and her peak flows have improved. You advise her to stay on this higher dose for the next 2 weeks, and that you will have your office nurse call to check on her.

When contacted in early March, her peak flows have stayed stable and she is advised to go back to her maintenance dose. You see her again in March for her CPX and over the rest of the year for follow up of her complex conditions she is seen in July, October for planned proactive care of her complex conditions and December twice due to a flare of her asthma. In addition, in September, she is seen by you for a bladder infection and treated appropriately. Mrs. J's Diagnostic Code for her Complex Care Management under all options is A250.

The billings for this calendar year for Mrs. J. are:

Month	Service	Fee Code	Dx Code
Jan.	Complex Care Management Planning Visit Diabetes CDM Anniversary	14033 16100 14050	R250 R250 250
Feb.	Phone call Office Visit – Asthma flare Office visit – Asthma flare follow up	14039 16100 16100	R250 493 493
March	Phone call CPX	14039 16101	A250 250
July	Office Visit – proactive follow up	16100	250
Sept.	UTI Office Visit	16100 15130	595 01L
Oct.	Office Visit – proactive follow up	16100	250
Dec.	Office Visit – Asthma flare Office Visit – Asthma flare	16100 16100	493 493

Complex Care Plan Template

Initial Planning Date: _____

Patient Name: _____

Condition #1: _____ **Condition #2:** _____

Dual Diagnostic Code: _____

Patient Values/Goals: _____

_____

_____

Plan for Management of Co-Morbid Conditions:

_____

_____

_____

_____

_____

Linkage with other Heath Care Professionals:

_____

_____

_____

Discussed with AHP: _____

Expected Outcomes:

_____

_____

_____

Time frame for Re-Evaluation: _____

Discussed with: Patient _____ **Representative:** _____

Re-Evaluation Date: _____

Change(s) to Plan, if any:

_____

_____

_____

Discussed with: Patient _____ **Representative:** _____ **AHP:** _____
