

GENERAL PRACTICE SERVICE COMMITTEE (GPSC) – FEE UPDATES

Conferencing Fees

- Updates to notes and Q and A's for fee items G14015 and G14016
- New fee item - G14017 General Practice Acute Care Discharge Conferencing Fee

Palliative Care – New Fees

- G14063 Palliative Care Planning Fee
- G14069 Palliative Care Telephone/E-mail Follow-up Management Fee

Cardiovascular Risk Assessment - Fee Item G14034

- Change to the Age Requirement

CONFERENCING FEES:

Facility Patient Conference Fee

G14015 General Practice Facility Patient Conference: when requested by a facility to review ongoing management of the patient in that facility or to determine whether a patient in a facility with complex supportive care needs can safely return to the community or transition to a supportive care or long-term care facility
- per 15 minutes or greater portion thereof.....\$40.00

Notes:

- i) Refer to Table 1 below for eligible patient populations.*
- ii) Must be performed in the facility and results of the conference must be recorded in the patient chart,*
- iii) Payable only for patients in a facility. Facilities limited to: palliative care facility LTC facility, rehab facility, assisted living, sub-acute facility, psychiatric facility, detox/drug and alcohol facility, community placement agency, disease clinic (DEC, arthritis, CHF, asthma, cancer or other palliative diagnoses, etc).*
- iv) Requesting care providers limited to: long term care nurses, home care nurses, care coordinators, liaison nurses, rehab consultants, psychiatrists, social workers, CDM nurses, any healthcare provider charged with coordinating discharge and follow-up planning.*
- v) Requires interdisciplinary team meeting of at least two health professionals in total, and will include family members when available.*
- vi) Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.*
- vii) Claim must state start and end times of the service.*
- viii) If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*
- ix) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
- x) Not payable on the same day for the same patient as the Community Patient Conference Fee (14016)*
- xi) Visit payable in addition if medically required and does not take place concurrently with the patient conference. Medically required visits performed consecutive to the Facility Patient Conference are payable.*

This fee is for patient care conferences taking place in a facility.

Eligibility:

This incentive payment is available to improve patient care to:

- All general practitioners who have a valid B.C. Medical Service Plan practitioner number (registered specialty 00). Practitioners who have billed any specialty fee in the previous 12 months are not eligible; and
- Whose majority professional activity is in full service family practice as described in the introduction; and,
- Is considered the most responsible GP for that patient at the time of service.
- This payment is billable for the groups of patients identified in Table 1.

Frequently Asked Questions:

- 1. How do I claim the Facility Patient Conference Fee payments?***
Submit the fee item G14015 (value \$40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).
- 2. What is the maximum number of payments allowed per patient?***
A maximum of four units (60 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year.
- 3. Is this payment eligible for rural premiums?***
Yes.
- 4. Are there circumstances where payment will be allowed even if the care conference did not occur in a face-to-face meeting in the facility?***
Face to face meetings are expected. Only under exceptional circumstances will care conferences by teleconference will be payable. For audit purposes, when this occurs, a chart entry is required to indicate that you were not physically present and the circumstances that prevented it.
- 5. If more than one patient is discussed at the same case management conference is the fee billable for each patient discussed?***
Yes. The fee is billable under the PHN of each of the patients discussed, for the length of time that each patient's care was discussed. Concurrent billing for more than one patient is not permitted. That is, if you attend a care conference and two patients are discussed over the course of an hour the total time billed must not exceed one hour.
- 6. Is the Facility Patient Conference Fee billable by physicians who are employed or under contract to a facility and would have attended the conference as a requirement of their employment or contract with the facility?***
No.

7. ***Is the Facility Patient Conference Fee billable by physicians working under salary, service contract or sessional arrangements?***
No. When provision of this service is included as a part of the contract for physicians working under these, funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.
8. ***Can this fee be billed if I also submitted a Community Patient or Acute Care Discharge Planning Conference Fee on the same day?***
No. It is not payable on the same day of service for the same patient as the Community Patient Conference Fee or the Acute Care Discharge Planning Conference Fee. The Community Patient Conference Fee is intended for patients living in the community while the Facility Patient Conference Fee is intended for patients in a facility. The Acute Care Discharge planning fee is to be used when the patient is in an acute care facility and the complexity of their condition requires a multi-disciplinary care conference to ensure a smooth transition back to the community other acute care or long term care facility.
- If a Community Patient Conference Fee or an Acute Care Discharge Planning Conference fee was billed and the patient is subsequently admitted to a facility included in the list as above, and a patient management conference is requested by that facility, fee item G14015 may be billed. Conversely, if a Facility Patient Conference Fee is billed and the patient is subsequently discharged from the facility and additional clinical action planning is required, fee item G14016 may be billed. If the facility patient is admitted to acute care, and subsequently requires a discharge planning conference prior to return to the initial facility, then the fee item G14017 may be billed for the acute care discharge planning conference. They may not, however, be billed on the same calendar day.
9. ***Are locums able to bill this bonus?***
Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.
10. ***Can I bill for patients covered by other provinces?***
No. this service is not covered under the reciprocal agreement with other provinces.
11. ***Is this fee billable by hospitalists or on behalf of hospitalists?***
No. Refer to bullet ix under the fee description above. Hospitalists are under contract to a facility and would have attended the conference as part of their duties.
12. ***Can a community-based GP bill this fee for the discharge planning of a patient from an acute-care hospital?***
No. Effective June 1, 2009, these are to be billed under the Acute Care Discharge Planning Fee (G14017).

Community Patient Conferencing Fee

G14016 General Practice Community Patient Conferencing Fee: Creation of a coordinated clinical action plan for the care of **community-based patients** with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other health care providers is required (e.g., Specialists, psychologists or counselors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry), as well as with the patient and possibly family members (as required due to the severity of the patients condition).
- per 15 minutes or greater portion thereof\$40.00

Notes:

- i) Refer to Table 1 for eligible patient populations.
- ii) Fee includes:
 - a) the interviewing of patient and family members as indicated and the conferencing with other health care providers as described above -- this does not require face-to-face interaction in all case; and;
 - b) As appropriate, interviewing of, and conferencing with patients, family members, and other community health care providers; organizing and reviewing appropriate laboratory and imaging investigations, administration of other types of testing as clinically indicated (e.g., Beck Depression Inventory, MMSE, etc); provision of degrees of intervention or No CPR documentation; and
 - c) The communication of that plan to patient, other health care providers, and family members or others involved in the provision of care, as appropriate; and
 - d) The care plan must be recorded in the chart and include the following information:
 - 1) Patient's Name; and
 - 2) Date of Service
 - 3) Diagnosis:
 - A) V15 (Frail Elderly)
 - B) V28 Palliative/End of Life Care
 - C) Mental Illness (enter ICD-9 code of qualifying illness)
 - D) Patients of any age with multiple medical needs or complex co-morbidity (enter ICD-9 for one of the major disorders)
 - 4) Reason for need of Clinical Action Plan
 - 5) Health Care Providers with whom you conferred & their role in provision of care
 - 6) Clinical Plan Determined, including tests ordered and/or administered
 - 7) Patient risks based on assessment of appropriate domains (list of co-morbidities and safety risks)
 - 8) List of priority interventions that reflect patient goals for treatment;
 - 9) What referrals will be made, what following about has been arranged (including timelines and contact information), as well as advanced planning information
 - 10) Start and stop times of service
- iii) Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.
- iv) Claim must state start and end times of service.
- v) Not payable to the same patient on the same date of service as the Facility Patient Conference fee (fee item G14015) or Acute Care Discharge Planning Conference fee (G14017).
- vi) Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.
- vii) Visit payable in addition if medically required and does not take place concurrently with clinical action plan.

Eligibility:

This incentive payment is available to improve patient care to:

- All general practitioners who have a valid B.C. Medical Service Plan practitioner number (registered specialty 00), except those with access to any specialty consultation fee; and
- Whose majority professional activity is in full service family practice as described in the introduction; is considered the most responsible general practitioners for that patient at the time of service; and
- Where the severity of the patient's condition justifies the development of a clinical action plan.

This new fee is intended to be a case conferencing fee for complex patients who are community based rather than facility based. The full Fee Code description is attached in Appendix 1. Under the 2006 agreement is limited to use in B.C. patients (put of province patients not eligible) who fall into five categories:

1. Frail Elderly; Diagnostic Code V15
2. Palliative Care; Diagnostic Code V58
3. End of Life; Diagnostic Code V58
4. Mental Illness; Appropriate Mental Health Diagnostic Codes see Appendix 2
5. Patients of any age with multiple medical needs or complex co-morbidity (two or more distinct but potentially interacting problems where care needs to be coordinated over time between several health disciplines); Diagnostic Code of one of the major disorders but on at some point, both will be required.

This fee is time based, and payable per 15 minutes or greater portion thereof. It is payable in addition to the actual visit fee code if the action plan conferencing requirements are done on the same day as a visit. A face to face visit is not required to bill this fee. While the visit fee does not need start/end times, the clinical action plan fee does require start and stop times. There is a maximum of six units (90 minutes) payable per calendar year per patient, with a maximum of four units (one hour) on any single day. This fee is available to those GPs in B.C. whose practice is primarily to provide longitudinal, comprehensive care to the patient, and who is considered the "Most Responsible Physician" for the patient at that time (including locums or partners in absence of the practitioner at the time the service is required). This fee is not available to physicians who are employed by or who are under contract with a facility or health authority who would otherwise have attended the conference as a requirement of their employment or contract. It is also not available for physicians working under salary, service contract or sessional arrangements.

This planning/conferencing fee is used when the complex patient's condition requires contacting other health care professionals and developing a plan for care to keep the patient stable in their community environment. Included in this is the administration of a Beck Depression Inventory, MMSE, etc. as well as reviewing and documenting Levels of Intervention and No CPR documentation as appropriate. It is not for referrals to the emergency room or to consultants when only a referral letter is required for an acute illness. If a telephone call to discuss management strategies while the patient is awaiting an assessment by a consultant is required, including discussing this plan with the patient +/- family members, then this fee is applicable.

When charting information to support this fee, one must include the date(s) of service, the diagnosis, the reason for the clinical action plan including risk factors, which other health care professionals were contacted in developing and implementing the plan, what tests (if any) were ordered and undertaken, what the details of the plan are, when the patient will be reassessed, along with the start and stop time(s) of the conferencing/planning. There are times where the development of the plan and the involvement of other health care providers may require time over two days, and each day would then have the fee billed with a different date and time of service, along with documentation of this in the chart.

Frequently Asked Questions

- 1. *How do I claim the Community Patient Conferencing Fee payments?***
Submit the fee item G14016 (value \$40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).
- 2. *What is the maximum number of payments allowed per patient?***
A maximum of four units (60 minutes) per day, to a maximum of six units (90 minutes) per calendar year.
- 3. *Is this fee billable if a claim for the Facility Patient Conferencing Fee or Acute Care Discharge Planning Conferencing Fee was also made for the patient on the same day?***
No.
- 4. *Is this payment eligible for rural premiums?***
Yes.
- 5. *Are locums able to bill this bonus?***
Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.
- 6. *Can I bill for patients covered by other provinces?***
No.
- 7. *Is the Community Patient Conferencing Fee billable by physicians working under salary, service contract or sessional arrangements?***
No. Physicians working under these funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.
- 8. *Am I eligible to bill this fee when I refer an acutely-ill patient and discuss the case with an Emergency Room Physician/Specialist/Emergency Department nurse?***
No. This fee covers the two-way collaborative conferencing with other providers in the development of a clinical action plan. The transmission of information in a referral process does not qualify.

New Fee Item Effective June 1, 2009:

Acute Care Discharge Planning Conferencing Fee

G14017 General Practice Acute Care Discharge Conference Fee: This fee is billable when a Discharge Planning Conference is performed upon the request of either an Acute Care facility, or by the GP accepting MRP status upon discharge, regarding a patient with complex supportive care needs, for review of condition(s) and planning for safe transition to the community or to a different facility; another acute care facility, or a supportive care or long-term care facility.
- per 15 minutes or greater portion thereof.....\$40.00

Eligible Patient Population (refer to Table 1 for details)

- Frail elderly (ICD-9 code V15)
- Palliative care (ICD-9 code V58)
- End of life (ICD-9 code V58)
- Mental illness
- Patients of any age with multiple medical needs or complex co-morbidity

Eligible Physician Population

In order to improve continuity of patient care upon discharge from an acute care facility, this incentive payment is available to all General Practitioners who:

- Have a valid B.C. Medical Service Plan practitioner number (registered specialty 00) (practitioners who have billed any specialty fee in the previous 12 months are not eligible); and
- Whose majority professional activity is in full service family practice as described in the introduction; and
- Is considered the most responsible GP for that patient following discharge from the acute care facility

Notes:

- i) *Refer to Table 1 for eligible populations.*
- ii) *Payable only for patients being discharged from an acute care facility to the community or to a different facility; another acute care facility, or a supportive care or Long Term Care facility.*
- iii) *Must be performed in the acute care facility and results of the conference must be recorded in the patient's chart in the acute care facility and the receiving GP's office chart (or receiving facility's chart in the case of inter-facility transfer) ;*
- iv) *Face-to-face conferencing is required; the only exception is if a patient is being discharged from an acute care facility in a different community, and a chart notation must be made to indicate this circumstance.*
- v) *Requesting care providers limited to: Facility-affiliated physicians and nurses, GP assuming MRP status upon patient's discharge, care coordinators, liaison nurses, rehab consultants, social workers, any healthcare provider charged with coordinating discharge and follow-up planning,*
- vi) *Requires interdisciplinary team meeting of the GP assuming MRP status upon discharge and a minimum of 2 other health professionals as enumerated above, and will include family members when appropriate;*

- vii) *Fee includes:*
 - a. *Where appropriate, interviewing of and conferencing with patient, family members, and other health providers of both the acute care facility and community;*
 - b. *Review and organization of appropriate clinical information;*
 - c. *The integration of relevant information into the formulation of an action plan for the clinical care of the patient upon discharge from the acute care facility, including provision of Degrees of Intervention and end of life documentation as appropriate;*
 - d. *The care plan must be recorded and must include patient identifiers, reason for the care plan, list of co-morbidities, safety risks, list of interventions, what referrals to be made, what follow-up has been arranged*
- viii) *This fee does not cover routine discharge planning from an acute-care facility, nor is this fee payable for conferencing with acute-care nurses during the course of a patient's stay in the acute care facility;*
- ix) *Maximum payable per patient is 90 minutes per calendar year. Maximum payable on any one day is 60 minutes.*
- x) *Claim must state start and end times of the service.*
- xi) *If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods.*
- xii) *Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
- xiii) *Medically required visits performed consecutive to the Acute Care Discharge Conference are payable.*
- xiv) *Submit the new fee item G14017 through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders*
- xv) *Not billable on the same day as Facility Patient or Community Patient Conferencing Fees (G14015 or G14016)*
- xvi) *Not billable on the same day as any GPSC planning fees (G14033, G14043, G14063 (Palliative Planning Fee)).*

Frequently Asked Questions:

1. ***How do I claim the Acute Care Discharge Planning Conference Fee payments?***
Submit the new fee item G14017 (value \$40 for each 15 minute unit or major portion thereof) through the MSP Claims System under the patient's PHN. The claim must include ICD-9 codes V15, V58, or the code for one of the major disorders (See Table 1).
2. ***What is the maximum number of payments allowed per patient?***
A maximum of four units (60 minutes) per day, to a maximum of 6 units (90 minutes) per calendar year.
3. ***Is this payment eligible for rural premiums?***
Yes.
4. ***Are there circumstances where payment will be allowed even if the care conference did not occur in a face-to-face meeting in the facility?***
Face to face meetings are expected. Only under exceptional circumstances will care conferences by teleconference will be payable. For audit purposes, when this occurs, a chart entry is required to indicate that you were not physically present and the circumstances that prevented it.

5. ***If more than one patient is discussed at the same case management conference is the fee billable for each patient discussed?***
Yes. The fee is billable under the PHN of each of the patients discussed, for the length of time that each patient's care was discussed. Concurrent billing for more than one patient is not permitted. That is, if you attend a care conference and two patients are discussed over the course of an hour the total time billed must not exceed one hour.
6. ***Is the Acute Care Discharge Planning Conference Fee billable by physicians who are employed or under contract to a facility and would have attended the conference as a requirement of their employment or contract with the facility?***
No.
7. ***Is the Acute Care Discharge Planning Conference Fee billable by physicians working in a or physicians working under salary, service contract or sessional arrangements?***
No. When provision of this service is included as a part of the contract for physicians working under these, funding arrangements are paid a set amount for their time, and therefore would not qualify for this payment.
8. ***Can this fee be billed if I also submitted a Community Patient or Facility Patient Conference Fee on the same day?***
No. The Acute Care Discharge Planning Conference fee (G14017) is not payable on the same day of service for the same patient as the Community Patient Conference Fee (G14016) or the Facility Patient Conference Fee (G14015). The Community Patient Conference Fee is intended for patients living in the community and the Facility Patient Conference Fee is intended for patients residing in a facility. The Acute Care Discharge planning fee is to be used when the patient is in an acute care facility and the complexity of their condition requires a multi-disciplinary care conference to ensure a smooth transition back to the community other acute care or long term care facility.
- If a Community Patient Conference Fee or a Facility Patient Conference fee was billed and the patient is subsequently admitted to an acute care facility, and a patient management conference is deemed to be needed, fee item G14017 may be billed. Conversely, if a Facility Patient Conference Fee is billed and the patient is subsequently admitted to acute care, and subsequently requires a discharge planning conference prior to return to the initial facility, then the fee item G14017 may be billed for the acute care discharge planning conference. They may not, however, be billed on the same calendar day.
9. ***Are locums able to bill this bonus?***
Yes. Locum coverage is considered part of the usual care provided by the host general practitioner.
10. ***Can I bill for patients covered by other provinces?***
No. this service is not covered under the reciprocal agreement with other provinces.
11. ***Is this fee billable by hospitalists or on behalf of hospitalists?***
No. Refer to bullet ix under the fee description above. Hospitalists are under contract to a facility and would have attended the conference as part of their duties.

Table 1: Eligible patients populations for the Facility Patient Conference Fee and the Community Patient Conference Fee

i. Frail elderly (ICD-9 code V15)

Patient over the age of 65 years with at least three 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:

- Are 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 a supportive living residence or hospice); and
- Have been diagnosed with a life-threatening illness or condition; and
- Have a life expectancy of up to six months, and
- Consent to the focus of care being palliative rather than treatment aimed at cure.

iii. End of life (ICD-9 code V58)

Patients of any age:

- Who have 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

Patients of any age with any of the following disorders are 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
- Sleep disorders
- Personality 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 co-morbidity (ICD-9 code XXX)

Patient of any age with multiple medical conditions or co-morbidities (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.

PALLIATIVE CARE PLANNING AND MANAGEMENT FEES – EFFECTIVE JUNE 1, 2009:

The Palliative Care Incentive is a new payment initiative that is intended to compliment the existing conferencing component of end-of-life care when sharing care with other health care professionals. To date, the GPSC has developed the community and facility patient conferencing fees which appropriately compensate the family physician for their role in conferencing with other team members in supporting the care needs for these patients.

Preparation and advance care planning are a critical first step once it has been determined that a patient’s condition is terminal. With the GPSC Palliative Care Incentive payment, family physicians will be encouraged to take the time needed to work through the various decisions and plans that need to be determined to ensure the best possible quality of life for dying patients and their families. A new “Palliative Care Planning fee” will compensate the family physician for undertaking and documenting a care plan that will include the following components:

- A statement of the patient's primary medical diagnosis;
- A statement that the patient is medically palliative based on the physician's medical diagnosis AND the patient's agreement to no longer seek treatment aimed at cure;
- A list of the potential health care needs and the plan for managing these needs. As an example this may include Home and Community Care support services such as home support, home nursing care, personal care, after-hours palliative care, respite and/or hospice care; access to palliative medications, and supplies and equipment through the Provincial Palliative Benefits Program;
- A detailed, current plan for symptom management, including completing the application form and process to access the Palliative Benefits Program when appropriate;
- A list of the clinical indicators on when referral/access to specialist palliative care services may be needed;
- A copy of the patient's most current advance directive if available; and
- Completion and retention of forms to support a planned natural home death when this is part of the patient goal (Notification of a Planned Home Death; No CPR form, etc.).
- Physicians and patients are encouraged to ensure these documents will be available to the local emergency room in the event of patient attendance there.

In addition, once the planning process has been completed and the planning fee successfully billed, the Family Physician or practice group will be able to access up to five phone/e-mail follow-up management fees.

G14063 Palliative Care Planning Fee \$100.00

This fee is payable upon the development and documentation of a Palliative Care Plan for patients who have been determined to have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to six months, and who consent to the focus of care being palliative rather than treatment aimed at cure. Medical Diagnoses include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy.

Eligible patients must be resident in the community; in a home or in assisted living or supportive housing. Facility-resident patients are not eligible for this initiative.

This fee requires the GP to conduct a comprehensive review of the patient's chart/history and assessment of the patient's current diagnosis to determine if the patient has a life-limiting condition that has become palliative and/or remains palliative. It 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.

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 B.C. 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 billed on the same day;*
- v) *Minimum required time 30 minutes in addition to visit time same day;*
- vi) *G14016, community patient conferencing fee payable on same day for same patient if all criteria met;*
- vii) *Not payable on same day as G14015, facility patient conferencing fee;*
- viii) *Not payable on same day as G14017, acute care discharge planning;*
- ix) *Not payable on the same day as G14069 (Palliative Care Telephone/E-mail management fee)*
- x) *G14050, G14051, G14052, G14053, G14033, G14034 not payable once Palliative Care Planning fee is billed as patient has moved from active management of chronic disease to palliative.*
- xi) *G14043, G14044, G14045, G14046, G14047, G14048, G14049 the GPSC Mental Health Initiative Fees are payable once G14063 has been billed provided all requirements are met, but are not payable on same day.*

G14069 Palliative Care Telephone/E-mail Follow-up Management Fee \$15.00

This fee is payable for two-way communication with eligible patients via telephone or e-mail for the provision of clinical follow-up management by the GP who has created and billed for the Palliative Care Planning fee (G14063). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

- i) *Payable to a maximum of 5 times following successful billing of Palliative Care Planning fee G14063;*
- ii) *Telephone/e-mail Management requires two-way communication between the patient and physician or medical staff on a clinical level; it is not payable for simple notification of office appointments;*
- iii) *Payable only to the physician paid for the Palliative Care Planning fee (G14063) unless that physician has agreed to share care with another delegated physician;*
- iv) *Not payable on the same day as a visit fee;*
- v) *Not payable on the same day as G14063, Palliative care planning fee*
- vi) *G14016, Community Patient 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 of G14016;*
- vii) *Not payable on same day as any of G14043, G14044, G14045, G14046, G14047, G14048 or G14049, GPSC Mental Health Initiative fees.*
- viii) *Not payable on same day as G14015, Facility Patient Conferencing Fee;*
- ix) *Not payable on same day as G14017, Acute Care Discharge Planning Conferencing Fee;*
- x) *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.*

Eligibility for G14063 and G14069

- Eligible patients are community based (living in their home, with family or assisted living).
- Payable only to the General Practitioner or practice group that accepts the role of being most responsible for longitudinal coordinated care of the patient for that calendar year;
- 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 a health authority or agency or who are under contract whose duties would otherwise include the provision of this care;
- Not payable to physicians working under a salary, service contract or sessional arrangements and whose duties would otherwise include the provision of this care.

G14034-Cardiovascular risk assessment fee

Effective June 1, 2009, the patient age range eligible for the GPSC cardiac risk assessment fee item G14034 has been expanded to 18-69 years, inclusive provided all other fee item criteria are met. Therefore the following note listed beneath fee item G14034 has been amended:

i) The eligible population will be males or females between 18 and 69 years of age, inclusive.

Reminder: The maximum calendar year limit per physician is 30 services.