GP SERVICES COMMITTEE
Complex Care INCENTIVES

Revised
2016

GPSC General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP Society of General Practitioners of BC

Complex Care Management Fees

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.

These items are ***payable only to the General Practitioner who is the most responsible general practitioner for the majority of the patient's longitudinal general practice care for the ensuing year.***

Billing Eligibility:

Physicians are eligible to participate in the GPSC incentive programs 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.

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.

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.

Complex Care Management Fees (G14033, G14075)

There are currently two Complex Care Management Incentives 14033 and 14075. Only Family Physicians who have submitted G14070 or G14071, (the Attachment Participation codes) have access to both complex care fees. Those not participating in Attachment continue to have access to the original Complex Care Management Fee (2 diagnoses) 14033. Please refer to the Attachment Section of the GPSC Billing Guide for further details of this initiative and the relevant fee incentives.

The Complex Care Management Fee (2 diagnoses) (G14033) was developed to compensate GPs for the management of complex patients residing in the community, who have documented confirmed diagnoses of 2 chronic conditions from at least 2 of the 8 categories listed below. Community patients are those residing in their home or in assisted living. Patients in acute or long term care facilities are not eligible.

Having comorbidities does not necessarily make a patient complex. To be eligible for the Complex Care Management Fee, 14033, the patient's co-morbidities 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, but on their over- all clinical impact, and the burden of illness the patient experiences.

G14033 Eligibility: Complex Care Condition Categories:

1) *Diabetes mellitus (type 1 and 2)*
2) *Chronic Kidney Disease (see FAQ #9)*
3) *Heart failure*

4) *Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.)*
5) *Cerebrovascular disease, excluding acute transient cerebrovascular conditions (eg. TIA, Migraine)*
6) *Ischemic heart disease, excluding the acute phase of myocardial infarct*
7) *Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.)*
8) *Chronic Liver Disease with evidence of hepatic dysfunction. (see FAQ #8)*

If a patient has more than 2 of the qualifying conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

The Attachment Patient Complex Care Fee (G14075) encompasses those patients with a qualifying diagnosis of Frailty as defined in the GPAC Guideline "Frailty in Older Adults – Early Identification and Management" (2012) with Moderate or Severe Frailty who do not otherwise qualify under the dual diagnostic eligibility for G14033 Complex Care Management Fee.

G14075 Patient Eligibilty: CSHA Clinical Frailty Scale*

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

* Taken from GPAC "Frailty in Older Adults – Early Identification and Management", Revised January 18, 2012
www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines

Patients are eligible for one of the Complex Care Management Fees, not both. If a patient already qualifies for G14033 there is no need or benefit to change to the Attachment Patient Complex Care Management fee G14075 even if the patient has the required level of frailty. For new patients who qualify under both complex care fees, FSFPs who are participating in the Attachment Initiative should choose the fee that best reflects the cause of complexity.

Both Complex Care Management Fees are advance payment for the complexity of caring for patients with eligible conditions during that calendar year and have the same basic rules:

- ✓ Community Based patients = Living at home or in Assisted Living (excludes those patients living in Residential or Long Term Care where there is 24 hour nursing care available)
- ✓ Payable once per calendar year per patient
- ✓ Visit (office or home visit) or CPx fee to indicate face-to-face interaction with patient same day billed same day.
- ✓ Minimum required time 30 minutes in addition to visit time same day. While not all the time needs to be face-to-face, the majority of the time must be for the development of the care plan jointly face-to-face with the patient and/or the patient representative as appropriate. **The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is. Effective August 1, 2015, documentation in the patient chart of total time spent in planning (face to face; review) and medical visit is required. There is no requirement to submit start/end times with claim for either complex care incentives as not all required time is face to face, as well the physician time to review of chart and finalizing of the plan may be on same or different day.**

- ✓ Maximum of five complex care of either category or unattached complex/high-needs patient attachment fees (G14033, G14075 and/or G14074) payable per day per physician
- ✓ Payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) for the management of the complex care patient during that calendar year.
- ✓ Successful billing of either the Complex Care Management Fee (G14033) or the Attachment Patient Complex Care Management Fee (G14075) allows access to 5 GP Telephone/email Follow-up fees (G14079) over the following 18 months. Once the Complex Care plan is reviewed and revised in the subsequent calendar year, the allowable G14079 resets to 4 over the following 18 months.

The Complex Care Management Visit can be provided and billed annually as appropriate, at any time in the calendar year.

To bill the Complex Care Management Fee (G14033) when a patient has more than 2 of the qualifying conditions, the submitted diagnostic code from Table 1 (below) should represent the two conditions creating the most complexity.

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://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/diagnostic-code-descriptions-icd-9

Consent Legislation Changes:

With the 2011 changes to "Health Care (Consent) and Care Facility (Admission) Act" and other Acts, patients with complex health conditions also need to know the potential impact of these changes on their care. Advance Care Planning (ACP) is an essential part of the management of all patients, and should be included in Complex Care Plan when clinically appropriate

Advance care planning is the process whereby a capable adult discusses their beliefs, values, wishes or instructions for future health care with trusted family and health care providers. Advance care planning may lead to a written Advance Care Plan (ACP). An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on conversations with trusted family/friend and health care provider. The ACP is to be used by a Substitute Decision Maker (SDM) to make health care decisions for the adult when incapable and this may include consent or refusal for treatment. The decisions are to be based on a healthcare provider's offer of medically appropriate care. An Advance Directive is a legal document consenting to or refusing specific treatment options and may or may not be included in the ACP. If it is, then health care providers are legally bound by consent refusals in the advance directive.
On September 1, 2011 changes to the *"Health Care (Consent) and Care Facility (Admission) Act" and other Acts*[1] come into effect. The following changes will impact all healthcare providers. Complex Care Patients will also need to know the potential impact on their care. Advance Care Planning is an essential part of the management of Complex Care Patients, and should be included at the time of the Complex Care Planning visit when clinically appropriate.

- Advance directives gain legal status
- Health Organizations, physicians, nurse practitioners, nurses & other regulated health care providers plus Emergency medical assistants (EMAs) are legally bound by consent refusals in an advance directive
- The list of people eligible to be chosen as temporary substitute decision makers is broadened
- The rules are tightened about who can be named as a representative, while at the same time a capable adult may name their representative without having to visit a lawyer or notary public
- A process is set out for making an application to court to resolve health care consent disputes

Advance Care Planning:

- Advance care planning is the **process** whereby a capable adult discusses their beliefs, values, wishes or instructions for future health care with trusted family and health care providers.
- Advance care planning **may** lead to a written **Advance Care Plan** (ACP). An ACP is a written summary of a capable adult's beliefs, values, wishes and/or instructions for future health care based on

[1] Representation Agreement Act, Power of Attorney Act, Adult Guardianship Act

conversations with trusted family/friend and health care provider. The ACP is to be used by a **Substitute Decision Maker** (SDM) to make health care decisions for the adult when incapable and this may include consent or refusal for treatment. The decisions are to be based on a healthcare provider's offer of medically appropriate care.

- An **Advance Directive may or may not be included in the ACP**. If it is, then health care providers are legally bound by consent refusals in the advance directive. Some exceptions do apply – see the Health Care Providers 'Guide to Consent to Health Care for further information.
- There are four options for Advance Care Plans & "Who Decides":
  Temporary Substitute Decision Makers decides
  Representative decides
  Representative decides using the Advance Directive
  Advance Directive – the adult decides in advance what should be done

Advance Directives:

- Must be made and signed by a capable adult and be witnessed by two witnesses or one witness who is a lawyer or notary public in good standing with the Society of Notaries Public. A witness cannot be a person who provides personal care, health care or financial services to the adult for compensation, nor the spouse, child, parent, employee or agent of such a person.
- When an Advance Directive is in place, Temporary Substitute Decision maker **is not** sought unless an exception applies
- If there is a legal representative, then decisions are based on the instructions in the Advance Directive. The adult may have instructed through the Representative Agreement that the AD may be followed independent of the representative.
- Must state that the adult knows that:
  – a health care provider may not provide to the adult any health care for which the adult refuses consent in the advance directive; and
  – a person may not be chosen to make decisions on behalf of the adult in respect of any health care for which the adult has given or refused consent in the advance directive

G14033 Annual Complex Care Management Fee (2 Diagnoses) $315

The Complex Care Management Fee is advance payment for the complex work of caring for patients with eligible conditions. It is payable upon the completion and documentation of a Complex Care Plan which includes Advance Care Planning when appropriate, as described below.

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

1. There has been a detailed review of the case/chart and of current therapies;
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Complex Care Management Fee is billed;
3. Specifies a clinical plan for the care of that patient's chronic diseases covered by the complex care fee;
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic diseases covered by the complex care fee;
5. Outlines expected outcomes as a result of this plan, including end-of-life issues (advance care planning) when clinically appropriate;
6. Outlines linkages with other allied care professionals who would be involved in the patient's care, and their expected roles;
7. Identifies an appropriate time frame for re-evaluation of the plan;
8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as appropriate.

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

Notes:

i) *Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions.*
ii) *Refer to Table 1 for eligible diagnostic categories.*
iii) *Payable once per calendar year per patient on the date of the complex care planning visit.*
iv) *Documentation of the Complex Care Plan is required in patient's chart.*
v) *A medical visit (in office or home) or CPx fee must be billed for same date of service. Visit time does not count toward required planning time.*
vi) *Minimum required planning time 30 minutes, to review chart and create the care plan collaboratively with the patient and/or their medical representative. The majority of the planning time must be face-to- face. Chart review does not need to be on same day as face-to-face planning.*
vii) *Chart documentation must include total work time (min. 35 minutes) and total face- to- face time (min. 20 minutes.) Total work time includes the combination of: chart review, face- to- face planning and same day medical visit. Total face- to face- time includes: face- to- face planning time plus the same day medical visit.*
viii) *G14016 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.*
ix) *G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.*
x) *Not payable once G14063 has been billed and paid as patient has been changed from active management of complex chronic conditions to palliative management.*
xi) *G14015, G14017, G14076 and G14079 not payable on the same day for the same patient.*
xii) *Maximum daily total of 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees per physician.*
xiii) *G14075 is not payable in the same calendar year for same patient as G14033.*
xiv) *Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.*
xv) *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.*
xvi) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

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;

G14075 GP Attachment Complex Care Management Fee $315

The GP Attachment Complex Care Management Fee is advance payment for the complex work of caring for patients with eligible conditions. It is payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) as described below. This Complex Care fee encompasses those patients with a qualifying diagnosis of Moderate or Severe Frailty as defined in the GPAC Guideline "Frailty in Older Adults – Early Identification and Management" (2012).

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

1. There has been a detailed review of the case/chart and of current therapies.
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the GP Attachment Complex Care Management Fee is billed.
3. Specifies a clinical plan for the care of that patient's chronic condition(s).
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic condition(s).

5. Outlines expected outcomes as a result of this plan, including any advance care planning for end-of-life issues when clinically appropriate.
6. Outlines linkages with other allied care professionals that would be involved in the care, their expected roles.
7. Identifies an appropriate time frame for re-evaluation of the plan.
8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as indicated.

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

Notes:

i) Payable only to Family Physicians who have successfully submitted the GP Attachment Participation Code G14070 or on behalf of Locum Family Physicians who have successfully submitted the GP Locum Attachment Participation Code G14071 on the same or a prior date in the same calendar year.

ii) Payable only for patients with documentation of moderate or severe frailty.

iii) Claim must include the diagnostic code V15.

iv) Payable once per calendar year per patient on the date of the complex care planning visit.

v) Documentation of the Complex Care Plan is required in patient's chart.

vi) A medical visit (in office or home) or CPx fee must be billed for same date of service. Visit time does not count toward required planning time.

vii) Minimum required planning time 30 minutes, to review chart and create the care plan collaboratively with the patient and/or their medical representative. The majority of the planning time must be face-to- face. Chart review does not need to be on same day as face-to-face planning.

viii) Chart documentation must include total work time (min. 35 minutes) and total face- to- face time (min. 20 minutes.) Total work time includes the combination of: chart review, face- to- face planning and same day medical visit. Total face- to face- time includes: face- to- face planning time plus the same day medical visit. G14077 payable on the same day for the same patient, for patients located in the community only as long term care facility patients are not eligible for 14075.

ix) Daily total 5 of any combination of G14033 complex care, G14075 Attachment Complex Care or G14074 GP unattached complex/high needs patient attachment fees 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, G14079 not payable on the same day for the same patient.

xiii) G14015, G14016 and G14017 not payable in addition, as these fees have been replaced by G14077 for FPs who have submitted the GP Attachment Participation Code.

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.

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 or G 14075 - $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 (including Advance Care Planning when appropriate) jointly with the patient as described above, and for the additional complexity of managing these patients until the Complex Care Plan is reviewed in a subsequent calendar year.

The initial service shall be the development of a Complex Care Plan for a patient residing in their home or assisted living (excluding care facilities) with the eligible condition(s). G14033 requires two or more chronic conditions from two different eligible categories, while G14075 is for patients with moderate or severe frailty. The creation of a care plan 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;

The diagnostic code for the Attachment Patient Complex Care Fee (G14075) must be V15 regardless of the age of the patient.

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 Complex Care Dual 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 G14079 - $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 5 times per patient per calendar year for patients on whom one or more of the portal planning incentives (G14033 Complex Care Planning, G14043 Mental Health Planning, G14053 COPD CDM with a COPD Action Plan, G14063 Palliative Planning or G14075 (Attachment Patient Complex Care Planning) has been successfully billed within the previous 18 months. While these patients also are eligible for the Attachment Patient Telephone Management fee G14076, it is recommended that for patients who are eligible for G14079, these should be utilized first (5 over the 18 months following the provision and billing of the eligible planning fees) before using the G14076 GP Attachment Telephone Management fees due to the limited number per participating FP (1500 per calendar year). These services will also be applied toward the majority source of care calculation for these patients.

Step 4. Using the Diagnostic Code(s) as appropriate to the patient's eligible condition(s)

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 G14033 complex care fee. 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.

The diagnostic code for the Attachment Patient Complex Care Fee (G14075) must be V15 regardless of the age of the patient or the underlying cause of the frailty.

Table 1: Complex Care Diagnostic codes (G14033)

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 (Hepatic Dysfunction)
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 (Hepatic Dysfunction)
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 (Hepatic Dysfunction)
H250	Heart Failure	Diabetes
H430	Heart Failure	Cerebrovascular Disease
H585	Heart Failure	Chronic Kidney Disease
H573	Heart Failure	Chronic Liver Disease (Hepatic Dysfunction)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease
D573	Diabetes	Chronic Liver Disease (Hepatic Dysfunction)
C585	Cerebrovascular Disease	Chronic Kidney Disease
C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Dysfunction)
K573	Chronic Kidney Disease	Chronic Liver Disease (Hepatic Dysfunction)

1. Frequently Asked Questions (General):

1.1. What is the purpose of the Complex Care Management Fees?

The Complex Care Management Fees have been created to provide recognition that those patients with co-morbid conditions or frailty level 6 and 7 who 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.

1.2. What is a Complex Care Plan?

The initial service allowing access to the complex care fees shall be the development of a Complex Care Plan for eligible patients residing in their home or assisted living (excluding care facilities). 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 of the following elements in the patient's chart that:

1. There has been a detailed review of the case/chart and of current therapies.
2. There has been a face-to-face visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the GP Attachment Complex Care Management Fee is billed.
3. Specifies a clinical plan for the care of that patient's chronic condition(s).
4. Incorporates the patient's values and personal health goals in the care plan with respect to the chronic condition(s).
5. Outlines expected outcomes as a result of this plan, including any advance care planning for end-of-life issues when clinically appropriate.
6. Outlines linkages with other allied care professionals that would be involved in the care, their expected roles.
7. Identifies an appropriate time frame for re-evaluation of the plan.
8. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care professionals as indicated.

1.3. How much time is required for billing the Complex Care Planning Incentives and how should the time spent face-to-face with the patient and in non-face-to-face review of the patient information be documented?

Both Complex Care fees require you to spend at least 30 minutes on the planning process, the majority of it face to face with the patient, in addition to the time spent on the medical visit which must be billed same day. Therefore, documentation of a minimum of 35 minutes total work time of which the majority must be face to face with the patient is required. Non face to face time includes time spent on chart review, documentation, discussion with allied care providers. **There is no requirement to document or submit start/end times.** See also FAQ 14 regarding the billing relationship between the complex care and conferencing fees.

Eg. Physician spends 10 minutes reviewing chart and any previous Complex Care Plan, to ensure all relevant information is available for the planning session with the patient. Patient is seen face to face to review current labs and health status, which takes 5 min, followed by 20 minutes of face-to-face planning encompassing creation of a care plan for the patient's chronic condition(s), articulation of the patient's goals of care and Advance Care Planning including resuscitation/levels of intervention choice. In addition to the details of the each component of the plan, documentation in the chart includes the following:

"Total time 35 minutes including face-to-face of 25 minutes."

1.4. 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.

1.5. 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 and therefore, Complex Care Management Fees are not applicable. 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.

1.6. 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.

1.7. What are the differences and similarities between the G14075 GP Attachment Complex Care Management Fee and the original G14033 Annual Complex Care Management Fee?

The GPSC received significant feedback that the original complex care incentive 14033 was too restricted and as a start to expanding the eligible patient population, developed the new G14075 GP Attachment Complex Care Management Fee for patients with moderate or severe frailty who do not meet the dual diagnostic criteria of the original G14033 Annual Complex Care Management Fee. FPs participating in the Attachment initiative have access to complex care incentive G14075 for existing patients and any new patients taken into their practice who meet the eligibility requirements.

Both Complex Care fees have the same basic rules:

- ✓ Community Based patients = Living at home or in Assisted Living (excludes those patients living in Residential or Long Term Care where there is 24 hour nursing care available)
- ✓ Payable once per calendar year per patient
- ✓ Visit (office or home visit) or CPx fee to indicate face-to-face interaction with patient same day billed same day.
- ✓ Not billable in acute care hospital setting
- ✓ Minimum required time 30 minutes in addition to visit time same day (not all needs to be face-to-face, but development of the care plan is done jointly face-to-face with the patient and/or the patient representative as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.
- ✓ Maximum of five complex care fees of either type or Unattached Complex/High-needs Patient Attachment fee (G14033, G14075 and/or G14074) payable per day per physician
- ✓ Payable upon the completion and documentation of the Complex Care Plan/Advance Care Plan (ACP) for the management of the complex care patient during that calendar year.

1.8. Why did GPSC create "fake" diagnostic codes for the original Complex Care Management Fee G14033?

TelePlan requires software in order 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 modification of current software, GPSC created different diagnostic codes to indicate different combinations of two eligible criteria.

1.9. What do I do if my patient has more than two of the eligible conditions for the original Complex Care Management Fee G14033 or would also qualify under the patient eligibility for the Attachment Complex Care Management Fee G14075?

When billing the Complex Care Management fee (14033) use the diagnostic code from Table 1 that indicates the two conditions causing the most complexity. If a patient already is qualified under the initial dual-diagnosis G14033 there is no need or benefit to change to the Complex Care Management fee G14075 even if the patient has the required level of frailty. For new patients who would qualify under both complex care fees, FSFPs who are participating in the Attachment Initiative should choose the one that most reflects the

cause of complexity. All subsequent visits/services should use the ICD-9 code for the condition requiring the visit/service.

1.10. Severe Frailty includes Palliative Patients. How does this impact the palliative Planning fee G14063?

Not all palliative patients are at the End-of-Life, and it is these "non-EOL" palliative patients who will require ongoing management beyond 6 months that would be appropriate for the G14075. Once they are at End-of-Life (life expectancy 6 months or less and eligible for palliative benefits plan – even if not applied for), the 14063 can be billed for Palliative Planning visit provided the G14075 or G14033 has not been billed in the previous 6 months. If a patient is determined to be in the last 6 months of life and it is decided to provide and bill for the Palliative Planning Visit through fee G14063, the complex care fees G14075 & G14033 as well as the CDM fees G14050, G14051, G14052 & G14053 are no longer billable.
Both 14075 & 14063 open the door to the GP Telephone/e-mail follow-up management fee (14079) and this is complemented by the additional Attachment telephone fee (14076) but family physicians should use all 5 of the 14079 first before using the limited 14076 (1500 per FP per calendar year).

1.11. Am I eligible to bill for the Attachment Patient Conferencing Fee (G14077) or 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 care professions about the care plan and any changes, then the services provided in conferencing with other allied care professionals is payable over and above the Complex Care Management fees (G14033, G14075), provided that the all criteria for the Conferencing fee are met. The time spent conferencing with allied care providers does not count toward the total time billed complex care fees (and vice versa). FSFPs who are participating in the Attachment Initiative should use the Attachment Patient Conferencing Fee (G14077) while FSFPs who are not participating should use the Community Patient Conferencing Fee (G14016).

1.12. What is the difference between the GP Telephone Management Fees (G14076 & G14079) and the Attachment Patient Conferencing Fee (G14077) or the Community Patient Conferencing Fee (G14016)?

The Telephone Management payments (G14076 & G14079) relate to services provided to the patient or the patient's medical representative as indicated. Both the Attachment Patient Conference Fee (G14077) and the Community Patient Conference Fee (G14016) relates to services spent conferencing with other allied care providers in a 2-way discussion on the provision of care to benefit the patient.

1.13. 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.

1.14. Do locums have access to billing the Complex Care fees?

Many of the GPSC incentives are for services or care that goes beyond the individual visit. Both Complex Care incentives include planning visit and pre-payment for time, intensity and complexity in the coming year, not just for the duration of the locum. Since the host FP is responsible for the follow-up management of the care incented through the initiatives, there must be agreement that it would be appropriate for the service to be provided by the locum. There are also implications in how the provision of these services and the resulting billing of the incentive fees will be treated in the locum agreement for fee splitting/payment. Therefore, before either of the Complex Care Incentives can be billed on behalf of services provided by Locums, the locum and host FP need to discuss the appropriateness and acceptability of this planning process to be provided by the locum.

Specifically with respect to the Attachment Complex Care incentive, if the host FP is agreeable to the locum seeing patients eligible for the Complex Care incentives to provide the planning visit as per fee description, then fee code G14075 for the provision of this service to patients with frailty level 6 or 7 by the locum, provided G14071 GP Locum Attachment Participation Code has been submitted earlier in the same calendar year.

1.15. Are the payments eligible for the rural premiums?
Effective November 1, 2014, the Complex Care Management fee (G14033) is eligible for the Rural Retention Premium. G14075 is not eligible for the rural retention premium.

2. Frequently Asked Questions (Clinical/Diagnostic):

2.1 What level of complexity is required in order to undertake and bill for a Complex Care Planning visit?
The Complex Care Management Incentives are intended to compensate for the "time, intensity and complexity" of caring for patients with multiple co-morbidities over the following year or so following the Complex Care Planning visit.

Having a specific diagnosis does not necessarily make a patient complex and so to be eligible for either of the Complex Care Management Fees, the individual patient conditions should be of sufficient severity and complexity to cause interference in their daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and warrant the development of a management plan. It is not the individual diagnosis itself, but the clinical impact of the diagnosis that is necessary for eligibility for the Complex Care Management fees.

Family Physicians are expected to use their clinical judgment when reviewing the impact of medical conditions on any given patient to determine if a patient with any given eligible diagnosis is of a level of complexity that will require a significant time and intensity of management over the following year or so to warrant undertaking a complex care planning visit.

2.2. If when managing a patient's medical condition, measurable testing (eg. eGFR, HgBA1C, PFTs, echocardiogram, etc) improves, does the patient still qualify for complex care G14033?
Eligibility is not simply about the medical diagnosis, but the clinical impact of that diagnosis that is important. If a person's measurements for their medical co-morbidities improve with management, the underlying condition has not been cured, but is being appropriately managed to prevent further progression of the condition Those conditions that improve because they are transient or self-limited would not qualify as chronic and complex, and so are not eligible for 14033.

2.3 What are instrumental and non-instrumental activities of daily living (IADL & NIADL) for determining patient eligibility for G14075?
Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community:

- Meal preparation
- Ordinary housework
- Managing finances
- Managing medications
- Phone use
- Shopping
- Transportation

Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care:

- Mobility in bed
- Transfers
- Locomotion inside and outside the home
- Dressing upper and lower body
- Eating
- Toilet use
- Personal hygiene
- Bathing

As per the GPAC Guideline "Frailty in Older Adults – Early Identification and Management" (2012), patients who require assistance for at least one ADL from each category are defined as having moderate Frailty.

2.4. Does Sleep Apnea qualify as an eligible condition for Complex Care 14033?

Sleep Apnea is considered a sleep disorder, not a respiratory disorder and as such, it does not qualify.

2.5. What is the level of abnormal laboratory testing that will qualify my chronic liver 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. Conditions that are not eligible include:
   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)
3) Conditions that may be eligible but that require additional consideration of the bigger clinical picture to determine the clinical impact of the condition include:

   a. Fatty liver disease with increased liver enzymes: Fatty liver is the result of the excess fat in liver cells. Fatty tissue slowly builds up in the liver when a person's diet exceeds the amount of fat his or her body can handle. A person has a fatty liver when fat makes up at least 5% of the liver. ***Simple fatty liver can be a completely benign condition and usually does not lead to liver damage***. However, once there is a buildup of fat, the liver becomes vulnerable to further injury, which may result in inflammation and scarring of the liver.

   b. Alcoholic hepatitis with increased liver enzymes: Alcoholic hepatitis is hepatitis (inflammation of the liver) due to excessive intake of alcohol. It is usually found in association with fatty liver, an early stage of alcoholic liver disease, and may contribute to the progression of fibrosis, leading to cirrhosis.

For a detailed outline of liver enzyme abnormalities and their connection to ongoing liver disease vs temporary/reversible non-chronic conditions if the underlying cause is addressed, the GPAC Guideline "Abnormal Liver Chemistry" can be found at:

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

2.6. What is required to confirm a diagnosis of Chronic Kidney Disease?

The presence of CKD should be established, based on presence of kidney damage and level of kidney function (estimated glomerular filtration rate [eGFR]), irrespective of diagnosis. All individuals with eGFR <60 for 3 months are classified as having chronic kidney disease, irrespective of the presence or absence of kidney damage. The rationale for including these individuals is that reduction in kidney function to this level or lower represents loss of half or more of the adult level of normal kidney function, which may be associated with a number of complications.

All individuals with kidney damage (defined as structural or functional abnormalities of the kidney based on abnormalities in the blood or urine [ACR at least 3.0 mg/mmol] or abnormalities in imaging tests) are classified as having chronic kidney disease, irrespective of the level of eGFR. The rationale for including individuals with eGFR 60 is that eGFR may be sustained at normal or increased levels despite substantial kidney damage and that patients with kidney damage are at increased risk of the two major outcomes of chronic kidney disease: loss of kidney function and development of cardiovascular disease.

Decreased eGFR may be acute or chronic. An acute decrease in eGFR does not necessarily indicate the presence of kidney damage/disease. For example, it is well known that a brief period of mildly decreased blood flow to the kidneys or transient partial obstruction of the urinary tract may cause decreased eGFR without kidney damage. However, a sustained decrease in blood flow or prolonged obstruction is often associated with kidney damage. Chronically decreased eGFR is more often associated with kidney damage. Decreased eGFR without recognized markers of kidney damage is very frequent in infants and older adults, and is usually considered to be "normal for age." Other causes of chronically decreased eGFR without kidney damage/disease in adults include vegetarian diets, unilateral nephrectomy, extracellular fluid volume depletion, and systemic illnesses associated with reduced kidney perfusion, such as heart failure and cirrhosis. It is not certain whether individuals with chronically decreased eGFR in the range of 60 to 89

mL/min/1.73 m2 without other evidence of kidney damage are at increased risk for adverse outcomes, such as toxicity from drugs excreted by the kidney or acute kidney failure. As a result, there is insufficient evidence to label individuals with eGFR 60 to 89 mL/min/1.73 m2, but without markers of kidney damage, as having chronic kidney disease. In clinical practice, it may be difficult to determine whether individuals with decreased eGFR alone have chronic kidney disease.

Misclassification is possible, and family physicians should carefully consider all aspects of the patient's clinical presentation when interpreting test results and determining evaluation and ongoing management. ***If the initial diagnosis of CKD was confirmed through more than just an abnormal eGFR, then while lab work may improve with good management, the underlying medical problem does not disappear. In order to reduce the risk of complications in the future, ongoing management must continue and as such, the complexity of caring for these patients continues.***

2.7. What is included under Neurodegenerative Disease as an eligible condition for 14033?
Neurodegenerative Disease is the umbrella term for the progressive loss of structure or function of neurons, including death of neurons. Examples of Chronic Neurodegenerative conditions include those degenerative disorders such as Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.

2.8. Does Epilepsy or seizure disorder qualify as a Chronic Neurodegenerative Disease?
Epilepsy/seizure disorder in and of itself is not a condition with an ongoing progressive loss of structure or function of neurons. Seizures may be a symptom of an underlying chronic neurodegenerative disorder that may qualify but as a stand-alone diagnosis, Epilepsy/Seizure Disorder does not qualify.

2.9. Does Downs Syndrome or other such genetic conditions qualify for 14033?
Chromosomal abnormalities are not chronic neurodegenerative disorders as these do not result in a progressive loss of structure or function of neurons, therefore this diagnosis is not eligible for 14033. However, ***depending on the level of disability, these patients may qualify for 14075 (Attachment Patient) Complex Care Management*** if they fulfill the requirements for moderate or severe frailty (help required in at least one task in each of the IADL & NIALD lists)

2.10. Does Mental Retardation or other cognitive impairment qualify for 14033?
Mental Retardation or other cognitive impairment is a functional diagnosis that in most cases does not result in a progressive loss of structure or function of neurons. If cognitive impairment is the symptom of an underlying eligible condition, then it is that underlying condition that would qualify, not the symptom. Therefore, depending on the underlying cause, this diagnosis is most likely not eligible for 14033. However, ***depending on the level of disability, these patients may qualify for 14075 (Attachment Patient) Complex Care Management*** if they fulfill the requirements for moderate or severe frailty (help required in at least one task in each of the IADL & NIALD)

2.11 Does evidence of multiple lacunar infarcts or cerebrovascular disease on CT scan without known event qualify under Cerebrovascular Disease for 14033?
Evidence of multiple lacunar infarcts or cerebrovascular disease on CT scan ***with symptoms that are of sufficient severity and complexity to cause interference in their daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and warrant the development of a management plan*** would be an eligible condition. It is not simply about a diagnosis made on a CT scan, but the clinical impact of that diagnosis that is necessary for eligibility for the Complex Care Management fee 14033**.**

2.12. Does diastolic heart dysfunction qualify under Ischemic Heart Disease for 14033?
Diastolic heart dysfunction is a functional diagnosis that **may** be the result of underlying ischemic heart disease. ***If it is due to underlying ischemic heart disease, and is clinically of sufficient severity and complexity to cause interference in their daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and and warrant the development of a management plan,*** then yes it would qualify. ***If the patient has heart failure as a result of diastolic heart dysfunction,*** then it is the heart failure that would be a qualifying diagnosis for

the purpose of 14033. Again, it is not simply the medical diagnosis, but the clinical impact of that diagnosis that is important.

2.13. Does Cor Pulmonale qualify under Ischemic Heart Disease for 14033?

Cor pulmonale is a condition that causes the right side of the heart to fail. Long-term high blood pressure in the arteries of the lung and right ventricle of the heart can lead to cor pulmonale. It is not usually due to ischemic heart disease, therefore would not be eligible unless it is a symptom due to underlying ischemic heart disease. However***, if the patient has heart failure as a result of cor pulmonale, then it is the heart failure that would be a qualifying diagnosis*** for the purpose of 14033, not the diagnosis of cor pulmonale. If either underlying ischemic heart disease and/or resultant heart failure is present then the patient would qualify using one of these diagnoses, not both.

Complex Care Management Fees

G14033	**Complex Care Annual Management Fee** (Table 1Diagnoses)	**$315**
G14075	**Attachment Patient Complex Care Management Fee** (Frailty Level 6 or 7)	**$315**

Complex Care Billing Example

You are a family physician who is participating in the Attachment Initiative. Mrs. J. is a 68 year old lady with diabetes, asthma and Parkinson's disease. While she lives in her own home, she requires assistance in at least one area of each of Instrumental and Non-Instrumental Activities of Daily Living. The local Home Care nurse visits her on a monthly basis. She has made an appointment to see you in January for review of her complex care plan that was set up the previous year. Prior to seeing Mrs. J, you spend 10 minutes reviewing her chart and you note that her frailty in large part due to her Parkinson's disease, is causing more of her complexity than are her other medical co-morbidities. When you see Mrs. J, you spend 5 minutes reviewing her current medications, most recent lab tests as well as her peak flow chart and her diabetes flow sheet. You then spend the next 20 minutes discussing her personal goals, advance care wishes and resulting complex care plan for the remainder of the year and set up an appointment for her to have her complete checkup 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 inhaled steroids has been 1 inhalation twice daily, so you ask her to increase to 2 inhalations 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 inhaled steroids. You contact the home care nurse to review the community plan for her management, and she agrees to see her early the following week and follows up with you by teleconference (15 minute conference each time). You see Mrs. J again 2 days after the home care nurse has visited 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 Diabetes and Parkinson's disease and in 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.

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

Month	Service	Fee Code	Dx Code
Jan.	Complex Care Management Planning – Moderate Frailty Documentation: *Total time 35 minutes including face-to-face of 25 minutes.* Diabetes CDM Anniversary	14075 16100 14050	V15 250 250
Feb.	Phone call by GP Office Visit – Asthma flare Conference call with home care nurse at time of visit Conference call with home care nurse prior to next visit Office visit – Asthma flare follow up	14079 or 14076 16100 14077 X 1 14077 X 1 16100	493 493 493 493 493
March	Phone call follow-up by office nurse CPX	14079 or 14076 16101	493 250
July	Office Visit – proactive follow up	16100	250
Sept.	UTI Office Visit	16100 15130	595 01L
Oct.	Office Visit – proactive follow up	16100	332
Dec.	Office Visit – Asthma flare Office Visit – Asthma flare	16100 16100	493 493

Complex Care Plan Template

Initial Planning Date: _____

Patient Name: _____

Qualifying Condition(s) _____ _____

Diagnostic Code: _____

Patient Values/Goals: _____

_____

_____

Plan for Management of any Co-Morbid Conditions:

_____

_____

_____

_____

_____

Linkage with other Allied Care Professionals:

_____

_____

_____

Expected Outcomes:

_____

_____

_____

Time frame for Re-Evaluation: _____

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

Re-Evaluation Date: _____

Change(s) to Plan, if any:

_____

_____

_____

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