GP SERVICES COMMITTEE
MATERNITY INCENTIVES

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General Practice Services Committee

doctors of bc

British Columbia

SGP Society of General Practitioners of BC

1.0 GPSC Preamble

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.

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.

Additional detailed eligibility requirements are identified in each section.

Definitions in GPSC Initiated Listings:

Full Service Family Physician:
GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g.: Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

General Practitioner with specialty training:
For the purpose of its incentives, GPSC defines a General Practitioner (GP) with specialty training as: "A GP who has specialty training and who provides services in that specialty area through a health authority supported or approved program".

Allied Care Provider:
For the purposes of its incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Physicians; Nurses; Nurse Practitioners; Mental Health Workers; Midwives, Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.

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

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

Allied Care Provider "Working Within" a Physician Practice:

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

Alternate Payment Program:
For the purposes of its incentives, GPSC defines Physicians working on an Alternative Payment Program (APP) as those working under Health Authority paid APP contracts. Agreements to pool FFS billings and pay out physicians in a mutually acceptable way (e.g.: per day, per shift, per hour, etc.) are not considered APP by GPSC. If services supported and paid through GPSC incentives are already included in a sessional, salary or service contract GPSC services are not billable in addition.

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

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

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

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

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

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

2.0 GP Obstetrical Delivery Incentives (G14004, G14005, G14008, G14009)

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.

This program is a continuation and expansion of the Full Service Family Practice Obstetrical Care Incentive Program introduced in 2003. It provides an incentive payment calculated at 50% of the MSC Payment Schedule delivery fee codes 14104, 14105, 14108 and 14109. The purpose of the payment is to encourage full service family practitioners to continue to provide obstetrical care, giving women the benefit of choice and longitudinal care.

Eligibility

The incentive payments are available to all general practitioners in B.C. who:

- in addition to being paid the delivery fee items 14104, 14105, 14108 and 14109 for the patient,
- provides the maternity care and is also responsible, or shares responsibility, for providing the patient's general practice medical care.

Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

Note: Value of G14004, G14005, G14008, G14009 is set equivalent to MSP Delivery Fees – subject to change April 1 annually.

	GP Obstetrical Delivery Incentives	Fee amount ($)
G14004	Obstetric Delivery Incentive for Full Service General Practitioner – associated with vaginal delivery and postnatal care	$288.77
Notes:	*i)* Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care *ii)* Payable only when fee item 14104 billed in conjunction *iii)* Maximum of one incentive per under fee time G14004, G14008, G14009 per patient delivered. *iv)* Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.	
G14005	Obstetric Delivery Incentive for Full Service General Practitioner – associated with management of labour and transfer for delivery to a higher level of care facility	$120.26
Notes:	*i)* Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care *ii)* Payable only when fee item 14105 billed in conjunction *iii)* Payable in addition to G14004 or G14009 when billed and paid to a different GP attending delivery in the receiving hospital. *iv)* Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.	

	GP Obstetrical Delivery Incentives	Fee amount ($)
G14008	Obstetric Delivery Incentive for Full Service General Practitioner – associated with postnatal care after elective caesarean-section	$59.41
Notes:	*i)* Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care *ii)* Payable only when fee item 14108 billed in conjunction *iii)* Maximum of one incentive per patient delivered *iv)* Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items.	
G14009	Obstetric Delivery Incentive for Full Service General Practitioner – associated with attendance at delivery and postnatal care associated with emergency caesarean section	$240.54
Notes:	*i)* Payable to the family physician who provides the maternity care and is responsible for or shares the responsibility for providing the patient's General Practice medical care *ii)* Payable only when fee item 14109 billed in conjunction *iii)* Maximum of one incentive per patient delivered *iv)* Maximum of 25 incentives per calendar year per physician under fee item G14004, G14005, G14008, G14009 or a combination of these items	

3.0 Maternity Network (G14010)

Eligible general practitioners can receive a quarterly payment each quarter ending March 31, June 30, September 30 & December 31 (which includes additional CMPA subsidy with an approximate value of $650 per year) to cover the costs of group/network activities for their shared care of obstetric patients (both assigned and unassigned obstetric patients). As part of the GPSC In-patient Initiative, members of Maternity Networks are eligible to bill the Unassigned In-patient Care fee G14088 for unassigned pregnant patients for whom they are the Most Responsible Physician (MRP). Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned. As a result the Maternity Network Registration form has been revised to include both billing and payment numbers for processing of this new incentive, and all networks are encouraged to submit an updated form.

	Eligibility for Maternity Network	**Fee amount ($)**
	To be eligible to be a member of the network, you must, for the three-month period up to the payment date: • Be a general practitioner in active practice in B.C.; • Have hospital privileges to provide obstetrical care; • Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care – see below). Refer to the Maternity Network Registration Form included in this workbook; • Cooperate with other members of the network so that one member is always available for deliveries (Assigned +/- Unassigned patients); • Make patients aware of the members of the network and the support specialists available for complicated cases; • Accept a reasonable number of referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy; the referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care); • Share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic prenatal record; and • Each doctor must schedule at least four deliveries in each six month period of time. • The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day).	$2100.00 per quarter

Please note that claims received for processing before the date of service, or with a date of service other than the last day in a quarter will be refused.

4.0 In-Patient Initiative & Relationship to Maternity Networks

The goals of the GPSC In-patient Care Initiative are to:

- Retain a critical mass of family physicians delivering in-patient care services;
- Enhance collaboration between FPs, and between FPs and Health Authorities;
- Better compensate and support family physicians practicing in the community as a means of encouraging them to care for their own patients and those patients without FPs (excludes obstetric patients when provider is part of a maternity network), when they are admitted to the hospital; and thereby
- Ensure patients' care is well-coordinated and comprehensive when they are transitioning between hospital and FP offices in the community.

As part of the GPSC In-patient Initiative, it is recognized that in the majority of hospitals that provide obstetric care, when a patient presents to a facility where they do not have a Family Physician who can provide the care they need, it is most commonly one of the family physicians in a local Maternity Network who ends up attending these women. These patients are considered "unassigned" and fall into the following categories:

- Live in the community but have no FP and have received no prenatal care (unattached in the community);
- Live in the community and are attached to an FP who does not provide obstetric services but have been under the care of a midwife and so are not assigned to a FP if admitted as an in-patient for care that is not within the scope of midwifery practice;
- Are visiting from another community where they have an FP and are receiving prenatal care and intending on delivery there;
- Are transferred from another community and have no FP at the admitting hospital who can provide care needed. Pregnant women who are admitted as in-patients under the "Most Responsible Physician" (MRP) care of the FP covering for the local Maternity Network that has agreed to care for unassigned patients (previously referred to as Doctor of the Day patients) are eligible for the Unassigned In-patient Care fee.

In most communities, when a woman becomes pregnant, her own FP may provide prenatal and obstetric services or if her FP does not do obstetrics as part of their practice, the patient will be referred to another provider (FP, Midwife or Obstetrician) who does provide obstetrics and essentially "shares care" with the FP for this portion of the patient's life journey. These patients are attached for the term of their pregnancy to the provider (and the call/coverage group) who is intending on delivering the baby and are not considered to be "Unassigned".

G14088-Unassigned In-Patient Fee

The term "Unassigned Inpatient" is used in this context to denote those patients whose Family Physician does not have admitting privileges in the acute care facility in which the patient has been admitted. The GP Unassigned Inpatient Care fee is designed to provide an incentive for Family Physicians to accept Most Responsible Physician status for an unassigned patient's hospital stay. It is intended to compensate the Family Physician for the extra time and intensity required to evaluate an unfamiliar patient's clinical status and care needs when the patient is admitted and is only billable once per hospital admission.

This fee is restricted to Family Physicians actively participating in the GP Unassigned Inpatient Care or the GP Maternity Networks. This fee is billable through the MSP Teleplan system and is payable in addition to the visit (13109, 13008, 00127) or delivery fee.

G14088	**GP Unassigned Inpatient Care Fee**	**$150.00**
Notes:	*i)* Payable only to Family Physicians who have submitted a completed GP Unassigned Inpatient Care Network Registration Form and /or a GP Maternity Network Registration Form. *ii)* Payable only to the Family Physician who is the Most Responsible Physician (MRP) for the patient during the in-hospital admission. *iii)* Payable once per unassigned patient per in-hospital admission in addition to the hospital visit (13109, 13008, 00127) or delivery fee. *iv)* Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care. *v)* Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.	

5.0 Conferencing and Provision of Advice within Maternity Network (G14077, G14019)

GP – Allied Care Provider Conference Fee (G14077)

The GPSC introduced fee incentives for conferencing with allied care providers (including Specialist Physicians and GPs with specialty training) in order to support improved collaborative care between participating FPs and other health care providers.

The GP-Allied Care Provider Conferencing (G14077) Incentive is available to those family physicians who are members of a GP Unassigned Inpatient Network and who provide care to patients who are not attached to them in the community, but who may be cared for in a shared care manner with the patient's community Family Physician.

GP – Advice to Nurse Practitioner/Registered Midwife Fee (G14019)

The intent of this fee is to support collaboration between community family physicians/FPs in focused practice obstetrics and nurse practitioners, as has been expanded effective March 1, 2018, to include registered midwives. This fee is billable when providing advice by telephone or in person to a Nurse Practitioner (NP) who is an independent practitioner providing care to patients under his/her MRP care. This fee is not billable for providing advice to a NP when the patient is attached to a GP. This fee is billable when providing advice by telephone or in person to a Registered Midwife who is an independent practitioner providing maternity care to patients under his/her MRP care.

Eligibility for G14019

These incentive payments to improve patient care and are available to:

- All general practitioners who have a valid BC 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;
- Patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care OR patients for whom the Midwife has accepted the responsibility of being the Most Responsible Provider for that patient's maternity care.

Restrictions

These payments are not available to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have attended the conference as a requirement of their employment. They are also not available to physicians who are working under salary, service contract or sessional arrangements who would otherwise have attended the conference as a requirement of their employment.

For the purposes of its incentives, when referring to physicians on APP, the GPSC is referring to physicians who are working under MoH or Health Authority paid APP contracts. Local group decisions to pool FFS billings and pay out in a mutually agreeable way (e.g. per day, per shift, per hour, etc.) are not considered APP by GPSC. If the services that are supported through the GPSC incentives are already included within the time for which a physician is paid under the contract, then it is not appropriate to also bill for the GPSC incentives.

G14077	GP Allied Care Provider Conference Fee – per 15 minutes or greater portion thereof	$40.00
Notes:	*i)* Payable only to Family Physicians who have successfully: a. Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; or b. Registered in a Maternity Network or GP Unassigned In-patient network on a prior date. *ii)* Payable only to the Family Physician who has accepted the responsibility of being the Most Responsible Physician for that patient's care. *iii)* Payable for two-way collaborative conferencing, either by telephone, videoconferencing or in person, between the family physician and at least one other allied care provider(s). Conferencing cannot be delegated. Details of Care Conference must be documented in the patient's chart (in office or facility as appropriate), including particulars of participant(s) involved in conference, role(s) in care, and information on clinical discussion and decisions made. *iv)* Conference to include the clinical and social circumstances relevant to the delivery of care. *v)* Not payable for situations where the purpose of the call is to: a. book an appointment b. arrange for an expedited consultation or procedure c. arrange for laboratory or diagnostic investigations d. convey the results of diagnostic investigations; e. arrange a hospital bed for a patient *vi)* If multiple patients are discussed, the billings shall be for consecutive, non-overlapping time periods. *vii)* Payable in addition to any visit fee on the same day if medically required and does not take place concurrently with the patient conference. (i.e. Visit is separate from conference time). *viii)* Payable to a maximum of 18 units (270 minutes) per calendar year per patient with a maximum of 2 units (30 minutes) per patient on any single day. *ix)* Start and end times must be included with the claim and documented in the patient chart. *x)* Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility, or communications which occur as part of regular work flow within a physician's community practice. *xi)* Not payable for simple advice to a non-physician allied care provider about a patient in a facility. *xii)* Not payable in addition to G14018. *xiii)* Not payable to physicians who are employed by or who are under contract to a facility or health authority who would otherwise have participated in the conference as a requirement of their employment. *xiv)* Not payable to physicians who are working under salary, service contract or sessional arrangements who would otherwise have participated in the conference as a requirement of their employment.	

G14019	GP -Advice to a Nurse Practitioner/ Midwife–Telephone or In Person	$40.00
Notes:	*i)* Payable for advice by telephone or in person in response to a request from a Nurse Practitioner (NP) in independent practice on patients for whom the NP has accepted the responsibility of being the Most Responsible Provider for that patient's community care OR in response to a request from a Registered Midwife in independent practice on patients for whom the Midwife has accepted the responsibility of being the Most Responsible Provider for that patient's maternity care. *ii)* Excludes advice to an NP about patients who are attached to the GP; excludes advice to a Registered Midwife about patients being cared for in a shared care model with a GP. *iii)* Payable for advice regarding assessment and management by the NP/midwife and without the responding physician seeing the patient. *iv)* Not payable for written communication (i.e. fax, letter, email). *v)* A chart entry, including advice given and to whom, is required. *vi)* NP/Midwife Practitioner number required in referring practitioner field when submitting fee through Teleplan. *vii)* Not payable for situations where the purpose of the call is to: a. book an appointment b. arrange for transfer of care that occurs within 24 hours c. arrange for an expedited consultation or procedure within 24 hours d. arrange for laboratory or diagnostic investigations e. convey the results of diagnostic investigations f. arrange a hospital bed for the patient *viii)* Limited to one claim per patient per day with a maximum of 6 claims per patient per calendar year. *ix)* Limit of five (5) G14019 may be billed by a GP on any calendar day. *x)* Not payable in addition to another service on the same day for the same patient by same GP. *xi)* Out-of-Office Hours Premiums may not be claimed in addition. *xii)* Not payable for communications which occur as a part of the performance of routine rounds on the patient if located in a facility. *xiii)* Not payable to physicians who are employed by or who are under contract to a facility or health authority, or who are working under salary, service contract or sessional arrangements and who would otherwise have provided the advice as a requirement of their employment.	

6.0 Communicating with Patients within Maternity Networks (G14076, G14078)

Telephone and other non-face-to-face 'visits' or 'touches' are a standard component of workflow in other jurisdictions. They have been shown to significantly improve efficiency of care and therefore practice capacity. When expanding patient care to include non-face-to-face care, whether by telephone, email or text, you must always determine if you have enough information to be confident appropriate advice is given. You documentation in the patient chart must indicate not only the nature of the patient request, but also the advice given.

G14076-GP Patient Telephone Management Fee

In this context, G14076 telephone 'visits' are seen as an important component of improving practice capacity. The intent is to avert the need for a patient to be physically seen in the practice in order to increase access for other patients and/or to address urgent problems to avert a patient visit to an urgent care facility or Emergency Department. G14076 can be used at the discretion of the Family Physician for any patient for whom that Family Physician has assumed the Most Responsible Physician role for any clinical reason that addresses the intent above. Each FP who has submitted G14070 (and locum submitting G14071) has access to 1500 G14076 fees per calendar year. G14076 is also available for those family physicians who are members of a GP Maternity Network or a GP Unassigned Inpatient Network and who provide care to patients who are not attached to them in the community, but who may be cared for in a shared care manner with the patient's community Family Physician.

G14078 GP Email/Text/Telephone Medical Advice Relay

G14078 has been developed to compensate for the 2-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice. This fee is not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals. Each FP who has submitted G14070 (and locum submitting G14071) has access to 200 G14078 fees per calendar year.

G14076	**GP Patient Telephone Management Fee**	**$20.00**
Notes:	*i)* Payable only to Family Physicians who have successfully: a. Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; or b. Registered in a Maternity Network or GP Unassigned In-patient network on a prior date. *ii)* Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care provider (e.g. Nurse, Nurse Practitioner) employed within the eligible physician practice. *iii)* Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed. *iv)* Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals. *v)* Payable to a maximum of 1500 services per physician per calendar year.	

	vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of G14077, G14018 G14050, G14051, G14052, G14053, G14250, G14251, G14252, G14253. *vii)* Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care. *viii)* Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.	

G14078	**GP Email/Text/Telephone Medical Advice Relay**	**$7.00**
Notes:	*i)* Payable only to Family Physicians who have successfully: a. Submitted G14070 or on behalf of Locum Family Physicians who have successfully submitted G14071 on the same or a prior date in the same calendar year; or b. Registered in a Maternity Network or GP Unassigned In-patient Network on a prior date. *i)* Email/Text/Telephone Relay Medical Advice requires 2-way relay/ communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice. *ii)* Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as the advice provided, modality of communication and confirmation the advice has been received. *iii)* Not payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals. *iv)* Payable to a maximum of 200 services per physician per calendar year. *v)* Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14077.	

7.0 FAQs: GP Obstetric Delivery Incentives (G14004, G14005, G14008, G14009)

1. When I submit a claim for the incentive payment based on fee items 14104, 14105, 14108 or 14109, what is the exact amount of the payment?
The obstetrical care incentive payment fee item codes are valued at 50% of the appropriate delivery item (items listed below):

- Fee code G14004 with item 14104
- Fee code G14005 with item 14105
- Fee code G14008 with item 14108
- Fee code G14009 with item 14109

2. How is the incentive billed?
In addition to billing 14104 (Delivery and post-natal care) a G14004 would be billed. If billing 14105 (Management of labour and transfer for delivery to higher level of care facility) a G14005 would be billed. If billing a 14108 (GP elective C-section and post-partum care (not the surgical assist fee) a G14008 would be billed. If billing 14109 (Delivery and postnatal care associated with emergency caesarean section) a G14009 would be billed, with the appropriate three-digit ICD-9 code, in order to receive the incentive. The maximum number of incentives payable per calendar year is 25 of any combination. They may be claimed under fee item G14004, G14005, G14008 or G14009 or a combination of these items but the combined total must not exceed 25.

3. How many delivery incentives may I bill in each calendar year?
You may bill incentives for up to 25 deliveries in each calendar year. This is for any combination of G14004, G14005, G14008 and G14009 (e.g. 20 X 14004 + 5 X G14009 = 25 incentives total). Multiple incentives may be billed on any given day, provided the annual maximum of 25 is not exceeded.

4. Is the delivery incentive for the first 25 deliveries of the year?
No. It is for any combination of deliveries up to a maximum of 25 in a year. It is up to the individual GP to decide which deliveries to bill the incentive payments on, provided the combined total of all incentive payments does not exceed 25 in a calendar year.

5. Is the obstetric delivery incentive billable in addition to the 14088 Unassigned Patient Care fee for "Doctor of the Day"/Unassigned pregnant patients seen in the Labour and Delivery Room?
If you are part of a maternity network (and have successfully submitted G14010 the GP Maternity Network Incentive) in the previous 3 months and you are asked to see a patient who does not have an obstetric provider (OB, GP, Midwife) at your hospital and IF you must admit the patient as an inpatient under your MRP care, whether the patient delivers or not, this patient is eligible for the 14088 Unassigned Inpatient Care fee in addition to any other fees billed. This includes any delivery fee (14104, 14109 as long as GP is MRP) or admission fee (13109,). If the patient is seen as an outpatient and subsequently sent home, the 14088 is not billable, only the assessment fee (13200, 00112, 00113, 00123, 00105 as appropriate for day and time +/- call in).

6. If I attend more than 25 deliveries in a calendar year does it matter which obstetric delivery incentive payments I choose to bill?
Most GPs providing obstetrics do not deliver more than 25 patients per year, so they should submit the delivery incentive for all their deliveries, regardless of type or number in any one day, to a maximum of 25 per calendar year. If the FP finds themselves in a position of possibly attending more than 25 deliveries in a year, the physician may choose whether to bill the incentive for an elective Caesarian section (G14008) at the time, or to wait for a future delivery to bill the higher G14004 or G14009.

However, there is a 90 day submission window from the date of service for any fee billed to MSP, so this must be considered when determining whether or not to bill the G14008 before the last 3 months of the year, as if the FP finds at the end of the year, the maximum number of 25 obstetric incentives have not been submitted, and the 90 day window has passed from the date of service of an elective C-section, the FP would have to ask MSP for permission to bill this with submission code "A".

7. What happens if I have billed for G14008, and later go over my limit of 25 obstetric delivery incentives per calendar year so I 'miss out' on billing the higher G14004 or G14009?
You can submit an electronic debit request to reverse the payment on a 14008; then subsequently bill the G14004 or G14009 if you qualify.

8. Are locums able to bill these obstetric delivery incentives?
Yes. Locum coverage is considered part of the usual care provided by the host general practitioner. Locums have their own limit of 25 delivery incentives per calendar year.

9. In practice situations where a patient's care may be shared amongst partners is the obstetric delivery incentive still applicable? If so, who bills it?
The physician performing the delivery (14104) or attendance at delivery and post-natal care associated with a C-section (14108 if elective or 14109 if emergency) may bill fee item G14004, G14008 or G14009. Practice groups providing on call patient coverage or access to patient records are considered to be sharing the responsibility of that patient's care and are eligible to bill one obstetric delivery incentive for the patient.

If a physician has provided attendance at labour and has had to transfer the patient for delivery to a higher level of care facility due to complications of labour the initial physician may bill 14105 and the delivery incentive G14005 for their part in the management of the patient's delivery. If the accepting physician who accepts the MRP care of the patient at the higher level of care facility is also a family physician, he/she may bill the G14088 Unassigned Inpatient Care fee in addition to the delivery fee. If the accepting FP attends the vaginal delivery then that physician may bill 14104 and the linked delivery incentive G14004. If after managing the labour, an emergency C/section is required, but the MRP is still the accepting family physician, then that physician may bill 14109 and the linked delivery incentive G14009.

10. If a GP refers a patient to me for only the maternity care including delivery either personally or as part of my shared obstetric group coverage and I return the care after 6 weeks post-partum to the referring GP, am I eligible to bill the delivery incentive?
Yes. GPs specializing in general practice/obstetrics who receive referrals from other GPs for maternity/obstetric care are considered to share in the general practice medical care of the patient, and so are eligible for the obstetric delivery incentive even if the patient returns to the referring GP after the postpartum care.

11. Is the obstetric delivery incentive billable if a delivery is performed during an on-call shift for a partner's patient?
Yes. This is considered shared care and eligible for one obstetric delivery incentive per patient.

12. How is the obstetric delivery incentive applied to multiple births?
Multiple births are considered one delivery, and thus eligible for one obstetric delivery incentive for the delivering mother.

13. Can I bill the obstetric delivery incentive for delivering mothers covered by other provinces?
Yes. B.C. has a reciprocal billing agreement with other provinces except Quebec. Treat patients from other provinces (except Quebec) who have their babies in B.C. as though they were B.C. residents.

14. Can I still bill the obstetric delivery incentive if another doctor helps me with

complications?
As long as you attend the delivery of the baby (or are prepared to until the need for an emergency C-section) and submit a claim for fee item 14104 or 14109 you may bill for the obstetrical incentive. If another doctor helps by performing a forceps rotation, emergency C-section, or other additional procedure you are also still eligible to bill the appropriate obstetric delivery incentive.

15. Can I still bill the obstetric delivery incentive G14005 if a doctor in another facility does the delivery?
As long as you attended the labouring patient and were prepared to do the delivery until the need for transfer to another facility of higher level of care (i.e. From facility without C/S capability to facility with C/S capability) and submit a claim for fee item 14105 you may bill for the obstetrical incentive G14005. If another doctor has performed a forceps rotation, emergency C-section, or other additional procedure you are still eligible.

16. Is this payment eligible for rural premiums?
Yes.

17. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the obstetric delivery incentive payments?
Yes. When claiming for the obstetric delivery incentive associated with vaginal delivery and post-natal care, submit an encounter record for the vaginal delivery (14104) along with a fee for service claim for the obstetrical delivery incentive (G14004). When claiming for the obstetric delivery incentive associated with attendance at delivery and post-natal care for an emergency C-section (14109), submit an encounter record for 14109 along with a fee for service claim for the obstetrical delivery incentive (G14009). When claiming for the GP elective C-section and postpartum care (14108), submit an encounter record for 14108 along with a fee for service claim for the obstetric delivery incentive (G14008). If a fee for service claim is submitted for 14104, 14108 or 14109, it will be refused or withdrawn as this service is funded through the alternative payment arrangement.

18. Are Emergency Room physicians eligible for this payment?
No. Emergency room physicians who happen to be on duty and deliver a baby have not shared the general practice maternity care.

8.0 FAQs: Maternity Network (G14010)

1. How do I register as a maternity network?
Please complete the Maternity Network Registration Form (see copy at end of this document) and submit by email to GPSCregistration@gov.bc.ca or by facsimile to 250-952-1417. Additional copies are available at: http://www.gpscbc.ca/billing-fees/incentive-program-fees under the 'Maternity Care Network' tab.

Registering as a member of a maternity care network provides opportunities for enhanced communication and dialogue among B.C.'s GPs providing this important service. If desired, GPs registering as a network will receive pertinent updates from the GP Services Committee and other organizations on maternity care supports, resources, and CME opportunities available in the province.

2. How do I claim payments?
After a quarter in which you have met the eligibility criteria, submit a claim along with your usual claims through TelePlan. (Only payable to registered members of a maternity network.). Effective December 31, 2006 use the following values in the claim:

- In the Fee item field: 14010 Claim amount: $2,100.00 as of December 31, 2009
- In the patient's PHN field: 9824870522
- In the Last name field: Maternity
- In the First initial field G
- If you require a date of birth, use: 2 November 1989
- For Date of service use: last day in a quarter
- Report the Diagnosis as: V26 (ICD-9 code for "procreative management")

3. What if I cannot find three other doctors to form a network?
If fewer than four general practitioners deliver babies at your hospital or, if there are other extenuating circumstances, request an exemption by faxing a written request along with the maternity network form to: Administrator, Maternity Care Network Initiative, 1-800-952-2895 (toll free). Exemptions may be granted for up to one year at which point if the circumstances have not changed, a subsequent request is required.

4. Does participating in this program mean the network members are on call for obstetrics for the community?
No. This is not an on call program. Although one eligibility criterion requires cooperation within the network to ensure that one member is always available for deliveries, participating in this program does not require you to be on call for patients outside your group.

5. Is the payment per doctor or per group?
As of June 30, 2006 the quarterly payment was initially set at $1,250. Effective December 31, 2009, the payment was increased to $2,100 per doctor.

6. Do we have to advertise that we accept referrals?
No, word of mouth is sufficient.

7. What if a doctor delivers 5 babies in one month, then none in the next seven months?
The condition of scheduling at least four deliveries in every six-month period seemed reasonable in ensuring a doctor was in active obstetrical practice. If this situation arises during the program, let the administrator know and the GP Services Committee will review the situation.

8. When a new FP joins a network, when does he/she become eligible to bill for the network incentive?

The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day). This means if a new member joins the network at prior to the half-way point in the three month quarter then G14010 can be submitted at the end of that quarter. For example, if the new member joined Feb 14 or earlier in the January-March quarter then G14010 can be submitted for Date of Service March 31.

9. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the maternity network payments?
Yes.

10. Are Locums eligible to bill the maternity network fee?
Yes, locums may be part of a maternity network and may submit G14010 provided they fulfill the 50% plus 1 day time requirement for each eligible quarter. Locums should register with a "home" network, even if they may work in different areas of the province providing obstetric are as part of their locum. Locums should maintain a record of practices worked and qualifying days, as the information may be required for future audits. Note: Only one physician (either host or locum) may bill the maternity network incentive for the same quarter.

11. Am I eligible to be in both a Maternity Network and an Assigned Inpatient Network?
The Maternity Network payment is for FPs who provide obstetric services for both assigned and unassigned maternity patients. The Assigned In-patient Network payment is for FPs who provide in-patient care services for their own and colleagues' non-obstetric patients (assigned) while the Unassigned In-patient Network payment is for FPs who provide in-patient care services for unassigned non-obstetric patients. Maternity patients are not included under either the Assigned or Unassigned In-patient Network if the FP is also participating in a GPSC Maternity Care Network because those patients are counted as part of that incentive. Therefore in order to participate in both a Maternity Network and an Unassigned Inpatient Network, you must be providing in-patient care for both pregnant and non-pregnant patients.

12. Is this payment eligible for rural premiums?
Yes.

9.0 FAQs: Unassigned In Patient Care and Maternity Networks

1. Do maternity In-patients qualify for the $150 Unassigned In-patient Care Fee?
If the FP is participating in the GPSC Maternity Care Networking Incentive, the 14088 is applicable when pregnant patients, with no FP in that community who would be able to manage them, are admitted as in-patients. If the patient delivers during the admission, the mother and baby are considered a dyad: one unit.

This incentive would be paid to the FP who is part of a Maternity Network with privileges to provide primary obstetric in-patient care and who is providing the MRP care for unassigned pregnant women admitted to the local hospital. Unassigned pregnant patients may be visiting the community, transferred from another community or may have had no prenatal care in the community (whether no care at all, care by an FP who does not have obstetric privileges and who has not yet transferred the patient to a provider for delivery or care under a midwife). Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned.
Accepting patients referred for prenatal care and possible delivery is a requirement of the Maternity Care Network Initiative. Accepting these maternity patients for the prenatal / delivery / 6 weeks post-partum period is considered a sharing of care with the referring FP, and these patients are therefore not unassigned. As these patients are assigned to the FP or group of FPs in the call group/clinic/network G14088 fee is not appropriate.

2. Do maternity patients who were cared for by a midwife and subsequently transferred care to the FP OB qualify for the $150 Unassigned In-patient Care Fee?
Yes. A midwife patient who is referred to and later admitted under an FP for MRP care qualifies for the $150 Unassigned In-patient Care Fee. If the patient delivers during the admission, the mother and baby are considered a dyad: one unit. If admitted under the specialist OB then the patient does not qualify even if the FP is involved in the delivery (e.g. assists at C/S) as the FP is not the MRP.
A midwife patient does not qualify for the Unassigned In-patient Care fee G14088 when the midwife and FPs are practicing in a multi-disciplinary care clinic but the FP ends up doing the delivery. The patient is assigned to the care providers of the multi-disciplinary care clinic pre-admission and is therefore not unassigned.

3. Do Newborns qualify as an Unassigned In-patient?
The baby and the mother are considered a dyad: one unit. If the mother was an Unassigned In-patient then the newborn is also considered Unassigned and together they would qualify as a unit for the $150 Unassigned In-patient Care Fee. If the mother was assigned, then the newborn is also considered assigned.

However, if a newborn was discharged home and then returns to be admitted as an unassigned inpatient under a Maternity Network GP as MRP (e.g. jaundice requiring phototherapy) then the G14088 is applicable for that newborn admission separate from the immediate delivery period. If a pediatrician is the MRP, then the G14088 is not applicable.

4. If an FP takes over from or shares the MRP role with a specialist, are they eligible to claim the $150 per Unassigned In-patient Fee?
The G14088 Unassigned In-patient Care fee it is only payable where concurrent care is being provided by an FP when there is/are significant medical issue(s) that is/are not within the scope of practice of the specialist and is unrelated to the purpose of admission under a specialist.

Concurrent care is defined by the preamble to fees as: "For those medical cases where the medical indications are of such complexity that the concurrent services of more than one medical practitioner are required for the adequate care of patient, subsequent visits should be claimed by each medical practitioner as required for that care. To facilitate payment, claims should be accompanied by an

electronic note record, and independent consideration will be given. For patients in I.C.U. or C.C.U. this information in itself is sufficient."

This means it is not just about having co-morbid medical diagnoses, but it is about the FP having to actively manage medical conditions that are unrelated to the reason for admission in order to justify the medically necessary billing of the 13008. The Diagnostic code needs to be for the medical condition that requires the active management by the FP, not the Dx code for the admitting diagnosis. An electronic note needs to outline why concurrent care by the FP is medically necessary.

5. Are patients who are admitted as an "out-patient" eligible?

Patients who are admitted as "Out-patients" are excluded as their "admission" to hospital is very short term and does not result in an overnight/multi day stay. Out-patient classification is intended for a specific reason such as an assessment (e.g. Emergency Room visit or Labour and Delivery Room evaluation), after which they are discharged directly home. If as a consequence of the procedure or assessment, the patient subsequently requires admission as an in-patient under the care of a family physician, and he/she does not have a family physician with the level of privileges required to provide the needed MRP care and so is admitted under a member of the "Unassigned In-patient Network" or the Maternity Network, then that FP is eligible to claim G14088 for accepting this unassigned in-patient.

6. Are there certain medical staff categories which are not eligible for the $150 G14088 Unassigned In-patient Care Fee?

The Unassigned In-patient Care Fee is intended to be available for Family Physicians (FPs) with active or equivalent medical staff privileges. The FP must have a level of privileging that allows them to assume MRP responsibility for a patient admitted to an acute care hospital. In some cases there maybe medical staff categories such as locum or temporary which can be eligible if the FP registers as part of an Unassigned In-patient Care Network.

7. Do out of Province unassigned maternity in-patients qualify for the G14088 Unassigned In-patient Care Fee of $150 in addition to the hospital visit or delivery fee?

All patients with valid medical coverage from any Canadian province or territory, with the exception of Quebec, are eligible for the G14088 billed in addition to the hospital visit or delivery fee when admitted as an unassigned in-patient to a hospital in BC under the MRP care of the eligible FP.

Patients from Quebec, out of country or those without valid medical coverage from another Canadian jurisdiction as outlined are to be treated as uninsured patients and billed directly for all services provided when admitted to a hospital in BC. All MSP and GPSC fees have a recommended uninsured (BCMA) rate but it is up to the discretion of the treating physician which fees and at which rate these "private" paying patients should be billed. As such it would be acceptable for the treating MRP FP to bill the private rate for the delivery and all relevant surcharges, or the 13109 (First Visit in hospital for the admission history and physical examination) if the patient does not deliver, plus the G14088 at the BCMA recommended uninsured rates, followed by the BCMA recommended rates for 13008 (+/- 13338 if the patient is the first patient seen on the day subsequent to the admission date when 13109 is billable). If patients have private insurance coverage when visiting Canada, you should always contact the insurance carrier to inquire if they will pay you directly or if the patient is expected to pay first and then submit the receipt to the company for reimbursement.

8. Is G14088 eligible for rural retention premiums?

No.

10.0 FAQs: Conferencing Incentives (G14077, G14019)

GP Allied Care Provider Conference Fee (G14077)

1. When is it appropriate to submit the G14077 GP Allied Care Provider Conference Fee?

G14077 is billable by physicians who have submitted G14070/71 or who are members of a GP Maternity or a GP Unassigned Inpatient Network. G14077, with a total of 18 units per calendar year and 2 units per calendar day has significant flexibility in when, where and how they can be accessed:

- Can be used when the patient is located in the community, acute care, sub-acute care, assisted living, long-term or intermediate care facilities, detox units, mental health units, etc. etc.
- Can be provided/requested at any stage of admission to a facility from ER through stay to discharge)
- Need to conference with at least 1 Allied Care Provider (including physicians) regardless of location.
- Can be done in person or by telephone.
- Can be initiated by either the FP or the Allied Care Provider.

2. Is G14077 GP Allied Care Provider Conference Fee billable for patients in acute care? Is the phrase "not billable for simple advice given to an allied care provider about a Patient in a facility" only intended to cover that specific instance and a case of a call for other than simple advice (for example) is billable even if the patient is in a facility?

FPs who have submitted G14010/71 may bill G14077 for conferences that occur for any patient in their practice (there are no diagnostic requirements with the G14077). There is also no patient location restriction for G14077. Patients may be in the community or in a facility (any facility including acute care and even in ER). The time requirements of billed per 15 minutes or greater portion thereof, to a maximum of 2 units per calendar day and 18 units per calendar year, requires start and end time to be documented in the patient chart and fee submission.

Simple/brief advice to a non-physician allied care provider is covered using 13005 for patients in community "care" (e.g. home health, palliative care, and public health services provided in the home) or any facility except acute care.

3. What "Allied Care Providers" are included in order to bill G14077?

G14077 is intended as compensation when the eligible FP undertakes a conference with any allied care provider – it is payable for FP participation, not the allied care provider participation. The physician component of conferencing cannot be delegated to a non-physician.

For the purposes of its incentives, when referring to Allied Care Providers, GPSC includes trained professionals with a scope of practice that allows the provision of medical and medically related services to patients. Examples include but are not limited to: Physicians; Nurses; Nurse Practitioners; Mental Health Workers; Midwives, Psychologists; Clinical Counsellors; School Counsellors; Social Workers; Registered Dieticians; Physiotherapists; Occupational Therapists; and Pharmacists etc.

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

4. Can G14077 be billed when a family physician conferences with Allied Care Providers working within a practice, either employed by the physicians or employed by a Health Authority (or other agency)?

Conversations for brief advice or update about a patient, between GP and an allied care provider that is working within the GP practice, are part of the normal medical office work flow and would not be eligible for G14077 as this does not meet the criteria. True case conferences that meet the requirements of G14077, whether scheduled or occurring due to an important change in patient status are not part of

normal daily work flow, and would be eligible for G14077, regardless who the employer of the allied care provider is. This would be similar to the hospital or long term care based patients, where G14077 is not billable for conversations with allied care providers when on routine rounds but would be billable for care conferences, discharge planning conferences, medication reviews (not when only for prescription renewals), etc. G14077 compensates for the physician time to conference, not the allied care provider with whom the conferencing is occurring.

5. If a hospital has a multidisciplinary team that meets to discuss the needs of inpatients with respect to issues such as placement, nutritional support, physio or rehab, and the condition of the patient necessitates a physician meeting with the group, will this team meeting be eligible for billing G14077?
Yes, FP conferencing with this group of Allied Care Providers (either in person or by teleconference or videoconference) would qualify for the use of G14077 regardless of the underlying patient medical condition that requires the conference to occur. There is a limit of 2 units (30 minutes) per calendar day per patient, and with the 18 units per calendar year, there is increased flexibility for using this fee across locations/scenarios of conferencing. Conversations that are part of the normal clinical hospital rounds would not be eligible for G14077 as this does not meet the criteria or intent of the conferencing fees.

6. Are locums able to access the G14077 when covering in an eligible practice?
Yes. Providing the Locum physician has submitted G14071 on the same day or earlier in the calendar year, they are eligible to submit G14077 for conferencing with allied care providers when covering a host FP who has submitted G14070. The number of units available are patient specific (18 per calendar year), not provider specific (host vs. locum FP).

7. In a multi-doctor clinic, is G14077 billable for conferencing services provided by one of the clinic FPs covering for a patient's FP when their own FP is not available (eg. Holiday or out of hours coverage)?
If all FPs in the clinic group have submitted G14070 and the patient in question is attached to one of them, then conferencing is appropriate. If the covering doc is conferencing for a patient that does not belong to the group (i.e. either another non-group FP or patient is unattached), then none of the conferencing fees would be appropriate, as these are restricted to the FP who provides the community MRP care for the patient on an ongoing longitudinal basis. When covering for a colleague in the absence of a locum, these patients may be booked or may be a walk-in/fit-in on any given day. Some of these conferences could occur on the weekend or in the evenings by the doc "on-call" for the group.
The important point is about the underlying relationship with the FP and the fact that in multi-doctor clinics, while the majority of the care is provided by the FP the patient is attached to, there are situations where the other FPs must cover not only out of office hours but also during office time. How each group of family physicians arranges this coverage is variable. It is not about where in the clinic the patient is care for. It's about the status of patient (attached or not) and well as whether or not the treating physician as submitted code G14070 or G14071 in the case of a locum at the clinic.

8. Am I eligible to bill G14077 in addition to receiving the Complex Care Planning and Management payment(s)?
Yes. If the physician needs to conference with allied care providers about the care plan and any changes, then the services provided in conferencing with other allied care providers and billed using G14077 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).

9. Can FPs who are in "Focused Practice" Obstetrics access G14077?
Yes, family physicians who provide care through a GP Maternity Network or a GP Unassigned Inpatient Network to patients who are not attached to them in the community are eligible to access G14077 for conferencing with allied care providers about these patients.

10. If I am part of a maternity network and I see a complex patient for whom I need to conference with their family physician, are we both able to bill for this conference?
Yes, each of the FP in a maternity network and the patient's family physician who has submitted G14070 in the same calendar year, may bill 1 unit of G14077 for this conference. If the patient's GP has not

submitted G14070 in the same calendar year, then there is nothing (s)he can bill, while the FP in a maternity or unassigned network may submit up to 2 units of G14077 if the time requirements are met.

11. Do FPs participating in a Residential Care Network but who do not have a separate community practice qualify to submit G14070 and access the additional codes available through the GPSC portal?
Yes, FPs who do not have a community practice but who are participating in a Residential Care Network are considered to have a community "practice" in the residential care site. As such, they are eligible to submit G14070 in order to access codes G14076 GP Patient Telephone Management, G14077 FP Allied Care Provider Conferencing & G14078 GP Email/Text/Telephone Medical Advice Relay, for the patients for whom they are MRP (or covering for the MRP). It is important to note that G14075 GP Frailty Complex Care is not applicable to patients in residential care.

12. How do I document the time spent conferencing about an individual patient for G14077 if the conferencing takes place over several time intervals on the same day, but cumulatively adds up to the greater part of 15 min?
G14077 can be billed for conferencing with allied care providers in person or by telephone. When conferencing with multiple providers over the course of a day, you should add up the total time spent conferencing and as well as documenting in the chart which providers you spoke to and when. When submitting the start/end time, use the start time of the first conversation and set the end time as the time it would have been if all the conversations had been done consecutively e.g. Chart documentation: Specialist X at 1100 – 1105 hr, home care RN at 1400 – 1410 hr for total time spent conferencing 15 min. Start time 1100 end time 1115 in fee submitted.

13. Is G14077 eligible for rural premiums?
No, G14077 is not eligible for rural premiums.

Advice to a Nurse Practitioner/Registered Midwife – Telephone or In Person (G14019)

1. If our local Division has collaborated with the Health Authority to start up a multi-disciplinary clinic for complex, high-needs patients who cannot be attached to a usual FSFP practice, can GPs supporting this approach bill this incentive when responding asked for advice about a patient who is attached to the NP in this model?
Yes, provided the NP is the MRP for that patient, if a GP is asked for advice about a patient without the FP seeing the patient, then G14019 is billable. This incentive can be used to support those NPs who become the MRP for patients involved in a multidisciplinary team model providing care for specific populations who would otherwise be "hard to attach". It is also an appropriate support in situations where an NP has a practice that is not formally connected with other providers, but when he/she feels having a virtual connection to local GPs would be beneficial for sustainability.

2. Can a GP bill this incentive when responding to a phone call by an NP who is providing MRP care for patients living in a Long Term Care Facility?

Yes, provided the NP is the MRP for that patient, if a GP is called for advice about a patient without the FP seeing the patient, then G14019 is billable.

3. Is G14019 billable when responding to calls from a NP or midwife about patients for whom the FP is sharing care with either the NP or midwife?
This is not for conferencing with an NP about patients who are attached to the FP. It is also not for advice to a Registered Midwife about patients being cared for in a shared care model with a FP.

4. What is the maximum number of payments allowed per patient or per physician?
There is a maximum of one claim per day, per patient with a maximum of 6 claims per calendar year per patient. There is also a limit of 5 G14019 billed by any GP on any calendar day.

5. Is this payment eligible for rural premiums?

No.

11.0 FAQs: Communicating with Patients within Maternity Networks (G14076, G14078)

G14076 GP Patient Telephone Management Fee and the G14078 GP Email/Text/Telephone Relay Fee

1. What is the difference between the G14076 GP Patient Telephone Management Fee and the G14078 GP Email/Text/Telephone Relay Fee?

G14076 GP Patient Telephone Management Fee is for a clinical discussion and provision of medical management by telephone only (not email or text message communication.) It may be provided by a physician or may be delegated only to a College-certified allied care provider (e.g. Nurse, Nurse Practitioner) employed within the eligible physician practice. It may help to think of the G14076 as a telephone visit. There is a cap of 1500 telephone fees (G14076) per participating FP per year.

G14078 GP Email/Text/Telephone Relay Fee is payable for 2-way relay/communication of medical advice from the physician to eligible patients, or the patient's medical representative, via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice. There is a cap of 200 Email/Text/Telephone Relay fees (G14078) per physician calendar year.

2. If when making a phone call to the patient there is no answer and a message regarding the medical advice is left on voice mail, can G14076 or G14078 be billed?

G14076 requires a clinical telephone discussion directly with the patient, so would not be billable in this situation. Provided the patient returns the call to confirm the message has been received, G14078 may be billed for this relay of medical advice from the physician.

3. What documentation is required and where must it be recorded to submit 14078?

The medical advice relayed to the patient must be documented in the clinical notes of the patient medical record. Additionally, the clinical notes must record who communicated with the patient or patient's medical representative, how the advice was communicated (phone/text/email) and confirmation the advice was received. It is not adequate to simply note that an email was sent and reference where it is archived in the email account. Having a flagging system that ensures sent emails get confirmation replies from patients is helpful, but you must still document in the clinical notes that the confirmation was received.

You may find it useful to review CMPA's advice on using electronic communication with patients:

CMPA's Consent Form for Electronic Communications

CMPA Information on Using Electronic Communications

4. Are locums able to provide telephone calls and bill G14076 GP Patient Telephone Management Fee?

Yes, Locum physicians who have submitted 14071 and are covering a host FP who has submitted 14070 may use 14076 when providing telephone visits to patients of the host FP. Each locum has their own allotment of 1500 telephone call fees per calendar year available.

5. Are locums able to authorize relay of advice by email/text/telephone and have G14078 GP Email/Text/Telephone Medical Advice Relay Fee billed?

Yes, Locum physicians who have submitted 14071 and are covering a host FP who has submitted 14070 may use 14078 for relaying medical advice to patients of the host FP. Each locum has their own200 telephone call fees per calendar year available.

6. G14076 GP Patient Telephone Management requires "a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care provider (ACP) "employed within the eligible physician practice". Which College certified ACPs qualify for making these calls to be eligible for the G14076 GP-Patient Telephone Management Fee to be billed?

14076 GP-Patient Telephone Call fee - is billable when the telephone call is made by the College-certified Allied Care Provider employed within the FP practice. This excludes the Medical Office Assistant. See the GPSC Preamble section for details on College-certified Allied Care Providers.

7. Does Worksafe pay for 14076 telephone visits or 14078 relay of medical advice when it is related to a Worksafe claim

Yes, but you must identify Worksafe as the insurer when submitting to Teleplan. When Worksafe is identified as the insurer, the 14076 or 14078 billed will not count toward the calendar year limit for these fees when payable by MSP as the insurer.

8. Is the use of Text Messaging acceptable in order to bill G14076 GP-Patient Telephone fee?

No. G14076 requires a clinical telephone discussion between the patient or the patient's medical representative and physician or College-certified allied care professionals working within the eligible physician office. The use of two way text messaging is covered under the G14078 GP Patient Email/Text/Telephone Medical Advice Relay Fee.

9. Can FPs who are in "Focused Practice" Obstetrics, or who provide Unassigned Inpatient care (previously referred to as "Doctor of the Day") access the G14076 GP-Patient Telephone Fee and/or the G14078 GP Email/Text/Telephone Medical Advice Relay Fee?

Yes, family physicians who provide care through a GP Maternity Network or a GP Unassigned Inpatient Network to patients who are not attached to them in the community are eligible to access G14076 for telephone visits with or G14078 for medical advice relayed to these patients.

10. Do FPs participating in a Residential Care Network but who do not have a separate community practice qualify to submit G14070 and access the additional codes available through the GPSC portal? this question appears in several places – can you find its variations so we can write one version that is used everywhere? Yes, FPs who do not have a community practice but who are participating in a Residential Care Network are considered to have a community "practice" in the residential care site. As such, they are eligible to submit G14070 in order to access codes G14076 GP Patient Telephone Management, G14077 FP Allied Care Provider Conferencing, and G14078 GP Email/Text/Telephone Medical Advice Relay, for the patients for whom they are MRP (or covering for the MRP). It is important to note that G14075 GP Frailty Complex Care is not applicable to patients in residential care.

11. Can I use G14078 to send out reminders that a specific follow-up or other service is now due (e.g. Pap test reminders, flu shot notices, etc.)?

No, this is the same as a notification of appointment and neither G14076 nor G14078 are billable.

12. Is G14078 billable for notifying patients of normal results from lab or other diagnostic tests?

The routine notification of normal results would not be covered by G14078. However, it would be appropriate to submit G14078 in cases where relaying or notifying a patient of a normal, or more correctly "negative", test result would impact care. Examples of when it would be appropriate to submit G14078 include (but are not limited to):

i. Someone who has had a biopsy of a lesion, letting them know there is no cancer is an important and acceptable use.
ii. Letting a mother know about a child's negative throat swab so no need to start (or no need to continue) antibiotics.
iii. Letting a patient who has been on iron for anemia know their hemoglobin has improved to a normal level, so they can decrease or stop their iron intake.

In these cases there is a clinical reason for relaying the negative results, as opposed to just a notification of normal results.

13. Are G14076 and/or G14078 eligible for rural premiums?

No, G14076 and G14078 is not eligible for rural premiums.