MEMORANDUM OF AGREEMENT

COLLABORATION ON VIRTUAL CARE FEES

BETWEEN:

HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA,
as represented by the Ministry of Health

(the "**Ministry**")

AND:

ASSOCIATION OF DOCTORS OF BC

(the "**Doctors of BC**")

AND:

MEDICAL SERVICES COMMISSION

(the "**MSC**")

(individually a "**party**" and collectively the "**parties**")

COLLABORATION ON VIRTUAL CARE FEES

WHEREAS:

A. At the outset of the COVID-19 pandemic, the parties agreed to make temporary changes to the MSP payment schedule, including establishing new temporary fees to support patient access to services and physician income security in a time of great uncertainty.

B. Changes to clinical services through telehealth over the course of the pandemic have impacted the expectations of both patients and physicians for how the delivery of health care services may be provided.

C. The temporary virtual fee structure has supported patient access to virtual medical services but has also created challenges in which some patients are facing barriers to obtaining appropriate in-person medical care.

D. The College of Physicians and Surgeons of BC ("**CPSBC**") has issued a clear Practice Standard with regards to virtual care that outlines the minimum standard of professional behaviour and ethical conduct expected by the CPSBC.

E. The parties agree that the exclusive provision of virtual care is inappropriate in most circumstances. In most cases the routine use of telehealth as a screening modality is also not appropriate.

F. The parties agree that appropriate care includes both in-person and virtual care. A patient can request an in-person or virtual visit which should be provided in a time frame appropriate to the urgency and type of patient concern. If the clinical judgement of the physician determines that an in-person visit is necessary for meeting care requirements, a patient request for a virtual visit will not override the professional judgement of the physician.

G. Recognizing the need to better integrate virtual care service delivery within practices in the post-pandemic environment, the parties agree there is a need to develop more detailed practice guidance on virtual care to use as a basis for more permanent rules and fees for virtual care services in the Payment Schedule.

H. The parties recognize the importance of consultation with Doctors of BC and its Sections to establish rules and fees that support the provision of appropriate medical services to patients.

Therefore, the parties agree to the following:

1. **Collaborative Review of Virtual Care Fees**

   a. "**Virtual Care Fees**" include all virtual care fees, including the temporary virtual care fees and revisions to fees to facilitate virtual care implemented during the COVID-19 pandemic.

   b. Any revisions of Virtual Care Fees will be carried out through the process set out in Articles 12 and 13 of the Physician Main Agreement ("**PMA**") as amended through this memorandum.

   c. The Ministry will notify the Doctors of BC (through the Tariff Committee), by no later than seventy-five (75) days from ratification, in writing, of its recommendation for the creation or revision of any Virtual Care Fee items in accordance with section 12.2 of the PMA, as modified below.

   d. In order to expedite the fee review process for Virtual Care Fees as outlined in section 12.2 (a)(i) (b), (c), (d) and (f) of the PMA as amended below, the parties will begin the process for selecting an ad hoc joint review panel within 2 weeks of when the Doctors of BC Board recommends that the PMA be sent to its members for approval so that, if it is required, it is available to begin its work without delay.

      i. 12.2(a)(i) consult with the Tariff Committee ~~and with Health Authorities~~ to identify any comments or concerns they may have respecting such recommendations, for up to 90 (ninety) days, commencing when the Government notifies the Doctors of BC, in writing, of its recommendation for the creation or revision of Virtual Care Fee items.

      ii. 12.2(b) If agreement is not reached between the Government and the Doctors of BC pursuant to section 12.2(a)(ii) within ~~90~~ 60 (sixty) days of written notification from the Government to the Doctors of BC of a proposed revision(s) pursuant to this section 12.2, ~~or such additional time as may be agreed,~~ the Government may ~~advise the Doctors of BC that it intends to~~ refer the matter to an ad hoc joint review panel as provided in section 12.2(c).

      iii. 12.2(c) The joint review panel must be appointed no later than ninety (90) days from ratification ~~within 60 days of the Government advising the Doctors of BC that it intends to refer the matter to an ad hoc joint review panel~~. The composition of the joint review panel shall be three members, with one member appointed by the Doctors of BC, one member appointed by the Government, and the third member who shall be the Chair, selected ~~from a roster of individuals agreed upon~~ by the Government and the Doctors of BC. ~~The members appointed shall be chosen so as to avoid conflicts of interest.~~ If the Government and the Doctors of BC cannot agree ~~have not agreed upon the roster,~~ by sixty (60) days from the ratification of the 2025 PMA, the MSC will appoint the Chair.

1. The funding for the cost of the Chair will be shared by the Ministry of Health and by Doctors of BC. Funding for the Doctors of BC portion of the cost of the Chair and of the Doctors of BC member on the joint review panel will be provided from one-time funds available to the Shared Care Committee.

iv. 12.2(d) The joint review panel must render a majority recommendation to the parties and the MSC within ~~three months of its appointment~~ one month of the date of referral under 12.2(b).

v. 12.2(f) If either the Government or the Doctors of BC does not support in writing the recommendation of the joint review panel within one week of the recommendations being issued, the MSC will decide the matter in accordance with section 13.2, and if the MSC decides that a change to the Guide to Fees should be made, the Doctors of BC will implement the change to the Guide to Fees.

e. Changes to the Virtual Care Fees as agreed to by Doctors of BC and the Ministry of Health and documented in Appendix A will be considered Revisions by Agreement and submitted to the MSC for implementation, subject to its review under Article 13.1 of the PMA, following ratification of the 2025 PMA.

2. Continuation of Temporary Virtual Care Fees

a. The MSC will not unilaterally cancel any of the temporary Virtual Care Fees nor act on the cancellation of any temporary Virtual Care Fee by the Provincial Health Officer.

b. Any changes to the temporary Virtual Care Fees will be accomplished through the application of Articles 12 and 13 of the PMA as amended by this Memorandum of Agreement.

3. Dispute Resolution

a. Where there is a dispute between the Ministry and Doctors of BC regarding the interpretation, application, operation or alleged breach of this Memorandum of Agreement, it shall be resolved in the same manner as set out in Article 22 of the PMA for resolution of Provincial Disputes.

IN WITNESS WHEREOF the parties have executed this Memorandum of Agreement by or in the presence of their respective duly authorized signatories as of the 1st day of April, 2025.

SIGNED, SEALED & DELIVERED on behalf of HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF BRITISH COLUMBIA, by the Minister of Health or their duly authorized representative:

Signature of Authorized Signatory

ROB BYERS
Name

A/ASSOC MIN OF HLTH
Position

THE CORPORATE SEAL of the ASSOCIATION OF DOCTORS OF BC was hereunto affixed in the presence of:

Signature of Authorized Signatory

DR. ADAM THOMPSON
Name

PRESIDENT
Position

C/S



MEDICAL SERVICES COMMISSION

Per: _____
Authorized Signatory

DR. ROBERT HALPENNY
Name

CHAIR - MSC
Position

APPENDIX A

The tracked changes (additions and deletions) will be applied to the version of the Payment Schedule in effect at the time of ratification.

GENERAL PREAMBLE

D. 1. Telehealth Services

"Telehealth Service" is defined as a medical practitioner delivered health service provided to a patient ~~via live image transmission of those images to a receiving medical practitioner at another approved site,~~ through the use of video ~~technology~~ **or telephone**. ~~"Video technology" means the recording, reproducing and broadcasting of live visual images utilizing a direct interactive video link with a patient.~~ **"Synchronous services" are defined as two-way, real-time, interactive communications, for example telephone or video calls. "Asynchronous services" are defined as time-delayed communication, for example fax, email, voice mail, text messaging or voice messaging.** ~~If the sending and/or receiving medical practitioner are not in a Health Authority approved site, the medical practitioner is responsible for the confidentiality and security of all records and transmissions related to the telehealth service. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those s~~Services which are designated as telehealth services are payable by MSP. ~~Other services/procedures require face-to-face encounters~~. Telehealth services do not include teleradiology or tele-ultrasound, which are regulated by their specific Sectional Preambles.

Telehealth services are payable only when provided as defined under the specific Preamble pertaining to the service rendered (e.g.: telehealth consultation - see Preamble D. 2.) to a patient with valid medical coverage. Patients must be informed and given opportunity to agree to services rendered using ~~this modality~~ **telehealth modalities**, without prejudice. **Medical practitioners, in consultation with patients, are responsible for determining the most appropriate modality for the provision of care.**

Notwithstanding the above, "telehealth examination" means an examination of a patient by the ~~consultant~~ **practitioner** at the receiving site using "telehealth services" as defined above but does not include the "face-to-face encounter" requirements referred to under Preamble A. 2.

In those cases where a specialist service requires a family physician at the patient's site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate in the "Referred by" field that a request was made for a family physician assisted assessment.

Telehealth visits are generally payable once per patient/per day/per medical practitioner. Any exceptions ~~to this policy~~ must comply with all Payment Schedule criteria for multiple visits. ~~If a medical practitioner initiates a telehealth visit but determines that the patient must be seen in-person, only one service may be claimed by the medical practitioner or their in-person substitute.~~ **Payment for a telehealth visit and an in-person visit by the same practitioner (or their in-person substitute) on the same day is not allowed unless a new assessment is required due**

to a change in the patient's condition or for a different condition. Information regarding the medical necessity and times of service should accompany claims.

Where a ~~receiving~~ medical practitioner, after having provided a telehealth consultation ~~service~~ to a patient, decides ~~s/he~~ **the patient** must **be** examine**d** ~~the patient~~ in person, the medical practitioner **or their in-person substitute (see preamble D. 2. 6. Referral and Transferral)** may claim a subsequent visit.

Where a telehealth service is interrupted for technical failure and is not able to be resumed within a reasonable period of time, and therefore is unable to be completed, the ~~receiving~~ medical practitioner should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.

~~Compensation for travel, scheduling and other logistics is the responsibility of the Regional Health Authority.~~ Rural Retention ~~fee-for-service~~ p**P**remiums are applicable to telehealth services and are payable based on the location of the receiving medical practitioner in eligible **Rural Subsidiary Agreement** (RSA) communities.

Telehealth services are available to MSP beneficiaries as well as residents of of Alberta and Yukon.

A medical practitioner must be located in British Columbia to be eligible to bill for telehealth services except for medical practitioners who are temporarily absent from British Columbia for 30 consecutive days or less. Exceptions may be made for programs approved by the Medical Services Commission.

The College of Physicians and Surgeons of British Columbia have confirmed that in this province, licensure is defined by the location of the medical practitioner. However, other jurisdictions may have other definitions. BC medical practitioners providing care via telehealth to patients outside the province must abide by the regulations set in the patient's home province.

See the appropriate Section for specific fee items and further criteria.

D. 3. 3. Counselling

Counselling is defined as the discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress, including the management of malignant disease. Counselling, to be claimed as such, must not be delegated and must last at least 20 minutes.

Counselling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the counselling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counselling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other

lifestyle behavioural patterns. Nor are the counselling codes generally applicable to the explanation of the results of diagnostic tests or approved laboratory facility services.

Not only must the condition be recognized as difficult by the medical profession, but the medical practitioner's intervention must of necessity be over and above the advice which would normally be appropriate for that condition. For example, a medical practitioner may have to use considerable professional skill counselling a patient (or a patient's parent) who has been newly diagnosed as having juvenile diabetes, in order for the family to understand, accept and cope with the implications and emotional problems of this disease and its treatment. In contrast, if simple education alone including group educational sessions (e.g.: asthma, cardiac rehabilitation and diabetic education) is required, such service could not appropriately be claimed under the counselling listings even though the duration of the service was 20 minutes or longer. It would be appropriate to apply for sessional payments for group educational sessions. Unless the patient is having significant difficulty coping, the counselling listings normally would not be applicable to subsequent visits in the treatment of this disease.

Other examples of appropriate claims under the counselling listings are Psychiatric Care, the counselling that may be necessary to treat a significant grief reaction, and conjoint therapy and/or family therapy for significant behavioural problems.

MSP payment of counselling under the counselling listings is limited to four sessions per year per patient unless otherwise specified. Subsequent counselling is payable under the other visit listings. ~~Counselling by telephone is not a benefit under MSP.~~

ALL SECTIONS IN MSC PAYMENT SCHEDULE

All telehealth headings in the MSC Payment Schedule will be amended to accommodate multiple modalities:
Telehealth Service ~~with Direct Interactive Video Link with the Patient:~~

FAMILY MEDICINE

Obstetrical Care

14090 FP Prenatal visit complete examination **(in-person only)**
14091 FP Prenatal visit subsequent examination **(in-person or telehealth)**

14094 FP Postnatal ~~office~~ visit
Notes:
i) Restricted to Family Physicians
ii) 14094 may be billed in the six weeks following delivery (vaginal or caesarean section).
iii) Not payable to the physician performing caesarean section.
iv) May be provided in-person or by telehealth.

GENERAL PRACTICE SERVICES COMMITTEE (GPSC) INITIATED LISTINGS

Complex Care Planning and Management Fees (G14033, G14075)

G14033 Complex Care Planning and Management Fee - 2 Diagnoses

The Complex Care Planning and Management Fee is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions. It is payable upon the completion and documentation of a care plan in the patient's chart.

Notes:

*i) Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*

ii) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions as listed in Table 1.

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

*iv) Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician**'s** ~~face to face~~ **in-person or telehealth** planning included under G14033.*

*v) Minimum required total planning time 30 minutes. The majority of the planning time must be ~~spent face to face~~ **in-person or by telehealth** between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").*

vi) Chart documentation must include:
1. the care plan;
2. total planning time (minimum 30 minutes); and
*3. physician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

vii) G14018, G14077, or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14033.

viii) G14050, G14051, G14052, G14053 payable on same day for same patient, if all other criteria met.

ix) Not payable once G14063 has been billed and paid.

x) *G14043, G14063, G14076 and G14078 not payable on the same day for the same patient.*
xi) *Maximum daily total of 5 of any combination of G14033 and G14075 per physician.*
xii) *G14075 is not payable in the same calendar year for same patient as G14033.*
xiii) *Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.*
xiv) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

G14075 Complex Care Planning and Management Fee – Frailty

The Complex Care Planning and Management Fee- Frailty is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for eligible patients of any age with documented frailty from any cause. Frailty is defined as requiring assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL). The effect of the frailty on the patient must be significant enough to warrant the development of a management plan.

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

Notes:

i) *Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*
ii) *Payable only for patients who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living, the effects of which are significant enough to warrant the development of a management plan.*
iii) *Claim must include the diagnostic code V15.*
iv) *Payable once per calendar year per patient on the date of the complex care planning visit.*
v) *Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician's ~~face to face~~ **in-person or telehealth** planning included under G14075.*
vi) *Minimum required total planning time 30 minutes. The majority of the planning time must be ~~face to face~~ **in-person or by telehealth** between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, be on different dates and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").*
vii) *Chart documentation must include:*
1. the care plan;

2. total planning time (minimum 30 minutes); and
*3. physician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

viii) G14018, G14077, or H14067 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for G14075.

ix) Maximum daily total 5 of any combination of G14033 and G14075 per physician.

x) G14075 not payable once G14063 has been billed.

xi) G14033 is not payable in the same calendar year for same patient as G14075.

xii) G14043, G14063, G14076, G14078 not payable on the same day for the same patient.

xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.

xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Prevention Fee (G14066)

G14066 Personal Health Risk Assessment (Prevention)
This fee is payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal primary medical care and who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, tobacco use, physically inactive, unhealthy eating, or at risk for substance use disorder). The FP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires an ~~face to face~~ **in-person or telehealth** visit with the patient or patient's medical representative.

G14066 is payable only to MRP Family Physicians who have submitted G14070 or G14071.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

The Ministry of Health website contains: The current Lifetime Prevention Schedule and the BC Prevention Guidelines.

Notes:

*i) Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*

ii) Payable only for patients with one or more of the following risk factors: Tobacco Use/Smoking, unhealthy eating, physical inactivity, medical obesity, or at risk for substance use disorder.

iii) Diagnostic code submitted with G14066 must be one of the following: Tobacco use/Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783), at risk for substance use disorder (V82).

iv) The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart.

*v) Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician's ~~face to face~~ **in-person or telehealth** planning included under G14066.*

vi) G14077 or H14067 payable on same day for same patient if all criteria met.

vii)G14033, G14043, G14063, G14076 and G14078 not payable on the same day for the same patient.

viii) Payable to a maximum of 100 patients per calendar year, per physician.

ix) Payable once per calendar year per patient.

x) Not payable once G14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management.

xi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Mental Health Planning Fee (G14043)

This fee is payable upon the completion and documentation of a care plan (as defined in the GPSC Preamble) in the patient's chart for patients with a confirmed eligible mental health diagnosis when the effect on the patient is significant enough to warrant the development of a care plan. This is not intended for patients with short-lived mental health symptoms (e.g.: normal grief, life transitions).

The Mental Health Planning Fee requires an ~~face to face~~ **in-person or telehealth** visit with the patient and/or the patient's medical representative and the physician.

G14043 is payable only to Family Physicians who have submitted G14070 or G14071. The Mental Health Planning Fee is payable only to the ~~family physician~~ **Family Physician** who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing year.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

G14043 FP Mental Health Planning Fee

Notes:

*i) Payable to the ~~family physician~~ **Family Physician** who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for G14070 in the same calendar year. Alternatively, if a locum and host Community Longitudinal ~~FP~~ **Family Physician** have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*

ii) *Payable only for patients with documentation of a confirmed eligible mental health diagnosis the effects of which are significant enough to warrant the development of a care plan. Eligible diagnoses are listed in Table 1. Not intended for patients with short lived mental health symptoms.*

iii) *Payable once per calendar year per patient. Not intended as a routine annual fee.*

iv) *Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician's ~~face to face~~ **in-person or telehealth** planning included under G14043.*

v) *Minimum required total planning time 30 minutes. The majority of the planning time must be ~~face to face~~ **in-person or by telehealth** between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) or another physician working within the eligible physician practice team. See Preamble definition of "working within" and "College-certified ACP").*

vi) *Chart documentation must include:*

- *~~a.~~ **1.** ~~T~~the care plan;*
- *~~b.~~ **2.** ~~T~~total planning time (minimum 30 minutes); and*
- *~~c.~~ **3.** ~~P~~physician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

vii) *G14077 or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for G14043.*

viii) *G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14075, G14076 and G14078 not payable on the same day for the same patient.*

ix) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*

Mental Health Management Fees (G14044, G14045, G14046, G14047, G14048)

G14044 FP Mental Health Management Fee age 2 – 49
G14045 FP Mental Health Management Fee age 50 – 59
G14046 FP Mental Health Management Fee age 60 – 69
G14047 FP Mental Health Management Fee age 70 – 79
G14048 FP Mental Health Management Fee age 80+

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee G14043 has been successfully billed. **FP Mental Health Management may be provided in-person or by telehealth.** The four MSP counselling fees (any combination of age-appropriate 00120 or telehealth counselling) must first have been paid in the same calendar year.

Notes:

i) *Payable only to:*

- *~~a.~~ **1.** MRP Family Physicians who have successfully submitted and met the requirements of G14070 in the same calendar year.*
- *~~b.~~ **2.** Locum Family Physicians who are covering for such a MRP FP when using this fee code, and have successfully submitted and met the requirements for G14071 on the same or a prior date in the same calendar year.*

ii) *Payable a maximum of 4 times per calendar year per patient.*

iii) *Not payable unless the four age-appropriate 00120 or telehealth counselling fees have already been paid in the same calendar year in any combination.*

iv) *For a prolonged visit for counselling (minimum time per visit – 20 minutes) (see Preamble D.3.3.)*

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

vi) Counselling may be provided ~~face to face or by videoconferencing~~ ***in-person or by telehealth****.*

vii) G14077 or H14067, payable on same day for same patient if all criteria met.

viii) G14043, G14076, G14078 not payable on same day for same patient.

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

x) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Palliative Care Planning Fee (G 14063)

This fee is payable upon the development and documentation of a care plan as described in the GPSC Preamble, for patients who in the ~~FP's~~ **Family Physician's** clinical judgement have reached the palliative stage of a life-limiting disease or illness, with life expectancy of up to 6 months, and who consent to the focus of care being palliative.

Examples include end-stage cardiac, respiratory, renal and liver disease, end stage dementia, degenerative neuromuscular disease, HIV/AIDS or malignancy. This fee requires an ~~face to face~~ **in-person or telehealth** visit and assessment of the patient. If the patient is incapable of participating in the assessment to confirm and agree to their being palliative, then the patient's alternate substitute decision maker or legal health representative must be consulted and asked to provide informed consent.

G14063 is payable only to Family Physicians who have submitted G14070 or G14071 in the same calendar year.

This fee is payable only to the ~~FP~~ **Family Physician** who commits to providing the majority of the patient's longitudinal comprehensive primary medical care ~~for the patient~~.

Patient Eligibility:

- Eligible patients must be living at home or in assisted living.
- Patients in Acute and Long Term Care Facilities are not eligible.

G14063 FP Palliative Care Planning Fee

Notes:

i) Payable only to Family Physicians who have successfully submitted and met the requirements for G14070. Alternatively, if a locum and host Community Longitudinal ~~FP~~ ***Family Physician*** *have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for G14071 in the same calendar year.*

ii) Requires documentation of the patient's medical diagnosis, determination that the patient has become palliative, and patient's agreement to no longer seek treatment aimed at cure.

iii) Patient must be eligible for BC Palliative Care Benefits Program (not necessary to have applied for palliative care benefits program).

*iv) Payable once per patient once patient deemed to be palliative. Under circumstances when the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new ~~FP~~ **Family Physician** who is assuming the ongoing palliative care for the patient.*

*v) Payable in addition to a visit fee ~~(home or office)~~ on the same day if medically required and does not take place during a time interval that overlaps with the physician ~~face to face~~ **in-person or telehealth** planning included under G14063.*

*vi) Minimum required total planning time 30 minutes. The majority of the planning time must be spent ~~face to face~~ **in-person or by telehealth** between physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other planning tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) working within the eligible physician practice team. (See Preamble definition of "working within" and "College-certified ACP").*

vii) Chart documentation must include:

1. the care plan;

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

*3. physician ~~face to face~~ **in-person or telehealth** planning time (minimum 16 minutes).*

viii) G14077 or H14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for G14063.

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

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

xi) G14050, G14051, G14052, G14053, G14250, G14251, G14252, G14253, G14033, G14066, G14075 not payable once Palliative Care Planning fee is billed and paid.

xii) The GPSC Mental Health Initiative Fees (G14043, G14044, G14045, G14046, G14047, G14048) are still payable once G14063 has been billed provided all requirements are met but are not payable on same day.

xiii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

FP Telehealth, Email, Text & Telephone Fees: Medical Advice to Patients ~~(G14076, G14078)~~

Cancel 14076 FP Patient Telephone Management Fee. All occurrences of 14076 in the MSC Payment Schedule will be replaced by 13706. 13706 does not currently require billing of FPSC portal code 14070, 14071, 14072 and should remain this way.

~~T~~13706 FP Delegated Patient **Communication** ~~Telehealth Management Fee~~

Notes:

*i) **Payable** ~~F~~f~~or~~ ~~verbal, real-time telephone or video technology~~ **synchronous** communication ~~discussion~~ **(e.g. telephone, video)** between the patient/~~or~~*

~~the~~*patient's medical representative and a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed* ~~*within*~~ ***by*** *a physician's practice. Not payable when the delegated representative is paid or funded by alternate means by a health authority or the Ministry of Health.*

ii) 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.*

iii) Not payable for prescription renewals ~~*s*~~ ***alone****.*

iv) ***Not payable for*** *anti-coagulation therapy by telephone (00043) or notification of appointments /*~~*or*~~ *referrals.*

v) Only one service payable per patient per day.

vi) Not payable on the same calendar day as a visit or service fee by same physician for same patient ***with the exception of 13005, 14018, 14050, 14051, 14052, 14053, 14067, 14077, 14250, 14251, 14252, 14253.*** ~~*14077, 14067, 14018, 14050, 14051, 14052, 14053, 13005.*~~

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

Cancel 14078 FP Email/Text/Telephone Medical Advice Relay. All occurrences of 14078 in the MSC Payment Schedule will be replaced by 13707. 13707 does not currently require billing of FPSC portal code 14070, 14071, 14072 and should remain this way.

~~T~~13707 FP Email/Text/Telephone Medical Advice Relay or ~~ReRX~~ **Prescription Renewal** Fee

Notes:

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

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) Payable for prescription renewals without patient interaction.

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

v) Only one service payable per patient per day.

vi) Not payable on the same ~~*calendar*~~ *day as a visit or service fee by same physician for same patient* ***with the exception of 14050, 14051, 14052, 14053, 14067, 14077, 14250, 14251, 14252, 14253.***~~*14077 or 14067*~~*.*

vii) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

OBSTETRICS AND GYNECOLOGY

Obstetrical Procedures

04190 Prenatal visit complete examination **(in-person only)**
04191 Prenatal visit subsequent examination **(in-person or telehealth)**

04717 Prenatal ~~office~~ visit for complex obstetrical patient
Notes:
i) May be provided in-person or by telehealth.
ii) Paid only for the following diagnoses:
…

04194 Postnatal ~~office~~ visit
Notes:
i) Restricted to Obstetrics and Gynecology specialists.
ii) 04194 may be billed in the six weeks following delivery (vaginal delivery or caesarean section).
iii) Not payable to the physician performing the caesarean section.
iv) May be provided in-person or by telehealth.

SPECIALIST SERVICES COMMITTEE INITIATED LISTINGS

Specialist Advice Fees ~~G10001, G10002, G10005~~

Cancel T10000 Urgent Specialist Advice on patient with previous visit/service – Initiated by a Specialist, General Practitioner or Health Care Practitioner. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request

G10001 Urgent Specialist Advice – Initiated by a Specialist, Family Physician or ~~Health Care Practitioner~~ **Allied Care Provider**. Verbal, real-time response within 2 hours of the initiating physician's or practitioner's request
Notes:
*i) Payable for **telehealth** ~~telephone, video technology~~ or face-to-face communication only. Not payable for written communication (i.e. fax, letter, email).*
ii) Document time of initiating request, time of response, as well as advice given and to whom.
*iii) Include the practitioner number of the physician or ~~Health Care Practitioner~~ **Allied Care Provider** requesting the advice in the "referred by" field when submitting claim.*
*iv) Not payable in addition to another service on the same day for the same patient by the same ~~practitioner~~ **physician**.*
v) Limited to one claim per patient per physician per day.
vi) ~~Not payable if there is a paid visit/service for the same condition by the same practitioner in the previous 180 days.~~

Cancel T10009 Specialist Advice for Patient Management on patient with previous visit/service – Initiated by a Specialist, General Practitioner, Allied Care Provider, or coordinator of the patient's care. Verbal real-time response within 7 days of initiating request

G10002 Specialist Advice for Patient Management – Initiated by a Specialist, Family Physician, Allied Care Provider, or coordinator of the patient's care. Verbal, real-time response within 7 days of initiating request.

Notes:

i) Payable for ***telehealth*** ~~*telephone, video technology*~~ *or face to face communication only. Not payable for written communication (i.e. fax, letter, email).*

ii) Document date of initiating request, date of the response, as well as advice given and to whom.

iii) Include the practitioner number of the physician or Allied Care Provider requesting advice in the "referred by" field when submitting claim. (For Allied Care Providers not registered with MSP use practitioner number 99987).

iv) Not payable in addition to another service on the same day for the same patient by the same ***physician*** ~~*practitioner.*~~

v) Limited to one claim per patient per physician per day and two services per patient per physician per week.

G10005 Specialist Email Advice for Patient Management–Initiated by a Specialist, Family Physician or Allied Care Provider. Response within 7 days of request

Notes:

i) Payable for email communication only. Maximum 3 services per patient per physician per day.

ii) Document date of request, date of the response, as well as advice given and to whom.

iii) Include the practitioner number of the physician or Allied Care Provider requesting advice in the "referred by" field when submitting claim. (For Allied Care Providers not registered with MSP use practitioner number 99987).

iv) Not payable in addition to another service on the same day for the same patient by same ~~*practitioner*~~***physician***.

v) Limited to 3 services per patient per physician per day.

vi) Limited to maximum of 12 services per patient per physician per year.

~~*vii) Not payable if there is a paid visit/service for the same condition by the same MD in the previous 30 days.*~~

Specialist Patient Follow-up Fees ~~**G10003, G10006**~~

Cancel 10006 Specialist Email Patient Management / Follow-up. All occurrences of 10006 in the MSC Payment Schedule will be replaced by 10007.

~~T~~10007 Specialist Email/Text/Telephone Medical Advice Relay or ~~ReRX~~ **Prescription Renewal** Fee

Notes:

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

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) *Payable for prescription renewals without patient interaction.*

iv) *Not payable for notification of appointments or referrals.*

v) *Only one service payable per patient per day.*

vi) ***A service must have been provided for the same patient by the same physician within the preceding 18 months.***

vii) *Not payable on the same calendar day as a visit or service fee by same physician for same patient* ***with the exception of 10004****.*

viii) *Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.*