

FREQUENTLY ASKED QUESTIONS

Temporary Changes for Telehealth, Telephone and Other Services

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There is no specific fee for completing the Clinically Extremely Vulnerable (CEV) attestation form (or letter) on its own, nor should patients be charged for this service. It is anticipated that the process will involve a visit with the patient and/or their caregiver. This can be billed through the appropriate in-person or telehealth fee.

RULE CHANGES

Daily Volume Limits: The Daily volume limit for in-office care for office visits, counselling, and complete examinations were reinstated effective October 1, 2020, as per the Provincial Health Officer.

Services directly related to COVID-19 should include diagnostic code C19.

Out-of-Province / Out-of-Country patients: In response to the COVID-19 pandemic, individuals present in BC who would otherwise not be eligible for coverage under MSP will be provided provincially insured health care coverage for services related to suspected or confirmed cases of infection with COVID-19. Services for unrelated conditions that are performed on MSP non-eligible patients will remain uninsured.

You as the provider will be responsible for determining whether your patient meets the criteria for this coverage for all services performed. Services related to COVID-19 for non-MSP eligible patients may be billed using the following generic Personal Health Number (PHN):

PHN: 9703740703

First Name: A

Surname: Coronavirus

Date of Birth: 08/01/1988

Services directly related to COVID-19 should include diagnostic code C19.

This generic PHN should not be used for beneficiaries who are eligible for MSP coverage for the date of service but who either do not yet have a PHN or whose coverage is not currently active. Those eligible patients should first establish their MSP coverage so that services can be billed under their own PHN.

Please note that an MSP beneficiary can access provincially insured health care benefits using the PHN that is printed on an expired BC Services Card with another form of identification. Providers may also notice an increase of patients presenting to them with confirmation of coverage letters. These letters have been issued in response to access to care during the COVID-19 pandemic.

Questions regarding billing using this generic PHN can be directed to Claims Billing Support at Health Insurance BC at:

Vancouver: (604) 456-6950

Elsewhere in BC: 1-866-456-6950

General Preamble D.1. Telehealth Services amended effective March 13, 2020 on a temporary basis

The first paragraph of Preamble D. 1. Telehealth Services is amended to the following (strikethrough deleted and bold added).

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. ~~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.~~ **Consultations, office visits, and non-procedural interventions where there is no telehealth fee may be claimed under the face-to-face fee with a claim note record that the service was provided via telehealth.** Telehealth services do not include teleradiology or tele-ultrasound, which are regulated by their specific Sectional Preambles.

Application of the rule changes:

All physicians, including locums, may utilize the Telehealth (video or telephone) fee codes per their section fee guides and the additional information in Preamble clause D.1. Telehealth Services may be provided from any location where privacy can be ensured, even your home should you be in quarantine or self-isolation.

Most visits provided by telephone by a physician should be billed under the Telehealth codes in your individual Section Fee Guide. Bill Telehealth services using in-person fee codes only if there is no applicable existing Telehealth fee code. When using in-person fee codes for Telehealth (video or telephone) services, you must include a note record with the submission that the service was provided via Telehealth.

Specialist Telehealth (video or telephone) fee codes apply regardless of location. Family doctors have in and out of office Telehealth fees – be sure to read the Family Physician FAQs for the definitions.

Services directly related to COVID-19 should include the diagnostic code C19.

Physicians should continue to use their professional judgement to determine whether the use of Telehealth (video or telephone) is clinically appropriate based on the circumstances of each patient. This includes any discussions where COVID-19 is the topic and is not restricted to patients who are seeking testing or have been tested.

A word about privacy and security:

During times of medical emergency, whether caring for an individual patient or a large scale public health crisis, physicians should always give priority to providing patient care to the best of their ability. In the current situation we recognize that physicians' office practices and delivery of care may be significantly impacted. Physicians should continue to act in the best interests of their patients and may need to adapt and be resourceful in a rapidly changing and challenging environment. Telehealth (video or telephone) care is one important way you can continue to care for patients while keeping your patients as well as yourself and your staff safe. Choose tools that work well for you and your patient regardless of whether they formally meet privacy and security requirements. That is secondary to delivering care.

You may obtain verbal consent and document in chart. Please also see: GMV PSP Module resources including the patient invitation and the confidentiality agreement that each patient must sign (and other important information and tools):

<https://www.pspexchangebc.ca/course/view.php?id=70§ion=19>

Section of Diagnostic Ultrasound Preamble amendment effective April 17, 2020 on a temporary basis

The following wording is deleted from the Section of Diagnostic Ultrasound Preamble (strikethrough deleted). The cancellation date will be determined by the Provincial Health Officer.

~~Preamble: Real-time Ultrasound Fees may only be claimed for studies performed when a physician is on site in the diagnostic facility for the purpose of diagnostic ultrasound supervision.~~

DIAGNOSTIC ULTRASOUND TELEMETRY

Definition: The electronic transmission of diagnostic ultrasound images from one site to another for interpretation.

For diagnostic ultrasound telemetry services to be considered as benefits under the Medical Services Plan:

- the transmitting and receiving sites must be located within ~~Medical Services Commission approved~~ and Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients
- the services are billed in accordance with the Telemetry Billing Guidelines

Telemetry Billing Guidelines:

- a) Services must be billed by the facility where the image was taken using the practitioner number of the physician who did the interpretation.
- b) Facility number field – the facility number of the diagnostic facility where the image was taken
- c) Sub-Facility field – the facility number of the diagnostic facility where the image was interpreted
– zeros if interpreted at the same site where the image was taken
- d) Service charges (fee items 01200 – 01202) are only billable when a physician is required to travel from home to hospital in order to perform a telemetry service for an outpatient and when the *MSC Payment Schedule* criteria are met.
- e) The original site should ensure that only one interpretation is billed to MSP.
- f) In those rare cases when a second radiological opinion is requested by the referring physician, a radiologist may bill for the service using fee item 08628, provided written radiological report is sent to the referring physician.

Real time ultrasound fees may only be claimed for studies performed by telemetry when

- The facility currently holds a remote site designation from the Medical Services Commission. (Facilities should recognize that once the volume of services justifies full-time radiologist’s coverage remote site designation may be removed.); and,
- The use of telemetry will not negatively affect the existing on-site visit; schedules of the radiologists; and,
- The majority of scans will continue to be scheduled when the visiting radiologist is on-site for the purpose of ultrasound supervision.

Section of Diagnostic Radiology Preamble amendment effective April 17, 2020 on a temporary basis. The following wording is deleted from the Section of Diagnostic Radiology Preamble (strikethrough deleted). The cancellation date will be determined by the Provincial Health Officer.

DIAGNOSTIC RADIOLOGY TELEMETRY

Definition: The electronic transmission of radiological images from one site to another for interpretation.

For diagnostic radiology telemetry services to be considered as benefits under the Medical Services Plan:

- the transmitting and receiving sites must be located within ~~Medical Services Commission-approved~~ and Diagnostic Accreditation Program accredited diagnostic facilities;
- the services are rendered to out-patients
- the services are billed in accordance with the Telemetry Billing Guidelines

Telemetry Billing Guidelines:

- g) Services must be billed by the facility where the image was taken using the practitioner number of the physician who did the interpretation.
- h) Facility number field – the facility number of the diagnostic facility where the image was taken
- i) Sub-Facility field – the facility number of the diagnostic facility where the image was interpreted
– zeros if interpreted at the same site where the image was taken
- j) Service charges (fee items 01200 – 01202) are only billable when a physician is required to travel from home to hospital in order to perform a telemetry service for an outpatient and when the *MSC Payment Schedule* criteria are met.
- k) The original site should ensure that only one interpretation is billed to MSP.
- l) In those rare cases when a second radiological opinion is requested by the referring physician, a radiologist may bill for the service using fee item 08628, provided written radiological report is sent to the referring physician.

General Preamble C. 27. Business Cost Premium amended effective May 1, 2020 on a temporary basis, revised effective June 1, 2020.

The BCP list of eligible fees has been temporarily amended to include telehealth fee items during COVID-19 pandemic to ensure BCP is paid given the majority of these services would have otherwise been provided to patients face-to-face at eligible physician offices.

Eligible BCP claims require a registered facility number and a community-based office service location code. While telehealth services do not need to be provided by the physician in their office, the appropriate facility number and service location code that

should be entered on the claim is based on where the service would have been provided if it had been performed face-to-face.

Temporary list of eligible Telehealth fee items:

00470	00471	00477	01155	01470	01472	01770	01772	01777	03310
03312	03317	04070	04072	04077	08070	08072	08077	13036	13037
13038	13041	13042	13236	13436	13536	13636	13736	13836	13237
13437	13537	13637	13737	13837	13238	13438	13538	13638	13738
13838	20207	20210	20214	22007	22010	22011	25007	25010	25012
25013	30070	30071	30072	30077	31107	31110	31112	32107	32110
32112	32114	32270	32271	32272	32277	32367	32372	32377	33107
33110	33112	33114	33260	33262	33267	32370	33270	33272	33277
33360	33362	33367	33421	33422	33423	33424	33427	33470	33472
33473	33474	33477	33540	33542	33547	33570	33572	33577	33630
33632	33635	33637	33640	33730	33732	33737	50507	50510	50511
50512	50514	50516	50517	50518	50519	51107	51110	51112	51115
60607	60610	60613	60614	60622	50515	60625	60626	60630	60631
60632	60633	60635	60636	60638	60639	66007	66010	66012	70070
70072	70077	70080	70087	77707	77710	77712	78007	78010	78012
79207	79210	79212	83070	94070	94072	94077			

General Preamble D. 3. 3. Counselling amended effective March 13, 2020 on a temporary basis

The following wording is deleted from General Preamble D. 3. 3. (strikethrough deleted).
The cancellation date will be determined by the Provincial Health Officer.

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.~~

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NEW FEE CODES FOR COVID-19 RELATED SERVICES

Effective date: March 17, 2020: These two new fees can be billed by any physician in addition to a Telehealth service (video or telephone) on the same day for the same patient. Fee codes T13701 (Office Visit for COVID-19 with test) and T13702 (Office Visit for COVID-19 without test) are both eligible for the BCP, as Visits are considered an eligible service under the BCP criteria.

Services directly related to COVID-19 should include diagnostic code C19.

T13701 Office Visit for COVID-19 with test..... \$50.00

NOTES:

- i) Payable for patients with suspected or active COVID-19 symptoms only.
- ii) COVID-19 testing must be performed.
- iii) Not intended for providing general information on a viral infection, including COVID-19.
- iv) Not payable in addition to any other office visits to the same physician for same patient, same day.

T13702 Office visit for COVID-19 without test \$40.00

NOTES:

- i) Payable for patients with suspected or active COVID-19 symptoms only.
- ii) Not intended for providing general information on a viral infection including COVID-19.
- iii) Not payable in addition to any other office visits to the same physician for same patient, same day.

Effective March 27, 2020: Three new, time-limited fees have been created for family physicians. There are two new fees that are similar to existing GPSC fees but expand accessibility and increase capacity to provide virtual care. There is one new fee to better enable communication between providers during the COVID pandemic.

T13707 is billable for a faxed prescription.

T13706 FP Delegated Patient Telehealth Management Fee \$20.12

(see notes on next page)

NOTES:

- i) For verbal, real-time telephone or video technology communication discussion between the patient or the patient's medical representative and a College-certified allied care provider (e.g.: Nurse, Nurse Practitioner) employed within 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, anticoagulation therapy by telephone (00043) or notification of appointments or referrals.
- iv) Only one service payable per patient per day.
- v) Not payable on the same calendar day as a visit or service fee by same physician for same patient.
- vi) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

T13707 FP Email/Text/Telephone Medical Advice Relay or ReRx Fee \$7.04

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.

(notes continued on next page)

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

T13708 FP COVID-19 communication with specialist and/or allied care provider \$43.23

NOTES:

- i) Payable to the Family Physician who participates in a 2 way telephone or video conference communication with a specialist and/or allied care provider about a patient regarding COVID-19.
- ii) T13708 FP COVID-19 communication with specialist and/or allied care provider cannot be delegated. No claim may be made where communication is with a proxy for either provider.
- iii) Payable in addition to any visit fee on the same day.
- iv) 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.
- v) Not payable in addition to G14018 or G14077 on the same day for the same patient.
- vi) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

New temporary fee item T10046 will be effective for service dates on or after July 1, 2022.

T10046 Assessment for COVID-19 therapeutics:
 This fee is payable for patient care related to COVID-19 treatment, including patient assessment, prescribing of COVID-19 therapeutics, completion of relevant documentation and forms, and arranging for treatment. May be provided either in-person and/or by telehealth – per 15 minutes or greater portion thereof \$43.50

(see notes on next page)

NOTES:

- i) Payable to a maximum of 60 minutes (4 units) per patient/per day.
- ii) Start and end times of the assessment must be entered in both the billing claim and the patient's chart.
- iii) Payable in addition to any visit or consult fee on the same day if medically required, provided the visit does not take place during a time interval that overlaps. Start and end times of the visit must be entered in the billing claim and the patient's chart.
- iv) Other services such as patient management and conference fees are payable in addition on the same day by the same physician, provided it does not take place during a time interval that overlaps. Start and end times of the other service must be entered in the billing claim and the patient's chart.

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Specialist New Fee items effective March 27, 2020 on a temporary basis, the following new fee items have been approved on a temporary basis. The cancellation date will be determined by the Provincial Health Officer.

T10007 is billable for a faxed prescription.

T10000 Urgent Specialist Advice for 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..... \$60.00

NOTES:

- i) Payable for 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 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 same practitioner.
- v) Limited to one claim per patient per physician per day.

T10007 Specialist Email/Text/Telephone Medical Advice Relay or ReRX Fee \$10.10

(see notes on next page)

NOTES:

- i) For verbal, real-time telephone and video technology communication (including other forms of electronic verbal communication) only. Not payable for written communication (i.e. fax, letter, e-mail).
- ii) Documentation in the medical record to show that the patient understood and acknowledged the information provided.
- iii) Include start and end times in the medical record, and in time fields when submitting claim.
- iv) Face-to-face service must have been billed for the same patient by the same physician within the preceding 18 months.

T10008 Urgent Specialist COVID-19 Advice – 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..... \$60.00

NOTES:

- i) Payable for telephone, video technology or face-to-face communication only about a patient regarding COVID-19. 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 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 same practitioner.
- v) Limited to two claims per patient per physician per day.
- vi) Not payable in addition to G10001 on the same day for the same patient.

T10009 Non-Urgent Specialist Advice for patient with previous visit/service – Initiated by a Specialist, General Practitioner or Allied Care Provider, or coordinator of the patient’s care. Verbal, real-time response within 7 days of initiating request \$40.00

(see notes on next page)

NOTES:

- i) Payable for 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 practitioner.
- v) Limited to one claim per patient per physician per day and two services per patient per physician per week.

Reactivation of temporary fee codes for Respiratory Immunization for patients 19 years of age or older effective October 1, 2022 with an end date of April 30, 2023.

T10040 Respiratory immunization for patients 19 years of age or older (with visit) \$5.43

NOTES:

- i) Payable for influenza (using ICD-9 code V048) and Pneumococcal (using ICD-9 code V05) and Pertussis during pregnancy (using ICD-9 code V036) immunizations.
- i) Payable in full with an office visit.
- ii) If the primary purpose of the service is for immunization, bill fee item 10041 using ICD-9 code V048 for influenza, and/or V05 for pneumococcal and/or V036 for Pertussis during pregnancy.

TB10041 Respiratory immunization for patients 19 years of age or older (without visit) \$14.00

NOTES:

- i) Payable for Influenza (using ICD-9 code V048 and Pneumococcal (using ICD-9 code V05) and Pertussis during pregnancy (using ICD-9 code V036) immunizations when the primary purpose of the service is for immunization.
- ii) Not payable with an office visit.

New temporary fee codes for COVID-19 Immunizations effective January 25, 2021

The cancellation date will be determined by the Provincial Health Officer.

T10042 COVID-19 immunization (with visit) \$5.45

(see notes on next page)

NOTES:

- i) Payable for COVID-19 immunization (ICD-9 code C19 must be entered on claim).
- ii) Payable in full with a visit.
- iii) If the primary purpose of the service is for immunization, bill fee item 10043 and 10044 if applicable.

TB10043 COVID-19 immunization (without visit) \$14.00

NOTES:

- i) Payable for COVID-19 immunization (ICD-9 code C19 must be entered on claim).
- ii) Not payable with a visit.

TB10044 Extended COVID-19 immunization (extra)..... \$17.62

NOTES:

- i) Payable for an extended COVID-19 immunization (ICD-9 code C19 must be entered on claim).
- ii) Paid only in addition to 10043 where physician time with the patient exceeds 10 minutes.
- iii) Start and end times must be entered in both the billing claim and the patient’s chart.
- iv) Not payable for immunizations provided as part of a health authority immunization program.
- v) Cannot be delegated to a nurse or other employee of the physician’s practice.

New temporary fee code for COVID-19 immunization advice effective April 15, 2021 The cancellation date will be determined by the Provincial health Officer.

The new temporary fee is available to all physicians in BC, and can be provided in-person or by Telehealth. Please hold claims until the Broadcast Message is received in the April 30 remittance.

T10045 COVID-19 immunization advice fee (extra)..... \$17.62

NOTES:

- i) Payable for COVID-19 immunization advice (ICD-9 code C19) must be entered on claim).
- ii) Paid only in addition to a visit for an unrelated condition and is paid in full.
- iii) Physician time with the patient for the advice must exceed 10 minutes exclusive of time spent on the base unrelated visit.
- iv) Start and end times must be entered in both the billing claim and the patient’s chart.

(notes continued on next page)

- v) Not payable with a COVID-19 immunization by the same practitioner, same day.
- vi) If COVID-19 immunization advice fee is provided with a visit for an unrelated condition and with a procedure, bill the procedure and 50% of a visit with ICD-9 code C19.
- vii) If COVID-19 immunization advice fee is provided as a stand-alone service, bill the appropriate visit code with ICD-9 code C19.
- viii) Cannot be delegated to a nurse or other employee of the physician's practice.

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New temporary fee code for COVID-19 perioperative complexity surcharge effective October 1, 2020 The cancellation date will be determined by the Provincial Health Officer.

T10050 COVID-19 Perioperative Complexity surcharge..... 60.00

NOTES:

- i) Payable for surgeries where the patient has been assessed in accordance with the BCCDC and Ministry of Health Infection Prevention and Control Protocol for Surgical Procedures during COVID-19 (Adult, Pediatric and Obstetrical), and falls into the yellow or red risk categories.
- ii) This fee includes time spent donning and doffing personal protective equipment.
- iii) Payable only for the procedures performed under general anesthesia which require airway management.
- iv) Restricted to surgeons, surgical assistants, and anesthesiologists.
- v) Must be billed by the same physician in addition to one of the following:
 - a) a surgical procedure
 - b) surgical assist
- vi) intensity and complexity level fee item
- vii) Maximum of one surcharge per surgeon/ anesthesiologist/surgical assistant per operation unless two surgeons perform two synchronous surgeries, or two anesthesiologists or two surgical assistants are required for clinical reasons.

(notes continued on next page)

- viii) If a patient requires more than one operation on the same day under separate anesthetics, the fee may be billed again by all perioperative team members if the criteria are met.
- ix) Not payable to physicians working under salary, service contract or sessional arrangements.
- x) Out-of-Office Hours operative surcharges (01210, 01211 and 10212) are not to be paid on the modifier.
- xi) Surgical fee modifiers are excluded from the calculation for total operative fee(s) for which surgical assist fees are based.

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New FP Telehealth Fee Items: The following new fee items have been approved on a temporary basis, effective June 1, 2020. The cancellation date will be determined by the Provincial Health Officer.

- Family physicians providing medical services by phone to patients may use the new temporary age-based telehealth fee codes rather than 14076.
- Telehealth (video or telephone) fees may not be delegated and billed to MSP. Continue to use 14076 when delegating a phone visit to a college certified allied care provider (ACP) who is employed by your practice.
- **Non-procedural interventions provided by video or telephone where there is no Telehealth fee may be claimed under the face-to-face fee with a claim note record that the service was provided via Telehealth.** Examples include: Long Term Care Facility visits, Palliative Care Facility visits, Group Medical Visits.
- These new fees have the same value as the in-person fee codes for visits (00100 series equivalents), counselling (00120 series equivalents), and consultations (00110 series equivalents).
- These fee codes are to be used regardless of the physician’s location (home, office, or Health Authority approved facility).
- Business Cost Premium (BCP) will apply to the new fee codes.

Telehealth Service with Direct Interactive Video Link with the Patient:

These fee items cannot be interpreted without reference to the Preamble D. 1.

T13236 Telehealth FP Consultation (age 0-1).....	\$85.40
T13436 Telehealth FP Consultation (age 2-49).....	\$77.63
T13536 Telehealth FP Consultation (age 50-59).....	\$85.40
T13636 Telehealth FP Consultation (age 60-69).....	\$89.28
T13736 Telehealth FP Consultation (age 70-79).....	\$100.91
T13836 Telehealth FP Consultation (age 80+).....	\$116.11

T13237	Telehealth FP Visit (age 0-1).....	\$34.90
T13437	Telehealth FP Visit (age 2-49).....	\$31.72
T13537	Telehealth FP Visit {age 50-59}.....	\$34.90
T13637	Telehealth FP Visit {age 60-69}.....	\$36.47
T13737	Telehealth FP Visit (age 70-79).....	\$41.22
T13837	Telehealth FP Visit (age 80+).....	\$47.59
T13238	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 0-1)	\$62.43
T13438	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 2-49)...	\$56.76
T13538	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 50-59).	\$62.43
T13638	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit- 20 minutes) (age 60-69)..	\$65.26
T13738	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 70-79).	\$73.77
T13838	Telehealth FP Individual counselling for a prolonged visit for counselling (minimum time per visit - 20 minutes) (age 80+)	\$85.12

NOTES:

- i) MSP will pay for up to four (4) individual counselling visits (any combination of age appropriate in office, out of office and telehealth) per patient per year (see Preamble D. 3. 3.)
- ii) Start and end time must be entered into both the billing claims and patient’s chart.
- iii) Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required.

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AMENDMENTS TO EXISTING FEE ITEMS

Effective June 1, 2020 on a temporary basis Amendment: Note iii of the indicated fee items has been amended to the following on a temporary basis (strikethrough deleted and bold added). The cancellation date will be determined by the Provincial Health Officer.

Chronic Disease Management Incentives-Fee For Service

PG14050	Incentive for MRP Family Physicians - annual chronic care incentive (diabetes mellitus)
PG14051	Incentive for MRP Family Physicians - annual chronic care incentive (heart failure).....

- PG14052 Incentive for MRP Family Physicians - annual chronic care incentive (hypertension)
- PG14053 Incentive for MRP Family Physicians - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD)

NOTES:

*iii) This item may only be billed after one year of care has been provided including at least two visits: **Both of the two required visits may be a physician visit.** Office, prenatal, home, long term care or **physician telehealth** visits qualify. **Alternatively, ⊖ one of the two required visits must be a physician visit, while the second visit may be:***

1. a telephone visit (PG14076) or
2. a group medical visit (13763-13781) or
3. ~~a telehealth visit (13017, 13018, 13037, 13038) or~~
4. an in-person visit with a College-certified allied care provider working within the family physician’s practice. team (PG14029).

(See Preamble definition of “working within” and “College-certified ACP”).

Chronic Disease Management Incentives – MRP Family Physicians under Alternate Payment/Funding Model Programs

- PG14250 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus).....
- PG14251 Incentive for MRP Family Physician (who bill encounter record visits) - annual chronic care incentive (heart failure).....
- PG14252 Incentive for MRP Family Physician (who bill encounter record visits) - annual chronic care incentive (hypertension)
- PG14253 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease - COPD).....

NOTES:

*iii) This item may only be billed after one year of care has been provided including at least two visits: **Both of the two required visits may be a physician visit.** Office, prenatal, home, long term care or **physician telehealth** visits qualify. **Alternatively, ⊖ one of the two required visits must be a physician visit, while the second visit may be:***

1. a telephone visit (PG14276) or
2. a group medical visit (13763-13781) or
3. ~~a telehealth visit (13017, 13018, 13037, 13038) or~~
4. an in-person visit with a College-certified allied care provider working within the family physician’s practice. team (PG14029).

(See Preamble definition of “working within” and “College-certified ACP”).

Section of General Practice amendment effective July 23, 2020 on a temporary basis

Amendment: Notes ii and iii of the indicated fee item have been amended on a temporary basis, effective July 23, 2020 (bold is added). The cancellation date will be determined by the Provincial Health Officer.

P00039 Management of Maintenance Opioid Agonist Treatment (OAT) for Opioid Use Disorder.....
 Management of ongoing maintenance Opioid Agonist Treatment for Opioid Use Disorder

NOTES:

- i) The physician does not necessarily have to have direct face-to-face contact with the patient for this fee to be paid.
- ii) 00039 is **not** the only fee payable for any medically necessary service associated with opioid agonist treatment for opioid use disorder. This includes but is not limited to the following:
 - a) At least one visit (in-person, telephone or video conference) per month with the patient after induction/stabilization on opioid agonist treatment is complete.
 - b) At least one in-person visit with the patient every 90 days. Exceptions to this criterion will be considered on an individual basis.
 - c) Supervised urine drug screening and interpretation of results.
 - d) Simple advice/communication with other allied care providers involved in the patients OAT.
- iii) Claims for treatment of co-morbid medical conditions, including psychiatric diagnoses other than substance use disorder, are billable using the applicable visit or service fees. Counselling and visit fees related only to substance use disorder are not payable in addition **with the exception of visits required to support Substance Use Risk Mitigation in the context of COVID-19 (claim note record must indicate "COVID-19 risk mitigation")**.
- iv) This fee is payable once per week per patient regardless of the number of services per week for management of OAT maintenance.
- v) This fee is not payable with out of office hours premiums.
- vi) Eligibility to submit claims for this fee item is limited to physicians who are actively supervising the patient's continuing use of opioid agonist medications for treatment of opioid use disorder.
- vii) This payment stops when the patient stops opioid agonist treatment.

Section of General Practice amendment effective June 1, 2020 on a temporary basis

Amendment: Note iii of the indicated fee items has been amended (strikethrough is deleted).

- PG14044 FP Mental Health Management Fee age 2–49
- PG14045 FP Mental Health Management Fee age 50–59
- PG14046 FP Mental Health Management Fee age 60–69
- PG14047 FP Mental Health Management Fee age 70–79
- PG14048 FP Mental Health Management Fee age 80+

NOTES:

- i) Payable only to:
 - a) MRP Family Physicians who have successfully submitted and met the requirements of PG14070 in the same calendar year.
 - b) 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 PG14071 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 in-person 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.
- vii) PG14077 or PH14067, payable on same day for same patient if all criteria met.
- viii) PG14043, PG14076, PG14078 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.

Effective March 23, 2020, The cancellation date will be determined by the Provincial Health Officer

Physicians should continue to use their professional judgement to determine whether use of virtual technology is clinically appropriate based on the circumstances of each patient.

GPSC Planning Fees 14033 Complex Care, 14075 Frailty, 14043 Mental Health, 14063 Palliative Care:

- All face-to-face planning required under the GPSC planning fees may now be provided by Telehealth: video or phone. Think of it as physician:patient planning.
- The existing time and documentation requirements will not change: total planning time (30 minutes) and physician:patient planning time (minimum 16 minutes).
- If medically indicated, a telehealth visit may be billed in addition. The time spent on this visit cannot be concurrent with the physician:patient planning time.
- Submit the appropriate planning fee code with a claim note record: service provided via Telehealth.

14066 Personal Health Risk Assessment fee:

The required face-to-face visit with the physician and patient to provide a personal health risk assessment can now be provided via telehealth. **Physicians should include a note record when billing 14066 if the visit was provided to the patient via telehealth.**

00114 Long Term Care Facility Visit:

- If the patient **is able to independently use a phone** and the physician feels that the encounter could be appropriately provided by Telehealth (video or telephone), then physicians will bill their face to face Long Term Care facility fee 00114 and **include the claim note record “service provided via Telehealth”**.
- If the patient **cannot independently use a phone** (e.g. due to dementia, hearing loss etc.) or does not have their own phone, the physician may review the patient’s medical status and any problems by telephone with an RN/LPN at the LTC facility, and bill the visit using 00114 and **include the claim note record “Service provided via Telehealth with RN/LPN”**.
- 13334 LTC First visit of the day bonus is not billable with 00114 provided via Telehealth

00127 Palliative Care Patient Facility visit:

- If the patient **is able to independently use a phone** and the physician feels that the encounter could be appropriately provided by Telehealth (video or telephone), then physicians will bill 00127 and **include the claim note record “service provided via Telehealth”**.
- If the patient **cannot independently use a phone** or does not have their own phone, the physician may review the patient’s medical status and any problems by telephone with an RN/LPN where the palliative care is provided, and bill the visit using 00127 and **include the claim note record “Service provided via Telehealth with RN/LPN”**.
- 13338 First visit of the day bonus is not billable with 00127 provided via Telehealth

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TEMPORARILY DELETED FEE ITEMS

The following fee items, headings and wording is temporarily deleted effective May 31, 2020. The cancellation date will be determined by the Provincial Health Officer. These cancelled fee items have been temporarily replaced with new fee items listed above.

- P13036 Telehealth FP in-office Consultation
- P13037 Telehealth FP in-office Visit
- P13038 Telehealth FP in-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes)
- P13016 Telehealth FP out-of-office Consultation
- P13017 Telehealth FP out-of-office
- P13018 Telehealth FP out-of-office Individual counselling for a prolonged visit for counselling (minimum time per visit – 20 minutes)

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FREQUENTLY ASKED QUESTIONS:

- More information and a downloadable billing cheat sheet can be found on the [BC Family Doctors](#) website.
- Details on new SSC fees can be found [here](#) and the FAQ available [here](#).

Q: If a physician is in quarantine (self-isolation), can they provide Telehealth (video or telephone) services?

A: Yes. Using the appropriate Telehealth fee codes per their fee guide.

Q: Can I still provide and bill for consultations via Telehealth (video or telephone) without providing the face-to-face components of the consultations?

A: This is being left to physician discretion. If the physician feels they could have performed the in-person consultation without an examination, then they can bill the Telehealth (video or telephone) consultation without an examination. Physicians should continue to use their professional judgement to determine whether use of virtual technology is clinically appropriate based on the circumstances of each patient.

Q: If I speak to my patient on the phone and determine they need to come in what do I bill?

A: You can bill **either** the telehealth fee codes for the telephone discussion **or** the appropriate in-person fee for the service provided face-to-face. Telehealth (video or telephone) and a face-to-face service are not billable on the same patient/same day by the same physician with the exception of the two new COVID fees T13701 and T13702.

Q: If I speak to my patient on the phone and determine they need to come in what is billed if they are seen by a different physician in our multi-physician clinic than the one they spoke with on the phone?

A: The telehealth fee codes for the telephone discussion are billable by the first physician and the appropriate in-person fee for the service provided face-to-face by the other physician. To avoid claim rejection, please indicate the service times on the claims.

Q: Do the telehealth fee codes apply to visits that are not COVID related?

A: Yes, this fee code and the Telehealth changes are not restricted to COVID related services. However, please be sure to use diagnostic code C19 for COVID related services.

Q: Can I swab my symptomatic or presumptive patients outside my office, such as in their cars in the parking lot?

A: Yes. You can also schedule these patients for the end of day or a separate day to minimize exposure risks.

Q: Are hospital in-patient visits billable via Telehealth in the same way LTC visits can?

A: As long as there is direct patient interaction, then yes this can be billed as the hospital visit with a note that it was performed via telehealth.

Reminder that the patient must be able to use a device on their own to have the conversation and interact with the physician. If assisted by a nurse, it is still billable with notation "Service provided via Telehealth with RN/LPN."

Q: Can Group Medical Visits be provided by Telehealth (video or telephone)?

A: Yes, this would be considered a non-procedural intervention and if they can arrange for the group to be held via Telehealth (video or telephone), then they can claim under

the face-to-face fee and enter “service provided via Telehealth” in the claim note record. Document the consent in the patient’s medical record. CMPA [Consent to use Virtual Care Tools](#) form.

Q: I am an emergency physician. How do we bill follow ups?

A: You can bill a LEVEL I (01811, 01821, 01831, 01841) code if you are doing the follow up from the hospital. If the follow up is done from home you should bill the appropriate [GP Telehealth Visit fee as listed in the table above](#).

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WORKSAFEBC AND ICBC SERVICES

Effective immediately WorksafeBC and ICBC will permit Telehealth (video and telephone) for anything that does not require a physical exam/assessment. Details are below, but if physicians encounter problems they should contact the regular ICBC/WorkSafeBC contacts listed below. If that fails then contact Doctors of BC. These changes will be in effect until an end date can safely be determined.

ICBC will be pausing all Driver’s Medical Examinations. An announcement from the Superintendent of Motor Vehicles is expected today.

From WorkSafeBC:

- The requirement that telehealth fees must involve video technology has been expanded to include telephone. Therefore, if you conduct services via telephone you can bill the appropriate telehealth fee codes in your Fee Guide. This includes services for all patients including COVID-19 patients.
- Consultations, office visits, and non-procedural interventions where there is no telehealth fee may be claimed under the face-to-face fee with a **claim note record and document on the consult report or physician’s report (Form 8/11)** that the service was provided via video technology or telephone are payable by WorkSafeBC.

Physicians should continue to use their professional judgement to determine whether use of virtual technology is clinically appropriate based on the circumstances of each patient.

If you have any questions please contact Health Care Services at HCSINQU@worksafebc.com.

From ICBC:

- Physicians are encouraged to deliver necessary care to ICBC patients by accessing available telehealth (video or telephone) services and billing the telehealth or applicable non-procedural fee code and making a notation in the patient record. Additionally, the Physician Telephone Management Fee code can also be leveraged in appropriate cases, invoiced directly to ICBC as outlined in the ICBC Fee Guide.
- Initial visits for the evaluation of recent injuries sustained by your patients may be scheduled in-clinic on an as-needed basis. Initial and Reassessment visits for the preparation of requested reports should be rescheduled in support of reducing non-essential in-person visits. When in-person visits can be resumed, these visits that require a physician exam to complete a report can be rescheduled.

Physicians should continue to use their professional judgement to determine whether use of telehealth is clinically appropriate based on the circumstances of each patient.

ICBC's Health Care Inquiry Unit is available to support most general and claim-specific questions, by calling 1-888-717-7150. MSP-Teleplan and Doctors of BC are also available to support specific billing questions.

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USEFUL LINKS:

- [Telehealth Fee Codes by Section](#)
- Doctors of BC website: [Coronavirus-Covid-19-updates](#)
- BC Family Doctors website: <https://bcfamilydocs.ca/>
 - [COVID-19 Resources for Doctors](#)
 - [BC Family Docs FAQ](#)
- Details on new SSC fees can be found [here](#) and the FAQ available [here](#).
- BCCDC COVID-19 Care [For Health Professionals](#)
- Information for your patients [For the public](#)
- COVID-19 and CMPA Protection – [What you need to know](#)
- Doctors Technology Office has created a [DTO's virtual care resource list](#) and [Privacy & Security Guide](#).
- Pharmacists can [refill prescriptions](#)
- College of Physicians and Surgeons of BC [COVID-19-updates](#)

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CONTACTS:

- If you have questions about billing, please e-mail economics@doctorsofbc.ca
- PPE Supplies: Physicians are advised to contact their Health Authority
 - Northern Health Contact: Mark De Cross, CFO for Northern Health
Email: ppe.request@northernhealth.ca
 - Fraser Health Contact: Fraser Health PPE Community Support Desk
Phone: 604-561-2037 // Email: PPECommunitysupport@fraserhealth.ca
 - Vancouver Coastal & Providence Health Care
Contact: Fill out form (VCH Community Services Form)
Email completed orders to: VCHCOVID-19CentralSupply@vch.ca
 - Interior Health Contact: Logistics Section Chief for IH EOC
Email: IHEOCLogistics@interiorhealth.ca
 - Island Health No specific contact provided. We recommend physicians contact the Emergency Operations Committee via Medical Affairs by email: MedStaffEngagement@viha.ca
 - PHSA will supply anyone on their medical staff with PPE for their Community Practices. Otherwise physicians should contact the respective Health Authority in which they work.
- Doctors Technology Office: Main Line: 604-638-5841 | 1 800 665 2262
Email: dtinfo@doctorsofbc.ca | [Webpage](#)

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