Family Physician Obstetrical Premiums (PG14004, PG14005, PG14008, PG14009) and Maternity Care Risk Assessment (PH14002)

The fees listed in this guide cannot be appropriately interpreted without the GPSC Preamble.

The following fees are payable to BC's eligible family physicians. The purpose of the payment is to encourage family physicians to continue to provide obstetrical care, giving pregnant patients the benefit of choice and longitudinal care. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

PH14002, PG14004, PG14005, PG14008, and PG14009 are payable only to family physicians who have submitted PG14070 or PG14071 in the same calendar year, or who are registered in a Maternity Network.

Fee Code	Description	Total Fee $
PH14002	**Maternity Care Risk Assessment**	**$50.00**
	This fee is payable to a CLFP who is the patient's MRP, OR a family physician who will be providing the majority of the patient's maternity care and is registered in a Maternity Network. This fee is payment for the increased time, intensity and complexity required to undertake a Maternity Care Risk Assessment with a pregnant patient based on the BC Antenatal Record, including the review of gestationally appropriate screening interventions, pregnancy risks, and patient comorbidities. This fee requires a face-to-face visit. A Maternity Care Risk Assessment includes, but is not limited to the following: • Reviewing history including present pregnancy, medical history, family history, lifestyle/social concerns, and medications/supplements. • Screening for use of alcohol, tobacco, cannabis and other substances. • Informed consent discussion of options for prenatal genetic screening, discussion of results, and follow up testing as appropriate for the patient's age, gestational age and local resources available. **Notes:** i) Payable only to: • MRP family physicians who have successfully submitted and met the requirements for PG14070 in the same calendar year; or • Locum family physicians who are covering for a MRP family physicians 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; or • Family physicians registered in a Maternity Network ii) Payable once per pregnancy per patient except in the case where a patient transfers their total ongoing prenatal care to another physician, the second physician also may charge a Maternity Care	

Fee Code	Description	Total Fee $
	Risk Assessment, as rendered. To facilitate payment, the reason for transfer should be stated with the claim. Temporary substitution of one physician for another physician (e.g. days off, vacation) is not considered a patient transfer. iii) Payable to a maximum of two per patient per pregnancy. iv) Payable in addition to a visit fee (home or office) on the same day if medically required provided the visit does not take place during a time interval that overlaps with the face-to-face planning included under PH14002. v) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.	
PG14004	**Obstetric Delivery Incentive for Family Physicians– associated with vaginal delivery and postnatal care**	**$375.40**
	Notes: *i)* Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully: a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or b. Registered in a Maternity Network on a prior date. *ii)* Payable only when fee item 14104 billed in conjunction *iii)* Maximum of one incentive under fee item G14004, G14008, G14009 per patient delivered. *iv)* Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.	
PG14005	**Obstetric Delivery Incentive for Family Physicians – associated with management of labour and transfer for delivery to a higher level of care facility**	**$156.34**
	Notes: *i)* Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully: a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or b. Registered in a Maternity Network on a prior date. *ii)* Payable only when fee item 14105 billed in conjunction *iii)* Payable in addition to PG14004 or PG14009 when billed and paid to a different FP attending delivery in the receiving hospital. *iv)* Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.	

PG14008	**Obstetric Delivery Incentive for Family Physicians– associated with postnatal care after elective caesarean-section**	**$77.23**
	Notes: *i)* Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully: a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or b. Registered in a Maternity Network on a prior date. *ii)* Payable only when fee item 14108 billed in conjunction *iii)* Maximum of one incentive under fee item G14004, G14008, G14009 per patient delivered. *iv)* Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items.	
PG14009	**Obstetric Delivery Incentive for Family Physicians – associated with attendance at delivery and postnatal care associated with emergency caesarean section**	**$312.70**
	Notes: *i)* Payable to the family physician who provides the maternity care, is responsible for or shares the responsibility for providing the patient's primary medical care, and who has successfully: a. Submitted PG14070, or on behalf of Locum Family Physicians who have successfully submitted code PG14071 on the same or prior date in the same calendar year; or b. Registered in a Maternity Network on a prior date. *ii)* Payable only when fee item 14109 billed in conjunction *iii)* Maximum of one incentive under fee item G14004, G14008, G14009 per patient delivered. *iv)* Maximum of 25 incentives per calendar year per physician under fee item PG14004, PG14005, PG14008, PG14009 or a combination of these items	

Maternity Network Initiative (H14010)

Eligible family physicians can receive a quarterly payment each quarter ending March 31, June 30, September 30, and December 31, to cover the costs of group/network activities for their shared care of obstetric patients (both assigned and unassigned obstetric patients).

To support conferencing with other health care providers and communication with patients, registration in a Maternity Network allows access to FP Conferencing Incentive PG14077 or PH14067 and FP - Patient telephone/advice Incentives PG14076 and PG14078. As part of the GPSC In-patient Initiative, members of Maternity Networks are eligible to bill the Unassigned In-patient Care fee H14088 for unassigned pregnant patients for whom they are the Most Responsible Physician (MRP). Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned.

Note: Claims received for processing before the date of service or with a date of service other than the last day in a quarter will be refused.

Registration in a Maternity Network provides access to the Obstetrical Delivery Incentives for Family Physicians (PG14004, PG14005, PG14008, and PG14009).

<table>
<tr><th>Fee Code</th><th>Description</th><th>Total Fee $</th></tr>
<tr><td>H14010</td><td>Maternity Care Network Initiative Payment</td><td>$2,100.00 per quarter</td></tr>
<tr><td></td><td>Eligibility:
• To be eligible to be a member of the network, you must, for the three-month period up to the payment date:
• Be a family physician in active practice in BC;
• Have hospital privileges to provide obstetrical care;
• Be associated and registered with a minimum of three other network members (special consideration will be given in those hospital communities with fewer than four doctors providing maternity care). Refer to the Maternity Network Registration Form found on the GPSC website at gpscbc.ca;
• Cooperate with other members of the network so that one member is always available for deliveries;
• Make patients aware of the members of the network and the support specialists available for complicated cases;
• Accept a reasonable number of referrals of pregnant patients from doctors who do not have hospital privileges to deliver babies (preferred first visit to the doctor planning to deliver the baby is no later than 12 weeks of pregnancy; the referring doctor may, with the agreement of the delivering doctor, provide a portion of the prenatal care);
• Share prenatal records (real or virtual) with other members of the network as practical, with the expectation to work toward utilizing an electronic prenatal record;
• Each doctor must schedule at least four deliveries in each six month period of time (April to September, October to March); and
• The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day).

<u>Billing Information for Maternity Care Network Initiative Payment:</u>

<table><tr><td>PHN:
Patient Last name:
Patient First name/initial:
Date of Birth:
Diagnostic code:
For Date of service use:
Billing Schedule:</td><td>982 487 0522
Maternity
G
November 2, 1989
V26
Last day in a calendar quarter
Last day of the month, per calendar quarter</td></tr></table></td><td></td></tr>
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Maternity Network and its relationship to the In-patient Care Initiative

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

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

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

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

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

FAQs: FP Obstetric Delivery Incentives (PG14004, PG14005, PG14008, PG14009)

1. Who is eligible to bill the FP Obstetric Delivery Incentives?
PG14004, PG14005, PG14008, and PG14009 are payable only to Family Physicians who have submitted PG14070 or PG14071 in the same calendar year, **OR** who are registered in a Maternity Network.

2. Is there a limit on the number of delivery incentives I can bill in each calendar year?
You may bill a maximum 25 incentives in each calendar year. The 25 total is the total of any combination of PG14004, PG14005, PG14008 and PG14009. If you do more than one delivery on a calendar day, then you may bill an incentive for each delivery, provided the annual maximum of 25 is not exceeded.

3. How do I bill the FP Obstetric Delivery Incentives?
- Submit PG14004 in addition to billing 14104
- Submit PG14005 in addition to billing 14105
- Submit PG14008 in addition to billing 14108
- Submit PG14009 in addition to billing 14109

4. I usually do more than 25 deliveries in a year. Must I bill the incentives for the first 25 of them?
No, you are free to decide which deliveries you want to bill the incentive payments for, provided the combined total of all incentive billings does not exceed 25 in a calendar year.

5. Is the H14088 Unassigned Inpatient Care fee billable for Unassigned pregnant patients seen in Labour and Delivery?
Yes, members of a maternity network who admit under their MRP care a maternity patient who does not have an obstetric provider (OB, FP, Midwife) at their hospital can bill the H14088 Unassigned In-patient Care fee. The fee is billable in addition to any delivery fee (PG14104, PG14109 as long as FP is MRP) or admission fee (13109). H14088 is only billable if the patient is admitted to hospital.

6. Are locums able to bill the FP obstetric delivery incentives?
Yes. Locums who have submitted PG14071 or are registered in a maternity network have their own limit of 25 delivery incentives per calendar year.

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

8. Can I still bill the obstetric delivery incentive if I have to refer to another doctor because of complications?
Yes, if you provide care and bill fee items PG14104 or PG14109 you may bill for the obstetrical incentive even if you have referred the patient due to complications (e.g. Referral for forceps rotation, emergency C-section, or other additional procedure).

9. When is obstetric delivery incentive PG14005 billable?
If you attended the labouring patient with the expectation of doing the delivery, but complications meant the patient had to be transferred to another facility for a higher level of care (i.e. from facility without C/S capability to facility with C/S capability) submit a claim for fee item 14105 and the obstetrical incentive PG14005 (provided you have not reached your annual maximum of 25 delivery incentives.

10. Are FPs remunerated under Alternate Payment/funding models which include provision of intrapartum care eligible to receive the obstetric delivery incentive payments?
Yes. When claiming for any of the obstetric delivery incentives submit an encounter record for the delivery along with a fee for service claim for the applicable obstetrical delivery incentive.

11. Are Emergency Room physicians eligible for this payment?
No. Emergency Room physicians who happen to be on duty and deliver a baby may not bill the delivery incentives.

12. As a maternity care provider, which CLFP Portal fees am I eligible to bill?
FPs who have submitted PG14070 may bill all of the CLFP Portal codes. FPs who are registered in a Maternity Network, but do not have a community practice and therefore are not eligible to submit PG14070 have access to:

- PG14076 FP Patient Telephone Management Fee, for providing telephone "visits" with your maternity patient
- PG14077 FP Conference with Allied Care Provider and/or Physician, for conferencing with other providers about your maternity patient
- PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician. Note that PH14067 should not be billed for conferencing activities that can be billed as 13005 or PG14077.
- PG14078 FP Email/Text/Telephone Medical Advice Relay, for relaying medical advice via text

For detailed information on the fees above, see the Conferencing & Telephone Management Billing Guide.

FAQs: Maternity Care Risk Assessment (PH14002)

1. How do I bill for the initial review of prenatal genetic screening, past obstetric history and risk assessment for current pregnancy?
Effective April 1, 2022, GPSC has implemented a Prenatal (PN) Risk assessment fee (14002). This is billable by FPs who have submitted the CLFP Portal Code (14070), a locum who has submitted 14071 and is working in a CLFP host practice, or who are registered in a Maternity Network. It is billable in addition to a medically necessary visit that is separate from the Maternity Care Risk Assessment service.

If you have had to provide a medically necessary visit for the patient to confirm pregnancy and then go on to reviewing the patient's history including present pregnancy, medical history, family history, lifestyle/social concerns, medications/supplements, screening for use of alcohol, tobacco, cannabis and other substances and discuss the options for PN genetic screening, discussion of results, and follow up testing as appropriate for the patient's age, gestational age and local resources available, you would bill an office visit plus 14002. As these two services must be separate in time, you must note in the chart that the examination/visit was first followed by 14002. However, there is no requirement to include a start or end time for either fee.

If you have provided a telehealth visit to review patient's history including present pregnancy, medical history, family history, lifestyle/social concerns, medications/supplements, screening for use of alcohol, tobacco, cannabis and other substances and discuss the options for PN genetic screening, discussion of results, and follow up testing as appropriate for the patient's age, gestational age and local resources available, you would bill 14002 only, unless there is an unrelated visit needed. If there is a separate medically necessary telehealth visit needed, you would also bill the age appropriate telehealth visit fee.

Subsequent to the Maternity Care Risk Assessment service, having the patient return after the dating Ultrasound or Nuchal Translucency scan for the first PN CPx visit to fill in any additional information and

the CPx portion of the PN form can then be billed using 14090 at that second visit. If all components are done at one visit, then 14002 is billable in addition to the first PN CPx fee 14090.

2. What if I do not do intrapartum obstetrics and subsequently transfer the patient to a different family physician outside my own office for the balance of the prenatal care and delivery?
14002 is payable once per pregnancy per patient except in the case where the ongoing PN care of a patient is transferred to another physician. In this situation, the second physician also may charge a Maternity Care Risk Assessment, as rendered. The transfer of care can occur at any point after the initial FP has provided and billed for the first PN CPx visit. To facilitate payment, the reason for transfer should be stated with the claim note record (e-note). Temporary substitution of one physician for another physician (e.g. days off, vacation) is not be considered as a patient transfer. The accepting FP is also able to bill 14090 first PN CPx with an e-note "transfer CPx at XX weeks" as she/he will need to ensure that any changes in the patient's medical, obstetric or psycho-social state are identified and addressed.

FAQs: Maternity Network (H14010)

1. How do I register as a member of a Maternity Network?
Please complete the Maternity Network Registration Form available on the GPSC website here under the Maternity Care tab. Complete the online PDF and submit the form to gpsc.billing@doctorsofbc.ca. An updated form must be submitted whenever a new FP joins the network, or when an FP leaves the network.

2. How do I claim the quarterly payments H14010?
Submit H14010 after each quarter in which you have been registered in a Maternity Network, as indicated below:

Billing Information for Maternity Care Network Initiative Payment:	
PHN:	982 487 0522
Patient Last name:	Maternity
Patient First name/initial:	G
Date of Birth:	November 2, 1989
Diagnostic code:	V26
For Date of service use:	Last day in a calendar quarter
Billing Schedule:	Last day of the month, per calendar quarter

3. What if I cannot find three other doctors to form a network?
If fewer than four FPs deliver babies at your hospital, or in other extenuating circumstances, request an exemption by submitting a written request along with the maternity network form to gpsc.billing@doctorsofbc.ca. Exemptions may be granted for up to one year at which point if the circumstances have not changed, a subsequent request is required.

4. Does participating in this program mean the network members are on call for obstetrics for the community?
No. This is not an on call program. Although one eligibility criterion requires cooperation within the

network to ensure that one member is always available for deliveries, participating in this program does not require you to be on call for patients of FPs who are not members of your maternity network.

5. Is the payment per doctor or per group?
The quarterly payment is per physician.

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

7. What if a doctor delivers five babies in one month, then none in the next seven months?
The requirement to schedule at least four deliveries in every six-month period is an attempt to ensure the FP is in active obstetrical practice. If this requirement cannot be met, let the GPSC know by emailing gpsc.billing@doctorsofbc.ca, and the Committee will review the situation.

8. When a new FP joins a network, when does he/she become eligible to bill for the network incentive?
The maternity care network is payable for participation in the network activity for the majority of the preceding calendar quarter (50% plus 1 day). This means if a new member joins the network prior to the half-way point in the three month quarter then H14010 can be submitted at the end of that quarter. For example, if the new member joined February 14 or earlier in the January-March quarter then H14010 can be submitted for Date of Service March 31. An amended network registration form must be submitted when the new member joins.

9. Are FPs remunerated under Alternate Payment/Funding models eligible to receive the Maternity Network payments?
Yes.

10. Are locums eligible to bill the maternity network fee?
Yes, locums may register in a Maternity Network and submit H14010 provided they fulfill the 50% plus 1 day time requirement for each eligible quarter. Locums should register with a "home" network, even if they may work in different areas of the province providing obstetric care as part of their locums. Locums should maintain a record of practices worked and qualifying days, as the information will be required for future audits. **Note: Only one physician (either host or locum) may bill the Maternity Network incentive for the same quarter.**

11. Am I eligible to participate in both a Maternity Network and Assigned and Unassigned In-patient Networks?
Yes. However, in order to participate in both a Maternity Network and an In-patient Network, you must be providing in-patient care for both maternity and non-maternity patients.

The Maternity Network quarterly payment goes to FPs providing obstetric services for both assigned and unassigned maternity patients. The Assigned In-patient Network payment is for FPs who provide in-patient care services for their own and colleagues' non-maternity patients (assigned) while the Unassigned In-patient Network payment is for FPs who provide in-patient care services for unassigned non-maternity patients. Maternity patients are not included under either the Assigned or Unassigned In-patient Network when the FP is also participating in a GPSC Maternity Care Network because those pregnant patients are counted as part of the Maternity Care Initiative.

12. As a member of a Maternity Network, which CLFP Portal fees am I eligible to bill?
FPs who have submitted PG14070 may bill all of the CLFP Portal codes. FPs who are registered in a Maternity Network, but do not have a community practice and therefore are not eligible to submit PG14070 have access to:

- PG14076 FP Patient Telephone Management Fee, for providing telephone "visits" with your maternity patient

- PG14077 FP Conference with Allied Care Provider and/or Physician, for conferencing with other providers about your maternity patient
- PH14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician. Note that PH14067 should not be billed for conferencing activities that can be billed as 13005 or PG14077.
- PG14078 FP Email/Text/Telephone Medical Advice Relay, for relaying medical advice via text

For detailed information on the fees above, see the Conferencing & Telephone Management billing guide and the In-patient Care billing guide.

FAQs: Unassigned In-patient Care and Maternity Networks

1. Do maternity in-patients qualify for the PG14088 Unassigned In-patient Care Fee?
Maternity patients admitted to a hospital where they do not have a maternity provider are considered unassigned. Members of a maternity network who admit these patients under their MRP care can bill the H14088 Unassigned In-patient Care fee. The fee is billable in addition to any delivery fee (14104, 14109 as long as FP is MRP) or admission fee (13109).

Maternity patients who have been referred to an FP for prenatal care and delivery are not considered unassigned. Accepting patients referred for prenatal care and delivery is a requirement of the Maternity Care Network Initiative. This is considered a sharing of care with the referring FP, and these patients are therefore not unassigned.

2. Do midwifery maternity patients whose hospital care is transferred to an FP OB qualify for the H14088 Unassigned In-patient Care Fee?
Yes these patients would be considered unassigned. However, midwifery patients who are referred to an FP OB during pregnancy for ongoing care and delivery would not qualify – they would be considered assigned. Similarly, a patient admitted under the MRP care of an OB/Gyn is not eligible for the H14088 even if the FP is involved in the delivery (e.g. assists at C/S) because the FP is not the MRP.
If a midwife and FP practice in a multi-disciplinary care clinic sharing care and the FP does the delivery that patient is also considered assigned.

3. Do newborns qualify as an Unassigned In-patient?
The baby and the mother are considered a dyad: one unit. If the mother is an Unassigned In-patient then the newborn is also considered Unassigned. Together they are considered a unit for one Unassigned In-patient Care Fee. If the mother is assigned, then the newborn is also considered assigned. However, if a unassigned newborn is discharged and later re-admitted as an unassigned in-patient under a Maternity Network FP as MRP (e.g. jaundice requiring phototherapy) then H14088 is billable for that second admission. If a pediatrician is the MRP, then the H14088 is not billable.

4. If an FP shares the MRP role with a specialist for an unassigned maternity patient, can the FP bill the H14088 Unassigned In-patient Care Fee?
In the unusual circumstance that an unassigned maternity patient is admitted under the MRP care of a specialist, but concurrent care is provided by an FP for a significant medical issue that is not within the scope of practice of the specialist, and is unrelated to the purpose of admission, the FP may bill the H14088.

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

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

5. Are patients who are admitted as an "out-patient" eligible?
Patients who are admitted as "out-patients" are not eligible for the H14088. Out-patient admission is intended for a specific purpose such as an assessment (e.g. Emergency Room visit or Labour and Delivery Room evaluation), after which the patient is discharged.

6. Can I bill H14088 for out of province unassigned maternity in-patients?
Yes, reciprocal billing applies to patients from all provinces except Quebec.