General Practice Services Committee

Palliative Care Planning Fee (PG14063)

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

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 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 a face-to-face 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.

PG14063 is payable only to Family Physicians who have submitted PG14070 or PG14071 in the same calendar year.

This fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the patient.

Patient Eligibility:

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

Fee Code	Description	Total Fee $
PG14063	**FP Palliative Care Planning Fee**	**$100.62**
	Notes: *i)* Payable only to Family Physicians who have successfully submitted and met the requirements for PG14070. Alternatively, if a locum and host Community Longitudinal FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 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 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 face to face planning included under PG14063. *vi)* Minimum required total planning time 30 minutes. The majority of the planning time must be spent face-to-face 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 planning time (minimum 16 minutes). *viii)* PG14077 or PH14067 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14063. *ix)* Not payable if PG14033 or PG14075 has been paid within 6 months. *x)* Not payable on same day as PG14043, PG14076 or PG14078. *xi)* PG14050, PG14051, PG14052, PG14053, PG14250, PG14251, PG14252, PG14253, PG14033, PG14066, PG14075 not payable once Palliative Care Planning fee is billed and paid. *xii)* The GPSC Mental Health Initiative Fees (PG14043, PG14044, PG14045, PG14046, PG14047, PG14048) are still payable once PG14063 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.	

FAQs: Palliative Care Planning Fee

1. What is the purpose of the Palliative Care Planning Fee?
Family Physicians provide care to patients and their families across the full spectrum of life. The Palliative Care Planning fee incentivizes family physicians to take the time needed to create a Care Plan to ensure the best possible quality of life for palliative patients who are in the last six months of life expectancy.

2. What is an "assisted living" facility?
Assisted Living is defined in the GPSC Preamble using the Ministry of Health definition.

3. Why is this fee limited to patients living in their homes or in assisted living?
Patients residing in a long term care facility or hospital have a resident team of health care providers available to share in the organization and provision of care and therefore GPSC Planning and Management Fees are not billable. Patients residing in their homes or in assisted living usually do not have such a team, making the planning and provision of care more complex and time consuming for the FP.

4. When can I bill the Palliative Care Planning Fee (PG14063)?
After submitting the appropriate Portal code on a prior date within that same calendar year, the FP may bill PG14063:

- when a patient is deemed palliative with a life expectancy of 6 months or less (the patient must be eligible for the BC Palliative Benefits program, although application for the program is not required) and the patient has agreed to a palliative approach to ongoing care
  and
- after the creation of an appropriate care plan as defined in the GPSC Preamble

5. Can more than one physician bill a Palliative Care Planning fee for the same patient?
In general, the PG14063 is billable once only for a palliative patient. However, if the patient moves communities after the initial palliative care planning fee has been billed, it may be billed by the new FP assuming the ongoing palliative care for the patient.

6. What is an Advance Directive?
An Advance Directive provides written consent or refusal to health care by the adult to a health care provider, in advance of a decision being required about that health care:

- Advance Directives must be written, signed by a capable adult and be witnessed by two witnesses or one witness who is a lawyer or notary public in good standing with the Society of Notaries Public. A witness cannot be a person who provides personal care, health care or financial services to the adult for compensation, nor the spouse, child, parent, employee or agent of such a person.

- The Ministry of Health has developed an Advance Directive form for individuals to use when undertaking advance care planning, although the use of this specific form is optional. This form can be found in the My Voice Advance Care Planning Guide located on the Ministry website.

7. What is an Advance Care Plan?
An Advance Care Plan is a written summary of a capable adult's wishes or instructions to guide a substitute decision maker if that person is asked by a physician or other health care provider to make a health care treatment decision on behalf of the adult.

An Advance Care Plan should include the following components that are additional to the GPSC Care Plan core elements described in the GPSC Preamble:

- A statement that the patient is medically palliative based on the physician's medical diagnosis AND the patient's agreement to no longer seek treatment aimed at cure;
- A list of the potential health care needs and the plan for managing these needs. As an example this may include Home and Community Care support services such as home support, home nursing care, personal care, after-hours palliative care, respite and/or hospice care; access to palliative medications, and supplies and equipment through the Provincial Palliative Benefits Program;
- A plan for symptom management, including completing the application form and process to access the Palliative Benefits Program when appropriate;
- A copy of the patient's most current Advance Directive if available; and
- Completion forms to support a planned natural home death when this is the patient's goal (Notification of a Planned Home Death; No CPR form, etc.)

  http://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf

8. How much time is required for billing the Palliative Care Planning Incentive and how should the time be documented?

GPSC planning fees require you to spend at least 30 minutes on the planning process, the majority of it face-to-face between physician and patient (or patient's medical representative.) Therefore, chart documentation of the planning process must include total planning time (minimum 30 minutes) and total physician-patient face-to-face time (minimum 16 minutes).

Total planning time includes the combination of physician-patient face-to-face planning and non-face-to-face planning, including chart review, review of relevant consultation recommendations, medication reconciliation, etc. Non-face-to-face planning activities may be delegated to an appropriate college-certified allied care provider working within the physician's office, and may take place on different days. There is no requirement to document or submit start/end times.

Time spent on any medically necessary visit billed in addition to the planning fee does not count toward planning time. Any conferencing with an allied care provider that results from the Palliative Care Planning visit is billable separately using the most appropriate conferencing fee, PG14077 or PH14067, if all criteria are met. The time spent conferencing does not count toward the Palliative Care Planning time and the time spent planning does not count toward required conferencing time.

E.g. You and/or your ACP spend 15 minutes on non-face-to-face planning work (chart review, medication reconciliation, palliative benefits form etc.) that day or another day. You then spend 25 minutes face-to-face with the patient collaboratively creating a plan for their care. Time Documentation: "Total planning time = 40 min; face to face planning time = 25 min".

9. Why are there billing restrictions excluding physicians "working under an Alternative Payment/Funding model" whose duties would otherwise include provision of this service"?
The current Fee-for-Service payment schedule may encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.

If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

10. Am I eligible to bill for the FP Conference with Allied Care Provider and/or physician fee (PG14077) or FP Brief Clinical Conference with Allied Care Provider and/or Physician (PH14067) in addition to the Palliative Care Planning fee?
Yes. If the physician who provides the Palliative Care plan needs to conference with allied care professionals about the patient then the conferencing is payable in addition to the planning fee, billing the most appropriate conferencing fee and provided the criteria for either PG14077 or PH14067 is met. The time spent conferencing with allied care providers does not count toward the total time billed for the planning fee (and vice versa).

11. Am I eligible to bill for the Chronic Disease Management, Complex Care or Prevention Fee(s) (PG14050, PG14051, PG14052, PG14053, PG14033, PG14075, PG14066) in addition to the Palliative Care Planning fee?
No. These fees are not payable once the Palliative Care Planning fee is billed because the patient has been changed from active management of chronic disease(s) to palliation.

However, not all palliative patients are at the end-of-life. These palliative patients may benefit from ongoing management of complex illnesses beyond six months, in which case providing a planning visit (PG14033 or PG14075) may be appropriate. Once they are at End-of-Life (life expectancy six months or less and eligible for palliative benefits plan – even if not applied for), the PG14063 can be billed after providing a Palliative Planning visit as long as PG14075 or PG14033 have not been billed in the previous six months.

5.0 Case Example

Mr. A. is a 65 patient with metastatic lung cancer. He and his wife visit his FP's office to review the feedback from the local cancer clinic. He has been advised by the oncologist that there is no further active management of his cancer that is aimed at cure available. He understands that he is now palliative and he and his wife want to discuss his options for care and make plans for his management in his home with community support. He is your last appointment of the day and you are able to spend 30 minutes with them reviewing his diagnosis, treatment, community care options. After the appointment your nurse completes all forms needed for a planned natural home death in addition to the Palliative Care Benefits application. In total this Planning visit takes 40 minutes – 30 minutes face-to-face planning and 10 minutes for the non-face-to-face planning completing forms.

The next day you contact the local home hospice program to discuss the plan for Mr. A in the community. You also follow up with the pharmacist to do a medication reconciliation. In total these two calls take 25 minutes.

Over the next 3 weeks, you see Mr A once for counseling and once for a follow up visit in the office, provide three telephone follow up visits, and then determine that home visits are the best course of planned care.

Over the next 2 months, you do four home visits and conference with community care twice for 15 minutes each time. In addition there are five short phone calls from home hospice requesting advice about management, all on separate days.

As Mr A's condition progresses his family need respite, so you arrange for admission to the local hospice. The day after admission you attend a 30 minute care conference to plan his management at the hospice. You see Mr A every second day for the first 2 weeks, then daily for the last 4 days prior to his death, for a total of 11 visits in the hospice. You have no other patients in hospice so Mr. A. is your first and only patient seen each day.

Billings for Mr. A

Service	**Fee Code**	**Value***
Visit #1: Palliative Care Planning Visit	PG14063	$100.62
Conference #1 with Home Hospice ACPs & pharmacist (25 min total)	PG14077 X2	$86.46
Visit #2: Counseling Visit	16120	
Telephone follow up management #1	PG14076	$20.12
Visit #3: Office Visit for follow up	16100	
Telephone follow up management #2	PG14076	$20.12
Telephone follow up management #3	PG14076	$20.12
Planned Home visit #1	00103	
Conference #2 with Home Hospice ACPs	PG14077 X1	$43.23
Call from Home Hospice – advice about patient in community care	13005	
Planned Home visit #2	00103	

Advice about patient in care #2	13005	
Planned Home visit #3	00103	
Conference #3 with allied care providers	PG14077 X 1	$43.23
Advice about patient in care #3	13005	
Advice about patient in care #4	13005	
Planned Home visit #4	00103	
Advice about patient in care #5	13005	
Conference #4 with allied care providers in hospice – 30 min	PG14077 X 2	$86.46
Palliative Visits in hospice** (first or only patient seen – note must submit billing each day separately, do not block bill in order to facilitate processing of first patient of the day incentive)	00127 X 11 + 13338 X 11	

** Only GPSC values included as MSP values are subject to change every April 1.
** Visits to palliative patients in facilities are billable on an ongoing basis for up to 180 days of care once the patient care has been deemed to be palliative. You can bill this day by day, or batch together as provided (e.g. by week, month or course of care).