Maternity Care Risk Assessment (H14002)

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

H14002 is payable only to family physicians who have submitted G14070 or G14071 in the same calendar year, or who are registered in a Maternity Network.

Fee Code	Description	Total Fee $
H14002	**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 G14070 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 G14071 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 Risk Assessment, as rendered. To facilitate payment, the reason for transfer should be stated with the claim. Temporary	

Fee Code	Description	Total Fee $
	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 H14002. v) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service. vi) G14033, G14043, G14063, G14066, G14076 and G14078 not payable on the same day for the same patient.	

Maternity Network Initiative

This fee is billable by physicians on fee-for-service, alternate payment (AP) models, as well as those who bill under the LFP Payment Model for facility-based pregnancy & newborn care.

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).

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.

For fee-for-service and applicable AP physicians:

To support conferencing with other health care providers and communication with patients, registration in a Maternity Network allows access to FP Conferencing Incentive G14077 or PH14067 and FP - Patient telephone/advice Incentives G14076 and G14078. As part of the FPSC Inpatient Care Initiative, members of Maternity Networks are eligible to bill the Unassigned Inpatient 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.

Registration in a Maternity Network provides access to the Obstetrical Delivery Incentives for Family Physicians (G14004, G14005, G14008, and G14009).

For physicians enrolled in the LFP Payment Model who have chosen to bill facility-based pregnancy & newborn care under the LFP Payment Model:

- Submitting a setting registration code for LFP Pregnancy & Newborn Services (98006) indicates that you will only claim for payment in accordance with the LFP Payment Schedule. It also indicates that you will not be claiming under fee-for-service or alternative payment models for services in that setting, except for Excluded Services.
- This means that you cannot bill fee-for-service codes related to pregnancy & newborn care in hospital. This includes communication and conferencing codes (G14077, PH14067, G14078), the Unassigned Inpatient Care fee (H14088), as well as the Obstetrical Delivery Incentives for Family Physicians (G14004, G14005, G14008, and G14009).

<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 FPSC website here;
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:</td><td>982 487 0522</td></tr><tr><td>Patient Last name:</td><td>Maternity</td></tr><tr><td>Patient First name/initial:</td><td>G</td></tr><tr><td>Date of Birth:</td><td>November 2, 1989</td></tr><tr><td>Diagnostic code:</td><td>V26</td></tr><tr><td>For Date of service use:</td><td>Last day in a calendar quarter</td></tr><tr><td>Billing Schedule:</td><td>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 Inpatient Care Initiative

The goals of the FPSC Inpatient Care Initiative are to:

- Retain a critical mass of family physicians delivering inpatient care services;
- Enhance collaboration between family physicians, and between family physicians 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 FPSC Inpatient 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 family physician and have received no prenatal care (unattached in the community);
- Live in the community and are attached to a family physician who does not provide obstetric services but have been under the care of a midwife and so are not assigned to a family physician if admitted as an inpatient for care that is not within the scope of midwifery practice;
- Are visiting from another community where they have an family physician and are receiving prenatal care and intending on delivery there;
- Are transferred from another community and have no family physician at the admitting hospital who can provide care needed. Pregnant patients who are admitted as inpatients under the "Most Responsible Physician" (MRP) care of the family physician 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 Inpatient Care fee.

In most communities, when a person becomes pregnant, her own family physician may provide prenatal and obstetric services or if her family physician does not do obstetrics as part of their practice, the patient will be referred to another provider (family physician, midwife or obstetrician) who does provide obstetrics and essentially "shares care" with the family physician 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: Maternity Care Risk Assessment (14002)

1. How do I bill for the initial review of prenatal genetic screening, past obstetric history and risk assessment for current pregnancy?
FPSC 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 FP 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

1. How do I register as a member of a Maternity Network?
Please complete the Maternity Network Registration Form available on the FPSC website here. Complete the online PDF and submit the form to fp.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 14010?
Submit 14010 after each quarter in which you have been registered in a Maternity Care 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 fp.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 physician 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 physician 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 fp.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 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 14010 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 14010 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 Care Network payments?
Yes.

10. Are locums eligible to bill the Maternity Care Network fee?
Yes, locums may register in a Maternity Network and submit 14010 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 Care Network and Assigned and Unassigned Inpatient Care Networks?
Yes. However, in order to participate in both a Maternity Network and an Inpatient Network, you must be providing inpatient 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 Inpatient Network payment is for FPs who provide inpatient care services for their own and colleagues' non-maternity patients (assigned) while the Unassigned Inpatient Network payment is for FPs who provide inpatient care services for unassigned non-maternity patients. Maternity patients are not included under either the Assigned or Unassigned Inpatient Network when the FP is also participating in a FPSC Maternity Care Network because those pregnant patients are counted as part of the Maternity Care Initiative.

12. As a member of a Maternity Care Network, which CLFP Portal fees am I eligible to bill?
FPs who have submitted 14070 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 14070 have access to:

- 14002 Maternity Care Risk Assessment, for providing the review of gestationally appropriate screening interventions, pregnancy risks, and patient comorbidities
- 14076 FP Patient Telephone Management Fee, for providing telephone "visits" with your maternity patient
- 14077 FP Conference with Allied Care Provider and/or Physician, for conferencing with other providers about your maternity patient
- 14067 FP Brief Clinical Conference with Allied Care Provider and/or Physician. Note that 14067 should not be billed for conferencing activities that can be billed as 13005 or 14077.
- 14078 FP Email/Text/Telephone Medical Advice Relay, for relaying medical advice via text

FAQs: Unassigned Inpatient Care and Maternity Networks

1. Do maternity inpatients qualify for the 14088 Unassigned Inpatient 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 14088 Unassigned Inpatient 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 14088 Unassigned Inpatient 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 14088 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 Inpatient?
The baby and the mother are considered a dyad: one unit. If the mother is an Unassigned Inpatient then the newborn is also considered Unassigned. Together they are considered a unit for one Unassigned Inpatient 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 inpatient under a Maternity Network FP as MRP (e.g. jaundice requiring phototherapy) then 14088 is billable for that second admission. If a pediatrician is the MRP, then the14088 is not billable.

4. If an FP shares the MRP role with a specialist for an unassigned maternity patient, can the FP bill the 14088 Unassigned Inpatient 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 14088.

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 14088. 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 14088 for out of province unassigned maternity inpatients?
Yes, reciprocal billing applies to patients from all provinces except Quebec.