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. These fees are not payable to physicians who have been paid for a Specialist consultation fee in the previous 12 months, with the exception of the emergency medicine consultation fee (01810) billed by physicians with certification in Emergency Medicine (CCFP-EM).

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 remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service. vi) G14033, G14043, G14063, G14066, G14076 and G14078 not payable on the same day for the same patient.	

Maternity Care Network Payment

The FPSC Maternity Care Network Payment supports family physicians providing full-scope maternity care to patients in their community to work together. Eligible FPs who meet the eligibility criteria can receive up to **$8,400 per year**. Payments will be remitted to eligible physicians on a quarterly basis ($2,100 per quarter).

Previously, physicians claimed this network payment every quarter by submitting the MSP fee code 14010. As of April 2025, physicians participating in a Maternity Care Network may claim the payment by submitting an FPSC claim form **once annually**. The payment amount remains the same and will continue to be remitted directly to physicians via their preferred MSP payee number on a quarterly basis.

For more information about the Maternity Care Network Payment, please click here or contact fp.billing@doctorsofbc.ca for more information.

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: Unassigned Inpatient Care and Maternity Networks

1. Do maternity inpatients qualify for the Unassigned Inpatient Care Fee (14088)?
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). FPs remunerated under the LFP Payment Model or an Alternative Payment model are not eligible to bill the 14088 Unassigned Inpatient Care Fee.

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?
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 14088?
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 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 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. FPs remunerated under the LFP Payment Model or an Alternative Payment model are not eligible to bill the 14088 Unassigned Inpatient Care Fee.