General Practice Services Committee

Methodology - Community Longitudinal Family Physician (CLFP) Payment
Frequently Asked Questions

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Last updated on September 1, 2022

BRITISH COLUMBIA

doctors of bc

The following document outlines the methodology for how payment amounts are determined for eligible family physicians who work under fee-for-service only. Payment amounts for eligible family physicians who work under an alternative payment model will vary according to the type and current terms of their contract. The GPSC will calculate and determine the respective amounts based on data received through MSP.

1. How are payment amounts for the CLFP Payment calculated?

For the 2022 CLFP Payment, eligible family physicians will receive a payment amount based on **the number** and **complexity** of Majority Source of Care (MSOC) patients associated with each family physician.

The CLFP Payment uses the MSOC methodology to estimate the number of patients attached to each family physician. MSOC patients are those who, during a 12-month period, received three or more family physician services and more than 50% of those services were provided by one family physician. A patient can be MSOC for only one family physician in a given 12 month period. Services include most office based primary care fees billed, including office visits, telehealth visits, conferencing, and minor office procedures etc. See Appendix A for those fees that are excluded from MSOC calculations.

The CLFP Payment uses the Adjusted Clinical Group (ACG) methodology to estimate the complexity of each MSOC patient by categorizing each patient into complexity categories relevant to general practice. The ACG methodology enables patient complexity to reflect a wide range of diagnoses and health conditions that can be expected to influence health care utilization.

For each eligible family physician, the number of MSOC patients and the complexity of each MSOC patient is combined to create an overall score. This overall score is used to determine the payment amount for each eligible family physician.

Majority Source of Care (MSOC) patients - estimating the number of patients attached to family physician

2. What are Majority Source of Care patients?

The CLFP Payment uses the Majority Source of Care (MSOC) methodology to estimate the number of patients attached to each family physician. MSOC patients are those who, during a 12-month period, had three or more family physician services and more than 50% of those services were provided by one family physician. A patient can be MSOC for only one family physician in a given 12 month period. Services include most office based primary care fees billed, including office visits, telehealth visits, conferencing, and minor office procedures etc. See Appendix A for those fees that are excluded from MSOC calculations. One or more family physician services provided by a single family physician to a single patient on a single day is considered as one patient service for the purposes of the MSOC calculation.

The CLFP Payment is primarily designed to support family physicians who work under fee-for-service and who provide longitudinal care to a panel of patients within community settings such as physician offices or health care clinics. As such, the GPSC uses a modified version of the MSOC methodology to determine eligibility and payment amounts of the CLFP Payment. For the CLFP Payment, only family physician services provided under fee-for-service are considered. In addition, consultative and surgical assistance visits as well as visits provided in

facilities such as hospitals and long term care facilities are not considered. Please see Appendix A for a list of fees/services that are not considered by the CLFP Payment.

3. The number of MSOC patients is fewer than the number of patients on my patient panel. Why?

MSOC patients are only those who, during a 12-month period, had three or more family physician services and more than 50% of those services were provided by one family physician. As a result, there will be patients on physicians' patient panel who will not be considered as MSOC patients for the purpose of calculating the CLFP Payment. A patient can be MSOC for only one family physician.

4. Why does the CLFP Payment currently use the MSOC methodology and not physicians' list of patient panel to calculate CLFP Payments?

Individual family physicians may apply varying definitions to define their patient panel (e.g. active vs inactive patients) that are most appropriate for their practice. To ensure that the CLFP Payment is allocated as equitably as possible across a diverse group of family physicians, the MSOC methodology employs a single definition of patient attachment that is applied equally to all family physicians. The MSOC methodology is used by GPSC to calculate CLFP Payment amounts and is not intended to be a substitute for the methods used by physicians at the practice level to define the size of their patient panels.

5. How does the CLFP Payment consider family physicians who work together in a group practice setting to share the longitudinal care of patients?

Generally, the CLFP Payment is intended to value relational continuity which is defined as "the ongoing, trusting therapeutic relationship between a patient and a primary care physician and their team, **where the patient sees this primary care physician the majority of the time** and results in improved health outcomes, decreased mortality, better quality of care, reduced healthcare costs, increased patient and provider satisfaction, fewer ER visits and hospital admissions."[1] Please see here for suggested approaches for enhancing relational continuity between family physicians (and their teams) and patients.

For family physicians in a shared practice setting, the MSOC methodology allows for patients to be seen by other family physicians as long as the patient saw the designated family physician for the majority (more than 50%) of their visits in 2021. For example, if a patient saw their designated family physician for their planned visits but saw other family physicians for their urgent visits, this patient would be considered MSOC of their designated family physician as long as the planned visits constituted more than 50% of their visits in 2021.

While the MSOC methodology may impact the number of MSOC patients for each individual family physician, a group of physicians sharing the longitudinal care of patients may come to a private arrangement on how their individual CLFP Payments may be shared.

[1] Toward Optimized Practice – Relational Continuity, Clinical Practice Guideline (June 2019). https://actt.albertadoctors.org/CPGs/Lists/CPGDocumentList/Relational-Continuity-CPG.pdf.

6. I bill MSP from more than one MSP Payee Number. Would this impact my number of MSOC patients?

No, the use of multiple of MSP Payee Numbers does not impact the number of MSOC patients for family physicians. Regardless of the number of Payee Numbers used by a family physician, all MSP fees submitted are linked to the individual practitioner who provided the service. The MSOC methodology does not consider Payee Numbers when allocating MSOC patients for family physicians.

7. Can I find out which of my patients are considered to be MSOC patients?

All eligible fee-for-service family physicians receiving the 2022 CLFP Payment will receive a detailed summary (by mail) explaining how their payment was calculated in comparison to other family physicians. While the summary provides physicians with their number of MSOC patients, it does not provide identifiable information for individual patients. Due to privacy reasons, the GPSC is not able to provide physicians with identifiable information about individual patients.

8. Can a patient be considered a MSOC patient for more than one family physician?

While a patient may visit multiple family physicians, MSOC patients are only those who, during a 12-month period, had three or more family physician services and more than 50% of such services were provided by one family physician. A patient can be MSOC for only one family physician in a given 12 month period.

Adjusted Clinical Group (ACG) System - estimating the complexity of each MSOC patient

9. What is the Adjusted Clinical Group (ACG) system?

The ACG system is a population/patient case-mix adjustment system developed by researchers at The Johns Hopkins University in Baltimore, Maryland, U.S.A.

In BC, the ACG system has been used by the Ministry of Health to estimate patient complexity since 2000. In 2000, the ACG system was implemented in the Mini-Profile to enable individual physicians to compare their costs and use of services with their peers. In 2001, the ACG system was implemented to measure patient complexity to administer Population Based Funding.

Under the ACG system, ICD-9 diagnostic codes are mapped to 32 Aggregated Diagnosis Groups (ADGs). Each ADG is a grouping of ICD-9 codes that are similar in terms of severity and likelihood of persistence of the health condition. A patient's ADGs is combined with the patient's age and gender to assign patient to one of 82 ACG categories relevant to general practice. All patients in BC are assigned to an ACG category.

The CLFP Payment uses the Adjusted Clinical Group (ACG) methodology to estimate the complexity of each MSOC patient by categorizing each patient into complexity categories relevant to general practice. The ACG methodology enables patient complexity to reflect a wide range of diagnoses and health conditions that can be expected to influence health care utilization.

10. Once patients are assigned to an ACG category, how does GPSC determine "by how much" a patient in one category is more or less complex from a patient in another category?

For reference, please see Appendix B for a listing of ACG categories relevant to general practice. Each ACG category is given a "complexity score" based on the average annual MSP payments (for family physicians) for patients in each ACG category. For example, for patients in ACG category 1710 (Pregnancy 0-1 ADGs), the average annual MSP payments to family physicians is $400, giving this category a complexity score of 400. For comparison, the ACG category 1900 (Acute minor and likely to recur, age 1) has a complexity score of 200. Therefore, for the purpose of allocating CLFP Payment funding, a patient in ACG category 1710 would be twice as complex as a patient in ACG category 1900.

11. Do my MSP billings impact the ACG assignments of patients?

The ACG assignments of patients are not impacted by the types of fee codes billed by physicians. Instead, ACG assignments are informed by the ICD-9 diagnostic codes that are submitted to MSP when physicians submit their billings.

12. What ICD-9 diagnostic codes are considered by the ACG system?

All ICD-9 diagnostic codes are considered by the ACG system. As best practice, physicians are advised to be as specific as possible when submitting ICD-9 diagnostic codes and to use 4th and 5th digits where possible. In BC, each MSP claim can accommodate up to three ICD-9 diagnostic codes. While MSP only considers the first of the three ICD-9 diagnostic codes for the purpose of claims processing, all ICD-9 diagnostic codes on a MSP claim (up to three) are considered by ACG system to estimate patient complexity.

13. How many ICD-9 diagnostic codes can I submit per MSP claim?

In BC, each MSP claim can accommodate up to three ICD-9 diagnostic codes. While MSP only considers the first of the three ICD-9 diagnostic codes for the purpose of claims processing, all ICD-9 diagnostic codes on a MSP claim (up to three) are considered by ACG system to estimate patient complexity.

14. Do my MSP billings for complex care planning (e.g. 14033, 14075) or chronic disease management (e.g. 14050-53) impact the ACG assignments of patients?

The ACG assignments of patients are not impacted by the types of fee codes billed by physicians. This means that the billing of complex care planning fees and/or chronic disease management fees would not, on their own, influence the ACG assignments of patients. Instead, ACG assignments are informed by the ICD-9 diagnostic codes that are submitted to MSP when physicians submit their MSP claims.

Compared to GPSC fees, such as complex care planning and chronic disease management fees, the ACG system enables the CLFP Payment to value a wider range of diagnoses and health conditions (e.g. pregnancy, mental health etc.) that can be expected to influence health care utilization.

15. Can I find out the ACG assignments for my patients?

ACG assignment information for each patient is confidential and is not available to physicians or to the public.

16. I have more questions about the CLFP Payment, who can I contact?

Please contact gpsc.billing@doctorsofbc.ca if you have further questions about the CLFP Payment.

Appendix A – Fees excluded from MSOC patient calculations

Fee Code	Fee Category	Fee Description
All non-FFS services are excluded (eg. encounter coding, shadow billing etc). Specifically, MSP fee items converted to $0 for encounter reporting from PBF clinics and APP physicians are excluded. Also fee code 96198 (used to report core services for registered patients at Northern Model clinics) is excluded.		
12110	General Practice	Consultation - in office (Age 0 - 1)
00110	General Practice	Consultation - in office (Age 2 - 49)
15310	General Practice	Consultation - in office (Age 50-59)
16110	General Practice	Consultation - in office (Age 60-69)
17110	General Practice	Consultation - in office (Age 70-79)
18110	General Practice	Consultation - in office (Age 80+)
12210	General Practice	Consultation - out of office (Age 0-1)
13210	General Practice	Consultation - out of office (Age 2-49)
15210	General Practice	Consultation - out of office (Age 50-59)
16210	General Practice	Consultation - out of office (Age 60-69)
17210	General Practice	Consultation - out of office (Age 70-79)
18210	General Practice	Consultation - out of office (Age 80+
14018	General Practice - GPSC	General Practice Urgent Telephone Conference with a Specialist Fee: Conferencing on an urgent basis (within 2 hours of request for a telephone conference) with a specialist or GP with specialty training by telephone followed by the creation, documentation, and implementation of a clinical action plan for the care of patients with acute needs; i.e. requiring attention within the next 24 hours and communication of that plan to the patient or patient's representative
14021	General Practice - GPSC	GP with Specialty Training Telephone Advice - initiated by a Specialist, General Practitioner or Allied Care Provider, Response within 2 hours
14022	General Practice - GPSC	GP with Specialty Training Telephone Advice for Patient Management - Initiated by a Specialist, General Practitioner or Allied Care Provider, Response in One Week - per 15 minutes or portion thereof
14023	General Practice - GPSC	GP with Specialty Training Telephone Patient Management/Follow-Up
13016	General Practice	Telehealth GP out-of-office Consultation
13036	General Practice	Telehealth GP in-office Consultation
00108	General Practice	Hospital visit
00109	General Practice	Acute care hospital admission examination
00128	General Practice	Supportive care hospital visit
14250	General Practice – GPSC	Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus)
14251	General Practice – GPSC	Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (heart failure)
14252	General Practice – GPSC	Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (hypertension)
14253	General Practice - GPSC	Incentive for Full Service General Practitioner (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease - COPD)
01811	Emergency medicine	Level I, Day
01821	Emergency medicine	Level I, Evening
01831	Emergency medicine	Level I, Night

Fee Code	Fee Category	Fee Description
01841	Emergency medicine	Level I, Sat Sun Stat Holiday
01812	Emergency medicine	Level II, Day
01822	Emergency medicine	Level II, Evening
01832	Emergency medicine	Level II, Night
01842	Emergency medicine	Level II, Sat Sun Stat Holiday
01813	Emergency medicine	Level III, Day
01823	Emergency medicine	Level III, Evening
01833	Emergency medicine	Level III, Night
01843	Emergency medicine	Level III, Sat Sun Stat Holiday
00193	General Practice	Non-CVT certified surgical assistance at open-heart surgery, per quarter hour or major portion thereof
00195	General Practice	Surgical Assistance - less than $317.00 inclusive
00196	General Practice	Surgical Assistance - $317.01 - $529.00 inclusive
00197	General Practice	Surgical Assistance - Over $529.00
00198	General Practice	Surgical Assistance - Time, after 3 hours of continuous surgical assistance for one patient, each 15 minutes or fraction thereof
13194	General Practice	First Surgical Assist of the Day
01210	Out of Office Premiums	Evening (1800 hours to 2300 hours) - 38.00% of surgical (or assistant) fee - minimum charge - MSP fee $54.93 / Doctors of BC fee $120.00 - maximum charge $378.93 / Doctors of BC fee $831.00
01211	Out of Office Premiums	Night (2300 hours to 0800 hours) - 61.00% of surgical (or assistant) fee - minimum charge - MSP fee $77.14 / Doctors of BC fee $169.00 - maximum charge MSP fee $532.14 / Doctors of BC fee $1164.00
01212	Out of Office Premiums	Out of Office Premiums: Saturday, Sunday or Statutory Holiday (Service rendered between 0800 hours and 2300 hours) - 38.00 % of surgical (or assistant) fee - minimum charge - MSP fee $54.93 / Doctors of BC fee $120.00 -maximum charge MSP fee $378.93 / Doctors of BC fee $831.00
19410	WorkSafeBC	Expedited surgical assist, Out of Office Surcharge, Operative evening (6pm to 11pm) 32.77% of surgical fee
19411	WorkSafeBC	Expedited surgical assist, Out of Office Surcharge, Operative night (11pm to 8am) 52.54% of surgical fee
19412	WorkSafeBC	Expedited surgical assist, Out of Office Surcharge, Operative Sat/sun/Holidays 32.77% of surgical fee
19545	WorkSafeBC	Expedited Surgical Assist - Level 1 (Surgery time up to 1.5 hours)
19546	WorkSafeBC	Expedited Surgical Assist – Level 2 (Surgery time 1.51 to 2.0 hours)
19547	WorkSafeBC	Expedited Surgical Assist – Level 3 (Surgery time 2.01 to 2.5 hours)
19548	WorkSafeBC	Expedited Surgical Assist – Level 4 (Surgery time 2.51 to 3.0 hours)
19549	WorkSafeBC	Expedited Surgical Assist – Level 5 (Surgery time 3.01 to 3.5 hours)
19551	WorkSafeBC	Expedited Surgical Assist – Level 6 (Surgery time 3.51 to 5.99 hours)
19552	WorkSafeBC	Expedited Surgical Assist – Level 7 (Surgery time 6.00 hours plus)
00114	Residential Care	Long term Care Facility Visit – One or multiple patients, per patient
00115	Residential Care	Nursing home visit - one patient, when patient seen between hours of 0800 hrs and 2300 hrs - any day
00127	Residential Care	Palliative Care Patient Facility Visit
13334	Residential Care	Community based GP long term care facility visit - first visit of the day bonus, extra
13008	In-hospital care	Community based GP: hospital visit (active hospital privileges)

Fee Code	Fee Category	Fee Description
13028	In-hospital care	Community based GP: supportive care hospital visit (active hospital privileges)
13109	In-hospital care	Community based GP: Acute care hospital admission examination
13338	In-hospital care	Community based GP, first facility visit of the day bonus, extra (active hospital privileges) (for routine, supportive or palliative care)
00039	Addiction care	Management of Maintenance Opioid Agonist Treatment (OAT) for Opioid Use Disorder

Appendix B – ACG Categories for General Practice

ACG Category Code	ACG Category Description
0100	Acute minor, age 1
0200	Acute minor, age 2-5
0300	Acute minor, age 6+
0400	Acute major
0500	Likely to recur, without allergies
0600	Likely to recur, with allergies
0700	Asthma
0800	Chronic medical, unstable
0900	Chronic medical, stable
1000	Chronic specialty
1100	Ophthalmological/dental
1200	Chronic specialty, unstable
1300	Psychosocial, without psychosocial unstable
1400	Psychosocial, with psychosocial unstable, without psychosocial stable
1500	Psychosocial, with psychosocial unstable, with psychosocial stable
1600	Preventive/administrative
1710	Pregnancy 0-1 ADGs[2]
1720	Pregnancy 2-3 ADGs, no major ADGs
1730	Pregnancy 2-3 ADGs, 1+ major ADGs
1740	Pregnancy 4-5 ADGs, no major ADGs
1750	Pregnancy 4-5 ADGs, 1+ major ADGs
1760	Pregnancy 6+ ADGs, no major ADGs
1770	Pregnancy 6+ ADGs, 1+ major ADGs
1800	Acute minor and acute major
1900	Acute minor and likely to recur, age1
2000	Acute minor and likely to recur, age 2-5
2100	Acute minor and likely to recur, age 6+, without allergy
2200	Acute minor and likely to recur, age 6+, with allergy
2300	Acute minor and chronic medical: stable
2400	Acute minor and eye/dental
2500	Acute minor and psychosocial without psychosocial unstable
2600	2600- Acute minor/psychosocial, w/psychosocial unstable, w/o psychosocial stable
2700	Acute minor and psychosocial with psychosocial unstable& stable
2800	Acute major and likely to recur
2900	Acute minor/acute major/likely to recur, age 1
3000	Acute minor/acute major/likely to recur, age 2-5
3100	Acute minor/acute major/likely to recur, age 6-11
3200	Acute minor/acute major/likely to recur, age 12+, no allergy
3300	Acute minor/acute major/likely to recur, age 12+, allergy
3400	Acute minor/likely to recur/eye & dental

[2] ADGs stands for Aggregated Diagnosis Groups. Each ADG is a grouping of ICD-9 codes that are similar in terms of severity and likelihood of persistence of the health condition. A patient's ADGs are combined with the patient's age and gender to assign patient to one of 82 ACG categories relevant to general practice.

ACG Category Code	ACG Category Description
3500	Acute minor/likely to recur/psychosocial
3600	Acute Minor/Acute Major/Likely to Recur/Chronic Medical: Stable
3700	Acute Minor/Acute Major/Likely to Recur/Psychosocial
3800	2-3 Other ADG Combinations, Age 1 to 17
3900	2-3 Other ADG Combinations, Males Age 18-34
4000	2-3 Other ADG Combinations, Females Age 18-34
4100	2-3 Other ADG Combinations, Age 35+
4210	4-5 Other ADG Combinations, Age 1 to 17, no major ADGs
4220	4-5 Other ADG Combinations, Age 1 to 17, 1+ major ADGs
4310	4-5 Other ADG Combinations, Age 18-44, no major ADGs
4320	4-5 Other ADG Combinations, Age 18-44, 1 major ADG
4330	4-5 Other ADG Combinations, Age 18-44, 2+ major ADGs
4410	4-5 Other ADG Combinations, Age 45+, no major ADGs
4420	4-5 Other ADG Combinations, Age 45+, 1 major ADG
4430	4-5 Other ADG Combinations, Age 45+, 2+ major ADGs
4510	6-9 Other ADG Combinations, Age 1 to 5, no major ADGs
4520	6-9 Other ADG Combinations, Age 1 to 5, 1+ major ADGs
4610	6-9 Other ADG Combinations, Age 6 to 17, no major ADGs
4620	6-9 Other ADG Combinations, Age 6 to 17, 1+ major ADGs
4710	6-9 Other ADG Combinations, Males Age 18-34, no major ADGs
4720	6-9 Other ADG Combinations, Males Age 18-34, 1 major ADG
4730	6-9 Other ADG Combinations, Males Age 18-34, 2+ major ADGs
4810	6-9 Other ADG Combinations, Females Age 18-34, no major ADGs
4820	6-9 Other ADG Combinations, Females Age 18-34, 1 major ADG
4830	6-9 Other ADG Combinations, Females Age 18-34, 2+ major ADGs
4910	6-9 Other ADG Combinations, Age 35+, 0-1 major ADGs
4920	6-9 Other ADG Combinations, Age 35+, 2 major ADGs
4930	6-9 Other ADG Combinations, Age 35+, 3 major ADGs
4940	6-9 Other ADG Combinations, Age 35+, 4+ major ADGs
5010	10+ Other ADG Combinations, Age 1 to 17, no major ADGs
5020	10+ Other ADG Combinations, Age 1 to 17, 1 major ADG
5030	10+ Other ADG Combinations, Age 1 to 17, 2+ major ADGs
5040	10+ Other ADG Combinations, Age 18+, 0-1 major ADGs
5050	10+ Other ADG Combinations, Age 18+, 2 major ADGs
5060	10+ Other ADG Combinations, Age 18+, 3 major ADGs
5070	10+ Other ADG Combinations, Age 18+, 4+ major ADGs
N/A	No Diagnosis or Only Unclassified Diagnosis (2 input files)
5200	Non-Users
5310	Infants: 0-5 ADGs, no major ADGs
5320	Infants: 0-5 ADGs, 1+ major ADGs
5330	Infants: 6+ ADGs, no major ADGs
5340	Infants: 6+ ADGs, 1+ major ADGs