General Practice Services Committee

3. Complex Care Planning and Management Fees (PG14033, PG14075)

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

There are two Complex Care Planning and Management Incentives: PG14033 and PG14075.

Effective April 1, 2020, both PG14033 and PG14075 are available only to MRP Family Physicians who have submitted PG14070 or PG14071. PG14033 and PG14075 are payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing calendar year.

Only one Complex Care Planning and Management Incentive may be billed for an individual patient in any given calendar year, even if the patient meets eligibility requirements for both PG14033 and PG14075. When patients meet eligibility requirements for both Complex Care Incentives, choose either PG14033 or PG14075—whichever best reflects the cause of their medical complexity.

To be eligible for either of the Complex Care Planning and Management Fees, the effects of the patient's condition(s) should be significant enough to warrant the development of a management plan. In other words, eligibility is not based solely on the individual diagnoses. Consideration should be given to the overall clinical impact of the diagnoses on the patient.

Fee Code	Description	Total Fee $
PG14033	**Complex Care Planning & Management Fee- 2 Diagnoses**	**$315.00**
	The Complex Care Planning and Management Fee is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for patients with two eligible conditions. It is payable upon the completion and documentation of a care plan in the patient's chart. **Patient Eligibility:** • Eligible patients must be living at home or in assisted living. • Patients in Acute and Long Term Care Facilities are not eligible. **PG14033 Complex Care Planning & Management Fee- 2 Diagnoses** The Complex Care Planning and Management Fee-2 Diagnoses was developed to compensate FPs for the management of complex patients living in their home or assisted living, who have documented confirmed diagnoses of 2 eligible conditions from at least 2 of the 8 categories listed below. <u>Eligible Complex Care Condition Categories:</u> 1) Diabetes mellitus (type 1 and 2) 2) Chronic Kidney Disease 3) Heart failure 4) Chronic respiratory Condition (asthma, emphysema, chronic bronchitis, bronchiectasis, Pulmonary Fibrosis, Fibrosing Alveolitis, Cystic Fibrosis etc.) 5) Cerebrovascular disease, excluding acute transient cerebrovascular conditions (e.g.: TIA, Migraine)	

6) Ischemic heart disease, excluding the acute phase of myocardial infarct
7) Chronic Neurodegenerative Diseases (Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia, etc.)
8) Chronic Liver Disease with evidence of hepatic dysfunction.

If a patient has more than 2 of the eligible conditions, the submitted diagnostic code from Table 1 should represent the two conditions creating the most complexity.

Notes:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host MRP 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) Payable only for patients with documentation of a confirmed diagnosis of two eligible conditions as listed in Table 1.

iii) Payable once per calendar year per patient on the date of the complex care planning visit.

iv) 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 physician face-to-face planning included under PG14033.

v) 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").

vi) 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).

vii) PG14018 or PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to time requirement for PG14033.

viii) PG14050, PG14051, PG14052, PG14053 payable on same day for same patient, if all other criteria met.

ix) Not payable once PG14063 has been billed and paid.

x) PG14043, PG14063, PG14076 and PG14078 not payable on the same day for the same patient.

xi) Maximum daily total of 5 of any combination of PG14033 and PG14075 per physician.

xii) PG14075 is not payable in the same calendar year for same patient as PG14033.

xiii) Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible.

xiv) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Diagnostic codes submitted with PG14033 billing must be from Table 1. If the patient has multiple comorbidities, the submitted diagnostic code should represent the two conditions creating the most complexity of care.

Table 1: Complex Care Diagnostic codes (PG14033)

Diagnostic Code	Condition One	Condition Two
N519	Chronic Neurodegenerative Disorder	Chronic Respiratory Condition
N414	Chronic Neurodegenerative Disorder	Ischemic Heart Disease
N428	Chronic Neurodegenerative Disorder	Heart Failure
N250	Chronic Neurodegenerative Disorder	Diabetes
N430	Chronic Neurodegenerative Disorder	Cerebrovascular Disease
N585	Chronic Neurodegenerative Disorder	Chronic Kidney Disease
N573	Chronic Neurodegenerative Disorder	Chronic Liver Disease (Hepatic Dysfunction)
R414	Chronic Respiratory Condition	Ischemic Heart Disease
R428	Chronic Respiratory Condition	Heart Failure
R250	Chronic Respiratory Condition	Diabetes
R430	Chronic Respiratory Condition	Cerebrovascular Disease
R585	Chronic Respiratory Condition	Chronic Kidney Disease
R573	Chronic Respiratory Condition	Chronic Liver Disease (Hepatic Dysfunction)
I428	Ischemic Heart Disease	Heart Failure
I250	Ischemic Heart Disease	Diabetes
I430	Ischemic Heart Disease	Cerebrovascular Disease
I585	Ischemic Heart Disease	Chronic Kidney Disease
I573	Ischemic Heart Disease	Chronic Liver Disease (Hepatic Dysfunction)
H250	Heart Failure	Diabetes
H430	Heart Failure	Cerebrovascular Disease
H585	Heart Failure	Chronic Kidney Disease
H573	Heart Failure	Chronic Liver Disease (Hepatic Dysfunction)
D430	Diabetes	Cerebrovascular Disease
D585	Diabetes	Chronic Kidney Disease
D573	Diabetes	Chronic Liver Disease (Hepatic Dysfunction)
C585	Cerebrovascular Disease	Chronic Kidney Disease

C573	Cerebrovascular Disease	Chronic Liver Disease (Hepatic Dysfunction)	
K573	Chronic Kidney Disease	Chronic Liver Disease (Hepatic Dysfunction)	

Fee Code	Description	Total Fee $
PG14075	**Complex Care Planning and Management Fee-Frailty**	**$315.00**

The Complex Care Planning and Management Fee- Frailty is payment for the creation of a care plan (as defined in the GPSC Preamble) and advance payment for the complex work of caring for eligible patients of any age with documented frailty from any cause. Frailty is defined as requiring assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily living (IADL & NIADL). The effect of the frailty on the patient must be significant enough to warrant the development of a management plan.

Patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL) are eligible for PG14075.

Instrumental Activities of Daily Living (IADL) = Activities that are required to live in the community	**Non-Instrumental Activities of Daily Living (NIADL)= Activities that are related to personal care**
Meal preparation	Mobility in bed
Ordinary housework	Transfers
Managing finances	Locomotion inside and outside the home
Managing medications	Dressing upper and lower body
Phone use	Eating
Shopping	Toilet use
Transportation	Personal hygiene
	Bathing

Patient Eligibility:

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

Notes:

i) Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host MRP 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) Payable only for patients who require assistance with at least one ADL from each of the instrumental and non-instrumental activities of daily

	living, the effects of which are significant enough to warrant the development of a management plan. *iii)* Claim must include the diagnostic code V15. *iv)* Payable once per calendar year per patient on the date of the complex care planning visit. *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 physician face to face planning included under PG14075. *vi)* Minimum required total planning time 30 minutes. The majority of the planning time must be face- to- face between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other 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, be on different dates 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)* PG14018 or PG14077 payable on the same day for the same patient. Time spent on conferencing does not apply to time requirement for PG14075. *ix)* Maximum daily total 5 of any combination of PG14033 and PG14075 per physician. *x)* PG14075 not payable once PG14063 has been billed *xi)* PG14033 is not payable in the same calendar year for same patient as PG14075. *xii)* PG14043, PG14063, PG14076, PG14078 not payable on the same day for the same patient. *xiii)* Eligible patients must be living at home or in assisted living. Patients in Acute or Long Term Care facilities are not eligible. *xiv)* Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.	

How to Bill Complex Care Incentives

To bill the Complex Care incentives, the FP must:

- Have submitted the appropriate Portal code within the same calendar year;
- Have a face-to-face visit with the eligible patient, and/or the patient's medical representative if appropriate;
- Review the patient's history/chart and create a Care Plan including the elements itemized above, which is billable only on the day of a face-to-face planning visit;
- Over the rest of the calendar year, conduct a review of the Complex Care Plan and provide other follow ups as clinically indicated. Follow-up may be face-to-face or by telephone/e-mail as appropriate, with the appropriate fee being payable.

More details on these steps are provided below.

Step 1. Submit Portal code

Effective April 1, 2020, the condition-based chronic disease management fees are only payable to the FP who has submitted PG14070 Portal (or PG14071 for locums) on a prior date.

Submission of the PG14070 Portal signifies that:

- You are providing full-service family practice services to your patients, and will continue to do so for the duration of that calendar year.
- You are confirming your doctor-patient relationship with your existing patients through a standardized conversation or 'compact'.

Submission of PG14071 signifies that you are a locum tenens providing coverage to an MRP family physician who has submitted PG14070.

Step 2. Create a Care Plan

The Complex Care Planning and Management Fees acknowledge that eligible patients require medical management that is more time intense and complex. This fee compensates the FP for the creation of a care plan (including Advance Care Planning when appropriate) jointly with the patient as described above, and for the additional complexity of managing these patients over the balance of the calendar year.

The initial service shall be the development of a Care Plan for a patient residing in their home or assisted living (excluding care facilities) with the eligible condition(s). PG14033 requires two or more chronic conditions from two different eligible categories, while PG14075 is for patients with who require assistance in at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL). The creation of a care plan requires fulfillment of the itemized elements of service and documentation of these as specified in the fee item above. The patient & or their representative or family should leave the planning process knowing there is a plan for their care and what that plan is.

The diagnostic code for the FP Complex Care Planning and Management Fee (PG14033) must be one of the codes from Table 1 below. If the patient has multiple co-morbidities, the submitted diagnostic code should reflect the two conditions creating the most complexity of care;

The diagnostic code for the FP Frailty Complex Care Fee (PG14075) must be V15 regardless of the age of the patient.

Step 3. Provide Follow-up Visits

Visits for the rest of the year are billable under the appropriate MSP fee and with the ICD-9 code of the presenting complaint. Table 1 Complex Care Dual Diagnostic codes should not be used for follow-up services; Table 1 codes were created for billing only the Complex Care Management Fee (PG14033).

Follow-up care may also be provided by telephone, billable by using the PG14076 FP-Patient Telephone Management fee. Additionally, FPs can also have access to PG14078 FP Email/Text/Telephone Medical Advice Relay fee to be billed for medical advice from the physician to eligible patients, or the patient's medical representative, that is relayed via email/text or telephone. The task of relaying the physician advice may be delegated to any Allied Care Provider or MOA working within the physician practice.

Neither PG14076 and PG14078 are payable for prescription renewals, anti-coagulation therapy by telephone (00043) or notification of appointments or referrals. See GPSC Conferencing and Telephone Advice Billing Guide for more details.

Step 4. Using the Diagnostic Code(s) as appropriate to the patient's eligible condition(s)

Many software programs in use in B.C. do not allow capture of more than one diagnostic code per billing. Diagnostic codes have therefore been developed to cover all combinations of any two of the chronic condition categories covered under the PG14033 complex care fee. These codes are listed below, and should be used only when submitting the FP Complex Care Planning and Management Fee (PG14033). All follow-up fees should use 'real' ICD-9 codes. When a patient has co-morbidities from more than two categories, the submitted diagnostic code should reflect the two conditions creating the most complexity of care.

The diagnostic code for the FP Frailty Complex Care Fee (PG14075) must be V15 regardless of the age of the patient or the underlying cause of the frailty. See the fee notes for the PG14033 Diagnostic Codes.

FAQs: General Questions on Complex Care codes

1. What is the purpose of the Complex Care Planning and Management Fees?

The Complex Care Planning and Management Fees were created to recognize care of patients with co-morbid conditions or patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL). It takes more time and effort to provide quality care to these complex patients, and these planning fees help reduce the financial disincentive to providing this care, as opposed to seeing more patients with simpler clinical conditions.

2. What is a Care Plan?

The care plan should be reviewed and revised as clinically indicated.
A care plan requires documentation of the following core elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that the Care Planning Incentive code is billed.
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers that would be involved in the care, their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. The patient & or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.

3. How much time is required for billing the Complex Care Planning and Management Incentives and how should the time spent be documented?
Both Complex Care fees require you to spend at least 30 minutes on the planning process, the majority of it face to face between physician and patient. 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. 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 complex care planning visit is billable separately using 14077 if all criteria are met. The time spent conferencing does not count toward the Complex Care Planning time and the time spent planning does not count toward required conferencing time.

E.g. 18 minutes spent face-to-face with the patient collaboratively creating a plan for their care and 20 minutes doing a physical exam. You and/or your ACP spend 15 minutes on non-face-to-face planning work (chart and current plan review, medication reconciliation, etc.) that day or another day. Documentation: "Total planning time = 33 min; face to face planning time = 18 min".

4. Why is this incentive limited to patients living in their homes or 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 Complex Care 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 organization and supervision of care more complex and time consuming for the FP.

5. What is an "assisted living" facility?
Assisted Living is defined in the GPSC Preamble using the MOH definition
https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living

6. Why are there restrictions excluding physicians "working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service"?
A Fee-for-Service payment model may encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. These complex care fees have been designed to offset this disincentive. If a physician is compensated for providing these time consuming services through terms of employment, or through payment models which compensate for time spent, their time is considered to be already compensated.

7. What is the difference between the PG14075 FP Frailty Complex Care Planning and Management Fee and the PG14033 FP Complex Care Management Fee?
The PG14033 applies to patients with two eligible co-morbidities (see Eligible Condition Table). The PG14075 applies to patients of any age who require assistance with at least one ADL from each of instrumental and non-instrumental activities of daily living (IADL & NIADL). Regardless of diagnoses or frailty, an individual patient is eligible for only one complex care planning and management fee (14033 or 14075.)

8. How do I bill if the patient has more than two of the eligible conditions for the FP Complex Care Planning and Management Fee PG14033 or also qualifies for the FP Frailty Complex Care Planning and Management Fee PG14075?
For patients who qualify under either of the complex care fees, choose the one that most reflects the cause of complexity. All subsequent visits/services should use the ICD-9 code for the condition requiring the visit/service.

9. How do the complex care planning and management incentives impact the Palliative Planning fee PG14063?
Not all palliative patients are at the End-of-Life. These palliative patients may require ongoing management of complex illnesses beyond 6 months, in which case providing a planning visit (14033 or 14075) may be appropriate. Once they are at End-of-Life (life expectancy 6 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 6 months. If a patient is determined to be in the last 6 months of life and a Palliative Planning visit PG14063 is provided and billed, the complex care fees PG14075 & PG14033 as well as the CDM fees PG14050, PG14051, PG14052 & PG14053 are no longer billable.

10. Can I bill the FP Allied Care Provider Conferencing Fee (PG14077) on the same day as 14033 or 14075?

If the physician conferences with an ACP or physician about the care plan and any changes made to it, 14077 is billable provided that the all criteria for the Conferencing fee are met. The time spent conferencing does not count toward the total time billed for the complex care fees (and vice versa.)

11. What is the difference between the FP Patient Telephone Management Fee (PG14076) and the FP Allied Care Provider Conferencing Fee (PG14077)?

14076 pays for clinical phone calls provided to the patient or the patient's medical representative and may be delegated to a College Certified ACP employed by the physician practice.
14077 pays for physician time spent conferencing with ACPs or other physicians about a patient, and may not be delegated.

12. Can I bill the Chronic Disease Management Fee(s) (PG14050/ PG14051/ PG14052/ PG14053) in addition to the Complex Care Planning and Management fees (14033 or 14075) for eligible patients?

Yes, they are payable on the same patient as long as the criteria for the fees are met.

13. Can locums bill the Complex Care planning fees?

There should be a discussion between the host MRP FP and the locum prior to the start of any locum about provision of and billing for services payable under GPSC initiated fees. Many of the GPSC initiated fees are for services or care beyond the individual visit. Both Complex Care Planning and Management fees include payment for the planning visit and pre-payment for the time, intensity and complexity of providing care in the coming year. Since the host FP will be responsible for the follow-up management of the care remunerated through the fees, there must be agreement that it would be appropriate for the planning visit to be provided by the locum. There are also considerations for how the billing of the fees will be treated in the locum agreement for calculation of fee splitting/payment.

14. I am planning to leave practice/retire – can I still bill the Complex Care incentives PG14033 and PG14075?

Because both PG14033 & PG14075 include payment for the planning visit and prepayment for the time, intensity and complexity of caring for eligible patients over the rest of the calendar year, you should only bill them if you will be providing care to that patient for the majority of the ensuing calendar year.

FAQs: Clinical/Diagnostic questions

1. What level of complexity is required for a patient to be eligible for the Complex Care Planning and Management incentives?

The Complex Care Planning and Management Incentives are intended to compensate for the "time, intensity and complexity" of creating a plan of care and managing patients with multiple co-morbidities or frailty over the year following the Complex Care Planning visit.

Having a specific diagnosis does not necessarily make a patient complex. FPs should use their clinical judgement and review the impact of the patient's medical conditions on their daily life. The impact should be of sufficient severity and complexity to cause interference in the patient's daily life, require ongoing medical management to prevent further complications and to improve overall quality of life, and warrant the development of a management plan.

2. If , as a result of medical management of a patient's medical condition, measurable testing (e.g. eGFR, HgBA1C, PFTs, echocardiogram, etc.) improves, does the patient still qualify for complex care PG14033?

Eligibility is not simply about the medical diagnosis, but the clinical impact of that diagnosis on the patient. If lab values or diagnostic testing/ imaging used to diagnose or follow a patient's medical conditions improve with management, the underlying condition persists. These patients continue to be eligible for a complex care planning visit. Medical conditions that improve because they are transient or self-limited do not qualify as chronic and complex, and so are not eligible for PG14033 or PG14075.

3. What are instrumental and non-instrumental activities of daily living (IADL & NIADL)?

See fee notes for activities.

4. Is Sleep Apnea a chronic respiratory condition ?

Sleep Apnea is considered a sleep disorder and as such it is not a diagnosis eligible under chronic respiratory condition.

5. What is the level of abnormal laboratory testing that identifies a patient as having "hepatic dysfunction"?

For the Complex Care Fee, Chronic Liver Disease with hepatic dysfunction will be defined as:

1) 'Chronic' refers to liver disease/dysfunction present for a period of at least six months;
2) 'Chronic Liver Disease with Hepatic Dysfunction' is defined as hepatic disease with evidence of liver dysfunction.
3) Conditions that are not eligible include:
   a) Self-limiting conditions (e.g. Acute Hepatitis A or B, mononucleosis, CMV, etc.);
   b) Hepatitis carrier states with normal liver function tests;
   c) Benign conditions with elevation of liver function tests (e.g. Gilbert's Syndrome, isolated elevation of a liver enzyme without other evidence of hepatic dysfunction)

Read the BC Guideline on Abnormal Liver Chemistry – Evaluation and Interpretation
http://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/abnormal-liver-chemistry

6. What is required to confirm a diagnosis of Chronic Kidney Disease?

The presence of CKD should be established based on presence of kidney damage and/or level of kidney function (estimated glomerular filtration rate [eGFR]), irrespective of diagnosis. All individuals with

eGFR <60 for 3 months are classified as having chronic kidney disease, irrespective of the presence or absence of kidney damage.

All individuals with kidney damage (defined as structural or functional abnormalities of the kidney based on abnormalities in the blood or urine [ACR at least 3.0 mg/mmol] or abnormalities in imaging tests) are classified as having chronic kidney disease, irrespective of the level of eGFR.

If the initial diagnosis of CKD was confirmed through more than an abnormal eGFR, then while lab work may improve with good management, the underlying medical problem persists. Read the BC Guideline on Chronic Kidney Disease: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/chronic-kidney-disease#scope

7. What is included under Neurodegenerative Disease as an eligible condition for PG14033?
Neurodegenerative Disease is an umbrella term for conditions which result from loss of structure or function of neurons, including death of neurons. Examples of Chronic Neurodegenerative conditions include Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, brain injury with a permanent neurological deficit, paraplegia or quadriplegia etc.

8. Are Epilepsy or seizure disorder Chronic Neurodegenerative Diseases?
Epilepsy/seizure disorder in and of itself is not a condition with an ongoing progressive loss of structure or function of neurons. Seizures may be a symptom of an underlying chronic neurodegenerative disorder that may qualify, but as a stand-alone diagnosis, Epilepsy/Seizure Disorder does not qualify.

9. Are patients with Down Syndrome eligible for either of the Complex Care planning fees?
Down Syndrome is a result of a chromosomal abnormality, and is not a diagnosis eligible for the PG14033. However, depending on the level of disability experienced by the patient, they may qualify for PG14075.

10. Are Intellectual or Developmental disability or other cognitive impairment eligible diagnoses for PG14033?
These are often functional diagnoses and not the result of a progressive neurodegenerative disease. If cognitive impairment is a result of an underlying eligible condition, then it is that underlying condition that would be one of the qualifying diagnoses for PG14033. Also, depending on the level of disability experienced by the patient, they may qualify for PG14075.

11. Does CT scan evidence of multiple lacunar infarcts or cerebrovascular disease qualify under Cerebrovascular Disease for PG14033?
Evidence of multiple lacunar infarcts or cerebrovascular disease on CT scan with symptoms that are of sufficient severity and complexity to cause interference in their daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and warrant the development of a management plan would be an eligible condition. It is not simply about a diagnosis made on a CT scan, but the clinical impact of that diagnosis that must be considered.

12. Does diastolic heart dysfunction qualify under Ischemic Heart Disease for PG14033?
Diastolic heart dysfunction may be the result of underlying ischemic heart disease. If it is due to underlying ischemic heart disease, and is clinically of sufficient severity and complexity to cause interference in daily life, require ongoing medical management to prevent further complications and to improve overall quality of life and warrant the development of a management plan, then yes it would qualify. If the patient has heart failure as a result of diastolic heart dysfunction, then it is the heart failure that would be a qualifying diagnosis for the purpose of PG14033. It is not simply the medical diagnosis, but the clinical impact of that diagnosis that is important.

13. Does Cor Pulmonale qualify under Ischemic Heart Disease for PG14033?
Cor pulmonale is a complication of Pulmonary Hypertension, not ischemic heart disease. As such it is not an eligible condition for 14033. However, if the patient has right heart failure as a result of cor pulmonale, then it is the heart failure that would be a qualifying diagnosis for the purpose of PG14033, not the diagnosis of cor pulmonale.

Case Example

Mrs. J. is a 68 year old woman with diabetes, asthma and Parkinson's disease. While she lives in her own home, she requires assistance in several of the Instrumental and Non-Instrumental Activities of Daily Living. The local Home Care nurse visits her on a monthly basis.

Mrs. J has made an appointment to see you in January for review of her care plan that was created the previous year. Prior to seeing Mrs. J, you spend 10 minutes reviewing her chart including current medications, most recent lab tests, peak flow chart and diabetes flow sheet. You recognize that her frailty, mainly due to her Parkinson's disease, is having the biggest clinical impact on her function.

When you see Mrs. J, you go over the results of your chart review with her. You then spend 20 minutes discussing her personal goals, advance care wishes and together create a care plan for the remainder of the year. Mrs. J also complains of a sore throat and dry cough. You diagnose a viral infection and advise on symptomatic treatment. You note that her Diabetes CDM (14050) anniversary date is the end of January.

In February, Mrs. J calls because her peak flow has suddenly dropped into her low yellow zone after visiting her daughter who has a cat. You ask her to increase her inhaled steroid and to come to see you the following day. At the visit there is no sign of acute infection, and you advise her to continue with the increased inhaled steroids. You contact the home care nurse to review the community plan for Mrs. J's management (15 minute phone call), and the nurse agrees to see her Mrs. J the following week.

After a home visit with Mrs. J the nurse calls to report on her findings and ask for further instructions. You spend 10 minutes on the phone. You see Mrs. J a week after the home care nurse visit and find her peak flows have returned to normal. You advise her to stay on the higher dose of inhaled steroid for a further 2 weeks, and that you will have your office nurse call to check on her.

When contacted by your office nurse by phone in early March, Mrs. J's peak flows have remained stable and the nurse tells her to go back to her maintenance dose.

You see Mrs. J again in March for a CPX. You follow up in July and October for planned proactive care of her diabetes, asthma and Parkinson's disease. Additionally, you see her for a bladder infection in September and twice in December for a flare of her asthma.

The billings for this calendar year for Mrs. J. are:

Month	Service	Fee Code	Dx Code
Jan.	Frailty Complex Care Planning Documentation: *Total planning time 30 minutes including face-to-face planning time of 20 minutes.* Same Day Medical Visit Diabetes CDM Anniversary	PG14075 16100 PG14050	V15 460 250
Feb.	Phone call by FP Office Visit – Asthma flare Conference with HC Nurse on day of office visit Conference with HC Nurse after home visit Office visit – Asthma flare follow up	PG14076 16100 PG14077 X 1 PG14077 X 1 16100	493 493 493 493 493
March	Phone call follow-up by office nurse CPX	PG14076 16101	493 250
July	Office Visit – proactive follow up	16100	250
Sept.	UTI Office Visit	16100 15130	595 01L
Oct.	Office Visit – proactive follow up	16100	332
Dec.	Office Visit – Asthma flare Office Visit – Asthma flare	16100 16100	493 493