General Practice Services Committee

Chronic Disease Management Incentives
Fee For Service (PG14050, PG14051, PG14052, PG14053)

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

The GPSC Chronic Disease Management Incentives compensate for the additional work, beyond the office visit, of providing guideline-informed care for the eligible condition(s) to the patient over a full twelve-month period. Guideline-informed care includes consideration of the patient's goals, values and comorbidities.

To confirm an ongoing doctor-patient relationship, there must be at least 2 visits billed over the previous 12 months. Visits provided by a locum or colleague covering for the MRP FP may be counted toward these 2 visits however, an electronic note indicating the locum or colleague coverage must be submitted with the claim. Patients in long-term care facilities are eligible when active chronic disease management is clinically appropriate.

When a new FP assumes the practice of another FP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fees are billable on the anniversary date of the previous billing, provided the new FP has continued to provide guideline-informed care for these patients. To demonstrate continuity, if some of the required visits have been provided by the previous FP, an electronic note should be submitted at the time of the CDM submission by the new FP, indicating they have taken over the practice of the previous FP and there has been continuity of care over 12 months. Documentation in the patient chart of the provision of patient self-management supports as part of the patient's chronic disease management is expected.

Effective April, 1, 2020, PG14050, PG14051, PG14052, PG14053 are payable only to MRP FPs who have submitted PG14070 or PG14071, or FPs who have submitted PG14072.

Fee Code	Description	Total Fee $
PG14050	**Incentive for MRP Family Physicians- annual chronic care incentive (diabetes mellitus)**	**$125.00**
	Notes: *i)* Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year. *ii)* Payable to Family Physicians who have successfully submitted PG14072. *iii)* Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year. *iv)* This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: 1. a telephone visit (PG14076) or 2. a group medical visit (13763 – 13781); or 3. a telehealth visit (13017, 13018, 13037, 13038); or	

	4. an in-person visit with a college-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definitions of "working within" and "college certified ACP"). *v)* Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble. *vi)* Claim must include the ICD-9 code for diabetes (250). *vii)* Payable once per patient in a consecutive 12 month period. *viii)* Payable in addition to fee items PG14051 or PG14053 for same patient if eligible. *ix)* Not payable once PG14063 has been billed and paid. *x)* If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.	
PG14051	**Incentive for MRP Family Physicians - annual chronic care incentive (heart failure)**	**$125.00**
	Notes: *i)* Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year. *ii)* Payable to Family Physicians who have successfully submitted PG14072. *iii)* Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a clinically appropriate level of guideline-informed care for heart failure in the preceding year. *iv)* This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: *v)* a telephone (PG14076); or *vi)* a group medical visit (13763 – 13781); or *vii)* a telehealth visit (13017, 13018, 13037, 13038); or *viii)* an in-person visit with a college-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within and "college certified ACP"). *ix)* Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble. *x)* Claim must include the ICD-9 code for congestive heart failure (428). *xi)* Payable once per patient in a consecutive 12 month period. *xii)* Payable in addition to items PG14050 or PG14053 for the same patient if eligible. *xiii)* Not payable once PG14063 has been billed and paid *xiv)* If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.	

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PG14052	**Incentive for MRP Family Physicians - annual chronic care incentive (hypertension)**	**$50.00**
	Notes: *i)* Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year. *ii)* Payable to Family Physicians who have successfully submitted PG14072. *iii)* Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year. *iv)* This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: *v)* a telephone visit (PG14076); or *vi)* a group medical visit (13763 – 13781); or *vii)* a telehealth visit (13017, 13018, 13037, 13038); or *viii)* an in-person visit with a college-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "college certified ACP"). *ix)* Not payable if the required two visits were provided while working under an alternate payment/funding model as described in the GPSC Preamble. *x)* Claim must include the ICD-9 code for hypertension (401). *xi)* Payable once per patient in a consecutive 12 month period. *xii)* Not payable if PG14050 or PG14051 paid within the previous 12 months. *xiii)* Not payable once PG14063 has been billed and paid. *xiv)* If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.	
PG14053	**Incentive for MRP Family Physicians - annual chronic care incentive (Chronic Obstructive Pulmonary Disease - COPD)**	**$125.00**
	Notes: *i)* Payable only to Family Physicians who have successfully submitted PG14070 or on behalf of Locum Family Physicians who have successfully submitted PG14071 on the same or a prior date in the same calendar year. *ii)* Payable to Family Physicians who have successfully submitted PG14072. *iii)* Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year. *iv)* This item may only be billed after one year of care has been provided including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: *v)* a telephone visit (PG14076); or *vi)* a group medical visit (13763 – 13781); or *vii)* a telehealth visit (13017, 13018, 13037, 13038); or	

	viii) *ix)* *x)* *xi)* *xii)* *xiii)* *xiv)*	an in-person visit with a college-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within and "college certified ACP"). Not payable if the required two visits were provided while working under an alternate payment/ funding model as described in the GPSC Preamble. Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496). Payable once per patient in a consecutive 12 month period. Payable in addition to fee items PG14050, PG14051 or PG14052 for the same patient if eligible. Not payable once PG14063 has been billed and paid If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.	

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Chronic Disease Management Incentives – MRP Family Physicians under Alternate Payment/Funding Model Programs (PG14250, PG14251, PG14252, PG14253)

Use the following CDM incentive fee codes if the required two visits were billed as an encounter record while working under sessional, salary, service or independent contractor contracts. Post review will be performed within 2 years and recoveries made if encounter records were not submitted for the required visits.

A new telephone management encounter code (PG14276) is billable for physicians on alternate payment/funding models.

Fee Code	Description	Total Fee $
PG14250	**Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus)**	**$125.00**
	Notes: *i)* Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care. *ii)* Applicable only for patients with documentation of a confirmed diagnosis of diabetes mellitus and the documented provision of a clinically appropriate level of guideline-informed care for diabetes in the preceding year. *iii)* This item may only be billed after one year of care including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: 1. a GSPC telephone visit (PG14276); or 2. a group medical visit; or 3. a telehealth visit; or 4. an in-person visit with a college-certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "college certified ACP") *iv)* Only payable to physicians who are employed by or who are on an alternate payment/funding model as described in the GPSC Preamble. *v)* Claim must include the ICD-9 code for diabetes (250). *vi)* Payable once per patient in a consecutive 12 month period. *vii)* Payable in addition to fee items PG14251 or PG14253 for same patient if eligible. *viii)* Not payable once PG14063 has been billed and paid *ix)* If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.	
PG14251	**Incentive for MRP Family Physician (who bill encounter record visits) - annual chronic care incentive (heart failure)**	**$125.00**
	Notes*:* *i)* Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care. *ii)* Applicable only for patients with documentation of a confirmed diagnosis of heart failure and the documented provision of a	

	clinically appropriate level of guideline-informed care for heart failure in the preceding year. *iii)* This item may only be billed after one year of care including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: 1. a GPSC telephone visit (PG14276); or 2. a group medical visit; or 3. a telehealth visit; or 4. an in-person visit with a college certified allied care provider; working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "college certified ACP"). *iv)* Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble. *v)* Claim must include the ICD-9 code for heart failure (428). *vi)* Payable once per patient in a consecutive 12 month period. *vii)* Payable in addition to items PG14250 or PG14253 for the same patient if eligible *viii)* Not payable once PG14063 has been billed and paid *ix)* If a visit is provided on the same date the incentive is billed both services will be paid at the full fee.	
PG14252	**Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (hypertension)**	**$50.00**
	Notes: *i)* Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care. *ii)* Applicable only for patients with documentation of a confirmed diagnosis of hypertension and the documented provision of a clinically appropriate level of guideline-informed care for hypertension in the preceding year. *iii)* This item may only be billed after one year of care including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: 1. a GPSC telephone visit (PG14276); or 2. a group medical visit; or 3. a telehealth visit; or 4. an in-person visit with a college certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "college certified ACP"). *iv)* Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble. *v)* Claim must include the ICD-9 code for hypertension (401). *vi)* Payable once per patient in a consecutive 12 month period. *vii)* Not payable if PG14250 or PG14251 paid within the previous 12 months. *viii)* Not payable once PG14063 has been billed and paid *ix)* If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.	

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PG14253	**Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (Chronic Obstructive Pulmonary Disease- COPD)**	**$125.00**
	Notes: *i)* Payable to the family physician who is the most responsible for the majority of the patient's longitudinal primary medical care. *ii)* Applicable only for patients with documentation of a confirmed diagnosis of COPD and the documented provision of a clinically appropriate level of guideline-informed care for COPD in the preceding year. *iii)* This item may only be billed after one year of care including at least two visits. Office, prenatal, home, long term care visits qualify. One of the two visits may be: 1. a GPSC telephone visit (PG14276); or 2. a group medical visit; or 3. a telehealth visit; or 4. an in-person visit with a college certified allied care provider working within the family physician's practice team (PG14029). (See Preamble definition of "working within" and "college certified ACP"). *iv)* Only payable to physicians who are on an alternate payment/funding model as described in the GPSC Preamble. *v)* Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496). *vi)* Payable once per patient in a consecutive 12 month period. *vii)* Payable in addition to fee items PG14250, PG14251 or PG14252 for the same patient if eligible. *viii)* Not payable once PG14063 has been billed and paid *ix)* If a visit is provided on the same date the incentive is billed; both services will be paid at the full fee.	

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Chronic Disease Management Visit Codes (PG14029, PG1276)

Allied Care Provider Code (PG14029)

To support team based care, college-certified Allied Care Providers (ACPs) may provide one of the two visits required for billing GPSC chronic disease management incentives. Visits provided by the college-certified ACP can be in person (PG14029) or by telephone (PG14076).

Fee Code	Description	Total Fee $
PG14029	**Allied Care Provider Code**	**$0.00**
	Notes: *i)* Applicable only for in-person medical services (office, home or LTC) provided by a college-certified allied care provider working within the family physician's practice team where the family physician has accepted responsibility for the provision of the care. (See Preamble definition of "working within" and "college certified ACP"). *ii)* Not payable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14077. *iii)* Billable on patients receiving guideline informed care who will be eligible for one of the chronic disease management incentives (CDM).	
PG14276	**Patient Telephone Management encounter code for MRP Family Physicians on alternate payment/funding models providing chronic disease management**	**$0.00**
	Notes: *i)* Billable only by MRP Family Physicians who are employed or under contract to a facility or working under an alternate payment/funding model to demonstrate one of the two required visits as per fees PG14250, PG14251, PG14252, and/or PG14253. *ii)* Telephone Management requires a clinical telephone discussion between the patient or the patient's medical representative and physician. Alternatively, telephone management may be billed when delegated to or a College-certified allied care provider (e.g. Nurse, Nurse Practitioner) employed by the eligible physician practice (see GPSC Preamble for definition of allied care provider "employed by" a physician practice and "college-certified ACP"). *iii)* Chart entry must record the name of the person who communicated with the patient or patient's medical representative, as well as capture the elements of care discussed. *iv)* Not billable for prescription renewal alone. *v)* Not billable for anti-coagulation therapy by telephone (00043) or notification of appointments or referrals. *vi)* Billable to a maximum of 1500 services per physician per calendar year. *vii)* Not billable on the same calendar day as a visit or service fee by same physician for same patient, with the exception of PG14250, PG14251, PG14252, PG14253.	

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FAQs: Chronic Disease Management

1. How do I claim the Chronic Disease Management incentive fees?
The chronic disease management (CDM) fees are only payable to the FP who has submitted PG14070 CLFP Portal (or PG14071 for locums) or LTC Portal (PG14072). See the billing guide for CLFP Portals PG14070/71 and LTC Portal PG14072 for further details and FAQs.

To claim the annual CDM incentives, patients must have a confirmed diagnosis of diabetes mellitus (please note this fee is not payable for pre-diabetes patients), heart failure, hypertension or chronic obstructive pulmonary disease.

There are two different sets of annual chronic care incentives, depending on the payment mechanism the eligible family physician works under. If the physician is paid by Fee-For-Service, the codes are:

PG14050 Incentive for MRP Family Physicians- annual chronic care incentive (diabetes mellitus)	PG14052 Incentive for MRP Family Physicians - annual chronic care incentive (hypertension)
PG14051 Incentive for MRP Family Physicians - annual chronic care incentive (heart failure)	PG14053 Incentive for MRP Family Physicians - annual chronic care incentive (Chronic Obstructive Pulmonary Disease - COPD)

If the physician is paid under an alternate payment/funding model and the required two visits were billed as encounter records, use:

PG14250 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (diabetes mellitus)	PG14252 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (hypertension)
PG14251 Incentive for MRP Family Physicians (who bill encounter record visits) - annual chronic care incentive (heart failure)	PG14253 Incentive for MRP Family Physicians (who bill encounter record visits) – annual chronic care incentive (COPD)

Post review will be performed within two years and recoveries will be made if encounter records were not submitted for the required visits.
Only one payment per diagnosis is payable per patient per year.
CDM fees are submitted through Teleplan using the relevant ICD 9 codes:

Diabetes mellitus – 250;	Hypertension – 401;
Heart failure - 428;	COPD – 491 or 492 or 494 or 496.

2. Are FPs paid under Alternate Payment/Funding models eligible to receive the chronic disease management payments?
Yes, provided payment for this service is not already specified in their contract. Please refer to FAQ #1 for more details on the specific codes that these physicians must use.

3. When should the incentive fee be billed?
All the GPSC CDM fees are only payable to the MRP FP who has submitted 14070/71 or 14072 and provides the majority of the patient's longitudinal family practice care. The CDM incentive fees may be billed once the patient has been provided guideline informed care for one full year for that particular condition. To confirm an ongoing doctor-patient relationship, there must be at least two visit fees or two encounter records (office; prenatal; home; long term care) billed in the 12 months prior to billing the CDM fee.

One of the two required visits may be:

- ✓ A GPSC telephone visit (PG14076 if FFS, or PG14276 if billing encounter record visits); or,
- ✓ a Group Medical Visit (13763 – 13781 if FFS);
- ✓ a telehealth visit (13017, 13018, 13037, 13038); or
- ✓ an in-person visit with a College-certified Allied Health Provider (PG14029) working within the family physician's practice

Review of physicians paid under an Alternate Payment/Funding model will be performed within two years and recoveries will be made if encounter records were not submitted for the required visits. Visits provided by a locum or other FP colleague covering for the MRP FP are included, however an electronic note indicating this must be submitted with the CDM claim.

Once successfully billed, the CDM fees may be billed on or after the anniversary date of the initial billing, provided guideline informed care has continued to be provided in the intervening 12 months.

4. Do I have to see the patient on the same day to bill the payment?
No, you do not have to see the patient on the day of billing the chronic disease management incentive fee. There must be at least two visits provided to each patient in the 12 months prior to billing the CDM fee. See FAQ #3 above.

5. Will PG14050, PG14051, PG14052 and PG14053 replace the usual MSP visit fees for those patients who have diabetes, heart failure, hypertension or COPD?
No. Billing for office visits should continue as usual. This incentive fee is billed *in addition to* any other fees incurred by usual patient care.

6. Do I have to provide all CDM care to the patient face-to-face?
Only one of the required two visits in the 12 months prior to submitting a claim for the CDM fees must be provided by the physician face-to-face with the patient. See FAQ#3 for more details.

7. Is it possible to claim all Chronic Disease Management fees in the same patient?
If a patient has any of the three conditions Diabetes, Heart Failure, and/or COPD and criteria are met for each condition, each annual fee may be billed separately.

If a patient has hypertension, the PG14052 cannot be billed in addition to Diabetes PG14050 or Heart Failure PG14051, as management of hypertension is included in the guideline for these 2 conditions.

If the patient has hypertension and COPD without diabetes or heart failure, then both the PG14052 and PG14053 may be billed on the same patient if all criteria are met.

CDM Allowable Combinations in Single Patient

	PG14050/PG14250	PG14051/PG14251	PG14052/PG14252	PG14053/PG14253
PG14050, PG14250		Yes	No	Yes
PG14051, PG14251	Yes		No	Yes
PG14052, PG14252	No	No		Yes
PG14053, PG14253	Yes	Yes	Yes	

8. Can I still bill the CDM codes if the patient is in a long term care facility?
Patients in long term care facilities are eligible; however, clinical judgment is needed in determining the appropriateness of following clinical practice guidelines in patients with dementia or very limited life expectancy.

9. Can I bill the payment even if the clinical or laboratory objectives have not been met?
The payment is for the provision of guideline-informed clinically appropriate care which takes account of individual patient's values and co-morbidities. It is not required that a patient meet any specific clinical outcome target. The physician should determine applicability of guideline recommendations according to the particular context of each patient. However, the CDM fees are not payment simply for a diagnosis of diabetes, heart failure, hypertension or COPD.

10. I have assumed/taken over the practice of another GP within the last 12 months. May I still bill for patients' Chronic Disease Management fees?
When a new FP assumes the practice of another FP who has been providing guideline-informed care to patients with eligible chronic conditions, the CDM fee is billable on its anniversary date provided the new FP has seen the patient and continued to provide guideline informed care. The transition from the old to the new FP is considered a shared year. To demonstrate continuity, if one of the two required visits was provided by the previous FP, an electronic note must be included with the initial submission of the CDM fee by the new FP. You may not bill the Chronic Disease Management fee if a patient did not receive the requisite level of care, or a chronic disease management fee code has been billed for the patient in the preceding 12 months.

11. Which College-certified Allied Care Providers working within the eligible physician practice qualify for providing services to be eligible for the PG14029 Allied Care Provider Practice Code to be submitted?
PG14029 is applicable to services provided to eligible patients by College-certified Allied Care Providers working within the family physician's practice, whether employed directly by the practice or embedded within the practice through a Health Authority agreement with the MRP FP. College certified ACPs include nurses, NP, LPN, dieticians, social workers, etc. (see the GPSC Preamble for definition of "Allied Care Provider".) Medical Office Assistants are excluded from the GPSC definition of Allied Care Provider as they do not have a clinical scope of practice. To be considered working within her/his scope of practice, the ACP must maintain his/her certification with their professional college, and maintain medical legal coverage.

12. Does the College-certified Allied Care Provider have to see my patients in the office in order for me to submit PG14029?
While these College-certified Allied Care Providers are working within your practice, it is not required that the support they provide your patients occur only within the office. For example, a nurse may be providing home visits to home bound patients with chronic conditions. See the GPSC Preamble for the definition of "working within" the physician practice.

13. Can I bill for patients covered by other provinces?
Patients covered by other provincial health plans, who are temporarily living in BC are not eligible. In border communities where a BC physician provides the majority of care for an Alberta or Yukon patient, those patients are eligible.

14. Where can I find the clinical guidelines and flow sheets?
The full Diabetes Care, Heart Failure Care, COPD Diagnosis and Management, and the Treatment of Essential Hypertension guidelines along with available GPAC Flow Sheets, are found on the BC Guidelines and Protocols web site, along with all other current guidelines.

15. Does obstructive sleep apnea qualify for the COPD CDM (PG14053)?
No. COPD and obstructive sleep apnea are two different conditions.

16. What supports are available for assisting my patients with COPD who are still smoking to quit?
Patients may be referred to a number of support groups and programs that are available within local communities. For more details, please go to the Ministry BC Smoking Cessation Program website.

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Case Example

William S, a 76 year old former smoker with a history of diabetes, hypertension and COPD has been your patient for the past 12 years. You have a nurse employed by your practice who provides chronic disease management support for your patients, including William. This year she sees him in February for review of his diabetes and its management.

Prior to William's office visit for Complex Care planning in April, the CDM nurse reviews his chart, does a medication reconciliation and ensures appropriate blood work is done in advance of the appointment. This takes her 15 minutes. During the visit you review William's medical conditions with him, as well as update his advance care plan created last year. You agree on a plan of care for the coming year, including self management of COPD exacerbations and frequency of blood work and home BP monitoring. This takes 20 minutes. William also complains of a rash, so you examine him and diagnose xerotic dermatitis. You prescribe appropriate treatment.

William returns in September for a planned CPX in the same month as the anniversary date of his Diabetes and COPD CDMs. You review his complex care plan including self-management of his diabetes and COPD, especially since winter is coming. He returns in November for the flu shot which is given by your office nurse. Later that month, he phones the office and speaks with the nurse about increased cough and a change in his sputum, but no fever. She reviews his COPD self management plan with him and gives appropriate advice. You follow up with William with an office visit two weeks later.

The billings for his management for this calendar year are:

Date	**Service Description**	**Fee Code**	**Diagnostic Code**
Feb	Visit with office nurse for review of diabetes	PG14029	250
April	Complex Care Management Planning Visit Visit for xerotic dermatitis	PG14033 17100	R250 692
September	CPX Diabetes CDM COPD CDM	17101 PG14050 PG14053	250 250 496
November	Flu shot	00010	33A
November	Phone call with nurse re exacerbation of COPD (separate day from flu shot)	PG14076	496
December	Office Follow up of COPD	17100	496