Prevention Fee (PG14066)

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

Fee Code	Description	Total Fee $
PG14066	**Personal Health Risk Assessment (Prevention)**	**$50.00**
	This fee is payable to the family physician who is most responsible for the majority of the patient's longitudinal primary medical care and who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, tobacco use, physically inactive, unhealthy eating or at risk for substance use disorder). The FP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and relevant BC Guidelines. The Personal Health Risk Assessment requires a face-to-face visit with the patient or patient's medical representative. PG14066 is payable only to MRP Family Physicians who have submitted PG14070 or PG14071. **Patient Eligibility:** • Eligible patients must be living at home or in assisted living. • Patients in Acute and Long Term Care Facilities are not eligible. The Ministry of Health website contains: The current Lifetime Prevention Schedule and the BC Prevention Guidelines. ***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 Community Longitudinal 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 one or more of the following risk factors: Tobacco Use/Smoking, unhealthy eating, physical inactivity, medical obesity, or at risk for substance use disorder. *iii)* Diagnostic code submitted with PG14066 must be one of the following: Tobacco use/Smoking (786), Unhealthy Eating (783), physical inactivity (785), Medical Obesity (783), at risk for substance use disorder (V82). *iv)* The discussion with the patient and the resulting preventive plan of action must be documented in the patient's chart. *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 face-to-face planning included under PG14066. *vi)* PG14077 or PH14067 payable on same day for same patient if all criteria met.	

	vii) PG14033, PG14043, PG14063, PG14076 and PG14078 not payable on the same day for the same patient. *viii)* Payable to a maximum of 100 patients per calendar year, per physician. *ix)* Payable once per calendar year per patient. *x)* Not payable once PG14063 has been billed and paid as patient has been changed from active management of chronic disease to palliative management. *xi)* Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.	

FAQs: PG14066 Personal Health Risk Assessment (Prevention)

1. Who can bill the PG14066?
PG14066 is only payable to the MRP FP who has submitted PG14070 Portal (or PG14071 for locums) on a prior date in the same year.

2. Are there any age restrictions for this Prevention fee?
No. Due to the broad nature of the target patient populations, the fee is inclusive of children and adolescents in addition to the adult population, with age appropriate prevention recommendations

3. Am I eligible to bill for an office visit, procedure, or conference fee on the same day?
Yes, if an additional medically necessary service is provided the same day as the face-to-face planning included under PG14066, the visit fee may also be billed. Similarly if the physician needs to conference with allied care professionals about the patient, then PG14077 is payable in addition to PG14066, if all fee requirements are met.

4. Is this fee billable in a group medical visit setting?
No. The Personal Health Risk Evaluation fee requires a one-on-one personal evaluation of health risks with the patient or the patient's medical representative. It requires the development of a personalized plan of action to address any risks identified.

5. Why is this fee payable only to the MRP FP?
The value of the risk evaluation and implementation of the resultant plan is highest when it occurs within an ongoing relationship between physician and patient over time. While the GPSC acknowledges that individual Family Physicians may practice in many different settings, including group practices, the key attributes of primary care indicate that having an individual FP who is the main coordinator of care provides the most efficient and effective primary health care. It has been shown that it is the MRP Family Physician who has the most impact on a patient's willingness to undertake changes in lifestyle choices and is key to the success and sustainability of those changes.

6. Can I provide a follow-up by telephone to the patient to review the progress of their personal prevention plan?
Yes, provision of follow-up management by telephone can be billed using the PG14076 FP Patient Telephone Management fee.

7. Is this billable by a locum in my office?
Yes, provided the locum has submitted PG14071, they have the same access to billing 100 prevention fees per calendar year per physician. The fees billed by the locum do not count toward the host FP limit, but the host FP and locum should discuss and agree prior to the start of the locum which GPSC fees are appropriate for the locum to bill.

8. Am I able to bill this on the same patient every year or is there a recommended frequency?
The Prevention fee is not meant to be used annually for the same patients. However, if in your clinical judgment, a repeat risk assessment is warranted, then it may be provided and billed.

9. Why are there billing restrictions excluding physicians "working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service"?
The current Fee-for-Service payment schedule may encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.

If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

10. When undertaking a personal health risk assessment, do I only discuss the specific risk factors relevant to the patient's eligibility?
No, to bill the Personal Health Risk Assessment fee the FP must review with the patient all the age and sex appropriate prevention interventions recommended in the Lifetime Prevention Schedule. Specific interventions related to the patient's individual risk that makes them eligible for the PG14066 will be part of the schedule, but the FP must include discussion of all appropriate recommendations for that patient (e.g. FIT testing; pap smear; mammography, Immunization status, etc.)

11. Must I use a flow sheet or paper Risk Scoring Sheet?
While there is no specific flow sheet or risk scoring sheet that is required for the personal health risk assessment, there are a number of tools available to use when providing this service. See the Appendix for links to these resources.

Case Examples

Example 1

Miss K is a 16 year old patient who has come in to see you due to severe dysmenorrhea. Her periods are very regular at 28 – 30 days. She has not tried any over the counter medications but is thinking she might want to start the birth control pill as her best friend went on it for this reason and has had a great decrease in the cramps. She is 5 ft 3 inches with a weight of 180 lbs which calculates to a BMI of. She does not smoke. She does not participate in any formal exercise program but does like to swim and has in fact passed her bronze cross in swimming. Miss K has no past medical history of illnesses or surgery. There is a family history of diabetes in her mother and maternal grandmother but no other significant family history. In asking further questions, you find she does not have a boyfriend and has not yet been sexually active. She did not have the HPV vaccine in school as her mom was not sure of this. Her other immunizations are up to date. You review the pros and cons of HPV and give her some information to take home for her parents to read and encourage them to come in to discuss this further if they feel it is appropriate for her to be immunized.

On examination, her BP is 115/70. You discuss the pros and cons of oral contraceptives for dysmenorrhea. You also discuss with her the concern of further weight gain from the pill and she admits she wants to try and lose some weight that has accumulated since puberty. After reviewing her options, she agrees to try naproxen 220 mg for the dysmenorrheal and to start swimming three times per week. Since her friend also likes to swim, she will see if they can do this together. You advise her to return after the next two menstrual cycles to see if the naproxen is working and to weigh her again.

When seen 2 ½ months later with her mother, she finds that the naprosyn has worked very well for her cramps. She has been swimming 3 – 4 times per week at the local pool as there is a lower rate for students under a local program aimed at increasing youth activity and fitness. She has lost 8 lbs and has also been following a more balanced diet. She feels great. Her mom notes that they have decided to undertake the HPV vaccination after reading the literature. You advise her that since she is included within the provincially funded ages, there is no additional cost. She agrees to fill a prescription and return for the injection after school the next Friday. At that time, she advises that since she has lost some weight and is confident she will continue with her improved lifestyle habits, she would like to start a low dose oral contraceptive.

The billings for Ms. K are:

Service #	Service	Fee Code	Dx Code
1	Office Visit Personal Health Risk Assessment	00100 14066	625 783
2	Office visit	00100	626
3	Office visit – contraceptive advice HPV immunization	00100 10028	34A 33A

Example 2

Mr. D is a 36 year old patient who presents to your office in March with concerns about his health as he is a smoker and has a body weight above ideal (BMI 35). He and his wife have just had newborn twins and he knows that he needs to make some changes in his lifestyle to ensure he sees them grow up. He has a family history of Coronary Artery Disease with both his father and a paternal uncle having had heart attacks before they were 60. His past history is negative for any medical conditions and his only surgical history is that of an appendectomy at age 10, but he has not seen you for the past 5 years. He

has not had a tetanus shot since becoming and adult and has never had the flu shot either. You discuss the need to update his Tetanus immunization but also the recommendation that he should have the flu shot annually in the fall due to the presence of infant children in the home. He agrees to have the Tetanus shot that same day, which you provide for him. He feels he is ready to seriously consider stopping smoking as he has read about the impact on childhood asthma and other illnesses if there are smokers in the home.

On examination, Mr. D's BP at this time is 170/95 and his pulse is 88 and regular. He has no history of chest pain or dyspnea. You review his status send him for blood work including a CBC, Fasting Blood Sugar, Lipid profile, Creatinine, Electrolytes and TSH. You advise him to do home BP checks and to write them down in a notebook and return to see you in 2 weeks. You discuss with him the various options for stopping smoking and refer him to the QuitNow program for more information.

When Mr. D returns 2 weeks later, you review his BP readings at different times during the day, and find his systolic levels range from 150 – 180 and diastolic from 90 – 105 (Mostly ~ 165/100). His BP at this visit is 170/100 and pulse is 82. You review the lab results and his efforts to stop smoking. His labs are as follows:

Total Cholesterol	6.8	FBS	5.2
HDL Cholesterol	0.88	Creatinine	105
LDL Cholesterol	4.1	Lytes, CBC, TSH	Normal
Triglycerides	1.80		

After advising Mr. D of the limitations of the Framingham Risk Scoring sheet, you calculate that his Total points are 9. This gives him an estimated 10 year CHD risk of 20%. With the low 10 year CHD risk for the population of 3%, his relative risk is 7 times that of the low 10 year population risk. You discuss this relative risk and the areas that he can change through lifestyle interventions. He has checked out the information on the QuitNow website and is preparing to stop smoking. He also agrees to undertake some exercise and diet changes, including reducing his salt intake. At this visit you give him a copy of your BP management sheet which has space for him to track his home BP. After the visit, you enter him in your CDM registry as he fulfills the criteria for hypertension.

He returns for follow up of his lifestyle interventions in 3 months, and his BP has only decreased to 155/95 at home on an average. You undertake a BP true reading and find his average is 155/100 today. He has been cigarette free for 4 weeks. He has lost 10 lbs and is walking every day. You discuss the risks and benefits of using medication for his hypertension given his family history. He agrees to start medication. Your office nurse phones him after 2 weeks to see how he is progressing and he reports he is tolerating the medication and his BP at home has been between 140/90 and 130/85. You reassess him in 3 monthly intervals until his BP is at an acceptable level (home readings averaging 125/80), by which time he has lost another 15 lbs. This has taken almost 10 months from the diagnosis of his hypertension. You provide his flu shot in the fall. At this time you advise him it is appropriate to repeat his laboratory testing before his next visit. At that follow-up exam, his BP is 120/80, and his lipids have also improved. You encourage him to maintain his new lifestyle choices, and follow his hypertension every 3 – 6 months as clinically indicated. Since it has been 1 year since the diagnosis of hypertension, you are eligible to bill the hypertension CDM.

The billings for Mr. D are:

Service #	**Service**	**Fee Code**	**Dx Code**
1	Office Visit Personal Health Risk Assessment	00100 14066	785 786
2	Office Visit for confirmation of hypertension	00100	401

3	Office Visit	00100	401
4	Telephone follow-up with RN	14076	401
5	Office Visit	00100	401
6	Office Visit	00100	401
7 (1 yr from Dx)	Office Visit Hypertension CDM	00100 14052	401 401

Appendix: Resources

Resources for Additional Patient Support

1. BC Lifetime Prevention Schedule Tool

2. Hypertension Guideline Lifestyle Change recommendations

3. Quit Now

4. Healthy Families BC including Food & Nutrition, Activity & Lifestyle, and Pregnancy & Parenting

5. Dietician Services at HealthLink (formerly Dial-a-dietician)

6. BC Recreation and Parks Association Walking programs (in partnership with ActNow)

7. Walk BC

8. BC Heart and Stroke Foundation – Health Living

9. Screening Mammography Program

Background Documents and Resources

1. BC Guidelines
   a) Cardiovascular Disease Primary Prevention
   b) Preventative Health
   c) Overweight and Obese Adults – diagnosis and Management
   d) Colorectal Screening for Cancer prevention in Asymptomatic Patients
   e) Breast Disease and Cancer: Diagnosis

2. Revised WHO Child Growth Standards (2010)

3. College of Family Physicians of Canada Preventive Care:
   a) Greig Health Record (ages 6 – 17)
   b) Pan-Canadian physical activity strategy
   c) Preventive Care Checklist Forms
   d) Preventive Medicine
   e) Rourke Baby Record

4. BC Childhood Immunization Schedule

5. Self-management Supports