BROADCAST MESSAGES

EFFEC. DATE (CCYYMMDD): 2019-01-01
CANCEL DATE (CCYYMMDD): 2019-01-15 TARGET TYPE: A1
TARGET KEY: MD – BC MEDICAL ASSOCIATION COPY MESSAGE FROM

BROADCAST TITLE: Amendment to Group Medical Visits G78763 – G78781 Inclusive
BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):

Effective January 1, 2019, the eligibility criteria, the description and notes for fees G78763 – G78781 Inclusive are amended to the following: \

Group Medical Visits G78763 – G78781 Inclusive

Eligibility

A Group Medical Visit (GMV) provides medical care in a group setting. A requirement of a GMV is a 1:1 interaction between each patient and the attending physician. Because this is a time-based fee, concurrent billing for other services during the time of the GMV is not permitted. The physician must be physically present at the GMV for the majority of each time interval billed. While portions of the GMV may be delegated to a non-physician staff member the Specialist must be present for a majority of the GMV and assumes clinical responsibility for the patients in attendance.

Group Medical Visits are an effective way of leveraging existing resources; simultaneously improving quality of care and health outcomes, increasing patient access to care and reducing costs. Group Medical Visits can offer patients an additional health care choice, provide them support from other patients and improve the patient-physician interaction. Physicians can also benefit by reducing the need to repeat the same information many times and free up time for other patients. Appropriate patient privacy is always maintained and typically these benefits result in improved satisfaction for both patients and physicians.

This fee is not intended for provision of group psychotherapy (00663, 00664, 00665, 00666, 00667, 00668, 00669, 00670, 00671, 00672, 00673, 00674, 00675, 00676, 00677, 00678, 00679, 00680, 00681).

Referred Cases

Group Medical Visit applies only when all patients in the group are receiving medically required treatment. These fees are not for efforts to persuade patients to alter diet or other lifestyle behavioral patterns, other than in the context of the individual medical condition.
Fee per patient, per 1/2 hour

G78763 Three patients
G78764 Four patients
G78765 Five patients

G78766 Six patients
G78767 Seven patients
G78768 Eight patients
G78769 Nine patients
G78770 Ten patients
G78771 Eleven patients
G78772 Twelve patients
G78773 Thirteen patients
G78774 Fourteen patients
G78775 Fifteen patients
G78776 Sixteen patients
G78777 Seventeen patients
G78778 Eighteen patients
G78779 Nineteen patients
G78780 Twenty patients
G78781 Greater than 20 patients (per patient)

Notes:

i) Submit a separate claim for each patient.
ii) Each patient must have an active referral.
iii) Start and end times required in both the medical record and time fields in the claim.
iv) Not payable with any other services for the same patient on the same day by the same physician.
v) If multiple physicians are involved, the group should be divided for claims purposes, with each physician claiming the appropriate rate for only the patients in their own fraction of the group. The claim note and patient chart should specify:
   a. Number of people in entire group
   b. Number of patients billed by billing physician
   c. Of the patients billed by the billing physician, how many were to each insurer
   d. Name of any other billing physicians

INITIATED BY: MOH

Copy to BCMA yes

AUTHORIZED BY Donna Bell

IF TARGET TYPE IS	**THEN TARGET KEY IS**
PY-PAYEES	PAYEE NO.
PR- PRACTITIONER	PRACTITIONER NO.
SP-SPECIALTY	SPECIALTY CODE
AI-ASSOCIATION IDENTIFIER	MD – BC MEDICAL ASSOCIATION
A -ALL	LEAVE TARGET KEY BLANK
PS-PAYEE STATUS	**C** - VESTED INTEREST LAB

F PRIMARY CARE
H - HOSPITAL
I - INACTIVE PAYEE
L - LABORATORY
M - ACTIVE PAYEE
V - 3RD PARTY- OUT OF PROVINCE
Y – ALTERNATIVE PAYMENTS PROGRAM