

## BROADCAST MESSAGES

**EFFECTIVE DATE (CCYYMMDD):** 2026-03-15      **TARGET TYPE:** SP  
**CANCEL DATE (CCYYMMDD):** 2026-04-15      **TARGET KEY:** 00  
**COPY MESSAGE FROM**

**BROADCAST TITLE (50 char):** CDM Preamble and Fee Amendments

**BROADCAST MESSAGE (UP TO 5 PAGES, 12 LINES PER PAGE, 76 CHARACTERS PER LINE):**

Effective March 1, 2026, the following Chronic Disease Management Fee Items (14050, 14051, 14052, 14053 and 14029) are amended:

- The preamble is amended for clarity.
- The fee titles for 14050, 14051, 14052, 14053 are updated.
- 14029 (Allied Care Provider Practice Code) is amended so that prenatal services are recognized as eligible under this fee item, and notes ii)-v) are amended for clarity.

Additionally, the Family Physicians billing under Alternate Payment/Funding Model Programs (14250, 14251, 14252, 14253) are amended:

- The preamble is amended for clarity.
- Fee titles are updated.
- Note iii) is updated for clarity.

### 3. Chronic Disease Management Fees (G14050, G14051, G14052, G14053, G14029)

Chronic Disease Management (CDM) fees compensate for the work of providing guideline-informed care to a patient with an eligible condition, including consideration of the patient's goals, values and comorbidities. Patients in long-term care facilities are eligible when active chronic disease management is clinically appropriate.

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. A claim note record note indicating the locum or colleague coverage must be submitted with the claim.

When a new family physician (FP) takes over patient care from another FP, CDM fees can be billed on the anniversary of the previous billing if both FPs provided guideline-informed care.

- If one or more of the required visits were done by the previous FP, the new FP should include a claim note record when submitting the CDM fee.
- The claim note record should indicate that they've assumed responsibility for the patient's care, and the previous FP's name.

Care provision must be documented in the patient's chart, including support provided to help build the patient's skills and confidence to manage their chronic condition.

CDM fees G14050, G14051, G14052, G14053, and G14029 are payable to MRP Family Physicians billing under Fee-For-Service who have submitted G14070, G14071, or G14072.

G14050 Annual chronic disease management fee  
(diabetes mellitus)

G14051 Annual chronic disease management fee (heart failure)

G14052 Annual chronic disease management fee (hypertension)

G14053 Annual chronic disease management fee (Chronic  
Obstructive Pulmonary Disease-COPD)

G14029 Allied Care Provider Practice Code

Notes:

- i) Applicable for medical services (office, prenatal, home or long-term care) 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 FPSC Preamble definition of "working within" and "College-certified ACP").
- ii) A College-certified allied care provider may provide one of the two visits required for billing chronic disease management fees.

- iii) Visits may be provided in-person or by telehealth (G14029, G14076).
- iv) Payable for care provided to a patient with a condition eligible for one of the chronic disease management fees.
- v) Not payable in addition to a visit fee on the same day to the same physician for the same patient, except for H14067 or G14077.
- vi) Not payable to physicians remunerated under the LFP Payment Model or an Alternative Payment model that includes payment for this service.

4. Chronic Disease Management fees for MRP Family Physicians billing under Alternate Payment/Funding Model Programs (G14250, G14251, G14252, G14253, G14276)

G14250, G14251, G14252, and G14253 are payable to FPs billing under sessional, salary, service or independent contractor contracts when the required two visits are billed as an encounter record. Post-adjudication monitoring will be performed within 2 years. If encounter records were not submitted for the required two visits, funds will be recovered.

G14250 Annual chronic disease management fee (diabetes mellitus) for MRP FPs on alternate payment/funding models

G14251 Annual chronic disease management fee (heart failure) for MRP FPs on alternate payment/funding models

G14252 Annual chronic disease management fee (hypertension) for MRP FPs on alternate payment/funding models

G14253 Annual chronic disease management fee (Chronic Obstructive Pulmonary Disease - COPD) for MRP FPs on alternate payment/funding models

The following amendments apply to fee items 14250, 14251, 14252 and 14253:

- iii) This item may only be billed after one year of care including at least two visits (in-person or telehealth). Office, prenatal, home, long-term care, group medical, or telehealth visits qualify.
  1. Only one of the qualifying visits may be a group medical visit.
  2. At least one of the two required visits must be a physician visit, while the other visit may be a physician visit or a visit with a College-certified allied care provider working within the Family Physician’s practice team (See FPSC Preamble definition of “working within” and “College-certified ACP”).

Copy to DoBC: Yes

INITIATED BY: MoH

AUTHORIZED BY: Donna Bell

**IF TARGET TYPE IS**

**THEN TARGET KEY IS**

<b>PY-PAYEES</b> -----	<b>PAYEE NO.</b>
<b>PR- PRACTITIONER</b> -----	<b>PRACTITIONER NO.</b>
<b>SP-SPECIALTY</b> -----	<b>SPECIALTY CODE</b>
<b>AI-ASSOCIATION IDENTIFIER</b> -----	<b>MD – BC MEDICAL ASSOCIATION</b>
<b>A -ALL</b> -----	<b>LEAVE TARGET KEY BLANK</b>
<b>PS-PAYEE STATUS</b> -----	<b>C - VESTED INTEREST LAB</b>
	<b>F - PRIMARY CARE</b>
	<b>H - HOSPITAL</b>
	<b>I - INACTIVE PAYEE</b>
	<b>L - LABORATORY</b>
	<b>M - ACTIVE PAYEE</b>
	<b>V - 3<sup>RD</sup> PARTY- OUT OF PROVINCE</b>
	<b>Y – ALTERNATIVE PAYMENTS PROGRAM</b>