GP SERVICES COMMITTEE
Mental Health INCENTIVES

Revised
April 2017

GPSC General Practice Services Committee

doctors of bc

BRITISH COLUMBIA

SGP Society of General Practitioners of BC

COMMUNITY-BASED MENTAL HEALTH INITIATIVE

The following incentive payments are available to B.C.'s eligible family physicians. The purpose of the incentive payments is to improve patient care. GPSC retains the right to modify or change fees.

Eligibility:

Physicians are eligible to participate in the GPSC incentive programs if they are:

1. A general practitioner who has a valid BC MSP practitioner number;
2. Currently in general practice in BC as a full service family physician;
3. The most responsible general practitioner for the majority of the patient's longitudinal general practice care; and
4. Practitioners who have billed any specialty consultation fee in the previous 12 months are not eligible.

GPSC defines a "Full Service Family Physician" (FSFP) as the FP who provides continuous comprehensive care to his/her patients and takes responsibility for the coordination of care needs for these patients. It is not about any specific set of services being provided by a specific individual; however, if the FP does not provide a particular service needed at any given time (e.g. Obstetrics) the FSFP will coordinate the referral to a colleague who is able to provide that service in a shared care arrangement with the FSFP until such time as that particular service is no longer required.

To access the GPSC Community-based Mental Health Initiative, FSFPs will identify their high-risk patients living at home or in assisted living, who meet the following criteria:

i) Eligible mental health diagnosis as listed in Appendix 1;
ii) Severity and Acuity level sufficient that developing a management plan to maintain the patient safely in the community would be appropriate

Additional factors that increase risk include drug or alcohol addiction, cognitive impairment, poor nutritional status, and socioeconomic factors such as homelessness. Given these factors, the approach to be encouraged is to manage the whole patient, not the disease.

The Mental Health Planning Fee and resulting access to an increased number of billable GP management (counseling equivalent) fees is intended to recognize the significant investment in time and skill such clients/patients require in General Practice. These Fee items are intended to acknowledge the vital role of the Family Physician in supporting patients with mental illness and addictions to remain safely in their home community. Once the Mental Health Plan is developed, GPs are encouraged to collaborate with community mental health resources, in providing longitudinal mental health support for these patients across the spectrum of care needs. This networking is complementary to and eligible for the conferencing fees if all other requirements are met. Family physicians participating in the GPSC Attachment Initiative can access the Attachment Patient Conferencing Fee (G14077) while FPs not participating will continue to have access to the Community Patient Conferencing Fee (G14016) for these conferences.

The initial GP/FP service providing access to the mental health care management fees shall be the development of a Mental Health Care Plan for a patient with significant mental health conditions residing in their home or assisted living (excludes long-term care facilities).

This fee requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of eligible mental health diagnosis. It requires a face-to-face visit with the patient, with or without the patient's medical representative requiring a minimum of 30 minutes face-to-face. If the planning process goes longer than 30 minutes face to face, or there is an additional medical condition managed outside the 30 minutes, the office visit is billable in addition to G14043. If the planning session includes counseling and the total time is 50 minutes or more, the office counseling visit is billable in addition to G14043. ***You must enter total start and end times when submitting face-to-face time based fees, and this must also be documented in the patient chart.***

From these activities (review, assessment, planning and documentation) a Mental Health Care Plan for that patient will be developed that documents in the patient's chart (see template at the end of this document):

- that there has been a detailed review of the patient's chart/history and current therapies;
- the patient's mental health status and provisional diagnosis by means of psychiatric history and mental state examination;
- the use of and results of validated assessment tools. GPSC strongly recommends that these evaluative tools, as clinically indicated, be kept in the patient's chart for immediate accessibility for subsequent review. Assessment tools such as the following are recommended, but other assessment tools that allow risk monitoring and progress of treatment are acceptable:
    - i) PHQ9, Beck Inventory, Ham-D for depression;
    - ii) MMSE for cognitive impairment;
    - iii) MDQ for bipolar illness;
    - iv) GAD-7 for anxiety;
    - v) Suicide Risk Assessment;
    - v) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
- Eligible mental health diagnosis (see Appendix 1);
- a summary of the condition and a specific plan for that patient's care;
- an outline of expected outcomes;
- outlined linkages with other health care professionals (Including Community Mental Health Resources and Psychiatrists) as indicated and/or available) who will be involved in the patient's care, and their expected roles;
- an appropriate time frame for re-evaluation of the Mental Health Plan;
- that the developed plan has been communicated verbally or in writing to the patient and/or the patient's medical representative, and to other health professionals as indicated. ***The patient & or their representative/ family should leave the planning process knowing there is a plan for their care and what that plan is.***

Once the Mental Health Plan has been created, the General Practitioner or practice group can access two additional supports:

1) GP Mental Health Management Fees (G14044, G14045, G14046, G14047, G14048) are an additional four (4) visit fees equivalent to the current age differential 00120 series. These fees are billable after the current 4 counselling Visit per year (age appropriate 00120 fees per MSP guide to fees) have been billed. G14044, G14045, G14046, G14047, G14048 are time based fees requiring a minimum of 20 minutes face-to-face counseling and must fulfill the same requirements from the preamble to fees as the MSP counseling fees. Beginning July 1, 2015, you must enter start and end times when submitting face-to-face time based fees, and this must also be documented in the patient chart.
2) GP Telephone/Email Management Fees (G14079); access to telephone/email follow-up fees to allow flexibility in providing non-face-to-face management/follow-up for these patients. These telephone/email follow-up services may be provided by the physician or other medical professionals that are directly under the family physician or practice group's supervision (e.g. MOA or Office nurse). The telephone follow up care fee is to be used for providing clinical management such as medication, symptom, and clinical status monitoring. It is not for simple appointment reminder or referral notification. The telephone management fee may be billed up to a maximum of 5 times in the 18 months following the successful billing of the G14043, for either physician-initiated or patient-initiated follow up.

   Access to these supportive fees is restricted to the GP who has been paid for the Mental Health Planning Fee (G14043) and is therefore Most Responsible GP (MRGP) for the care of that patient for the eligible mental health condition. The only exception would be if the billing GP has the approval of the Most Responsible GP (eg. locum or shared coverage), and this must be documented as an electronic note entry accompanying the billing.

The original telephone/e-mail follow up management fee G14079 is billable up to 5 times in the 18 months following the successful billing of one (or more) of the following incentives on eligible patients: G14053 (COPD CDM); G14033 (Complex Care Planning); G14043 (Mental Health Planning); or G14063 (Palliative Planning). In addition, FSFPs who are participating in the "GP for Me" or Attachment Initiative have access

to additional telephone visit fees to support the ongoing provision of care for any patient in their practice through the Attachment Patient Telephone Management fee G14076.

Either of the fees for telephone management (G14079 & G14076) may be billed on the same day as the conferencing fees (Attachment Patient Conference fee (G14077) or Community Patient Conferencing fee (G14016) provided the patient has not been seen and had any visit or other service code billed and all other criteria are met. The time spent with the patient on the telephone is compensated through one of the telephone fees and therefore does not count toward the time requirement of the conferencing fee.

The Community-based Mental Health Initiative remains outside the "Attachment Initiative" portal and are available to any Full Service Family Physician (FSFP) to support the management of their patients with eligible conditions. Please also refer to the Attachment Section of the GPSC Billing Guide for further details of this initiative and the relevant fee incentives.

Patient Eligibility for GPSC Mental Health Initiative Fees

- Eligible patients must be living at home or in assisted living. Long-Term Care Facility based patients are not eligible.
- Payable only to the General Practitioner that accepts the role of being Most Responsible for the longitudinal, coordinated care of the patient for that calendar year;
- Not payable to physicians who have been paid for any specialty consultation fee in the previous 12 months;
- Not payable to physicians who are employed by or who are under contract whose duties would otherwise include provision of this care;
- Not payable to physicians working under salary, service contract or sessional arrangements and whose duties would otherwise include provision of this care.

G14043 GP Mental Health Planning Fee $100

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients living at home or in assisted living. Patients in acute or long term care facilities are not eligible. Patients must have a confirmed eligible mental health diagnosis of sufficient severity and warrant the development of a management plan. This is not intended for patients with self-limited or short lived mental health symptoms *(e.g. situational adjustment reaction, normal grief, life transitions)*. The Mental Health Planning Fee requires a face-to-face visit with the patient and/or the patient's medical representative.

A Mental Health Plan requires documentation of the following elements in the patient's chart:

1. There has been a detailed review of the patient's chart/history and current therapies;
2. The patient's confirmed eligible mental health diagnosis, psychiatric history and current mental state;
3. The use of and results of validated assessment tools. Examples of validated assessment tools include:
    a. PHQ9, Beck Inventory, Ham-D depression scale;
    b. MMSE;
    c. MDQ;
    d. GAD-7;
    e. Suicide Risk Assessment;
    f. Audit (Alcohol Use Disorders Identification Test), CAGE, T-ACE;
4. Specifies a clinical plan for the care of that patient's psychiatric illness. Outlined linkages with other allied care professionals and community resources who will be involved in the patient's care, and their expected roles;
5. Identifies an appropriate time frame for re-evaluation of the Mental Health Plan;
6. Provides confirmation that the Mental Health plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other allied care professionals as indicated. ***The patient and/or their representative should leave the planning visit knowing there is a plan for their mental health care and what that plan is.***

Successful billing of the Mental Health Planning fee G14043 allows access to 4 counselling equivalent mental health management fees in that same calendar year which may be billed once the 4 MSP counselling fees (00120) have been utilized.

Successful billing of the mental health planning fee (G14043) allows access to 5 Telephone/e-mail follow-up fees (G14079) per calendar year in the subsequent 18 months.

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 only for patients with documentation of a confirmed eligible mental health diagnosis of sufficient severity to warrant the development of a management plan. Not intended for patients with self-limited or short lived mental health symptoms.

ii) Payable once per calendar year per patient. Not intended as a routine annual fee.

iii) Minimum required face to face time 30 minutes.

iv) Visit fee on same day only payable in addition if total time exceeds 39 minutes; counselling fee on same day only payable in addition if total time exceeds 49 minutes.

v) G14043 claim must state start and end times of the total service (planning plus any additional visit/counselling). Start and end times must also be documented in patient chart.

vi) G14016 or G14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for 14043.

vii) G14015, G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14074, G14075, G14076 and G14079 not payable on the same day for the same patient.

viii) Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.

ix) Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.

GP Mental Health Management Fees:

G14044 GP Mental Health Management Fee age 2–49
G14045 GP Mental Health Management Fee age 50–59
G14046 GP Mental Health Management Fee age 60–69
G14047 GP Mental Health Management Fee age 70–79
G14048 GP Mental Health Management Fee age 80+

These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee G14043 has been successfully billed. The four MSP counselling fees (age-appropriate 00120) must first have been paid in the same calendar year.

Notes:

i) Payable a maximum of 4 times per calendar year per patient.

ii) Payable only if the Mental Health Planning Fee (G14043) has been previously billed and paid in the same calendar year by the same physician.

iii) Payable only to the physician paid for the GP Mental Health Planning Fee (G14043), unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note.

iv) Not payable unless the four age-appropriate 00120 fees have already been paid in the same calendar year

v) Minimum time required is 20 minutes.

vi) ***Claim must include Start and End times. Start and end times must also be documented in patient chart.***
vii) *G14016 or G14077, payable on same day for same patient if all criteria met.*
viii) *G14015, G14043, G14076, G14079 not payable on same day for same patient.*
ix) *Not payable to physicians who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care.*
x) *Not payable to physicians working under salary, service contract or sessional arrangements whose duties would otherwise include provision of this care.*

Frequently Asked Questions:

1. What is the purpose of the Mental Health Initiative Fees?
Family Physicians provide the majority of mental care in BC. This is time consuming and is often not adequately compensated, so the Mental Health fees have been created to provide compensation for the provision of this care. Additionally, there is known benefit from having a longer planning visit with patients suffering from chronic mental health conditions and this initiative was developed to remove the financial barrier to providing this care, as opposed to seeing a greater number of patients with simpler clinical conditions.

2. What is the difference between "assisted living" and "care facilities"?
There are a wide range of living facilities currently available. Some, referred to under the terms of this initiative as 'assisted living' facilities, provide only basic supports such as meals and housecleaning, and do not provide their residents with nursing and other health support. A "care facility" on the other hand, is defined under the terms of this initiative as being a facility that does provide supervision and support from other health professionals such as nurses.

3. Why is this incentive limited to patients living in their homes or in assisted living?
While there may be exceptions, patients resident in a facility such as a Psychiatric Long Term Care Facility or hospital usually have available a resident team of other health care providers to share in the organization and provision of care, and therefore, the GPSC Mental Health Initiatives fee items are not applicable. Patients residing in their homes or in assisted living usually do not have such a team, and the organization and supervision of care is usually more complex and time consuming for the GP.

4. When can I bill the Mental Health Planning Fee (G14043)?
This fee is payable once per calendar year per patient. The GP may bill this fee upon:
1) confirmation that a patient has an eligible mental health condition as per appendix 1;
2) determined that the severity and acuity level of this eligible mental health condition is of sufficient severity to warrant the development of a management plan, and
3) creation of a Mental Health Plan for that patient that includes all of the elements outlined in fee G14043

5. What is a Mental Health Plan?
The initial service allowing access to the mental health care fees shall be the development of a Mental Health Plan for a patient residing in their home or assisted living (excludes care facilities) with a confirmed eligible mental health condition. This plan should be reviewed and revised as clinically indicated. Creation of a Mental Health Plan requires the GP to conduct a comprehensive review of the patient's chart/history, assessment of the patient's current psychosocial symptoms/issues by means of psychiatric history, mental status examination, and use of appropriate validated assessment tools, with confirmation of eligible diagnosis (see appendix 1). It requires a face-to-face visit with the patient, with or without the patient's medical representative. ***The patient & or their representative/ family should leave the planning process knowing there is a plan for their care and what that plan is.***

A Mental Health Plan requires documentation of the following elements in the patient's chart:

1. There has been a detailed review of the patient's chart/history and current therapies;
2. The patient's confirmed eligible diagnosis, psychiatric history and current mental state.
3. Examples of validated assessment tools include:
   a) PHQ9, Beck Depression Inventory, Ham-D depression scale;
   b) MMSE ;
   c) MDQ
   d) GAD-7
   e) Suicide Risk Assessment;
   f) Audit (Alcohol Use Disorders Identification Test CAGE; T-ACE);
4. Specifies a clinical plan for the care of that patient's psychiatric illness;
5. Outlines linkages with other allied care professionals and community resources who will be involved in the patient's care, and their expected roles.
6. Identifies an appropriate time frame for re-evaluation of the Mental Health Plan;
7. *Provides confirmation that the Mental Health plan has been communicated verbally or in writing to the patient and/or the patient's Medical Representative, and to other involved allied care professionals as appropriate. The patient and/or their representative/family should leave the planning process knowing there is a plan for their care and what that plan is.*

6. How much time is required for billing the Mental Health Planning Incentives and how should the time be documented?

The Mental Health Planning fee (G14043) require a minimum of 30 minutes face-to-face for the planning component. If the time goes beyond 39 minutes (due to the mental health plan or other medical reason) then an age differential office visit fee (00100) may be billed in addition to the G14043. If the time goes beyond 49 minutes and the preamble requirements for counseling are fulfilled, the age differential MSP counseling fee (00120) may be billed in addition. Effective August 1, 2015, start and end times for the total service time provided must be documented in the patient chart and are also required to be submitted with the fee to MSP.

Eg. Patient seen at 1600 hr for 40 minutes face-to-face planning visit that includes components of the Mental Health Plan as per FAQ 5. In addition, the patient required a 5 minute review of hypertension and refill of medications. Document in chart and submit with G14043 claim to MSP start time 1600 hr, end time 1645 hr. If instead, the patient was seen for a 55 minute planning visit that included 20 minutes of counseling as per preamble, document in chart and submit with G14043 claim to MSP start time 1600 hr, end time 1655 hr.

7. When can I bill the Mental Health Management Fees (G14044-G14048)?

The MSP counselling fees (the 00120 series) are limited to 4 visits per patient per calendar year. Managing patients with a significant mental health diagnosis, however, may require more than 4 counselling visits per year. The GPSC Mental Health Management fees provide an additional 4 counselling visits per calendar year to provide counselling to these patients. They are payable only after all 4 MSP counselling fees of the 00120 series have been utilized and only if the GP has billed and been paid for the Mental Health Care Planning Fee. They are payable to a maximum of 4 times per calendar year, at the same rate as the age-appropriate 00120 series counselling fee. Both the MSP Counseling fees and GPSC Mental Health Management fees (counseling equivalent) require a minimum of 20 minutes and must meet the criteria found in the preamble to fees regarding counseling. ***Effective August 1, 2015, the GPSC Mental Health Management (counseling) fees will require start and end time documented in the patient chart and included when submitting the claim to MSP.***

8. When can I bill the GP Telephone/Email Management fee (G14079)?

There is evidence that the follow-up of patients with significant mental illness does not always need to be face-to-face or by the physician. This fee (G**14079**) is payable for 2-way clinical interaction provided between the GP or delegated practice staff (e.g. office RN or MOA) in follow-up on the Mental Health

Planning Fee (G14043). This fee is payable only if the GP or practice has billed and been paid for at least one of the portal GPSC incentives, including the Mental Health Planning Fee (G14043).

9. When can I bill the Attachment Patient Telephone Management fee (G14076)?

Patients who are eligible for the original G14079 GP Telephone/e-mail Management Fee are also eligible for additional new G14076 GP Attachment Telephone Management fees if their FP is participating in a GP for Me (attachment). FPs are encouraged to think about how they would spread the restricted number of new Telephone fees they will have access to in this prototyping phase when providing telephone follow-up to patients who would also be eligible under the original telephone/e-mail fee.

Therefore, if a Family Physician thinks he/she will make a lot of these telephone calls, and any of them are for patients who are eligible for the G14076, it would be best to use all 5 of the G14079 for these patients first before using the new G14076. This way, you leave the "arrows in the quiver" for other patients who do not qualify for the G14079 unless you have used all 5 of the G14079 already, then you can use 14076 if you still have any left of your 1500 in that calendar year.

10. Why are there restrictions excluding physicians "who are employed by or who are under contract to a facility and whose duties would otherwise include provision of this care" or to "physicians working under salary, service, or sessional arrangements?"

This incentive has been designed to remove the disincentive that exists under current fee for service payments to provide more time-consuming complex care to a patient, instead of choosing to see a greater number of patients of a simpler clinical nature. The physician's time is considered to be already compensated if he/she is under a contract "whose duties would otherwise include provision of this care", or is being compensated by a salary, service, or sessional arrangement.

11. Am I eligible to bill for the Attachment Patient Conferencing Fee (G14077) or the Community Patient Conferencing Fee (G14016) in addition to receiving the Mental Health Care payment(s)?

Yes. The mental health care payment(s) relates to services provided to the patient. The new "Mental Health Management Fees" (G14044-G14048) for non-face-to-face care still relates to the services provided to the patient. If it is appropriate for some of this care to be provided by phone, then the physician is compensated for this. If as a result of the Mental Health Planning visit (G14043), follow up Mental Health Management visit (G14044-G14048) or as a result of Telephone Management (G14079 or G14076), the physician needs to conference with allied care professions about the care plan and any changes, then the services provided in conferencing with other health care professionals is payable over and above the management payments, provided that the all criteria for the Conferencing fee are met. FSFPs who are participating in the Attachment Initiative should use the Attachment Patient Conferencing Fee (G14077) while FSFPs who are not participating should use the Community Patient Conferencing Fee (G14016). The time spent on the phone or e-mail with the patient for the non-face-to-face complex care management does not count toward the total time billed under the community patient conferencing fee.

12. Am I eligible to bill for the Chronic Disease Management Fee(s) (G14050, G14051, G14052, G14053) in addition to these Mental Health Initiative fees?

Yes. Patients with mental health diagnoses still often have co-existing medical conditions. For those patients with Diabetes (G14050), Congestive Heart Failure (G14051), Hypertension (G14052) or COPD (G14053), the appropriate CDM payment(s) are payable in addition to the Mental Health Care payment(s). See CDM section for rules for billing of CDM incentives for patients with multiple comorbid conditions.

13. If the GP Mental Health Management fees (G14044-14048) are restricted to the GP who has been paid for the Mental Health Planning Fee (G14043), what do group practices do when they share the care of the patient, or when a locum is covering?

An exception has been made, allowing another GP to bill for these fees with the approval of the Most Responsible GP (MRGP). This allows flexibility in situations when patient care is shared between GPs. In order to facilitate processing of any claims for telephone/e-mail advice fees by a locum or colleague who has been designated to provide this service, an electronic note should be entered stating "locum/covering for Dr. X billing number YYYYY".

If a disagreement arises about the billing of this service, the GP Services Committee will adjudicate based upon whether the Most Responsible GP, i.e the GP paid for the Annual Complex Care Fee, approved or did not approve the service provided. The GP Services Committee feels that this provides the maximum flexibility while still maintaining responsibility.

14. Am I able to provide a mental health planning visit and bill G14043 each year for my patients with qualifying mental health conditions?

G14043 is not intended to be a routine annual planning visit for all patients with qualifying mental health conditions. This prolonged planning visit is to be utilized for patients whose mental illness is of sufficient clinical severity to warrant the development of a management plan. In a subsequent calendar year, when the FP's clinical evaluation supports the need for the development or review of a patient's mental health plan, it is appropriate to provide and bill for this service. For some patients this may be consecutive years, but for others, not. The submission and payment of G14043 allows access to counseling visits beyond the 4 MSP 00120 fees per calendar year for those patients who would benefit from this due to the severity of their eligible mental health condition.

15. Can I access the Mental Health Management fees if I have billed for the Mental Health Planning fee but have not yet been paid for it?

Adjudication of any billings for Mental Health Management fees will depend upon whether the GP is eventually paid for the Mental Health Care Planning Fee. In other words, if a GP bills for the Mental Health Planning Fee (G14043) and provides—and bills for— a follow-up Management service under G14044, G14045, G14046, G14047, G14048, or G14079 prior to receiving payment for G14043, payment for those follow-up Management billings will be made only if G14043 is subsequently paid to that GP. Until that time any follow-up services will show as "BH" on the remittance.

16. Does "Chronic Pain" qualify as an eligible mental health diagnosis for the GPSC Mental Health Planning Fee (14043)?

Chronic Pain qualifies as an eligible mental health diagnosis only when it is present in association with a psychological condition (Dx code 307.80, 307.89). When chronic pain is present due only to a physical condition and without associated psychological condition(s), it does not qualify for the GPSC Mental Health Planning Fee (G14043).

In addition, if the Mental Health Planning Fee (G14043) is billed for a patient who does have an associated psychological condition, all other criteria of the G14043 Planning Fee must be met.

17. Does Substance Abuse and/or Addictions qualify as an eligible mental health diagnosis for the GPSC Mental Health Planning Fee (G14043)?

Both Alcohol Dependency (303) and Substance Abuse (non-nicotine) (304) qualify as eligible mental health diagnoses. If the Mental Health Planning Fee (G14043) is billed for a patient with either Alcohol or Substance abuse issues, all other criteria of the G14043 Planning Fee must be met.

18. Are any of the Mental Health Incentive fees eligible for the Rural Retention Premium?

Effective November 1, 2014, the Mental Health Incentive fees are eligible for the Rural Retention Premium.

Mental Health Initiative Fees

G14043	**Mental Health Planning Fee** (Eligible Mental Health Diagnoses)	**$100**
G14044	**GP Mental Health Management Fee age 2–49**	
G14045	**GP Mental Health Management Fee age 50–59**	
G14046	**GP Mental Health Management Fee age 60–69**	
G14047	**GP Mental Health Management Fee age 70–79**	
G14048	**GP Mental Health Management Fee age 80+**	

Value of G14044/45/46/47/48 is set equivalent to MSP Age differential counseling 00120 – subject to change April 1 annually.

BILLING EXAMPLE

A long time patient of yours comes in with her 35 year old brother John, who has just moved from another city. He has brought his clinical records with him and needs a prescription refill. His past history includes Bipolar Disorder with situational anxiety, managed with Lithium, an anti-depressant and an anxiolytic. He advises you he has not had a lithium level in the past 6 months, and with the stress of moving is worried about his mental health. You confirm he is not at risk of harm currently and he is staying with his sister until he finds a place of his own. You send him for some baseline bloodwork including a lithium level, arrange for him to come in for a 30 minute mental health planning session in 2 weeks and ask him to complete a take home risk assessment questionnaire to bring to that appointment.

He returns at 1600 hr, your last appointment of the day, and you undertake a review of his eligible Mental Health diagnosis of Bipolar Disorder, review his risk assessment and develop a plan for management of his mental health condition. The total time spent is 40 minutes. He agrees to come to see you on a monthly basis for the next 3 months, and that at that third visit, you will review the direction of the plan for the following time. His Lithium level was low, so you adjust his medication dose. Jointly you agree that he also needs referral to the local mental health team as he is having some adjustment anxiety with his recent move. You advise him that you will contact mental health directly to discuss the management plan you have jointly developed and that your office will call him in 3 days to follow up on how he is tolerating this change as well as to discuss any feedback from the mental health worker. The mental health planning visit has taken 30 minutes to complete. The following day you contact the mental health team and spend 10 minutes discussing the case and management plan for the patient. They will see him the following week, and when you contact the patient as agreed 2 days later, you advise him of this information, plus review his status.

Over the course of the year, John sees you on a planned pro-active basis monthly for the next 3 months, then every 2 months for the last 6 months of the year. The first three visits were counseling sessions of at least 20 minutes but the other 2 were regular visits. In addition there were 2 crisis intervention counseling sessions of at least 20 minutes, each with one follow up phone call management. He is also attending at the local mental health clinic on a regular basis and you have had 2 more telephone conversations with his therapist around his management plan related to the acute crisis intervention, each one lasting 10 – 15 minutes.

Billing for calendar year:

Service#	Type of Visit	Fee Code	Diagnostic Code
1	Office Visit	00100	296
2	Mental Health Planning Visit Start time 1600 hr, end time 1640 hr. Office visit	14043 00100	296 296
3	Conferencing with AHP	14077 or 14016 X 1	296
4	Telephone Follow Up	14079 or 14076	296
5	Counseling (#1 MSP)	00120	296
6	Counseling (#2 MSP)	00120	296
7	Counseling (#3 MSP)	00120	296
8	Office Visit	00100	296
9	Counseling (Acute Crisis - #4 MSP)	00120	296
10	Community Patient Conferencing	14077 or 14016 X 1	296
11	Telephone Follow Up	14079 or 14076	296

12	Counseling (Acute Crisis - # 1 GPSC)	14044	296
13	Community Patient Conferencing	14077 or 14016 X 1	296
14	Telephone Follow Up	14079 or 14076	296
15	Office Visit	00100	296

If John also had any Chronic Disease Conditions covered under the CDM incentives, these are also billable in addition to any of the mental health fees as appropriate.

Mental Health Care Plan Template

Care Plan for _____ Chart Review Date _____

Eligible Mental Health Diagnosis: _____

Medications:

_____

_____

_____

Current concerns or problems:

_____

_____

_____

Risk Screening Tool Results:

_____

_____

Current supports and strengths:

_____

_____

Summary of Condition:

_____

_____

Plan:

_____

_____

Expected Outcomes:

_____

Communication with the following health professionals is approved by client:

_____

Reassessment will be in:

_____

Appendix 1.

The following list of diagnosis and acceptable ICD9 codes are applicable for the Mental Health Planning and Management Fee, fee items G14043, G14044 – G14048, and G14079:

	DIAGNOSIS	ICD-9
Adjustment Disorders:		
	Adjustment Disorder with Anxiety	309
	Adjustment Disorder with Depressed Mood	309
	Adjustment Disorder with Disturbance of Conduct	309
	Adjustment Disorder with Mixed Anxiety and Depressed Mood	309
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