GP SERVICES COMMITTEE
Mental Health INCENTIVES

Revised
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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 Care 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 G14077 conferencing fee if all other requirements are met. Family physicians who have submitted G14070/71 can access the GP Allied Care Provider Conferencing Fee (G14077) while FPs who have not submitted the GPSC Portal code will not be able to bill for these conferences.

The GPSC Mental Health Management (counseling equivalent) fees are applicable to mental health counseling provided either face-to-face or by videoconferencing. This aligns with the MSP counseling visits per calendar year in person (00120 age-appropriate) or telehealth counselling (13018, 13038). The MSP codes are payable up to 4 of any combination of these in person or by videoconferencing per calendar year. Once all 4 MSP counseling codes are utilized, provided there has been a successful billing of G14043, there is access to an additional 4 GPSC counseling equivalent (in-person or by videoconferencing) over the remainder of that calendar year.

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

This planning fee requires a face-to-face visit with the patient, with or without the patient's medical representative. ***Effective October 1, 2017, while the minimum required total planning time remains 30 minutes, only the majority of the planning time must be face-to-face with the***

physician, to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The balance of the total planning time may be non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) and may be on different dates. Some of this non-face-to-face planning may be delegated to a College-certified allied care providers as appropriate within their scope of practice (eg. Nurse, Nurse Practitioner, Social Worker) who is employed within the eligible physician practice. There is no longer a requirement to enter or document start and end times when submitting G14043. Chart documentation must include:

1. ***The care plan;***
2. ***Total planning time (minimum 30 minutes); and***
3. ***Face to face planning time (minimum 16 minutes).***

Additional medically required visit, including counseling that is provided outside the 30 minutes of planning time, does not count toward the total planning time and is billable in addition to G14043. If counseling is provided in addition to the planning visit, start and end times must still be entered for the counseling service as per MSP requirements.

A Care Plan requires documentation of the following core elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. **The patient & or their representative/family should leave the planning process knowing there is a plan for their 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 (any combination of 00120 age differential or telehealth counselling codes) have been utilized.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. 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.

In addition, FSFPs who have submitted G14070 (G14071 for Locums) have access to additional telephone visit fees to support the ongoing provision of care for any patient in their practice through the GP Patient Telephone Management fee G14076 and the GP Email/Text/Telephone Medical Advice Relay Fee G14078.

Either of G14076 or G14078 may be billed on the same day as the GP-Allied Care Provider Conference fee (G14077) 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 or patient's medical representative on the telephone does not count toward the time requirement of the conferencing fee.

The Community-based Mental Health Initiative remains outside the G14070/71 GPSC portal and are available to any Full Service Family Physician (FSFP) to support the management of their patients with eligible conditions.

Eligibility Criteria 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.

For the purpose of its incentives when referring to assisted living, GPSC utilizes the ministry definition as found at:
http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living

For the purpose of its incentives, GPSC considers patients living in group homes to be living in community.

G14043 GP Mental Health Planning Fee $100

This fee is payable upon the development and documentation of a Care Plan for patients with a confirmed eligible mental health diagnosis of sufficient severity and warrant the development of a care 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. **The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive general practice care for the ensuing year.**

A Care Plan requires documentation of the following core elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient's care for the next year;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. **The patient & or their representative/family should leave the planning process knowing there is a plan for their 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 (any combination of 00120 age differential or telehealth counselling codes) have been utilized.

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 care 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) Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place concurrently with the face to face planning included under G14043.

iv) Minimum required total planning time 30 minutes. The majority of the planning time must be face-to- face to create the care plan collaboratively with the patient and/or their medical representative (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers (eg. Nurse, Nurse Practitioner) employed within the eligible physician practice.

v) Chart documentation must include:

1. *The care plan;*
2. *Total planning time (minimum 30 minutes); and*
3. *Face-to-face planning time (minimum 16 minutes)*

vi) 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) G14044, G14045, G14046, G14047, G14048, G14033, G14063, G14075, G14076 and G14078 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 or telehealth counseling) 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 or telehealth counseling (13018, 13038) fees have already been paid in the same calendar year*
v) *Minimum time required is 20 minutes.*
vi) ***Start and end times must be included with the claim and documented in the patient chart.***
vii) *Counselling may be provided face-to-face or by videoconferencing*
viii) *G14077, payable on same day for same patient if all criteria met.*
ix) *G14043, G14076, G14078 not payable on same day for same patient.*
x) *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.*
xi) *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 allied care providers 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 care plan, and
3) creation of a Care Plan for that patient that includes all of the elements outlined in fee G14043

5. What is a Care Plan for patients with eligible mental health conditions?
The initial service allowing access to the mental health care fees shall be the development of a Care Plan for a patient residing in their home or assisted living (excludes long term care facilities) with a confirmed eligible mental health condition. This plan should be reviewed and revised as clinically indicated. Creation of a Care 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).

A Care Plan requires documentation of the following core elements in the patient's chart:

1. There has been a detailed review of the case/chart and of current therapies therapies;
2. Name and contact information for substitute decision maker;
3. Documentation of eligible condition(s);
4. There has been a face-to-face planning visit with the patient, or the patient's medical representative if appropriate, on the same calendar day that Care Planning Incentive code is billed;
5. Specifies a clinical plan for the patient's care;
6. Documentation of patient's current health status including the use of validated assessment tools when available and appropriate to the condition(s) covered by the care planning incentive;
7. Incorporates the patient's values, beliefs and personal health goals in the creation of the care plan;
8. Outlines expected outcomes as a result of this plan, including advance care planning when clinically appropriate;
9. Outlines linkages with other allied care providers who would be involved in the patient's care, and their expected roles;
10. Identifies an appropriate time frame for re-evaluation of the plan;
11. Provides confirmation that the care plan has been created jointly and shared with the patient and/or the patient's medical representative and has been communicated verbally or in writing to other involved allied care providers as appropriate. **The patient & 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 Incentive and how should the time be documented?

The Mental Health Planning fee (G14043) has a minimum required total planning time of 30 minutes. The majority of the planning time must be face- to- face with the patient or the patient's medical representative, to create the care plan collaboratively (minimum 16 minutes). The non-face-to-face planning (review chart and existing care plan(s), medication reconciliation, etc.) may be on different dates and may be delegated to a College-certified allied care providers employed within the eligible physician practice. ***Effective October 1, 2017, there will be no requirement to submit or document start and end times as not all the planning work is required to be face-to-face or even on the same day. There is still a requirement to document the total planning time and the total face-to-face planning time in the patient's chart.*** **The time for any additional visit or counseling will not count toward the planning visit. Any counseling provided in addition to the planning visit will still require start and end times as per MSP requirement in order to bill the age appropriate counseling fee (00120 series).** .

Eg. On the day prior to the scheduled Mental Health Planning visit, you undertake a review of any hospitalizations or psychiatric reports of your patient with a diagnosis of bipolar disorder, the previous care plan plan developed, and the medication reconciliation done by your office nurse with the clinical pharmacist working in your practice (5 minutes of your time and 10 minutes of your nurse and pharmacist time for a total of 15 minutes non-face-to-face planning time). Your patient is seen the next day for a 20 minute face-to-face planning visit to determine the mental health supports that will be needed over the rest of the calendar year. This is followed by a review of the patient's medical co-morbidity of hypertension and refill of medications. Documentation in the chart is of total planning time of 35 minutes, total Face-to-face planning time with patient of 20 minutes and submit with G14043 claim to MSP with no start end times required. If instead, the patient was seen for the same planning visit and also a25 minute counseling visit starting at 1600 hr for current flare of depression in addition to the planning visit as per preamble, document in chart and submit with G14043 claim to MSP without any start/end times, but submit the age appropriate counseling fee with start time 1600 hr, end time 1625 hr hr.

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

The MSP counselling fees (any combination of the 00120 series and/or telehealth counseling fees 13018, 13038) 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 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. ***Like the MSP counseling codes, the GPSC Mental Health Management (counseling) fees require start and end time documented in the patient chart and included when submitting the claim to MSP.***

8. To which College-certified allied care providers employed within the eligible physician practice may I delegate some of the non-face-to-face planning work to be eligible for the G14043 GP Mental Health Planning Fee to be billed?

Family Physicians may delegate some of the non-face-to-face planning work to college certified allied care providers who are employed directly by the Full Service FP, who are working within her/his scope of practice, and who maintain his/her certification with their professional college, as well as maintain medical legal coverage to do so. This would include nurses, NP, LPN, dieticians, social workers, etc. but excludes the Medical Office Assistant as they do not have a clinical scope of practice.

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

Family Physicians who have submitted the G14070 or G14071 portal code are eligible to bill G14076 GP-Patient Telephone Management fees for any patients for whom they are the community MRP, including those with mental health conditions eligible for G14043.

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 Allied Care Provider Conferencing Fee (G14077) in addition to receiving the GPSC Mental Health Incentives?

FSFPs who have submitted G14070 (or G14071 if a locum) may submit the GP Allied Care Provider Conferencing Fee (G14077) while FSFPs who have not submitted the GPSC Portal code G14070/71 will not be able to bill for these conferences. The GPSC mental health incentives are payment for services provided to the patient. The expansion of the Mental Health Management Fees (G14044-G14048) to include counseling provided by videoconferencing for non-face-to-face care still relates to the services provided to the patient. If as a result of the Mental Health Planning visit (G14043), follow up Mental Health Management visits (G14044-G14048) or as a result of GP-Patient Telephone Management (G14076), the physician needs to conference with allied care providers about the care plan and any changes or other aspects of patient management, then the services provided in conferencing with allied care providers (including specialists) is payable in addition to the GPSC Mental Health incentives, provided that the all criteria for the Conferencing fee are met. The time spent with the patient (whether in person, by video-link or on the phone) does not count toward the required time billed for the 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 counseling fees (age appropriate 00120 series or telehealth counseling 13018 or 13038) 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, or G14048, 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?

Yes, 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 20 minute mental health planning session in 2 weeks and ask him to complete a take home risk assessment questionnaire to bring to that appointment.

A few days prior to the planning visit, your office nurse reviews the old charts you have received and pulls out relevant information from recent mental health services and on the day prior to the planning visit you undertake a medication reconciliation with the community pharmacist who fills his prescriptions. The total time of this non-face-to-face planning work is 30 minutes (nurse and FP). He returns for his planning visit and you undertake a review of his eligible Mental Health diagnosis of Bipolar Disorder, review the risk assessment and develop a plan for management of his mental health condition. 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 remainder of the calendar year. 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. You note that his Lithium level is low, so you adjust his medication dose. He notes he has been a bit tired and you find his conjunctiva are pale so you discuss possible anemia and order a CBC. You advise him that your office will call him in 3 days to follow up on how he is tolerating this change, the results of his CBC, as well as to discuss any feedback from the mental health worker. The mental health planning visit has taken 20 minutes to complete in addition to the "visit" to assess his complaint of fatigue, and the total planning time spent is 50 minutes (20 minutes face to face and 30 minutes non-face-to-face). 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 20 minutes face to face, total Planning time 50 minutes over 3 separate days (FP & RN). Office visit	14043 00100	296 280
3	Conferencing with ACP	14077 or	296
4	Telephone Follow Up	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	296
11	Telephone Follow Up	14076	296
12	Counseling (Acute Crisis - # 1 GPSC)	14044	296
13	Community Patient Conferencing	14077 or	296
14	Telephone Follow Up	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.

Appendix 1. GPSC Mental Health Initiative – Approved Diagnoses

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