GP SERVICES COMMITTEE
Mental Health INCENTIVES

Revised
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BRITISH COLUMBIA MEDICAL ASSOCIATION

BRITISH COLUMBIA
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Society of General Practitioners

COMMUNITY-BASED MENTAL HEALTH INITIATIVE

Family physicians will identify their high-risk patients living in the community (i.e. home or assisted living) who meet the following criteria:

i) Axis I diagnosis confirmed by DSM IV criteria;
ii) Severity and Acuity level causing sufficient interference in activities of daily living 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 physician will need to accept the role of being Most Responsible for the longitudinal, coordinated care of that patient.

The Mental Health Planning Fee and resulting access to an increased number of billable GP management/counseling 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 GP 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 Community Patient Conferencing Fee (14016) if all other requirements are met.

The initial GP/FP service providing 'Portal' 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 (excluding 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 diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative.

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;
- DSM-IV Axis 1 confirmatory diagnostic criteria;
- 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, 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 (00120 fees per MSP guide to fees) have been billed.

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 14043, for either physician-initiated or patient-initiated follow up.

   The GP Telephone/Email Management Fee may be billed on the same day as the community patient conferencing fee (14016) provided all other criteria are met, but the time spent with the patient on the telephone does not count toward the time requirement of the conferencing fee.

Access to these supportive fees is restricted to the GP that 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 submitted Axis 1 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 a note entry accompanying the billing.

Eligibility

- Eligible patients must be community based, (living in their home or assisted living). Facility based patients are <u>not</u> eligible.
- Payable only to the General Practitioner or practice group 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

This fee is payable upon the development and documentation of a patient's Mental Health Plan for patients resident in the community (home or assisted living, excluding care facilities) with a confirmed Axis I diagnosis of sufficient severity and acuity to cause interference in activities of daily living and warrant the development of a management plan. 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 diagnosis through DSM IV diagnostic criteria. It requires a face-to-face visit with the patient, with or without the patient's medical representative. From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- 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;
- DSM-IV Axis 1 confirmatory diagnostic criteria;
- 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 and/or their representative should leave the planning visit knowing there is a plan for their mental health care and what that plan is.***

Notes:

i) Requires documentation of the patient's mental health status and diagnosis by means of psychiatric history, mental state examination, and confirmatory DSM IV diagnostic criteria. Confirmation of Axis 1 Diagnosis is required for patients eligible for the GP Mental Health Planning Fee. *Not intended for patients with self-limiting or transient mental health symptoms (e.g. Brief situational adjustment reaction, normal grief, life transitions) for whom a plan for longer term mental health care is not necessary.*

ii) Payable once per calendar year per patient;

iii) Payable in addition to a visit fee billed same day;

iv) Minimum required time 30 minutes. This time does not count towards visit fee same day;

v) G14016, community conferencing fee payable on same day for same patient, if all criteria met;

vi) Not payable on the same day as G14044, G14045, G14046, G14047, G14048 (GP Mental Health Management Fees);

vii) Not payable on the same day as G14049 (GP Mental Health Telephone/Email Management fee)

viii) Not intended as a routine annual fee if the patient does not require ongoing Mental Health Plan review and revision;

ix) G14015, Facility Patient Conferencing Fee, not payable on same day for same patient as facility patients are not eligible.

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 GP Mental Health Management required beyond the four (4) MSP counselling fees (age-appropriate 00120 fees billable under the MSP guide to fees) for patients with a chronic mental health condition on whom a Mental Health Plan has been created and billed. Access to this fee is restricted to the GP that 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 submitted Axis 1 condition. The only exception would be if the

billing GP has the approval of the Most Responsible GP, and this must be documented as a note entry accompanying the billing.
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;
iv. Not payable unless the age-appropriate 00120 series has been fully utilized;
v. Minimum time required is 20 minutes; this time does not count towards GP Mental Health Planning Fee if performed same day;
vi. Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14079 (GP Telephone/Email Management Fee);
vii. G14016 (Community Patient Conferencing Fee) payable on same day or same patient if all criteria met;
viii. G14015 (Facility Patient Conferencing Fee) not payable on same day as facility patients not eligible;
ix. CDM fees (G14050, G14051, G14052, G14053) payable if all criteria met.

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 are unable to 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. 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 (14043)?
This fee is payable once per calendar year per patient. The GP may bill this fee upon:

1) confirmation through DSM IV criteria that a patient has an Axis I disorder;
2) determined that the severity and acuity level of this Axis I disorder is causing sufficient interference in activities of daily living that developing a management plan to maintain the patient safely in the community would be appropriate, 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 diagnosed Axis One 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 diagnosis through DSM IV diagnostic criteria (See information following FAQs). 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.***

From these activities (review, assessment, planning and documentation) a Mental Health Plan for that patient will be developed that documents in the patient's chart:

- 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;
    vi) Audit (Alcohol Use Disorders Identification Test) for Alcohol Misuse;
- DSM-IV Axis 1 confirmatory diagnostic criteria;
- 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.

6. When can I bill the Mental Health Management Fees (14044-14048)?

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.

7. When can I bill the GP Telephone/Email Management fee?

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 new fee (**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).

8. 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.

9. Am I eligible to bill for 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" (G14044-14048) 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 (G14044-14048) or as a result of the GP Telephone/Email Management (G14079), the physician needs to conference with allied health 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 mental health care payments. It is payable on the same day as long as all criteria are met. The time spent on the phone with the patient for the GP Telephone/Email Management (G14079) does not count toward the total time billed under the Community Patient Conferencing Fee (G14016).

10. 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.

11. 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.

12. 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 G14033 is subsequently paid to that GP. Until that time any follow-up services will show as "BH" on the remittance.

14. Does "Chronic Pain" qualify as an Axis I diagnosis for the GPSC Mental Health Planning Fee (14043)?

Chronic Pain qualifies as an Axis I diagnosis only when it is present in association with a psychological condition (DSM 307.80, 307.89). When chronic pain is present due only to a physical condition and without associated psychological condition(s), it is an Axis III diagnosis and does not qualify for the GPSC Mental Health Planning Fee (14043).

In addition, if the Mental Health Planning Fee (14043) is billed for a patient who does have an associated psychological condition, all other criteria of the 14043 Planning Fee must be met. These include:

- The billing physician must be the GP who accepts responsibility for the ongoing longitudinal care for that patient
- A full assessment that includes:

- A detailed review of the chart, history, and current therapies
- Psychiatric history and mental state examination
- The use of and results of validated assessment tools for the psychological disorder and, in this case, the pain disorder
- DSM-IV Axis I confirmatory diagnostic criteria
- A summary of the condition and a specific plan for that patient's care
- An outline of expected outcomes
- Linkages with other health care professionals as appropriate
- A time frame for re-evaluation of the Mental Health Plan

- Communication of the plan to the patient and/or patient's medical representative, and to other health professionals as indicated

15. Does Substance Abuse and/or Addictions qualify as an Axis I diagnosis for the GPSC Mental Health Planning Fee (14043)?

Both Alcohol Dependency (303) and Substance Abuse (non-nicotine) (304) qualify as Axis I diagnoses. If the Mental Health Planning Fee (14043) is billed for a patient with either Alcohol or Substance abuse issues, all other criteria of the 14043 Planning Fee must be met. These include:

- The billing physician must be the GP who accepts responsibility for the ongoing longitudinal care for that patient
- A full assessment that includes:
  - A detailed review of the chart, history, and current therapies
  - Psychiatric history and mental state examination
  - The use of and results of validated assessment tools for the psychological disorder and, in this case, the alcohol and/or substance disorder
  - DSM-IV Axis I confirmatory diagnostic criteria
  - A summary of the condition and a specific plan for that patient's care
  - An outline of expected outcomes
  - Linkages with other health care professionals as appropriate
  - A time frame for re-evaluation of the Mental Health Plan
- Communication of the plan to the patient and/or patient's medical representative, and to other health professionals as indicated

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

Only the follow-up Management service under G14045, G14046, G14047 and G14048 are eligible as these have MSP equivalents (00120, 15320, 16120, 17120, 18120).

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 the scheduled time, your last appointment of the day, and you undertake a review of his Axis 1 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.

Service#	**Type of Visit**	**Fee Code**	**Diagnostic Code**
1	Office Visit	00100	296
2	Mental Health Planning Visit Office visit	14043 00100	296 296
3	Community Patient Conferencing	14016 X 1	296
4	Telephone Follow Up	14049	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	14016 X 1	296
11	Telephone Follow Up	14049	296
12	Counseling (Acute Crisis - # 1 GPSC)	14044	296
13	Community Patient Conferencing	14016 X 1	296
14	Telephone Follow Up	14049	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 _____

DSM IV Diagnosis: **Axis 1: _____**

Axis 2: _____

Axis 3: _____

Axis 4: _____

Axis 5: _____

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:

_____