5. Mental Health Fees
Planning Fee (PG14043)

The fees listed in this guide cannot be appropriately interpreted without the GPSC Preamble.

This fee is payable upon the completion and documentation of a care plan (as defined in the GPSC Preamble) in the patient's chart for patients with a confirmed eligible mental health diagnosis when the effect on the patient is significant enough to warrant the development of a care plan. This is not intended for patients with short-lived mental health symptoms (e.g. 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 and the physician.

Effective April 1, 2020, PG14043 is payable only to Family Physicians who have submitted PG14070 or PG14071. The Mental Health Planning Fee is payable only to the family physician who commits to providing the majority of the patient's longitudinal comprehensive primary medical care for the ensuing year.

Successful billing of the Mental Health Planning fee PG14043 allows access to four counselling equivalent mental health management fees in that same calendar year which may be billed once the four 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.

Fee Code	Description	Total Fee $
PG14043	**FP Mental Health Planning Fee**	**$100.00**
	Notes: *i)* Payable to the family physician who is most responsible for the majority of the patient's longitudinal care and who has successfully submitted and met the requirements for PG14070 in the same calendar year. Alternatively, if a locum and host MRP FP have agreed that the locum may provide a planning visit, the locum must have successfully submitted and met the requirements for PG14071 in the same calendar year. *ii)* Payable only for patients with documentation of a confirmed eligible mental health diagnosis the effects of which are significant enough to warrant the development of a care plan. Eligible diagnoses are listed in Table 1. Not intended for patients with short lived mental health symptoms. *iii)* Payable once per calendar year per patient. Not intended as a routine annual fee. *iv)* Payable in addition to a visit fee (home or office) on the same day if medically required and does not take place during a time interval that overlaps with the physician face-to-face planning included under PG14043.	

v) Minimum required total planning time 30 minutes. The majority of the planning time must be face-to-face between the physician and patient (or patient's medical representative) to create the care plan collaboratively (minimum 16 minutes). Other tasks (review chart and existing care plan(s), medication reconciliation, etc.) may take place on different dates, may be done with or without the patient, and may be delegated to a College-certified allied care provider (e.g. Nurse, Nurse Practitioner) or another physician working within the eligible physician practice team. See Preamble definition of "working within" and "college certified ACP").

vi) Chart documentation must include:
1. The care plan;
2. Total planning time (minimum 30 minutes); and
3. Physician face-to-face planning time (minimum 16 minutes).

vii) PG14077 payable on same day for same patient if all criteria met. Time spent on conferencing does not apply to 30 minute time requirement for PG14043.

viii) PG14044, PG14045, PG14046, PG14047, PG14048, PG14033, PG14063, PG14075, PG14076 and PG14078 not payable on the same day for the same patient.

ix) Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.

Table 1

Effective April 1, 2020, the following list of eligible diagnoses and ICD-9 codes is to be used when billing the Mental Health Planning and Management Fees, PG14043, PG14044 – PG14048:

CATEGORY	DIAGNOSIS	ICD-9
Anxiety Disorders	Anxiety Disorders	300, 308, 50B
Bipolar and Related Disorders	Bipolar	296
	Cyclothymia	301.13
Depressive Disorders	Depressive disorders	311
Dissociative Disorder	Dissociative Disorders	300
Eating Disorders	Eating Disorders	307, 307.1
Gender Dysphoria	Gender Dysphoria	302
Impulse Control Disorders	Impulse Control Disorders	312
Neurocognitive Disorders	Delirium	293
	Dementia	290, 331, 331.0, 331.2
	Attention Deficit Disorder	314

Neurodevelopmental disorders	Autism Spectrum Disorder	299.0
	Pervasive Developmental Disorder	299.0
Obsessive-Compulsive & Related Disorders	Obsessive-Compulsive Disorder	300
	Body Dysmorphic Disorder	300.7
Schizophrenia and other Psychotic Disorders	Schizophrenia and other Psychotic Disorders	293, 295, 297, 298
Sexual Dysfunction	Sexual Dysfunction	302
Sleep Disorders	Sleep wake disorders: Insomnia/ hypersomnolence/ narcolepsy	307.4, 347
	Parasomnias	307.4
	Breathing-Related Sleep Disorders	780.5
Somatic Symptom & Related Disorders	Factitious Disorder	300, 312
	Pain Disorder with Affective Symptoms	338
	Somatic Symptom Disorder	300.8
	Conversion Disorder	300.1
Substance Use Disorders	Substance Use Disorder: Alcohol	303
	Substance Use Disorder: Drugs	304
Trauma and stressor related disorders	Adjustment Disorders	309
	Post-Traumatic Stress Disorder	309

Mental Health Management Fees
(PG14044, PG14045, PG14046, PG14047, PG14048)

Fee Codes	Description	Total Fee $
	Mental Health Management Fees	
PG14044	FP Mental Health Management age 2-49	$56.41
PG14045	FP Mental Health Management Fee age 50–59	$62.05
PG14046	FP Mental Health Management Fee age 60–69	$64.86
PG14047	FP Mental Health Management Fee age 70–79	$73.32
PG14048	FP Mental Health Management Fee age 80+	$84.60
	These fees are payable for prolonged counselling visits (minimum time 20 minutes) with patients on whom a Mental Health Planning fee PG14043 has been successfully billed. The four MSP counselling fees (any combination of age-appropriate 00120 or telehealth counselling) must first have been paid in the same calendar year. ***Notes:*** *i)* Payable only to the physician who has previously billed and been paid the Mental Health Planning fee (PG14043) in the same calendar year, unless that physician has agreed to share care with another delegated physician. To facilitate payment, the delegated physician must submit an electronic note. *ii)* Payable a maximum of 4 times per calendar year per patient. *iii)* Not payable unless the four age-appropriate 00120 or telehealth counselling (13018, 13038) fees have already been paid in the same calendar year in any combination. *iv)* Minimum time required is 20 minutes. *v)* Start and end times must be included with the claim and documented in the patient chart. *vi)* Counselling may be provided face-to-face or by videoconferencing *vii)* PG14077, payable on same day for same patient if all criteria met. *viii)* PG14043, PG14076, PG14078 not payable on same day for same patient. *ix)* Documentation of the effect(s) of the condition on the patient and what advice or service was provided is required. *x)* Not payable to physicians working under an Alternative Payment/Funding model whose duties would otherwise include provision of this service.	

FAQs: Mental Health Planning and Management fees

1. Who can bill the Mental Health fees?
Effective April 1, 2020, GPSC Mental Health Planning fee 14043 and the MH management fees 14044-14048 are only payable to the FP who has submitted PG14070 Portal (or PG14071 for locums) in the same calendar year. See the GPSC Portal Fee Guide and FAQs for more information.

2. What is the purpose of the Mental Health fees?
Family Physicians provide the majority of mental health care in BC. This can be time consuming and inadequately remunerated under fee for service. The GPSC Mental Health Planning fee provides compensation for time taken to create a plan of care for the patient's mental health for the following year. The GPSC Mental Health Management fees provide payment for an additional 4 prolonged visits for counseling, in addition to the 4 covered by 0120, for patients on whom a MH plan has been created and billed.

3. What is an "assisted living" facility?
Assisted Living is defined in the GPSC Preamble using the Ministry of Health definition:
https://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/care-options-and-cost/assisted-living

4. Why is this incentive limited to patients living in their homes or assisted living?
Patients residing in a Long Term Care Facility or hospital have a resident team of health care providers available to share in the organization and provision of care and therefore GPSC Planning and Management Fees are not billable. Patients residing in their homes or in assisted living usually do not have such a team, making the planning and provision of care more complex and time consuming for the FP.

5. When can I bill the Mental Health Planning Fee (PG14043)?
After submitting the appropriate Portal code on a prior date within that same calendar year, the FP may bill PG14043:

1) If a patient has an eligible mental health condition as per appendix 1; and
2) The effects of the mental health condition on the patient are significant enough to warrant the development of a care plan; and
3) After creation of a care plan for that patient's MH condition. See the GPSC Preamble for definition of a care plan.

   NOTE: This fee is not intended for patients with short lived mental health symptoms such as usual grief, life transitions. Although it is payable once per calendar year per eligible patient, it is not intended as a routine annual service for most patients.

6. What is a Care Plan?
The FP should first complete an assessment of the patient's psychosocial issues, psychiatric history, and current mental status using appropriate validated assessment tools, to confirm the eligible psychiatric diagnosis (see appendix 1).
The care plan should then be created collaboratively with the patient.
The care plan should be reviewed and revised as clinically indicated.
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;
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 the 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 that would be involved in the care, 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.

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

GPSC planning fees require you to spend at least 30 minutes on the planning process, the majority of it face to face between physician and patient (or patient's medical representative.) Therefore, chart documentation of the planning process must include total planning time (minimum 30 minutes) and total physician:patient face-to-face time (minimum 16 minutes).

Total planning time includes the combination of physician:patient face- to-face planning and non-face-to-face planning, including chart review, review of relevant consultation recommendations, medication reconciliation, etc. Non-face-to-face planning activities may be delegated to an appropriate college certified allied care provider working within the physician's office, and may take place on different days. There is no requirement to document or submit start/end times.

Time spent on any medically necessary visit billed in addition to the planning fee does not count toward planning time. Any conferencing with an allied care provider that results from the complex care planning visit is billable separately using 14077 if all criteria are met. The time spent conferencing does not count toward the Complex Care Planning time and the time spent planning does not count toward required conferencing time.

E.g. The day before a scheduled Mental Health Planning visit for your 48 year old patient with known bipolar illness, you review the medical record including hospital reports, psychiatric consultations, recent blood work, and the medication reconciliation done by your office nurse with the clinical pharmacist (5 minutes of your time and 10 minutes of nurse and pharmacist time). You see the patient the next day for a 20 minute face-to-face planning visit. The planning visit is followed by a review of the patient's hypertension and refill of BP meds. Document total planning time of 35 minutes and total face-to-face planning time 20 minutes. Submit 140433, dx code 296 and 0100 dx code 401.

8. When can I bill the Mental Health Management Fees (PG14044-PG14048)?

The MSP counselling fees (any combination of the 00120 series and/or telehealth counseling fee 13038) are limited to 4 visits per patient per calendar year. Managing patients with a significant mental health diagnosis may require more than 4 counselling visits per year. If a MH planning fee has been billed for a patient, and the patient has already had 4 such counselling visits billed in the same calendar year, the GPSC Mental Health Management fees may then be used for providing up to an additional 4 counselling visits in the calendar year. Remember the MH management fees are only billable if a MH planning visit has been billed AND the patient has already been provided 4 of any combination of 0120 and 13038.

Visits billed under the MH management fees must meet the same criteria as visits billed under 0120, including a minimum 20 minutes time requirement. Like the MSP counseling codes, the GPSC Mental Health Management fees require start and end times to be documented in the chart and included with the claim submission to MSP.

9. Which College-certified allied care providers may I delegate some of the non-face-to-face planning work of the PG14043 GP Mental Health Planning visit , in order to bill the fee?
Non face to face planning may be delegated to any college certified allied care provider working within the family physician's practice, whether employed directly by the Practice or embedded within the practice through a Health Authority agreement with the MRP family physician.

College certified ACPs are governed by a provincial regulatory body or college and include nurses, NP, LPN, dieticians, social workers, etc. (see GPSC Preamble for definition of "Allied Care Provider".) Medical Office Assistants are excluded from the GPSC definition of Allied Care Provider as they do not have a clinical scope of practice. The college certified ACP must maintain their certification with their regulatory body.

10. Why are there billing restrictions excluding physicians "working under an Alternative Payment/Funding model" whose duties would otherwise include provision of this service"?
The current Fee-for-Service payment schedule may encourage the provision of a higher volume of easier services as opposed to fewer, more complex and time-intensive services. This incentive has been designed to offset this disincentive.
If a physician is already compensated for providing these services through terms of employment, or through time-neutral payments such as salary, service, or sessional arrangements, their time is considered to be already compensated.

11. Am I eligible to bill for the FP Conference with Allied Care Provider and/or Physician fee Fee (PG14077) in addition to the Mental Health fees?
If the physician who provides the MH plan needs to conference with allied care professionals about the patient then the conferencing is payable in addition to the planning or management fees, provided the criteria for the 14077 fee is met. The time spent conferencing with allied care providers does not count toward the total time billed for the planning or management fees (and vice versa).

12. Am I eligible to bill for the Chronic Disease Management Fee(s) (PG14050, PG14051, PG14052, PG14053) and/or the Complex Care Planning and Management fee 14033 or 14075 in addition to these Mental Health Fee fees?
Yes, they are payable on the same patient as long as the criteria for the fees are met.

13. If the FP Mental Health Management fees (PG14044-PG14048) are restricted to the GP who has been paid for the Mental Health Planning Fee (PG14043), 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 FP to bill these management fees with the approval of the MRP FP. This allows flexibility in situations when patient care is shared between FPs. In order to facilitate processing of any claims 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".

14. Am I able to provide a mental health planning visit and bill PG14043 each year for my patients with qualifying mental health conditions?

PG14043 is not intended to be a routine annual planning visit for all patients with qualifying mental health conditions. However, when the impact of a patient's mental illness is significant enough to warrant

the development/review of a management plan annually, then you may provide such a planning visit and bill for it. For some patients this may be consecutive years, but for others, not.

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

Pain Disorder with Affective Symptoms qualifies as an eligible mental health condition (DX 338). When chronic pain is present without associated psychological symptoms(s), it does not qualify as an eligible condition under the GPSC Mental Health Planning Fee (PG14043).

16. Does Substance Use Disorder related to alcohol or drugs qualify as an eligible mental health diagnosis for the GPSC Mental Health Planning Fee (PG14043)?

Yes.

6.0 Case 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 says he has not had a lithium level done in the past 6 months. You order some baseline bloodwork including a lithium level, and arrange an appointment for a mental health planning visit. You 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 John's old charts pulling out relevant information from recent mental health services. On the day prior to the planning visit you undertake a medication reconciliation with John's community pharmacist. The total time spent on this non-face-to-face planning work is 30 minutes (nurse and FP).

At John's planning visit, you spend 20 minutes reviewing his diagnosis of Bipolar Disorder, the history of his previous psychiatric care, his current functioning and symptoms and together develop a plan for management of his bipolar illness. He agrees to monthly appointments for the next 3 months, at which time you will reassess the plan. You recommend referral to the local mental health team and tell him that you will contact the team directly to inform them of the management plan you have jointly developed. You note that his Lithium level is low, and you adjust his medication dose. John also complains of a rash on his feet. You diagnoses tinea and recommend OTC cream. You advise John that your office will call him in 3 days to follow up on his increased lithium dose. Chart documentation includes the care plan and total planning time 50 minutes with 20 minutes face to face.

The following day you contact the mental health team and spend 10 minutes discussing John's illness and circumstances, and the management plan you developed with him. Two days later your office nurse contacts John to review how he is tolerating the increased Lithium dose.

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. He also comes in once urgently because of increased symptoms of depression. 5 of the seven visits are counseling sessions of at least 20 minutes, two of which warranted a telephone follow up for clinical management. John also attends the local MH team during the year and you have 2 telephone conversations with his psychiatrist to discuss medication management, each call 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 Office visit for tinea	14043 00100	296 110
3	Conferencing with ACP at MH team	14077	296
4	Telephone Follow Up Office nurse with John	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 (#4 MSP)	00120	296
10	Telephone Conference with psychiatrist	14077	296
11	Telephone Follow Up with John	14076	296
12	Counseling (# 1 GPSC)	14044	296

13	Telephone Conference with psychiatrist	14077	296
14	Telephone Follow Up with John	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.