

DEMENTIA CARE - POTENTIAL SERVICE SCENARIO FOR GP'S

See Example #1 and GPSC Full Service Family Practice Incentives

Visit 1	Visit 2		Visit 3	Visit 4	Visit 5	
Initial visit - regular visit by patient for minor complaint - possible cognitive difficulties noted - patient to book appointment for full examination	Full examination - physical check-up - identify contributing medical conditions to cognitive decline - review medications - identify neurological abnormalities - order blood tests/imaging	Community Patient Conference (following complete exam) - discuss patient issues/symptoms - conduct patient assessment (SMMSE, GDS) - disclose possible diagnosis/prognosis - address issues/ concerns - discuss medications - consult with family - organize care plan with other healthcare providers - confirm to patient and family after conferencing with AHP	Follow-up visit (30-minute mental health planning visit) - review test results - confirm diagnosis - review any change in symptoms - complete prescription process - address family concerns - provide info on education and support services - provide ongoing support - develop and document patient's mental health plan	Follow-up visit within 12 weeks of prescribing - check for tolerability - note improvement/deterioration - follow up with family to see how they are handling the diagnosis - discuss ongoing care plan - address needs and concerns	6-month reassessment within 24 weeks of prescribing - reassess patient (SMMSE, GDS, etc.) - evaluate response to medication - complete prescription renewal process - address patient and family needs/ concerns - discuss powers of attorney, representation agreements/wills	Community Patient Conference (following reassessment) - update care plan with other care providers - confirm to patient and family after conferencing with AHP
Bill office visit	Bill Complete Examination	+ Bill Community Patient Conferencing Fee	Bill Mental Health Planning Fee (if requirements for 14043 not met – bill office visit or counselling fee as appropriate)	Bill Office Visit	Bill Office Visit	+ Bill Community Patient Conferencing Fee

Office Visit

0 – 49	00100	\$28.90
50 – 59	15300	\$31.88
60 – 69	16100	\$33.23
70 – 79	17100	\$36.12
80 +	18100	\$37.57

Complete Examination

0 – 49	00101	\$62.03
50 – 59	15301	\$68.23
60 – 69	16101	\$71.34
70 – 79	17101	\$77.54
80 +	18101	\$80.64

Counselling (Individual)*

0 – 49	00120	\$50.31
50 – 59	15320	\$55.34
60 – 69	16120	\$57.86
70 – 79	17120	\$62.90
80 +	18120	\$65.41

OTHER FEE OPTIONS – please refer to the MSC Payment Schedule for appropriate use of these fees

COMMUNITY-BASED MENTAL HEALTH INITIATIVE – Physicians have the option of developing a treatment plan for patients diagnosed with cognitive impairment. Once the diagnosis is confirmed, a separate appointment is made with the patient to complete a Mental Health Plan. For details on the Community-based Mental Health Initiative and fee guidelines, go to www.health.gov.bc.ca/msp/legislation/bcmaagree_faqs_fsf.html.

Billing Codes: Mental Health Planning fee - G14043 - \$100.00, Mental Health Management fee – 14044/14045/14046 / 14047 / 14048 - \$50.31/\$55.34/\$57.86/\$62.89/\$65.41. (Please note Mental Health Management appointments are counselling-equivalent and available once Mental Health Planning fee – 14043 – is billed and all 4 MSP age-appropriate 00120 are used up.)

COMMUNITY PATIENT CONFERENCING FEE – 14016 - \$40/15 min (maximum 90 minutes per year, 60 minutes per day) – must relate to, but be separate from, a patient visit.

HOME VISIT – 00103 - \$105.91 – call placed between 0800 and 2300 hours any day (effective April 1, 2009).

Dementia Patient Example

Example #1: Mr. B, 73 years old, arrives for his office visit accompanied by his two children. They are concerned that, since his wife's death a year ago, he has deteriorated significantly. The house is dirty and his personal hygiene has slipped. He is not eating and has lost weight, and is drinking more than he used to. He is no longer as interested in his family's activities and, on occasion, he has forgotten the names of his grandchildren. You initially meet with all three, and then you excuse the daughters and meet alone with Mr. B. He is unkempt, his clothes hang on his body, and he doesn't engage in conversation with you as he did in the past. He admits to drinking at least a bottle of wine per day, and frequently comments that he wished he had died before his wife. You arrange to have him return for a full physical examination.

Mr. B returns for a CPX with his family accompanying him. You see him alone and undertake a complete examination, including full neurologic assessment. You order laboratory investigations. At this point you also personally administer a Beck Depression Inventory and a Mini-Mental Status Examination, which reveals severe depression and mild cognitive impairment. You then meet with the patient and, with his permission, his children and discuss your findings. Jointly, you develop a plan that includes further investigation and a home assessment by the Quick Response Team/ Geriatric Outreach/ Home Care Nurse. Mr. B tells you to follow up with his children as his memory "hasn't been so good." Following this, through the course of the day you conference with Quick Response Team/ Geriatric Outreach/ Home Care Nurse (depending on your community) to arrange for a home visit assessment, and also conference with a psychiatrist to discuss initiation of treatment and arrange for him to be seen. You phone his pharmacist to prescribe the antidepressant agreed upon during the telephone conference with the psychiatrist and to arrange for all his medications to be blister-packed as he has been forgetting to take them. You then phone his daughter to advise her of the steps taken and the appointments you have made for him, and arrange a follow-up 30 minute visit in two weeks to review the results of further testing and home assessments and to develop a longer term plan.

At the follow up Mental Health Planning visit, you review the results and confirm the diagnosis of early dementia. You repeat the MMSE with the family present to assist in the development of a long term management plan and outline expected outcomes. You discuss patient, family and community care roles in ongoing monitoring and management and arrange a follow up visit within 12 weeks to review prescription tolerance and effectiveness.

You see the patient again for a 6 month reassessment; repeat the MMSE and any other testing as appropriate. You discuss with the patient and his family the status of his condition, as well as the issue of power of attorney and representation agreements. You conference with the Geriatric Outreach team later that same day to discuss any changes to the management plan.

Billing: *You are eligible in this case to bill 17101 for the full physical examination. You are also eligible to bill the appropriate units of 14016 for the time following the examination spent administering the Beck and MMSE, and organizing the initial care plan with other health care providers and with the patient and family. As well, you provided a separate 30-minute mental health planning visit (14043) and if, in addition, you conference with other community health care providers on the same day, you are eligible to bill additional 14016 units if all criteria are met.*

Notes:

- 1. The community patient conferencing (14016) fee compensates family physicians for the creation of a coordinated clinical action plan for the care of community-based patients identified in [Table 1](#). The clinical action plan fee depends not on the diagnosis alone, but rather the severity of the problems. As such, the fee is billable only when case conferencing and collaborative planning with other health care providers is required (e.g., specialists, psychologists or counsellors, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists in medicine or psychiatry), as well as with the patient and possibly family members, in order to develop the clinical action plan.*
- 2. The Mental Health Planning Fee (14043) 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 maximum units of conferencing that can be billed are 6 per calendar year with no more than 4 units on any one calendar day.*

COMMUNITY GP MENTAL HEALTH INITIATIVE

G14043 – GP Mental Health Planning Fee-.....\$100.00

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;
 - 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.

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 (eg. 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 in addition to visit time same day;*
- v) *G14016, community conferencing fee payable on same day for same patient, if all criteria met;*
- iv) *Not payable on the same day as G14044, G14045, G14046, G14047, G14048 (GP Mental Health Management Fees);*

- v) *Not payable on the same day as 14049 (GP Mental Health Telephone/Email Management fee)*
- vi) *Not intended as a routine annual fee if the patient does not require ongoing Mental Health Plan review and revision;*
- vii) *G14015, Facility Patient Conferencing Fee, not payable on same day for same patient as facility patients are not eligible.*

G14044-GP Mental Health Management Fee age 2–49.....	\$50.31
G14045-GP Mental Health Management Fee age 50 – 59.....	\$55.34
G14046-GP Mental Health Management Fee age 60–69	\$57.86
G14047-GP Mental Health Management Fee age 70–79	\$62.89
G14048-GP Mental Health Management Fee age 80+	\$65.41

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.

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;*
- vi. *Not payable on same day as G14043 (GP Mental Health Planning Fee), or G14049 (GP Mental Health Telephone/Email Management Fee);*
- vii. *G14016 (Community Patient Conferencing Fee) payable 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) payable if all criteria met.*

G14049 – GP Mental Health Telephone/Email Management Fee.....\$15.00

This fee is payable for 2-way communication with eligible patients via telephone or email for the provision of clinical follow-up management by the GP who has created and billed for the GP Mental Health Planning Fee (G14043). This fee is not to be billed for simple appointment reminders or referral notification.

Notes:

- i. *Payable to a maximum of 5 times per calendar year per patient;*
- ii. *Not payable unless the GP/FP is eligible for and has paid for the GP Mental Health Planning Fee (G14043) during the same calendar year;*
- iii. *Telephone/Email Management requires 2-way communication between the patient and physician or medical office staff on a clinical level; it is not payable for simple notification of office appointments;*
- iv. *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;*
- v. *G14016, Community Patient Conferencing Fee, payable on same day for same patient if all criteria met. Time spent on telephone under this fee with patient does not count toward the time requirement for the G14016;*
- vi. *Not payable on the same calendar day as a visit or service fee by same physician for same patient with the exception of G14016;*
- vii. *Chart entry must record the name of the person who communicated with the patient or patient’s medical representative, as well as capture the elements of care discussed.*

COMMUNITY PATIENT CONFERENCING FEE

14016 General Practice Community Patient Conferencing Fee

Creation of a coordinated clinical action plan for the care of **community-based patients** with more complex needs. Payable only when coordination of care and two-way collaborative conferencing with other health care providers is required (e.g., specialists, psychologists or counsellors, long-term care case managers, home care or specialty care nurses, physiotherapists, occupational therapists, social workers, specialists (medicine or psychiatry) as well as with the patient and possibly family members (as required due to the severity of the patient's condition).

- per 15 minutes or greater portion thereof..... \$40.00

Notes:

- i. *Refer to Table 1 for eligible patient populations.*
- ii. *Fee includes:*
 - a) *the interviewing of patient and family members as indicated and the conferencing with other health care providers as described above -- this does not require face-to-face interaction in all case; and;*
 - b) *As appropriate, interviewing of, and conferencing with patients, family members, and other community health care providers; organizing and reviewing appropriate laboratory and imaging investigations, administration of other types of testing as clinically indicated (e.g., Beck Depression Inventory, MMSE, etc); provision of degrees of intervention or No CPR documentation; and*
 - c) *The communication of that plan to patient, other health care providers, and family members or others involved in the provision of care, as appropriate; and*
 - d) *The care plan must be recorded in the chart and include the following information:*
 1. *Patient's Name; and*
 2. *Date of Service*
 3. *Diagnosis:*
 - a) *V15 (Frail Elderly)*
 - b) *V28 Palliative/End of Life Care*
 - c) *Mental Illness (enter ICD-9 code of qualifying illness)*
 - d) *Patients of any age with multiple medical needs or complex co-morbidity (enter ICD-9 for one of the major disorders)*
 4. *Reason for need of Clinical Action Plan*
 5. *Health Care providers you conferred with & their role in provision of care*
 6. *Clinical Plan Determined, including tests ordered and/or administered*
 7. *Patient risks based on assessment of appropriate domains (list of co-morbidities and safety risks)*
 8. *List of priority interventions that reflect patient goals for treatment;*
 9. *What referrals will be made, what follow up has been arranged (including timelines and contact information), as well as advanced planning information*
 10. *Start and stop times of service*
- iii. *Maximum payable per patient is 90 minutes per calendar year, 60 minutes maximum per single day.*
- iv. *Claim must state start and end times of service.*
- v. *Not payable to the same patient on the same date of service as the Facility Patient Conference fee (fee item 14015).*
- vi. *Not payable to physicians who are employed by or who are under contract to a facility who would otherwise have attended the conference as a requirement of their employment or contract with the facility; or physicians working under salary, service contract or sessional arrangements.*
- vii. *Visit payable in addition if medically required and does not take place concurrently with clinical action plan.*