Fiscal changes for core mental health services delivered by fee-for-service physicians

Research Atlas

ICES Institute for Clinical Evaluative Sciences

Fiscal Changes for Core Mental Health Services Delivered by Fee-for-service Physicians

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Key Terms & Concepts

- core mental health services
- Mental Health Reform
- psychotropic medication
- antidepressant
- psychotherapy

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Key Messages

✔ **Between 1992/93 and 1997/98, costs for fee-for-service core mental health services rose 12.7 per cent, a rate slightly higher than the increases for total health and total OHIP costs.**

✔ **The major contributor to the growth in core mental health care costs was an increase in the percentage of Ontario's population who used those core services.**

✔ **However, groups that were underserved in 1992/93, as far as core mental health services are concerned, (particularly, males, adolescents, the elderly and residents of rural and Northern Ontario) continued to be underserved five years later.**

Background

Core mental health services include the assessment, diagnosis and treatment of emotional, mental or addiction problems. They are typically provided by psychiatrists to individuals with a psychiatric disorder but may also involve other types of health care professionals (e.g. family doctors) and other types of conditions (e.g. psychotherapy for a person diagnosed with cancer). They fit into a broader range of mental health care, which would include preventive interventions, as well as education and supportive counselling.

The most appropriate way to deliver both core and more general mental health care to the residents of Ontario has been a provincial concern for the past two decades. The desired characteristics of a reformed mental health care system are outlined in a series of Ministry of Health publications, beginning with the Graham report issued in 1988,[1] followed by *Putting People First*[2] and most recently, *Making it Happen*.[3] Hallmarks of this reformed system include equitable access, a better matching of services to those with greatest need and a seamless continuum of care centered on the individual rather than on separate mental and physical conditions.

Early efforts to implement Mental Health Reform began with the psychiatric hospitals—the most expensive sector—and focused on moving from an inpatient system to a less expensive and less restrictive community-based model of care. More recently, attention has also been paid to the next most expensive sector—care providers who are paid through the Ontario Health Insurance Plan (OHIP).[4,5]

This is the first of two Atlas Reports describing OHIP-provided core mental health services. This report describes fiscal changes between 1992/93 and 1997/98 and examines some of the contributors to these changes. It also provides descriptions, based on the 1997/98 claims data, of core mental health care billings, the number of users and average visits for each of Ontario's 16 District Health Councils (DHCs) (for a more detailed description of the DHCs, see Iron[6]). The second report—*Fee-for-service Core Mental Health Services: Changes in Provider Source and Visit Frequency*—focuses on changes in the provider source of core mental health services (i.e. general versus specialty physicians) and in the frequency of visits made for such care.[7] It is important to note that previous work[4,5] reported on the broader spectrum of mental health care while this and the second Atlas Report focus on the narrower category of core services.

Methods

The primary sources of data in this report were all 1992/93 and 1997/98 claims to OHIP (excluding claims for laboratory tests). Claims related to core mental health care services were selected using a Ministry of Health list of mental health care fee codes. A subset of that list was identified as core services and covered psychiatric assessments and consultations, various types of psychotherapy and treatments specific to psychiatry, such as electroconvulsive therapy (see Technical Appendix for details). Claims that were submitted for any of these fee codes were used to calculate the amount of OHIP spending on core mental health services, as well as the number of users and visits. Diagnostic information, while it was available, was not used because of limitations in the data (see Interpretive Cautions).

Other information in the OHIP claims data was used to determine patterns in spending, number of users and number of visits across age and sex groups and the province's health planning regions. The analysis was restricted to those individuals who were 15 years or over during the year of claim submission. Some preliminary information is also provided at both the provincial and DHC level on who provides core mental health services.

To provide a larger perspective for interpretation of the findings, information about the provincial population and the Ministry of Health's overall expenditures was drawn from the 1993 and 1998 Censuses and the Minister of Finance's Budget Papers. All financial information, including OHIP billings, was converted into 1997-dollar equivalents. For overall spending, the Consumer Price Index adjustment for health was used.[8] For OHIP core mental health care, adjustments were made for inflation within OHIP spending using methods described in a previous Atlas Report.[9]

Interpretive Cautions

While this combination of data presents a good overall picture, there are many details that it cannot provide, especially at the individual OHIP user's level. It cannot comment on the appropriateness or adequacy of the services provided. Most importantly, there is no information about the outcome of these services, and therefore an important means of assessing the results outlined in this report is unavailable.

Another limitation is that the measurement of core mental health care is not precise. The Ministry of Health's list of fee codes, which was used to develop the measure, contains only procedures that are primarily mental health related (for example, psychotherapy or assessment by a psychiatrist). However, there are other services that should be counted which are not included. For example, short visits for the purpose of monitoring antidepressant or other psychotropic medication would be considered core mental health care. However, these visits would probably be billed as "minor" or "intermediate assessments"—fee codes which could apply to both physical and mental health conditions—and therefore would not be included on the Ministry of Health's list. A possible solution would be to use a combination of fee and diagnosis codes to define core mental health services, but this also has limitations. The major limitation is the probable lack of consistency in applying diagnostic categories across providers. In particular, physicians report anecdotally that they may "downcode" diagnoses (that is, use a less severe mental health diagnosis or even a non-mental-health diagnosis) because of concerns about stigmatizing their patients. Therefore, only fee codes were used to define core mental health services in this report with the consequence that the numbers and percentages are probably underestimated. (For a discussion of various types of OHIP mental health care where both fee code and diagnosis are considered, see Lin and Goering.[10])

Because this data only covers the core mental health care billed through the fee-for-service sector, the care delivered through the provincial psychiatric hospitals is not covered in this report. Thus, the fiscal resources devoted to core mental health care by the province are certainly underreported. However, there is likely only a small impact on the percentage of Ontarians reported as receiving care. In addition, some DHCs have higher proportions of physicians who are not paid through fee-for-service. For these DHCs, the core mental health care delivered by GP/FPs (e.g. Hamilton-Wentworth; Waterloo Region-Wellington-Dufferin) and by psychiatrists (e.g. Quinte, Kingston, Rideau Valley) is underreported.

Findings and Discussion

Provincial Results

Between 1992/93 and 1997/98, the cost of OHIP core mental health services rose at a slightly faster rate than either total health or total OHIP expenditures (Exhibit 1). The cost of core mental health services grew by nearly 13 per cent, equivalent to $27.5 million in 1997 dollars. The comparable increases for the Ministry of Health's total operating expenditures and total OHIP costs are 12 and 11 per cent.

There are several factors that might explain the rise in core mental health care costs. There could be an increase in the percentage of Ontarians who are receiving this type of care, or users might be making a larger number of visits. Alternatively, physicians could be shifting to more expensive types of services.[11] Each of these possibilities is explored in Exhibits 2 and 3.

Exhibit 2 shows that some of the rise in costs was due to an increase in the percentage of the population who received core mental health services. In 1997/98 there were approximately 104,000 more users of core mental health services compared with 1992/93. While the total provincial population and total number of all OHIP users also grew in that same time period, the change in core mental health care was much more pronounced. The rise in core mental health service users (13%) was almost twice the increase in the province's population and more than three times the increase in total OHIP users. Interestingly, during the same time period, total OHIP coverage decreased from 89 per cent of Ontario's population in 1992/93 to 86 per cent in 1997/98.

The total number of visits made by all OHIP users and by core mental health service users is also shown in Exhibit 2. Although core mental health care visits were a small percentage of total OHIP visits in both 1992/93 and 1997/98 (between 4.7 and 5.0%), their rate of increase was nearly double the growth of total OHIP visits.

Exhibit 3 translates the findings in Exhibits 1 and 2 into per capita rates and averages. Total operating expenses for the Ministry of Health grew from $1,916 for each Ontario resident in 1992/93 to $2,002 in 1997/98—a 4.5 per cent increase. Per capita OHIP spending increased at a slightly lower rate (3.4%), and per capita core mental health care spending at a slightly higher rate (5.1%).

The average number of visits barely changed. Average OHIP visits increased from 12.7 visits per user to 12.8 visits while average core mental health care visits actually decreased slightly from 5.9 to 5.7 visits. Average costs per visit did increase for both OHIP and core mental health care, but at different rates. The average OHIP cost increased by about $2 per visit; the average core mental health care increase was about half that amount.

The results in Exhibits 1 through 3 indicate that greater coverage of the Ontario population was the largest contributor to the rise in core mental health care costs. While the average cost per visit rose slightly, it accounted for only a small portion of the increase. If, for example, the only change between 1992/93 and 1997/98 was the increase from $47.48 to $48.50 per core mental health care visit, costs would have risen by $5.2 million instead of $27.5 million. The factors that are represented by average number of visits per user appear to have had no influence at all.

An obvious question is how the increased coverage is spread across different segments of Ontario's population. From the perspective of Mental Health Reform, the desired result would be more equitable access by groups which have previously been found to have the greatest gap between need and receipt of services—specifically men, adolescents, the elderly, and residents of rural or Northern Ontario.[4,5]

However, the sociodemographic and regional characteristics of the 1992/93 and 1997/98 core mental health care users (Exhibit 4) remained quite stable. The largest percentage of users was young to middle-aged adults (between 20 to 44 years). The majority of users were women, while less than 10 per cent of users were from rural areas. The largest percentage resided in the Toronto health planning region. Except for the aging of users over the five-year period, any changes were small. There were slight increases in the percentages of rural users (from 8.5 to 8.8%) and of users living in the North (from 5.9 to 6.2%). (Services provided by fly-in outreach programs located in several of the province's universities are not included in the OHIP claims data. Consequently, other sources of information should be developed to evaluate the effect of such programs on underserved areas such as Northern Ontario.) Future monitoring will determine whether these are early signs of better service delivery to rural and northern users or simply normal fluctuations in a stable pattern.

District Health Council Findings

The 1997/98 numbers of core mental health care users, visits and billings for each of the province's 16 DHCs are shown in Exhibit 5. Exhibits 6 through 9 convert these statistics into per capita billings, percentage of the population who use core mental health services, average number of visits per user and average billing per visit for each DHC. In each of these graphs, the provincial figure is shown by a straight line, and DHCs within the same region are shown in the same shaded block to facilitate provincial and regional comparisons. These data show that greater costs are related both to higher percentages of the DHC population using core mental health services—echoing the findings for the province overall—and to a greater average number of visits by core mental health care users. However, the average billings per visit showed very little variation across DHCs.

Exhibit 10 shows the age and sex composition of core mental health care users by DHC. There are some variations, particularly in the percentages of the youngest and oldest age groups, but the overall patterns are remarkably similar.

These data provide a baseline for future evaluations of OHIP expenditures for core mental health care at the DHC level. They also suggest areas for further investigations of psychiatric cost and coverage variations across different areas of the province. Some caution should be exercised, however, since additional data are needed to determine whether there are natural cycles over time in the DHC patterns of care.

Conclusions

Population surveys in North America have consistently found that between 50 to 75 per cent of individuals who appear to have serious mental, emotional or addiction problems report receiving no help or treatment.[12-15] The resulting concern among mental health experts and population health planners has led to national and regional campaigns to educate the public,[16,17,18] efforts to sensitize family physicians and general practitioners to the signs of mental illness and substance abuse,[19] and detailed guidelines on the most appropriate methods of treatment.[20,21] Unfortunately, studies of those who are receiving treatment also suggest a poor match between need and use, in that there is a portion of the population which has few indicators of severity but consumes large amounts of resources.[22]

The growth in the percentage of Ontario's population receiving core mental health services could be an outcome that is desirable, particularly if the new individuals receiving care are those with a previously untreated, serious problem. There are important questions that need future attention. Are Ontarians with the greatest need for core mental health care the ones who are receiving it? If not, what are the barriers to the match between need and care? Is this growth in coverage occurring because there are more physicians, a greater awareness by the public and doctors already in practice, more sensitivity among newly trained graduates, or a shift from non-mental health procedures to core mental health services? The answers to these questions should provide details on the users and delivery of core mental health care, the regulation of physician supply, medical and continuing education and other aspects of fee-for-service care.

While access to core mental health services in Ontario has improved, the results in this report indicate that equitable access has not. New users in 1997/98 came from the same population groups as old users rather than being from groups (such as men, adolescents or the elderly) which seem to be under-served if their need for care were considered.[4,5]

The results also show that practice patterns, as reflected in average visits per user and average cost per visit, have remained stable. From a purely cost perspective, this is at best a neutral finding. However, proper interpretation of these findings requires that province-wide information be collected on severity and outcomes. The desired scenario is that the number of visits and intensity of intervention are matched to the seriousness of the user's condition and that core mental health services are provided when they are the most cost-effective and appropriate alternative. There are clearly major issues surrounding provider availability, system barriers, and individual choice and perceptions that still need to be addressed to achieve Mental Health Reform's vision of equitable access and a better matching of services to those in greatest need.

Exhibit 1: Changes in Health, OHIP and OHIP Core Mental Health Care Expenditures in Ontario, 1992/93–1997/98

	1992/93		1997/98		Rate of Change	
Expenditures	**(Thousands)**	**%**	**(Thousands)**	**%**	**(Thousands)**	**%**
Total Health Expenditures[1]	16,330,284	100.0	18,284,000	100.0	1,966,000	12.0
All OHIP Billings[2]	3,721,322	22.8	4,129,363	22.6	408,041	11.0
OHIP Core Mental Health Care Billings[3]	216,032	1.3	243,508	1.3	27,476	12.7

Data Source: Ontario Health Insurance Plan (OHIP); 1996 and 1999 Ontario Budget Papers, Minister of Finance, Toronto, Ontario

[1] 1996 and 1999 Ontario Budget Papers, Minister of Finance, Toronto, Ontario

[2] Dollars adjusted to 1997 dollars using CPI for health (Statistics Canada, 1999)

[3] Dollars adjusted to 1997 dollars using Formula 2 from Supply of Physicians' Services in Ontario[9]:

$$\text{Standard price of a selected fee code} = \frac{\text{Total amount billed on that fee code in 1997/98}}{\text{Total \# of services billed for that fee code in 1997/98}}$$

Exhibit 2: Changes in Number of Users Aged 15 Years and Over and Frequency of Visits in Ontario, 1992/93–1997/98

	1992/93		1997/98		Rate of Change	
Users	**(Thousands)**	**%**	**(Thousands)**	**%**	**(Thousands)**	**%**
Total Provincial Population	8,512	100.0	9,131	100.0	618	7.3
All OHIP Users	7,565	88.9	7,880	86.3	315	4.2
OHIP Core Mental Health Care Users	775	9.1	879	9.6	104	13.4
Visits						
All OHIP Visits	95,802	100.0	100,919	100.0	5,118	5.3
OHIP Core Mental Health Care Visits	4,550	4.7	5,020	5.0	470	10.3

Data Source: Ontario Health Insurance Plan (OHIP); Statistics Canada, CANSIM Matrices 6367-6379

Exhibit 3: Changes in per Capita Spending, Average Visits per User Aged 15 Years and Over and Average Billing per Visit for OHIP Core Mental Health Care Services in Ontario, 1992/93 and 1997/98

Per Capita Spending[1]	1992/93	1997/98	Rate of Change (%)
Total Health	$1,916.46	$2,002.43	4.5
All OHIP	$437.16	$452.24	3.4
OHIP Core Mental Health Care	$25.38	$26.67	5.1
Average Visits/User			
All OHIP	12.7	12.8	0.8
OHIP Core Mental Health Care	5.9	5.7	-3.4
Average Cost/Visit			
All OHIP	$38.84	$40.92	5.4
OHIP Core Mental Health Care	$47.48	$48.50	2.1

Data Source: Ontario Health Insurance Plan (OHIP); 1996 and 1999 Ontario Budget Papers, Minister of Finance, Toronto, Ontario; Statistics Canada, CANSIM Matrices 6367-6379

[1] Calculated as 1997 dollar-equivalents per total provincial population

Exhibit 4: Sociodemographic and Regional Characteristics of OHIP Core Mental Health Care Users in Ontario, 1992/93 and 1997/98

Characteristics of OHIP Core Mental Health Care Users		1992/93 (%)	1997/98 (%)
Age:	15-19	3.8	4.1
	20-44	53.3	48.2
	45-64	29.3	32.7
	65 +	13.6	15.1
Women		64.4	64.2
Rural		8.5	8.8
Health Planning Region:	South West	11.7	11.3
	Central South	8.3	8.6
	Central West	15.1	15.4
	Toronto	28.6	28.1
	Central East	14.0	14.1
	East	16.4	16.4
	North	5.9	6.2

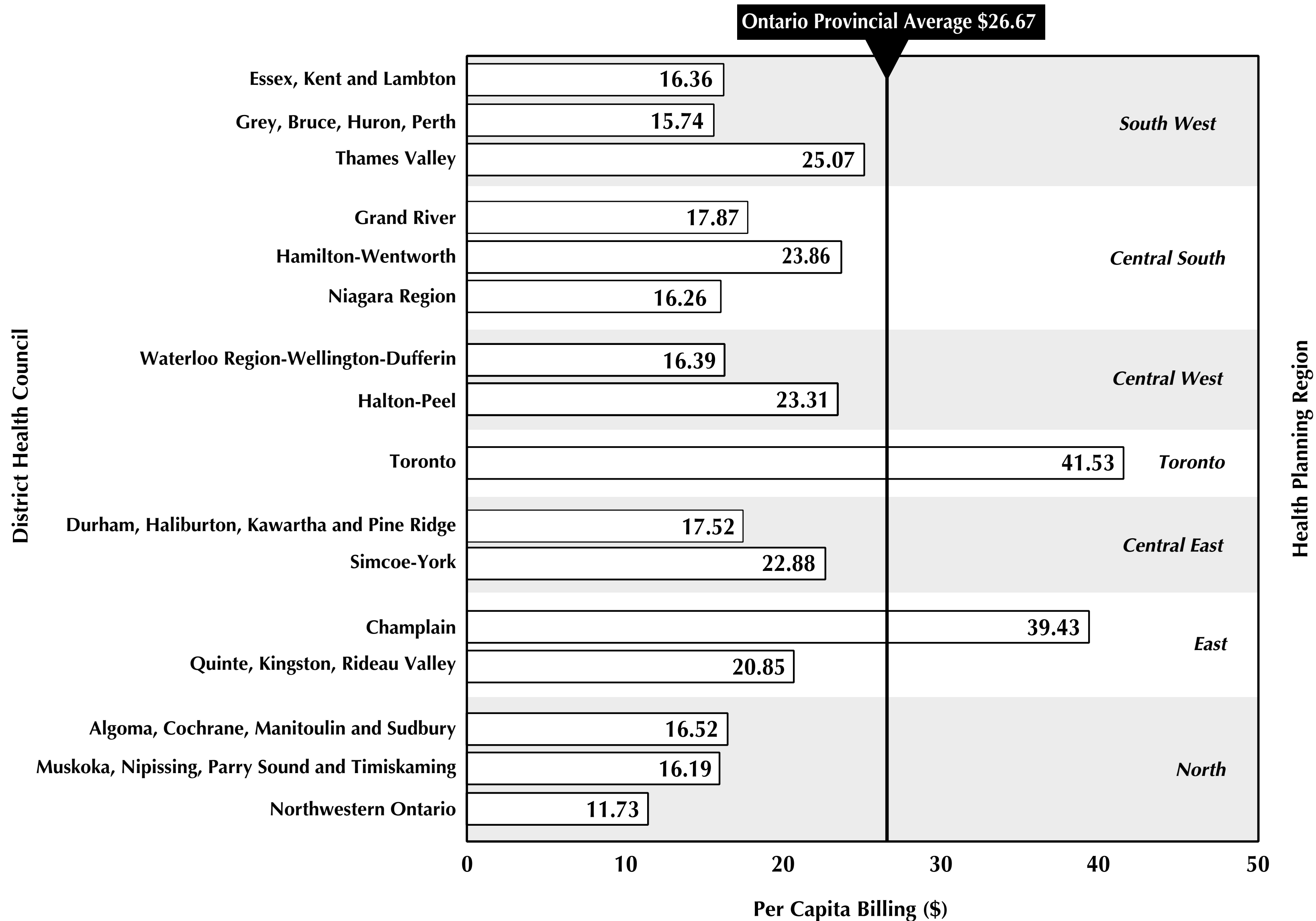
Data Source: Ontario Health Insurance Plan (OHIP)

Exhibit 5: OHIP Core Mental Health Care Users Aged 15 Years and Over, Visits and Billings by District Health Council in Ontario, 1997/98

		1997/98 Core Mental Health Care (in thousands)		
Health Planning Region	**District Health Council**	**Users**	**Visits**	**Billings ($)**
South West	• Essex, Kent and Lambton	36.4	174.5	8,065
	• Grey, Bruce, Huron, Perth	16.8	77.8	3,736
	• Thames Valley	45.7	238.2	11,903
Central South	• Grand River	14.4	63.4	3,263
	• Hamilton-Wentworth	35.6	183.3	9,369
	• Niagara Region	25.2	114.0	5,494
Central West	• Waterloo Region-Wellington-Dufferin	37.6	182.0	8,532
	• Halton-Peel	96.8	477.8	24,049
Toronto	• Toronto	245.4	1,773.9	86,073
Central East	• Durham, Haliburton, Kawartha and Pine Ridge	51.3	223.0	10,879
	• Simcoe-York	71.8	374.8	18,175
East	• Champlain	108.2	713.9	33,485
	• Quinte, Kingston, Rideau Valley	35.2	170.2	8,378
North	• Algoma, Cochrane, Manitoulin and Sudbury	25.3	122.0	5,733
	• Muskoka, Nipissing, Parry Sound and Timiskaming	15.4	58.9	2,809
	• Northwestern Ontario	13.6	48.3	2,357

Data Source: Ontario Health Insurance Plan (OHIP)

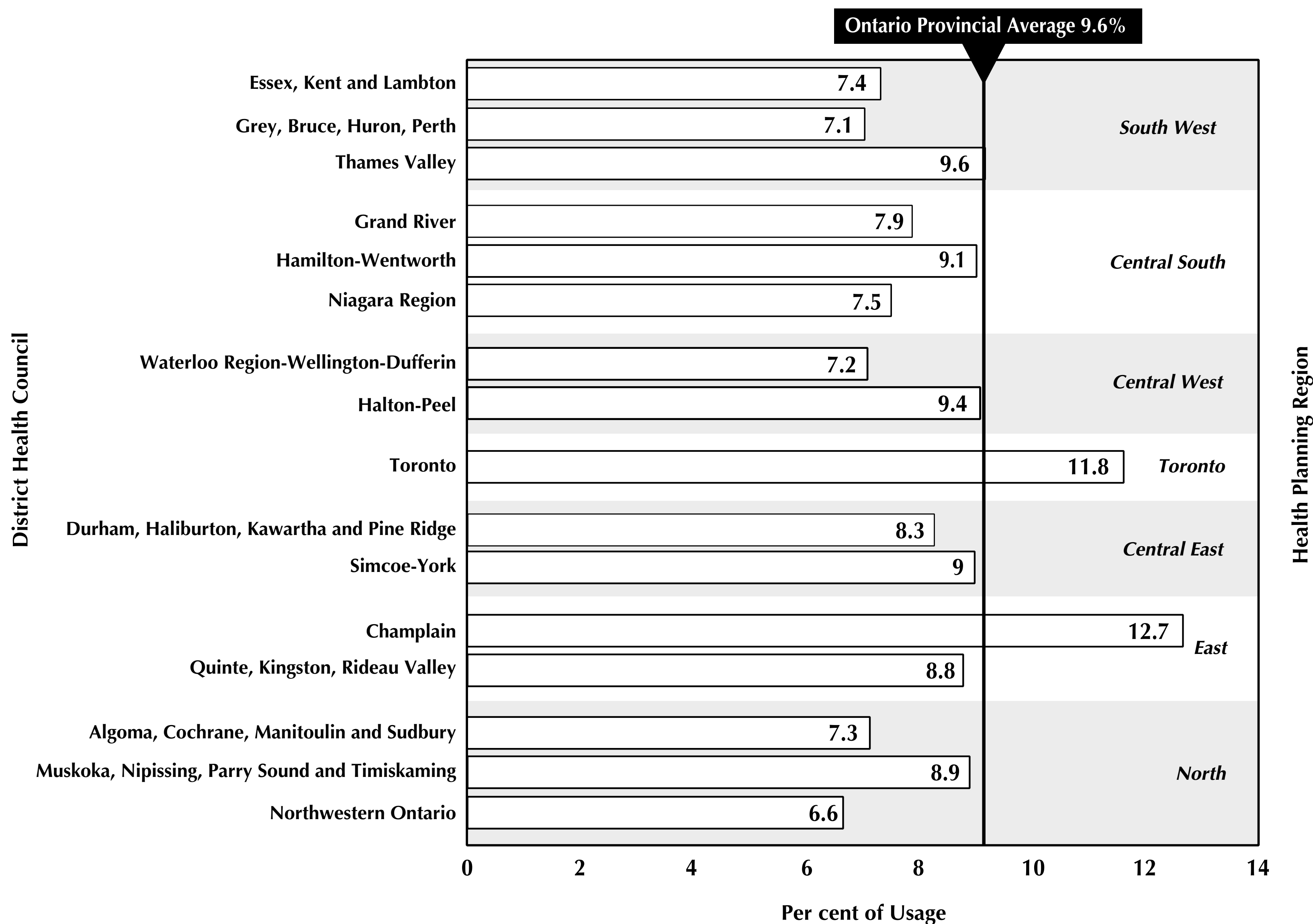
Exhibit 6: Per Capita[1] OHIP Core Mental Health Care Billings by District Health Council in Ontario, 1997/98



Data Source: CANSIM Matrices 6367-6379, Ontario Health Insurance Plan (OHIP)

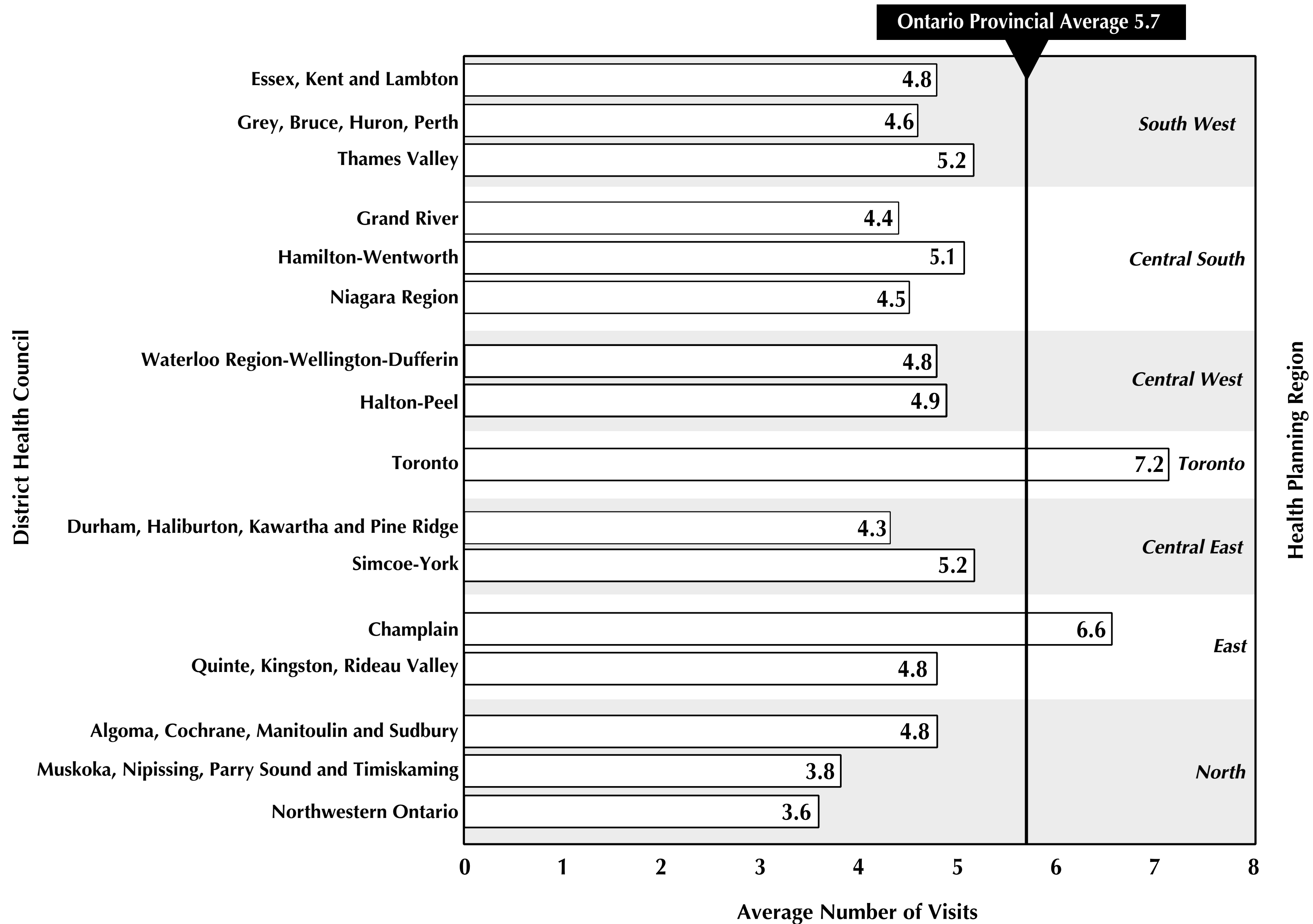
[1] Calculated as 1997 dollar-equivalents per total provincial population

Exhibit 7: Per cent of Population Aged 15 Years and Over Using OHIP Core Mental Health Care by District Health Council in Ontario, 1997/98



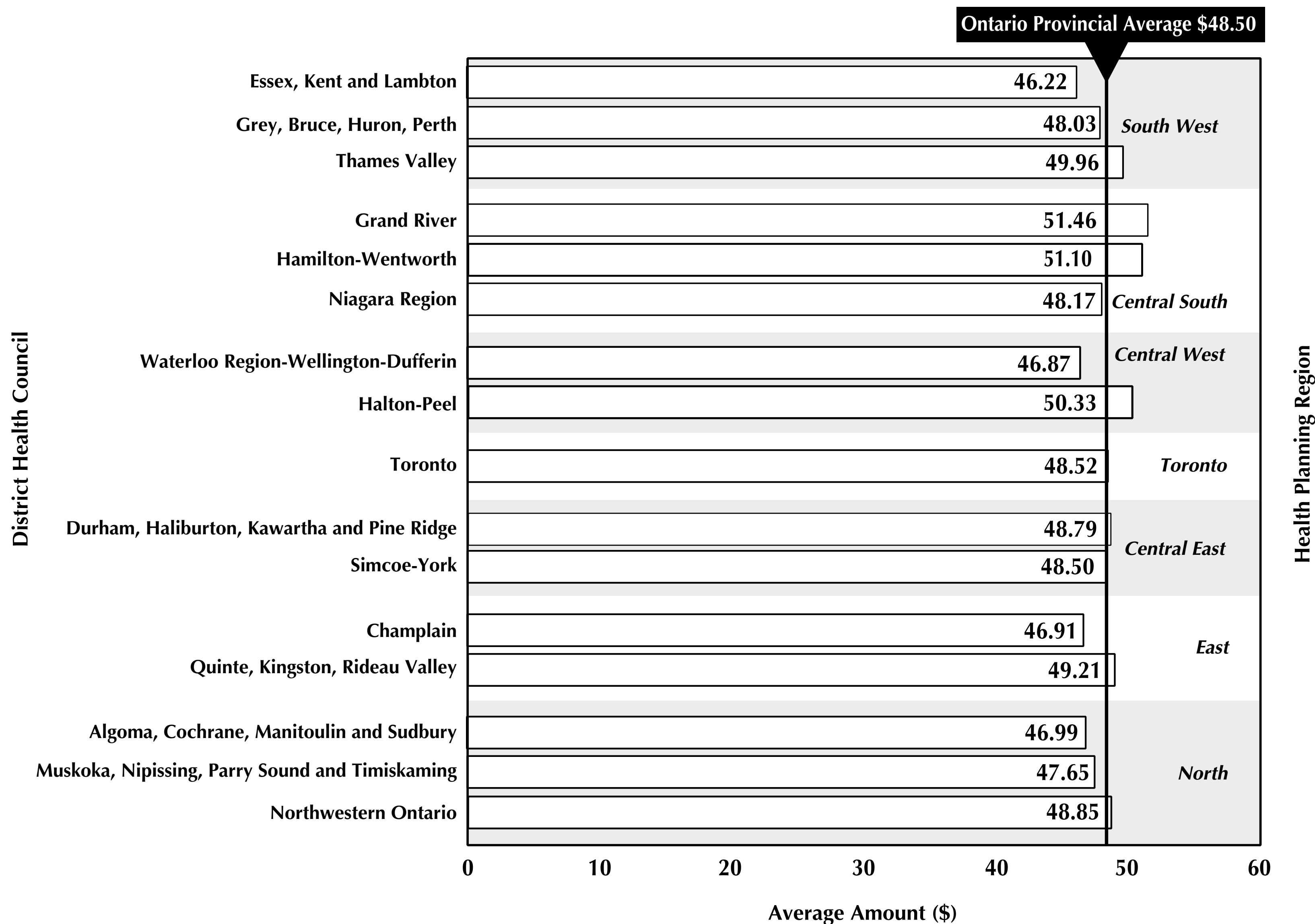
Data Source: CANSIM Matrices 6367-6379, Ontario Health Insurance Plan (OHIP)

Exhibit 8: Average Number of OHIP Core Mental Health Care Visits per User Aged 15 Years and Over by District Health Council in Ontario, 1997/98



Data Source: CANSIM Matrices 6367-6379, Ontario Health Insurance Plan (OHIP)

Exhibit 9: Average Amount of OHIP Core Mental Health Care Billings per Visit by District Health Council in Ontario, 1997/98



Data Source: CANSIM Matrices 6367-6379, Ontario Health Insurance Plan (OHIP)

Exhibit 10: Age and Sex Characteristics of OHIP Psychiatric Care Users Aged 15 Years and Over by District Health Council in Ontario, 1997/98

		Age (%)				Women (%)
Health Planning Region	**District Health Council**	**15-19**	**20-44**	**45-64**	**65+**	
South West	• Essex, Kent and Lambton	4.2	47.0	33.0	15.7	64.1
	• Grey, Bruce, Huron, Perth	5.0	45.9	31.3	17.8	64.2
	• Thames Valley	4.4	49.4	31.3	14.9	65.7
Central South	• Grand River	5.0	48.5	31.9	14.6	65.7
	• Hamilton-Wentworth	4.7	49.2	29.7	16.4	65.2
	• Niagara Region	4.5	47.7	32.0	15.8	63.4
Central West	• Waterloo Region-Wellington-Dufferin	4.4	49.7	32.1	13.8	64.2
	• Halton-Peel	4.4	50.0	34.3	11.3	65.1
Toronto	• Toronto	3.0	48.1	31.9	17.1	63.0
Central East	• Durham, Haliburton, Kawartha and Pine Ridge	4.8	48.7	32.8	13.8	64.7
	• Simcoe-York	5.0	47.0	35.3	12.7	65.2
East	• Champlain	3.9	46.1	34.1	15.8	64.0
	• Quinte, Kingston, Rideau Valley	4.2	47.2	32.7	16.0	66.2
North	• Algoma, Cochrane, Manitoulin and Sudbury	5.2	50.0	32.1	12.8	64.4
	• Muskoka, Nipissing, Parry Sound and Timiskaming	4.4	46.2	33.1	16.4	65.0
	• Northwestern Ontario	5.7	52.3	29.0	13.1	67.4
Ontario Total		**4.1**	**48.2**	**32.7**	**15.1**	**64.2**

Data Source: Ontario Health Insurance Plan (OHIP)

Glossary

core mental health services
the assessment, diagnosis and treatment of emotional, mental or addiction problems by a health or allied health professional. Core mental health services are one component of a broader range of mental health services which also include prevention, education and supportive counselling.

psychiatric disorder
an emotional or mental illness characterized by a particular set of symptoms and problems, lasting a significant length of time, and accompanied by considerable discomfort and difficulty in normal functioning. Specific disorders and how they are defined and diagnosed are detailed, and periodically updated, in the *International Classification of Disease* (ICD) and the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* (DSM).

Mental Health Reform
an ongoing initiative by the Ontario Ministry of Health to create a more systematic, integrated and rational mental health care system. The impetus of this effort began with the 1988 Graham report.[1]

psychotropic medication
medication prescribed for the purpose of alleviating or controlling psychiatric symptoms.

antidepressant
medication prescribed for the purpose of alleviating or controlling the psychiatric symptoms specifically associated with depression.

psychotherapy
a form of treatment for psychiatric disorders or less serious emotional, mental or addiction problems consisting of interaction (usually verbal) between the individual suffering the problem and a trained therapist. Psychotherapy may be used alone or in combination with pharmacotherapy (the use of psychotropic medications).

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Technical Appendix

OHIP Core Mental Health Fee Codes[1]

OHIP Fee Codes	DESCRIPTION
G471	Electroconvulsive Therapy (single/multiple)
K004	Family Psychotherapy
K006	Hypnotherapy
K007	Individual Psychotherapy
K008	Diagnostic/therapeutic Interview, child psychiatric problem/learning disability
K010	Group Psychotherapy—per member—(7th hour onward/day)
K011	Group Psychotherapy (hypnosis)
K012	Group Psychotherapy (4 people)
K024	Group Psychotherapy (5 people)
K025	Group Psychotherapy (6 to 12 people)
N110	Lobectomy
Z458	Electroconvulsive Therapy (cerebral)

Psychiatrist—Only OHIP Fee Codes

OHIP Fee Codes	DESCRIPTION
A191	Minor Assessment
A193	Specific Assessment
A194	Partial Assessment
A195	Consultation
A196	Repeat Consultation
A197	Consultation on behalf of disturbed child (interview with parents)
A198	Consultation on behalf of disturbed child (interview with child)
A395	Limited Consultation
C121	Further (hospital) Fees—visits due to intercurrent illness
C192	Hospital Subsequent Visits (up to 5 weeks)
C193	Hospital Specific Assessment
C194	Hospital Specific Reassessment
C195	Hospital Consultation
C196	Hospital Repeat Consultation
C197	Hospital Subsequent Visit (6th to 13th week)
C198	Hospital Concurrent Care
C199	Hospital Subsequent Visit (after 13th week)
C395	Hospital Limited Consultation
K190	Psychiatrist—Individual Psychotherapy
K191	Family Psychiatric Care—Inpatient

Psychiatrist—Only OHIP Fee Codes (Cont'd)

OHIP Fee Codes	DESCRIPTION
K192	Individual Hypnotherapy
K193	Family Therapy (inpatient)
K194	Group Hypnotherapy
K195	Family Therapy (outpatient)
K196	Family Psychiatric Care—outpatient
K197	Individual Psychotherapy (outpatient)
K198	Psychiatric Care (inpatient)
K199	Psychiatric Care (outpatient)
K200	Group Psychotherapy (inpatient - 4 people)
K201	Group Psychotherapy (inpatient - 5 people)
K202	Group Psychotherapy (inpatient - 6 to 12 people)
K203	Group Psychotherapy (outpatient - 4 people)
K204	Group Psychotherapy (outpatient - 5 people)
K205	Group Psychotherapy (outpatient - 6 to 12 people)
K206	Group Psychotherapy (outpatient - per member, 7th hour onward)
K207	Group Psychotherapy (inpatient - per member, 7th hour onward)
K568	Diagnostic Interview of child/parent
K620	Mental Health Act Assessment—Consultation
K623	Mental Health Act Assessment—Application
K624	Mental Health Act Assessment—Certification
K629	Mental Health Act Assessment—Recertification
W195	Long-term Institutional Care - Consultation
W196	Long-term Institutional Care - Repeat consultation
W395	Long-term Institutional Care - Limited consultation

[1]Based on original list of mental health related codes from the Ontario Ministry of Health with the exception that the following codes were deleted:

OHIP Fee Codes	DESCRIPTION
C982	Palliative Care
K002	Interview with relatives on behalf of patient
K003	Interview with CAS or legal guardian on behalf of patient
K013	Counselling (educational)
K014	Counselling (transplant recipients, donors, etc.)
K015	Counselling (relatives of terminally ill patients, etc.)
K016	Genetic Assessment
K019	Genetic Counselling (individual/family)
K020	Genetic Counselling (relatives)

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