Health Care Connect Implements Two (2) New Unattached Patient Fees

Health Care Connect (HCC) was launched in February 2009. Recently, the ministry worked with the Ontario Medical Association (OMA) to make improvements to HCC based on valuable feedback received from physicians across the province.

In addition to the fees and fee enhancements set out in Appendix 1 Billing the New Unattached Patient Fees and Fee Enhancements Fact Sheet (June 2009), two new fees are being introduced effective April 1, 2011:

- Q056A HCC Upgrade Patient Status
- Q057A HCC Greater Than Three Months

All family physicians in a Patient Enrolment Model (PEM) who enroll HCC patients are eligible to bill the new fees. Existing New Patient fees continue to be available to all physicians in PEM Models. All fees applicable to new patients may only be billed once by the same physician enrolling the same patient.

To be eligible for HCC fees and fee enhancements, physicians are required to notify their Care Connector in advance of accepting a patient from HCC. Any new patient fees for patients enrolled through HCC will not be subject to any billing maximums.
HCC Upgrade Patient Status (Q056A)

When registering for HCC, all patients complete a health needs questionnaire which determines if the patient’s health needs are considered complex-vulnerable. If an enrolling physician believes, in his/her clinical opinion, that the patient would be deemed significantly more complex or vulnerable than the vast majority of the typical patients in a family medicine practice, and the patient accepted from HCC has not been identified as complex-vulnerable by the HCC program, the physician can bill the HCC Upgrade Patient Status (Q056A) Fee Schedule Code.

When billing this code, eligible physicians will receive a one-time payment of $850 for enrolling the patient through HCC ($350 new patient fee and $500 Enhanced Payments for Caring for Complex Vulnerable Patients as per the Billing the New Unattached Patient Fees and Fee Enhancements Fact Sheet, June 2009).

To be eligible for this fee:

- The patient must be referred to the billing physician through HCC.
- The physician must, in his/her clinical opinion, believe that the patient would be deemed significantly more complex or vulnerable than the vast majority of typical patients in a family medicine practice.
- The physician must keep recorded documentation of the rationale for the decision to bill the code (i.e. how the patient was more complex than indicated in their HCC patient health history). The ministry reserves the right to request this documentation.
- The patient must not be identified by HCC as a complex-vulnerable patient.
- The service date of the claim must be on or after April 1, 2011.
- The physician must enroll the patient within three (3) months of referral from a Care Connector. Physicians are required to enroll the patient using the Patient Enrolment and Consent to Release Personal Health Information (enrolment/consent) form and the New Patient Declaration form. (A physician may also submit a Q200A Per Patient Rostering Fee followed by the submission of the enrolment/consent form).
- The physician can only bill this fee (Q056A) at the point of enrolment when the patient signs the enrolment/consent form.
- If the physician bills this code and ministry systems confirm the patient is registered on HCC as complex vulnerable and enrolled within three (3) months of the referral date, it will automatically replace the Q056A code with the Complex Vulnerable New Patient Fee code (Q053A) and pay $350. The claim will appear on the physicians Remittance Advice with Explanatory Code ‘P9 Complex New Patient’. The Physician will be eligible to receive the Complex Capitation or the Complex FFS Payment for 12 consecutive months from the patient’s enrolment effective date.
- Physicians are advised to verify with their software vendor that their billing system can reconcile a claim where the Fee Schedule Code has been replaced.
- Where the patient is not enrolled the claim will pay at zero dollars with Explanatory Code ‘I6-Premium not Applicable’.
- Claims submitted for patients who have completed the Enrolment Consent forms prior to April 1, 2011 will reject EPA ‘Network Billing not allowed’.
• If the physician bills the Q056A code for a patient not registered on HCC or the patient is not enrolled within three (3) months of the referral date, the claim will reject with one of the following Explanatory codes:
  - ‘HCC Not Eligible’ or ‘HCE Enrolment After 3 mos’

• The Q056A code cannot be billed in addition to: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Complex Vulnerable New Patient Fee (Q053A), Mother/Newborn New Patient Fee (Q054A), and Multiple Newborn Fee (Q055A), HCC Greater Than Three Months (Q057A) billed by the same physician for the same patient. Subsequent claims will reject with Explanatory Code ‘A3L – Other new patient fee already paid.’

• If the physician bills a subsequent Q056A code for the same patient, the claim will pay at zero dollars with Explanatory Code ‘M1 – Maximum fee allowed for these services has been reached’.

**HCC Greater Than Three Months (Q057A)**

Effective April 1, 2011, physicians who accept a patient who has been registered with HCC for 90 days or more are eligible to bill the new Q057A code.

When billing this code, physicians will receive a one-time payment of $200 for enrolling the patient through HCC. A Care Connector will inform physicians if the patient has been registered with HCC for 90 days or more.

To be eligible for this fee:

• The patient must be referred to the billing physician through HCC.
• The patient must have been registered with HCC for 90 days or more.
• The patient must not be identified by HCC as a complex-vulnerable patient.
• The physician must enroll the patient within three (3) months of referral from a Care Connector. Physicians are required to enroll the patient using the enrolment/consent form and the *New Patient Declaration* form. (A physician may also submit a Per Patient Rostering Fee Q200A followed by the submission of the enrolment/consent form).
• If the physician bills this code and ministry systems confirm the patient is registered on HCC as complex vulnerable and enrolled within three (3) months of the referral date, it will automatically replace the Q057A code with the Complex Vulnerable New Patient Fee code (Q053A) and pay $350. The claim will appear on the physicians Remittance Advice with Explanatory Code ‘P9 Complex New Patient’. The Physician will be eligible to receive the Complex Capitation or the Complex FFS Payment for 12 consecutive months from the patient’s enrolment effective date.
• Physicians are advised to verify with their software vendor that their billing system can reconcile a claim where the Fee Schedule Code has been replaced.
• Where the patient is not enrolled the claim will pay at zero dollars with Explanatory Code ‘I6-Premium not Applicable.’
• Claims submitted for patients who have completed the Enrolment Consent forms prior to April 1, 2011 will reject EPA ‘Network Billing not allowed.’
If the physician bills the Q057A code for a patient not registered on HCC or the patient is not enrolled within three (3) months of the referral date, the claim will reject with one of the following Explanatory codes:

- ‘HCC Not Eligible’ or ‘HCE Enrolment After 3 mos’

The Q057A code cannot be billed in addition to: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Complex Vulnerable New Patient Fee (Q053A), Mother/Newborn New Patient Fee (Q054A), and Multiple Newborn Fee (Q055A), HCC Upgrade Patient Status (Q056A) billed by the same physician for the same patient. Subsequent claims will reject with Explanatory Code ‘A3L – Other new patient fee already paid.’

If the physician bills a subsequent Q057A code for the same patient, the claim will pay at zero dollars with Explanatory Code ‘M1 – Maximum fee allowed for these services has been reached’

If the Q057A code is billed for a patient who has not been registered on HCC for 90 days or more, the claim will reject to the physicians error report with reason code ‘HCC – Not Eligible’.

Existing New Patient Fee Schedule Codes

If the physician bills the Q013A, Q023A, or Q033A code and ministry systems confirm that the patient is registered on HCC as complex-vulnerable and enrolled within three (3) months, and the ministry system will automatically replace the existing new patient fee code with the Complex Vulnerable New Patient Fee code (Q053A) and pay $350. The claim will appear on the physicians Remittance Advice with Explanatory Code ‘P9 Complex New Patient’. The Physician will be eligible to receive the Complex Capitation or the Complex FFS Payment for 12 consecutive months from the patient’s enrolment effective date.

If the patient is not registered on HCC the system will automatically apply the billing rules associated to Q013A, Q023A or Q033A and pay the appropriate fee.

Where the patient is not enrolled the claim will pay at zero dollars with Explanatory Code ‘I6-Premium not Applicable’.

For additional fees and fee and enhancements available to eligible physicians who accept patients through HCC, please see Billing the New Unattached Patient Fees and Fee Enhancements Fact Sheet (June 2009).

To accept patients from HCC, please call 310-CCAC and ask to speak with a Care Connector. Care Connectors are nurses located within Community Care Access Centres (CCACs) and are the main contact for patient referrals.

For further information about HCC, please contact the ministry at 1-866-766-0266.
Appendix 1: Billing the New Unattached Patient Fees and Fee Enhancements

FACT SHEET
Ministry of Health and Long-Term Care
Primary Health Care

Billing the New Unattached Patient Fees and Fee Enhancements

June 2009

Eligible Patient Enrolment Models (PEMS):
- Comprehensive Care Model (CCM)
- Family Health Group (FHG)
- Family Health Network (FHN)
- Family Health Organization (FHO)
- Blended Salary Model (BSM)
- Community Health Centre (CHC)
- Group Health Centre (GHC)
- St. Joseph’s Health Centre (SJHC)
- Weeneebayko Health Ahtuskeywin (WHA)
- Rural and Northern Physician Group Agreement (RNPAGA)
- South Eastern Ontario Academic Medical Organization (SEAMO)

Effective July 1, 2009, the Ministry will implement systems to enable physicians to bill and be paid the new Unattached Patient Fees as set out in Appendix D of the 2008 Physician Services Agreement between the Ministry and the OMA.

The new fees will be claimed through the regular billing process and may be billed retroactive to February 1, 2009. Any unattached patient fee claims being held can be submitted starting July 1, 2009.

Complex Vulnerable New Patient Fee

All family physicians in a Patient Enrolment Model (PEM) who enrol complex-vulnerable patients through the Health Care Connect Program are eligible to bill the new complex-vulnerable fee. Existing new patient fees continue to be available to family physicians in PEM models. All fees applicable to new patients may only be billed once by the same physician enrolling the same patient.

- A one-time payment of $350 for enrolling the patient through Health Care Connect
- Payment of all new patient fees requires the patient to be enrolled to the billing physician within three (3) months of being attached. Physicians are required to enroll the patient using the Patient Enrolment and Consent to Release Personal Health Information (enrolment/consent) form and the New Patient Declaration i.e. completed and retained in your files. A physician may also submit a Q200A Per Patient Rostering Fee followed by the submission of the enrolment/consent form.
Billing:

Physicians will be paid the Complex Vulnerable New Patient Fee through the submission of existing new patient fee codes (Q013A, Q023A, Q033A, and Q043A) or a new Q053A fee code.

**Existing new patient fee codes:**
- If the physician bills with Q013A, Q023A, Q033A, or Q043A, Ministry systems will check to see if the patient is registered on Health Care Connect as complex-vulnerable and enrolled within three (3) months, and will automatically replace the existing new patient fee code with the new Complex Vulnerable New Patient Q053A fee code and pay $350. The claim will appear on the physician’s Remittance Advice (RA) with Explanatory Code ’P9 COMPLEX NEW PATIENT’.
- Physicians are advised to verify with their software vendor that their billing system can reconcile a claim where a fee code has been replaced.
- If the patient is not registered on Health Care Connect as complex-vulnerable, Ministry systems will automatically apply the billing rules associated with the Q013A, Q023A, Q033A, or Q043A and pay the appropriate fee (i.e. Q013 will pay at $100).
- Where the patient is not enrolled, the claim will pay at zero dollars with Explanatory Code ’16 – Premium Not Applicable’.

**New Q053A fee code:**
- If the physician bills with the new Complex Vulnerable New Patient Q053A fee code, and if the patient is registered on Health Care Connect as complex-vulnerable and enrolled within three (3) months, the claim will pay $350.
- If the physician bills the Q053A and the patient is not registered on Health Care Connect as complex-vulnerable or is enrolled but not within three (3) months, the claim will reject with one of the following Explanatory Codes:
  - ’HCC – Not Eligible’
  - ’HCE – Enrolment After 3 Mos’
- Where the patient is not enrolled, the claim will pay at zero dollars with Explanatory Code ’16 – Premium Not Applicable’.
- The Q053A Complex Vulnerable Patient Fee cannot be billed in addition to the: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Mother/Newborn New Patient Fee (Q054A), and Multiple Newborn Fee (Q055A) billed by the same physician for the same patient. Subsequent claims will reject with Explanatory Code ’A3L – Other new patient fee already paid.’

**Enhanced Payments for Caring for Complex Vulnerable Patients**

PEM physicians who enroll a patient through Health Care Connect are eligible to receive enhanced payments for caring for complex-vulnerable patients for 12 consecutive months from the patient’s enrolment effective date. Ministry systems will automatically initiate the enhanced payments based on enrolment of the complex-vulnerable patient. No action is required on the part of the physician to initiate the enhanced payment.
Complex Capitation Payment:
- Effective July 1, 2009, for physicians in harmonized models, a complex capitation payment of $500 will be distributed over the 12 month period and paid monthly as a new complex capitation payment.
- The complex capitation payment will be retroactive to February 1, 2009.
- The complex capitation payment will be paid to the Group RA or to the Solo RA where physicians have selected solo level payments. The payments will be made under the following accounting transactions:
  - CXCP – ‘Complex Vulnerable Capitation Payment’
  - CXAJ – ‘Complex Vulnerable Capitation Adjmt’
- If a patient’s enrolment ends before 12 months, the complex capitation payment will end one day following the patient’s enrollment end date.
- If a patient is transferred to a new physician, including physicians in the same group, the complex capitation payment will end.
- The complex capitation payment will be excluded from all Access Bonus calculations.

Group Reporting:
- A new monthly Complex Capitation Group Payment report will provide a breakdown by physician of the current month and year to date payments.
- The ‘Total Complex Cap Payment’ will be added to the existing Group Total – Summary Report reporting the current month and year to date totals for all physicians.

Detail Patient Reporting:
For harmonized models receiving Base Rate and Comprehensive Care Capitation (FHN, FHO, GHC):
- The complex payment amount for each patient will be reported monthly in a new ‘Complex Amount’ column added to the renamed Base Rate, Comprehensive Care & Complex Capitation Payment Detail Report and the Base Rate, Comprehensive Care & Complex Capitation Payment Reconciliation Detail Report.

For harmonized models receiving only Comprehensive Care Capitation (RNPGA, WHA, SJHC, SEAMO, BSM, FHG, CCM):
- The complex payment amount for each patient will be reported monthly in a new ‘Complex Amount’ column added to the renamed Comprehensive Care Capitation & Complex Capitation Detail Report and the Comprehensive Care Capitation & Complex Payment Reconciliation Detail Report

Solo Physician Reporting:
- Each physician will receive a new monthly Complex Capitation Payment Summary Report on their Solo RA (solo level payment) or the Group RA (group level payment) that will report the current month’s total complex capitation payments.

Complex FFS Premium:
For physicians in non-harmonized models (FHG, CCM), a 150% payment of the fee-for-service (FFS) value of all fees billed applicable to any complex-vulnerable patients during the first year of care. This will be paid monthly as a new complex FFS premium.
No action is required on the part of the physician to initiate the enhanced payment. The changes to Ministry payment systems are underway and the effective date will be communicated as soon as it is available.

**Mother/Newborn New Patient Fee**

Appendix D of the 2008 *Physician Services Agreement* also sets out new fees for PEM physicians who enrol as new patients an unattached mother within two weeks of giving birth or women after 30 weeks of pregnancy.

**NOTE:** An unattached mother and newborn are not required to be enrolled through Health Care Connect in order for the PEM physician to claim this fee.

- A one-time payment of $350 for physicians taking on as a new patient an unattached mother and newborn within two weeks of giving birth or an unattached woman after 30 weeks of pregnancy.
- Payment of the Mother/Newborn New Patient Fee requires both the mother and newborn to be enrolled to the billing physician using the *Patient Enrolment and Consent to Release Personal Health Information* (enrolment/consent) form and the *New Patient Declaration* is completed and retained in your files. A physician may also submit a Q200A Per Patient Rostering Fee followed by the submission of the enrolment/consent form.
- The new Mother/Newborn fee codes Q054A and Q055A will not be subject to any billing maximums.

**Billing:**

- Physicians will bill a new Mother/Newborn New Patient Q054A fee code that will pay $350 for enrolling both the mother and newborn.
- Physicians are required to bill the Q054A claim with the mother's Health Number.
- If the mother has been enrolled through Health Care Connect as complex-vulnerable, the physician should bill the Q053A Complex Vulnerable New Patient Fee instead of the Q054A to be eligible for the Enhanced Payment (Complex Capitation or Complex FFS Premium).
- For women after 30 weeks of pregnancy, physicians are to bill the Q054A at the time of enrolment.
- Where the mother is not enrolled, the claim will pay at zero dollars with Explanatory Code ‘16 – Premium Not Applicable’.
- The Q054A Mother/Newborn New Patient Fee cannot be billed in addition to the: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Complex/Vulnerable Patient Fee (Q053), and Multiple Newborn Fee (Q055A) billed by the same physician for the same patient. Subsequent claims will reject with error code ‘A3L – Other new patient fee already paid.

**Multiple Births:**

- In the case of multiple births, physicians will bill a new Multiple Newborn Q055A fee code for each additional newborn of an unattached mother and the claim will pay $150 per newborn.
- Physicians are required to bill the Q055A claim with the newborn's Health Number.
• Payment of the Multiple Newborn New Patient Fee requires each newborn to be enrolled to the billing physician within three (3) months of birth.
• If the physician bills the Q055A and the newborn is enrolled but not within three (3) months of birth, the claim will reject with Explanatory Code ‘HCE – Enrolment After 3 Mos’
• Where the newborn is not enrolled, the claim will pay at zero dollars with Explanatory Code ‘16 – Premium Not Applicable’

Expanded Access to Unattached Patient Codes

Appendix D of the 2008 Physician Services Agreement also sets out expansion of both existing and new fees applicable to the new patients of all family physicians in PEM models.

The extension of the Q013A New Patient Fee means that CCM, RNPGA, and WHA physicians will be able to bill this fee retroactive to April 1, 2009. Physicians who billed a Q013A between April 1, 2009 and June 30, 2009 that resulted in a reject should re-submit the claim after July 1, 2009.

The existing billing maximums associated with Q013A and Q033A will apply to all PEM physicians. Any new patient fees for patients enrolled through Health Care Connect will not be subject to any billing maximums.

For further information, please contact the Ministry at 1-866-766-0266.