Billing & Payment Guide for General Practitioner Focused Palliative Care (GPFPC) Physicians

Salaried Models Unit - Primary Health Care
Ministry of Health and Long-Term Care
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Introduction

This guide provides billing and payment information for General Practitioner Focused Palliative Care (GPFPC) Agreement physicians. When working as a GP Focused Palliative Care physician, all services must be submitted using your GP Focused Palliative Care Group number.

All claims are subject to the Ministry of Health and Long-Term Care’s (ministry) existing six-month stale-date policy and all normal processing rules and regulations.

This guide also advises how to submit claims in order to assist with your monthly reconciliation process. You may require billing software changes to interact with ministry systems. For example, you may wish to contact your software vendor to: (i) help you improve your claims reconciliation, (ii) avoid unnecessary claims rejections, (iii) enable you to submit for new tracking codes, and, (iv) manage variations between fees billed and paid and tracking codes approved at zero dollars.

For additional Fact Sheets/INFOBulletins related to specific incentives, visit the MOHLTC Health Care Professional internet site or contact your MOHLTC Representative team at 1-866-766-0266.

Claims inquiries should continue to be directed to your local OHIP office.
Payments and Reporting

Claim Submission Requirements

- All services you provide while working as a GPFPC physician must be submitted with your four character group identifier CXXX followed by six digit provider number and two digit specialty code (e.g. C000-123456-00)
- All claims are subject to the Ministry of Health and Long-Term Care’s six month stale date policy and all normal processing rules and regulations

Shadow Billing Premium

- Physicians receive a 5% premium of the fee schedule code value based on the schedule of benefits for services provided that pay at zero dollars with explanatory code ‘I2 – Service is globally funded’
- The premium is paid as an accounting adjustment with the text line “BLENDED FEE FOR SERVICE PREMIUM” equal to the sum of all physicians’ earned premium amounts
- Services that contribute to a physician’s premium each month will be reported on both his/her solo RA and the group RA in the Blended Fee-For-Service Premium Detail Report
- Each physician’s total premium payment amount is also reported in the Blended Fee-For-Service Premium Summary Report on the group RA

Shadow Billing Premium on Age Premium

- Shadow Billed Services provided to patients in the age range for an age premium will be eligible for the Blended Premium on the Age Premium
- A second Blended Fee for Service Premium will appear on the group RA in accounting adjustments and is the sum of all physicians amounts
- A breakdown for each physician will appear in their “Premium Payment” report on the group RA in the line item “Blended Premium”

Tracking Q Codes for After Hours and Outside the Community

Q091A (After Hours Tracking Code)

- All services provided after hours will be paid fee for service provided the after hours tracking code Q091A is an item on same the claim with the same service date
The Q091A tracking code will be paid at zero dollars ($0) with an explanatory code 30 (This service is not a benefit of OHIP)

Q093A (Outside of Community Tracking Code)
- All services provided outside the community will be paid fee for service provided the Outside of Community tracking code Q093A is an item on the same claim with the same service date
- The Q093A tracking code will be paid at zero dollars ($0) with an explanatory code 30 (This service is not a benefit of OHIP) All services paying fee for service due to the Q093A tracking code will contribute to the Fee for Service Cap.

After Hours Service Payments and After Hours Threshold
- All services in this section contribute to the After Hours Threshold
- Once the group After Hours Threshold is met any service amounts over will contribute towards the Fee for Service Cap

After Hours Palliative Care In-Home Service Payments
- When fee schedule codes A902A, A945A or K023A are billed on the same claim with the same service date as a B996A or B997A all items will be paid fee for service plus 10%
- When any other fee schedule codes are billed on the same claim as B996A or B997A, the other fee schedule codes will pay fee for service and the B996A or B997A will be paid fee for service plus 10%
- When fee schedule codes A902A, A945A or K023A are billed on the same claim with the same service date as a B998A and Q091A (After Hours Tracking Code) the A902A, A945A or K023A and B998A will be paid fee for service plus 10% and the Q091A will be paid at zero with explanatory code 30 (not a service of OHIP)
- Any other fee schedule codes are billed on the same claim as B998A and a Q091A, the other fee schedule codes will be paid fee for service and the B998A will be paid fee for service plus 10% and the Q091A will be paid at zero with explanatory code 30 (not a service of OHIP)
- When fee schedule codes K023A, W777A, W872A, or W882A are billed on the same claim as a W994A, W996A or W998A, all items will pay fee for service plus 10%
- When any other fee schedule codes are billed on the same claim as a Q091A, the fee schedule codes will be paid fee for service and the Q091A will be paid at zero with explanatory code 30 (not a service of OHIP)
After Hours Palliative Care Hospital Service Payments

- All allowable fee schedule codes billed on the same claim with the same service date as a C994A, C995A, C996A, C997A, C986A or C987A will pay fee for service.

Other After Hours Services Payments

Any fee codes allowed to be submitted with one of the following special trip codes will pay fee for service for all services on the same service date on the same claim.

<table>
<thead>
<tr>
<th>Special Trip Fee Schedule Code</th>
<th>Description of code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A994A – A996A, A998A</td>
<td>Office</td>
</tr>
<tr>
<td>K994A – K999A</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>Q994A – Q998A, Q960A-Q964A</td>
<td>Other – non professional setting</td>
</tr>
<tr>
<td>U994A - U999A</td>
<td>Hospital Out Patient</td>
</tr>
</tbody>
</table>

After Hours Threshold

The following table summarizes the After Hours Threshold by FTE under the GP Focused Palliative Care Agreement:

<table>
<thead>
<tr>
<th>FTE</th>
<th>After Hours Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 FTE</td>
<td>$11,256</td>
</tr>
<tr>
<td>0.6 FTE</td>
<td>$13,505</td>
</tr>
<tr>
<td>0.7 FTE</td>
<td>$15,756</td>
</tr>
<tr>
<td>0.8 FTE</td>
<td>$18,007</td>
</tr>
<tr>
<td>0.9 FTE</td>
<td>$20,257</td>
</tr>
<tr>
<td>1.0 FTE</td>
<td>$22,509</td>
</tr>
</tbody>
</table>

- The first year a GPFPC group commences the After Hours Cap amount will be prorated based on the commencement date of the GPFPC on the Ministry’s Corporate Provider database.
- Any new physician joining the group after the group effective date will have their After Hours Threshold prorated amount added to group cap amount.
Fee for Service (FFS) Not Contributing to the Fee for Service Cap

Emergency room unscheduled visits:
- All fee schedule codes billed on the same claim with the K994A to K999A pay FFS
- Obstetrical deliveries

Workplace Safety Insurance Board (WSIB) services
- Physicians are eligible to submit and receive payment for services including but not limited to services provided under the Workplace Safety and Insurance Act.
- A WSIB service must be identified as ‘WCB’ on the claim.

Services provided to out-of-province patients
- Physicians are eligible to submit and receive payment for services provided to out-of province patients.
- The service must be identified as ‘RMB’ on the claim for an out-of-province patient (with the exception of Quebec).

Other Ministry Services

Palliative Care Premium
- Physicians belonging to a GPFPC group are not entitled to receive the Out of Office Service Bonus for Palliative Care Premium
- Any eligible services provided prior to joining a GPFPC group will contribute towards the premium and payment will be made if the appropriate threshold is met

Continuing Medical Education (CME)
A physician may claim 24 hours of credits each fiscal year for 1 Full Time Equivalent (FTE)
- A physician is only entitled to the prorated value of CME based on their FTE equivalency with the group
• Credits are also prorated for the total number of months in the fiscal year that the physician has been affiliated to the group

For example:

<table>
<thead>
<tr>
<th>Name</th>
<th>Start date</th>
<th>FTE Count</th>
<th>Max MAINPRO-M1 credits</th>
<th>Total Combined Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A</td>
<td>April 1, 2012</td>
<td>1.0</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Dr. B</td>
<td>April 1, 2012</td>
<td>0.5</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Dr. C</td>
<td>October 1, 2012</td>
<td>1</td>
<td>10</td>
<td>12</td>
</tr>
</tbody>
</table>

Group CME Cap:
• The total of all physicians’ FTE values on April 1st is the value of CME credits the group is entitled to for the entire fiscal year
• Any physician joining a GPFPC group during the fiscal year will have their CME values prorated by FTE and number of months active in the group in the fiscal year
  o E.g. The Cap is calculated by the number of number of FTE’s x 24 credits (e.g. if the group has 2.5 FTE then the group’s cap is 2.5 x 24 = 60 credits)

Number of Services:
• The number of CME credits is broken down into 15 minute units. A physician is entitled to 96 - fifteen minute units (24 x 4 fifteen minute units = 96 fifteen minute units). The payment for each 15 minute unit, or one (1) service, is $25.00. For example:
  • When a physician is billing a CME claim for a 1 hour Main Pro C course the physician is to submit the fee code Q555A and the number of services on the claim is 4.

 Carry Over Credits:
• Maximum Carry Over Credits - A physician can carry forward any entitlement of unused credits from the previous fiscal that were allocated in the previous fiscal and not carried forward from any other fiscal
• Using carry over credits – Carry over credits can be applied to claims for CME eligible activity completed in the current and/or previous fiscal year

Proof of Attendance:
• Physicians must retain proof of attendance at the conference/seminar as a condition of payment
The Ministry will undertake a periodic review of CME payment claims and may request proof of attendance from a physician for the conference/seminar of which payment was made in order to verify.

CME Submission Information:
- Credits will be prorated based on physicians effective date with the group
- Physicians leaving the GPFPC group to join another CME entitled group during a fiscal year will not have their CME credits prorated
- CME is based on the fiscal year April 1 to March 31

Fee for Service Cap
The following table summarizes the FFS Cap by FTE under the GP Focused Palliative Care Agreement:

<table>
<thead>
<tr>
<th>FTE</th>
<th>Permissible Fee-For-Service Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 FTE</td>
<td>$137,500</td>
</tr>
<tr>
<td>0.6 FTE</td>
<td>$113,000</td>
</tr>
<tr>
<td>0.7 FTE</td>
<td>$88,500</td>
</tr>
<tr>
<td>0.8 FTE</td>
<td>$64,000</td>
</tr>
<tr>
<td>0.9 FTE</td>
<td>$39,500</td>
</tr>
<tr>
<td>1.0 FTE</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

- The first year a GPFPC group commences the FFS Cap amount will be prorated based on the commencement date of the GPFPC on CPDB
- Any new physician joining the group after the group effective date will have their prorated amount added to group cap amount

Values that accumulate towards the FFS Cap include:
- The full FFS value for each fee schedule code as per the Schedule of Benefits (SOB) of all claims submitted with the Q093A tracking code under CXXX group number.
- The full FFS value for each fee schedule code as per the SOB of all claims submitted under non-CXXX group numbers (regardless of the amount actually paid for each claim).
- If the After Hours Threshold is exceeded, the excess amount will be counted towards the FFS Cap. However, if the After Hours Threshold is not exceeded, the excess cannot be used to supplement the FFS Cap.
- The FFS Cap will be pooled among all physician members of the Group and the Group total will be applied to the calculations.
Explanatory and Error Codes

Remittance Advice Common Explanatory Codes

Note: Claims that are reported on the Remittance Advice have been processed by the MOHLTC. As with Fee-for-Service claims, please continue to contact the Claims Payment Division of your local MOHLTC Office to address any discrepancies.

I2 – Service is globally funded
This explanatory code will report on the monthly RA for services included in your base payments. The claim will pay at zero dollars.

30 – This service is not a benefit of MOHLTC
This explanatory code will report on the RA for claims with the Q091A and Q093A tracking codes. These codes are billed at zero dollars and will pay at zero dollars with an explanatory code 30.

M1 – Maximum fee allowed for these services has been reached
This explanatory code will report on the monthly RA when the maximum fee allowed for this service has been reached.

Claims Error Report Common Rejection Codes

Note: Claims that are reported on the Claims Error Report have been rejected and should be corrected and if eligible, resubmitted for payment. As with Fee-for-Service claims, please continue to contact the Claims Payment Division of your local MOHLTC office for further guidance.

A2A – Outside age limit
The service has been billed for a patient whose age is outside of the criteria for that service.

AD9 – Not allowed alone
Claims are being submitted without a valid assessment code on the same service date.

EPA – Billing not approved
Physician is ineligible to submit a Q-code.