Effective April 1, 2013, Phase 2 – the Automation of the GP Focus HIV claim payments will be implemented. Any services submitted with a service date on or after April 1, 2013 will be calculated and paid correctly by the ministry claims processing system. Physicians will no longer have to submit claims information to the ministry manually.

New HIV After-Hours Fee Code (Q017A)

A new HIV After-Hours Fee Code Q017A, has been implemented effective April 1, 2013. The Q017A will replace the Q091A and the Q012A. The Q017A must be submitted with any services provided after-hours in order for the claim to be entitled to the after-hours payment provisions in your agreement.

When the Q017A is on the same claim as one of the following fee schedule codes, A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K022A, K030A, K033A, K130A, K131A, K132A, or Q050A and the patient is enrolled to you or a physician in your group, the Q017A will pay 30% of the fee schedule codes listed above on the claim and the fee code will pay fee for service.

When the Q017A is on the same claim as the A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K022A, K030A, K033A, or Q050A and the patient is not enrolled to anyone in your group, the Q017A will pay at $0 with explanatory code I6 – Premium not Applicable. The fee schedule codes on the claim will pay fee for service.

When the Q017A is on the same claim with any other fee schedule codes other than the fee schedule codes mentioned above, the Q017A will pay at $0 with an explanatory code of IA –
‘Services billed are not eligible for the premium’ and the fee schedule codes on the claim will pay fee for service.

For services provided prior to April 1, 2013, HIV physicians must continue to submit the Q091A and Q012A. For any service dates on or after April 1, 2013, you will no longer be able to submit the Q012A or the Q091A for after-hours processing if the claim has a service date of April 1, 2013 forward. The Q012A and Q091A will reject EPA – Network billing not approved.

**Fee for Service Billings**

Effective April 1, 2013, when an HIV physician submits a K022A and an A007A on the same claim for a patient enrolled to a physician in a different Patient Enrolment Model (PEM), both the K022A and the A007A will pay fee for service.

When an HIV physician submits one of the following fee schedule codes G372A, G538A, G590A, or Z117A for a patient enrolled to a physician in a different PEM, all services will pay fee for service.

**Manual Payments**

You will continue to receive manual payments up to and including the November 2013 Remittance Advice as long as claims were processed with a service date prior to March 31, 2013.

**Future Phases of the Automation Implementation**

**Phase 3** is the automation of the Base, Administration and After-Hours On-Call payments. These payments will be calculated and paid each month on the HIV group RA. The change in the payment schedule from end of month to Remittance Advice will be a managed process to ensure there are no negative financial impacts to physicians. More information on how we are transitioning from the month-end to RA payment cycle and what reporting will be available, will be provided once the ministry is ready to implement.

**Phase 4** is the automation of the Fee for Service Cap and the After-Hours Cap (Threshold). This implementation will provide reporting on the group RA for the FFS Cap and the After-Hours Threshold and provide the monthly accumulations by physicians and the group cap amount. More information on this implementation will be provided once the ministry is ready to implement.