

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Physicians, Hospitals, Clinics and Laboratories

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**Re: Implementation of the 2008 Physician Services Agreement –
Changes Effective October 1, 2010**

In keeping with the provisions of the 2008 Physician Services Agreement, a number of changes to the Schedule of Benefits for Physician Services are being implemented. This INFOBulletin will provide information on where to access detailed information about these changes, as well as information regarding the implementation of these changes, including any steps that may require physician participation. **The new version of the Schedule is available at:**

www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

Hard copies of the Schedule will not be distributed.

- 1. Fee code changes – Fee increases, Fee decreases, Deleted fee codes, New fee codes, Revisions to existing fee code descriptors, anaesthetist and assistant unit changes.**
- 2. Implementation of Schedule Changes – Retroactive Adjustments.**
- 3. New Case Conference Fee Codes and Bariatric Management Fee Codes**
- 4. New Telephone Consultation Fee Codes**
- 5. New Diagnostic Codes**

1. Fee Code Changes

In keeping with section 3.2 of the agreement to introduce a 3% global increase to the Schedule of Benefits, there are a number of fee code changes being introduced retroactively. The fee code changes will be effective October 1, 2010. Charts, showing details concerning the fee code changes, are available with this bulletin at:

http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

2. Implementation of Schedule Changes – Retroactive Adjustments

The following chart details, by category, the systems solution being implemented to correctly pay claims according to the provisions of the October 1, 2010 Schedule of Benefits. The comments column includes instructions where provider action is required.

Target dates for retroactive payments are tentatively scheduled for the December 2010 remittance, with the exception of Opted-out providers who will have their retroactive payments processed at a later date.

Claims to be adjusted retroactively are those which:

- a. are on the list of services with fee code/amount changes effective October 1, 2010;
- b. have service dates of October 1, 2010 up to and including October 31, 2010;
- c. are for Health Claim Payment, Reciprocal Medical Billing and Work Place Safety Insurance Board payment programs; and
- d. were processed and paid on the November 2010 Remittance Advice.

Claims with service dates on or after October 1, 2010 and processed after November 1, 2010 will be paid according to the new schedule.

Should physician action be required to complete the process, the form to use for claim adjustments is called the “Remittance Advice Inquiry” form. This form is available online at:

www.health.gov.on.ca/english/providers/forms/form_menus/ohip_prof_fm.html

The Ministry will monitor the submission of claims to ensure they are submitted correctly (revisions).

Category	Comments
Fee Increase/Decrease Deleted Fee Schedule Code Opted-in physicians	<p>An automated system adjustment will be performed for fee increases, decreased fees and deleted fee codes. Detailed claim item adjustments are tentatively scheduled to appear on the December 2010 remittance advice. Any premium payments associated with adjusted claim items will also be reconciled during the automated process. No action is required by the physician.</p> <p>In the event a claim for a deleted service is submitted after November 1, 2010 for a service rendered on or after October 1, 2010, the claim will be redirected to the provider’s error report. The claim may be resubmitted if the service is eligible for payment under an alternate fee code.</p>

Category	Comments
Fee Increase/Decrease Opted-out physicians	<p>Opted –out physicians should NOT collect fee increases from patients.</p> <p>Fee increases will be paid directly to the physician and will appear as a summary level adjustment identified by Clerk ID “GFFO – 3% GENERAL FEE PAYMENT OPTED-OUT”. No action is required by the physician.</p> <p>Physicians must ensure, through their local office, that the ministry has their correct mailing address and banking information.</p>
New Fee Schedule Code Fee Schedule Code Revision	<p>If a claim was not previously submitted and the service is now eligible for payment under a new fee schedule code; a claim may be submitted for payment within 6 months of the date of service.</p> <p>If a claim was previously submitted and a new or revised fee schedule code more accurately reflects the service provided, the physician must submit a remittance advice inquiry to their local office and request the claim be adjusted to pay in accordance with the provisions of the new schedule.</p>
Anaesthetist and Assistant Services <ul style="list-style-type: none"> ➤ Unit Fee Increase ➤ Base Unit Revisions ➤ Triple Time Units 	<p>An automated system adjustment will be performed to apply the assistant and anaesthesia unit fee increase to surgical assistant and anaesthesia services. Detailed claim item adjustments are tentatively scheduled to appear on the December 2010 remittance advice. No action is required by the physician.</p> <p>The number of anaesthesia base units for E546 was reduced to zero. An automated system adjustment to recover fees is tentatively scheduled to appear as detailed claim item adjustments on the December 2010 remittance advice. No action is required by the physician.</p> <p>Manual adjustments are required for all assistant or anaesthesia services where the number of base units has been revised. Physicians must submit a remittance advice inquiry to their local office and request the adjustment of all relevant claim items to ensure payment is made in accordance with the new base unit rate.</p> <p>If additional time units are payable as a result of the change to assistant triple time units, the physician must submit a remittance advice inquiry to their local office requesting adjustment of relevant claim items.</p>

3. New Case Conference Fee Codes and Bariatric Management Fee Codes

These fee codes will have broad system impacts, especially in terms of collaborative care achieving better quality patient outcome and system efficiencies. The new case conference fees effective October 1, 2010 are:

K700	Palliative Care Out-patient Case Conference	\$27.50
K701	Mental Health Out-patient Case Conference	\$27.50
K702	Bariatric Out-patient Case Conference at a RATC	\$27.50
K703	Geriatric Out-patient Case Conference	\$27.50
K704	Paediatric Out-patient Case Conference	\$27.50
K708	Multidisciplinary Cancer Case Conference (MCCC) Participant	\$10.00
K709	Multidisciplinary Cancer Case Conference (MCCC) Chairperson	\$20.00

Refer to the Schedule of Benefits for limitations on payments for these services. For example, no other case conference or telephone consultation service is *eligible for payment* with K700 for the same patient on the same day.

K702 is *only eligible for payment* when rendered for a patient registered in a Bariatric Regional Assessment Treatment Centre (RATC). K702 is *only eligible for payment* for physicians identified to the ministry as working in a Bariatric RATC. Physicians must contact their local office to ensure they are identified to the ministry as working in a Bariatric RATC.

This requirement for identification as a Bariatric RATC physician is also required for claims submission of the following two new fee codes:

K090	Management of a pre-operative bariatric patient at a Bariatric RATC
K091	Monthly management of a post-operative bariatric patient at a Bariatric RATC

4. New Telephone Consultation Fee Codes

These fee codes are the second of the two 'types' of new fee codes with broad system impacts. These codes are intended to reduce unneeded face to face consultations where the treating physician needs support from a specialist. In each case, the referring physician claims a different fee code than the consultant physician. The new telephone consultation fee codes effective October 1, 2010 are:

K730	Telephone Consultation - Physician to Physician - Referring physician	\$27.50
K731	Telephone Consultation - Physician to Physician - Consultant physician	\$35.50
K732	Telephone Consultation – CritiCall - Referring physician	\$27.50
K733	Telephone Consultation – CritiCall - Consultant physician	\$35.50

K734	Emergency Department - Physician to Physician Telephone Consultation - Referring physician	\$27.50
K735	Emergency Department - Physician to Physician Telephone Consultation - Consultant physician	\$35.50
K736	Emergency Department - CritiCall Telephone Consultation - Referring physician	\$27.50
K737	Emergency Department - CritiCall Telephone Consultation - Consultant physician	\$35.50

Refer to the Schedule of Benefits for limitations on payments for these services. For example, K730 is not eligible for payment when a face-to-face consult or a telemedicine consultation is rendered by the consultant physician on the same day or day following the telephone consultation for the same patient

5. New Diagnostic Codes for Colonoscopies

The following new diagnostic codes related to colonoscopies are being added to the diagnostic code table. The new diagnostic codes will assist in gathering statistics on colonoscopies.

- 545 - Colon Positive Fecal occult blood
- 546 - Colon Surveillance
- 547 - Colon Family history of colon cancer
- 548 - Colon Screening

In addition to the diagnostic codes for colonoscopies, one additional diagnostic code is being added to the diagnostic code table:

- 725 - Polymyalgia rheumatic

INFOBulletins and the updated version of the Schedule reflecting the October 1, 2010 changes are available on the Ministry of Health and Long-Term Care website:

www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html