INFOBulletin

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

To: **Physicians, Registered Nurse Practitioners, Hospitals and Clinics**

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Re: Implementation of 2012 Physician Services Agreement – Amendments to the Schedule of Benefits for Physician Services Effective April 1, 2013

1. Background

This bulletin describes changes to the Schedule of Benefits for Physician Services (Schedule of Benefits) resulting from the 2012 Physician Services Agreement (PSA). New fee codes are introduced to reflect best available evidence and improvements in technology.

2. Updates related to January 1, 2013 Implementation

Cervical Screening:

The Schedule of Benefits' cervical screening fee code (G365) has been amended to reflect Cancer Care Ontario's (CCO) new guidelines for cervical cancer screening. Cervical screening is insured once every three years if the result of the papanicolaou smear is normal. Cervical screening is not an insured service when rendered to an individual younger than 21 years of age or older than 70 years of age.

Papanicolaou Smear (G394) for follow-up of an abnormal or inadequate test remains an insured service. Fee code G394 is also payable annually for screening immuno-compromised women.

3. Implementation of 0.5% payment discount effective April 1 2013:

Section 1.1 of the 2012 PSA indicates a 0.5% payment discount will be applied on all physician payments to be effective April 1, 2013. A separate INFOBulletin will describe the implementation details for this provision.

4. New Fee Codes:

a. Intensive or Coronary Care Premium (C101) is re-introduced into the schedule.

b. A new add-on fee (E431) to Papanicolaou Smear follow-up (G394) is introduced for services rendered outside of hospital. This fee code is only payable with G394 and is not eligible to be paid with G365.

c. **E-Services:**
E-assessment services are being introduced for dermatology and ophthalmology.

An E-assessment service is a service performed by a specialist when a primary care physician requests an opinion and/or recommendations from the specialist for management of a specific patient by providing information electronically through a secure server (e.g. secure messaging, EMR).

The specialist is required to review all relevant data provided by the primary care physician, including the review of any additional information that may be submitted subsequent to the initial request. For the purpose of this service, "relevant data" may include family/patient history, history of the presenting complaint, laboratory and diagnostic tests, and visual images where indicated.

- The service is only eligible for payment if the specialist has provided an opinion and/or recommendations for patient management to the primary care physician within 30 days from the date of the request.
- The service is not payable for transferring the patient to another physician, arranging a consultation, assessment or K-prefix time-based service, or if a K- prefix time-based service is performed within 30 days of the E assessment service. In addition, in cases where the specialist or primary care physician receives compensation for participation in the E-assessment other than by fee-for-service, the service is not eligible for payment.
- A consultation, a different assessment or visit rendered by the specialist for the same patient for the same diagnosis within 60 days following the request for the specialist e-assessment is only payable as a specific or partial assessment, as appropriate to the service rendered.
- K738 (Physician to physician e-consultation – Referring physician) is eligible for payment to the primary care physician when this physician is required to collect additional data (for example dermatology or ophthalmology images not present in the primary care physician's records) to support the specialist's e-assessment. K738 is not eligible for

payment where existing data is already available in the primary care physician's records for submission to the specialist.

Four service types are introduced:

i. **Initial e-assessment** is the first e-assessment performed by a particular specialist that is requested by the primary care physician for a specific patient and diagnosis where the specialist must review all relevant data provided by the primary care physician and provide a written opinion that includes a diagnosis and/or management advice to the primary care physician; the written opinion can be provided either electronically or by mail. This service is limited to one per patient per specialist per 12 month period unless there is a second request from the primary care physician unrelated to the diagnosis of the first e-assessment. No more than two initial E-assessments are payable per patient per specialist in a 12 month period.

ii. **Repeat e-assessment** is the first e-assessment performed by a particular specialist following an initial e-assessment or consultation by that specialist that is requested by the primary care physician for the same diagnosis where the specialist must review all relevant data provided by the primary care physician and provide an opinion that includes management advice to the primary care physician. This service is limited to one per patient per specialist per 12 month period unless there is a second request from the primary care physician unrelated to the diagnosis of the first e-assessment. No more than two repeat e-assessments are payable per patient per specialist in a 12 month period.

iii. **Follow-up e-assessment** is the limited e-assessment rendered for follow-up by the specialist who has previously rendered any insured service to the patient for the same diagnosis. The specialist must review all relevant information submitted and provide an opinion and/or management advice to the primary care physician. This service is limited to: one per patient per specialist per day; four per patient per specialist per 12 month period; and an overall total of one thousand services per physician per twelve month period.

iv. **Minor e-assessment** is a brief e-assessment rendered by the specialist. The specialist must review all relevant information submitted and provide an answer to the primary care physician's specific clinical question. This service is limited to: one per patient per specialist per day; 12 per patient per specialist per 12 month period; and an overall total of two thousand services per specialist per twelve month period.

The primary care physician may ask a specific question related to the patient where the information provided is limited and the question asked is very specific. An example is where the primary care physician has initiated a treatment recommended by the specialist, and the primary care physician requests a brief email response related to proper dosing adjustments. One service may include multiple emails. The specialist may choose to return their opinion by phone.

d. **Chronic Disease Shared Appointments:**

Chronic disease shared appointment is a pre-scheduled primary care service rendered for chronic disease management, to two or more patients with the same diagnosis of one of the diseases listed below, that consists of assessment and the provision of advice and information in respect of diagnosis, treatment, health maintenance and prevention.

Each patient must have an established diagnosis of one of the following chronic diseases:

- Diabetes
- Congestive Heart Failure
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Hypercholesterolemia
- Fibromyalgia

The physician must be in constant personal attendance for the duration of the appointment session, although another appropriately qualified health professional may lead parts of the educational component of the session (for example, a diabetic educator or nurse). In addition, a clinically appropriate assessment must be rendered to each patient by the same physician as a component of the chronic disease shared appointment.

Chronic disease shared appointment - per patient - maximum 8 units per patient per day

K140 - 2 patients.....per unit 31.40
K141 - 3 patients.....per unit 20.90
K142 - 4 patients.....per unit 15.80
K143 - 5 patients.....per unit 13.00
K144 - 6 to 12 patients.....per unit 11.05

A claim must be submitted for each patient receiving a service. For example, if three patients are seen in a shared appointment, K141 is submitted for each patient. If four patients are seen, K142 is submitted for each patient.

e. **New Diagnostic Code: Fibromyalgia:**
To support the implementation of the above Chronic Disease Shared Appointments, a new diagnostic code has been introduced for fibromyalgia. This new diagnostic code is 726.

f. **Complex House call Assessment (A900 - $45.15):**
A complex house call assessment is a primary care service rendered in a patient's home to a patient that is considered either a frail elderly patient or a housebound patient. The service provided must satisfy, at a minimum, all of the requirements of an intermediate assessment.

1. **A frail elderly patient is defined as:**
    a. 65 years or older with one or more of the following age-related illness(es), condition(s) or presentation(s):
        - Complex medical management needs;
        - Polypharmacy;
        - Cognitive impairment (e.g. dementia or delirium);
        - Age-related reduced mobility or falls; and/or
        - Unexplained functional decline not otherwise specified; and
    b. resides in a home that includes:
        - the patient's home;
        - assisted living or retirement residence (but does not include a long-term care home); and
    c. meets one or more of the following criteria:
        - meets the criteria to be admitted to a long term care home, including the definition of ALC; and/or
        - requires ongoing care for chronic conditions that if left untreated may result in institutionalization or unnecessary or prolonged hospital stays.

2. **A person will be considered housebound where the following criteria are met:**
    a. The person has great difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
    b. Transportation and other strategies to remedy the access difficulties have been considered but are not available or not appropriate in the person's circumstances; and
    c. The person's care and support requirements can be effectively and appropriately delivered at home.

5. Amendments to Existing Services/Payments

a. After Hours Premiums (E400B, E400C, E402A, E403A, E401B, E401C, E409A, E410A, E412A, E413A) are increased by 10 points. For example, E400B is increased from 40% to 50%. This amendment restores these premiums to their value prior to April 1, 2012 effective April 1, 2013.

b. Anaesthesia units for E137C, E138C, E139C, E140C, E141C, E143C, E144C, E145C, E146C, E147C, E149C, Z580, Z555C, Z491C, Z492C, Z493C, Z494C, Z495C, Z499C, Z496C, Z497C, Z498C, Z606C and Z607C are increased from four to five units.

c. The schedule language for consultations is revised to include commentary. The purpose is to remind physicians of the following:

- The referring physician must determine if multiple requests by a patient or the patient’s representative to different physicians in the same specialty for the same condition are medically necessary. Services that are not medically necessary are uninsured.

- If the physician rendering the service to a patient requests another physician to submit a consultation request for that service after the service has been provided, a consultation is not payable. The visit fee appropriate to the service rendered may be claimed.
- Where a physician who has been paid for a consultation for the patient for the same diagnosis makes a request for a referral from another physician for ongoing management of the patient, the service rendered following the referral is not payable as a consultation.

d. Diabetes management incentive (Q040) is reduced from $75 to $60.

e. Laparoscopic premium (E792, E793, E862, E863) is increased from 10% to 25%. This amendment restores these premiums to their value prior to April 1, 2012 effective April 1, 2013.

f. Radiology imaging for low back pain – commentary relating to s. 18.2 (1) and 18.2 (2) of the Health Insurance Act has been deleted.

g. Optical Coherence Tomography (OCT). The fee for OCT services (G818 and G820) is increased from $25 to $35. In addition a new fee code (G821 - $35.00) is introduced for the active management of retinal disease with laser or intravitreal injections when the physician interprets the results and either performs the procedure or supervises the performance of the procedure.

h. Diagnostic Services Rendered by the Referring Physician otherwise known as the self-referral provision has been deleted from the Schedule of Benefits retroactive to April 1, 2012.

Charts detailing all of the fee code changes referenced within are available as attachments to this bulletin at:
http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

The new version of the Schedule is available at:
www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

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