INFOBulletin

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

To: **Physicians, Hospitals, and Clinics**

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

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1. Background

This bulletin describes changes to the Schedule of Benefits for Physician Service ("Schedule") effective October 1, 2013 resulting from the 2012 Physician Services Agreement between the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA). These changes include the introduction of new fee codes to reflect best available evidence and improvements in technology, as well as amendments to existing services and payments.

2. New Fee Codes

Optical Coherence Tomography (OCT):

On April 1, 2013, fee code G821 was introduced for OCT to be used when a patient is receiving active treatment for retinal disease with an annual limit of four per patient.

As part of the 2012 Physician Services Agreement, the OMA and Ministry agreed to ask the Ontario Health Technology Assessment Committee (OHTAC) to evaluate the evidence for frequency of performing optical coherence tomography. OHTAC has recommended more frequent use of OCT in children and patients under active treatment for retinal disease.

Ontario

To align with the OHTAC recommendation, two new fee codes are being introduced with an April 1, 2013 effective date, for OCT for patients receiving active treatment of retinal disease for up to eight additional services annually for two years and for children younger than 18 years of age for up to twelve services annually.

New Codes:

G822 - OCT unilateral or bilateral - active management with laser or intravitreal injections for neovascularization associated with:

i retinal disease, e.g. wet acute macular degeneration;
ii diabetic macular edema; or
iii retinal vein occlusion

when the physician interprets the results and either performs the procedure or supervises the performance of the procedure
..... 25.00

Payment Rules:

1. G822 is limited to a maximum of 8 services per patient per 12 month period and a maximum of 16 services per patient for 24 consecutive months.
2. G822 is *only eligible for payment* when the limit of any combination of G818, G820 or G821 is reached.

G823 - OCT unilateral or bilateral - evaluation of an infant/child/adolescent with retinal disease and/or glaucoma (including genetic retinal abnormalities and cancer), or low vision associated with or resulting in developmental delay when the physician interprets the results and either performs the procedure or supervises the performance of the procedure on a patient younger than 18 years of age..... 35.00

Payment Rules:

1. G823 is limited to a maximum of 12 services per 12 month period.
2. G818, G820, G821 and G822 are not eligible for payment when rendered on a patient younger than 18 years of age.

Claims Submission:

As the G822 and G823 are being introduced with an effective date retroactive to April 1, 2013 please note the following claims submission deadlines are being extended as follows:

Services Dates within:	**Must be submitted by:**
April 2013	November 18, 2013
May 2013	December 18, 2013
June 2013	January 18, 2014
July 2013	February 18, 2014

Services Dates within:	Must be submitted by:
August 2013	March 18, 2014
September 2013	April 18, 2014

Positron Emission Tomography (PET) Scan:

Based on recommendations from the PET Steering Committee, the following three new indications are being added to the list of insured indications for PET and Computed Tomography (CT) scans:

- prior to liver metastases from colorectal cancer,
- the staging of nasopharyngeal cancer, and
- the evaluation of metastatic squamous cell carcinoma in neck nodes.

New Codes:

Metastatic squamous cell carcinoma – evaluation of neck nodes

J711 Metastatic squamous cell carcinoma – evaluation of neck nodes 237.50

Note: J711 is only insured when the primary disease site is unknown after radiologic and clinical investigation.

Liver metastasis from colorectal cancer

Prior to surgery for resection of metastatic lesions from colorectal cancer only when:
a. The surgical procedure on the liver is high risk; or
b. The patient is considered at high risk for surgery.

Commentary: Examples of high risk liver surgical procedures are multiple staged liver resection or where vascular reconstruction is required.

J712 Liver metastasis from colorectal cancer..... 237.50

Staging nasopharyngeal carcinoma

J713 Staging of nasopharyngeal carcinoma…….....237.50

3. Amendments to Existing Services/Payments

Colonoscopy:

As a follow up to the colonoscopy code changes made in January 2013, the payment rules for Z499 are being amended.

Z499 is now insured for patients 40 years of age or older or 10 years younger than the earliest age of diagnosis of the youngest affected relative.

Cervical Screening:

In January 2013, the Schedule cervical screening fee code (G365) was amended to reflect CCO's new guidelines. Routine cervical screening is insured once every three (3) years (or 36 months) if the result of a previous pap smear is normal.

The frequency of G365 has been amended to once every 33 months to accommodate for scheduling as some patients may be seen just prior to the recommended time interval.

Additionally, the payment rules for G394 (additional) have been amended to allow for payment in the following situations:

- follow-up of abnormal pap smear; or
- inadequate pap smear; or
- annually in a patient who is immunocompromised, e.g. HIV-positive or taking long-term immunosupressants; or
- a patient with a history of oncogenic HPV-typing; or
- where the physician is of the opinion that the patient is a member of a vulnerable group that may have difficulty accessing the services within the specified time period.

The medical records requirements for G394 has been amended to add "or documentation of difficulties in accessing the service within the specified time period" to align with the new payment rules.

Paediatric Out-Patient Case Conference:

The payment rules for the paediatric out-patient case conference code K704 are being amended to clarify that of the physicians participating in the case conference, only the most responsible physician must have a specialty designation of Paediatrics (26) or Psychiatry (19). Physicians from other specialties may participate and bill this code.

Mental Health Case Conference:

The payment rules for the mental health out-patient case conference code K701 are being amended to clarify that of the physicians participating in the case conference, only the most

responsible physician must have a specialty designation of Psychiatry (19). Physicians from other specialties may participate and bill this code.

Home Care Application:

The language for the home care application code (K070) and the home care supervision codes (K071 and K072) have been amended to clarify when these codes should be billed.

K070 is now limited to one service per home care admission per patient and is not eligible for payment if the patient is currently receiving home care.

K071 is limited to a maximum of one service per patient per physician per week for eight weeks following admission to the home care program and to a maximum of two services per patient per week for eight weeks.

K072 is limited to a maximum of two services per month per patient per physician after the eighth week following admission to a home care program and to a maximum of four services per patient per month.

Hyperbaric Oxygen Therapy (HBOT):

Following recommendations from the Undersea and Hyperbaric Medical Society, Idiopathic Sudden Sensorineural Hearing Loss (ISSHL) is being added to the list of insured indications for HBOT use.

HBOT is only eligible for payment for Idiopathic Sudden Sensorineural Hearing Loss (ISSHL) when the following conditions are met:

a. The patient is treated concurrently with corticosteroid unless corticosteroids are contraindicated; and
b. The treatment is initiated within 14 days of a diagnosis of ISSHL is made or confirmed by an otolaryngologist.

Transplant Services:

Instructions have been added to the Surgical Preamble which provide claims submission instructions for transplant recipients and donors for both Ontario and out-of-province recipients/donors.

Individual/Family Developmental and/or Behavioural Care (K122/K123)

Language for these services has been amended to allow payment for eligible physicians seeing patients older than 18 years of age and less than 22 years of age.

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 .

Further information about these changes is available at:

http://www.health.gov.on.ca/en/pro/programs/phys_services/default.aspx

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. If you would like to order a paper copy or compact disk (CD) of the Schedule for a fee, please visit
https://www.publications.serviceontario.ca

Physicians without access to the Internet can contact ServiceOntario at 1-800-668-9938.

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