INFOBulletin

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

To: All Health Care Providers

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Re: **Claim Adjustments – New Explanatory Codes**

Effective July 2019 two new Explanatory Codes are being introduced to assist health care providers in understanding and reconciling adjustments to previously processed claims.

These new explanatory codes will be used when the Ministry of Health (the ministry) processes an adjustment to a previously submitted claim after working with health care providers to update their registration and/or affiliations.

New Explanatory Codes:

Explanatory Code	Description	Assessment Reason
EP	This payment is an adjustment on an earlier account due to a provider registration update	• You are no longer active to bill on the service date of this claim • You are no longer affiliated to the group number used on the service date of this claim
EN	Network Billing Not Allowed	• You are no longer affiliated to a group eligible to bill this Primary Care model specific Fee Schedule Code (FSC) on the service date of this claim

Claims adjustments with an ‘EP’ or ‘EN’ explanatory code applied will have the payment recovered and will be re-processed at zero ($0.00) dollars. If the service was provided, you will need to submit a Remittance Advice Inquiry to correct the claim. Reasons for correction with examples are:

1. Correct the group number on the claim to reflect where the service was provided.

   e.g.

   A Family Health Organization (FHO) physician submits a claim for an A007A with a service date of April 1st, 2019 using the FHO group number for their enrolled patient.

   Payment of the eligible Blended Fee-For-Service premium is made for this claim.

   In May 2019, the physicians request to end their affiliation with the FHO as of March 1st, 2019 is processed.

   Since this change is processed retroactively to the billed service, the A007A claim will be adjusted and paid at $0.00 with the new ‘EP’ explanatory code.

2. Correct the FSC on the claim to a FSC your primary care patient enrolment model is eligible to bill.

   e.g.

   A Family Health Network (FHN) physician submits a claim for an A007A along with a Q012A after-hours premium code with a service date of March 15th, 2019 using the FHN group number for their enrolled patient.

   Payment of the Blended Fee-For-Service premium for the A007A along with the eligible after-hours premium is made for this claim.

   In April 2019, the physicians request to end their affiliation with the FHN and join the Comprehensive Care Model (CCM) group effective March 1st, 2019 is processed.

   Since this change is processed retroactively to the billed service, the A007A will be adjusted to be paid at $0.00. The after-hours claim will be adjusted and paid at $0.00 with the ‘EN’ explanatory code as the physician is no longer with a FHN and is no longer eligible to bill the Q012A. CCM group physicians are only eligible for after-hours payments using the Q016A fee code.

3. Correct the FSC on the claim to a FSC you are eligible to bill as a Fee-For-Service provider.

4. Correct the service date on the claim if billed with the wrong date to accurately reflect when the service was provided when affiliated to your group.

If you believe there may have been an error in processing your registration update that led to these claim adjustments or for any inquiries regarding the changes outlined in this bulletin please contact the Service Support Contact Centre by phone at **1-800-262-6524** or by email at:

SSContactCentre.MOH@ontario.ca