

Bulletin



Bulletin Number	Date	Direct inquiries to
4502 - Revised	December 23, 2009	Ministry of Health and Long-Term Care
Distribution		(address below)
Physicians, Hospitals, Clinics and Laboratories		

Subject: Amendment to Bulletin 4502 - 2008 Physician Services Agreement Update – Changes effective October 1, 2009.

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 Bulletin 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.

- 1. Fee code changes – Fee increases, Fee decreases, Deleted fee codes, New fee codes, Revisions to existing fee code descriptors, Anaesthesia unit increases and decreases**
- 2. Implementation of Schedule Changes – Retroactive Adjustments**
- 3. New specialties**
- 4. Special Visit Premiums**
- 5. Appendix Q (new): Primary Care codes**

1. Fee code changes

In keeping with section 3.2 of the Agreement to introduce a 5% global increase to the Schedule of Benefits, there are a number of fee code changes being introduced retroactively effective to October 1, 2009. Charts are available showing all fee increases, fee decreases, deleted fee codes, new fee codes, revision to existing fee code descriptors, and Anaesthetist unit increases and decreases on-line here:

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

2. Implementation of Schedule Changes – Retroactive Adjustments

The following chart details by type of fee code change the systems solution being implemented to correctly pay claims according to the provisions of the October 1, 2009 Schedule of Benefits.

The chart also shows the target date when each change will appear on physician Remittance Advices. The target dates shown on the chart may change as the system must process a large number of claims and the

Processing Sites				
Hamilton 119 King Street West, 10 th Floor Box 2280, Station A L8P 4Y7	Kingston 1055 Princess Street, Suite 401 Box 9000 K7L 5A9	London 217 York Street, 5 th Floor Box 5700, Station A N6A 4L6	Oshawa Executive Tower, Oshawa Centre 419 King Street West Box 635 L1J 7J2	Thunder Bay 435 James Street South Suite 113 P7E 6T1
Mississauga 201 City Centre Drive Suite 300 L5B 2T4	Ottawa Fuller Building 75 Albert Street, 7 th Floor K1P 5Y9	Sudbury 199 Larch Street Suite 801 P3E 5R1	Toronto 47 Sheppard Avenue East Suite 505 M2N 7E7	Contact Information www.health.gov.on.ca INFOline: 1-800-664-8988

adjustment of some claims may be deferred. Please note that in some situations, physician and ministry local office input is required to enact the retroactive adjustments.

Information regarding adjustments to payments for Specialist Physician Contracts (APPs) and Primary Health Care Flow-through will be communicated in a future bulletin.

Claims to be adjusted retroactively are those which:

1. are on the list of services with fee code/amount changes effective October 1, 2009;
2. have service dates of October 1, 2009 up to and including October 31, 2009; and
3. were processed and paid on the November 2009 Remittance Advice.

Claims with service dates on or after October 1, 2009 and processed after November 1, 2009 will be paid according to the new Schedule.

For clarification:

- Claims submitted in October at the old rates will be automatically corrected to the new rates as per the chart below.
- Specifically, for Anaesthesia & Surgical Assistants:
 - claims submitted in October using the **old** basic units will be automatically adjusted again for payment on the January RA.
 - claims submitted in October using the **new** basic units will be automatically adjusted again for payment on the January RA. Physicians in this case will either be over or under paid. Physicians should contact their local office and request a claim adjustment for services rendered and submitted in October back to the old basic units so they will be adjusted correctly.
 - Claims for service dates on or after October 1, 2009 submitted on or after November 1, 2009 should have the new units included before the claim is submitted. If physicians have already submitted these claims at old basic unit rates, they must contact their local office to request a claim adjustment.

The form to use for claim adjustments is called the “Remittance Advice Inquiry” form and is available online at: www.health.gov.on.ca/english/providers/forms/form_menu/ohip_prof_fm.html

The ministry will monitor the submission of claims to ensure they are submitted correctly.

Type of Fee Change	Solution	Target Payment Date	Comments and Examples
Fee Increases – applicable to Opt-in physicians and Reciprocal Medical Billing System/Workplace Safety Insurance Board claims.	Automated Item-by- Item Retroactive Adjustments	December 2009 / January 2010 Remittance Advice	<p>Example:</p> <p>Claim for a 72 year old patient receiving a general assessment on Oct. 15 and paid on the Nov. RA.:</p> <p>General Assessment Service: Original Claim – A003A paid at \$61.00 Adjustment 1 on Dec. RA - A003A reversal of -\$61.00 Adjustment 2 on Dec. RA – A003A paid at \$68.75</p> <p>Geriatric Premium: Original Premium Paid - \$9.15 Adjustment 1 on Dec. RA – premium reversal of -\$9.15 Adjustment 2 on Dec RA – premium paid at \$10.31 Additional payment of \$1.16 (\$10.31-\$9.15) on Dec. RA</p>

Type of Fee Change	Solution	Target Payment Date	Comments and Examples																				
<ul style="list-style-type: none"> Exclusion – all surgical codes including, those surgical codes eligible for age premiums and/or after hours anaesthetic premiums. Exclusion – K121A claims Exclusion – telemedicine claims 	Automated Item-by-Item Retroactive Adjustments	January 2010 Remittance Advice	<p>To ensure eligible age and after hour premiums pay correctly, surgical codes are being processed separately.</p> <p>Example:</p> <p>Claims were paid for a 72 year old patient undergoing a 4 hour and 15 minute surgery on October 26th</p> <table border="1" data-bbox="797 470 1398 800"> <thead> <tr> <th>Fee Code/ Physician</th> <th>Original Claim</th> <th>Jan. RA Adjustment1</th> <th>Jan RA Adjustment 2</th> </tr> </thead> <tbody> <tr> <td>S043A/ Surgeon</td> <td>\$690.90</td> <td>-\$690.90</td> <td>\$866.95</td> </tr> <tr> <td>S043B/ Assistant</td> <td>\$410.40</td> <td>-\$410.40</td> <td>\$472.32</td> </tr> <tr> <td>S043C Anaesthetist</td> <td>\$648.76</td> <td>-\$648.76</td> <td>\$741.54</td> </tr> <tr> <td>Anaesthesia Age Premium</td> <td>\$13.24</td> <td>-\$13.24</td> <td>\$14.54</td> </tr> </tbody> </table>	Fee Code/ Physician	Original Claim	Jan. RA Adjustment1	Jan RA Adjustment 2	S043A/ Surgeon	\$690.90	-\$690.90	\$866.95	S043B/ Assistant	\$410.40	-\$410.40	\$472.32	S043C Anaesthetist	\$648.76	-\$648.76	\$741.54	Anaesthesia Age Premium	\$13.24	-\$13.24	\$14.54
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Fee Increases (Opt-Out)	Automated Summary Level Retroactive Adjustments	December 2009 / January 2010 Remittance Advice	<p>Physicians should NOT collect the fee increases from patients. The fee increases will be paid directly to the physician.</p> <p>Physicians must ensure, through their local office, that the ministry has their correct mailing address and banking information.</p>																				
New codes – Scenario 1 – the new code replaces an existing code	Physicians must request that the applicable claim items be adjusted. The local office will adjust the claim to pay under the new fee code.	<p>The resubmission must be done within 6 months of the original service date on the claim.</p> <p>Payment will occur on the Remittance Advice the month after the resubmission was adjudicated.</p>	<p>Example – a physician submitted a claim with a service date in October 2009 and paid on the November 2009 RA. The originally billed fee code would be eligible for payment under a new fee code under the provisions of the new Schedule.</p> <p>The physician must send an inquiry to the local office and request that existing claim and the specific item(s) on the claim be adjusted to be the new fee code.</p> <p>A post audit will be performed to ensure duplicate payments are not made for the same service. If duplicate payment occurs, recoveries will be instituted</p>																				
New Codes – Scenario 2 – the code is for a new insured service. It was not previously billed under a different fee code	Physician submits claims for these services	Remittance Advice following the month the claim was processed	<p>Physicians may now submit claims for new services with service dates of October 1, 2009 or later.</p> <p>If a patient was billed for an uninsured service during October 2009, but the service is now insured, the physician must reimburse the patient for the full amount charged to the patient.</p>																				
New Codes – Most Responsible Physician (E082 and E083) - For	The physician can submit	Payment will occur on the RA the month	E082 and E083 are billable once per day by eligible physicians as add-on codes defined in the October 2009 Schedule of Benefits. E082 and E083 are eligible for payment																				

Type of Fee Change	Solution	Target Payment Date	Comments and Examples
eligible MRP services rendered by eligible physicians on or after October 1, 2009, if a physician submitted a fee code that is eligible for E082 or E083 but neglected to submit the E add-on code.	the appropriate E add-on code and the system will pay. A post payment audit will be performed to ensure only eligible physicians have submitted claims for E add-on codes.	after the claim is processed. Physicians may now submit claims for new services with service dates of October 1, 2009. All submissions/r esubmissions must be done within 6 months of the service date.	beginning October 1, 2009. Eligible physicians include physicians: <ul style="list-style-type: none"> • Whose hospitals have confirmed with the ministry through the established process that they do not receive top-ups for inpatient clinical care; and • Who receive top-ups but who have signed consent forms and whose hospital has confirmed with the ministry that top-ups will be reduced by the appropriate amount.
Fee decreases <ul style="list-style-type: none"> • Adjustment of overpayments will occur 	Automated claim by claim adjustments	December 2009 / January 2010 Remittance Advice	If a fee code was decreased, the fee paid amount will be adjusted.
Deleted codes	Automated claim by claim adjustments or OCCS adjustments by local ministry office	January and / or February 2010 Remittance Advice	A claim with a deleted code which was diverted to OCCS will have the deleted code fee value reduced to \$0.00 by the local ministry office at the time the claim is dealt with through OCCS. Other deleted codes will be dealt with through automated adjustments. These codes will be retroactively reduced with recoveries made on the January and/or February 2010 Remittance Advice.
Fee Code Descriptor Revisions	Some items may be adjusted through the automated adjustment process. Physicians must request that the applicable claim items be adjusted.		Physicians should wait for the results of the automated item-level adjustments, on the December RA, before submitting adjustments through the local ministry office. If physicians do not submit adjustments, the claim may be adjusted through a post payment review.
Surgical Assist Time unit changes	Automated Retroactive Adjustments.	January 2010 Remittance Advice.	Applicable age premium adjustments will be completed as required.
Anaesthesia unit changes	Automated Retroactive Adjustments.	January 2010 Remittance Advice	Applicable age premium and after hours premium adjustments will be completed as required.

3. New specialties

Five new specialties are being introduced in to the Schedule of Benefits for Physician Services as follows:

- Endocrinology & Metabolism (15)
- Nephrology (16)
- Vascular Surgery (17)
- Medical Oncology (44)
- Infectious Disease (46)

In addition, Specialty 09 – Cardiovascular and Thoracic Surgery’s name is being changed to Specialty 09 – Cardiac Surgery.

Not all claims submitted by physicians with one of the new specialties will require adjustments. For example, if the physician is an endocrinologist but submitted a claim for an assessment where the fee code is scheduled to receive an increase and the claim was submitted under the specialty of Internal Medicine the physician does not have to resubmit a claim. The fee code values of the ‘new’ specialty are with the same as those of the ‘old’ specialty and the claims processing system will automatically increase the payment for this fee code. It is not necessary to resubmit a claim so the new specialty appears on the claim.

4. Special Visit Premiums

The Schedule of Benefits section related to Special Visit Premiums (SVPs) has undergone a number of changes. Special Visit Premiums are payments made to physicians when a visit has been initiated by a patient for the purpose of rendering a non-elective service or an elective service.

Physicians who have withheld claims pending implementation of the changes should now submit those claims. If SVPs were paid on the November RA and need to be adjusted, physicians should contact their local ministry office and request that the claim items be adjusted. The local office will adjust the claim to pay under the new fee code structure, except in the circumstances described in the next paragraph.

Special Visit Premium Maximum Limits

The logic for the special visit premiums has not been fully implemented. As a temporary solution the first patient seen and additional patient seen maximum limits were set to 5 services each. A number of physicians are submitting more than 5 services for the first patient seen premium resulting in the services greater than 5 being reduced to \$0.00 with explain code “MD” – Daily Maximum has been Exceeded.” Local offices cannot manually adjust the additional services in order to pay the services. As a result there will be the need for a system retroactive adjustment to correct these claims payments. The timing of this system adjustment has not been determined.

5. Appendix Q: Information on Primary Care Q Codes

A new Appendix Q has been added to the Schedule of Benefits in order to provide a reference document for the Primary Care Q codes that currently exist.

A revised Schedule of Benefits for Physician Services, including all changes effective October 1, 2009, will be distributed to physicians in the near future.

Bulletins and the updated version of the Schedule reflecting the October 1, 2009 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

This Bulletin is a general summary provided for information purposes only. Physicians, hospitals and other health care providers are directed to review the *Health Insurance Act*, Regulation 552 and the Schedules under that regulation, for the complete text of the provisions. You can access this information on-line at: www.e-laws.gov.on.ca/. In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulation, the legislation and/or regulation prevails.