

Bulletin



Bulletin Number 4435	Date April 1, 2006	Direct inquiries to Ministry of Health and Long-Term Care Processing Office (address below)
Distribution Physicians, Hospitals, Clinics and Laboratories		

Subject: Schedule of Benefits for Physician Services Amendments – April 1, 2006

1. Fee increases
2. New fee codes
3. Revisions to specific codes
4. Second assistant claims
5. Hospital in-patient diagnostic services
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7. Amendment chart

In accordance with the 2004 Physician Services Agreement, a number of changes are being made to the Schedule of Benefits for Physician Services effective April 1, 2006.

1. Fee Increases

Effective April 1, 2006, fee increases to specific codes will be implemented. These fee increases are summarized in the attached table.

The fee increases will be implemented into the OHIP claims processing system effective April 1, 2006.

2. New Fee Codes

Six new fee codes will be introduced to the Schedule of Benefits for Physician Services effective April 1, 2006.

Office locations

Barrie 34 Simcoe St. Suite 102 L4N 6T4	Etobicoke 3300 Bloor St. W., Unit 142 M8X 2W8	Hamilton 119 King St. W 10th fl. P.O. Box 2280, Stn. A L8P 4Y7	Kenora 220-808 Robertson St. P9N 1X9	Kingston 1055 Princess St. P.O. Box 9000 K7L 5A9	Kitchener 1400 Weber St. E. Unit B2 N2A 3Z8	London 217 York St., 5th Floor Station A N6A 5P9
Mississauga 201 City Centre Dr. P.O. Box 7020, Stn. A L5B 2T4	Newmarket 465 Davis Dr. Unit 108 L3Y 8T2	North Bay 101-447 McKeown Ave. P1B 9S9	North York 4400 Dufferin St N Unit A4-A5 M3H 6A8	Oakville Oakville Town Centre II 220 North Service Rd. W. L6M 2Y3	Oshawa Exec. Tower, Oshawa Centre. 419 King St. W. P.O. Box 635 L1J 7J2	Ottawa Fuller Building 75 Albert Street K1P 5Y9
Ottawa Government Service Centre 110 Laurier Ave W K1P 1J1	Owen Sound 1400 1st Ave. W Suite # 2. N4K 6Z9	Peterborough 300 Water St, 1st Fl North Tower K9J 3C7	St. Catharines 301 St. Paul St. Mezzanine Level L2R 3M8	Sarnia 452 Christina St. N. N7T 5W4	Sault Ste. Marie Roberta Bondar Place 70 Foster Dr., Ste. 100 P6A 6V4	Scarborough 2063 Lawrence Ave. E. M1R 2Z4
Sudbury 199 Larch St., Suite 801 P3E 5R1	Thunder Bay 435 James St. S. , Suite 113 P7E 6T1	Timmins 38 Pine St. N., Suite 110 P4N 6K6	Toronto 47 Sheppard Ave.E. Suite 417 M2N 7E7	Toronto-Downtown 777 Bay St, Suite M212 M5G 2C8	Windsor 1427 Ouellette Ave. N8X 1K1	Head Office P.O. Box 48 Kingston, ON K7L 5J3

I) MTO Form Fee

The following text will be inserted on page A23 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation (MTO)

Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation (MTO) requires providing to MTO information that satisfies the requirements of the Highway Traffic Act or any applicable regulations, and includes providing any additional information to MTO regarding a previous report related to the same medical condition.

K035 Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation 34.85

Claims submission instruction:

Claims in excess of one per 12 month period by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

The joint Ministry of Health and Long Term Care/Ontario Medical Association Forms Committee has worked with the Ministry of Transportation to develop a reporting form to assist with the mandatory reporting of a patient’s medical condition to MTO. This form and additional information will be available as of April 1, 2006 on the Ministry of Transportation website at www.mto.gov.on.ca or by telephone 416-235-1773 (Toronto area) or 1-800-268-1481.

II) Northern Health Travel Grant (NHTG) Form

The following text will be inserted on page A23 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

Northern Health Travel Grant Application Form

K036 Completion of Northern Health Travel Grant Application Form 10.25

[Commentary:

K036 is payable to both the referring physician and specialist physician.]

III) General/Family Physician Emergency Department Assessment

The following text will be inserted on page A3 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

General/Family Physician Emergency Department Assessment

General/Family Physician Emergency Department Assessment is an assessment of a patient that satisfies as a minimum the requirements of an intermediate assessment and is rendered by the patient’s general/family physician in an emergency department funded under an Emergency Department Alternative Funding Agreement (ED AFA). For that visit, the service includes any re-assessment of the patient by the general/family physician in the emergency department and any appropriate collaboration with the emergency department physician.

The service is only eligible for payment when the general/family physician's attendance is required because of the complexity, obscurity or seriousness of the patient's condition.

A100 - General/Family Physician Emergency Department Assessment.....\$76.90

Payment rule:

No other service (including special visit or other premiums) rendered by the same physician to the same patient during the same visit to the emergency department is eligible for payment with this service.

Claims submission instruction:

For claims payment purposes, the hospital number associated with the emergency department must be submitted on the claim.

[Commentary:

- 1. Services described as A100 rendered in an emergency department not funded under an ED AFA may be payable under other existing fee schedule codes.*
- 2. In the event the patient is subsequently admitted to hospital, and the general/family physician remains the MRP for the patient, the General/Family Physician Emergency Department Assessment constitutes the admission assessment. See General Preamble GP29 for additional information.]*

In support of the introduction of this fee code, the schedule has also been amended to reference the *General/Family Physician Emergency Department Assessment* on pages GP29 (Admission Assessments) and GP65 (Emergency Department Alternative Funding Agreements) of the General Preamble.

IV) Fibromyalgia/chronic fatigue syndrome care

The following text will be inserted on page A19 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

Fibromyalgia/chronic fatigue syndrome care

Fibromyalgia/chronic fatigue syndrome care is the provision of care to patients with fibromyalgia or chronic fatigue syndrome. The service includes the common and specific elements of all insured services listed under "Family Practice & Practice In General" in the "Consultations and Visits" section of the Schedule.

K037 Fibromyalgia/chronic fatigue syndrome care. per unit 51.70

Payment rules:

- 1. K037 is a time based service with time calculated based on units. Unit means 1/2 hour or major part thereof – see General Preamble GP6, GP37 for definitions and time-keeping requirements.*
- 2. No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K037 to the same patient by the same physician.*

V) Enucleation – ocular surgery

The following text will be inserted on page Y7 under the Orbit, Excision subsection of the Ocular and Aural Surgical Procedures section of the Schedule of Benefits effective April 1, 2006:

E109 Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles 4 328.40 5

Note:

E102 or E103 are not eligible for payment with E109.

VI) Monthly management of a nursing home or home for the aged patient

A fee code (W010) for the monthly management of a patient in a nursing home or home for the aged is introduced on pages GP66-GP67 of the General Preamble, and pages A12 and A42 of the Consultations and Visits section, of the Schedule of Benefits for Physician Services effective April 1, 2006.

Monthly Management of a Nursing Home or Home for the Aged Patient is the provision by the most responsible physician (MRP) of routine medical care, management and supervision of a patient in a nursing home or home for the aged for one month. The service requires a minimum of two W-prefix assessments of the patient each month. The service is payable at \$85.70.

For complete service provision elements, payment rules, and claims submission instructions related to this new service, please see pages GP66-GP67 of the Schedule and the attached Q & As.

Please note that the LTC capitation rates for Primary Care Network, Family Health Network and Health Service Organization Agreements include the W010 code. When a physician who is participating in these models bills a W010 for an enrolled patient, the claim will be paid at \$0 with explanatory code I2 (service is globally funded) and the physician will receive the blended premium for the claim. Services billable as W010 for non-enrolled patients by these physicians will be paid fee-for-service.

Physicians in Family Health Networks, Health Service Organizations and Primary Care Networks should refer to their agreement for details on enrolling LTC patients.

Physicians participating in a Family Health Group or in a Comprehensive Care Agreement will be paid on a fee for service basis for W010 claims.

3. Revisions to Specific Codes

Effective April 1, 2006, changes will be made to the wording/definitions of the fee codes listed in the attached table.

4. Second surgical assistant claims

The following text will be inserted on page GP53 of the General Preamble section of the Schedule of Benefits effective April 1, 2006.

When more than one assistant was required for a surgical procedure, unless the service is listed below, the second assistant's service is only eligible for payment following authorization by a medical consultant and requires submission of a letter from the surgeon outlining the reason the second assistant was required. The amount payable for the second assistant is calculated in the same manner as the amount payable for the first assistant.

Services where a second assistant's services are payable and authorization is not required;

R240	R241	R326	R327	R440	R487
R594	S091	S092	S096	S098	S099
S213	S214	S267	S270	S271	S274
S275	S294	S295	S298	S300	S321
S416	S429	S440	S441	S453	

Currently, as S091, S092, S096, S098, and S099 do not have assigned anaesthesia units, surgical assistants are required to use the generic fee codes (S073, S074, S075) as appropriate for claiming units for these services. These generic claims will be manually assessed by Ministry claims staff who will monitor for S091A, S092A, S096A, S098A, S099A same patient, same day until such time as permanent automated claims system adjustments are available.

5. Hospital In-patient Diagnostic Services

Per section 20.2 of the 2004 Physician Services Agreement between the Ontario Medical Association and the Ministry of Health and Long-Term Care: details regarding physicians billing OHIP for the professional fee for diagnostic services provided on hospital in-patients are being finalized and will be communicated to hospitals and physicians at a later date.

6. New Diagnostic Code

A new diagnostic code has been introduced for claims submission:

249 – Pre-diabetes (i.e. impaired fasting glucose and/or glucose tolerance)

7. Amendment Chart

Chart 1 – Fee increases, new fee codes, fee code deletions and revised fee codes

This Bulletin is a general summary provided for informational 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.

Bulletins and the updated version of the Schedule of Benefits are available on the Ministry of Health and Long-Term Care website <http://www.health.gov.on.ca/>.