

**Schedule of Benefits for Physician Services Changes**  
**Effective April 1, 2006**  
**Questions and Answers**

Please note that the following information is 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 complete information regarding these changes. You can access this information on-line at: [www.e-laws.gov.on.ca/](http://www.e-laws.gov.on.ca/). In the event of a conflict or inconsistency between this information 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/>.

**1. What changes are being made to the Physician Schedule of Benefits?**

Effective April 1, 2006, the Schedule of Benefits for Physician Services under Regulation 552 of the *Health Insurance Act* is amended for fee increases, the introduction of new fee codes, fee code deletions and revisions to specific fee codes.

**2. Why are these changes being made?**

These changes are being made in support of the 2004 Physician Services Agreement. Additional amendments recommended by the Ontario Medical Association's Central Tariff Committee and jointly agreed to between the OMA and the Ministry.

**3. When do these changes become effective?**

The amendments to the Physician Schedule of Benefits are being implemented effective April 1, 2006.

**4. How will these changes be communicated to physicians and stakeholders?**

An OHIP Bulletin and corresponding page of the Schedule of Benefits will be sent to stakeholders detailing the changes that are being implemented.

**5. What new fee codes are being introduced?**

Effective April 1, 2006 six new fee codes are being added to the Schedule of Benefits. These include:

- a fee for mandatory reporting of medical condition to MTO (K035) - \$34.85,
- a fee for the completion of Northern Health Travel Grant Application Form (K036) - \$10.25,

- a General/Family Physician Emergency Department Assessment (A100) - \$76.90,
- an all-inclusive fee for fibromyalgia/chronic fatigue syndrome care (K037) - \$51.70,
- a fee for enucleation/evisceration, with insertion of implant and reattachment of extraocular muscle (E109) - \$328.40, and
- a fee code for the monthly management of a patient in a nursing home or home for the aged (W010) - \$85.70.

## **6. What is the new fee code for Monthly Management of a Nursing Home or Home for the Aged patient?**

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 per calendar month. The service is payable at \$85.70.

This code is intended to remunerate the physician for routine care of the patient on a monthly basis and includes the following services:

- Services described by subsequent visits (e.g. W003, W008);
- Services described by additional visits due to “intercurrent illness” (W121) unless the physician sees the patient for more than 4 Wxxx visits in one month;
- Services described by palliative care subsequent visits (e.g. W872);
- Services described by admission assessments (e.g. W102, W104, W107);
- Services described by pre-dental/pre-operative assessments (e.g. W903);
- Services described by annual health or annual physical examinations (e.g. W109);
- Services described by Visit for Pronouncement of Death (W777) or Certification of death (W771) - if the services are not performed in conjunction with a special visit;
- Service described by anticoagulation supervision (G271);
- Completion of CCAC application and home care supervision (K070, K071, K072);
- Services described by the following diagnostic and therapeutic procedures – venipuncture (G489), injection (G372, G373), immunization (G538, G539, G590, G591), Pap smear (G365, G394, E430), intravenous (G379), and laboratory test codes (G001, G002, G481, G003, G004, G005, G006, G007, G008, G009, G010, G011, G012, G014);
- Medication reviews;
- All discussions with the staff of the institution related to the patient’s care;

- All telephone calls from the staff of the institution, patient, patient's relative(s) or patient's representative in respect of the resident between the hours of 0700 hours and 1700 hours Monday to Friday (excluding holidays);
- Ontario Drug Benefit Limited Use prescriptions/forms or Section 8 Ontario Drug Benefits Act requests.

A diagnostic code is not required for payment for this service.

Payment rules and claims submission instructions are found on page GP 67 of the General Preamble of the Schedule of Benefits.

**7. Are physicians who have rostered their LTC patients entitled to receive the Monthly Management fee?**

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.

**8. Are assessments requiring a special visit to the LTC facility included in the number of required assessments for W010?**

No. Assessments requiring a special visit should be billed using the A-code plus appropriate special visit premium.

Services not included in the Monthly Management fee include:

- a. Visits which qualify for a special visit premium;
- b. Services described under interviews, psychotherapy or counselling with the patient, patient's relative(s) or patient's representative lasting 20 or more minutes and where all other criteria for these services are met.
- c. Services rendered by a specialist who is not the MRP or who is not replacing an absent MRP.

**9. Is there a list that shows all codes involved?**

The description of the service in the General Preamble provides the types of services that W010 encompasses. As some specialists may be providing ongoing

care as the MRP, W010 will include their corresponding routine visit codes, i.e. for geriatrics – W073, W078, W121, W972, W272, W274, W277, W279, W074 as well as practice in general codes W903, W777, W771 and the G codes.

Specialists may provide care to patients and are eligible for payment for their W-code assessments when a physician under a different specialty is billing the Monthly Management fee.

**10. What should I bill if I visit the patient once, but the patient is then transferred to a hospital for the remainder of the month?**

The appropriate “W” subsequent visit fee. However, if the patient is transferred to a hospital and dies within 48 hours, W010 may be claimed.

**11. Are there any other circumstances when W010 can be billed if I have not provided two visits in the month?**

W010 can be billed when less than two assessments were rendered during the month and/or when the patient was not in the institution for a full calendar month if:

- a. a patient was newly admitted to the institution and an admission assessment was rendered, or
- b. in the event of the death of a patient while in the institution or within 48 hours of transfer to hospital.

**12. Appendix I of the 2004 Physician Services Agreement states “... must have signed a contract with the LTC facility where he/she is practicing based on a common template developed by the Parties.” I haven’t received a common contract – can I still bill the code?**

Yes. The contract has not yet been developed by the Parties.

**13. If I have been billing W010 for a patient, but then do not provide 2 visits in a certain month, what should I bill?**

The appropriate W-code should be billed, i.e. W003 for subsequent visit to nursing home or home for the aged patient.

**14. What happens if I plan to take a two week vacation, but have a colleague covering my visits – can these visits count towards the provision of two visits a month?**

Visits provided by another physician with whom you have an arrangement can count towards the two visits per month minimum, providing the other physician does not also bill for the visits. If one physician bills W010; and a second GP bills W008 - either W008 will not pay if W010 is paid first or W010 will be reduced by value of W008.

**15. How do I bill W121 for visits after the 4th visit?**

In the Schedule language for W010, the claims payment instructions indicate that physicians need to use the manual review indicator to be paid for W121 when billed in the same month as W010. No additional documentation will be requested.

**16. A LTC resident is transferred to hospital during the month and is then transferred back to the long term care facility but is being cared for by the same physician the entire time; could the attending physician bill both W010 and the appropriate hospital C codes in the same month?**

W010 is for services in the LTC, and appropriate hospital C codes are for services provided to the patient while in the hospital. They are independent fee codes and each can be billed as long as the service provisions of each are met.

**17. A physician is caring for a resident and has billed W010 for several months. The resident then becomes unstable (e.g. acute CVA, acute decline in health) and now requires six to eight visits per month. What would be the appropriate billing?**

Once W010 is claimed for a patient, W010 must be claimed for an entire twelve months. If additional visits are medically necessary beyond the four visits included in W010, W121 may be claimed during the month for the additional visits using a manual review indicator.

**18. What new diagnostic code is being communicated by means of this amendment package?**

The following new diagnostic code has been introduced for claims submission:

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

**19. When am I eligible to bill the professional fee for 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.