Ontario

FACT SHEET

Ministry of Health and Long-Term Care
Primary Health Care

Community Health Centre (CHC) Payment and Reporting Guide

April 1, 2009

Effective April 1, 2009, Community Health Centre (CHC) Physicians will receive monthly incentive and bonus payments that have been processed and calculated by a new semi-automated claims processing system created by the Ministry of Health and Long-Term Care (ministry) specifically for the CHC Model.

CLAIMS SUBMISSIONS IN PURKINJE CLINICAL MANAGEMENT SYSTEM (CMS)

The new system will process claims entered in Purkinje CMS for enrolled patients, non-enrolled patients and registered non-insured clients monthly depending on the type of incentive and bonus payment.

Service dates of the claims to be processed must be on or after April 1, 2009. Service dates before April 1, 2009 will be rejected to the Monthly Claims Error Detail Report and will not be eligible for payment in the new system.

STALE DATING

The ministry has waived the standard six (6) month stale dating claims processing policy at this time. However, claims should be entered in Purkinje CMS and submitted to the ministry as soon as possible in order to allow timely payment processing.

MONTHLY PAYMENT DEPOSITED INTO THE CHC GROUP BANK ACCOUNT

Each CHC will receive a lump sum payment deposited into its group bank account at the end of each month which reflects incentives and bonuses processed and calculated in the preceding month.

MONHTHLY REPORTING

Each CHC will be able to download reports mid-month which reflects incentives and bonuses processed and calculated in the preceding month.

Ontario

MONTHLY PAYMENT

The services provided by CHC Physicians and entered in Purkinje CMS will be processed, calculated and paid monthly as one of the following:

1. Salary-Linked Adjustment (SLA) payments; or
2. Non SLA payments.

The monthly payment deposited into the CHC group bank account will be a lump sum of both SLA and Non SLA payments.

INCENTIVES AND BONUSES CONTRIBUTING TO THE SLA PAYMENT

- Comprehensive Care Capitation Payment*
- Comprehensive Care Capitation Reconciliation Payment*
- Seniors Care Premium*
- Blended Fee-For-Service Premium*
- Fee-For-Service payments for:
    - New Patient Fee
    - New Graduate – New Patient Fee
    - Unattached Patient Fee
    - After Hours Premium*
    - Diabetes Management Incentive*
    - Heart Failure Management Incentive*
    - Initial Smoking Cessation Counselling Fee*
    - Follow up Smoking Cessation Counselling Fee*
    - Fecal Occult Blood Test Distribution and Counselling Fee*
    - Preventive Care Management Codes
- Special Premiums for:
    - Prenatal Care
    - Home Visits
    - Palliative Care
    - Serious Mental Illness

**A three percent General Fee Payment (3% GFP) applies to these eligible incentives and bonuses per the 2008 Physician Services Agreement negotiated between the Ontario Medical Association (OMA) and the ministry.*

MONTHLY SLA PAYMENT CALCULATION

Incentives and bonuses contributing to the SLA Payment are earned by individual CHC Physicians but are pooled across the CHC Model each month. As a result, each CHC Physician receives an equal monthly SLA Payment. This monthly SLA Payment reflects the services provided by the CHC Model.

The following mathematical formula calculates the monthly SLA Payment per Full Time Equivalent (FTE) Physician:

$$\text{Monthly SLA Payment Per FTE Physician} = \frac{\text{Sum of monthly incentives and bonuses contributing to SLA Payment}}{\text{Monthly total filled FTE Physicians in CHC Model*}}$$

**Filled FTE Physicians are recorded monthly by each CHC. The monthly total number of filled FTE Physicians in the CHC Model is equal to the sum of the filled FTE Physician in each CHC.*

INCENTIVES AND BONUSES CONTRIBUTING TO THE NON SLA PAYMENT

- Fee-For-Service payments for services funded by ministries other than the Ministry of Health and Long-Term Care
- Special Premiums for:
    - Hospital Services
    - Obstetrical Deliveries
    - Office Procedures

MONTHLY NON SLA PAYMENT CALCULATION

Incentives and bonuses contributing to the Non SLA Payment are paid to individual CHC Physicians who earn them. As a result, each CHC Physician receives a Non SLA Payment which reflects the services provided by the individual CHC Physician.

SALARY-LINKED ADJUSTMENT (SLA) CONTRIBUTIONS

Comprehensive Care Capitation Payment

- Calculated separately for enrolled patients and registered non-insured clients monthly based on capitation rates for age/sex categories.
- The 3% GFP applies to the calculation for enrolled patients and registered non-insured clients.
- Reports on the Provider Summary Report under the SLA Contributions subheading.
- A summary reports on the Comprehensive Care Capitation Payment Summary Report under the Insured Enrolled Patients and Non-Insured Patients headings.
- Details report on the Comprehensive Care Capitation Payment Detail Report under the Insured Enrolled Patients and Non-Insured Patients headings.

Comprehensive Care Capitation Reconciliation (CC Cap Recon) Payment

- Calculated separately for enrolled patients and registered non-insured clients who have become enrolled or non-enrolled in the processing month or who have changed age categories in the processing month.
- The 3% GFP applies to the calculation for enrolled patients and registered non-insured clients.
- Capitation rates for the age/sex categories are pro-rated and can result in either positive or negative reconciliation.
- Reports on the Provider Summary Report under the SLA Contributions subheading.
- Details on the Comprehensive Care Capitation Reconciliation Detail Report under the Insured Enrolled Patients and Non-Insured Patients headings.

Seniors Care Premium

- An additional fifteen percent (15%) premium calculation for capitation rates for enrolled patients and registered non-insured clients who are 65 years of age and older.
- Capitation rates have been increased to include the 15% premium for these age categories.
- The 3% GFP applies to the capitation rates including the 15% Seniors Care Premium.
- It does not report separately on the Provider Summary Report.

Blended Fee-For-Service Premium (Shadow Billing Premium)

- A monthly five percent (5%) Shadow Billing Premium calculated separately on the approved amount of included services provided to enrolled patients, non-enrolled patients and registered non-insured clients.

- These services are processed at zero dollars with explanatory code 'I2 – Service is globally funded' on the Monthly Claims Processing Detail Report, and a 5% premium of the amount allowed in the Schedule of Benefits for Physician Services is calculated.

- The 3% GFP applies to the calculated 5% premium for enrolled patients, non-enrolled patients and registered non-insured clients.

- Services that contribute to a Physician's premium each month report on the monthly Blended Fee-For-Service Premium Detail Report. Each Physician's Blended FFS Premium earned monthly also report on the monthly Provider Summary Report under the SLA Contributions subheading.

New Patient Fee (Q013A)

- A FFS Payment calculation for enrolling up to 60 patients per fiscal year (April 1st to March 31st) who were previously without a family Physician.

- It is calculated as follows:

  Q013A $100.00 (for patients up to and including age 64 years)
  Q013A $120.00 (for patients between ages 65 and 74 years, inclusive)
  Q013A $180.00 (for patients age 75 years and older)

- A New Patient must meet the criteria outlined on the *New Patient Declaration Form*. The New Patient must sign both the *New Patient Declaration Form* and the *Patient Enrolment and Consent to Release Personal Health Information Form*. The *Patient Enrolment and Consent to Release Personal Health Information Form* must be submitted to the ministry for processing and the *New Patient Declaration Form* must be filed in the Physician's office.

- It will be paid once per patient and does not apply to the newborns of your existing patients. Physicians are encouraged to enrol newborn patients and submit the *Patient Enrolment and Consent to Release Personal Health Information Form*s for these patients immediately after the parent or guardian completes the *Patient Enrolment and Consent to Release Personal Health Information Form*.

- It is not allowed in addition to the New Graduate – New Patient Fee (Q033A) or the Unattached Patient Fee (Q023A) for the same patient. Subsequent claims will be rejected to the Monthly Claims Error Detail Report with error code 'A3L – Other new patient fee already paid.'

- Physicians are encouraged to continue to accept New Patients and submit fees after they have reached their New Patient Fee maximum of 60 per fiscal year (April 1st to March 31st). New Patient Fee codes exceeding 60 will be processed at zero dollars with explanatory code 'M1 – Maximum fee allowed for these services has been reached' on the Monthly Claims Processing Detail Report.

- If a Q013A service is processed for a patient who has completed the *Patient Enrolment and Consent to Release Personal Health Information Form* with the billing Physician but who has yet to be enrolled to the billing Physician on ministry systems, the Q013A service will be processed at zero dollars with explanatory code 'I6 – Premium not applicable. When the patient becomes enrolled to the billing Physician on ministry systems, the Q013A service will be automatically adjusted for processing, providing the service date of the Q013A service is on or after the date the patient becomes enrolled on ministry systems (this is the date on the *Patient Enrolment and Consent to Release Personal Health Information Form* and is not the day the enrolment is processed by the ministry).

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

New Graduate – New Patient Incentive (Q033A)

- A FFS Payment calculation for New Graduates for enrolling up to 300 patients who were previously without a family Physician during their first year of practice with an eligible Patient Enrolment Model (PEM).

- It is calculated as follows:

  Q033A $100.00 (for patients up to and including age 64 years)
  Q033A $120.00 (for patients between ages 65 and 74 years, inclusive)
  Q033A $180.00 (for patients age 75 years and older)

- A New Patient must meet the criteria outlined on the *New Patient Declaration Form*. The New Patient must sign both the *New Patient Declaration Form* and the *Patient Enrolment and Consent to Release Personal Health Information Form*. The *Patient Enrolment and Consent to Release Personal Health Information Form* must be submitted to the ministry for processing and the *New Patient Declaration Form* must be filed in the Physician's office.

- A New Graduate is a Physician who has completed his/her family medicine post-graduate training and is licensed to practice in Ontario within three years of joining a PEM. International Medical Graduates are included as New Graduates. The ministry verifies Physicians identified as New Graduates on Purkinje CMS to ensure all eligibility criteria are met.

- For Physicians who are unidentified as New Graduates and who submit Q033A services, these claims will be rejected to the Monthly Claims Error Detail Report as error code 'EQJ – Practitioner not eligible on service date.' These claims must be resubmitted using the New Patient Fee (Q013) code. For Physicians who are incorrectly identified as New Graduates on Purkinje CMS by the ministry, payments which exceed the 60 New Patient Fees will be recovered by the ministry.

- It will be paid once per patient and does not apply to the newborns of your existing patients. Physicians are encouraged to enrol newborn patients and submit the *Patient Enrolment and Consent to Release Personal Health Information Form*s for these patients immediately after the parent or guardian completes the *Patient Enrolment and Consent to Release Personal Health Information Form*.

- It is not allowed in addition to the New Patient Fee (Q013A) or the Unattached Patient Fee (Q023A) for the same patient. Subsequent claims will be rejected to the Monthly Claims Error Detail Report with error code 'A3L – Other new patient fee already paid.'

- New Graduate – New Patient Fee codes exceeding 300 will be processed at zero dollars with explanatory code 'M1 – Maximum fee allowed for these services has been reached' on the Monthly Claims Processing Detail Report.

- When a New Graduate's twelve month eligibility period has ended, and regardless if he/she has reached the 300 New Graduate – New Patient Fee maximum during this time period, the Physician can still enrol New Patients. At this time, he/she will be eligible to claim up to 60 New Patient Fees (Q013A) until the end of the fiscal year (April 1st to March 31st).

- If a Q033A service is processed for a patient who has completed the *Patient Enrolment and Consent to Release Personal Health Information Form* with the New Graduate but who has yet to be enrolled on ministry systems, the Q033A service will be processed at zero dollars with explanatory code 'I6 – Premium not applicable on the Monthly Claims Processing Detail Report. When the patient becomes enrolled to the New Graduate on ministry systems, the Q033A service will be automatically adjusted for processing, providing the service date of the Q033A service is on or after the date the patient becomes enrolled to the New Graduate on ministry systems (this is the date on the *Patient Enrolment and Consent to Release Personal Health Information Form* and is not the day the enrolment is processed by the ministry).

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Unattached Patient Fee (Q023A)

- A FFS Payment calculation of $150.00 premium for enrolling acute care patients previously without a family Physician and who have had an acute care in-patient stay within the last three (3) months. An acute care in-patient stay is a stay of at least one night in hospital as an in-patient for an acute illness. Emergency department visits and day surgery stays do not qualify.

- It is not allowed in addition to the New Patient Fee (Q013A) or New Graduate – New Patient Fee (Q033A) for the same patient. Subsequent claims will be rejected to the Monthly Claims Error Detail Report with error code 'A3L – Other new patient fee already paid.'

- It is allowed once per patient but there is no maximum number of patients.

- Newborns are eligible for the Unattached Patient Fee only if the mother does not have a family Physician and the newborn has been admitted to a Level II or higher Neonatal Intensive Care Unit (NICU) within the last three (3) months.

- An Unattached Patient must sign both the *Unattached Patient Declaration Form* and the *Patient Enrolment and Consent to Release Personal Health Information Form* within three (3) months of discharge from an in-hospital visit. The *Patient Enrolment and Consent to Release Personal Health Information Form* must be submitted to the ministry for processing and the *New Patient Declaration Form* must be filed in the Physician's office.

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

After Hours Premium (Q012A)

- A FFS Payment calculation of twenty percent (20%) on the approved value of the following fee codes for scheduled and unscheduled services provided during a scheduled After Hours block coverage to enrolled patients and registered non-insured clients of the CHC:

  A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A and K017A.

- It is calculated as follows:

  A001A - $17.75 and Q012A - $3.55
  A003A - $61.00 and Q012A - $12.20
  A004A - $30.70 and Q012A - $6.14
  A007A - $31.95 and Q012A - $6.29
  A008A - $10.25 and Q012A - $2.05
  A888A - $28.55 and Q012A - $5.71
  K005A - $51.70 and Q012A - $10.34
  K013A - $51.70 and Q012A - $10.34
  K017A - $30.40 and Q012A - $6.08

- The 3% GFP applies to the calculated 20% premium.

- It must be submitted in Purkinje CMS with one the above fee codes and must have the same service date as the accompanying fee code or the service will be rejected to the Monthly Claims Error Detail Report with error code 'AD9 – Premium not allowed alone.' It must be resubmitted in order for the 20% premium to be calculated and paid.

- If the patient is not enrolled to the CHC on ministry systems on the service date of the Q012A claim, an explanatory code 'I6 – Premium not applicable' will report on the Monthly Claims Processing Detail Report. The service billed along with the Q012A code will be processed (subject to all other claims processing rules). When the patient becomes enrolled to the billing Physician on ministry systems, the Q012A service will be automatically adjusted for processing, providing the service date of the Q012A service is on or after the date the patient becomes enrolled on ministry systems (this is the date on the *Patient Enrolment and Consent to Release Personal Health Information Form* and is not the day the enrolment is processed by the ministry).

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Diabetes Management Incentive (Q040A)

- A FFS Payment calculation of $60.00 per 365 day period for coordinating, providing and documenting all required elements of care for enrolled diabetic patients and registered non-insured diabetic clients.

- The 3% GFP applies to the $60.00 calculation.

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- Completion of a flow sheet to be maintained in the patient's record is required, which includes the required elements of diabetes management and complication risk assessment consistent with the Canadian Diabetes Association (CDA) 2003 Clinical Practice Guidelines.

- It is calculated for patients enrolled to Physicians identified on ministry systems. The assigned Physician in Purkinje CMS must match the Physician identified on ministry systems or the Q040A service will be rejected to the Monthly Claims Error Detail Report as error code 'EPA – CHC billing not approved.'

- There is a maximum of one Q040A fee code for each enrolled diabetic patient or registered non-insured diabetic client per 365 day period. Diabetes Management Incentives (Q040A) exceeding one will be processed at zero dollars with explanatory code 'M1 – Maximum fee allowed for these services has been reached' on the Monthly Claims Processing Detail Report.

- For more information and an example of the recommended flow sheet, please refer to the April 2006 Diabetes Management Incentive Fact Sheet.

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Initial Add-on Smoking Cessation Fee (E079A)

- A FFS Payment calculation of $15.40 per 365 day period for having dialogue with enrolled patients, non-enrolled patients and registered non-insured clients who smoke.

- The 3% GFP applies to the $15.40 calculation.

- Physicians may use the following items from the March 2008 Smoking Cessation Fees Fact Sheet to help facilitate and document initial dialogue with their patients and clients who smoke:
    - Smoking Cessation Guidelines For Physicians, and
    - Smoking Cessation Flow Sheet.

- Alternatively, Physicians may document that the smoking cessation dialogue, consistent with the 5As model of the Clinical Tobacco Intervention program, has taken place. Please refer to the April 2006 Smoking Cessation Fees Fact Sheet for more information on the flow sheet and 5As model.

- It must be submitted in Purkinje CMS with one of the following office-based or long-term care consult/visit codes that is within the realm of providing comprehensive primary care, including prenatal and postnatal care:

  A001A, A003A, A004A, A005A, A006A, A007A, A008A, A903A, A905A, K005A, K007A, K013A, K017A, P003A, P004A, P005A, P008A, W001A, W002A, W003A, W004A, W008A, W010A, W102A, W104A, W107A, W109A and W121A.

- It must be submitted in Purkinje CMS with one the above fee codes and must have the same service date as the accompanying fee code or the service will be rejected to the Monthly Claims Error Detail Report with error code 'AD9 – Premium not allowed alone.' It must be resubmitted in order for the fee to be processed.

- It is calculated for patients enrolled to Physicians identified on ministry systems. The assigned Physician in Purkinje CMS must match the Physician identified on ministry systems or the E079A service will be rejected to the Monthly Claims Error Detail Report as error code 'EPA – CHC billing not approved.'

- There is a maximum of one E079A fee code for each enrolled patient or registered non-insured client who has committed to quit smoking per 365 day period. Initial Add-on Smoking Cessation Fees (E079A) exceeding one will be processed at zero dollars with explanatory code 'M1 – Maximum fee allowed for these services has been reached' on the Monthly Claims Processing Detail Report.

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Smoking Cessation Counselling Fees (K039A and Q042A)

K039A

- A FFS Payment calculation of $33.45 for providing a dedicated subsequent counselling session with enrolled patients, non-enrolled patients and registered non-insured clients who have committed to quit smoking.

- The 3% GFP applies to the $33.45 calculations.

- There is a maximum of two K039A counselling sessions per patient in the 365 day period following the service date of a valid Initial Add-on Smoking Cessation Fee (E079A).

- Services exceeding two K039A will be processed at zero dollars with explanatory code 'M1 – Maximum fee allowed for these services has been reached' on the Monthly Claims Processing Detail Report.

- Counselling services that are not submitted in the 365 day period following the service date of a valid E079A will be rejected to the Monthly Claims Error Detail Report as error code 'PAA – No initial fee previously paid.'

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Q042A

- An additional FFS Payment calculation of $7.50 for providing a dedicated subsequent counselling session with enrolled patients and registered non-insured clients who have committed to quit smoking.
- The 3% GFP applies to the $7.50 calculations.
- There is a maximum of two Q042A counselling sessions per patient in the 365 day period following the service date of a valid Initial Add-on Smoking Cessation Fee (E079A).
- Services exceeding two Q042A will be processed at zero dollars with explanatory code 'M1 – Maximum fee allowed for these services has been reached' on the Monthly Claims Processing Detail Report.
- They are calculated for patients enrolled to Physicians identified on ministry systems. The assigned Physician in Purkinje CMS must match the Physician identified on ministry systems or the Q042A service will be rejected to the Monthly Claims Error Detail Report as error codes 'EPA – CHC billing not approved.'
- Counselling services that are not submitted in the 365 day period following the service date of a valid E079A will be rejected to the Monthly Claims Error Detail Report as error code 'PAA – No initial fee previously paid.'
- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Heart Failure Management Incentive (Q050A)

- A FFS Payment calculation of $125.00 per 365 day period for coordinating and documenting all required elements of care for enrolled heart failure patients and registered non-insured heart failure clients.
- The 3% GFP applies to the $125.00 calculation.
- Completion of a flow sheet to be maintained in the patient's record is required, which includes the required elements of heart failure management consistent with the Canadian Cardiovascular Society Recommendations on Heart Failure 2006 and 2007.
- It is calculated for patients enrolled to Physicians identified on ministry systems. The assigned Physician in Purkinje CMS must match the Physician identified on ministry systems or the Q050A service will be rejected to the Monthly Claims Error Detail Report as error code 'EPA – CHC billing not approved.'

- There is a maximum of one Q050A fee code for each enrolled heart failure patient or registered non-insured heart failure client per 365 day period. Heart Failure Management Incentives (Q050A) exceeding one will be processed at zero dollars with explanatory code 'M1 – Maximum fee allowed for these services has been reached' on the Monthly Claims Processing Detail Report.

- For more information and an example of the recommended flow sheet, please refer to the April 2008 Heart Failure Management Incentive Fact Sheet.

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Fecal Occult Blood Test Distribution and Counselling Fee (Q150A)

- A FFS Payment calculation of $7.00 per 730 day period for providing a Fecal Occult Blood Test (FOBT) kit directly to enrolled patients, non-enrolled patients and registered non-insured clients who are at risk of colorectal cancer.

- The 3% GFP applies to the $7.00 calculation.

- Physicians must:
    - Meet with the enrolled patient, non-enrolled patient or registered non-insured client and assess his/her medical and family history to determine if the FOBT is appropriate;
    - Educate the enrolled patient, non-enrolled patient or registered non-insured client during an office visit on correct use of the FOBT kid; and
    - Provide a separate laboratory requisition form for the FOBT (i.e. no other tests on the requisition).

- There is a maximum of one Q150A fee code for each enrolled patient, non-enrolled patient or registered non-insured client per 730 day period. Fecal Occult Blood Test Distribution and Counselling Fees (Q150A) exceeding one will be processed at zero dollars with explanatory code 'M4 – Maximum fee allowed for these services by one or more practitioners has been reached' on the Monthly Claims Processing Detail Report.

- Reports on the monthly Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Preventive Care Management Service Enhancement Codes (Q001A to Q005A)

- A FFS Payment of $6.86 for the administrative effort and material costs associated with informing eligible enrolled patients about the value of five (5) preventive care interventions and to encourage them to receive applicable services.

- Reports on the Provider Summary Report as a Fee-For-Service Payment under the SLA Contributions subheading.

Pap Smear (Q001A)

- It may be submitted every two (2) years for any given female enrolled patient between 35 and 70 years who is contacted for the purpose of scheduling a Pap Smear.

Mammogram (Q002A)

- It may be submitted every two (2) years for any given female enrolled patient between 50 and 70 years of age who is contacted for the purpose of scheduling a mammogram.

Influenza Vaccine (Q003A)

- It may be submitted annually for any given enrolled patient over the age of 65 who is contacted for the purpose of scheduling an influenza vaccination.

Immunizations (Q004A)

- It may be submitted once for any given enrolled patient between 18 and 24 months of age, whose parent or guardian is contacted for the purpose of scheduling an appointment for ministry supplied immunizations pursuant to the guidelines set by the National Advisory Committee on Immunization.

Colorectal Cancer Screening (Q005A)

- It may be submitted every two (2) years for any given enrolled patient between 50 and 75 years of age who is contacted for the purpose of scheduling an appointment for colorectal screening by Fecal Occult Blood Testing (FOBT).

Tracking and Exclusion Codes

- Identify an enrolled patient as having received the preventive care service or identify the enrolled patient as having met the eligibility criteria to exclude him or her from the target population for the specific preventive care service.

- Submission is completely voluntary. They have been introduced to assist Physicians, if desired, in tracking enrolled patients receiving preventive care services or those who should be excluded from the target population for a service.

- Processed at zero dollars with explanatory code '30 – Service is not a benefit of OHIP' on the Monthly Claims Processing Detail Report.

- There are five (5) Tracking Codes. It may be submitted once the Physician has knowledge that the enrolled patient has received the preventive care service. The service may have been rendered by the billing physician or elsewhere. For preventive care services requiring a test (ie. Fecal Occult Blood Test (FOBT), a Physician may submit the applicable Tracking Code once the results of the test have been reported.)

- There are three (3) Exclusion Codes. It may be submitted once the Physician has confirmed that the intervention is not appropriate for the enrolled patient according to the exclusion criteria.

Influenza Vaccine for Enrolled Patients between 35 and 70 years of age

Tracking Code Q130A
Exclusion Code Not applicable

Pap Smear for Enrolled Patients between 35 and 70 years of age

Tracking Code Q011A
Exclusion Code Q140A

- Exclusions apply for women who have had a hysterectomy, or who are being treated for cervical diseases that preclude regular screening Pap tests.

Mammogram for Enrolled Patients between 50 and 70 years of age

Tracking Code Q131A
Exclusion Code Q141A

- Exclusions apply for women who have had a mastectomy, or who are being treated for clinical breast disease.

Immunizations for Enrolled Patients under two years of age

Tracking Code Q132A
Exclusion Code Not applicable

Colorectal Screening for Enrolled Patients between 50 and 74 years of age

Tracking Code Q133A
Exclusion Code Q142A

- Exclusions apply for patients with known cancer being followed by a Physician; with known inflammatory bowel disease; with a history of malignant bowel disease; or with any disease requiring regular colonoscopies for surveillance purposes.

Special Premiums

- In any fiscal year (April 1st to March 31st), Physicians are eligible to qualify for all Special Premiums with the exception of both Obstetrical Deliveries and Prenatal Care as Physicians are only eligible for one. Physicians earn the higher value Obstetrical Deliveries.

- Physicians must reach the Special Premium Accumulations thresholds for Prenatal Care, Home Visits, Palliative Care and Serious Mental Illness in order to earn Premium Contributions.

- Special Premium Accumulations and Contributions for Prenatal Care, Home Visits, Palliative Care and Serious Mental Illness report monthly on the Summary Report: Special Premiums - Salary-Linked Adjustments. They also report monthly on the Provider Summary Report under the SLA Contributions subheading.

- At this time, only services provided to insured patients accumulate and contribute to Special Premiums. However, services provided to registered non-insured clients effective April 1, 2009 which are eligible for Special Premium Accumulations and Contributions will be recorded in the system until the ministry reconciles at the end of the fiscal year 2009/10 to determine if Physicians reached the Special Premium Accumulation thresholds.

- Special Premium Accumulations are pro-rated based on the effective date of the CHC or CHC Physician, whichever is later. However, Physicians are still eligible to achieve the maximum if sufficient services are submitted in that fiscal year. At this time, Special Premium Accumulations thresholds are not pro-rated. However, the ministry will reconcile at the end of the fiscal year 2009/10 to determine if Physicians who joined a CHC mid-fiscal year reached the pro-rated Special Premium Accumulation thresholds.

Prenatal Care
- Patients must be enrolled to a Physician in the CHC or registered as a registered non-insured client.
- Fee codes P003A and/or P004A must be billed.
- Minimum service level is five (5) patients.
- SLA Contribution is $2,000.00.

Home Visits (Other than Palliative Care)
- Patients must be enrolled to a Physician in the CHC or registered as a registered non-insured client.
- Fee codes A901A and/or A902A must be billed.
- Minimum level is one hundred (100) visits.
- SLA Contribution is $2,000.00.

Palliative Care
- K023A must be billed for the patient.
- Patient may be enrolled or non-enrolled or is a registered non-insured client.
- Minimum service level is four (4) patients.
- SLA Contribution is $2,000.00.

Serious Mental Illness (PC-SMI)
- For providing Comprehensive Primary Care to a minimum of five (5) enrolled patients or registered non-insured clients with diagnoses of bipolar disorder or schizophrenia or registered non-insured clients.

- Minimum service level is five (5) patients or clients for Level One for a SLA Contribution of $1,000.00 and an additional SLA Contribution of $1,000.00 for an additional five (5) patients or clients for Level Two (total of $2,000.00).

- Services for enrolled patients and registered non-insured clients with bi-polar disorders must be indicated by submitting the tracking code Q020A along with the service code that was rendered. The Q020A services will be processed at zero dollars with explanatory code ’30 – Service is not a benefit of OHIP’ on the Monthly Claims Processing Detail Report.

- Services for enrolled patients with schizophrenia must be indicated by submitting the tracking code Q021A along with the service code that was rendered. The Q021A services will be processed at zero dollars with explanatory code '30 – Service is not a benefit of OHIP' on the Monthly Claims Processing Detail Report.

- If the patient is not enrolled to the billing Physician on ministry systems on the service date, an explanatory code 'I6 – Premium not applicable' will report on the Monthly Claims Processing Detail Report. The service billed along with the Q020A or Q021A code will be processed (subject to all other claims processing rules). When the patient becomes enrolled to the billing Physician on ministry systems, the Q020A or Q021A service will be automatically counted towards the cumulative count for this Special Premium, providing the service date of the Q020A or Q021A service is on or after the date the patient becomes enrolled on ministry systems (this is the date on the *Patient Enrolment and Consent to Release Personal Health Information Form* and is not the day the enrolment is processed by the ministry).

NON SALARY-LINKED ADJUSTMENT (SLA) CONTRIBUTIONS

Fee-For-Service (FFS) Payment for Other Ministry Funded Services

- The following services are recovered either in whole or in part from other ministries and contribute to Non SLA Payments:

  K018A, K021A, K050A, K051A, K052A, K053A, K054A, K055A, K065A and K066A.

Special Premiums

- In any fiscal year (April 1st to March 31st), Physicians are eligible to qualify for all Special Premiums with the exception of both Obstetrical Deliveries and Prenatal Care as Physicians are only eligible for one. Physicians earn the higher value Obstetrical Deliveries.

- Physicians must reach the Special Premium Accumulations thresholds for Hospital Services, Obstetrical Deliveries and Office Procedures in order to earn Premium Payments.

- Special Premium Accumulations and Payments for Hospital Services, Obstetrical Deliveries and Office Procedures report monthly on the Payment Summary Report: Special Premiums – Non Salary-Linked Adjustments. They also report monthly on the Provider Summary Report under the Non SLA Contributions subheading.

- At this time, only services provided to insured patients accumulate to Special Premiums Payments. However, services provided to registered non-insured clients effective April 1, 2009 which are eligible for Special Premium Accumulations and Payments will be recorded in the system until the ministry reconciles at the end of fiscal year 2009/10 to determine if Physicians reached the Special Premium Accumulation thresholds.

- Special Premium Accumulations are pro-rated based on the effective date of the CHC or CHC Physician, whichever is later. However, Physicians are still eligible to achieve the maximum if sufficient services are submitted in that fiscal year. At this time, Special Premium Accumulation thresholds are not pro-rated. However, the ministry will reconcile at the end of the fiscal year 2009/10 to determine if Physicians who joined a CHC mid-fiscal year reached the pro-rated Special Premium Accumulation thresholds.

Hospital Services
- Patient may be enrolled or non-enrolled or is a registered non-insured client.
- Minimum service level is $2,000.00 in claims from the list in Appendix A.
- Payment is $5,000.00.

Obstetrical Deliveries
- Patients may be enrolled or non-enrolled or is a registered non-insured client.
- Minimum service level is five (5) claims from the list in Appendix B.
- Payment is $5,000.00.

Office Procedures

- Patients must be enrolled to a Physician in the CHC or registered as a registered non-insured client.
- Minimum service level is $1,200.00 in claims from Appendix C.
- Payment is $2,000.00.

REPORTING

CHC Group Payment Summary Report

- A single monthly report for each CHC group to be used to pay individual Physicians in the CHC group.
- Identifies the total monthly payment deposited into a CHC's group bank account and also records all payments deposited in the fiscal year (April 1st to March 31st).
- Shows the monthly SLA Payment Calculation for the CHC Model; including the monthly total SLA Contributions and total filled FTE Physicians for the CHC Model.
- Identifies the monthly Non SLA Payment earned by and owing to individual Physicians. Also records the Non SLA Payments paid to individual Physicians in the fiscal year (April 1st to March 31st).
- Identifies the monthly SLA Payment owing to individual Physicians based on the monthly SLA Payment Calculation for the CHC Model. Also records SLA Payments paid to individual Physicians in the fiscal year (April 1st to March 31st).
- See Appendix D for a sample CHC Group Payment Summary Report.

Provider Summary Report

- A monthly report for each individual Physician in the CHC group to be used to record all claims processing information for Physicians.
- A monthly summary of the following:
    - Services to Insured Patients:
        - Total Non SLA Payments; and
        - Total SLA Contributions
    - Services to Non-Insured Patients
        - Total Non SLA Payments; and
        - Total SLA Contributions
- Only identifies monthly Non SLA Payments owing to the individual Physician. This is the same amount that reports on the CHC Group Payment Summary Report as a monthly Non SLA Payment for the same Physician.
- Shows the monthly SLA Contributions for the individual Physician. Does not show the monthly SLA Payment owing to the individual Physician (as this information can only be found on the CHC Group Payment Summary Report).
- See Appendix E for a sample Provider Summary Report.

Blended Fee-For-Service Premium Detail Report

- A monthly report for each individual Physician in the CHC group that records all processed Shadow Billed claims (claims processed at zero dollars with explanatory code 'I2 – Service is globally funded' on the Monthly Claims Processing Detail Report) eligible for a 5% premium of the amount allowed in the Schedule of Benefits for Physician Services.

- Listed by Fee Schedule Code (FSC) separately for Insured Patients and Non-Insured Patients. The Number of Services for each FSC reports with the corresponding Total Fee Approved. The 5% premium is calculated on the Total Fee Approved values for each FSC.

- Identifies the Total Monthly Premium for individual Physicians and records Premiums calculated in the fiscal year (April 1st to March 31st). The 5% premium of Shadow Billed claims is also retroactively adjusted.

- The Total Monthly Premium for individual Physicians is the same amount that reports on the Provider Summary Report under the Services to Insured Patients and Services to Non-Insured Patients headings; under the Blended Fee-For-Service Premium subheadings.

- See Appendix F for a sample Blended Fee-For-Service Detail Report.

Monthly Claims Processing Detail Report

- A monthly report for each individual Physician in the CHC group that records all processed claims, including Shadow Billed claims (claims processed at zero dollars with explanatory code 'I2 – Service is globally funded'), Fee-For-Service claims and tracking and exclusion codes. Rejected claims do not report here.

- Listed separately for Insured Patients and Non-Insured Patients. However, claims contributing to the monthly SLA Payment and Non SLA Payment report together; they are not separated.

- Sorted by Patient Name for Insured Patients and Non-Insured Patients.

- Explanatory Codes report for processed Shadow Billed claims and tracking and exclusion codes. A list of common Explanatory Codes is provided as the last page. No Explanatory Codes report for processed Fee-For-Service claims.

- The monthly Total Amount Paid for individual Physicians is the sum of all Fee-For-Service claims for the Physicians.

- The monthly Total Amount Paid for individual Physicians is the same amount that reports on the Provider Summary Report under the Services to Insured Patients and Services to Non-Insured Patients headings; under the SLA Contributions and Non SLA Payment subheadings; Fee-For-Service.

- See Appendix G for a sample Monthly Claims Processing Detail Report.

Monthly Claims Error Detail Report

- A monthly report for each individual Physician in the CHC group that records all rejected claims, including Shadow Billed claims, Fee-For-Service claims and tracking and exclusion codes. Processed claims do not report here.

- A report is only generated if there is a minimum of one rejected claim for a Physician. A Physician who does not have any of his or her claims entered in Purkinje CMS rejected does not receive a report.

- Listed separately for Insured Patients and Non-Insured Patients. However, claims contributing to the monthly SLA Payment and Non SLA Payment report together; they are not separated.

- Sorted by Patient Name for Insured Patients and Non-Insured Patients.

- Error Codes report for all rejected claims and tracking and exclusion codes. A list of common Error Codes is provided as the last page.

- Assuming a rejected claim is eligible for processing, Physicians can correct the error (as identified by the Error Code) and re-enter the claim in Purkinje CMS for reprocessing in the subsequent month. It is the responsibility of the Physician to re-enter rejected claims in Purkinje CMS as the system will not automatically correct the error for reprocessing.

- See Appendix H for a sample Monthly Claims Processing Error Report.

Summary Report: Special Premiums – Salary-Linked Adjustments

- A monthly report for each individual Physician in the CHC group that records all Premium Accumulations and Premium Contributions for enrolled patients.

- A monthly summary of the following Special Premiums – SLA for Insured Patients:
    - Home Visits;
    - Palliative Care;
    - PC-SMI (Serious Mental Illness); and
    - Prenatal Care.

- Identifies the monthly Premium Accumulations and Premium Contributions when Premium Accumulations thresholds are reached for individual Physicians and records Premiums calculated in the fiscal year (April 1st to March 31st).

- The monthly Premium Contribution for individual Physicians is the same amount that reports on the Provider Summary Report under the Services to Insured Patients heading; under the SLA Contributions subheading; Special Premiums.

- See Appendix I for a sample Summary Report: Special Premiums – Salary-Linked Adjustments report.

Payment Summary Report: Special Premiums – Non Salary-Linked Adjustments

- A monthly report for each individual Physician in the CHC group that records all Premium Accumulations and Premium Payments for enrolled patients.

- A monthly summary of the following Special Premiums – Non SLA for Insured Patients:
    - Hospital Services;
    - Obstetrics; and
    - Office Procedures.

- Identifies the monthly Premium Accumulations and Premium Payments when Premium Accumulations thresholds are reached for individual Physicians and records Premiums paid in the fiscal year (April 1st to March 31st).

- The monthly Premium Payment for individual Physicians is the same amount that reports on the Provider Summary Report under the Services to Insured Patients heading; under the Non SLA Payments subheading; Special Premiums.

- See Appendix J for a sample Payment Summary Report: Special Premiums – Non Salary-Linked Adjustments report.

Comprehensive Care Capitation Summary Report

- A monthly report for each individual Physician in the CHC group that identifies a demographic breakdown of enrolled patients and registered non-insured clients by age/sex.

- Provides the following:
    - Capitation rates for enrolled patients and registered non-insured clients per day in each age/sex category;
    - Number of enrolled patients and registered non-insured clients in each age/sex category;
    - Number of Member Days for enrolled patients and registered non-insured clients in the reporting month in each age/sex category; and
    - Combined Total for female and male enrolled patients and registered non-insured clients for each age/sex category.

- Capitation rates have been increased to include the Seniors Care Premium, an additional fifteen percent (15%) premium calculation for capitation rates for enrolled patients and registered non-insured clients who are 65 years of age and older

- Listed separately for Insured Enrolled Patients and Non-Insured Patients; females and Males are recorded separately. However, enrolled patients and registered non-insured clients report together; they are not separated.

- The monthly Comprehensive Care Capitation Amount for individual Physicians is the same amount that reports on the Provider Summary Report under the Services to Insured Patients and Services to Non-Insured Patients headings; under the SLA Contributions and Non SLA Payments subheadings; Comprehensive Care Capitation.

- See Appendix K for a sample Comprehensive Care Capitation Summary Report.

Comprehensive Care Capitation Detail Report

- A monthly report for each individual Physician in the CHC group that identifies a detailed list of individual enrolled patients and registered non-insured clients.

- Provides the following:
    - Enrolled patient Health Number (blank for registered non-insured client);
    - Enrolled patient and registered non-insured client Sex;
    - Enrolled patient and registered non-insured client Birth Date;
    - Enrolled patient and registered non-insured client Name;
    - Enrolled patient and registered non-insured client Age;
    - Number of Member Days enrolled patients and registered non-insured clients are eligible for capitation payments;
    - Number of Member Days for enrolled patients and registered non-insured clients; and
    - Total Amount for enrolled patients and registered non-insured clients.

- Capitation rates have been increased to include the Seniors Care Premium, an additional fifteen percent (15%) premium calculation for capitation rates for enrolled patients and registered non-insured clients who are 65 years of age and older

- Listed separately for Insured Enrolled Patients and Non-Insured Patients. However, enrolled patients and non-insured clients report together; they are not separated.

- Sorted by Patient Name for Insured Enrolled Patients and Non-Insured Patients.

- The monthly Comprehensive Care Capitation Amount for individual Physicians is the same amount that reports on the Provider Summary Report under the Services to Insured Patients and Services to Non-Insured Patients headings; under the SLA Contributions and Non SLA Payments subheadings; Comprehensive Care Capitation.

- See Appendix L for a sample Comprehensive Care Capitation Detail Report.

Comprehensive Care Capitation Reconciliation Detail Report

- A monthly report for each individual Physician in the CHC group that identifies financial and neutral transactions as a result of enrolled patients and registered non-insured clients who have:
    - Become retroactively enrolled, registered or non-enrolled in the reporting month; or
    - Changed age categories in the reporting month; or
    - Had a name change.

- A report is only generated if reconciliation occurs. A Physician who does not have any reconciliation to his or her enrolled patients or registered non-insured clients does not receive a report.

- Provides the following:
    - Enrolled patient Health Number (blank for registered non-insured client);
    - Enrolled patient and registered non-insured client Sex;
    - Enrolled patient and registered non-insured client Birth Date;
    - Enrolled patient and registered non-insured client Name;
    - Enrolled patient and registered non-insured client Enrolment Start date
    - Reconciliation Processing Date;
    - Start and end dates for reconciliation;
    - Number of Member Days for reconciliation for enrolled patients and registered non-insured clients; and
    - Total reconciliation amount for enrolled patients and registered non-insured clients.

- Listed separately for Insured Enrolled Patients and Non-Insured Patients. However, enrolled patients and non-insured clients report together; they are not separated.

- The monthly Comprehensive Care Capitation Reconciliation Amount for individual Physicians is the same amount that reports on the Provider Summary Report under the Services to Insured Patients and Services to Non-Insured Patients headings; under the SLA Contributions and Non SLA Payments subheadings; Comprehensive Care Capitation Reconciliation.

- See Appendix M for a sample Comprehensive Care Capitation Payment Detail Report.

Enrolment Report Non-Insured Patient Summary

- A monthly report for each individual Physician in the CHC group that summarizes the total number of registered non-insured clients.

- Does not provide detailed client information.

- See Appendix N for a sample Enrolment Report Non-Insured Patient Summary report.

Enrolment Report Non-Insured Patient Details

- A monthly report for each individual Physician in the CHC group that details the number of registered non-insured clients.
- Provides details of non-insured clients who have become registered or who have ended their registration with the individual Physician in the reporting monthly period.
- Does not provide a comprehensive list of non-insured clients registered to the individual Physician.
- Identifies the Registered Non-Insured Client Name, Date of Birth (DOB), Gender, Enrolment (Registration) Date and End Date.
- See Appendix O for a sample Enrolment Report Non-Insured Patient Details report.