Billing & Payment Guide for Blended Salary Model (BSM) Physicians

Family Health Teams, Primary Health Care

Ministry of Health and Long-Term Care

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Introduction

This guide provides an update on primary care incentives available to Blended Salary Model (BSM) Physicians and replaces the *Family Health Team Blended Salary Model Fact Sheet* dated December 2006.

The BSM model is available to Patient Enrolment Model (PEM) physicians who are employed by a Community Sponsored Family Health Team (CS FHT). It has been designed to ensure that the PEM physicians are compensated fairly and appropriately for providing a comprehensive set of services to their enrolled patients.

A PEM signatory physician submits claims for services following current claims submission practices. All claims are subject to the Ministry of Health and Long-Term Care's (ministry) existing six-month stale date policy and all normal processing rules and regulations. Claims related inquiries should be directed to your local ministry OHIP Claims Office.

This guide also advises how to submit claims in order to assist with the monthly reconciliation process. You may require billing software changes to interact with ministry systems. For example, you may wish to contact your software vendor to: (i) help you improve your claims reconciliation, (ii) avoid unnecessary claims rejections, (iii) enable you to submit for new premium codes, and, (iv) manage variations between fees billed and paid and tracking codes approved at zero dollars.

Please refer to the Community Sponsored Funding Agreement (CSFA) and the 2008 Memorandum of Agreement (MOA) between the ministry and the Ontario Medical Association (OMA) for a complete list of Primary Care incentives.

For more Primary Health Care information such as Fact Sheets, INFOBulletins and Forms visit the Ministry of Health and Long-Term Care Health Care Professional internet site or contact your ministry representative at 1-866-766-0266.

Payments and Reporting

1. Base Salary Linked to Enrolment

Salary levels are linked to an individual BSM physician's roster size. The salary levels as of September 1, 2011 are as follows:

Salary Level	Target Roster Size	Salary
Level 1	1,300	$158,367.05
Level 2	1,475	$179,559.69
Level 3	1,650	$200,752.35

Annual Salary Determination

Each year, the salary level will be determined for the next fiscal year, based on the total number of patients enrolled as of March 31st (Schedule 1, Section 3.3).

In Year Salary Increases/Decreases

The ministry conducts a quarterly review of each physician's roster size. (Schedule 1 Section 3.3). The ministry will report salary level increases or decreases to the FHT in the *FHT Monthly Compensation Report*.

Increases:

- A BSM physician is eligible for a higher salary due to an increase in their roster size to the next level up to a maximum of level 3 funding.

Decreases:

- Salary is adjusted down where there is a 10 % or more decrease in the minimum target roster size.
    - Level 1 (1,300 enrolled patients): if patient roster falls below 1,170;
    - Level 2 (1,475 enrolled patients): if patient roster falls below 1,327;
    - Level 3 (1,650 enrolled patients): if patient roster falls below 1,485.

- There will be no change to the salary where the roster size of a particular level decreases by less than 10%.

Part-Time Physician Salary

- BSM physicians with fewer than 1,300 enrolled patients are considered part-time;
- The part-time salary amount is the "level 1 base salary", pro-rated on a per-patient basis (using 1,300 patients as 1.0 FTE);
- The part-time physician provides a minimum 0.20 FTE service commitment (i.e. 8 hours per week);
- The part-time physician must communicate to their enrolled patients the days they are available. Patients may access care from other members of the FHT when necessary.

- The FHT ensures that part-time physicians:
    - provide their required service commitment to the FHT including the after hours service coverage requirements;
    - have another member physician or health care provider available to care for the part-time physician's patients when he/she is not available.

Example Part-Time BSM Arrangements

Enrolled Roster	Annual Base Salary	FTE Proportional to Roster Size	Expected Physician Service Commitment
260	$31,673.41	0.20	8 hours per week
520	$63,346.82	0.40	16 hours per week
780	$95,020.23	0.60	24 hours per week
1,040	$126,693.64	0.80	32 hours per week
1,300	$158,367.05	1.00	40 hours per week

2. Capitation Payments

a. Comprehensive Care Capitation Payment

- Comprehensive Care (CC) Capitation payments are based on the age and sex of each enrolled patient.
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to CC Capitation payments.
- Physicians providing Block Coverage receive an average monthly capitation rate of $1.72 per enrolled patient, increasing to $2.48 per enrolled patient after 12 months of becoming a PEM physician. Note: Physicians migrating from one PEM to another will continue to be paid at the CC Capitation rate they were eligible for prior to the transition.
- CC Capitation payments are reported as an accounting transaction with the text line "COMP CARE CAPITATION" on the monthly group Remittance Advice (RA).
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to CC Capitation payments. Adjustments are reported as an accounting adjustment with the text line "COMP CARE RECONCILIATION" on the monthly group RA.

3. Comprehensive Care Capitation Payment Reporting

The following three capitation reports are provided monthly:

a. Comprehensive Care Capitation Payment Summary Report

- This report provides a demographic breakdown of enrolled patients by age/sex, CC Capitation rate per day in each category, number of member days in the reporting period per category and the total CC Capitation Payment amount.
- Reported on the monthly RA.

b. Comprehensive Care Capitation Payment Detail Report

- This paper report provides a complete list of enrolled patients including the name, health number, age, number of member days in the reporting period per category, and the CC Capitation Payments for each enrolled patient.

c. Comprehensive Care Capitation Payment Reconciliation Detail Report

- This paper report provides the effective and end date information of enrolled patients retroactively added or ended from the roster.
- This paper report displays financial and neutral transactions that affect your enrolled patients.
- For example, a financial transaction could result from retroactive enrolment activity or a neutral transaction could result from a name change.

4. Benefits

Benefits are paid directly to the CS FHT and are calculated at 20% of the physician salary. As the employer of the BSM physician, it is the responsibility of the FHT to make all appropriate mandatory remittances (e.g. employer deductions).

As the employer, the CS FHT must also ensure that the appropriate deductions are made from the BSM salary, including Federal Income Tax and mandatory benefits such as the employee's share of CPP and EI.

The FHT is expected, in conjunction with the physician on whose behalf any payments may be made, to determine additional components of the benefit compensation package.

5. Premiums

a. Seniors Care Premium

- BSM physicians receive an additional 15% payment for CC Capitation Payments for enrolled patients 65 years of age and older.
- No action is required as the CC Capitation rates have been increased by 15% for the age/sex categories 65 years and older.

b. Shadow Billing Premium

- PEM physicians receive a 5% premium on the approved amount of included services provided to all enrolled patients.
- Physicians should submit for these included services at regular Fee-for-Service (FFS) rates. These claims are paid at zero dollars with explanatory code '**I2 – Service is globally**

funded', and 5% of the amount allowed in the Schedule of Benefits is paid monthly to the group RA.

- The premium is paid as an accounting transaction with the text line "BLENDED FEE FOR SERVICE PREMIUM" equal to the sum of all physicians' earned premium amounts.
- Services that contribute to a physician's premium each month will be reported on the group RA in the Blended Fee-For-Service Premium Detail Report as an accounting transaction with the text line "BLENDED FEE FOR SERVICE PREMIUM".
- Each physician's total premium payment amount is also reported in the Blended Fee-For-Service Premium Summary Report on the group RA.

6. Fee-for-Service (FFS)

a. Services Provided External to the FHT

- There is no limit on FFS billings for services provided by PEM physicians working outside the FHT to enrolled or non-enrolled patients in locations other than the FHT.

b. Excluded Services

- Claims for excluded services will be paid for all patients (enrolled or non-enrolled) in accordance with all medical rules and at the appropriate Schedule of Benefits amount.

c. Workplace Safety Insurance Board (WSIB) services

- Physicians are eligible to submit and receive payment for insured services including but not limited to services provided under the Workplace Safety and Insurance Act.
- A WSIB service must be identified as 'WCB' on the claim.

d. Services provided to out-of-province patients

- Physicians are eligible to submit and receive payment for services provided to out-of-province patients.
- The service must be identified as 'RMB' on the claim for an out-of-province patient (with the exception of Quebec).

e. Other ministry funded services

- Physicians are eligible to receive payment for services that are recovered in whole or in part from a ministry of the government other than the Ministry of Health and Long-Term Care.
- Physicians should submit these services (K018A, K021A, K050A, K051A, K052A, K053A, K054A, K055A, K061A, K065A and K066A) for the amount set out in the Schedule of Benefits.

7. FFS Billing Limit (Hard Cap)

- The FFS billing limit refers to services provided to non-enrolled patients in the FHT setting. This is the ceiling level the ministry will pay for FFS claims submitted for services provided to non-enrolled patients seen in the FHT in a fiscal year. The FFS billing limit for part-time PEM physicians is pro-rated.

- The FFS billing limit is a group pool totalling $17,757.64 per physician for fiscal year 2011/12.

- Each physician's FFS billing limit accumulations will be reported monthly on the BSM group RA in the *FFS Core Service Ceiling Report*.
- Amounts exceeding the FFS billing limit will be recovered from the BSM RA as an accounting transaction with the text line "FFS CORE SERVICE PAYMENT CEILING ADJMT".

8. Access Bonus

- PEM physicians may receive an Access Bonus payment for their enrolled patients.
- The Access Bonus payment will be calculated and paid semi-annually as the sum of each physician's Access Bonus calculations with semi-annual reconciliation.
- The Access Bonus for enrolled patients will be calculated as 8.69% of a physician's monthly base salary minus any Outside Use.
- The Access Bonus payment for enrolled patients is paid as an accounting transaction with the text line "ACCESS BONUS PAYMENT" on the April and October group RAs.
- If one or more physicians have a negative Access Bonus, then the BSM group's Access Bonus payment will be reduced by this amount.
- If all physicians in the BSM have a negative Access Bonus or the individual physician's Negative Access Bonus exceeds the positive Access Bonus amount for the group of physicians, then the BSM group will have a negative Access Bonus; the Access Bonus payment will be zero dollars and no recovery will be made from the BSM.

9. Outside Use

- A physician's Outside Use is equal to the dollar value of included services provided to his/her enrolled patients by a family physician outside the BSM group.
- Billings of identified GP Focused Practice Physicians will be excluded from Outside Use accumulations.
- Each physician's Outside Use accumulations will be reported on the monthly BSM group RA and to the individual physician on his/her monthly solo RA in the Outside Use Access Bonus Detail Report.

Rostering Fee

10. Per Patient Rostering Fee (Q200A)

- A $5.00 per patient incentive payment for the **initial** enrolment of patients for the first 12 months of joining any PEM.
- A Q200A may be submitted once for each patient who completes, signs, and dates the *Patient Enrolment and Consent to Release Personal Health Information* (E/C) form.
- The Q200A will trigger enrolment-related payments, thus physicians are advised not to wait to bill for the Q200A until the patient appears on an *Enrolment Activity Report*.

- A Q200A submitted for a patient who has attempted to enrol with another family physician before six weeks have passed or attempted to enrol with more than two physicians in the same year will be rejected to the *Claims Error Report* with error code '**EP4 – Enrolment restriction**.'

Processing Rules:

- The Q200A is not associated with any other fee schedule code and may be submitted separately or in combination with other fee schedule codes.
- The service date of the Q200A claim must match the date the patient signed the E/C form.
- The completed E/C form should be submitted to the ministry within 90 days of claiming the Q200A. If an E/C form is not received, the patient's enrolment will be cancelled and all associated enrolment-related payments will be recovered.
- Q200A claims will be subject to all regular claim processing (e.g. stale dating rules).
- Once a physician's Q200A payment eligibility period has ended, he/she will no longer receive payment for the Q200A. However, he/she is encouraged to continue to submit the Q200A to enrol patients and trigger enrolment-related payments. To avoid reconciliation after the 12 month eligibility period, physicians should bill the Q200A at zero dollars; these claims will be processed and paid at zero dollars with explanatory code '**I9 – Payment not applied/expired**' and will report on the monthly RA.

New Patient Fees

11. Common Rules – All Models

- Eligible patients are those who do not have family physicians because they have moved to a new community, their family physician has changed communities, retired, passed away, or changed practice type, or they have never had a family physician.
- The patient completes and signs the E/C form.
- The physician and patient sign a *New Patient Declaration* form to be kept in the physician's office.
- A physician may submit for both a New Patient Fee and a Per Patient Rostering Fee (Q200A) for the same patient. The New Patient Fee and the Q200A should be submitted on the same claim with the same service date.
- Only one New Patient Fee is allowed per physician / patient combination. Subsequent claims will be rejected to the *Claims Error Report* with error code '**A3L – Other new patient fee already paid**.'
- NOTE: Newborns of enrolled patients do not qualify as new patients for the New Patient fees; newborns are only eligible if their mother also does not have a family physician. Physicians are encouraged to enrol newborn patients and submit the Per Patient Rostering Fee (Q200A) for these patients to trigger enrolment-related payments immediately after the parent or guardian completes the E/C form.

12. New Patient Fee (Q013A)

- An incentive payment for enrolling up to 60 patients per fiscal year who were previously without a family physician.
- A physician is eligible for a maximum of 60 Q013A services per fiscal year. However, physicians are encouraged to continue to accept New Patients and submit a Q013A claim after they have reached their New Patient Fee maximum. This will assist the ministry in determining the number of new patients that PEM physicians accept into their practices.
- New Patient Fee codes exceeding 60 will be processed and paid at zero dollars with explanatory code '**M1 – Maximum fee allowed for these services has been reached**' and will report on the monthly RA.

Processing Rules:

- The Q013A may be submitted separately or in combination with other fee schedule codes rendered at the same visit.
- The service date of the Q013A must match the date the patient signs the *New Patient Declaration* and the E/C form.
- If a Q013A claim is submitted for a patient who has completed the E/C form with the billing Physician but has yet to be enrolled on the ministry database, the Q013A will be processed and paid at zero dollars with explanatory code '**I6 – Premium not applicable**' and reported on the monthly RA. Other services submitted on the same claim will be processed for payment (subject to all other ministry rules). When a subsequent enrolment or Q200A for the patient is processed in the following twelve-month period, the Q013A will be automatically adjusted for payment, providing the service date of the Q013A is on or after the patient's signature date on the E/C form.

Billing Tip:

Bill the Q013A 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 over)

To accommodate software billing systems that will not support varying amounts for the same fee schedule code, physicians have the option to bill Q013A, with the fee amount equal to $100.00 regardless of the patient's age. Ministry systems will automatically approve the appropriate fee based on the patient's age.

13. Unattached Patient Fee (Q023A)

- A $150.00 premium will be paid for enrolling acute care patients previously without a family physician. There is no maximum number of patients.
- To be eligible for the Unattached Patient Fee, at the time of enrolment the patient does not have a family physician **and** they have had an acute care in-patient stay within the previous 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.
- 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.
- The Billing Tips and Processing Rules for claiming the Unattached Patient Fee are the same as the New Patient Fee. Please see New Patient Fee for more information.

14. New Graduate – New Patient Incentive (Q033A)

- An incentive payment for New Graduates during their first year of practice with the BSM for enrolling up to 300 patients who were previously without a family physician.
- A New Graduate is a physician who joins a BSM within three (3) years of completing his/her family medicine post graduate training and being licensed to practice in Ontario. International Medical Graduates are included as New Graduates.
- For physicians who do not qualify as New Graduates on the ministry database and who submit Q033A services, these claims will be rejected to the *Claims Error Report* as error code '**EQJ – Practitioner not eligible on service date**.' These claims must be resubmitted using the New Patient Fee (Q013A) code.
- A New Graduate is eligible for a maximum of 300 Q033A services in his/her first year of practice in a BSM (12 months beginning with their effective date of joining the PEM). New Graduate – New Patient Fee codes exceeding 300 will be processed and paid at zero dollars with explanatory code '**M1 – maximum fee allowed for these services has been reached**' and will report on the monthly RA.
- When a New Graduate's twelve month eligibility period has ended, 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.
- The Billing Tips and Processing Rules for claiming the New Graduate – New Patient Incentive are the same as the New Patient Fee. Please see New Patient Fee for more information.

15. New Patient Fee FOBT Positive/Colorectal Cancer (CRC) Increased Risk (Q043A)

- As part of the ColonCancerCheck program the ministry will provide Cancer Care Ontario (CCO) with a list of physicians who are currently accepting new patients with positive FOBT or at increased risk of colorectal cancer (CRC).
- Physicians will write the words ColonCancerCheck (CCC) on the *New Patient Declaration* form.
- Bill the Q043A as follows:

  $150.00 (for patients up to and including age 64 years)
  $170.00 (for patients between ages 65 and 74 years inclusive)
  $230.00 (for patients age 75 years and over)

- For complete information please refer to the *April 2008 New and Enhanced Incentives for Colorectal Screening Fact Sheet*.

16. Complex Vulnerable New Patient Fee (Q053A)

- A one-time payment of $350.00 for enrolling complex vulnerable patients through the Health Care Connect Program.
- Physicians will be paid the Complex Vulnerable New Patient fee through the submission of existing new patient fee codes (Q013A, Q023A, Q033A, and Q043A) or the Q053A fee code.
- Existing new patient fee codes:
  - If billed using Q013A, Q023A, Q033A or Q043A, Ministry systems will check to see that the patient is registered as complex-vulnerable and enrolled within three (3) months.
  - Once enrolment is verified, ministry systems will automatically replace the existing new patient fee code with the new Complex Vulnerable New Patient Q053A fee code and pay $350.00.
  - If the patient is not registered on Health Care Connect as complex-vulnerable, ministry systems will automatically apply the billing rules associated with the Q013A, Q023A, Q033A, or Q043A and pay the appropriate fee (i.e. Q013A will pay at $100 or appropriate age-related dollar premium).
- Q053A fee code:
  - If physician bills with new Complex Vulnerable New Patient Q053A fee code and if the patient is registered on Health Care Connect as complex-vulnerable and enrolled within three (3) months, the claim will pay at $350.00.
  - If both of the above requirements are not met (i.e. not registered on Health Care Connect and not enrolled within 3 months), the claim will reject with on the following Explanatory Codes:

    'HCC-Not Eligible'
    'HCE-Enrolment After 3 Mos'

17. Mother Newborn New Patient Fee (Q054A)

- A one-time payment of $350.00 for physicians enrolling an unattached mother and newborn within two weeks of giving birth or an unattached woman after 30 weeks of pregnancy.
- Physicians are required to bill the Q054A claim with the mother's Health Number.
- There is no billing maximum associated with Q054A.
- Payment of the Mother/Newborn New Patient Fee requires both the mother and newborn to be enrolled to the billing physician.
- If the mother has been enrolled through Health Care Connect as complex-vulnerable, the physician should bill the Q053A Complex Vulnerable New Patient Fee instead of the Q054A to be eligible for the Enhanced Payment (Complex Capitation Payment).

18. Multiple/Newborn Fee (Q055A)

- In the case of multiple births, physicians may bill a new Multiple Newborn Q055A fee code for each additional newborn of an unattached mother and the claim will be $150.00 per newborn.
- Physicians are required to bill the Q055A claim with the newborn's Health Number.

- Payment requires each newborn to be enrolled to the billing physician within three (3) months of birth.
- If the physician bills the Q055A and the newborn is not enrolled within three (3) months of birth, the claim will reject with Explanatory Code '**HCE-Enrolment After 3 Mos**'

19. Health Care Connect (HCC) Upgrade Patient Status (Q056A)

- A physician who accepts an HCC referred non-complex/vulnerable patient but whom the physician (in his/her clinical opinion) believes the patient to be complex and/or vulnerable, the physician is eligible to bill the HCC Upgrade Patient Status Q056A.
- There is no billing maximum associated with Q056A.
- When billing this code physicians will receive a one-time payment of $850.00 in recognition of the Q053A one-time payment of $350 and the Complex FFS Premium ($500.00). For more details on the Complex FFS Premium, refer to section entitled *Incentives*.
- If the physician bills the HCC Upgrade Patient Status Q056A for a patient not registered on Health Care Connect the claim will reject with the following Explanatory Code:
  'HCC Not Eligible'
- If the physician bills the HCC Upgrade Patient Status Q056A for a patient that is not enrolled within three (3) months of the HCC referral date, the claim will reject with the following Explanatory Code:
  'HCE Enrolment After 3 mos'
- If the physician bills the HCC Upgrade Patient Status Q056A for a patient that is not enrolled to the billing physician the claim will have the following Explanatory Code applied:
  'I6 Premium Not Applicable'
- The HCC Upgrade Patient Status Q056A cannot be billed in addition to: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Mother/Newborn New Patient Fee (Q054A), and Multiple Newborn Fee (Q055A), Complex Vulnerable New Patient Fee (Q053A), HCC Greater Than Three Months (Q057A) billed by the same physician for the same patient. Subsequent claims will reject with Explanatory Code:
  'A3L Other New Patient Fee Already Paid'

20. HCC Greater Than (HCC GT) Three Months (Q057A)

- Physicians who accept a non-complex-vulnerable patient who has been registered with Health Care Connect for 90 days or more are eligible to bill the new HCC GT Three Months Q057A.
- When billing this code, eligible physicians will receive a one-time payment of $200.00 for enrolling the patient through Health Care Connect. A Care Connector will inform physicians if the non-complex-vulnerable patient has been registered with Health Care Connect for 90 days or more.
- There is no billing maximum associated with Q057A.
- If the physician bills the HCC GT Three Months Q057A for a patient not registered on Health Care Connect the claim will reject with the following Explanatory Code:
  'HCC Not Eligible'

- If the physician bills the HCC GT Three Months Q057A for a patient that is not enrolled within three (3) months of the HCC referral date, the claim will reject with the following Explanatory Code:
  'HCE Enrolment After 3 mos'
- The HCC GT Three Months Q057A cannot be billed in addition to: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Mother/Newborn New Patient Fee (Q054A), and Multiple Newborn Fee (Q055A), Complex Vulnerable New Patient Fee (Q053A), HCC Upgrade Patient Status (Q056A) billed by the same physician for the same patient. Subsequent claims will reject with Explanatory Code:
  'A3L Other New Patient Fee Already Paid'

Incentives

21. Complex Capitation Payment

- PEM physicians who enrol a patient through Health Care Connect are eligible to receive enhanced payments for caring for complex-vulnerable patients for 12 consecutive months from the patient's enrolment effective date. Ministry systems will automatically initiate the enhanced payments based on enrolment of the complex-vulnerable patient. No action is required on the part of the physician to initiate the enhanced payment.
- For physicians in harmonized models, a complex capitation payment of $500.00 will be distributed over the 12 month period and paid monthly as a new complex capitation payment.
- The complex capitation payment will be paid to the Group RA or to the Solo RA where physicians have selected solo level payments. The payments will be made under the following accounting transactions:
  - CXCP – 'Complex Vulnerable Capitation Payment'
  - CXAJ – 'Complex Vulnerable Capitation Adjmt'
- If a patient's enrolment ends before 12 months, the complex capitation payment will end one day following the patient's enrolment end date.
- If a patient is transferred to a new physician, including physicians in the same group, the complex capitation payment will end.
- The complex capitation payment will be excluded from all Access Bonus calculations.

22. After Hours Premium (Q012A)

- Physicians are eligible for a 30% premium on the value of the following fee codes for scheduled and unscheduled services provided during a scheduled After Hours block coverage: A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K030A K033A and Q050A.
- The Q012A may only be billed when the above services are rendered to the enrolled patients of the billing physician or any other physician in the same BSM during a scheduled after hours session.
- The Q012A must be submitted in order to receive the 30% premium.

- The Q012A must have the same service date as the accompanying fee code or the claim will be rejected to the *Claims Error Report* with error code '**AD9 – Premium not allowed alone**.' However, if the service code was previously approved without a valid After Hours premium code, the Q012A may be submitted separately for the same patient with the same service date.
- If the patient is not enrolled on the ministry database, an explanatory code '**I6 – Premium not applicable**' will report on the monthly RA. The service billed along with the Q012A code will be paid (subject to all other ministry rules). When a subsequent enrolment for the patient is processed in the following twelve-month period, the Q012A will be automatically adjusted for payment, providing the service date of the Q012A is on or after the date the patient signed the E/C form.
- The maximum number of services allowed for each Q012A is one. If the number of services is greater than one, the After Hours premium will reject to the *Claims Error Report* with error code '**A3H – Maximum number of services**.' If the physician has seen the patient on two occasions on the same day where the Q012A is applicable, the second claim should be submitted with a manual review indicator and supporting documentation.
- If the physician has provided more than one half-hour (i.e. major part of a second half-hour) of counseling or mental health care, ensure the number of services for Q012A is one and claim the appropriate fee.

Example:

Code	Number of Services	Amount
K005A	2	$125.00
Q012A	1	$37.50

Billing Tip:

Bill services and associated Q012A codes at 30% of the corresponding service code as follows:

A001A - $21.70 and Q012A - $6.51	A003A - $77.20 and Q012A - $23.16
A004A - $38.35 and Q012A - $11.51	A007A - $34.70 and Q012A - $10.41
A008A - $13.05 and Q012A - $3.91	A888A - $35.40 and Q012A - $10.62
K005A - $62.75 and Q012A - $18.83	K013A - $62.75 and Q012A - $18.83
K017A - $43.60 and Q012A - $13.08	K030A - $39.20 and Q012A - $11.76
K033A - $38.15 and Q012A - $11.45	Q050A - $125.00 and Q012A - $37.50

- To accommodate software billing systems that will not support varying amounts for the same fee schedule code, physicians have the option to bill Q012A with the fee amount equal to the highest fee amount paid ($37.50). Ministry systems will automatically approve the appropriate fee.
- If the service code was previously approved without a valid After Hours' premium code the Q012A may be submitted separately for the same patient, with the same date of service.
- Common Questions and Answers can be found on the *After Hours Service Requirements Update, Questions & Answers, February 2011.*

23. Congestive Heart Failure Incentive (Q050A)

- The Congestive Heart Failure (CHF) Management Incentive fee code Q050A is a $125.00 annual payment available to physicians for coordinating, and documenting all required elements of care for enrolled heart failure patients. This requires completion of a flow sheet to be maintained in the patient's record that includes the required elements of heart failure management consistent with the Canadian Cardiovascular Society Recommendations on Heart Failure 2006 and 2007.
- A physician is eligible to submit for the CHF Management Incentive annually for an enrolled heart failure patient once all the required elements of the patient's heart failure care are documented and complete. This may be achieved after a minimum of two patient visits.
- A physician may submit a Q050A for an enrolled heart failure patient once per 365 day period. Congestive Heart Failure Incentives exceeding one will be processed and paid at zero dollars with explanatory code '**M1 – Maximum fee allowed for these services has been reached**' and reported on the monthly RA.
- Physicians may choose to use the CHF Patient Care Flow Sheet or one similar to track a patient's care. All the required elements must be recorded. It is intended that the flow sheet be completed over the course of the year to support a planned care approach for heart failure management.
- For more information and an example of the recommended flow sheet, please refer to the *April 2008 Heart Failure Management Incentive Fact Sheet*.

24. Diabetes Management Incentive (Q040A)

- A $75.00 annual payment for coordinating, providing and documenting all required elements of care for diabetic patients.
- 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.
- The Q040A is payable for enrolled and non-enrolled diabetic patients.
- A physician may submit a Q040A for a diabetic patient once per 365 day period. Diabetes Management Incentives exceeding one will be processed and paid at zero dollars with explanatory code '**M1 – Maximum fee allowed for these services has been reached**' and reported on the monthly RA.
- The Q040A may be submitted separately or in combination with other fee schedule codes once all elements of the flow sheet are completed.
- For more information and an example of the recommended flow sheet, please refer to the *April 2006 Diabetes Management Incentive Fact Sheet*.

25. Smoking Cessation Counselling Fees

Initial Smoking Cessation Fee (E079A)

- The E079A is an annual incentive payment available to all primary care physicians who dialogue with their patients who smoke.

- PEM physicians are eligible to bill the E079A for counselling patients who smoke. These patients may be enrolled or non-enrolled patients as long as the billing physician is the most responsible primary care provider. E079A is only eligible for payment when rendered in conjunction with one of the following services: 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 or W121A.
- The medical record for this service must document that an initial smoking cessation discussion has taken place, by either completion of a flow sheet or other documentation consistent with the most current guidelines of the "Clinical Tobacco Intervention" (CTI) program, otherwise the service is not eligible for payment.
- E079A is limited to a maximum of one service per patient per 365 day period.

Counselling Fee (Q042A).

- An additional incentive payment for physicians who provide a dedicated subsequent counselling session with their enrolled patients who have committed to quit smoking.
- A physician is eligible to receive payment for a maximum of two follow-up Q042A Smoking Cessation Counselling Fees if:
  1. The physician had previously billed a valid Initial Add-on Smoking Cessation Fee (E079A).
  2. The Smoking Cessation Counselling Fee is billed in the 365 day period following the service date of a valid Initial Add-on Smoking Cessation Fee.

- A maximum of two counselling sessions are payable at $7.50 in the 365 day period following the service date of a valid Initial Add-on Smoking Cessation Fee (E079A).
- For more information please refer to the *March 2008 Smoking Cessation Fees Fact Sheet*.

Special Bonuses and Premiums

- In any fiscal year, physicians are eligible to qualify for all Special Premiums for both enrolled and non-enrolled patients in the following bonus categories: Home Visits, Long-Term Care, Labour and Delivery and Palliative Care.
- A physician's Special Premium accumulations and payments are reported monthly on his/her solo RA and the group RA in a Payment Summary Report for the physician.
- Special Premium Payments are paid to the physician on his/her monthly solo RA as an accounting transaction with the text line "SPECIAL PREMIUM PAYMENT" based on approved claims processed.
- Premiums are pro-rated based on the commencement date of the group or PEM physician, whichever is later. However, the PEM physician is still eligible to achieve the maximum if sufficient services are submitted in that fiscal year.

26. Special Premiums

a. Labour and Delivery Special Premium

The following Fee Schedule Codes will contribute to the Labour and Delivery special premium thresholds for enrolled and non-enrolled patients: P006A, P007A, P009A, P018A and P020A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	5 or more patients served	23 or more patients served
Annual Bonus	$5,000	$8,000

b. Palliative Care Special Premium

The following additional Fee Schedule Codes will accumulate to Palliative Care special premium thresholds for enrolled and non-enrolled patients: K023A, C882A, A945A, C945A, W882A, W872A and B998A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	4 or more patients served	10 or more patients served
Annual Bonus	$2,000	$5,000

c. Home Visits (Other than Palliative Care) Special Premium

The following additional Fee Schedule Codes will accumulate to Home Visits special premium thresholds for enrolled and non-enrolled patients: A901A, A902A, B910A, B914A, B916A, B990A, B992A, B994A, and B996A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	B	C
Necessary annual criteria	3 or more patients served and 12 or more encounters	6 or more patients served and 24 or more encounters	17 or more patients served and 68 or more encounters
Annual Bonus	$1,000	$2,000	$5,000

d. Long-Term Care Premium

The following additional Fee Schedule Codes will accumulate to Long-Term Care premium thresholds for enrolled and non-enrolled patients: W001A, W002A, W003A, W004A, W008A, W010A, W102A, W104A, W107A, W109A, W121A, W777A, and W903A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	12 or more patients served	36 or more patients served
Annual Bonus	$2,000	$5,000

e. Office Procedures Special Premium

- After submitting valid claims for services from Schedule 1 Appendix 5 of the Community Sponsored Funding Agreement, totaling a minimum of $1,200.00 in any fiscal year.
- Payment is $2,000.
- Enrolled patients only.

f. Prenatal Care Special Premium

- After submitting valid claims for fee schedule codes P003 and/or P004 for prenatal care during the first 28 weeks of gestation for five (5) or more BSM enrolled patients in any fiscal year.
- Payment is $2,000.
- Enrolled patients only.

g. Hospital Services Special Premium

After submitting valid claims totaling $2,000.00 in any fiscal year for the following fee codes: A933A, C002A, C003A, C004A, C005A, C006A, C007A, C008A, C009A, C010A, C121A, C122A, C123A, C124A, C142A, C143A, C777A, C905A, C933A and H001A.

- Payment of $5,000
- The amount payable increases from $5,000.00 to $7,500.00 for BSM physicians who are located in either:

(i) an area with a score on the OMA Rurality Index of Ontario ("OMA RIO") greater than 45 (the "Designated RIO Area"); or

(ii) one of the following five (5) Northern Urban Referral Centres: Sudbury, Timmins, North Bay, Sault Ste Marie or Thunder Bay, or such other northern community that may be agreed to in writing by the OMA and the ministry.

In order to be eligible for the $7,500.00 payment, either the office the PEM physician regularly provides BSM services (as registered with the ministry) or the hospital in which he/she regularly provides hospital services will be located in the Designated RIO Area or the Northern Urban Referral Centre (as the case may be).
Once the physician's total accumulation of contributing claims reaches $6,000 or more an additional payment of $5,000 will be made for a total of $12,500.

- Enrolled and non-enrolled patients.

h. Premiums for Primary Health Care for Patients with Serious Mental Illness (SMI)

A payment (per fiscal year) for providing Comprehensive Primary Care to a minimum of five (5) enrolled patients with diagnoses of bipolar disorder or schizophrenia.

In order to receive the premium payment, a physician must reach the following thresholds:

Bonus Level	1	2
Necessary annual criteria	5 or more patients served	10 or more patients served
Annual Bonus	$1,000	$2,000

- The payment will be included in the Special Premium payment paid to the physician on his/her monthly solo RA as an accounting transaction with the text line “SPECIAL PREMIUM PAYMENT”.
- A physician’s SMI accumulations and payments are reported monthly on his/her solo RA and the group RA in a Payment Summary Report for the physician.
- Patients must be enrolled to the billing physician.
- Services for enrolled patients with bi-polar disorders must be indicated by submitting the tracking code Q020A at zero dollars along with the service code that was rendered. Services for enrolled patients with schizophrenia must be indicated by submitting the tracking code Q021A at zero dollars along with the service code that was rendered. Q020A and Q021A claims will be paid at zero dollars with explanatory code ‘**30 – Service is not a benefit of OHIP**.’
- If the patient is not enrolled to the billing physician on the ministry database, an explanatory code ‘**I6 – Premium not applicable**’ will report on the monthly RA. The service billed along with the Q020A or Q021A will be paid (subject to all other ministry rules). When a subsequent enrolment for the patient is processed in the following twelve month period, the Q020A or Q021A will automatically be counted towards the cumulative count for this premium.

27. Rurality Gradient Premium

- Annual premium for physicians who qualify based on their OMA RIO score.
- To be eligible, a physician’s OMA RIO score must be between 40.00 and 49.99. The premium is $5,000 for a RIO score of 40.00 and each additional increment of five (5) points above 40.00 qualifies for an additional $1,000.
- A physician’s RIO score is determined by matching his/her current postal code of the practice address to a pre-determined list of OMA RIO scores.
- The premium is paid monthly to the individual physician on his/her solo RA as an accounting transaction with the text line “RURALITY GRADIENT PREMIUM”.

Preventive Care

Eligible PEM physicians may receive Cumulative Preventive Care Payments and bonuses for maintaining specified levels of preventive care to their enrolled patients.

28. Preventive Care Management Service Codes (Q001A to Q005A)

- Physicians are eligible for a $6.86 payment for the administrative effort and material costs associated with informing eligible enrolled patients about the value of preventive care interventions and to encourage them to receive applicable services.
- Please refer to Schedule 1 Section 3.5 of the Community Sponsored Funding Agreement for detailed information regarding the conditions for claiming the service enhancement codes.

a. Pap Smear (Q001A)

Physicians may submit the Q001A for $6.86 every two (2) years for any female enrolled patient between 35 and 70 years who is contacted for the purpose of scheduling a Pap smear.

b. Mammogram (Q002A)

c. Physicians may submit the Q002A for $6.86 every two (2) years for any female enrolled patient between 50 and 70 years of age who is contacted for the purpose of scheduling a mammogram.

d. Influenza Vaccine (Q003A)

Physicians may submit the Q003A for $6.86 annually for any enrolled patient over the age of 65 who is contacted for the purpose of scheduling an influenza vaccination.

e. Immunizations (Q004A)

Physicians may submit the Q004A for $6.86 once for any 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.

f. Colorectal Cancer Screening (Q005A)

Eligible physicians may submit the Q005A at $6.86 for enrolled patients aged 50-74 years inclusive who have been contacted for the purpose of scheduling an appointment for colorectal cancer screening (once per patient every two years).

Please refer to the *Colorectal Cancer Screening Management Fee Fact Sheet* (*April 2008*) for the details of the rules for claiming this code.

29. Fecal Occult Blood Testing (FOBT) Fees

a. FOBT Distribution and Counseling Fee Q150A

- The Q150A $7.00 incentive payment is available to all primary care physicians in Ontario who provide the FOBT kit directly to their enrolled and non-enrolled patients.
- The PEM physician is required to meet with the patient to educate them on the correct use of the FOBT kit, and provide a separate laboratory requisition form for the FOBT (i.e. no other tests on the requisition).
- The Q150A is limited to a maximum of one service per patient every 730 day period. When a second Q150A code is billed for a patient by any other provider in the same 730 day period the Q150A will pay zero dollars with the explanation code **M4 "Maximum Fee Allowed for these services by one or more practitioners has been reached**".

30. Cumulative Preventive Care Bonus Codes

- Per fiscal year, bonus payments may be claimed for the five (5) preventive care categories above, where designated levels of preventive care to specific patient populations are achieved.
- Physicians will receive an information package including the procedures for claiming the cumulative bonus in April of each year.
- Bonuses are paid to the BSM on the monthly group RA.
- A physician's bonus payments are reported monthly on his/her solo RA and the group RA in a Payment Summary Report for the physician.
- Physicians also receive Preventive Care Target Population/Service Reports (provided in September and April) to assist with identifying enrolled patients who:

    i. Are in the target population in each preventive care category, and
    ii. Where consent has not been revoked, have received according to the ministry's records, a preventive care procedure during the specified time including those received outside the BSM.

Preventive Care Category	Achieved Compliance Rate	Fee Payable	Service Enhancement Code
Influenza Vaccine	60% 65% 70% 75% 80%	$220 $440 $770 $1100 $2200	Q100A Q101A Q102A Q103A Q104A
Pap Smear	60% 65% 70% 75% 80%	$220 $440 $660 $1320 $2200	Q105A Q106A Q107A Q108A Q109A
Mammography	55% 60% 65% 70% 75%	$220 $440 $770 $1320 $2200	Q110A Q111A Q112A Q113A Q114A
Childhood Immunization	85% 90% 95%	$440 $1100 $2200	Q115A Q116A Q117A
Colorectal Cancer Screening	15% 20% 40% 50% 60% 70%	$220 $440 $1100 $2200 $3300 $4000	Q118A Q119A Q120A Q121A Q122A Q123A

31. Tracking and Exclusion Codes

- Physicians may submit tracking and exclusion codes to assist in tracking patients receiving preventive care services or those who should be excluded from the target population.

Preventive Care Category	Tracking Code	Exclusion Code
Pap Smear	Q011A	Q140A
Mammogram	Q131A	Q141A
Influenza Vaccination	Q130A	n/a
Immunizations	Q132A	n/a
Colorectal Cancer Screening	Q133A	Q142A

32. Telephone Health Advisory Services (THAS)

- The BSM shall receive an automatic monthly payment of $400.00 per FTE physician to a maximum monthly payment of $2000 for the group's participation in THAS.
- THAS payments are paid monthly to the BSM on the group RA as an accounting transaction with the text line "TELEPHONE HEALTH ADVISORY SERVICE PYMT".

33. Continuing Medical Education (CME) Payment

- Fee Schedule Codes associated to the CME course type:
  - Q555A – Main Pro C
  - Q556A – Main Pro M1
- Physicians are eligible for 96 fifteen minute units (24 CME hours) per fiscal year paid out at $25.00 per unit.
- When a physician is billing a CME claim for a 1 hour Main Pro C course the physician is to submit the fee code Q555A at $0 and the number of services on the claim is 4
- CME is paid monthly to the physician on his/her solo RA as an accounting transaction with the text line "CONTINUING MEDICAL EDUCATION PAYMENT".
- CME can be carried over to a maximum of 192 units (48 hours) in one fiscal year.
- Maximum of 20 out of 24 hours for MAINPRO-M1 (Q556A), balance of hours must be MAINPRO-C (Q555A).
- For more information please refer to the *July 2008 Continuing Medical Education (CME) Automation Fact Sheet.*

34. In Office Service Bonus (IOSB) Payment

Background: In Office Service Bonus Payment

- Through the 2008 Physician Services Agreement, the Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA) have developed an annual In Office Service Bonus Payment.
- The In Office Service Bonus Payment is intended to recognize Patient Enrolment Model (PEM) physicians and PEM physician groups who provide a broad range of in-office services under the categories of complex procedures, mental health, minor office procedures and reproductive health.
- The total value of the incentive payment in respect of 2010/2011 services was $5 million increasing to $10 million in the second year and subsequent years.

In Office Service Bonus Payment Structure

The In Office Service Bonus (IOSB) is structured in four categories of care with patient and service level thresholds:

Category	Patient Threshold	Visit Threshold
Complex	75	150
Mental Health	75	150
Minor Procedures	40	80
Reproductive Health	100	200

The patient threshold is a distinct count of enrolled and non-enrolled patients in the category.

The visit threshold is the total number of services provided to the distinct patient population for the category.

Complex Category

Complex Fee Schedule Codes	
K030A	Diabetic Management Assessment (DMI)
K022A	Patients infected with HIV - time-based all-inclusive
E079A	Initial discussion with patient re: smoking cessation
K039A	Smoking cessation follow-up visit
K029A	Insulin therapy support (its)
Q040A	Diabetic Management Incentive Code
Q042A	Smoking cessation counselling
Q050A	CHF Flow Sheet
K037A	Fibromyalgia/chronic fatigue syndrome care

In order to earn the complex category the physician must provide at least 150 services to 75 distinct patients.

Mental Health Category

Mental Health Fee Schedule Codes	
K005A	Primary mental health care
K007A	Psychotherapy - individual care
K008A	Counselling with child and/or parent
K004A	psychotherapy - family - 2 or more family members
K013A	Counselling - individual care

In order to earn the mental health category the physician must provide at least 150 services to 75 distinct patients.

Minor Procedures Category

Minor Procedures Fee Schedule Codes	
G370A	bursa, joint, ganglion or tendon sheath injection and/or aspiration
Z101A	incision - abscess or haematoma - local anaesthetic
Z103A	incision - abscess or haematoma - local anaesthetic - palmar or plantar spaces
Z104A	incision - abscess or haematoma - local anaesthetic - perianal
Z106A	incision - abscess or haematoma - local anaesthetic - ischiorectal or pilonidal
Z113A	incision - biopsy(s) - any method, when sutures are not used
Z114A	incision - foreign body removal - local anaesthetic
Z116A	incision - biopsy(s) - any method, when sutures are used
Z117A	finger or toe-nail - chemical and/or cryotherapy treatment of minor skin lesions - one or more lesions, per treatment
Z118A	incision - aspiration of superficial lump for cytology
Z122A	excision - cyst, haemangioma, lipoma - face/neck
Z123A	excision - cyst, haemangioma, lipoma - face or neck - local anaesthetic - two lesions
Z124A	excision - cyst, haemangioma, lipoma - face or neck - local anaesthetic - three or more lesions
Z125A	excision - cyst, haemangioma, lipoma - areas other than face or neck - local anaesthetic - single lesion
Z126A	excision - cyst, haemangioma, lipoma - areas other than face or neck - local anaesthetic - two lesions
Z127A	excision - cyst, haemangioma, lipoma - areas other than face or neck - local anaesthetic - three or more lesions
Z128A	finger or toe-nail - simple, partial or complete, nail plate excision requiring anaesthesia - one
Z139A	operations on the breast - incision - aspiration of cyst
Z153A	skin & subcutaneous tissue - repair - debridement and dressing
Z154A	suture of lacerations - up to 5 cm if on face and/or requires tying of bleeders and/or closure in layers
Z156A	excision - e.g. verruca, keratosis, pyogenic granuloma, molluscum - removal by excision and suture - single lesion
Z157A	excision - e.g. verruca, keratosis, pyogenic granuloma, molluscum - removal by excision and suture - two lesions
Z158A	excision - e.g. verruca, keratosis, pyogenic granuloma, molluscum - removal by excision and suture - three or more lesions
Z159A	excision - e.g. verruca, keratosis, pyogenic granuloma, molluscum - removal by electrocoagulation &/or curetting - single lesion
Z160A	excision - e.g. verruca, keratosis, pyogenic granuloma, molluscum - removal by electrocoagulation &/or curetting - two lesions

Z161A	excision - e.g. verruca, keratosis, pyogenic granuloma, molluscum - removal by electrocoagulation &/or curetting - three or more les
Z162A	excision - single or multiple sites - naevus - removal by excision and suture - single lesion
Z163A	excision - naevus - removal by excision and suture - two lesions
Z164A	excision - naevus - removal by excision and suture - three or more lesions
Z169A	excision - plantar verruca - removal by electrocoagulation and/or curetting - single lesion
Z170A	excision - plantar verruca - removal by electrocoagulation and/or curetting - two lesions
Z171A	excision - plantar verruca - removal by electrocoagulation and/or curetting - three or more lesions
Z173A	incision - abscess or haematoma - local anaesthetic - subcutaneous - two
Z174A	incision - abscess or haematoma - local anaesthetic - subcutaneous - three or more
Z176A	suture of lacerations - up to 5 cm
Z314A	respiratory - nose - reconstruction - treatment of epistaxis (nasal hemorrhage) - cauterization (iop) - unilateral
Z543A	digestive - anus - endoscopy - anoscopy
Z544A	digestive - anus - incision - biopsy
Z545A	digestive - anus - incision - thrombosed haemorrhoid

In order to earn the minor procedures category the physician must provide at least 80 services to 40 distinct patients.

Reproductive Health Category

Reproductive Health Fee Schedule Codes	
G365A	Gynaecology - max one per patient per 12 month, excluding smears
P003A	prenatal care - general assessment
P004A	prenatal care - minor prenatal assessment
P005A	prenatal care - antenatal preventative health assessment
G394A	Papanicolaou Smear - for follow-up of abnormal or inadequate smears
E430A	Papanicolaou smears performed outside hospital
G378A	Gynaecology - insertion of intrauterine contraceptive device
Z770A	Female genital - corpus uteri - incision or excision - endometrial stapling
P008A	Obstetrics - post natal care in office

In order to earn reproductive health category the physician must provide at least 200 services to 100 distinct patients.

Calculating the IOSB Payment

In Office Service Bonus Payment is based on a ‘point system’ as follows:

- If you are eligible in one category you earn 1 point
- If you are eligible in two categories you earn 3 points
- If you are eligible in three categories you earn 6 points
- If you are eligible in all four categories you earn 10 points

The value of one point will be determined at the end of the year:

($5 Million) in 2010 / (Total # of Points Earned by all physicians) = value of one point

($10 Million) in 2011 and every year following / (Total # of Points Earned by all physicians) = value of one point

Locum Contributions to In Office Service Bonus

The services provided by Locum physicians since April 1, 2010 to enrolled patients only will contribute to the threshold of the In Office Service Bonus category for the enrolling physician. The patient must be actively enrolled in the same group the locum physician is affiliated to on the date of service.

PEM Signatory Physician with a Locum Affiliation to another PEM Group

When locum services are provided to enrolled and non-enrolled patients, the service contributes to the IOSB threshold of the billing physician.

Frequency of In Office Service Bonus Payment

To ensure the program remains within budget the bonus amount will be calculated and paid at the end of the fiscal year plus M7 (claims submitted for processing up to seven months from the service date) data (December RA). The end of the fiscal year is March 31st plus seven months has the payment issued and reported each year on the December RA. The Ministry waits for M7 data in order to ensure all eligible claims are selected for inclusion towards thresholds.

Remittance Advice Contribution Reporting

A new report "In Office Service Bonus Summary Report" will be shown on the Remittance Advice (RA). This report accumulates all eligible claims with service dates in the fiscal year indicated.

Locum contributions to IOSB will appear on the report under the IOSB category with their total contribution values, month to date and year to date totals. Locums will be identified on the report with their claims submission number. Each locum will remain on the report for the entire fiscal year if there are year to date contributions.

IN OFFICE SERVICE BONUS SUMMARY REPORT FISCAL 2010
CLAIMS WITH SERVICE DATES: APRIL 1, 2010 - MARCH 31, 2011
PHYSICIAN: 123456

CATEGORY	PREMIUM ACCUMULATIONS CURRENT MONTH PTS/SRV	YTD PTS/SRV
COMPLEX:		
MIN SERVICE LEVEL 75/150:	0/0	0/0
MENTAL HEALTH:		
MIN SERVICE LEVEL 75/150:	3/6	3/6
*(222222)	3/6	3/6
MINOR PROCEDURES:		
MIN SERVICE LEVEL 40/80:	0/0	0/0
REPRODUCTIVE HEALTH:		
MIN SERVICE LEVEL 100/200:	0/0	0/0

Remittance Advice Payment Reporting

A new “In Office Service Bonus Payment Report” will be shown on the RA in December of each fiscal year for physicians who are receiving a payment. This payment report will appear on the RA until the end of the current fiscal. For this year only the report will first appear on the January 2012 RA.

```
IN OFFICE SERVICE BONUS PAYMENT REPORT        FISCAL 2010
PHYSICIAN:  123456


VALUE PER POINT                                    $   603.00

TOTAL POINTS EARNED                                    10

TOTAL IN OFFICE SERVICE BONUS PAYMENT              $ 6,030.00
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The value per point is calculated by taking the total number of points earned by PEM physicians in the province and dividing this number into the total payment for the fiscal year. The value per point is the same for every eligible PEM physician in the province.

The total points earned are the total number of points earned in the fiscal year.

- If you are eligible in one category you earn 1 point
- If you are eligible in two categories you earn 3 points
- If you are eligible in three categories you earn 6 points
- If you are eligible in all four categories you earn 10 points

The total in office service bonus payment is the total payment amount you will receive this fiscal year. It is calculated by taking the value per point multiplied by the total points earned resulting in the total IOSB payment.

New Accounting Transaction

The Office Service Bonus Payment will be paid on the December RA under the accounting transaction: IOSB ‘IN OFFICE SERVICE BONUS PAYMENT’

The payment issued will equal the amount reported on the “`IN OFFICE SERVICE BONUS PAYMENT REPORT`” alongside the line item “`TOTAL IN OFFICE SERVICE BONUS PAYMENT`”.

All payments and reporting related to In Office Service Bonus Payment will appear on the solo RA.

Explanatory and Error Codes

REMITTANCE ADVICE COMMON EXPLANATORY CODES

Note: Claims that are reported on the Remittance Advice have been processed by the ministry. As with Fee-for-Service claims, for any discrepancies please continue to contact the Claims Payment Division of your local OHIP Claims Office.

I2 – Service is globally funded
This explanatory code will report on the monthly RA if a claim is submitted for an Included service for an enrolled patient. The claim will pay at zero dollars.

I6 – Premium not applicable
This explanatory code will report on the monthly RA if a Q-code is billed for a patient who is not enrolled in the ministry database on the service date. The assessment code billed along with the Q-code will be paid (subject to all other ministry rules).

I9 – Payment not applied/expired
This explanatory code will report on the monthly RA if a Q200A is billed by a physician whose payment eligibility period for the Q200A has ended. The patient is successfully enrolled on the ministry database; however the $5.00 PPRF will not pay.

30 – This service is not a benefit of MOHLTC
This explanatory code will report on the RA for claims using the Q020A, Q021A, and preventive care tracking and exclusion codes. The tracking and exclusion codes are billed at zero dollars and will pay at zero dollars with an explanatory code 30.

M1 – Maximum fee allowed for these services has been reached
This explanatory code will report on the monthly RA when the maximum fee allowed for this service has been reached.

CLAIMS ERROR REPORT COMMON REJECTION CODES

Note: Claims that are reported on the Claims Error Report have been rejected and should be corrected and if eligible, resubmitted for payment. As with Fee-for-Service claims, please continue to contact the Claims Payment Division of your local OHIP Claims Office for further guidance.

A2A – Outside age limit
The service has been billed for a patient whose age is outside of the criteria for that service.

A3H – Maximum number of services
The number of services on a single claim for a Q012A is one.

A3L – Other New Patient Fee already paid

Physician bills a subsequent New Patient Fee (Q013A), New Graduate-New Patient Fee (Q033A) or Unattached Patient Fee (Q023A) for a patient who they have previously submitted and received payment for one of the above codes.

AD9 – Not allowed alone
Claims are being submitted without a valid assessment code on the same service date.

EPA – BSM billing not approved
Physician is ineligible to submit a Q-code.

EP1 – Enrolment transaction not allowed
A Q200A submitted for a patient with an incorrect version code, or who is either enrolled with another physician with the same effective date, or for a patient who should contact their local OHIP Claims Office regarding their eligibility.

EP3 – Check service date/enrolment date
Physicians are only eligible to submit Q200A claims within 6 months of the effective date of enrolment of the patient on the ministry database. A Q200A submitted after 6 months will be rejected to the Claims Error Report with error code EP3.

EP4 – Enrolment restriction applied
A Q200A submitted for a patient who has attempted to enrol with another family physician before six weeks have passed or attempted to enrol with more than two physicians in the same year.

EP5 – Incorrect fee schedule code for group type
A Q200A/Q201A submitted is incorrect for group type.

EQJ – Practitioner not eligible on Service Date
If a New Graduate bills the New Patient fee (Q013A) or a physician that is not a New Graduate bills the New Graduate – New Patient fee (Q033A).

PAA – No Initial Fee Previously Paid
If a Q042A has been submitted with a service date that is not within the 365 day period following the service date of an E079A

BSM Excluded Codes

FSC [1.]	DESCRIPTION
C989	Obstetrical Delivery with Sacrifice of Office Hours
E079	Initial discussion with patient, to eligible services
E100C	Attendance at delivery - per ¼ hour - time units only
E406	Evenings (17:00h - 24:00h) Monday to Friday
E407	Saturdays, Sundays or Holidays daytime and evenings 07:00h - 24:00h)
E408	Nights (00:00h - 07:00h)
E409	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s)
E410	Nights (00:00h – 07:00h) - increase the procedural fee(s) by
E411	Sole delivery premium
E414	High risk obstetrical premium
E500	For the third and each subsequent delivery, subject to the payment rules set out below, for each additional delivery, to P006, P018, P020, P041 or P042
E502	Vaginal birth after caesarean section (VBAC) whether successful or unsuccessful
G590	Influenza agent
H055	Consultation
H065	Consultation in Emergency Medicine
H100	Emergency department investigative ultrasound
H101	Minor assessment - Monday to Friday - Daytime (08:00h to 17:00h)
H102	Comprehensive assessment and care - Monday to Friday - Daytime (08:00h to 17:00h)
H103	Multiple systems assessment - Monday to Friday - Daytime (08:00h to 17:00h)
H104	Re-assessment - Monday to Friday - Daytime (08:00h to 17:00h)
H105	In-patient interim admission orders
H112	Nights (00:00h to 08:00h)
H113	Daytime and evenings (08:00h to 24:00h) on Saturdays, Sundays or Holidays
H121	Minor assessment
H122	Comprehensive assessment and care - Nights (00:00h to 08:00h)
H123	Multiple systems assessment - Nights (00:00h to 08:00h)
H124	Re-assessment - Nights (00:00h to 08:00h)
H131	Minor assessment - Monday to Friday - Evenings (17:00h to 24:00h)
H132	Comprehensive assessment and care - Monday to Friday - Evenings (17:00h to 24:00h)
H133	Multiple systems assessment - Monday to Friday - Evenings (17:00h to 24:00h)
H134	Re-assessment - Monday to Friday - Evenings (17:00h to 24:00h)
H151	Minor assessment - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)
H152	Comprehensive assessment and care - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)
H153	Multiple systems assessment - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)
H154	Re-assessment - Monday to Friday - Saturdays, Sundays and Holidays - Daytime and Evenings (08:00h to 24:00h)
H400	20:00h – 24:00h Sessions – Monday to Friday (other than holidays)
H401	00:00h – 04:00h Sessions – Monday to Friday (other than holidays)
H402	04:00h – 08:00h Sessions – Monday to Friday (other than holidays)
H403	00:00h – 04:00h
H404	04:00h – 08:00h Sessions – Saturdays, Sundays, Holidays
H405	08:00h – 12:00h Sessions – Saturdays, Sundays, Holidays
H406	12:00h – 16:00h Sessions – Saturdays, Sundays, Holidays
H407	16:00h – 20:00h Sessions – Saturdays, Sundays, Holidays
H408	20:00h – 24:00h Sessions – Saturdays, Sundays, Holidays
H980	First person seen Weekdays Daytime (07:00-17:00)

H981	Additional person(s) seen Weekdays Daytime (07:00-17:00)
H984	First person seen Evenings (17:00- 24:00) Monday through Friday
H985	Additional person(s) seen Evenings (17:00- 24:00) Monday through Friday
H986	First person seen Nights (00:00- 07:00)
H987	Additional person(s) seen Nights (00:00- 07:00)
H988	First person seen Sat., Sun. and Holidays (07:00- 24:00)
H989	Additional person(s) seen Sat., Sun. and Holidays (07:00- 24:00)
K018	Sexual assault examination – female
K021	Sexual assault examination - male
K039	Smoking cessation follow-up visit
K050	Health Status Report and Activities of Daily Living Index (completion of amalgamated forms)
K051	Health Status Report (completed separately)
K052	Activities of Daily Living Index (completed separately)
K053	A Limitation to Participation Form
K054	Mandatory Special Necessities Benefit Request Form
K055	Application for Special Diet Allowance
K056	Application for Pregnancy/Breast-feeding Nutritional Allowance
K061	Taking of blood samples in a hospital setting at the request of a police officer
K065	Eye examination rendered to patients between the ages 20 and 64 who are recipients of income support under the *Ontario Disability Support Program Act*, 1997
K066	Eye examination rendered to patients between the ages 20 and 64 who are recipients of income assistance or benefits under the *Ontario Works Act*, 1997
K734	Physician to physician telephone consultation – Referring physician
K735	Physician to physician telephone consultation – Consultant physician
K736	CritiCall telephone consultation - Referring physician
K737	CritiCall telephone consultation - Consultant physician
K990	First person seen Weekdays Daytime (07:00-17:00)
K991	Additional person(s) seen Weekdays Daytime (07:00-17:00)
K992	First person seen Weekdays Daytime (07:00 -17:00) with Sacrifice of Office Hours
K993	Additional person(s) seen Weekdays Daytime (07:00 -17:00) with Sacrifice of Office Hours
K994	First person seen Evenings (17:00- 24:00) Monday through Friday
K995	Additional person(s) seen Evenings (17:00- 24:00) Monday through Friday
K996	First person seen Nights (00:00- 07:00)
K997	Additional person(s) seen Nights (00:00- 07:00)
K998	First person seen Sat., Sun. and Holidays (07:00- 24:00)
K999	Additional person(s) seen Sat., Sun. and Holidays (07:00- 24:00)
P031	Prophylactic cervical cerclage - any technique
P034	Uterine inversion, manual replacements
P006	Vaginal
P009	Attendance at labour and delivery
P010	Attendance of obstetric consultant(s) at delivery
P018	Caesarean section
P020	Operative delivery, i.e. mid-cavity extraction or assisted breech delivery
P023	Oxytocin infusion for induction or augmentation of labour
P029	Manual removal of retained placenta
P030	Cervical ripening using topical, oral or mechanical agents, maximum once per pregnancy
P036	Repair of laceration - vaginal
P038	When patient transferred to another centre for delivery
P039	Repair of laceration - cervical
P041	Caesarean section including tubal interruption
P042	Caesarean section including hysterectomy
P014C	Introduction of catheter for labour analgesia including first dose
P016C	Maintenance of obstetrical epidural anaesthesia (one unit for each ½ hour to a maximum of 12)
Q001 – Q899	Primary Health Care fee schedule codes – do not form part of the Schedule of Benefits
Z734	Double set up examination to rule out placenta previa, or trial of forceps - failed leading to caesarean section (same physician)
Z774	Postpartum haemorrhage - exploration of vagina and cervix, uterine curettage
Z775	Pharmacological management of P.I.H. and toxemia by I.V therapy to be billed once per patient,

	per pregnancy
Z776	Fetal blood sampling
Z777	Breech presentation - external cephalic version with or without tocolysis - to be claimed in hospital after 35 weeks, once per pregnancy

1. All Fee Schedule Codes have suffix A unless otherwise noted (e.g. E100C)

Q Codes

The following is a complete listing of all Q codes that Blended Salary Model (BSM) Signatory physicians are eligible to submit. The conditions for payment of these Q codes have been described throughout the guide.

CODE	DESCRIPTION	FEE
Rostering Fees		
Q200A	Per Patient Rostering Fee	$5

New Patient Fees		
Q013A	New Patient Fee (Max 60/fiscal year)	$100/120/180
Q023A	Unattached Patient Fee	$150
Q033A	New Grad/New Patient Fee (Max 300 in the first year in an eligible model)	$100/120/180
Q043A	New Patient Fee FOBT Positive/Colorectal Cancer (CRC) Increased Risk	$150/170/230
Q053A	HCC Complex-Vulnerable Patient Fee	$350
Q054A	HCC Unattached Mother and Newborn Fee	$350
Q055A	HCC Unattached Multiple Newborn Fee	$150
After Hours Fees		
Q012A	After Hours Fee	30%

Chronic Disease Management		
Q040A	Diabetes Management Incentive (Annual)	$75
Q042A	Smoking Cessation Counselling Fee (2 / year)	$7.50

Q050A	Heart Failure Management Incentive (Annual)	$125

Continuing Medical Education		
Q555A	Main Pro C (Max 96 services (or 24 credits) per fiscal year) (1 service = $25)	Bill at $0
Q556A	Main Pro M1 (Max 96 services (or 24 credits) per fiscal year) (1 service = $25)	Bill at $0
Q557A	Other (Max 96 services (or 24 credits) per fiscal year) (1 service = $25)	Bill at $0

Tracking and Exclusion Codes		
Q011A	Pap Smear Tracking Code	$0
Q020A	Premiums for Primary Health Care for Patients with Serious Mental Illness - Tracking Code for Services for Patients with a Diagnosis of Bipolar Disorder	$0
Q021A	Premiums for Primary Health Care for Patients with Serious Mental Illness - Tracking Code for Services for Patients with a Diagnosis of Schizophrenia	$0
Q130A	Influenza Vaccine Tracking Cod	$0
Q131A	Mammography Tracking Code	$0
Q132A	Childhood Immunizations Tracking Code	$0
Q133A	Colorectal Cancer Screening Tracking Code	$0
Q140A	Pap Smear Exclusion Code	$0
Q141A	Mammography Exclusion Code	$0
Q142A	Colorectal Cancer Screening Exclusion Code	$0
Preventive Care Fees and Bonuses		
Q150A	FOBT Distribution and Counseling Fee (Once per patient every two years)	$7
Q001A	Preventive Care Management Service Enhancement Fee – Pap Smear (Once per patient every two years)	$6.86

Q002A	Preventive Care Management Service Enhancement Fee – Mammography (Once per patient every two years)	$6.86
Q003A	Preventive Care Management Service Enhancement Fee – Influenza Vaccine (Once per patient per year)	$6.86
Q004A	Preventive Care Management Service Enhancement Fee – Childhood Immunizations (Once per patient)	$6.86
Q005A	Preventive Care Management Service Enhancement Fee – Colorectal Cancer Screening (Once per patient every two years)	$6.86
Q100A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 60% ($220)	Bill at $0
Q101A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 65% ($440)	Bill at $0
Q102A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 70% ($770)	Bill at $0
Q103A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 75% ($1100)	Bill at $0
Q104A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 80% ($2200)	Bill at $0
Q105A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 60% ($220)	Bill at $0
Q106A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 65% ($440)	Bill at $0
Q107A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 70% ($660)	Bill at $0
Q108A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 75% ($1320)	Bill at $0
Q109A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 80% ($2200)	Bill at $0
Q110A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 55% ($220)	Bill at $0
Q111A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 60% ($440)	Bill at $0
Q112A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 65% ($770)	Bill at $0
Q113A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 70% ($1320)	Bill at $0

Q114A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 75% ($2200)	Bill at $0
Q115A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations – 85% ($440)	Bill at $0
Q116A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations – 90% ($1100)	Bill at $0
Q117A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations – 95% ($2200)	Bill at $0
Q118A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 15% ($220)	Bill at $0
Q119A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 20% ($440)	Bill at $0
Q120A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 40% ($1100)	Bill at $0
Q121A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 50% ($2200)	Bill at $0
Q122A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 60% ($3300)	Bill at $0
Q123A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 70% ($4000)	Bill at $0