bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4312	**May 21, 1998**	**Ministry of Health Processing Office** *(address below)*
Distribution: **Physicians, Hospitals, Clinics, and Laboratories**		

Subject **REVISIONS TO PHYSICIANS' SCHEDULE OF BENEFITS, AND OTHER REQUIREMENTS**

A. Physicians' Schedule of Benefits, Appendix F: New MCSS Forms

Effective June 1, 1998, Ministry of Community and Social Services (MCSS) Form 4, Form 5 and the form "Request for Supplementary Information" will be discontinued.

MCSS has two new forms for use in the Ontario Disability Support Program (ODSP): the Health Status Report Form (HSR) and the Activities of Daily Living Form (ADL). There is also a new form for the Ontario Works program: the Medical Report Form.

As of June 1, 1998, the descriptions and fee values for the codes in Appendix F to the Schedule of Benefits will be changed, as follows:

K051	MCSS Health Status Report form (HSR)	$50.00
K052	MCSS Activities of Daily Living form (ADL)	$20.00
K053	MCSS Medical Report Form	$15.00

Assessments using the old forms and completed prior to June 1, 1998, can be submitted for payment for up to 6 months as is current practice.

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B. Maximums for Physical Therapy Services

The April 1, 1998, changes to the physicians' Schedule of Benefits introduced a new maximum of 20 Miscellaneous Therapeutic Services (G467) per patient per year, with medical exception based upon specialist referral. This maximum applies to G467 services claimed by physicians. Physical therapy services claimed by Schedule 5 facilities have a maximum of 150 services per patient per year.

C. Specific Services in April 1, 1998 Changes (e.g., Bone Density)

The April 1, 1998, changes to the physicians' Schedule of Benefits introduced a number of changes involving benefit periods. For Periodic Oculo-Visual Assessments only, services prior to April 1, 1998, are included when determining whether a service is an insured service. In all other cases, only those services provided after April 1, 1998, are included when determining whether a service is an insured service. For example, when determining whether bone density measurements are an insured service, only services provided after April 1, 1998, are considered.

D. Non-Malignant Skin Lesions

Pre-malignant lesions, lesions suspected of being malignant but with no biopsy done, and lesions suspected of being malignant but negative on biopsy are all, by default, benign lesions and should be claimed using the fee codes for Group 1 to 5 lesions, as applicable, subject to the conditions in Appendix D.

E. Health Insurance Act - Record Keeping Requirements

As a reminder, for all services rendered after May 1, 1996, an amendment to the Health Insurance Act dealt with requirements for records. In addition to those requirements established by the respective professional regulatory bodies, the Act requires physicians, practitioners and health facilities to maintain records that establish:

1. An insured service was provided.
2. The service for which an account is submitted was the service provided.
3. The service provided was medically necessary or, in the case of practitioners, therapeutically necessary.

In addition, records must be prepared promptly when the service is provided.

In the absence of a record as described above, the fee payable for the service is nil.

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Ontario Ministry of Health and Long-Term Care