bulletin

Ontario

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Subject **UTILIZATION MANAGEMENT AND OTHER CHANGES TO THE PHYSICIANS' SCHEDULE OF BENEFITS, JULY 1, 1998**

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The effective date for these changes is July 1, 1998. Replacement pages for the Schedule of Benefits will follow. The amended Schedule will be available on the Ministry's Web Site (www.gov.on.ca/health) in July.

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This bulletin provides a description of the changes to the Schedule of Benefits recommended by the Physician Services Committee to manage OHIP payments for physician services within the authorized fee-for-service budget. These changes are listed below under "Utilization Management". In addition to the utilization management changes, there are other changes which reflect a periodic update to Schedule contents following consultation with the OMA. These updates are listed below under "Other Changes".

1. UTILIZATION MANAGEMENT

A. Prenatal Ultrasounds

Prenatal ultrasound limited to maximum of 2 examinations per normal pregnancy including one complete examination on or after 16 weeks and one limited examination before 16 weeks for Maternal Serum Screening Program. Maximums do not apply to new codes for high risk or complicated pregnancies. Prenatal ultrasound examinations not included in above codes are not an insured service. Codes and descriptions on page G2 amended as follows:

	Pregnancy	H	P_1	P_2
	- Complete - on or after 16 weeks gestation			
J159/J459	(maximum one per normal pregnancy)	48.80	29.10	21.80
J160/J460	- Complete - for high risk pregnancy or complications of pregnancy	48.80	29.10	21.80
J157/J457	- Gestational age for Maternal Serum Screening Program - before 16 weeks gestation (maximum one per normal pregnancy)	32.10	21.80	19.20
J158/J458	- Limited - for high risk pregnancy or complications of pregnancy	32.10	21.80	19.20

J163/J463 is amended as follows:

J163/J463	Pelvis, limited study - for other than pregnancy	32.10	21.80	19.20
J161/J461	Intracavitary ultrasound, limited - for other than pregnancy	32.10	21.80	19.20

Below J194/J464 Follicle Monitoring studies the Note is changed to read:

...Additional ultrasounds may be claimed as J164/J464.

B. Second Patient Special Visit Premiums

Special visit premiums are eliminated with the exception of visits to patients in the emergency department, hospital out-patient department or to hospital in-patients. SOB page xxi section B.5(d) iii is changed as follows:

(d)iii Physician on Call: When an on-call physician practising..... premium K99-. Submit claims for insured services rendered to all subsequent patients who arrive in the Emergency Department while the physician is still in the hospital or its environs, using the "H" prefix (H1_ codes) listings.

Page xxxvi section B.23 section (g) is replaced with the following:

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g. Where special visit premiums are payable for the first patient seen at a location and insured services are rendered by the physician to an additional patient seen at the same location, the "additional patient" premiums are not payable unless the additional patient himself/herself qualifies for a special visit.

No "additional patient" premium is payable for services rendered to additional patients seen during visits to homes, long term care institutions, offices and other non-professional settings while the physician is there rendering a special visit to another patient.
No "additional patient" premium is payable for services rendered to additional patients seen during a special visit to a hospital unless the physician has been specifically asked by the hospital staff to see the additional patient or patients.

Patients who drop in to the office while the physician is there for reasons other than rendering a special visit do not qualify for any of the special visit premiums.
The maximum number of special visit premiums including "additional patient" premiums is one per patient to a maximum of ten at any one location.

Subparagraphs (j) to (n) are amended as follows:

(j) Special Visits to Emergency Department or OPD:

K990	Daytime Special Visit (Monday to Friday) - first patient seen	add	16.70
K991	- For each additional patient requiring a special visit and seen during the same special visit, add 30% to consultation or visit - minimum pemium	add	9.50
K992	Emergency Call with Sacrifice of Office hours - first patient seen	add	33.40
K993	- For each additional patient requiring a special visit and seen during the same special visit, add 30% to consultation or visit - minimum premium	add	14.30
K994	Evenings (17:00h - 24:00h) and Saturdays, Sundays, Holidays -first patient seen .	add	33.40
K995	- For each additional patient requiring a special visit and seen during the same special visit, add 30% to consultation or visit - minimum premium	add	14.30
K996	Nights (0:00h - 7:00h) - first patient seen	add	50.20
K997	- For each additional patient requiring a special visit and seen during the same special visit, add 50% to consultation or visit - minimum premium	add	22.00

Subparagraph (o) is changed to read:

(k) Special Visit to Hospital In-patient: Use the appropriate listing above but substitute the prefix "C" for "K" (e.g. C990 instead of K990).

Subparagraph (j) is changed to read:

(l) Special Visit to the Patient's Home or Equivalent (regardless of how many patients seen at the same location. No "additional patient" premium payable): *(Descriptions and fees unchanged for B990/B992/ B994/B996.)*

Subparagraph (p) is changed to read:

(m) Special Visit to Long-Term Care Institution (regardless of how many patients seen at the same location. No "additional patient" premium payable.)
W990 Daytime, Monday to Friday..... 16.70
W992 Emergency call with sacrifice of office hours..... 33.40
W994 Evenings (17:00h - 24:00h) Saturdays, Sundays, Holidays 33.40

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W996 Nights (0:00h - 7:00h)..... 50.20

Subparagraph (q) is changed to read:

(n) Special Visit to Office or Other Similar Facility: use the appropriate listing above (subparagraph (m)) but substitute the prefix "A" for "W" (e.g., A990 instead of W990).

Subparagraph (r) is changed to read:

(o) Special Visit to any non-professional setting not listed above: use appropriate listing above (subparagraph (m)) but substitute the prefix "Q" for "W" (e.g. Q990 instead of W990).

Subparagraph (t)(ii) p xxxvii is changed to read:

The fee would.....*(no change).*.....special visit is:

1. If the special visit was made between 07:00h and 24:00h, Monday through Friday inclusive, a total fee of $41.50 (B910) for the first patient seen and only the appropriate assessment fee from General Listings for each additional patient seen during the same visit.
2. If the special visit was made between 07:00h and 24:00h, Saturdays, Sundays and holidays, a total fee of $46.50 (B914) for the first patient seen and only the appropriate assessment fee from General Listings for each additional patient seen during the same visit.
3. If the special visit was made between 24:00h and 07:00h any night of the week, a total fee of $49.80 (B916) for the first patient seen and only the appropriate assessment fee from General Listings for each additional patient seen during the same visit.

C. Attendance at Resuscitation

A maximum of three physicians may claim full resuscitation fees. Additional physicians beyond the first three may claim equivalent to detention fees. Page J8 is changed as follows:

Life Threatening Emergency Situation **-** Being in.....billable intervention.

		Proced.Fee
	Amount payable per physician per life threatening emergency situation for the first three physicians for which a claim is submitted and paid	
G521	- first 1/4 hour.	75.70
G523	- second 1/4 hour	37.80
G522	- after first ½ hour (per 1/4 hour or major part thereof)	24.90
G391	Amount payable per physician per life threatening emergency situation for the fourth and subsequent physicians for which a claim is submitted and paid (per 1/4 hour or major part thereof)	19.40

Other Resuscitation - is different .....billable intervention. When G395 is claimed in conjunction with G512, G522 or G523 for services rendered to the same patient by the same physician same day the amount payable for G395 is reduced to the amount payable for G391.

	Amount payable per physician per other resuscitation for the first three physicians for which a claim is submitted and paid	
G395	- first 1/4 hour	38.90
G391	- after first 1/4 hour (per 1/4 hour or major part thereof)	19.40

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G391	Amount payable per physician per other resuscitation for the fourth and subsequent physicians for which a claim is submitted and paid (per 1/4 hour or major part thereof)	19.40

D. Attendance at Delivery

Non-consultant physicians may claim attendance at delivery only if in attendance during labour. Obstetrics Preamble page K1 is changed as follows:

SPECIFIC ELEMENTS.....
o Attendance at labour: This is a service of being in constant or periodic attendance on a patient during stages one and two of labour but without completion of the delivery, to provide all aspects of care. This includes....

P038	Attendance at labour when patient transferred to another centre for delivery	102.30
P011	Attendance at labour when same physician assists or gives anesthesia at Cesarean section or operative delivery and claims separately as assistant or anesthetist	150.05
P009	Attendance at labour and delivery by physician other than obstetric consultant	318.11
P010	Attendance of obstetric consultant(s) at delivery	102.30

Amount payable for attendance of a physician other than an obstetric consultant at only delivery is zero.

E. Papanicolaou Test

The maximum number of negative Pap tests is one per year when billed as a separate service. One negative Pap test is already included in the consultation fee (A205), and one is included in the general (A003) and specific assessment(A203) codes. The later can be billed up to twice within a year if different diagnostic codes are used for each visit. Patients may potentially receive up to 4 pap tests per year without the use of the supplementary code(G365) which is now limited to once per year. A new code (G394) is to be used for additional follow-up tests when the prior test report was:

a. *atypical squamous cell of undetermined significance(ASCUS - Bethesda grading system);*
b. *atypical glandular cell of undetermined significance(AGUS);*
c. *low-grade squamous intraepithelial lesion (LSIL);*
d. *high-grade squamous intraepithelial lesion(HSIL); or*
e. *when the prior test was reported as "unsatisfactory" or"satisfactory but limited by...".*

Page J14 is changed to read:

+G365	Periodic Papanicolaou Smear - maximum one per patient per 12 month period, excluding smears provided in conjunction with a consultation, repeat consultation, general or specific assessment or reassessment	4.10

+G394 Additional Papanicolaou Smear - for follow-up of abnormal or inadequate smears 4.10

F. Travel Medicine Services

Pre-departure travel medicine services are not insured services. Appendix A (office copy of Regulation 552) will be amended to add a new section stating:

The following are deemed not to be insured services and not to be part of insured services rendered by physicians or practitioners: A service or treatment , including immunization or the administration of any drug, rendered to an insured person in connection with, and for the sole purpose of, travelling to a country outside of Canada.

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The following are deemed not to be insured services: A service provided by a laboratory, physician or hospital that supports a service that is deemed not to be an insured service.

G. Follow-up Diagnostic Professional Fees
In specified circumstances, a repeat diagnostic service by the same physician previously rendering a consultation is payable at the same rate as Professional Component P2. The following is added to the "Specific Elements" section of the Nuclear Medicine preamble page B1 and Diagnostic Ultrasound preamble page G1:

The amount payable for the Professional Component P1 for a service rendered to a patient shall be reduced to the amount payable for the same service at the Professional Component P2 rate where the physician who renders the P1 service has:

A. Rendered an assessment of the same patient within 30 days immediately preceding the day upon which the P1 service is rendered to that patient; AND
B. Rendered any consultation(full, limited or repeat) in respect of the same patient within the 365 days immediately preceding the day upon which the P1 service is rendered to that patient.

The preamble to Diagnostic and Therapeutic Procedures page J1 is changed so the first paragraph below Non-Invasive Diagnostic Procedures reads:

Some non-invasive diagnostic procedures are divided into a technical component and a professional component which, for some services, may have two levels identified as P1 and P2. The amount payable for the Professional Component P1 for a service rendered to a patient shall be reduced to the amount payable for the same service at the Professional Component P2 rate where the physician who renders the P1 service has:

A. Rendered an assessment of the same patient within 30 days immediately preceding the day upon which the P1 service is rendered to that patient; AND
B. Rendered any consultation (full, limited or repeat) in respect of the same patient within the 365 days immediately preceding the day upon which the P1 service is rendered to that patient.

H. Chronic Dialysis Team Fee
Amend page J11 to delete entries for G326, G332 and G333, including description for home/self - care dialysis and note below G333. Insert new subheading and fee description as follows below entry for R854:

Chronic Dialysis Team Fee - is the all-inclusive benefit per patient per week for professional aspects of managing chronic dialysis and end-stage renal failure in dialysis patients. It is a modality independent fee and is equal in monetary value whether the dialysis is delivered in hospital, community or home and whether it is hemodialysis or peritoneal dialysis. The team fee includes the

services of all physicians routinely or periodically participating in the patient's dialysis treatment at:

a. the patient's principal treatment centre;
   or
b. at a place other than the patient's principal treatment centre ("auxiliary treatment centre") where 3 or more dialysis treatments are rendered to the patient during the 7-day period referred to below.

The amount payable is in respect of a 7-day period of care, commencing at midnight Sunday and is payable to the most responsible physician. Except as set out below, the amount payable to another physician in respect of these services rendered to a patient in respect of whom a claim is submitted and paid for this code, is nil.

When a full 7-day period of team care is not rendered at the patient's principal treatment centre due to absence of the patient with treatment at an auxiliary treatment centre, the amount claimed for treatment at the principal treatment centre is reduced on a pro rata basis to equal 1/7 of the weekly fee for each day that the patient is the responsibility of the principal treatment centre.

In addition to the common elements of insured services and the specific elements of Diagnostic and Therapeutic Procedures, the team fee includes the following elements:

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A. All consultations and visits for management and supervision of chronic dialysis treatments regardless of frequency, type or location of service and includes chronic dialysis of hospital inpatients.
B. All consultations and visits within the scope of practice of nephrology and general internal medicine for assessment and treatment of complications of chronic dialysis and management of end stage renal disease and its complications in chronic dialysis patients.
C. All related counselling, interviews, psychotherapy of patients and family members;
D. All related case conferences.

The team fee does not include:

E. Assessments and special visit premiums for emergent calls to the emergency department.
F. Admission assessments and subsequent visits to acute care hospital in-patients for treatment of complications of dialysis, chronic renal disease or intercurrent illness.
G. Any other diagnostic and therapeutic procedures, including acute dialysis treatments.
H. Consultations and assessments by specialists in other than internal medicine or internal medicine sub-specialists other than nephrologists.
I. Primary care by the patient's family physician.
J. Assessment by a renal transplantation specialist for entry into a transplantation program.
K. Intermittent chronic hemodialysis treatment at an auxiliary treatment centre if fewer than three dialysis treatments are rendered to the patient in the 7-day period referred to above.

	Chronic dialysis weekly team fee - claim the code representing the predominant location and modality	
#G860	- hospital hemodialysis	123.32
#G861	- hospital peritoneal dialysis	123.32
#G862	- hospital self-care or satellite hemodialysis	123.32
#G863	- independent health facility hemodialysis	123.32
#G864	- home peritoneal dialysis	123.32
#G865	- home hemodialysis	123.32
#G866	Intermittent hemodialysis - at an auxiliary treatment centre (per treatment, maximum 2 per patient per 7-day period referred to above)	59.80
Note:	Where 3 or more treatments are rendered per 7-day period at an auxiliary treatment centre, the service comprises the chronic dialysis weekly team fee paid at the full amount, regardless of the number of treatments rendered.	

I. Sleep Studies

Sleep studies services are redefined with technical component H and professional components P_1

and P_2. The following is the text of the new section within Diagnostic and Therapeutic Procedures:

SPECIFIC ELEMENTS

The technical component H of the procedure is payable only for services provided in the out-patient department of a hospital or in an off-site premise operated by the hospital corporation that has received approval under section 4 of the Public Hospitals Act.

The specific elements for the technical component H include the specific elements for the technical component of non-invasive diagnostic procedures listed in the Preamble to Diagnostic and Therapeutic Procedures.

OTHER TERMS AND DEFINITIONS

1. For the services rendered outside a hospital setting the only fees payable under the Health Insurance Act are listed under the column P (use suffix C). Fees for the technical component of these services are only payable under the Independent Health Facilities Act.
2. Fees for the technical component of services rendered in an Independent Health Facility are listed in the Schedule of Facility Fees.
3. For services provided for hospital out-patients, the total benefit is arrived at by adding H plus P_1 (first code listed,

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e.g., J890) or by adding H plus P_2 (second code listed e.g., J690). When coding the total benefit use suffix A; when coding the technical portion only, use suffix B; when coding the professional portion only use suffix C.

Code	SLEEP STUDIES	H	P_1	P_2
J890/J690	Level 1 - Overnight sleep study with continuous monitoring of oxygen saturation, ECG, ventilation by plethysmography and additional monitoring to stage sleep (EEG, EOG, and sub-mental EMG) and with technician attendance during study period. P_1 to also include physician attendance at set up, monitoring and interpretation (special visit premiums may not be claimed)	371.10	169.40	63.40
J891/J691	Level 2 - Overnight sleep study with continuous monitoring of oxygen saturation, ECG and ventilation by plethysmography and with technician attendance during study period. P_1 to also include physician attendance at set up, monitoring and interpretation, (special visit premiums may not be claimed).	232.10	125.50	46.90
J892/J692	Level 3 - Overnight sleep study with monitoring to stage sleep (EEG, EOG, sub-mental EMG) and continuous monitoring of ECG with technician in attendance during study period. P_1 to also include physician attendance at set up, monitoring and interpretation (special visit premiums may not be claimed).	189.30	125.50	46.90
J893	Multiple Sleep Latency Test	69.00	48.30	0.00

As indicated in bulletin 4308 dated April 3, 1998, only operators of facilities providing sleep study services on and before April 3, 1998 will be eligible to apply for a licence under the grandfather clause of the Independent Health Facilities Act. The Ministry will forward IHF application forms to eligible operators based on billing data in the OHIP claims payment system. Applications will be forwarded following the July 1, 1998 change to the Schedule of Benefits.

Facility operators have one year to submit their licensing application. During this one-year period claims will continue to be submitted to OHIP in the current manner (with the new fee schedule codes noted above). Any inquiries regarding IHF licensing should be directed to Provider Services Branch, Facility Payment and Policy at (613) 547-6637 (Kingston).

J. Threshold Fee Reductions

As announced in Bulletin 4309, technical fees will be subject to the first level of threshold reductions. When the "Total Amount Payable" (which does not include any of the codes listed in Appendix E) reaches or exceeds the first threshold level, associated technical payments to a physician for services not rendered in a hospital or an independent health facility will be reduced by one-third. The technical fee reduction will remain at one-third even if the "Total Amount Payable" for other fees passes subsequent threshold levels.

2. OTHER CHANGES

K. Extended Certificate Registered Nurses (ECRNs)

Certain diagnostic procedures may be referred by an ECRN. Criteria for additional views are specified. Preamble to Diagnostic Radiology is amended to include the following paragraphs:

5. If insured diagnostic radiology procedures yield abnormal findings or if they would yield information which in the opinion of the radiologist would be insufficient governed by the needs of the patient and the requirements of the referring physician or practitioner the radiologist may add further views and claim for them (if listed).

30. Mammography or X-ray of the chest, ribs, arm, wrist, hand, leg, ankle or foot, rendered in an independent health facility or a hospital out-patient department, is insured when referred by a registered nurse holding an extended certificate of registration.

The following are added to Preamble to Diagnostic Ultrasound page G2, "Other Terms and Definitions":

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9. If insured diagnostic ultrasound procedures yield abnormal findings or if they would yield information which in the opinion of the interpreting physician would be insufficient governed by the needs of the patient and the requirements of the referring physician or practitioner, the interpreting physician may add further views and claim for them (if listed).
10. Ultrasound of the abdomen, pelvis or breast, rendered in an independent health facility or a hospital out-patient department, is insured when referred by a registered nurse holding an extended certificate of registration.

L. Community Medicine, Occupational Medicine and Public Health
Specialists qualified in the above specialties are assigned billing numbers with the Internal Medicine suffix (13). To reflect this existing policy, the title of the Internal Medicine section of "Consultations and Visits" is amended to:

INTERNAL MEDICINE, COMMUNITY MEDICINE, OCCUPATIONAL MEDICINE AND PUBLIC HEALTH (13)

M. Clarification of Lung Transplantation Fee Description
Page P6 is changed to clarify the description of fee code M155:

M155 #	Lung transplant (one lung)	18	1453.90	25

N. Practice in General Codes Billed by Specialists
General Preamble section B.17, p. xxix is changed to add the services counselling, HIV primary care and palliative care support to the list of 'Practice in General' codes which can be claimed by specialists.

O. Oximetry at Rest Professional Fee
The Professional Fee for J323 O2 Saturation by Oximetry at Rest has been removed from the OMA Schedule. The parallel change to Pulmonary Function Studies page H2 is made by placing "-"in the Professional (P) Fee column:

		H	P	T
J323	O_2 saturation by oximetry at rest, with or without O_2.....	4.20	-	

P. Cataract Assistant Fees
Page Y2, word "NIL" is replaced with blank space for surgical assistant's basic units for E140 and E950 to allow claims on an Independent Consideration using code M400B in accordance with General Preamble.

Q. Circumcision
Page U1, description of S573 is changed to clarify that prior approval of medically necessary

circumcision is ONLY required for patients less than one year of age:

	Circumcision - for physical symptomatology only			
#S573	- for patients aged one year or older	3	82.90	4
	- for infants less than one year of age. Prior approval			
#S577	required. Circumcision for neonatal phimosis not a benefit	3	82.90	4

R. Perianal Warts

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Appendix D, Surface Pathology, 8.(b) is changed to include perianal warts:

> (b) Removal or treatment of warts by any means is an insured service in the case of plantar warts, perianal and genital warts and all warts in immunocompromised patients.

S. Palliative Care Support
New section on Palliative Care Support added to page A3 as follows:

Palliative Care Support: Palliative Care Support is a time-based all-inclusive visit fee per patient per day for the purpose of providing pain and symptom management, emotional support and counselling to patients with terminal disease in the final year of life. The service includes any combination of common and specific elements of any insured service listed under "Family Practice and Practice In General" in the "Consultations and Visits" section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble. When a physician submits a claim for rendering any other consultation or visit to the same patient on the same day for which the physician submits a claim for Palliative Care Support, the Palliative Care Support is included (in addition to the common elements) as a specific element of the other insured service.

Individual care - Unit means ½ hour or major part thereof - see General Preamble for definitions and time-keeping requirements.

K023	-	per unit	47.30

T. HIV Primary Care
New sections on HIV Primary Care added to page A3 as follows:

HIV Primary Care: Primary care of patients infected with the Human Immunodeficiency Virus (HIV) is a time-based all-inclusive visit fee per patient per day which includes any combination of common and specific elements of any insured service listed under "Family Practice and Practice In General" in the "Consultations and Visits" section and, in all cases, includes the same minimum time period requirements described for counselling in the General Preamble. When a physician submits a claim for rendering any other consultation or visit to the same patient on the same day for which the physician submits a claim for HIV Primary Care, the HIV Primary Care service is included (in addition to the common elements) as a specific element of the other insured service.

Individual care - Unit means ½ hour or major part thereof - see General Preamble for definitions and time-keeping requirements.

K022	-	per unit	47.30

U. Bone Mineral Density Measurements

The Ministry of Health and the Ontario Medical Association have accepted changes recommended by the Physician Services Committee (PSC) regarding payment policy for bone mineral density (BMD) testing. The changes are as follows: testing as an insured service is to be limited to dual energy xray absorptiometry (DXA) using the axial technique on a minimum of two sites including spine and hip; single site axial testing will be insured only when two sites are technically unfeasible; BMD testing of single site by axial DXA technique will be paid at zero; and, peripheral DXA is considered investigational and is therefore an uninsured service.

New fee code definitions for DXA are added to Diagnostic Radiology section page D6:

Dual-energy X-ray Absorptiometry (DXA) - Axial technique only. Maximum one per patient per year (see Diagnostic Radiology Preamble)

		H	P
X153	- two or more sites (must include hip and spine)	85.00	45.43
X153	- one site (must be either spine or hip, only if two sites technically unfeasible due to prosthesis or deformity)	66.00	38.00

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