bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4332	**April 1, 1999**	**Ministry of Health Processing Office** *(address below)*
Distribution: **Physicians, Hospitals, Clinics, and Laboratories**		

Subject **1999 / 2000 PAYMENTS FOR PHYSICIAN SERVICES**

1. **Schedule of Benefits Fee Increases**

The 1997 Agreement between the Ministry of Health and the Ontario Medical Association (OMA) includes provisions for increases to the Schedule of Benefits ("the Schedule") in 1999/2000, conditional on meeting the terms which were outlined in the Agreement. The terms have been met and the full increase is payable. An across-the-board increase of 1.45% will be applied to all fees in the Schedule. Additional funding will be used to implement the changes to the Schedule, as recommended by the OMA.

2. **April 1, 1999 Schedule Changes**

The changes recommended for April 1, 1999 include:

- New Fee Schedule Codes
- Deleted Fee Schedule Codes
- Amended Fee Schedule Codes
- Revisions To Underweighted Fees

A description of the changes and fees is provided in Appendix A of this bulletin.

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3. **Other Changes to the Schedule**

   The Ministry is also implementing several other outstanding changes:

- New definitions for pathology "Specimen"
- Revised eligibility for Influenza Immunization
- Electrocardiograms requested by Registered Nurse in Extended Class (RN (EC))
- Prenatal Ultrasounds requested by Midwives
- Ultrasound Fees Correction
- Ontario Hepatitis C Assistance Program (OHCAP)
- Delegation of P1 Professional Component
- Follow-up Diagnostic Professional Fees
- New Consultation and Visits section for specialty of Community Medicine
  (Separate bulletin to follow regarding registration for this specialty)

   A description of these changes and the fee is provided in Appendix B.

4. **Changes for G467 and Audiology fees deferred**
   The Physician Services Committee continues to review options for change to G467 and Audiology fees. No changes are being implemented on April 1, 1999.
5. **Hospital Technical Fee Reductions for 1999/2000**
   A tripartite committee of the Ministry of Health, the OMA, and the Ontario Hospital Association (OHA) has recommended a decrease of the technical fee reduction for services provided in hospitals from 6.7% to 3.0%, This reduction will commence with claims having a service date of April 1, 1999.

6. **Thresholds**
   Thresholds for 1999 / 2000 remain the same: GPs: $300,000 (first threshold level) and Specialists: $380,000 (first threshold level). The exemptions from threshold also remain the same as indicated in Appendix E of the Schedule of Benefits.

   The Specialist Retention Initiative (SRI) program will continue to be available for physicians who are eligible for the program. (Re: Bulletin 4323 November 30, 1998)

   Contact the Northern Health Programs and Planning Branch for more information at: 705-670-7280.

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7. **Schedule update package**

   The Schedule is being updated to include the following:

   - Amended pages to reflect changes recommended by the OMA; and
   - **A Numeric Index which lists the current fee codes reflecting both adjustments to under-weighted fees and the uniform 1.45% increase as well as the page references. This index should be used to determine the new fee to be claimed for insured services provided ON OR AFTER April 1, 1999. The amounts shown elsewhere in the Schedule reflect relative amounts payable PRIOR to April 1, 1999 and remain in the Schedule for information purposes only.**

   A full reprint of the schedule will follow in the future.

8. **Transitional payment rules**
   The claims processing system will be programmed to pay the new fee in lieu of a lesser fee claimed for a transitional period to allow physicians time to update billing systems. A grace period of four months (July 31, 1999) will be provided to all providers.
9. **Communications and Web-Site**
   This bulletin, an updated version of the Schedule and other background communications are available on the Ministry's web site at: www.health.gov.on.ca

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APPENDIX A – April 1, 1999 Changes

NEW FEE SCHEDULE CODES

Location	Code	Description	Fee
GENERAL PREAMBLE	**C988B**	Special Visit to Assist at Non-Elective Surgery With Sacrifice of Hours	$ 33.90
CONSULTATIONS & VISITS	**A902**	Housecall Assessment –Pronouncement of Death in the Home	$ 38.80
	K191	Family Psychiatric care, in-patient per ½ hour or major part thereof	$ 58.45
	K196	Family Psychiatric care, out-patient per ½ hour or major part thereof	$ 58.45
	K199	Psychiatric care, out-patient, per ½ hour or major part thereof	$ 56.65
	A055	Community Medicine Consultation – Office	$ 70.30
	C055	Community Medicine Consultation – in-patient	$ 70.30
	W055	Community Medicine Consultation – nursing home	$ 70.30
	A405	Community Medicine Limited Consultation-office	$ 54.40
	C405	Community Medicine Limited Consultation – in-patient	$ 54.40
	W405	Community Medicine Limited Consultation – nursing home	$ 54.40
	C813	Midwife – Requested Emergency Assessment	$ 54.60
	C815	Midwife-Requested Special Emergency Assessment	$106.95
MRI	**X499**	Three dimensional MRI acquisition sequence	$ 59.80
	X488 **X489**	Multiple extremities- imaging of two or more joints at one sitting	$104.55 $ 52.25
DIAGNOSTIC & THERAPEUTIC PROCEDURES	**L829**	Hemoglobinopathy interpretation	$ 12.00
	L851	Organ or large specimen	$ 69.05

	L852	Complex small or large specimen	$110.50
	L853	Comprehensive large specimen	$138.10
	E582	When testing with penicillin minor determined mixture outside a hospital setting, add...	$ 10.70
	G174	Dobutamine stress test- when rendered outside of hospital…add	$ 36.65
	G192	Video fluoroscopic multichannel urodynamics	$ 68.75

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Location	Code	Description	Fee
DIGESTIVE SYSTEM	**Z784** **Z785**	Polyps or tumors of the rectum or sigmoid	$199.30 $307.75
UROGENITAL SYSTEM	**E784**	Hydrodistension of bladder and/or bladder biopsy – general anesthetic - add…	$ 46.50
FEMALE GENITAL SYSTEM	**Z766**	Loop electrosurgical excision procedure (LEEP)	$ 72.80
	Z770	Endometrial sampling	$ 27.10
	S776	Staging pelvic node lymphadenectomy for carcinoma (laparoscopic or open)	$309.50
	S781	Para-aortic lymph node dissection (laparoscopic or open)	$309.50
	S762	Radical trachelectomy, 8 assistant base units; 8 anesthesia base units	$575.20

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DELETED FEE SCHEDULE CODES

LOCATION	CODE	DESCRIPTION
MRI	**X422**	M.R.I. – head – multislice I.R.
	X432	M.R.I. – neck – multislice I.R
	X442	M.R.I. – thorax – multislice I.R
	X452	M.R.I. – abdomen – multislice I.R
	X462	M.R.I. – pelvis – multislice I.R
	X472	M.R.I. – extremities – multislice I.R
	X491	M.R.I. – limited spine (one segment) – multislice I.R
	X494	M.R.I. – intermediate spine (2 adjoining segments) multislice I. R.
	X497	M.R.I. – complex spine (2 or more non-adjoining segments) – multislice I.R.
DIAGNOSTIC & THERAPEUTIC PROCEDURES	**G474**	Urethral pressure profile alone including interpretation
	G472	Minor teleradiotherapy X-ray
	G484	Cystometrogram with selective sacral nerve block studies
DIGESTIVE SYSTEM	**Z572**	Electrocoagulation and or excision of rectal carcinoma (I.O. P.) –repeat
	Z573	Electrocoagulation and or excision of rectal carcinoma (I.O. P.) –repeat
UROGENITAL SYSTEM	**E774** **E779**	Balloon dilatation of prostrate and bladder neck
	S479	Cystotomy or Cystostomy and electrocoagulation of tumor
FEMALE GENITAL SYSTEM	**E850**	Vulvectomy – with bilateral inguinal node dissection with or without skin graft
	E851	Vulvectomy – with bilateral common iliac node dissection with skin graft
	S705	Ligation – of varicose vein of the labia
	S713	Culdotomoy – incision and exploration
	S769	Hysterectomy (with or without adnexa) – Radical (Schauta) - vaginal

	Z581	Office endometrial curettage (I.O.P.)
	Z719	Endometrial biopsy, cytology – wash or brush (I.O.P.)

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AMENDED FEE SCHEDULE CODE DESCRIPTIONS OR CONDITIONS

Page Reference or Code	Description
General Preamble	
B.3.(f)	Amended description for *Diagnostic Radiology Consultation*
B.4.(y)	Amended preamble description to include *Family Psychiatric Care*
B.5.(b)	Amended conditions for visits to patients in designated palliative care beds regardless of facility type.
B20.(d)	New codes & conditions for Surgical Assistants with sacrifice of Office Hours
Consultations and Visits	
A13	new Laboratory Medicine heading to include;*Hematopathology, Neuropathology & Medical biochemistry*
A22 – K199	Psychiatric care redefined as *in-patient*
Diagnostic Radiology	
F1 – X421, X431, X441, X451, X461, X471, X490, X493, X496, X486	Amended descriptions
Diagnostic & Therapeutic Procedures	
J3 – G208	serial oral provocation testing amended to include *single or double blind technique*
J23 –G443, G530	amended note to indicate that *central auditory testing* on behalf of school boards or other third parties is uninsured.
J25 – G193	redefined *Complete Multichannel Urodynamic Assessment*
J25 – G475	redefined *Cystometrogram*
Surgical Procedures	
Musculoskeletal System	
N3, N7, N10, n20, N24, N27 – E595	new note applying maximum of 2 "R" codes in conjunction with E595
Respiratory System	
P3 – Z342	limited bronchoscopy redefined to include placement of *endobronchial blocker*
Cardiovascular System	
Q2 – Z415	amend to include *removal and/or replacement* of cardiovertor/ defibrillator
Q2 – E654	new note to E654: *second and subsequent anastomoses* to be claimed at 50% of E654

Digestive System	
S6 – Z571, E720	revisions to *excision of polyps through colonoscope*
S9 – Z755, Z761	revision to *electrocoagulation of polyps or tumors*
S10 – S269, S275, S270, S267, S271	revisions to *hepatectomy* codes.
Urinary System	
T4 – Z635	code relocated to prostate endoscopy section page U3
T4 – E775	revision to *catheterization of ureter*s
T4 – E777	revision to *manometry*
T4 – Z602, Z603, Z611	revised definition for bladder catheterization
T4 – E776	revision to include any of: *transurethral biopsy, brush biopsy of pelvis or insertion of ureteric stent*
Female Genital System	
V4 – S763	amend to read *radical (Wertheim or Schauta) including node dissection*

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REVISIONS TO UNDERWEIGHTED FEES

Fee Schedule Code	Fees prior to April 1, 1999	*Fees as of April 1, 1999
A007	$24.80	$26.00
A003	$48.20	$51.50
C195	$114.55	$127.80
K198	$50.80	$51.55
G193	$30.80	$40.90
S271	$1169.30	$1281.35
Z635	$54.50	$121.55
E790	$4.00	$8.25
Z621	$9.70	$12.75
N220	$697.45	$713.35

***The above fees reflect the revisions to relative weight as well as the uniform fee increase of 1.45%.**

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APPENDIX B - Other Changes

The following changes are reflected in the amended Schedule of Benefits package issued April 1, 1999.

1. **DIAGNOSTIC AND THERAPEUTIC PROCEDURES**
   Effective April 1, 1999 the addition of new definitions for "Specimen" are added to the Pathology preamble pages J16, J17.

   Addition of: L851 Organ or Large Specimen
   L852 Complex Small or Large Specimen
   L853 Comprehensive Large Specimen
2. **INFLUENZA IMMUNIZATION**
   Bulletin 4326 issued November 30, 1998 advised that the Ministry of Health has expanded the influenza immunization program to also cover patient care staff working in long term care facilities. The Schedule of Benefits page (J18) has been amended accordingly to reflect this change.
3. **ELECTROCARDIOGRAMS REQUESTED BY Registered Nurse in the Extended Class (RN(EC)).**
   As a follow-up to Bulletin 4325, issued November 30, 1998, the Schedule of Benefits page J6 has been amended.
4. **PRENATAL ULTRASOUNDS REQUESTED BY MIDWIVES**
   Bulletin 4324 and Bulletin 1001 outline the requirements for requests of prenatal ultrasounds by midwives. Refer to Diagnostic Ultrasound preamble page G2 for details.
5. **ULTRASOUND FEES CORRECTION**
   Bulletin 4322 – November 1998 advised that the amended Schedule of Benefits page (G2.1) would be issued with the correct fees.

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6. **ONTARIO HEPATITIS C ASSISTANCE PROGRAM (OHCAP)**
   The Ministry of Health has announced the establishment of the Ontario Hepatitis C Assistance Plan (OHCAP) to provide financial compensation to patients infected with Hepatitis C resulting from a blood transfusion in an Ontario hospital. The OHCAP application form is completed, in part, by the patient's attending physician who certifies the patient's history of Hepatitis C infection.

   The Ministry has established two new fee codes for the purpose of submission of claims for completion of the OHCAP Application Form. Fees may be claimed by either family physicians or specialists.

   The new codes (page A4) are effective as of December 1, 1998.
7. **DELEGATION OF P1 PROFESSIONAL COMPONENT**
   Many diagnostic tests in the Schedule of Benefits are associated with a professional component that may be billed either at a P1 or P2 level, depending on whether the physician both performed and interpreted the test or only provided the interpretation.

   On February 1, 1998, the preambles to Nuclear Medicine and Diagnostic Therapeutic Procedures sections of the Schedule of Benefits were amended to require that any physician claiming P1 must personally perform and interpret the test. This precluded physicians who claim P1 from delegating performance of the test to another qualified physician.

   Effective January 1, 1999, the February 1, 1998 changes described above are rescinded. Refer to new pages B1 and J1.
8. **FOLLOW-UP DIAGNOSTIC PROFESSIONAL FEES**
   On July 1, 1998, the Schedule was amended to indicate that certain repeat diagnostic services claimed as professional fee P1 by the same physician who claimed an associated consultation, would be reduced to P2. The rule was immediately suspended due to concerns raised by physicians. The Schedule has been updated accordingly to rescind this requirement on pages B1, G1, and J1 effective January 1, 1999.

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