Bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4355	**July 1, 2000**	**Ministry of Health Processing Office** *(address below)*
Distribution: **Physicians, Hospitals, Clinics, Laboratories**		

Subject **Changes to the Physician Schedule of Benefits and Related Changes**

1. Increase to Schedule of Benefits of 1.95% effective April 1, 2000
2. New or Amended Fees effective July 1, 2000
3. Discounted Fees Eliminated effective January 1, 2000
4. Threshold Levels Increased effective April 1, 2000

The Ministry of Health and Long-Term Care (MOHLTC) and the Ontario Medical Association (OMA) have reached a 4-year agreement. The agreement is effective from April 1, 2000 to March 31, 2004 inclusive. The following revisions to the Physicians Schedule of Benefits and physician payments implement the fee-for-service component of the Physician Services Agreement for 2000/2001. Other provisions of the agreement will be provided in a subsequent communication including the Maternity Leave Benefits Program.

These changes are being implemented July 1, 2000. The effective dates of the changes are indicated with each of the four items.

Please note that amended pages of the Schedule of Benefits have not been distributed with this Bulletin. **Please use the information provided with this Bulletin to bill the new fee codes or you can access an updated version of the Schedule on the Ministry's web site www.health.gov.on.ca. The across-the-board fee increase of 1.95% will be applied automatically to all claim submissions for services provided after April 1, 2000 and processed after July 1, 2000 with the exception of claims for the technical components of diagnostic services.**

The Ministry of Health and Long-Term Care will publish a complete new edition of the Schedule that will incorporate all changes from February 1, 1998 to July 1, 2000. The new edition will be published in a smaller binder for distribution in July 2000.

1. Increase to the Schedule of Benefits

The Schedule of Benefits has been revised to provide a 1.95% increase to all fees, except technical fees for diagnostic services, effective April 1, 2000. As per the agreement, the Committee on Technical Fees will make recommendations regarding technical fees. The current 7% reduction to technical fees for services rendered in hospitals and independent health facilities is maintained. Technical fees for services rendered in other locations will continue to be subject to the first level of threshold reduction.

The amounts payable for insured services that are rendered on or after July 1, 2000 will be set out in the new edition of the Schedule of Benefits. Retroactive payments for services that are provided on or after

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April 1, 2000, and paid prior to July 1, 2000, will be made at a later date to be determined. Information will be provided in a subsequent communication.

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.

2. New or Amended Fee Codes

The following new fees or amended fees are being introduced effective July 1, 2000.

K070 Home Care Application $16.50

The new Home Care Application fee is payable to the most responsible physician for personal completion and submission of a home care service request form to the Community Care Access Centre (CCAC) on behalf of a patient for whom the physician provides on-going medical care. The fee is payable when the form is submitted to CCAC. If the form is completed in whole or in part by a person other than the physician or the physician's employee, the fee payable is zero. This fee is payable to general practitioners and specialists in addition to the appropriate assessment fee.

K071 Acute Home Care Supervision $10.40

K072 Chronic Home Care Supervision $10.40

The new Acute Home Care Supervision and Chronic Home Care Supervision fees are payable to the most responsible physician who personally provides advice, direction or information in response to an inquiry from CCAC staff or CCAC contracted staff on behalf of a patient for whom the physician provides on-going medical care. The date, question, response and identity of the health care staff must be recorded in the patient's health care record. This fee is payable to both general practitioners and specialists.

Acute Home Care Supervision, K071, is payable to a maximum of one per patient every two weeks for the first 12 weeks following admission to the home care program. Chronic Home Care Supervision, K072, is payable to a maximum of one per patient per month commencing the thirteenth week following admission to the home care program.

The amount payable for home care supervision in excess of the maximums, without the required record of service in the patient's medical record, or with a consultation or visit for the same patient on the same day by the same physician, is zero.

E075 Geriatric General Assessment Premium

A new 20% premium for geriatric general assessment is payable to the most responsible physician in addition to a general assessment. It is payable once per 12-month period for a patient aged 75 years or older and for whom the physician provides on-going primary care. The amount payable for additional geriatric general assessment premiums claimed by any physician for the same patient in the same 12-month period are payable at zero. This fee is payable to general practitioners only.

E411 Sole Delivery Premium

This new 50% premium is payable in addition to labour and delivery services, P006A, P009A, P018A, P020A or P038A, when the physician performs only one delivery in a calendar day. This premium is payable to a maximum of 25 sole delivery premium services per physician, per 12-month period. It is not payable to assistants or anesthetists.

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A933, C933 On-call Admission General Assessment $75.00

These new fee codes are payable under specified circumstances, for non-elective inpatient admissions, provided through an emergency department or on transfer from another hospital or long-term care facility, by a family or general practitioner who participates in the hospital's on-call roster. The physician must be the most responsible physician with respect to subsequent in-patient care following the admission. The fees are payable for the first admission per patient, per 30-day period. Additional on-call admission general assessments for the same patient, by the same or different physician, per 30-day period, are payable as a general re-assessment.

Assessment codes paid at rates comparable to General Assessments and Intermediate Assessments

The payment amounts for the following fee codes will be increased to $52.50 to be consistent with the fee for a Family Practice & Practice-in-General General Assessment, A003.

A/C/W903	Pre-dental/pre-operative general assessment
C003	General assessment of non-emergency hospital in-patient
W102	Family Practice admission assessment - Long Term Institutional Care
W109	Family Practice annual physical examination - Long Term Institutional Care
K269	Pediatrics annual health examination - Adolescent
H262	Pediatrics low birthweight baby care - Initial visit
W562	Pediatrics admission assessment - Long Term Institutional Care
W272	Geriatrics admission assessment - Long Term Institutional Care
W279	Geriatrics annual physical examination – Long Term Institutional Care
W232	Internal Medicine admission assessment - Long Term Institutional Care
W239	Internal Medicine annual physical examination - Long Term Institutional Care
W419	Physical Medicine annual physical examination - Long Term Institutional Care
W512	Physical Medicine admission assessment - Long Term Institutional Care

The payment amounts for the following fee codes will be increased to $26.50 to be consistent with the fee for a Family Practice & Practice-in-General Intermediate Assessment, A007.

A/C/W777	Intermediate assessment - pronouncement of death
K033	Individual counseling
K041	Group counseling

The payment amount for the following fee code will be increased to $27.00 to maintain relativity with the fee for a Family Practice & Practice-in-General Intermediate Assessment, A007.

A888	Partial assessment at an emergency department equivalent

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After-hour and Special Visit Premiums

The time period at which after-hour and special premiums become effective is changed from 17:00h to 18:00h. All non-elective hospital services rendered evenings, nights, weekends and holidays are now exempted from thresholds. After-hours and special visit premiums are increased as follows.

Surgical Assistants' Services

General Preamble, Section 20 (d), after-hours premiums payable when a case commences

E400B	Evenings (18:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays. Premium increased from 40% to 45%.
E401B	Nights (00:00h - 07:00h). Premium increased from 50% to 62.5%.

General Preamble, Section 20 (e), special visit premiums payable when a physician is required to make a special visit to assist at non-elective surgery with sacrifice of office hours for a case commences

C998B	Evenings (18:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays. Premium increased from $33.90 to $43.70.
C999B	Nights (00:00h - 07:00h). Premium increased from $50.75 to $65.60.

Anesthetists' Services

General Preamble, Section 22 (e), after-hour premiums payable when a case commences

E400C	Evenings (18:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays. Premium increased from 40% to 45%.
E401C	Nights (00:00h – 07:00h). Premium increased from 50% to 62.5%.

General Preamble, Section 22 (f), special visit premiums payable for a case that commences

C998C	Evenings (18:00h – 24:00h), Saturdays, Sundays, Holidays or non-elective surgery with sacrifice of office hours. Premium increased from $33.90 to $43.70.
C999C	Nights (00:00h – 07:00h). Premium increased from $50.95 to $65.60.

Special Visit Premiums

General Preamble, Sections 23 (g), The maximum number of special visit premiums including "additional patient(s)" is one per patient to a maximum of 10 during a single visit to a patient(s) in an emergency or out-patient department and a maximum of 3 during a single visit to hospital inpatient(s).

General Preamble, Sections 23 (j and k), payable for special visits to emergency department or outpatient department (prefix K) or hospital inpatient (prefix C)

C/K991	Daytime Special Visit (07:00h - 18:00h) Monday to Friday, for additional patients requiring a special visit and seen during the same special visit. New maximum premium of $17.30 per patient.
C/K993	Emergency call with sacrifice of office hours, for additional patients requiring a special visit and seen during the same special visit. New maximum premium of $34.55 per patient.
C/K994	Evenings (18:00h - 24:00h), Saturdays, Sundays, Holidays - first patient seen. Premium increased from $33.90 to $43.70.

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C/K995	For additional patients requiring a special visit and seen during the same special visit. Premium increased from 30% to 40%. Minimum increased from $14.80 to $20.60. New maximum premium of $43.70 per patient.
C/K996	Nights (00:00h - 07:00h) - first patient seen. Premium increased from $50.95 to $65.60.
C/K997	For additional patients requiring a special visit and seen during the same special visit. Premium increased from 50% to 62.5%. Minimum increased from $22.75 to $31.20. New maximum premium of $65.60 per patient.

General Preamble, Section 23 (l), special visit to patient's home or a multiple resident dwelling. Payable only for first patient seen, regardless of number of patients seen during one visit to a home or to one or more living units in a multiple resident dwelling

B994	Evenings (18:00h - 24:00h), Saturdays, Sundays, Holidays. Premium increased from $39.00 to $50.70.
B996	Nights (00:00h - 07:00h). Premium increased from $58.65 to $76.20.

General Preamble, Sections 23 (m) and (n), special visit to long-term care institutions (prefix W) and office or other similar facility (prefix A) regardless of how many patients seen at the same location. No "additional patient" premium payable.

A/W994	Evenings (18:00 - 24:00h), Saturdays, Sundays, Holidays. Premium increased from $33.90 to $43.70.
A/W996	Nights (24:00 - 07:00). Premium increased from $50.95 to $65.60.

After-hour Premiums
General Preamble, Section (25)

E409	Evenings (18:00h - 24:00h), Saturdays, Sundays or Holidays. Premium increased from 30% to 40%.
E410	Nights (00:00h - 07:00h). Premium increased from 50% to 62.5%.

3. Discounted fees

Effective January 1, 2000, discounted fees for physicians who established practices in areas that were designated as over-supplied are eliminated. Information on retroactive adjustments will be provided in a subsequent communication.

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4. Increase to Threshold Reduction Levels and Services Exempted from Threshold

Calculations Effective April 1, 2000

Effective April 1, 2000, for fiscal year 2000/2001, the threshold levels at which reductions are calculated will increase by $10,000. For General/Family Practitioners, the starting level will increase from $320,000 to $330,000 and for specialists from $400,000 to $410,000. The threshold reductions only take effect as these higher OHIP earnings amounts are reached.

The threshold reductions are calculated at the following percentages after a physician reaches the revised payment amounts shown below.

Reduction Rate	**33.3%**	**66.7%**	**75%**
Old Payment Amounts Prior to April 1, 2000			
GPs	$320,000	$345,000	$370,000
Specialists	$400,000	$425,000	$450,000
Revised Payment Amounts Effective April 1, 2000			
GPs	$330,000	$355,000	$380,000
Specialists	$410,000	$435,000	$460,000

Calculation of Threshold Reduction

The method of calculation is unaffected, except that each threshold level has increased by $10,000. The reductions are calculated at the percentages above as physicians reach the level of payments noted. However, to reach those payment amounts, the actual billings are higher, since payments are reduced once the threshold is reached. The calculations take these reduction amounts into account prior to determining the level and percentage deduction to apply. The new total billing amounts that correspond to each revised payment level above are shown below.

Reduction Rate	**33.3%**	**66.7%**	**75%**
Billed Amounts Effective April 1, 2000			
GPs	$330,000	$367,500	$442,500
Specialists	$410,000	$447,500	$522,500

After-Hours Non-Elective Hospital Services Exempted from Threshold Calculations

As per the April 2000 Agreement, after-hours non-elective hospital services are excluded from a physician's income used to calculate their threshold billing amount. Once a physician's income has reached his/her threshold, subsequent services will be reduced at the applicable rate, including those for after-hours hospital services. After-hours services include all hospital based services provided evening, nights, weekends and holidays, such as:

- Special Visit to Hospital In-Patient: C994, C995, C996, C997 and associated services
- Special Visit to Emergency Department or Out-Patient Department: K994, K995, K996, K997 and associated services
- C998B and C999B: Surgical assistant special visit premiums and associated services
- E400B and E401B: Surgical assistant after-hour premiums and associated services
- C998C and C999C: Anesthesia special visit premiums and associated services

- E400C and E401C: Anesthesia after-hour premiums and associated services

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- C109 and C110: Special visit for non-elective diagnostic and therapeutic procedures and associated services

- E402 and E403: Special visit for epidurals and associated services

- E409 and E410: After-hour premiums for non-elective surgical procedures and associated services

Emergency Department – Physician on Duty: H151 to H154, H121 to H124, H112, H113 and associated services

Necessary system changes to reflect these exemptions will be implemented no later than November 1, 2000 and all exemptions will be retroactive to April 1, 2000.

To enable the processing of your claims and retroactive payments, effective immediately, physicians are required to submit, for the same patient, those in-hospital after-hour non-elective services, and the associated services, on the same claim record. No other services should be included on this claim record. Claims submitted without a valid hospital number will not be exempted from the physician's threshold income.

Further information regarding the processing of the retroactive payments will be communicated at a later time.

Communications

Bulletins and the updated version of the Schedule may be seen on the Ministry of Health and Long-Term Care web site **www.health.gov.on.ca**.

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