Bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4435	April 1, 2006	Ministry of Health and Long-Term Care Processing Office
Distribution		(address below)
Physicians, Hospitals, Clinics and Laboratories		

Subject: Schedule of Benefits for Physician Services Amendments – April 1, 2006

1. **Fee increases**
2. **New fee codes**
3. **Revisions to specific codes**
4. **Second assistant claims**
5. **Hospital in-patient diagnostic services**
6. **New diagnostic code**
7. **Amendment chart**

In accordance with the 2004 Physician Services Agreement, a number of changes are being made to the Schedule of Benefits for Physician Services effective April 1, 2006.

1. Fee Increases

Effective April 1, 2006, fee increases to specific codes will be implemented. These fee increases are summarized in the attached table.

The fee increases will be implemented into the OHIP claims processing system effective April 1, 2006.

2. New Fee Codes

Six new fee codes will be introduced to the Schedule of Benefits for Physician Services effective April 1, 2006.

Office locations

Barrie
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Etobicoke
3300 Bloor St. W., Unit 142
M8X 2W8

Hamilton
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Kenora
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P9N 1X9

Kingston
1055 Princess St.
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Kitchener
1400 Weber St. E. Unit B2
N2A 3Z8

London
217 York St., 5th Floor
Station A
N6A 5P9

Mississauga
201 City Centre Dr.
P.O. Box 7020, Stn. A
L5B 2T4

Newmarket
465 Davis Dr.
Unit 108
L3Y 8T2

North Bay
101-447 McKeown Ave.
P1B 9S9

North York
4400 Dufferin St N
Unit A4-A5
M3H 6A8

Oakville
Oakville Town Centre II
220 North Service Rd. W.
L6M 2Y3

Oshawa
Exec. Tower,
Oshawa Centre.
419 King St. W.
P.O. Box 635 L1J 7J2

Ottawa
Fuller Building
75 Albert Street
K1P 5Y9

Ottawa
Government Service Centre
110 Laurier Ave W
K1P 1J1

Owen Sound
1400 1st Ave. W
Suite # 2.
N4K 6Z9

Peterborough
300 Water St, 1st Fl
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K9J 3C7

St. Catharines
301 St. Paul St.
Mezzanine Level
L2R 3M8

Sarnia
452 Christina St. N.
N7T 5W4

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Roberta Bondar Place
70 Foster Dr., Ste. 100
P6A 6V4

Scarborough
2063 Lawrence Ave. E.
M1R 2Z4

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199 Larch St.,
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P3E 5R1

Thunder Bay
435 James St. S. ,
Suite 113
P7E 6T1

Timmins
38 Pine St. N.,
Suite 110
P4N 6K6

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47 Sheppard Ave.E.
Suite 417
M2N 7E7

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777 Bay St,
Suite M212
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1427 Ouellette Ave.
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Head Office
P.O. Box 48
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K7L 5J3

I) MTO Form Fee

The following text will be inserted on page A23 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation (MTO)

Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation (MTO) requires providing to MTO information that satisfies the requirements of the Highway Traffic Act or any applicable regulations, and includes providing any additional information to MTO regarding a previous report related to the same medical condition.

K035 Mandatory Reporting of Medical Condition to the Ontario Ministry of Transportation 34.85

Claims submission instruction:
Claims in excess of one per 12 month period by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation.

The joint Ministry of Health and Long Term Care/Ontario Medical Association Forms Committee has worked with the Ministry of Transportation to develop a reporting form to assist with the mandatory reporting of a patient's medical condition to MTO. This form and additional information will be available as of April 1, 2006 on the Ministry of Transportation website at www.mto.gov.on.ca or by telephone 416-235-1773 (Toronto area) or 1-800-268-1481.

II) Northern Health Travel Grant (NHTG) Form

The following text will be inserted on page A23 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

Northern Health Travel Grant Application Form

K036 Completion of Northern Health Travel Grant Application Form 10.25

[Commentary:
K036 is payable to both the referring physician and specialist physician.]

III) General/Family Physician Emergency Department Assessment

The following text will be inserted on page A3 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

General/Family Physician Emergency Department Assessment

General/Family Physician Emergency Department Assessment is an assessment of a patient that satisfies as a minimum the requirements of an intermediate assessment and is rendered by the patient's general/family physician in an emergency department funded under an Emergency Department Alternative Funding Agreement (ED AFA). For that visit, the service includes any re-assessment of the patient by the general/family physician in the emergency department and any appropriate collaboration with the emergency department physician.

The service is only eligible for payment when the general/family physician's attendance is required because of the complexity, obscurity or seriousness of the patient's condition.

A100 - General/Family Physician Emergency Department Assessment.……$76.90

Payment rule:
No other service (including special visit or other premiums) rendered by the same physician to the same patient during the same visit to the emergency department is eligible for payment with this service.

Claims submission instruction:
For claims payment purposes, the hospital number associated with the emergency department must be submitted on the claim.

[Commentary:
1. *Services described as A100 rendered in an emergency department not funded under an ED AFA may be payable under other existing fee schedule codes.*
2. *In the event the patient is subsequently admitted to hospital, and the general/family physician remains the MRP for the patient, the General/Family Physician Emergency Department Assessment constitutes the admission assessment. See General Preamble GP29 for additional information.]*

In support of the introduction of this fee code, the schedule has also been amended to reference the *General/Family Physician Emergency Department Assessment* on pages GP29 (Admission Assessments) and GP65 (Emergency Department Alternative Funding Agreements) of the General Preamble.

IV) Fibromyalgia/chronic fatigue syndrome care
The following text will be inserted on page A19 of the Consultations and Visits section of the Schedule of Benefits effective April 1, 2006:

Fibromyalgia/chronic fatigue syndrome care
Fibromyalgia/chronic fatigue syndrome care is the provision of care to patients with fibromyalgia or chronic fatigue syndrome. The service includes the common and specific elements of all insured services listed under "Family Practice & Practice In General" in the "Consultations and Visits" section of the Schedule.

K037 Fibromyalgia/chronic fatigue syndrome care. . . . . per unit 51.70

Payment rules:
1. *K037 is a time based service with time calculated based on units. Unit means ½ hour or major part thereof – see General Preamble GP6, GP37 for definitions and time-keeping requirements.*
2. *No other consultation, assessment, visit or time based service is eligible for payment when rendered the same day as K037 to the same patient by the same physician.*

V) Enucleation – ocular surgery

The following text will be inserted on page Y7 under the Orbit, Excision subsection of the Ocular and Aural Surgical Procedures section of the Schedule of Benefits effective April 1, 2006:

 # E109 Enucleation/evisceration with insertion of implant and reattachment of extraocular muscles 4 328.40 5

Note:
E102 or E103 are not eligible for payment with E109.

VI) Monthly management of a nursing home or home for the aged patient

A fee code (W010) for the monthly management of a patient in a nursing home or home for the aged is introduced on pages GP66-GP67 of the General Preamble, and pages A12 and A42 of the Consultations and Visits section, of the Schedule of Benefits for Physician Services effective April 1, 2006.

Monthly Management of a Nursing Home or Home for the Aged Patient is the provision by the most responsible physician (MRP) of routine medical care, management and supervision of a patient in a nursing home or home for the aged for one month. The service requires a minimum of two W-prefix assessments of the patient each month. The service is payable at $85.70.

For complete service provision elements, payment rules, and claims submission instructions related to this new service, please see pages GP66-GP67 of the Schedule and the attached Q & As.

Please note that the LTC capitation rates for Primary Care Network, Family Health Network and Health Service Organization Agreements include the W010 code. When a physician who is participating in these models bills a W010 for an enrolled patient, the claim will be paid at $0 with explanatory code I2 (service is globally funded) and the physician will receive the blended premium for the claim. Services billable as W010 for non-enrolled patients by these physicians will be paid fee-for-service.

Physicians in Family Health Networks, Health Service Organizations and Primary Care Networks should refer to their agreement for details on enrolling LTC patients.

Physicians participating in a Family Health Group or in a Comprehensive Care Agreement will be paid on a fee for service basis for W010 claims.

3. Revisions to Specific Codes

Effective April 1, 2006, changes will be made to the wording/definitions of the fee codes listed in the attached table.

4. Second surgical assistant claims

The following text will be inserted on page GP53 of the General Preamble section of the Schedule of Benefits effective April 1, 2006.

When more than one assistant was required for a surgical procedure, unless the service is listed below, the second assistant's service is only eligible for payment following authorization by a medical consultant and requires submission of a letter from the surgeon outlining the reason the second assistant was required. The amount payable for the second assistant is calculated in the same manner as the amount payable for the first assistant.

Services where a second assistant's services are payable and authorization is not required;

R240	*R241*	*R326*	*R327*	*R440*	*R487*
R594	*S091*	*S092*	*S096*	*S098*	*S099*
S213	*S214*	*S267*	*S270*	*S271*	*S274*
S275	*S294*	*S295*	*S298*	*S300*	*S321*
S416	*S429*	*S440*	*S441*	*S453*	

Currently, as S091, S092, S096, S098, and S099 do not have assigned anaesthesia units, surgical assistants are required to use the generic fee codes (S073, S074, S075) as appropriate for claiming units for these services. These generic claims will be manually assessed by Ministry claims staff who will monitor for S091A, S092A, S096A, S098A, S099A same patient, same day until such time as permanent automated claims system adjustments are available.

5. Hospital In-patient Diagnostic Services

Per section 20.2 of the 2004 Physician Services Agreement between the Ontario Medical Association and the Ministry of Health and Long-Term Care: details regarding physicians billing OHIP for the professional fee for diagnostic services provided on hospital in-patients are being finalized and will be communicated to hospitals and physicians at a later date.

6. New Diagnostic Code

A new diagnostic code has been introduced for claims submission:

249 – Pre-diabetes (i.e. impaired fasting glucose and/or glucose tolerance)

7. Amendment Chart

Chart 1 – Fee increases, new fee codes, fee code deletions and revised fee codes

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Bulletins and the updated version of the Schedule of Benefits are available on the Ministry of Health and Long-Term Care website http://www.health.gov.on.ca/.

CHART 1

Schedule of Benefits Changes Effective April 1, 2006

This chart represents fee increases, new fee codes, fee code deletions and revised fee codes in the Schedule of Benefits for Physician Services effective April 1, 2006.

Fee Code	Fee Code Description	Change	Existing Fee	April 1, 2006 Fee
A921	Medical management of early pregnancy, subsequent visit	Fee increase	$29.70	$30.20
P008	Postnatal assessment	Fee increase	$29.70	$30.20
A007	Family Practice & Practice in General - Intermediate assessment	Fee increase	$29.70	$30.20
A777	Family Practice & Practice in General - Pronouncement of death - office	Fee increase	$29.70	$30.20
C777	Family Practice & Practice in General - Pronouncement of death - hospital	Fee increase	$29.70	$30.20
W777	Family Practice & Practice in General - Pronouncement of death - long-term care facility	Fee increase	$29.70	$30.20
H055	Emergency Medicine - Consultation	Fee increase	$84.40	$86.10
H065	Family Practice & Practice in General - Physician on Duty - Consultation in Emergency Medicine	Fee increase	$56.25	$57.40
H101	Family Practice & Practice in General - Physician on Duty - Monday to Friday - Daytime (08:00h – 17:00h) - Minor assessment	Fee increase	$14.70	$15.00
H102	Family Practice & Practice in General - Physician on Duty - Monday to Friday - Daytime (08:00h – 17:00h) - Comprehensive assessment and care	Fee increase	$36.45	$37.20
H103	Family Practice & Practice in General - Physician on Duty - Monday to Friday - Daytime (08:00h – 17:00h) Multiple systems assessment	Fee increase	$29.65	$30.25
H104	Family Practice & Practice in General - Physician on Duty - Monday to Friday - Daytime (08:00h – 17:00h) - Re-assessment	Fee increase	$14.70	$15.00
H105	Family Practice & Practice in General - Physician on Duty - In-patient Interim Admission Orders	Fee increase	$18.10	$18.45
H112	Family Practice & Practice in General - Physician on Duty - Nights (00:00h - 08:00h) - Premium per patient visit	Fee increase	$14.70	$15.00
H113	Family Practice & Practice in General - Physician on Duty - Daytime and evenings (08:00h - 24:00h) on Saturdays, Sundays or Holidays - Premium per patient visit	Fee increase	$8.65	$8.80
H121	Family Practice & Practice in General - Physician on Duty - Nights (00:00h - 08:00h) - Minor assessment	Fee Increase	$25.75	$26.25
H122	Family Practice & Practice in General - Physician on Duty - Nights (00:00h - 08:00h) - Comprehensive assessment	Fee Increase	$63.80	$65.10
H123	Family Practice & Practice in General - Physician on Duty - Nights (00:00h - 08:00h) - Multiple systems assessment	Fee increase	$51.90	$52.95
H124	Family Practice & Practice in General - Physician on Duty - Nights (00:00h - 08:00h) - Re-assessment	Fee Increase	$25.75	$26.25
H131	Family Practice & Practice in General - Physician on Duty - Evenings (17:00h - 24:00h) - Minor assessment	Fee increase	$16.15	$16.45

CHART 1

Schedule of Benefits Changes Effective April 1, 2006

Fee Code	Fee Code Description	Change	Existing Fee	April 1, 2006 Fee
H132	Family Practice & Practice in General - Physician on Duty - Evenings (17:00h - 24:00) - Comprehensive assessment	Fee Increase	$40.10	$40.90
H133	Family Practice & Practice in General - Physician on Duty - Evenings (17:00h - 24:00h) - Multiple systems assessment	Fee increase	$32.65	$33.30
H134	Family Practice & Practice in General - Physician on Duty - Evenings (17:00h - 24:00h) - Re-assessment	Fee increase	$16.15	$16.45
H151	Family Practice & Practice in General - Physician on Duty - Saturdays, Sundays, Holidays - Minor assessment	Fee Increase	$22.05	$22.50
H152	Emergency Department - Physician on Duty - Saturdays, Sundays, Holidays - Comprehensive assessment	Fee Increase	$54.70	$55.80
H153	Family Practice & Practice in General - Physician on Duty - Saturdays, Sundays, Holidays - Multiple systems assessment	Fee increase	$44.50	$45.40
H154	Family Practice & Practice in General - Physician on Duty - Saturdays, Sundays, Holidays - Re-assessment	Fee Increase	$22.05	$22.50
K030	Family Practice & Practice in General - Diabetic Management Assessment	Fee increase	$34.75	$35.25
K033	Family Practice & Practice in General - Counselling, individual - over 3 services	Fee increase	$29.70	$30.20
K041	Family Practice & Practice in General - Counselling, group - over 3 services	Fee increase	$29.70	$30.20
K035	Mandatory reporting of medical condition to MTO	New fee code	N/A	$34.85
K036	Northern Health Travel Grant form	New fee code	N/A	$10.25
A100	GP Emergency Department Assessment	New fee code	N/A	$76.90
W010	Monthly Management Fee - Long Term Care	New fee code	N/A	$85.70
E109	Enucleation/evisceration	New fee code	N/A	$328.40
K037	Fibromyalgia/chronic fatigue syndrome	New fee code	N/A	$51.70
Z166/Z167/Z168	Group 3 - Removal by excision and suture	Delete	N/A	N/A
E codes	E049, E052, E054, E055, E056, E572 Anaesthesia units	Delete	N/A	N/A
J654/J854	Obsolete techniques for measuring bone mineral density	Delete	$0.00	N/A
Surgical Preamble	Surgical Preamble #18	Delete	N/A	N/A
Laboratory Medicine	Other Terms and Definitions - #4	Delete	N/A	N/A
E550	Closed irrigation during surgical procedures	Revision	$63.15	$63.15
General Preamble	Claiming Second Surgical Assistant	Revision	N/A	N/A
General Preamble	Revise wording to clarify how time units for Surgical Assistant are accumulated	Revision	N/A	N/A
G345	Taxol (revise descriptor to include 4 new drugs - rituximab, trastuzumab, bortezomib, docetaxel)	Revision	$63.15	$63.15
S727	Ovarian debulking - Revision to descriptor	Revision	$884.85	$884.85

CHART 1

Schedule of Benefits Changes Effective April 1, 2006

Fee Code	Fee Code Description	Change	Existing Fee	April 1, 2006 Fee
Heading	Anterior vitrectomy - Remove the word "planned" from heading	Revision	N/A	N/A
Chemotherapy	Revision to descriptor	Revision	N/A	N/A
E149	Vitreous aspiration, posterior needle	Revision	$181.75	$181.75
N185/N288/ N287/N289	Harvesting nerve grafts	Revison	N/A	N/A
S640	Stereotactic Prostate Brachytherapy	Revision	N/A	N/A
Musculoskeletal Preamble	Post-op care visits #5	Revision	N/A	N/A
G590	Influenza agent - add **injection**	Revision	$3.83	$3.83
A888	Emergency Department Equivalent - partial assessment	Revison	$28.55	$28.55
G900	Residual urine measurement	Revision	$12.70	$12.70
C122/C123/C124	Most Responsible Physician - Subsequent visit - Day following admission assessment	Revision	$46.15	$46.15
A115	Major eye examination	Revision	$42.15	$42.15
E077	Revise wording to allow primary care models to bill	Revision	$10.25	$10.25
F139	Fee code F139 missing	Revision	$342.55	$342.55
Respiratory	Spelling error transethmoidol should be **transethmoidal**	Revision	$612.65	$612.65
E001C	E001C missing from numeric index	Revision	N/A	N/A
Pulmonary	Spelling error methylcholine should be **methacholine**	Revision	$49.50	$49.50
Numeric Index	Correct fees for all spine fee codes	Revision	N/A	N/A
General Preamble	ER Sessional Fees - Fees amended to include April 1, 2004 fee increase	Revision	$71.00	$72.80
A - Consult & Visits	There is an asterick without a note before K018/K021	Revision	$308.70	$308.70
E652/E646	E652 and E646 needs to be above Interruption of bronchial heading	Revision	$183.00	$183.00
J - Diag Therapeutic	Spelling error Tenchkov should be **Tenckhoff**	Revision	N/A	N/A
General Preamble	Listed Air Ambulance Transfer as (A111) and should be (K111).	Revision	N/A	N/A
E764	Change wording E764 only applies to umbilical hernias when done with other (non-hernia) surgery	Revision	$96.85	$96.85
K023	Revise descriptor to include "**support**"	Revision	$51.70	$51.70
E595	Remove the 5 anaesthesia units listed	Revision	$63.15	$63.15
General Preamble	SVP - Revise Commentary to remove:**"including additional patient premiums"**	Revision	N/A	N/A
E378/E379	Stereotactic Navigation	Revision	N/A	N/A
General Preamble	Palliative Care Assessment	Revision	N/A	N/A
G - Diagnostic Radiology	Extra cranial vessel assessment (J201)	Revision	N/A	N/A

Schedule of Benefits for Physician Services Changes
Effective April 1, 2006
Questions and Answers

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1. **What changes are being made to the Physician Schedule of Benefits?**

   Effective April 1, 2006, the Schedule of Benefits for Physician Services under Regulation 552 of the *Health Insurance Act* is amended for fee increases, the introduction of new fee codes, fee code deletions and revisions to specific fee codes.

2. **Why are these changes being made?**

   These changes are being made in support of the 2004 Physician Services Agreement. Additional amendments recommended by the Ontario Medical Association's Central Tariff Committee and jointly agreed to between the OMA and the Ministry.

3. **When do these changes become effective?**

   The amendments to the Physician Schedule of Benefits are being implemented effective April 1, 2006.

4. **How will these changes be communicated to physicians and stakeholders?**

   An OHIP Bulletin and corresponding page of the Schedule of Benefits will be sent to stakeholders detailing the changes that are being implemented.

5. **What new fee codes are being introduced?**

   Effective April 1, 2006 six new fee codes are being added to the Schedule of Benefits. These include:
   - a fee for mandatory reporting of medical condition to MTO (K035) - $34.85,
   - a fee for the completion of Northern Health Travel Grant Application Form (K036) - $10.25,

- a General/Family Physician Emergency Department Assessment (A100) - $76.90,
- an all-inclusive fee for fibromyalgia/chronic fatigue syndrome care (K037) - $51.70,
- a fee for enucleation/evisceration, with insertion of implant and reattachment of extraocular muscle (E109) - $328.40, and
- a fee code for the monthly management of a patient in a nursing home or home for the aged (W010) - $85.70.

6. What is the new fee code for Monthly Management of a Nursing Home or Home for the Aged patient?

Monthly Management of a Nursing Home or Home for the Aged Patient is the provision by the most responsible physician (MRP) of routine medical care, management and supervision of a patient in a nursing home or home for the aged for one month. The service requires a minimum of two W-prefix assessments of the patient per calendar month. The service is payable at $85.70.

This code is intended to remunerate the physician for routine care of the patient on a monthly basis and includes the following services:

- Services described by subsequent visits (e.g. W003, W008);
- Services described by additional visits due to "intercurrent illness" (W121) unless the physician sees the patient for more than 4 Wxxx visits in one month;
- Services described by palliative care subsequent visits (e.g. W872);
- Services described by admission assessments (e.g. W102, W104, W107);
- Services described by pre-dental/pre-operative assessments (e.g. W903);
- Services described by annual health or annual physical examinations (e.g. W109);
- Services described by Visit for Pronouncement of Death (W777) or Certification of death (W771) - if the services are not performed in conjunction with a special visit;
- Service described by anticoagulation supervision (G271);
- Completion of CCAC application and home care supervision (K070, K071, K072);
- Services described by the following diagnostic and therapeutic procedures – venipuncture (G489), injection (G372, G373), immunization (G538, G539, G590, G591), Pap smear (G365, G394, E430), intravenous (G379), and laboratory test codes (G001, G002, G481, G003, G004, G005, G006, G007, G008, G009, G010, G011, G012, G014);
- Medication reviews;
- All discussions with the staff of the institution related to the patient's care;

- All telephone calls from the staff of the institution, patient, patient's relative(s) or patient's representative in respect of the resident between the hours of 0700 hours and 1700 hours Monday to Friday (excluding holidays);
- Ontario Drug Benefit Limited Use prescriptions/forms or Section 8 Ontario Drug Benefits Act requests.

A diagnostic code is not required for payment for this service.

Payment rules and claims submission instructions are found on page GP 67 of the General Preamble of the Schedule of Benefits.

7. Are physicians who have rostered their LTC patients entitled to receive the Monthly Management fee?

The LTC capitation rates for Primary Care Network, Family Health Network and Health Service Organization Agreements include the W010 code. When a physician who is participating in these models bills a W010 for an enrolled patient, the claim will be paid at $0 with explanatory code I2 (service is globally funded) and the physician will receive the blended premium for the claim. Services billable as W010 for non-enrolled patients by these physicians will be paid fee-for-service.

Physicians in Family Health Networks, Health Service Organizations and Primary Care Networks should refer to their agreement for details on enrolling LTC patients.

Physicians participating in a Family Health Group or in a Comprehensive Care Agreement will be paid on a fee for service basis for W010 claims.

8. Are assessments requiring a special visit to the LTC facility included in the number of required assessments for W010?

No. Assessments requiring a special visit should be billed using the A-code plus appropriate special visit premium.

Services not included in the Monthly Management fee include:

a. Visits which qualify for a special visit premium;
b. Services described under interviews, psychotherapy or counselling with the patient, patient's relative(s) or patient's representative lasting 20 or more minutes and where all other criteria for these services are met.
c. Services rendered by a specialist who is not the MRP or who is not replacing an absent MRP.

9. Is there a list that shows all codes involved?

The description of the service in the General Preamble provides the types of services that W010 encompasses. As some specialists may be providing ongoing

care as the MRP, W010 will include their corresponding routine visit codes, i.e. for geriatrics – W073, W078, W121, W972, W272, W274, W277, W279, W074 as well as practice in general codes W903, W777, W771 and the G codes.

Specialists may provide care to patients and are eligible for payment for their W-code assessments when a physician under a different specialty is billing the Monthly Management fee.

10. What should I bill if I visit the patient once, but the patient is then transferred to a hospital for the remainder of the month?

The appropriate "W" subsequent visit fee. However, if the patient is transferred to a hospital and dies within 48 hours, W010 may be claimed.

11. Are there any other circumstances when W010 can be billed if I have not provided two visits in the month?

W010 can be billed when less than two assessments were rendered during the month and/or when the patient was not in the institution for a full calendar month if:

a. a patient was newly admitted to the institution and an admission assessment was rendered, or
b. in the event of the death of a patient while in the institution or within 48 hours of transfer to hospital.

12. Appendix I of the 2004 Physician Services Agreement states "… must have signed a contract with the LTC facility where he/she is practicing based on a common template developed by the Parties." I haven't received a common contract – can I still bill the code?

Yes. The contract has not yet been developed by the Parties.

13. If I have been billing W010 for a patient, but then do not provide 2 visits in a certain month, what should I bill?

The appropriate W-code should be billed, i.e. W003 for subsequent visit to nursing home or home for the aged patient.

14. What happens if I plan to take a two week vacation, but have a colleague covering my visits – can these visits count towards the provision of two visits a month?

Visits provided by another physician with whom you have an arrangement can count towards the two visits per month minimum, providing the other physician does not also bill for the visits. If one physician bills W010; and a second GP bills W008 - either W008 will not pay if W010 is paid first or W010 will be reduced by value of W008.

15. How do I bill W121 for visits after the 4th visit?

In the Schedule language for W010, the claims payment instructions indicate that physicians need to use the manual review indicator to be paid for W121 when billed in the same month as W010. No additional documentation will be requested.

16. A LTC resident is transferred to hospital during the month and is then transferred back to the long term care facility but is being cared for by the same physician the entire time; could the attending physician bill both W010 and the appropriate hospital C codes in the same month?

W010 is for services in the LTC, and appropriate hospital C codes are for services provided to the patient while in the hospital. They are independent fee codes and each can be billed as long as the service provisions of each are met.

17. A physician is caring for a resident and has billed W010 for several months. The resident then becomes unstable (e.g. acute CVA, acute decline in health) and now requires six to eight visits per month. What would be the appropriate billing?

Once W010 is claimed for a patient, W010 must be claimed for an entire twelve months. If additional visits are medically necessary beyond the four visits included in W010, W121 may be claimed during the month for the additional visits using a manual review indicator.

18. What new diagnostic code is being communicated by means of this amendment package?

The following new diagnostic code has been introduced for claims submission:

249 – Pre-diabetes (i.e. impaired fasting glucose and/or glucose tolerance)

19. When am I eligible to bill the professional fee for in-patient diagnostic services?

Per section 20.2 of the 2004 Physician Services Agreement between the Ontario Medical Association and the Ministry of Health and Long-Term Care: details regarding physicians billing OHIP for the professional fee for diagnostic services provided on hospital in-patients are being finalized and will be communicated to hospitals and physicians at a later date.