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Ministry of Health

Ministry of Long-Term Care

Ontario Health Insurance Plan

INFOBulletin

Kaplan Board of Arbitration Award Year 4- Release 4 Changes

Release 4 Changes have been implemented with an effective date of April 1, 2020. Changes relate to Fee Schedule Codes E060A, A631A, A632A, E386A and E683A.

To: All Providers

Category: Physician Services

Written by: Claims Services Branch, Ontario Health Insurance Plan Division

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The Ministry of Health (ministry) and the Ontario Medical Association (OMA) have been working together to implement physician compensation increases in accordance with the 2019 Kaplan Board of Arbitration Award (the Award).

This will be achieved through amendments to physician compensation under contracts and to regulations under the *Health Insurance Act*, including [the Schedule of Benefits for Physician Services](http://www.health.gov.on.ca/en/pro/programs/ohip/sob/)

<http://www.health.gov.on.ca/en/pro/programs/ohip/sob/> (the Schedule).

Please see [INFOBulletin 4762](http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4762.aspx)

<http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4762.aspx>

for a summary of all Schedule changes effective April 1, 2020. These changes are being implemented in the OHIP claims system through phased releases.

The following Release 4 changes are being implemented September 1, 2020 with an effective date of April 1, 2020.

E060A-Post Renal Transplant Assessment Premium

The Post Renal Transplant Assessment Premium, E060A is effective April 1, 2020 as per the Schedule of Benefits for Physicians Services (the Schedule). Payment rules set out in the Schedule were implemented on September 1, 2020.

This assessment premium is not eligible for payment when rendered in an emergency department, emergency department equivalent to a hospital in-patient, or patients seen in a long-term care facility.

Claims Submissions

- E060A is restricted to physicians with the Nephrology specialty (16).
- E060A is required to be submitted with a diagnostic code; if not the claim will reject to providers error report with error code **'V21-diagnostic code required'**.
- E060A is eligible for payment for three years following a kidney transplant, and premium payment is based on the first relevant item found; S431A, S434A and S435A.
- E060A must be billed with FSC A163A, A164A, A161A, A168A.
- If E060A is submitted alone or with a different assessment fee code other than one above or one has not been previously submitted the incoming claim will pay at \$0 with explanatory code **'DF-Corresponding fee code has not been claimed or was approved at \$0'**.
- If E060A is submitted with one of the listed assessment fee codes and there is no S431A, S434A or S435A on the claim or submitted within the last three years, the incoming claim will pay at \$0 with explanatory code **'S9-Initial procedure not found'**.
- If E060A is submitted with a Service Location Indicator of HIP (Hospital In-Patient) or HED (Hospital Emergency Department), the claim will pay at \$0 with explanatory code **'D9-Not allowed to a hospital department'**.

New Fee Schedule Code A631A and A632A-Minor Assessment

Fee Schedule Code	Description
A631A	Minor Assessment-A minor assessment is the service rendered when a nuclear medicine specialist evaluates a patient on a non-emergent basis resulting in the cancellation or deferral of a planned diagnostic nuclear medicine procedure due to procedural difficulties, including lack of patient cooperation, if no other diagnostic nuclear medicine procedure is rendered.
A632A	Minor Assessment-A minor assessment is the service when a nuclear medicine specialist evaluates a patient on a non-emergent basis on the advisability of performing a diagnostic nuclear medicine procedure which eventually is not done.

- A631A and A632A can't be billed together; if billed together the first FSC submitted will pay and the other FSC will pay at \$0 with explanatory code **'D7-Not allowed in addition to other procedure'**.
- A631A and A632A are restricted to physicians with the Nuclear Medicine specialty (63).
- If a procedure or assessment FSC has been previously paid for the same patient on the same service date as an incoming A631A/A632A, the incoming claim will pay at \$0 with explanatory code **'D7-Not allowed in addition to other procedure'**.
- If there has been A631A/A632A previously paid for the same patient on the same service date as a procedure or assessment FSC the incoming claim will pay at \$0 with explanatory code **'D7-Not allowed in addition to other procedure'**.

E386A and E683A increase on add-on percentage

Fee Schedule Code	Description
E386A	Extradural decompression-spinal cord or cauda equina, tumour or infection-add-on percentage increase from 40% to 42%
E683A	Lungs and pleura-excision-when performed toroscopically or by VATS-add-on percentage increase from 25% to 28%

- This increase is effective April 1, 2020 and was implemented on September 1st, 2020.
- A MADJ will be required to reprocess claims that were previously paid at the old rate for service dates on or after April 1, 2020.
- Further information will be communicated to physician through an INFOBulletin in advance of the MADJ.

Medical Claims Adjustments (MADJ)

Due to staged implementations, Medical Claims Adjustments (MADJ) may be required. Further information will be provided in advance of a MADJ.

- Please note that during the MADJ process, the claims processing system selects an entire claim for reprocessing.
- A single claim can include multiple fee schedule codes and all codes will be reprocessed.
- Claims that were reprocessed with no change in payment will appear on the Remittance Advice (RA) with explanatory code '**55-This deduction is an adjustment on an earlier account**' and '**57-This payment is an adjustment on an earlier account**'. These two transactions will net to zero with no payment impact but will report on the Remittance Advice for reconciliation purposes.

Keywords/Tags

E060A; A613A; A632A; E386A; E683A; Kaplan; Year 4; Release 4

For more information

For any further inquiries, please contact the [Service Support Contact Centre](mailto:SSContactCentre.MOH@ontario.ca) <<mailto:SSContactCentre.MOH@ontario.ca>> via email or by phone at 1-800-262-6524.

The latest version of the Schedule is available on the [Ministry of Health](http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html) <http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html> website. Hard copies of the Schedule will not be distributed. If you would like to order a paper copy or compact disc (CD) of the Schedule for a fee, please visit [Publications Ontario](https://www.publications.gov.on.ca/) <<https://www.publications.gov.on.ca/>>. Physicians without access to the Internet can contact ServiceOntario at 1-800-668-9938.

This bulletin is a general summary provided for information purposes only. Physicians are directed to review the *Health Insurance Act*, Regulation 552, and the

schedules under that regulation, for the complete text of the provisions. You can access this information at [ontario.ca/laws](http://www.ontario.ca/laws/) <<http://www.ontario.ca/laws/>>. In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulations, the legislation and/or regulations prevail.