INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: All Providers

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Re: Kaplan Board of Arbitration Award Year 4-Release 3 Changes-Technical Fee increases, New Fee Code E986A and Changes to E676A/B Fee Code

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 (the Schedule).

Please see INFOBulletin 4762 "Kaplan Board of Arbitration Award Year 4-Release 2 Changes" 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 3 changes are being implemented July 1, 2020 with an effective date of April 1, 2020.

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Technical Fees Increase

Effective April 1, 2020, all technical fees listed in the Schedule have been increased by the global rate of 3.5446%. Per the Award, these increases do not apply to hospital technical fees, as such the technical component of a diagnostic service set out in Appendix E and rendered in hospital is payable at 96.58% of the listed fee in the column headed “T”; please refer to GP 11 of the Schedule for details.

All hospital services, whether provided in or out of hospital, require technical fees to be submitted with a Service Location Indicator (SLI) of: Hospital Out Patient (HOP), Hospital Referred Patient (HRP), Hospital Day Surgery (HDS), or Hospital Emergency Department (HED).

Note: Technical fees are not payable for inpatients (SLI = Hospital In Patient).

Claims Submissions

- Technical services are defined by Fee Schedule Codes (FSC) with a B suffix for Diagnostic Radiology, Diagnostic Ultrasound, Nuclear Medicine-In Vivo, Pulmonary Function Studies, Sleep Studies and for Diagnostic and Therapeutic Technical Procedures with any suffix
- Current reductions remain in effect (i.e.technical fee reduction and silver reduction)
- If a claim is submitted with a fee billed higher than the fee approved amount after the reduction is applied, the claim will be paid at the lower amount and will have explanatory code **‘80-Technical Fee adjustment for hospitals’**
- This does not apply to Out-of-Province claims, which will be paid at the higher amount

New Fee Schedule Code E986A

Fee Schedule Code	Description
E986A	Suprarenal or supraceliac aortic proximal control-add on code to R802, R817, R877, R783, R784, R785, R858 or R859

- If a claim is submitted for E986A and is billed without one of the listed services above and there is not an approved claim on history, the claim will pay at $0 with explantory code ‘**DF-corresponding fee code has not been claimed or was approved at $0**’
- When submitting a claim for E986A the claim must include a diagnostic code, Master Number (MN) and an admit date. If these are not included, the claim will reject to the provider/group error report

Changes to Fee Schedule Codes E676A-Morbidly obese patient, surgeon and E676B-Morbidly obese patient, surgical assistant

The following procedure codes have been added to the list of eligible codes to which E676A/B are eligible for payment:

- M142A/B-Pneumonectomy
- M143A/B-Lobectomy
- M144A/B-Segmental resection
- S089A/B-Partial oesophageal resection and reconstruction
- S090A/B-Total thoracic oesophageal resection
- S207A/B-Appendectomy

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.

For more information

For any further inquiries, please contact the Service Support Contact Centre via email or by phone at 1-800-262-6524.

The latest version of the Schedule is available on the Ministry of Health website. Hard copies of the Schedule will not be distributed. If you would like to order a paper copy or compact disk (CD) of the Schedule for a fee, please visit Publications Ontario. 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. In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulations, the legislation and/or regulations prevail.