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Bulletin 230705 — PSA related adjustments to Schedule of Benefits: Release 4

Claims payment system changes have been implemented to fee schedule codes G550A and G869A

To: All Physicians

Category: Physician Services

Written by: Claims Services Branch; Health Programs and Delivery Division

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Background

The Ministry of Health and the Ontario Medical Association have been working together to implement the 2021 Physician Services Agreement.

As described in INFOBulletin 230310 (<https://www.ontario.ca/document/ohip-infobulletins-2023/bulletin-230310-physician-services-agreement-related-adjustments>), permanent adjustments to fee codes within the Schedule of Benefits for Physician Services (the Schedule) have been made effective April 1, 2023. Adjustments to the claims payment system related to these Schedule changes

are being introduced through staged implementations to ensure correct payment of claims in accordance with the Schedule.

The following Release 4 changes are being implemented on July 1, 2023, with an effective date of April 1, 2023.

G550A – Pessary Care

G550A is eligible for payment for the same patient, any physician, 6 times per 12-month period. Services in excess of the limit will pay at \$0 with explanatory code **‘D6 - Limit of payment for this procedure reached’**.

G550A is not eligible for payment on the same service date, to the same patient, by any physician as G398A.

- If G550A and G398A are submitted on the same claim, G398A will pay in full and G550A will pay at \$0 with explanatory code **‘D7 - Not allowed in addition to other procedure’**.
- If G550A and G398A are submitted on separate claims, the first fee code submitted will approve for payment and the second will pay at \$0 with explanatory code **‘D7 - Not allowed in addition to other procedure’**

Please note, G550A is not eligible for payment under Virtual Care. G550A submitted with a modality indicator of K300A or K301A will pay at zero dollars with explanatory code **‘B8 - Service Not Eligible for Payment Virtually’**.

G869A – Botulinum toxin injection(s) of bladder detrusor muscle

G869A is eligible for payment for the same patient, any physician once per 12-week period. Services in excess of the limit will pay at \$0 with explanatory code **‘M1 - Maximum fee allowed or maximum number of service has been reached same/any provider’**.

G869A is not payable on the same date, by the same physician, for the same patient as other Botulinum Toxin injections.

- If G869A and one of G870A to G875A are submitted on the same claim for the same service date, G869 will pay in full and the G870A to G875A will pay at \$0 with explanatory code **'D7 - Not allowed in addition to other procedure'**
- If G869A and one of G870 to G875 are submitted on separate claims by the same physician for the same patient and same date of service, the first fee code will approve for payment and the second will pay at \$0 with explanatory code **'D7 - Not allowed in addition to other procedure'**

Please note, Electromyography and/or Ultrasonic Guidance codes G877A – G880A and E543A are not eligible for payment with G869A. When these codes are submitted by the same physician, for the same patient and same service date as G869A, they will pay at \$0 with explanatory code **'DF - Corresponding fee code was not billed or paid at zero'**.

G869A is not eligible under Virtual Care. G869A submitted with a modality indicator of K300A or K301A will pay at zero dollars with explanatory code **'B8 - Service Not Eligible for Payment Virtually'**.

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. No action is required on the part of the physician.

Keywords/Tags

G550; G869; Physician Services Agreement; PSA; Physician Payment Committee; PPC

Contact Information