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Bulletin 240505 — PSA related adjustment to the Schedule of Benefits: Release 11

New payment rules are being applied to critical care specialty visits and fee schedule codes M112A, R740A, E521A, A930A, C930A, W930A and A021A

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 schedule codes (FSCs) 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 11 changes are being implemented May 1, 2024, with an effective date of April 1, 2023.

The impacted fee schedule codes will have new payment rules applied to them.

Critical Care Specialty Visits

- A715A - Consultation – Office
- C715A - Consultation – Hospital
- A915A - Limited consultation - Office
- C915A - Limited consultation - Hospital
- A116A - Repeat consultation - Office
- C116A - Repeat consultation - Hospital
- A713A - Medical specific assessment - Office
- C713A - Medical specific assessment - Hospital
- A114A - Medical specific re-assessment - Office
- C114A - Medical specific re-assessment - Hospital
- A111A - Complex medical specific re-assessment – Office
- C111A - Complex medical specific re-assessment – Hospital
- A118A - Partial assessment – office
- A710A - Comprehensive consultation (≥75 mins) – office
- C710A - Comprehensive consultation (≥75 mins) – hospital
- C112A - Subsequent visit in hospital - first five weeks
- C117A - Subsequent visit in hospital - sixth to thirteenth week inclusive
- C119A - Subsequent visit in hospital - after thirteenth week
- C118A - Concurrent care

Respiratory Surgical Procedure

- M112A - Sternal debridement and rewiring with or without special mechanical instrumentation – as sole procedure

Cardiac Surgical Procedures

- R740A - Left atrial appendage occlusion/excision by suture or device, sole procedure.
- E521A - Left atrial appendage occlusion/excision by suture or device, when done in conjunction with another procedure

Uveitis And Ocular Inflammatory Diseases

- A930A - Uveitis and ocular inflammatory diseases consultation - Office
- C930A - Uveitis and ocular inflammatory diseases consultation - Hospital
- W930A - Uveitis and ocular inflammatory diseases consultation – Long-Term Care

Advanced Dermatology Consultation

- A021A - Advanced Dermatology Consultation

Claims Submission

The fee codes are payable as follows:

Critical Care Specialty Visits

1. All Critical Care FSCs listed are only payable with an OHIP speciality of 11 (Critical Care Medicine) and require a diagnostic code.
2. A715A, C715A, A915A, C915A, A116A, C116A, A710A and C710A require a referring practitioner number.
3. C715A, C915A, C116A, C713A, C114A, C111A, C710A, C112A, C117A, C119A and C118A require a master number.
4. C112A, C117A, C119A and C118A require an admission date.
5. A713A is allowed with a maximum of one other general assessment within a 12-month period and C713A is allowed with a maximum of one other hospital assessment within a 90-day period by the same physician and for the same patient. Additional services submitted will be approved at payment value of FSC A114A or C114A with explanatory code '**C2 - Allowed at re-assessment fee**'.
6. If C713A is submitted and there exists other specific assessments on the same claim or history, provided by the same physician, to the same patient and **on the same service date**, the claim will be approved at a payment value of FSC C114A with explanatory code '**C2 - Allowed at re-assessment fee**'.
7. A maximum of any 4 A/C713A and/or A/C111A are eligible for payment in full within a 12-month period. Additional services will be approved at payment value of FSC A/C114A with explanatory code '**V7 - Allowed at medical/specific re-assessment fee**'.
8. If A/C715A, A/C915A, A/C116A, A/C114A, A/C710A or A/C713A are submitted for **both** emergency and hospital consultation or assessment on the same claim or history, provided by the same physician, for same patient, **on the same date of service**, one FSC will approve in full and the others will be approved at a payment value of FSC A118A or C112A with explanatory code '**V8 - This service paid at lower fee as per stated OHIP policy**'.
9. A maximum of 2 A114A services is allowed on same claim or history, for same patient within 12 months. Additional services will be approved at a reduced valued of FSC A118A with explanatory code '**V8 - This service paid at lower fee as per stated OHIP policy**'.
10. A/C715A submitted with other consultation codes within 12 months with the same diagnostic code or within 24 months with a different diagnostic code will be

rejected to the provider's error report with error code **'AC1- Maximum reached-resubmit alternate FSC'**.

11. A715A, A915A, A116A, A114A, A111A or A710A submitted along with an independent operative procedure (for example: Z101A) **on same service date** and any other consultation fee code submitted within 3 months on the same claim or history, by the same physician, for same patient will be approved at a payment value of FSC A118A with explanatory code **'V8 - This service paid at lower fee as per stated OHIP policy'**.
12. A maximum of 1 C713A or C114A submitted for a hospital assessment or re-assessment is eligible for payment to the same patient by any physician **during the same hospitalization**. Additional claims submitted will be approved at a reduced value of FSC C112A with explanatory code **'HA -Admission assessment claimed by another physician - hospital visit fee applied'**.
13. E083A and E084A will pay a 30% premium of the approved value of FSCs C112A and C117A.
14. FSCs submitted for a hospital subsequent visit are adjusted based on the admission date.
15. A111A, A114A, A116A, A118A, A710A, A715A or A915A submitted with A008A, B910A, B911A, B914A, B915A, B916A, B917A, G334A, K018A, K021A, P003A or P004A provided by the same physician, for the same patient, on the same service date, on the same claim or history will pay at zero dollars with explanatory code **'D7 - Not allowed in addition to other procedure'**.
16. A111A, A114A, A116A, A118A, A710A, A713A, A715A or A915A submitted with K002A and/or K003A by the same physician, for the same patient, on the same service date, on same claim or history will be reduced to the fee value of K002A or K003A with explanatory code **'DC - Procedure paid previously not allowed in addition to this procedure - fee adjusted to pay the difference'**.
17. If A/C111A is submitted and there exists on the same claim or history G365A and/or G394A provided by the same physician, to the same patient, on the same service date, the fee paid will be reduced to the first item with explanatory code **'D7 - Procedure already allowed-visit fee adjusted'**.

Respiratory Surgical Procedure

1. Only one of M112A and another surgical procedure, including E041A, E048A, E056A, is eligible for payment for the same patient, on the same service date and to the same physician. If both codes are submitted, one will pay at \$0 with explanatory code **'D7 - Not allowed in addition to other procedure'**.

Cardiac Surgical Procedures

1. Only one of R740A and another surgical procedure including E041A, E048A, E056A is eligible for payment for the same patient, on the same service date and to the same physician. If both codes are submitted, one will pay at \$0 with explanatory code **'D7 - Not allowed in addition to other procedure'**.
2. E521A is only eligible for payment when submitted with another surgical procedure, except for R740A, by the same physician, for the same patient and same service date. If a relevant surgical procedure is not found on the same claim or history, E521A will be paid at zero dollars with explanatory code **'DF - Corresponding fee code was not billed or paid at zero'**.

Uveitis and Ocular Inflammatory Diseases Consultation

1. A930A, C930A and W930A are eligible for payment when billed by a physician with a specialty of 23 (Ophthalmology).
2. A930A, C930A and W930A require a diagnostic code.
3. A930A, C930A and W930A require a referring practitioner number.
4. If A930A, C930A or W930A are submitted with an additional consultation by the same physician, for the same patient, with the same diagnosis, within a 24-month period, and is not provided to a patient who has been admitted to hospital or seen in the emergency department, the claim will be rejected to the provider's error report with error code **'AC1 - Maximum Reached Resubmit Alternate FSC'**.
5. One additional consultation rendered by the same physician, to the same patient is also eligible for payment once every 12-month period if rendered for a clearly defined unrelated diagnosis.
6. A930A, C930A, W930A are not eligible for payment under virtual care. If any of the fee codes are submitted with K300A or K301A, they will approve at zero dollars with explanatory code **'B8 - Service Not Eligible for Payment Virtually'**.

Advanced Dermatology Consultation

1. A021A is only payable to physicians with an OHIP specialty of 02 (Dermatology) and requires a valid diagnostic code.
2. A021A is not eligible for payment to the same physician for the same patient and on the same date of service as G365A or G394A.
3. If A021 and G365A or G394A are submitted by the same physician, for the same patient and on the same service date, the following will occur:
 - A021A will pay in full and G365A or G394A will approve at zero dollars with explanatory code **'D3 - Not allowed in addition to visit fee'** or
 - If G365A or G394A was already approved for payment to the same physician, for the same patient and on the same service date, A021A will be reduced by the amount of G365A or G394A with explanatory code **'D5 - Procedure already allowed - visit fee adjusted'**.
4. If an additional consultation is submitted by the same physician, for the same patient, with the same diagnosis, within a 24-month period, and is not provided to a patient who has been admitted to hospital or seen in the emergency department, the claim will be rejected to the provider's error report with error code **'AC1 - Maximum Reached Resubmit Alternate FSC'**.
5. One additional consultation rendered by the same physician, to the same patient is also eligible for payment once every 12-month period if rendered for a clearly defined unrelated diagnosis.
6. A021A is eligible to be provided virtually with the Video Modality (K300A) only. A021A billed with the Telephone Modality (K301A) will approve at zero dollars with explanatory code **'B1- Service Not Eligible for Payment When Delivered by Telephone'**.
7. A021A provided by video will be an eligible insured consultation for the purpose of establishing the patient-physician relationship.

Medical Claims Adjustments (MADJ)

Due to staged implementations, Medical Claims Adjustments may be required. Further

information will be provided in advance of a Medical Claims Adjustment.

Please note: No action is required by the physician.

Keywords/Tags

M112; respiratory surgical procedure; R740A; E521A; Cardiac Surgical Procedures; Critical Care Specialty Visits; A/C715A; A/C915A; A/C116A; A/C713A; A/C114A; A/C111A; A/C118; A/C710A; C112A; C117A; C119A; E083A; A930A; C930A; W930A; Uveitis and ocular inflammatory diseases consultation; A021; Advanced Dermatology Consultation; Physician Services Agreement; PSA; Physician Payment Committee; PPC

Contact information

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