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Bulletin 240605 — PSA related medical claims adjustment: Release 11

Payments for critical care specialty visits and fee schedule codes A930A, C930A, W930, A021A, M112A, R740A, and E521A have been reprocessed

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 (<https://www.ontario.ca/page/ohip-schedule-benefits-and-fees#section-1>) (the schedule) have been made effective April 1, 2023.

The payment rules for the following fee service codes were implemented on May 1, 2024, with an effective date of April 1, 2023. See INFOBulletin 240505 (<https://www.ontario.ca/document/ohip-infobulletins-2024/bulletin-240505-psa-related-adjustment-schedule-benefits-release>) for additional information.

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

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

Advance Dermatology Consultation

- A021A – Advanced Dermatology Consultation

Respiratory and Cardiac Surgical Procedures

- M112A – Sternal rewiring with or without special mechanical instrumentation – as sole procedure
- R740A – Left atrial appendage occlusion/excision by suture or device – as sole procedure
- E521A – Left atrial appendage occlusion/excision by suture or device when done in conjunction with another procedure... add

As a result, a Medical Claims Adjustment (MADJ) was required to reprocess related claims.

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

Medical claims adjustment processing

Claims assessed and with service dates between April 1, 2023, and May 1, 2024 were subject to adjustments by the MADJ

- **Critical Care Specialty Visits** (A715A, C715A, A915A, C915A, A116A, C116A, A713A, C713A, A114A, C114A, A111A, C111A, A118A, A710A, C710A, C112A, C117A, C119A and C118A)
- **Uveitis and Ocular Inflammatory Diseases** (A930A, C930A and W930A)
- **Advanced Dermatology Consultation** (A021A)
- **Respiratory and Cardiac Surgical Procedures** (M112A, R740A, E521A)

The claims system will reprocess these claims in accordance with the schedule of benefits. The adjustments will begin to appear on the June 2024 Remittance Advice (RA).

All claims submitted with these Fee Schedule Codes have been corrected to conform with the payment rules.

Please note during the MADJ process, the claims processing system selects an entire claim and reprocesses it. Since an individual claim can include multiple Fee Schedule Codes, all of the codes in the claim will be reprocessed.

Claims reprocessed with no change in payment will appear on the Remittance Advice with explanatory codes **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 \$0 with no payment impact but will report on the Remittance Advice for reconciliation purposes.

Claim items that are reprocessed and are not eligible for payment in accordance with the schedule will be accompanied with one of the following explanatory codes:

- B1 – Service Not Eligible for Payment When Delivered by Telephone
- B8 – Service Not Eligible for Payment Virtually
- C2 – Allowed at re-assessment fee
- D3 – Not allowed in addition to visit fee
- D5 – Procedure already allowed - visit fee adjusted
- D7 – Not allowed in addition to other procedure
- DC – Procedure paid previously not allowed in addition to this procedure – fee

adjusted to pay the difference

- HA – Admission assessment claimed by another physician - hospital visit fee applied
 - M1 – Maximum fee allowed or maximum number of service has been reached same/any provider
 - I2 – Service is globally funded
 - V7 – Allowed at medical/specific re-assessment fee
 - V8 – This service paid at lower fee as per stated OHIP Policy
 - 66 – Reduced per Alternative Payment Program (APP) Funding Contract
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Keywords/Tags

Physician Services Agreement; PSA; Physicians; Payments; A/C715A; A/C915A; A/C116A; A/C713A; A/C114A; A/C111A; A/C118; A/C710A; C112A; C117A; C119A; A021A; A930A; C930A; W930A; Uveitis and ocular inflammatory diseases consultation; Advanced Dermatology Consultation; Medical Claims Adjustment; MADJ; FSC; Cardiac surgery procedures; R740A; E521A; Respiratory surgery procedures; M112A

Contact information

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