MINISTRY OF HEALTH AND LONG-TERM CARE
Primary Health Care Team

FACT SHEET

Title: Billing and Payment Information for Family Health Network (FHN) Signatory Physicians

Date: October 2006

As of your commencement date, all services you provide as a Family Health Network (FHN) Signatory Physician should be submitted with your primary care four letter B-group identifier followed by your six digit provider number and two digit specialty code (e.g. BXXX-123456-00).

All claims are subject to the Ministry of Health and Long-Term Care's (MOHLTC) existing six-month stale-date policy and all normal processing rules and regulations. Claims related inquiries should be directed to your local MOHLTC office.

Once your FHN has been set up to use your B-group number for MRI/MRO and Electronic Data Transfer (EDT) (if applicable), further billing software changes may be required to interact with MOHLTC systems. For example, you may wish to contact your software vendor to avoid unnecessary claims rejections, help you to improve your claims reconciliation, enable you to submit for new premium codes, variations between fees billed and paid, and tracking codes approved at zero dollars.

The attached information provides advice on how to submit claims in order to assist with your monthly reconciliation process. Please refer to your FHN Agreement and the 2004 Memorandum of Agreement (MOA) between the MOHLTC and the Ontario Medical Association (OMA) for a complete list of Primary Care incentives.

Fact Sheets Available for More Information

January 2006 – Tracking and Exclusion Codes Fact Sheet
January 2006 – After hours Premium – Common Questions and Answers
January and March 2006 – Unattached Patient Fee Claims Submission Fact Sheets
March 2006 – New Graduate – New Patient Fact Sheet
April 2006 - Diabetes Management Incentive Fact Sheet
April 2006 – Smoking Cessation Fees Fact Sheet
April 2006 – Preventive Care Cumulative Bonus Management Procedures (revised March 2005)

For more information, please contact your local MOHLTC office or your MOHLTC site team at 1-866-766-0266.

1. Base Rate Payment

- Base Rate Payments are calculated based on the age and sex of each enrolled patient.
- The new base rate payment multiplier is $108.36. This replaces the multiplier found in Appendix I Schedule 1 of the FHN Agreement effective April 1st, 2006.
- This will appear as an accounting transaction with the text line "NETWORK BASE RATE PAYMENT".
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to Base Rate payments. Adjustments will be reported as accounting transactions with the text line "BASE RATE RECONCILIATION ADJMT".
- FHNs have the option to have Base Rate Payments received by the individual physician or by the group. The following table explains where these payments will be deposited and reported based on whether the group chooses solo or group payment.

	Capitation to FHN	Capitation to Solo
Base Rate Payment and Reconciliation	FHN Group RA	Individual Physician's RA

2. Long-Term Care Base Rate Payment

- Long-Term Care (LTC) Base Rate Payments are made for enrolled patients in LTC facilities.
- Physicians receive an annual net base rate payment of $941.16 (effective April 1st, 2006) per LTC enrolled patient, prorated monthly.
- This payment is not based on the age and sex of the enrolled patients.
- The LTC Base Rate Payment is included in the Base Rate Payment amount which appears on the RA as noted above.
- When enrolling LTC patients, "LTC" must be clearly noted on the top of the E/C form.
- Please refer to the FHN agreement and the MOA for obligations associated with choosing to enrol LTC patients.

3. Comprehensive Care Capitation Payment

- Comprehensive Care (CC) Capitation payments are based on the age and sex of each enrolled patient.
- Physicians receive an average monthly capitation rate of $1.42 per enrolled patient.
- CC Capitation payments are reported as an accounting transaction with the text line "COMP CARE CAPITATION".
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to CC Capitation payments. Adjustments are reported as accounting transactions with the text line "COMP CARE RECONCILIATION".
- FHNs have the option to have CC Capitation Payments received by the individual physician or by the group. The following table explains where these payments will be deposited and reported based on whether the group chooses solo or group payment.

	Capitation to FHN	Capitation to Solo
CC Capitation Payment and Reconciliation	FHN Group RA	Individual Physician's RA

4. Base Rate and Comprehensive Care Capitation Payment Reporting

The following four capitation reports are provided monthly.

a. Base Rate Payment Summary Report

- This report provides a demographic breakdown of enrolled patients by age/sex, capitation rate per day in each category, number of member days in each category and the total Base Rate payment amount.
- The LTC Base Rate Payment amount is included but is not broken down by age/sex.

b. Comprehensive Care Capitation Payment Summary Report

This report provides a demographic breakdown of enrolled patients by age/sex (including LTC patients), CC Capitation rate per day in each category, number of member days in each category and the total CC Capitation payment amount.

c. Base Rate and Comprehensive Care Capitation Payment Detail Report

This report provides the name, health number, age, number of member days in the reporting period, and the Base Rate and CC Capitation payments for each enrolled patient (including LTC).

d. Base Rate and Comprehensive Care Capitation Payment Reconciliation Detail Report

- This report displays financial and neutral transactions that affect a physician's enrolled patients.
- For example, a financial transaction could result from retroactive enrolment activity or a neutral transaction could result from a name change.

	Capitation to FHN	Capitation to Solo
Base Rate Payment Summary Report	FHN Group RA	Individual Physician's RA
Comprehensive Care Capitation Summary Report	FHN Group RA	Individual Physician's RA
Base Rate and Comprehensive Care Capitation Payment Detail Report	Paper Reports sent to Lead Physician	Paper Reports sent to Lead Physician for distribution to Individual Physicians
Base Rate and Comprehensive Care Capitation Payment Reconciliation Detail Report	Paper Reports sent to Lead Physician	Paper Reports sent to Lead Physician for distribution to Individual Physicians

5. Seniors Care Premium

- FHN Physicians receive an additional 15% payment increase for Base Rate and CC Capitation payments for enrolled patients 70 years of age and older.
- No action is required as the Base Rate and CC Capitation rates have been increased by 15% for the age/sex categories 70 years and older.

6. 10% of Core Services to Enrolled Patients

- A 10% premium on the approved amount of included services provided to enrolled patients (LTC and non-LTC).
- Physicians should submit for these included services at regular Fee-for-Service (FFS) rates. These claims are paid at zero dollars with explanatory code 'I2 – Service is Globally Funded', and 10% of the amount allowed in the Schedule of Benefits is paid to the group on the monthly FHN RA.
- The 10% will appear as an accounting transaction with the text line "BLENDED FEE FOR SERVICE PREMIUM" and is paid as the sum of all physicians' amounts.

7. Fee-for-Service (FFS)

a. Core Services to Non-Enrolled

Claims submitted for services included in the Base Rate (i.e. Included Services), but for non-enrolled patients will be paid in accordance with all medical rules and at the appropriate Schedule of Benefits amount.

b. Non-Core Services

Claims for services excluded from the Base Rate (i.e. Excluded Services) will be paid for all patients (enrolled or non-enrolled) in accordance with all medical rules and at the appropriate Schedule of Benefits amount.

c. Workplace Safety Insurance Board (WSIB) services

- FHN Physicians are eligible to submit and receive payment for uninsured services including but not limited to services provided under the Workplace Safety and Insurance Act.
- A WSIB service must be identified as 'WCB' on the claim.

d. Services provided to out-of province patients

- FHN Physicians are eligible to submit and receive payment for services provided to out-of province patients.
- The service must be identified as 'RMB' on the claim for an out-of-province patient.

e. Other MOHLTC funded services

- FHN Physicians are eligible to receive payment for services that are recovered in whole or in part from a Ministry of the government other than the MOHLTC.
- FHN Physicians should submit these services (K018A, K021A, K050A, K051A, K052A, K053A, K054A, K055A, and K061A) for the amount set out in the Schedule of Benefits.

8. Core Service Ceiling Level (Hard Cap)

- Hard Cap refers to the ceiling level for FFS claims for Included Services to non-enrolled patients in a fiscal year.
- The Hard Cap is effective 12 months from the commencement of a new FHN physician.
- Hard Cap ceiling is a pool totalling $47,500 per physician for the 2006/07 fiscal year.
- Amounts exceeding the Hard Cap will be recovered from the FHN RA with an accounting transaction with the text line “FFS CORE SERVICE PAYMENT CEILING ADJMT”.

9. Access Bonus

- The Access Bonus Payment is a payment for providing primary health care services to your enrolled patients.
- The Access Bonus is the Maximum Special Payment minus the Outside Use where the:
    - Maximum Special Payment = Base Rate x 0.2065
    - Outside Use = value of Included Services provided to your enrolled patients by a family physician outside of the FHN.
- If an Access Bonus is achieved, the payment is made to the group in April and October.
- Identified General Practitioner (GP) Psychotherapists’ billings do not impact the Access Bonus.
- Oculo-visual assessments (A110A and A112A), regardless of billing physician, do not impact the Access Bonus.

10. Per Patient Rostering Fee (Q200A)

- An incentive payment of $5.00 per patient is paid for the initial enrolment of patients for 12 months following the effective date of the FHN Agreement, or the date a physician joins the FHN, whichever is later.
- A Q200A may be submitted for each patient who completes, signs, and dates the *Patient Enrolment and Consent to Release Personal Health Information* (E/C) form.

Note: Because the Q200A will trigger enrolment-related payments physicians are advised **not** to wait to bill for the Q200A until the patient appears on an Enrolment Activity Report.

- The service date of the Q200A claim should be the patient’s signature date on the E/C form.
- The completed E/C form should be submitted to the MOHLTC within 60 days of claiming the Q200A. If an E/C form is not received, the patient’s enrolment will be cancelled and all associated enrolment-related payments will be recovered.
- Once a physician’s Q200A payment eligibility period has ended, he/she will no longer receive payment for Q200A. However, he/she is encouraged to continue to submit the Q200A to enrol patients and trigger enrolment-related payments. To avoid reconciliation after the 12 month eligibility period, physicians should bill the Q200A at zero dollars.
- The PPRF will appear on the FHN RA.

11. New Patient Fee (Q013A)

- An incentive payment for enrolling up to 50 patients per year who were previously without a family physician.
- The Q013A may be claimed when a physician enrols a New Patient who has completed a *New Patient Declaration* form and the E/C form. The criteria for New Patients are outlined on the form. The claiming FHN physician must keep the declaration on file.
- The New Patient Fee is allowed once per patient and does not apply to the newborns of your patients. Physicians are encouraged to enrol newborn patients and submit the Per Patient Rostering Fee (Q200A) for these patients to trigger enrolment-related payments immediately after the parent or guardian completes the E/C form.
- This fee is not allowed in addition to the New Graduate – New Patient Fee or the Unattached Patient Fee for the same patient.
- A physician may submit for both a New Patient Fee (Q013A) and a Per Patient Rostering Fee (Q200A) for the same patient. The Q013A and the Q200A should be submitted on the same claim with the same service date.
- There is a maximum of 50 Q013A services eligible per fiscal year (April 1st to March 31st). However, physicians are encouraged to continue to accept New Patients and submit fees after they have reached their New Patient Fee maximum. New Patient Fee codes exceeding 50 will be reported on the FHN's monthly RA with explanatory code 'M1 maximum fee allowed for these services has been reached'.

Processing Rules:

- This code is not associated with any other fee schedule code and may be submitted separately or in combination with other fee schedule codes.
- The service date of the Q013A must match the date the patient signs the *New Patient Declaration* and the E/C form.
- If a Q013A claim is submitted for a patient who has completed the E/C form with the billing physician but has yet to be enrolled on MOHLTC database, the Q013A will be processed and paid at zero dollars with explanatory code 'I6 – Premium not applicable' and reported on the FHN's monthly RA. Other services submitted on the same claim will be processed for payment. When a subsequent enrolment for the patient is processed in the following twelve-month period, the Q013A will be automatically adjusted for payment, providing the service date of the Q013A is on or after the patient's signature date on the E/C form.

Billing Tip:

Bill the Q013A as follows:

Q013A $100.00 (for patients up to and including age 64 years)
Q013A $110.00 (for patients between ages 65 and 74 years inclusive)
Q013A $120.00 (for patients age 75 years and over)

To accommodate software billing systems that will not support varying amounts for the same fee schedule code, physicians have the option to bill Q013A, with the fee amount equal to $100.00 regardless of the patient's age. MOHLTC systems will automatically approve the appropriate fee based on the patient's age.

12. New Graduate-New Patient Incentive (Q033A)

- An incentive payment for New Graduates for enrolling up to 150 patients who were previously without a family physician.
- A New Graduate is a physician who has completed his/her family medicine post-graduate training and was licensed to practice within three (3) years of joining a FHN or July 1st, 2005, whichever is later. International Medical Graduates are included as New Graduates.
- A New Graduate is eligible for a maximum of 150 New Graduate – New Patient Fees (Q033A) in his/her first year of practice in a FHN (12 months beginning with their effective date of joining the FHN).
- This fee is not allowed in addition to the New Patient Fee or the Unattached Patient Fee for the same patient.
- The New Graduate - New Patient Fee is allowed once per patient and does not apply to the newborns of existing patients. Physicians are encouraged to enrol newborn patients and submit the Per Patient Rostering Fee (Q200A) for these patients to trigger enrolment-related payments immediately after the parent or guardian completes the E/C form.
- A physician may submit for both a New Graduate – New Patient Fee (Q033A) and a Per Patient Rostering Fee (Q200A) for the same patient. The Q033A and the Q200A should be submitted on the same claim with the same service date.
- Q033A may be claimed when a physician registers a New Patient who has completed a *New Patient Declaration* and the E/C form. The criteria for New Patients are outlined on the form. The claiming FHN physician must keep the declaration on file.
- When a New Graduate's twelve month eligibility period has ended, the physician can still enrol New Patients. At this time, he/she will be eligible to claim up to 50 New Patient Fees (Q013A) until the end of the fiscal year.
- The Billing Tip and Processing Rules for claiming the New Graduate – New Patient Fee are the same as the New Patient Fee. Please see #11 for more information.

13. Unattached Patient Fee (Q023A)

- A $150.00 premium will be paid for enrolling acute care patients previously without a family physician.
- The criteria for Unattached Patients are that at the time of enrolment the patient did not have a family physician and they have had an acute care in-patient stay within the previous three (3) months.
- An acute care in-patient stay is a stay of at least one night in hospital as an in-patient for an acute illness. Emergency department visits and day surgery stays do not qualify.
- Newborns are eligible for the Unattached Patient Fee, only if the mother does not have a family physician and the newborn has been admitted to a Level II or higher Neonatal Intensive Care Unit (NICU) within the last three (3) months.
- The payment of this incentive is subject to the physician accepting responsibility for providing comprehensive care for the patient by enrolling the patient and completing the *Unattached Patient Declaration* and the E/C form within three (3) months of discharge from an in-hospital visit. The physician must keep the *Patient Declaration* on file.
- This fee is not allowed in addition to the New Graduate – New Patient Fee (Q033A) or the New Patient Fee (Q013A) for the same patient.

- A physician may submit for both an Unattached Patient Fee (Q023A) and a Per Patient Rostering Fee (Q200A) for the same patient. The Q023A and the Q200A should be submitted on the same claim with the same service date.
- The Unattached Patient Fee is allowed once per patient but there is no maximum number of patients.
- The Processing Rules for claiming the Unattached Patient Fee are the same as the New Patient Fee. Please see #11 for more information.

14. After Hours Premium (Q012A)

- FHN Physicians are eligible for a 20% premium on the value of fee codes A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A and K017A for scheduled and unscheduled services provided during a scheduled After Hours block coverage.
- Q012A may only be billed when the above services are rendered to the enrolled patients of a FHN physician or enrolled patients of any other physician in the same FHN.
- Q012A must be submitted in order to receive the 20% premium.
- Q012A must have the same service date as the accompanying fee code or the claim will reject to a Claims Error Report with error code 'AD9 – Premium not allowed alone'.
- If the patient is not enrolled on the MOHLTC database an explanatory code 'I6' will appear on the monthly FHN RA. The service billed along with the Q012A code will be paid (subject to all other MOHLTC rules). If an enrolment for the patient is subsequently processed within a 12 month period, the Q012A code will be automatically re-assessed for payment.
- The maximum number of services allowed for each Q012A is one. If the number of services is greater, the After Hours premium will reject to a Claims Error Report with error code 'A3H – maximum number of services'. If the physician has seen the patient on two occasions on the same day where the Q012A is applicable, the second claim should be submitted with a manual review indicator and supporting documentation.
- If the physician has provided more than one half-hour (i.e. major part of a second half-hour) of counselling or mental health care, ensure the number of services for Q012A is one and claim the appropriate fee.

Example:

Code	Number of Services	Amount
K005A	2	103.40
Q012A	1	20.68

Billing Tip:

Bill services and associated Q012A codes at 20% of the corresponding service code as follows:

A001A - $17.75 and Q012A - $3.55
A003A - $58.20 and Q012A - $11.64
A004A - $30.70 and Q012A - $6.14
A007A - $30.20 and Q012A - $6.04
A008A - $10.25 and Q012A - $2.05
A888A - $28.55 and Q012A - $5.71
K005A - $51.70 and Q012A - $10.34
K013A - $51.70 and Q012A - $10.34
K017A - $30.40 and Q012A - $6.08

To accommodate software billing systems that will not support varying amounts for the same fee schedule code, physicians have the option to bill Q012A with the fee amount equal to $10.34 regardless of the patient's age. MOHLTC systems will automatically approve the appropriate fee based on the patient's age.

If the service code was previously approved without a valid after hours the Q012A may be submitted separately for the same patient, with the same date of service.

15. Newborn Care Episodic Fee (Q014A)

- A premium of $13.65 for each well-baby visit, up to a maximum of eight per patient, to enrolled patients in the first year of life.
- The patient must be enrolled with a physician in your FHN.
- The Q014A may only be billed with a valid A007A intermediate assessment code. Q014A services billed in conjunction with any other service will result in a rejected claim that will appear on a Claims Error Report with reject code 'AD9 – not allowed alone'.
- Q014A services that are billed with an A007A assessment that does not have the same service date will reject and appear on your Claims Error Report with a reject code of 'AD9'.
- The Q014A and the assessment must have the same service date and the service date must be before the patient's first birthday. If a Q014A is billed for a patient who is one year of age or older, the claim will be rejected and appear on a Claims Error Report with a reject code 'A2A – outside of age limit'.
- If more than eight Q014A services for the same patient are submitted, the additional services will be reported on the monthly FHN RA with Explanatory Code 'M1'.
- A Q014A service that is billed for a patient who is not enrolled with the FHN physician or with any physician in the FHN will be paid at zero with explanatory code 'I6'. This will allow the accompanying assessment to be paid rather than reject the entire claim. If a subsequent enrolment for the patient is processed in the following twelve-month period, the Q014A will be automatically reprocessed for payment, providing the service date of the Q014A is on or after the patient's signature date on the E/C form.
- The premium will be paid to the FHN RA.

16. Diabetes Management Incentive (Q040A)

- A sixty dollar ($60) annual payment for coordinating, providing, and documenting all required elements of care for enrolled diabetic patients.
- Completion of a flow sheet to be maintained in the patient's record is required, which includes the required elements of diabetes management and complication risk assessment consistent with the Canadian Diabetes Association (CDA) 2003 Clinical Practice Guidelines.
- Q040A is payable for patients enrolled with the billing physician.
- A physician may submit a Q040A fee code for an enrolled diabetic patient once per 365 day period. The Q040A may be submitted separately or in combination with other fee schedule codes once all elements of the flow sheet are completed.
- This will be paid to the FHN RA.
- For more information and an example of the recommended flow sheet, please refer to the April 2006 Diabetes Management Incentive Fact Sheet.

17. Smoking Cessation Fees (Q041A and Q042A)

a. Initial Add-on Smoking Cessation Fee (Q041A)

- A fifteen dollar ($15) annual incentive payment available to physicians for dialogue with their enrolled patients who smoke.
- Physicians may use the following items from the April 2006 Smoking Cessation Fees Fact Sheet to help facilitate and document initial dialogue with their patients who smoke:
  - Smoking Cessation Guidelines For Physicians, and
  - Smoking Cessation Flow Sheet.
- Alternatively, physicians may document that the smoking cessation dialogue, consistent with the 5As model of the Clinical Tobacco Intervention program, has taken place. Please refer to the April 2006 Smoking Cessation Fees Fact Sheet for more information on the flow sheet and 5As model.
- To claim the Add-on Initial Smoking Cessation Fee, a physician must submit the Q041A with one of the following office-based or long-term care consult/visit codes with the same service date that is within the realm of providing comprehensive primary care, including prenatal and postnatal care:
  A001A, A003A, A004A, A005A, A006A, A007A, A008A, A903A, K005A, K007A, K013A, K017A, P003A, P004A, P005A, P008A, W001A, W002A, W003A, W004A, W008A, W010A, W102A, W104A, W107A, W109A and W121A
- This will be paid to the FHN RA.

b. Smoking Cessation Counselling Fee (Q042A)

- An incentive payment for physicians who provide a dedicated subsequent counselling session with their enrolled patients who have committed to quit smoking.
- Submit the Q042A for $1.50 with an intermediate assessment (A007A) with the same service date.
- The MOHLTC will pay for a maximum of two counselling sessions in the 365 day period following the service date of a valid Initial Add-on Smoking Cessation Fee (Q041A).
- This will be paid to the FHN RA.

18. Special Bonuses/Premiums

- In any fiscal year, physicians are eligible to qualify for all Special Premiums with the exception of Obstetrical Deliveries and Prenatal Services. If a physician qualifies for both Obstetrical Deliveries and Prenatal Services, he/she will receive payment for Obstetrical Deliveries, the higher value premium.
- Special Payment accumulations and payments are reported on both the solo and FHN RA.
- Special Premium Payments are paid automatically on the solo RA as an accounting transaction with the text line “SPECIAL PREMIUM PAYMENT” based on approved claims processed.
- Premiums are pro-rated based on the commencement date of the FHN or FHN physician, whichever is later. However, the FHN physician is still eligible to achieve the maximum if sufficient services are submitted in that fiscal year.
- The six Special Premiums are:

a. Obstetrical Deliveries Special Premium

- Patients may be enrolled or non-enrolled.
- Minimum service level is 5 claims from the list in Appendix I Schedule 3 of the FHN agreement
- Payment is $3,200

b. Hospital Services Special Premium

- Patient may be enrolled or non-enrolled
- Minimum service level is $2,000 in claims from the list in Appendix I Schedule 4 of the FHN agreement
- Payment is $5,000
- Note: FHNs with an Ontario Medical Association (OMA) Rurality Index of Ontario (RIO) score of 45.00 or greater qualify for a payment of $7,500. Physicians practicing in Northern Urban Referral Centres (NURCs) qualify for the $7,500 payment regardless of RIO score.

c. Palliative Care Special Premium

- K023A must be billed for the patient
- Patient may be enrolled or non-enrolled
- Minimum service level is 4 patients
- Payment is $2,000

d. Office Procedures Special Premium

- Patients must be **enrolled** to a physician in the FHN
- Minimum service level is $1,200 in claims from Appendix I Schedule 5 of the FHN agreement
- Payment is $2,000

e. Prenatal Care Special Premium

- Patients must be **enrolled** to a physician in the FHN
- Fee codes P003A and/or P004A must be billed
- Minimum service level is 5 patients
- Payment is $2,000

f. Home Visits (Other than Palliative Care) Special Premium

- Patients must be **enrolled** to a physician in the FHN
- Fee codes A901A and/or A902A must be billed
- Minimum level is 100 visits
- Payment is $2,000

19. Premiums for Primary Health Care for Patients with Serious Mental Illness (SMI) (Q020A and Diagnostic Code 295)

- An annual payment per fiscal year for providing Comprehensive Primary Care to a minimum of five enrolled patients with diagnoses of bipolar disorder or schizophrenia.
- Minimum service level is five patients for Level One and an additional five patients for Level Two.

- Payment is $1,000 for Level One and an additional $1,000 for Level Two (total of $2,000) and will be included in the Special Premium payment which is reported on the solo and FHN monthly RA as an accounting transaction with the text line “SPECIAL PREMIUM PAYMENT”.
- Patients must be enrolled to the billing FHN physician.
- Bi-polar disorder must be indicated by submitting the tracking code Q020A at zero dollars along with the service code that was rendered.
- Services for patients with schizophrenia must be indicated by billing diagnostic code 295 on a submitted FFS claim.
- The premium and target levels may be pro-rated according to the FHN or FHN Physician’s commencement date, whichever is later. Payments will be made when services for the required number of patients are reached. Each FHN physician is eligible for the maximum payment.
- Q020A and services with diagnostic code 295 that are submitted for patients that are not formally enrolled with the FHN physician will be processed but will not be counted towards the SMI premium. If a subsequent enrolment for the patient is processed in the following twelve-month period, the Q020A service and/or any services with diagnostic code 295 provided after enrolment will automatically be counted towards the cumulative count for this premium.

20. Preventive Care Management Service Enhancement Codes (Q001A to Q005A)

- FHN Physicians are eligible for a $6.86 payment for the administrative effort and material costs associated with informing eligible enrolled patients about the value of preventive care interventions and to encourage them to receive applicable services.
- This is paid to the FHN RA.
- Please refer to Appendix I of the FHN Agreement for detailed information regarding the conditions for claiming the service enhancement codes.

a. Pap Smear (Q001A)

Physicians may submit the Q001A for $6.86 every two (2) years for any given female enrolled patient between 35 and 70 years who is contacted for the purpose of scheduling a Pap smear.

b. Mammogram (Q002A)

Physicians may submit the Q002A for $6.86 every two (2) years for any given female enrolled patient between 50 and 70 years of age who is contacted for the purpose of scheduling a mammogram.

c. Influenza Vaccine (Q003A)

Physicians may submit the Q003A for $6.86 annually for any given enrolled patient over the age of 65 who is contacted for the purpose of scheduling an influenza vaccination.

d. Immunizations (Q004A)

Physicians may submit the Q004A for $6.86 once for any given enrolled patient between 18 and 24 months of age, whose parent or guardian is contacted for the purpose of scheduling an appointment for MOHLTC supplied immunizations pursuant to the guidelines set by the National Advisory Committee on Immunization.

e. Colorectal Cancer Screening (Q005A)

Physicians may submit the Q005A for $6.86 every two (2) years for any given enrolled patient between 50 and 75 years of age who is contacted for the purpose of scheduling an appointment for colorectal screening by Fecal Occult Blood Testing (FOBT).

21. Cumulative Preventive Care Management Service Enhancement Codes

- Annual bonus payments may be claimed for the five (5) preventive care categories above, where designated levels of preventive care to specific patient populations are achieved.
- Physicians will receive an information package including the procedures for claiming the cumulative bonus for the current fiscal year in April 2007.
- Payments are made to the FHN RA.
- Physicians also receive Preventive Care Target Population/Service Reports (provided in September and April) to assist with identifying enrolled patients who:
    - are in the target population in each preventive care category, and
    - where consent has not been revoked, have received, according to the MOHLTC's records, a preventive care procedure during the specified time, including those received outside the FHN.
- Physicians may submit Tracking and Exclusion Codes to assist in tracking patients receiving preventive care services or those who should be excluded from the target population. For more information, please refer to the January 2006 – Tracking and Exclusion Codes Fact Sheet.

	Tracking Code	**Exclusion Code**
Pap Smear	Q011A	Q140A
Mammogram	Q131A	Q141A
Influenza Vaccination	Q130A	n/a
Immunizations	Q132A	n/a
Colorectal Cancer Screening	Q133A	Q142A

22. Telephone Health Advisory Services (THAS)

- FHNs shall receive an automatic monthly payment of four hundred dollars ($400) per FHN Physician to a maximum monthly payment of $2000 for the group's participation in THAS.
- Payment is made monthly to the FHN RA as an accounting transaction with the text line "TELEPHONE HEALTH ADVISORY SERVICE PYMT".
- For more information, please refer to Section 6.3 of the FHN Agreement.

23. Group Management and Leadership Payment (GMLP)

- FHN's shall receive an administrative payment of one dollar per patient per fiscal year prorated daily for each patient enrolled to a maximum of $25,000 (prorated based on the FHN's commencement date).
- Automatic payment is made on the monthly FHN RA as an accounting transaction with the text line "GROUP MANAGEMENT AND LEADERSHIP PAYMENT".

24. Continuing Medical Education (CME) Payment

- FHN Physicians may submit for a fee of $100 per hour for each hour spent at a continuing medical education conference or seminar.
- The MOHLTC will pay for a maximum of 24 hours per fiscal year (pro-rated based on the physician's effective date with the FHN).
- Payment is made on the solo RA as an accounting transaction with the text line "CONTINUING MEDICAL EDUCATION PAYMENT".
- Physicians should mail or fax CME invoices to the following location for payment processing:

  1055 Princess Street
  Suite 201
  Kingston ON K7L 5T3

  Fax: (613) 545-4344

REMITTANCE ADVICE COMMON EXPLANATORY CODES

Note: Claims that are reported on the Remittance Advice have been processed by the MOHLTC. As with Fee-for-Service claims, for any discrepancies please continue to contact the Claims Payment Division of your local MOHLTC Office.

I2 – Service is globally funded
This explanatory code will appear on the monthly RA if a claim is submitted for a complement funded service for an enrolled or non-enrolled patient. The claim will pay at zero dollars.

I6 – Premium not applicable
This explanatory code will appear on the monthly RA if a Q code is billed for a patient who is not enrolled in the MOHLTC database on the service date. The assessment code billed along with the Q code will be paid (subject to all other MOHLTC rules).

I9 – Payment not applied/expired
This explanatory code will appear on the monthly RA if a Q200A is billed by a WHA Physician whose payment eligibility period for the Q200A has ended. The patient is successfully enrolled on the MOHLTC database; however the $5.00 PPRF will not pay.

30 – This service is not a benefit of MOHLTC
This explanatory code will appear on the RA for claims using the Q020A, Q021A, and Q022A tracking codes. The tracking codes are billed at zero dollars and will pay at zero dollars with an explanatory code 30.

M1 – Maximum fee allowed for these services has been reached
This explanatory code will appear on the monthly RA when the maximum fee allowed for this service has been reached.

CLAIMS ERROR REPORT COMMON REJECTION CODES

Note: Claims that are reported on the Claims Error Report have been rejected and should be corrected and resubmitted for payment. As with Fee-for-Service claims, please continue to contact the Claims Payment Division of your local MOHLTC office for further guidance.

A2A – Outside Age Limit
The service has been billed for a patient whose age is outside of the criteria for that service.

A3H – Maximum number of services
The number of services on a single claim for a Q012A code is one.

A3L – Other New Patient Fee already paid
Physician bills a subsequent New Patient Fee (Q013A), New Graduate-New Patient Fee (Q033A) or Unattached Patient Fee (Q023A) for a patient who they have previously submitted and received payment for one of the above codes.

AD9 – Not allowed alone
Claims are being submitted without a valid assessment code on the same service date.

EPA – PCN billing not approved
Claim for a Q-code submitted for a patient with a service date prior to a physician's effective date, or a claim for a Q-code for which a physician is not eligible.

EP1 – Enrolment transaction not allowed
A Q200A code submitted for a patient with an incorrect version code, or who is either enrolled with another physician with the same effective date, or for a patient who should contact their local MOHLTC office regarding their eligibility.

EP3 – 'Check service date/enrolment date'
A Q200A has been submitted by a physician for a patient that already has an existing enrolment to the same physician with a different date.

EP4 – Enrolment restriction applied
A Q200A code submitted for a patient who has attempted to enrol with another family physician before six weeks has passed or attempted to enrol with more than two physicians in the same year.

EP5 – Incorrect fee schedule code for group type
A Q-code submitted is incorrect for group type.

EQB – Practitioner inactive on service date
Claims submitted by a FHN physician using a solo number instead of the FHN group number after the FHN physician has commenced.

EQJ – Practitioner not eligible on Service Date
If a New Graduate bills the New Patient fee (Q013A) or a physician that is not a New Graduate bills the New Graduate – New Patient fee (Q033A).

PAA - No Initial Fee Previously Paid
If a Q042A has been submitted with a service date that is not within the 365 day period following the service date of a Q041A fee code.