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

FACT SHEET

Title: Billing and Payment Information for Rural and Northern Physician Group Agreement (RNPGA) Group Physicians

Date: October 2006

As of June 1st, 2006, all services you provide as an RNPGA Group 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 MOHLTC's existing six-month stale-date policy and all normal processing rules and regulations. You should continue to submit any remaining eligible services for dates prior to June 1st, 2006, using your existing Alternate Payment Plan (APP) billing number. All claims-related inquiries should be directed to your local MOHLTC office toll free 1-800-416-4006 or 1-416-675-4010.

Once your RNPGA has been set up to use its 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, RNPG may wish to contact its software vendor to avoid unnecessary claims rejections, help to improve claims reconciliation, and enable RNPGA Physicians 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 RNPG 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.

Note: For those group's who have selected Group Enrolment, references to an RNPGA Physician's enrolled patients are those patients who are enrolled to him/her by virtue of the Group Physician's acknowledgement on the *Patient Enrolment and Consent to Release Personal Health Information* (E/C) form.

Fact Sheets Attached for More Information

January 2006 – Tracking and Exclusion Codes Fact Sheet
January 2006 – After Hours Premium – Common Questions & Answers Fact Sheet
February 2006 – Per Patient Rostering Fee (Q200A) Fact Sheet
April 2006 – Diabetes Management Incentive Fact Sheet
April 2006 – Smoking Cessation Fees Fact Sheet

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

1. Comprehensive Care Capitation Payment

- Comprehensive Care Capitation payments are based on the age and sex of each enrolled patient.
- RNPGA Physicians receive an average monthly capitation rate of $1.42 per enrolled patient.
- Payment is made on the RNPGA monthly Remittance Advice (RA) as an accounting transaction equal to the sum of each RNPGA Physician's Comprehensive Care Capitation payment with the text line "COMP CARE CAPITATION."
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to your Comprehensive Care Capitation payments. Adjustments are also paid as an accounting transaction that is equal to the sum of each RNPGA Physician's adjustments on the RNPGA RA with the text line "COMP CARE RECONCILIATION."

Reporting:

The following capitation reports are provided to your Lead Physician:

Comprehensive Care Capitation Payment Summary Report

- One report is provided for each RNPGA Physician on the monthly RNPGA RA.
- The report provides a demographic breakdown of enrolled patients by age/sex, Comprehensive Care Capitation rate per day in each category, number of member days and the total capitation payment amount.

Comprehensive Care Capitation Payment Detail Report

- A paper report for each RNPGA Physician is mailed monthly.
- The report provides the name, health number, age, number of member days in the reporting period, and the Comprehensive Care Capitation payment amount for each enrolled patient.

Comprehensive Care Capitation Payment Reconciliation Detail Report

- A paper report for each RNPGA Physician is mailed monthly.
- The report displays financial and neutral transactions that affect a RNPGA 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.

2. Seniors Care Premium

- RNPGA Physicians receive an additional 15% payment increase for Comprehensive Care Capitation payments for enrolled patients 70 years of age and older.
- No action is required as the Comprehensive Care Capitation rate has been increased by 15% for the age/sex categories 70 years and older.

3. Shadow Billing Premium

- A 5% premium is paid on the approved amount of services funded under the Basic Remuneration of the Agreement that are submitted by RNPGA Physicians for enrolled and non-enrolled patients.
- RNPGA Physicians should submit for services funded under the Basic Remuneration of the Agreement at regular Fee-for-Service (FFS) rates. The individual claims are paid at zero dollars with explanatory code 'I2 – service is globally funded,' and a 5% premium is calculated and paid the group on the monthly RNPGA RA.
- The 5% 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.

4. Fee-For-Service (FFS) Payments

RNPGA Physicians are eligible to receive the following Fee-For-Service (FFS) payments:

a. Specialized Services (Q022A)

- RNPGA Physicians are eligible to submit and receive payment for providing the following four (4) Specialized Services to enrolled and non-enrolled patients:
  - **Obstetrical Delivery Services** – eligible for payment anytime.
  - **Minor Surgical Services** – eligible for payment when services are provided during the night or weekend, or on a Recognized Holiday per the terms of the Agreement.
  - **Assistance in Surgery** – eligible for payment when services are provided during the night or weekend, or on a Recognized Holiday per the terms of the Agreement.
  - **Anaesthesia Services** - eligible for payment when services are provided during the night or weekend, or on a Recognized Holiday per the terms of the Agreement.
- A complete list of eligible fee schedule codes for each of the Specialized Services is attached in Appendix A.
- To receive payment for Minor Surgical Services, Anaesthesia Services, and for services provided for Assistance in Surgery, the physician must submit the applicable fee schedule code with tracking code Q022A for the same patient with the same service date.
- The Q022A should be billed at zero dollars.
- The Q022A must be submitted in order to receive payment for the relevant fee schedule code.
- The Q022A will be processed at zero dollars with an explanatory code '30 – this service is not a benefit of OHIP'.

b. Workplace Safety Insurance Board (WSIB) services

- RNPGA 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.

c. Services provided to out-of province patients

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

d. Other MOHLTC funded services

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

5. Per Patient Rostering Fee (Q200A)

Note: All RNPGA Physicians are encouraged to submit the Q200A to enrol their patients on the MOHLTC's database. However, only RNPGA groups who have selected the Per Patient Rostering Fee enrolment payment option are eligible for the five dollar ($5.00) payment associated with the Q200A fee code.

- For those groups who have not selected the lump sum enrolment payment, an incentive payment of $5.00 per patient is paid for the initial enrolment of patients for thirty six (36) months following a group's registration effective date up to a maximum combined total of $25,000.
  Note: Physicians who join an existing RNPGA after the group's registration effective date are eligible for the Q200A for twelve (12) months or until the end of the group's thirty-six (36) month payment eligibility period, whichever is later. A Q200A may be submitted for each patient who completes signs and dates the E/C form.
  Note: Because Q200A will trigger enrolment-related payments, RNPGA Physicians are advised to submit the Q200A when the patient enrolls and not to wait 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 an RNPGA 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 discrepancies at the group's end after the eligibility period, physicians should bill the Q200A at zero dollars.
- Please refer to the RNPGA February 2006 Per Patient Rostering Fee (Q200A) Fact Sheet for more information.

6. After Hours Premium (Q012A)

- RNPGA 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 a physician's enrolled patients or enrolled patients of any other Group Physician in the same RNPGA.

- 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 the Q012A will be processed at zero dollars with an explanatory code 'I6- premium not applicable' which will appear on the monthly RNPGA RA. The service code billed along with the Q012A code will be processed (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 the 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 $11.64. MOHLTC systems will automatically approve the appropriate fee.

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.

7. 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.

Note: In models that have group enrolment, RNPGA Physicians are eligible to submit and receive payment for the Q040A for patients enrolled to him/her by virtue of the RNPGA Physician's acknowledgement on the E/C form.

- RNPGA Physicians 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.
- For more information and an example of the recommended flow sheet, please refer to the April 2006 Diabetes Management Incentive Fact Sheet.

8. Smoking Cessation Fees (Q041A and Q042A)

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

- A fifteen dollar ($15) annual incentive payment available to RNPGA Physicians for dialogue with their enrolled patients who smoke.
- RNPGA 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, RNPGA 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 an RNPGA 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

b. Smoking Cessation Counseling Fee (Q042A)

- An incentive payment for RNPGA 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).

9. Special Bonuses/Premiums

- In any fiscal year, RNPGA Physicians are eligible to qualify for all Special Premiums with the exception of Obstetrical Deliveries and Prenatal Services. (If an RNPGA 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 RNPGA RA.
- Special Payments are paid on the RNPGA RA.

- Premiums will be paid automatically on the RNPGA RA as the sum of each physician's premium payments with the text line "SPECIAL PREMIUM PAYMENT" based on approved claims processed.
- The minimum service levels and payment amounts are prorated based on the RNPGA Physician's commencement date. However, the RNPGA Physician is still eligible to achieve the maximum premium if sufficient services are submitted in that fiscal year.

Example:

- RNPGA Physicians commence June 1st, 2006.
- Minimum service and payment levels for all Special Premiums are pro-rated based on the number of months remaining in the fiscal year (in this example, ten). For instance, a pro-rated Palliative Care Special Premium may have a service level of three (3) K023 fee codes for a premium payment of $1,500. (Non-pro-rated service level and premium payment is four (4) K023A fee codes and $2,000 respectively.)
- If the RNPGA Physician reaches a non-pro-rated service level the MOHLTC will pay the non-pro-rated premium payment. Therefore, if the physician above provides the fourth K023 service, he/she will receive the additional $500 payment.
- The MOHLTC will pay the maximum value of Special Payments based on the number of designated Full Time Equivalents (FTEs) in the RNPGA.

Example: An RNPGA consists of six (6) physicians who together fill three (3) FTEs. This RNPGA is eligible to receive a maximum Special Payment of $50,100. ($16,700 multiplied by the number of FTEs in the RNPGA.)

Special Payment	Maximum Payment Value
Hospital Services	$7,500.00
Offices Procedures	$2,000.00
Prenatal Services	$0.00
Home Visits	$2,000.00
Palliative Services	$2,000.00
Obstetrical Deliveries	$3,200.00
Total	**$16,700.00**

Note: Any payments exceeding the maximum value based on the number of Full Time Equivalents (FTEs) in the RNPGA will be recovered on the following month's RNPGA RA.

a. Obstetrical Deliveries Special Premium

- Patients may be enrolled or non-enrolled.
- Minimum service level is 5 claims from the list in Schedule 3 of the RNPG 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 Schedule 4 of the RNPG Agreement.
- Payment is $7,500.

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 Group Physician in the RNPGA
- Minimum service level is $1,200 in claims from attached list of Minor Surgical Services provided in Appendix A.
- Payment is $2,000

e. Prenatal Care Special Premium

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

10. Premiums for Primary Health Care for Patients with Serious Mental Illness (SMI) (Q020A and Q021A)

- An incentive payment for providing Comprehensive Primary Care to a minimum of five enrolled patients with diagnoses of bipolar disorder or schizophrenia.
- The MOHLTC will pay the maximum value based on the number of Full Time Equivalents (FTEs) in the RNPGA.
- Any payments exceeding the maximum value based on the number of designated Full Time Equivalents (FTEs) in the RNPGA will be recovered on the following RNPGA RA.
- 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) will be paid on the RNPGA RA with the text line “SPECIAL PREMIUM PAYMENT.”
- Service levels and payments will be reported on the solo and the RNPGA RA.
- Patients must be enrolled to the billing RNPGA Group 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 the tracking code Q021A at zero dollars along with the service code that was rendered.
- The premium and target levels will be pro-rated according to the commencement date of the RNPGA Physician. Payments will be made when services for the required number of patients are reached. Each RNPGA Physician is eligible for the maximum payment.
- Q020A and Q021A codes that are submitted for patients that are not formally enrolled with the RNPGA 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 and/or Q021A will be automatically counted towards the cumulative count for this premium.

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

- RNPGA 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.
- Please refer to Appendix D3 Section 6.2 of the RNPG 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 once every two years for any given enrolled female 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 once every two 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 of $6.86 once every two 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).

12. Cumulative Preventive Care Management Service Enhancement Codes

- Annual bonus payment may be claimed for the five (5) preventive care categories above, where designated levels of preventive care to specific patient populations are achieved.
- RNPGA Physicians will receive an information package that includes the procedures for claiming the cumulative bonus for the current fiscal year in April 2007.
- RNPGA 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 MOHLTC records, a preventive care procedure during the specified time, including those services received outside the RNPGA.

- 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.

Preventive Care Bonus Category	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

13. Telephone Health Advisory Services (THAS)

- An RNPGA group shall receive an automatic monthly payment of four hundred dollars ($400) per RNPGA Physician to a maximum monthly payment of $2000 for the RNPGA's participation in THAS.
- Payment is made monthly to the RNPGA RA as an accounting transaction with the text line "TELEPHONE HEALTH ADVISORY SERVICE PYMT."
- For more information, please refer to Appendix D1 of the RNPG Agreement.

14. Group Management and Leadership Payment (GMLP)

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

15. Continuing Medical Education (CME) Payment

- RNPGA Physicians may submit for a fee of $100 per hour for each hour spent at a Mainpro M1 or C continuing medical education conference or seminar.
- The MOHLTC will pay for a maximum of 24 hours per fiscal year (pro-rated based on the percentage FTE and physician's effective date with the group).
- RNPGA Physicians should submit CME invoices to their site team contact for payment processing.
- Payment is made on the RNPGA RA as an accounting transaction with the text line "CONTINUING MEDICAL EDUCATION PAYMENT" that is equal to the sum of each physician's payment.

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.

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 (Q013), New Graduate-New Patient Fee (Q033) or Unattached Patient Fee (Q023) 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 Q code submitted for a patient with a service date prior to the 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 for 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.

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
A Q042A has been submitted with a service date that is not within the 365 day following the service date of a Q041A fee code.

Appendix A – Eligible Fee Schedule Codes for Specialized Services

Obstetrical Delivery Services

C989, E409, E410, E411, E414, E500, E502, P006, P009, P010, P018, P020, P022, P023, P028, P029, P030, P036, P038, P039, P041, P042, Z766, Z774, Z775 (All suffix “A”)

Minor Surgical Services

G420, Z101, Z173, Z174, Z103, Z106, Z104, Z114, Z118, Z116, Z113, Z156, Z157, Z158, Z159, Z160, Z161, Z162, Z163, Z164, Z166, Z167, Z168, Z169, Z170, Z171, Z122, Z123, Z124, Z125, Z126, Z127, Z096, R048, R049, R050, R094, R040, R041, R018, R019, R020, R031, R032, R033, Z314, Z315, Z316, G370, G371, F004, F005, E558, F006, F008, F009, E504, F012, F013, F102, F016, F017, F018, D001, E576, D004, E577, D007, D012, Z200, Z201, Z202, Z203, Z204, Z211, Z213, Z154, Z175, Z177, Z179, Z190, Z191, Z192, Z110, Z128, Z129, Z130, Z131, Z117, Z141, Z139, Z515, Z567, Z527, Z547, Z528, Z580, Z555, E740, E741, E747, E705,Z535, Z536, Z714, Z733, Z736, Z847, Z848, Z845, Z854, Z874, Z915, Z904, G378, G361, Z770 (All suffix “A”)

Assistance in Surgery

Fee schedule codes with prefix "D" "E" "F" "G" "M" "N" "P" "R" "S" and "Z" and fee schedule codes C998 and C999 (Suffix "B" only)

Anaesthesia Services

Fee schedule codes with prefix "D" "E" "F" "G" "M" "N" "P" "R" "S" and "Z" and fee schedule codes C998 C999 and G224A (Suffix "C" only)