MINISTRY OF HEALTH AND LONG-TERM CARE
Primary Health Care and Family Health Teams

FACT SHEET

Title: Billing and Payment Information for Family Health Group (FHG) Signatory Physicians

Date: December 2007

As a Family Health Group (FHG) Signatory Physician you may continue to submit claims for services following your current claims submission practices. 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.

You may require billing software changes 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 advises how to submit claims in order to assist with your monthly reconciliation process. Please refer to your FHG Letter of 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 – 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 2007 – Cumulative Preventive Care Bonus Information Fact Sheet
April 2007 – Information and Procedures for Claiming the Cumulative Preventive Care Bonus (revised March 2007)
November 2007 – Memorandum of Agreement Reassessment Initiatives Effective October 1, 2007

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 (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, increasing to $1.80 after 12 months of joining a FHG.
- On January 1, 2008 the average monthly capitation rate increases to $1.50 for the first 12 months of joining a FHG and then increases to $2.15 per rostered person.
- CC Capitation payments are reported as an accounting transaction with the text line “COMP CARE CAPITATION” on the monthly solo Remittance Advice (RA).
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to CC Capitation payments. Adjustments are reported as an accounting transaction with the text line “COMP CARE RECONCILIATION” on the monthly solo RA.

2. Comprehensive Care Capitation Payment Reporting

The following three capitation reports are provided monthly.

a. Comprehensive Care Capitation Payment Summary Report

- This report provides a demographic breakdown of enrolled patients by age/sex, CC Capitation rate per day in each category, number of member days in each category and the total CC Capitation payment amount.
- This report appears on the solo RA.

b. Comprehensive Care Capitation Payment Detail Report

- This report provides the name, health number, age, number of member days in the reporting period, and the CC Capitation payments for each enrolled patient.
- This is a paper report sent to the individual physician.

c. 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.
- This is a paper report sent to the individual physician.

3. Seniors Care Premium

- Physicians receive an additional 15% payment for CC Capitation payments for enrolled patients 70 years of age and older.
- No action is required as the CC Capitation rates have been increased by 15% in each of these categories.

4. Comprehensive Care Premium

- This is a 10% premium on the approved amount of eligible services (listed below) provided to enrolled/assigned patients of a physician or enrolled/assigned patients of any other physician in the same group.
- Physicians can submit these services at regular Fee-for-Service (FFS) rates and these claims will automatically be paid at 110% of the regular FFS rate on the monthly RA.
- The eligible services for this premium are:

A001A, A003A, A007A, A008A, A888A, A901A, A902A, C010A, C882A, G365A, G538A, G539A, G590A, G591A, K005A, K013A, K017A, K022A, K023A, and K030A

- To avoid discrepancies when reconciling Comprehensive Care Services rendered to assigned and enrolled patients you may wish to add the 10% premium to the value of the applicable Fee Schedule Code when submitting claims for payment.

5. 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 group, or the date a physician joins the group, 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 encouraged to promptly submit a Q200A for each patient enrolled. The subsequent submission and processing of the enrolment form(s) will formally enroll the patient so that the patient appears on the Enrolment Activity Report.

Processing Rules:

- The service date of the Q200A claim must be the same as 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. After the payment eligibility period (ie: first 12 months of joining any Patient Enrolment Model) has expired the Q200A will be paid at $0 with an explanatory code of '**I9** – Payment not applied/expired'. To avoid issues with reconciliation after the 12 month eligibility period, physicians should submit the Q200A at zero dollars.

6. New Patient Fee (Q013A)

- This is an incentive payment for enrolling up to 55 patients per fiscal year who were previously without a family physician. Effective April 1, 2008, the annual maximum will increase to 60 New Patient Fees per fiscal.
- 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 physician must retain the *New Patient Declaration* on file.
- The New Patient Fee is allowed once per patient and does not apply to newborns of your existing patients. Physicians are encouraged to enrol newborn patients and submit the Per Patient Rostering Fee (Q200A) for these patients in order to trigger enrolment-related payments as soon as 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 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 (ie: date the patient signed the E/C and Declaration form).
- There is a maximum of 55 Q013A (maximum increases to 60 effective April 1, 2008) services eligible per fiscal year (April 1st to March 31st). However, physicians are encouraged to continue to accept New Patients and submit the New Patient code after they have reached their New Patient Fee maximum. This will assist the Ministry in determining the number of new patients that FHG physicians accept into their practices.
- New Patient Fee codes exceeding 55 (60 effective April 1, 2008) will be reported on the 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 valid fee schedule service codes, as provided.
- The service date of the Q013A must be the same date that 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 (ie: neither a Q200A or E/C form have been processed), the Q013A will be processed and paid at zero dollars with explanatory code '**I6** – Premium not applicable' and reported on the monthly RA. Other services submitted on the same claim will be processed for payment. When a subsequent enrolment form or Q200A 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:

Q013A $100.00 (for patients up to and including age 64 years)
Q013A $120.00 (for patients between ages 65 and 74 years inclusive)
Q013A $180.00 (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.

7. New Graduate-New Patient Incentive (Q033A)

- This is an incentive payment for New Graduates, who are in their first year of practice in a Patient Enrolment Model (PEM), for enrolling up to 300 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 is licensed to practice within three (3) years of joining a PEM. International Medical Graduates are included as New Graduates.
- A New Graduate is eligible for a maximum of 300 New Graduate – New Patient Fees (Q033A) in his/her first year of practice in a PEM (12 months beginning with the effective date of joining the PEM).
- 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 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 as soon as the parent or guardian completes the E/C form.
- A physician may submit 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 (ie: date the patient signed the E/C and Declaration form.
- 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 PEM physician must keep the declaration on file.

  Q033A $100.00 (for patients up to and including age 64 years)
  Q033A $120.00 (for patients between ages 65 and 74 years inclusive)
  Q033A $180.00 (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 Q033A, 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.
- 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 55 (60 effective April 1, 2008) New Patient Fees (Q013A) until the end of the current fiscal year.
- Please refer to the March 2006 New Graduate – New Patient Fact Sheet (Q033A).

8. 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** the patient 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.
- To be eligible for this payment incentive the physician agrees to accept responsibility for providing comprehensive care to the enrolling patient. The patient completes the *Unattached Patient Declaration* and the E/C form within three (3) months of discharge from an in-hospital stay. The physician must retain 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 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 (ie: date the patient signs the E/C and *Unattached Patient Declaration*).
- The Unattached Patient Fee is allowed once per patient but there is no maximum number of Unattached Patients to which a physician is eligible.
- Please refer to the March 2006 Unattached Patient Fee Claims Submission Fact Sheet.

9. After Hours Premium (Q012A)

- 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 Services session.
- Q012A may only be billed when the above services are rendered to the enrolled/assigned patients of any physician within the same group.
- Q012A must be submitted in order to receive the 20% premium.
- Q012A must have the same service date as the accompanying eligible fee code or the claim will reject to your Claims Error Report with error code '**AD9** – Premium not allowed alone'.
- If the patient is not enrolled on the MOHLTC database (ie: neither a Q200A nor E/C form has been processed) an explanatory code '**I6**' will appear on the monthly RA. The service billed along with the Q012A code will be paid (subject to all other MOHLTC rules). If an enrolment or Q200A 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 separate 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 - $61.00 and Q012A - $12.20
A004A - $30.70 and Q012A - $ 6.14
A007A - $31.45 and Q012A - $ 6.29
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 of billing Q012A with the fee amount equal to $12.20 (ie: highest percentage code) regardless of the associated service. MOHLTC systems will automatically approve the appropriate fee based on the eligible service code.

If the service code was previously approved without a valid After Hours' premium code the Q012A may be submitted separately for the same patient, with the same date of service.

Common Questions and Answers can be found on the January 2006 After Hours Premium Fact Sheet.

10. Diabetes Management Incentive (Q040A)

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

11. Smoking Cessation Fees (Q041A and Q042A)

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

- This is 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 that are within the realm of providing comprehensive primary care, including prenatal and postnatal care. Both the Q041 and the following service codes must have the same date of service:

  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 Counselling Fee (Q042A)

- This is 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).

- For more information please refer to the April 2006 Smoking Cessation Fees Fact Sheet.

12. Palliative Care Special Premium

- This is an annual payment per fiscal year for providing services to four or more palliative care patients.
- Valid K023A claims must be submitted for the patient.
- Patients may be enrolled, assigned, or not enrolled.
- In the month of qualifying, a payment of $2,000 will be paid automatically on the monthly RA as an accounting transaction with the text line “SPECIAL PREMIUM PAYMENT” based on approved claims processed.
- This premium is prorated based on the effective date of the group or physician, whichever is later. However, the physician is still eligible to achieve the maximum if four patients are seen in that fiscal year.

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

- This is 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 achieving Level Two (total of $2,000) will be included in the Special Premium payment which is reported on the monthly RA as an accounting transaction with the text line “MENTAL HEALTH CARE PREMIUM PAYMENT” in the month(s) in which the qualifying level is reached.
- Patients must be enrolled to the billing 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 are identified by the use of diagnostic code 295 on a submitted Fee-For-Service claim.
- The premium and target levels may be pro-rated according to the group or the physician’s effective date, whichever is later. Payments will be made when services for the required number of patients are reached. Each 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 billing 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 any services with diagnostic code 295 provided after enrolment will automatically be included towards the cumulative count for this premium.

14. Cumulative Preventive Care Management Service Enhancement Codes

- Annual bonus payments may be claimed for five (5) preventive care categories, where designated levels of preventive care to specific patient populations are achieved.
- Physicians must meet the minimum roster size in order to be eligible for the bonuses.
- The requirements for the minimum roster sizes are as follows.
    - Eligibility is based on a physician’s roster size on March 31st of the current bonus year (e.g. March 31st, 2008, for the 2007/208 fiscal year).
    - In each bonus year, a physician must have a minimum roster size of 650 enrolled patients on the last day of the fiscal year (e.g. March 31st, 2008 for the 2007/2008 fiscal year)
    - New Graduates **in their first year of practice** with a Patient Enrolment Model (PEM) will be required to have a minimum roster size of 450 enrolled patients.
- Physicians 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 service during the specified time, including those received outside the group.
- Physicians are encouraged to submit Tracking and Exclusion Codes to assist in tracking patients who have received preventive care services or those who should be excluded from the target population.

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

- For more information, please refer to the 2006/2007 Cumulative Preventive Care Bonus Information Fact sheet and the Information and Procedures for Claiming the Cumulative Preventive Care Bonus (revised March 2007).

Processing Rules:

- Eligibility is based on achieving a minimum roster size which is determined by conducting a snapshot of your enrolled patients as of March 31st each year. To ensure that your roster accurately reflects all patient enrolments up to March 31st, you are encouraged to submit a Q200A for patients enrolled by March 31st. The enrolment forms can be submitted thereafter. Only those patients for whom the ministry has processed a Q200A or enrolment form before March 31st will be included in the roster snapshot. Enrolment forms or Q200As submitted and/or processed after March 31st, for patients who were enrolled prior to March 31st, will not be counted in your roster snapshot and could negatively impact your eligibility for Cumulative Preventative Care Bonuses.

15. Telephone Health Advisory Services (THAS)

- FHGs of less than ten physicians will be paid $1000 per month. FHGs with ten or more physicians will be paid $2000 per month to provide this service to patients on their roster.
- Payment is made monthly to the FHG RA as an accounting transaction with the text line “TELEPHONE HEALTH ADVISORY SERVICE PYMT”.
- For more information, please refer to Appendix E, of the FHG Letter of Agreement.

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.

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 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 a tracking code. The tracking code is 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.

PM – Minimum Roster Size Not Met
This explanatory code will appear on the monthly RA when a physician who does not meet the minimum roster size submits a claim for a Cumulative Preventive Care Bonus. PM will appear and the claim will be paid at $0.

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'
Physicians are only eligible to submit Q200A claims within six months of the effective date of enrolment of the patient on the MOHLTC database. A Q200A submitted after six months will be rejected to the Claims Error Report with error code EP3.

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
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.