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

FACT SHEET

Title: **BILLING INFORMATION FOR PRIMARY CARE NETWORKS**
(New Incentive Payments outlined in the October 1, 2004, PCN Addendum)

Date: **January 2005**

GENERAL PRIMARY CARE NETWORK (PCN) BILLING INFORMATION

As indicated below, each PCN physician will submit the required claims using normal billing practices. New premiums will be reported on your monthly Remittance Advice (RA). All claims are subject to normal MOHLTC Stale Date policy.

All premiums will be calculated based on patient rosters, and paid and reported to the individual PCN physician.

At this time, there are no billing software changes required to interact with ministry systems. However, you may wish to call your vendor to inform him/her regarding new codes and rule information. Additionally, a new "I6" Explanatory Code (Premium not Applicable) will be used by the ministry to identify Q codes that have been processed and paid at zero to allow the accompanying assessment code to be properly processed for payment. These services may appear on your reconciliation exception report and you may decide that you would like to have them treated differently by your reconciliation software to avoid manually reconciling each of these items.

If a premium is paid at $0 with I6 and a patient enrolment is subsequently processed with an enrolment date prior to the date of the premium, the premium will be reprocessed and paid automatically. There is no need for further action from the physician (unless the premium is reprocessed with explanatory code I7 – please see the New Patient Fee section).

Please refer to the PCN Addendum dated October 1, 2004, for basic information.

Premiums and Bonuses

1. Special Premiums (Effective April 1, 2002)

- **In any fiscal year a PCN Physician is eligible to qualify for a maximum of two (2) Special Premiums**
- **Special premiums will not be paid for both obstetrical deliveries and prenatal care.**
- **Premiums will be paid automatically based on approved claims processed.**

If a physician joined a PCN mid fiscal year, all minimum levels and associated payments will be pro-rated, although the physician is still eligible to achieve the maximums if sufficient services are submitted.

1.1 Obstetrical Deliveries Special Premium

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

1.2 Hospital Services Special Premium

- Patient may be enrolled or non-enrolled
- Minimum service level is $2,000 in claims from the list in Appendix II Schedule C of the PCN Addendum
- Payment is $5,000

1.3 Palliative Care Special Premium

- K023 must be billed for the patient
- Patient may be enrolled or non-enrolled
- Minimum service level is 4 patients
- Payment is $2,000

1.4 Office Procedures Special Premium

- Patients **must be enrolled** to a physician in the PCN
- Minimum service level is $1,200 in claims from the list in Appendix III Schedule C of the PCN Addendum
- Payment is $2,000

1.5 Prenatal Care Special Premium

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

1.6 Home Visits (Other than Palliative Care) Special Premium

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

2. After Hours Care Premium

- A 10% premium is paid on the value of fee codes A001A, A003A, A004A, A007A, A008A, and A888A
- Q012A must be submitted in order to receive the 10%
- Q012A must have the same service date as the accompanying assessment

- Patients must be enrolled to a physician in the PCN
- Other PCN incentives may be claimed in conjunction with this premium code and associated assessment.

TIP:
Bill assessments (included fee codes are paid at $0.00) and Q012A at 10% of assessment as follows:

A001A - $17.30 and Q012A – $1.73 A003A - $54.10 and Q012A - $5.41
A004A - $29.95 and Q012A - $3.00 A007A - $28.50 and Q012A - $2.85
A008A - $10.00 and Q012A - $1.00 A888A - $27.85 and Q012A - $2.79

If your software does not support multiple amounts for the same fee code, please bill the highest amount ($5.41) and the system will reduce it accordingly.

If the assessment was previously approved, then you may submit the Q012A alone, with the same assessment date.

If you are able to submit Q012 back to the six month claims submission window, please do so. However, if you are unable to do so, the ministry will reconcile to December 31 2004. Reconciliation details will be communicated at a later date.

3. Senior Care Premium

- A 10% premium is paid on the value of valid claims for fee code A003 (general assessments) performed on patients between the ages of 65 and 74 inclusive.
- This premium must be claimed using fee schedule code Q065.
- The service date on Q065 must match the date of the assessment
- Patients must be enrolled to a physician in the PCN
- The Q065 premium may be claimed a maximum of once per patient per fiscal year (April 1st - March 31st)
- Other PCN incentives may be claimed in conjunction with this premium code and assessment.

TIP:
Bill a general assessment A003A at $54.10 and a Q065A at $5.41.

If the assessment was previously approved, then you may submit the Q065A alone, with the same service date.

If you are able to submit Q065 back to the six month claims submission window, please do so. However, if you are unable to do so, the ministry will reconcile to December 31 2004. Reconciliation details will be communicated at a later date.

4. Newborn Care Episodic Fee

- Bill using fee code Q015, paid at $7.98
- Patient must be enrolled to a physician in the PCN
- Paid for up to 8 well baby visits (A007) in the first year of life.
- The add-on code Q015 must accompany each submitted Well Baby Care claim

TIP:
Bill a well-baby visit A007A at $28.50 and a Q015A at $7.98

If the assessment was previously paid, then you may submit the Q015A alone, with the same assessment date.

If you are able to submit Q015 back to the six month claims submission window, please do so. However, if you are unable to do so, the ministry will reconcile to December 31 2004. Reconciliation details will be communicated at a later date.

5. Premiums for Primary Health Care of Patients with Serious Mental Illness

- Patients must enrolled to the billing PCN physician
- Bi-polar disorder must be indicated by billing Q020A and schizophrenia must be indicated by billing Q021A
- Q021A and Q020A are tracking codes and are billed and paid at zero dollars
- Minimum service level is 5 patients for level one and an additional 5 for level two for a total of 10 patients
- Payment is $1,000 for level one and an additional $1,000 for level two for a total of $2,000

TIP: If you have been providing primary care to an enrolled patient with a serious mental illness since April 1, 2004, bill Q020A or Q021A, as appropriate for the patient, with a current service date.

6. New Patient Fee

- New Patient fee is billed using Q013A
- Patient must have signed the New Patient Declaration Form, which should be retained in your office
- Patient enrolment effective date (the date the patient signed the form) and the service date of the Q013A must be the same
- A maximum of 50 New Patient Fees will be allowed per fiscal year
- The New Patient Fee is allowed once per patient and does not apply to newborns of enrolled patients
- If the service date of the claim does not match the patient enrolment date, the claim will reject EPF – Enrolment Date Mismatch
- If there is no patient enrolment when the claim is received, the Q013A pays $0 with an explanatory code of I6
- If the enrolment form is then received and the service date of the claim does not match the patient enrolment date the Q013A will be reprocessed and paid $0 with explanatory code I7 – Claim Date Does Not Match Patient Enrolment Date.
- If the enrolment form is then received and the service date matches the patient enrolment date, the Q013A will be reprocessed and paid according to the age of the patient

TIP:
Bill Q013A $100.00 for patients up to and including 64 years old
Bill Q013A $110.00 for patients between 65 and 74 years
Bill Q013A $120.00 for patients 75 years old and over

If your software does not support multiple amounts for the same fee code, please bill the Q013A at $100 and the system will adjust it accordingly.

COMMON EXPLANATORY CODES

I2 - Service is Globally Funded
This explanatory code will appear on the RA when a core service is provided to an enrolled patient and the subsequent claim is processed for payment. The fee allowed amount on the claim will be reduced to zero when this explanatory code is reported.

I6 - Premium not applicable
This explanatory code will appear on the monthly RA if a "Q" service is billed for a patient who is not appropriately enrolled in the ministry database on the service date. The assessment code billed along with the "Q" code will be paid (subject to all other ministry rules). All other EPA rejects will continue to be rejected and reported on your daily claims error reports

30 - This service is not a benefit of OHIP
This explanatory code will appear on the RA for claims using the Q020A and Q021A tracking codes for patients with serious mental illness. The tracking codes are associated with the "Premium for Primary Health Care of Patients with Serious Mental Illness". The Q020A and Q021A are billed at $0.00 and pay $0.00 with the explanatory code 30.

M1 - Maximum fees allowed for these services have been reached
This explanatory code will appear on the RA for Preventive Care services (Q001A-Q004A) exceeding the limits for these services, Patient Registration (Q013A) services exceeding the fiscal maximum of 50 services, and the FHN newborn Episodic Fee (Q015A) services exceeding eight services per patient.

M5 - Monthly maximum has been reached
This explanatory code will appear on the RA for Preventive Care services (Q001A-Q004A) exceeding the monthly limits for these services.

COMMON ERROR CODES

A2A - Outside of age limit
Claim has rejected for a registered patient who was not within the specific age range for service code submitted. For example, Q065A (Senior Care Premium) was billed with a general assessment A003A for a registered patient who is not between the ages of 65 and 74 inclusive.

A3H - Maximum number of services
The number of services on a single claim for a Q-code is one.

AD8 - Not allowed alone
Incorrect assessment billings, weekend or statutory holiday codes billed other days of the week.

AD9 - Premium not allowed alone
Claims billed with Q012A (After Hours Care Premium) and Q065A (Senior Care Premium) are being submitted without a valid assessment code on the same service date. For example, Q012A must be submitted with assessment code A001A, A003A, A004A, A007A, A008A or A888A.

EPA - PCN billing not approved (claim for Q code submitted for a patient not rostered to the billing physician at the date of service)
Patient must be registered or enrolled with an active PCN to bill Q code.

EPF - Enrolment date mismatch
Service date does not match the patient's enrolment effective date