Billing & Payment Guide for Family Health Organization (FHO) Physicians

Blended Models - Primary Health Care
Ministry of Health and Long-Term Care
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Ministry of Health and Long-Term Care
Copies of this report can be obtained from
INFOline: 1-866-532-3161
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Introduction

This guide provides an update on primary care incentives made available to Family Health Organization (FHO) Physicians and replaces the ***Billing and Payment Information for FHO Signatory Physicians*** Fact Sheet, May 2007.

As a Family Health Organization (FHO) 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.

This guide also advises how to submit claims in order to assist with your monthly reconciliation process. You may require billing software changes to interact with MOHLTC systems. For example, you may wish to contact your software vendor to: (i) help you improve your claims reconciliation, (ii) avoid unnecessary claims rejections, (iii) enable you to submit for new premium codes, and, (iv) manage variations between fees billed and paid and tracking codes approved at zero dollars.

Please refer to your FHO Agreement and the 2008 Memorandum of Agreement (MOA) between the MOHLTC and the Ontario Medical Association (OMA) for a complete list of Primary Care incentives.

For additional Fact Sheets/INFOBulletins related to specific incentives, visit the MOHLTC Health Care Professional internet site or contact your MOHLTC Representative team at 1-866-766-0266.

Claims inquires should continue to be directed to your local OHIP office.

Payments and Reporting

Capitation Payments

Your Family Health Organization (FHO) has made the choice to direct their Base Rate and Comprehensive Care Capitation payments to either their monthly solo Remittance Advice (RA) or their monthly group's RA (solo bank account or group bank account respectively).

Base Rate Payment

- Base Rate Payments are calculated based on the age and sex of each enrolled patient.
- The FHO average net Base Rate Payment effective October 1, 2010 is $132.25 (includes Seniors Care Premium) based on included Fee-Schedule Codes.
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to Base Rate Payments.
- Base Rate Payments and Adjustments are either paid monthly to the FHO on the group RA or to the individual physician on his/her solo RA.
- Base Rate Payments and Adjustments are processed as accounting adjustments with the text line "NETWORK BASE RATE PAYMENT" and "BASE RATE RECONCILIATION ADJMT" respectively on the monthly RA. For group payments, these accounting adjustments are equal to the sum of each physician's payment and adjustment amounts.

Long-Term Care (LTC) Base Rate Payment

- Long-Term Care (LTC) Base Rate Payments are provided for enrolled patients in LTC facilities.
- Physicians receive an annual net base rate payment of $1073.80 per LTC enrolled patient, prorated monthly.
- This payment is not age and sex adjusted.
- The LTC Base Rate Payment is included in the Base Rate Payment amount which is paid monthly to the FHO or to the individual physician as noted above.
- When enrolling LTC patients, "LTC" must be clearly noted on the top of the Patient Enrolment and Consent (E/C) form.
- Please refer to the FHO agreement and the Memorandum of Agreement (MOA) between the Ministry and the OMA for obligations associated with choosing to enrol LTC patients.

Comprehensive Care Capitation Payment

- Comprehensive Care (CC) Capitation payments are based on the age and sex of each enrolled patient.
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to CC Capitation payments.

- Physicians receive an average monthly capitation rate of $1.63 per enrolled patient for the first twelve months, and $2.34 for month thirteen and beyond. Note: Physicians migrating from one Patient Enrolment Model (PEM) to another will continue to be paid at the CC Capitation rate they were eligible for prior to the transition.
- CC Capitation payments and adjustments are paid monthly to the FHO on the group RA or to the individual physician on his/her solo RA.
- CC Capitation payments and adjustments are processed as accounting adjustments with the text line "COMP CARE CAPITATION" and "COMP CARE RECONCILIATION" respectively on the monthly RA. For group payments, these accounting adjustments are equal to the sum of each physician's payment and adjustment amounts.

Base Rate and Comprehensive Care Capitation Payment Reporting

The following four capitation reports are provided monthly:

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 the reporting period per category and the total Base Rate Payment amount.
- The LTC Base Rate Payment amount is included but is not broken down by age/sex.
- Reported on the monthly RA.

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 the reporting period per category and the total CC Capitation Payment amount.
- Reported on the monthly RA.

Base Rate, Comprehensive Care and Complex Vulnerable Capitation Payment Detail Report

- This paper report provides a complete list of your enrolled patients including the name, health number, age, number of member days in the reporting period per category, and the Base Rate and CC Capitation Payments for each enrolled patient (including LTC).

Base Rate, Comprehensive Care and Complex Vulnerable Capitation Payment Reconciliation Detail Report

- This paper report provides the effective and end date information of enrolled patients retroactively added or ended from your roster.

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

Report	Group Level FHOs (group capitation)	Solo Level FHOs (solo capitation)
Base Rate Payment Summary Report	FHO Group RA	Individual physician's RA
Comprehensive Care Capitation Summary Report	FHO Group RA	Individual physician's RA
Base Rate and Comprehensive Care Capitation Payment Detail Report	Paper reports sent to Lead physician for distribution to Individual physicians	Paper reports sent to individual physician
Base Rate and Comprehensive Care Capitation Payment Reconciliation Detail Report	Paper reports sent to Lead physician for distribution to Individual physicians	Paper reports sent to individual physician

Premiums

Seniors Care Premium

- Physicians receive an additional 15% payment for Base Rate and CC Capitation Payments for enrolled patients 65 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 65 years and older.

Shadow Billing Premium

- Physicians receive a 15% premium on the approved amount of included services provided to all 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 15% of the amount allowed in the Schedule of Benefits is paid monthly to the FHO on the group or solo RA.
- The premium is paid as an accounting transaction with the text line "BLENDED FEE FOR SERVICE PREMIUM" equal to the sum of all physicians' earned premium amounts.
- Services that contribute to a physician's premium each month will be reported on both his/her solo RA and the group RA in the Blended Fee-For-Service Premium Detail Report as an accounting transaction with the text line "BLENDED FEE FOR SERVICE PREMIUM".
- Each physician's total premium payment amount is also reported in the Blended Fee-For-Service Premium Summary Report on the group RA.

Fee-for-Service (FFS)

Core Services to Non-Enrolled Patients

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

Non-Included 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.

Workplace Safety Insurance Board (WSIB) services

- Physicians are eligible to submit and receive payment for 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.

Services provided to out-of-province patients

- 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 (with the exception of Quebec).

Other MOHLTC funded services

- 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.
- Physicians should submit these services (K018A, K021A, K050A, K051A, K052A, K053A, K054A, K055A, K061A, K065A and K066A) for the amount set out in the Schedule of Benefits.

Core Service Ceiling Level/Hard Cap

- Hard Cap refers to the ceiling level the Ministry will pay for FFS claims for Included Services to non-enrolled patients in a fiscal year.
- A new FHO physician is exempt from the Hard Cap for the first 12 months following his/her effective date with the FHO. **Note:** This exemption does not apply to physicians who commence with a FHO and were previously affiliated to a PEM where a Hard Cap applied.
- Hard Cap ceiling is a group pool totalling $52,833 per physician as of April 1, 2011.
- Each physician's Hard Cap accumulations will be reported monthly on the FHO group RA in the FFS Core Service Ceiling Report.

- Amounts exceeding the Hard Cap will be recovered from the FHO RA as an accounting transaction with the text line “FFS CORE SERVICE PAYMENT CEILING ADJMT”

Access Bonus

- FHO physicians will receive two separate Access Bonus payments:
- For their enrolled patients (non-LTC) and
- For their LTC-enrolled patients.
- Both will be paid monthly as the sum of each physician’s Access Bonus calculations with semi-annual reconciliation.
- The Access Bonus for enrolled patients will be calculated as 0.1859 of a physician’s monthly Base Rate Payment minus any Outside Use.
- The Access Bonus for LTC-enrolled patients will be calculated at a rate of 0.2065 of a Physician’s monthly Base Rate Payment minus any Outside Use.
- Access Bonus payments for enrolled patients are paid as an accounting transaction with the text line “ACCESS BONUS PAYMENT” on the monthly group RA.
- Semi-Annual Reconciliation Adjustments for enrolled patients are processed as an accounting transaction with the text line “ACCESS BONUS RECONCILIATION” on the group RA.
- Access Bonus payments for LTC-enrolled patients are paid as an accounting transaction with the text line “LTC ACCESS BONUS PAYMENT” on the monthly group RA.
- Semi-Annual Reconciliation Adjustments for LTC-enrolled patients are processed as an accounting transaction with the text line “LTC ACCESS BONUS RECONCILIATION” on the group RA.
- If one or more physicians have a negative Access Bonus, then the FHO group’s Access Bonus payment will be reduced by this amount.
- If all physicians in the FHO have a negative Access Bonus or the individual physician’s Negative Access Bonus exceeds the positive Access Bonus amount for the group of physicians, then the FHO group will have a negative Access Bonus; the Access Bonus payment will be zero dollars and no recovery will be made from the FHO.

Outside Use

- A physician’s Outside Use is equal to the dollar value of included services provided to his/her enrolled patients by a family physician outside the group.
- Billings of identified GP Focus Practice physicians and physicians delivering services in MOHLTC-designated Urgent Care Clinics will be excluded from Outside Use accumulations.
- Each physician’s Outside Use accumulations will be reported on the monthly FHO group RA and to the individual physician on his/her monthly solo RA in the Outside Use Non-LTC Access Bonus Detail Report and Outside Use LTC Access Bonus Detail Report.
- Outside use reports are available in XML format via Medical Electronic Data Transfer (EDT).

Rostering Fee

Per Patient Rostering Fee (Q200A)

- A $5.00 per patient incentive payment for the **initial** enrolment of patients for the first 12 months of joining any PEM.
- A Q200A may be submitted once for each patient who completes, signs, and dates the Patient Enrolment and Consent to Release Personal Health Information (E/C) form.
- The Q200A will trigger enrolment-related payments, thus physicians are advised not to wait to bill for the Q200A until the patient appears on an Enrolment Activity Report.
- A Q200A submitted for a patient who has attempted to enrol with another family physician before six weeks have passed or attempted to enrol with more than three (3) physicians in the same year will be rejected to the Claims Error Report with error code '**EP4 – Enrolment restriction.'**

Processing Rules:

- The Q200A 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 Q200A claim must match the date the patient signed the E/C form.
- The completed E/C form should be submitted to the MOHLTC within 90 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.
- Q200A claims will be subject to all regular claim processing rules (e.g. stale-dating).
- 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; these claims will be processed and paid at zero dollars with explanatory code '**I9 – Payment not applied/expired**' and will report on the monthly RA.

New Patient Fees

Common Rules

- A new patient is one who does not have a family physician because they have moved to a new community, their family physician has changed communities, retired, passed away, or changed practice type, or they have never had a family physician.
- The patient completes and signs the Patient Enrolment and Consent to Release Personal Health Information (E/C) form.

- The physician and patient sign a New Patient Declaration form to be kept in the physician's office.
- A physician may submit for both an applicable New Patient Fee and a Per Patient Rostering Fee (Q200A) for the same patient. The New Patient Fee and the Q200A should be submitted on the same claim with the same service date.
- Only one New Patient Fee is allowed per physician / patient combination. Subsequent claims will be rejected to the Claims Error Report with error code '**A3L – Other new patient fee already paid**.'
- NOTE: Newborns of enrolled patients do not qualify as new patients for the New Patient fees; newborns are only eligible if their mother also does not have a family physician. 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.
- For New Patient Fees that pay varying amounts based on patient age, physicians have the option to bill with the fee amount equal to the lowest value. MOHLTC systems will automatically approve and pay the appropriate fee. See "Billing Tip" for further details.

New Patient Fee (Q013A)

- An incentive payment for enrolling up to 60 patients per fiscal year who were previously without a family physician.
- A physician is eligible for payment of up to a maximum of 60 Q013A services per fiscal year. However, physicians are encouraged to continue to accept New Patients and submit a Q013A claim after they have reached their New Patient Fee maximum. This will assist the Ministry in determining the number of new patients that FHO physicians accept into their practices.
- New Patient Fee codes exceeding 60 will be processed and paid at zero dollars with explanatory code '**M1 – Maximum fee allowed for these services has been reached'** and will report on the monthly RA.

Processing Rules:

- The Q013A may be submitted separately or in combination with other fee schedule codes rendered at the same visit.
- 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 the MOHLTC database, 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 (subject to all other MOHLTC rules). When a subsequent enrolment 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:

Bill the Q013A as follows:

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.

Unattached Patient Fee (Q023A)

- A $150.00 premium will be paid for enrolling **acute care** patients previously without a family physician. There is no maximum number of patients.
- To be eligible for the Unattached Patient Fee, at the time of enrolment the patient does 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 Billing Tip and Processing Rules for claiming the Unattached Patient Fee are the same as the New Patient Fee. Please see #10 for more information.

New Graduate – New Patient Incentive (Q033A)

- An incentive payment for New Graduates during their first year of practice with the FHO 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 was licensed to practice within three (3) years of joining a Patient Enrolment Model (PEM). As well, a physician is considered a New Graduate if he/she is an International Medical Graduate who completed his/her family medicine post-graduate training and was licensed to practice or granted a certificate for independent practice as a family physician in Ontario within three (3) years of joining a PEM
- For physicians who do not qualify as New Graduates on the MOHLTC database and who submit Q033A services, these claims will be rejected to the Claims Error Report as error code '**EQJ – Practitioner not eligible on service date**.' These claims must be resubmitted using the New Patient Fee (Q013A) code.

- A New Graduate is eligible for a maximum of 300 Q033A services in his/her first year of practice in a FHO (12 months beginning with their effective date of joining the PEM). New Graduate – New Patient Fee codes exceeding 300 will be processed and paid at zero dollars with explanatory code '**M1 – maximum fee allowed for these services has been reached**' and will report on the monthly RA.
- 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 60 New Patient Fees (Q013A) until the end of the fiscal year.
- The Billing Tip and Processing Rules for claiming the New Graduate – New Patient Incentive are the same as the New Patient Fee. Please see #10 for more information.

New Patient Fee FOBT Positive/Colorectal Cancer (CRC) Increased Risk (Q043A)

- Physicians will write the words ColonCancerCheck (CCC) on the New Patient Declaration form.

Bill the Q043A as follows:

$150 for patients up to and including 64 years of age
$170 for patients 65 – 74 years of age, and
$230 for patients 75 years of age and older

- For complete information on the following please refer to the ***New and Enhanced Incentives for Colorectal Screening*** Fact Sheet, April 2008.

Complex Vulnerable New Patient Fee (Q053A)

- A one-time payment of $350 for enrolling a patient through the Health Care Connect (HCC) Program, registered as complex/vulnerable.
- Physicians will be paid the Complex Vulnerable New Patient fee through the submission of existing new patient fee codes (Q013A, Q023A, Q033A, and Q043A) or the Q053A fee code.
- Existing new patient fee codes:
    - If billed using Q013A, Q023A, Q033A or Q043A, Ministry systems will check to see that the patient is registered as complex-vulnerable and enrolled within three (3) months of the HCC referral date.
    - Once enrolment is verified, Ministry systems will automatically replace the existing new patient fee code with the new Complex Vulnerable New Patient Q053A fee code and pay $350.

- If the patient is not registered on Health Care Connect as complex-vulnerable, Ministry systems will automatically apply the billing rules associated with the Q013A, Q023A, Q033A, or Q043A and pay the appropriate fee (i.e. Q013 will pay at $100 or appropriate age-related dollar premium).

- If physician bills with new Complex Vulnerable New Patient Q053A fee code and if the patient is registered on Health Care Connect as complex-vulnerable and enrolled within three (3) months, the claim will pay at $350.
- If both of the above requirements are not met (i.e. not registered on Health Care Connect and not enrolled within 3 months), the claim will reject with on the following Explanatory Codes:

'HCC-Not Eligible'
'HCE-Enrolment After 3 Mos'

Mother Newborn New Patient Fee (Q054A)

- A one-time payment of $350 for physicians enrolling an unattached mother and newborn within two weeks of giving birth or an unattached woman after 30 weeks of pregnancy.
- Physicians are required to bill the Q054A claim with the mother's Health Number.
- There is no billing maximum associated with Q054A code.
- Payment of the Mother/Newborn New Patient Fee requires both the mother and newborn to be enrolled to the billing physician.
- If the mother has been enrolled through Health Care Connect as complex-vulnerable, the physician should bill the Q053A Complex Vulnerable New Patient Fee instead of the Q054A to be eligible for the Enhanced Payment (Complex Capitation Payment).

Multiple/Newborn Fee (Q055A)

- In the case of multiple births, physicians may bill a new Multiple Newborn Q055A fee code for each additional newborn of an unattached mother and the claim will be $150.00 per newborn.
- Physicians are required to bill the Q055A claim with the newborn's Health Number.
- There is no billing maximum associated with Q055A code.
- Payment requires each newborn to be enrolled to the billing physician within three (3) months of birth.
- If the physician bills the Q055A and the newborn is not enrolled within three (3) months of birth, the claim will reject with Explanatory Code '**HCE-Enrolment After 3 Mos'**.

Health Care Connect (HCC) Upgrade Patient Status (Q056A)

- A physician who accepts an HCC referred non-complex/vulnerable patient but whom the physician (in his/her clinical opinion) believes the patient to be complex and/or vulnerable,

the physician is eligible to bill the HCC Upgrade Patient Status Q056A Fee Schedule Codes (FSC).

- There is no billing maximum associated with Q056A code.
- When billing this code physicians will receive a one-time payment of $850 in recognition of the Q053A one-time payment of $350 and the Complex FFS Premium. For more details on the Complex FFS Premium, refer to section entitled Incentives.
- If the physician bills the HCC Upgrade Patient Status Q056A FSC for a patient not registered on Health Care Connect the claim will reject with the following Explanatory Code:

'HCC Not Eligible'

- If the physician bills the HCC Upgrade Patient Status Q056A FSC for a patient that is not enrolled within three (3) months of the HCC referral date, the claim will reject with the following Explanatory Code:

'**HCE Enrolment After 3 mos'**

- If the physician bills the HCC Upgrade Patient Status Q056A FSC for a patient that is not enrolled to the billing physician the claim will have the following Explanatory Code applied:

'I6 Premium Not Applicable'

- The HCC Upgrade Patient Status Q056A FSC cannot be billed in addition to: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Mother/Newborn New Patient Fee (Q054A), and Multiple Newborn Fee (Q055A), Complex Vulnerable New Patient Fee (Q053A), HCC GT Three Months (Q057A) billed by the same physician for the same patient. Subsequent claims will reject with Explanatory Code:

'A3L Other New Patient Fee Already Paid'

HCC Greater Than (HCC GT) Three Months (Q057A)

- Physicians who accept a non-complex-vulnerable patient who has been registered with Health Care Connect for 90 days or more are eligible to bill the new HCC GT Three Months Q057A Fee Schedule Code.
- When billing this code, eligible physicians will receive a one-time payment of $200 for enrolling the patient through Health Care Connect. A Care Connector will inform physicians if the non-complex-vulnerable patient has been registered with Health Care Connect for 90 days or more.
- There is no billing maximum associated with Q057A code.
- If the physician bills the HCC GT Three Months Q057A FSC for a patient not registered on Health Care Connect the claim will reject with the following Explanatory Code:

'HCC Not Eligible'

- If the physician bills the HCC GT Three Months Q057A FSC for a patient that is not enrolled within three (3) months of the HCC referral date, the claim will reject with the following Explanatory Code:

'HCE Enrolment After 3 mos'

- The HCC GT Three Months Q057A FSC cannot be billed in addition to: New Patient Fee (Q013A), Unattached Patient Fee (Q023A), New Patient/New Graduate Fee (Q033A), FOBT New Patient Fee (Q043A), Mother/Newborn New Patient Fee (Q054A), and Multiple Newborn Fee (Q055A), Complex Vulnerable New Patient Fee (Q053A), HCC Upgrade Patient Status (Q056A) billed by the same physician for the same patient. Subsequent claims will reject with Explanatory Code:

'A3L Other New Patient Fee Already Paid'

Incentives

Complex Capitation Payment

- After an approved payment for code Q053A, PEM physicians who enrol a patient through Health Care Connect are eligible to receive enhanced payments for caring for complex-vulnerable patients for 12 consecutive months from the patient's enrolment effective date. Note: This does not apply to approved code Q056A since the $850 paid account for the complex capitation payment. Ministry systems will automatically initiate the enhanced payments based on enrolment of the complex-vulnerable patient. **No action is required on the part of the physician to initiate the enhanced payment**.
- For physicians in harmonized models, a complex capitation payment of $500 will be distributed over the 12 month period and paid monthly as a new complex capitation payment.
- The complex capitation payment will be paid to the Group RA or to the Solo RA where physicians have selected solo level payments. The payments will be made under the following accounting transactions:

CXCP – 'Complex Vulnerable Capitation Payment'
CXAJ – 'Complex Vulnerable Capitation Adjmt'

- If a patient's enrolment ends before 12 months, the complex capitation payment will end one day following the patient's enrolment end date.
- If a patient is transferred to a new physician, including physicians in the same group, the complex capitation payment will end.
- The complex capitation payment will be excluded from all Access Bonus calculations.

After Hours Premium (Q012A)

- Physicians are eligible for a 20% premium on the value of the following fee codes for scheduled and unscheduled services provided during a scheduled After Hours block coverage: A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K030A, and Q050A.
- A FHO Physician who provides services on Recognized Holidays shall be entitled to receive payment of the After Hours Premiums for such services to Enrolled Patients.
- The Q012A may only be billed when the above services are rendered to the enrolled patients of the billing physician or any other physician in the same FHO during a scheduled after hours session.
- The Q012A must be submitted in order to receive the 20% premium.
- The Q012A must have the same service date as the accompanying fee code or the claim will be rejected to the Claims Error Report with error code '**AD9 – Premium not allowed alone**.' However, 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 service date.
- If the patient is not enrolled on the MOHLTC database, an explanatory code '**I6 – Premium not applicable**' will report on the monthly RA. The service billed along with the Q012A code will be paid (subject to all other MOHLTC rules). When a subsequent enrolment for the patient is processed in the following twelve-month period, the Q012A will be automatically adjusted for payment, providing the service date of the Q012A is on or after the date the patient signed the E/C form.
- The maximum number of services allowed for each Q012A is one. If the number of services is greater than one, 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	58.35 * 2 = $116.70
Q012A	1	23.34

Billing Tip:

Bill services and associated Q012A codes at 20% of the corresponding service code as follows: [April 1, 2011]

A001A - $20.60 and Q012A - $4.12	A003A - $71.25 and Q012A - $14.25
A004A - $35.40 and Q012A - $7.08	A007A - $33.10 and Q012A - $6.62
A008A - $12.50 and Q012A - $2.50	A888A - $33.75 and Q012A - $6.75
Q040A - $75.00 and Q012A - $15.00	Q050A - $125.00 and Q012A - $25.00
K005A - $58.35 and Q012A - $11.67	K013A - $58.35 and Q012A - $11.67
K017A - $41.60 and Q012A - $8.32	K030A - $37.40 and Q012A - $7.48

- 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 the highest fee amount paid ($25.00). Ministry systems will automatically approve the appropriate fee.
- Common questions and answers can be found on the After Hours Service Requirements Update Questions & Answers, February 2011.

Newborn Care Episodic Fee (Q015A)

- A premium of $13.99 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 FHO.
- The Q015A may only be billed with a valid A007A intermediate assessment code. Q015A 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'**.
- Q015A 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 – not allowed alone**'.
- The Q015A and the assessment must have the same service date and the service date must be before the patient's first birthday. If a Q015A 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 Q015A services for the same patient are submitted, the additional services will be reported on the monthly FHO RA with Explanatory Code '**M1 – Maximum fee allowed for these services has been reached**'.
- A Q015A service that is billed for a patient who is not enrolled with the FHO physician or with any physician in the FHO will be paid at zero with explanatory code '**I6 – Premium not applicable**'. 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 Q015A will be automatically reprocessed for payment, providing the service date of the Q015A is on or after the patient's signature date on the E/C form.
- The premium will be paid to the FHO or solo RA.

Congestive Heart Failure Incentive (Q050A)

- The Congestive Heart Failure (CHF) Management Incentive fee code Q050A is a $125 annual payment available to physicians for coordinating, and documenting all required elements of care for enrolled heart failure patients. This requires completion of a flow sheet to be maintained in the patient's record that includes the required elements of heart failure management consistent with the Canadian Cardiovascular Society Recommendations on Heart Failure 2006 and 2007.
- A physician is eligible to submit for the CHF Management Incentive for an enrolled heart failure patient once all the required elements of the patient's heart failure care are documented and complete. This may be achieved after a minimum of two patient visits.
- A physician may submit a Q050A fee code for an enrolled heart failure patient once per 365 day period. Congestive Heart Failure Incentives exceeding one will be processed and paid at zero dollars with explanatory code '**M1 – Maximum fee allowed for these services has been reached**' and reported on the monthly RA.
- Physicians may choose to use the CHF Patient Care Flow Sheet or one similar to track a patient's care. All the required elements must be recorded. It is intended that the flow sheet be completed over the course of the year to support a planned care approach for heart failure management.
- For more information and an example of the recommended flow sheet, please refer to the ***Heart Failure Management Incentive*** Fact Sheet, April 2008.

Diabetes Management Incentive (Q040A)

- A $75 annual payment for coordinating, providing and documenting all required elements of care for 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.
- The Q040A is payable for enrolled and non-enrolled diabetic patients.
- A physician may submit a Q040A fee code for a diabetic patient once per 365 day period. Diabetes Management Incentives exceeding one will be processed and paid at zero dollars with explanatory code '**M1 – Maximum fee allowed for these services has been reached**' and reported on the monthly RA.
- 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 ***Diabetes Management Incentive*** Fact Sheet, April 2006.

Smoking Cessation Counselling Fees

Initial Smoking Cessation Fee (E079A)

- The E079A is an annual incentive payment available to all primary care physicians who dialogue with their patients who smoke.
- FHO physicians are eligible to bill the E079A fee code for counselling patients who smoke. These patients may be enrolled, assigned or non-enrolled patients as long as the billing physician is the most responsible primary care provider. E079A is only eligible for payment when rendered in conjunction with one of the following services: A001A, A003A, A004A, A005A, A006A, A007A, A008A, A903A, A905A,K005A, K007A, K013A, K017A, P003A, P004A, P005A, P008A, W001A, W002A, W003A, W004A,W008A, W010A, W102A, W104A, W107A, W109A or W121A.
- The medical record for this service must document that an initial smoking cessation discussion has taken place, by either completion of a flow sheet or other documentation consistent with the most current guidelines of the "Clinical Tobacco Intervention" (CTI) program, otherwise the service is not eligible for payment.
- E079A is limited to a maximum of one service per patient per 365 day period.

Counselling Fee (Q042A)

- An additional incentive payment for physicians who provide a dedicated subsequent counselling session with their enrolled patients who have committed to quit smoking.
- A physician is eligible to receive payment for a maximum of two follow-up Q042A Smoking Cessation Counselling Fees if:
- The physician had previously billed a valid Initial Add-on Smoking Cessation Fee (E079A).
- The Smoking Cessation Counselling Fee is billed in the 365 day period following the service date of a valid Initial Add-on Smoking Cessation Fee.
- A maximum of two counselling sessions are payable at $7.50 in the 365 day period following the service date of a valid Initial Add-on Smoking Cessation Fee (E079A).
- For more information please refer to the ***Smoking Cessation Fees*** Fact Sheet, March 2008.

Special Bonuses and Premiums

- In any fiscal year, physicians are eligible to qualify for all Special Premiums for both enrolled and non-enrolled patients in the following bonus categories: Home Visits, Long-Term Care, Labour and Delivery and Palliative Care.
- A physician's Special Premium accumulations and payments are reported monthly on his/her solo RA and the group RA in a Payment Summary Report for the physician.
- Special Premium Payments are paid to the physician on his/her monthly 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 FHO group or FHO physician, whichever is later. However, the FHO physician is still eligible to achieve the maximum if sufficient services are submitted in that fiscal year.

Special Premiums

Labour and Delivery Special Premium

The following Fee Schedule Codes will contribute to the Labour and Delivery special premium thresholds for enrolled and non-enrolled patients: P006A, P007A, P009A, P018A and P020A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	5 or more patients served	23 or more patients served
Annual Bonus	$5,000	$8,000

Palliative Care Special Premium

The following additional Fee Schedule Codes will accumulate to Palliative Care special premium thresholds for enrolled and non-enrolled patients: K023A, C882A, A945A, C945A, W882A, W872A and B998A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	4 or more patients served	10 or more patients served
Annual Bonus	$2,000	$5,000

Home Visits (Other than Palliative Care) Special Premium

The following additional Fee Schedule Codes will accumulate to Home Visits special premium thresholds for enrolled and non-enrolled patients: A901A, A902A, B910A, B914A, B916A, B990A, B992A, B994A, and B996A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	B	C
Necessary annual criteria	3 or more patients served and 12 or more	6 or more patients served and 24 or more	17 or more patients served and 68 or

	encounters	encounters	more encounters
Annual Bonus	$1,000	$2,000	$5,000

Long-Term Care Premium

The following additional Fee Schedule Codes will accumulate to Long-Term Care premium thresholds for enrolled and non-enrolled patients: W010A, W102A, W002A, W008A, W121A, W003A, W001A, W109A, W107A, W777A, W903A, W004A and W104A.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	A	C
Necessary annual criteria	12 or more patients served	36 or more patients served
Annual Bonus	$2,000	$5,000

Office Procedures Special Premium

- After submitting valid claims for services from Appendix I Schedule 5 of the FHO Agreement, totalling a minimum of $1,200.00 in any fiscal year (services
- Payment is $2,000.
- Enrolled patients only.

Prenatal Care Special Premium

- After submitting valid claims for fee schedule codes P003 and/or P004 for prenatal care during the first 28 weeks of gestation for five (5) or more FHO Enrolled Patients in any fiscal year.
- Payment is $2,000.
- Enrolled patients only.

Hospital Services Special Premium

- After submitting valid claims totalling $2,000.00 in any fiscal year for the following f ee codes: A933A, C002A, C003A, C004A, C005A, C006A, C007A, C008A, C009A, C010A, C121A, C122A, C123A, C124A, C142A, C143A, C777A, C905A, C933A and H001A.
- Payment of $5,000
- The amount payable increase from $5,000.00 to $7,500.00 for FHO Physicians who are located in either:

    - an area with a score on the OMA Rurality Index of Ontario (“OMA RIO”) greater than 45 (the “Designated RIO Area”); or
    - one of the following five (5) Northern Urban Referral Centres: Sudbury, Timmins, North Bay, Sault Ste Marie or Thunder Bay, or such other northern community that may be agreed to in writing by the OMA and the Ministry.

- In order to be eligible for the $7,500.00 payment, either the office the FHO Physician regularly provides FHO Services (as registered with the Ministry) or the hospital in which he/she regularly provides hospital services will be located in the Designated RIO Area or the Northern Urban Referral Centre (as the case may be). Once the physician's total accumulation of contributing claims reaches $6,000 or more an additional payment of $5,000 will be made for a total of $12,500.
- Enrolled and non-enrolled patients.

Premiums for Primary Health Care for Patients with Serious Mental Illness (SMI)

A payment (per fiscal year) for providing Comprehensive Primary Care to a minimum of five (5) enrolled patients with diagnoses of bipolar disorder or schizophrenia.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	1	2
Necessary annual criteria	5 or more patients served	10 or more patients served
Annual Bonus	$1,000	$2,000

- The payment will be included in the Special Premium payment paid to the physician on his/her monthly solo RA as an accounting transaction with the text line "SPECIAL PREMIUM PAYMENT".
- A physician's SMI accumulations and payments are reported monthly on his/her solo RA and the group RA in a Payment Summary Report for the physician.
- Patients must be enrolled to the billing physician.
- Services for enrolled patients with bi-polar disorders must be indicated by submitting the tracking code Q020A at zero dollars along with the service code that was rendered. Services for enrolled patients with schizophrenia must be indicated by submitting the tracking code Q021A at zero dollars along with the service code that was rendered. Q020A and Q021A claims will be paid at zero dollars with explanatory code '**30 – Service is not a benefit of OHIP**.'
- If the patient is not enrolled to the billing physician on the MOHLTC database, an explanatory code '**I6 – Premium not applicable**' will report on the monthly RA. The service billed along with the Q020A or Q021A code will be paid (subject to all other MOHLTC rules). When a subsequent enrolment for the patient is processed in the following twelve-month period, the Q020A or Q021A will automatically be counted towards the cumulative count for this premium.

Rurality Gradient Premium

- Annual premium for physicians who qualify based on their OMA Rurality Index of Ontario (RIO) Score.
- To be eligible, a physician's OMA RIO Score must be between 40.00 and 49.99. The premium is $5,000 for a RIO score of 40.00 and each additional increment of five (5) points above 40.00 qualifies for an additional $1,000.
- A physician's RIO score is determined by matching his/her current postal code of the practice address to a pre-determined list of OMA RIO scores.
- The premium is paid monthly to the individual physician on his/her solo RA as an accounting transaction with the text line "RURALITY GRADIENT PREMIUM".

Preventive Care

Eligible FHO physicians may receive Cumulative Preventive Care Payments and bonuses for maintaining specified levels of preventive care to their enrolled patients.

Preventive Care Management Service Codes (Q001A to Q005A)

- 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 I of the FHO Agreement for detailed information regarding the conditions for claiming the service enhancement codes.

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.

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.

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.

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.

Colorectal Cancer Screening (Q005A)

Eligible physicians may submit the Q005A fee code at $6.86 for enrolled patients aged 50 -74 years inclusive who have been contacted in the prescribed manner for the purpose of scheduling an appointment for colorectal cancer screening (once per patient every two years).

Please refer to the ***Colorectal Cancer Screening Management Fee*** Fact Sheet, April 2008 for the details of the rules for claiming this code.

Fecal Occult Blood Testing (FOBT) Fee (Q150A)

- The Q150A seven dollar ($7) incentive payment is available to all primary care physicians in Ontario who provide the FOBT kit directly to their enrolled and non-enrolled patients.
- The FHO physician is required to meet with the patient to educate them on the correct use of the FOBT kit, and provide a separate laboratory requisition form for the FOBT (i.e. no other tests on the requisition).
- The Q150A is limited to a maximum of one service per patient every 2-year period. When a second Q150A code is billed for a patient by any other provider in the same 2-year period the Q150A will pay zero dollars with the explanation code **M4 "Maximum Fee Allowed for these services by one or more practitioners has been reached**".

Cumulative Preventive Care Bonus Codes

- Per fiscal year, bonus payments may be claimed for the five (5) preventive care categories 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 in April of each year.
- Bonuses are paid to the FHO on the monthly group or solo RA.
- Physician's bonus payments are reported monthly on his/her solo RA and the group RA in a Payment Summary Report for the physician.
- 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 FHO.

Preventive Care Category	Achieved Compliance Rate	Fee Payable	Service Enhancement Code
Influenza Vaccine	60%	$220	Q100A
	65%	$440	Q101A
	70%	$770	Q102A
	75%	$1100	Q103A
	80%	$2200	Q104A
Pap Smear	60%	$220	Q105A
	65%	$440	Q106A
	70%	$660	Q107A
	75%	$1320	Q108A
	80%	$2200	Q109A
Mammography	55%	$220	Q110A
	60%	$440	Q111A
	65%	$770	Q112A
	70%	$1320	Q113A
	75%	$2200	Q114A
Childhood Immunization	85%	$440	Q115A
	90%	$1100	Q116A
	95%	$2200	Q117A
Colorectal Cancer Screening	15%	$220	Q118A
	20%	$440	Q119A
	40%	$1100	Q120A
	50%	$2200	Q121A
	60%	$3300	Q122A
	70%	$4000	Q123A

Tracking and Exclusion Codes

To better assist physicians in monitoring patient status and determining service levels achieved, tracking and exclusion codes are used for identification purposes. When submitted, these codes will identify the patient as having received the preventive care service or identify the patient as

having met the criteria for being excluded from the target population for a specific preventive care service. For example, if a patient informs a FHO physician that he/she received their influenza vaccination at a flu clinic at work, then the tracking code can be submitted by the FHO physician.

Submission of the tracking and exclusion codes is voluntary and is not required in order to receive a Cumulative Preventive Care Bonus. Tracking and exclusion codes will be reported on the Preventive Care Target Population/Service Reports for 30 months from the date of service for all categories with the exception of Influenza Vaccine. The tracking code for the Influenza Vaccine will only be reported on the following April's Preventive Care Target Population/Service Report – Previous Report.

Preventive Care 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

Other Payments

Telephone Health Advisory Services (THAS)

- FHOs shall receive an automatic monthly payment of $400 per physician to a maximum monthly payment of $2000 for the group's participation in THAS.
- THAS payments are paid monthly to the FHO on the group RA as an accounting transaction with the text line "TELEPHONE HEALTH ADVISORY SERVICE PYMT".

Group Management and Leadership Payment (GMLP)

- FHO'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 FHO's commencement date).
- GMLP payments are paid monthly to the FHO on the group RA as an accounting transaction with the text line "GROUP MANAGEMENT AND LEADERSHIP PAYMENT".
- A physician's GMLP accumulations are reported monthly on his/her solo RA and on the group RA on the Payment Summary Report.
- GMLP accumulations and payment for the entire FHO are reported monthly on the solo and group RA in the GMLP Report.

- The premium may be adjusted when a physician ends his/her affiliation with the FHO or his/her practice address changes. All adjustments will be processed as an accounting transaction with the text line "RURALITY GRADIENT RECONCILIATION". Please advise the Ministry immediately of any changes to your practice address or your affiliation to the FHO.
- Individual physician information is provided monthly on both the group and solo RAs on each physician's Payment Summary Report.

Continuing Medical Education (CME) Payment

- Fee Schedule Codes associated to the CME course type:

  Q555A – Main Pro C
  Q556A – Main Pro M1
  Q557A- Other

- Physicians are eligible for 96 fifteen minute units (24 CME hours) per fiscal year, paid out at $25.00 per unit.
- When a physician is billing a CME claim for a 1 hour Main Pro C course the physician is to submit the fee code Q555A at $0 and the number of services on the claim is 4.
- CME is paid monthly to the physician on his/her solo RA as an accounting transaction with the text line "CONTINUING MEDICAL EDUCATION PAYMENT".
- CME can be carried over to a maximum of 192 units (48 hours) in one fiscal year
- Maximum of 20 out of 24 hours for MAINPRO-M1 (Q556A), balance of hours must be MAINPRO-C (Q555A).
- For more information please refer to the ***Continuing Medical Education (CME) Automation*** Fact Sheet, July 2008.

Explanatory and Error Codes

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 report on the monthly RA if a claim is submitted for an Included service for an enrolled patient. The claim will pay at zero dollars.

I6 – Premium not applicable
This explanatory code will report 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 report 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 report on the RA for claims using the Q020A, Q021A, and preventive care tracking and exclusion codes. The tracking and exclusion 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 report 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 if eligible, 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 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 – FHO billing not approved
Physician is ineligible to submit a Q-code.

EP1 – Enrolment transaction not allowed
A Q200A 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 6 months of the effective date of enrolment of the patient on the MOHLTC database. A Q200A submitted after 6 months will be rejected to the Claims Error Report with error code EP3.

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

EP5 – Incorrect fee schedule code for group type
A Q200A/Q201A 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 an E079A

FHO Included Codes

Family Health Organization (FHO) Included Codes – January 2011 Core Services: Fee Codes included in the base rate payment * New since 2007 template agreement		
	A001	Minor Assess.-F.P./G.P.
	A003	Gen. Assess. -F.P./G.P.
	A004	Gen.Re-Assess-F.P./G.P.
	A007	Intermed.Assess/Well Baby Care-F.P./G.P./Paed.
	A008	Mini Assessment-F.P./G.P.
	A110	Periodic Oculo-Visual Assess 19 & Under
	A112	Periodic Oculo-Visual Assess 65 Yrs +
	A777	Intermediate Assessment - Pronouncement Of Death
	A901	House call Assessment
	A903	Gen/Fam Pract-Pre-Dental/Oper.Assess Limit 2 Per Year/Pt
*	A917	Focused Practice Assessment – Sport medicine
*	A927	Focused Practice Assessment – Allergy
*	A937	Focused Practice Assessment – Pain management
*	A947	Focused Practice Assessment – Sleep medicine
*	A957	Focused Practice Assessment – Addiction medicine
*	A967	Focused Practice Assessment – Care of the elderly medicine
	A990	Special Visit To Office-Daytime-(Mon-Fri) 1st Pat. Seen
	A994	Special Visit To Office-Nights-Sat-Sun. Hols.-1st Pat.5-12mn
	A996	Special Visit-Office-Nights(12mn-7am) 1st Pt.
*	A998	Special Visit-Other (non-professional setting) Sat-Sun. Hols.(07:00-24:00)
	B990	Special Visit to Patient's Home - Elective visit, regardless of time or day of week
	B992	Special Visit to Patient's Home - Emergency call with sacrifice of office hours
*	B993	Special Visit To Patient's Home-Sat-Sun. Hols.(07:00-24:00)
	B994	Special Visit to Patient's Home - Evenings Monday to Friday - daytime and evenings on Weekends or Holidays
	B996	Special Visit to Patient's Home - Nights (00:00h - 07:00h), non-elective
	C882	Palliative care - Subsequent visits by the Most Responsible Physician - F.P./G.P

Family Health Organization (FHO) Included Codes – January 2011 Core Services: Fee Codes included in the base rate payment * New since 2007 template agreement		
	C903	Pre-dental/pre-operative general assessment - F.P./G.P
	E542	- When performed outside hospital
	G001	D./T. Proc.-Lab.Med.-Cholesterol Total
	G002	D./T. Proc-Lab.Med.-Glucose Quantitative Or Semi Quantitative
	G004	D./T. Proc-Lab.Med.-Occult.Blood
	G005	D./T. Proc-Lab.Med.-Pregnancy Test
	G009	D./T. Proc-Lab.Med.-Urinalysis Routine Etc.
	G010	D./T. Proc-Lab.Med.-Urinalysis - One Or More Parts.W/0.Micro.
	G011	D./T. Proc-Lab.Med.-Fungus Culture Incl. Koh & Smear
	G012	D./T. Proc-Lab.Med.-Wet Preparation (For Fungus, Trich,Para)
	G014	Lab.Med.Streptococcus In Office
	G123	For each additional Paravertebral nerve block (see G228)
	G197	D./T. Proc-Allergy-Skin Tests-Prof.Comp.
	G202	D./T. Proc.-Allergy-Hyposensitization
	G205	D./T. Proc.-Allergy-Insect Venom Desensitization
	G209	Skin testing - technical component, to a maximum of 50 P.A.
	G212	D./T. Proc.-Allergy-Hyposensitization Injection Plus Basic
	G223	Somatic or peripheral nerves - additional nerve(s) or site(s)
	G227	Obturator nerve - Other cranial nerve block
	G228	Paravertebral nerve block of cervical, thoracic or lumbar or sacral or coccygeal nerves
	G231	Somatic or peripheral nerves not specifically listed - one nerve or site
	G235	Somatic or peripheral nerves not specifically listed - Supraorbital
	G271	D./T. Proc.-Cardiov.- Anticoagulant Supervision
	G310	Electrocardiogram - twelve lead - technical component
	G313	Electrocardiogram - twelve lead - professional component
	G365	D./T. Proc.-Gynaecology-Papanicolaou Smear
	G370	Bursa, joint, ganglion or tendon sheath and/or aspiration
	G371	Bursa, joint, ganglion or tendon sheath and/or aspiration - each additional site or area, to a maximum of 3

Family Health Organization (FHO) Included Codes – January 2011 Core Services: Fee Codes included in the base rate payment * New since 2007 template agreement		
	G372	D./T. Proc.-Injections-Intradermal/Muscular Etc. Ea. Add.
	G373	D./T. Proc.-Inj. Intradermal/Musc. Basic Fee (Shick Test)
	G375	D./T. Proc.-Injection/Infusion-Intralesional Infiltration
	G377	D./T. Proc-Inj/Inf.-Intralesion.-Infiltration 3/More Lesions
	G378	Insertion of intrauterine contraceptive device.
	G379	D./T. Proc.-Inj./Infusion-Intravenous-Child Or Adult
	G381	Chemotherapy - Single injection
	G384	D./T. Proc.-Infiltration For Trigger Point
	G385	D./T. Proc.-As G384-More Than One Site (Add)
	G420	D&T,Otolar.-Syringing&/Exten.Curett'g/Debridem't
	G435	D./T. Proc.-Ophth.-Tonometry
	G462	D&T,Inject/Infus'n-Admin Oral Polio Vacc.
	G481	D./T. Proc-Cardio-Hgb Screen/Hct.-Phys.Office-With Visit
	G482	D./T. Proc.-Venipuncture-Child
	G489	D./T. Proc.-Venipuncture- Adol./Adult.
	G525	Otolaryng. Diag.Hearing Test Prof.Comp.To G440
	G538	D&T Immunization-With Visit, Each Inject.
	G539	D&T Immunization-Sole Reason,First Injection
	J301	Simple Spirometry - Volume versus Time Study
	J304	Flow Volume Loop - Volume versus Flow Study
	J324	Simple Spirometry - repeat after bronchodilator
	J327	Flow Volume Loop - repeat after bronchodilator
	K001	Detention – per full quarter hour
	K002	Interviews with relatives or a person authorized to make a treatment decision
	K003	Interviews with Children’s Aid Society (CAS) or legal guardian on behalf of patient
	K004	Family Psychotherapy-2/More Members-Per 1/2hr.
	K005	Individual Care Per 1/2 Hr
	K006	Hypnotherapy-G.P.-Ind. Per 1/2 Hour
	K007	Ind. Psychotherapy Per Half Hour - Gp

Family Health Organization (FHO) Included Codes – January 2011 Core Services: Fee Codes included in the base rate payment * New since 2007 template agreement		
	K008	Diag.Interview W/Child &/Or Parent-Per 1/2hr.
	K013	Counselling-One Or More People-Per 1/2hr.
	K015	Counselling-Relative On Behalf Of Pt.See Para.B20 (C)
	K017	Annual Health Exam-Child Aft. 2nd Birthday
*	K700	Palliative Care out-patient case conference
*	K702	Bariatric out-patient case conference
*	K703	Physician to Physician telephone consultation (referring physician)
*	K730	Physician to physician telephone consultation – Referring physician
*	K731	Physician to physician telephone consultation – Consultant physician
*	K732	CritiCall telephone consultation - Referring physician.
*	K733	CritiCall telephone consultation - Consultant physician
	Q990	Special Visit to non-professional setting - Daytime Monday to Friday
	Q992	Special Visit to non-professional setting - Emergency call with sacrifice of office hours
	Q994	Special Visit to non-professional setting - Evenings Monday to Friday or Weekends or Holidays
	Q996	Special Visit to non-professional setting - Nights (00:00h - 07:00h)
*	Q998	Special Visit to non-professional setting – Sat-Sun-Hols. (07:00h - 24:00h)
	R048	Malignant Lesions - Face or neck - Simple excision - single lesion
	R051	Laser surgery on Group 1-5 and malignant lesions
	R094	Malignant Lesions - Other areas - Simple excision - single lesion
	Z101	Incision - Skin-Inc.-Abscess-Subcut.-One -Loc.Anaes.
	Z110	Extensive debridement of onychogryphotic nail involving removal of multiple laminae
	Z113	Incision - Biopsy any method, when sutures are not used
	Z114	Incision - Foreign body removal local anaesthetic
	Z116	Incision - Biopsy(Ies) - Any Method, When Sutures Are Used
	Z117	Chemical And/Or Cryotherapy Treatment Of Minor Skin Lesions - One Or More Lesions, Per Treatment
	Z122	Cyst, Haemangioma, Lipoma - Face Or Neck - Local Anaesthetic - Single Lesion
	Z125	Cyst, Haemangioma, Lipoma - Other Areas - Local Anaesthetic - Single Lesion

Family Health Organization (FHO) Included Codes – January 2011 Core Services: Fee Codes included in the base rate payment * New since 2007 template agreement		
	Z128	Simple, Partial Or Complete, Nail Plate Excision Requiring Anaesthesia - One
	Z129	Simple, Partial Or Complete, Nail Plate Excision Requiring Anaesthesia - Multiple
	Z153	Debridement And Dressing - Major (Not To Be Claimed In Addition To Z176)
	Z154	Suture Of Lacerations - Up To 5 Cm If On Face And/Or Requires Tying Of Bleeders And/Or Closure In Layers
	Z156	Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Excision And Suture - Single Lesion
	Z157	Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Excision And Suture - Two Lesions
	Z158	Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Excision And Suture - Three Or More Lesions
	Z159	Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Electrocoagulation And/Or Curetting - Single Lesion
	Z160	Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Electrocoagulation And/Or Curetting - Two Lesions
	Z161	Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Electrocoagulation And/Or Curetting - Three Or More Lesions
	Z162	Group 2 - Nevus - Removal By Excision And Suture - Single Lesion
	Z169	Group 3 - Plantar Verruca - Removal By Electrocoagulation And/Or Curetting - Single Lesion
	Z170	Group 3 - Plantar Verruca - Removal By Electrocoagulation And/Or Curetting - Two Lesions
	Z171	Group 3 - Plantar Verruca - Removal By Electrocoagulation And/Or Curetting - Three Or More Lesions
	Z175	Skin-Suture-Laceration - 5.1 To 10 Cm.
	Z176	Skin-Suture-Laceration-Up To 5cm.
	Z314	Treatment Of Epistaxis (Nasal Haemorrhage) - Cauterization - Unilateral
	Z315	Treatment Of Epistaxis (Nasal Haemorrhage) - Anterior Packing - Unilateral
	Z535	Endoscopy - Sigmoidoscopy With Or Without Anoscopy - - With Rigid Scope
	Z543	Endoscopy - Anoscopy (Proctoscopy)
	Z545	Incision - Thrombosed Haemorrhoid(S)
	Z611	Catheterization - Acute Retention, Change Of Foley Catheter Or Suprapubic Tube

Family Health Organization (FHO) Included Codes – January 2011 Core Services: Fee Codes included in the base rate payment * New since 2007 template agreement		
		Or Instillation Of Medication - Hospital
	Z847	Incision - Removal Embedded Foreign Body - Local Anaesthetic - One Foreign Body

Fsc	FHO Long-Term Care Codes – January 2011 Fee codes included in the Long-Term Care Base Rate Payment * New since FHO 2007 Template Agreement DESCRIPTION
A001A	Minor Assess. - F.P./G.P.
A003A	Gen. Asses. - F.P./G.P. Annual Health with Diag. Code 917
A004A	Gen. Re-Assess. - F.P./G.P.
A007A	Intermed. Assess./Well Baby Care - F.P./G.P./Paed.
A008A	Mini Assessment - F.P./G.P.
A110A	GP Periodic oculo-visual assessm. ages 19 or below
A112A	GP Periodic oculo-visual assessm. ages 65 and over
A903A	Pre-dental Gen. Assess. FP/GP
A990A	Spec. visit Each daytime (Mon. to Fri.)
A994A	Nights Sp. Visit Office(5 pm to 12 mn), Sat/Sun/Hol First Pt.
A996A	Spec. Visit Nights (12 mn to 7 am), First Pt.
*A998A	Special Visit-Other (non-professional setting) Sat-Sun. Hols.(07:00-24:00)
*E430A	Papanicolaou Smear outside of hospital
G001A	Lab.med.in office -Cholesterol total
G002A	Lab.med.in office -glucose quant/semi-quantitative
G004A	Lab.med.in office -occult blood
G005A	Lab.med.in office- pregnancy test
G009A	Lab.med.in office -urinalysis routine
G010A	Lab.med.in office-one/more parts of G009 w'out microscopy
G011A	Lab.med.in office-fungus culture incl.KOH & smear
G012A	Lab.med.in office-wet prep'tion (fungus,trichm.parasites)
G014A	Lab.Med. - Streptoccus in office
G197A	Allergy-skin tests prof.comp.to G209
G202A	Allergy-hyposensitization 1/more inj (incl. assess)
*G205A	Insect venom desensitisation (immunotherapy) - per injection (max 5/day).
G212A	Allergy-hyposens inj.(G700+G202) (sole reason visit)
G271A	Cardiov/Anticoag supervision - telep. advice - per mth
G365A	Gynaec.Papanicolaou smear

Fsc	FHO Long-Term Care Codes – January 2011 Fee codes included in the Long-Term Care Base Rate Payment * New since FHO 2007 Template Agreement DESCRIPTION
G372A	Inj/inf.intramusc/subcut/intraderm.with visit
G373A	Inj/inf.as G372 but sole reason for visit 1st inj.
G375A	Intrales.infil.one/two lesions
G377A	Intrales.infil.3/more
G379A	Inj/inf.intravenous-child/adult
G384A	Inj/inf.infiltration tissues,trigger point
G385A	Inj/inf.each add'l site add to G384(max 2)
G420A	Otolaryng - ear syringing/curetting (not with Z907)- unilat/bilat.
G435A	Ophthal – Tonometry
*G462A	Administration of oral polio vaccine
G481A	Lab.med.in office -Hb./Hct.screen any method/instr.
G482A	Cardiovasc. - Venipuncture - child
G489A	Cardiovasc. - Venipuncture - adolescent/adult
G525A	Otolaryng - Diagnostic Hearing Tests - prof comp to G440
G538A	Inj/inf immunization per visit each injection or additional Flu inject.
G539A	Immunization sole reason first injection Flu injection vaccine
K004A	Family - Psychotherapy - (2 or more) per 1/2 hr
K005A	Primary Mental Health Care
K006A	Individual - Hypnotherapy - per 1/2 hr
K007A	Individual - Psychotherapy – per 1/2 hr./GP
K008A	Diag. Interview/counselling child/parent, per 1/2 hr
K013A	Counselling - per 1/2 hr Limit 3 per year per phys only Educ Dial
K015A	Counselling - Catastrophic on behalf of pt see para B20(c)
K017A	Ann. Health Exam. - Child after second birthday no Diag.req'd.
W001A	General Practice-Subseq. Visits per mth. - Chr/Conval Hosp/LTIC
W002A	General Practice-First four visits per mth. - Chr/Conval Hosp/LTIC
W003A	General Practice-First two visits per mth. - Nurs. Home/Aged
W004A	Gen. Pract.-Gen. Re-Assess. in Nurs. Home/covered by Ext. Care Legisl.

Fsc	FHO Long-Term Care Codes – January 2011 Fee codes included in the Long-Term Care Base Rate Payment * New since FHO 2007 Template Agreement DESCRIPTION
W008A	Subseq. Visits - Nurs. Home/Aged - Covered by Ext. Care Leg
*W010A	Monthly management fee (per patient per month)
W102A	Adm. Assess. Type 1 - Chr/Conval Hosp - LTIC - GP
W104A	Adm. Assess. Type 2 - Chr/Conval Hosp - LTIC - GP
W105A	Consult. - Chr/Conval. Hosp - LTIC – GP
W106A	Repeat Consult. - Chr/Conval Hosp - LTIC – GP
W107A	Adm. Assess. Type 3 - Chr/Conval Hosp - LTIC - GP
W109A	Ann. Phys. Exam - Chr/Conval Hosp - LTIC – GP
W121A	LTIC Ac. Intercurrent illness, in excess of monthly max
*W771A	Certification of death
W777A	Visit for Pronouncement of Death LTIC
W872A	Terminal Care N.H/G.P. Family Pract.
W882A	Terminal Care - Chron. Hosp/N.Homes etc.,G.P./Fam. Pr.
W903A	Pre-dental/pre-surg. Gen. Assess.
Z101A	Skin - Inc. Abscess/haematoma Subcut. Local anaes - one
Z176A	Skin-Suture/laceration-up to 5 cm

Q Codes

The following is a complete listing of all Q codes that Family Health Organization (FHO) Signatory physicians are eligible to submit. The conditions for payment of these Q codes have been described throughout the guide.

CODE	DESCRIPTION	FEE
Rostering Fees		
Q200A	Per Patient Rostering Fee	$5
New Patient Fees		
Q013A	New Patient Fee (Max 60/fiscal year)	$100/120/180
Q023A	Unattached Patient Fee	$150
Q033A	New Grad/New Patient Fee (Max 300 in the first year in an eligible model)	$100/120/180
Q043A	New Patient Fee FOBT Positive/Colorectal Cancer (CRC) Increased Risk	$150/170/230
Q053A	HCC Complex-Vulnerable Patient Fee	$350
Q054A	Unattached Mother and Newborn Fee	$350
Q055A	Unattached Multiple Newborn Fee	$150
Q056A	Health Care Connect (HCC) Upgrade Patient Status	$850
Q057A	HCC Greater Than Three Months	$200
After Hours Fees		
Q012A	After Hours Fee	20%
Newborn Care Fees		
Q015A	Newborn Care Episodic Fee	$13.99
Chronic Disease Management		
Q040A	Diabetes Management Incentive (Annual)	$75
Q042A	Smoking Cessation Counselling Fee (2 / year)	$7.50
Q050A	Heart Failure Management Incentive	$125

CODE	DESCRIPTION	FEE
	(Annual)	
Continuing Medical Education		
Q555A	Main Pro C (Max 96 services (or 24 credits) per fiscal year) (1 service = $25)	Bill at $0
Q556A	Main Pro M1 (Max 80 services (or 20 credits) per fiscal year) (1 service = $25)	Bill at $0
Q557A	Other (Max 96 services (or 24 credits) per fiscal year) (1 service = $25)	Bill at $0
Tracking and Exclusion Codes		
Q011A	Pap Smear Tracking Code	$0
Q020A	Premiums for Primary Health Care for Patients with Serious Mental Illness - Tracking Code for Services for Patients with a Diagnosis of Bipolar Disorder	$0
Q021A	Premiums for Primary Health Care for Patients with Serious Mental Illness - Tracking Code for Services for Patients with a Diagnosis of Schizophrenia	$0
Q130A	Influenza Vaccine Tracking Cod	$0
Q131A	Mammography Tracking Code	$0
Q132A	Childhood Immunizations Tracking Code	$0
Q133A	Colorectal Cancer Screening Tracking Code	$0
Q140A	Pap Smear Exclusion Code	$0
Q141A	Mammography Exclusion Code	$0
Q142A	Colorectal Cancer Screening Exclusion Code	$0
Preventive Care Fees and Bonuses		
Q150A	FOBT Distribution and Counselling Fee (Once per patient every two years)	$7
Q001A	Preventive Care Management Service Enhancement Fee – Pap Smear (Once per patient every two years)	$6.86
Q002A	Preventive Care Management Service Enhancement Fee – Mammography (Once per patient every two years)	$6.86

CODE	DESCRIPTION	FEE
Q003A	Preventive Care Management Service Enhancement Fee – Influenza Vaccine (Once per patient per year)	$6.86
Q004A	Preventive Care Management Service Enhancement Fee – Childhood Immunizations (Once per patient)	$6.86
Q005A	Preventive Care Management Service Enhancement Fee – Colorectal Cancer Screening (Once per patient every two years)	$6.86
Q100A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 60% ($220)	Bill at $0
Q101A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 65% ($440)	Bill at $0
Q102A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 70% ($770)	Bill at $0
Q103A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 75% ($1100)	Bill at $0
Q104A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Influenza Vaccine – 80% ($2200)	Bill at $0
Q105A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 60% ($220)	Bill at $0
Q106A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 65% ($440)	Bill at $0
Q107A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 70% ($660)	Bill at $0
Q108A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 75% ($1320)	Bill at $0
Q109A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Pap Smear – 80% ($2200)	Bill at $0
Q110A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 55% ($220)	Bill at $0
Q111A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography –	Bill at $0

CODE	DESCRIPTION	FEE
	60% ($440)	
Q112A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 65% ($770)	Bill at $0
Q113A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 70% ($1320)	Bill at $0
Q114A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Mammography – 75% ($2200)	Bill at $0
Q115A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations – 85% ($440)	Bill at $0
Q116A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations – 90% ($1100)	Bill at $0
Q117A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Childhood Immunizations – 95% ($2200)	Bill at $0
Q118A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 15% ($220)	Bill at $0
Q119A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 20% ($440)	Bill at $0
Q120A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 40% ($1100)	Bill at $0
Q121A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 50% ($2200)	Bill at $0
Q122A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 60% ($3300)	Bill at $0
Q123A	Cumulative Preventive Care Management Service Enhancement Code (Preventive Care Bonus) Colorectal Cancer Screening – 70% ($4000)	Bill at $0