INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Physicians

Published By: Health Services Branch

Date Issued: September 1, 2011, revised January 9, 2012 **Bulletin #:** 4540

Re: 2008 Physician Services Agreement – Changes Effective September 1, 2011

Note: K124 was listed incorrectly in Chart #1. K124 should have been listed as follows:

Fee Code	Existing Fee	September 1, 2011 Fee
K124	$55.05 per unit minimum 20 minutes per unit	7% increase, per unit (31.35) minimum units reduced to 10 minutes, per unit

Fee Schedule Code Changes Effective September 1, 2011

In keeping with the provisions of the 2008 Physician Services Agreement, a number of changes to the Schedule of Benefits for Physician Services are being implemented. This INFOBulletin provides information on where to access detailed information about these changes, as well as information regarding the implementation of these changes.

The new version of the Schedule is available at:

www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

Hard copies of the Schedule will not be distributed. If you would like to order a paper copy or a compact disk (CD) of the Schedule for a fee, please visit https://www.publications.serviceontario.ca/ecom/.

Physicians without access to the Internet can contact ServiceOntario at 1-800-668-9938.

1. **Fee Code Changes**

   In keeping with section 3.2 of the Agreement that introduces a 4.25% global increase to the Schedule of Benefits, there are a number of fee code changes being introduced, effective September 1, 2011.

Charts showing details about the fee code changes are available with this INFOBulletin at:

www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

Please Note: Chart 1 was revised on January 9, 2012. All other charts remain the same.

2. Consultations – Payment Policy

When a physician submits claims for consultations in excess of the limit of one per 12 month period for the same patient, the claim is adjusted to the amount payable for a re-consultation. (If the patient is referred to the same consultant with a clearly defined unrelated diagnosis, the limit is increased to two.)

As of September 1, 2011, if a consultation is submitted and the maximum number of consultations has been reached, the review error condition **AC1 – (MAX REACHED-RESUB ALT FSC)** will be applied. Physicians should resubmit using the appropriate re-consultation or assessment fee code.

Emergency Medicine Consultations (H055, H066) in excess of the limits will continue to be reduced to multiple systems assessments (H103).

3. New Fee Schedule Codes (FSCs) and disallowed fee code combinations

As of September 1, 2011, when new FSCs are billed in combination with new or existing FSCs that are not permitted according the Schedule of Benefits, the first claim item processed will be paid. Any others submitted on the same day for the same patient will be disallowed with explanatory code D7. Subsequent codes will not be paid at the difference in fees if they have a higher fee. Physicians may contact their district office if they wish to correct the submitted claim.