CIRRUS
CONSULTING GROUP

Cirrus Billing and Payment Guide
for Family Health Organization (FHO) Physicians

TABLE OF CONTENTS

PAYMENTS AND REPORTING

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.

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 ministry 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. Ministry 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 ministry 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 ministry 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. Ministry 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 ministry 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:

$150.00 for patients up to and including 64 years of age
$170.00 for patients 65 – 74 years of age, and
$230.00 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 $350.00 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 $350.00.
- 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. Q013A will pay at $100.00 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 $350.00.
- 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 $350.00 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 the Q054A fee 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 new born 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 the Q055A fee 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 code.
- There is no billing maximum associated with the Q056A fee code.
- When billing this code physicians will receive a one-time payment of $850.00 in recognition of the Q053A one-time payment of $350.00 and the Complex FFS Premium ($500.00). For more details on the Complex FFS Premium, refer to section entitled Incentives.
- If the physician bills the HCC Upgrade Patient Status Q056A fee code 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 fee code 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 fee code 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 fee code 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 code.
- When billing this code, eligible physicians will receive a one-time payment of $200.00 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 the Q057A fee code.
- If the physician bills the HCC GT Three Months Q057A fee code 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 fee code 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 fee code 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

AFTER HOURS PREMIUM (Q012A)

- Physicians are eligible for a 30% premium on the value of the following fee codes for scheduled and unscheduled services provided during a scheduled After Hours block 18 coverage: A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K030A, K033A, 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 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 ministry 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 ministry 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	$125.00
Q012A	1	$37.50

Billing Tip:

Bill services and associated Q012A codes at 30% of the corresponding service code as follows:

A001A - $21.70 and Q012A - $6.51
A003A - $77.20 and Q012A - $23.16
A004A - $38.35 and Q012A - $11.51
A007A - $34.70 and Q012A - $10.41
A008A - $13.05 and Q012A - $3.91
A888A - $35.40 and Q012A - $10.62
K005A - $62.75 and Q012A - $18.83
K013A - $62.75 and Q012A - $18.83
K017A - $43.60 and Q012A - $13.08
K030A - $39.20 and Q012A - $11.76
K033A - $38.15 and Q012A - $11.45
Q050A - $125.00 and Q012A - $37.50

- 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 $125.00 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 $75.00 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 en rolled, 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	D
Necessary annual criteria	3 or more patients served and 12 or more encounters	6 or more patients served and 24 or more encounters	17 or more patients served and 68 or more encounters	13 or more patients served and 128 or more encounters
Annual Bonus	$1,000	$2,000	$5,000	$8,000

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
- 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 39 (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)

This premium is 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	12 or more patients served	36 or more patients served
Annual Bonus	$2,000	$5,000

- 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 "SPECIALPREMIUM 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 ministry 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 ministry 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.

OTHER PAYMENTS

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.

BILLING CODES

IN BASKET CODES- LONG-TERM CARE

Fee codes included in the Long-Term Care Base Rate Payment.

Fsc	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	lntermed. 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.
E070A	Geriatric General Assessment Premium — patient aged 70 or older
E071A	Geriatric Intermediate Assessment Premium — patient aged 70 or older
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 without 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)
G212A	Allergy-hyposens inj.(G700+G202) (sole reason visit)
G271A	Cardiov/Anticoag supervision - telep. advice - per mth
G365A	Gynaec.Papanicolaou smear.
G372A	Inj/infintramusc/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	Inyintintravenous-child/adult
G384A	Inj/inf.infiltration tissues, trigger point
G385A	lnj/inf.each add'I site add to G384 (max 2)
G420A	Otolaryng - ear syringing/curetting (not with Z907)-unilat/bilat.
G435A	Ophthal — Tonometry
G481A	Lab.med.in office -Hb./Hct.screen any method/instr.
G482A	Cardiovasc. - Venipuncture - child

Fsc	Description
6489A	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
G590A	Active Immunization influenza agent with visit
G591A	Active Immunization influenza agent sole reason
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. reqtd.
Z101A	Skin - Inc. Abscess/haematoma Subcut. Local anaes - one
Z176A	Skin-Suture/lac-up to 5 cm
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.
W008A	Subseq. Visits - Nurs. Home/Aged - Covered by Ext. Care Leg
W102A	Adm. Assess. Type 1 - Chr/Conval Hosp - [TIC - 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
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.

IN BASKET CODES- NON LONG-TERM CARE

Fee codes included in the Base Rate Payment.

Fsc	Description
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 Yr/Pt
A990	Special Visit To Office-Daytime-(Mon-Fri) 1st Pat. Seen
A994	Special Visit To Office-Nights-Sat-Sun. Hols.-1 st Pat.5-12mn
A996	Special Visit-Office-Nights(12mn-7am) 1st Pt.
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
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
C903	Pre-dental/pre-operative general assessment - F.P./G.P
E075	Geriatric General Assessment Premium - patient aged 75 or older
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/O. 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

Fsc	Description
G209	Skin testing - technical component, to a maximum of 50 P.A.
G212	WT. 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 coccyc
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.- Anticoagpervision
G310	Electrocardiogram - twelve lead - technical component
G313	Electrocardiogram - twelve lead - professional compo-nent
G365	D./T. Proc.-Gynaecology-Pap.anicolaou Smear
G370	Bursa, joint, ganglion or tendon sheath and/or aspira-tion
G371	Bursa, joint, ganglion or tendon sheath and/or aspira-tion - each additional site or area, to a maximum of 3
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 Trisser 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 creen/Hct.-Phys.Office-With Visit
G482	D.fT. 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

Fsc	Description
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
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
Q990	Special Visit to non-professional setting - Daytime Mon to Fri
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)
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(les) - 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
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 - Sin. Is 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 Or Instillation Of Medication - Hospital
Z847	Incision - Removal Embedded Foreign Body - Local Anaesthetic - One Foreign Body

* Effective October 1, 2005, E075 is replaced with E070 (Geriatric Intermed Assess Pre-Prem A007 Pts=70 Yrs Add) and E071 (genriatric intermediate assessment premium- patient aged 70 or older)

Periodic Health Visit Description and Fees		
Code	**Age Requirement**	**Fee**
K017	Child (aged 2 to 15)	$43.60
K130	Adolescent (16-17 yrs)	$77.20
K131	Adult aged 18 to 64 inclusive	$50.00
K132	Adults 65 years of age and older	$77.20

EXPLANATORY AND ERROR CODES

REMITTANCE ADVICE COMMON EXPLANATORY CODES

Note: Claims that are reported on the Remittance Advice have been processed by the ministry. As with Fee-for-Service claims, for any discrepancies please continue to contact the Claims Payment Division of your local ministry OHIP Claims 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 ministry database on the service date. The assessment code billed along with the Q-code will be paid (subject to all other ministry 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 ministry 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.

Explanatory Codes - Full List

Code	Explanation
C1	"Allowed as repeat/limited consultation/midwife-requested emergency assessment"
C2	Allowed at re-assessment fee
C3	Allowed at minor assessment fee
C4	Consulatation not allowed with this service; paid assessment
C5	Allowed as multiple systems assessment
C6	Allowed at type 2 admission assessment
C7	An admission assessment (C003) or general re-assessment (C004) may not be claimed by any physician within 30 days following a pre-operative assessment.
C8	Payment reduced to geriatric consultation fee - maximum number of comprehensive geriatric consulations has been reached.
C9	"Allowed as in-patient interim admission orders - initial assessment already claimed by other physician."
DA	"Maximum for this procedure reached. Paid as repeat/chronic procedure.
DC	"Procedure paid previously not allowed in addition to this procedure. Fee adjusted to pay the difference.
DD	Not allowed as diognostics code is unrelated to major eye exam.
DG	Diagnostic/miscellaneous services for hospital patients are not payable on a fee-for-service basis-included in the hospital global budget
DH	Ventilatory support allowed with haemodialysis
DM	Paid/disallowed in accordance with MOH policy regarding an emergency department equivalent.
DN	Allowed as prudental block in addition to procedure - as per stated OHIP policy.
DP	Procedure paid previously allowed at 50% in addition to this procedure - fee adjusted to pay the difference.
DS	Not allowed - mutually exlusive code billed.
DT	In-Patient-Fee not allowed
DX	Diagnostic code is not eligible with FSC
D1	Allowed as repeat procedure; initial procedure; initial procedure previously claimed.
D2	Additional procedures allowed at 50%
D3	Not allowed in addition to visit fee.
D5	Procedure already allowed. Visit fee adjusted.
D6	Limit of payment for this procedure reached.
D7	Not allowed in addition to other procedure.
DB	Allowed with specific procedures only.
D9	Not allowed to a hospital department.
EV	Check health card for current version code.
El	Service date is proior to start of eligibility.
E2	Incorrect version code for service date.
E3	Version code not on file for HN
E4	Service date is after the eligibility termination date.
E5	Service date is not within an eligible period.
FF	Additional payment for the claim shown.
Fl	Additional fractures/dislocations allowed at 85%
F2	Allowed in accordance with transferred care.
F3	Previous attempted reductions (open or closed) allowed at 85%
F5	Two weeks aftercare included in fracture fee.
G1	Other ciritical/comprehensive care already paid.

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 ministry OHIP Claims 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 ministry OHIP Claims 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 ministry 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