Bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
N/A	April 4, 2005	Ministry of Health and Long-Term Care Processing Office
Distribution		(address below)
Hospital Administrators		

Subject: **NEW INTERPROVINCIAL BILLING RATES FOR OUTPATIENT HOSPITAL SERVICES AND HIGH COST PROCEDURE SERVICES EFFECTIVE APRIL 1, 2005**

The Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC) has introduced updated interprovincial hospital billing rates for outpatient services and high cost procedure services provided on or after April 1, 2005. Regional Ministry of Health and Long-Term Care (MOHLTC) Finance Managers have provided the new outpatient billing and high cost procedure rates to individual hospitals. The four documents attached are as follows: Interprovincial Out-Patient Rates, Interprovincial Billing Rates for High Cost Procedures, Interprovincial Billing Rates for Bone Marrow and Stem Cell Transplant Services, and the Rules of Application for Bone Marrow and Stem Cell Transplant Services. Also, there are three new billing codes effective April 1, 2005. Codes 100 and 108 regarding interprovincial high cost procedures and code 607 regarding bone marrow and stem cell transplants.

Codes 106 and 108, for kidney and kidney/pancreas transplants respectively, do not include the organ procurement and transportation costs in their block rate: this reflects the proportionally high number of live donors compared to the other organ transplant procedures.

The current billing principle of "multiple services – one rate" will continue to apply, namely billing for the outpatient service with the highest rate only when more than one service is received during an outpatient visit or on a given day. Contact your local Ministry Regional Finance Manager for further information on rates.

In order to efficiently process your hospital's reciprocal billing claims, the ministry requires that all invoices contain your hospital's corporation 3-digit facility number and the correct rate. At this time, consistent with national protocols, given that most provinces and territories reciprocal billing systems only accept the International Statistical Classifications of Diseases ICD-9-CM coding, Ontario hospitals must also submit their claims using ICD-9-CM reporting.

Office locations

Barrie
34 Simcoe St.
Suite 102
L4N 6T4

Etobicoke
3300 Bloor St. W., Unit 142
M8X 2W8

Hamilton
119 King St. W
P.O. Box 2280, Stn. A
L8N 4C8

Kenora
220-808 Robertson St.
P9N 1X9

Kingston
1055 Princess St.
P.O. Box 9000
K7L 5A9

Kitchener
1400 Weber St. E. Unit B2
N2A 3Z8

London
217 York St., 5th Floor
Station A
N6A 4L6

Mississauga
201 City Centre Dr.
P.O. Box 7020, Stn. A
L5A 3M1

Newmarket
465 Davis Dr.
Unit 108
L3Y 8T2

North Bay
101-447 McKeown Ave.
P1B 9S9

North York
4400 Dufferin St N
M3H 6A8

Oakville
Oakville Town Centre II
220 North Service Rd. W.
L6M 2Y3

Oshawa
Exec. Tower,
Oshawa Centre.
419 King St. W.
P.O. Box 635 L1H 8L4

Ottawa
Fuller Building
75 Albert Street
K1P 5Y9

Owen Sound
981 2nd Avenue E.
N4K 2H5

Peterborough
550 Lansdowne St. W.
K9J 8J8

St. Catharines
301 St. Paul St.
Mezzanine Level
L2R 3M8

Sarnia
452 Christina St. N.
N7T 5W4

Sault Ste. Marie
Roberta Bondar Place
70 Foster Dr., Ste. 100
P6A 6V4

Scarborough
2063 Lawrence Ave. E.
M1R 2Z4

Sudbury
199 Larch St.,
Suite 801
P3E 5R1

Thunder Bay
435 James St. S. ,
Suite 113
P7E 6T1

Timmins
38 Pine St. N.,
Suite 110
P4N 6K6

Toronto
47 Sheppard Ave.E.
Suite 417
M2N 7E7

Windsor
1427 Ouellette Ave.
N8X 1K1

Head Office
P.O. Box 48
Kingston, ON
K7L 5J3

INTERPROVINCIAL OUT-PATIENT RATES

Effective April 1, 2005

Service Code	Description	Rate
01	Standard Out-patient Visit (excluding the specific services listed below for which other service codes apply).	**$158**
02	Day Care Surgery (including hyperbaric oxygen therapy).	**$635**
03	Hemodialysis	**$341**
04	Computerized Axial Tomography	**$310**
05	Referred-in Laboratory Specimens: composite fee for all specimens referred to an institution for laboratory tests where the patient concerned is not present.	**$ 38**
06	Cancer chemotherapy visit.	**$726**
07	Cyclosporine/Tacrolimus/AZT/Activase/Erythropoietin/Growth Hormone therapy visit: the rate applicable to the Standard Out-patient visit applies plus the actual drug costs.	
08	Lithotripsy for common bile duct stones per day, including Radiologist services and Ultrasound procedures. (*Lithotripsy for stones within the gall-bladder is excluded).*	**$786**
09	Lithotripsy for kidney stones per kidney per day, including Radiologist services and Ultrasound procedures.	**$786**
10	*Cancelled - Second Out-Patient visit same day.*	
11	Magnetic Resonance Imaging per day, including Radiologist services.	**$707**
12	Radiotherapy Services.	**$248**
13	Pacemaker replacement: the invoiced price of the device (*invoice required*) in addition to the rate applicable to either the Standard Out-patient Visit or Day Care Surgery.	
15	High Cost Referred-in Laboratory Specimens: the rate provided in the host province's schedule of benefits for laboratory medicine applies; or, in the absence of a scheduled rate, an amount that is negotiated between the provincial plans. (*Genetic screening is excluded).*	

All rates are composite charges that include non-invasive procedures and necessary diagnostic interpretations.

INTERPROVINCIAL BILLING RATES FOR HIGH COST PROCEDURES

Effective for discharges on or after **April 1, 2005**

SERVICE CODE	DESCRIPTION	RATE ($)
	Transplants*:	
100 *	Organ Procurement - Out-of-Country	When an organ is acquired from outside Canada, the cost of the organ procurement can be billed to the recipient's home province using the following formula: the established High Cost Procedure Rate (codes 101 to 104 only), plus the actual out-of-country procurement cost, minus $16,702 for in-country organ procurement. For codes 106 and 108: the actual invoice cost. Do not subtract the in-country procurement cost of $16,702. The actual out-of-country procurement invoice must accompany the reciprocal billing claim.
101	Heart	88,662.00
102	Heart & Lung	125,224.00
103	Lung	143,193.00
104	Liver	90,836.00
*105***	*Cancelled - See 600 Series*	
106	Kidney	24,699.00
*107***	*Cancelled - See 600 Series*	
108 *	Kidney & Pancreas	30,429.00
	Lithotripsy, including Radiologist Services and Ultrasound Procedures:	
201	- Kidney Stones	**$ 786.00** per kidney per day in addition to the authorized per diem rate of the hospital.
202	- Common Bile Duct Stones (Lithotripsy for stones within the gall-bladder is excluded.)	**$ 786.00** per day in addition to the authorized per diem rate of the hospital.
301	Magnetic Resonance Imaging, including radiologist services and necessary diagnostic interpretation services.	**$ 707.00** maximum per day in addition to the authorized per diem rate of the hospital.
	Special Implants:	
310	Cochlear Implant	The invoiced price of the device (invoice required) plus the authorized per diem rate of the hospital for any associated in-patient days of stay.
311	Pacemaker	

Refer to the Rules of Application for Billing Organ Transplant Services.

** Codes 100 and 108 are new.*

***Refer to the Interprovincial Billing Rates for Bone Marrow and Stem Cell Transplant Services (Effective for discharges on or after September 1, 1998).*

INTERPROVINCIAL BILLING RATES FOR BONE MARROW AND STEM CELL TRANSPLANT SERVICES

(Effective for discharges on or after **April 1, 2005**)

Service Code	Service Category	Maximum Length of Stay (MLOS)	Basic Block Rate	Add-on Standard High Cost Per Diem over MLOS
600	Acquisition Costs (outside Canada)	--	Invoice Cost	Invoice Cost
601	Adult Autologous <72 hour discharge	--	$19,282	--
602	Paediatric Autologous <72 hour discharge	--	$23,138	--
603	Adult Autologous >72 hour	16 days	$43,384	$1,607
604	Paediatric Autologous >72 hour	13 days	$57,846	$2,892
605	Adult Allogeneic excl. Matched Unrelated Donor (MUD) patients	25 days	$99,837	$1,714
606	Paediatric Allogeneic	25 days	$123,618	$3,107
607 *	Adult Allogeneic MUD patients	25 days	$120,512	$1,714

Refer to the Rules of Application for Bone Marrow and Stem Cell Transplant Services.

Prior to September 1, 1998, refer to Service Codes 105 and 107 on the Interprovincial Billing Rates for High Cost Procedures (effective for discharges on or after April 1, 1998), and the Rules of Application for Billing Transplant Services.

**** Code 607 is new***

RULES OF APPLICATION FOR BONE MARROW AND STEM CELL TRANSPLANT SERVICES

1. Any inpatient stay, separate and distinct from an admission for a bone marrow/stem cell transplant (i.e. for pre-procedure assessment, stabilization, etc.), will be billed at the authorized per diem rate of the hospital.

2. Each outpatient visit will be billed at the authorized interprovincial outpatient rate.

3. Each block rate includes all facility costs associated with a single transplant episode including inpatient and diagnostic costs. For purposes of calculating the Maximum Length of Stay, the inpatient stay includes the date of admission but not the date of discharge.

4. The Add-on Standard High Cost Per Diem can be billed for inpatient days in excess of the Maximum Length of Stay during the inpatient admission in which the transplant was performed.

5. Acquisition Costs:

    a) When bone marrow/stem cell is acquired within Canada, the costs are included in the block rate. The transplant centre is responsible for paying the acquisition cost.

    b) When bone marrow/stem cell is acquired from outside Canada, the actual invoice cost paid by the transplant centre can be billed to the recipient's home province. The actual invoice must accompany the reciprocal billing claim.

6. Cases discharged within 72 hours from date of procedure are to be billed at the 72-hour discharge (adult or paediatric) rate by the hospital who performed the transplant service.

7. Paediatric refers to person 17 years of age and under.

8. Persons who are discharged and develop complications related to a bone marrow or stem cell transplant, may be re-admitted for inpatient stays at the authorized per diem rate of the hospital and not the Add-on Standard High Cost Per Diem.

9. Any repeat inpatient stay for the same patient for a repeat bone marrow or stem cell transplant will be treated as a new case and will be billable as described in these Rules.

10. With the exception of acquisition costs in 5(b), claims for bone marrow/stem cell transplants must be billed as a complete claim at the time of discharge.

11. Diagnostic coding is mandatory and should indicate the principle cause or final diagnosis of the transplant case.

12. Bone marrow/stem cell transplants performed as part of clinical trials or for diagnoses for which the treatment is still considered experimental are not eligible for reciprocal billing.