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

Blended Models – Primary Health Care
Ministry of Health and Long-Term Care
November 2014
Version 1.0

Ontario

Introduction

This guide provides an update on primary care incentives made available to Family Health Organization (FHO) Physicians and replaces the ***Billing and Payment Guide for FHO Signatory Physicians*** dated March 2012.

The group you have joined has opted for the "Solo Payments" option. What this means to you is:

The following payments you earn will be paid to the group and deposited into the group bank account:

Access Bonus (non-Long-Term Care and Long-Term Care)
Golar LNG Partners LP **(**GMLP**)**

The following payments will be directed to your solo bank account:

- Base Rate Payment
- Long-Term Care (LTC) Base Rate Payment (included in Base Rate Payment)
- Comprehensive Care Capitation Payment
- Seniors Care Premium (included in Comprehensive Care Capitation
- Blended Fee for Service Premium (Shadow Billing Premium)
- *Fee for Service Payments
- Special Premiums
- Preventive Care Bonus
- Continuing medical education **(**CME**)**

*Fee for Service payments will be deposited into your group bank account and reported on your group RA if you submit with your group number OR deposited into your solo bank account and reported on your solo RA if you use your solo billing number.

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 (ministry) existing six-month stale-date policy and all normal processing rules and regulations. Claims related inquiries should be directed to the Service Support Contact Centre at: 1-800-262-6524.

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 ministry 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 Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA) for a complete list of Primary Care incentives.

For additional INFOBulletins related to specific incentives, visit the Ministry of Health and Long-Term Care Health Care Professional internet site at:

http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bulletin_11000

or contact your ministry representative team at 1-866-766-0266.

Claims inquiries are to be directed to the Service Support Contact Centre at: 1-800-262-6524.

Capitation Payments

Your Family Health Organization (FHO) has made the choice to direct their Base Rate and Comprehensive Care Capitation payments to your monthly solo Remittance Advice (RA), solo bank account.

Base Rate Payment

- Base Rate Payments are calculated based on the age and sex of each enrolled patient.
- The FHO average annual base rate capitation payment is $144.08 excluding Seniors Care Premium (September 1, 2011).
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to base rate payments.
- Base rate payments and adjustments are paid monthly to the 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 solo 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 bate payments are provided for enrolled patients in LTC facilities.
- FHO physicians receive an annual LTC base rate payment of $1,202.66 per LTC enrolled patient, prorated monthly (September 1, 2011).
- 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 solo RA.
- LTC patients are enrolled by using the Q202A FSC.
- As stated in the FHO agreement and the Memorandum of Agreement (MOA) between the ministry and the OMA, obligations associated with the care of enrolled LTC patients are as follows:
- Completing a medication review ever three months;
- Conducting all discussions relating to the enrolled LTC Patient with the care staff of the Long-Term Care Facility;

- Except for recognized holidays, participating in all telephone calls from the Long Term Care Facility in respect of the enrolled LTC Patient during reasonable and regular office hours from Monday through Friday; and
- Performing on average two assessments per month per enrolled Patient.

Comprehensive Care Capitation Payment

- Comprehensive Care (CC) capitation payments are based on the age and sex of each enrolled patient, including Long Term Care enrolled patients.
- Retroactive enrolment activity (adding and removing of patients) may cause adjustments to CC capitation payments.
- Physicians receive an average monthly capitation rate of $1.72 per enrolled patient for the first twelve months, and $2.48 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 solo RA
- As of September, 2011, CC capitation will be reduced by approximately 50% per patient per day for each patient a physician enrols over 2,400 patients. Physicians who have received Comprehensive Care Capitation payments for 12 or more months are subject to the reduction which will be applied to the individual physician's roster size. Refer to INFOBulletin 11082.
- 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. Base Rate and Comprehensive Care Capitation Payment Reporting.

The following four capitation reports are provided monthly:

Base Rate Payment Summary Report

- This paper 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 group and solo RA.

Comprehensive Care Capitation Payment Summary Report

- This paper 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 group and solo 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.

Complex Capitation Payment

- 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. 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 $500.00 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 Solo RA 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.

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.

Premiums

Blended Fee for Service Premium (Shadow Billing Premium)

- Physicians receive a 15% premium on the approved amount of included services provided to all enrolled patients (LTC – Appendix A and non-LTC – Appendix B).
- 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 solo RA.
- The premium is paid as an accounting transaction with the text line "BLENDED FEE FOR SERVICE PREMIUM" on the physician' solo RA.
- 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.

Blended Fee for Service on Age Premium (Shadow Billing Premium)

- Shadow Billed Services provided to patients in the age range for an age premium will be eligible for the Blended Premium on the Age Premium. See Statement of Benefits for details.

- A second Blended Fee for Service Premium will appear on the solo RA in accounting adjustments and is the sum of all physicians' amounts.
- Details will appear in your "Premium Payment" report on the physician's solo RA on the line item "Blended Premium".

Fee-for-Service (FFS)

Fee for service payments will be deposited into your solo bank account and reported on your solo RA when you submit with your solo billing number.

Core Services to Non-Enrolled Patients

- Claims submitted for CORE 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 Reciprocal Medical Billing (RMB) on the claim for an out-of-province patient (with the exception of Quebec).

Other Ministry 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 Ministry of Health and Long-Term Care.
- 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.

- Each physician in the group has a hard cap ceiling of $55,900 for the 2013/14 fiscal year.
- Each physician's hard cap amount is totalled together for the group hard cap ceiling.
- Any core services provided to non-enrolled patients by the group physicians are accumulated and once the amount surpasses the group's hard cap ceiling amount, that amount is recovered.
- Each physician's Hard Cap accumulations will be reported monthly solo RA in the FFS Core Service Ceiling Report.
- Amounts exceeding the Hard Cap will be recovered from each physician's solo RA as an accounting transaction with the text line "FFS CORE SERVICE PAYMENT CEILING ADJMT".

Access Bonus

- FHO physicians may be entitled to receive two separate Access Bonus payments:
- For their enrolled patients (non-LTC) and
- For their LTC-enrolled patients.
- If both are earned, they will be paid monthly as the sum of each group 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 the dollar value of included services provided to his/her enrolled patients by a General Practitioner outside the group.
- Billings of identified GP Focus Practice physicians and physicians delivering services in ministry-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.

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 must be kept by the physician and not submitted to the ministry.
- 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**'.

Long-Term Care Per Patient Rostering Fee (Q202A)

- A $5.00 per patient incentive payment for the **initial** enrolment of patients for the first 12 months of joining any PEM.
- A Q202A 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 who is a resident of a Long-Term Care Facility.
- The Q202A will trigger enrolment-related payments.
- For record keeping purposes, record "LTC" on the top of the signed EC form to help with reconciling your enrolled patients.

Processing Rules:

- The Q202A 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 Q202A claim must match the date the patient signed the E/C form.
- The completed E/C form should be kept by the physician.
- Q202A claims will be subject to all regular claim processing rules (e.g. stale-dating).
- Once a physician's Q202A payment eligibility period has ended, he/she will no longer receive payment for Q202A. However, he/she is encouraged to continue to submit the Q202A to enrol patients and trigger enrolment-related payments. To avoid reconciliation after the 12 month eligibility period, physicians should bill the Q202A at zero dollars; these claims will be processed and paid at zero dollars with explanatory code '**I9 – Payment not applied/expired**'.

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 both the Patient Enrolment and Consent to Release Personal Health Information (E/C) form and the New Patient Declaration 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.

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 both 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 Q200A enrolment date.

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.

New Patient Fee (Q013A)

- An incentive payment for enrolling up to 60 patients per fiscal year who were previously without a family physician. Health Care Connect (HCC) non-complex patients billed with a Q013A are not subject to maximums.
- 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'.**

Unattached Patient From Hospital 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 Q013A New Patient Fee.

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**'.
- 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 page 15 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.
- Billing the Q053A will trigger enhanced payments (see more on enhanced payments on page 9).
- 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 both 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 Multiple Newborn Q055A fee code in addition to the Q054A Mother New Born New Patient 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 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 session coverage: A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K030A, K033A, K130A, K131A, K132A 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 - $33.70 and Q012A - $10.11
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
K130A - $77.20 and Q012A – $23.16
K131A - $50.00 and Q012A - $15.00
K132A - $77.20 and Q012A - $23.16
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 ($37.50). Ministry systems will automatically approve the appropriate fee.

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 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 solo 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.

Add-on Smoking Cessation 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 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.

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: A900A, A901A, A902A, B990A, B992A, B993A, 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	32 or more patients served and 128 or more encounters
Annual Bonus	$1,500	$3,000	$5,000	$8,000

Complex House Call Assessment – 20% and House Call Assessment Premium – 85%

The Complex House Call Assessment – 20% and the House Call Assessment Premium – 85% are being implemented December 2014. You will be informed by separate INFOBulletin of the details of these payments.

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 for enrolled and non-enrolled patients totalling $2,000.00 in any fiscal year for the following fee codes: A933A, C002A, C003A, C004A, C005A, C006A, C007A, C008A, C009A, C010A, C121A, C122A, C123A, C124A, C142A, C143A, C777A, C905A, C933A, E082A, E083Aand H001A.

Bonus Level	Level 1	Level 2
Necessary annual criteria	Upon accumulation of $2,000 in applicable codes	Upon accumulation of $6,000 in applicable codes a payment of $2,500
Annual Bonus Total	$5,000	$7,500

- 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.

Bonus Level	Level 1	Level 2
Necessary annual criteria	Upon accumulation of $2,000 in applicable codes	Upon accumulation of $6,000 in applicable codes a payment of $5,000
Annual Bonus Total	$7,500	$12,500

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	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 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.

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 at least 40.00 and above. The premium is $5,000 for a RIO score of 40 to 49 and each additional increment of five (5) points above 49 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. You will find the Information and Procedures for Claiming the Cumulative Preventive Care Bonus at:

OHIP - Bulletins - Health Care Professionals - MOHLTC

Cumulative Preventive Care Bonus Codes

- Physicians may claim five (5) preventive care categories when designated levels of preventive care to specific patient populations are achieved
- Each April and September physicians receive two (2) Target Population Service Reports;
- one for the previous fiscal to be used for the calculation of their bonus and
- one for the current fiscal to help identify enrolled patients who:
- are in the target population in each preventive care category and,
- have received, according to the ministry's records, a preventive care procedure during the specified time, including those received outside the FHO.
- Physicians will receive an information package including the procedures for claiming the cumulative bonus in April of each year.
- Bonuses are paid to the physician's solo RA.
- Physicians' 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:

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

Group Management and Leadership Payment (GMLP)

- The FHO 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 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.
- 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

- 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 Bulletin, 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 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.

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

APPENDIX – A

FHO Included Codes

Fee Schedule Code	Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * 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
A900	Complex House Call Assessment
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.

Fee Schedule Code	Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
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
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

Fee Schedule Code	Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
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
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)

Fee Schedule Code	Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
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
G840	DTaP–IPV-Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus – pediatric
G841	DTaP–IPV–Hib—Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Virus, Haemophilus influenza type b pediatric
G842	HB - Hepatitis B
G843	HPV - Human Papillomavirus type 6, 11, 16, 18
G844	Men-C-C-Meningococcal C Conjugate
G845	MMR-Measles, Mumps, Rubella
G846	Pneu - Pneumococcal Conjugate
G847	TdaP-Tetanus, Diphtheria, accellular Pertussis–adult
G848	Var-Varicella
J301	Simple Spirometry - Volume versus Time Study
J304	Flow Volume Loop - Volume versus Flow Study
J324	Simple Spirometry - repeat after bronchodilator

Fee Schedule Code	Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
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
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
K130A	Periodic Health Visit - adolescent
K131A	Periodic Health Visit – adult aged 18 to 64 inclusive
K132A	Periodic Health Visit – adult aged 65 years and above
K700	Palliative Care out-patient case conference
K702	Bariatric out-patient case conference
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

Fee Schedule Code	Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
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
R048C	Malignant Lesions - Face or neck - Simple excision - single lesion - if the physician administered the anaesthetic
R051C	Laser surgery on Group 1-5 and malignant lesions - if the physician administered the anaesthetic
R094C	Malignant Lesions - Other areas - Simple excision - single lesion - if the physician administered the anaesthetic
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

Fee Schedule Code	Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
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

Fee Schedule Code		Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
Z162		Group 2 - Nevus - Removal By Excision And Suture - Single Lesion
Z175		Skin-Suture-Laceration - 5.1 To 10 cm
Z176		Skin-Suture-Laceration-Up To 5 cm
Z314		Treatment Of Epistaxis (Nasal Hemorrhage) - Cauterization - Unilateral
Z128C		Simple, Partial Or Complete, Nail Plate Excision Requiring Anesthesia - One - if the physician administered the anaesthetic
Z129C		Simple, Partial Or Complete, Nail Plate Excision Requiring Anesthesia - Multiple - if the physician administered the anaesthetic
Z154C		Suture Of Lacerations - Up To 5 Cm If On Face And/Or Requires Tying Of Bleeders And/Or Closure In Layers - if the physician administered the anaesthetic
Z156C		Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Excision And Suture - Single Lesion - if the physician administered the anaesthetic
Z157C		Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Excision And Suture - Two Lesions - if the physician administered the anaesthetic
Z158C		Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Excision And Suture - Three Or More Lesions - if the physician administered the anaesthetic
Z159C		Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Electrocoagulation And/Or Curetting - Single Lesion - if the physician administered the anaesthetic

Fee Schedule Code		Family Health Organization (FHO) Included Codes – Core Services: Fee codes included in the Base Rate Payment * DESCRIPTION
Z160C		Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Electrocoagulation And/Or Curetting - Two Lesions - if the physician administered the anaesthetic
Z161C		Group 1 - Verruca, Keratosis, Pyogenic Granuloma - Removal By Electrocoagulation And/Or Curetting - Three Or More Lesions - if the physician administered the anaesthetic
Z162C		Group 2 - Nevus - Removal By Excision And Suture - Single Lesion - if the physician administered the anaesthetic
Z175C		Skin-Suture-Laceration - 5.1 To 10 cm. - if the physician administered the anaesthetic
Z176C		Skin-Suture-Laceration-Up To 5 cm. - if the physician administered the anaesthetic
Z314C		Treatment Of Epistaxis (Nasal Hemorrhage) - Cauterization - Unilateral - if the physician administered the anaesthetic
Z315		Treatment Of Epistaxis (Nasal Hemorrhage) - Anterior Packing - Unilateral
Z535		Endoscopy - Sigmoidoscopy With Or Without Anoscopy - - With Rigid Scope
Z543		Endoscopy - Anoscopy (Proctoscopy)
Z545		Incision - Thrombosed Hemorrhoid(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

APPENDIX – B

FHO Long-Term Care Included Codes

Fee Schedule Code	FHO Long-Term Care Codes – Fee codes included in the Long-Term Care Base Rate Payment * 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)

Fee Schedule Code	FHO Long-Term Care Codes – Fee codes included in the Long-Term Care Base Rate Payment * DESCRIPTION
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
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.

Fee Schedule Code	FHO Long-Term Care Codes – Fee codes included in the Long-Term Care Base Rate Payment * DESCRIPTION
G539A	Immunization sole reason first injection Flu injection vaccine
G590A	Injection of Influenza Agent
G840A	Diphtheria, Tetanus, and acellular Pertussis vaccine/Inactive Poliovirus vaccine (DTaP-IPV) - paediatric
G841A	Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio virus, Haemophilus influenza type b (DTaP-IPV-Hib) - paediatric
G842A	Hepatitis B (HB)
G843A	Human Papillomavirus (HPV)
G844A	Meningococcal C Conjugate (Men-C)
G845A	Measles, Mumps, Rubella (MMR)
G846A	Pneumococcal Conjugate
G847A	Diphtheria, Tetanus, acellular Pertussis (Tdap) - adult
G848A	Varicella (VAR)
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.
K130A	Mini Assessment – adolescent
K131A	Mini Assessment – adult age 18 to 64 inclusive
K132A	Mini Assessment – adult 65 years of age and older

Fee Schedule Code	FHO Long-Term Care Codes – Fee codes included in the Long-Term Care Base Rate Payment * DESCRIPTION
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.
*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

Appendix – C

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
Q202A	Long-Term Care 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
Incentives		
Q012A	After Hours Premium	30%
Q015A	Newborn Care Episodic Fee	$13.99
Q040A	Diabetes Management Incentive (Annual)	$75

CODE	DESCRIPTION	FEE
Incentives continued		
Q042A	Smoking Cessation Counselling Fee (2 / year)	$7.50
Q050A	Heart Failure Management Incentive (Annual)	$125
Special Premiums		
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
Cumulative Preventive Care Bonus		
	Influenza	
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

CODE	DESCRIPTION	FEE
Cumulative Preventive Care Bonus - continued		
	Pap Smear	
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
	Mammography	
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 – 60% ($440)	Bill at $0
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

CODE	DESCRIPTION	FEE
Cumulative Preventive Care Bonus - continued		
	Childhood Immunization	
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
	Colorectal Cancer Screening	
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

CODE	DESCRIPTION	FEE
Cumulative Preventive Care Bonus - continued		
Tracking and Exclusion Codes		
Q011A	Pap Smear Tracking Code	$0
Q130A	Influenza Vaccine Tracking Code	$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
Q555A	Main Pro C	$0
Q556A	Main Pro M1	$0