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Ministry of Health
Ministry of Long-Term Care

Ontario Health Insurance Plan

INFOBulletin

Kaplan Year 4 changes to S207A, G496A, K181A, and G601A

New rules are being applied to Fee Schedule Codes S207A, G496A, K181A and Amendments to G601A

To: All Providers
Category: Physician Services
Written by: Claims Services Branch, Ontario Health Insurance Plan Division
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Background

The Ministry of Health (ministry) and the Ontario Medical Association (OMA) have been working together to implement physician compensation increases in accordance with the 2019 Kaplan Board of Arbitration Award (the Award).

This will be achieved through amendments to physician compensation under contracts and to regulations under the *Health Insurance Act*, including the Schedule of Benefits for Physician Services (the Schedule).

Please see ministry INFOBulletin 4762 <http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4762.aspx> titled 'Kaplan Board of Arbitration Award Year 4 -Release 2 Changes' for a summary of all Schedule changes effective April 1, 2020. These changes are being implemented in the Ontario Health Insurance Plan (OHIP) claims system through phased releases.

New Rules for the following Fee Schedule Codes (FSCs)

- S207A-Appendectomy, intact or ruptured
- G496A-Electroencephalogram (EEG) with time-locked video recording
- K181A-Management of Acute Cerebral Vascular syndrome with peripheral tPA (tissue plasminogen activator)

S207A

- If an S207A is submitted with FSCs S313A, S314A, Z594A or E686A for

same patient, same physician and same service date the S207A will pay and the other FSC will pay at $0 with explanatory code **'D7-Not allowed in addition to other procedure'.**
- If one or more S313A, S314A, Z594A or E686A code has previously paid for the same patient, same physician, same service date, the incoming claim will pay at $0 with explanatory code **'D7-Not allowed in addition to other procedure'.**
- S207A is a lifetime code, meaning it is only billable once per patient per lifetime. If billed more than once per patient, per lifetime the incoming claim will reject **'40-This service allowed only once for same patient'.**

G496A

- G496A is not allowed with G415A, G418A, G543A-sleep deprived/induced EEG professional component.
- If G496A is on the same claim as G415A, G418A or G543A, for the same service date, same patient, and same physician, the G496A will pay and the other FSC/s will pay at $0 with explanatory code **'D7-Not allowed in addition to other procedure'.**
- If one of the claims have previously paid and there is an incoming claim for the same patient, service date and same physician, the incoming claim will pay at $0 with explanatory code **'D7-Not allowed in addition to other procedure'.**
- G496A is not eligible for payment with any sleep study FSC.
- G496A was previously rejecting AC4 on self referrals, as October 1st self referrals are acceptable for payment. If providers haven't resubmitted claims that were rejected AC4 for G496A can now do so.

K181A

- K181A is restricted to physicians with the Neurology specialty (18).
- K181A is eligible for payment with A/C384A-Consultation for acute cerebral vascular syndrome.

Amendments to Fee Schedule Code G601A

Amendments to FSC G601A are reflected in the Schedule effective April 1, 2020. The medical claims payment system has been updated on October 1, 2020 to apply these changes as defined in the Schedule for service dates April 1, 2020 onwards. The existing FSC G601A has been amended to allow G601A-Level A Neonatal intensive care 2nd to 30th day, inclusive to be billed from 2nd day onwards.

Previously, FSC G602A was used for 31st day onwards, but that fee code was ended March 31, 2020. Â Claims submitted with service dates of April 1, 2020 onwards for G602A will reject to the physicians' error report with **'A3E-No such FSC'.** These claims can be resubmitted with fee code G601A**.** For these claims or for claims not yet submitted for services which may now be stale-dated, the ministry is planning on implementing a system change to provide an exemption until December 31, 2020.This change is tentatively planned to be implemented on December 1, 2020 and will be communicated once confirmed.

Medical Claims Adjustments (MADJ)

Due to staged implementations, Medical Claims Adjustments (MADJ) may be required. Further information will be provided in advance of a MADJ.

- Please note that during the MADJ process, the claims processing system selects an entire claim for reprocessing.
- A single claim can include multiple fee schedule codes and all codes will be reprocessed.
- Claims that were reprocessed with no change in payment will appear on the Remittance Advice (RA) with explanatory code **'55-This deduction is an adjustment on an earlier account'** and **'57-This payment is an adjustment on an earlier account'**. These two transactions will net to zero with no payment impact but will report on the RA for reconciliation purposes.

Keywords/Tags

S207A; G496A; K181A; G601A; Year 4; Kaplan; Release 2

Contact Information

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