



Important Fee Information for Primary Care Physicians in Patient Enrolment Models

Demystifying Tracking Codes, Exclusion Codes and Preventive Care Bonuses

by Dr. Suzanne Strasberg

All physicians in Patient Enrolment Models (PEMs) are eligible for preventive care bonuses for co-ordinating the provision of Pap smears, mammograms, flu shots, fecal occult blood testing (FOBT), and immunizations to children under two years of age that receive all immunizations by the 30th month.

The bonus payment varies according to the percentage of patients that receive the service and patients must be formally enrolled to be eligible.

On April 1, 2006, all PEM physicians became eligible to receive the preventive care bonus for patients between the ages of 50 -74 who receive fecal occult blood testing (FOBT).

For Family Health Group (FHG) and Comprehensive Care Model (CCM) physicians, the remaining four preventive care bonuses (Pap smears, mammograms, flu shots, and immunizations to children under two years of age) will be introduced on April 1, 2007.

Note: Aligned model physicians (Family Health Networks, Primary Care Networks, Health Service Organizations) are already eligible for these bonuses.

To assist PEM physicians in managing the preventive care bonuses, the Ministry of Health and Long-Term Care will provide physicians with a list of all eligible enrolled patients in each category — this is called the *Preventive Care Target Population/Service Report*. It is sent twice yearly (usually in September and April).

The *Target Population/Service Report* also reports services provided by you or any other physician who has billed OHIP for your enrolled patients or for whom you have submitted a tracking or exclusion code

As the patient's primary care physician, it is not essential that you perform the service to receive the credit. For example, if your patient receives a flu shot from your partner, you will be credited for that service having been provided to your enrolled patient, and the Ministry will be aware that the patient received the flu shot because G590 or G591 will have been billed.

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The MOH also knows that the patient is enrolled to you so at the same time you receive the list of all your eligible enrolled patients, (the *Target Population/Service Report*) it will include those patients that OHIP is aware are eligible and have received the service.

Another example is a Pap smear. When the Pap is read by the cytologist and the lab bills OHIP, the MOH will know the service has been provided, whether you or another physician actually did the Pap smear, and that eligible patient will show up on the list of enrolled patients who have received the service that the Ministry generates for you.

Why use Tracking Codes?

There is no requirement for doctors to use the tracking codes in any manner — they are entirely optional and were developed exclusively to serve as a tool for doctors and/or office staff to establish a strategy to identify patients on a go forward basis and maximize the opportunities inherent in the bonus and premiums structure. Tracking codes are optional. They do not need to be used to receive payment for the preventive care services to be paid. Most of the time you do not need to use them.

The Ministry will be able to know which of your eligible patients have received the service through OHIP billing records. However, if OHIP is not billed for the service, the Ministry has no information to report back to the physician on the *Target Population/Service Report*.

Accordingly, using a tracking code alerts the Ministry that a service has been performed. Tracking codes should be used in instances where an OHIP billing will not be generated when a procedure is performed. The most common situations in which they will be helpful are as follows:

1. If your patient receives a flu shot at work or at a public health office.
2. If a Pap smear is read in a hospital. In this case, the payment comes out of the global budget and no OHIP billing is made.
3. If your patient has a mammogram at an Ontario Breast Screening Program clinic. There is no data sharing agreement between these clinics and the Ministry, so the patients screened will not appear on your list.

When the tracking codes are billed in these situations, the Ministry will report the service date of the tracking codes on the *Target Population/Service Report* so you don't need to remember them.

You do not need to use the codes. You can track these patients any way you like.

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Why use Exclusions Codes?

Exclusions codes can be used to identify those patients who are eligible for a preventive care service but do not require it — for example, a woman who has had a total abdominal hysterectomy not needing a Pap smear. A full list of tracking and exclusion codes can be accessed at: www.oma.org/PC/documents/TrackingandBonusesJan06.pdf

Like the situation where the patient had a flu shot at work, there is no way for the MOH to know that the patient did not need the service.

You can choose to track the patients that meet the requirements for exclusion any way you like, but if you use the exclusion criteria, the MOH will collect the data and it will be reported on the *Target Population/Service Report* indicating that the patient may be excluded from the bonus calculations.

Note: If both the preventive care service and the exclusion code are submitted, the exclusion code will be reported on the *Target Population/Service Report* indicating that the patient may be removed from the Target Population.

Sample calculation

Enrolled female patients between the ages of 35 and 70 who receive Pap smears are eligible for the bonus. Before April 1, 2007 (likely November and then again in April) the Ministry will send you a *Target Population/Service Report* of all your enrolled female patients between the ages of 35 and 70 (the “Target Population” for the bonus category). Let’s say in your practice that is 410 women.

Now, if you feel that the Ministry has omitted some service provided to your enrolled patients, you can check your charts and add these services to the information provided by the Ministry.

For instance, if you want to do your own verification by having your billing package check for all the women between ages 35 and 70 whom you have billed E430 (Pap smear tray fee) in the 30 months prior to April 1, 2007, and you find some that have not appeared on the list, add them to the numerator. Let’s say in this case the number is 300.

The *Target Population/Service Report* will also identify any patients for which you have submitted an exclusion code. Let’s say 10 women in your practice have had hysterectomies and do not require Pap smear.

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Calculation

R = Number of enrolled patients who have received the service (either through billing codes or use of tracking codes or physician self-tracking method).

E = Number of eligible enrolled patients.

X = Number of excluded patients (using exclusion code tracking or physician self tracking methods).

P = Proportion of eligible enrolled patients served.

$$P=R/(E-X)$$

In our Pap smear example:

R = 300 enrolled patients received Pap smears in the last 30 months.

E = 410 enrolled female patients between the ages 35 –70.

X = 10 patients who meet the exclusion criteria.

$$P = 300/(410-10) = 75\%$$

Colorectal Screening Bonus (Fecal Occult Blood Testing)

Recently, all physicians with a total roster of 450 patients or more were sent a *Target Population/Service Report* of their eligible enrolled patients (Target Population) between the ages of 50 and 74. Included are patients who had received the treatment as indicated by OHIP billings, or who were tracked using the FOBT tracking code. Additionally, any patients whom the physician had excluded using the FOBT exclusion code are reported.

In order to bill the FOBT bonus, physicians should calculate the percentage of screened patients using the formula above. Once this is done, the appropriate percentage code can be billed. The codes for the various percentages are listed below:

Coverage Level	Fee Payable	Q Code
15%	\$220	Q118A
20%	\$440	Q119A
40%	\$1,100	Q120A
50%	\$2,200	Q121A

For information on how to submit this information using EDT or a paper claim, please refer to the October 2006 Ministry bulletin. It can be viewed on the OMA website at: www.oma.org/PC/documents/Sept1stColorectalProceduresOct1006.pdf

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