Ontario Virtual Care Program: Secure Messaging Proof-of-Concept Pilot

Billing Guide

Digital and Analytics Strategy Division, Ministry of Health

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Ontario

Note: This document is technical in nature and is available in English only due to its limited targeted audience. This publication has been exempted from translation under the French Language Services Act.

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1 Purpose

The purpose of this Ontario Virtual Care Program: Secure Messaging Proof-of-Concept Pilot Billing Guide (Billing Guide) is to identify the terms and conditions for remuneration of *secure messaging service encounters* by the Ministry of Health's (Ministry's) Ontario Virtual Care Program (OVCP) under the Secure Messaging Proof-of-Concept (PoC) Pilot.

The authorized duration of the Secure Messaging PoC Pilot is from April 1, 2024 to March 31, 2026. The *effective date* of an individual physician's participation in the pilot is as defined below.

This Billing Guide is only applicable for those physicians registered in the Secure Messaging PoC Pilot.

2 Definitions

For the purposes of this Billing Guide and the Ontario Virtual Care Program: Secure Messaging Proof-of-Concept Pilot Registration Contract (Registration Contract), the following definitions apply, and have been *italicized* throughout the Billing Guide and Registration Contract for cross-reference:

effective date is the date that a physician registered in the Secure Messaging PoC Pilot can begin delivering and submitting claims for *secure messaging service encounters* under the Secure Messaging PoC. The effective date is specific to each physician and will be set-out in the e-mail confirmation that the physician's registration has been processed and approved.

existing/ongoing patient-physician relationship includes where at least one of the following is true:

i) Where a physician is providing a *secure messaging service encounter* to a patient where there has been at least one insured service under the Ontario Health Insurance Plan (OHIP) with a direct physical encounter between the patient and that physician (family and general practice physician or specialist) in the preceding 24-months; or

ii) Where a physician is providing a *secure messaging service encounter* to a patient who has signed the Ministry's Patient Enrollment and Consent to Release Personal Health Information form and is enrolled to that physician or another

physician within the same group (who is signatory/locum to a Ministry alternate funding plan agreement); or

iii) Where a specialist or *GP Focused Practice physician* has provided an OHIP-insured consultation by video set out in Appendix J – Section 1 of the Schedule of Benefits for Physician Services in the preceding 24-months to that patient; or

- A consultation billed as an insured service under K083 or as an uninsured video visit service funded under OVCP and rendered prior to December 1, 2022, is considered evidence of an *existing/ongoing patient-physician relationship*.

iv) Where a physician has provided any of the following OHIP-insured services in the preceding 24-months:

- A920 – Medical management of early pregnancy - initial service by video or telephone,
- A945/C945 – Special palliative care consultation by video,
- A680/C680 – Initial assessment - substance abuse by video,
- A814, A817, A818 – Midwife or Aboriginal Midwife-Requested Assessments (MRAs) by video,
- A802 – Extended midwife or Aboriginal Midwife-requested genetic assessment by video,
- A801 – Comprehensive midwife or Aboriginal Midwife-requested genetic assessment by video,
- A800 – Midwife or Aboriginal Midwife-requested genetic assessment by video,
- A253 – Optometrist-Requested Assessment (ORA) by video,
- A256 – Special optometrist-requested assessment by video,
- A957 – Addiction medicine focused practice assessment (FPA) by video,
- K680 – Substance abuse – extended assessment by video.

GP Focused Practice physician means a physician who has been designated by the bi-lateral Ministry-Ontario Medical Association (OMA) GP Focused Practice Review Committee or a physician who is eligible for the focused practice psychotherapy premium.

Monthly Management Fee means the monthly payment for funded *secure messaging service encounters*.

- See **Section 5.4 Monthly Management Fee Payment** for payment details.

patient's representative means the legal representative of a patient.

secure messaging service encounter means an exchange of secure messages, transmitted between a patient or *patient's representative* and a physician, encompassing all messages that were exchanged to undertake and complete the clinical service for the presenting health issue(s), which includes the physician soliciting the appropriate patient information, analyzing the information, and providing appropriate management and/or advice related to the patient's presenting health issue(s).

- The associated fee code and terms and conditions for funded *secure messaging service encounters* are found in **Section 5.1 Fee Code** and **Section 5.2 Terms and Conditions**.

3 Overview

The Secure Messaging PoC Pilot enables registered physicians to receive compensation from the OVCP for *secure messaging service encounters* according to the remuneration framework provided in this Billing Guide. The PoC is intended to increase access to care and gather further evidence on the use of secure messaging at a larger scale in Ontario than has been possible to date.

To join the PoC and be eligible to submit claims, physicians must complete the registration process and receive approval from the Ministry for secure messaging billing privileges (See **Section 4 Registration** for further details).

For the *secure messaging service encounter* to be funded, the *secure messaging service encounter* must meet the terms and conditions outlined in **Section 5.2 Terms and Conditions**, which include (but are not limited to) that the physician and patient, or *patient's representative,* participating in the *secure messaging service encounter* must be:

- using the secure messaging functionality of a virtual visit solution that is verified for secure messaging by Ontario Health and listed on Ontario Health's Verified Solution List;
- physically located in Ontario at the time(s) when they send their message(s) contributing to their side of the *secure messaging service encounter*; and
- are within an existing/ongoing patient-provider relationship.

Claims for OVCP-funded *secure messaging service encounters* will be submitted, paid and reported through the Ontario claims submission process in accordance with the requirements described in **Section 5.3 Claims Submission**, **Section 5.4 Monthly Management Fee Payment**, and **Section 5.5 Reporting** below.

4 Registration

Through the registration process found at www.ontariohealth.ca/secure-messaging-proof-of-concept-pilot, physicians must:

1. complete and electronically sign the “Secure Messaging Proof-of-Concept Pilot Registration Contract”;
2. complete the “Secure Messaging Proof-of-Concept Pilot Registration Survey”; and
3. submit to Ontario Health.

When an application is submitted, the physician will receive e-mail confirmation to the primary e-mail address the physician provided during registration, noting that the application has been received.

When registration has been processed, the physician will receive e-mail confirmation to the physician’s primary e-mail address, which will confirm whether the application has been approved and, if so, the *effective date* of the physician’s registration in the Secure Messaging PoC. The *effective date* is the first service date a *secure messaging service encounter* can be delivered and claimed within the Secure Messaging PoC Pilot. Any *secure messaging service encounters* delivered prior to the *effective date* are not eligible for payment and the associated claim(s) will be rejected.

The registration for the Secure Messaging PoC Pilot is open until July 31, 2024.

5 Billing Information and Requirements for Funded Secure Messaging Service Encounters

5.1 Fee Code

K303A - **Secure messaging service encounter**: an exchange of secure messages, transmitted between a patient or *patient's representative* and a physician, encompassing all messages that were exchanged to undertake and complete the clinical service for the presenting health issue(s), which includes the physician soliciting the appropriate patient information, analyzing the information, and providing appropriate management and/or advice related to the patient's presenting health issue(s).

5.2 Terms and Conditions

a) *Secure messaging service encounters* require that, in the physicians' professional opinion in accordance with accepted professional standards and practice, the patient's care and support requirements can be effectively and appropriately delivered by secure messaging.

b) *Secure messaging service encounters* must be either: 1) initiated by the patient, or the *patient's representative*; or 2) initiated by the physician as a clinically appropriate follow-up to a preceding service initiated by the patient or the *patient's representative*.

c) *Secure messaging service encounters* must include the physician soliciting the appropriate patient information, analyzing the information, and providing appropriate management and/or advice related to the patient's presenting health issue(s).

- For clarity, common examples of secure messaging exchanges that **would not meet** the requirements for a funded *secure messaging service encounter* include (but are not limited to):
    - Administrative encounters (such as, scheduling request, request for medical records, update on status of a referral).
    - One-way dissemination of information (such as, sending test results, notification of vaccination clinics).

- Patient sends additional/missing information or seeks clarification from a previous service.
- Patient sends an update from a service with another health care provider.
- Patient requests a doctor's note.
- Patient requests a prescription renewal, and it is not necessary to solicit information, analyze and provide management and/or advice to address the request.

d) Secure message service encounters must be provided within an existing/ongoing patient-physician relationship.

- If a K303A is claimed and an *existing/ongoing patient-physician relationship* does not exist on the service date, the service will reject to the physician's error report with the error code 'AT3 – No Pat-Phys Relationship'.

e) The patient for which the *secure messaging service encounter* is delivered must have a valid Ontario health card on the service date.

f) Both the physician and patient, or *patient's representative*, participating in the *secure messaging service encounter* must be physically located in Ontario at the time(s) when they send their message(s) contributing to their side of the *secure messaging service encounter*.

g) *Secure messaging service encounters* must be delivered using the secure messaging functionality of a virtual visit solution that is verified for secure messaging by Ontario Health and listed on Ontario Health's Verified Solution List.

h) *Secure messaging service encounters* must be personally rendered by the physician and may not be delegated or provided by medical trainees under supervision for payment purposes.

i) *Secure messaging service encounters* must include at least one message from the patient, or *patient's representative*, and at least one message from the physician.

j) The patient, or the *patient's representative*, must be given a reasonable amount of time to review the medical advice or information and ask follow-up questions before ending the *secure messaging service encounter*.

k) If a *secure messaging service encounter* is discontinued before all the required elements of the service (as per the definition) are completed, or it becomes apparent to the physician during the service that the service cannot be completed solely through secure messaging, the *secure messaging service encounter* is not funded.

- Common examples of a secure messaging exchange that would **not meet** the requirements for a funded *secure messaging service encounter* under the above situations would include (but are not limited to):
    - Triaging of the patient's health issue(s) to be addressed by an in-person or other virtual service.
    - Patient ceases to respond to the secure messaging exchange before all required elements of the service are complete.
    - Patient attends an in-person or other virtual service for the same health issue(s) for which the *secure messaging service encounter* was initiated, while the *secure messaging service encounter* is in progress, leading to the completion of the service outside of the *secure messaging service encounter*.
    - Patient's health issue(s) requires a medically necessary OHIP-insured service to address (such as, direct physical encounter).

l) *Secure messaging service encounters* must be documented in the patient's medical record, including (but not limited to) all messages, images or documents exchanged during the service, and mode of communication (namely, secure messaging) – including the verified virtual visit solution used.

- See the College of Physicians and Surgeons of Ontario (CPSO) Medical Records Documentation Policy for more information.

5.3 Claims Submission

a) Physician's OHIP billing number registration must be complete and in force.

b) Physician's Secure Messaging PoC Pilot registration must be complete and in force.

- K303A claimed by a physician with a service date prior to the *effective date* of the physician's Secure Messaging PoC Pilot registration or prior to the start date of the Secure Messaging PoC pilot will reject to the physician's error report with the error code 'ET7' - Provider Not Registered for Secure Messaging Pilot'.

c) Physicians will need to submit claims for each eligible K303A 'Secure Messaging Service Encounter' within three months of the service date.

- Inclusion of the appropriate diagnostic code for the clinical service is required.

    - If the diagnostic code field is left blank or filled with spaces, the claim will reject to the physician's error report with the error code 'V21 - Diagnostic Code Required'.
    - If the diagnostic code provided is not numeric, the claim will reject to the physician's error report with the error code 'V16 - Unacceptable Diagnostic Code'.
    - If the diagnostic code provided is equal to 000, 999, or not an eligible diagnostic code, the claim will reject to the physician's error report with error code 'V22 - Invalid Diagnostic Code'.
    - Further information on eligible diagnostic codes can be found under Claims Submission of the Resources for Phsyicians.
- Inclusion of the appropriate group number is required. This would be the same solo or group number used when other services (such as, OHIP-insured services) are provided through that care setting.
- The service date of the K303A is the day the service with the patient was completed.

d) K303A must be the only service(s) included in a claim.
    - OHIP-insured premiums, management fees, and other add-ons are not payable with K303A.
    - If a K303A is submitted with any other services on the same claim, the claim will reject to the physician's error report with the error code 'EP7– Code Must be Billed Alone'.

e) There is a limit of one K303A delivered by the same physician, to the same patient, on the same service date.

f) K303A will not contribute towards any thresholds for OHIP-insured premiums, management fees, add-ons, hard cap or the Fee-For-Service ceiling.

g) K303A cannot be claimed under Reciprocal Medical Billing (RMB) or Workplace Safety and Insurance Board (WCB) payment programs.
    - K303A claimed under the RMB payment program will reject to the physician's error report with the error code 'R04 – Service Excluded from RMBS'.
    - K303A claimed under the WCB payment program will reject to the physician's error report with the error code 'VW1– Invalid WCB Service'.

5.4 Monthly Management Fee Payment

a) The claims system will count the number of approved K303A services rendered by the physician within the service month.

- The count includes all K303A services delivered to all patients by the physician in the month, irrespective of if K303A was claimed solo or under group number(s).

b) The total count of approved K303A services delivered in the month will allocate the physician to the appropriate *Monthly Management Fee* payment tiers, which include:

- Tier 1: Minimum K303A count of 15 = $150 per service month*
- Tier 2: Minimum K303A count of 30 = $300 per service month*
- Tier 3: Minimum K303A count of 45 = $450 per service month*

* Rates represent the full Fee-For-Service amount.

c) The physician will only receive one *Monthly Management Fee* payment based on the payment tier they qualify for in each service month.

- There is no proration of the payment tier or payment amount based on the relative number of days the physician has been eligible to bill, or has delivered services, in the given service month.

d) The *Monthly Management Fee* payment will be made monthly.

- Adjustments:
  - If a higher tier is subsequently reached for a past service month the difference will be paid.
  - If due to retroactive negations, the number of K303A falls below the threshold of the tier previously paid the applicable amount will be recovered to account for the appropriate payment for the tier now met.

e) The payment rate is determined based on the physician's group affiliation(s) in the following order of priority.

i) For non-locum physicians affiliated to a Blended Salary Model (BSM)/ Community Sponsored Agreement (CSA), Family Health Network (FHN), Family Health Organization (FHO), Group Health Centre (GHC), Rural and Northern Physician Group Agreement (RNPGA), St. Joseph's Health Centre (SJHC), Sioux Lookout Agreements (SLA), Weeneebayko Area Health Authority (WAHA), GP Focused Practice HIV 1 or Care of the Elderly 1:

- All payments will be at the shadow billing rate of the group regardless of the enrolment status of the patient (if applicable for that model) to whom the K303A is delivered. This will apply to all K303A claims whether submitted solo or under any group number (including another primary care group or Alternative Payment Program or Alternative Funding Plan group).
- Income Stabilization and New Graduate Entry Program physicians may register for the PoC and submit claims for K303A if they wish their services to be tracked and to participate in the PoC evaluation; however, they are not eligible to receive the Monthly Management Fee payment on top of their salary.
- Adjustments:
  - If a physician is retroactively affiliated to one of the above groups for a service month where they previously received the full Fee-For-Service payment, the previously paid *Monthly Management Fee* will be adjusted to the group's shadow billing rate.
  - Conversely, if a physician is retroactively removed from one of the above groups for a service month where they received the shadow billing rate, the payment will be adjusted to the full Fee-For-Service amount.

ii) For non-locum physicians who do not meet criteria i) and are in GP Focused Practice Palliative Care 2 or Care of the Elderly 2 groups, Homeless Shelter Agreement groups, Family Health Team Specialist groups, Aboriginal Family Health Teams, or Toronto Palliative Care Associates (TPCA):

- All payments will be at the highest shadow billing rate of the group under which a K303A was claimed for that service month.
- If no K303A claims are submitted under the group in the service month, see criteria iii) and iv) below to determine payment rate.

iii) For physicians who have one or more affiliations to an Alternative Payment Program (APP) or Alternative Funding Plan (AFP) group, including Academic Health Science Centre (AHSC) and Emergency Department Alternate Funding Agreements (EDAFAs), and who do not meet criteria i) or ii):

- Single APP/AFP**:** If the physician is affiliated to a single APP/AFP, and the physician has claimed at least one K303A under the APP/AFP group for that service month they will be paid at the global funding premium rate.

- Multiple APPs/AFPs: If the physician is affiliated to multiple APPs/AFPs they will be paid at the highest global funding premium rate under which a K303A was claimed for that service month.
- If no K303A claims are submitted under the APP/AFP group for that service month, see criteria iv) to determine payment rate.
- Adjustments:
  - If an APP/AFP physician was paid at a lower global funding premium rate, but subsequently submits a claim for that service month under a group with a higher rate, the previously paid payment will be adjusted to the higher global funding premium rate.
  - If an APP/AFP physician was previously paid the full Fee-For-Service payment, but subsequently submits a K303A for that service month under an APP/AFP group, the previous payment will be adjusted to the APP/AFP global funding premium rate.
  - If a physician was previously paid at an APP/AFP global funding premium rate, but subsequently removes their affiliation to that APP/AFP for that service month, the payment will be adjusted to either the new highest global funding premium rate under which a K303A was submitted for that service month, or to the full Fee-For-Service amount if no other APP/AFP affiliation is applicable.

iv) All other physicians, including:

- Locum physicians affiliated to a group mentioned in i) and ii);
- Family Health Group (FHG) and Comprehensive Care Model (CCM) signatory providers; and
- All other physicians who do not meet criteria i) – iii) above,

will receive the full Fee-For-Service payment amount for the tier they qualify for.

f) Payments will be processed through the Ontario claims submission process and made on the solo Remittance Advice (RA) regardless of whether K303A was submitted solo or under group number(s).

5.5 Reporting

a) The monthly Secure Messaging PoC Pilot detailed report will be provided in PDF format through the web-enabled Medical Claims Electronic Data Transfer (MCEDT) service as a separate report from the RA.

b) Physicians must register their solo billing number with MCEDT to receive the report. The report will not be provided in paper format for physicians not enrolled for MCEDT.

5.6 List of Error and Explanatory Codes

There following are common error and explanatory codes that are applicable for *secure messaging service encounters*:

1. ET7– Not Reg Secure Messaging
2. AT3 – No Pat-Phys Relationship
3. B3 – Patient-Physician Relationship Requirements Not Met
4. EP7 – Code Must Be Billed Alone
5. V21 – Diagnostic Code Required
6. V16 – Unacceptable Diagnostic Code
7. V22 – Invalid Diagnostic Code
8. R04 – Service Excluded from RMBS
9. VW1 – Invalid WCB Service

The full list of error and explanatory codes can be found at Error Report Rejection Conditions and Remittance Advice Explanatory Codes/Messages respectively.

6 Further Information

6.1 Questions

For **registration process related inquiries**, please contact OVCPregistration@ontariohealth.ca

For **billing related inquiries**, please contact the Service Support Contact Centre at: 1-800-262-6524 or SSContactCentre.MOH@ontario.ca

6.2 Additional Resources

Secure Messaging Proof-of-Concept Pilot page:
www.ontariohealth.ca/secure-messaging-proof-of-concept-pilot