Primary Care Q-Codes

Quick Reference Guide

Economics, Policy & Research

OMA
ONTARIO MEDICAL ASSOCIATION

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Code	Description	Fee	Eligible Models	Page
After Hours Premium Fees				
Q012A/ Q016A	***After Hours Fees*** Is eligible for payment for enrolled patients seen during regular after-hours services held after 5pm on weekdays or any time on weekends or statutory holidays.	30% premium	Q012A - FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA Q016A - CCM	7
Newborn Care Fees				
Q014A/ Q015A	***Newborn Care Episodic Fee*** Is eligible for payment for each well-baby visit, up to a maximum of 8 per patient, to enrolled patients in the first year of life.	Q014A - $15.05 Q015A - $13.99	Q014A – FHN/ SEAMO Q015A – FHO	7
Serious Mental Illness (SMI) Bonus				
Q020A/ Q021A	**SMI Fee** Is an annual payment for providing Comprehensive Primary Care to a minimum of 5 enrolled patients with diagnoses of bipolar disorder (Q020A) or schizophrenia (Q021A).	$1,000 (5-9 patients) $2,000 (10+ patients)	Q020A - FHN/FHO/FHG Q021A - FHN/FHO *FHG bill applicable fee schedule code with diagnostic code 295 for the schizophrenia bonus.	8
New Unattached Patient Fees				
Q200A	***Per Patient Rostering Fee Code*** Q200 is a per Patient Rostering Fee Code that is billed at zero dollars. This fee code 'triggers' enrolment and must be submitted to the Ministry of Health when a physician enrols a patient.	$0	CCM, FHG, FHN, FHO, RNPGA, BSM, SJHC, SEAMO, WHA	9
Q202A	***LTC Per Patient Rostering Fee Code*** Q200 is a LTC per Patient Rostering Fee Code that is billed at zero dollars. This fee code 'triggers' enrolment and must be submitted to the Ministry of Health when a physician enrols an LTC patient.	$0	FHN, FHO	9
Q023A	***New Unattached Patient Fee - from Hospital*** May be claimed for enrolling a new unattached patient who had an acute care hospital in-patient stay within the previous three months. There are no limits on the number Q023 claims a physician can claim. A physician may submit for both Q023 and a Per Patient Rostering Fee Code (Q200A) for the same patient.	$150	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA	9
Q043A	***New Patient Fee Abnormal/Increased Risk CRC*** May be claimed for enrolling a new unattached patient through the ColonCancerCheck program; patient with a abnormal FIT result or at increased risk of colorectal cancer (CRC)	$150 (age < 65) $170 (65-74) $230 (75+)	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA	10

Code	Description	Fee	Eligible Models	Page
Q053A	***New Unattached Patient Fee - HCC Complex/Vulnerable Patient*** May be claimed for enrolling a new unattached patient through the Health Care Connect (HCC) program where the patient is identified by HCC as complex-vulnerable.	$350	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA	11
Chronic Disease Management Fees				
Q040A	***Diabetes Annual Flow Sheet Fee*** Is an annual fee for providing ongoing management of a diabetic patient. Q040 is only eligible for payment if the physician has rendered a minimum of three K030 services for the same patient in the same 12-month period to which the Q040 service applies. Additionally, completion of the flow sheet must be done.	$60	FFS, CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA	11
Q042A	***Smoking Cessation Counselling Fee*** May be claimed for providing a dedicated follow-up counselling session with their enrolled patients who have committed to quit smoking within 12 months following an E079. (Max 2 per year).	$7.50	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA	12
Q050A	***Heart Failure Management Incentive Fee*** Is an annual payment available to physicians for coordinating, and documenting all required elements of care for enrolled heart failure patients.	$125	CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA	12
FOBT Preventive Care Fees and Bonuses				
Q150A	***Colorectal Cancer Screening Fee*** Available to all family physicians in Ontario who provide counselling the patient on screening and the use of the FIT and for completing and submitting the requisition to LifeLabs. (Max of one per patient every two years).	$7	All family physicians in Ontario including PEM physicians are eligible.	13
Q152A	***Colorectal Cancer Screening Test Completion Fee*** Available to all eligible family physicians in Ontario to be submitted once the patient's FIT results have been reviewed by the family physician and communicated to the patient.	$5	All family physicians in Ontario including PEM physicians are eligible. See note for further restrictions.	13
Basic Flu Shot Fee				
Q590A	Basic Flu Shot Fee – per visit premium	$5.10	FHN, FHO	14

Preventive Care Bonuses[1,2]

Description	Codes	Compliance Rate	Fee Payable	Eligible Models	Page
Influenza Vaccine	**Q100A** **Q101A** **Q102A** **Q103A** **Q104A**	60% 65% 70% 75% 80%	$220 $440 $770 $1,100 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size.	15
Influenza Vaccine Tracking Code	**Q130A**		$0		
Pap Smear	**Q105A** **Q106A** **Q107A** **Q108A** **Q109A**	60% 65% 70% 75% 80%	$220 $440 $660 $1,320 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size.	16
Pap Smear Tracking Code Pap Smear Exclusion Code	**Q011A** **Q140A**		$0 $0		
Mammography	**Q110A** **Q111A** **Q112A** **Q113A** **Q114A**	55% 60% 65% 70% 75%	$220 $440 $770 $1,320 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size.	16
Mammography Tracking Code Mammography Exclusion Code	**Q131A** **Q141A**		$0 $0		
Childhood Immunization	**Q115A** **Q116A** **Q117A**	 85% 90% 95%	 $440 $1,100 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size.	17
Childhood Immunization Tracking Code	**Q132A**		$0		
Colorectal Cancer Screening	**Q118A** **Q119A** **Q120A** **Q121A** **Q122A** **Q123A**	15% 20% 40% 50% 60% 70%	$220 $440 $1,100 $2,200 $3,300 $4,000	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM and FHG physicians who meet the minimum roster size.	17
Colorectal Cancer Screen - Tracking Code - Exclusion Code	 **Q133A** **Q142A**		 $0 $0		

[1] For FHG and CCM models, the minimum eligible roster size for the Preventive Care Fees and Bonuses is 650 except for new graduates in their first year of the model then it is 450.

[2] PEM physicians who are eligible to receive the Preventive Care Bonus Fees (Q100A-Q123A) are not eligible to claim Q152. FHG and CCM physicians are not eligible to claim Q152 except where (i) the FHG/CCM physician is identified as new graduates and have not met the minimum roster size of 450 enrolled patients; or (ii) the FHG/CCM physician roster size is less than 650 enrolled patients.

Tracking and Exclusion Codes

Codes	Category	Description	Fee	Page
Q011A	Pap Smear	Pap Smear Tracking Code	$0	18
Q130A	Influenza Vaccine	Influenza Vaccine Tracking Code	$0	18
Q131A	Mammography	Mammography Tracking Code	$0	18
Q132A	Childhood Immunization	Childhood Immunizations Tracking Code	$0	18
Q133A	Colorectal Cancer Screening	Colorectal Cancer Screening Tracking Code	$0	18
Q140A	Pap Smear	Pap Smear Exclusion Code – applies to women who have had a hysterectomy, or who are being tested for cervical diseases that preclude regular screening Pap tests and also any female who is not sexually active.	$0	18
Q141A	Mammography	Mammography Exclusion Code – applies to women who have had a mastectomy, or who are being treated for clinical breast disease.	$0	18
Q142A	Colorectal Cancer	Colorectal Cancer Screening Exclusion Code – applies for patients with known cancer being followed by a physician; with known inflammatory bowel disease; who have has a colonoscopy within the last 10 years; with a history of malignant bowel disease; or with any disease requiring regular colonoscopies for surveillance purposes.	$0	18

After Hours Premium Fees

Q012A/Q016A – After Hour Fees

Description

- No claims for premiums may be made for services rendered between 8:00am and 5:00pm.
- The after-hours premiums may be billed for enrolled patients seen during regular after hour services held after 5pm on weekdays or any time on weekends or statutory holidays.
- The services must be available to scheduled and non-scheduled patients. The services must be held during regularly scheduled times and the physician must make his/her patients aware of the dates and times such services are available.
- Premiums should not be billed for patients who are seen after 5:00 p.m. because the physician's clinic is behind schedule nor is it the intention for physicians to alter regular daytime hours solely for the purpose of billing.
- Physicians must be available during regular office hours to provide comprehensive care to their patients. This obligation is specified in the FHG and FHO and other Agreements.

Fees:

Code	Fee	Eligible Models
Q012A	30%	FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA
Q016A	30%	CCM

Payment Rules

Physicians can receive a 30% premium on the value of the following fee codes: A001A, A003A, A004A, A007A, A008A, A888A, K005A, K013A, K017A, K030A, K033A, K130A, K131A, K132A and Q050. In order to receive that After Hour Premium, the Q012A or Q016A must be submitted.

Newborn Care Fees

Q014A/Q015A – Newborn Care Episodic Fee

Description

The Q014A and Q015A are premiums that are received for each well-baby visit, up to a maximum of 8 per patient, to enrolled patients in the first year of life. These codes may only be billed with a valid A007A intermediate assessment code. If it is billed in conjunction with any other service, it will result in a rejected claim that will appear on a Claims Error Report with reject code 'AD9 – not allowed alone'.

Fees:

Code	Fee	Eligible Models
Q014A	$15.05	FHN, SEAMO
Q015A	$13.99	FHO

Payment Rules

The Q014/Q015 and A007A must have the same service date and the service date must be before the patient's first birthday. If it is billed with an A007A assessment that does not have the same service date,

it will be rejected and appear on your Claims Error Report with a rejection code 'A2A –outside of age limit'.

If a subsequent enrolment for the patient is processed in the following twelve-month period, the code will be automatically reprocessed for payment, providing the service date of the code is on or after the patient's signature date on the E/C form.

Serious Mental Illness (SMI) Bonus

Q020A/Q021A – SMI Fee

Description
The SMI is an annual bonus for providing Comprehensive Primary Care to a minimum of 5 enrolled patients with diagnoses of bipolar disorder and/or schizophrenia. Fee Schedule codes for services provided to these patients must be accompanied by tracking code Q021A for schizophrenia and tracking code Q020A for bipolar disorder, and the patient must be rostered in order for the premium to be paid. **For physicians in a FHG, the schizophrenia bonus is tracked by submitting the diagnostic code 295 along with the service fee code.**

Fees:

Number of Patients	Bipolar and/or Schizophrenia
5 to 9	$1,000
10+	$2,000

Payment Rules
These codes are paid during the fiscal year and will be included in the Special Premium Payment which is reported on the monthly RA as an accounting transaction with the text line. The minimum service level is 5 patients for Level One and an additional 5 patients for Level Two.

Q020A and services with diagnostic code 295 that are submitted for patients that are not formally enrolled with the billing physician will be processed but will not be counted towards the SMI premium. If a subsequent enrolment for the patient is processed in the following twelve-month period, the Q020A and/or any services with diagnostic code 295 provided after enrolment will automatically be included towards the cumulative count for this premium.

New Unattached Patient Fees

Q200A – Per Patient Rostering Fee Code

Description
Q200 is a per Patient Rostering Fee Code that is billed at zero dollars. This fee code must be submitted to the Ministry of Health when a patient is enrolled with the physician as it triggers enrolment in their system.

Submission Rules
As of February 1st, 2013 physicians are no longer required to send the Enrolment/Consent form to MOHLTC, but must keep in office for record keeping. The service date for the Q200 must be the date on the E/C form.

Eligible Models
CCM, FHG, FHN, FHO, RNPGA, BSM, SJHC, SEAMO, WHA

Q202A – Long Term Care (LTC) Per Patient Rostering Fee Code

Description
Q202 is a LTC per Patient Rostering Fee Code that is billed at zero dollars. This fee code must be submitted to the Ministry of Health when an LTC patient is enrolled with the physician as it triggers enrolment in their system.

Submission Rules
As of February 1st,2013 physicians are no longer required to send the Enrolment/Consent form to MOHLTC, but must keep in office for record keeping. The service date for the Q202 must be the date on the E/C form.

Eligible Models
FHN and FHO only.

Q023A – New Unattached Patient Fee – From Hospital

Description
Q023A may be claimed for enrolling a new unattached patient who had an acute care hospital in-patient stay within the previous three months. The service date of a Q023A claim must be the same as the date on the E/C form and the Declaration form.

Fee: $150

Payment Rules
There are no limits on the number of Q023A a physician can claim. This fee is restricted to patients who at the time of enrolment did not have a family physician and had an acute care in-patient stay within the previous three months. A physician may submit both Q023A and a Per Patient Rostering Fee Code (Q200A) for the same patient.

For any individual patient a physician may only claim an Unattached Patient Fee. Both the unattached patient (or parent/legal guardian where applicable) and the enrolling physician must complete both the Patient Enrolment and Consent to Release Personal Health Information form and the Unattached Patient Declaration form.

Newborns qualify as unattached patients if they meet the following two criteria:
(i) the mother does not have a family physician; and
(ii) the newborn has been admitted to a Level II or higher Neonatal Intensive Care Unit (NICU) within the last three months. If a Level II bed is not available, a newborn who meets the criteria for a Level II nursery but is cared for in a Level I nursery would qualify. Typically, the discharge summary for these babies would indicate a diagnosis other than healthy newborn.

Eligible Models
CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

Q043A – New Patient Fee Abnormal/Increased Risk CRC

Description
As part of the ColonCancerCheck program, Cancer Care Ontario is collecting and maintaining a referral list of physicians who are currently accepting new patients with an abnormal FIT result or at increased risk of colorectal cancer (CRC).

Patients without a family physician can request a FIT through Telehealth Ontario by calling (Toll-free: 1-866-828-9213 or Toll-free TTY: 1-866-797-0007).

The patient will complete the FIT and mail it to the laboratory for processing in the postage prepaid envelope or drop it off at a LifeLabs specimen collection centre.

For patients without a family physician and when normal results are obtained, the ColonCancerCheck program will send a letter to the patient informing them of the results and to return for screening in two years' time.

For patients without a family physician and when abnormal results are obtained, the program will contact a physician from the referral list to arrange an appointment for follow-up care (e.g. referral to colonoscopy).

Fees: $150 (for patients up to and including 64 years of age)
$170 (for patients 65 to 74 years of age)
$230 (for patients 75 years of age and older)

Payment Rules

- To be eligible for the New Patient Fee Abnormal/Increased Risk CRC, the physician and patient will complete and sign a Patient Enrolment and Consent to Release Personal Health Information (enrolment/consent) form and a New Patient Declaration form. The patient is given a copy of the enrolment/consent form and the physician retains a copy of both forms for practice records.
- If a physician's software program does not support multiple amounts for the same fee code, the physician may bill the Q043A for $150.00 and the ministry's system will adjust it accordingly.
- The service date of a Q043A claim must be the same as the date on the enrolment/consent form and the New Patient Declaration form.
- There is no annual limit on the number of services (Q043A) a physician is eligible to claim.

Eligible Models
CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

Q053A – New Unattached Patient Fee – HCC Complex/Vulnerable Patient

Description
Q053A is a one-time payment of $350 for enrolling a complex/vulnerable patient through the Health Care Connect Program.

Fee: $350

Payment Rules
It is the same payment amount regardless of the age of the patient. This code requires the patient to be registered with Health Care Connect as a complex/vulnerable patient.

The patient must be enrolled with the physician within three months of being registered with Health Care Connect and must be deemed a Complex Vulnerable patient by Health Care Connect to be able to bill this fee code.
Eligible Models
CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

Chronic Disease Management Fees

Q040A – Diabetes Annual Flow Sheet Fee

Description
Q040A can be paid for an enrolled or non-enrolled diabetic patient once per year. This requires completion of a flow sheet to be maintained in the patient's record that includes the required elements of diabetes management and complication risk assessment consistent with the Canadian Diabetes Association (CDA). It is intended that the flow sheet be completed over the course of the year to support a planned care approach to diabetes management.

Fee: $60

Payment Rules
Q040 is only eligible for payment if the physician has rendered a minimum of three K030 services for the same patient in the same 12-month period to which the Q040 service applies.

The code may be submitted separately or in combination with other fee schedule codes. If a second Q040A is submitted for a patient within 365 days of a previously processed Q040A for the same patient by the same physician, the second Q040A will be processed at $0 with an explanatory code "M1 – Maximum fee allowed for these services has been reached." If the second Q040A is submitted by a different physician, the second Q040A will be rejected to the daily claims error report with the error code "A36 – Claimed by other Pract". If a physician submits a Q040A but does not have "Billing Specialty 00 - Family Practice and Practice in General", the claim will reject with the error code "AD4 – Ineligible Specialty".

Eligible Physicians
FFS, CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

Q042A – Smoking Cessation Counselling Fee

Description
Q042A is an additional fee for physicians who provide a dedicated follow-up counselling session with their enrolled patients who have committed to quit smoking.

Fee: $7.50

Payment Rules

A physician is eligible to receive per year payment for a maximum of two follow-up Q042A Smoking Cessation counselling fees if:

1. The physician had previously billed a valid Initial Add-on Smoking Cessation Fee (E079A) claim, and
2. The K039 fee code is billed in the 12 months following the service date of a valid E079 claim.

Note: In models that have group enrolment, a physician is eligible to submit and receive payment for Q042A for patients affiliated to him/her by virtue of the physician's acknowledgement on the Patient Enrolment and Consent to Release Personal Health Information (E/C) form.

Eligible Models
CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

Q050A – Heart Failure Management Incentive Fee

Description
Q050A is a $125 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. Physicians may choose to use the Heart Failure Patient Care Flow Sheet or one similar to track a patient's care. 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.

Fee: $125

Payment Rules
A physician is eligible to submit for the CHF Management Incentive annually for an enrolled heart failure patient once all the required elements of the patient's heart failure care are documented and complete. The flow sheet must track the following: comprehensive physical examination, laboratory monitoring of Na+, K+, serum creatinine and eGFR, patient education for modifiable risk factor reduction and self-management, pharmacologic management for appropriate use of first-line, and symptom relief and preventive medications.

Eligible Models
CCM, FHG, FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA

FIT Preventive Care Fees and Bonuses

Q150A – Colorectal Cancer Screening Fee

Description
Physicians no longer need to maintain an inventory of, or distribute colorectal cancer screening tests (i.e., gFOBT). Instead, physicians will submit requisitions to LifeLabs (e.g., by fax or certified electronic medical record), and LifeLabs will mail FIT kits directly to their patients. Physicians will bill the existing Q150A for counselling the patient on screening and the use of the FIT and for completing and submitting the requisition to LifeLabs.

Fee: $7

Payment Rules
To claim the fee the physician must:

- Discuss and assess the patient's medical and family history, and eligibility to determine if the FIT is appropriate for the patient;
- Confirm the patient's date of birth and address for the FIT kit;
- Educate the patient during an office visit on the correct use of the FIT kit; and
- Submit the completed FIT requisition form to LifeLabs (e.g., by fax 1-833-676-1427 or certified electronic medical record).
- The Q150A fee code is billable for patients at average risk of developing colorectal cancer, ages 50 to 74 years.
- The Q150A fee code is billable for all patients enrolled and non-enrolled.
- The Q150A fee code is limited to a maximum of one service per patient every 730-day period.
- When a second Q150A code is billed for a single patient by any other provider in the same 730-day period, the Q150A will pay zero dollars ($0) and have the explanation code M4 "Maximum Fee Allowed for these services by one or more practitioners has been reached' applied to the claim.

Eligible Models
All family physicians in Ontario including physicians participating in Patient Enrolment Models are eligible.

Q152A – Colorectal Cancer Screening Test Completion Fee

Description
Q152A is a fee available to family physicians in Ontario to be submitted once the patient's once the patient's FIT results have been reviewed by the physician and communicated to the patient. Q152A may be billed once per patient per two years.

Physicians participating in Patient Enrolment Models (PEMs) who are eligible to receive the Preventive Care Bonus Fees (Q100A-Q123A) are not eligible to claim Q152. FHG and CCM physicians are not eligible to claim Q152 except where (i) the FHG/CCM physician is identified as new graduates and have not met the minimum roster size of 450 enrolled patients; or (ii) the FHG/CCM physician roster size is less than 650 enrolled patients.
Fee: $5

Payment Rules
Q152A can only be billed once per patient two years.

Eligible Models
Physicians participating in Patient Enrolment Models who are eligible for Preventive Care Bonus Payment are not eligible to bill this fee code.

FHG and CCM physicians identified as new graduates will be eligible when they have not met the minimum roster size of 450 enrolled patients. As well, all other FHG and CCM physicians will be eligible when their roster sizes are less than 650 enrolled patients.
Family physicians who are not in one of the Patient Enrolment Models are eligible to claim this fee code.

Q590 – Basic Flu Shot Fee-Per-Visit Premium

Description
The Q590A 'basic flu shot fee-per-visit premium FHN/FHO' is payable under the Family Health Network (FHN) and Family Health Organization (FHO) contracts for the provision of influenza vaccination where the provision of the influenza vaccine is the sole reason for the visit. FHN and FHO physicians may submit Q590A "basic flu shot fee-per-visit premium FHN/FHO" fee in conjunction with G590 influenza vaccinations for the flu season.

Fee: $5.10

Payment Rules
The Q590A is payable for enrolled and non-enrolled patients. If it is submitted by a physician who is not a member of a FHN or FHO group the claim will reject to the physician's error report EPA 'Network Billing Not Allowed'. The Q590A fee code is not payable in addition to the G700A "sole visit premium" fee schedule code. For flu shots administered together with a medical assessment, the appropriate assessment code should be billed together with a G590; the Q590A fee code is not payable with an assessment. The Eligible Models are: FHN and FHO.

Preventive Care Fees and Bonuses (Q100A-Q123A)

Eligible Patient Enrolment Model (PEM) physicians may receive Cumulative Preventive Care Bonuses for maintaining specified levels of preventive care to their enrolled patients. There are five preventive care categories for which an individual physician may earn an annual bonus.

The requirements for the **FHG and CCM** minimum roster sizes are as follows.

• Eligibility is based on a physician's roster size on March 31st of the current bonus year (e.g. March 31st, 2013, for the 2012/2013fiscal year).

• In each bonus year, a physician must have a minimum roster size of 650 enrolled patients on the last day of each fiscal year (e.g. March 31st, 2013 for the 2012/2013 fiscal year)

• New Graduates in their first year of practice with a FHG or CCM will be required to have a minimum roster size of 450 enrolled patients. It is important to remember that the minimum roster size is calculated based on the physician's enrolled patient roster on March 31st of each year.

There are **no minimum roster size requirements for FHO or FHN** physicians to be eligible for this bonus.

Influenza Vaccine

This bonus fee is based on the percentage of the target population who have received the influenza vaccine appropriate for that influenza season by January 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled patients who are 65 years or older as of December 31st of the fiscal year.

Description	Code	Compliance Rate (of enrolled pts >= 65 yrs old)	Bonus Fee	Eligible Models
Influenza Vaccine	**Q100A** **Q101A** **Q102A** **Q103A** **Q104A**	60% 65% 70% 75% 80%	$220 $440 $770 $1,100 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM & FHG physicians who meet the minimum roster size.

Pap Smear

This bonus is based on the percentage of the target population who have received a Pap smear in the 42 months prior to March 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled female patients who are between 21 and 69 years of age, inclusive, as of March 31st of the fiscal year.

Description	Code	Compliance Rate (enrolled female pts between 21 – 69 yrs old)	Bonus Fee	Eligible Models
Pap Smear	**Q105A** **Q106A** **Q107A** **Q108A** **Q109A**	60% 65% 70% 75% 80%	$220 $440 $660 $1,320 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM & FHG physicians who meet the minimum roster size.

Mammography

This bonus is based on the percentage of the target population who have received a mammogram in the 30 months prior to March 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled female patients who are between 50 and 74 years of age, inclusive, as of March 31st of the fiscal year.

Description	Code	Compliance Rate (of enrolled female pts between 50 – 74 yrs old)	Bonus Fee	Eligible Models
Mammography	**Q110A** **Q111A** **Q112A** **Q113A** **Q114A**	55% 60% 65% 70% 75%	$220 $440 $770 $1,320 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM & FHG physicians who meet the minimum roster size.

Childhood Immunizations

This bonus is based on the percentage of the target population who have received all of the ministry-supplied immunizations as recommended by the National Advisory Committee on Immunization. The target population consists of enrolled patients who are aged 30 to 42 months of age, inclusive as of March 31st of the fiscal year. These patients must have received all applicable immunizations by their 30th month of age.

Description	Code	Compliance Rate (of enrolled pts between 30 – 42 mths old)	Bonus Fee	Eligible Models
Childhood Immunizations	**Q115A** **Q116A** **Q117A**	85% 90% 95%	$440 $1,100 $2,200	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM & FHG physicians who meet the minimum roster size.

Colorectal Cancer Screening

This bonus is based on the percentage of the target population who have received a Fecal Occult Blood Test (FOBT) in the 30 months prior to March 31st of the fiscal year for which the bonus is being claimed. The target population consists of enrolled patients who are between 50 and 74 years of age, inclusive, on March 31st of the fiscal year.

Description	Code	Compliance Rate (of enrolled pts between 50 – 74 years old)	Bonus Fee	Eligible Models
Colorectal Cancer Screening	**Q118A** **Q119A** **Q120A** **Q121A** **Q122A** **Q123A**	15% 20% 40% 50% 60% 70%	$220 $440 $1,100 $2,200 $3,300 $4,000	FHN, FHO, RNPGA, BSM, GHC, SJHC, SEAMO, WHA, CCM & FHG physicians who meet the minimum roster size.

Tracking and Exclusion Code Fees

To help physicians monitor patient status and determine service levels achieved, tracking and exclusion codes have been introduced. 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.

Tracking and Exclusion codes may be submitted using the normal billing practices used to submit fee-for-service claims and premium codes applicable to their agreement. As with other tracking codes, the fee billed should be zero dollars, and the fee paid on the Remittance Advice (RA) will be zero dollars with explanatory code 30 – "This service is not a benefit of OHIP".

Code	Category	Description	Fee Payable
Q011A	Pap Smear	Pap Smear Tracking Code	$0
Q130A	Influenza Vaccine	Influenza Vaccine Tracking Code	$0
Q131A	Mammography	Mammography Tracking Code	$0
Q132A	Childhood Immunization	Childhood Immunizations Tracking Code	$0
Q133A	Colorectal Cancer Screening	Colorectal Cancer Screening Tracking Code	$0
Q140A	Pap Smear	Pap Smear Exclusion Code - applies to women who have had a hysterectomy, or who are being tested for cervical diseases that preclude regular screening Pap tests and also any female who is not sexually active.	$0
Q141A	Mammography	Mammography Exclusion Code - applies to women who have had a mastectomy, or who are being treated for clinical breast disease.	$0
Q142A	Colorectal Cancer	Colorectal Cancer Screening Exclusion Code - applies for patients with known inflammatory bowel disease; who have has a colonoscopy within the last 10 years; with a history of malignant bowel disease; or with any disease requiring regular colonoscopies for surveillance purposes.	$0

Additional Information

For additional information, please refer to the Primary Care Resources area of the OMA website to review and download fact sheets for Q-codes.

Document compiled by the OMA's Economics, Policy & Research department

Please forward questions to economics@oma.org