New and Amended Services for Addiction Medicine and In-Office Urine Laboratory Testing for Drugs of Abuse

INTRODUCTION
What is the Education and Prevention Committee (EPC)?
The Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA) have jointly established the Education and Prevention Committee (EPC). The EPC’s primary goal is to educate physicians about submitting OHIP claims that accurately reflect the services provided and that are in compliance with the law.

What is an Interpretive Bulletin?
Interpretive Bulletins are prepared jointly by the Ministry and the OMA to provide general advice and guidance to physicians on specific billing matters. They are provided for education and information purposes only and express the Ministry’s and OMA’s understanding of the law at the time of publication. The information provided in this Bulletin is based on the April 1, 2012, Schedule of Benefits — Physician Services (Schedule). While the OMA and Ministry make every effort to ensure that this Bulletin is accurate, the Health Insurance Act (HIA) and Regulations are the only authority in this regard and should be referred to by physicians. Changes in the statutes, regulations or case law may affect the accuracy or currency of the information provided in this Bulletin. In the event of a discrepancy between this Bulletin and the HIA or its Regulations and/or Schedule under the regulations, the text of the HIA, Regulations and/or Schedule prevail.

EPC Bulletins are available on the OMA website (http://www.oma.org/Resources/Pages/EPCbulletins.aspx). The Schedule is available on the Ministry website (http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html).

Purpose
The purpose of this Interpretive Bulletin is to provide physicians, primarily those treating patients with drug addictions, with information on new and amended services introduced into the Schedule effective September 1, 2011.

What is new and what has changed?
• Three new fee codes have been introduced for the monthly management of patients in an Opioid Agonist Maintenance Program (OAMP).

• Two new fee codes have been introduced for point of care urine drug testing (G042 and G043), and changes have been introduced to the payment rules for creatinine testing (G039), as well as the existing point of care drug testing fee codes (G040 and G041).

New Fee Codes for OAMP
The new fee codes introduced into the Schedule are:
• K682 – OAMP monthly management fee – intensive (per month)
• K683 – OAMP management fee – maintenance (per month)
• K684 – OAMP team premium (per month) added to K682 or K683

Monthly Management Fees (K682 and K683)
These services are for the management and supervision, for one calendar month, of a patient in an OAMP; however, there are very specific requirements with regard to who is eligible for payment of these services. The claims are only eligible for payment to:
• The physician who is most responsible for the management and supervision of that patient; and
• A physician who has an active general exemption for methadone maintenance treatment for opioid dependence (pursuant to Section 56 of the Controlled Drugs and Substances Act 1996).

What is required in order for a management fee to be eligible for payment?

Required Services
The required services, which must be rendered personally by the physician submitting the claim (either by direct patient encounter or by Telemedicine), and which must be for the purposes of treating the patient’s addiction, are:
• A consultation, assessment or visit (from the Consultation and Visits section of the Schedule; or
• An individual K-prefix time-based service that is not a case conference or a group service (e.g., counselling [K013], psychotherapy [K007]).

Note: a service that is primarily for the purpose of providing a prescription does not constitute a required service, nor does it count toward the requirements of K682 or K683.

In addition to the services listed above, the specific elements of the management fee also include:
• All medication reviews;
• Adjusting the dose of the opioid agonist therapy;
• Prescribing additional therapy;
• Discussions with pharmacists;
• Discussions with, and providing advice and information to, the patient, their relative(s), representative(s) or other caregiver(s) either in person, by phone, fax or email on matters related to the opioid agonist maintenance (regardless of who initiates the discussion); and
• All other discussions in relation to the patient’s opioid dependency except where the discussion is payable as a separate service (e.g., physician-to-physician telephone consultation).

Limits per patient:

<table>
<thead>
<tr>
<th>Service</th>
<th>Per Month</th>
<th>Per 12-Month Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>K682 – intensive management</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>K683 – maintenance management</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>

Note that the management fee maximums apply per patient and not per physician. Therefore, if the physician most responsible for the patient changes, the new physician who is now most responsible for the patient may be eligible for payment of the monthly management fee as long as the previous physician who was most responsible has not been paid the management fee for that month.

These management services are only eligible for payment when the required services (see “Required Services” in the column opposite) are personally rendered by the physician submitting the claim. As with all insured services submitted for payment to OHIP, physicians are responsible for all claims submitted using their billing number.

Team Premium (K684)
The OAMP team premium may also be eligible for payment in addition to the monthly management fee (K682 or K683) for the management of an OAMP patient receiving an opioid agonist. The premium is eligible for payment to the physician most responsible for the OAMP management of the patient when:
• That physician provides the service described as the intensive (K682) or maintenance (K683) management in the month;
• That physician supervises the members of the OAMP management team during that month (which also consists of at least two other non-physician members who have successfully completed a training program in addiction medicine that includes opioid agonist management);
• At least one in-person therapeutic encounter with the patient (that is not for the primary purpose of urine testing or the provision of a prescription) is rendered in the month by a management team member (who is not a physician); and
• The required patient encounters are documented in the patient’s medical record.

Claims submission tip
Physicians submitting claims for the monthly management fee and the team premium should wait until the required services (e.g., assessment/K-prefix service) have been rendered before submitting the claim for K682 and K683. Likewise with K684, the claim for this service should not be submitted until the claim for K682 or K683 has been submitted. Services for an assessment or time-based code can be submitted on the same claim as K682/K683 and K684; however, if submitting in this manner, list K682/K683 after the assessment or time-based code(s), and list K684 after K682/K683.

See pages A50-A51 of the Schedule for full descriptions,
definitions and payment rules for these services.

**Example 1**

Dr. A has an active exemption for methadone maintenance treatment for opioid dependence in accordance with the federal law.

At their first meeting in the middle of January, Dr. A spends an hour with Patient A while rendering an initial assessment for substance abuse (A680). Dr. A begins the patient on suboxone maintenance and continues to assess the patient every week and then every second week for the first six months of treatment while the patient adjusts to the medication, stops using drugs and builds up to full “take home” privileges.

Is Dr. A eligible for payment of the monthly management fees?
Yes, Dr. A is assessing the patient at least twice a month regarding the addiction. This qualifies for the intensive management fee (K682), as long as all other payment requirements are met.

Over the next five months, the patient attends for one monthly assessment and Dr. A is eligible for payment of the maintenance management fee (K683). In the 12th month, however, the patient relapses on opioids and must be seen weekly again. Because the intensive management fee (K682) is only eligible for payment up to six times in a 12-month period, only the maintenance management fee (K683) is eligible for payment.

Over the course of this year, Dr. A’s nurses, who are all trained in addiction medicine including opioid agonist management, also see the patient when he attends the office for therapeutic addiction treatment and, at these visits, he does not see Dr. A. At these visits, the nurse tests urine, reviews the current health status of the patient (relapses, drug side-effects, etc.), and records the encounter in the patient’s medical record. In any month where a nurse has rendered such a service for the patient (and when the encounter was not solely for urine testing and/or providing a prescription), Dr. A is eligible for payment of the team premium (K684); however, he is not eligible for payment of an assessment when the nurse sees the patient.

**Point-of-Care (POC) Urine Drug Testing – New Codes and Amendments to Existing Codes**

Amendments have been made to two existing codes for urine drug testing which limit the number of tests eligible for payment in a calendar month. As such, two new codes have been introduced with the same description as the existing services, but which pay at a lesser fee when it is necessary to render additional urine drug tests beyond the maximums payable for the initial codes.

<table>
<thead>
<tr>
<th>Description</th>
<th>Existing Code</th>
<th>New Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target drug testing, urine (qualitative or quantitative)</td>
<td>G041</td>
<td>G042</td>
</tr>
<tr>
<td>Drugs of abuse screen, urine (must include testing for at least four drugs of abuse*)</td>
<td>G040</td>
<td>G043</td>
</tr>
</tbody>
</table>

* May include any of the following: alcohol, methadone, methadone metabolite, morphine, a synthetic or semi-synthetic opiate, cocaine, benzodiazepines, amphetamines, methamphetamines, cannabinoids, barbiturates or any other drug of abuse.

These POC laboratory services are not eligible for payment unless the monthly management service (K682 or K683), or a consultation, assessment or time-based service involving a direct physician encounter with the patient, is payable in the same month to the physician rendering the test(s).

In addition, these services are:
- Subject to limits per patient in a calendar month (i.e., not per physician);
- Eligible for payment per test; and
- Only eligible for payment when the result of the test(s), the physician’s interpretation of the results of the test(s), and the treatment (based on the test results) is documented in the patient’s permanent medical record.

The monthly limits vary depending on whether K682 or K683 has been claimed by any physician in that month:
- When claimed in a month where K682 or K683 are payable for the patient:

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Per Patient Per Month</th>
</tr>
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<tbody>
<tr>
<td>G040 and/or G041</td>
<td>5 (any combination)</td>
</tr>
<tr>
<td>G042 and/or G043</td>
<td>4 (any combination)</td>
</tr>
</tbody>
</table>

- When not claimed with K682 or K683 (i.e., for management of a patient with chronic pain, an addiction, or receiving opioid agonist treatment where K682 or K683 is not payable to any physician for that patient in that month):

<table>
<thead>
<tr>
<th>Service</th>
<th>Maximum Per Patient Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>G040, G041, G042 and/or G043</td>
<td>3 (any combination)</td>
</tr>
</tbody>
</table>

Note: only one of these services (G040, G041, G042 or G043) is eligible for payment per urine sample.
Claims submission tip
Physicians submitting claims for these POC urine tests should ensure that the required service(s) (e.g., assessment, K682, K683, etc.) have been rendered and submitted for payment before submitting claims for any of these services. They may be submitted on the same claim, however, if submitting in this manner, list the POC urine tests after K682/K683.

Additional amendment to POC testing for creatinine testing (G039)
G039 is only eligible for payment when it is rendered to rule out urine tampering, and payment is limited to a maximum of two tests per patient in a week (a period of seven consecutive days).

See pages J56 of the Schedule for full descriptions, definitions and payment rules for these services.

Example 2
In a continuation of Example 1, Dr. A and/or his opioid management team are testing the urine of Patient A on an ongoing basis. In this situation, where Dr. A is also eligible for payment of one of the monthly management fees (K682 or K683), Dr. A is eligible for payment of up to five target drug tests (G041) or drugs of abuse screens where at least four drugs of abuse are being tested (G040). Once five claims have been paid, Dr. A is eligible for an additional four claims for target drug tests (G042) or drugs of abuse screens (G043).

Because of the payment requirements for these urine tests, when should Dr. A submit his claims for these services? After the first assessment is rendered, Dr. A can submit at least the first three urine tests with the assessment claim, however, until the requirements for the monthly management fee code are met and the claim has been assessed for payment (for K682 or K683), other claims for the urine tests will reject to the error report with a reason code of “AMR,” which means that the minimum service requirements have not been met. Please refer to the “Claims submission tip” above.

Please reference EPC Bulletin Volume 10, Number 4, which provides information on specific substance abuse assessments introduced into the Schedule in October 2010.