2023/24 Ontario Hospital Interprovincial Billing Rates Frequently Asked Questions (FAQs)

1. **What services can be billed under the interprovincial hospital billing agreements?**

   The interprovincial hospital billing agreements facilitate the billing and payment of medically necessary insured hospital services for eligible beneficiaries of provincial/territorial health insurance plans. Insured hospital services provided to out-of-province patients must be billed in accordance with the interprovincial hospital billing agreements. Only insured hospital services may be billed reciprocally.

   For services not billable under the interprovincial hospital billing agreements, the Ontario hospital can request prior written approval directly from the patient’s home province or territory. If prior approval cannot be obtained by the Ontario hospital, payment for the services would be the patient’s responsibility.

2. **How should hospitals handle billing for services that cannot be billed under the interprovincial hospital billing agreements?**

   Services that are not covered under the interprovincial hospital billing agreements are listed in Schedule F: Services Excluded under the Canadian Interprovincial Agreements for the Reciprocal Processing of Out-of-Province Medical and Hospital Claims. These services are excluded from reciprocal billing. Unless other bilateral arrangements are made for the payment of excluded services, or prior approval to proceed is obtained from the patient’s home province, costs for hospital services are the patient’s responsibility, and should be billed directly to the patient by the hospital.

INPATIENT RATES

3. **What methodology was used to calculate the new interprovincial hospital billing rates that are effective on or after April 1st, 2023?**

   The inpatient per diem rates were calculated by the Canadian Institute for Health Information (CIHI) using a standardized national methodology and the most recent hospital-specific data. For a small number of hospitals for which no hospital-specific data was available, provincial, or national averages were used.

   The inpatient per diem rate includes both the direct costs of providing care to inpatients as well as a portion of the indirect costs of the hospital. It includes the costs of the inpatient nursing units (712 functional centres, including Operating Room and Post Anaesthetic Recovery Room), including all employee compensation, supply costs, drug costs, minor equipment purchases and expenses, and all sundry expenses reported in those units. It also includes an allocation of the diagnostic/therapeutic services expenses (714 functional centres) that would have been provided to hospital inpatients. In addition, the per diem includes a portion of all centralized service expenses in the hospital such as hospital administrative expenses (711 functional centres),

laundry and linen, information systems, health records and education (718 functional centre) expenses.

For 2023/24, the hospital-specific rates were calculated by CIHI based on 2020/21 Management Information System (MIS) data each hospital reported, which were then inflated to 2022/23 with the following increases:

Updated to 2021/2022	Applied a 4.28% increase	Determined from Ontario's MIS data
Updated to 2022/2023	Applied a 3.76% increase	Determined from Ontario's MIS data
Updated to 2023/2024	Applied at 5.9% increase	CPI + 2%

For 2023/24, there are no significant changes made to the standard methodology.

4. **The inpatient billing rate for my hospital has increased (or decreased) from the previous year. Can you help me understand why the rate has changed from the previous year?**

   The hospital-specific inpatient per diem rate was calculated by CIHI using the most recent data submitted by your hospital, and a methodology agreed upon by all jurisdictions. The hospital's rate may vary from year to year due to changes in the costs (hospital expenses and revenues) and/or activity (workload, patient days, patient visits, etc.) reported by the hospital to CIHI.

   It should be noted, due to the pandemic most of Ontario hospitals incurred decreases in patient volumes but increases in operational costs during 2020-21. As a result, their inpatient billing rates went up significantly compared with 2019-20 (pre-pandemic). The Rate Review Working Group (RRWG) members agreed to revisit the issue once 2021-22 CIHI data and rate calculations are available in early 2023.

   It is also recognized that the number of out of province cases significantly decreased while associated unit costs have increased.

OUTPATIENT RATES

5. **How can my organization act if it has not yet implemented the appropriate system changes to process the new outpatient rates by April 1, 2023? It should be noted the new outpatient rate structure was established in the 2021/22 fiscal year.**

   Hospitals may submit interprovincial billing claims for outpatient services within 12 months of providing these services. If your hospital has not yet implemented the appropriate system changes to process the new outpatient rates by April 1, 2023, you may submit relevant interprovincial billing claims once the necessary system changes are effective, provided that these changes are made within 12 months of providing outpatient services for out-of-province patients.

6. **Are there any changes to the outpatient rates for the 2023/24 fiscal year? How do these new rates differ from the historical rates that jurisdictions have used for years?**

   No, although the outpatient rates have been revised in 2023/24, the format of the rate schedule does not differ from last year's schedule.

1) **Two sets of rates:** The rate schedule contains two sets of rates:

   - One set of rates that <u>include</u> physician compensation for non-invasive and diagnostic procedures; and
   - One set of rates that <u>exclude</u> physician compensation for non-invasive and diagnostic procedures.

   Ontario has selected the physician fees excluded set of outpatient rates, which will apply to all Ontario hospitals. **Note, Ontario hospitals will continue to use the combined set of rates that include physician compensation for non-invasive and diagnostic procedures for all Quebec claims for the 2023/24 fiscal year and onwards, until further notice**.

2) **Low-Medium-High Categories for Day Care Surgery:** A single rate for the Day Care Surgery Service Code (Code 02) has been replaced by three Day Care Surgery rates:

   - a low-cost rate;
   - a medium-cost rate; and
   - a high-cost rate.

   Day Care Surgery visits have been assigned to one of these categories based on the Canadian Classification of Interventions (CCI) Intervention Code that represents the chief reason for the patient's visit to the hospital.

7. Are there any changes to the outpatient rates listing for billing year 2023/24?

Yes, service code 21/71 - X-ray with Cardiac Catheterization have been removed from Standard Outpatient and added as a separate category to recognize higher resources consumed by the procedure. The service code assignment was changed for the cardiac catheterization code – on an interim basis – as the result of an RRWG priority issue investigation. Future work to address high-cost standard outpatient visits is ongoing.

8. What data are the outpatient rates based on?

The rates are based on ambulatory (outpatient) data provided to CIHI's Canadian Patient Cost Database (CPCD) from Canadian hospitals. This database is an ideal data source for rate calculation because it contains clinical information that describes the diagnoses and interventions performed on ambulatory patients as well as financial information that describes the expenses incurred during the patient's visit. The costing of patient visits is an onerous process and currently only three jurisdictions submit data to the CPCD: Alberta, Nova Scotia and Ontario. In aggregate, the three provinces submit approximately eight million costed patient visits annually to the CPCD, the overwhelming majority of which are used to inform the annual rate calculation exercise.

In the new schedule of rates, average costs for each Service Code are based on three years of CPCD data to improve the robustness of the average costs that are relied upon.

9. **How is physician compensation reported to the CPCD?**

   The CPCD contains data elements that allow its data providers to separately identify the patient costs related to both (i) physician compensation of a salaried nature and (ii) physician compensation of a non-salaried nature. Reporting the patient costs in this level of detail allows for greater transparency in the analysis of full patient costs.

   Presently, Alberta and Nova Scotia provide data to the CPCD with their physician compensation identified, while Ontario does not. However, discussions with Ontario have indicated that there is some physician compensation present in Ontario's CPCD submission. This physician compensation is not identifiable as such but is instead grouped with other non-physician related expenses in other CPCD data elements. Because Ontario's physician compensation is not identifiable, the proportion of Ontario's patient costs reported to the CPCD that are related to physician compensation cannot be ascertained.

   The inability to identify the physician compensation component of all CPCD data submissions is one of the factors that has necessitated the development of a two-rate outpatient rate model.

10. **How do we know that the new schedule of rates is an improvement over the previous schedule?**

    Of the eight million costed patient visits that the CPCD receives annually, approximately 100,000 represent out-of-province hospital visits. CIHI compared the remuneration revenue returned by both the historical rate schedule and the proposed rate schedule with the reported costs of these 100,000 out-of-province hospital visits. In aggregate, the difference between the costs and the remuneration revenue decreased considerably when the proposed rate schedule was used.

11. **Why aren't the out-of-province data submitted to the CPCD used alone for the rate calculation?**

    While there are 100,000 costed out-of-province outpatient visits submitted annually to the CPCD, they are not distributed evenly across all Service Codes. Some Service Codes have too low a volume of out-of-province outpatient visits to use this information to calculate reliable annual outpatient rates. Including all visits (in province and out-of-province) increases these sample sizes and does not diminish the integrity of the estimates.

12. What are the cost thresholds used to group the Low, Medium and High-Cost day surgeries?

Service Code	Service Code Description	Cost Group	Cost Group Description
2	Day Care Surgery	Low	The cost* is < $2,000
2	Day Care Surgery	Medium	The cost* is ≥ $2,000 and < $10,000
2	Day Care Surgery	High	The cost* is ≥ $10,000

**Cost refers to the average cost per visit for each unique CACS intervention code.*

13. How is a Day Care Surgery visit classified to a Low, Medium or High category?

The classification of a Day Care Surgery visit to Low, Medium and High categories is based on the CCI Intervention Code reported on the patient's abstract that is most responsible for the visit's resource use. CIHI reviewed the distribution of the average costs of all Day Care Surgery visits by reported CCI Intervention Code. Based on this review, CIHI developed thresholds for Low, Medium and High costs.

14. Is every Day Care Surgery-related CCI Intervention Code assigned to a Low, Medium or High category?

In order for a Day Care Surgery-related CCI Intervention Code to be assigned to a category, it must be reported in at least one patient visit in the CPCD. As the CPCD is not a comprehensive representation of all outpatient visits encountered in Canada, it is possible that some Day Surgery-related interventions are not reported to it. Day Care Surgery interventions that are not reported to the CPCD will be assigned to the Medium category by default, as it is the broadest category of the three.

15. Will Low, Medium and High assignments for Day Care Surgery interventions change from one rate calculation to the next?

Assignments of Day Care Surgery interventions to Low, Medium and High categories will remain consistent for each version of the CCIs. Presently, CIHI updates the CCI on a three-year schedule. The schedule for updating the assignments will mimic the CCI schedule; that is, an intervention will maintain its categorization over the three years. However, the average costs associated with each category will be updated every year.

16. **In the proposed outpatient rate schedule, what outpatient rate claims will require a CCI Intervention Code?**

    In the proposed schedule, any Day Care Surgery claim (Low, Medium or High) will require a CCI Intervention Code. The CCI Intervention Code must represent the surgical intervention that was performed during the patient's visit.

    It is important to ensure the correct CCI codes pertaining to the low, medium and high cost day surgery rates are used. Using the wrong CCI codes will result in the home provinces/territories requesting an adjustment to the claim, and therefore results in the payment of the claim being recovered back from the Ontario hospital.

17. **How are claims related to Day Care Surgery visits submitted in cases where more than one CCI Intervention Code is used, i.e. one CCI Intervention Code is assigned to the Low category and one CCI Intervention Code is assigned to the Medium category?**

    For billing purposes, only claim the CCI Intervention Code with the higher rate amount/category.

18. **What can be submitted through Reciprocal Hospital Billing if a day surgery for an outpatient was cancelled?**

    If a patient is registered at a hospital as an out-patient and their day surgery is cancelled before they are seen by a physician or receiving treatment, code 01 may be billed.

19. **How was the PET-CT scan rate calculated?**

    Aggregate direct costs and volumes for PET-CT scans are reported annually to CIHI's Canadian MIS Database. An indirect cost allocation is calculated using a sample of CPCD records for patients that reported a PET-CT scan as an intervention. The volumes, direct costs and indirect cost ratio are used together to calculate an average full cost for patients that have PET-CT scans.

20. **Why are only certain PET-CT scan rates eligible for reciprocal billing?**

    Some jurisdictions require legislative changes to allow certain PET-CT scans to be billed through the reciprocal billing mechanism. Therefore, the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC) determined that only a sub-set of PET-CT scans could currently be reciprocally billed.

HIGH COST PROCEDURES

21. **Are there any changes to the In-Country Organ Procurement and Bone Marrow/Stem Cell transplant rates?**

    The In-Country Organ Procurement billing rate was inflated using the national inflationary increase of 5.94% (CPI plus 2%). Heart, Lung, Liver and Kidney were calculated based on CIHI's 2021-22 estimate and then the national 5.94% increase (CPI plus 2%) for 2023-24.

For the Bone Marrow/Stem Cells Transplant rate, the current 2021/22 billing rate has been inflated using the national inflationary increase of 5.94% (CPI plus 2%).

NEWBORN

22. What is the interprovincial billing rate for well newborns on and after April 1, 2023?

The interprovincial per diem billing rate for “well” newborns had increased from $1,042 to $1,167 on and after April 1, 2023.

Well newborns are defined as those newborns that receive care under the diagnostic code Z38*** series only.

When a newborn receives standard ward patient care, the authorized standard ward per diem rate may be billed. When a newborn receives care in an intensive care unit, the authorized intensive care unit per diem rate may be billed. The well newborn rate is not billed when the authorized standard ward and/or the intensive care unit per diem rate is billed.

PHYSICIAN BILLING

23. Will physicians be paid for professional fees at the rates outlined in the Ontario Schedule of Benefits or at the rates outlined in the "patient’s/resident’s" Province Schedule of Benefits?

Under the Physician Fees Excluded outpatient model (that Ontario adopted) professional fees may be billed in addition to the outpatient rates, either by the physician or on the physician’s behalf. For physician services billed through the reciprocal medical billing system (RMBS), claims will be billed and paid at the rates outlined in the Ontario Schedule of Benefits.

Quebec **does not** participate in reciprocal medical billing. When providing services to Quebec residents, your billing options include the following:

1) **Bill the Quebec patient directly.**
   Hospitals/physicians are to follow heir own billing policies when establishing the rate they bill patients (Ontario fee schedule rate or uninsured patient rate). The patient can then seek reimbursement from the Quebec Health Plan (up to the rates payable for those services under the Quebec fee schedule) and/or private insurance, if applicable.

   If payment is received directly from a patient, in addition to a detailed invoice of the services provided, please ensure the patient is provided with proof of payment; so that they can seek reimbursement from their home plan.

2) **Bill the Régie de l’assurance maladie du Québec (RAMQ) directly.**

   Contact information can be found at http://www.ramq.gouv.qc.ca/en/contact-us/citizens/pages/contact-us.aspx. You will be paid the applicable Quebec rates outlined in their respective fee schedule for the services rendered. You will also need to ensure that the patient’s Quebec health care card is valid.

To bill Quebec directly, use the Quebec “Out of Province Claim for Physician Services” form (4292). The form is available online at: https://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/formulaires/4292.pdf

24. Will Diagnostic Imaging/Cardio Physicians have to submit claims directly to the MOH at the Ontario Schedule of Benefits rates?

Under the ‘Physician Fees Excluded’ model, Diagnostic Imaging/Cardio physicians or hospital billing departments may submit claims directly to the MOH or to the patient’s home jurisdiction, following the same process that is done for other outpatient and inpatient claims. Alternatively, these physicians may continue to be paid by the hospital should that be the process the hospital and physicians agree upon.

Refer to the response for question #23 that notes the options and process for billing Quebec patients.

25. Is there is any differences in the physician rates in other provinces and the Ontario Physician Schedule of Benefits rates?

The MOH is responsible for maintaining the Ontario Schedule of Benefits for Physician Services, in consultation with the Ontario Medical Association. The MOH does not maintain fee schedules for other provinces and territories and therefore cannot speak to the differences in rates compared to OHIP rates. However, the ministry is aware that some provinces and territories may have lower rates than the Ontario Schedule of Benefits. Ontario hospitals may consider working with their respective Ontario Health Regions and submitting in-year requests to the ministry for additional funding should they experience financial pressures from providing services to out-of-province patients.

26. Is there a Fee for Service (FFS) interprovincial electronic claim form which MOH is going to implement in the light of the intended changes? If yes, can we have the technical details of such to see if we can implement it for the hospital's physician groups?

At this time, the MOH will not be implementing any new methods of billing (e.g. electronic claim form).

A physician is permitted to bill professional fees associated with interprovincial inpatient stays or outpatient services. Ontario physicians may either bill for services rendered through reciprocal medical billing or alternative methods (e.g. billing the home jurisdiction or patient directly). Ontario physicians are to use the Ontario fee schedule when billing reciprocally as there are no separate fee codes associated with out-of-province patients and physician billings.

Billing through reciprocal medical billing is recommended when an out-of-province resident presents a valid health card from their home jurisdiction. This ensures payment under the Ontario fee schedule rate. Payment for all services except those listed in the exclusion list will be paid at the OHIP rate.

It should be noted Quebec does not participate in reciprocal medical billing therefore Ontario physicians may either bill RAMQ or the patient directly. Refer to the response for question #23 that notes the options and process for billing Quebec patients.

27. The FFS Physician billings for professional fees can be billed based on the OHIP Fee Schedule. Does this include services provided to Quebec patients?

Under the Physician Fees Excluded outpatient model (which Ontario will be adopting) professional fees may be billed in addition to the outpatient rates, either by the physician or on the physician's behalf. For physician services billed through the reciprocal medical billing system (RMBS), claims will be billed and paid at the rates outlined in the Ontario Schedule of Benefits.

Given that Quebec does not participate in reciprocal medical billing, services would be billed directly to RAMQ, and paid at the Quebec rates outlined in their respective fee schedule. Refer to the response for question #23 that notes the options and process for billing Quebec patients.

28. Do the out-of-province FFS patients have to be submitted separately from our regular OHIP submissions or can they be included in one submission under each group for the hospital?

Out-of-province FFS patients can be included, as indicated in the Technical Specification (http://www.health.gov.on.ca/en/pro/publications/ohip/docs/techspec_interface_hcsm.pdf).

It is recommended you consult your software vendor on how to submit reciprocal medical billing claims. You may also refer to the Technical Specifications for further assistance. For any technical/reciprocal medical billing claims support please contact Service Support Contact Centre at 1-800-262-6524.

Note: Quebec does not participate in reciprocal medical billing. Refer to the response for question #23 that notes the options and process for billing Quebec patients.

29. Do the out-of-province FFS submissions get uploaded to the same MOH portal as the regular OHIP FFS submissions if they are required to be separated?

Yes, they get uploaded to the same MOH portal as the regular OHIP FFS submissions.

30. Will they be remitted electronically like our OHIP FFS remittances and downloaded monthly from the MOH portal if they are separated?

http://www.health.gov.on.ca/en/pro/publications/ohip/docs/techspec_interface_hcsm.pdf

Yes, they will be included in your monthly Remittance Advice.

31. If these claims do not go through the same FFS OHIP submission the technical specifications for the out-of-province claims are dramatically different and are not able to handle the FFS codes to be submitted. Is there a new technical specification file coming out for us to use?

If you are unable to submit RMB claims, it is recommended you consult your software vendor.

BILLING IN GENERAL

32. What are the billing rules if two or more outpatient activities are provided to the same patient on the same day?

If the same patient, at the same hospital has two or more outpatient activities (service codes 01-15) on the same day, regardless of whether the patient was discharged and readmitted (as an outpatient), to the same hospital on the same day, only one outpatient activity can be billed by the hospital (i.e., the one activity with the highest rate).

When two or more outpatient activities (service codes 01-15) are provided to the same patient on the same day at the same hospital and, the patient is later admitted to the same hospital on an inpatient basis on the same day the outpatient services were provided, only one outpatient activity can be billed by the hospital (i.e., the one activity with the highest rate) plus the inpatient rate for that day.

33. What are the billing rules for inpatient/outpatient services provided on the same day?

If a patient has an outpatient service and is later admitted to the same hospital on an inpatient basis the same day, the hospital can bill **both** the outpatient service and the inpatient rate for that day. In this case, both the admission and outpatient date of service are the same (and there will be two claims for the patient on one day – an outpatient service claim and an inpatient claim).

If a patient is discharged from the hospital and has an outpatient service at the same hospital on the same day, the hospital can bill for the outpatient service. In this case, both the discharge and outpatient date are the same.

34. Should the master number or facility number be used when submitting claims to the MOH for reciprocal billing purposes? Do merged or amalgamated facilities submit separate billing claims for individual sites and/or programs?

All Ontario hospital reciprocal billing claims (both inpatient and outpatient) must be submitted to the MOH using the hospital's 3-digit facility number. The 4-digit master number should not be used.

Merged or amalgamated facilities with separate sites and/or programs must submit billing claims using the parent organization's facility number. The facility number is a 3-digit number, unique to each hospital and used to identify a hospital as a legal corporate entity.

35. How will the MOH process the payments for interprovincial billing claims from multi-site hospitals?

The MOH will process payments using the current banking information on file. Multi-site hospitals should use one bank account.

36. What timelines apply when requesting approval to submit a reciprocal hospital claim which has been denied by the Workers Compensation Board (WCB) / Workplace Insurance Safety Insurance Board (WSIB) where the service/discharge date is more than 12 months in the past?

Hospitals have 12 months from the date of the written denial notification from WCB/WSIB to submit a claim through Reciprocal Hospital billing.

For denied WCB/WSIB claims, that are more than 12 months from the date of the denial letter, the hospital must obtain approval from the home province/territory to submit the claim. Approval is at the discretion of the home province/territory.

RESOURCES / INFORMATION

37. What if an out-of-province resident does not present a valid health card?

A valid health card must be presented at the time of service. If a valid health card is not provided at the time of service, or if the health card has expired, the hospital should bill the patient directly and the patient can then seek reimbursement from their home health insurance plan.

Note: it is recommended to charge the approved in-patient or out-patient rate according to the service and provide the patient with a detailed invoice for reimbursement purposes.

38. Where can I find the MOH's website for interprovincial hospital billing communications?

INFOBulletins on interprovincial hospital billing can be found at:

www.health.gov.on.ca/english/providers/program/ohip/bulletins/bulletin_interprovincial.html

39. Is reciprocal billing claim submission on paper forms still acceptable to the MOH?

No, the submission of reciprocal billing claims via paper is no longer acceptable. If your hospital has not migrated from paper to electronic submission, please have your IT department follow the technical specifications located at the link below in order to complete that migration.
http://www.health.gov.on.ca/en/pro/publications/ohip/docs/techspec_icd.pdf

Please register your hospital for Medical Claims Electronic Data Transfer (MCEDT) internet-based claims submission. This website contains information about MCEDT in general:
http://www.health.gov.on.ca/en/pro/publications/ohip/mcedt_mn.aspx

40. Who can I contact for help/support?

For inquires related to reciprocal hospital billing, please use the following chart to determine the best area of contact:

SUBJECT	CONTACT
Interprovincial and reciprocal billing policies, procedures and rates	Hospitals.Branch-HSQFD@ontario.ca
Physician billing and payment	Service Support Contact Centre at SSContactCentre.MOH@ontario.ca 1-800-262-6524
Status/timing of payment, adjustments or other financial related questions	RHBS-SUBMISSION@ontario.ca