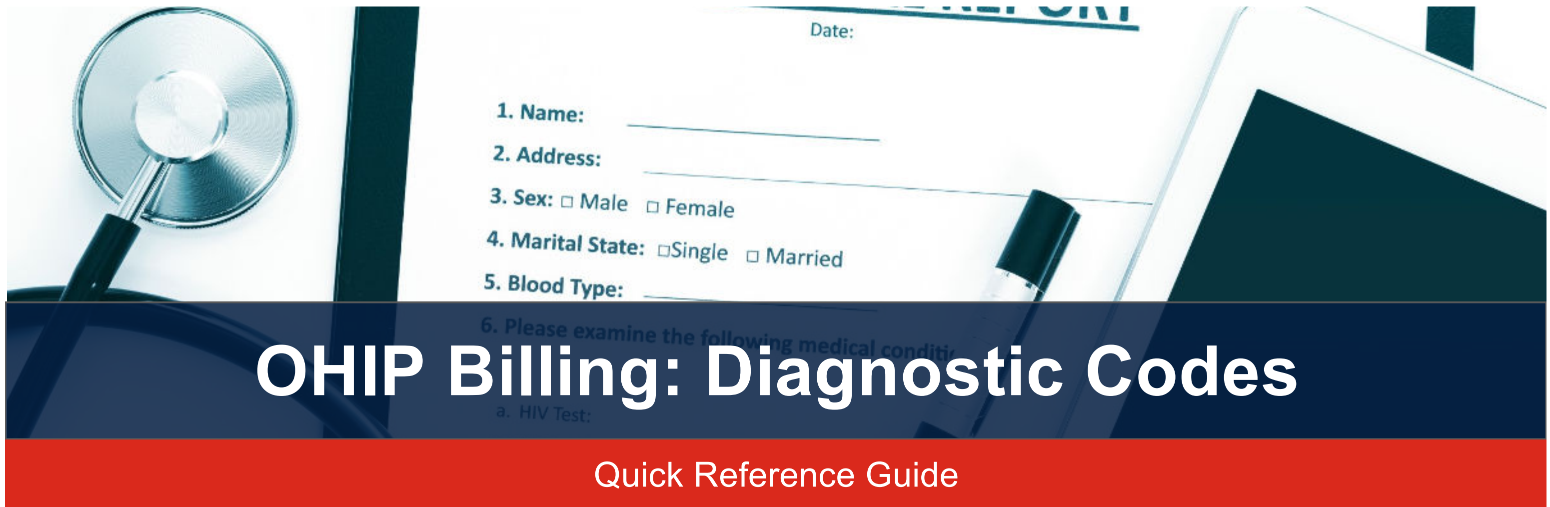

OHIP Billing: Diagnostic Codes

Quick Reference Guide

This short guide will help you understand the most common diagnostic codes related to the new acuity modifier payment and how to use them appropriately.

What is the new acuity modifier payment?

Effective April 1, 2024, physicians in the FHN and FHO models will receive an additional payment based on the acuity of patients enrolled, measured by the CIHI population grouping method. This additional payment offsets the changes to the preventive care bonus and the FFS hard cap.

Each patient in Ontario is assigned a risk score based on:

- Age
- Sex
- Activities of daily living (ADL) and
- Health condition(s) using the CIHI POP Grouper.

Within each age-sex group, the patients are sorted in ascending order of their risk scores and divided into five bands.

What do the bands represent?

The bands represent the patients' complexity or 'acuity,' ranging from one (least acute) to five (most acute). As a reminder, "acuity" encompasses acute and chronic conditions affecting patients' demand for healthcare resources.

Male	Band 1	Band 2	Band 3	Band 4	Band 5
Average Payment Increase from 2023 age-sex model (%)	1.2%	2.0%	2.9%	4.2%	7.2%

Female	Band 1	Band 2	Band 3	Band 4	Band 5
Average Payment Increase from 2023 age-sex model (%)	1.3%	2.0%	2.7%	3.7%	6.0%

By categorizing patients into bands based on complexity permutations, we create five tiers, each comprising around 1.1 million potential complexities. The lower bands contain non-users and acute disorders, while higher bands house complex and chronic cases requiring extensive healthcare resources, leading to higher acuity payments

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Acute and Chronic Condition Diagnostic Codes

It is important that physicians use the most precise diagnostic codes in their OHIP claims to ensure proper assignment to bands and maximize patient capitation. Avoid utilizing generic diagnostic codes during patient consultations. Doing so may impact patient classification into bands and subsequent payments. Additionally, knowing which diagnostic codes belong to acute and chronic conditions can help better define a patient's complexity by the Ministry.

Condition	Diagnostic Code	Description
Acute	595	Disease of Urinary System: Cystitis
	009	Intestinal Infectious Diseases: Diarrhea, gastro-enteritis, viral gastro- enteritis
	034	Other Bacterial Diseases: Streptococcal sore throat, scarlet fever
	372	Eye: Conjunctiva disorders (e.g., conjunctivitis, pterygium)
	569	Other diseases of Intestine and Peritoneum: Anal or rectal polyp, rectal prolapse, anal or rectal stricture, rectal bleeding, other disorders of intestine
	391	Rheumatic Fever and Rheumatic Heart Disease: Rheumatic fever with endocarditis, myocarditis, or pericarditis
	708	Other Diseases of Skin and Subcutaneous Tissue: Allergic urticaria (hives)
	460	Acute nasopharyngitis, common cold
	850	Sprains, Strains and Other Trauma: Concussion
	780	Signs and Symptoms Not Yet Diagnosed: Convulsions, ataxia, vertigo, headache, except tension headache and migraine
Chronic	054	Viral Diseases Accompanied by Rash: Herpes simplex, cold sore
	428	Ischaemic and Other Forms of Heart Disease: Congestive heart failure
	401	Hypertensive Disease: Essential, benign hypertension
	300	Neuroses and Personality Disorders: Anxiety neurosis, hysteria, reactive depression, neurasthenia, obsessive-compulsive neurosis
	706	Other Diseases of Skin and Subcutaneous Tissue: Acne, acne vulgaris,
	696	Other Inflammatory Conditions: Psoriasis
	714	Rheumatoid arthritis, Still's disease

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Chronic	493	Asthma, allergic bronchitis
	592	Disease of Urinary System: Stone in kidney or ureter
	346	Central Nervous System: Migraine

Note: Because patient diagnoses should be precise, we advise against using diagnostic code **'799- Non-specific Abnormal Findings: Other ill-defined conditions**' and other generic diagnostic codes during patient visits. You can find the full list of diagnostic codes here.

Frequently Asked Questions

What exactly does the new acuity modifier payment take into consideration?

The system considers fee codes billed by family physicians and any other claims in other settings, such as hospitals and emergency departments. Although OHIP currently only accepts a single diagnosis per claim, a patient's diagnostic profile is assembled of all a patient's physician visits and health-system encounters over many years.

For example, data from inpatient and emergency department visits allow multiple diagnostic codes to be reported simultaneously. Accurate diagnosis reporting with each OHIP claim can help to ensure that patient complexity is properly captured by the methodology.

What is the timeframe of billing data that is being used to group patients into bands?

When assigning patients to complexity bands, the Ministry looks at data that goes back:
- 5 years for chronic conditions (i.e. asthma, cancer, diabetes)
- 2 years for acute conditions (i.e. URTIs, UTIs, stitches)

It takes two diagnoses to trigger the acuity modifier to be updated.

Do service codes affect what band a patient is assigned to?

No, billing different service codes does not affect a patient's band assignment. Whether you bill K030, A005 or K013, it does **not** affect the band to which a patient is ultimately assigned.

Does my roster size affect the new acuity payments?

All roster sizes, including those with fewer than 1000 patients, will receive the new acuity payments. Physicians with more enrolled patients receive higher capitation payments, and the new system further recognizes the acuity of each patient.

What happens when a specialist sees my patient?

If a patient goes to see a specialist and that specialist bills a different diagnosis, it helps the family provider with the acuity modifier. So, if you know a patient is seeing a cardiologist for CHF, you should bill a different diagnosis when that patient comes to see you as their family physician.

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Frequently Asked Questions

As a physician, how will I receive this payment?

According to the latest updates from the Ministry, all FHN and FHO physicians who practiced during the fiscal year 2022/2023 will receive a new one-time acuity payment disbursed as a lump sum for the fiscal year 2024/2025. You would have already received this payment in the May 2024 remittance advice (RA) alongside your regular capitation amount.

This one-time payment for the entire fiscal year 2024/2025 will be listed under the accounting transaction '**BASE RATE ACUITY PAYMENT**'.

Physicians who commenced practice in the fiscal year 2023/2024 or will begin practicing in fiscal 2024-2025 will receive their one-time new acuity payment for 2024/2025 in the fall of 2025. This is because the data for physicians who started practising after April 1, 2023, is incomplete to make a one-time interim payment after April 1, 2024.

The complete data for these physicians will be available after the summer of 2025, and their interim payment will be made after September 1, 2025. This payment is retroactive for April 1, 2024, and March 31, 2025.

Reminder to physicians: It's important to note that patient assignment to bands is the responsibility of the Ministry, not physicians. As a physician, your role remains unchanged. You will continue to submit your claims as usual and reflect the patient diagnosis on the claim using diagnostic codes. This process ensures that you can focus on providing the best care for your patients without the added burden of patient assignment.