Diabetes billing codes during COVID-19 – temporary payments equivalent to selected management fees

- Ministry of Health (MOH) is allowing K081 or K082 codes to qualify providers to bill the Q040 code in 2021 (provided that you have used the Diabetic Diagnostic Code -250 with them, and documented care with a diabetic flow sheet*), for those patients with diabetes who you are actively managing.

Fee code	Descriptor	Value
Q040	GP/FP-Diabetes management incentive-annual	$60.00
K081	Temporary code • Intermediate assessment of an insured patient by telephone or video, or advice or information by telephone or video to a patient's representative regarding health maintenance, diagnosis, treatment and/or prognosis, if the service lasts a minimum of 10 minutes • Psychotherapy, psychiatric or primary mental health care, counselling or interview conducted by telephone or video, if the service lasts a minimum of 10 minutes	$36.85
K082	Temporary code • Psychotherapy, psychiatric or primary mental health care, counselling or interview conducted by telephone or video per unit (unit means half hour or major part thereof) for an insured patient	$67.75
K030	Diabetic management assessment	$40.55

- What does this mean to you?
  - If you have seen a diabetic patient and completed a diabetic flow sheet* a minimum of three times between April 1, 2020 – March 31, 2021 you can submit a Q040 code following the third visit.
  - If you saw your diabetic patient in-person then you would have billed the K030 but after March 17, 2020 you may have only seen them virtually and as a result, you would have had to bill the K081 or K082 codes.
  - So your billing history for that patient during that 12-month period could look like any of the following combinations, which would all qualify you to bill the Q040:
    - K030, K081/2, K081/2 OR
    - K081/2, K081/2, K081/2 OR
    - K030, K030, K081/2
  - There are no specific limits to the number of K081 and K082 codes you can bill per patient, however when combining these codes with the diabetes diagnostic code (250), follow the maximums set for the regular diabetes billing codes (K030 and Q040). K030 is limited to a maximum of 4 per patient per 12-month period, and Q040 is limited to a maximum of 1 per patient per 12-month period.
- Other notes:
  - K081 and K082 are included in-basket for capitated and salaried primary care enrolment models, and Q040 is out of basket.
  - When you are billing for visits done with diabetic patients via OTN then use code K030.
  - The new K codes can be used for follow-ups. Use the code with the closest workflow and dollar value.

For more information, visit http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4764.aspx

** A completed flow sheet or other documentation tool that demonstrates that all of the required elements of comprehensive diabetes care, as per the most current Diabetes Canada guidelines, has been provided to the patient for the previous 12-month period.*

400 University Ave Suite 2100
Toronto, ON M5G 1S5
647-260-7880
www.cep.health