

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Physicians

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Re: Funding for physician and hospital services for patients who do not have provincial health insurance during COVID-19 effective March 21, 2020

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As part of Ontario's efforts to stop the spread of COVID-19, the Ministry of Health (ministry) is committed to ensuring that all people in Ontario receive medically necessary health care during the COVID-19 outbreak.

To this end, and until further notice, the ministry has established temporary payment mechanisms to facilitate hospital and physician payments for medically necessary services provided to patients who are not currently insured under OHIP or another provincial plan.

Remuneration for physician services provided in hospital

Physicians who perform services for uninsured patients in a hospital setting will be remunerated by the hospital at existing rates listed in the [Schedule of Benefits for Physician Services](#) (the Schedule). **Hospitals can now submit claims for these services to OHIP.**

The ministry has provided a tracking spreadsheet to all hospitals with the information required for reimbursement of hospital services and physician services performed in hospital. Physicians are expected to report this information to the hospital where the service was provided. Hospitals will be responsible for submitting reports to the ministry for reconciliation, and hospitals will distribute payment to physicians.



Remuneration for physician services provided in the community

For services performed outside the hospital setting, the ministry has introduced the following temporary fee codes for the provision of medically necessary physician services provided to uninsured patients in the community.

These codes are for services rendered on or after March 21, 2020.

Fee Codes and Payment

Effective May 1, 2020, system changes have been implemented in association with the temporary Fee Schedule Codes (FSCs) listed below. **Physicians can now submit claims for these temporary FSCs:**

K087: minor assessment of an uninsured patient provided in-person or by telephone or video or advice or information provided in-person or by telephone or video to an uninsured patient's representative regarding health maintenance, diagnosis, treatment and/or prognosis-\$23.75

K088:

- a. intermediate assessment of an uninsured patient provided in-person or by telephone or video, or advice or information provided in-person or by telephone or video to an uninsured patient's representative regarding health maintenance, diagnosis, treatment and/or prognosis, if the service lasts a minimum of 10 minutes; or
- b. 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

K089: psychotherapy, psychiatric or primary mental health care, counselling or interview conducted in-person or by telephone or video per unit (unit means half hour or major part thereof)-per unit \$67.75

Payment Requirements

1. The services must be documented on the patient's medical record (including the start and stop times).
2. If K087, K088 or K089 are claimed, no charge can be billed to, or payment received from, the patient or the patient's representative.

Claims Submission Requirements

Physicians can submit for these codes using their group billing number where the service was provided, or their solo billing number.

The codes cannot be billed using one of the COVID-19 Assessment Centre group billing numbers.

The codes cannot be billed with a Service Location Indicator of 'OTN'.

Physicians will be paid Fee-For-Service for the above K-codes.

No additional premiums or payment will be allowed with these codes.

The fee billed on the claim should equal the value of the service multiplied by the number of patients serviced. For example, if K087 is claimed for 3 patients seen during the same day, the fee billed should be \$71.25 (3 x \$23.75).

The number of services for K089 represent the total number of 30 minute intervals spent with all uninsured persons in a single day. For K089A, the current timekeeping rules for psychotherapy remain. See page GP54 of the Schedule for information time units and minimum time requirements.

Claim submissions for these codes must also adhere to the following requirements:

- The claim must be submitted with the Billing Number of the physician who provided the service
- The Health Number field on the claim must be left blank
- The Version Code field on the claim must be left blank
- The Birth Date field on the claim must be left blank
- The Service Date on the claim will be the date the service was provided
- If a physician submits these claims with a Health Number or Version Code, the claim will reject VHB-No HN Required for FSC"

If a physician submits these claims with a value in the Birth Date, the claim will reject VH1-Invalid Health Number.

For any inquiries, please contact the [Service Support Contact Centre](#) at 1-800-262-6524.