GENERAL PREAMBLE

INTRODUCTION

[Commentary:
The *Health Insurance Act* and, to a lesser extent, the *Independent Health Facilities Act* and the *Commitment to the Future of Medicare Act*, provide the legal foundation and framework for the *Schedule* of Benefits for Physician Services ("the *Schedule*").

The Schedule lists services insured by *OHIP* and includes the General Preamble (which impacts all physicians), Consultations and Visits section (which applies to all specialties) and specific system and/or specialty sections (including specialty preambles).

The General Preamble provides details about billing requirements for all physicians as follows:

The initial **Definitions Section** (GP2) begins with general definitions of key terms and phrases used in the Schedule. Those terms and phrases are italicized throughout the General Preamble as an indication that further information is available in the Definitions Section. The second group of defined terms refers specifically to maximums, minimums, and time or unit-based services.

The information provided in the **General Information Section** (GP6) is the foundation for the remainder of the General Preamble. A variety of subjects are reviewed as detailed in the table of contents. This is followed by the **Constituent and *Common Elements* of Insured Services** (GP9). Next is the section which lists the ***Specific Elements* of Assessments** (GP11). The next section provides information on **Consultations and Assessments** (GP12) followed by the section regarding services provided only in **Hospitals and Other Institutions** (GP26).

The next section focuses on psychotherapy, counselling, and related services, followed by a similar review of services that involve interviews. The remaining sections include special visits, surgical assistants' services, anaesthesiologists' services, and others as listed in the table of contents.]

GENERAL PREAMBLE

DEFINITIONS

GENERAL DEFINITIONS

The words, phrases, and abbreviations defined below are italicized throughout the General Preamble for cross-reference. Unless otherwise specified, the following terms and expressions have the following meanings:

A. Age Definitions

adolescent	a person 16 or 17 years of age
adult	a person 18 years of age and older
child	a person 2 years to and including 15 years of age
infant	a person from 29 days up to, and less than, 2 years of age
newborn	a person from birth up to, and including, 28 days of age

B. Time Definitions

12 month period	any period of 12 consecutive months
calendar year	the period from January 1 to December 31
day	a calendar day
fiscal year	from April 1 of one year to March 31 of the following year
month	a calendar month
week	any period of 7 consecutive days

C. Other Definitions

Act	Health Insurance Act
Body Mass Index (BMI)	the ratio of the patient's mass (measured in kilograms) to the square of the patient's height (measured in metres)
Bariatric Regional Assessment and Treatment Centre (RATC)	a facility that is approved and funded by the Ministry of Health and Long-Term Care for the assessment and treatment of morbid obesity for persons who have been referred to the facility for that purpose.
common elements	the components that are included in all insured physician services
constituent elements	the common elements and, where applicable, the specific elements of an insured service
CPSO	College of Physicians and Surgeons of Ontario
emergency department equivalent	an office or other place, including Urgent Care Centres, Walk-in Clinics, Extended Hours Clinics, or other settings (other than a hospital emergency department) in which the only insured services provided are to patients who do not have pre-arranged appointments
general anaesthesia	all forms of anaesthesia except local infiltration
"H" fee	a fee set out in the Schedule for the technical component of a diagnostic service provided either in a hospital or in an offsite premise operated by the hospital corporation that has received approval under section 4 of the *Public Hospitals Act*

GENERAL PREAMBLE

DEFINITIONS

holiday (for other than "H" prefix emergency department listings and Emergency Department Equivalent - A888) means all of the following:

1. Family Day, Good Friday, Victoria Day, Canada Day, Civic *Holiday*, Labour Day, Thanksgiving, New Year's Day, and if the *holiday* falls on a Saturday or Sunday either the Friday before or the Monday following the *holiday*, as determined at the choice of the physician.
2. Boxing Day and if Boxing Day falls on a Saturday, the Monday following Boxing Day.
3. Christmas Day and
   - **a.** if Christmas Day falls on a Sunday, the Friday before Christmas Day;
     or
   - **b.** if Christmas Day falls on a Saturday, the Friday before and the Monday following Christmas Day.

holiday (for "H" prefix emergency department listings and Emergency Department Equivalent - A888) means all of the following:

Family Day, Good Friday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving, New Year's Day, December 25 through December 31 (inclusive) and,

- **a.** if Christmas Day falls on a Saturday or Sunday, the Friday before Christmas Day;
  and
- **b.** if New Year's Day falls on a Saturday or Sunday, the Monday following New Year's Day;
  and
- **c.** if Canada Day falls on a Saturday or Sunday either the Friday before or the Monday following Canada Day, as determined at the choice of the physician.

[Commentary:

1. Only services rendered on a *holiday* as defined above and listed as a *holiday* premium or service, e.g. certain special visit premiums, after-hours premiums and H-code emergency department services, are eligible for payment as *holiday* claims.
2. Special visit premiums are *not eligible for payment* with A888.]

home — patient's place of residence including a multiple resident dwelling or single location that shares a common external building entrance or lobby, such as an apartment block, rest or retirement home, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility, or group home and other than a hospital or Long-Term Care institution

independent operative procedure (IOP) — a procedural code with a "Z" prefix (which is payable in addition to the amount payable for an assessment)

major preoperative visit — the consultation or assessment where the decision to operate is made, regardless of the time interval between the major preoperative visit and the surgery

may include — when "may" or "may include" are used in the description of a listed service, all of the other services, or elements of, or components of insured services that are referred to following the terms "may", "may include", and that are performed in conjunction with the listed service are optional, but when rendered are included in the amount payable for the listed service

medical consultant — a designated MOHLTC physician

MOHLTC — Ministry of Health and Long-Term Care

most responsible physician — the attending physician who is primarily responsible for the day-to-day care of a hospital in-patient

not eligible for payment — when a service or a claim submitted for a service is described as "not eligible for payment", the service remains an insured service for which the amount payable is zero

[Commentary:
Patients cannot be charged for services described as "*not eligible for payment*" as they remain insured services.]

OHIP — Ontario Health Insurance Plan

OMA — Ontario Medical Association

only eligible for payment — when a service is described as "only eligible for payment" when certain conditions are met and those conditions are not met, the service becomes not eligible for payment.

GENERAL PREAMBLE

DEFINITIONS

[Commentary:
Patients cannot be charged for services described as "*only eligible for payment*" as they remain insured services.]

palliative care — care provided to a terminally ill patient in the final year of life where the decision has been made that there will be no aggressive treatment of the underlying disease and care is to be directed to maintaining the comfort of the patient until death occurs

patient's representative — the legal representative of a patient

"P", "P1" or "P2" fee — the fee for the professional component of a diagnostic service

professional component — a class of service listed in the Schedule headed by a column listed "P" or "P1" or "P2" or with "professional component" listed opposite the service

[Commentary:
Additional information including the requirements for performing the *professional component* is found in the individual preambles to the applicable sections of the Schedule.]

referral — written request by one physician for the provision of expert services by another physician to the patient of the referring physician

rendered personally by the physician — means that the service must be personally performed by the physician and may not be delegated to any other person. Services that are required to be "rendered personally by the physician" are uninsured if this requirement is not met

Schedule — Schedule of Benefits for Physician Services

specialist — a physician who holds one of the following:

1. a certification issued by the Royal College of Physicians and Surgeons of Canada (RCPSC);
2. a certificate of registration issued by the *CPSO* to a physician who has successfully completed the Assessment program for International Medical Graduates (APIMG) in a recognized medical or surgical specialty;
3. a certificate of registration as a *specialist* issued by the *CPSO* to a physician employed;
   - in a full-time teaching or full-time research appointment in a recognized medical or surgical specialty other than family or general practice; and
   - by the faculty of medicine of an Ontario university at the rank of assistant professor or higher; or
4. a certificate of registration issued on the order of the Registration Committee of the *CPSO* to a physician who practices in a recognized medical or surgical specialty other than family or general practice, where the requirements of registration are otherwise not met, and to which certificate terms, conditions, or limitations may be attached.

specific elements — specific components, in addition to the common elements, that are included in particular insured physician services found in the General Preamble or the specialty section of the Schedule

"T" fee — the fee for the technical component of a service listed in the Pulmonary Function Studies section of the Schedule

technical component — a class of service listed in the Schedule headed by a column listed "H" or "T" or with "technical component" listed opposite the service

[Commentary:
Additional information including the requirements for performing the *technical component* is found in the individual preambles to the applicable sections of the schedule.]

transferal — permanent or temporary complete transfer of the responsibility for the care of the patient from one physician to another

[Commentary:
A *transferal* occurs, for example, where the first physician is leaving temporarily on *holiday*s and is unable to continue to treat the patient.]

uninsured service — a service that is not prescribed as "insured" under the Act

with or without — when "with or without" are used in the description of a listed service, all of the other services, or elements of, or components of insured services that are referred to following the terms "with or without", and that are performed in conjunction with the listed service are optional, but when rendered are insured and are included in the amount payable for the listed service

DEFINITIONS

MAXIMUMS, MINIMUMS AND TIME OR UNIT-BASED SERVICES

In this Schedule when the amount payable for a service is described:

a. In terms of a maximum number of services without reference to a specific time period to which the maximum applies, this means that the maximum refers to a maximum number of services per patient per day. Those services rendered to the same patient on the same day in excess of the maximum for that patient on that day are *not eligible for payment*.

b. In terms of a maximum number of services with reference to a specific time period to which the maximum applies, the services are calculated per patient and the number of services is based upon services rendered chronologically. Those services rendered to the same patient during that specific time period in excess of the maximum for that patient are *not eligible for payment*.

c. In terms of a maximum with reference to a specific part of the anatomy, this means a maximum number of services per patient per day. Those services rendered in excess of the maximum for that specific part of the anatomy per patient on that day are *not eligible for payment*.

d. In terms of a minimum number of services without reference to a specific time period to which the minimum applies, this means that the minimum refers to a minimum number of services per patient per day. With the exception of those services listed in the “Diagnostic Radiology” section of the Schedule or unless specifically stated otherwise, where less than the number of services required to satisfy the minimum are rendered, the services are *not eligible for payment*.

e. In terms of “repeat” or “repeats”, except with respect to repeat consultations or unless otherwise stated, this means the same service(s) is rendered to the same patient by the same physician on the same day.

f. In terms of a minimum required duration of time, the physician must record on the patient’s permanent medical record or chart the time when the insured service started and ended. If the patient’s permanent medical record or chart does not include this required information, the service is *not eligible for payment*.

g. Based upon the number of “units” of service rendered, the physician must record on the patient’s permanent medical record or chart the time when the insured service started and ended. If the patient’s permanent medical record or chart does not include this required information, the service is *not eligible for payment*.

GENERAL PREAMBLE

GENERAL INFORMATION

[Commentary: Services Insured by *OHIP*
The Schedule is established under section 37.1 of regulation 552 under the Act. The fees listed are the amounts payable by *OHIP* for insured services. Insured services under the Act are limited to those which are listed in this Schedule, medically necessary, are not otherwise excluded by legislation or regulation, and are rendered personally by physicians or by others delegated to perform them where such delegation is authorized in accordance with the Schedule requirements for delegated services.

Some services are specifically listed as uninsured in regulation 552, section 24 of the Act (see Appendix A), such as a service that is solely for the purpose of altering or restoring appearance. Other services may be uninsured depending on the circumstances. An example of a service which is uninsured in limited circumstances is psychotherapy, which is uninsured where it is a requirement for the patient to obtain a dipl*oma* or degree or to fulfill a course of study. Other examples of commonly *uninsured service*s include missed appointments or procedures, circumcision except if medically necessary, and certain services rendered and documents and forms completed in connection with non-medically necessary requests (e.g. life insurance application).]

[Commentary: Modifications to the Schedule
Under agreement between the *MOHLTC* and the *OMA*, additions, deletions, fee changes, or other modifications to the Schedule, are made by the *MOHLTC* following consultation with the *OMA*. Physicians who wish to have modifications to the Schedule considered should submit any proposals to the Physician Services Payment Committee (PSPC) through the appropriate clinical section of the *OMA*.

In the situation where a new therapy or procedure is being introduced into Ontario, and the physicians performing the new therapy or procedure wish to have a new fee item inserted into the Schedule, the following process is recommended.

An application for a new fee related to the new therapy or procedure should be submitted by the appropriate section(s) of the *OMA* to the PSPC for consideration, with documentation supporting the introduction of this item into the Schedule. The PSPC will advise *OHIP* whether or not this new therapy is experimental. If the PSPC and the *MOHLTC* agree that the item is experimental, the service is deemed uninsured (in accordance with section 24 of regulation 552 under the Act), and will not be introduced into the Schedule. If the *MOHLTC*, on the advice of the PSPC, determines that the new therapy or procedure is not experimental, the fee application will be handled in the usual manner as detailed above.]

[Commentary: Medical Research
Examinations or procedures for the purpose of a research or survey program are not insured services, nor are services provided by a laboratory or a hospital that support an examination or procedure that is for the purpose of research or a survey. The exception to this is that an assessment conducted to determine if an insured person is suitable for such a program is not necessarily an *uninsured service* (see section 24 of regulation 552 under the Act - this is provided as Appendix A of the Schedule).]

[Commentary: Medical Records
All insured services must be documented in appropriate records. The Act requires that the record establish that:

1. an insured service was provided;

2. the service for which the account is submitted is the service that was rendered; and

3. the service was medically necessary.

The medical record requirements as found in the Act are listed in Appendix G of the Schedule.]

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

[Commentary:
Claims for payment must be submitted to *OHIP* in the form and by the medium (e.g. electronic data transmission; machine readable input) as set out in sections 38.3 to 38.5 of regulation 552 under the Act and must contain the information required by the regulation and the General Manager of *OHIP*. Regulation 552 under the Act can be found at:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900552_e.htm.

Claims must be submitted within six *month*s of the date the service was rendered, except in extenuating circumstances. A claim cannot be accepted for payment unless it meets all of the technical and formal requirements set out in the Act and regulations.]

1. The fee is payable only to the physician who rendered the service personally, or by the physician whose delegate rendered the service where delegation is authorized in accordance with the Schedule.

2. Where more than one physician renders different components of a listed service, only one fee is payable for that service, and the fee is payable only where the Schedule provides that different physicians may perform different components of the service.

[Commentary:
Where an insured service contains several components (e.g. surgical procedures that include post-operative care or fracture care), the components of the service are not divisible among physicians for claims purposes and the physicians are responsible for apportioning payment amongst themselves.]

3. Where the Schedule provides that different physicians may substitute for one another in performing the total service, only one fee is payable for the service.

[Commentary:
When physicians routinely or frequently substitute for each other in providing hospital visits to registered bed patients in active treatment hospitals, e.g. *week*end coverage or daily rounds by various members of a group, the *most responsible physician* may claim for all the visits.]

Specialist services

When a service rendered by a *specialist* comprises part of an insured consultation or assessment that falls within the scope of his or her *specialist* practice, the service is *not eligible for payment* unless the claim for the service is submitted either:

a. unless otherwise noted, in respect of a service described in the portions of the Consultations and Visits section of this Schedule that reflects the physician's Royal College of Physicians and Surgeons of Canada specialty, as documented in the records maintained by the *MOHLTC* for claims payment purposes; or

b. in respect of a service described in this Schedule under the following sub-headings which can be claimed by any specialty: psychotherapy, counselling, HIV primary care, *palliative care* support, hypnotherapy, certification of mental illness, interviews, genetic assessments, midwife-requested emergency and special emergency assessments, *home* care application, or *home* care supervision.

When a service rendered by a *specialist* does not fall within the scope of the *specialist*'s practice and/or the *specialist* is providing primary care in a family or general practice setting, the service is *only eligible for payment* when the claim is submitted using the appropriate code from the "Family Practice & Practice in General" listings.

When more than one assessment is rendered to a patient during the same visit by the same physician who is qualified in one or more specialties, only one assessment is payable.

[Commentary:
Any additional assessment is *not eligible for payment*.]

Use of Codes, Prefixes and Suffixes

[Commentary:
Services are generally, but not necessarily, listed by anatomical system or specialty for convenience.]

The alpha-numeric fee code opposite the service listing in this Schedule must be set out in the claim submitted, together with the required suffix.

Surgical Codes: In the surgical part of the Schedule, the required suffixes are:

suffix A if the physician performs the procedure;

suffix B if the physician assisted at the surgery; and

suffix C if the physician administered the anaesthetic.

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

Diagnostic Services Rendered at a Hospital

The *technical component* of those diagnostic services that are listed with "*technical component*" or in a column headed "H" or "T" is *not eligible for payment* if the service is rendered to a patient who:

1. is an in-patient of a hospital; or
2. attends a hospital where he or she receives an insured diagnostic service; and
3. within 24 hours of receiving that diagnostic service, is admitted to the same hospital as an in-patient in connection with the same condition, illness, injury or disease in relation to which the diagnostic service was rendered.

[Commentary:

1. For those diagnostic services which have both technical and *professional component*s listed under one fee schedule code, the technical and *professional component*s are claimed separately. The claim for the *technical component* is submitted using the fee schedule code with the suffix B and the claim for the *professional component* is submitted using the fee schedule code with a suffix C.
2. The *technical component* may be listed as either "*technical component*" or in a column headed "H" or "T". The *professional component* may be listed as either "*professional component*" or in a column headed "P", "P1" or "P2".]

The *technical component* of a diagnostic service listed in the column headed with an "H" and rendered outside of a hospital is *not eligible for payment* under the *Health Insurance Act*.

Technical Component Requirements

The *technical component* of a diagnostic procedure as described in the relevant section of the Schedule is *only eligible for payment* where:

1. the physician has the necessary training and experience to personally render the *technical component* of the service; and
2. the physician maintains documentation that describes the process by which the physician monitors quality assurance in accordance with professional standards.

[Commentary:

1. The physician submitting a claim for the *technical component* is responsible for the complete quality assurance process for all elements of the *technical component* of the service, including data acquisition, reporting, and record keeping. The physician must be able to demonstrate the above upon request by the *MOHLTC*.
2. For delegated services rendered in the physician's office, see the Delegated Procedures section in the General Preamble of this Schedule.]

Consultation and Assessment Codes

There are four different prefixes used for consultations and assessments listed in the "Consultations and Visits" section of the Schedule. The codes with the "A" prefix are described as the "General Listings". These must be used when submitting a claim for consultations and assessments except in the following situations when the code listed below must be used:

1. **acute care hospital – non-emergency in-patient services** – "C" prefix codes;
2. **long term care institution – non-emergency in-patient services** – "W" prefix codes;
3. **emergency department – services rendered by a physician on duty** – "H" prefix (H1- codes); or
4. **rehabilitation unit – services rendered by a *specialist* in Physical Medicine** – "H" prefix codes (H3XX codes)

[Commentary:
Submit claim using an "A" prefix assessment when an assessment is rendered in conjunction with a special visit premium. Information regarding when special visit premiums are payable is found on pages GP44 to GP52 of the General Preamble.]

Independent Consideration (IC)

Services listed in the Schedule without specified fees are identified as "IC" and are given independent consideration by the *medical consultant*. Claims for such services must be submitted with a supporting letter explaining the amount of the fee claimed, and must include an appropriate operative or consultation report, and a comparison of the scope and difficulty of the procedure in relation to non-IC procedures in the Schedule. For treatment of tumours not listed in the Schedule, surgeons must use the IC code, R993, and for surgical procedures not listed, but similar to a listed service, the code, R990.

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

[Commentary:
This Schedule identifies the *constituent elements* that comprise insured services. *Common elements* apply to all insured services and *specific elements* apply to specific groups of services where identified either in the General Preamble or in the preamble to a specific system and/or specialty sections of the Schedule. There may be additional specific requirements ("required elements of service", "payment rules", "claims submission instructions" or "notes") for some individual services, and these are noted with the description of any such service within the Schedule. In order to determine the correct claim to use for a service rendered, the necessary information is found by reviewing the *common elements*, *specific elements*, and service specific information.

No charges may be made (except to *OHIP*) for an insured service rendered to an insured person or for any of the *constituent elements* of such insured services. This is prohibited by the Act and/or the *Commitment to the Future of Medicare Act*.

Most services include as a constituent element of the service the provision of the premises, equipment, supplies, and personnel used in the performance of the common and *specific elements* of the service. This is not, however, the case for services denoted by codes marked with the prefix "#", and for services that are divided into *professional and technical components* where only the *professional component* is an insured service under the Act.

For those codes denoted with the prefix "#" and performed in a hospital, the premises, equipment, supplies, and personnel used to perform all elements of the service are funded by the hospital global budget.

For those services denoted with the prefix "#" and provided in an Independent Health Facility, the premises, equipment, supplies, and personnel are funded under the facility fee set out in the *Independent Health Facilities Act*.

Patients cannot be charged for the premises, equipment, supplies and personnel for services denoted with the prefix "#" rendered outside of a hospital or Independent Health Facility if the premises, equipment, supplies and personnel support, assist or provide a necessary adjunct to an insured service denoted with the prefix "#" as charging a patient would be contrary to the *Independent Health Facilities Act*.]

COMMON ELEMENTS OF INSURED SERVICES

All insured services include the skill, time, and responsibility involved in performing, including when delegated to a non-physician in accordance with the Delegated Procedures Section (GP42) of the General Preamble, supervising the performance of the *constituent elements* of the service.

Unless otherwise specifically listed in the Schedule, the following elements are common to all insured services.

A. Being available to provide follow-up insured services to the patient and arranging for coverage when not available.

B. Making arrangements for appointment(s) for the insured service.

C. Travelling to and from the place(s) where any element(s) of the service is (are) performed.

[Commentary:
Travelling to visit an insured person outside of the usual geographical area of practice of the person making the visit is an *uninsured service* – see Regulation 552 section 24(1) paragraph 1 under the Act.]

D. Obtaining and reviewing information (including history taking) from any appropriate source(s) so as to arrive at any decision(s) made in order to perform the elements of the service.

Appropriate sources include but are not limited to:

1. patient and *patient's representative*

2. patient charts and records

3. investigational data

4. physicians, pharmacists, and other health professionals

5. suppliers and manufacturers of drugs and devices

6. relevant literature and research data.

E. Obtaining consents or delivering written consents, unless otherwise specifically listed in the Schedule.

F. Keeping and maintaining appropriate medical records.

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

G. Providing any medical prescriptions except where the request for this service is initiated by the patient or *patient's representative* and no related insured service is provided.

H. Preparing or submitting documents or records, or providing information for use in programs administered by the *MOHLTC*.

I. Conferring with or providing advice, direction, information, or records to physicians and other professionals associated with the health and development of the patient.

J. Such planning, preparation, and administration for the performance of the elements of the service directly attributable either to a specific patient or to a physician maintaining his/her practice, unless otherwise specifically listed in the Schedule.

K. Except for services denoted by codes marked with the prefix "#", or for services that are divided into *professional and technical component*s where only the *professional component* is an insured service under the Act, providing premises, equipment, supplies, and personnel for the *common elements* of the service.

L. Waiting times associated with the provision of the service(s).

While no occasion may arise for performing elements A, B, C, D, F, G, H or K when performed in connection with the *specific elements* of a service, these are included in the service.

GENERAL PREAMBLE

SPECIFIC ELEMENTS OF ASSESSMENTS

In addition to the *common elements*, all services which are described as assessments, or as including assessments (e.g. consultations), include the following *specific elements*:

A. A direct physical encounter with the patient including taking a patient history and performing a physical examination.

B. Other inquiry (including taking a patient history), carried out to arrive at an opinion as to the nature of the patient's condition, (whether such inquiry takes place before, during or after the encounter during which the physical examination takes place) and/or follow-up care.

C. Performing any procedure(s) during the same encounter as the physical examination, unless the procedure(s) is(are) separately listed in the Schedule and an amount is payable for the procedure in conjunction with an assessment.

"Procedure" in this context includes obtaining specimens, preparation of the patient, interpretation of results and, unless otherwise specified, all diagnostic (including laboratory) and therapeutic (including surgical) services;

D. Making arrangements for any related assessments, procedures or therapy, and/or interpreting results.

E. Making arrangements for follow-up care.

F. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:

1. the service; and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

G. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is provided.

H. Providing premises, equipment, supplies, and personnel for the *specific elements* of the service except for any aspect(s) that is (are) performed in a hospital or nursing *home*.

While no occasion may arise for performing elements C, D, E, G, or H, when performed in connection with the other *specific elements*, they are included in the assessment.

GENERAL PREAMBLE

CONSULTATIONS

CONSULTATION

Definition/Required elements of service:

A consultation is an assessment rendered following a written request from a referring physician who, in light of his/her professional knowledge of the patient, requests the opinion of another physician competent to give advice in this field because of the complexity, seriousness, or obscurity of the case, or because another opinion is requested by the patient or *patient's representative*.

[Commentary:

1. The referring physician must determine if multiple requests by a patient or the *patient's representative* to different physicians in the same specialty for the same condition are medically necessary. Services that are not medically necessary are uninsured.
2. If the physician rendering the service requests another physician to submit a consultation request for that service after the service has been provided, a consultation is not payable. The visit fee appropriate to the service rendered may be claimed.
3. Where a physician who has been paid for a consultation for the patient for the same diagnosis makes a request for a *referral* for ongoing management of the patient, the service rendered following the *referral* is not payable as a consultation.

A consultation includes the services necessary to enable the consultant to prepare a written report (including findings, opinions, and recommendations) to the referring physician. Except where otherwise specified, the consultant is required to perform a general, specific or medical specific assessment, including a review of all relevant data.

The following are additional requirements for a consultation:

a. A copy of the written request for the consultation, signed by the referring physician must be kept in the consulting physician's medical record, except in the case of a consultation which occurs in a hospital, long-term care institution or multi-specialty clinic where common medical records are maintained. In such cases, the written request may be contained on the common medical record.

b. The request identifies the consultant by name, the referring physician by name and billing number, and identifies the patient by name and health number.

c. The written request sets out the information relevant to the *referral* and specifies the service(s) required.

In the event these requirements are not met, the amount payable for a consultation will be reduced to a lesser assessment fee.

[Commentary:
The request would ordinarily also include the appointment date and appropriate clinical information, such as the reason for the *referral* for consultation, present and past history, physical findings and relevant test results and reports.]

Payment rules:

1. Where a consultant is requested by a resident or intern to perform a consultation, the amount payable for the service will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant.
2. Consultations, except for repeat consultations (as described immediately below), are limited to one per *12 month period* unless the same patient is referred to the same consultant a second time within the same *12 month period* with a clearly defined unrelated diagnosis in which case the limit is increased to two per *12 month period*. The amount payable for consultations in excess of these limits will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant.

CONSULTATIONS

REPEAT CONSULTATION

Definition/Required elements of service:

A repeat consultation is an additional consultation rendered by the same consultant, in respect of the same presenting problem, following care rendered to the patient by another physician in the interval following the initial consultation but preceding the repeat consultation.

A repeat consultation has the same requirements as a consultation including the requirement for a new written request by the referring physician.

LIMITED CONSULTATION

Definition/Required elements of service:

A limited consultation is a consultation which is less demanding and, in terms of time, normally requires substantially less of the physician's time than the full consultation. Otherwise, a limited consultation has the same requirements as a full consultation.

Under the heading of "Family Practice & Practice in General", a limited consultation is the service rendered by any physician who is not a *specialist*, where the service meets all the requirements for a consultation but, because of the nature of the *referral*, only those services which constitute a specific assessment are rendered.

EMERGENCY ROOM (ER) PHYSICIAN CONSULTATION

Payment rules:

1. The amount payable for a consultation by an ER Physician will be adjusted to a lesser assessment fee under either of the following circumstances:
   - **a.** the patient is referred by another ER physician in the same hospital; or
   - **b.** the service is rendered in any location other than the emergency department or other critical care area in a hospital, or to a critically ill patient in a hospital.
2. ER reports constitute adequate documentation of the written report of the consultation as long as the rendering of all *constituent elements* is clearly documented on all copies of the report. If the consulting physician fails to ensure that a copy of the ER report is sent to the physician who referred the patient, the amount payable for the service will be adjusted to the amount payable for an assessment.

Claims submission instruction:

Claims for ER Physician consultations are to be submitted using H055 for a *specialist* in emergency medicine (FRCP) and H065 for all other physicians.

SPECIAL SURGICAL CONSULTATION

Definition/Required elements of service:

A special surgical consultation is rendered when a surgeon provides all the appropriate elements of a regular consultation and is required to devote at least fifty minutes exclusively to the consultation with the patient.

> **[Commentary:**
> The calculation of the 50 minute minimum excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

Claims submission instruction:

Claims for special surgical consultations are to be submitted using either A935 or C935, as applicable.

GENERAL PREAMBLE

ASSESSMENTS

Specific requirements for assessments listed in the "Consultations and Visits" section of the Schedule are set out below:

GENERAL ASSESSMENT

Definition/Required elements of service:

A general assessment is a service, rendered at a place other than in a patient's *home* that requires a full history (the elements of which must include a history of the presenting complaint, family medical history, past medical history, social history, and a functional inquiry into all body parts and systems), and, except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts and systems, and *may include* a detailed examination of one or more parts or systems.

Payment rules:

General assessments are limited to one per patient per physician per *12 month period* unless either of the following circumstances is met in which case the limit is increased to two per *12 month period*:

1. the patient presents a second time with a complaint for which the diagnosis is clearly different and unrelated to the diagnosis made at the time of the first general assessment; or
2. at least 90 days have elapsed since the date of the last general assessment and the second assessment is a hospital admission assessment.

The amount payable for general assessments in excess of these limits will be adjusted to a lesser assessment fee.

PERIODIC HEALTH VISIT

Definition: A periodic health visit (including a primary or secondary school examination) is performed on a patient, after their second birthday, who presents and reveals no apparent physical or mental illness. The service must include an intermediate assessment, a level 2 paediatric assessment or a partial assessment focusing on age and gender appropriate history, physical examination, health screening and relevant counselling.

Payment rules:

Periodic health visit is limited to one per patient per *12 month period* per physician.

[Commentary:
Periodic health visits in excess of the limit are not insured.]

Claims submission instruction:

Submit claims for periodic health visits using the fee codes listed below.

No diagnostic code is required

Family Practice & Practice in General	Paediatrics
K017 - *child*	K269 - 12 to 17 years
K130 - *adolescent*	K267 - 2 to 11 years
K131 - *adult* age 18 to 64 inclusive	
K132 - *adult* 65 years of age and older	

GENERAL RE-ASSESSMENT

Definition/Required elements of service:

A general re-assessment includes all the services listed for a general assessment, with the exception of the patient's history, which need not include all the details already obtained in the original assessment.

Payment rules:

With the exception of general re-assessments rendered for hospital admissions, general re-assessments are limited to two per *12 month period*, per patient per physician. The amount payable for general re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

PRE-DENTAL/PRE-OPERATIVE ASSESSMENTS

[Commentary:
For Definition and terms and conditions see page A4.]

SPECIFIC ASSESSMENT AND MEDICAL SPECIFIC ASSESSMENT

Definition/Required elements of service:

Specific assessment and medical specific assessment are services rendered by *specialist*s, in a place other than a patient's *home*, and require a full history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

Payment rules:

Specific assessments or medical specific assessments are limited to one per patient per physician per *12 month period* unless either of the following circumstances are met in which case the limit is increased to two per patient per physician per *12 month period*:

1. the patient presents a second time with a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first specific assessment in that *12 month period*; or
2. in the case of a medical specific assessment, at least 90 days have elapsed since the date of the last specific assessment and the second assessment is a hospital admission assessment.

The amount payable for specific or medical specific assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments (see below) are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

SPECIFIC RE-ASSESSMENT AND MEDICAL SPECIFIC RE-ASSESSMENT

Definition/Required elements of service:

Specific re-assessment and medical specific re-assessment are services rendered by *specialist*s and require a full, relevant history and physical examination of one or more systems.

[Commentary:
As outlined on page GP26, admission assessments are deemed to be a specific re-assessment or medical specific re-assessment under either of the following circumstances:

1. for those procedures prefixed with a "Z" or noted as an *IOP*, by a surgical *specialist* who has assessed the patient prior to admission in respect of the same illness; or
2. for those patients who have been assessed by a physician and subsequently admitted to the hospital for the same illness by the same physician.]

Payment rules:

Specific re-assessments or medical specific re-assessments are limited to two per patient per physician per consecutive *12 month period* except for specific re-assessments rendered for hospital admissions. The amount payable for specific or medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT

Definition/ Required elements of service:

A complex medical specific re-assessment is a re-assessment of a patient because of the complexity, obscurity, or seriousness of the patient's condition and includes all the requirements of a medical specific re-assessment. The physician must report his/her findings, opinions, or recommendations in writing to the patient's primary care physician or the amount payable for the service will be adjusted to a lesser assessment fee.

Payment rules:

Complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period*. The amount payable for complex medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

PARTIAL ASSESSMENT

Definition/ Required elements of service:

A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and appropriate record.

CHRONIC DISEASE ASSESSMENT PREMIUM

Definition/ Required elements of service:

Chronic disease assessment premium is payable in addition to the amount payable for an assessment when all of the following criteria are met:

a. The assessment is a

- **i.** medical specific assessment;
- **ii.** medical specific re-assessment;
- **iii.** complex medical specific re-assessment;
- **iv.** partial assessment; or
- **v.** level 2 paediatric assessment

b. The service is rendered by a physician registered with *OHIP* as having one of the following specialty designations:

07(Geriatrics), 15(Endocrinology & Metabolism), 18(Neurology), 26(Paediatrics), 28(Pathology), 31(Physical Medicine), 34(Therapeutic Radiology), 44(Medical Oncology), 46(Infectious Disease), 47(Respiratory Disease), 48(Rheumatology), 61(Haematology), 62(Clinical Immunology).

c. The assessment is rendered in an office setting or an out-patient clinic located in a hospital, other than an emergency department.

[Commentary:
The chronic disease assessment premium is not payable for assessments rendered to in-patients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department.]

d. The patient has an established diagnosis of a chronic disease, documented in the patient's medical record.

GENERAL PREAMBLE

ASSESSMENTS

Payment rules:

The following is a list of the diagnostic codes as specified by *OHIP* that must accompany the claim for payment purposes:

042	AIDS
043	AIDS-related complex
044	Other human immunodeficiency virus infection
250	Diabetes mellitus, including complications
286	Coagulation defects (e.g. haemophilia, other factor deficiencies)
287	Purpura, thrombocytopenia, other haemorrhagic conditions
290	Senile dementia, presenile dementia
299	*Child* psychoses or autism
313	Behavioural disorders of *child*hood and adolescence
315	Specified delays in development (e.g. dyslexia, dyslalia, motor retardation)
332	Parkinson's Disease
340	Multiple Sclerosis
343	Cerebral Palsy
345	Epilepsy
402	Hypertensive Heart Disease
428	Congestive Heart Failure
491	Chronic Bronchitis
492	Emphysema
493	Asthma, Allergic Bronchitis
515	Pulmonary Fibrosis
555	Regional Enteritis, Crohn's Disease
556	Ulcerative Colitis
571	Cirrhosis of the Liver
585	Chronic Renal Failure, Uremia
710	Disseminated Lupus Erythaematosus, Generalized Scleroderma, Dermatomyositis
714	Rheumatoid Arthritis, Still's Disease
720	Ankylosing Spondylitis
721	Other seronegative spondyloarthropathies
758	Chromos*oma*l An*oma*lies
765	Prematurity, low-birthweight *infant*
902	Educational problems

[Commentary:
The chronic disease assessment premium is not payable in situations where the diagnosis has not been established.]

ASSESSMENTS

LEVEL 1 PAEDIATRIC ASSESSMENT

Definition/Required elements of service:

A Level 1 paediatric assessment includes one or both of the following:

a. a brief history and examination of the affected part or region or related to a mental or emotional disorder; or

b. brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.

LEVEL 2 PAEDIATRIC ASSESSMENT

Definition/Required elements of service:

A Level 2 paediatric assessment is a paediatric service that requires a more extensive examination than a level 1 paediatric assessment. It requires a history of the presenting complaint(s), inquiry concerning, and examination of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.

A Level 2 paediatric assessment also includes well baby care, which is a periodic assessment of a well *newborn*/*infant* during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or *patient's representative* regarding health care.

INTERMEDIATE ASSESSMENT

Definition/Required elements of service:

An intermediate assessment is a primary care general practice service that requires a more extensive examination than a minor assessment. It requires a history of the presenting complaint(s), inquiry concerning, and examination of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.

INTERMEDIATE ASSESSMENT – PRONOUNCEMENT OF DEATH

Definition/Required elements of service:

Intermediate assessment – pronouncement of death is the service of pronouncing a patient dead in a location other than in the patient's *home*. This service *may include* any counselling of relatives that is rendered during the same visit, and completion of the death certificate.

[Commentary:

1. For pronouncement of death in the *home*, see house call assessments (page A3 of the Schedule).

2. Submit the claim for this service using the diagnostic code for the underlying cause of death, as recorded on the death certificate, rather than the immediate cause of death.]

MINOR ASSESSMENT

Definition/Required elements of service:

A minor assessment includes one or both of the following:

a. a brief history and examination of the affected part or region or related to a mental or emotional disorder; or

b. brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.

ASSESSMENTS

PERIODIC OCULO-VISUAL ASSESSMENT

Definition/Required elements of service:

A periodic oculo-visual assessment is an examination of the eye and vision system rendered primarily to determine if a patient has a simple refractive error (defined as myopia, hypermetropia, presbyopia, anisometropia or astigmatism) for patients aged 19 or less or aged 65 or more. This service includes all components required to perform the assessment (ordinarily a history of the presenting complaint, past medical history, visual acuity examination, ocular mobility examination, slit lamp examination of the anterior segment, ophthalmoscopy, tonometry) advice and/or instruction to the patient and provision of a written refractive prescription if required.

Payment rules:

1. This service is limited to one per patient per *12 month period* regardless of whether the first claim is or has been submitted for a service rendered by an optometrist or physician. Services in excess of this limit or to patients aged 20 to 64 are not insured services.
2. Any other insured service rendered by the same physician (other than an ophthalmologist) to the same patient the same day as a periodic oculo-visual assessment is *not eligible for payment*.

[Commentary:

1. Other consultation and visit codes are not to be used as a substitute for this service when the limit is reached.
2. Re-assessment following a periodic oculo-visual assessment is to be claimed using a lesser assessment fee code and diagnostic code 367.]

FIRST VISIT BY PRIMARY CARE PHYSICIAN AFTER HOSPITAL DISCHARGE

E080	First visit after hospital discharge premium, to other service listed in payment rule 5 below	add	25.00

Payment rules:

1. Subject to payment rules 2 through 5, E080 is *only eligible for payment* for a visit with the patient's primary care physician in the physician's office or the patient's *home* within two *week*s of discharge following in-patient admission to an acute care hospital.

[Commentary:

This premium is not payable for visits rendered to patients in locations other than the physician's office or patient's *home*. As such, the premium is not payable for services rendered in places such as Nursing *Home*s, *Home*s for the Aged, chronic care hospitals, etc.]

2. E080 is *not eligible for payment* if the admission to hospital was for the purpose of obstetrical delivery unless the mother required admission to an ICU during the hospital stay.
3. E080 is *not eligible for payment* if the admission to hospital was for the purpose of *newborn* care unless the *infant* required admission to a NICU during the hospital stay.
4. E080 is *not eligible for payment* if the admission to hospital was for the purpose of performing day surgery.
5. E080 is *only eligible for payment* when rendered with the following services:
   A001, A003, A004, A007, A008, A261, A262, A263, A264, A888, A900, A901, A903, K004–K008, K013, K014, K022, K023, K028-K030, K032, K033, K037, K623, P003, P004, P008.

ASSESSMENTS

DETENTION

Definition/Required elements of service:

Detention is payable following another insured service when a physician is required to spend considerable extra time in active treatment and/or monitoring of the patient to the exclusion of all other work and in this section is based on full 15-minute time units. The *specific elements* are those for assessments.

K001 Detention – per full quarter hour 21.10

Payment rules:

1. Detention is payable under the following circumstances:

Service	Minimum time required in delivery of service before detention is payable
minor, partial, multiple systems assessment, level 1 and level 2 paediatric assessment, intermediate assessment, focused practice assessment or subsequent hospital visit	30 minutes
specific or general re-assessment	40 minutes
consultation, repeat consultation, specific or general assessment, complex dermatology assessment, complex endocrine neoplastic disease assessment, complex neuromuscular assessment, complex physiatry assessment, complex respiratory assessment, enhanced 18 *month* well baby visit, midwife-requested anaesthesia assessment, midwife-requested assessment, midwife-requested genetic assessment or optometrist-requested assessment	60 minutes
initial assessment-substance abuse, special community medicine consultation, special family and general practice consultation, special optometrist-requested assessment, special *palliative care* consultation, special surgical consultation or midwife-requested special assessment	90 minutes
comprehensive cardiology consultation, comprehensive community medicine consultation, comprehensive endocrinology consultation, comprehensive family and general practice consultation, comprehensive geriatric consultation, comprehensive infectious disease consultation, comprehensive internal medicine consultation, comprehensive midwife-requested genetic assessment, comprehensive nephrology consultation, comprehensive respiratory disease consultation, comprehensive physical medicine and rehabilitation consultation, comprehensive rheumatology consultation, special paediatric consultation, special genetic consultation or special neurology consultation	120 minutes
extended comprehensive geriatric consultation, extended midwife-requested genetic assessment, extended special genetic consultation, extended special paediatric consultation, or paediatric neurodevelopmental consultation	180 minutes

2. Detention is *not eligible for payment* in conjunction with diagnostic procedures, obstetrics, and those therapeutic procedures where the fee includes an assessment (e.g. non-*IOP* surgery).

3. Detention is *not eligible for payment* for time spent waiting.

4. For the purposes of calculation of time units payable for detention, the start time commences after the minimum time required for the assessment or consultation listed in the table has passed.

5. K001 is *not eligible for payment* for same patient same day as A190, A191, A192 A195, A197, A198, A695, A795 or A895.

Claims submission instructions:
Claims for detention are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

ASSESSMENTS

DETENTION-IN-AMBULANCE

Definition/Required elements of service:

Detention-in-Ambulance is payable for constant attendance with a patient in an ambulance, to provide all aspects of care to the patient. Time is calculated only for that period during which the physician is in constant attendance with the patient in the ambulance. The service includes an initial examination and ongoing monitoring of the patient's condition and all interventions, except in those circumstances in which the Schedule provides for separate or additional payment for the intervention.

K101	Ground ambulance transfer with patient per quarter hour or part thereof.....	42.10
K111	Air ambulance transfer with patient per quarter hour or part thereof	126.40
K112	Return trip without patient to place of origin following air or ground ambulance transfer, per half hour or major part thereof	25.05

Claims submission instruction:

Claims for Detention-in-Ambulance are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
K101 is not applicable to attendance in a vehicle other than an ambulance, in which case K001 may apply.]

DETENTION FOR THE TRANSPORT OF DONOR ORGANS

Definition/Required elements of service:

Detention for the Transport of Donor Organs is payable for time travelling to and from a donor centre (excluding time spent in the donor centre) for the purpose of collecting and transporting to the recipient hospital (a) donor organ(s), including fresh bone being harvested.

K102	Per quarter hour or part thereof (not eligible for payment with K001).....	20.20

Claims submission instruction:

Claims for Detention for the Transport of Donor Organs are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
Claims will be adjudicated on the basis of the most time-efficient means of travel to and from a donor centre.]

NEWBORN CARE

Definition/Required elements of service:

Newborn care is the routine care of a well *newborn* for up to the first ten days of life in hospital or *home* and includes an initial general assessment and subsequent assessments, as may be indicated, and instructions to the caregiver(s) regarding the *newborn*'s health care.

Payment rules:

1. *Newborn* care is limited to a maximum of one per patient except when a well baby is transferred to another hospital in which case the fee for *newborn* care may be payable to a physician at both hospitals.

   [Commentary:
   An example where this is possible is if the transfer occurred because of the state of health of the mother.]

2. Despite the requirement that to be eligible for a special visit premium the call be non-elective (see GP44), a special visit premium is payable in addition to this service if a physician is required to make an additional visit to the hospital outside of his or her normally scheduled hospital rounds to facilitate discharge of the *newborn* the same day as the visit.

LOW BIRTH WEIGHT BABY CARE

Definition:

Low birth weight baby care is any assessment of a well *newborn*/*infant* weighing less than 2.5 kilograms at birth.

ASSESSMENTS

WELL BABY CARE

Definition/Required elements of service:

Well baby care is a periodic assessment of a well *newborn*/*infant* during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or *patient's representative* regarding health care.

ENHANCED 18 MONTH WELL BABY VISIT

Definition/Required elements of service:

Enhanced 18 *month* well baby visit is the service rendered when a physician performs all of the following in respect of a *child* from 17-24 *month*s of age:

a. Those services defined as "well baby care";

b. An 18 *month* age-appropriate developmental screen; and

c. Review with the patient's parent/guardian, legal representative or other caregiver of a brief standardized tool (completed by the patient's parent/guardian, legal representative or other caregiver) that aids the identification of *child*ren at risk of a developmental disorder.

Medical record requirements:
This service is eligible for payment only when, in addition to the medical record requirements for well baby care, an 18 *month* age-appropriate developmental screen and concerns identified from the review of the brief standardized tool with the parent/guardian, legal representative or other caregiver are recorded in the patient's permanent medical record.

[Commentary:
An example of an 18 *month* age-appropriate developmental screen would be that outlined in the Rourke Baby Record and an example of a brief standardized tool completed by the parent/guardian, legal representative or other caregiver that aids the identification of *child*ren at risk of a developmental disorder would be the Nipissing District Developmental Screen or similar parental questionnaire.]

PSYCHIATRIC ASSESSMENT UNDER THE MENTAL HEALTH ACT

Definition/Required elements of service:

A psychiatric assessment under the *Mental Health Act* (K620, K623, K624, and K629) includes such psychiatric history, inquiry, and examination of the patient, as is appropriate, to enable the physician to complete, and includes completing, the relevant forms and to notify the patient, family, *patient representative* and relevant authorities under the *Mental Health Act*, where appropriate.

ASSESSMENTS

E-ASSESSMENTS

Definition/Required elements of service:

An e-assessment is a service performed by a *specialist* when a primary care physician requests an opinion and/or recommendations from the *specialist* for management of a specific patient by providing information electronically through a secure server (e.g. secure messaging, EMR). The *specialist* is required to review all relevant data provided by the primary care physician, including the review of any additional information that may be submitted subsequent to the initial request. For the purpose of this service, "relevant data" *may include* family/patient history, history of the presenting complaint, laboratory and diagnostic tests, and visual images where indicated.

In addition to the *Common Elements*, E-assessments include the *specific elements* of assessments, as listed in the General Preamble, except for paragraphs A and B.

Payment rules:

1. E-assessments are *only eligible for payment* if the *specialist* has provided an opinion and/or recommendations for patient management to the primary care physician within 30 days from the date of the request

2. E-assessments are *not eligible for payment* to the *specialist* in the following circumstances

- **a.** when the purpose of the electronic communication is to arrange for transfer of the patient's care to any physician; or
- **b.** when rendered in whole or in part to arrange for a consultation, a different assessment, visit, or K-prefix time-based services, procedure(s), or diagnostic investigation(s); or
- **c.** when the *specialist* renders a K-prefix time-based service for the same patient within 30 days following the request for the *specialist* e-assessment; or
- **d.** in circumstances where the primary care physician or *specialist* receives compensation, other than by fee-for service under this Schedule, for participation in the e-assessment.

3. A consultation, a different assessment or visit rendered by the *specialist* for the same patient for the same diagnosis within 60 days following the request for the *specialist* e-assessment is only payable as a specific or partial assessment, as appropriate to the service rendered.

4. K738 is eligible for payment to the primary care physician when this physician is required to collect additional data (for example dermatology or ophthalmology images not present in the primary care physician's records) to support the *specialist*'s e-assessment. K738 is *not eligible for payment* where existing data is already available in the primary care physician's records for submission to the *specialist*.

[Commentary:

1. Following the primary care physician's request, the *specialist* decides whether an e-assessment is the most appropriate service in the circumstances. In some cases, direct patient contact or a consultation by videoconference may be more appropriate.

2. Payment, other than by fee-for-service, includes compensation where the physician receives remuneration under a salary, primary care, stipend, APP or AFP model.

3. Physicians who receive compensation other than by fee-for-service under this Schedule should consult their contract for guidance on shadow-billing.]

Medical record requirements:

An e-assessment is *only eligible for payment* if all of the following elements are included in the patient's permanent medical record of the *specialist*:

1. patient's name and health number;

2. name of the primary care physician;

3. date of, and reason for, the request; and

4. opinion, diagnosis, advice and/or recommendations of the *specialist*.

Claims submission instructions:

An e-assessment is *only eligible for payment* if the *specialist* includes the primary care physician's billing number with the claim.

GENERAL PREAMBLE

ASSESSMENTS

INITIAL E-ASSESSMENT

Definition/Required elements of service:

Initial e-assessment is the first e-assessment performed by a particular *specialist* that is requested by the primary care physician for a specific patient and diagnosis where the *specialist* must review all relevant data provided by the primary care physician and provide a written opinion that includes a diagnosis and/or management advice to the primary care physician.

[Commentary:
The time and intensity of this service is the same as a regular consultation. The *specialist* may choose to return their opinion by phone, however, a written opinion must be provided electronically or by mail.]

Payment rules:
Initial e-assessments are limited to a maximum of one per patient per *specialist* per *12 month period* unless the primary care physician makes a second request in relation to a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first e-assessment in that same *12 month period*, in which case the limit is increased to a maximum of two per patient per *specialist* per *12 month period*.

[Commentary:
If a subsequent e-assessment is related to the diagnosis made at the time of the initial e-assessment, then this service is payable as a repeat e-assessment, follow-up e-assessment or minor e-assessment as appropriate to the service rendered.]

REPEAT E-ASSESSMENT

Definition/ Required elements of service:

Repeat e-assessment is the first e-assessment performed by a particular *specialist* following an initial e-assessment or consultation by that *specialist* that is requested by the primary care physician for the same diagnosis where the *specialist* must review all relevant data provided by the primary care physician and provide an opinion that includes management advice to the primary care physician.

[Commentary:
The time and intensity of this service is the same as a specific assessment. The *specialist* may choose to return their opinion by phone.]

Payment rules:
Repeat e-assessments are limited to a maximum of one per patient per physician per *12 month period* unless the primary care physician makes a second request in relation to a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first e- assessment in that same *12 month period*, in which case the limit is increased to a maximum of two per patient per physician per *12 month period*.

FOLLOW-UP E-ASSESSMENT

Definition/ Required elements of service:

A follow-up e-assessment is the limited e-assessment rendered for follow-up by the *specialist* who has previously rendered any insured service to the patient for the same diagnosis. The *specialist* must review all relevant information submitted and provide an opinion and/ or management advice to the primary care physician.

[Commentary:
The time and intensity of the service is the same as a partial assessment. The *specialist* may choose to return their opinion by phone.]

Payment rules:

Follow-up e-assessment is limited to a maximum of:

1. one (1) service per patient per day, same physician;
2. four (4) services per patient same physician per *12 month period*; and
3. one thousand (1000) services per physician per *12 month period*.

ASSESSMENTS

MINOR E-ASSESSMENT

Definition/ Required elements of service:

A minor e-assessment is a brief e-assessment rendered by the *specialist*. The *specialist* must review all relevant information submitted and provide an answer to the primary care physician's specific clinical question.

Payment rules:
Minor e-assessment is limited to a maximum of:

1. one (1) service per patient per day, same physician;

2. twelve (12) services per patient same physician per *12 month period*; and

3. two thousand (2000) services per physician per *12 month period*.

[Commentary:
A minor e-assessment is where the primary care physician may ask a specific question related to the patient where the information provided is limited and the question asked is very specific. An example is where the primary care physician has initiated a treatment recommended by the *specialist*, and the primary care physician requests a brief email response related to proper dosing adjustments. One service *may include* multiple emails. The *specialist* may choose to return their opinion by phone.]

ACUTE CARE HOSPITAL – NON-EMERGENCY IN-PATIENT SERVICES ("C" PREFIX SERVICES)

A. Admission Assessment – General Requirements

Definition:

a. An admission assessment is the initial assessment of the patient rendered for the purpose of admitting a patient to hospital.

b. The admitting physician is the physician who renders the admission assessment.

Payment rules:

1. Except as outlined below in paragraph 3, when the admitting physician has not previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a consultation, general or medical specific or specific assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.
2. Except as outlined below in paragraph 3, if the admitting physician has previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a general re-assessment or specific re-assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.
3. When a hospital in-patient is transferred from one physician to another physician, only one consultation, general or specific assessment or reassessment is eligible for payment
per patient admission. The amount eligible for payment for services in excess of this limit will be adjusted to a lesser assessment fee. An additional admission assessment is *not eligible for payment* when a hospital inpatient is transferred from one physician to another physician within the same hospital.

Admission Assessments by Specialists:

When a patient has been assessed by a *specialist* in the emergency room (ER) or out-patient department (OPD) and that physician renders a service described as a consultation, specific assessment, or medical specific assessment and subsequently admits the patient to hospital, the initial consultation, specific, or medical specific assessment constitutes the admission assessment.

When a patient has been assessed by a *specialist* in the ER or OPD, and that physician renders any other assessment other than those listed in the paragraph immediately above, and that physician subsequently admits the patient to hospital, an admission assessment is eligible for payment in addition to the initial assessment, if each service is rendered separately.

[Commentary:
In accordance with the surgical preamble, a hospital admission assessment by the surgeon is *not eligible for payment*, unless it is the "major pre-operative visit" (i.e., the consultation or assessment which may be claimed when the decision to operate is made and the operation is scheduled).]

Admission Assessments by General and Family Practitioners:

When a patient has been assessed by a general or family practitioner in the emergency room (ER) or out-patient department (OPD) and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital, the initial consultation, general assessment, general re-assessment constitutes the admission assessment.

When a patient has been assessed by a general or family practitioner in the ER or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, and subsequently admits the patient to hospital, an admission assessment is eligible for payment in addition to the initial assessment, if each assessment is rendered separately.

Payment rules:

A933/C933/C003/C004 are *not eligible for payment* for an admission assessment for an elective surgery patient when a pre-operative assessment has been rendered to the same patient within 30 days of admission by the same physician.

Admission Assessments by General and Family Practitioners in an Emergency Department Funded under an Emergency Department Alternative Funding Agreement:

When a patient has been assessed by the patient's general or family practitioner in an emergency room and that physician subsequently admits the patient to hospital, the General/Family Physician Emergency Department Assessment constitutes the admission assessment if the physician remains the *most responsible physician* for the patient.

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Admission Assessments by Emergency Physicians:

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital as the *most responsible physician* or that physician is asked to perform the admission assessment (even though the patient is admitted under a different *most responsible physician*), the initial consultation, general assessment, or general re-assessment constitutes the admission assessment.

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, and subsequently renders the admission assessment, (even if the patient is admitted under a different *most responsible physician*), the admission assessment is payable as C004, in addition to the initial assessment, if both services are rendered separately.

Admission Assessment by the Most Responsible Physician (MRP**) Premium**

E082 Admission assessment by the MRP, to admission assessment.....add 30%

Payment rules:

1. E082 is *only eligible for payment* once per patient per hospital admission.

2. E082 is *only eligible for payment*:

a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or

b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.

3. E082 is *not eligible for payment* for transfers within the same hospital.

4. E082 is not applicable to any other service or premium.

[Commentary:

1. E082 is *only eligible for payment* when the admitting physician is the *MRP*. If the *MRP* does not render the admission assessment, E082 is *not eligible for payment* for any service rendered by any physician during that hospital admission.

2. E082 is *not eligible for payment* for a patient admitted for obstetrical delivery or for a *newborn*.

3. E082 is not applicable for any consultation or assessment related to day surgery.]

B. Subsequent Visit

Definition:

A subsequent visit is any routine assessment in hospital following the hospital admission assessment.

Attendance at Surgery: If, in the interest of the patient, the referring physician is asked to be present by the patient or the *patient's representative*, but does not assist at the procedure, the attendance at surgery by the referring physician constitutes a hospital subsequent visit.

Multidisciplinary care: Except where a single service for a team of physicians is listed in this Schedule (e.g. the *week*ly team fee for dialysis), when the complexity of the medical condition requires the services of several physicians in different disciplines, each physician visit constitutes a subsequent visit.

Payment rules:

1. Except in the circumstances outlined in paragraph 2, or when a patient is referred from one physician to another (see Claims submission instruction below), subsequent visits are limited to one per patient, per day for the first 5 *week*s after admission, 3 visits per *week* from 6 to 13 *week*s after admission, and 6 visits per *month* after 13 *week*s. Services in excess of the limit are *not eligible for payment*.
2. After 5 *week*s of hospitalization, any assessment in hospital required as a result of an acute intercurrent illness in excess of the *week*ly or *month*ly limits set out above constitutes C121 – "additional visit due to intercurrent illness". The *week*ly or *month*ly limits set out above do not apply to additional visits due to intercurrent illness.
3. When a physician is already in the hospital and assesses one of his/her own patients or patients transferred to his/her care, the service constitutes a subsequent visit. If a physician assesses another physician's patient on an emergency basis, the General Listings ("A" prefix) apply.

Claims submission instruction:

When a hospital in-patient is referred from one physician to another physician, the date the second physician assessed the patient for the first time is considered the "admission date" for the purposes of determining the appropriate subsequent visit fee code.

[Commentary:
When a hospital in-patient is transferred from one physician to another physician, subsequent visits by the second physician are calculated based on the actual admission date of the patient.]

C. Subsequent visit by the *Most Responsible Physician* (*MRP*)

Subsequent visit by the MR**P –** da**y following the hospital admission assessment (C122)**

Definition:

Subsequent visit by the *MRP* - day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Subsequent visit by the MRP **– second** day **following the hospital admission assessment (C123)**

Definition:

Subsequent visit by the *MRP* - second day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Payment rules:

1. C122, C123 are limited to a maximum of one each per hospital admission.

   [Commentary:
   C122, C123 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be payable at a lesser visit fee.]

2. C122, C123 are *not eligible for payment*:

   a. when rendered to the same patient the same day as C124 (Subsequent visit by the *MRP* - day of discharge);

   b. for a patient admitted for obstetrical delivery or *newborn* care; or

   c. for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

3. C122, C123 are not payable for a subsequent visit rendered by a surgeon to a hospital in-patient following non-Z prefix surgery.

   [Commentary:
   The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

4. When a patient is transferred to another physician within the same hospital during either of these days, C122 or C123 are only payable to the physician who was the *MRP* for the majority of the day.

5. When a patient is transferred to another physician at a different hospital, the day of transfer shall be deemed for payment purposes to be the day of admission.

6. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For first and second subsequent visits by the *MRP* following transfer from an Intensive Care Area (C142, C143), see General Preamble page GP31.]

Subsequent visit by the MR**P -** da**y of discharge (C124)**

Definition/Required elements of service:

Subsequent visit by the *MRP* – day of discharge is payable to the physician identified as the *MRP* for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

The discharge summary must include as a minimum the following information:

a. reason for admission;

b. procedures performed during the hospitalization;

c. discharge diagnosis; and

d. medications on discharge.

Payment rules:

1. C124 is only payable to the *MRP* and limited to one service per hospital admission.

2. C124 is *not eligible for payment* under any of the following circumstances:

- **a.** The patient was discharged within 48 hours of admission to hospital (calculated from the actual date of admission to hospital);
- **b.** The admission was for obstetrical delivery unless the mother required admission to an ICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **c.** The admission was for *newborn* care unless the *infant* was admitted to a NICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **d.** For transfers within the same hospital; or
- **e.** For discharges directly from a NICU or ICU where NICU or ICU critical care per diem services were rendered the same day.

[Commentary:
In the case of conflicting claims for this service, the physician to whom the patient has rostered (virtual or actual) may receive the payment for the service.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

D. First subsequent visit by the *MRP* following transfer from an Intensive Care Area

First subsequent visit by the MR**P following transfer from an Intensive Care Area (C142)**

Definition:

First subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Second subsequent visit by the MRP **following transfer from an Intensive Care Area (C143)**

Definition:

Second subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Payment rules:

1. C142, C143 are limited to a maximum of one each per hospital admission.

[Commentary:
1. C142, C143 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be eligible for payment at a lesser visit fee.
2. C142 or C143 are *not eligible for payment* for visits rendered to patients who were in an Intensive Care Area only for monitoring purposes.]

2. C142, C143 are *not eligible for payment* to the same physician who rendered Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services prior to the patient's transfer.

3. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

[Commentary:
For Subsequent visit by the *MRP* – first and second day following the hospital admission assessment (C122, C123), see General Preamble page GP29.]

4. C142, C143 are *not eligible for payment*:

a. when rendered to the same patient the same day as C124 (Subsequent visit by the *MRP* – day of discharge), or

b. for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

5. C142, C143 are not payable for visits rendered by a surgeon to a hospital in-patient in the first two *week*s following non-Z prefix surgery.

[Commentary:
The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

6. When a patient is transferred to another physician within the same hospital, C142 or C143 are only payable to the physician who was the *MRP* for the majority of the day of the transfer.

E. Subsequent visit and palliative care visit by the MRP premium

E083 Subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982 .....add 30%

Payment rules:

1. E083 is *only eligible for payment* once per patient per day.

2. E083 is *only eligible for payment*:

a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or

b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.

3. E083 is *not eligible for payment* for *palliative care* visits to patients in designated *palliative care* beds in Long-Term Care Institutions.

4. E083 is not applicable to any other service or premium.

[Commentary:

1. E083 is *only eligible for payment* with subsequent visits and *palliative care* visits rendered by the *MRP*.

2. Examples of subsequent visits eligible for payment with E083 are C002, C007, C009, C132, C137, C139, C032, C037 or C039.

3. E083 is *not eligible for payment* with C121 additional visits for intercurrent illness.]

F. Concurrent Care

Definition/Required elements of service:

Concurrent care is any routine assessment rendered in hospital by the consultant following the consultant's first major assessment of the patient when the family physician remains the *most responsible physician* but the latter requests continued directive care by the consultant.

Payment rules:

Claims for concurrent care are limited to 4 per *week* during the first *week* of concurrent care, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.

G. Supportive Care

Definition:

Supportive care is any routine visit rendered in hospital by the family physician who is not actively treating the case where:

a. the patient is under the care of another physician;

b. the supportive care is rendered at the request of the patient or family; and

c. the care is provided for purposes of liaison or reassurance.

Payment rules:

Claims for supportive care are limited to 4 per *week* during the first *week* of supportive care, determined from the date of the first supportive visit, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.

LONG-TERM CARE INSTITUTION: NON-EMERGENCY IN-PATIENT SERVICES

("W" PREFIX SERVICES)

These services apply to patients in chronic care hospitals, convalescent hospitals, nursing *home*s, *home*s for the aged and designated chronic or convalescent care beds in hospitals other than patients in designated *palliative care* beds - "W" prefix services.

A. Admission Assessment

Type 1 Admission Assessment

Definition/Required elements of service:

A Type 1 admission assessment is a general assessment rendered to a patient on admission.

Payment rules:

If the physician has rendered a consultation, general assessment, or general re-assessment of the patient prior to admission, the amount payable for the service will be adjusted to a lesser fee.

Type 2 Admission Assessment

Definition/Required elements of service:

A Type 2 admission assessment occurs when the admitting physician makes an initial visit to assess the condition of the patient following admission and has previously rendered a consultation, general assessment or general re-assessment of the patient prior to admission.

Type 3 Admission Assessment

Definition/Required elements of service:

A Type 3 admission assessment is a general re-assessment of a patient who is re-admitted to the long-term care institution after a minimum 3 day stay in another institution.

B. Subsequent Visit

Definition:

A subsequent visit is any routine assessment following the patient's admission to a long-term care institution.

Payment rules:

Claims for these subsequent visits are subject to the limits described with each individual service as found under the applicable specialty in the Consultations and Visits section.

Claims submission instructions:

1. Submit claims for acute intercurrent illnesses requiring visits other than special visits using W121. When acute intercurrent illness requires a special visit, submit claims using the appropriate fees under General Listings ("A" prefix) and premiums.

   [Commentary:
   Claims for W121 are payable for visits for acute intercurrent illness whenever rendered. Such claims are not dependent on whether the *month*ly limit on the number of subsequent visits has been reached.]

2. When a physician is already in the institution and is asked to assess one of his/her own in-patients, the subsequent visit listings ("W" prefix) apply. However, if he/she is already in the institution and asked to assess another physician's patient on an emergency basis, submit claims using the General Listings ("A" prefix).

EMERGENCY DEPARTMENT - "H" PREFIX EMERGENCY DEPARTMENT SERVICES

For the purpose of emergency department – "H" prefix emergency department services:

"Hospital Urgent Care Clinic" means a clinic operated by a hospital corporation that provides services similar to some or all of those provided by an emergency department but that is open to the public for less than 24 hours in any given 24 hour period.

"Emergency Department Physician" means a physician:

a. working in a hospital emergency department specifically for the purpose of rendering services to unscheduled patients who attend the emergency department to receive physician services; or

b. working in a Hospital Urgent Care Clinic specifically for the purpose of rendering services to unscheduled patients who attend the Hospital Urgent Care Clinic to receive physician services.

There are specific "H" prefix listings (H1 – codes) for consultations, multiple systems assessments, minor assessments, comprehensive assessment and care and re-assessments rendered by the Emergency Department Physician. With the exception of the consultation fee (where a specific fee code exists for a *specialist* in emergency medicine), any physician on duty (regardless of specialty) in the emergency department must submit using these listings.

The "H" prefix listings under the heading, "Emergency Department Physician" on pages A11, A12 in the Consultations and Visits section of the Schedule, apply in the following circumstances:

a. when a full- or part-time Emergency Department Physician is working for a pre-arranged designated period of time or shift; or

b. for services rendered by an on-call physician where the service does not qualify for claiming a special visit premium.

PALLIATIVE CARE ASSESSMENT

Definition: A palliative care assessment is any routine assessment rendered by the most responsible physician for the purpose of providing palliative care to a patient other than one in a designated palliative care bed at the time the assessment was rendered.

Claims submission instruction:

Submit claims for *palliative care* visits, other than those in designated *palliative care* beds, using the appropriate "C" or "W" prefix *palliative care* fee schedule codes.

[Commentary:

1. *Palliative care* visits to patients in designated *palliative care* beds, regardless of facility type, are to be claimed using C882 or C982, as applicable.
2. Services rendered to patients whose unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death do not constitute *palliative care* assessments.]

MONTHLY MANAGEMENT OF A NURSING HOME OR HOME FOR THE AGED PATIENT

Definition/Required Elements of Service:

*Month*ly Management of a Nursing *Home* or *Home* for the Aged Patient is the provision by the *most responsible physician* (*MRP*) of routine medical care, management and supervision of a patient in a nursing *home* or *home* for the aged for one calendar *month*. The service requires a minimum of two assessments of the patient each *month*, where these assessments constitute services described as "W" prefix assessments.

The requirements above are subject to the exceptions as described in payment rule #8.

[Commentary:
As with all services described as assessments, direct physical encounter with the patient is required.]

In addition to the *common elements*, this service includes the provision of the following services by any physician to the same patient during the *month*.

A. Services described by subsequent visits (e.g. W003, W008).

B. Services described by additional visits due to “intercurrent illness” (W121) except if the conditions described in Payment rule #7 are satisfied.

C. Services described by *palliative care* subsequent visits (e.g. W872).

D. Services described by admission assessments (e.g. W102, W104, W107).

E. Services described by pre-dental/pre-operative assessments (e.g. W903).

F. Services described by periodic health visit or general re-assessments (e.g. W109, W004).

G. Services described by visit for pronouncement of death (W777) or certification of death (W771) except if the services are performed in conjunction with a special visit.

H. Service described by anticoagulation supervision (G271).

I. Completion of CCAC application and *home* care supervision (K070, K071, K072).

J. Services described by the following diagnostic and therapeutic procedures – venipuncture (G489), injection (G372, G373), immunization (G538, G590), Pap smear (G365, G394, E430, E431), intravenous (G379), and laboratory test codes (G001, G002, G481, G004, G005, G009, G010, G011, G012, G014).

K. All medication reviews.

L. All discussions with the staff of the institution related to the patient’s care.

M. All telephone calls from the staff of the institution, patient, patient’s relative(s) or *patient’s representative* in respect of the patient between the hours of 0700 hours and 1700 hours Monday to Friday (excluding *holiday*s).

N. Ontario Drug Benefit Limited Use prescriptions/forms or Section 8 *Ontario Drug Benefits Act* requests.

MONTHLY MANAGEMENT OF A NURSING HOME OR HOME FOR THE AGED PATIENT

Payment rules:

1. Except as outlined in payment rule #8, this service is *only eligible for payment* once per patient per calendar *month*.
2. This service is *only eligible for payment* to the *MRP*.
3. When W010 is rendered, none of the services listed as a component of W010 and rendered to the patient by any physician during the *month* are eligible for payment.
4. In the temporary absence of the patient's *MRP* (e.g. while that physician is on vacation), W010 remains payable to the patient's *MRP* if the service is performed by another physician.
5. In the event the *MRP* renders one "W" prefix assessment in a calendar *month* and the same physician has rendered W010 to that patient within the previous 11-*month* period, only that "W" prefix assessment in that *month* is eligible for payment.
6. In the event the *MRP* renders two, three or four "W" prefix assessments in a calendar *month* and the same physician has rendered W010 to that patient within the previous 11-*month* period, only W010 is eligible for payment.
7. In the event the *MRP* renders more than four "W" prefix assessments to the same patient in a *month* and the same physician has rendered W010 to that patient within the previous 11-*month* period, any subsequent visits for intercurrent illness rendered by the *MRP* to the same patient in excess of four in a *month* are payable as W121 in addition to payment of W010.
8. Despite the definition set out above, the requirements of W010 are met when less than two "W" prefix assessments were rendered during the *month* and/or when the patient was not in the institution for a full calendar *month* if:
   - **a.** a patient was newly admitted to the institution and an admission assessment was rendered; or
   - **b.** in the event of the death of a patient while in the institution or within 48 hours of transfer to hospital.
9. Age related premiums otherwise applicable to any component service of W010 are *not eligible for payment* in addition to W010.

Claims submission instructions:

1. Claims for W010 may be submitted when the minimum required elements of the service have been rendered for the *month*.

   [Commentary:
   - **a.** Payment for W010 is for mangement of the patient for the entire *month* for all the services listed as components of the W010 service, regardless of when the claim for W010 is submitted.
   - **b.** When claiming W010, do not also submit claims for "W" prefix services listed as components of the W010 for the same *month*.]

2. The admission date of the patient must be provided on the claim for W010 or the service is *not eligible for payment*.
   - **a.** Submit claims for W121 which meet the requirements outlined in payment rule #7 using the manual review indicator.

   [Commentary:
   Examples of services not included in the *Month*ly Management fee include:
   - **a.** visits which qualify for a special visit premium.
   - **b.** services described under interviews, psychotherapy or counselling with the patient, patient's relative(s) or *patient's representative* lasting 20 or more minutes and where all other criteria for these services are met.
   - **c.** services described as physician to physician telephone consultations.
   - **d.** services rendered by a *specialist* who is not the *MRP* or who is not replacing an absent *MRP*.]

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

Psychotherapy, Hypnotherapy and all forms of Counselling, Primary Mental Health, and Psychiatric Care rendered by telephone, other electronic communications or in the physical absence of the patient (or patient's relative or *patient representative* as the case may be) are not insured services unless otherwise specifically listed in the Schedule.

SPECIFIC ELEMENTS

In addition to the *common elements*, all Psychotherapy, Hypnotherapy, Counselling, Primary Mental Health, and Psychiatric Care include the following *specific elements*.

A. Performing the appropriate therapy or interaction (described below) with the patient(s) or, in the case of K014, K015, and H313, the patient's relative(s) or *patient's representative*, which *may include* the appropriate inquires (including obtaining a patient history, and a brief physical examination) carried out in order to arrive at an opinion as to the nature of the patient's condition (whether such inquiry takes place before, during or after the encounter during which the therapy or other interaction takes place); any appropriate procedure(s), related service(s), and/or follow-up care.

B. Performing any procedure(s) during the same encounter as the therapy or other interaction unless the procedure(s) is(are) separately listed in the Schedule and an amount is payable for the procedure in conjunction with the therapy or interaction.

C. Making arrangements for any related assessments, procedures, or therapy.

D. Making arrangements for follow-up care.

E. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:

- **a.** the service; and
- **b.** in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

F. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is rendered.

G. Providing premises, equipment, supplies, and personnel for the *specific elements* of the service.

While no occasion may arise for performing elements B, C, D and F, when performed in connection with the other *specific elements* they are included in the service.

Payment rules:

1. These services are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient's relative or *patient's representative* as the case may be) and the physician in person is as follows:

# Units	Minimum Time with Patient
1 unit	20 minutes
2 units	46 minutes
3 units	76 minutes [1h 16m]
4 units	106 minutes [1h 46m]
5 units	136 minutes [2h 16m]
6 units	166 minutes [2h 46m]
7 units	196 minutes [3h 16m]
8 units	226 minutes [3h 46m]

2. Except for in-patient individual psychotherapy by a psychiatrist or in-patient individual psychiatric care for which the time can be consecutive or non-consecutive, for all other services in this section the time units must be calculated based upon consecutive time spent rendering the service.

3. Psychotherapy performed outside a hospital, psychiatric care, primary mental health care, or hypnotherapy rendered the same day as a consultation or other assessment by the same physician to the same patient is *not eligible for payment* unless there are clearly defined different diagnoses for the two services.

[Commentary:
Except as noted in payment rule #2 (where non-consecutive services can be cumulated), services less than 20 minutes do not constitute any of the services defined in this section and constitute the type of assessment rendered in the circumstances.]

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

PSYCHOTHERAPY/FAMILY PSYCHOTHERAPY

Definition:

Psychotherapy is any form of treatment for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where a physician deliberately establishes a professional relationship with a patient with the purpose of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.

Family psychotherapy is psychotherapy rendered to the patient in the presence of one or more members of the patient's household.

Payment rules:

1. Psychotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.
2. Subsequent visits rendered by the same psychiatrist to the same patient on the same day as in-patient individual psychotherapy are *not eligible for payment*.

PSYCHIATRIC CARE/FAMILY PSYCHIATRIC CARE/PRIMARY MENTAL HEALTH CARE

Definition:

Psychiatric care/family psychiatric care/primary mental health care are services encompassing any combination or form of assessment and treatment by a physician for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where there is consideration of the patient's biological and psychosocial functioning.

Family psychiatric care is psychiatric care of the patient carried out by the physician in the presence of one or more family members or in the presence of professional caregivers not on staff at the facility where the patient is receiving the care.

Payment rules:

Subsequent visits rendered by the same psychiatrist to the same patient on the same day as individual in-patient psychiatric care are *not eligible for payment*.

FOCUSED PRACTICE PSYCHOTHERAPY PREMIUM

The focused practice psychotherapy premium is payable aut*oma*tically to an eligible physician subject to the definitions and rules described below.

Definitions:

"Qualifying services" means K004A, K006A, K007A, K010A, K012A, K019A, K020A, K024A K025A, K122A and K123A.

"*Fiscal year*" means April 1 - March 31st.

"Qualifying year" means the *fiscal year* preceding the date of determination of eligibility.

"Date of determination of eligibility" means the date upon which the General Manager determines that the conditions for payment in (1) or (2) below, have been met.

"All payments" means all payments made to the physician for insured services listed in this Schedule other than payments made for insured services listed in this Schedule for which a technical fee is payable.

Payment rules:

For the *12 month period* following the date of determination of eligibility for the premium, the amount payable to a physician shall be aut*oma*tically increased by 12% for each of the following services rendered by the physician: K004, K006, K007, K010, K012, K019, K020, K024, and K025, in the following circumstances:

1. when the sum of all payments made to the physician for the qualifying services rendered in the qualifying year exceeds 50% of the sum of all payments made to the physician in the qualifying year; or
2. when the sum of all payments made to the physician for the qualifying services rendered in the qualifying year is at least 40% but not more than 49% of the sum of all payments made to the physician in the qualifying year and the requirements set out in (1.) were met by the physician in respect of the *fiscal year* preceding the qualifying year.

[Commentary:
While K122 and K123 are qualifying services for the purpose of determining eligibility for the focused practice psychotherapy premium, the premium is not payable for K122 and K123.]

HYPNOTHERAPY

Definition:

Hypnotherapy is a form of treatment that has the same goals as psychotherapy but is rendered with the patient under hypnosis.

Payment rules:

Hypnotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.

COUNSELLING

Definition/Required elements of service:

Counselling is a patient visit dedicated solely to an educational dialogue with a physician. This service is rendered for the purpose of developing awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention.

[Commentary:

1. Advice given to a patient that would ordinarily constitute part of a consultation, assessment, or other treatment, is included as a common or constituent element of the other service, and does not constitute counselling.
2. Detention time may be payable following a consultation or assessment when a physician is required to spend considerable extra time in treatment or monitoring of the patient. See GP20 for further information.]

Payment rules:

1. With the exception of the codes listed in the table below, no other services are eligible for payment when rendered by the same physician the same day as any type of counselling service.

E080	G010	G039	G040	G041	G042	G043	G202	G205	G365	G372	G384
G385	G394	G462	G480	G489	G482	G538	G590	G840	G841	G842	G843
G844	G845	G846	G847	G848	H313	K002	K003	K008	K014	K015	K031
K035	K036	K038	K682	K683	K684	K730					

2. Individual and group counselling services are limited to 3 units per patient per physician per year at the higher fee (K013 or K040 respectively); the amount payable for services rendered in excess of this limit will be adjusted to a lesser fee (K033 or K041 respectively).
3. If the patient does not have a pre-booked appointment, the amount payable for this service will be adjusted to a lesser assessment fee.

A. Individual Counselling

Definition:

Individual counselling is counselling rendered to a single patient.

B. Group Counselling

Definition:

Group Counselling is counselling rendered to two or more patients with a similar medical condition or situation.

Payment rules:

1. Group counselling is *only eligible for payment* when all of the following conditions are fulfilled:
   - **a.** The group counselling is pre-booked; and
   - **b.** When there is an ongoing physician-patient relationship.
2. In addition to meeting the usual medical record requirements for the service, the physician must also maintain a separate record (independent of the patient's medical record) of the names and health numbers of all persons in attendance at each group counselling session or the service is *not eligible for payment*.

Claims submission instruction:

The claim must be submitted under the health number of the group member for whom, when the service was rendered, the largest number of counselling units had previously been claimed by the physician during the year in which the service is rendered.

[Commentary:
Group counselling does not apply to lectures.]

C. Transplant Counselling

Definition/Required elements of service:

Transplant counselling is payable in circumstances where transplant or donation is imminent, for the purpose of providing the recipient, donor or family member with adequate information and clinical data to enable that person to make an informed decision regarding organ transplantation.

Claims submission instruction:

The claim must be submitted under the health number of the recipient or donor.

D. Counselling of Relatives on Behalf of a Catastrophically or Terminally Ill Patient

Definition:

Counselling of relatives on behalf of a catastrophically or terminally ill patient is counselling rendered to a relative or relatives or representative of a catastrophically or terminally ill patient, for the purpose of developing an awareness of modalities for treatment of the patient and/or his or her prognosis.

Claims submission instruction:

The claim must be submitted under the health number of the patient who is catastrophically or terminally ill.

E. Rehabilitation Counselling

Definition:

Rehabilitation counselling is counselling rendered for the purpose of developing an awareness of the modalities for treatment of the patient and/or his or her prognosis.

INTERVIEWS

SPECIFIC ELEMENTS

In addition to the *common elements*, all services described as interviews include the following *specific elements*.

A. Obtaining information from, engaging in discussion with, and providing advice and information to interviewee(s) on matters related to the patient's condition and care.

B. Providing premises, equipment, supplies and personnel for the *specific elements* of the service.

Payment rules:

1. These services are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient's relative or *patient's representative* as the case may be) and the physician in person is as follows:

# Units	Minimum time
1 unit:	20 minutes
2 units:	46 minutes
3 units:	76 minutes [1h 16m]
4 units:	106 minutes [1h 46m]
5 units:	136 minutes [2h 16m]
6 units:	166 minutes [2h 46m]
7 units:	196 minutes [3h 16m]
8 units:	226 minutes [3h 46m]

[Commentary:

1. Services less than 20 minutes in duration do not constitute any of the services defined in this section and constitute the type of assessment rendered in the circumstances.

2. Inquiry, discussion or provision of advice or information to a patient, patient's relative or representative that would ordinarily constitute part of a consultation, assessment (including those services which are defined in terms of an assessment) is included as a common or constituent element of the other service, and does not constitute an interview.]

2. If an appointment for the interview is not separately booked, the amount payable for this service will be adjusted to a lesser fee.

3. All services described as interviews must be rendered personally by the attending physician or they become *uninsured service*s.

GENERAL PREAMBLE

DELEGATED PROCEDURE

Definition:

The term “procedure” as it is used in this section does not include services such as assessments, consultations, psychotherapy, counselling etc.

Payment rules:

1. Where a procedure is performed by a physician’s employee(s) in the physician’s office, the service remains insured using the existing fee codes if all the following requirements are met:

   a. the procedure is one which is generally and historically accepted as a procedure which may be carried out by the nurse or other medical assistant in the employ of the physician; and

   b. subject to the exceptions set out below, at all times during the procedure, the physician (although he or she may be otherwise occupied), is:

      i. physically present in the office or clinic at which the service is rendered in order to ensure that procedures are being performed competently; and

      ii. available immediately to approve, modify or otherwise intervene in a procedure, as required, in the best interests of the patient.

2. Exceptions to the requirement for physician presence during the delegated procedure.

   Where all of the following conditions are met, the simple office procedures listed in the table below remain insured despite the physician not being physically present:

   a. the non-physician performing the procedure is properly trained to perform the procedure, he/she reports to the physician, and the procedure is rendered in accordance with accepted professional standards and practice;

   b. the procedure is performed only on the physician’s own patient, as evidenced by either an ongoing physician/patient relationship or a consultation/assessment rendered by the physician to the patient on the same day as the procedure is performed; and

   c. the same medical record requirements must be met as if the physician personally had rendered the service. The record must be dated, identify the non-physician performing the service, and contain a brief note on the procedure performed by the non-physician.

Claims submission instruction:

A locum tenens replacing an absent physician in the absent physician’s office may submit claims for delegated procedures under either his/her own billing number or the billing number of the physician he/she is replacing.

COMMON PROCEDURAL DESCRIPTION	APPLICABLE FEE CODES	CURRENT PAGE #
Venipuncture	G480, G482, G489	J7
Injections and immunizations	G372, G373, G538, G590, G840, G841, G842, G843, G844, G845, G846, G847, G848	J43, J43
Ultraviolet light therapy	G470	J29
Administration of oral polio vaccine	G462	J43
Simple office laboratory procedures	G001, G002, G004, G005, G009, G010, G011, G012, G014, G481	J52
Ear syringing, curetting or debridement	G420	J77
B.C.G. inoculation	G369	J42
Simple Spirometry and Flow Volume Loop	J301, J324, J304, J327	H3
Casts	Z198-Z209, Z211, Z213, Z216, Z873	N5

[Commentary:
Claims for services delegated to an individual employed by the physician submitting the claim are payable by *OHIP*. Claims are not payable for delegated services provided by an individual who is employed by a facility or organization such as a public hospital, public health unit, industrial clinics, long-term care facilities or Family Health Teams.]

AGE-BASED FEE PREMIUMS

1. Despite any other provision in this Schedule, the amount payable for the following services rendered on or after October 1, 2009 to an insured person who falls into the age group described in the Age Group column of the following Age Premium Table is increased by the percentage specified in Percentage Increase column opposite the Age Group:

a. A consultation, limited consultation or repeat consultation rendered by a *specialist*, as those services are defined in this Schedule.

b. A surgical procedure listed in Parts K to Z inclusive of this Schedule.

c. Basic and time unit surgical assistant services listed in Parts K to Z inclusive of this schedule.

age premium table		
Item	**Age Group**	**Percentage Increase**
1	Less than 30 days of age	30%
2	At least 30 days but less than one year of age	25%
3	At least one year but less than two years of age	20%
4	At least two years but less than five years of age	15%
5	At least five years but less than 16 years of age	10%

2. Despite any other provision in this Schedule, the amount payable for the following services rendered on or after October 1, 2009 to an insured person who is at least 65 years of age, as those services are defined in this Schedule, is increased by 15 per cent:

a. A general assessment (A003, A903, C003, C903, W102, W109 or W903).

b. A general re-assessment (A004, C004, W004)

c. An intermediate assessment (A007).

d. A house call assessment (A901)

e. A focused practice assessment (A917, A927, A937, A947, A957 or A967).

f. A periodic health visit (K132)

SPECIAL VISIT PREMIUMS

Special visit means a visit initiated by a patient or an individual on behalf of the patient for the purpose of rendering a non-elective service or, if rendered in the patient's *home*, a non-elective or elective service.

A special visit premium is payable in respect of a special visit rendered to an insured person, subject to the conditions and limitations set out below. All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Payment rules:

1. Special visit premiums are *only eligible for payment* when rendered with certain services listed under "Consultations and Visits" and "Diagnostic and Therapeutic Procedures" sections of this Schedule.
2. Regardless of the time of day at which the service is rendered, special visit premiums are *not eligible for payment* in the following circumstances:
   - **a.** for patients seen during rounds at a hospital or long-term care institution (including a nursing *home* or *home* for the aged);
   - **b.** in conjunction with admission assessments of patients who have been admitted to hospital on an elective basis;
   - **c.** for non-referred or transferred obstetrical patients except, in the case of transferred obstetrical patients for a special visit for obstetrical delivery with sacrifice of office hours for the first patient seen (C989);
   - **d.** for services rendered in a place, other than a hospital or long-term care facility, that is scheduled to be open for the purpose of diagnosing or treating patients;
   - **e.** for a visit for which critical care team fees are payable under this Schedule;
   - **f.** in conjunction with any sleep study service listed in the sleep studies section of this Schedule; or
   - **g.** for services rendered to patients who present to an office without an appointment while the physician is there, or for patients seen immediately before, during or immediately after routine or ordinary office hours even if held at night or on *week*ends or *holiday*s.
3. Special visit premiums are *not eligible for payment* with services described by emergency department "H" prefix fee codes.

[Commentary:
For elective *home* visits rendered during daytime, evenings, nights or *week*ends, submit claim(s) using fee codes found under the column titled "Elective *Home* Visit" of Special Visit Premium Table VI listed on page GP50.]

Sacrifice of office hours means an insured service rendered when the demands of the patient and/or the patient's condition are such that the physician makes a previously unscheduled non-elective visit to the patient at a time when the physician had an office visit booked with one or more patients but, because of the previously unscheduled non-elective visit, any such office visit was delayed or cancelled.

SPECIAL VISIT PREMIUMS

PREMIUMS

[Commentary:
Special visit premiums are in respect of either or both: a "travel premium" and a "patient seen" premium (i.e. "first person seen premium" or "an additional person seen premium").]

A. Travel Premium

Definition/required elements of service:

A travel premium is *only eligible for payment* for travel from one location to another location ("the destination") subject to the payment rules below.

A travel premium is *not eligible for payment* when a physician is required to travel from one location to another within the same long-term care facility, hospital complex or within buildings situated on the same hospital campus.

[Commentary:

1. A first person seen premium may be eligible for payment in this circumstance.

2. Only one travel premium is eligible for payment for each separate trip to a destination regardless of the number of patients seen in association with each trip.]

B. First person seen premium

A first person seen premium is eligible for payment for the first person seen at the destination under one of the following circumstances ("the eligible times"):

1. if the insured service is commenced evenings (17:00 hr-24:00 hr) Monday to Friday; daytime or evenings on Saturdays, Sundays, and *Holiday*s; or nights (24:00 hr-07:00 hr);

2. if rendered requiring sacrifice of office hours; or

3. if rendered during daytime hours (07:00 - 17:00 hrs Monday through Friday) in circumstances in which a travel premium is eligible for payment.

C. Additional person premium

An additional person premium is *only eligible for payment* for services rendered at the destination to additional patients seen in emergency departments, outpatient departments, long-term care institutions or to hospital inpatients, provided that each additional patient service is commenced during the eligible times.

[Commentary:
Special visit premiums are *not eligible for payment* for elective services rendered at a long-term care institution, including a nursing *home* or *home* for the aged, even when the long-term care institution is the "*home*" of the patient.

Submit claims for routine elective visits in these locations as subsequent visits. For example, if the physician is called to a nursing *home* to see a patient for a non-elective problem at 8AM, and subsequently sees his/her routine patients on rounds, those additional patients do not qualify for the additional person premium.]

LIMITS FOR SPECIAL VISIT PREMIUMS

Special visit premiums in excess of the maximums listed in the Special Visit Premium Tables are *not eligible for payment*.

The maximums apply to the number of patients where special visit premiums may be eligible for payment on that service date or in the time period specified.

LIMITS FOR GERIATRIC HOME VISIT SPECIAL VISIT PREMIUMS

For the purpose of special visit premiums under the heading "Geriatric *Home* Visit Special Visit Premiums", the special visit premiums listed under Table X are *only eligible for payment* to:

a. a *specialist* in Geriatrics (07); or

b. a physician with an exemption to access bonus impact in Care of the Elderly from the *MOHLTC*.

LIMITS FOR EMERGENCY DEPARTMENT PHYSICIAN

For the purpose of special visit premiums under the heading "Emergency Department Physician", "Emergency Department Physician" means a physician:

a. who on a day when the physician is scheduled to work in a hospital emergency department specifically for the purpose of rendering services to patients who attend the emergency department for physician services,

  i. is requested by the emergency department to attend at a time when the physician is not otherwise scheduled to work in the emergency department; and

  ii. who is not at the hospital at the time the emergency department request for attendance is made; or

b. is on-call on a scheduled basis specifically to be available to a hospital emergency department to render services to patients who attend the emergency department for physician services and who is not at the hospital at the time the emergency department request for attendance is made.

[Commentary:
Emergency room physicians may be primarily funded either through an Emergency Department Alternate Funding Arrangement (ED-AFA) or fee-for-service.]

In addition to the general restrictions regarding special visits as outlined above, there are specific restrictions which apply to special visit premiums for services rendered in the emergency department by Emergency Department Physicians (as defined above). These limits are listed in the Special Visit Premiums table under the heading “Emergency Department by Emergency Department Physician” (Table V). Special Visit Premiums listed in the Special Visit Premiums table under the heading "Emergency Department" (Table I) are *not eligible for payment* to Emergency Department Physicians (as defined above).

[Commentary:

1. First patient seen and additional person seen premiums for Emergency Department Physicians are eligible for payment only when the physician is required to travel, as defined under “Travel Premium” page GP45, to make a special visit to the hospital emergency department.
2. If the Emergency Department Physician is at the hospital at the time the emergency department request for attendance is made, the appropriate H prefix code may be eligible for payment.
3. If the Emergency Department Physician is called to a hospital ward on a non-elective basis, the General Listings ("A" prefix) apply and "C" prefix first person seen/additional person seen special visit premium may be eligible for payment.]

Note:
When special visits are rendered by physicians when they are not on duty to the emergency department, the limits for special visit premiums under the heading "Emergency Department" (Table I) apply (GP48). For patients assessed during this visit to the emergency department beyond the defined limits, submit claims for all subsequent patients using the "H" prefix listings.

SPECIAL VISIT PREMIUMS

Medical record requirements:

Special Visit Premiums are *only eligible for payment* if the following requirements are met:

1. For fee codes listed in Tables I, II, III, IV, VI, VII, VIII, IX and X the time at which the special visit takes place must be documented on the medical record.
2. For fee codes listed in Table V;
   - **a.** the time of the request to attend in the emergency department must be documented on the medical record; and
   - **b.** The specific situation requiring the physician's attendance must be documented on the medical record.

[Commentary:
When a special visit service occurs in a hospital, emergency department or long-term care institution where common medical records are maintained, the time when the visit takes place may be documented anywhere in the common medical record.]

Claims submission instructions:

Submit claims using the appropriate A-prefix assessment fee from the “General Listings” for an assessment rendered in conjunction with a special visit premium.

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE I

Emergency Department

Not eligible for payment to Emergency Department Physicians (see definition GP46)

	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00 - 17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 K960	$36.40 K961	$36.40 K962	$36.40 K963	$36.40 K964
First Person Seen	$20.00 K990	$40.00 K992	$60.00 K994	$75.00 K998	$100.00 K996
Additional Person(s) seen	$20.00 K991	$40.00 K993	$60.00 K995	$75.00 K999	$100.00 K997
Maximums (per time period)					
Travel premiums	2	2	2	6	unlimited
Persons seen (first person and additional person(s))	10	10	10	20	unlimited

SPECIAL VISIT PREMIUM TABLE II

Hospital Out-Patient Department

	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 U960	$36.40 U961	$36.40 U962	$36.40 U963	$36.40 U964
First person seen	$20.00 U990	$40.00 U992	$60.00 U994	$75.00 U998	$100.00 U996
Additional person(s) seen	$20.00 U991	$40.00 U993	$60.00 U995	$75.00 U999	$100.00 U997
Maximums (per time period)					
Travel premiums	2	2	2	6	unlimited
Persons seen (first person and additional person(s))	10	10	10	20	unlimited

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE III

Hospital In-Patient	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 C960	$36.40 C961	$36.40 C962	$36.40 C963	$36.40 C964
First person seen	$20.00 C990	$40.00 C992	$60.00 C994	$75.00 C986	$100.00 C996
Additional person(s) seen	$20.00 C991	$40.00 C993	$60.00 C995	$75.00 C987	$100.00 C997
Maximums (per time period)					
Travel premiums	2	2	2	6	unlimited
Persons seen (first person and additional person(s))	10	10	10	20	unlimited

SPECIAL VISIT PREMIUM TABLE IV

Long-Term Care Institution	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 W960	$36.40 W961	$36.40 W962	$36.40 W963	$36.40 W964
First person seen	$20.00 W990	$40.00 W992	$60.00 W994	$75.00 W998	$100.00 W996
Additional person(s) seen	$20.00 W991	$40.00 W993	$60.00 W995	$75.00 W999	$100.00 W997
Maximums (per time period)					
Travel premiums	2	2	2	6	unlimited
Persons seen (first person and additional person(s))	10	10	10	20	unlimited

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE V

Emergency Department by Emergency Department Physician (as defined on GP46)

	Weekdays Daytime (07:00-17:00)	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 H960	$36.40 H962	$36.40 H963	$36.40 H964
First person seen	$20.00 H980	$60.00 H984	$75.00 H988	$100.00 H986
Additional person(s) seen	$20.00 H981	$60.00 H985	$75.00 H989	$100.00 H987
Maximums (per time period)				
Travel premiums	2	2	4	unlimited
Persons seen (first person and additional person(s))	5	5	10	unlimited

SPECIAL VISIT PREMIUM TABLE VI

Special Visits to Patient's *Home* (other than Long-Term Care Institution)

	Weekdays Daytime (07:00-17:00) Non-elective	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours Non-elective	Evenings (17:00-24:00) Monday through Friday Non-elective	Sat., Sun. and Holidays (07:00-24:00) Non-elective	Nights (00:00-07:00) Non-elective	Elective home visit
Travel Premium	$36.40 B960	$36.40 B961	$36.40 B962	$36.40 B963	$36.40 B964	$36.40 B960
First person seen	$27.50 B990	$44.00 B992	$66.00 B994	$82.50 B993	$110.00 B996	$27.50 B990
Maximums (per time period)						
Travel premiums	2	2	2	6	unlimited	2
First person seen	10	10	10	20	unlimited	10

Note:

1. The maximum number of services per physician per day for B960 is 2, for any combination of non-elective and elective visits.
2. The maximum number of services per physician per day for B990 is 10, for any combination of non-elective and elective visits.
3. Special visit to patient's *home* premiums are *only eligible for payment* for first patient seen, regardless of number of patients seen during one visit to a *home* or to one or more living units in a multiple resident dwelling. A multiple resident dwelling is a single location that shares a common external building entrance or lobby e.g. apartment block, rest or retirement *home*, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility or group *home*.

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE VII

***Palliative Care Home* Visit**	**Weekdays Daytime (07:00-17:00)**	**Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours**	**Evenings (17:00-24:00) Monday through Friday**	**Sat., Sun. and Holidays (07:00-24:00)**	**Nights (00:00-07:00)**
Travel Premium	$36.40 B966	$36.40 B966	$36.40 B966	$36.40 B966	$36.40 B966
First person seen	$82.50 B998	$82.50 B998	$82.50 B998	$82.50 B998	$110.00 B997
Maximums (per time period)					
Travel premiums	unlimited	unlimited	unlimited	unlimited	unlimited
First person seen	unlimited	unlimited	unlimited	unlimited	unlimited

SPECIAL VISIT PREMIUM TABLE VIII

Physician Office	**Weekdays Daytime (07:00-17:00)**	**Evenings (17:00-24:00) Monday through Friday**	**Sat., Sun. and Holidays (07:00-24:00)**	**Nights (00:00-07:00)**
Travel Premium	$36.40 A960	$36.40 A962	$36.40 A963	$36.40 A964
First person seen	$20.00 A990	$60.00 A994	$75.00 A998	$100.00 A996
Maximums (per time period)				
Travel premiums	1	1	1	unlimited
First person seen	1	1	1	unlimited

SPECIAL VISIT PREMIUMS

SPECIAL VISIT PREMIUM TABLE IX

Other (non-professional setting not listed)	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 Q960	$36.40 Q961	$36.40 Q962	$36.40 Q963	$36.40 Q964
First person seen	$20.00 Q990	$40.00 Q992	$60.00 Q994	$75.00 Q998	$100.00 Q996
Maximums (per time period)					
Travel premiums	1	1	1	1	unlimited
First person seen	1	1	1	1	unlimited

SPECIAL VISIT PREMIUM TABLE X

Geriatric *Home* Visit	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 B986	$36.40 B986	$36.40 B986	$36.40 B986	$36.40 B986
First person seen	$82.50 B988	$82.50 B988	$82.50 B988	$82.50 B988	$110.00 B987
Maximums (per time period)					
Travel premiums	unlimited	unlimited	unlimited	unlimited	unlimited
First person seen	unlimited	unlimited	unlimited	unlimited	unlimited

SPECIAL VISIT PREMIUM TABLE - OBSTETRICAL DELIVERY WITH SACRIFICE OF OFFICE HOURS

Obstetrical Delivery with Sacrifice of Office Hours	Weekdays Daytime (07:00-17:00)	Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
	$0.00	$76.40 C989	$0.00	$0.00	$0.00
Maximums (per time period)					
First person seen	0	1	0	0	0

TEAM CARE IN TEACHING UNITS

[Commentary:
Joint recommendations made by the *CPSO* and the *OMA* governing the charging of fees for services rendered by interns and residents in clinical teaching units were accepted by the *MOHLTC* on the understanding that the *CPSO* and medical schools ensure adherence to the rules governing these billing procedures. These recommendations were that the staff physician may make a claim to *OHIP* for services rendered by his/her intern or resident if the following requirements are met:

1. the responsible staff physician must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient at the earliest possible moment;
2. no fees are to be charged for services given by the intern or resident prior to his identification taking place;
3. when patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the physician responsible must be personally identified to the patient. The physician's relationship to the team must be defined by the clinical teaching unit director and his/her role must be known to the patient and other members of the team.]

Payment rules:

Where a service is rendered by an intern or resident in a clinical teaching unit or setting ("teaching service"), there is no amount payable to the intern or resident for the service. A service rendered by an intern or resident may be payable to the responsible staff physician where that physician assumes full responsibility for the appropriateness and the quality of the teaching service and the teaching service is rendered under the following circumstances:

1. Where the teaching service is a physical procedure, the responsible staff physician is, at the time of the procedure, physically located in the clinical teaching unit, and immediately available to intervene.
2. Where the teaching service is psychotherapy (and the presence of the responsible staff physician would distort the psychotherapy milieu) and that physician carefully reviews the record of the session with the intern or resident and thus supervises the psychotherapy. The number of time units payable is calculated as the lesser of:
   a. the time spent by the responsible staff physician in discussion with the intern or resident; or
   b. the time spent by the staff physician directly supervising the interview between the intern or resident and the patient.

   The maximum number of time units payable to the responsible staff physician for such psychotherapy is the number of time units spent by the intern or resident with the patient.

   [Commentary:
   The service date to be used is the date the intern or resident saw the patient.]
3. In other circumstances, an amount may be payable to the responsible staff physician for services provided by interns or residents on those days when the responsible staff physician actually supervises the patient's care as evidenced by the presence of that physician in the clinical teaching unit on that day. This involves a physical visit to the patient and/or a chart review and detailed discussion between the responsible staff physician and the other member(s) of the health team.
4. In those situations where the responsible staff physician may supervise concurrently multiple procedures or services through the use of other members of the team, the total claims submitted by the responsible staff physician must not exceed the amount that staff physician might claim in the absence of the other members of the team.

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

SPECIFIC ELEMENTS

In addition to the *common elements*, assistance at surgery includes the following *specific elements*.

A. Preparing or supervising the preparation of the patient for the procedure.

B. Performing the procedure by any method, or assisting another physician in the performance of the procedure(s), assisting with the carrying out of all recovery room procedures and the transfer of the patient to the recovery room, and any ongoing monitoring and detention rendered during the immediate post-operative and recovery period, when indicated.

C. Making arrangements for any related assessments, procedures, or therapy, (including obtaining any specimens from the patient) and/or interpreting results.

D. When medically indicated, monitoring the condition of the patient for post-procedure follow-up until the first post-operative visit.

E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies, and personnel for services identified with prefix # for any aspect(s) of A, C, D, and E that is (are) performed in a place other than the place in which the surgical procedure is performed.

While no occasion may arise for performing elements A, C, D or E, when performed in connection with the *specific elements* of a service, these are included in the service.

CALCULATION OF FEE PAYABLE: BASIC UNITS AND TIME UNITS

Except where "nil" is listed opposite the service in the column headed with "Asst", the amount payable for the surgical assistant service is calculated by adding together the number of basic and time units and multiplying that total by the unit fee.

Assistant Unit Fee $12.04

Basic Units: The number of basic units is the number of units listed opposite the service in the column headed with "Asst", except

a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units is that listed in the column headed with "Asst" opposite the service that describes the major procedure; or

b. where no basic unit is listed opposite the service in the column headed with "Asst" and where "nil" is not listed opposite the service in the column headed with "Asst", the number of basic units is that listed opposite the service under the column headed with "Anae". This type of service is *only eligible for payment* upon authorization by a *medical consultant* following submission of a letter from the surgeon outlining the reason the assistant was required. Submit claims for this type of service using fee code M400B.

Where "nil" is listed opposite the service in the column headed with "Asst", the assistant's service is *not eligible for payment*.

Time Units: For the purpose of calculating time units, time is determined per operation as the total of the following, excluding any time spent waiting between surgical procedures:

a. time spent by the physician in direct contact with the patient in the operating room prior to scrub time to assist with patient preparation; and

b. time spent by the physician assisting at the patient's surgery starting with scrub time and ending when the physician is no longer required to be in attendance with that patient.

Time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour or less	1 unit
After the first hour	2 units
After 2.5 hours	3 units

Claims submission instruction:

Submit claims for assisting at surgery using the suffix "B", with the procedural code.

[Commentary:
See Appendix H for a table stating the duration of surgical assisting and corresponding time units.]

SURGICAL ASSISTANTS' SERVICES

AFTER HOURS PREMIUMS

These premiums are payable when a case commences:

E400B	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays - increase the total assistant's fee by	50%
E401B	Nights (00:00h – 07:00h) - increase the total assistant's fee by.....	75%

REPLACEMENT SURGICAL ASSISTANT

When one surgical assistant ("the first assistant") starts a procedure and is replaced by another surgical assistant ("the replacement assistant") during a surgical procedure:

a. The amount payable to the first assistant is calculated by adding the listed procedural basic units plus time units for the time the first assistant is in attendance.

b. The service provided by the replacement assistant constitutes E005B based on the number of time units for the time the replacement assistant is in attendance.

Payment rules:

1. Base units are *not eligible for payment* to the replacement assistant.

2. Time units for the replacement assistant are calculated based on the total time the replacement assistant participates in the case. Time unit values are calculated in the same manner as would have applied to the original assistant had he/she not been replaced.

[Commentary:
As an example, if the original assistant is eligible for double time units when the replacement assistant takes over, the replacement assistant is also eligible for double time units.]

3. E400B or E401B is eligible for payment with E005B only if the beginning of the case commences after hours.

Medical record requirements:
E005B is *only eligible for payment* when the start and stop times are documented in the patient's permanent medical record.

SPECIAL VISIT PREMIUMS

All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Sacrifice of Office Hours

[Commentary:
For the definition of Sacrifice of Office Hours, see GP44.]

C988B	Special visit premium to assist at non-elective surgery with sacrifice of office hours - first patient seen	76.40

Payment rules:

C988B is *not eligible for payment* in respect of any special visits to assist at surgery in a calendar *month* if the amount payable for all surgical assistant's fees (including special visit premiums associated with performing surgical assistant services) rendered by the physician in that *month* is greater than 20% of the total amount payable for all insured services rendered by the physician in that *month*.

Evenings, Weekend/Holiday **and Nights**

C998B	Evenings (17:00h - 24:00h) Monday to Friday, first patient seen	60.00
C983B	Saturdays, Sundays or Holidays, daytime and evenings (07:00h -24:00h), first patient seen	75.00
C999B	Nights (00:00h - 07:00h), first patient seen	100.00

Payment rules:

1. C988B, C998B, C983B and C999B are *only eligible for payment* for the first patient seen on each special visit.
2. C988B, C998B, C983B, C999B are *only eligible for payment* when the physician is required to travel from one location to another location, as defined under "Travel Premium", page GP45.

[Commentary:
1. The specific requirements for special visits are found on pages GP44 to GP52.
2. These premiums are eligible for payment in addition to the E400 and E401 premiums.]

SPECIAL VISIT PREMIUM TABLE - SURGICAL ASSISTANT SERVICES

Surgical Assistant Services	**Weekdays Daytime (07:00-17:00)**	**Sacrifice of Office Hours**	**Evenings (17:00-24:00) Monday through Friday**	**Sat., Sun. and Holidays (07:00-24:00)**	**Nights (00:00-07:00)**
	$0.00	$76.40 C988B	$60.00 C998B	$75.00 C983B	$100.00 C999B
Maximums (per time period)					
First person seen	0	1	2	6	unlimited

SURGICAL ASSISTANTS' SERVICES

CANCELLED SURGERY – ASSISTANT SERVICES

Payment rules:

1. If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.
2. When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the assistant has scrubbed but is not required to do anything further, the service is payable as E006B with the actual number of time units added to 6 basic units for this service.

[Commentary:
If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee listed at the start of this section.]

SECOND ASSISTANT

Payment rules:

When more than one assistant was required for a surgical procedure, unless the service is listed below, the second assistant's service is *only eligible for payment* following authorization by a *medical consultant* and requires submission of a letter from the surgeon outlining the reason the second assistant was required. The amount payable for the second assistant is calculated in the same manner as the amount payable for the first assistant.

Services where a second assistant's services are payable and authorization is not required:

E645	M111	M117	M134	M142	P042	P051	P052	P056	P059
R008	R009	R013	R014	R015	R016	R055	R056	R067	R069
R134	R135	R136	R140	R182	R240	R241	R244	R326	R327
R334	R393	R438	R440	R441	R483	R487	R545	R553	R568
R593	R594	R617	R645	R701	R702	R704	R712	R713	R714
R715	R718	R726	R727	R728	R729	R733	R734	R735	R737
R738	R742	R743	R746	R747	R749	R764	R770	R771	R772
R785	R786	R799	R800	R801	R802	R803	R804	R811	R815
R817	R818	R830	R832	R858	R863	R870	R872	R874	R876
R877	R927	R929	R920	R930	S005	S007	S090	S091	S092
S096	S098	S099	S120	S125	S189	S213	S214	S267	S270
S271	S274	S275	S294	S295	S298	S300	S321	S416	S429
S440	S441	S453	S454	S462	S484	S750	S758	S759	S816

SURGICAL ASSISTANT STANDBY

Definition/Required elements of service:

E101B is a time-based service limited to one surgical case per physician per day payable for standby as a surgical assistant following a minimum of 30 minutes of unforeseen delay beyond the scheduled start time for surgery. The physician must be physically present in the operating room suite for the period between the scheduled and actual surgical start time.

Payment rules:

1. For calculation of time units, the start time for this service commences 30 minutes after the scheduled surgical start time and ends when the surgery actually commences as recorded in the hospital's operating suite records. There are no basic units.
2. E101B is *not eligible for payment* if during the standby time for which E101B would otherwise be eligible for payment, other insured services are rendered for which payment is made by *OHIP*.

[Commentary:
E101B is payable with after hours premiums.]

ANAESTHESIOLOGISTS' SERVICES

SPECIFIC ELEMENTS

In addition to the *common elements*, the *general anaesthesia* service includes the following *specific elements*.

A. Supervising the preparation of the patient for anaesthesia.

B. Performing the anaesthetic procedure, and procedures associated with the anaesthetic procedure which are not separately payable including providing all supportive measures to the patient during and immediately after the period of anaesthesia; transfer of or assisting with the transfer of the patient to the recovery room; all indicated recovery room procedures, and ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any assessments, procedures, or therapy, including obtaining any specimens (except for arterial puncture Z459), and/or interpreting the results, on matters related to the service.

D. Making, or supervising the making of, arrangements for follow-up care and when medically indicated, post-procedure monitoring of the patient's condition until the next insured service is provided.

E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies, and personnel for any aspect(s) of *specific elements* A, C, D, and E that is (are) performed in a place other than the place in which the general anaesthetic service is performed.

While no occasion may arise for performing elements C, D or E, when performed in connection with the other *specific elements*, they are included in the general anaesthetic service.

The *general anaesthesia* service includes:

a. a pre-anaesthetic evaluation, with *specific elements* as for assessments (see GP11);

b. the anaesthetic procedure; and

c. post-anaesthetic follow-up.

Note:

1. With the exception of the listings in the "Consultations and Visits" section, all references to an anaesthesiologist in this Schedule are references to any physician providing anaesthetic services.

2. As defined in the General Preamble (see GP2), *general anaesthesia*, for the purposes of this Schedule, includes all forms of anaesthesia except local infiltration, unless otherwise specifically listed.

CALCULATION OF FEE PAYABLE – BASIC AND TIME UNITS

The amount payable for the anaesthesia service is calculated by adding the number of basic and time units and multiplying the total by the anaesthesiologist unit fee.

Anaesthesiologist Unit fee $15.01

Basic Units: The number of basic units is the number of basic units listed opposite the service in the column headed with "Anae" except,

a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units listed in the column headed with "Anae" opposite the service that describes the major procedure; or

b. where the basic units are listed as IC, or where no basic units are listed, the amount payable is calculated by adding the appropriate time units to the basic units listed for a comparable procedure (taking into account the region, modifying conditions, or techniques).

Time Units: Time units are calculated on the basis of time spent by the anaesthesiologist and commence when the anaesthesiologist is first in attendance with the patient in the OR for the purpose of initiating anaesthesia and end when the anaesthesiologist is no longer in attendance (when the patient may safely be placed under custo*mar*y post-operative supervision). Time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour	1 unit
After the first hour up to and including the first 1.5 hours	2 units
After 1.5 hours	3 units

Claims submission instruction:

Submit claims for anaesthesia services rendered with a surgical procedure using the suffix "C", with the procedural code.

[Commentary:
see Appendix H for a table stating the duration of the anaesthesia service and corresponding time units.]

AFTER HOURS PREMIUMS

These premiums are payable when a case commences:

E400C	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays - increase the total anaesthetic fee by	50%
E401C	Nights (00:00h – 07:00h) - increase the total anaesthetic fee by	75%

SPECIAL VISIT PREMIUMS

All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Anaesthesia special visit premiums are *only eligible for payment* when an anaesthesiologist is required to travel, as defined under "Travel Premium" page GP45, to make a special visit to the hospital to administer an anaesthetic for a case that commences:

Evenings, Weekend/Holiday**, Nights and Sacrifice of Office Hours**

C998C	Evenings (17:00h - 24:00h) Monday to Friday; or for non-elective surgery with sacrifice of office hours - Weekdays	60.00
C985C	Saturdays, Sundays or Holidays daytime and evenings (07:00h - 24:00h).....	75.00
C999C	Nights (00:00h - 07:00h).....	100.00

Payment rules:

C998C, C985C and C999C are eligible for payment only for the first patient seen on each special visit.

[Commentary:

1. The specific requirements for special visits are found in pages GP44 to GP52.

2. These premiums are payable in addition to the E400 and E401 premiums.]

SPECIAL VISIT PREMIUM TABLE - ANAESTHESIA SERVICES

Anaesthesia Services

	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
	$0.00	$60.00 C998C	$60.00 C998C	$75.00 C985C	$100.00 C999C
Maximums (per time period)					
First person seen	0	2	2	6	unlimited

CANCELLED SURGERY - ANAESTHESIA SERVICES

Payment rules:

1. If an anaesthesiologist examines a patient prior to surgery and the surgery is cancelled prior to the induction of anaesthesia, the service rendered constitutes a hospital subsequent visit.
2. When an anaesthetic has begun but the operation is cancelled prior to commencement of surgery, the service constitutes E006C with the actual number of time units added to 6 basic units for this service.

[Commentary:
If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee.]

SECOND ANAESTHESIOLOGIST

Unless otherwise specified in the Schedule, when the anaesthetic services of more than one anaesthesiologist are necessary in the interest of the patient, the service provided by the second anaesthesiologist constitutes E001C with the actual number of time units (based on the actual time assisting the first anaesthesiologist) added to 6 basic units.

REPLACEMENT ANAESTHESIOLOGIST

When one anaesthesiologist starts a procedure and is replaced by another anaesthesiologist ("the replacement anaesthesiologist") during a surgical procedure or delivery:

a. the amount payable to the first anaesthesiologist is calculated by adding the listed procedural basic units plus time units for the time the first anaesthesiologist is in attendance;

b. except in the case of continuous conduction anaesthesia, the service provided by the replacement anaesthesiologist constitutes E005C based on the actual number of time units and 6 basic units.

Note:
E005C qualifies for the premiums E400C or E401C only if the case commences after hours (see GP59).

[Commentary:
1. Each anaesthesiologist must indicate, as part of the medical record, his/her starting and finishing times.
2. For continuous conduction anaesthesia, the replacement anaesthesiologist submits claims using the applicable continuous conduction anaesthesia fee code.]

OBSTETRICS – CONTINUOUS CONDUCTION ANAESTHESIA

P014C, introduction of a catheter for labour analgesia, including the first dose, has a value of 6 basic units.

E111A Combined spinal-epidural for labour, to P014C ..... add 50.00

P016C time units for maintenance of obstetrical epidural anaesthesia are calculated on the basis of 1 unit for each ½ hour of time to a maximum of 12 units.

E100C time units for attendance at delivery are calculated on the basis of 1 unit for each ¼ hour

[Commentary:
1. As these services fall under the definition of *general anaesthesia*, the *specific elements* for *general anaesthesia* apply to P014C, P016C and E100C.
2. For additional information on obstetrical anaesthesia services, see page K8 of the Schedule.]

EXTRA UNITS

Extra Units: An amount is payable for extra units in addition to basic units when an anaesthesiologist administers an anaesthetic to:

Fee code	Criteria	Number of extra units
E021C	premature *newborn* less than 37 *week*s gestational age	9 units
E014C	*newborn* to 28 days	5 units
E009C	*infant* from 29 days to 1 year of age	4 units
E019C	*infant* or *child* from 1 year to 8 years of age inclusive	2 units
E007C	*adult* aged from 70 to 79 years, inclusive	1 unit
E018C	*adult* aged 80 years and older	3 units
E010C	patient with *body mass index (BMI)* > 40	2 units
E011C	patient in prone position during surgery	4 units
E024C	patient in sitting position during surgery, greater than 60 degrees upright	4 units
E025C	unanticipated massive transfusion – transfusion of at least one blood volume of red blood cells	10 units
E012C	patient who is known to have malignant hyperthermia or there is a strong suspicion of susceptibility, and the anaesthetic requires full malignant hyperthermia set up and management	5 units
E022C	ASA III - patient with severe systemic disease limiting activity but not incapacitating	2 units
E017C	ASA IV – patient with incapacitating systemic disease that is a constant threat to life	10 units
E016C	ASA V – moribund patient not expected to live 24 hours *with or without* operation	20 units
E020C	ASA E - patient undergoing anaesthesia for emergency surgery which commences within 24 hours of operating room booking, to E022C, E017C or E016C	4 units

Note:
E025C is *only eligible for payment* for an unanticipated transfusion of blood during a surgical procedure where:

1. greater than 70 ml/kg of red blood cells are transfused for a patient with a weight up to 50 kg; or

2. 10 or more units of red blood cells are transfused for a patient with a weight exceeding 50 kg.

[Commentary:
1. For E010, BMI is calculated by dividing the patient's weight (in kilograms) by the square of the patient's height (in metres).

2. E025C is defined by the amount of blood transfused rather than the amount of blood loss. The volume of blood transfused does not include blood collected from a cell saver, hemodilution techniques or non-red blood cell components.]

Payment rules:

1. In the description of E022C, E016C, E017C and E020C, reference to ASA level for Physical Status Classification means the level determined by the anaesthesiologist at the time of the pre-operative anaesthesia assessment.

[Commentary:
The level determined above does not vary, for example, when complications arise during surgery.]

2. E016C, E017C and E020C are *not eligible for payment* when anaesthesia is rendered to a brain dead patient for organ donations.

REPLACEMENT OF LISTED BASIC UNITS

Circumstances under which the listed basic units for a procedure are replaced with the following basic units:

Fee code	Description	Replace Number of Basic units with
E650C	when a pump (*with or without* an oxygenator and *with or without* hypothermia) is used in conjunction with an anaesthetic	28 units
E645C	off pump coronary artery bypass grafting, to R742 or R743	40 units
E002C	when hypothermia is used by the anaesthesiologist in procedures not specifically identified as requiring hypothermia	25 units
E013C	when anaesthetic management is required for the emergency relief of acute upper airway (above the carina) obstruction (excluding choanal atresia)	10 units

ANAESTHESIA FOR NERVE BLOCK PROCEDURES

When a physician renders an anaesthesia service in support of services performed by another physician listed in Nerve Blocks for Acute Pain Management, Interventional Pain Injections or the Peripheral/Other Nerve Block sections of the Schedule the anaesthesia service is *only eligible for payment* as one of the following:

E030C Procedural sedation.....4 basic units

Note:
Extra units listed on GP61 are not payable with E030C.

E031C General anaesthesia or deep sedation.....4 basic units

Note:
Extra units listed on GP61 are not payable with E031C.

[Commentary:
Z432C is *not eligible for payment* for an anaesthesia service in support of a nerve block.]

ANAESTHESIOLOGISTS' SERVICES

ANAESTHESIA FOR OCULAR SURGERY, EXAMINATION UNDER ANAESTHESIA, COLONOSCOPY, SIGMOIDOSCOPY AND CYSTOSCOPY

For the purposes of E023C, anaesthesia means an anaesthesia service other than local infiltration, topical anaesthesia or procedural sedation rendered in support of the listed procedures. E023C replaces the listed basic units and time units for anaesthesia for these procedures.

E023C Anaesthesia service for E137, E138, E139, E140, E141, E143, E144, E145, E146, E147, E149, Z432, Z606, Z607, Z491, Z492, Z493, Z494, Z495, Z496, Z497, Z498, Z499, Z555 or Z580 ..... 6 basic units, plus time units.

[Commentary:

1. Deep sedation, *general anaesthesia* or regional anaesthesia, performed by an anaesthesiologist, are examples of anaesthesia that may be rendered for E023C.

2. Anaesthesia extra units listed on GP61 are eligible for payment with E023C.

3. Local infiltration or topical anaesthesia used as an anaesthetic for any procedure is *not eligible for payment*.]

Note:

For the purposes of anaesthesia services the following definitions apply:

1. Procedural Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

2. Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

3. *General Anaesthesia* is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

ANAESTHESIA ADMINISTERED BY SAME PHYSICIAN PERFORMING A PROCEDURE

1. Except as described in paragraph 2, when a physician administers an anaesthetic, nerve block and/or other medication prior to, during, immediately after or otherwise in conjunction with a diagnostic, therapeutic or surgical procedure which the physician performs on the same patient, the administration of the anaesthetic, nerve block and/or other medication is *not eligible for payment*.

2. A major or minor peripheral nerve block, major plexus block, neuraxial injection (*with or without* catheter) or intrapleural block (*with or without* catheter) for post-operative pain control (with a duration of action more than 4 hours) is eligible for payment as G224 when rendered in conjunction with a procedure which the physician performs on the same patient. With the exception of a bilateral pudendal block (where only one service is eligible for payment), G224 is eligible for payment once per region per side where bilateral procedures are performed.

[Commentary:

For additional information, refer to the Nerve Blocks for Acute Pain Management, Interventional Pain Injections and the Peripheral/Other Nerve Block sections of the Schedule.]

GENERAL PREAMBLE

SUPPORTIVE CARE/MONITORING BY SURGICAL ASSISTANT OR ANAESTHESIOLOGIST

SPECIFIC ELEMENTS

In addition to the *common elements*, supportive care or monitoring by the surgical assistant or anaesthesiologist includes the following *specific elements*.

A. Being in constant attendance at a surgical procedure for the sole purpose of monitoring the condition of the patient (including appropriate physical examination and inquiry) and being immediately available to provide, and including the provision of, special supportive care to the patient.

B. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:

1. the service; and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

C. Providing premises, equipment, supplies, and personnel for any aspect(s) of the *specific elements* of the service that is(are) performed at a place other than the place in which the attendance occurs.

While no occasion may arise for performing element B, when performed in connection with the other elements it is included in the service.

CALCULATION OF FEE PAYABLE

The fee for this service is calculated in the same manner as for assistant and anaesthesia services.

		Asst	Anae
E003	Supportive care/Monitoring	6	4

Note:

1. For E003B, the assistants' premiums apply as for assistants' services.

2. Anaesthesia extra units listed on GP61 are *not eligible for payment* with E003C.

OTHER PREMIUMS

INTENSIVE OR CORONARY CARE UNIT PREMIUM

C101 For each patient seen on a visit to ICU or CCU (subject to the exceptions set out below) ..... add 9.10

Payment rules:
C101 is *not eligible for payment* with Supportive Care or with Critical Care, Ventilatory Care, Comprehensive Care, Acquired Brain Injury Management or Neonatal Intensive Care where team fees are claimed.

[Commentary:
C101 is also payable alone when no other separate fee is payable for the service provided in the ICU or CCU (e.g. post-operative care by surgeon).]

AFTER HOURS PROCEDURE PREMIUMS

These premiums are payable only when the following criteria are met:

a. the service provided is one of the following:

Non-elective Surgical Procedures (including fractures or dislocations), Obstetrical Deliveries, Clinical Procedures Associated with Diagnostic Radiological Examinations, Ground Ambulance Transfer (K101), Air Ambulance Transfer (K111), Transport of Donor Organs (K102), Return Trip (K112), or one of the following Major Invasive Procedures:

E111A	G060	G061	G062	G065	G066	G067	G068	G082	G083	G085	G090
G091	G092	G099	G117	G118	G119	G125	G176	G177	G178	G179	G211
G222	G224	G246	G248	G249	G260	G261	G262	G263	G268	G269	G275
G277	G279	G280	G282	G287	G288	G290	G294	G295	G297	G298	G303
G309	G322	G323	G324	G330	G331	G336	G347	G348	G349	G356	G376
G379	G380	G509	J001 to J068								

and;

b. the procedure is either (a) non-elective; or (b) an elective procedure which, because of an intervening surgical emergency procedure(s) was delayed and commenced between:

Emergency Department Physician

E412 Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by 20%

E413 Nights (00:00h – 07:00h) - increase the procedural fee(s) by 40%

Physician – other than an Emergency Department Physician

E409 Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by 50%

E410 Nights (00:00h – 07:00h) - increase the procedural fee(s) by 75%

Payment rules:

1. E409/E410 is not payable for a procedure rendered by an Emergency Department Physician
2. E412/E413 is only payable for a procedure rendered by an Emergency Department Physician who at the time the service was rendered is required to submit claims using “H” prefix emergency services.

[Commentary:
See General Preamble GP34 for definitions and conditions for Emergency Department Physician.]

OTHER PREMIUMS

AFTER HOURS SPECIAL VISIT PREMIUMS FOR DIAGNOSTIC SERVICES

All special visit premiums are subject to the maximums, limitations and conditions set out in the "Special Visit Premium Table" applicable in the circumstances.

Subject to the provision set out below, these special visit premiums are eligible for payment for non-elective services rendered by *specialist*s in Diagnostic Radiology, Radiation Oncology or Nuclear Medicine for an acute care hospital in-patient, out-patient or emergency department patient for services listed in the following sections of the Schedule:

Nuclear Medicine, Radiation Oncology, Diagnostic Radiology, Clinical Procedures Associated with Diagnostic Radiology Examinations, Magnetic Resonance Imaging and Diagnostic Ultrasound.

When a physician providing one or more of the foregoing non-elective services renders a special visit (as defined under “Special Visit” page GP44) in the hospital during the time periods set out below for the purpose of interpreting the results of a diagnostic service, performing a procedure, rendering a diagnostic radiology or nuclear medicine consultation or to conclude that a procedure is not medically indicated, a special visit premium is eligible for payment payable in addition to the appropriate diagnostic radiology or nuclear medicine consultation, interpretation, or procedural fee, or by itself if the decision is made not to perform the procedure.

Payment rules:

1. These special visit premiums are *not eligible for payment* for services rendered outside of a hospital, for example via PACS.
2. Only one special visit person seen premium is eligible for payment per patient regardless of the number of eligible services rendered during the same special visit for that patient.
3. These special visit premiums are *not eligible for payment* in addition to any other special visit premium for the same special visit.
4. For the purpose of interpreting the results of a diagnostic service or performing a diagnostic service, these special visit premiums are *only eligible for payment* if the request for the interpretation relates to a patient’s condition requiring urgent interpretation that affects the patient’s management.

[Commentary:
The specific requirements for special visits are found on pages GP44 to GP52.]

SPECIAL VISIT PREMIUM TABLE - NON ELECTIVE DIAGNOSTIC SERVICES

Non-elective Diagnostic Services	**Evenings (17:00-24:00) Monday through Friday**	**Sat., Sun. and *Holiday*s (07:00-24:00)**	**Nights (00:00-07:00)**
Travel Premium	$36.40 C102	$36.40 C103	$36.40 C104
First person seen	$60.00 C109	$75.00 C108	$100.00 C110
Additional person(s) seen	$60.00 C105	$75.00 C106	$100.00 C107
Maximums (per time period)			
Travel premiums	2	6	unlimited
Persons seen (first and additional persons)	2	6	unlimited

[Commentary:
For the purposes of non-elective diagnostic services special visit premiums, first person seen and additional person(s) seen mean the eligible diagnostic service(s) rendered for each individual patient.]

OTHER PREMIUMS

AFTER HOURS SPECIAL VISIT PREMIUMS

The following premiums are payable for providing management and supervision of continuous catheter infusions for analgesia for a hospital in-patient (G247) rendered during the time periods set out below:

E402 Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturday, Sunday or Holidays .....add 40%

E403 Nights (00:00h – 07:00h) .....add 50%

[Commentary:
For additional information, refer to the Nerve Blocks for Acute Pain Management section of the Schedule.]

AFTER HOURS PREMIUMS FOR URGENT CT/MRI INTERPRETATION

Subject to the provisions set out below, these premiums are payable in addition to the CT or MRI services listed in the Diagnostic Radiology and Magnetic Resonance Imaging sections of the Schedule for interpreting a CT and/or MRI study on an urgent basis via a picture archiving and communication system (PACS), using diagnostic workstations and monitors consistent with Digital Imaging and Communications in Medicine (DICOM) standards. The physician must be physically present in Ontario at a location other than the hospital where the patient receives the CT or MRI study and provide the interpretation via PACS, including review of any relevant prior images available through the PACS.

Evenings, Weekend/Holiday **and Nights**

E406	Evenings (17:00h - 24:00h) Monday to Friday.....	60.00
E407	Saturdays, Sundays or Holidays daytime and evenings 07:00h - 24:00h)	75.00
E408	Nights (00:00h - 07:00h)	100.00

Payment rules:

1. These premiums are *only eligible for payment* for an urgent CT or MRI interpretation for an acute care hospital in-patient, emergency department or Hospital Urgent Care Clinic patient and only if the following requirements are satisfied:

- **a.** the *referral* for the interpretation relates to a patient's condition that requires urgent interpretation of a CT or MRI study for the urgent management of the patient;
- **b.** the *referral* is from a physician or oral and maxillofacial surgeon who has privileges at the hospital where the service is rendered;
- **c.** the interpreting physician has radiology privileges at the hospital where the request for the service originates; and
- **d.** the interpretation is transmitted to the referring physician within three hours of the completion of the CT/MRI study.

Note:
If the request for interpretation occurs prior to an eligible after hours period, but the interpretation cannot be provided prior to that eligible after hours period due to factors beyond the control of the interpreting physician, these premiums remain eligible for payment if the payment rules are otherwise satisfied.

2. E406, E407 and E408 are limited to a maximum of one per patient, per physician, per day, regardless of the number of CT and/or MRI images interpreted for that patient.

3. After hours premiums in excess of the maximums listed in the After Hours Premium Table are *not eligible for payment*.

Medical record requirements:
These premiums are *only eligible for payment* if the patient's permanent medical record contains the following information:

1. The time of the request and the time of the transmission of the interpretation; and

2. A description of any factors referred to in the note above.

OTHER PREMIUMS

AFTER HOURS PREMIUM TABLE – Urgent CT/MRI Services

Urgent CT/MRI Services	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and *Holiday*s (07:00-24:00)	Nights (00:00-07:00)
	$60.00 E406	$75.00 E407	$100.00 E408
Maximums (per time period)	2	6	Unlimited

TRAUMA PREMIUM

Definition/Required elements of service:

The trauma premium is payable for each of the services and units described below when:

a. rendered either on the day of the trauma or within 24 hours of the trauma; and

b. for trauma patients age 16 or more who have an Injury Severity Score (ISS) of greater than 15, or for patients less than age 16 who have an Injury Severity Score of greater than 12.

E420 Trauma premium .....add 50%

Payment rules:

1. The premium is applicable to the following services and units;

a. services listed in the Consultation and Visits Section (Section A of the Schedule);

b. services listed in the Obstetrics Section (Section K of the Schedule);

c. services listed in the Surgical Procedures section (Section M through Z of the Schedule);

d. the following resuscitative services: G395, G391, G521, G522 and G523.

e. basic and time units provided by surgical assistants; or

f. basic and time units provided by anaesthesiologists.

2. The premium is payable only for the services for which the medical record lists the ISS score.

Claims submission instruction:

For claims payment purposes, the trauma premium and associated services must be submitted on the same claim record.

[Commentary:
Other special visit and after hours premiums are payable with services eligible for the trauma premium in accordance with the Schedule. However, the trauma premium is not applicable to these services.]

GENERAL PREAMBLE

EMERGENCY DEPARTMENT SESSIONAL FEES

Definition:

For the purposes of this part,

"eligible hospital" means a hospital, designated by the *MOHLTC* as eligible for Emergency Department sessional fees which provides 24 hour Emergency Department coverage on a continuing basis.

"sessional unit" means each one hour period, commencing on the hour, on any day (including *week*ends or *holiday*s) between 20:00 and 08:00h.

"sessional period" refers to the four hour block for each of the sessional unit codes below.

"sessional physician" means the physician to whom payment is made in respect of a sessional unit.

Payment rules:

1. The amount payable for a sessional unit for all insured services rendered during that hour and for being on call to provide such insured services is $72.80.
2. Claims for sessional units shall be submitted in accordance with the following codes:

Sessions – Monday to Friday (other than *holiday*s)

H400	20:00h – 24:00h	72.80
H401	00:00h – 04:00h	72.80
H402	04:00h – 08:00h	72.80

Sessions – Saturdays, Sundays, *Holiday*s

H403	00:00h – 04:00h	72.80
H404	04:00h – 08:00h	72.80
H405	08:00h – 12:00h	72.80
H406	12:00h – 16:00h	72.80
H407	16:00h – 20:00h	72.80
H408	20:00h – 24:00h	72.80

3. Services rendered to any person present in the Emergency Department of the hospital on or before 08:00h of any non-*holiday week*day, and not assessed by the sessional physician before that time, are eligible for payment in addition to the sessional fee.
4. Services rendered to any person present in the Emergency Department of the eligible hospital before 20:00h and not assessed by the sessional physician on or before that time shall be deemed to have been rendered during the sessional unit.
5. Claims for sessional units are eligible for payment only if the following conditions are met:
   a. the claim for the sessional unit is submitted using the *OHIP* identification number assigned by the *MOHLTC* for physicians claiming such services at each eligible hospital;
   b. in addition to the claim submitted for the sessional unit, claims are submitted at $0.00 for each and every other insured service rendered during the sessional period to which the sessional unit applies, using the appropriate codes listed in the Schedule; and
   c. all physicians providing insured services in that eligible hospital during any sessional unit submit claims for those services on a sessional unit basis only, except as specifically outlined below.

EMERGENCY DEPARTMENT SESSIONAL FEES

6. With the exceptions noted in section 7, where a fee is paid in respect of a sessional unit,

a. services rendered in the hospital during the sessional unit by any physician are *not eligible for payment*; and

b. services rendered anywhere by the sessional physician during that sessional unit are *not eligible for payment*.

7. Section 6 does not apply to the following:

a. services which comprise the daily, routine scheduled care of in-patients;

b. services rendered during a sessional unit by a physician other than the sessional physician who is

i. a *specialist*; or

ii. a general practice physician if the services comprise an obstetrical delivery, immediate post-delivery care of a *newborn*, anaesthesia (other than local anaesthesia), or surgery that requires the services of an anaesthesiologist;

c. services, other than assessments, consultations, counselling or psychotherapy, rendered during a sessional unit by:

i. a *specialist* who is the sessional physician, if the services are procedures that would normally require the services of a *specialist*; or

ii. a general practice physician who is the sessional physician if the services comprise an obstetrical delivery, immediate post-delivery care of a *newborn*, anaesthesia (other than local anaesthesia) or surgery that requires the services of an anaesthesiologist;

d. services rendered during a sessional unit by a supplementary physician where, in extraordinary or catastrophic circumstances, the sessional physician requires the assistance of a supplementary physician due to a high volume of patients and/or the serious nature of illness and/or injury of one or more patients; or

e. services rendered during a sessional unit by the sessional physician to a resident of a nursing *home* or other chronic care institution, at such nursing *home* or other institution.

GENERAL PREAMBLE

EMERGENCY DEPARTMENT ALTERNATIVE FUNDING AGREEMENTS

When one or more physicians have contracted with the *MOHLTC* to provide insured physician services under an emergency department alternative funding agreement (ED AFA) in lieu of fee-for-service payments under the Schedule, then no insured service encompassed by the contract relating to the emergency department alternative funding agreement is payable, whether or not the physician who renders the service is a party to the contract unless the physician is/are:

a. a second on-call physician who either does or does not participate in the ED AFA and who can submit fee-for-service claims under the hospital's ED AFA second on-call group number;

b. general practitioner experts ('GP Experts') who, in accordance with the ED AFA, are entitled to submit fee-for-service claims under the hospital's ED AFA GP Expert group number; or

c. the patient's general/family physician only for services payable as A100 - General/Family Physician Emergency Department Assessment.

GENERAL PREAMBLE

NOT ALLOCATED