

GENERAL PREAMBLE

INTRODUCTION

The Schedule of Benefits is divided into a number of sections. The first section is entitled "General Preamble". It sets out the general definitions as well as the constituent elements common to all insured services, and specific elements for services listed in "Consultations and Visits" section of the Schedule and for services not listed elsewhere. Also listed in the General Preamble are premiums payable for services, and the circumstances under which they may be paid.

The next section is "Consultations and Visits", starting with Family Practice & Practice In General, followed by a similar listing for each of the recognized specialty groups in alphabetical order. This is followed by separate sections applicable to Nuclear Medicine, Radiation Oncology, Diagnostic Radiology, Clinical Procedures Associated with Diagnostic Radiological Examinations, Magnetic Resonance Imaging (MRI), Diagnostic Ultrasound, Pulmonary Function Studies, Diagnostic and Therapeutic Procedures, Obstetrics and Surgical Procedures.

The surgical procedures are listed by anatomical system. Under each system the procedures carried out within the system have been grouped under such sub-headings as Incision, Excision, Suture, Repair, etc. Thus each procedure listed may be located through determination of the anatomical system to which it applies, and the type of procedure. This method of listing has no relationship to the specialty which may be engaged in surgery upon this particular system.

The fees listed under Diagnostic and Therapeutic Procedures may be claimed in addition to the appropriate consultation or visit fees unless the procedure is the sole reason for the visit. In this latter circumstance, a basic fee-per-visit premium G700 may be added to those procedures marked (+). Fees are generally but not necessarily listed by anatomical system or specialty, but in whatever manner which is most expeditious. Listings for biopsies, endoscopies, aspirations, etc. are set out in the surgical part of the Schedule as "Z" codes.

The basic values for anesthetists and assistants at surgery are expressed in time units rather than dollars. The total fees for these services are calculated by adding the basic and time units together and multiplying the sums by the appropriate dollar values stated in the "Numeric Index".

For most surgical procedures only the major pre-operative visit, i.e. consultation or appropriate assessment fee, may be claimed in addition to the surgical fee.

Certain surgical procedures have been listed as "Z" codes (Independent Operative Procedures - IOP). When a consultation or visit (assessment) plus an IOP procedure are both rendered to the same patient, separate claims for each service may be submitted.

GENERAL PREAMBLE

The schedule contains an alpha-numeric code opposite the listings. This code with the appropriate suffix, must be used in making claims for services rendered.

In the surgical part of the Fee Schedule, physicians submitting claims in coded form should add to the code numbers, the suffix A if they perform the procedure, the suffix B if they have assisted at the surgery and the suffix C if they have administered the anesthetic.

Diagnostic Services Eligible for Payment by OHIP for Hospital Services

Diagnostic services that are listed with "technical component" or in a column headed "H" or "T" and "professional component" or in a column headed "P", "P1", or "P2" are not eligible for payment if the service is rendered to a patient who:

- a. **is an in-patient of a hospital;**
- or**
- b.
 - i. **attends a hospital where he or she receives an insured diagnostic service, and**
 - ii. **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 components listed under one fee schedule code, the technical and professional components 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*.

NUCLEAR MEDICINE - IN VIVO

PREAMBLE

SPECIFIC ELEMENTS

Nuclear Medicine procedures are divided into a professional component listed in the columns headed with a "P1" or "P2", and a technical component listed in the column headed with an "H". The technical component of the procedure subject to the conditions stated under "Diagnostic Services Eligible for Payment by OHIP for Hospital Services" on page GP2, is eligible for payment only if the service is:

- a. rendered at a hospital;
- or
- b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

In addition to the common elements, the components of Nuclear Medicine procedures include the following specific elements.

For Professional Component P₁

- A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the technical component of the procedure.
- B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.
- C. Where appropriate, post procedure monitoring, including intervening except where this constitutes a separately billable service.
- D. Interpreting the results of the diagnostic procedure.
- E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

Element D must be personally performed by the physician who claims for the service. If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician who must personally perform the service.

The physician must claim the P₂ fee, even if the P₁ service has been performed, if he/she has performed a consultation or other assessment in conjunction with the P₁ service.

For Professional Component P₂

- A. Interpreting the results of the diagnostic procedure.
- B. Providing premises for any aspect(s) of the specific elements, that is(are) performed at a place other than the place in which the procedure is performed.

Element A must be personally performed by the physician who claims for the service.

DIAGNOSTIC RADIOLOGY

PREAMBLE

SPECIFIC ELEMENTS

Diagnostic Radiology procedures are divided into a professional component listed in the column headed with a "P", and a technical component listed in the column headed with an "H". The technical component of the procedures subject to the conditions stated under "Diagnostic Services Eligible for Payment by OHIP for Hospital Services" on page GP2, is eligible for payment only if the service is :

- a. rendered at a hospital; or
- b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

In addition to the common elements, the components of Diagnostic Radiology procedures include the following specific elements.

For Professional Component P

- A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the technical component of the procedure.
- B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable (e.g. injections which are an integral part of the study) and of any fluoroscopy.
- C. Where appropriate, post procedure monitoring, including intervening except where this constitutes a separately billable service.
- D. Interpreting the results of the diagnostic procedure.
- E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician who must personally perform the service. Element D must be personally performed by the physician who claims for the service.

For Technical Component H

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure or assisting in the performance of fluoroscopy.
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, patient or patient's representative(s), whether by telephone or otherwise, on matters related to the service.
- F. Preparing and transmitting a written, signed and dated interpretive report of the procedure to the referring physician.
- G. Providing premises, equipment, supplies and personnel for all specific elements of the technical and professional components except for the premises for any aspect(s) of A and D of the professional component that is(are) not performed at the place in which the procedure is performed.

DIAGNOSTIC ULTRASOUND

PREAMBLE

SPECIFIC ELEMENTS

Diagnostic Ultrasound procedures are divided into a professional component listed in the columns headed with a "P1" or "P2", and a technical component listed in the column headed with an "H". The technical component of the procedures subject to the conditions stated under "Diagnostic Services Eligible for Payment by OHIP for Hospitals Services" on page GP2, is eligible for payment only if the service is:

- a. rendered at a hospital;
- or
- b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

In addition to the common elements, the components of Diagnostic Ultrasound procedures include the following specific elements.

For Professional Component P₁

- A. Being physically present in the ultrasound department or facility to provide clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the technical component of the procedure.
- B. Either
 - a. the performance of some or all of the procedure; or
 - b. the review of the images obtained before the patient leaves the department/office, so as to be able to modify the examination while the patient is still in the department/office.
- C. Where appropriate, post procedure monitoring, including intervening except where this constitutes a separately billable service.
- D. Interpreting the results of the diagnostic procedure.
- E. Providing premises for any aspect of D that is performed at a place other than the place in which the procedure is performed.

Elements A, B, C and D must be personally performed by the physician who claims for the service.

PULMONARY FUNCTION STUDIES

PREAMBLE

SPECIFIC ELEMENTS

Pulmonary Function diagnostic procedures are divided into a professional component listed in the columns headed with a "P", and a technical component listed in the columns headed with an "H" or a "T". The technical component "H" of the procedure subject to the conditions stated under "Diagnostic Services Eligible for Payment by OHIP for Hospitals Services" on page GP2, is eligible for payment only if the service is:

- a. rendered at a hospital;
- or
- b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

The technical component "T" of the procedure is eligible for payment for services rendered in a physician's office or a hospital with the latter subject to the conditions stated under "Diagnostic Services Eligible for Payment by OHIP for Hospital Services" on page GP2.

In addition to the common elements, the components of Pulmonary Function diagnostic procedures include the following specific elements.

For Professional Component P

- A. Providing clinical supervision, including approving, modifying and/or intervening in the performance of the procedure where appropriate, and quality control of all elements of the technical component of the procedure.
- B. Performance of any clinical procedure associated with the diagnostic procedure which is not separately billable.
- C. Where appropriate, post procedure monitoring, including intervening except where this constitutes a separately billable service.
- D. Interpreting the results of the diagnostic procedure.
- E. Providing premises for any aspect(s) of A and D that is(are) performed at a place other than the place in which the procedure is performed.

If the physician claiming the fee for the service is personally unable to perform elements A, B and C, these may be delegated to another physician, who must personally perform the service.

Element D must be personally performed by the physician who claims for the service.

For Technical Component H and T

- A. Preparing the patient for the procedure.
- B. Performing the diagnostic procedure.
- C. Making arrangements for any appropriate follow-up care.
- D. Providing records of the results of the procedure to the interpreting physician.
- E. Discussion with, and providing information and advice to, patient or patient's representative(s), whether by telephone or otherwise, on matters related to the service.

DIAGNOSTIC AND THERAPEUTIC PROCEDURES

SLEEP STUDIES

SPECIFIC ELEMENTS

Sleep Studies are divided into a professional component listed in the columns headed with a "P1" or "P2", and a technical component listed in the column headed with an "H". The technical component of the procedure subject to the conditions stated under "Diagnostic Services Eligible for Payment by OHIP for Hospital Services" on page GP2, is eligible for payment only if the service is:

- a. rendered at a hospital;
- or
- b. rendered at an off-site premise operated by a hospital corporation that has received approval under section 4 of the *Public Hospitals Act*.

The specific elements for the technical component "H" include the specific elements for the technical components of non-invasive diagnostic procedures listed in the Preamble to Diagnostic and Therapeutic Procedures.

OTHER TERMS AND DEFINITION

1. Professional and technical components are claimed separately. Claims for the technical component H are submitted using listed fee code with suffix B. Claims for professional component P₁ are submitted using first listed fee code with suffix C (e.g. J890C), while claims for professional component P₂ are submitted using second listed fee code with suffix C (e.g. J690C).
2. For the services rendered outside a hospital setting, the only fees payable under the *Health Insurance Act* are for the professional component listed under the P₁ or P₂ columns (use suffix C). Fees for the technical component of these services are only payable under the *Independent Health Facilities Act* and are listed in the Schedule of Facility Fees.
3. Overnight sleep studies are limited to a maximum of two per 12-month period (any combination of study levels) unless written prior authorization is obtained from the Ministry of Health and Long-Term Care's Medical Consultant. For services rendered on or after October 1, 1999, the 12-month period is determined from October 1, 1998 onwards.