

Explanation of Codes – May 2010

Explanatory Code	Description
AP	This payment is made according to the legislated rate for the service rendered
C1	Allowed as repeat/limited consultation/midwife - requested emergency assessment
C2	Allowed at re-assessment fee
C3	Allowed at minor assessment fee
C4	Consultation not allowed with this service; paid assessment
C5	Allowed as multiple systems assessment
C6	Allowed as type 2 admission assessment
C7	An admission assessment (C003) or general re-assessment (C004) may not be claimed by any physician within 30 days following a pre-dental/pre-operative assessment
C8	Payment reduced to geriatric consultation fee -- maximum number of comprehensive geriatric consultations has been reached
C9	Allowed as in-patient interim admission orders - initial assessment already claimed by other physician
DA	Maximum for this procedure reached. Paid as repeat/chronic procedure
DB	Other dialysis procedure already paid
DC	Procedure paid previously not allowed in addition to this procedure. Fee adjusted to pay the difference.
DD	Not allowed as diagnostic code is unrelated to original major eye exam
DE	Lab tests already paid; visit fee adjusted
DG	Diagnostic/miscellaneous services for hospital in-patients are not payable on a fee-for-service basis – included in hospital global budget
DH	Ventilatory support allowed with haemodialysis
DL	Allowed at listed fee for laboratory tests performed in the physician's office
DM	Paid/disallowed in accordance with Ministry of Health and Long-Term Care (MOHLTC) policy regarding an emergency department equivalent
DN	Allowed as prudenal block in addition to procedure - as per stated OHIP policy
DP	Procedure paid previously allowed at 50% in addition to this procedure – fee adjusted to pay the difference
DS	Not allowed - mutually exclusive code billed
DT	In-patient technical fee not allowed
DV	Service is included in Monthly Management Fee for long term care patients
DX	Diagnostic code is not eligible with Fee Schedule Code (FSC)
D1	Allowed as repeat procedure; initial procedure previously claimed
D2	Additional procedures allowed at 50%
D3	Not allowed in addition to visit fee
D4	Procedure allowed at 50% with visit
D5	Procedure already allowed. Visit fee adjusted
D6	Limit of payment for this procedure reached
D7	Not allowed in addition to the other procedure claimed
D8	This service can only be paid when billed with another specific procedure
D9	Not allowed to a hospital department

Explanation of Codes – May 2010 (Continued)

Explanatory Code	Description
EA	Service date is not within an eligible period - services provided on or after the 20 th of this month will not be paid unless eligibility status changes
EB	Coding added/changed in accordance with Schedule of Benefits
EF	Incorrect version code - service provided on or after the 20th of this month will not be paid unless the current version code is provided
EV	Check health card for current version code (applicable for service dates prior to Feb 1/93)
E1	Service date is prior to start of eligibility
E2	Incorrect version code for service date
E4	Service date is after the eligibility termination date
E5	Service date is not within an eligible period
FF	Additional payment for the claim shown
F1	Additional fractures/dislocations allowed at 85%
F2	Allowed in accordance with transferred care
F3	Previous attempted reductions (open or closed) allowed at 85%
F5	Two weeks aftercare included in fracture fee
F6	Allowed as minor/partial assessment
GF	Coverage lapsed. Bill patient for future claims
G1	Other critical/comprehensive care already paid
HA	Admission assessment claimed by another physician. Hospital visit fee applied
HF	Concurrent or supportive care already claimed in period
HM	Not a valid master number on date-of-service
H1	Admission assessment or Emergency Room (ER) assessment already paid
H2	Allowed as subsequent visit; initial visit previously claimed
H3	Maximum fee allowed per week after 5th week
H4	Maximum fee allowed per week after 6th week to paediatricians
H5	Maximum fee allowed per month after 13th week
H6	Allowed as supportive or concurrent care
H7	Allowed as chronic care
H8	Hospital number and/or admission date required for in-hospital service
H9	Concurrent care already claimed by another doctor
I2	Service is globally funded
I3	Fee Schedule Code (FSC) is not on the Independent Health Facilities (IHF) licence profile for the date specified
I4	Records show this service has been rendered by another practitioner, group or Independent Health Facilities (IHF)
I5	Service is globally funded and Fee Schedule Code (FSC) is not on Independent Health Facilities (IHF) license profile
I6	Premium not applicable
I8	Confirmation not received
I9	Payment not applicable/expired
J3	Approved for stale date processing
J7	Claim submitted six months after service date
LA	Lab service is funded by special lab agreement
LS	Paid in accordance to special lab agreement
L1	This service paid to another laboratory
L2	Not allowed to non-medical laboratory director
L3	Not allowed in addition to other laboratory procedure(s)
L4	Not allowed to attending physicians

Explanation of Code – May 2010 (Continued)

Explanatory Code	Description
L5	Not allowed in addition to other procedure paid to another laboratory
L6	Procedure paid previously to another laboratory, not allowed in addition to this procedure – fee adjusted to pay the difference
L7	Not allowed; referred specimen
L8	Not to be claimed with prenatal/fetal assessment as of July 1, 1993
L9	Laboratory services for hospital in-patients or out-patients are not payable on a fee-for-service basis – included in the hospital global budget
MA	Maximum number of sessions has been reached
MC	Maximum of 2 patient care conferences has been reached in a 12 month period
MD	Daily maximum has been exceeded
MN	Maximum number of occipital nerve block sessions has been reached
MS	Maximum allowed for sleep studies in a 12 month period by one or more physician has been reached
MX	Maximum of 2 arthroscopy "R" codes with E595 has been reached
MY	Yearly maximum has been exceeded
M1	The maximum fee/ number of services payable has been reached for this service
M2	Maximum allowance for radiographic examination(s) by one or more practitioners
M3	Maximum fee allowed for pre-natal care
M4	Maximum fee allowed for these services by one or more practitioners has been reached
M5	Monthly maximum has been reached
M6	Maximum fee allowed for special visit premium - additional patient seen
O1	Fee for obstetric care apportioned
O2	Previous prenatal care already claimed
O3	Previous prenatal/postnatal care already claimed by another doctor
O4	Office visits relating to pregnancy and claimed prior to delivery included in obstetric fee
O5	Not allowed in addition to delivery
O6	Medical induction/stimulation of labour allowed once per pregnancy
O7	Allowed as subsequent prenatal visit. Initial prenatal visit already claimed
O8	Allowed once per pregnancy
O9	Not allowed in addition to post-natal care
PM	Minimum roster size not met
P2	Maximum fee allowed for low birth weight care
P3	Maximum fee allowed for newborn care
P4	Fee for newborn/low birth weight care is not billable with neonatal intensive care
P5	Over age for paediatric rates of payment
P6	Over age for well-baby care
Q8	Lab not licensed to perform this test on date-of-service
RD	Duplicate, paid in Reciprocal Medical Billing System (RMBS)
R1	Only one health exam allowed in a 12 month period
R2	10 well baby visits allowed up to two years of age

Explanation of Code – May 2010 (Continued)

Explanatory Code	Description
R3	Well child exam (age 2-5 years) allowed within a 12 month period
SA	Surgical procedure allowed at consultation fee
SB	Normal preoperative visit included in surgical fee. Visit fee previously paid – surgical fee adjusted
SC	Not allowed, major preoperative visit already claimed
SD	Not allowed, Team/Assist fee already claimed
SE	Major pre-operative visit previously paid and admission assessment previously paid – surgery reduced by the admission assessment
S1	Bilateral surgery, one stage, allowed at 85% higher than unilateral
S2	Bilateral surgery, two stage, allowed at 85% higher than unilateral
S3	Second surgical procedure allowed at 85% of fee listed in the Schedule of Benefits for Physician Services
S4	Procedure fee reduced when paid with related surgery or anaesthetic
S5	Not allowed in addition to major surgical fee
S6	Allowed as subsequent procedure. Initial procedure previously claimed
S7	Normal pre and post operative care included in fee paid for surgery...these visits are not payable
T1	Fee allowed according to surgery claim
VA	Procedure fee reduced. Consultation/visit fees not allowed in addition
VB	Additional Oculo-visual assessment (OVA) is allowed once within the 2nd year for patients aged 20-64, following a periodic OVA
VG	Only one geriatric general assessment premium per patient per 12 month period
VM	Oculo-visual minor assessment is allowed within 12 consecutive months following a major eye exam
VP	Allowed with specific visit only
VR	Visit Fee Reduced premium not applicable
VS	Date-of-service was a Saturday, Sunday or statutory holiday
VX	Complexity premium not applicable to visit fee
V1	Allowed as repeat assessment; initial assessment previously claimed
V2	Allowed as extra patient seen in the home
V3	Not allowed in addition to procedural fee
V4	Date-of-service was not a Saturday, Sunday or a statutory holiday
V5	Only 1 Oculo-visual assessment (OVA) allowed within a 12 month period for age 19 and under or 65 and over – and one within 24 months for age 20-64
V6	Allowed as minor assessment; initial assessment already claimed
V7	Allowed at medical/specific re-assessment fee
V8	This service paid at lower fee as per stated OHIP policy
V9	Only one initial office visit allowed within a 12 month period
X2	Gastrointestinal (G.I.) tract includes cine and video tape
X3	Gastrointestinal (G.I.) tract includes survey film of abdomen
X4	Only one Bone Mineral Density (BMD) allowed within a 36-month period for low risk patients
X5	Only one Bone Mineral Density (BMD) allowed within a 12 month period for a high risk patient

Explanation of Code – May 2010 (Continued)

Explanatory Code	Description
00	Dummy explain code
09	Fee Schedule Code(s) used is not correct. Please resubmit using appropriate code(s) from OHIP Schedule of Benefits
10-29	Codes for rerouted claims (See Appendix D)
30	This service is not a benefit of OHIP
32	Our records show that this service has already been submitted and paid
35	OHIP records show this service rendered has been claimed previously (used on pay practitioner duplicate claims)
36	OHIP records show this service has been rendered by another practitioner, Group, Lab
37	The listed benefit for this code is now 0 - Laboratory Medicine Services (LMS) units
40	This service or related service allowed only once for same patient
45	Specialty code restriction on Fee Schedule Code (FSC)
48	Paid as submitted - clinical records may be requested for verification purposes
49	Paid according to the average fee for this service. Independent consideration will be given if clinical records/operative reports presented
50	Paid according to the Schedule of Benefits for Physician Services
51	Fee Schedule Code changed in accordance with OHIP Schedule of Benefits
52	Fee-for-service assessed by Medical Consultant
53	Fee allowed according to appropriate item in a previous OHIP Schedule of Benefits
54	Interim payment. Claim under review
55	This deduction is an adjustment on an earlier account
56	Claim under review
57	This payment is an adjustment on an earlier account
58	Claimed by another physician within group
59	Practitioner's notification; Workers Compensation Board (WCB) claims
60	Not a benefit of the Reciprocal Medical Billing Agreement
61	Out-of-Country (OOC) claims paid greater \$9999.99 (prior approval on file)
65	This service is included in the approved hospital daily rate
66	Reduced per Alternate Payment Program (APP) funding contract
70	OHIP records show corresponding procedure(s)/visit(s) on this day claimed by another physician
80	Technical fee adjustment for hospitals