

Bulletin



Bulletin Number 3075	Date July 30, 2007	Direct inquiries to Ministry of Health and Long-Term Care Processing Sites (address below)
Distribution Designated Physiotherapy Clinics		

SUBJECT: CHANGES TO OHIP-FUNDED PHYSIOTHERAPY SERVICES

- (1) Assignment of Services to Support Personnel**
- (2) Requirements for Ordering Physiotherapy**
- (3) Process for Additional Funding for Physiotherapy Services**
 - **New Fee Code - Submission of Claims for Additional Services**

(1) Assignment of Services to Support Personnel: Several conditions for payment by OHIP relating to the use of physiotherapy support personnel have been introduced and are effective April 1, 2005. To qualify for payment, an assigned service must be delivered by a person who is:

- (a) employed by a designated physiotherapy clinic, and
- (b) whose qualifications and training in respect of a physiotherapy service satisfy the standards for professional practice of the College of Physiotherapists of Ontario in respect of Physiotherapist Support Personnel.

An “assigned service” means a physiotherapy service rendered:

- (a) under the direction and supervision of a designated physiotherapist in accordance with the standards of the College of Physiotherapists of Ontario that apply in respect of physiotherapists working with physiotherapist support personnel,
- (b) to a patient with whom the supervising designated physiotherapist has an ongoing professional relationship, and
- (c) when the designated physiotherapist is available to direct and supervise the support personnel at the time the service is rendered.

Clinical records for assigned services must indicate the name of the person who actually rendered the service, the name of the designated physiotherapist who directed and supervised the rendering of the service, and the number of his or her licence or certificate of registration issued by the College of Physiotherapists of Ontario, details of the aspects of the treatment plan assigned to the support worker, the level of supervision required and the date of reassessment by the designated physiotherapist who directed and supervised the provision of the assigned service.

(2) Requirements for Ordering Physiotherapy: Referrals for insured physiotherapy services must be ordered by a physician, or, for residents of LTC homes, a physician or the registered nurse most responsible for a resident’s nursing care in the LTC home. This change is retroactive to April 1, 2005.

Processing Sites			
Hamilton 119 King Street West, 10 th Floor P.O. Box 2280, Stn A L8P 4Y7	Kingston 1055 Princess Street, Suite 401 P.O. Box 9000 K7L 5A9	London 217 York Street, 5 th Floor Station A N6A 5P9	Mississauga 201 City Centre Drive Suite 300 L5B 2T4
Oshawa Executive Tower, Oshawa Centre 419 King Street West P.O. Box 635 L1J 7J2	Ottawa Fuller Building 75 Albert Street K1P 5Y9	Sudbury 199 Larch Street Suite 801 P3E 5R1	Toronto 47 Sheppard Avenue East Suite 505 M2N 7E7

(3) Process for Additional Funding for Physiotherapy Services: A temporary process was originally communicated in Bulletin 3071, dated December 1, 2005. Effective immediately, in exceptional circumstances based on medical need, the per patient service maximum may be increased by up to 50 services per fiscal year. The following documentation is required to be maintained by the physiotherapy provider:

- patient name, address, date of birth, health number, including version code
- dates on which services were provided during the fiscal year
- written certificate from a physician or, for residents of LTC homes, a physician or the nurse most responsible for a resident's nursing care in the LTC home, that states the insured person is subject to a disability or impairment that can reasonably be expected to improve with the proposed physiotherapy service, and
- a written plan of care provided by the physiotherapist most responsible for the insured person's care that:
 - i. identifies the nature of the insured person's ongoing impairment or disability,
 - ii. contains an analysis of the physiotherapist's current assessment findings which identifies the insured person's ongoing functional problems, and
 - iii. contains a description of the proposed physiotherapy services, treatment goals and discharge plan and specifies the number of days, not to exceed 50, in the remainder of the fiscal year for which approval of additional insured physiotherapy services are requested.
- Copies of the initial assessment of the insured person and any ongoing reassessments performed during the fiscal year that demonstrate, using generally accepted outcome measures, whether progress has been made as a result of the provision of physiotherapy services and the degree of that progress.

The service maximums are as follows:

- A maximum of 100 insured services per person per year for those younger than 20 and 65 years of age and over, for in-home services, and for recipients of ODSP, OW and Family benefits.
- A maximum of 50 insured services per person per year for individuals between 20 and 64, following acute hospitalization.

New Fee Code - Submission of Claims for Additional Services

- Fee-for-service claims submitted for the provision of physiotherapy services in excess of the identified maximums are to be submitted using fee code V841 (Additional Visit Based on Exceptional Medical Need).
- Fee code V841 is to be used for services provided once the allowable service maximums have been exhausted for fee codes V828, V829, V830, V831, V832, and V840.
- The amount payable by OHIP for fee code V841 is \$12.20.
- A maximum of 50 additional services per person per year will be insured, subject to medical need and the supporting documentation required by the regulation and as outlined above. This documentation does not need to be submitted to the ministry but must be maintained by the Designated Physiotherapy Clinic. All claims paid are monitored and analyzed by the ministry. The requirements for disclosure by the provider are set out under Section 37.1(6) of the *Health Insurance Act* and Section 21 of Regulation 552. Failure to supply the requested clinical records may lead to payment recovery for identified claims and may lead the ministry to perform pre-payment audits and withhold future payments.

This Bulletin is a general summary provided for information purposes only. Health care providers are directed to review the *Health Insurance Act*, Regulation 552 and the Schedules under that regulation, for the complete text of the provisions. You may access this information on-line at www.e-laws.gov.on.ca. In the event of a discrepancy between this bulletin and the Act or regulations and/or Schedules under regulations, the text of the Act, regulations and/or Schedules will prevail.