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PHYSICIAN PAYMENT – SCHEDULE OF BENEFITS FOR PHYSICIAN SERVICES

2. Physician PAYMENT – SCHEDULE OF BENEFITS FOR PHYSICIAN SERVICES

2.1 Overview

The Ministry of Health and Long-Term Care (ministry) makes payments for services insured by the Ontario Health Insurance Plan (OHIP) in accordance with the payment requirements listed in the Schedule of Benefits for Physician Services (Schedule). The Schedule lists approximately 6,000 physician services and includes extensive preambles and notes that provide detailed conditions for payment of insured services. The Schedule is a document incorporated by reference into Regulation 552 under the *Health Insurance Act* (HIA) and is amended only by regulation change. The HIA, specifically Section 24 of Regulation 552, also contains a listing of explicitly uninsured services and should be read in conjunction with the Schedule and the rest of Regulation 552.

Changes to the Schedule include the addition of new services, deletion of obsolete services and redefinition of existing services. Individual physicians who wish to propose changes may submit proposals to the Physician Services Payment Committee through the appropriate clinical section of the OMA.

The HIA stipulates that only medically necessary services are insured. Sometimes, a service may be either insured or uninsured depending on the medical indications for the service. For some services, specific indications have been explicitly included as conditions for payment in the fee code definition. The physician must ensure that the appropriate indications are documented in the patient's medical record in order to satisfy the payment requirements.

For many procedures that may be considered cosmetic, the Schedule requires that the physician obtain prior approval from the ministry (i.e. complete the Request for Approval of Payment for Proposed Surgery form (0691-84)). Such requirements are described either in notes adjacent to applicable fee codes or in Appendix D of the Schedule.

The ministry regularly makes INFOBulletins available on the ministry public internet site. INFOBulletins offer information on payment, program or policy changes with regard to the Schedule and/or other payment information. Some INFOBulletins are mailed to physicians; however this practice is changing and increasingly INFOBulletins are only being posted electronically (see link at end of this section).

Separate fee schedules also exist for other practitioners, medical laboratories (licensed under the Laboratory and Specimen Collection Centre Licensing Act) and independent health facilities (licensed under the Independent Health Facilities Act).

2.2 General Preamble

Note:

This is intended to be a brief overview of the critical elements within the General Preamble, and not a substitute for the actual document.

The first section of the Schedule is the "General Preamble". The General Preamble provides details about billing requirements for all physicians. The **Definitions** section of the General Preamble lists general definitions of key terms and phrases used in the Schedule. Information regarding a number of topics is provided under **General Information**. This is followed by the **Constituent and Common Elements of Insured Services** and the **Specific Elements of Assessments.** The next sections provide information on **Consultations** and **Assessments** followed by the section regarding services provided only in **Hospitals and Other Institutions**. The next section focuses on psychotherapy, counselling, and related services, followed by a similar review of services that involve interviews. The remaining sections include information on delegated procedures (with regard to payment by OHIP), age-based premiums, special visit premiums, surgical assistants' services, anaesthesiologists services, other premiums, emergency department sessional fees and emergency department alternative funding agreements.

In addition to the information provided in the General Preamble, it is necessary to review service specific information provided elsewhere in the Schedule to have a complete understanding of the requirements for a particular service.

The following is an overview of the issues and information contained within the General Preamble that may guide you in a more detailed examination of the General Preamble.

Note:

In the event of a conflict between this overview and the full text of the General Preamble, the General Preamble prevails. You are expected to be familiar with all the relevant provisions of the General Preamble and applicable legislation and regulations. All claims for payment will be determined in accordance with the Schedule and not with this overview. For specific details and definitions, refer specifically to the General Preamble.

Common and Constituent Elements

All insured services include the skill, time and responsibility involved in performing the service. Unless otherwise specifically stated in the Schedule, the elements that are common to all insured services include:

- Being available to provide **follow-up** insured services to the patient or making arrangements for coverage when you are not available.
- Making any arrangements for **appointment(s)** involving the insured service.

- Obtaining and **reviewing information** (including taking history) to make the appropriate decisions to perform elements of the service.
- Obtaining **consents** or delivering written consents.
- Keeping and maintaining appropriate **medical records.**
- Providing any **medical prescriptions**, except where the request for this service is initiated by the patient (or their representative) and no insured service is provided.
- Preparing or submitting **documents**, **records** or **information** for use in programs administered by the ministry.
- Conferring with or providing advice, direction, information or records to physicians and other professional associated with the health and development of the patient.
- Providing **premises, equipment**, **supplies** and **personnel** for the service.

Please refer to the General Preamble for the full text.

Assessments and Consultations

For all services that are described as **assessments**, or as including assessments, the following is a list of the **specific elements**, in addition to the common elements:

- Direct **physical encounter** with the patient including any appropriate physical examination and ongoing monitoring of the patient's condition where indicated. These services **cannot** be delegated.
- Other **inquiry,** including patient history, carried out in order to arrive at any opinion as to the nature of the patient's condition, appropriate procedures, related services and/or follow-up care which may be required.
- Performing any procedure(s) during the same encounter as the physical examination unless separately listed in the Schedule and payable in addition to the assessment (examples include obtaining specimens, preparing the patient, interpreting results).
- Making **arrangements** for related assessments, procedures, therapy, interpreting results and appropriate follow-up care.
- Discussion with and providing **advice** and **information,** including prescribing therapy to the patient (or their representative) by telephone or otherwise on matters related to the service and when appropriate, to convey the results of a related procedure prior to future patient visit (e.g. it would not normally be necessary to schedule a second visit with a patient to review the results from a diagnostic test such as a throat swab; however, if an examination such as an exercise stress test was ordered in the first appointment, then it may be necessary to have the patient return for a second appointment to discuss the results and the second appointment would accordingly be an insured service for which a claim could be submitted).

- When medically indicated, monitoring the condition of the patient and intervening until the next insured service is provided.
- Providing the premises, equipment, supplies and personnel for the specific elements of the service (except for those performed in a hospital or nursing home).

Please refer to the General Preamble for the full text.

Annual limits may apply to various codes, including individual consultation and assessment codes.

A **consultation** (e.g. A135 for Internal Medicine) is a service provided upon a **written request** from a referring physician, who, in light of his or her professional knowledge of the patient, requests the opinion of another physician competent to give advice in this field or because another opinion was requested by the patient (or their representative). The consultant must perform a general or specific assessment, including the review of all relevant data. The consultant physician must submit his or her findings, opinions, and recommendations **in writing** to the referring physician. A copy of the written request must be maintained in the consulting physician's medical record except in the case of a consultation which occurs in a hospital, nursing home, long-term care facility where common patient medical records are maintained. In such cases, the written request may be kept in the common medical record.

In the absence of a written request, the amount payable for the consultation shall be reduced to the amount payable for an assessment. A consultation is not to be claimed as such:

- When a patient presents him or herself to a consultant's office without a referral from his or her primary physician; or,
- When the patient simply asks his or her primary physician for the name of a specialist and the patient approaches the specialist directly (refer to Bulletin 4318).

A **repeat consultation** (e.g. A136 for Internal Medicine) is an additional consultation rendered by the same consultant regarding the same problem, following care rendered to the patient by another physician following the initial consultation. If a consultant asks a patient to return for a later examination, this visit is not a repeat consultation.

A **limited consultation** (e.g., A435 for Internal Medicine) involves all elements of a full consultation, but requires substantially less of the physician's time than a full consultation. For example, when a physician sees a patient in consultation for a plantar wart a limited consultation code would be appropriate.

The Education and Prevention Committee (EPC), a joint committee of the ministry and the OMA, has published an EPC Interpretive Bulletin on the topic of consultations (Bulletin Volume 4, No. 4 titled "Referrals for Consultation" – see link at end of this section).

A **general assessment** (A003) is a family practice service provided somewhere other than the patient's home and includes a full history (including medical, family and social history) and except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts.

A **periodic health visit** is a general assessment of an individual who has no apparent physical or mental illness and which takes place after the second birthday. It may include instructions to the patient and/or parents regarding health care. A periodic health visit should be claimed as follows:

- **Family Practice and Practice in General**

  K017 – child after second birthday

  K130 – adolescent

  K131 – adult aged 18-64

  K132 – adult 65 years of age and older

- **Paediatrics**

  K267 – child age 2 to 11 years (no diagnostic code required)

  K269 – adolescent age 12 to 17 years (no diagnostic code required)

A periodic health visit is limited to one per patient per year by any one physician.

A **general re-assessment** (A004) is a family practice code that includes all of the services included in a general assessment, with the exception of the patient's history (which need not include all the details already obtained in the original assessment).

A **minor assessment** (A001) includes a brief history and examination of the affected part, region or disorder and/or brief advice or information regarding health maintenance, diagnosis, treatment, and/or prognosis. For example, seeing

a patient with a simple skin rash or conjunctivitis would be billed as a minor assessment. This is a family practice code but should also be billed by specialists practicing outside of their specialty and/or in a primary care practice setting.

An **intermediate assessment** (A007) is a primary care service that requires a more extensive examination than a minor assessment. It also requires a history of the presenting complaint(s), inquiry concerning and examination of the affected part(s), region(s), system(s) or mental and emotional disorder as needed to make a diagnosis, exclude a disease and or assess function. This is a family practice code but should also be billed by specialists practicing outside of their specialty and/or in a primary care practice setting.

Non-emergency Acute Care Hospital In-patient Services

Non-emergency acute care hospital in-patient services include consultations and assessments rendered to admitted patients on a non-emergency basis and utilize the "C" prefix code. This includes, but is not limited to **admission assessments**, **subsequent visits, concurrent care**, and **supportive care**.

Emergency Department - Emergency Physician on Duty

Emergency Department – Emergency Physician on Duty: There are specific "H" prefix listings (H1-codes) for consultations, multiple systems assessments, minor assessments, comprehensive assessments and re-assessments rendered by the physician on duty in the Emergency Room. Any physician on duty or on-call in the emergency department should use these fee codes unless a special visit is required. If a special visit is required to the Emergency Department (e.g., the physician is called from home to make a special visit to see a patient in the Emergency Department and must travel to the hospital), the appropriate 'A' prefix fee code should be claimed for the first patient assessed (in addition to the special visit premium code(s)).

If the emergency department physician on call (or off duty) is already in the hospital or hospital environs a special visit premium cannot be billed when the physician is called to the Emergency Department. See the section on 'Special Visit Premiums' below for more information.

Psychotherapy and Counselling Services

Psychotherapy (K007) is treatment for mental illness, behavioral maladaptations or emotional problems, in which a physician deliberately establishes a professional relationship with a patient for the purpose of removing or modifying existing symptoms attributed to the problem.

Individual counselling (K013, K033) is defined as a patient visit dedicated solely to an educational dialogue between the patient and a physician. Advice provided to a patient that would ordinarily constitute part of a consultation, assessment or other treatment, is included as a common or constituent element of such other service, and does not constitute counselling in this context. If the patient does not have a pre-booked appointment, the amount payable for this service will be adjusted to a lesser assessment fee.

Delegated Procedure

A **Delegated Procedure** is a procedure carried out by a physician's employee where the service remains insured if certain conditions are met. Procedures in this context do not include such services as assessments, consultations, psychotherapy, counselling, etc. One of the requirements (with few exceptions) is for "direct supervision", that is, the physician must be physically present in the office or clinic at which the service is rendered. For more information including payment rules for delegated procedures, refer to the 'Delegated Procedure' section of the General Preamble.

The EPC has also published an EPC Interpretive Bulletin on the topic of payment for delegated procedures (Volume 9, No. 1 titled "Payment Requirements for Delegated Services" – see link at the end of this section).

Special Visit Premiums

Special visit premiums may be payable when a physician is required to make a medically necessary visit to a patient at a specific location. Special visits are generally non-elective; however, if a special visit is required at the patient's home, the visit may be non-elective or elective.

A **non-elective visit** is one that is initiated by a patient or by an individual on behalf of the patient (e.g. nurse) for the purpose of rendering a non-elective service.

An **elective home visit** is a visit to a patient's home deemed medically necessary by the physician, initiated by the physician and carried out at a time convenient to the physician.

The General Preamble contains several tables, each representing a different location for a special visit (e.g. long-term care institution, patient's home, hospital

in-patient, etc.). Please refer to the table representing the location of the special visit to determine the appropriate fee code(s).

Special visits may have two components:

1. A travel component; and/or
2. A person seen component (first person seen and additional person(s) seen).

The travel component of a special visit requires the physician to travel from one location to another to see the patient (e.g., from home to the hospital). Travel from one location of a hospital facility/complex to another location within the same facility/complex does not qualify for the travel premium (even if they are separate buildings).

In order for the first person seen premium to be eligible for payment, the physician must meet the requirement for travel. Additional persons seen may also qualify for a premium if there is a need to see other patients on a non-elective basis at the same location as part of the same visit. The travel component is not payable for additional persons seen at the same location.

Full payment rules and requirements, including the medical record requirements, are listed in the General Preamble under 'Special Visit Premiums'.

The EPC published an EPC Interpretive Bulletin on the topic of special visit premiums (Volume 7, No. 1 titled "Special Visit Premiums" - see link at the end of this section).

Other than a hospital or long-term care facility, special visits do not apply when rendered in a place that is open for patients to attend (e.g., walk-in clinic). Patients seen during office hours held on nights or Saturdays, Sundays, or holidays do not qualify for any of the special visit premiums.

Surgical Assistants' Services

The **Surgical Assistants' Services** section of the General Preamble provides a list of specific elements for assistance at surgery as well as information regarding these services.

Appendix H of the Schedule contains a chart to assist in determining the number of assistant time units for billing purposes.

The EPC published an EPC Interpretive Bulletin on the topic of surgical assistants' services (Volume 8, No. 3 titled "Surgical Assistant Services" - see link at the end of this section).

Anesthesiologists' Services

The anesthesiologists' section of the General Preamble provides a list of specific elements for anesthesiologists' services as well as information regarding these services.

Appendix H of the Schedule contains a chart to assist in determining the number of anaesthesia time units for billing purposes.

For further details or clarification regarding any of these topics, please refer to the Schedule or contact your local OHIP office.

2.3 Schedule of Benefits Appendices

There are several appendices found at the end of the Schedule. With the exception of **Appendix D**, these appendices do not form part of the Schedule; however, they do contain information that may be helpful. Regulations, such as those excerpted within the appendices are subject to change. Physicians are reminded to acquaint themselves with the current text of these regulations.

Appendix included as part of the Schedule:

Appendix D - This section contains information regarding the criteria for OHIP coverage for surgical procedures that are for the purpose of altering or restoring appearance, including surface pathology and sub-surface pathology.

Appendices as attachments to the Schedule:

Appendix A – Provides an on-line reference and link to Section 24 of Regulation 552 under the HIA.

Appendix B – Provides on-line references and links to Regulation 114/94 relating to **Conflict of Interest** and **Records** in accordance with the Medicine Act, 1991.

Appendix C – Information on Benefits Outside Ontario as well as Interprovincial Reciprocal Billing of Medical Claims.

Appendix F – Services set out here are not "insured services" within the meaning of the HIA but are paid by the ministry, acting as a paying agent on behalf of the Ministry of Community and Social Services (MCSS), the Ministry of the Attorney General, the Ministry of the Community and Correctional Services, and the Workplace Safety and Insurance Board (WSIB). This appendix includes a list of important forms for physicians relating to the **MCSS Ontario Disability Support Program** and **MCSS Ontario Works Program.**

Appendix G – Provides on-line references and links to medical record requirements as found in the Medicine Act, 1991 and the HIA.

Appendix H – Table listing the number of units payable based on the duration of time spent rendering anaesthesia or surgical assistant services.

Appendix Q – Provides descriptions and information for 'Q' prefix codes for primary care models.

Following the Appendices, you will find **the Alpha Numeric Index.**

2.4 Links to on-line documents

Use the following links to access on-line documents referenced in this section:

The Schedule:

http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

INFOBulletins (also formerly published as Bulletins):

http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

EPC Interpretive Bulletins are published in the Ontario Medical Review and also available on the OMA's public site at:

https://www.oma.org/Resources/Pages/EPCbulletins.aspx

Note:

Schedule page references may not be current in all EPC Interpretive Bulletins as they reflect content in the version of the Schedule stated in the Bulletin. Other Schedule changes may also have taken effect since publication and the current version of the Schedule should always be consulted for accuracy of payment rules.