

2. PHYSICIAN PAYMENT AND POLICY

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2. PHYSICIAN PAYMENT AND POLICY

2.1 Schedule of Benefits Overview

The Ministry of Health and Long-Term Care (MOHLTC) makes payments in accordance with the contents of the [Schedule of Benefits](#) (“the Schedule”). This lists approximately 5,000 medically necessary physician services and includes extensive preambles and notes that provide detailed conditions for insured services. Separate fee schedules also exist for other practitioners, private medical laboratories and independent health facilities. The physicians’ Schedule is a legal document authorized by the [Health Insurance Act](#) and is amended only by regulation. The [Health Insurance Act, Regulation 552](#) also contains a listing of explicitly uninsured services (provided with the Schedule as Appendix A) and should be read in conjunction with the Schedule.

Changes to the Schedule are discussed with the [Ontario Medical Association](#) (OMA) and may 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 through their respective OMA section to the OMA Central Tariff Committee (CTC). The CTC recommendations which are formally endorsed by the OMA Council may then be considered by the ministry for incorporation into future editions of the Schedule.

The [Health Insurance Act](#) 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, the appropriate indications have been explicitly included as conditions in the fee code definition. The physician must ensure that the appropriate indications are documented in the patient medical record for audit purposes.

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 code or in Appendix D of the Schedule of Benefits.

The ministry regularly distributes [OHIP bulletins](#) that give notice of Schedule changes or provide additional information on physician payment policies.

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, counseling, 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 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 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 General Preamble and not with this overview. For specific details and definitions, refer to the General Preamble of the Schedule of Benefits.

Common and Constituent Elements

All insured services include the skill, time and responsibility involved in performing the constituent elements of the service. As a provider, you should be aware of the following list of elements that are common to all insured services:

- 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

2.2 General Preamble (Continued)

- 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 **physician records**
- Providing any **medical prescriptions**, including associated in-person, telephone or other electronic communications, except where the request for this service is initiated by the patient and an accompanying insured service is not provided (e.g., if a patient calls and requests a prescription renewal by phone, you may provide a renewal with or without charge to the patient)
- Providing or submitting **documents, records or information** to other professionals associated with the health and development of the patient, or to the Ministry of Health and Long-Term Care for use in programs. While no charge may be made for forms required by the ministry, there are a few exceptions where a fee code is assigned, such as the Hepatitis C form (K026, K027) and the home care referral form (K070).
- Providing **premises, equipment, supplies and personnel** for the service

Assessments and Consultations

For all services that are described as **assessments**, or as including assessments, the following is a list of **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
- Making **arrangements** for appropriate follow-up care
- Providing **advice and information** as to the results of procedures and/or related assessments that may have been arranged. This assumes that the results can be reported upon prior to any further patient visits. For example, 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.

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

2.2 General Preamble (Continued)

Further information on some commonly provided services is listed as follows:

A **Consultation** (e.g., A135 for Internal and Occupational Medicine) is a service provided upon a **written request** from a referring physician. The consultant is obliged to 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 or multi-specialty clinic 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 and Occupational 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 and Occupational 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 with a plantar wart a limited consultation code would be billed.

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.

2.2 General Preamble (Continued)

An **annual health or annual physical examination, including primary or secondary school examination** is a general assessment of an individual who has no apparent physical or mental illness that takes place after the second birthday. It may include instructions to the patient and/or parents regarding health care. An Annual Health Examination should be claimed as follows:

- **Family Practice and Practice in General**

A003 – adult or adolescent (with diagnostic code 917)

K017 – child after second birthday (no diagnostic code required)

- **Paediatrics**

K267 – child after second birthday (no diagnostic code required)

K269 – adolescent (no diagnostic code required)

Annual Health Examination 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.

An **intermediate assessment** (A007) is a service for physicians providing family practice or paediatric services and is more extensive than a minor assessment.

2.2 General Preamble (Continued)

Detention (K001) is a time-based service (one unit = a full 15 minutes) that follows another insured service when a physician is required to spend considerable extra time in active treatment and/or monitoring of a patient.

Detention may be payable if a physician spends:

- more than 30 minutes with the patient providing a minor, partial, multiple systems or intermediate assessment or subsequent hospital visit
- more than 40 minutes with the patient providing a specific or general re-assessment
- more than 1 hour with the patient providing a consultation, repeat consultation, specific or general assessment
- more than 90 minutes with the patient providing a Special Palliative Care Consultation (A945, C945) or a Special Surgical Consultation (A935)

Claims for detention are assessed by a medical consultant on an Independent Consideration basis and should be accompanied by a written explanation.

Detention may not be claimed for time spent waiting for an operating room, x-rays, lab reports, obstetrical deliveries, etc.

Detention-in-ambulance (K101, K111) pays for constant attendance and care of a patient in an ambulance.

Non-emergency Acute Care Hospital In-patient Services

Non-emergency acute care hospital in-patient services include consultations and assessments rendered to registered bed 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**. For special visits, the “A” prefix codes are to be used, as well as the appropriate premium code.

2.2 General Preamble (Continued)

Emergency Department - Emergency Physician on Duty

Emergency Department – Emergency Physician on Duty: There are specific listings “H” prefix (H1-codes) for consultations, multiple systems assessments, minor assessments and re-assessments rendered by the physician on duty during regular and premium hours. Any physician on duty in the emergency department should claim these fees. These listings also apply to the services rendered by physicians who provide on-call emergency room coverage for designated periods of time and limit the services they provide, in the community served by the hospital, predominantly to emergency room coverage. When special visits are rendered by such physicians, codes with “A” prefix and the appropriate special visit premiums K99x - may be claimed for the first patient seen:

- for a maximum of two special visits that commence after 08:00h and before 17:00h
- for a maximum of three special visits after 17:00h and before 24:00h
- for the number of special visits rendered after 00:00h and before 08:00h

An **Emergency Physician not on Duty** required to make a special visit to the Emergency Department would claim the appropriate “A” prefix code and the appropriate special visit premium K99x for the first patient assessed; all subsequent patients assessed would be claimed using the “H” prefix codes.

A physician on call for the Emergency Department would bill the initial special visit(s) (to a maximum of ten) using “A” codes and appropriate special visit premiums K99x.

If the physician on call is already in the hospital or environs a special visit premium cannot be billed when the physician is called to the Emergency Department.

2.2 General Preamble (Continued)

Psychotherapy and Counselling Services

Psychotherapy (K007) is treatment for mental illness, behavioural 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 counseling 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, counseling, etc. Unless certain exceptions are met, one of the requirements is for "direct supervision", that is, the physician must be physically present in the office or clinic at which the service is rendered (for complete information refer to the [General Preamble](#)).

2.2 General Preamble (Continued)

Special Visit Premiums

A **special visit** requires the physician to travel from one location to another to see the patient or may involve an emergency call with sacrifice of office hours. The appropriate **special visit premium** applies when a physician makes a special visit outside of normal office hours or an emergency call with sacrifice of office hours. Special visit premiums are applicable in addition to fees for certain services.

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

Except for those visits rendered to palliative care patients, a physician providing an elective home visit must claim, in addition to the appropriate "A" prefix service, B990, even if the elective visit is rendered at night, on Saturdays, Sundays and holidays (subject to the restriction based on volume of special visits laid out on page GP46). For example, a pre-booked or pre-planned house call on a weekend or evening would be claimed as B990 and appropriate assessment code, rather than B994 (the special visit premium code for evenings, weekends and holidays) and the appropriate assessment code.

A separate special visit premium – Special visit for the purpose of providing palliative care, elective or non-elective (B998) is payable for special visits rendered to palliative care patients in their home.

NOTE:

In order to claim a special visit premium for a sacrifice of office hours (e.g., K992) a physician must be required to immediately leave his or her office to visit the patient (perform a special visit), and the physician must have had an office visit booked with one or more patients during the affected office hours, but because of the special visit, it was necessary to delay or cancel such visits.

Special visits to the patient's Home or Equivalent: if the total amount billed for insured services including special visit premiums to patient's homes or equivalents and long-term care institutions in any calendar month is more than 20 percent (of the total amount payable on all claims submitted for services rendered in that month) no special visit premium is payable. The physician must submit claim for such services using fee schedule codes B910, B914 or B916 in lieu of a combination of an assessment plus special visit premium.

2.2 General Preamble (Continued)

Special visits do not apply when rendered in a place other than a hospital or long-term care facility that is open for patients to attend, such as a walk-in clinic. For example, if a physician has an office and a secretary is present the physician cannot bill for a special visit if the physician drives to the office to see a patient(s), including weekends and evenings. 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.

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.

For further details or clarification regarding any of these issues, please refer to the General Preamble of the [Schedule of Benefits](#) or contact your [local OHIP office](#).

2.3 Schedule of Benefits Appendices

All appendices are found in the Appendices section at the end of the Schedule of Benefits. Appendix **D** forms part of the Schedule of Benefits for the purposes of payment of claims. While the other appendices do not, they contain information that may be helpful. Regulations, such as those excerpted within the appendices are subject to change. Physicians are cautioned to acquaint themselves with the current text of these regulations.

Appendix included as part of the Schedule of Benefits:

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 of Benefits:

Appendix A – Provides an Internet link to [Section 24 of Regulation 552](#) of Revised Regulations of Ontario, 1990 under the [Health Insurance Act](#).

Appendix B – Provides an Internet link to regulations relating to **Conflicts of Interest** in accordance with Section 15, 16 and 17 and **Records** in accordance with Section 18 and 19 of Ontario Regulation 241/94 made under 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 [Health Insurance Act](#) 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 Solicitor General, and the Workplace Safety 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 an Internet link to medical record requirements as found in the Health Insurance Act.

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

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