2. PROVIDER PAYMENTS AND POLICY

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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 Order-in-Council. 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 procedures that may be considered cosmetic, the Schedule requires that the physician obtain prior approval from the ministry (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

The first section of the Schedule is the "General Preamble". Common definitions and the constituent elements and specific elements of insured services are described. Premiums payable for services, and the circumstances under which they may be paid, are listed. 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:

This is intended to be a brief overview of the critical elements within the General Preamble, and not a substitute for the actual document. 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
- 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 or decline to prescribe over the phone)

2.2 General Preamble (Continued)

- 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 forms are often completed without charge to OHIP, 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

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 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 acceptable to ask the patient to return for a second appointment to discuss the results.
- Annual limits may apply to individual consultation and assessment codes

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 consultation can only be billed upon receipt of a written request from the referring physician except in the case of a consultation which occurs in a hospital, nursing home, long-term care facility or multi-specialty clinic in which common patient medical records are maintained.

2.2 General Preamble (Continued)

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/herself to a consultant's office without a referral from his or her primary physician; or 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) requires all of the elements of a full consultation and requires intervening assessment(s) and a repeat referral by the primary physician. 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.

Anesthetic Consultation (A015, C015) applies if an anesthetist consultation is requested by another physician because of the **complexity, obscurity or seriousness of the case** prior to administration of an anaesthetic. In such a case the anesthetist may claim a consultation fee as well as the anesthetic fee. If the consultation is provided less than 36 hours prior to administration of the anesthetic, this consultation should be claimed under code E015.

The routine **pre-anesthetic evaluation** of the patient required by the *Public Hospitals Act* does not qualify as a consultation, regardless of where and when this evaluation is performed, as this evaluation is included in the fee for the anesthetic. **Anesthetic consultations** do not apply when hospital, departmental by-laws, statutes or policies require automatic consultations on any patient requiring an anesthetic.

An **emergency room (ER) physician consultation** (H055) is not to be claimed for the routine transfer of care to the ER nor for provision of treatment for a previously diagnosed condition. For example, referral for abdominal pain could be billed as a consultation but referral for suturing of a simple laceration would not be billed as a consultation.

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 an examination of **all** body parts.

2.2 General Preamble (Continued)

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. It requires a history taking and examination of more than one body system.

A **house call assessment** (A905) is a primary care service that is at least as extensive as an intermediate assessment. It is only billable for the first patient seen at the home, and other patients that may require assessment should be billed at the appropriate intermediate or minor assessment level. The house call code is billed in conjunction with the appropriate special visit premium. For example, if a patient requests a house call because that patient is bedridden on the weekend, the codes billed would be A901 and B994.

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. For example, if a physician spends 30 minutes with a patient, an assessment is claimed but if the physician spends a minimum of 45 minutes with the patient, an assessment and a detention may be claimed.

Claims for detention are assessed by a medical consultant on an Independent Consideration basis and should be accompanied by a written explanation. The following conditions apply when detention follows an assessment, 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)

2.2 General Preamble (Continued)

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.

Newborn care is the routine care of a "well baby" up to ten days of age. This includes an initial general assessment and the appropriate subsequent assessments, as well as instructions to the parent(s) regarding health care.

Low birth weight baby care is any assessment, of a well baby weighing less than 2.5 kilograms at birth (see General Preamble, codes H262 and H263).

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. This takes place after the second birthday and may include instructions to the patient and/or parents regarding health care. An Annual Health Examination may be billed to the ministry, unless deemed not to be an insured service, and 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)

The Annual Health Examination is limited to one per patient per year by any one physician.

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: 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 code and the appropriate special visit premium K99x for the first patient assessed; all subsequent patients assessed would be claimed using the H prefix.

A physician on call in the Emergency Department or environs 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.

Interviews

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 counseling (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. In addition, the counseling must have been scheduled prior to the time the service is rendered. If the service is not scheduled, the claim for the service will be paid at a lesser assessment fee.

2.2 General Preamble (Continued)

Group counseling (K040, K041) is defined as a patient visit dedicated solely to an educational dialogue between two or more persons and a physician. This service is provided for the purpose of developing an awareness of the group members' common problems or situations, of prevention and/or treatment methods, and to provide advice and information. The counseling must have been scheduled prior to the time the service was rendered and if not so scheduled, the claim for the service will be paid at a lesser assessment fee.

Delegated Procedure

Delegated Procedure is a procedure carried out by a physician's employee, under the direct supervision of the physician in his/her office. Procedures in this context do not include such services as assessments, consultations, psychotherapy, counseling, etc. Direct supervision requires that during the procedure the physician be physically present in the office or clinic at which the service is rendered. For complete, accurate information refer to Schedule of Benefits.

Transfer of Care

This takes place where the responsibility for the care of the patient is completely transferred permanently or temporarily from one physician to another. For example, a physician covering for another temporarily due to a vacation should consider the patients as being temporarily transferred (not referred) to their care. Consultations cannot be billed in instances where care has been transferred.

Surgical Assistants

The **Surgical Assistants' Services** section of the General Preamble provides a list of specific elements for assistance at surgery.

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.

A physician providing an elective home visit may claim, in addition to the appropriate fee under the heading "General Listings", the premiums listed in paragraph 23 (m) only, but using Code B990, even if the elective visits are rendered at night, on Saturdays, Sundays and Holidays (subject to the conditions laid out in paragraph 23 (r)). 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.

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). Special visits do not apply to routine visits to registered hospital patients.

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 bill B910, B914 or B916 in lieu of a combination assessment plus premium.

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.

2.2 General Preamble (Continued)

For further details or clarification regarding any of these issues, please refer to the General Preamble of the Schedule of Benefits or contact a medical consultant, preferably in writing, at your local ministry office.

2.3 Schedule of Benefits Appendices

Appendix **D** and **E** appear at the end of the General Preamble and form part of the Schedule of Benefits for the purposes of payment of claims. Appendix **A, B, C** and **F** are **attachments** to the Schedule of Benefits and can be found in the "Appendices" section at the end of the Schedule of Benefits binder. They are not part of the Schedule of Benefits, but contain information from other sources 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.

Appendices included in the General Preamble as part of the Schedule of Benefits:

Appendix D – This section contains information regarding **cosmetic surgery**, including surface pathology and sub-surface pathology.

Appendix E – Lists **Physician Fee Codes Excluded from Threshold Calculation of "Total Amount Payable"**

2.3 Schedule of Benefits Appendices (Continued)

Appendices as attachments to the Schedule of Benefits:

Appendix A – A list of **uninsured services**, according to Section 24 of Regulation 552 of Revised Regulations of Ontario, 1990 under the *Health Insurance Act*.

Appendix B – **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 GPs relating to the **MCSS Ontario Disability Support Program** and **MCSS Ontario Works Program.**

Following Appendices A, B, C, and F you will find the Alphabetic Index and the Alpha Numeric Index. In addition, it is important to read the Special Visits to Emergency Department or Out Patient Department (OPD) and Special Visit to the Patient's Home or Equivalent.

2.4 Questions and Answers

Does OHIP pay for the services of nurse practitioners?

No, OHIP does not insure the services of a nurse practitioner (NP). Claims to OHIP for assessments, counselling, psychotherapy and various other services can only be submitted when performed personally by the physician. Delegated procedures, for the purpose of payment by OHIP, are the same for NPs as for other persons. An example of a delegated procedure that can be performed by a nurse or other person, and billed by the physician to OHIP, is a venipuncture or urinalysis.

How do nurse practitioners get paid?

It is the intent of the Ministry of Health and Long-Term Care to pay nurse practitioners directly for the services that they provide rather than indirectly through fee-for-service payments to physicians. For example, the ministry provided funds to community health centres and other agencies in May 1998 to hire nurse practitioners in salary arrangements. In March 1999, the ministry provided an additional annual increase of $10 million to hire 86 salaried nurse practitioners in under-serviced areas and long-term care facilities.