GENERAL PREAMBLE

INTRODUCTION

[Commentary:

The *Health Insurance Act* and, to a lesser extent, the *Independent Health Facilities Act* and the *Commitment to the Future of Medicare Act*, provide the legal foundation and framework for the *Schedule* of Benefits for Physician Services ("the *Schedule*").

The *Schedule* lists services insured by *OHIP* and includes the General Preamble (which impacts all physicians), Consultations and Visits section (which applies to all specialties) and specific system and/or specialty sections (including specialty preambles).

The General Preamble provides details about billing requirements for all physicians as follows:

The initial **Definitions Section** (GP2) begins with general definitions of key terms and phrases used in the *Schedule*. Those terms and phrases are italicized throughout the General Preamble as an indication that further information is available in the Definitions Section. The second group of defined terms refers specifically to maximums, minimums, and time or unit-based services.

The information provided in the **General Information Section** (GP7) is the foundation for the remainder of the General Preamble. A variety of subjects are reviewed as detailed in the table of contents. This is followed by the **Constituent and Common Elements of Insured Services** (GP13). Next is the section which lists the **Specific Elements of Assessments** (GP15). The next section provides information on **Consultations and Assessments** (GP16) followed by the section regarding services provided only in **Hospitals and Other Institutions** (GP28).

The next section focuses on psychotherapy, counselling, 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 the table of contents.

There are two new appendices to the *Schedule:* the *Health Insurance Act* requirements for medical records and a table that summarizes time units for assisting at surgery and anaesthesia services.]

GENERAL PREAMBLE

DEFINITIONS

GENERAL DEFINITIONS

The words, phrases, and abbreviations defined below are italicized throughout the General Preamble for cross-reference. Unless otherwise specified, the following terms and expressions have the following meanings:

a. Age Definitions

adolescent	a person 16 or 17 years of age
adult	a person 18 years of age and older
child	a person 2 years to and including 15 years of age
infant	a person from 29 days up to, and less than, 2 years of age
newborn	a person from birth up to, and including, 28 days of age

b. Time Definitions

12 month period	any period of 12 consecutive months
calendar year	the period from January 1 to December 31
day	a calendar day
fiscal year	from April 1 of one year to March 31 of the following year
month	a calendar month
week	any period of 7 consecutive days

c. Other Definitions

Act	*Health Insurance Act*
common elements	the components that are included in all insured physician services
constituent elements	the common elements and, where applicable, the specific elements of an insured service
CPSO	College of Physicians and Surgeons of Ontario
emergency department equivalent	an office or other place, including Urgent Care Centres, Walk-in Clinics, Extended Hours Clinics, or other settings (other than a hospital emergency department) in which the only insured services provided are to patients who do not have pre-arranged appointments
general anaesthesia	all forms of anaesthesia except local infiltration
"H" fee	a fee set out in the Schedule for the technical component of a diagnostic service provided either in a hospital or in an offsite premise operated by the hospital corporation that has received approval under section 4 of the *Public Hospitals Act*

GENERAL PREAMBLE

DEFINITIONS

GENERAL DEFINITIONS

holiday (for other than "H" prefix emergency department listings) means all of the following:

1. Family Day, Good Friday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving, New Year's Day, and if the holiday falls on a Saturday or Sunday either the Friday before or the Monday following the holiday, as determined at the choice of the physician.
2. Boxing Day and if Boxing Day falls on a Saturday, the Monday following Boxing Day.
3. Christmas Day and
   - **a.** if Christmas Day falls on a Sunday, the Friday before Christmas Day;

     or
   - **b.** if Christmas Day falls on a Saturday, the Friday before and the Monday following Christmas Day.

holiday (for "H" prefix emergency department listings) means all of the following:

Family Day, Good Friday, Victoria Day, Canada Day, Civic Holiday, Labour Day, Thanksgiving, New Year's Day, December 25 through December 31 (inclusive) and,

- **a.** if Christmas Day falls on a Saturday or Sunday, the Friday before Christmas Day;

  and
- **b.** if New Year's Day falls on a Saturday or Sunday, the Monday following New Year's Day;

  and
- **c.** if Canada Day falls on a Saturday or Sunday either the Friday before or the Monday following Canada Day, as determined at the choice of the physician.

[Commentary:
Only services rendered on a holiday as defined above and listed as a holiday premium or service, e.g. certain special visit premiums, after-hours premiums and H-code emergency department services, are eligible for payment as holiday claims.]

home	patient's place of residence including a multiple resident dwelling or single location that shares a common external building entrance or lobby, such as an apartment block, rest or retirement home, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility, or group home and other than a hospital or Long-Term Care institution
independent operative procedure (IOP)	a procedural code with a "Z" prefix (which is payable in addition to the amount payable for an assessment)
major preoperative visit	the consultation or assessment where the decision to operate is made, regardless of the time interval between the major preoperative visit and the surgery

GENERAL PREAMBLE

DEFINITIONS

may include	when “may” or “may include” are used in the description of a listed service, all of the other services, or elements of, or components of insured services that are referred to following the terms “may”, “may include”, and that are performed in conjunction with the listed service are optional, but when rendered are included in the amount payable for the listed service
medical consultant	a designated MOHLTC physician
MOHLTC	Ministry of Health and Long-Term Care
most responsible physician	the attending physician who is primarily responsible for the day-to-day care of a hospital in-patient
not eligible for payment	when a service or a claim submitted for a service is described as “not eligible for payment”, the service remains an insured service for which the amount payable is zero

[Commentary:
Patients cannot be charged for services described as “not eligible for payment” as they remain insured services.]

OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
only eligible for payment	when a service is described as “only eligible for payment” when certain conditions are met and those conditions are not met, the service becomes not eligible for payment.

[Commentary:
Patients cannot be charged for services described as “only eligible for payment” as they remain insured services.]

palliative care	care provided to a terminally ill patient in the final year of life where the decision has been made that there will be no aggressive treatment of the underlying disease and care is to be directed to maintaining the comfort of the patient until death occurs
patient’s representative	the legal representative of a patient
“P”, “P_1” or “P_2” fee	the fee for the professional component of a diagnostic service
professional component	a class of service listed in the *Schedule* headed by a column listed “P” or “P_1” or “P_2” or with “professional component” listed opposite the service

[Commentary:
Additional information including the requirements for performing the professional component is found in the individual preambles to the applicable sections of the *Schedule*.]

referral	written request by one physician for the provision of expert services by another physician to the patient of the referring physician

GENERAL PREAMBLE

DEFINITIONS

rendered personally by the physician means that the service must be personally performed by the physician and may not be delegated to any other person. Services that are required to be "rendered personally by the physician" are uninsured if this requirement is not met

Schedule Schedule of Benefits for Physician Services

specialist a physician who holds one of the following:

1. a certification issued by the Royal College of Physicians and Surgeons of Canada (RCPSC);
2. a certificate of registration issued by the CPSO to a physician who has successfully completed the Assessment program for International Medical Graduates (APIMG) in a recognized medical or surgical specialty;
3. a certificate of registration as a specialist issued by the CPSO to a physician employed;
   - in a full-time teaching or full-time research appointment in a recognized medical or surgical specialty other than family or general practice; and
   - by the faculty of medicine of an Ontario university at the rank of assistant professor or higher; or
4. a certificate of registration issued on the order of the Registration Committee of the CPSO to a physician who practices in a recognized medical or surgical specialty other than family or general practice, where the requirements of registration are otherwise not met, and to which certificate terms, conditions, or limitations may be attached.

specific elements specific components, in addition to the common elements, that are included in particular insured physician services found in the General Preamble or the specialty section of the Schedule

"T" fee the fee for the technical component of a service listed in the Pulmonary Function Studies section of the Schedule

technical component a class of service listed in the Schedule headed by a column listed "H" or "T" or with "technical component" listed opposite the service

[Commentary:
Additional information including the requirements for performing the technical component is found in the individual preambles to the applicable sections of the *schedule*.]

transferal permanent or temporary complete transfer of the responsibility for the care of the patient from one physician to another

[Commentary:
A transferal occurs, for example, where the first physician is leaving temporarily on holidays and is unable to continue to treat the patient.]

uninsured service a service that is not prescribed as "insured" under the *Act*

with or without when "with or without" are used in the description of a listed service, all of the other services, or elements of, or components of insured services that are referred to following the terms "with or without", and that are performed in conjunction with the listed service are optional, but when rendered are insured and are included in the amount payable for the listed service

MAXIMUMS, MINIMUMS AND TIME OR UNIT-BASED SERVICES

In this Schedule when the amount payable for a service is described:

a. In terms of a maximum number of services without reference to a specific time period to which the maximum applies, this means that the maximum refers to a maximum number of services per patient per *day*. Those services rendered to the same patient on the same *day* in excess of the maximum for that patient on that day are *not eligible for payment*.

b. In terms of a maximum number of services with reference to a specific time period to which the maximum applies, the services are calculated per patient and the number of services is based upon services rendered chronologically. Those services rendered to the same patient during that specific time period in excess of the maximum for that patient are *not eligible for payment*.

c. In terms of a maximum with reference to a specific part of the anatomy, this means a maximum number of services per patient per day. Those services rendered in excess of the maximum for that specific part of the anatomy per patient on that day are *not eligible for payment*.

d. In terms of a minimum number of services without reference to a specific time period to which the minimum applies, this means that the minimum refers to a minimum number of services per patient per day. With the exception of those services listed in the "Diagnostic Radiology" section of the *Schedule* or unless specifically stated otherwise, where less than the number of services required to satisfy the minimum are rendered, the services are *not eligible for payment*.

e. In terms of "repeat" or "repeats", except with respect to repeat consultations or unless otherwise stated, this means the same service(s) is rendered to the same patient by the same physician on the same day.

f. In terms of a minimum required duration of time, the physician must record on the patient's permanent medical record or chart the time when the insured service started and ended. If the patient's permanent medical record or chart does not include this required information, the service is *not eligible for payment*.

g. Based upon the number of "units" of service rendered, the physician must record on the patient's permanent medical record or chart the time when the insured service started and ended. If the patient's permanent medical record or chart does not include this required information, the service is *not eligible for payment*.

GENERAL PREAMBLE

GENERAL INFORMATION

[Commentary: Services Insured by *OHIP*
The *Schedule* is established under section 37.1 of regulation 552 under the *Act*. The fees listed are the amounts payable by *OHIP* for insured services. Insured services under the *Act* are limited to those which are listed in this *Schedule*, medically necessary, are not otherwise excluded by legislation or regulation, and are rendered personally by physicians or by others delegated to perform them where such delegation is authorized in accordance with the *Schedule* requirements for delegated services.

Some services are specifically listed as uninsured in regulation 552, section 24 of the *Act* (see Appendix A), such as a service that is solely for the purpose of altering or restoring appearance. Other services may be uninsured depending on the circumstances. An example of a service which is uninsured in limited circumstances is psychotherapy, which is uninsured where it is a requirement for the patient to obtain a diploma or degree or to fulfill a course of study. Other examples of commonly uninsured services include missed appointments or procedures, circumcision except if medically necessary, and certain services rendered and documents and forms completed in connection with non-medically necessary requests (e.g. life insurance application).]

[Commentary: Modifications to the *Schedule*
Under agreement between the *MOHLTC* and the *OMA*, additions, deletions, fee changes, or other modifications to the *Schedule*, are made by the *MOHLTC* following consultation with the *OMA*. Physicians who wish to have modifications to the *Schedule* considered should submit any proposals to the Central Tariff Committee (CTC) of the *OMA* through the appropriate clinical section.

In the situation where a new therapy or procedure is being introduced into Ontario, and the physicians performing the new therapy or procedure wish to have a new fee item inserted into the *Schedule*, the following process is recommended.

An application for a new fee related to the new therapy or procedure should be submitted by the appropriate section(s) of the *OMA* to the CTC for consideration, with documentation supporting the introduction of this item into the *Schedule*. The CTC will advise *OHIP* whether or not this new therapy is experimental. If the CTC and the *MOHLTC* agree that the item is experimental, the service is deemed uninsured (in accordance with section 24 of regulation 552 under the *Act*), and will not be introduced into the *Schedule*. If the *MOHLTC*, on the advice of the CTC, determines that the new therapy or procedure is not experimental, the fee application will be handled in the usual manner as detailed above.]

[Commentary: Medical Research
Examinations or procedures for the purpose of a research or survey program are not insured services, nor are services provided by a laboratory or a hospital that support an examination or procedure that is for the purpose of research or a survey. The exception to this is that an assessment conducted to determine if an insured person is suitable for such a program is not necessarily an uninsured service (see section 24 of regulation 552 under the *Act* - this is provided as Appendix A of the *Schedule*).]

GENERAL INFORMATION

[Commentary: Medical Records
All insured services must be documented in appropriate records. The *Act* requires that the record establish that:

1. an insured service was provided;

2. the service for which the account is submitted is the service that was rendered;

and

3. the service was medically necessary.

The medical record requirements as found in the *Act* are listed in Appendix G of the *Schedule*.]

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

[Commentary:
Claims for payment must be submitted to *OHIP* in the form and by the medium (e.g. electronic data transmission; machine readable input) as set out in sections 38.3 to 38.5 of regulation 552 under the *Act* and must contain the information required by the regulation and the General Manager of *OHIP*. Regulation 552 under the *Act* can be found at:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900552_e.htm.

Claims must be submitted within six months of the date the service was rendered, except in extenuating circumstances. A claim cannot be accepted for payment unless it meets all of the technical and formal requirements set out in the *Act* and regulations.]

1. The fee is payable only to the physician who rendered the service personally, or by the physician whose delegate rendered the service where delegation is authorized in accordance with the *Schedule*.

2. Where more than one physician renders different components of a listed service, only one fee is payable for that service, and the fee is payable only where the *Schedule* provides that different physicians may perform different components of the service.

[Commentary:
Where an insured service contains several components (e.g. surgical procedures that include post-operative care or fracture care), the components of the service are not divisible among physicians for claims purposes and the physicians are responsible for apportioning payment amongst themselves.]

3. Where the *Schedule* provides that different physicians may substitute for one another in performing the total service, only one fee is payable for the service.

[Commentary:
When physicians routinely or frequently substitute for each other in providing hospital visits to registered bed patients in active treatment hospitals, e.g. weekend coverage or daily rounds by various members of a group, the most responsible physician may claim for all the visits.]

GENERAL PREAMBLE

GENERAL INFORMATION

GENERAL PAYMENT RULES

Specialist services

When a service rendered by a specialist comprises part of an insured consultation or assessment that falls within the scope of his or her specialist practice, the service is *not eligible for payment* unless the claim for the service is submitted either:

a. in respect of a service described in the portions of the Consultations and Visits section of this *Schedule* that reflects the physician's Royal College of Physicians and Surgeons of Canada specialty, as documented in the records maintained by the *MOHLTC* for claims payment purposes;

or

b. in respect of a service described in this *Schedule* under the following sub-headings which can be claimed by any specialty: psychotherapy, counselling, HIV primary care, palliative care support, hypnotherapy, certification of mental illness, interviews, genetic assessments, midwife-requested emergency and special emergency assessments, home care application, or home care supervision.

When a service rendered by a specialist does not fall within the scope of the specialist's practice and/or the specialist is providing primary care in a family or general practice setting, the service is *only eligible for payment* when the claim is submitted using the appropriate code from the "Family Practice & Practice in General" listings.

When more than one assessment is rendered to a patient during the same visit by the same physician who is qualified in one or more specialties, only one assessment is payable.

[Commentary:
Any additional assessment is *not eligible for payment*.]

Use of Codes, Prefixes and Suffixes

[Commentary:
Services are generally, but not necessarily, listed by anatomical system or specialty for convenience.]

The alpha-numeric fee code opposite the service listing in this *Schedule* must be set out in the claim submitted, together with the required suffix.

Surgical Codes: In the surgical part of the *Schedule*, the required suffixes are:

suffix A if the physician performs the procedure;

suffix B if the physician assisted at the surgery; and

suffix C if the physician administered the anaesthetic.

GENERAL PREAMBLE

GENERAL PAYMENT RULES

Diagnostic Services Rendered at a hospital

The Technical component of those diagnostic services that are listed with "technical component" or in a column headed "H" or "T" and "professional component" or in a column headed "P", "P1", or "P2" are not eligible for payment if the service is rendered to a patient who:

1. is an in-patient of a hospital;

or

2.

a. attends a hospital where he or she receives an insured diagnostic service;

and

b. within 24 hours of receiving that diagnostic service, is admitted to the same hospital as an in-patient in connection with the same condition, illness, injury or disease in relation to which the diagnostic service was rendered.

[Commentary:

1. For those diagnostic services which have both technical and professional components listed under one fee schedule code, the technical and professional components are claimed separately. The claim for the technical component is submitted using the fee schedule code with the suffix B and the claim for the professional component is submitted using the fee schedule code with a suffix C.

2. The technical component may be listed as either "technical component" or in a column headed "H" or "T". The professional component may be listed as either "professional component" or in a column headed "P", "P_1" or "P_2".]

The technical component of a diagnostic service listed in the column headed with an "H" and rendered outside of a hospital is *not eligible for payment* under the *Health Insurance Act*.

GENERAL PREAMBLE

GENERAL PAYMENT RULES

Consultation and Assessment Codes

There are four different prefixes used for consultations and assessments listed in the "Consultations and Visits" section of the *Schedule*. The codes with the "A" prefix are described as the "General Listings". These must be used when submitting a claim for consultations and assessments except in the following situations when the code listed below must be used:

1. **acute care hospital – non-emergency in-patient services** – "C" prefix codes;
2. **long term care institution – non-emergency in-patient services** – "W" prefix codes;
3. **emergency department – services rendered by a physician on duty** – "H" prefix (H1- codes); or
4. **rehabilitation unit – services rendered by a specialist in Physical Medicine** – "H" prefix codes (H3XX codes)

[Commentary:
Submit claim using an "A" prefix assessment when an assessment is rendered in conjunction with a special visit premium. Information regarding when special visit premiums are payable is found on pages GP47 to GP52 of the General Preamble.]

Independent Consideration (IC)

Services listed in the *Schedule* without specified fees are identified as "IC" and are given independent consideration by the *medical consultant*. Claims for such services must be submitted with a supporting letter explaining the amount of the fee claimed, and must include an appropriate operative or consultation report, and a comparison of the scope and difficulty of the procedure in relation to non-IC procedures in the *Schedule*. For treatment of tumours not listed in the *Schedule*, surgeons must use the IC code, R993, and for surgical procedures not listed, but similar to a listed service, the code, R990.

GENERAL PREAMBLE

CONSTITUENT AND COMMON ELEMENTS OF INSURED SERVICES

[Commentary:
This *Schedule* identifies the constituent elements that comprise insured services. *Common elements* apply to all insured services and specific elements apply to specific groups of services where identified either in the General Preamble or in the preamble to a specific system and/or specialty sections of the *Schedule*. There may be additional specific requirements ("required elements of service", "payment rules", "claims submission instructions" or "notes") for some individual services, and these are noted with the description of any such service within the *Schedule*. In order to determine the correct claim to use for a service rendered, the necessary information is found by reviewing the common elements, specific elements, and service specific information.

No charges may be made (except to *OHIP*) for an insured service rendered to an insured person or for any of the constituent elements of such insured services. This is prohibited by the *Act* and/or the *Commitment to the Future of Medicare Act*.

Most services include as a constituent element of the service the provision of the premises, equipment, supplies, and personnel used in the performance of the common and specific elements of the service. This is not, however, the case for services denoted by codes marked with the prefix "#", and for services that are divided into professional and technical components where only the professional component is an insured service under the *Act*.

For those codes denoted with the prefix "#" and performed in a hospital, the premises, equipment, supplies, and personnel used to perform all elements of the service are funded by the hospital global budget.

For those services denoted with the prefix "#" and provided in an Independent Health Facility, the premises, equipment, supplies, and personnel are funded under the facility fee set out in the *Independent Health Facilities Act*.

Patients cannot be charged for the premises, equipment, supplies and personnel for services denoted with the prefix "#" rendered outside of a hospital or Independent Health Facility if the premises, equipment, supplies and personnel support, assist or provide a necessary adjunct to an insured service denoted with the prefix "#" as charging a patient would be contrary to the *Independent Health Facilities Act*.]

COMMON ELEMENTS OF INSURED SERVICES

All insured services include the skill, time, and responsibility involved in performing, including when delegated to a non-physician in accordance with the Delegated Procedures Section (GP45) of the General Preamble, supervising the performance of the constituent elements of the service.

Unless otherwise specifically listed in the *Schedule*, the following elements are common to all insured services.

A. Being available to provide follow-up insured services to the patient and arranging for coverage when not available.

B. Making arrangements for appointment(s) for the insured service.

C. travelling to and from the place(s) where any element(s) of the service is (are) performed.

[Commentary:
travelling to visit an insured person outside of the usual geographical area of practice of the person making the visit is an uninsured service – see Regulation 552 section 24(1) paragraph 1 under the *Act*.]

D. Obtaining and reviewing information (including history taking) from any appropriate source(s) so as to arrive at any decision(s) made in order to perform the elements of the service.

Appropriate sources include but are not limited to:

1. patient and patient's representative(s)

2. patient charts and records

3. investigational data

4. physicians, pharmacists, and other health professionals

5. suppliers and manufacturers of drugs and devices

6. relevant literature and research data.

E. Obtaining consents or delivering written consents, unless otherwise specifically listed in the *Schedule.*

F. Keeping and maintaining appropriate medical records.

G. Providing any medical prescriptions except where the request for this service is initiated by the patient or patient's representative(s) and no related insured service is provided.

H. Preparing or submitting documents or records, or providing information for use in programs administered by the *MOHLTC.*

I. Conferring with or providing advice, direction, information, or records to physicians and other professionals associated with the health and development of the patient.

J. Such planning, preparation, and administration for the performance of the elements of the service directly attributable either to a specific patient or to a physician maintaining his/her practice, unless otherwise specifically listed in the *Schedule*.

K. Except for services denoted by codes marked with the prefix "#", or for services that are divided into professional and technical components where only the professional component is an insured service under the *Act*, providing premises, equipment, supplies, and personnel for the common elements of the service.

L. Waiting times associated with the provision of the service(s).

While no occasion may arise for performing elements A, B, C, D, F, G, H or K when performed in connection with the specific elements of a service, these are included in the service.

GENERAL PREAMBLE

SPECIFIC ELEMENTS OF ASSESSMENTS

In addition to the common elements, all services which are described as assessments, or as including assessments (e.g. consultations), include the following specific elements:

A. A direct physical encounter with the patient including taking a patient history and performing a physical examination.

B. Other inquiry (including taking a patient history), carried out to arrive at an opinion as to the nature of the patient's condition, (whether such inquiry takes place before, during or after the encounter during which the physical examination takes place) and/or follow-up care.

C. Performing any procedure(s) during the same encounter as the physical examination, unless the procedure(s) is(are) separately listed in the *Schedule* and an amount is payable for the procedure in conjunction with an assessment.

"Procedure" in this context includes obtaining specimens, preparation of the patient, interpretation of results and, unless otherwise specified, all diagnostic (including laboratory) and therapeutic (including surgical) services;

D. Making arrangements for any related assessments, procedures or therapy, and/or interpreting results.

E. Making arrangements for follow-up care;

F. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative(s)*, whether by telephone or otherwise, on matters related to:

1. the service;

and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

G. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is provided.

H. Providing premises, equipment, supplies, and personnel for the specific elements of the service except for any aspect(s) that is (are) performed in a hospital or nursing home.

While no occasion may arise for performing elements C, D, E, G, or H, when performed in connection with the other specific elements, they are included in the assessment.

GENERAL PREAMBLE

CONSULTATIONS

CONSULTATION

Definition/Required elements of service:

A consultation is an assessment rendered following a written request from a referring physician who, in light of his/her professional knowledge of the patient, requests the opinion of another physician competent to give advice in this field because of the complexity, seriousness, or obscurity of the case, or because another opinion is requested by the patient or *patient's representative*.

A consultation includes the services necessary to enable the consultant to prepare a written report (including findings, opinions, and recommendations) to the referring physician. Except where otherwise specified, the consultant is required to perform a general, specific or medical specific assessment, including a review of all relevant data.

The following are additional requirements for a consultation:

a. A copy of the written request for the consultation, signed by the referring physician must be kept in the consulting physician's medical record, except in the case of a consultation which occurs in a hospital, long-term care institution or multi-specialty clinic where common medical records are maintained. In such cases, the written request may be contained on the common medical record.

b. The request identifies the consultant by name, the referring physician by name and billing number, and identifies the patient by name and health number.

c. The written request sets out the information relevant to the *referral* and specifies the service(s) required.

In the event these requirements are not met, the amount payable for a consultation will be reduced to a lesser assessment fee.

[Commentary:
The request would ordinarily also include the appointment date and appropriate clinical information, such as the reason for the *referral* for consultation, present and past history, physical findings and relevant test results and reports.]

Payment rules:

1. Where a consultant is requested by a resident or intern to perform a consultation, the amount payable for the service will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant.

2. Consultations, except for repeat consultations (as described immediately below), are limited to one per *12 month period* unless the same patient is referred to the same consultant a second time within the same *12 month period* with a clearly defined unrelated diagnosis in which case the limit is increased to two per *12 month period*. The amount payable for consultations in excess of these limits will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant.

REPEAT CONSULTATION

Definition/Required elements of service:

A repeat consultation is an additional consultation rendered by the same consultant, in respect of the same presenting problem, following care rendered to the patient by another physician in the interval following the initial consultation but preceding the repeat consultation.

A repeat consultation has the same requirements as a consultation including the requirement for a new written request by the referring physician.

LIMITED CONSULTATION

Definition/Required elements of service:

A limited consultation is a consultation which is less demanding and, in terms of time, normally requires substantially less of the physician's time than the full consultation. Otherwise, a limited consultation has the same requirements as a full consultation.

Under the heading of "Family Practice & Practice in General", a limited consultation is the service rendered by any physician who is not a specialist, where the service meets all the requirements for a consultation but, because of the nature of the referral, only those services which constitute a specific assessment are rendered.

EMERGENCY ROOM (ER) PHYSICIAN CONSULTATION

Payment rules:

1. The amount payable for a consultation by an ER Physician will be adjusted to a lesser assessment fee under either of the following circumstances:

   a. the patient is referred by another ER physician in the same hospital;

   or

   b. the service is rendered in any location other than the emergency department or other critical care area in a hospital, or to a critically ill patient in a hospital.

2. ER reports constitute adequate documentation of the written report of the consultation as long as the rendering of all constituent elements is clearly documented on all copies of the report. If the consulting physician fails to ensure that a copy of the ER report is sent to the physician who referred the patient, the amount payable for the service will be adjusted to the amount payable for an assessment.

Claims submission instruction:

Claims for ER Physician consultations are to be submitted using H055 for a specialist in emergency medicine (FRCP) and H065 for all other physicians.

SPECIAL SURGICAL CONSULTATION

Definition/Required elements of service:

A special surgical consultation is rendered when a surgeon provides all the appropriate elements of a regular consultation and is required to devote at least fifty minutes exclusively to the consultation with the patient.

> **[Commentary:**
> The calculation of the 50 minute minimum excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

Claims submission instruction:

Claims for special surgical consultations are to be submitted using either A935 or C935, as applicable.

GENERAL PREAMBLE

ASSESSMENTS

Specific requirements for assessments listed in the "Consultations and Visits" section of the *Schedule* are set out below:

GENERAL ASSESSMENT

Definition/Required elements of service:

A general assessment is a service, rendered at a place other than in a patient's home that requires a full history (the elements of which must include a history of the presenting complaint, family medical history, past medical history, social history, and a functional inquiry into all body parts and systems), and, except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts and systems, and may include a detailed examination of one or more parts or systems.

Payment rules:

General assessments are limited to one per patient per physician per *12 month period* unless either of the following circumstances is met in which case the limit is increased to two per *12 month period*:

1. the patient presents a second time with a complaint for which the diagnosis is clearly different and unrelated to the diagnosis made at the time of the first general assessment; or

2. at least 90 days have elapsed since the date of the last general assessment and the second assessment is a hospital admission assessment.

The amount payable for general assessments in excess of these limits will be adjusted to a lesser assessment fee.

ANNUAL HEALTH OR ANNUAL PHYSICAL EXAMINATION

Definition: An annual health or annual physical examination (including a primary or secondary school examination) is a general assessment performed on a patient, after their second birthday, who presents and reveals no apparent physical or mental illness.

Payment rule:

Annual health examinations are limited to one per patient per *12 month period* per physician and constitute "general assessments" for the purpose of calculating general assessment limits set out above.

[Commentary:
Annual health examinations in excess of the limit are not insured.]

Claims submission instruction:

Submit claims for annual health examinations using:

Family Practice & Practice in General	Paediatrics
A003 – adult or adolescent – diagnostic code 917	K269 * - adolescent
K017 * - child after second birthday	K267 * - child after second birthday

* No diagnostic code required

ASSESSMENTS

GENERAL RE-ASSESSMENT

Definition/Required elements of service:

A general re-assessment includes all the services listed for a general assessment, with the exception of the patient's history, which need not include all the details already obtained in the original assessment.

Payment rule:

With the exception of general re-assessments rendered for hospital admissions, general re-assessments are limited to two per *12 month period*, per patient per physician. The amount payable for general re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

PRE-OPERATIVE AND PRE-DENTAL GENERAL ASSESSMENT

Definition/Required elements of service:

Pre-operative and Pre-dental general assessments are general assessments required prior to surgery or a dental procedure under anaesthesia in hospital.

Payment rule:

When a pre-operative assessment is followed within 30 days by an elective hospital admission, an admission general assessment (C003) or general re-assessment (C004) is *not eligible for payment*.

> **[Commentary:**
> Pre-operative and pre-dental general assessments constitute "general assessments" for the purpose of calculating general assessment limits set out above.]

GENERAL PREAMBLE

ASSESSMENTS

SPECIFIC ASSESSMENT AND MEDICAL SPECIFIC ASSESSMENT

Definition/Required elements of service:

Specific assessment and medical specific assessment are services rendered by specialists, in a place other than a patient's home, and require a full history of the presenting complaint and detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function.

Payment rule:

Specific assessments or medical specific assessments are limited to one per patient per physician *per 12 month period* unless either of the following circumstances are met in which case the limit is increased to two per patient per physician per *12 month period*:

1. the patient presents a second time with a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first specific assessment in that *12 month period*;

   or

2. in the case of a medical specific assessment, at least 90 days have elapsed since the date of the last specific assessment and the second assessment is a hospital admission assessment.

The amount payable for specific or medical specific assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments (see below) are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

SPECIFIC RE-ASSESSMENT AND MEDICAL SPECIFIC RE-ASSESSMENT

Definition/Required elements of service:

Specific re-assessment and medical specific re-assessment are services rendered by specialists and require a full, relevant history and physical examination of one or more systems.

[Commentary:
As outlined on page GP28, admission assessments are deemed to be a specific re-assessment or medical specific re-assessment under either of the following circumstances:

1. for those procedures prefixed with a "Z" or noted as an IOP, by a surgical specialist who has assessed the patient prior to admission in respect of the same illness;

   or

2. for those patients who have been assessed by a physician and subsequently admitted to the hospital for the same illness by the same physician.]

Payment rule:

Specific re-assessments or medical specific re-assessments are limited to two per patient per physician per consecutive *12 month period* except for specific re-assessments rendered for hospital admissions. The amount payable for specific or medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

GENERAL PREAMBLE

ASSESSMENTS

COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT

Definition/ Required elements of service:

A complex medical specific re-assessment is a re-assessment of a patient because of the complexity, obscurity, or seriousness of the patient's condition and includes all the requirements of a medical specific re-assessment. The physician must report his/her findings, opinions, or recommendations in writing to the patient's primary care physician or the amount payable for the service will be adjusted to a lesser assessment fee.

Payment rule:

Complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period.* The amount payable for complex medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

PARTIAL ASSESSMENT

Definition/ Required elements of service:

A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and appropriate record.

CHRONIC DISEASE ASSESSMENT PREMIUM

Definition/ Required elements of service:

Chronic disease assessment premium is payable in addition to the amount payable for an assessment when all of the following criteria are met:

a. The assessment is a

i. medical specific assessment;

ii. medical specific re-assessment;

iii. complex medical specific re-assessment;

iv. partial assessment;

or

v. level 2 paediatric assessment

b. The service is rendered by a physician registered with OHIP as having one of the following specialty designations:

07(Geriatrics), 13(Internal Medicine), 18(Neurology), 26(Paediatrics), 28(Pathology), 31(Physical Medicine), 34(Therapeutic Radiology), 41(Gastroenterology), 47(Respiratory Disease), 48(Rheumatology), 60(Cardiology), 61(Haematology), 62(Clinical Immunology)

c. The assessment is rendered in an office setting or an out-patient clinic located in a hospital, other than an emergency department.

[Commentary:
The chronic disease assessment premium is not payable for assessments rendered to in-patients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department.]

d. The patient has an established diagnosis of a chronic disease, documented in the patient's medical record.

GENERAL PREAMBLE

ASSESSMENTS

Payment rule:

The following is a list of the diagnostic codes as specified by OHIP that must accompany the claim for payment purposes :

042	AIDS
043	AIDS-related complex
044	Other human immunodeficiency virus infection
250	Diabetes mellitus, including complications
286	Coagulation defects (e.g. haemophilia, other factor deficiencies)
287	Purpura, thrombocytopenia, other haemorrhagic conditions
290	Senile dementia, presenile dementia
299	Child psychoses or autism
313	Behavioural disorders of childhood and adolescence
315	Specified delays in development (e.g. dyslexia, dyslalia, motor retardation)
332	Parkinson's Disease
340	Multiple Sclerosis
343	Cerebral Palsy
345	Epilepsy
402	Hypertensive Heart Disease
428	Congestive Heart Failure
491	Chronic Bronchitis
492	Emphysema
493	Asthma, Allergic Bronchitis
515	Pulmonary Fibrosis
555	Regional Enteritis, Crohn's Disease
556	Ulcerative Colitis
571	Cirrhosis of the Liver
585	Chronic Renal Failure, Uremia
710	Disseminated Lupus Erythaematosus, Generalized Scleroderma, Dermatomyositis
714	Rheumatoid Arthritis, Still's Disease
720	Ankylosing Spondylitis
721	Other seronegative spondyloarthropathies
758	Chromosomal Anomalies
765	Prematurity, low-birthweight infant
902	Educational problems

[Commentary:
The chronic disease assessment premium is not payable in situations where the diagnosis has not been established.]

LEVEL 1 PAEDIATRIC ASSESSMENT

Definition/Required elements of service:

A level 1 paediatric assessment includes one or both of the following:

a. a brief history and examination of the affected part or region or related to a mental or emotional disorder;

or

b. brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.

LEVEL 2 PAEDIATRIC ASSESSMENT

Definition/Required elements of service:

A level 2 paediatric assessment is a paediatric service that requires a more extensive examination than a level 1 paediatric assessment. It requires a history of the presenting complaint(s), inquiry concerning, and examination of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.

A Level 2 Paediatric Assessment also includes well baby care, which is a periodic assessment of a well newborn/infant during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or patient's representative(s) regarding health care.

INTERMEDIATE ASSESSMENT

Definition/Required elements of service:

An intermediate assessment is a primary care general practice that requires a more extensive examination than a minor assessment. It requires a history of the presenting complaint(s), inquiry concerning, and examination of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.

INTERMEDIATE ASSESSMENT – PRONOUNCEMENT OF DEATH

Definition/Required elements of service:

Intermediate assessment – pronouncement of death is the service of pronouncing a patient dead in a location other than in the patient's home. This service *may include* any counselling of relatives that is rendered during the same visit, and completion of the death certificate.

[Commentary:

1. For pronouncement of death in the home, see house call assessments (page A2 of the *Schedule*).

2. Submit the claim for this service using the diagnostic code for the underlying cause of death, as recorded on the death certificate, rather than the immediate cause of death.]

MINOR ASSESSMENT

Definition/Required elements of service:

A minor assessment includes one or both of the following:

a. a brief history and examination of the affected part or region or related to a mental or emotional disorder;

or

b. brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.

GENERAL PREAMBLE

ASSESSMENTS

PERIODIC OCULO-VISUAL ASSESSMENT

Definition/Required elements of service:

A periodic oculo-visual assessment is an examination of the eye and vision system rendered primarily to determine if a patient has a simple refractive error (defined as myopia, hypermetropia, presbyopia, anisometropia or astigmatism) for patients aged 19 or less or aged 65 or more. This service includes all components required to perform the assessment (ordinarily a history of the presenting complaint, past medical history, visual acuity examination, ocular mobility examination, slit lamp examination of the anterior segment, ophthalmoscopy, tonometry) advice and/or instruction to the patient and provision of a written refractive prescription if required.

Payment rules:

1. This service is limited to one per patient per *12 month period* regardless of whether the first claim is or has been submitted for a service rendered by an optometrist or physician. Services in excess of this limit or to patients aged 20 to 64 are not insured services.

2. Any other insured service rendered by the same physician (other than an ophthalmologist) to the same patient the same day as a periodic oculo-visual assessment is *not eligible for payment*.

[Commentary:

1. Other consultation and visit codes are not to be used as a substitute for this service when the limit is reached.
2. Re-assessment following a periodic oculo-visual assessment is to be claimed using a lesser assessment fee code and diagnostic code 367.]

FIRST VISIT BY PRIMARY CARE PHYSICIAN AFTER HOSPITAL DISCHARGE

E080 First visit after hospital discharge premium, to other service listed in payment rule 5 below . . . . . add 25.00

Payment rules:

1. Subject to payment rules 2 through 5, E080 is *only eligible for payment* for a visit with the patient's primary care physician in the physician's office or the patient's home within two weeks of discharge following in-patient admission to an acute care hospital.

[Commentary:
This premium is not payable for visits rendered to patients in locations other than the physician's office or patient's home. As such, the premium is not payable for services rendered in places such as Nursing Homes, Homes for the Aged, chronic care hospitals, etc.]

2. E080 is *not eligible for payment* if the admission to hospital was for the purpose of obstetrical delivery unless the mother required admission to an ICU during the hospital stay.
3. E080 is *not eligible for payment* if the admission to hospital was for the purpose of newborn care unless the infant required admission to a NICU during the hospital stay.
4. E080 is *not eligible for payment* if the admission to hospital was for the purpose of performing day surgery.
5. E080 is *only eligible for payment* when rendered with the following services:

   A001, A003, A004, A007, A008, A261, A262, A263, A264, A888, A901, A903, K004–K008, K013, K014, K022, K023, K028-K030, K032, K033, K037, K623, P003, P004, P008.

GENERAL PREAMBLE

ASSESSMENTS

DETENTION

Definition/Required elements of service:

Detention is payable following another insured service when a physician is required to spend considerable extra time in active treatment and/or monitoring of the patient to the exclusion of all other work and in this section is based on full 15-minute time units. The specific elements are those for assessments.

K001 Detention – per full quarter hour 21.10

Payment rules:

1. Detention is payable under the following circumstances:

Service	Minimum time required in delivery of service before detention is payable
minor, partial, multiple systems assessment, level 1 and level 2 paediatric assessment, intermediate assessment, or subsequent hospital visit	30 minutes
specific or general re-assessment	40 minutes
consultation, repeat consultation, specific or general assessment, or midwife-requested assessment	60 minutes
special palliative care consultation (A945, C945), special surgical consultation (A935, C935), or a midwife-requested special assessment	90 minutes
comprehensive geriatric consultation or geriatric psychiatric consultation	120 minutes
psychiatric neurodevelopmental or paediatric neurodevelopmental consultation	180 minutes

2. Detention is *not eligible for payment* in conjunction with diagnostic procedures, obstetrics, and those therapeutic procedures where the fee includes an assessment (e.g. non-IOP surgery).

3. Detention is *not eligible for payment* for time spent waiting.

4. For the purposes of calculation of time units payable for detention, the start time commences after the minimum time required for the assessment or consultation listed in the table has passed.

Claims submission instruction:

Claims for detention are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

DETENTION-IN-AMBULANCE

Definition/Required elements of service:

Detention-in-Ambulance is payable for constant attendance with a patient in an ambulance, to provide all aspects of care to the patient. Time is calculated only for that period during which the physician is in constant attendance with the patient in the ambulance. The service includes an initial examination and ongoing monitoring of the patient's condition and all interventions, except in those circumstances in which the *Schedule* provides for separate or additional payment for the intervention.

K101	Ground ambulance transfer with patient per quarter hour or part thereof	42.10
K111	Air ambulance transfer with patient per quarter hour or part thereof	126.40
K112	Return trip without patient to place of origin following air or ground ambulance transfer, per half hour or major part thereof	25.05

Claims submission instruction:

Claims for Detention-in-Ambulance are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
K101 is not applicable to attendance in a vehicle other than an ambulance, in which case K001 may apply.]

DETENTION FOR THE TRANSPORT OF DONOR ORGANS

Definition/Required elements of service:

Detention for the Transport of Donor Organs is payable for time travelling to and from a donor centre (excluding time spent in the donor centre) for the purpose of collecting and transporting to the recipient hospital (a) donor organ(s), including fresh bone being harvested.

K102	Per quarter hour or part thereof (*not eligible for payment* with K001)	20.20

Claims submission instruction:

Claims for Detention for the Transport of Donor Organs are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
Claims will be adjudicated on the basis of the most time-efficient means of travel to and from a donor centre.]

GENERAL PREAMBLE

ASSESSMENTS

NEWBORN CARE

Definition/Required elements of service:

Newborn care is the routine care of a well newborn for up to the first ten days of life in hospital or home and includes an initial general assessment and subsequent assessments, as may be indicated, and instructions to the caregiver(s) regarding the newborn's health care.

Payment rules:

1. Newborn care is limited to a maximum of one per patient except when a well baby is transferred to another hospital in which case the fee for newborn care may be payable to a physician at both hospitals.

   [Commentary:
   An example where this is possible is if the transfer occurred because of the state of health of the mother.]

2. Despite the requirement that to be eligible for a special visit premium the call be non-elective (see GP47), a special visit premium is payable in addition to this service if a physician is required to make an additional visit to the hospital outside of his or her normally scheduled hospital rounds to facilitate discharge of the newborn the same day as the visit.

LOW BIRTH WEIGHT BABY CARE

Definition:

Low birth weight baby care is any assessment of a well *newborn/infant* weighing less than 2.5 kilograms at birth.

WELL BABY CARE

Definition/Required elements of service:

Well baby care is a periodic assessment of a well *newborn/infant* during the first two years of life including complete examination with weight and measurements, and instructions to the parent(s) or *patient's representative(s)* regarding health care.

PSYCHIATRIC ASSESSMENT UNDER THE *MENTAL HEALTH ACT*

Definition/Required elements of service:

A psychiatric assessment under the *Mental Health Act* (K620, K623, K624, and K629) includes such psychiatric history, inquiry, and examination of the patient, as is appropriate, to enable the physician to complete, and includes completing, the relevant forms and to notify the patient, family, patient representative and relevant authorities under the *Mental Health Act*, where appropriate.

GENERAL PREAMBLE

ACUTE CARE HOSPITAL – NON-EMERGENCY IN-PATIENT SERVICES ("C" PREFIX SERVICES)

A. Admission Assessment – General Requirements

Definition:

An admission assessment is the initial assessment of the patient rendered for the purpose of admitting a patient to hospital.

Payment rules:

1. Except as outlined below in paragraph 3, when the *most responsible physician* has not previously assessed the patient for the presenting illness, the admission assessment constitutes a consultation, general or medical specific or specific assessment depending on the specialty of the physician and the nature of the service rendered.

2. Except as outlined below in paragraph 3, if the *most responsible physician* has previously assessed the patient for the presenting illness, the admission assessment constitutes a general re-assessment or specific re-assessment depending on the specialty of the physician and the nature of the service rendered.

3. When a hospital in-patient is transferred from one physician to another physician, only one consultation, general or specific assessment or reassessment is payable per patient admission. The amount payable for services in excess of this limit will be adjusted to a lesser assessment fee.

Admission Assessments by Specialists:

When a patient has been assessed by a *specialist* in the emergency room (ER) or out-patient department (OPD) and that physician renders a consultation, specific assessment, or medical specific assessment and subsequently admits the patient to hospital, the initial consultation, specific, or medical specific assessment constitutes the admission assessment.

When a patient has been assessed by a *specialist* in the ER or OPD, and that physician renders any other assessment other than those listed in the above paragraph, and that physician subsequently admits the patient to hospital, the fee is payable for an admission assessment in addition to the initial assessment, if both assessments are rendered separately.

[Commentary:
In accordance with the surgical preamble, a hospital admission assessment by the surgeon is *not eligible for payment*, unless it is the "major pre-operative visit" (i.e., the consultation or assessment which may be claimed when the decision to operate is made and the operation is scheduled).]

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Admission Assessments by General and Family Practitioners:

When a patient has been assessed by a general or family practitioner in the emergency room (ER) or out-patient department (OPD) and that physician renders a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital, the initial consultation, general assessment, general re-assessment constitutes the admission assessment.

When a patient has been assessed by a general or family practitioner in the ER or OPD and that physician renders any other assessment other than those listed in the above paragraph, and subsequently admits the patient to hospital, the fee is payable for an admission assessment in addition to the initial assessment, if both assessments are rendered separately.

Payment rule:

A933/C933/C003/C004 are *not eligible for payment* for an admission assessment for an elective surgery patient when a pre-operative assessment has been claimed within 30 days of admission by the same physician.

Admission Assessments by General and Family Practitioners in an Emergency Department Funded under an Emergency Department Alternative Funding Agreement:

When a patient has been assessed by the patient's general or family practitioner in an emergency room and that physician subsequently admits the patient to hospital, the General/Family Physician Emergency Department Assessment constitutes the admission assessment if the physician remains the *most responsible physician* for the patient.

Admission Assessments by Emergency Physicians:

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital as the *most responsible physician* or that physician is asked to perform the admission assessment (even though the patient is admitted under a different *most responsible physician*), the initial consultation, general assessment, or general re-assessment constitutes the admission assessment.

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders any other assessment other than those listed in the above paragraph, and subsequently renders the admission assessment, (even if the patient is admitted under a different *most responsible physician*), the admission assessment is payable as C004, in addition to the initial assessment, if both services are rendered separately.

B. Subsequent Visit

Definition:

A subsequent visit is any routine assessment in hospital following the hospital admission assessment.

> **Attendance at Surgery:** If, in the interest of the patient, the referring physician is asked to be present by the patient or the *patient's representative(s)*, but does not assist at the procedure, the attendance at surgery by the referring physician constitutes a hospital subsequent visit.
>
> **Multidisciplinary care:** Except where a single service for a team of physicians is listed in this *Schedule* (e.g. the weekly team fee for dialysis), when the complexity of the medical condition requires the services of several physicians in different disciplines, each physician visit constitutes a subsequent visit.

Payment rules:

1. Except in the circumstances outlined in paragraph 2, or when a patient is referred from one physician to another (see Claims submission instruction below), subsequent visits are limited to one per patient per day for the first 5 weeks after admission, 3 visits per week from 6 to 13 weeks after admission, and 6 visits per month after 13 weeks. Services in excess of the limit are *not eligible for payment.*

2. After 5 weeks of hospitalization, any routine assessment in hospital required as a result of an acute intercurrent illness in excess of the weekly or monthly limits set out above constitutes C121 – "additional visit due to intercurrent illness". The weekly or monthly limits set out above do not apply to additional visits due to intercurrent illness.

3. When a physician is already in the hospital and assesses one of his/her own patients or patients transferred to his/her care, the service constitutes a subsequent visit. If a physician assesses another physician's patient on an emergency basis, the General Listings ("A" prefix) apply.

Claims submission instruction:

When a hospital in-patient is referred from one physician to another physician, the date the second physician assessed the patient for the first time is considered the "admission date" for the purposes of the determining the appropriate subsequent visit fee code.

> **[Commentary:**
> When a hospital in-patient is transferred from one physician to another physician, subsequent visits by the second physician are calculated based on the actual admission date of the patient.]

C. Subsequent visit by the *Most Responsible Physician* (MRP)

Subsequent visit by the MRP – day following the hospital admission assessment (C122)

Definition:

Subsequent visit by the MRP - day following the hospital admission assessment is payable to the physician identified as the patient's MRP for rendering a subsequent visit on this day.

Subsequent visit by the MRP – second day following the hospital admission assessment (C123)

Definition:

Subsequent visit by the MRP - second day following the hospital admission assessment is payable to the physician identified as the patient's MRP for rendering a subsequent visit on this day.

Payment rules:

1. C122, C123 are limited to a maximum of one each per hospital admission.

   [Commentary:
   C122, C123 are only payable for visits rendered by the MRP. Services rendered by physicians who are not the MRP may be payable at a lesser visit fee.]

2. C122, C123 are *not eligible for payment:*

   a. when rendered to the same patient the same day as C124 (Subsequent visit by the MRP - day of discharge);

   b. for a patient admitted for obstetrical delivery or newborn care;

      or

   c. for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

3. C122, C123 are not payable for a subsequent visit rendered by a surgeon to a hospital in-patient following non-Z prefix surgery.

   [Commentary:
   The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

4. When a patient is transferred to another physician within the same hospital during either of these days, C122 or C123 are only payable to the physician who was the MRP for the majority of the day.

5. When a patient is transferred to another physician at a different hospital, the day of transfer shall be deemed for payment purposes to be the day of admission.

6. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For first and second subsequent visits by the MRP following transfer from an Intensive Care Area (C142, C143), see General Preamble page GP33.]

Subsequent visit by the MRP - day of discharge (C124)

Definition/Required elements of service:

Subsequent visit by the MRP – day of discharge is payable to the physician identified as the MRP for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

The discharge summary must include as a minimum the following information:

a. reason for admission;

b. procedures performed during the hospitalization;

c. discharge diagnosis;

and

d. medications on discharge.

Payment rules:

1. C124 is only payable to the MRP and limited to one service per hospital admission.

2. C124 is *not eligible for payment* under any of the following circumstances:

a. The patient was discharged within 48 hours of admission to hospital (calculated from the actual date of admission to hospital);

b. The admission was for obstetrical delivery unless the mother required admission to an ICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;

c. The admission was for newborn care unless the infant was admitted to a NICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;

d. For transfers within the same hospital;

or

e. For discharges directly from a NICU or ICU where NICU or ICU critical care per diem services were rendered the same day.

[Commentary:
In the case of conflicting claims for this service, the physician to whom the patient has rostered (virtual or actual) may receive the payment for the service.]

D. First subsequent visit by the MRP following transfer from an Intensive Care Area

First subsequent visit by the MRP following transfer from an Intensive Care Area (C142)

Definition:

First subsequent visit by the MRP following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Second subsequent visit by the MRP following transfer from an Intensive Care Area (C143)

Definition:

Second subsequent visit by the MRP following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Payment rules:

1. C142, C143 are limited to a maximum of one each per hospital admission.

   [Commentary:
   1. C142, C143 are only payable for visits rendered by the MRP. Services rendered by physicians who are not the MRP may be eligible for payment at a lesser visit fee.
   2. C142 or C143 are not eligible for payment for visits rendered to patients who were in an Intensive Care Area only for monitoring purposes.]

2. C142, C143 are not eligible for payment to the same physician who rendered Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services prior to the patient's transfer.

3. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For Subsequent visit by the MRP – first and second day following the hospital admission assessment (C122, C123), see General Preamble page GP31.]

4. C142, C143 are not eligible for payment:
   a. when rendered to the same patient the same day as C124 (Subsequent visit by the MRP – day of discharge), or
   b. for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

5. C142, C143 are not payable for visits rendered by a surgeon to a hospital in-patient in the first two weeks following non-Z prefix surgery.

   [Commentary:
   The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

6. When a patient is transferred to another physician within the same hospital, C142 or C143 are only payable to the physician who was the MRP for the majority of the day of the transfer.

E. Concurrent Care

Definition/Required elements of service:

Concurrent care is any routine assessment rendered in hospital by the consultant following the consultant's first major assessment of the patient when the family physician remains the *most responsible physician* but the latter requests continued directive care by the consultant.

Payment rule:

Claims for concurrent care are limited to 4 per week during the first week of concurrent care, and 2 claims per week thereafter. Services in excess of this limit are *not eligible for payment*.

F. Supportive Care

Definition:

Supportive care is any routine visit rendered in hospital by the family physician who is not actively treating the case where:

a. the patient is under the care of another physician;

b. the supportive care is rendered at the request of the patient or family;

and

c. the care is provided for purposes of liaison or reassurance.

Payment rule:

Claims for supportive care are limited to 4 per week during the first week of supportive care, determined from the date of the first supportive visit, and 2 claims per week thereafter. Services in excess of this limit are not eligible for payment.

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

LONG-TERM CARE INSTITUTION: NON-EMERGENCY IN-PATIENT SERVICES ("W" PREFIX SERVICES)

These services apply to patients in chronic care hospitals, convalescent hospitals, nursing homes, homes for the aged and designated chronic or convalescent care beds in hospitals other than patients in designated palliative care beds - “W” prefix services.

A. Admission Assessment

Type 1 Admission Assessment

Definition/Required elements of service:

A Type 1 admission assessment is a general assessment rendered to a patient on admission.

Payment rule:

If the physician has rendered a consultation, general assessment, or general re-assessment of the patient prior to admission, the amount payable for the service will be adjusted to a lesser fee.

Type 2 Admission Assessment

Definition/Required elements of service:

A Type 2 admission assessment occurs when the admitting physician makes an initial visit to assess the condition of the patient following admission and has previously rendered a consultation, general assessment or general re-assessment of the patient prior to admission.

Type 3 Admission Assessment

Definition/Required elements of service:

A Type 3 admission assessment is a general re-assessment of a patient who is re-admitted to the long-term care institution after a minimum 3 day stay in another institution.

B. Subsequent Visit

Definition:

A subsequent visit is any routine assessment following the patient’s admission to a long-term care institution.

Payment rule:

Claims for these subsequent visits are subject to the limits described with each individual service as found under the applicable specialty in the Consultations and Visits section.

Claims submission instructions:

1. Submit claims for acute intercurrent illnesses requiring visits other than special visits using W121. When acute intercurrent illness requires a special visit, submit claims using the appropriate fees under General Listings (“A” prefix) and premiums.

   [Commentary:
   Claims for W121 are payable for visits for acute intercurrent illness whenever rendered. Such claims are not dependent on whether the monthly limit on the number of subsequent visits has been reached.]

2. When a physician is already in the institution and is asked to assess one of his/her own in-patients, the subsequent visit listings (“W” prefix) apply. However, if he/she is already in the institution and asked to assess another physician’s patient on an emergency basis, submit claims using the General Listings (“A” prefix).

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

EMERGENCY DEPARTMENT - "H" PREFIX EMERGENCY DEPARTMENT SERVICES

There are specific "H" prefix listings (H1 – codes) for consultations, multiple systems assessments, minor assessments, comprehensive assessment and care and re-assessments rendered by the physician on duty. With the exception of the consultation fee (where a specific fee code exists for a specialist in emergency medicine), any physician on duty (regardless of specialty) in the emergency department must submit using these listings.

The "H" prefix listings under the heading, "Emergency Department – Physician on Duty" on pages A9, A10 in the Consultations and Visits section of the *Schedule*, apply in the following circumstances:

a. when full- or part-time emergency physicians are continuously present in the emergency department or its environs for a pre-arranged designated period of time or shift;

b. to the services rendered by physicians who provide on-call emergency department coverage for designated periods of time, and limit the services they provide in the community served by the hospital predominantly to emergency department coverage;

or

c. for services rendered by an on-call physician where the service does not qualify for claiming a special visit premium.

[Commentary:

1. Examples where the service would not qualify for a special visit premium include:

a. the limit of 10 special visit premiums during the same special visit has been exceeded;

or

b. the service was provided to a patient who arrived in the emergency department after those patients responsible for the special visit were examined and the physician was still in the hospital or environs.

2. Refer to GP47 to GP52 for further information.]

PALLIATIVE CARE ASSESSMENT

Definition: A palliative care assessment is any routine assessment rendered by the *most responsible physician* for the purpose of providing *palliative care* to a patient other than one in a designated palliative care bed at the time the assessment was rendered.

Claims submission instruction:

Submit claims for palliative care visits, other than those in designated palliative care beds, using the appropriate "C" or "W" prefix palliative care fee schedule codes.

[Commentary:

1. Palliative care visits to patients in designated palliative care beds, regardless of facility type, are to be claimed using C882 or C982, as applicable.

2. Services rendered to patients whose unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death do not constitute palliative care assessments.]

MONTHLY MANAGEMENT OF A NURSING HOME OR HOME FOR THE AGED PATIENT

Definition/Required Elements of Service:

Monthly Management of a Nursing Home or Home for the Aged Patient is the provision by the most responsible physician (MRP) of routine medical care, management and supervision of a patient in a nursing home or home for the aged for one calendar month. The service requires a minimum of two "W" prefix assessments of the patient each month.

The requirements above are subject to the exceptions as described in payment rule #8.

> **[Commentary:**
> As with all services described as assessments, direct physical encounter with the patient is required.]

In addition to the common elements, this service includes the provision of the following services by any physician to the same patient during the month.

A. Services described by subsequent visits (e.g. W003, W008).

B. Services described by additional visits due to “intercurrent illness” (W121) except if the conditions described in Payment rule #7 below are satisfied.

C. Services described by palliative care subsequent visits (e.g. W872).

D. Services described by admission assessments (e.g. W102, W104, W107).

E. Services described by pre-dental/pre-operative assessments (e.g. W903).

F. Services described by annual health/annual physical examinations or general re-assessments (e.g. W109, W004).

G. Services described by Visit for Pronouncement of Death (W777) or Certification of Death (W771) except if the services are performed in conjunction with a special visit.

H. Service described by anticoagulation supervision (G271).

I. Completion of CCAC application and home care supervision (K070, K071, K072).

J. Services described by the following diagnostic and therapeutic procedures – venipuncture (G489), injection (G372, G373), immunization (G538, G539, G590, G591), Pap smear (G365, G394, E430), intravenous (G379), and laboratory test codes (G001, G002, G481, G003, G004, G005, G006, G007, G008, G009, G010, G011, G012, G014).

K. All medication reviews.

L. All discussions with the staff of the institution related to the patient’s care.

M. All telephone calls from the staff of the institution, patient, patient’s relative(s) or patient’s representative in respect of the patient between the hours of 0700 hours and 1700 hours Monday to Friday (excluding holidays).

N. Ontario Drug Benefit Limited Use prescriptions/forms or Section 8 *Ontario Drug Benefits Act* requests.

GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Payment rules:

1. Except as outlined in payment rule #8, this service is *only eligible for payment* once per patient per calendar month.

2. This service is *only eligible for payment* to the MRP.

3. When W010 is rendered, none of the services listed as a component of W010 and rendered to the patient by any physician during the month are eligible for payment.

4. In the temporary absence of the patient's MRP (e.g. while that physician is on vacation), W010 remains payable to the patient's MRP if the service is performed by another physician.

5. In the event the MRP renders one "W" prefix assessment in a calendar month and the same physician has rendered W010 to that patient within the previous 11-month period, only that "W" prefix assessment in that month is eligible for payment.

6. In the event the MRP renders two, three or four "W" prefix assessments in a calendar month and the same physician has rendered W010 to that patient within the previous 11-month period, only W010 is eligible for payment.

7. In the event the MRP renders more than four "W" prefix assessments to the same patient in a month and the same physician has rendered W010 to that patient within the previous 11-month period, any subsequent visits for intercurrent illness rendered by the MRP to the same patient in excess of four in a month are payable as W121 in addition to payment of W010.

8. Despite the definition set out above, the requirements of W010 are met when less than two "W" prefix assessments were rendered during the month and/or when the patient was not in the institution for a full calendar month if:

   a. a patient was newly admitted to the institution and an admission assessment was rendered,

   or

   b. in the event of the death of a patient while in the institution or within 48 hours of transfer to hospital.

9. Age related premiums otherwise applicable to any component service of W010 are *not eligible for payment* in addition to W010.

Claims submission instructions:

1. Except in the circumstances described in payment rule #8, submit at the end of the month.

2. The admission date of the patient must be provided on the claim for W010 or the service is *not eligible for payment.*

3. Submit claims for W121 which meet the requirements outlined in payment rule #7 using the manual review indicator.

[Commentary:
Examples of services not included in the Monthly Management fee include:

a. visits which qualify for a special visit premium.

b. services described under interviews, psychotherapy or counselling with the patient, patient's relative(s) or patient's representative lasting 20 or more minutes and where all other criteria for these services are met.

c. services rendered by a specialist who is not the MRP or who is not replacing an absent MRP.]

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

Psychotherapy, Hypnotherapy and all forms of Counselling, Primary Mental Health, and Psychiatric Care rendered by telephone, other electronic communications or in the physical absence of the patient (or patient's relative or patient representative as the case may be) are not insured services unless otherwise specifically listed in the *Schedule*.

SPECIFIC ELEMENTS

In addition to the common elements, all Psychotherapy, Hypnotherapy, Counselling, Primary Mental Health, and Psychiatric Care include the following specific elements.

A. Performing the appropriate therapy or interaction (described below) with the patient(s) or, in the case of K014, K015, and H313, the patient's relative(s) or *patient's representative(s*), which may include the appropriate inquires (including obtaining a patient history, and a brief physical examination) carried out in order to arrive at an opinion as to the nature of the patient's condition (whether such inquiry takes place before, during or after the encounter during which the therapy or other interaction takes place); any appropriate procedure(s), related service(s), and/or follow-up care.

B. Performing any procedure(s) during the same encounter as the therapy or other interaction unless the procedure(s) is(are) separately listed in the *Schedule* and an amount is payable for the procedure in conjunction with the therapy or interaction.

C. Making arrangements for any related assessments, procedures, or therapy.

D. Making arrangements for follow-up care.

E. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative(s)*, whether by telephone or otherwise, on matters related to:

a. the service;

and

b. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

F. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is rendered.

G. Providing premises, equipment, supplies, and personnel for the specific elements of the service.

While no occasion may arise for performing elements B, C, D and F, when performed in connection with the other specific elements they are included in the service.

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

Payment rules:

1. These services are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient's relative or patient's representative as the case may be) and the physician in person is as follows:

# Units	Minimum time with patient
1 unit:	20 minutes
2 units:	46 minutes
3 units:	76 minutes [1h 16m]
4 units:	106 minutes [1h 46m]
5 units:	136 minutes [2h 16m]
6 units:	166 minutes [2h 46m]
7 units:	196 minutes [3h 16m]
8 units:	226 minutes [3h 46m]

2. Except for in-patient individual psychotherapy by a psychiatrist or in-patient individual psychiatric care for which the time can be consecutive or non-consecutive, for all other services in this section the time units must be calculated based upon consecutive time spent rendering the service.

3. Psychotherapy performed outside a hospital, psychiatric care, primary mental health care, or hypnotherapy rendered the same day as a consultation or other assessment by the same physician to the same patient is *not eligible for payment* unless there are clearly defined different diagnoses for the two services.

   [Commentary:
   Except as noted in payment rule #2 (where non-consecutive services can be cumulated), services less than 20 minutes do not constitute any of the services defined in this section and constitute the type of assessment rendered in the circumstances.]

PSYCHOTHERAPY/FAMILY PSYCHOTHERAPY

Definition:

Psychotherapy is any form of treatment for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where a physician deliberately establishes a professional relationship with a patient with the purpose of removing, modifying or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development.

Family psychotherapy is psychotherapy rendered to the patient in the presence of one or more members of the patient's household.

Payment rules:

1. Psychotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.

2. Subsequent visits rendered by the same psychiatrist to the same patient on the same day as in-patient individual psychotherapy are *not eligible for payment*.

PSYCHIATRIC CARE/FAMILY PSYCHIATRIC CARE/PRIMARY MENTAL HEALTH CARE

Definition:

Psychiatric care/family psychiatric care/primary mental health care are services encompassing any combination or form of assessment and treatment by a physician for mental illness, behavioural maladaptations, and/or other problems that are assumed to be of an emotional nature, where there is consideration of the patient's biological and psychosocial functioning.

Family psychiatric care is psychiatric care of the patient carried out by the physician in the presence of one or more family members or in the presence of professional caregivers not on staff at the facility where the patient is receiving the care.

Payment rule:

Subsequent visits rendered by the same psychiatrist to the same patient on the same day as individual in-patient psychiatric care are *not eligible for payment*.

GENERAL PREAMBLE

PSYCHOTHERAPY, PSYCHIATRIC AND COUNSELLING SERVICES

HYPNOTHERAPY

Definition:

Hypnotherapy is a form of treatment that has the same goals as psychotherapy but is rendered with the patient under hypnosis.

Payment rule:

Hypnotherapy is *not eligible for payment* when rendered on the same day to the same patient by the same physician as obstetrical delivery.

COUNSELLING

Definition/Required elements of service:

Counselling is a patient visit dedicated solely to an educational dialogue with a physician. This service is rendered for the purpose of developing awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention.

[Commentary:

1. Advice given to a patient that would ordinarily constitute part of a consultation, assessment, or other treatment, is included as a common or constituent element of the other service, and does not constitute counselling.

2. Detention time may be payable following a consultation or assessment when a physician is required to spend considerable extra time in treatment or monitoring of the patient. See GP25 for further information.]

Payment rules:

1. With the exception of the codes listed in the table below, no other services are eligible for payment when rendered by the same physician the same day as any type of counselling service.

E080	G010	G202	G205	G365	G372	G384	G385	G394	G462	G480	G482
G489	G538	G590	H313	K002	K003	K008	K014	K015	K031	K035	K036
K038											

2. Individual and group counselling services are limited to 3 units per patient per physician per year at the higher fee (K013 or K040 respectively); the amount payable for services rendered in excess of this limit will be adjusted to a lesser fee (K033 or K041 respectively).

3. If the patient does not have a pre-booked appointment, the amount payable for this service will be adjusted to a lesser assessment fee.

A. Individual Counselling

Definition:

Individual counselling is counselling rendered to a single patient.

B. Group Counselling

Definition:

Group Counselling is counselling rendered to two or more patients with a similar medical condition or situation.

Payment rule:

In addition to meeting the usual medical record requirements for the service, the physician must also maintain a separate record (independent of the patient's medical record) of the names and health numbers of all persons in attendance at each group counselling session or the service is *not eligible for payment*.

Claims submission instruction:

The claim must be submitted under the health number of the group member for whom, when the service was rendered, the largest number of counselling units had previously been claimed by the physician during the year in which the service is rendered.

C. Transplant Counselling

Definition/Required elements of service:

Transplant counselling is payable in circumstances where transplant or donation is imminent, for the purpose of providing the recipient, donor or family member with adequate information and clinical data to enable that person to make an informed decision regarding organ transplantation.

Claims submission instruction:

The claim must be submitted under the health number of the recipient or donor.

D. Counselling of Relatives on Behalf of a Catastrophically or Terminally Ill Patient

Definition:

Counselling of relatives on behalf of a catastrophically or terminally ill patient is counselling rendered to a relative or relatives or representative of a catastrophically or terminally ill patient, for the purpose of developing an awareness of modalities for treatment of the patient and/or his or her prognosis.

Claims submission instruction:

The claim must be submitted under the health number of the patient who is catastrophically or terminally ill.

E. Rehabilitation Counselling

Definition:

Rehabilitation counselling is counselling rendered for the purpose of developing an awareness of the modalities for treatment of the patient and/or his or her prognosis.

GENERAL PREAMBLE

INTERVIEWS

SPECIFIC ELEMENTS

In addition to the common elements, all services described as interviews include the following specific elements.

A. Obtaining information from, engaging in discussion with, and providing advice and information to interviewee(s) on matters related to the patient's condition and care.

B. Providing premises, equipment, supplies and personnel for the specific elements of the service.

Payment rules:

1. These services are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient's relative or *patient's representative* as the case may be) and the physician in person is as follows:

# Units	Minimum time
1 unit:	20 minutes
2 units:	46 minutes
3 units:	76 minutes [1h 16m]
4 units:	106 minutes [1h 46m]
5 units:	136 minutes [2h 16m]
6 units:	166 minutes [2h 46m]
7 units:	196 minutes [3h 16m]
8 units:	226 minutes [3h 46m]

[Commentary:

1. Services less than 20 minutes in duration do not constitute any of the services defined in this section and constitute the type of assessment rendered in the circumstances.

2. Inquiry, discussion or provision of advice or information to a patient, patient's relative or representative that would ordinarily constitute part of a consultation, assessment (including those services which are defined in terms of an assessment) is included as a common or constituent element of the other service, and does not constitute an interview.]

2. If an appointment for the interview is not separately booked, the amount payable for this service will be adjusted to a lesser fee.

3. All services described as interviews must be rendered personally by the attending physician or they become uninsured services.

GENERAL PREAMBLE

DELEGATED PROCEDURE

Definition:

The term "procedure" as it is used in this section does not include services such as assessments, consultations, psychotherapy, counselling etc.

Payment rules:

1. Where a procedure is performed by a physician's employee(s) in the physician's office, the service remains insured using the existing fee codes if all the following requirements are met:

   a. the procedure is one which is generally and historically accepted as a procedure which may be carried out by the nurse or other medical assistant in the employ of the physician;

   and

   b. subject to the exceptions set out below, at all times during the procedure, the physician (although he or she may be otherwise occupied), is:

      i. physically present in the office or clinic at which the service is rendered in order to ensure that procedures are being performed competently;

      and

      ii. available immediately to approve, modify or otherwise intervene in a procedure, as required, in the best interests of the patient.

2. Exceptions to the requirement for physician presence during the delegated procedure.
   [Commentary:
   Some procedures may not require the physical presence of a physician for direct supervision. These exceptions to the physical presence of a physician requirement for direct supervision may be made upon recommendations of the *OMA* and the CPSO.]

   Where all of the following conditions are met, the simple office procedures listed in the table below remain insured despite the physician not being physically present:

   a. the non-physician performing the procedure is properly trained to perform the procedure, he/she reports to the physician, and the procedure is rendered in accordance with accepted professional standards and practice;

   b. the procedure is performed only on the physician's own patient, as evidenced by either an ongoing physician/patient relationship or a consultation/assessment rendered by the physician to the patient on the same day as the procedure is performed; and

   c. the same record-keeping requirements must be met as if the physician personally had rendered the service. The record must be dated, identify the non-physician performing the service, and contain a brief note on the procedure performed by the non-physician.

Claims submission instruction:

A locum tenens replacing an absent physician in the absent physician's office may submit claims for delegated procedures under either his/her own billing number or the billing number of the physician he/she is replacing.

GENERAL PREAMBLE

DELEGATED PROCEDURE

COMMON PROCEDURAL DESCRIPTION	APPLICABLE FEE CODES	CURRENT PAGE #
Venipuncture	G480, G482, G489	J7
Injections and immunizations	G372, G373, G538, G590, G591	J33, J34
Ultraviolet light therapy	G470	J22
Administration of oral polio vaccine	G462	J34
Simple office laboratory procedures	G001, G002-G012, G014, G481	J42
Ear syringing, curetting or debridement	G420	J55
B.C.G. inoculation	G369	J33
Simple Spirometry and Flow Volume Loop	J301, J324, J304, J327	H3
Casts	Z198-Z209, Z211, Z213, Z216, Z873	N4
Major Debridement and Dressing	Z153	M7

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

Definition/Required elements of service:

A special visit is a service initiated by a patient or an individual on behalf of a patient. Subject to the conditions outlined below, the special visit premium is payable when a physician is required to travel from one location to either:

a. another location in response to a non-elective call;

b. a patient's home as an elective visit regardless of time of visit - claim may be submitted using B990;

or

c. a patient's home either as an elective or non-elective visit if the visit is for the purpose of providing palliative care for visits Monday to Sunday (07:00h - 24:00h) - claim may be submitted using B998. For palliative care visits during nights (00:00h to 07:00h) - claim may be submitted using B996.

Payment rules:

1. Special visit premiums are *only eligible for payment* when rendered with certain services listed under "Consultations and Visits" and "Diagnostic and Therapeutic Procedures".

2. A special visit premium is *not eligible for payment* in the following circumstances:

a. for patients seen during rounds at a hospital or long-term care institutions;

b. in conjunction with admission assessments of patients who have been admitted to hospital on an elective basis;

c. for non-referred or transferred obstetrical patients except, in the case of transferred obstetrical patients for a special visit for obstetrical delivery with sacrifice of office hours for the first patient seen (C989);

d. when the physician travels from one location to another within the same hospital or long-term care institution;

e. for services rendered in a place, other than a hospital or long-term care facility, that is open for the purpose of diagnosing or treating patients;

f. for a visit for which critical care team fees are payable under this *Schedule*, regardless of the time at which the service is performed.

[Commentary:
Special visit premiums are not payable for services rendered to patients who present to the office without an appointment while the physician is there or for patients seen during routine or ordinary office hours even if held at night or on weekends or holidays.]

SACRIFICE OF OFFICE HOURS PREMIUM

Definition/Required elements of service:

This premium is payable when a special visit is rendered requiring sacrifice of office hours as the demands of the patient and/or the patient's condition are such that the physician makes an immediate, previously unscheduled emergency visit to the patient at a time when the physician had an office visit booked with one or more patients but, because of the special visit, any such office visit was delayed or cancelled.

GENERAL PREAMBLE

ADDITIONAL PATIENT PREMIUM

Definition:

An additional patient premium is only eligible for payment for services rendered to additional patients seen in emergency departments, outpatient departments, or to hospital inpatients, provided that each additional patient is seen in circumstances that would otherwise satisfy all the requirements for a special visit premium with the exception of the requirement for travel from one location to another and subject to the specific limits outlined below.

> **[Commentary:**
> No additional special visit premium is payable for services rendered to additional patients seen in locations other than emergency departments, outpatient departments, or to hospital inpatients.]

Payment rule:

With the exception of services outlined below rendered by Emergency Physicians, special visit premiums are limited to ten (one first patient premium and 9 additional patient premiums) during the same special visit to an emergency or outpatient department, and three (one first patient premium and 2 additional patient premiums) during the same special visit to hospital inpatients.

LIMITS FOR EMERGENCY PHYSICIANS

In addition to the general restrictions regarding special visits as outlined in this section, there are specific restrictions which apply to special visit premiums for services rendered in the emergency department by:

a. Full or part-time emergency physicians;

or

b. Physicians who render on-call emergency department coverage for designated periods of time, and limit the services they provide in the community served by the hospital, predominantly to emergency department coverage.

Payment rules:

1. When special visits are rendered by full or part-time emergency physicians when they are not on duty to the emergency department, a special visit premium is payable only for the first patient seen (first patient special visit premium). Additional patient premiums are *not eligible for payment*. Submit claims for all subsequent patients assessed during this visit to the emergency department using the “H” prefix listings.

2. When special visits are rendered by physicians who render on-call emergency department coverage for designated periods of time, and limit the services they provide in the community served by the hospital, predominantly to emergency department coverage, a special visit premium is payable only for the first patient seen (first patient special visit premium). Additional patient premiums are *not eligible for payment*. Special visit premiums for the first patient seen are further limited to:

   a. two for insured services rendered between 07:00h and 17:00h;

   and

   b. three for insured services rendered between 17:00h and 24:00h

   Submit claims for all subsequent patients assessed during this visit to the emergency department using the “H” prefix listings.

   [Commentary:
   There is no limit on first patient special visit premiums for patients seen between 24:00h and 7:00h.]

RESTRICTION BASED ON VOLUME OF SPECIAL VISITS

Payment rule:

Despite any other provisions of this *Schedule*, if the total amount that would otherwise be payable for all insured services (including special visit premiums) rendered by a physician (other than a physician whose practice consists primarily of palliative care services or psychogeriatric services) during all special visits made to patients' homes or equivalents and long-term care institutions in any calendar month is more than 20% of the total amount that would otherwise be payable for all insured services rendered by that physician in that month, then special visit premiums are not eligible for payment in respect of any special visit made that month to a patient's home or equivalent or to a long-term care institution and the service that would otherwise constitute the assessment component of the visit is instead:

B910	If the service was rendered between 07:00h and 24:00h, Monday through Friday inclusive for the first patient seen .	45.10
B914	If the special visit was made between 07:00h and 24:00h, on Saturdays, Sundays, and Holidays, for the first patient seen	50.50
B916	If the special visit was made between 24:00h and 07:00h any night of the week, for the first patient seen	54.15

Claims submission instruction:

Claims for additional patients seen during the same visit in these circumstances are to be submitted using the appropriate assessment fee from the "General Listings".

SPECIAL VISIT PREMIUMS – FEE CODES AND VALUES

A. Special Visit to Hospital Emergency Department

K990	Daytime (07:00h -17:00h) Monday to Friday - first patient seen	18.20
K991	- additional patients requiring a special visit and seen during the same special visit, add 30% to consultation or visit fees to a maximum premium per patient of 18.20 with a minimum premium per patient	10.35
K992	Emergency call with sacrifice of office hours - first patient seen	36.30
K993	- additional patients requiring a special visit and seen during the same special visit, add 30% to consultation or visit fees to a maximum premium per patient of 36.30 with a minimum premium per patient	15.55
K994	Evenings (17:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - first patient seen	54.55
K995	- additional patients requiring a special visit and seen during the same special visit, add 50% to consultation or visit fees to a maximum premium per patient of 54.55 with a minimum premium per patient	27.30
K996	Nights (00:00h - 07:00h) - first patient seen.	81.85
K997	- additional patients requiring a special visit and seen during the same special visit, add 75% to consultation or visit fees to a maximum premium per patient of 81.85 with a minimum premium per patient	40.95

B. Special Visit to Hospital Out-Patient Department

U990	Daytime (07:00h -17:00h) Monday to Friday - first patient seen	18.20
U991	- additional patients requiring a special visit and seen during the same special visit, add 30% to consultation or visit fees to a maximum premium per patient of 18.20 with a minimum premium per patient	10.35
U992	Emergency call with sacrifice of office hours - first patient seen	36.30
U993	- additional patients requiring a special visit and seen during the same special visit, add 30% to consultation or visit fees to a maximum premium per patient of 36.30 with a minimum premium per patient	15.55
U994	Evenings (17:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, or Holidays - first patient seen	54.55
U995	- additional patients requiring a special visit and seen during the same special visit, add 50% to consultation or visit fees to a maximum premium per patient of 54.55 with a minimum premium per patient	27.30
U996	Nights (00:00h - 07:00h) - first patient seen.	81.85
U997	- additional patients requiring a special visit and seen during the same special visit, add 75% to consultation or visit fees to a maximum premium per patient of 81.85 with a minimum premium per patient	40.95

C. Special Visit to Hospital In-patient

C990	Daytime (07:00h - 17:00h) Monday to Friday - first patient seen	18.20
C991	- additional patients requiring a special visit and seen during the same special visit, add 30% to consultation or visit fees to a maximum premium per patient of 18.20 with a minimum premium per patient	10.35
C992	Emergency call with sacrifice of office hours - first patient seen	36.30
C993	- additional patients requiring a special visit and seen during the same special visit, add 30% to consultation or visit fees to a maximum premium per patient of 36.30 with a minimum premium per patient	15.55
C994	Evenings (17:00h - 24:00h) Monday to Friday or daytime and evenings on Saturday, Sundays or Holidays - first patient seen	54.55
C995	- additional patients requiring a special visit and seen during the same special visit, add 50% to consultation or visit fees to a maximum premium per patient of 54.55 with a minimum premium per patient	27.30
C996	Nights (00:00h - 07:00h) - first patient seen.	81.85
C997	- additional patients requiring a special visit and seen during the same special visit, add 75% to consultation or visit fees to a maximum premium per patient of 81.85 with a minimum premium per patient	40.95

D. Special Visit to Patient's Home or a Multiple Resident Dwelling

Payable only for first patient seen, regardless of number of patients seen during one visit to a home or to one or more living units in a multiple resident dwelling. A multiple resident dwelling is a single location that shares a common external building entrance or lobby e.g. Apartment block, rest or retirement home, commercial hotel, motel or boarding house, university or boarding school residence, hostel, correctional facility or group home. First patient seen:

B990	Elective visit, regardless of time or day of week	20.90
B990	Daytime (07:00h - 17:00h) Monday to Friday, non-elective	20.90
B992	Emergency call with sacrifice of office hours	41.75
B994	Evenings (17:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays, non-elective	63.80
B996	Nights (00:00h - 07:00h), non-elective	95.80
B998	Special visit for the purpose of providing palliative care, elective or non-elective visit - Monday to Sunday (07:00h - 24:00h), first patient seen for palliative care.	63.80

E. Special Visit to Long-Term Care Institution

First patient seen, regardless of how many patients seen at the same location. No "additional patient" premium payable.

W990	Daytime (07:00h - 17:00h) Monday to Friday.	18.20
W992	Emergency call with sacrifice of office hours	36.30
W994	Evenings (17:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays.	54.55
W996	Nights (00:00h - 07:00h)	81.85

F. Special Visit to Office or Other Similar Facility

First patient seen, regardless of how many patients seen at the same location. No "additional patient" premium payable.

A990	Daytime (07:00h - 17:00h) Monday to Friday.	18.20
A994	Evenings (17:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays.	54.55
A996	Nights (00:00h - 07:00h)	81.85

G. Special Visit to any non-professional setting not listed above

First patient seen, regardless of how many patients seen at the same location. No "additional patient" premium payable.

Q990	Daytime (07:00h - 17:00h) Monday to Friday.	18.20
Q992	Emergency call with sacrifice of office hours	36.30
Q994	Evenings (17:00h - 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays.	54.55
Q996	Nights (00:00h - 07:00h)	81.85

GENERAL PREAMBLE

SPECIAL VISIT PREMIUMS

Location of Special Visit	Weekdays Daytime (07:00 to 17:00)	Sacrifice of Office Hours	Evenings (17:00 – 24:00) and Sat., Sun. and Holidays	Nights (24:00-07:00)
		Fee Codes		
Office - first patient seen	A990		A994	A996
Hospital In-patient - first patient seen - additional patient	C990 C991	C992 C993	C994 C995	C996 C997
Emergency Dept. - first patient seen - additional patient	K990 K991	K992 K993	K994 K995	K996 K997
Other (Non-professional setting not listed) - first patient seen	Q990	Q992	Q994	Q996
Hospital Out-patient - first patient seen - additional patient	U990 U991	U992 U993	U994 U995	U996 U997
LTC Institution - first patient seen	W990	W992	W994	W996
Special Visits to Patient's Home - first patient seen Elective Non-elective Palliative care	 B990 B990 B998	 B990 B992 B998	 B990 B994 B998	 B990 B996 B996

SPECIAL VISIT FOR OBSTETRICAL DELIVERY WITH SACRIFICE OF OFFICE HOURS

C989 First patient seen, limited to one per calendar day 36.30

TEAM CARE IN TEACHING UNITS

[Commentary:
Joint recommendations made by the *CPSO* and the *OMA* governing the charging of fees for services rendered by interns and residents in clinical teaching units were accepted by the *MOHLTC* on the understanding that the *CPSO* and medical schools ensure adherence to the rules governing these billing procedures. These recommendations were that the staff physician may make a claim to *OHIP* for services rendered by his/her intern or resident if the following requirements are met:

1. the responsible staff physician must be present in the clinical teaching unit at the time the services are rendered and must be identified to the patient at the earliest possible moment;
2. no fees are to be charged for services given by the intern or resident prior to his identification taking place;
3. when patient care is rendered in a clinical teaching unit or other setting for clinical teaching by a health care team, the physician responsible must be personally identified to the patient. The physician's relationship to the team must be defined by the clinical teaching unit director and his/her role must be known to the patient and other members of the team.]

Payment rules:

Where a service is rendered by an intern or resident in a clinical teaching unit or setting ("teaching service"), there is no amount payable to the intern or resident for the service. A service rendered by an intern or resident may be payable to the responsible staff physician where that physician assumes full responsibility for the appropriateness and the quality of the teaching service and the teaching service is rendered under the following circumstances:

1. Where the teaching service is a physical procedure, the responsible staff physician is, at the time of the procedure, physically located in the clinical teaching unit, and immediately available to intervene.

2. Where the teaching service is psychotherapy (and the presence of the responsible staff physician would distort the psychotherapy milieu) and that physician carefully reviews the record of the session with the intern or resident and thus supervises the psychotherapy. The number of time units payable is calculated as the lesser of:

   a. the time spent by the responsible staff physician in discussion with the intern or resident;

   or

   b. the time spent by the staff physician directly supervising the interview between the intern or resident and the patient.

   The maximum number of time units payable to the responsible staff physician for such psychotherapy is the number of time units spent by the intern or resident with the patient.

   [Commentary:
   The service date to be used is the date the intern or resident saw the patient.]

3. In other circumstances, an amount may be payable to the responsible staff physician for services provided by interns or residents on those days when the responsible staff physician actually supervises the patient's care as evidenced by the presence of that physician in the clinical teaching unit on that day. This involves a physical visit to the patient and/or a chart review and detailed discussion between the responsible staff physician and the other member(s) of the health team.

4. In those situations where the responsible staff physician may supervise concurrently multiple procedures or services through the use of other members of the team, the total claims submitted by the responsible staff physician must not exceed the amount that staff physician might claim in the absence of the other members of the team.

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

SPECIFIC ELEMENTS

In addition to the common elements, assistance at surgery includes the following specific elements.

A. Preparing or supervising the preparation of the patient for the procedure.

B. Performing the procedure by any method, or assisting another physician in the performance of the procedure(s), assisting with the carrying out of all recovery room procedures and the transfer of the patient to the recovery room, and any ongoing monitoring and detention rendered during the immediate post-operative and recovery period, when indicated.

C. Making arrangements for any related assessments, procedures, or therapy, (including obtaining any specimens from the patient) and/or interpreting results.

D. When medically indicated, monitoring the condition of the patient for post-procedure follow-up until the first post-operative visit.

E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the *patient's representative(s)*, whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies, and personnel for services identified with prefix # for any aspect(s) of A, C, D, and E that is (are) performed in a place other than the place in which the surgical procedure is performed.

While no occasion may arise for performing elements A, C, D or E, when performed in connection with the specific elements of a service, these are included in the service.

CALCULATION OF FEE PAYABLE: BASIC UNITS AND TIME UNITS

Except where "nil" is listed opposite the service in the column headed with "Asst", the amount payable for the surgical assistant service is calculated by adding together the number of basic and time units and multiplying that total by the unit fee.

Assistant Unit Fee $11.40

Basic Units: The number of basic units is the number of units listed opposite the service in the column headed with "Asst", except

a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units is that listed in the column headed with "Asst" opposite the service that describes the major procedure;

or

b. where no basic unit is listed opposite the service in the column headed with "Asst" and where "nil" is not listed opposite the service in the column headed with "Asst", the number of basic units is that listed opposite the service under the column headed with "Anae". This type of service is *only eligible for payment* upon authorization by a medical consultant following submission of a letter from the surgeon outlining the reason the assistant was required. Submit claims for this type of service using fee code M400B.

Where "nil" is listed opposite the service in the column headed with "Asst", the assistant's service is *not eligible for payment*.

Time Units: For the purpose of calculating time units, time is determined per operation as the total of the following, excluding any time spent waiting between surgical procedures:

a. time spent by the physician in direct contact with the patient in the operating room prior to scrub time to assist with patient preparation;

and

b. time spent by the physician assisting at the patient's surgery starting with scrub time and ending when the physician is no longer required to be in attendance with that patient.

Time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour or less	1 unit
After the first hour	2 units

Claims submission instruction:

Submit claims for assisting at surgery using the suffix "B", with the procedural code.

[Commentary:
See Appendix H for a table stating the duration of surgical assisting and corresponding time units.]

AFTER HOURS PREMIUMS

These premiums are payable when a case commences:

E400B	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays - increase the total assistant's fee by	50%
E401B	Nights (00:00h – 07:00h) - increase the total assistant's fee by.	75%

SPECIAL VISIT PREMIUMS

C988B	Special visit premium to assist at non-elective surgery with sacrifice of office hours - first patient seen per physician per day, maximum one per day	36.30

Payment rule:

C988B is *not eligible for payment* in respect of any special visits to assist at surgery in a calendar month if the amount payable for services rendered by the physician in that month for all surgical assistant's fees (including special visit premiums associated with performing surgical assistant services) is greater than 20% of the total amount payable for all insured services rendered by that physician in that month.

These special visit premiums are payable only for the first patient seen on each special visit (regardless of how many patients are seen during the same visit to the hospital).

C998B	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays, first patient seen	54.55
C999B	Nights (00:00h – 07:00h), first patient seen	81.85

[Commentary:

1. The specific requirements for special visits are found on pages GP47 - GP52.

2. These premiums are payable in addition to the E400 and E401 premiums.]

GENERAL PREAMBLE

SURGICAL ASSISTANTS' SERVICES

CANCELLED SURGERY – ASSISTANT SERVICES

Payment rules:

1. If the procedure is cancelled prior to induction of anaesthesia, the service constitutes a subsequent hospital visit.

2. When an anaesthetic has begun but the operation is cancelled due to a complication prior to commencement of surgery and the assistant has scrubbed but is not required to do anything further, the service is payable as E006B with the actual number of time units added to 6 basic units for this service.

   [Commentary:
   If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee listed at the start of this section.]

SECOND ASSISTANT

Payment rule:

When more than one assistant was required for a surgical procedure, unless the service is listed below, the second assistant's service is *only eligible for payment* following authorization by a *medical consultant* and requires submission of a letter from the surgeon outlining the reason the second assistant was required. The amount payable for the second assistant is calculated in the same manner as the amount payable for the first assistant.

Services where a second assistant's services are payable and authorization is not required:

M111	M117	M134	M142	P042	P051	P052	P056	P059	R008
R009	R013	R014	R015	R016	R055	R056	R067	R069	R134
R135	R136	R140	R182	R240	R241	R244	R296	R326	R327
R334	R393	R438	R440	R441	R464	R483	R487	R545	R553
R568	R593	R594	R617	R645	R701	R702	R711	R712	R713
R714	R715	R718	R726	R727	R728	R729	R733	R734	R735
R737	R738	R742	R743	R746	R747	R749	R764	R770	R771
R772	R785	R786	R799	R800	R801	R802	R803	R804	R811
R815	R817	R818	R830	R832	R858	R863	R870	R872	R874
R920	R927	R929	R930	S005	S007	S090	S091	S092	S096
S098	S099	S120	S125	S189	S213	S214	S267	S270	S271
S274	S275	S294	S295	S298	S300	S321	S416	S429	S440
S441	S453	S454	S462	S484	S750				

SURGICAL ASSISTANT STANDBY

Definition/Required elements of service:

E101B is a time-based service limited to one surgical case per physician per day payable for standby as a surgical assistant following a minimum of 30 minutes of unforeseen delay beyond the scheduled start time for surgery. The physician must be physically present in the operating room suite for the period between the scheduled and actual surgical start time.

Payment rules:

1. For calculation of time units, the start time for this service commences 30 minutes after the scheduled surgical start time and ends when the surgery actually commences as recorded in the hospital's operating suite records. There are no basic units.

2. E101B is *not eligible for payment* if during the standby time for which E101B would otherwise be eligible for payment, other insured services are rendered for which payment is made by *OHIP*.

   [Commentary:
   E101B is payable with after hours premiums.]

SPECIFIC ELEMENTS

In addition to the common elements, the general anaesthesia service includes the following specific elements.

A. Supervising the preparation of the patient for anaesthesia.

B. Performing the anaesthetic procedure, and procedures associated with the anaesthetic procedure which are not separately payable including providing all supportive measures to the patient during and immediately after the period of anaesthesia; transfer of or assisting with the transfer of the patient to the recovery room; all indicated recovery room procedures, and ongoing monitoring and detention during the immediate post-operative and recovery period.

C. Making arrangements for any assessments, procedures, or therapy, including obtaining any specimens (except for arterial puncture Z459), and/or interpreting the results, on matters related to the service.

D. Making, or supervising the making of, arrangements for follow-up care and when medically indicated, post-procedure monitoring of the patient's condition until the next insured service is provided.

E. Discussion with, and providing any advice and information, including prescribing therapy to the patient or the patient's representative(s), whether by telephone or otherwise, on matters related to the service.

F. Providing premises, equipment, supplies, and personnel for any aspect(s) of specific elements A, C, D, and E that is (are) performed in a place other than the place in which the general anaesthetic service is performed.

While no occasion may arise for performing elements C, D or E, when performed in connection with the other specific elements, they are included in the general anaesthetic service.

The general anaesthesia service includes:

a. a pre-anaesthetic evaluation, with specific elements as for assessments (see GP15);

b. the anaesthetic procedure;

and

c. post-anaesthetic follow-up.

Note:

1. With the exception of the listings in the "Consultations and Visits" section, all references to an anaesthesiologist in this *Schedule* are references to any physician providing anaesthetic services.

2. As per the definitions section (see GP2), general anaesthesia, for the purposes of this *Schedule*, includes all forms of anaesthesia except local infiltration.

CALCULATION OF FEE PAYABLE – BASIC AND TIME UNITS

The amount payable for the anaesthesia service is calculated by adding the number of basic and time units and multiplying the total by the anaesthesiologist unit fee.

Anaesthesiologist Unit fee. 13.24

Basic Units: The number of basic units is the number of basic units listed opposite the service in the column headed with "Anae" except,

a. where multiple or bilateral surgical procedures are performed during the same anaesthetic, the number of basic units listed in the column headed with "Anae" opposite the service that describes the major procedure;

or

b. where the basic units are listed as IC, or where no basic units are listed, the amount payable is calculated by adding the appropriate time units to the basic units listed for a comparable procedure (taking into account the region, modifying conditions, or techniques).

Time Units: Time units are calculated on the basis of time spent by the anaesthesiologist and commence when the anaesthesiologist is first in attendance with the patient in the OR for the purpose of initiating anaesthesia and end when the anaesthesiologist is no longer in attendance (when the patient may safely be placed under customary post-operative supervision). Time units are calculated for each 15 minutes or part thereof. The unit value of each 15 minute period or part thereof is:

During the first hour	1 unit
After the first hour up to and including the first 1.5 hours	2 units
After 1.5 hours	3 units

Claims submission instruction:

Submit claims for anaesthesia services rendered with a surgical procedure using the suffix "C", with the procedural code.

[Commentary:
see Appendix H for a table stating the duration of the anaesthesia service and corresponding time units.]

AFTER HOURS PREMIUMS

These premiums are payable when a case commences:

E400C	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays - increase the total anaesthetic fee by	50%
E401C	Nights (00:00h – 07:00h) - increase the total anaesthetic fee by	75%

SPECIAL VISIT PREMIUMS

These special visit premiums are payable only for the first patient seen on each special visit (regardless of how many patients are seen during the same visit to the hospital).

Anaesthesia special visit premiums are payable when an anaesthesiologist is required to make a special visit to the hospital to administer an anaesthetic for a case that commences:

C998C	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays or for non-elective surgery with sacrifice of office hours	54.55
C999C	Nights (00:00h – 07:00h)	81.85

[Commentary:

1. The specific requirements for special visits are found in pages GP47 to GP52.

2. These premiums are payable in addition to the E400 and E401 premiums.]

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

CANCELLED SURGERY - ANAESTHESIA SERVICES

Payment rules:

1. If an anaesthesiologist examines a patient prior to surgery and the surgery is cancelled prior to the induction of anaesthesia, the service rendered constitutes a hospital subsequent visit.

2. When an anaesthetic has begun but the operation is cancelled prior to commencement of surgery, the service constitutes E006C with the actual number of time units added to 6 basic units for this service.

[Commentary:
If the operation is cancelled after surgery has commenced, the amount payable is calculated by adding the listed procedural basic units plus time units and multiplying the total by the unit fee.]

SECOND ANAESTHESIOLOGIST

Unless otherwise specified in the *Schedule*, when the anaesthetic services of more than one anaesthesiologist are necessary in the interest of the patient, the service provided by the second anaesthesiologist constitutes E001C with the actual number of time units (based on the actual time assisting the first anaesthesiologist) added to 6 basic units.

REPLACEMENT ANAESTHESIOLOGIST

When one anaesthesiologist starts a procedure and is replaced by another anaesthesiologist during a surgical procedure or delivery:

a. the amount payable to the first anaesthesiologist is calculated by adding the listed procedural basic units plus time units for the time the first anaesthesiologist is in attendance;

b. except in the case of continuous conduction anaesthesia, the service provided by the replacement anaesthesiologist constitutes E005C based on the actual number of time units and no basic units. E005C qualifies for the premiums E400C or E401C only if the case commences after hours (see GP59). Each anaesthesiologist should state on his/her claim card which part of the anaesthetic is being claimed including his/her starting and finishing times.

[Commentary:

1. Each anaesthesiologist must indicate, as part of the medical record, his/her starting and finishing times.
2. For continuous conduction anaesthesia, the replacement anaesthesiologist submits claims using the applicable continuous conduction anaesthesia fee code.]

OBSTETRICS – CONTINUOUS CONDUCTION ANAESTHESIA

P014C, introduction of a catheter for anaesthesia, including the first dose, has a value of 6 basic units.

P015C time units for maintenance and/or supervision are calculated on the basis of 1 unit for each ½ hour of time to a maximum of 6 units.

P016C time units for maintenance of obstetrical epidural anaesthesia are calculated on the basis of 1 unit for each ½ hour of time to a maximum of 12 units.

Note:
P015 is *not eligible for payment* when rendered the same day to the same patient as P016.

E100C time units for attendance at delivery are calculated on the basis of 1 unit for each ¼ hour

[Commentary:

1. As these services fall under the definition of general anaesthesia, the specific elements for general anaesthesia apply to P014C, P015C, P016C and E100C.

2. For additional information on obstetrical anaesthesia services, see page K7 of the *Schedule*.]

EXTRA UNITS

Extra Units: An amount is payable for extra units in addition to basic units when an anaesthesiologist administers an anaesthetic to:

Fee code	Criteria	Number of extra units
E021C	premature newborn less than 37 weeks gestational age	9 units
E014C	newborn to 28 days	5 units
E009C	infant from 29 days to 1 year of age	4 units
E019C	infant or child from 1 year to 8 years of age inclusive	2 units
E007C	adult aged from 70 to 79 years, inclusive	1 unit
E018C	adult aged 80 years and older	3 units
E010C	patient with body mass index (BMI) > 45	2 units
E011C	patient in prone position during surgery	4 units
E012C	patient who is known to have malignant hyperthermia or there is a strong suspicion of susceptibility, and the anaesthetic requires full malignant hyperthermia set up and management	5 units
E004C	patient requiring controlled hypotension, when it is carried out in association with anaesthesia using any technique to deliberately lower and maintain the mean blood pressure by at least 25%	10 units
E022C	ASA III - patient with severe systemic disease limiting activity but not incapacitating	4 units
E017C	ASA IV – patient with incapacitating systemic disease that is a constant threat to life	10 units
E016C	ASA V – moribund patient not expected to live 24 hours with or without operation	20 units
E020C	ASA E - patient undergoing anaesthesia for emergency surgery which commences within 24 hours of operating room booking, to E022C, E017C or E016C	4 units

[Commentary:
For E010, BMI is calculated by dividing the patient's weight (in kilograms) by the square of the patient's height (in metres).]

GENERAL PREAMBLE

ANAESTHESIOLOGISTS' SERVICES

Payment rules:

1. Incidental hypotension from the use of any anaesthetic agent does not constitute controlled hypotension.

2. In the description of E022C, E016C, E017C and E020C, reference to ASA level for Physical Status Classification means the level determined by the anaesthesiologist at the time of the pre-operative anaesthesia assessment.

   [Commentary:
   The level determined above does not vary, for example, when complications arise during surgery.]

3. E016C, E017C and E020C are *not eligible for payment* when anaesthesia is rendered to a brain dead patient for organ donations.

REPLACEMENT OF LISTED BASIC UNITS

Circumstances under which the listed basic units for a procedure are replaced with the following basic units:

Fee code	Description	Replace Number of Basic units with
E650C	when a pump (with or without an oxygenator and with or without hypothermia) is used in conjunction with an anaesthetic	28 units
E645C	off pump coronary artery bypass grafting, to R742 or R743	40 units
E002C	when hypothermia is used by the anaesthesiologist in procedures not specifically identified as requiring hypothermia	25 units
E013C	when anaesthetic management is required for the emergency relief of acute upper airway (above the carina) obstruction (excluding choanal atresia)	10 units

ANAESTHESIA ADMINISTERED BY PHYSICIAN PERFORMING THE PROCEDURE

Except as set out in paragraphs a and b below, when a physician administers an anaesthetic and/or other medication prior to, during, or immediately after (a) procedure(s) which he/she performs on the same patient, only the procedure is eligible for payment.

a. When a physician administers an ankle, brachial plexus, pudendal, femoral, intercostal, sciatic, ilioinguinal, iliohypogastric, ulnar, median, or radial nerve block prior to, or during, (a) procedure(s) which he/she performs on the same patient, the service constitutes G224 (see Nerve Blocks listed in the Diagnostic and Therapeutic Procedures Section). With the exception of a bilateral pudendal block (where only one service is payable when bilateral services are performed), G224 is payable once per region per side where bilateral procedures are performed.

b. When an epidural is inserted for pain relief, the applicable code is G125 or G118.

GENERAL PREAMBLE

SUPPORTIVE CARE/MONITORING BY SURGICAL ASSISTANT OR ANAESTHESIOLOGIST

SPECIFIC ELEMENTS

In addition to the common elements, supportive care or monitoring by the surgical assistant or anaesthesiologist includes the following specific elements.

A. Being in constant attendance at a surgical procedure for the sole purpose of monitoring the condition of the patient (including appropriate physical examination and inquiry) and being immediately available to provide, and including the provision of, special supportive care to the patient.

B. Discussion with, and providing advice and information, including prescribing therapy to the patient or the patient's representative(s), whether by telephone or otherwise, on matters related to:

1. the service;

and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

C. Providing premises, equipment, supplies, and personnel for any aspect(s) of the specific elements of the service that is(are) performed at a place other than the place in which the attendance occurs.

While no occasion may arise for performing element B, when performed in connection with the other elements it is included in the service.

CALCULATION OF FEE PAYABLE

The fee for this service is calculated in the same manner as for assistant and anaesthesia services.

		Asst	Anae
E003	Supportive care/Monitoring	6	6

Note:

1. For E003B, the assistants' premiums apply as for assistants' services.

2. For E003C, the anaesthesiologists' premiums apply as for anaesthesiologists' services.

INTENSIVE OR CORONARY CARE UNIT PREMIUM

C101 For each patient seen on a visit to ICU or CCU (subject to the exceptions set out below) . . . . . add 8.65

Payment rule:

C101 is *not eligible for payment* with Supportive Care or with Critical Care, Ventilatory Care, Comprehensive Care, or Neonatal Intensive Care where team fees are claimed.

[Commentary:
C101 is payable when no other separate fee is payable for the service provided in the ICU or CCU (e.g. post-operative care by surgeon).]

AFTER HOURS PROCEDURE PREMIUMS

These premiums are payable only when the following criteria are met:

a. the service provided is one of the following:

Non-elective Surgical Procedures (including fractures or dislocations), Obstetrical Deliveries, Clinical Procedures Associated with Diagnostic Radiological Examinations, Ground Ambulance Transfer (K101), Air Ambulance Transfer (K111), Transport of Donor Organs (K102), Return Trip (K112), or one of the following Major Invasive Procedures:

G082	G083	G085	G090	G091	G092	G099	G117	G118	G119	G125	G176
G177	G178	G179	G211	G246	G249	G261	G262	G263	G268	G269	G275
G277	G280	G282	G288	G294	G295	G297	G298	G303	G304	G309	G323
G324	G330	G331	G336	G347	G348	G349	G356	G380	G509	J001 to J068	

and;

b. the procedure is either (a) non-elective; or (b) an elective procedure which, because of an intervening surgical emergency procedure(s) was delayed and commenced between:

E409 Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays - increase the procedural fee(s) by 50%

E410 Nights (00:00h – 07:00h) - increase the procedural fee(s) by . . 75%

Payment rules:

1. E409/E410 is not payable for a procedure rendered by a physician rendering services in an emergency department who at the time the service was rendered would have been required to submit claims using “H” prefix emergency services (see GP36 of the General Preamble).

AFTER HOURS SPECIAL VISIT PREMIUMS

Non-elective Diagnostic and Therapeutic Procedures

Subject to the provision set out immediately below, these special visit premiums are payable in addition to the fees listed for:

Non-elective Diagnostic and Therapeutic Procedures, including Laboratory Medicine, Nuclear Medicine, Radiation Oncology, Diagnostic Radiology, Clinical Procedures Associated with Diagnostic Radiology Examinations, Magnetic Resonance Imaging, Diagnostic Ultrasound, and Pulmonary Function Studies.

When a physician providing one or more of the foregoing services makes a special visit to the hospital during the time periods set out below for the purpose of interpreting the results of a diagnostic service, performing a procedure, seeing a patient in consultation or to conclude that a procedure is not medically indicated, a premium is payable in addition to the appropriate consultation, interpretation, or procedural fee, or by itself if the decision is made not to perform the procedure. For such services submit using:

C109	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays or Holidays.	36.30
C110	Nights (00:00h – 07:00h)	54.60

AFTER HOURS SPECIAL VISIT PREMIUMS

The following premiums are payable for maintenance/supervision for epidural catheter for relief of pain (G247) for visits rendered during the time periods set out below:

E402	Evenings (17:00h – 24:00h) Monday to Friday or daytime and evenings on Saturday, Sunday or Holidays	add 40%
E403	Nights (00:00h – 07:00h)	add 50%

Note:
See Nerve Blocks, Diagnostic and Therapeutic Procedures.

TRAUMA PREMIUM

Definition/Required elements of service:

The trauma premium is payable for each of the services and units described below when:

a. rendered either on the day of the trauma or within 24 hours of the trauma;

and

b. for trauma patients age 16 or more who have an Injury Severity Score (ISS) of greater than 15, or for patients less than age 16 who have an Injury Severity Score of greater than 12.

E420 Trauma premium . . . . . add 50%

Payment rules:

1. The premium is applicable to the following services and units;

a. services listed in the Consultation and Visits Section (Section A of the *Schedule*);

b. services listed in the Obstetrics Section (Section K of the *Schedule*);

c. services listed in the Surgical Procedures section (Section M through Z of the *Schedule*);

d. the following resuscitative services: G395, G391, G521, G522 and G523.

e. basic and time units provided by surgical assistants;

or

f. basic and time units provided by anaesthesiologists.

2. The premium is payable only for the services for which the medical record lists the ISS score.

Claims submission instruction:

For claims payment purposes, the trauma premium and associated services must be submitted on the same claim record.

[Commentary:
Other special visit and after hours premiums are payable with services eligible for the trauma premium in accordance with the Schedule. However, the trauma premium is not applicable to these services.]

GENERAL PREAMBLE

EMERGENCY DEPARTMENT SESSIONAL FEES

Definition:

For the purposes of this part,

"eligible hospital" means a hospital, designated by the *MOHLTC* as eligible for Emergency Department sessional fees which provides 24 hour Emergency Department coverage on a continuing basis.

"sessional unit" means each one hour period, commencing on the hour, on any day (including weekends or holidays) between 20:00 and 08:00h.

"sessional period" refers to the four hour block for each of the sessional unit codes below.

"sessional physician" means the physician to whom payment is made in respect of a sessional unit.

Payment rules:

1. The amount payable for a sessional unit for all insured services rendered during that hour and for being on call to provide such insured services is $72.80.

2. Claims for sessional units shall be submitted in accordance with the following codes:

Sessions – Monday to Friday (other than holidays)

H400	20:00h – 24:00h	72.80
H401	00:00h – 04:00h	72.80
H402	04:00h – 08:00h	72.80

Sessions – Saturdays, Sundays, Holidays

H403	00:00h – 04:00h	72.80
H404	04:00h – 08:00h	72.80
H405	08:00h – 12:00h	72.80
H406	12:00h – 16:00h	72.80
H407	16:00h – 20:00h	72.80
H408	20:00h – 24:00h	72.80

3. Services rendered to any person present in the Emergency Department of the hospital on or before 08:00h of any non-holiday weekday, and not assessed by the sessional physician before that time, are eligible for payment in addition to the sessional fee.

4. Services rendered to any person present in the Emergency Department of the eligible hospital before 20:00h and not assessed by the sessional physician on or before that time shall be deemed to have been rendered during the sessional unit.

5. Claims for sessional units are eligible for payment only if the following conditions are met:

a. the claim for the sessional unit is submitted using the *OHIP* identification number assigned by the *MOHLTC* for physicians claiming such services at each eligible hospital;

b. in addition to the claim submitted for the sessional unit, claims are submitted at $0.00 for each and every other insured service rendered during the sessional period to which the sessional unit applies, using the appropriate codes listed in the *Schedule*;

and

c. all physicians providing insured services in that eligible hospital during any sessional unit submit claims for those services on a sessional unit basis only, except as specifically outlined below.

6. With the exceptions noted in section 7, where a fee is paid in respect of a sessional unit,

a. services rendered in the hospital during the sessional unit by any physician are *not eligible for payment;*

and

b. services rendered anywhere by the sessional physician during that sessional unit are *not eligible for payment*.

7. Section 6 does not apply to the following:

a. services which comprise the daily, routine scheduled care of in-patients;

b. services rendered during a sessional unit by a physician other than the sessional physician who is

i. a specialist,

or

ii. a general practice physician if the services comprise an obstetrical delivery, immediate post-delivery care of a newborn, anaesthesia (other than local anaesthesia), or surgery that requires the services of an anaesthesiologist;

c. services, other than assessments, consultations, counselling or psychotherapy, rendered during a sessional unit by:

i. a specialist who is the sessional physician, if the services are procedures that would normally require the services of a specialist,

or

ii. a general practice physician who is the sessional physician if the services comprise an obstetrical delivery, immediate post-delivery care of a newborn, anaesthesia (other than local anaesthesia) or surgery that requires the services of an anaesthesiologist;

d. services rendered during a sessional unit by a supplementary physician where, in extraordinary or catastrophic circumstances, the sessional physician requires the assistance of a supplementary physician due to a high volume of patients and/or the serious nature of illness and/or injury of one or more patients;

or

e. services rendered during a sessional unit by the sessional physician to a resident of a nursing home or other chronic care institution, at such nursing home or other institution.

GENERAL PREAMBLE

EMERGENCY DEPARTMENT ALTERNATIVE FUNDING AGREEMENTS

When one or more physicians have contracted with the *MOHLTC* to provide insured physician services under an emergency department alternative funding agreement (ED AFA) in lieu of fee-for-service payments under the *Schedule*, then no insured service encompassed by the contract relating to the emergency department alternative funding agreement is payable, whether or not the physician who renders the service is a party to the contract unless the physician is/are:

a. a second on-call physician who either does or does not participate in the ED AFA and who can submit fee-for-service claims under the hospital's ED AFA second on-call group number;

b. general practitioner experts ('GP Experts') who, in accordance with the ED AFA, are entitled to submit fee-for-service claims under the hospital's ED AFA GP Expert group number,

or

c. the patient's general/family physician only for services payable as A100 - General/Family Physician Emergency Department Assessment.

GENERAL PREAMBLE

NOT ALLOCATED