# OHIP Payments for Long Term Care Services

## Quick Reference Guide

Economics, Policy & Research

OMA
ONTARIO MEDICAL ASSOCIATION

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## Quick Reference Guide[1]

The purpose of this reference guide is to provide a general overview on the available codes and payment rules for billing OHIP for service claims related to treating patients in Long-Term Care (LTC). The full definitions, payment rules and medical record requirements of the services described in this guide are detailed in the OHIP Schedule of Benefits[2] (the "Schedule").

This guide contains the following sections:

(A) "W" Prefix Services
(B) Palliative Care
(C) Case Conferences, Interviews and Counselling
(D) Eligible Primary Care Bonuses
(E) Rostered vs Non-rostered LTC Patients
(F) Special Visit Premiums
(G) Telephone/E-Consultation and Virtual Care

## A: "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.

In general, when billing for an LTC patient, either a W010 (Monthly Management of a Nursing Home or Home for the Aged Patient) code can be billed or individual W Prefix Codes for services rendered can be billed; but not both. Details will be laid out below.

### (a) W010 – Monthly Management of a Nursing Home or Home for the Aged Patient (Long-Term Care)

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 assessments of the patient each month, where these assessments constitute services described as "W" prefix assessments.**

[1] **Disclaimer**: Every effort has been made to ensure that the contents of this Guide are accurate. Members should, however, be aware that the laws, regulations and other agreements may change over time. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of applicable Regulations with the Government of Ontario including but not limited to the Ministry of Health (MOH), and the College of Physicians and Surgeons of Ontario (CPSO). Members are advised that the ultimate authority in matters of interpretation and payment of insured services (as well as determination of what constitutes an uninsured service) are in the purview of the government. Members are advised to request updated billing information and interpretations – in writing – by contacting their regional OHIP office.

[2] OHIP Schedule of Benefits, Physician Services, May 23, 2023 (effective July 1, 2023) (http://www.health.gov.on.ca/en/pro/programs/ohip/sob/).

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 are satisfied. (See Payment Rule 7 below)
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 periodic health visit 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, G590), Pap smear (G365, G394, E430, E431), intravenous (G379), and laboratory test codes (G001, G002, G481, G004, G005, 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.

**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.

Once a physician has claimed a W010 service, then W010 must be claimed subsequently going forward. Physicians are not to switch back and forth between billing the W010 and for example the W003 and W008. If a physician does not want to claim W010 for a specific patient, then they must begin by billing the other W Prefix Codes, such as the W003 and W008, from the onset of services being rendered.

Usually, the service requires a minimum of two assessments of the patient each month, however, if a physician only performs one subsequent visit in the month but has otherwise claimed a W010 in the previous 11 months, then the single subsequent visit is payable as a W010 in that month. If the physician has performed two, three or four subsequent visits in a particular month and has claimed at least one W010 in the preceding 11 months, only W010 is payable. However, if the physician performs a subsequent visit in excess of four in a month and has claimed W010 in the preceding 11 months, then the visits in excess of four may be payable as W121 if the visit(s) were for intercurrent illness. W121 must be submitted for manual review.

Effective April 1, 2013, W010 is being paid at nil to physicians in the FHN/FHO groups who have regularly enrolled patients (Q200) that reside in a Long-Term Care (LTC) facility. The rejected claims show on the RA with the explanation code "EQP – Enrolment type not eligible." To continue receiving W010, the affected physician groups must either enrol these patients as LTC patients (using a Q202), or de-enrol them and provide care on a fee-for-service basis.

### (b) Admission Assessments, Subsequent Visits, and Ongoing Care in LTC if not billing the W010 monthly management fee code:

These codes below are included in the monthly management fee, W010, and cannot be billed in addition to it (except if the conditions described in Payment rule #7 above in relation to the W121 is satisfied). If a physician chooses not to bill the W010 code, then visits can be billed as appropriate from the W-Prefix codes listed. For example, a physician can bill an appropriate Admission Assessment on admission to LTC, and then the appropriate subsequent visit codes can be billed for services rendered.

**Nursing home or home for the aged (Long-Term Care Only):**

| Fee Code | Service |
|---|---|
| W003 | Nursing home or home for the aged – First 2 subsequent visits per patient per month |
| W008 | Nursing home or home for the aged – Additional subsequent visits (max 2 per patient per month) |
| W872 | Nursing home or home for the aged – Palliative care |

**Nursing home or home for the aged (Long-Term Care) and Complex Continuing Care:**

| Fee Code | Service |
|---|---|
| W121 | Non-Emergency LTC In-patient services - Additional visits due to intercurrent illness |
| W102 | General Assessment on Admission – Type 1 |
| W104 | General Assessment on Admission – Type 2 |
| W107 | General Assessment on Admission – Type 3 |
| W109 | Periodic Health Visit |
| W004 | General re-assessment of patient in nursing home |
| W903 | Pre-dental/pre-operative general assessment (Maximum 2 per 12 month period) |
| W777 | Intermediate Assessment – Pronouncement of death |
| W771 | Certification of death (Completion of death certificate alone) |

**Admission Assessments**[3]
W102 – Type 1 Admission Assessment
A general assessment rendered to a patient on admission.

W104 – Type 2 Admission Assessment
Applies 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.

W107 – 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.

**Subsequent Visits**[4]
A subsequent visit is any routine assessment following the patient's admission to a long-term care Institution.

W003 – first 2 subsequent visits per patient per month
W008 – additional subsequent visits (maximum 2 per patient per month)

For palliative care subsequent visits, please see the palliative care subsection of this guide.

**Death in LTC**
For pronouncement of death in a LTC facility (regardless of type of facility) with completion of the death certificate, physicians are to bill W777 and for completion of the death certificate alone, bill W771 (subject to the same conditions as A777).

[3] OHIP Schedule, page GP49
[4] OHIP Schedule, page GP49

**Special Considerations:**

**Death in LTC:**
When pronouncement of death requires a special visit then general listing fees would apply (A777) in addition to the Special Visit Premium. This can be billed in addition to the W010.

An Electronic Medical Certificate of Death can be billed for using A771 with no special visit premium applicable. This can be billed in addition to the W010.

**W Prefix Codes and FFS cap for physicians in a FHO:**
Only FHO in-basket services[5] to non-enrolled patients will count towards the FHO FFS limit. The majority of W-Prefix codes are out of the basket and as such do not contribute to the hard cap.

**On Call Funding:**
This is not an OHIP paid service. Funding is provided to each Long-Term Care Home under the "Physician on-call program"[6] and is based on the number of licensed and approved beds in operation at the home as of January 1st of each funding year.

Any in-year changes to bed counts, approved under the act, may result in prorated funding adjustments as determined by the Ministry of Health.

## B: Palliative Care

Palliative care is defined in the OHIP Schedule of Benefits as "*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*".[7]

Several palliative care codes can be billed for palliative patients in LTC. In general, palliative care case management G512 can billed weekly in addition to K Prefix Codes as the conditions for the services are met. For physicians not billing the W010 (Monthly Management of a Nursing Home or Home for the Aged Patient) fee code, there are also W Prefix subsequent visit codes than can be billed.

| Fee Code | Service |
|---|---|
| G512 | Palliative Care Case Management |
| G511 | Telephone Management of Palliative Care (per call) |
| K023 | Palliative Care Support (>20 min.) |
| K015 | Counselling of relatives - on behalf of catastrophically or terminally ill patient |
| W882 | Palliative Care Subsequent Visit – GP, Chronic care/ Convalescent |
| W872 | Palliative Care Subsequent Visit (<20 min) – GP, Nursing home/home for the aged |
| W972 | Palliative Care Subsequent Visit (<20 min) – Specialist, Nursing home/home for the aged |

[5] https://www.oma.org/siteassets/oma/media/member/membermappedpdfs/practice-professional-support/primary-care/fee-codes-in-FHO-FHN.pdf
[6] https://www.ontario.ca/page/physician-call-program-guidelines
[7] OHIP Schedule, page GP5

**G512 - Palliative Care Case Management**[8]
is a service rendered for providing supervision of palliative care to a patient for a period of one week, commencing at midnight Sunday, and includes the following specific elements.

A. Monitoring the condition of a patient including ordering tests and interpreting test results.
B. Discussion with and providing telephone advice to the patient, patient's family or patient's representative even if initiated by the patient, patient's family or patient's representative.
C. Arranging for assessments, procedures or therapy and coordinating community and hospital care including but not limited to urgent rescue palliative radiation therapy or chemotherapy, blood transfusions, paracentesis/thoracentesis, intravenous or subcutaneous therapy.
D. Providing premises, equipment, supplies and personnel for all elements of the service

**Payment rules:**

1. The service is only eligible for payment when rendered by the physician most responsible for the patient's care, or by a physician substituting for this physician.
2. G511, K071 or K072 are not eligible for payment to any physician when rendered during a week that G512 is rendered.
3. G512 is limited to a maximum of one per week (Monday to Sunday inclusive) per patient and, in the instance a patient is transferred from one most responsible physician to another, is only eligible for payment to the physician who rendered the service the majority of the week.
4. In the event of the death of the patient or where care commences on any day of the week, G512 is eligible for payment even if the service was not provided for the entire week.

**G511 – Telephone Management of Palliative Care**[9]
The provision by telephone of medical advice, direction or information at the request of the patient, patient's relative(s), patient's representative or other caregiver(s), regarding a patient receiving palliative care at home. The service must be rendered personally by the physician and is eligible for payment only when a dated summary of the telephone call is recorded in the patient's medical record.

**Payment rules:**

1. This service is limited to a maximum of two services per week.
2. This service is not eligible for payment if rendered the same day as a consultation, assessment, time-based service or other visit by the same physician.
3. This service is not eligible for payment if a claim is submitted for K071 or K072 for the same telephone call.
4. This service is only eligible for payment when rendered by the physician most responsible for the patient's care or by a physician substituting for this physician.

**W882/W872 – Palliative Care Subsequent Visits**
A subsequent visit is any routine assessment following the patient's admission to a long-term care institution. The applicable palliative care subsequent visit code depends on the type of facility. For visits to patients in a Chronic Care or Convalescent Hospital, GPs are eligible for **W882.** For visits to patients in a Nursing home or home for the aged, GPs are eligible for **W872.**

[8] OHIP Schedule, page J102

[9] OHIP Schedule, page J101

W872 is not eligible for payment when the W010 (Monthly Management of a Nursing Home or Home for the Aged Patient) fee code is being billed in the same month.

**K023 – Palliative Care Support**[10]
Palliative care support is a time-based service payable for providing pain and symptom management, emotional support and counselling to patients receiving palliative care.

**Payment rules:**
1. With the exception of A945/C945, any other services listed under the "Family Practice & Practice in General" in the "Consultations and Visits" section of the Schedule are not eligible for payment when rendered with this service.
2. Start and stop times must be recorded in the patient's permanent medical record or the service will be adjusted to a lesser paying fee
3. When the duration of A945 or C945 exceeds 50 minutes, one or more units of K023 are payable in addition to A945 or C945, provided that the minimum time requirements for K023 units occurs 50 minutes after the start time for A945 or C945.
4. This service is claimed in units. Unit means ½ hour or major part thereof - see General Preamble GP7, GP55 for definitions and time-keeping requirements.

Details surrounding time units for K023 can be seen in the following section.

## C: Case Conferences, Interviews, and Counselling

These codes below are billed based on time units and require documentation of a start and stop time.

| Fee Code | Service |
|---|---|
| K124 | Long-term care/CCAC case conference |
| K705 | Long-term care – high risk patient conference |
| K002 | Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act |
| K013 | Counselling – Individual Care – first three units of K013 and K040 combined per patient per provider per 12-month period, per unit |
| K033 | Counselling – Individual Care – additional units |

### Case Conferences:
A case conference is a pre-scheduled meeting, conducted for the purpose of discussing and directing the management of an individual patient. It must be conducted by personal attendance, videoconference or by telephone (or any combination thereof).[11]

[10] OHIP Schedule, page A45
[11] OHIP Schedule, page A27

**Payment Rules:**[12]

1. A case conference is only eligible for payment if the physician is actively participating in the case conference, and the physician's participation is evident in the record.
2. A case conference is only eligible for payment in circumstances where there is a minimum of 10 minutes of patient related discussion.
3. A case conference is only eligible for payment if the case conference is pre-scheduled.
4. Any other insured service rendered during a case conference is not eligible for payment.
5. A case conference is not eligible for payment in circumstances where the required participants necessary to meet the minimum requirements of the case conference service receive remuneration, in whole or in part, from the physician claiming the service.
6. The case conference is not eligible for payment to a physician who receives payment, other than by fee-for-service under this Schedule, for the preparation and/or participation in the case conference.
7. Where payment for a case conference is an included element of another service, services defined as case conferences are not eligible for payment.

**Medical record requirements**:[13]

A case conference is only eligible for payment where the case conference record includes all of the following elements:

1. identification of the patient;
2. start and stop time of the discussion regarding the patient;
3. identification of the eligible participants, and
4. the outcome or decision of the case conference.

One common medical record in the patient's chart for the case conference signed or initialled by all physician participants (including listing the time the service commenced and terminated and individual attendance times for each participant if different) would satisfy the medical record requirements for billing purposes.

**K124 – Long-term care/CCAC case conference.**[14]

For this type of care conference there is a requirement for participation by the physician most responsible for the care of the patient and at least **2 other participants that include physicians, regulated social workers, employees of a CCAC and/or regulated health professionals** regarding a long-term care institution inpatient.

**Payment rules:**

1. K124 is limited to a maximum of 4 services per patient, per physician, per 12 month period.
2. A maximum of 8 units of K124 are payable per physician, per patient, per day.
3. K124 is not eligible for payment for radiation treatment planning services listed in the Radiation Oncology section of the Schedule of Benefits.
4. Services described in the supervision of postgraduate medical trainees section of the Schedule of Benefits are not eligible for payment as K124.

[12] OHIP Schedule, page A28

[13] OHIP Schedule, page A28

[14] OHIP Schedule, page A34

**K705 – Long-term care – high risk patient conference**[15]
This type of care conference risk requires the participation by a physician and at least **2 other participants that include physicians, employees of a CCAC, regulated social workers and/or regulated health professionals** regarding a long-term care institution high risk inpatient. A high-risk patient is a patient identified by staff in the long-term institution with clinical instability based on a change in the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) for Nursing Homes.

**Payment rules:**
1. K705 is limited to a maximum of 4 services per patient, per physician, per 12-month period.
2. A maximum of 8 units of K705 are payable per physician, per patient, per day.
3. K705 is not eligible for payment for radiation treatment planning services listed in the Radiation Oncology section of the Schedule of Benefits.
4. Services described in the supervision of postgraduate medical trainees section of the Schedule of Benefits are not eligible for payment as K124.

**Case Conference Time Units**

| # Units | Minimum time |
|---|---|
| 1 unit | 10 minutes |
| 2 units | 16 minutes |
| 3 units | 26 minutes |
| 4 units | 36 minutes |
| 5 units | 46 minutes |
| 6 units | 56 minutes |
| 7 units | 66 minutes [1h 6m] |
| 8 units | 76 minutes [1h 16m] |

## Interviews:

Interviews are for 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.[16]

Interviews are not eligible for payment when the information being obtained is part of the history normally included in the consultation or assessment of the patient. The interview must be a booked, separate appointment lasting at least 20 minutes. Unit means ½ hour or major part thereof.

**K002 – Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act**[17]

**Payment rules:**
1. K002 is only eligible for payment if the physician can demonstrate that the purpose of the interview is not for the sole purpose of obtaining consent.

## Counselling:

[15] OHIP Schedule, page A34
[16] OHIP Schedule, page GP61
[17] OHIP Schedule, page A24

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.[18]

Individual counselling is counselling rendered to a single patient. The patient must have a pre-booked appointment as otherwise the claim for the service will be paid at the lesser assessment fee. These are billed as units and unit means ½ hour or major part thereof.

**K013 – Individual Care (First 3 Units per year)[19]**
There is a limit of 3 units (Individual or Group Counselling) per patient per physician per year at this higher fee.

**K033 – Individual Care (Additional units)[20]**
Bill this for additional units beyond the first 3 units (Individual or Group Counselling) per patient per physician per year at this lesser fee.

**K005 – Primary Mental Health Care[21]**
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.

**K015 – Counselling of relatives - on behalf of catastrophically or terminally ill patient**
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.

The claim must be submitted under the health number of the patient who is catastrophically or terminally ill.[22]

**Time units for K002, K013, K033, K015 and K023**

| # 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] |

[18] OHIP Schedule, page GP58
[19] OHIP Schedule, page A17
[20] OHIP Schedule, page A17
[21] OHIP Schedule, page GP56, A17
[22] OHIP Schedule, page GP60

## D: Eligible Primary Care Bonuses

Physicians participating in Patient Enrollment Models (PEMs) may be eligible to receive the annual Palliative Care Special Premium and/or the LTC Special Premium paid directly by OHIP, once certain thresholds are reached.

There are two threshold levels: Level 1 is for all eligible physicians including PEMs and Level 3 is for eligible PEM physicians only.

| Level | Annual Criteria | Annual Bonus |
|---|---|---|
| **Palliative Care Special Premium** | | |
| 1 | Four or more patients | $2,400 |
| 3 | 10 or more patients | An additional $3,600 for a total of $6,000 |
| **LTC Special Premium** | | |
| 1 | 12 or more patients | $2,400 |
| 3 | 36 or more patients | An additional $3,600 for a total of $6,000 |

## E: Rostered vs Non-rostered LTC Patients

**Rostered LTC patient:**

For each patient rostered, the physician receives a base rate (not age and sex adjusted) of $1,223.22. In addition to the base rate, LTC patients qualify for a 20.65% access bonus. Physicians will also receive 19.41% shadow billing on the fee value of W010 ($115.25).

In a scenario where a physician bills only W010 for their rostered LTC patient for a 12-month period:

$1,223.22 + (19.41% x 12 x $115.25) = $1,491.66 per patient and a potential maximum of 20.65% x $1,223.23 (i.e., maximum of $252.59) for access bonus.

**Non-rostered patient:**

In a scenario where a physician bills only W010 for their non-rostered LTC patient for a 12-month period:

12 x $115.25 = $1,383.00 per patient

## F: Special Visit Premiums

Visits to LTC are often eligible to be billed with special visit premiums (SVPs) when a visit is initiated by a patient or an individual on behalf of the patient for the purpose of rendering a non-elective service.[23]

Regardless of the time of day at which the service is rendered, special visit premiums are **not** eligible for payment for patients seen during rounds at a hospital or long-term care institution (including a nursing home or home for the aged). Likewise, SVPs may not be claimed in conjunction with visits to a LTC facility to admit patients on an elective basis.

SVPs have three components: (1) the travel premium, (2) the first person seen premium, and (3) an additional person seen premium (where applicable). Each component of the special visit premium is separately billable and is to be claimed in conjunction with an "A" prefix assessment code, based on the type of service rendered. As an example, if a physician was called in to see a patient in a LTC facility on the weekend, then the appropriate OHIP submission would consist of two "W" prefix SVPs (W963 travel and W998 patient premiums) + the applicable "A" prefix assessment fee (e.g. A777).

The following table summarizes Special Visit Premiums that may be claimed in conjunction with an assessment rendered to a patient in the following locations:

### Long-Term Care Institution

| **Premium** | **Weekdays Daytime (07:00-17:00)** | **Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours** | **Evenings (17:00-24:00) Monday through Friday** | **Sat., Sun. and Holidays (07:00- 24:00)** | **Nights (00:00-07:00)** |
|---|---|---|---|---|---|
| Travel Premium | $36.40<br>W960<br>(max. 2 per time period) | $36.40<br>W961<br>(max. 2 per time period) | $36.40<br>W962<br>(max. 2 per time period) | $36.40<br>W963<br>(max. 6 per time period) | $36.40<br>W964<br>(no max. per time period) |
| First person seen | $20.00<br>W990<br>(max. 10 (total of first and additional person seen) per time period) | $40.00<br>W992<br>(max. 10 (total of first and additional person seen) per time period) | $60.00<br>W994<br>(max. 10 (total of first and additional person seen) per time period) | $75.00<br>W998<br>(max. 20 (total of first and additional person seen) per time period) | $100.00<br>W996<br>(no max. per time period) |
| Additional person(s) seen | $20.00<br>W991<br>(max. 10 (total of first and additional person seen) per time period) | $40.00<br>W993<br>(max. 10 (total of first and additional person seen) per time period) | $60.00<br>W995<br>(max. 10 (total of first and additional person seen) per time period) | $75.00<br>W999<br>(max. 20 (total of first and additional person seen) per time period) | $100.00<br>W997<br>(no max. per time period) |

[23] OHIP Schedule, page GP65

## G: Telephone/E-Consultation and Virtual Care

| Fee Code | Service |
|---|---|
| K730 | Physician to Physician Telephone Consultation – Referring Physician |
| K731 | Physician to Physician Telephone Consultation – Consulting Physician |
| K738 | Physician to Physician E-Consultation – Referring Physician |
| K739 | Physician to Physician E-Consultation – Consultant Physician |

### Telephone/E-Consult

**K730 – Physician to physician telephone consultation – Referring physician[24]**

Physician to physician telephone consultation is a service where the referring physician or nurse practitioner, in light of his/her professional knowledge of the patient, requests the opinion of a physician (the "consultant physician") by telephone who is competent to give advice in the particular field because of the complexity, seriousness, or obscurity of the case.

The referring physician/NP initiates the telephone consultation with the intention of continuing the care, treatment and management of the patient. When the purpose of the telephone discussion is to arrange for transfer of the patient's care to any physician, the service is not eligible for billing. A record of the consultation must be kept by the physician(s) who submits a claim for the service. The services are only eligible for payment when a minimum of 10 minutes of patient-related discussion for any given patient has occurred.

**K738 – Physician to physician telephone consultation – Referring physician[25]**

Physician to physician e-consultation is a similar service to the physician/NP to physician telephone consultation except that both the request and opinion are sent by electronic means through a secure server.

This service is only eligible for payment if the consultant physician has provided an opinion and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.

### Virtual Care

Virtual Care Services are not eligible for payment for services provided to hospital inpatients or patients in a Long-Term Care institution unless all of the following requirements have been met:

- The physician providing the service is not the patient's MRP.
- The hospital/Long-Term Care institution does not have a physician on staff and present in the community with the expertise to render the necessary service, as documented by the referring physician in the patient's medical record.
- An assessment with a direct physical encounter by the referring physician must have been completed within 30 days preceding a virtual in-patient specialist consultation to confirm the need for a consultation.

[24] OHIP SOB pages A37

[25] OHIP SOB pages A37

# OHIP Payments for Select Services: Quick Reference for OHIP Billing[26]

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| **Monthly Management of a Nursing Home or Honed for the Aged Patient** | |
| W010 | - Minimum of two in-person visits per month<br>- Can be billed < 2 visits in cases where:<br>(a) a patient was newly admitted, and an admission assessment was performed; or<br>(b) death of the patient occurred while in the institution; or<br>(c) within 48 hours of transfer to hospital |
| **Long-Term Care Case Conference** | |
| K124 | - Must be pre-scheduled<br>- Must include the MRP and two other participants (e.g., regulated health professional)<br>- K124 is billed in 10-minute units<br>- Maximum 8 units per case conference; maximum services per patient, per physician, per 12-month period |
| **Long-Term Care – High Risk Patient Case Conference** | |
| K705 | - Similar to K124, but the MRP doesn't need to be present; another physician directing the care on behalf of the MRP is permitted<br>- Applies to high risk patient identified by staff in the long-term institution with clinical instability based on a change in the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) for Nursing Homes. |
| **Scheduled Meetings (billed per unit, ½ hour or major part thereof)** | |
| K002 | Interviews with relatives or a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act |
| K013/K033 | Individual counselling |
| K015 | Counselling of relatives – on behalf of catastrophically or terminally ill patient |
| K023 | Palliative care support |
| **Palliative Care Case Management Fee** | |
| G512 | - Includes all support for patient (e.g., monitoring patient condition, arranging necessary services, phone support to both patient and family)<br>- Billed weekly, by the MRP<br>- Weeks are from Monday to Sunday at midnight; commonly billed Sunday.<br>- Eligible for payment on weeks when the patient wasn't seen, but physician was still available for palliative support |
| **Special Visit Premiums** | |
| W9xx Codes | - Non-elective services initiated by patient or on behalf of the patient<br>- An eligible claim will have an A-prefix visit code (e.g., A007) + travel premium (if travel occurred) + first person seen.<br>- If providing a special visit to more than one patient at the institution, the eligible claim will have an A-prefix visit code + travel premium (if travel occurred) + additional person seen. |

[26] Please note that the information contained in this resource is strictly for general reference and may not address all possible billing scenarios that may arise or all possible billing codes. The information included may not contain all payment rules and/or medical record requirements. Physicians are to select the most appropriate service code, which best represents the service provided.