

Quick Billing Tips: Geriatric

July 2026

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Disclaimer:

Every effort has been made to ensure that the contents of this document is 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.

[OHIP Schedule of Benefits April 1, 2026](#)

For more information email: info@oma.org

OHIP Billing Number

An OHIP billing number is required to submit claims for services rendered. It is also required to register for Medical Claims Electronic Data Transfer (MCEDT) and Health Card Validation (HCV) services.

Eligibility Requirements

To apply for OHIP, applicants must:

- Hold a valid certification from CPSO
- Have an Ontario practice address (list all addresses where services are regularly provided and identify the primary practice site, where possible)
- Complete and sign the [Application for OHIP Billing Number for Health Professionals](#) form
- Provide banking information to support direct payment

Processing Timeline: Applications may take up to **15 business days** to process.

Billing Before Receiving an OHIP Billing number

- Claims can be submitted retroactively for up to **three (3) months** after the billing number is issued.
- Services **cannot** be billed if provided before the effective date on the CPSO certificate.



Physicians are **legally responsible** for all OHIP claims submitted and paid in conjunction with their billing number, even if they didn't submit or receive the payment directly.

As such, physicians should always **be aware of the claims and payments** made under their billing number.

Schedule of Benefits

What is considered insured?

- Listed in the Schedule of Benefits
- Medically necessary
- Not otherwise excluded by legislation or regulation and
- Rendered personally by a physician (or otherwise delegated where delegation is authorized)

Documentation Required

- All insured services must be documented in the patient's medical record. The record must establish:
 - An insured service was provided
 - The service claimed to OHIP was the service that was rendered; and
 - The service was medically necessary



For minimum required duration of time and number of "units" of service rendered, physicians must document when the insured service started and stopped in the patient's medical records.

Definitions (see definitions in GP2)

Time Definitions

- 12-month period: any period of 12 consecutive months
- Calendar year: the period from January 1 to December 31
- 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
- Day: a calendar day

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

Not eligible for payment: The service remains an insured service for which the amount payable is \$0.

Only Eligible for payment : When certain conditions are met and if those conditions are not met, the service becomes not eligible for payment

Patients **cannot** be charged for services described as “not eligible for payment” or “only eligible for payment” as they remain insured services.



May Include: Services that are performed in conjunction with the listed service are optional, but when rendered are included in the amount payable for the listed service

With or Without: Services 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, & Time or Unit-based Services

If a physician does not satisfy the requirements, the service is insured but the amount is \$0.

Minimum

- Less than the number of services required to satisfy the minimum are rendered, the services are not eligible for payment.

Maximum

- X # of services, per patient, per day
- X # of services, per patient, per [specific time period]
- X # of services, with reference to a specific part of the anatomy, per patient, per day

Services in excess of these limits are **not** eligible for payment.

Time/Unit based services

- The physician must record on the patient's permanent medical record or chart the time when the insured service started and ended.



For minimum required duration of time and number of “units” of service rendered, physicians must document when the insured service started and stopped in the patient's medical records.

Special Visit Premiums

A special visit is a visit that requires the physician to assess a patient:

- in response to a request initiated by the patient or a person caring for the patient (non-elective visit); or
- on a physician-initiated visit to a patient's home (elective visit) provided the patient's home is not a Long-Term Care facility, including a nursing home or home for the aged.

Assessments are eligible when:

- Assessment rendered in patient's home (elective or non-elective service)
- Assessment rendered in any other location (non-elective only)

Comprises of: Travel premium and First person or additional person seen

Claims for an assessment rendered in conjunction with a special visit premium are to be submitted using the appropriate A-prefix assessment fee from the "General Listings" (with some exception, such as K023 Palliative care support), regardless of the location or type of facility to which the special visit applies.

- If the assessment is a C005, submit as A005 + SVP
- If the assessment is K023 or G521, submit as is + SVP

Not eligible for payment when:

- For patients seen during rounds at a hospital or long-term care institution (including a nursing home or home for the aged).
- In conjunction with admission assessments of patients who have been admitted to hospital on an elective basis.
- 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).
- For services rendered in a place, other than a hospital or long-term care facility, that is scheduled to be open for the purpose of diagnosing or treating patients.
- For a visit for which critical care team fees are payable under the Schedule.
- In conjunction with any sleep study service listed in the sleep studies section of this Schedule.
- For services rendered to patients who present to an office without an appointment while the physician is there, or for patients seen immediately before, during or immediately after routine or ordinary office hours, even if held at night or on weekends or holidays.
- For visits in the emergency room where the "H" prefix assessment codes may be payable.
- SVPs are not eligible for payment for elective visits⁵ (unless it is an elective call to a patient's home). There is no SVP for additional patients seen at home visits, regardless of the number of patients seen during a visit to a private home or a multiple resident dwelling (such as an apartment building, retirement home or seniors' complex). The physician must still satisfy the requirement to travel from one location to another in order to be eligible for the first person seen premium.
- SVPs are not eligible for payment to emergency physicians during the time the physician has a scheduled shift to work in the emergency department.
- SVPs are not eligible for payment with A007 or A001 when rendered in a patient's home.

Hospital In-Patient

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	\$37.40 C960 <i>(max 2 per time period)</i>	\$37.40 C961 <i>(max 2 per time period)</i>	\$37.40 C962 <i>(max 2 per time period)</i>	\$37.40 C963 <i>(max 6 per time period)</i>	\$37.40 C964 <i>(no max per period)</i>
First Person seen	\$20.55 C990 <i>(max 10 (total of first and additional person seen) per time period)</i>	\$41.10 C992 <i>(max 10 (total of first and additional person seen) per time period)</i>	\$61.70 C994 <i>(max 10 (total of first and additional person seen) per time period)</i>	\$77.10 C986 <i>(max 20 (total of first and additional person seen) per time period)</i>	\$102.80 C996 <i>(no max. per time period)</i>
Additional Person(s) seen	\$20.55 C991 <i>(max 10 (total of first and additional person seen) per time period)</i>	\$41.10 C993 <i>(max 10 (total of first and additional person seen) per time period)</i>	\$61.70 C995 <i>(max 10 (total of first and additional person seen) per time period)</i>	\$77.10 C987 <i>(max 20 (total of first and additional person seen) per time period)</i>	\$102.80 C997 <i>(no max. per time period)</i>

Geriatric Home Visit

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	\$37.40 B986 <i>(no max. per time period)</i>	\$37.40 B986 <i>(no max. per time period)</i>	\$37.40 B986 <i>(no max. per time period)</i>	\$37.40 B986 <i>(no max. per time period)</i>	\$37.40 B986 <i>(no max. per time period)</i>
First Person seen	\$91.80 B988 <i>(no max. per time period)</i>	\$91.80 B988 <i>(no max. per time period)</i>	\$91.80 B988 <i>(no max. per time period)</i>	\$91.80 B988 <i>(no max. per time period)</i>	\$113.10 B987 <i>(no max. per time period)</i>

Geriatric Fee Codes

Consultations and Assessments (see definitions in GP40)

Title	Code	Amount	When to use
Consultations			
All consultative services require a written referral from a physician or nurse practitioner and a written report back to the referring professional (including findings, opinions and recommendations).			
Consultation	A075	\$223.30	
Consultation in association with special visit	A070	\$255.85	- Applies to hospital in-patient, LTC in-patient or ED patient - Submit claim with SVP
Comprehensive geriatric consultation	A775	\$342.25	- Spends at minimum 75 minutes with the patient exclusive of time spent rendering any other service to the patient. - Patient is > 65 years or service is for assessment of dementia
Extended comprehensive geriatric consultation	A770	\$442.40	- Spends at minimum 90 minutes with the patient exclusive of time spent rendering any other service to the patient. - Patient is > 65 years or service is for assessment of dementia
Repeat consultation	A076	\$113.35	Interim care by another physician
Limited consultation	A375	\$113.35	
Assessments			
Medical specific assessment	A073	\$99.05	- Full history and detailed exam of affected part/region/system <u>One per patient per physician per 12 months</u> period unless one of following applies: - The 2nd assessment is clearly different and unrelated to the diagnosis made at the time of the first general assessment. At least 90 days have elapsed since the date of the last general assessment, and - the 2nd assessment is a hospital admission assessment.
Medical specific re-assessment	A074	\$79.85	- Full, relevant history and exam of one or more systems <u>Two per patient per physician per 12 month</u> period unless rendered for a hospital admission.
Complex medical specific re-assessment	A071	\$103.80	- Full, relevant history and exam of one or more systems + report to primary care physician - Any combination of medical specific assessments and complex medical specific reassessments are limited to <u>4 per patient per physician per 12 month period.</u>
Partial assessment	A078	\$49.65	- History of presenting complaint, the necessary exam, advice to patient <u>No limit</u>

Chronic Disease Assessment Premium	E078	Add 50%	- Can be applied to A073, A074, A071, and A078. - Diagnosis must be established. Refer to GP25-GP26 for eligible diagnostic codes. - Not for in-patient, LTC or ER patients
Geriatric Telephone Support	K077	\$43.10	- Per unit - Initiated by caregiver - Patient has established diagnosis of dementia - Minimum of 10 minutes of patient-related discussion - Maximum 2 units per patient, per day. Maximum 12 K077 per patient per 12 month period.

Hospital Work

Title	Code	Amount	When to use
Subsequent visits			
First 5 weeks following hospitalization	C072	\$40.05	- Per visit Limit: 1 visit per patient per day
Sixth – thirteenth week inclusive	C077	\$40.05	- Per visit Limit: 3 visits per patient per week
After thirteenth week	C079	\$40.05	- Per visit Limit: 6 visits per patient per month
Concurrent Care	C078	\$40.05	- Per visit - Max 4 per week (first week) and 2 per week thereafter
Additional visits due to intercurrent illness	C121	\$40.05	- Per visit - No limits - See GP43
Palliative care visits (designated palliative care bed)	C982	\$40.05	- Per visit - No limits - See GP 50
Subsequent visit and palliative care visit by the Most Responsible Physician (MRP) Premium			
Subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982	E083	Add 30%	Not applicable to any other service or premium
Saturday, Sunday or Holiday subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982	E084	Add 45%	

Discharge by MRP	C124	\$71.80	- One service per hospital admission - Requires completion of the discharge summary by the physician within 48 hours of discharge, - Arranging for follow-up and prescription, if any - Not eligible for transfers within the same hospital (even if your facility requires a discharge summary for transfers).
Day of discharge, medically complex patient	C126	\$95.10	- Patient has been admitted to hospital for a min. 7 consecutive days and a minimum of 3 diagnoses that contributed to the stay - Must be 45min - Only one C124 or C126 is eligible for payment per hospital admission

General Practice and Family Medicine Fee Codes

Title	Code	Amount	When to use
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	K002	\$80.00	- Per unit - All interviews must be pre-booked, separate and lasting at least 20 minutes - Interviews <u>are not eligible</u> for payment when the information being obtained is part of the history normally included in the consultation or assessment of the patient
Individual - Counselling	K013	\$80.00	- Per unit - First three units of K013 and K040 combined per patient per provider per 12-month period - Patient visit dedicated solely to an educational dialogue with a physician - Must be pre-booked, separate and lasting at least 20 minutes

Miscellaneous

Detention

K001 - \$21.10 per full 15-minute time unit

- This service 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. It is billed in full 15-minute time units.
- Billing time begins only after the minimum time required for the corresponding assessment or consultation, as outlined in the table on page GP30-GP31 of the Schedule of Benefits, has elapsed.
- **Claims submission:** Claims are assessed by a medical consultant on an IC basis and require the submission of a written explanation.
- **Not eligible for payment:**
 - For time spent waiting.
 - In conjunction with diagnostic procedures, obstetrics, and those therapeutic procedures where the fee includes an assessment.
 - Not eligible for payment for same patient same day as A190, A191, A192 A195, A197, A198, A695, A795 or A895.

Multiple services in a single encounter



Generally, OHIP pays for one assessment per patient interaction. Physicians may bill the appropriate procedural code(s), in addition to the assessment, unless otherwise specified.

Multidisciplinary Care

- It applies to assessments/visits to hospital inpatients.
- When the complexity of the medical condition requires the services of several physicians in different disciplines, each physician visit constitutes a subsequent visit.
- It requires manual submission of claim for the second physician.

Transfer of Care

- When Physician A acts as a substitute for Physician B.
- For example: where the first physician is leaving temporarily on holidays and is unable to continue to treat the patient.
- Referrals for consultations should not be issued to Physician A.

Case Conference Codes

- Must include participation by the physician most responsible for the care of the patient and at least 2 other eligible participants specified are present.
- Time based services calculated in 10-minute increments.



- **Medical Record Requirements:** A single medical record in the patient's chart for the case conference, signed or initialed by all participating physicians.
- **Not eligible for payment** for educational purposes such as rounds, continuing professional development, or any meeting where the conference is not for the purpose of discussing and directing the management of an individual patient.

Limits:

- A maximum of 4 services per patient, per physician, per 12-month period.
- A maximum of 8 units are payable per physician, per patient, per day.
- Not eligible if supervision of postgraduate medical trainees.

Case Conferences for hospital patients

Code	Eligible Participant	Eligible Patient	Amount
K121	• Physicians • Regulated social workers • Regulated health professionals	Hospital inpatient in an acute care, chronic care or rehabilitation hospital	\$37.05 per unit
K124	• Physicians • Regulated social workers • Regulated health professionals • Employee of a Ontario Health atHome	Long-term care institution in patient or Ontario Health atHome	\$37.05 per unit
K703	• Physicians • Regulated social workers • Regulated health professionals Restricted to Geriatrics (07) or a physician with an exemption to access bonus impact in care of the Elderly from the MOHLTC	Geriatric outpatients	\$37.05 per unit

Consultation with Another Physician

Title	Code	Amount	When to use
Telephone Consultation (Physician to Physician) - All services rendered by the consultant physician to provide opinion/ advice/recommendations on patient care, treatment and management to the referring physician. The consultant physician is required to review all relevant data provided by the referring physician or nurse practitioner. - Minimum of 10 minutes of patient-related discussions. - Both referring and consultant physicians must be in Ontario at the time of service. - This service is eligible for payment in addition to visits or other services provided to the same patient on the same day by the same referring physician.			
Consultant Physician	K731	\$47.75	Limit: 1 payment per patient per day
Referring Physician	K730	\$37.05	Limit: 1 payment per patient per day
Physician on duty in an emergency department or hospital urgent care clinic			
Consultant Physician	K735	\$47.75	Limit: 1 payment per patient per day
Referring Physician	K734	\$37.05	Limit: 1 payment per patient per day
Email Consultation (Physician to Physician) - This service is <i>only eligible for payment</i> 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. - Both the request and opinion are sent by electronic means through a <u>secure server</u>. - The consultant physician shall provide the report to the nurse practitioner and the patient's primary care provider, if applicable.			
Referring physician	K738	\$16.45	Eligible for payment when the call is to collect additional data to support specialist re-assessment.
Consultant physician	K739	\$20.50	

Not eligible when:

- Discussion is to arrange the transfer of patient care.
- In whole or part to arrange for a consultation, assessment, or K-prefix time service, procedures or diagnostic investigations.
- To discuss the results of diagnostic investigations.
- When specialists renders a visit on the same day/following day of the physician-to-physician consultation for the same patient.

Virtual Care

Establishing physician-patient relationship

- A patient has had at least one insured service with a direct physical encounter with the physician in the preceding 24 months; or
- A specialist provides an eligible consultation by video or
- A physician provides any of the following services:
 - A920: Medical management of early pregnancy – initial service (video or by phone)
 - A945: Special palliative care consultation (video)
 - C945: Special palliative care consultation (video)
 - A253: Optometrist-requested assessment (video)
 - A256: Special optometrist-requested assessment (video)
 - A680: Initial assessment – substance abuse (video)
 - C680: Initial assessment – substance abuse (video)
 - A957 – Addiction medicine FPA by Video,
 - K680 – Substance abuse – extended assessment by video.



Comprehensive Virtual Care

If there is a physician-patient relationship:

- 100 % of the OHIP Schedule rate for services rendered by video.
- 85 % of the OHIP Schedule rate for services rendered by phone.
- 95 % of the OHIP Schedule rate for K007 GP psychotherapy, K005 primary mental health care, K197 individual outpatient psychotherapy, and K198 outpatient psychiatric care when rendered over the phone.

Limited Virtual Care

If there is **no** physician-patient relationship:

- A101: Limited virtual care service – \$20 (video)
- A102: Limited virtual care service – \$15 (phone)



For video consultations to be eligible for OHIP payment, physicians must use a platform included on Ontario's Health Verified Virtual Visit Solution list.

OHIP Claim Reconciliation Process

Submission Timeline

Submit Claims	3 months to submit
Error Report	Unlimited amount of time to correct
Remittance Advice Inquiry (RAI)	7 months to submit RAIs from the date of the RA
Internal Review Committee	20 days from receiving response from RAI
Health Service Appeal & Review Board (HSARB)	30-day limit after receiving OHIP decision

Understanding Error and Explanatory Codes

Error Codes: 3-character codes found in the error report.

Explanatory Codes: 2-character codes found in the RA report.

Billings on your Error report won't show up on your RA report. Cross reference to find gaps.

Processes

Resubmission of a previously rejected claim that is now stale dated

Correct all errors and resubmit the claim(s) in a single stale dated claim file via the Medical Claims Electronic Data Transfer (MCEDT).

- Send an email to ClaimsManagement@ontario.ca with
 - Billing number /group number
 - List of outstanding claims
 - Confirmation of stale-dated claims was uploaded
 - Error reports

Note: Billings on your Error report won't show up on your RA report.

Manual Review

Inquiries regarding services that are unusual, complex, or don't fit the standard billing rules. For example, billing the same code on the same day for the same patient or resubmitting an incorrect version code.

- Use the manual review indicator field in your EMR
- Send supporting documentation through eSubmit

Remittance Advice Inquiry (RAI)

Inquiries regarding overpayments, underpayments or claim submissions that were modified by the Ministry of Health. For example, change a partial assessment to a general assessment.

- Inquiries can be submitted electronically to the ministry using [eSubmit](#) or mailed/faxed to 1-905-434-4186 using a "Remittance Advice Inquiry" form (0918-84).

Health Services Appeal & Review Board (HSARB)

The Board has the authority to change the General Manager's decision if it is satisfied that OHIP made an error in interpreting the *Health Insurance Act* in your case. Your choice to participate in oral, electronic or written hearings.

- The Board recommends that all requests for appeal and review, submissions, materials, and inquiries be sent via email to hsarb@ontario.ca or faxed to HSARB at 416-327-8524.

Billing Best Practices

1. Know the rules before you bill

- Use the most current Schedule of Benefits from the Ontario Health Insurance Plan (OHIP).
- Understand service limits, time requirements, and premium eligibility.

2. Document to support the claim

- Your chart must justify the service code billed (history, exam, medical decision-making).
- Ensure time-based codes clearly document start/stop times when required.
- Record location, modality (e.g., in-person vs. virtual), and patient consent where applicable.

3. Bill accurately and promptly

- Submit claims daily or weekly to avoid backlog and missed deadlines.
- Verify patient eligibility at each visit.
- Double-check diagnostic and fee codes before submission.

4. Understand common errors

- Avoid duplicate billing or billing mutually exclusive codes.
- Be aware of frequency limits and age restrictions.
- Ensure virtual care meets Ministry requirements.

5. Monitor and reconcile

- Review remittance advice reports regularly.
- Track rejected or reduced claims and resubmit promptly.
- Audit your own billing periodically to identify patterns or gaps.

6. Stay current

- Watch for updates from the Ministry of Health and the Ontario Medical Association (OMA).
- Attend billing education sessions early in practice.

Tip: Bill what you did, document what you billed, and review what you were paid.

Additional Resources

- [OHIP Schedule of Benefits](#)
- [OHIP Claims Submission Process](#) (including manual review and stale dated claims)
- [OMA Post Payment Review Process](#)
- [OMA Billing Resources including delegated services, special premiums etc.](#)
- [OHIP Info Bulletins](#)
- [Education and Prevention Committee Billing Briefs](#)
- [OMA Uninsured Services Resources](#)
- OMA Mobile app
- For more information, email: info@oma.org