Ontario Medical Association

Home Care Billing Cheat Sheet

December 2023

Agenda

1. Time Units
2. Home Care Codes
3. Common Palliative Care Codes
4. Common Geriatric Care Codes
5. Pronouncement of Death & Death Certificate
6. Home Visits: Special Visit Premiums & Travel Codes
7. Consultation with Another Physician
8. Resources

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 July 2023

Introduction

A home in the Schedule of Benefits is defined as 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.

Time Units

- Billed in time units.
- Minimum time for the first unit = 20 minutes.
- Minimum time for subsequent unit – greater part of 30 minutes (16 minutes)

# 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]

Important requirement for all time-based codes:
Start and stop times (not duration, but actual start and stop times) **must** be recorded in the patient's medical record to be eligible for payment.

Home Care Codes

Title	Code	Amount	Notes
Home Care Application (Completion and submission of application)	K070	$31.75	1. K070 is limited to one per home care admission per patient. 2. Not eligible for payment if: • the patient is currently receiving home care. • part or all the application is completed by a person other than the physician.
Home Care Supervision (Acute)	K071	$21.40	1. K071 is limited to a maximum of one service per patient per physician per week for 8 weeks following admission to the home care program. 2. K071 is limited to a maximum of two services per patient per week for 8weeks. 3. Not eligible for payment if: • There is no record of service in the patient's file. • Part or all of the application is completed by a person other than the physician. • When rendered during a week that G512 is rendered.
Home Care Supervision (Chronic)	K072	$21.40	1. K072 is limited to a maximum of 2 services per month per patient per physician after the 8th week following admission to the home care program. 2. K072 is limited to a maximum of four services per patient per month. 3. Not eligible for payment if: • There is no record of service in the patient's file. • Part or all of the application is completed by a person other than the physician. • When rendered during a week that G512 is rendered.
Complex House Call Assessment*	A900	$54.50	1. A complex house call assessment is only eligible for payment for the first person seen during a single visit to the same location. 2. Not eligible for payment unless the patient is a frail elderly patient or a housebound patient and demonstrate that an intermediate assessment was rendered.

Special Family and General Practice Consultation	A911	$ 150.70	1. Must provide all the elements of a consultation and spends a minimum of 50 minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient. 2. No other consultation, assessment, visit, or counselling service is eligible for payment when rendered the same day to the same patient by the same physician.
Comprehensive Family and General Practice Consultation	A912	$ 226.05	1. Must provide all the elements of a consultation and spends a minimum of 75 minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient. 2. No other consultation, assessment, visit or counselling service is eligible for payment when rendered the same day to the same patient by the same physician.
Mandatory reporting of the medical condition to the MTO	K035	$36.25	Claims in excess of one per 12-month per physician, will require a manual review submission, accompanied by supporting documentation.
Long-Term Application Form	K038	$45.15	Completion and Submission of form.
Telephone Reporting – Specified Reportable disease to MOH	K034	$36.00	1.K034 is limited to a maximum of one service per physician, per patient, per specified reportable disease, per 12-month period. 2.K034 is only eligible for payment when the telephone report is personally rendered by the physician. 3.K034 is only eligible for payment for specified reportable diseases listed in Regulation 559/91.

***Note:**

1.For the purposes of A900, a frail elderly patient is a patient who is 65 years of age or over who has one or more of the following:
a. Complex medical management needs, that may include polypharmacy;
b. Cognitive impairment (e.g. dementia or delirium);
c. Age-related reduced mobility or falls; or
d. Unexplained functional decline not otherwise specified.

2. For the purposes of A900, a housebound patient is a patient who meets all the following criteria:
a. The person has difficulty in accessing office-based primary health care services because of medical, physical, cognitive, or psychosocial needs/conditions;
b. Transportation and other strategies to remedy the access difficulties have been considered but are not available or not appropriate in the person's circumstances; and
c. The person's care and support requirements can be effectively and appropriately delivered at home.

Common Palliative Care Billing Codes

Title	Code	Amount	Notes
Palliative Care Support	K023	$74.70	Payable for providing pain and symptom management, emotional support and counselling to patients receiving palliative care.
Special Palliative Care Consultation	A945	$159.20	1. Requested due to need for specialized management for palliative care. Requirement includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling and consideration of appropriate community services, where indicated. 2. Consultation is more than 50 minutes.
Palliative Care Weekly Management Fee	G512	$67.75	1. For providing supervision of palliative care to a patient for a period of one week, commencing at midnight Sunday. 2. Only eligible for the most responsible physician or by a physician substituting for this physician. 3. Limited to a maximum of one per week (Monday to Sunday inclusive) per patient in the instance a patient is transferred from one MRP to another, only the MRP who rendered the service majority of the week is eligible for payment. 4. G512 is eligible for payment even if the service was not provided for the entire week, due to death of the patient. 5. G511, K071 or K072 are not eligible for payment to any physician when rendered during a week that G512 is rendered.
Palliative Care Out-Patient Case Conference	K700	$32.45	1. Must include at least 2 other regulated healthcare providers (physicians, nurse, social worker) who is at least 65 years or less than 65 years with dementia. 2. Not eligible for payment with any other case conference or telephone consultation service for the same patient on the same day. 3. Limited to a maximum of 4 services per patient, per physician, per 12-month period. 4. A maximum of 8 units of K700 are payable per physician, per patient, per day.

Common Geriatric Billing Codes

Title	Code	Amount	Notes
Interviews with relatives/ person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act	K002	$70.10	1. Not eligible for payment when the information being obtained is part of the history normally included in the consultation or assessment of the patient. 2. The interview must be a booked, separate appointment lasting at least 20 minutes.
Geriatric Consultation	A075	$ 202.55	
Comprehensive Geriatric Consultation	A775	$310.45	1. Must be performed by a physician with a certificate of special competence in Geriatrics and where the patient has spent at least 75 minutes with the patient. 2. Not eligible if service was rendered on the same patient within 2 years.
Extended comprehensive geriatric consultation	A770	$ 401.30	Is eligible for payment when: 1. The consultation is for the assessment of dementia regardless of the patient's age. 2. Where the physician spends at least 90 minutes with the patient exclusive of time spent rendering any other service to the patient. 3. The service has not been rendered on the same patient by the same consultant within the previous 2 years. 4. The service is performed by a physician with a certificate of special competence in geriatrics.
Focused Practice Assessment (FPA) Care of Elderly	A967	$ 37.95	Physicians should be prepared to provide to the ministry documentation demonstrating training and/or experience on request. Cannot be combined with any other consultation, assessment, visit or counselling code.
Limited Consultation	A375	$ 105.25	

Medical Specific Assessment	A073	$ 90.45	This service occurs in a place other than a patient's home and requires 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. Max of one per 12 months *unless rendered for a hospital admission*, or if the second visit is an unrelated diagnosis.
Medical Specific Re-assessment	A074	$ 72.90	Requires a full, relevant history and physical examination of one or more systems. Max of 2 per 12 months unless rendered for a hospital admission.
Geriatric Out-patient Case Conference	K703A	$32.45	1. Must include at least 2 other regulated healthcare providers (physicians, nurse, social worker) who is at least 65 years or less than 65 years with dementia. 2. Not eligible for payment with any other case conference or telephone consultation service for the same patient on the same day. 3. Limited to a maximum of 4 services per patient, per physician, per 12-month period. 4. A maximum of 8 units of K703 are payable per physician, per patient, per day. 5.Only eligible for payment to a specialist in Geriatrics or a physician with an exemption to access bonus impact in Care of the Elderly from the MOH.
Specific neurocognitive assessment	K032	$70.10	1. Must include: a test of memory, attention, language, visuospatial function, and executive function. 2. A minimum of 20 minutes and must be completed on the same day.
Extended Specific Neurocognitive Assessment	K042	$ 140.20	1. Minimum of 46 minutes (consecutive/ non-consecutive) and must be exclusively dedicated to this service on the same day.
Geriatric Psychiatric Consultation	A795	$ 310.45	1. For a psychiatrist for a patient aged 75 years or older and must include all the elements of A195 and a minimum of 75 minutes of direct contact with the patient exclusive of discussion with caregivers or any separately payable services. 2. One per patient, per physician, per 5 years. 3. Must be pre-scheduled a minimum of 24 hours prior to the visit.

Individual Care Counselling	K013/K033	$70.10	Limited to 3 K013 units per patient per year; additional units billed as K033.
Group Counselling (2 or more persons)	K040/K041	$70.10	Where no group members have received more than 3 units of any counselling paid under codes K013 and K040 combined per provider per 12-month period per unit.
Geriatric telephone support	K077	$40.05 per unit	This is the service initiated by a caregiver where a physician provides telephone support to a caregiver(s) for a patient with an established diagnosis of dementia. 1.A maximum of two (2) units of K077 are eligible for payment per patient per day. 2.A maximum of eight (8) K077 units are eligible for payment per patient per 12-month period. 3.K077 is only eligible for payment where: a.there is a minimum of 10 minutes of patient-related discussion; and b.the physician: i. is a specialist in Geriatrics (07); or ii. has a certificate of special competence in Geriatrics; or iii. has an exemption to access bonus impact in Care of the Elderly from the MOH. 4.In circumstances where a physician receives compensation, other than by fee-for-service under this Schedule, for the provision of telephone support for caregivers, this service is not eligible for payment to that physician.

Pronouncement of Death & Death Certificate

Title	Code	Amount	Notes
House call assessment - Pronouncement of death in the home	A902	$54.50	This service includes completion of the death certificate personally and counselling of any relatives which may be rendered during the same visit. Submit the claim using the diagnostic code for the underlying cause of death as recorded on the death certificate.
Electronic Death Certificate only	A771A	$20.60	The form is not currently available on the Ontario Central Forms Registry. Visit: https://learn.oma.org/module-1/effective-ohip-billing-in-palliative-care/ or contact OMA for the form.

Home Visits: Special Visit Premium & Travel Codes

A visit initiated by a patient or an individual on behalf of the patient for the purpose of rendering a non-elective service or, if rendered in the patient's home, a non-elective or elective service.

Special Visits to Patient's Home (other than 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 – Friday	Sat, Sun and Holidays (07:00-24:00)	Nights (00:00-07:00)	Elective Home Visit
Travel Premium (non-elective	$36.40 B960 (no max. per time period)	$36.40 B961 (no max. per time period)	$36.40 B962 (no max. per time period)	$36.40 B963 (no max. per time period)	$36.40 B964 (no max. per time period)	$36.40 B960 (no max. per time period)
First Person seen (non-elective)	$27.50 B990 (no max. per time period)	$44.00 B992 (no max. per time period)	$66.00 B994 (no max. per time period)	$82.50 B993 (no max. per time period)	$110.00 B996 (no max. per time period)	$27.50 B990 (no max. per time period)
Additional person(s) seen	-	-	-	-	-	-
Travel premium	2	2	2	6	Unlimited	2
Person(s) seen	10	10	10	20	Unlimited	10

Note: First Person Seen Premium - The first person seen premium is eligible for payment for the first person seen at the destination if rendered during the eligible times (see the appropriate tables); or if rendered requiring sacrifice of office hours. See the special premium resource for more details.

Geriatric Home Special Visits and Travel Codes

Only eligible for payment to a specialist in Geriatrics or a physician with an exemption to access bonus impact in Care of the Elderly from the MOH.

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with sacrifice of office hours	Evenings (17:00-24:00) Monday – Friday	Sat, Sun and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 B986 (no max. per time period)	$36.40 B986 (no max. per time period)	$36.40 B986 (no max. per time period)	$36.40 B986 (no max. per time period)	$36.40 B986 (no max. per time period)
First Person seen	$82.50 B988 (no max. per time period)	$82.50 B988 (no max. per time period)	$82.50 B988 (no max. per time period)	$82.50 B988 (no max. per time period)	$110.00 B987 (no max. per time period)

Palliative Care Special Visits and Travel Codes

Premium	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with sacrifice of office hours	Evenings (17:00-24:00) Monday – Friday	Sat, Sun and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium (non-elective	$36.40 B966 (no max. per time period)	$36.40 B966 (no max. per time period)	$36.40 B966 (no max. per time period)	$36.40 B966 (no max. per time period)	$36.40 B966 (no max. per time period)
First Person seen (non-elective)	$82.50 B998 (no max. per time period)	$82.50 B998 (no max. per time period)	$82.50 B998 (no max. per time period)	$82.50 B998 (no max. per time period)	$110.00 B997 (no max. per time period)
Additional person(s) seen	-	-	-	-	-
Travel premium	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Person(s) seen	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Example of how to bill:

Assessment + Special Visit Premium + Travel

Consultation with Another Physician

<table>
<tr><th>Title</th><th>Code</th><th>Amount</th><th>When to use</th></tr>
<tr><td colspan="4">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 consulting 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.
Must include start and stop times.
Name of referring and consulting physician.
Reason for consultation and the recommendations of the consultant physician.
Not eligible when:
Discussion is to arrange transfer of patient care.
When arranging for a consultation
When rendered primarily to discuss results of diagnostic investigations or
When a consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day following the physician-to-physician telephone consultation for the same patient.</td></tr>
<tr><td>Consulting Physician</td><td>K731</td><td>$41.85</td><td>Not on Duty
Limit: 1 payment per patient per day</td></tr>
<tr><td>Consulting Physician</td><td>K735</td><td>$41.85</td><td>Physician on duty in an emergency dept or urgent care clinic
Limit: 1 payment per patient per day</td></tr>
<tr><td>Referring Physician</td><td>K730</td><td>$32.45</td><td>Not on duty
Limit: 1 payment per patient per day</td></tr>
<tr><td>Referring Physician</td><td>K734</td><td>$32.45</td><td>Physician on duty in an emergency dept or urgent care clinic
Limit: 1 payment per patient per day</td></tr>
<tr><td colspan="4">Email Consultation (Physician to Physician)
Payment rules:
K738 and K739 are each limited to a maximum of one service per patient per day.
K738 and K739 are each limited to a maximum of six services per patient, any physician, per 12-month period.
K738 and K739 are each limited to a maximum of 400 services per physician, per 12-month period.
Not eligible when:
When the purpose of the electronic communication is to arrange for transfer of the patient's care to any physician;
When rendered in whole or in part to arrange for a consultation, assessment, visit, or K-prefix time-based services, procedure(s), or diagnostic investigation(s);
When rendered primarily to discuss results of diagnostic investigation(s); or
When a consultant physician renders a consultation, assessment, visit, or K-prefix time-based service, on the same day or next day following the physician/nurse practitioner to physician e-consultation for the same patient.
For specialists in Dermatology (02) or Ophthalmology (23).</td></tr>
</table>

Medical Record Requirements: • patient's name and health number; • name of the referring or nurse practitioner and consultant physicians; • reason for the consultation; and • the opinion and recommendations of the consultant physician.			
Consulting Physician	K738	$16.00	
Referring Physician	K739	$20.50	• Eligible for payment when the call is to collect additional data to support specialist re-assessment.

Resources

- Schedule of Benefits – Effective July 24, 2023
- OMA FHO/FHN In-Basket Fee Codes
- GP Focused Practice Program, Policies and Codes
- Special Visit Premium Guide
- For more information, email economics@oma.org