OHIP Payments for Hospital Services

Quick Reference Guide

Economics, Policy & Research

OMA
ONTARIO MEDICAL ASSOCIATION

OHIP Payments for Hospital Services
Quick Reference Guide[1]

The purpose of this guide is to provide a general overview on the OHIP payment rules for hospital services. 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) General Information
(B) Admission Assessments
(C) Subsequent Visits to Hospital In-patients
(D) Other Routine Visits to Hospital In-patients
(E) Patient Discharge
(F) Most Responsible Physician (MRP) Codes and Premiums
(G) Hospitalist Premium
(H) Transferal of Care vs Referral of Care
(I) Critical Care
(J) Special Visits
(K) Miscellaneous Services
(L) Additional Resources

A: General Information

Services provided to hospital patients, regardless of whether that service occurs in the emergency department (ED), outpatient department (OPD) or in-patient department (IPD), are to be claimed using the codes in the physician's own specialty listing (i.e., Section A of the Schedule, "Consultations and Visits"). This applies to services such as consultations, assessments and subsequent visits.

The exception is for the "Emergency Department Physician", which is a physician working in a hospital ED/hospital urgent care clinic for the purpose of rendering services to unscheduled patient who attend the ED/hospital urgent care clinic to receive physician services.[3] There are specific "H" prefix listings (H1-codes) for consultations and assessments and any physician on duty (regardless of specialty) must submit using these listings.[4]

[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 t 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] This Quick Reference Guide is based on the OHIP Schedule of Benefits (SOB), Physician Services, March 19, 2020 (effective April 1, 2020) (http://www.health.gov.on.ca/en/pro/programs/ohip/sob/).
[3] OHIP SOB, April 2020, page GP50
[4] OHIP SOB, April 2020, page A14-A15

B: Admission Assessments

The Schedule defines an admission assessment as "*the initial assessment of the patient rendered for the purpose of admitting the patient to hospital*."[5] Note that the admission date is the date that the admission assessment occurs.[6]

Only one admission assessment is eligible for payment per hospital admission. When a patient is transferred from one physician to another physician within the same hospital, an additional admission assessment is not eligible for payment.

Admission assessment: any previous assessment by admitting physician > 90 days ago
When the admitting physician has **not** previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a:

General/Family Physician	Specialist
• Consultation; or • General assessment	• Consultation; • Medical specific assessment; or • Specific assessment

Admission Assessment: previous assessment by admitting physician < 90 days ago
When the admitting physician has previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a:

General/Family Physician	Specialist
• General re-assessment	• Specific re-assessment

Admission Assessment: following a separately rendered initial assessment
When a patient has been assessed by a physician in the ER or OPD and that physician renders any other assessment other than those listed in the table below, and subsequently admits the patient to hospital, an admission assessment is eligible for payment in addition to the initial assessment, if each assessment is rendered separately.

General/Family Physician	Specialist
• Consultation; • General assessment; or • General re-assessment	• Consultation; • Medical specific assessment; or • Specific assessment

The service rendered for the admission assessment will depend on the specialty of the physician, the nature of the service rendered and any applicable payment rules. Note that all constituent, common and specific elements associated with the particular service provided as admission assessment are required, as outlined in the Schedule.

[5] OHIP SOB April 2020, page GP40

[6] The patient may arrive at the hospital the day before the admission date occurs (e.g., arriving at the hospital in the late evening, but the admission assessment is not performed until the following morning). Physicians should ensure that they are linking the admission date, for billing purposes, with the service date of the admission assessment.

On-call Admission Assessment
An on-call admission assessment is the first hospital in-patient admission general assessment per patient per 30-day period, provided:

a) The physician is a general practitioner or family physician participating in the hospital's on-call roster whether or not the physician is on-call the day the service is rendered;
b) The admission is non-elective; and
c) The physician is the most responsible physician with respect to subsequent in-patient care.

C: Subsequent Visits to Hospital In-patients

The Schedule defines a subsequent visit as *"any routine assessment in hospital following the hospital admission assessment."*[7] Most subsequent visits[8] are limited as follows:

Subsequent visit	Maximums
First 5 weeks following admission	Maximum 1 visit per patient, per day
Sixth to thirteenth week inclusive	Maximum 3 visit per patient, per week
After thirteenth week	Maximum 6 visits, per patient, per month

D: Other Routine Visits to Hospital In-patients

Additional Visits due to Intercurrent Illness
After 5 weeks of hospitalization, visits (with the exception of pediatric subsequent visits) are restricted to 3 visits per week (sixth to thirteenth week of hospitalization) or 6 visits per month (after the thirteenth week of hospitalization). Assessments in hospital required as a result of an acute intercurrent illness[9] that are in excess of the aforementioned limits, can be claimed as C121 "additional visit due to intercurrent illness". The weekly or monthly limits set out in Section C of this document do not apply to additional visits due to intercurrent illness.

Palliative Care Visits to Patients in Designated Palliative Care Beds
Palliative care visits to patients are to be claimed using C882 (general/family physician) or C982 (specialist).[10] Unlike the subsequent visit codes, palliative care visits do not have service limits.

Multidisciplinary Care
Except where a single service for a team of physicians exists (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.

[7] OHIP SOB April 2020, page GP43
[8] Pediatric subsequent visits (C262) are limited to one per patient, per day for the duration of the admission. These may only be claimed by pediatricians (26).
[9] Claims for additional visits due to intercurrent illness will have a different diagnostic code than claims for the admission assessment and subsequent visits.
[10] If the visit is more than 20 minutes in length, K023 may be eligible for payment instead of C882 or C982.

E: Patient Discharge

Patient discharge (C124 subsequent visit – day of discharge), for OHIP payment purposes, refers to a patient who is being discharged from the hospital and not for a patient who is being transferred to another area/ward in the same hospital. This service is also not eligible for payment for patients who have expired in hospital. Since most hospitals require discharge notes as an internal requirement for both transfers within hospital and deceased patients, physicians may mistake this activity as eligible to be paid as C124.[11]

The discharge service is only eligible for payment when:

- The service is rendered by the most responsible physician (MRP);
- The service occurs at least 48 hours from the patient admission.

The service requires the MRP to provide a subsequent visit, arrange any appropriate follow-up care and to complete a discharge summary (reason for admission, procedures performed during hospitalization, discharge diagnosis and medications on discharge) within 48 hours.

F: Most Responsible Physician (MRP) Codes and Premiums

All admission assessments, subsequent visits and palliative care visits are eligible for a premium when rendered by the most responsible physician (MRP). Admission assessments may be eligible to be paid with E082 and subsequent visits/palliative care visits may be eligible to be paid with E083 or E084 (the latter for a visit that occurs on a Saturday, Sunday or Holiday). Subsequent visits that occur on the two days following the admission assessment have dedicated billing codes, as listed below; otherwise, physicians are to claim E083 with the subsequent visits codes listed in their respective specialty listing (e.g., general/family practice physicians' subsequent visit codes are C002, C007 and C009).

All codes listed in the table below have several associated payment rules and restrictions. Refer to the Schedule's General Preamble for complete information.

Service (when rendered by MRP)	MRP Premium
Admission assessment (most appropriate assessment code)	E082
C122 Subsequent visit by the MRP – day following the hospital admission assessment	E083 / E084
C123 Subsequent visit by the MRP – second day following the hospital admission assessment	E083 / E084
C124 Subsequent visit by the MRP – day of discharge	E083 / E084
Subsequent visit (as per specialty specific listings in the OHIP Schedule)	E083 / E084
C882 Palliative care visit	E083 / E084
C982 Palliative care visit	E083 / E084

[11] Refer to the OHIP Schedule for additional restrictions on this code.

G: Hospitalist Premium

Physicians who meet defined service levels for caring for hospital inpatients may be eligible for a premium. The premium is applicable to physicians with specialty 00 (General and Family Practice) and 13 (Internal Medicine) based on volume of service encounters and with a minimum of 1500 core services billed on at least 110 distinct days in the previous fiscal year.[12]

Those meeting the eligibility requirements for the premium will receive a 17% payment on the qualifying services listed below, with the exception of E082.

- A933A-On-call admission assessment
- C933A-On-call admission assessment
- C002A-Subsequent visit-first five weeks
- C007A-Subsequent visit-6th to13th weeks
- C009A-Subsequent visit-after 13th week
- C122A-Subsequent visit by MRP-day following hospital admission assessment
- C123A-Subsequent visit by MRP-second day following the hospital assessment
- C124A-Subsequent visit by MRP-day of discharge
- C132A-Subsequent visit-first five weeks
- C137A-Subsequent visit-6th to 13th week
- C139A-Subsequent visit-after 13th week
- C142A-First subsequent visit by MRP following transfer from an Intensive Care area
- C143A-Second subsequent visit by MRP following transfer from an Intensive Care area
- C882A-Palliative care-GP
- C982A-Palliative care-all other specialties
- E082A-Admission assessment by the Most Responsible Physician premium

H: Transferal of Care vs Referral of Care

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 determining the appropriate subsequent visit fee code.

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.

A referral might be issued when a physician requires the provision of expert services by another physician. More commonly, physicians will experience transferals, which is the permanent or temporary complete transfer of the responsibility for the care of the patient from one physician to another. An example of a transferal is when a patient is assessed in the emergency department and subsequently admitted to the acute care ward. Referrals for consultation (for example) are not eligible for payment for transfers of care, but are eligible for payment if a consultation request is made to provide expert advice on the complexity, seriousness, or obscurity of a particular case.

[12] April 1 of one year to March 31 of the following year

I: Critical Care

Life Threatening Critical Care
This service is rendered to a patient with a critical illness or a critical injury, which is one that acutely impairs one or more vital organ(s) causing vital organ system failure as a result of which imminent life threatening deterioration in the patient's condition is highly probable.

Examples of vital organ system failure include but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and or respiratory failure.

Other Critical Care
The service rendered when a physician provides resuscitation assessment and procedures in an emergency in circumstances other than those described as "life threatening critical care", where there is a potential threat to life or limb of such a type that without resuscitation efforts by the physician, there is a high probability the patient will suffer loss of limb or require "life threatening critical care".

Code	Life Threatening Critical Care	Other Critical Care
G521	- first ¼ hour (or part thereof)	-
G523	- second ¼ hour (or part thereof)	-
G522	- after first ½ hour, per ¼ hour (or part thereof)	-
G395	-	- first ¼ hour (or part thereof)
G391	- per ¼ hour (or part thereof) for fourth and subsequent physicians	- after first ¼ hour per ¼ hour (or part thereof)

Life threatening critical care codes G521, G523 and G522 are payable per patient to the first 3 physicians. Fourth and subsequent physicians should claim payment using G391.

Other critical care codes G395 and G391 are payable per patient to the first 3 physicians. Services rendered by subsequent physicians (beyond 3) are not eligible for payment.

The services listed below are not eligible for payment when rendered to the same patient by the same physician on the same day as any code describes as life threatening critical care or other critical care:

- Assessment and ongoing monitoring of the patient's condition.
- Intravenous lines.
- Cutdowns.
- Arterial and/or venous catheters.
- Central venous pressure (CVP) lines.
- Endotracheal intubation.
- Tracheal toilet.
- Blood gases.
- Nasogastric intubation with/without anaesthesia with/without lavage.
- Urinary catheters.
- Pressure infusion sets and pharmacological agents.

In addition to the elements listed, life threatening critical care also includes defibrillation and cardioversion.

Critical Care: Payment Rules[13]

- Start and stop times of the service must be recorded in the patient's permanent medical record
- The service is only eligible for payment for services rendered by the physician at the bedside or in the emergency department or on the hospital floor where the patient is located.
- Time unit total may include time which is consecutive or non-consecutive
- During the time reported for the claim, the physician cannot provide services to other patients. The physician time calculated must be physician time spent fully devoted to the care of the patient and excludes time spent on separately billable interventions.
- G395 is not eligible for payment with G521, G522 or G523 for services rendered to the same patient by the same physician on the same day.
- Consultation or assessments rendered before or after provision of life threatening or other critical care may be eligible for payment on a fee-for-service basis but not when claiming Critical Care (intensive care area), Ventilatory Support, Comprehensive Care or Neonatal Intensive Care per diem fees.[14]

J: Special Visits

A special visit is one that is initiated by the patient or patient representative (e.g., nurse) for the purpose of rendering a non-elective service. Physicians who make special visits to the hospital are eligible to bill special visit premiums (SVP) specific to hospital in-patients. Special visits are eligible for payment whether the visit is for a physician's own patient or for another physician's patient.

When the physician is on site (i.e., when the travel premium is not eligible for payment) and asked to make a special visit to a hospital in-patient, a SVP first person seen code is not eligible for payment when the special visit occurs between 07:00 – 17:00, Monday to Friday, unless there has been a sacrifice of office hours.

For complete information on SVPs and their application, refer to the OHIP Schedule of the OMA Quick Reference Guide: OHIP Payments for Special Visit Premiums.[15]

K: Miscellaneous Services

Home Care[16]

When completing an application for home care services, K070 Home care application may be eligible for payment. The completion of the application is eligible for payment only in circumstances where the physician completes the application in whole. K070 is eligible for payment in addition to an assessment fee, where applicable. If patient is already receiving home care services, K070 is not eligible for payment. K071 or K072 may be eligible for making adjustments to home care services.

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[13] Refer to the Schedule for the complete list of payment rules.
[14] Physicians report that despite this payment rule, claims for consultations and assessments rendered before or after the critical care service are frequently rejected unless submitted manually with documentation.
[15] https://www.oma.org/member/section/practice-&-professional-support/ohip-billing-resources?type=topics
[16] OHIP SOB April 2020, page A55

Interviews[17]
An interview with a person who is authorized to make a treatment decision on behalf of the patient in accordance with the Health Care Consent Act may be eligible for payment as K002. This time-based service should be rendered in situations where medically necessary information cannot be obtained from or given to the parent or guardian because of illness, incompetence , etc. The purpose of the interview is not for the sole purpose of obtaining consent nor is the information being obtained a part of the history normally included in the consultation or assessment of the patient.

This time based service must be a booked, separate appointment to be eligible for payment. Claims should be submitted using the patient's health number and diagnosis.

Primary Mental Health Care[18]
Primary mental health care (K005) are time-based 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. This code is not to be billed in conjunction with other consultations and visits rendered by a physician during the same patient visit unless there are clearly different diagnoses for the two services.

Hospital In-patient Case Conference[19]
A case conference is a pre-scheduled meeting, conducted for the purpose of discussing and directing the management of an individual patient. A case conference for an in-patient specifically (K121), requires participation by the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers and/or regulated health professionals regarding a hospital in-patient. A case conference can be conducted by personal attendance, videoconference or by telephone (or any combination thereof). For a detailed explanation of the payment rules, medical record requirements and time keeping requirements, refer to the OMA Quick Reference Guide titled, "OHIP Payments for Case Conference Services".[20]

I: Additional Resources

- Education and Prevention Committee Interpretive Bulletin Vol 4, No 1 - New Subsequent Visit Codes and Changes to Post-Operative Care by the Surgeon: https://www.oma.org/wp-content/uploads/0401epc_bulletin.pdf
- Education and Prevention Committee Interpretive Bulletin Vol 5, No 3 - Subsequent Visit Codes and Post-Operative Care: https://www.oma.org/wp-content/uploads/0503epc_bulletin.pdf
- Education and Prevention Committee Interpretive Bulletin Vol 8, No. 4 – Life Threatening Critical Care (G521, G522, G523, G391) and Other Critical Care (G391 and G395): https://www.oma.org/wp-content/uploads/0804epc_bulletin.pdf

[17] OHIP SOB April 2020, page A26 and pages GP7, GP54-GP61
[18] OHIP SOB April 2020, page A19 and pages GP7, GP54-GP61
[19] OHIP SOB April 2020, pages A29-A38
[20] https://www.oma.org/member/section/practice-&-professional-support/ohip-billing-resources?type=topics

OHIP Payments for Hospital Services: Quick Reference for OHIP Billing[21]

General & Family Practice Physicians		Specialists	
Admission Assessments[22]			
A/C005	Consultation	A/Cxxx	Consultation
A/C003	General assessment	A/Cxxx	Medical specific assessment
A/C004	General re-assessment	A/Cxxx	Specific assessment
A/C933	On-call admission assessment	A/Cxxx	Specific re-assessment
Subsequent Visits and Palliative Care by MRP			
C122	- Day following admission assessment	C122	- Day following admission assessment
C123	- Second day following admission assessment	C123	- Second day following admission assessment
C002 + E083/4	- First five weeks	Cxx2 + E083/4	- First five weeks
C007 + E083/4	- Sixth to thirteenth week inclusive (max 3/week)	Cxx7 + E083/4	- Sixth to thirteenth week inclusive (max 3/week)
C009 + E083/4	- After thirteenth week (max 6/month)	Cxx9 + E083/4	- After thirteenth week (max 6/month)
C882 + E083/4	Palliative care	C982 + E083/4	Palliative care
C124 + E083/4	- Day of discharge	C124 + E083/4	- Day of discharge
Subsequent Visits and Palliative Care (by non-MRP)			
C002	- First five weeks	Cxx2	- First five weeks
C007	- Sixth to thirteenth week inclusive (max 3/week)	Cxx7	- Sixth to thirteenth week inclusive (max 3/week)
C009	- After thirteenth week (max 6/month)	Cxx9	- After thirteenth week (max 6/month)
C882	Palliative care	C982	Palliative care
Other Routine Visits			
C010	Supportive care	-	-
C008	Concurrent care	Cxx8	Concurrent care
C121	Additional visits intercurrent illness	C121	Additional visits intercurrent illness

Special Visit Premiums to Hospital In-patients					
	Weekday Daytime (07:00-17:00)	**Weekday Daytime – with sacrifice**	**Weekday Evenings (17:00-24:00)**	**Sat, Sun & Holidays (07:00-24:00)**	**Nights (00:00-07:00)**
Travel Premium	C960	C961	C962	C963	C964
First person seen	C990	C992	C994	C986	C996
Additional person	C991	C993	C995	C987	C997
Maximums (per time period)					
Travel	2	2	2	6	Unlimited
Persons seen	10	10	10	20	Unlimited

[21] 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.
[22] When the admission assessment is rendered by the MRP, add E082 premium to the appropriate admission assessment code

OHIP Payments for Hospital Services: Quick Reference for OHIP Billing[23]

<table>
<tr><th colspan="5">Life Threatening Critical Care</th></tr>
<tr><td colspan="5">Amount payable per physician per patient for the first three physicians</td></tr>
<tr><td>G521</td><td colspan="3">- first ¼ hour (or part thereof)</td><td>$110.55</td></tr>
<tr><td>G523</td><td colspan="3">- second ¼ hour (or part thereof)</td><td>$55.20</td></tr>
<tr><td>G522</td><td colspan="3">- after first ½ hour, per ¼ hour (or part thereof)</td><td>$36.35</td></tr>
<tr><td>G391</td><td colspan="3">Fourth and subsequent physicians – per ¼ hour (or part thereof)</td><td>$28.35</td></tr>
<tr><th colspan="5">Other Critical Care</th></tr>
<tr><td colspan="5">Amount payable per physician per patient for the first three physicians</td></tr>
<tr><td>G395</td><td colspan="3">- first ¼ hour (or part thereof)</td><td>$56.80</td></tr>
<tr><td>G391</td><td colspan="3">- after first ¼ hour, per ¼ hour (or part thereof)</td><td>$28.35</td></tr>
<tr><th colspan="5">Time-based Services</th></tr>
<tr><td>K121</td><td colspan="3">Hospital in-patient case conference (per 10 min unit)</td><td>$31.35</td></tr>
<tr><td>K002</td><td colspan="3">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 (per 20 min unit)</td><td>$67.75</td></tr>
<tr><td>K005</td><td colspan="3">Primary mental health care – individual care (per 20 min unit)</td><td>$67.75</td></tr>
<tr><td>K013/K033</td><td colspan="3">Counselling – individual care (per unit)</td><td>$67.75/$47.70</td></tr>
<tr><td>K015</td><td colspan="3">Counselling of relatives - on behalf of catastrophically or terminally ill patient - 1 or more persons (per unit)</td><td>$67.75</td></tr>
<tr><th colspan="5">Palliative Care Services</th></tr>
<tr><td>A/C945</td><td colspan="3">Special palliative care consultation</td><td>$159.20</td></tr>
<tr><td>K023</td><td colspan="3">Palliative care support (per unit)</td><td>$67.75</td></tr>
<tr><td>G512</td><td colspan="3">Palliative care case management fee (per patient, per week)</td><td>$67.75</td></tr>
<tr><th colspan="5">Forms</th></tr>
<tr><td>K038</td><td colspan="3">Long-Term application - completion of LTC health report form</td><td>$45.15</td></tr>
<tr><td>K070</td><td colspan="3">Home care application</td><td>$31.75</td></tr>
<tr><th colspan="5">Procedures[24]</th></tr>
<tr><td>Z331</td><td>Diagnostic thoracentesis</td><td>Z804</td><td colspan="2">Lumbar puncture</td></tr>
<tr><td>Z332</td><td>Therapeutic thoracentesis</td><td>Z176/Z175</td><td colspan="2">Repair of laceration <5cm/5.1-10 cm</td></tr>
<tr><td>Z590</td><td>Diagnostic paracentesis</td><td>Z101</td><td colspan="2">Incision of abscess/haematoma</td></tr>
<tr><td>Z591</td><td>Therapeutic paracentesis</td><td>G370</td><td colspan="2">Injection/aspiration of joint/bursa, ganglion or tendon</td></tr>
<tr><td>Z116</td><td>Biopsy with sutures</td><td>Z117</td><td colspan="2">Chemical and/or cryotherapy</td></tr>
<tr><td>Z113</td><td>Biopsy without sutures</td><td>G268</td><td colspan="2">Cannulation of artery</td></tr>
<tr><td>G420</td><td colspan="4">Ear syringing and/or extensive curetting or debridement unilateral or bilateral</td></tr>
<tr><th colspan="5">After Hours Procedure Premiums</th></tr>
<tr><td>E409[25]</td><td colspan="4">Evenings (17:00h-24:00h) Monday to Friday or daytime and on Sat., Sun., Holidays</td></tr>
<tr><td>E410</td><td colspan="4">Nights (00:00h – 07:00h)</td></tr>
</table>

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[24] Note: the descriptions of the procedures listed are in some cases abbreviated. Refer to the OHIP Schedule of Benefits for the complete descriptor.

[25] E409 and E410 apply to “Physician – other than an Emergency Department Physician”