OMA Ontario Medical Association

Neurology Billing Cheat Sheet

Updated: December 2023

Agenda

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

Unit of Times

- 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.

Consultations

A consultation is an assessment rendered following a written request from a referring physician or nurse practitioner.

A consultation includes the services necessary to enable the consultant to prepare a written report (including findings, opinions, and recommendations) to the referring physician or nurse practitioner. Where the referral is made by a nurse practitioner, the consultant shall provide the report to the nurse practitioner and the patient's primary care provider, if applicable.

Consultations: Office-based or Outpatient clinic

Title	Code	Amount	Notes
Consultation	A185	$184.40	Must be requested by another physician or nurse practitioner
Special Neurology Consultation	A180	$310.45	• All elements of A185 and • Spend a minimum of **75** minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.
Extended Special Neurology Consultation	A682	$401.30	• All elements of A185 and • Spend a minimum of **90** minutes of direct contact with the patient exclusive of time spent rendering any other separately billable intervention to the patient.
Limited Consultation	A385	$87.70	This service is less demanding and, in terms of time, normally requires substantially less of the physician's time than the full consultation.
Repeat Consultation	A186	$87.70	Seeing the patient again for the same issue, following care rendered to the patient by another physician in the interval following the initial consultation but preceding the repeat consultation.

Assessments: Office-based or Outpatient Clinic Title	Code	Amount	Notes
Medical Specific Assessment	A183	$82.40	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 o*ne* per 12 months unless rendered for a hospital admission, or if the se*cond* visit is an unrelated diagnosis
Medical Specific Re-Assessment	A184	$64.95	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.
Complex Medical Specific Re-Assessment	A181	$75.20	This service is a re-assessment of a patient because of the complexity, obscurity, or seriousness of the patient's condition and includes all the requirements of a medical specific re-assessment. The physician must report his/her findings, opinions, or recommendations in writing to the patient's primary care physician. Max of 4 per 12 months, or any combination of A183 + A181 to a max of 4 per 12 months
Partial Assessment	A188	$39.40	This is a limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient and appropriate record
Chronic Disease Assessment Premium	E078	Add 50%	Applies to eligible diseases, please refer to page 16 or GP26 in the Schedule for diagnostic codes, as a premium to A183, A184, A181 or A188.
Complex Neuromuscular Assessment	A113	$93.95	Must contain all the elements of medical specific re-assessment of the neuromuscular system where the complexity of the condition requires the continuing management by a neurologist: a. generalized peripheral neuropathies; b. myopathies; c. diseases of the neuromuscular junction; or d. diseases of the motor neurone. Limit: 6 per patient, per physician, 12-month period. **Not eligible** for payment to a physician: • for the initial evaluation of the patient by that physician or • For payment with E078

Specific neurocognitive assessment	K032	$70.10	An assessment of neurocognitive function rendered personally by the physician where all of the following requirements are met: **a.** test of memory, attention, language, visuospatial function, and executive function. Examples of neurocognitive assessment batteries which would be acceptable are the short form of the Behavioral Neurology Assessment (BNA) or the Dementia Rating Scale (DRS) **b.** a minimum of 20 minutes (consecutive or non-consecutive) and must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day; and **c.** the start and stop time(s) must be recorded in the patient's medical record.
Extended specific neurocognitive assessment	K042	$140.20	An assessment of neurocognitive function rendered personally by the physician where all of the following requirements are met: **a.** test of memory, attention, language, visuospatial function and executive function; **b.** a minimum of 46 minutes (consecutive or non-consecutive) must be dedicated exclusively to this service (including administration of the tests and scoring) and must be completed on the same day; and **c.** the start and stop time(s) must be recorded in the patient's medical record. Examples of extended neurocognitive assessment batteries which would be acceptable, where the minimum time requirement has been met, are: • Montreal Cognitive Assessment (MOCA), • Toronto Cognitive Assessment (TorCA), • Frontal Assessment battery Only one of K032 or K042 is eligible for payment to the same physician, same day.
Detention	K001	$ 21.10	Per full quarter hour See General Preamble GP30 for circumstances that detention is payable.

Hospital In Patient Consultation and Assessments

Title	Code	Amount	When to use
Consultation	C185	$184.40	Subject to the same conditions as A185
Comprehensive Neurology Consultation	C180	$310.45	Subject to same conditions as C185 Minimum time spent 75 minutes
Special Neurology Consultation	C682	$401.30	Subject to the same conditions as A682
Consultation and management of ACVS	C384	$200.00	Subject to the same conditions as A384
Consultation and Management for Acute Cerebral Vascular Syndrome (ACVS)	A384	$200.00	Must have all the elements of a consultation (A185) for suspected ACVS and if necessary, treatment with intravenous thrombolysis therapy and post-administration monitoring.
	K181	$90.00	After first 30 minutes, must include intravenous thrombolysis therapy and monitoring, per 30-minute unit (or major part thereof)
			Limits: 1. A384 and K181 are only eligible for payment for patients seen within the intravenous thrombolysis therapy timeframe. 2. A384 and K181 must be rendered in a hospital with CT or MRI facilities onsite. 3. A384 and K181 are only eligible for payment to a specialist in Neurology. 4. A384 and K181 are only eligible for payment if the physician remains in constant attendance with the patient. 5. G521, G522, G523, or G391 are not eligible for payment with A384 or K181. 6. K181 is only eligible for payment for patients treated with intravenous thrombolysis therapy. Limited to a maximum of 6 units per patient per day.
Limited Consultation	C385	$87.70	
Repeat Consultation	C186	$87.70	
Medical Specific Assessment	C183	$82.40	Subject to same conditions as A186
Medical Specific Re-Assessment	C184	$64.95	
Complex Medical Specific Re-Assessment	C181	$75.20	

Complex neuromuscular assessment	C113	$93.95	Must contain all the elements of medical specific re-assessment-for the management of ongoing complex neuromuscular disorders
	C182	$34.10	First 5 weeks per visit
	C187	$34.10	6-13 weeks inclusive (max 3 per patient per week)
	C189	$34.10	13+ weeks (max 6 per patient per month)
Subsequent visits by the Most Responsible Physician (MRP)	C122	$61.15	Day following the hospital admission assessment
	C123	$61.15	Second day following the hospital admission assessment
	C124	$61.15	Day of discharge
Subsequent visits by the MRP following transfer from an Intensive Care Area	C142	$61.15	First subsequent visit by the MRP following transfer from an Intensive Care Area
	C143	$61.15	Second subsequent visit by the MRP following transfer from an Intensive Care Area
Additional visits due to intercurrent illness by MRP	C121	$34.10	Per visit
Concurrent care by MRP	C188	$34.10	Limited to 4 per week during the first week of concurrent care and 2 claims per week thereafter.
Palliative care by MRP	C982	$34.10	Per visit 1. Palliative care visits to patients in designated palliative care beds, regardless of facility type, as applicable. 2. Services rendered to patients whose unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death do not constitute palliative care assessments.
Certification of death by MPR	C771	$20.60	Subject to the same conditions as A771
Intermediate assessment - Pronouncement of death by MRP	C777	$37.95	Subject to the same conditions as A777
Intensive Care Unit Premium	C101	Add $9.10	For each patient seen on an ICU or CCU visit. Not eligible for payment with Supportive Care, Critical Care, Ventilatory Care, Comprehensive Care, Acquired Brain Injury Management or Neonatal Intensive Care where team fees are claimed. C101 is also payable alone when no other service was provided in the ICU or CCU

Life Threating Critical Care For the purpose of this service, a critical illness or critical injury is one that acutely impairs one or more vital organ system(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.]			
First ¼ hour (or part thereof)	G521	$111.80	Amount payable per physician per patient for the first three physicians
Second ¼ hour (or part thereof)	G523	$57.65	
After first ½ hour, per ¼ hour (or part thereof)	G522	$38.00	
Emergency or Out-Patient Dept (ODP)	Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.		

Non-Emergency Long-Term Care In-Patient Services (e.g., Chronic Care Hospitals, Nursing Homes)

Title	Code	Amount	When to use
Consultation	W185	$184.40	Subject to the same conditions as A185
Special Neurology Consultation	W180	$310.45	Subject to the same conditions as A180
Extended Special Neurology Consultation	W682	$401.30	Subject to the same conditions as A682
Limited Consultation	W385	$87.70	
Repeat Consultation	W186	$87.70	
Complex Neuromuscular assessment	W113	$93.95	Subject to the same conditions as A113
General re-assessment of patient in nursing home	W184	$20.60	May only be claimed 6 months after Periodic Health visit
Subsequent Visits			
Chronic Care or Convalescent Hospital	W182	$34.10	First 4 subsequent visits per patient per month per visit
	W181	$34.10	Additional subsequent visits (maximum of 6 per patient per month) per visit
	W982	$34.10	Palliative care per visit
Nursing Home	W183	$34.10	First 2 subsequent visits per patient per month per visit
	W188	$34.10	Additional subsequent visits (maximum of 3 per patient per month) per visit
	W972	$34.10	Palliative care per visit
	W121	$34.10	Additional visits due to intercurrent illness

Special Visit Premium

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

Emergency Department

Not eligible for payment to Emergency Department Physicians (see definition GP67)

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 K960 (max 2 per time period)	$36.40 K961 (max 2 per time period)	$36.40 K962 (max 2 per time period)	$36.40 K963 (max 2 per time period)	$36.40 K964 (max 2 per time period)
First Person seen	$20.00 K990 (max 10 (total of first and additional person seen) per time period)	$40.00 K992 (max 10 (total of first and additional person seen) per time period)	$60.00 K994 (max 10 (total of first and additional person seen) per time period)	$75.00 K998 (max 20 (total of first and additional person seen) per time period)	$100.00 K996 (no max. per time period
Additional Person(s) seen	$20.00 K991 (max 10 (total of first and additional person seen) per time period)	$40.00 K993 (max 10 (total of first and additional person seen) per time period)	$60.00 K995 (max 10 (total of first and additional person seen) per time period)	$75.00 K999 (max 20 (total of first and additional person seen) per time period)	$100.00 K997 (no max. per time period

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	$36.40 C960 (max 2 per time period)	$36.40 C961 (max 2 per time period)	$36.40 C962 (max 2 per time period)	$36.40 C963 (max 2 per time period)	$36.40 C964 (max 2 per time period)
First Person seen	$20.00 C990 (max 10 (total of first and additional person seen) per time period)	$40.00 C992 (max 10 (total of first and additional person seen) per time period)	$60.00 C994 (max 10 (total of first and additional person seen) per time period)	$75.00 C986 (max 20 (total of first and additional person seen) per time period)	$100.00 C996 (no max. per time period
Additional Person(s) seen	$20.00 C991 (max 10 (total of first and additional person seen) per time period)	$40.00 C993 (max 10 (total of first and additional person seen) per time period)	$60.00 C995 (max 10 (total of first and additional person seen) per time period)	$75.00 C987 (max 20 (total of first and additional person seen) per time period)	$100.00 C997 (no max. per time period

Specific Diagnostic and Therapeutic Procedures

EEG

Title	Code	Amount	When to use
Routine EEG - professional component	G415	$23.15	A routine EEG consists of at least a twenty-minute recording with referential and bipolar montages and at least eight channels (except in neonates). Hyperventilation and photic stimulation should be done in all cases where clinically possible.
Routine EEG - professional component (16 - 21 channel EEG)	G418	$ 62.50	
Prolonged EEG Monitoring- Professional component	G545	$14.70 per unit	Videotape recording of clinical signs in association with spontaneous EEG. Unit means ¼ hour or major part thereof. Limited to a maximum of 12 units
Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add to routine fees. Professional component	G546	$30.45	Radiotelemetry or portable recordings to monitor spontaneous EEG from a freely moving patient, add to routine fees
Ambulatory EEG Monitoring- Professional component	G555	$120.00	This is to include 12 to 24 hours of EEG monitoring. The fee includes EEG electrodes and other physiological parameters felt necessary to arrive at an appropriate electrographic diagnosis.
Clinical Programming of Deep Brain Stimulator (DBS)	G547	$185.70	Includes one or more visits for DBS checking, minor and major DBS adjustments, and intensive programming. First implantation site (maximum 1 per patient)
Clinical Programming of Deep Brain Stimulator (DBS) -additional implantation site(s)	G549	$157.85	Maximum 1 per patient
Electrophysiological assessment-of Deep Brain Stimulators	G548	$278.85	Includes measuring electrode impedance, recording EEG and EMG, rectification, averaging, frequency analysis and cross correlation. Minimum of 3 hours. Physician must be physically present throughout assessment

Sleep Studies

Title	Code	Amount	When to use
Therapeutic study for sleep related breathing disorders -Level 1 therapeutic study	J895	$370.75 – H $97.50 - P	1. There is a limit of one therapeutic study per patient during any two consecutive 12-month periods except where prior approval has been given. 2. J895 rendered to the same patient during the same 12-hour period as J896 or J897 is not eligible for payment.
Initial diagnostic study -Level 1 Diagnostic study	J896	$370.75 – H $97.50 - P	1. A maximum of one initial diagnostic study is eligible for payment per patient per lifetime. 2.All subsequent overnight sleep studies constitute “repeat diagnostic” or “therapeutic” studies.
Repeat diagnostic study -Level 1 Diagnostic study	J897	$370.75 – H $97.50 - P	1. Repeat diagnostic studies are limited to one per patient, per facility, per 12-month period except where prior approval has been given. 2. Repeat diagnostic studies performed in the same facility that performed the initial diagnostic study are not eligible for payment in the 12-month period following an initial diagnostic study except where prior approval has been given.

Injections/Infusions- Botulinum Toxin Service & Nerve Blocks

Title	Code	Amount	When to use
Injections/Infusions- Botulinum Toxin Service			
Botulinum toxin injection(s) for blepharospasm, (unilateral or bilateral)	G871	$120.00	
Botulinum toxin injection(s) for sialorrhea, (unilateral or bilateral)	G874	$50.00	
Botulinum toxin injection for the following conditions: Oromandibular dystonia, limbdystonia, cervical dystonia or spasticity • First Injection • Each additional injection to a maximum of 11, to G875	• G875 • G876	• $40.00 • Add $10.00	
EMG and/or ultrasound guidance for Botulinum toxin injections • With EMG guidance (when required to determine the injection site), for one injection, to G870, G873, G874, or G875 • With EMG guidance (when required to determine the injection site), for two or more injections, to G870, G873, G874 or G876	• G877 • G878	• Add $18.85 • Add $28.10	

Nerve Blocks			
Somatic or peripheral nerves not specifically listed • One nerve or site • additional nerve(s) or site(s)	• G231 • G223	• $34.10 • Add $17.10	G921 is not eligible for payment same patient same day with G232.
Ganglion/Plexus injection Spheno-palatine ganglion block, transnasal topical, uni or bilateral	G921	$12.50	

Other

Title	Code	Amount	When to use
Lumbar Puncture	Z804	$150.00	Not eligible for payment with C-suffix anaesthesia services rendered for surgical procedures, obstetrical anaesthesia procedures or with epidural services. Includes injection of any medication/ therapeutic agent and includes image guidance if performed.
Particle repositioning maneuver	G403	$21.15	For benign paroxysmal positional vertigo
Peripheral nerve block - minor	G061	$30.00	Limit: A maximum of 4 services per patient per physician per day
Amytal Test (Wada)-bilateral	G410	$68.40	Supervision and co-ordination of tests
Electrocorticogram	G413	$170.85	Supervision and interpretation not eligible if claimed with G267 on same patient on same day
Katzman test	G551	$170.85	Subarachnoid infusion test including lumbar puncture
Occipital nerve block	G264	$34.10	First block per day (maximum 1 per day to a maximum of 16 first blocks per calendar year)
	G265	$17.10	Each additional unilateral block following G264 per spinal level per day when G264 is payable in full (maximum 3 per day to a maximum of 48 additional blocks per calendar year)
Procedures Involving neural elements. Programming infusion pump or dorsal column stimulator	Z943	$142.20	

Physical Medicine – Needle Electromyography and Nerve Conduction Studies			
Schedule A – Professional Component	G456	$99.90	Complete procedure i.e. conduction studies on two or more nerves presumed to be involved in the disease process together with EMG studies of appropriate muscles, as necessary and/or detailed studies of neuromuscular transmission. It also includes as necessary study of normal nerve and/or opposite side for comparison.
Schedule B – Professional Component	G457	$61.95	Limited procedure i.e. conduction studies on a single nerve (motor and/or sensory conduction) and/or limited EMG studies of the involved muscle(s) and or limited neuromuscular transmission study.
Schedule C – Technical Component	G471	$28.90	Not eligible for payment with G455 or G466 same patient same day.
Vascular System			
Extra-cranial vessel assessment-above aortic arch Duplex scan i.e. simultaneous real time, B-mode imaging and frequency/spectral analysis	J201	$55.05 - H $24.65 - P	
Transcranial doppler assessment of intracranial circulation	J189	$23.65	J189 is not eligible for payment with J186, J187 or J188 same patient same day

Chronic Disease Assessment Premium

Title	Code	Amount	When to use
Definition/ Required elements of service: Chronic disease assessment premium is payable in addition to the amount payable for an assessment when all of the following criteria are met: a. The assessment is a i. medical specific assessment; ii. medical specific re-assessment; iii. complex medical specific re-assessment; iv. partial assessment; or v. level 2 paediatric assessment. The chronic disease assessment premium is **not** payable in situations where the diagnosis has not been established.	E078	add 50%	The chronic disease assessment premium is not payable for assessments rendered to inpatients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department

The following is a list of the diagnostic codes as specified by OHIP that must accompany the claim for payment purposes (General Preamble GP26) for the list of the diagnostic codes that must accompany the claim for payment purposes.

Diagnostic Code	Description
042	AIDS
043	AIDS-related complex
044	Other human immunodeficiency virus infection
250	Diabetes mellitus, including complications
286	Coagulation defects (e.g. haemophilia, other factor deficiencies)
282	Hereditary hemolytic anemia (e.g., thalassemia, sickle-cell anemia)
287	Purpura, thrombocytopenia, other haemorrhagic conditions
290	Senile dementia, presenile dementia
299	Child psychoses or autism
313	Behavioural disorders of childhood and adolescence
315	Specified delays in development (e.g. dyslexia, dyslalia, motor retardation)
332	Parkinson's Disease
340	Multiple Sclerosis
343	Cerebral Palsy
345	Epilepsy
402	Hypertensive Heart Disease
428	Congestive Heart Failure
491	Chronic Bronchitis

492	Emphysema
493	Asthma, Allergic Bronchitis
515	Pulmonary Fibrosis
555	Regional Enteritis, Crohn's Disease
556	Ulcerative Colitis
571	Cirrhosis of the Liver
585	Chronic Renal Failure, Uremia
710	Disseminated Lupus Erythaematosus, Generalized Scleroderma, Dermatomyositis
714	Rheumatoid Arthritis, Still's Disease
720	Ankylosing Spondylitis
721	Other seronegative spondyloarthropathies
758	Chromosomal Anomalies
765	Prematurity, low-birthweight infant
902	Educational problems

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

Virtual Care Billing

Modality modifier

- **K300A for video or K301A for phone**

Two levels of virtual care services reimbursement are to be established: Comprehensive virtual care and Limited virtual care.

Comprehensive Virtual Care

Delivered in an ongoing physician-patient relationship, defined as:

- Where the patient has had at least one insured service with a direct physical encounter with the physician in the preceding 24-months; or
- Where a specialist or GP focus practice physician provides an eligible insured consultation by video

Virtual consultations done by phone and billed using **K083** count as establishing the P-to-P relationship.	• Pays at the same rate as the corresponding in-person service when provided by video. • Pays at 85% of the corresponding in-person service when provided by telephone.

Limited Virtual Care

An assessment which includes at a minimum, history-taking and medically appropriate exam to arrive at a diagnosis and provide an appropriate management plan and/or management, and when provided, the other specific elements of assessments.
Delivered in the absence of an ongoing physician-patient relationship and practice, the person's care and support requirements can be effectively and appropriately delivered by Video or Telephone.

Limited Virtual Care by Video	A101	$20.00
Limited Virtual Care by Telephone	A102	$15.00

Virtual Care Payment Parameters

- Existing requirements for in-person care will apply with the exception of a direct physical encounter.
- Must be clinically appropriate to provide virtually.
- Virtual service must be initiated by a patient or in follow up to a medically necessary visit.
- Physicians must offer in-person.
- If a visit is started virtually and finished in person, only the in-person is payable – no triage.
- Video must be performed on a Ministry verified platform.
- Only eligible for payment if an in-person service would have been performed.
- Hospital and LTC virtual care permitted only if there are no physicians who can provide that service locally.

Virtual Care Services are not eligible for payment unless the delivery modality is documented on the patient's medical record.
Both the patient and physician must be located in Ontario for the services to be insured and payable under OHIP.

Practice in General

Title	Code	Amount	When to use
Home Care Application	K070	$31.75	K070 is limited to one per home care admission per patient. Not eligible for payment if the patient is currently receiving home care
Home Care Supervision (Acute and Chronic)	K071/K072	$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 8 weeks. 3. 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. 4. K072 is limited to a maximum of four services per patient per month.
Hospital Inpatient Case Conference	K121	$ 32.45	Per unit Is eligible for payment for a case conference regarding a hospital in-patient at an acute care hospital, chronic care hospital, or rehabilitation hospital. K121 is not eligible for payment for a resident in a long-term care institution. Limit: A maximum of 4 services per patient, per physician, per 12- month period. A maximum of 8 units of K121 are payable, per patient, per day.
Individual Care Counselling	K013/K033	$70.10	Limited to 3 K013 units per patient, per physician, per year; additional units billed as K033.
Group Counselling	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
Counselling of relatives - on behalf of catastrophically or terminally ill patient	K015	$70.10	Counselling for 1 or more persons
Mandatory reporting of the medical condition to the MTO	K035	$36.25	Once per 12 month only. Claims in excess of one per *12-month period* by the same physician for the same patient should be submitted using the manual review indicator and accompanied by supporting documentation

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. • 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.			
Consultant Physician	K731	$41.85	Not on Duty Limit: 1 payment per patient per day
Consultant Physician	K735	$41.85	Physician on duty in an emergency dept or urgent care clinic Limit: 1 payment per patient per day
Referring Physician	K730	$32.45	Not on duty Limit: 1 payment per patient per day
Referring Physician	K734	$32.45	Physician on duty in an emergency dept or urgent care clinic Limit: 1 payment per patient per day
Email Consultation (Physician to Physician)			
Referring physician	K738	$16.00	Eligible for payment when the call is to collect additional data to support specialist re-assessment.
Consultant physician	K739	$20.50	
• Definition/Required elements of service – Consultant physician(s) • This service includes all services rendered by the consultant physician(s) necessary to provide advice on patient management. The consultant physician(s) is required to review all relevant data provided by the referring physician/nurse practitioner.			
CritiCall telephone consultation - Consultant physician	K733	$41.85	
CritiCall telephone consultation - Referring physician	K732	$32.45	

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, virtual care, special premiums etc.
- OMA Permanent virtual care codes: a visual guide
- OMA Virtual care FAQs (updated)
- OMA Guide for Uninsured Services
- WSIB physician fee schedule
- HST exempt services (MD Tax)

For more information, email economics@oma.org