GENERAL SURGERY (03)

GENERAL LISTINGS

A035	Consultation	90.30
A935	Special surgical consultation (see General Preamble GP19).	160.00
A036	Repeat consultation	60.00
A033	Specific assessment	44.40
A034	Partial assessment	26.85

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP76.

C035	Consultation	90.30
C935	Special surgical consultation (see General Preamble GP19).	160.00
C036	Repeat consultation	60.00
C033	Specific assessment	44.40
C034	Specific re-assessment	28.90

Subsequent visits

C032	- first five weeks	per visit	31.00
C037	- sixth to thirteenth week inclusive (maximum 3 per patient per week)	per visit	31.00
C039	- after thirteenth week (maximum 6 per patient per month)	per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	61.15
C123	- second day following the hospital assessment	61.15
C124	- day of discharge	61.15

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	61.15
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	61.15

C121	Additional visits due to intercurrent illness (see General Preamble GP43)	per visit	31.00
C038	Concurrent care	per visit	31.00
C982	Palliative care (see General Preamble GP50)	per visit	31.00

GENERAL SURGERY (03)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP76.

W035	Consultation	90.30
W036	Repeat consultation	60.00

Subsequent visits (see General Preamble GP49)

Chronic care or convalescent hospital

W032	- first 4 subsequent visits per patient per month .....per visit	32.20
W031	- additional subsequent visits (maximum of 6 per patient per month).....per visit	21.20
W982	- palliative care (see General Preamble GP50) .....per visit	32.20

Nursing *home* or *home* for the aged

W033	- first 2 subsequent visits per patient per month .....per visit	32.20
W038	- subsequent visits per month (maximum of 3 per patient per month).....per visit	21.20
W972	- palliative care (see General Preamble GP50) .....per visit	32.20
W121	Additional visits due to intercurrent illness (see General Preamble GP49) .....per visit	31.00

GENERAL THORACIC SURGERY (64)

GENERAL LISTINGS

A645	Consultation	98.55
A935	Special surgical consultation (see General Preamble GP19).	160.00
A646	Repeat consultation	60.00
A643	Specific assessment	44.40
A644	Partial assessment	24.10

EMERGENCY OR OUT-PATIENT DEPARTMENT (OPD)

Physician in hospital but not on duty in the Emergency Department when seeing patients in the Emergency or OPD - use General Listings.

NON-EMERGENCY HOSPITAL IN-PATIENT SERVICES

See General Preamble GP40 to GP48. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP76.

C645	Consultation	98.55
C935	Special surgical consultation (see General Preamble GP19).	160.00
C646	Repeat consultation	60.00
C643	Specific assessment	44.40
C644	Specific re-assessment	25.95

Subsequent visits

C642	- first five weeks ... per visit	31.00
C647	- sixth to thirteenth week inclusive (maximum 3 per patient per week) ... per visit	31.00
C649	- after thirteenth week (maximum 6 per patient per month) ... per visit	31.00

Subsequent visits by the Most Responsible Physician (MRP)

See General Preamble GP44 to GP45 for terms and conditions.

C122	- day following the hospital admission assessment	61.15
C123	- second day following the hospital assessment	61.15
C124	- day of discharge	61.15

Subsequent visits by the MRP following transfer from an Intensive Care Area

See General Preamble GP46 for terms and conditions.

C142	- first subsequent visit by the MRP following transfer from an Intensive Care Area	61.15
C143	- second subsequent visit by the MRP following transfer from an Intensive Care Area	61.15
C121	Additional visits due to intercurrent illness (see General Preamble GP43) ... per visit	31.00
C648	Concurrent care ... per visit	31.00
C982	Palliative care (see General Preamble GP50) ... per visit	31.00

GENERAL THORACIC SURGERY (64)

NON-EMERGENCY LONG-TERM CARE IN-PATIENT SERVICES

Non-Emergency Long-Term Care In-Patient Services includes Chronic Care Hospitals, Convalescent Hospitals, Nursing *Home*s, *Home*s for the Aged, designated chronic or convalescent care beds in hospitals and nursing *home*s or *home*s for the aged, other than patients in designated *palliative care* beds. For emergency calls and other special visits to in-patients, use General Listings and Premiums when applicable - see General Preamble GP65 to GP76.

W645	Consultation	98.55
W646	Repeat consultation	60.00

GENERAL PREAMBLE

SPECIFIC ELEMENTS OF ASSESSMENTS

In addition to the *common elements*, all services which are described as assessments, or as including assessments (e.g. consultations), include the following *specific elements*:

A. A direct physical encounter with the patient including taking a patient history and performing a physical examination.

B. Other inquiry (including taking a patient history), carried out to arrive at an opinion as to the nature of the patient's condition, (whether such inquiry takes place before, during or after the encounter during which the physical examination takes place) and/or follow-up care.

C. Performing any procedure(s) during the same encounter as the physical examination, unless the procedure(s) is(are) separately listed in the Schedule and an amount is payable for the procedure in conjunction with an assessment.

"Procedure" in this context includes obtaining specimens, preparation of the patient, interpretation of results and, unless otherwise specified, all diagnostic (including laboratory) and therapeutic (including surgical) services;

D. Making arrangements for any related assessments, procedures or therapy, and/or interpreting results.

E. Making arrangements for follow-up care.

F. Discussion with, and providing advice and information, including prescribing therapy to the patient or the *patient's representative*, whether by telephone or otherwise, on matters related to:

1. the service; and

2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment(s).

G. When medically indicated, monitoring the condition of the patient and intervening, until the next insured service is provided.

H. Providing premises, equipment, supplies, and personnel for the *specific elements* of the service except for any aspect(s) that is (are) performed in a hospital or nursing *home*.

While no occasion may arise for performing elements C, D, E, G, or H, when performed in connection with the other *specific elements*, they are included in the assessment.

GENERAL PREAMBLE

CONSULTATIONS

CONSULTATION

Definition/Required elements of service:

A consultation is an assessment rendered following a written request from a referring physician or *nurse practitioner* who, in light of his/her professional knowledge of the patient, requests the opinion of a physician (the "consultant physician") competent to give advice in this field because of the complexity, seriousness, or obscurity of the case, or because another opinion is requested by the patient or *patient's representative*.

[Commentary:

1. The referring physician or *nurse practitioner* must determine if multiple requests by a patient or the *patient's representative* to different physicians in the same specialty for the same condition are medically necessary. Services that are not medically necessary are uninsured.

2. If the physician rendering the service requests a referring physician or *nurse practitioner* to submit a consultation request for that service after the service has been provided, a consultation is not payable. The visit fee appropriate to the service rendered may be claimed.

3. Where a physician who has been paid for a consultation for the patient for the same diagnosis makes a request for a *referral* for ongoing management of the patient, the service rendered following the *referral* is not payable as a consultation.]

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. Except where otherwise specified, the consultant is required to perform a general, specific or medical specific assessment, including a review of all relevant data.

The following are additional requirements for a consultation:

a. A copy of the written request for the consultation, signed by the referring physician or *nurse practitioner* must be kept in the consulting physician's medical record, except in the case of a consultation which occurs in a hospital, long-term care institution or multi-specialty clinic where common medical records are maintained. In such cases, the written request may be contained on the common medical record.

b. The request identifies the consultant by name, the referring physician or *nurse practitioner* by name and billing number, and identifies the patient by name and health number.

c. The written request sets out the information relevant to the *referral* and specifies the service(s) required.

In the event these requirements are not met, the amount payable for a consultation will be reduced to a lesser assessment fee.

[Commentary:

The request would ordinarily also include the appointment date and appropriate clinical information, such as the reason for the *referral* for consultation, present and past history, physical findings and relevant test results and reports.]

Payment rules:

1. Consultations rendered to the same patient by the same physician for the same diagnosis are limited to one service per two consecutive *12 month periods* except:

a. When the additional consultation service(s) is a repeat consultation;

CONSULTATIONS

b. When a consultant has rendered a consultation service to a patient in any location and the same consultant is referred to the same patient a second time with the same diagnosis, then the number of consultations eligible for payment is a total of two services per two consecutive *12 month periods* only when:

i. the second consultation is rendered for a hospital inpatient or a patient in an Emergency Department; and

ii. the consultation is rendered more than 12 *months* but less than 24 *months* following the first consultation.

See the Table below.

Limits on Consultation Services Rendered for the Same Problem Within Two Consecutive 12 Month Periods

Patient location where consultation rendered		**Total consultation services eligible for payment in two consecutive 12 month periods**	
First consultation	**Second consultation**	**Services rendered within first 12 months**	**Services rendered between 12 and 24 months**
All locations	Hospital Inpatient or Emergency Department	One service	One service
All locations	All locations except hospital inpatient or Emergency Department	One service	One Service

2. Consultations rendered to the same patient by the same consultant with a clearly defined unrelated diagnosis are limited to one service every 12 *months.*

3. The amount payable for consultations will be adjusted to the amount payable for a general or specific assessment, depending upon the specialty of the consultant where:

a. consultations are in excess of the above limits;

b. the payment requirements of a repeat consultation are not met; or

c. the consultation is requested by a Medical Trainee.

Note:

1. The above limits are applicable to all consultations, including time-based and age-specific consultation services (e.g. special, extended and comprehensive consultations) but not repeat consultations.

CONSULTATIONS

2. In the preoperative preparation of a patient undergoing the following low risk elective surgical procedures under local anaesthesia and/or I.V. sedation, a preoperative consultation by any physician is *only eligible for payment* where the medical record demonstrates the consultation is medically necessary.

a. cataract surgery;

b. colonoscopy;

c. cystoscopy;

d. carpal tunnel surgery; or

e. arthroscopic surgery.

[Commentary:
Such medically necessary consultations would be very uncommon.]

GENERAL PREAMBLE

CONSULTATIONS

REPEAT CONSULTATION

Definition/Required elements of service:

A repeat consultation is an additional consultation rendered by the same consultant, in respect of the same presenting problem, following care rendered to the patient by another physician in the interval following the initial consultation but preceding the repeat consultation.

A repeat consultation has the same requirements as a consultation including the requirement for a new written request by the referring physician or *nurse practitioner.*

LIMITED CONSULTATION

Definition/Required elements of service:

A limited consultation is a consultation which is less demanding and, in terms of time, normally requires substantially less of the physician's time than the full consultation. Otherwise, a limited consultation has the same requirements as a full consultation.

Under the heading of "Family Practice & Practice in General", a limited consultation is the service rendered by any physician who is not a *specialist*, where the service meets all the requirements for a consultation but, because of the nature of the *referral*, only those services which constitute a specific assessment are rendered.

EMERGENCY ROOM (ER) PHYSICIAN CONSULTATION

Payment rules:

1. The amount payable for a consultation by an ER Physician will be adjusted to a lesser assessment fee under either of the following circumstances:
   - **a.** the patient is referred by another ER physician in the same hospital; or
   - **b.** the service is rendered in any location other than the emergency department or other critical care area in a hospital, or to a critically ill patient in a hospital.
2. ER reports constitute adequate documentation of the written report of the consultation as long as the rendering of all *constituent elements* is clearly documented on all copies of the report. If the consulting physician fails to ensure that a copy of the ER report is sent to the physician or *nurse practitioner* who referred the patient, the amount payable for the service will be adjusted to the amount payable for an assessment.

Claims submission instruction:

Claims for ER Physician consultations are to be submitted using H055 for a *specialist* in emergency medicine (FRCP) and H065 for all other physicians.

SPECIAL SURGICAL CONSULTATION

Definition/Required elements of service:

A special surgical consultation is rendered when a surgeon provides all the appropriate elements of a regular consultation and is required to devote at least fifty minutes exclusively to the consultation with the patient.

> **[Commentary:**
> The calculation of the 50 minute minimum excludes time devoted to any other service or procedure for which an amount is payable in addition to the consultation.]

CONSULTATIONS

Claims submission instruction:

Claims for special surgical consultations are to be submitted using either A935 or C935, as applicable.

GENERAL PREAMBLE

ASSESSMENTS

Specific requirements for assessments listed in the "Consultations and Visits" section of the Schedule are set out below:

GENERAL ASSESSMENT

Definition/Required elements of service:

A general assessment is a service, rendered at a place other than in a patient's *home* that requires a full history (the elements of which must include a history of the presenting complaint, family medical history, past medical history, social history, and a functional inquiry into all body parts and systems), and, except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts and systems, and *may include* a detailed examination of one or more parts or systems.

Payment rules:

General assessments are limited to one per patient per physician per *12 month period* unless either of the following circumstances is met in which case the limit is increased to two per *12 month period*:

1. the patient presents a second time with a complaint for which the diagnosis is clearly different and unrelated to the diagnosis made at the time of the first general assessment; or
2. at least 90 days have elapsed since the date of the last general assessment and the second assessment is a hospital admission assessment.

The amount payable for general assessments in excess of these limits will be adjusted to a lesser assessment fee.

PERIODIC HEALTH VISIT

Definition: A periodic health visit (including a primary or secondary school examination) is performed on a patient, after their second birthday, who presents and reveals no apparent physical or mental illness. The service must include an intermediate assessment, a level 2 paediatric assessment or a partial assessment focusing on age and gender appropriate history, physical examination, health screening and relevant counselling.

Payment rules:

Periodic health visit is limited to one per patient per *12 month period* per physician.

[Commentary:
Periodic health visits in excess of the limit are not insured.]

Claims submission instruction:

Submit claims for periodic health visits using the fee codes listed below.

No diagnostic code is required

ASSESSMENTS

Family Practice & Practice in General

Code	Description
K017	*child*
K130	*adolescent*
K131	*adult* age 18 to 64 inclusive
K132	*adult* 65 years of age and older

Paediatrics

Code	Description
K269	12 to 17 years
K267	2 to 11 years

GENERAL RE-ASSESSMENT

Definition/Required elements of service:

A general re-assessment includes all the services listed for a general assessment, with the exception of the patient's history, which need not include all the details already obtained in the original assessment.

Payment rules:

With the exception of general re-assessments rendered for hospital admissions, general re-assessments are limited to two per *12 month period*, per patient per physician. The amount payable for general re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

PRE-DENTAL/PRE-OPERATIVE ASSESSMENTS

[Commentary:
For Definition and terms and conditions see page A4.]

SPECIFIC ASSESSMENT AND MEDICAL SPECIFIC ASSESSMENT

Definition/Required elements of service:

Specific assessment and medical specific assessment are services rendered by *specialist*s, in a place other than a patient's *home*, and require 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.

Payment rules:

Specific assessments or medical specific assessments are limited to one per patient per physician per *12 month period* unless either of the following circumstances are met in which case the limit is increased to two per patient per physician per *12 month period*:

1. the patient presents a second time with a complaint for which a clearly different diagnosis is made, unrelated to the diagnosis made at the time of the first specific assessment in that *12 month period*; or
2. in the case of a medical specific assessment, at least 90 days have elapsed since the date of the last specific assessment and the second assessment is a hospital admission assessment.

The amount payable for specific or medical specific assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments (see below) are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

SPECIFIC RE-ASSESSMENT AND MEDICAL SPECIFIC RE-ASSESSMENT

Definition/Required elements of service:

Specific re-assessment and medical specific re-assessment are services rendered by *specialist*s and require a full, relevant history and physical examination of one or more systems.

[Commentary:
As outlined on page GP40, admission assessments are deemed to be a specific re-assessment or medical specific re-assessment under either of the following circumstances:

1. for those procedures prefixed with a "Z" or noted as an *IOP*, by a surgical *specialist* who has assessed the patient prior to admission in respect of the same illness; or

2. for those patients who have been assessed by a physician and subsequently admitted to the hospital for the same illness by the same physician.]

Payment rules:

Specific re-assessments or medical specific re-assessments are limited to two per patient per physician per consecutive *12 month period* except for specific re-assessments rendered for hospital admissions. The amount payable for specific or medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

COMPLEX MEDICAL SPECIFIC RE-ASSESSMENT

Definition/ Required elements of service:

A complex medical specific re-assessment 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 or the amount payable for the service will be adjusted to a lesser assessment fee.

Payment rules:

Complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period*. The amount payable for complex medical specific re-assessments in excess of this limit will be adjusted to a lesser assessment fee.

In addition, any combination of medical specific assessments and complex medical specific re-assessments are limited to 4 per patient per physician per *12 month period*. The amount payable for these services in excess of this limit will be adjusted to a lesser assessment fee.

ASSESSMENTS

PARTIAL ASSESSMENT

Definition/ Required elements of service:

A partial assessment is the 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

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

b. The service is rendered by a physician registered with *OHIP* as having one of the following specialty designations:

07(Geriatrics), 15(Endocrinology & Metabolism), 18(Neurology), 26(Paediatrics), 28(Pathology), 31(Physical Medicine), 34(Therapeutic Radiology), 44(Medical Oncology), 46(Infectious Disease), 47(Respiratory Disease), 48(Rheumatology), 61(Haematology), 62(Clinical Immunology).

c. The assessment is rendered in an office setting or an out-patient clinic located in a hospital, other than an emergency department.

[Commentary:
The chronic disease assessment premium is not payable for assessments rendered to in-patients of any hospital, patients seen in a long-term care facility or patients seen in an emergency department.]

d. The patient has an established diagnosis of a chronic disease, documented in the patient's medical record.

ASSESSMENTS

DETENTION

Definition/Required elements of service:

Detention 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 and in this section is based on full 15-minute time units. The *specific elements* are those for assessments.

K001 Detention – per full quarter hour 21.10

Payment rules:

1. Detention is payable under the following circumstances:

ASSESSMENTS

Service	Minimum time required in delivery of service before detention is payable
minor, partial, multiple systems assessment, level 1 and level 2 paediatric assessment, intermediate assessment, focused practice assessment or subsequent hospital visit	30 minutes
specific or general re-assessment	40 minutes
consultation, repeat consultation, specific or general assessment, complex dermatology assessment, complex endocrine neoplastic disease assessment, complex neuromuscular assessment, complex physiatry assessment, complex respiratory assessment, enhanced 18 *month* well baby visit, midwife-requested anaesthesia assessment, midwife-requested assessment, midwife-requested genetic assessment or optometrist-requested assessment	60 minutes
initial assessment-substance abuse, special community medicine consultation, special family and general practice consultation, special optometrist-requested assessment, special *palliative care* consultation, special surgical consultation or midwife-requested special assessment	90 minutes
comprehensive cardiology consultation, comprehensive community medicine consultation, comprehensive endocrinology consultation, comprehensive family and general practice consultation, comprehensive geriatric consultation, comprehensive infectious disease consultation, comprehensive internal medicine consultation, comprehensive midwife-requested genetic assessment, comprehensive nephrology consultation, comprehensive respiratory disease consultation, comprehensive physical medicine and rehabilitation consultation, comprehensive rheumatology consultation, special paediatric consultation, special genetic consultation or special neurology consultation	120 minutes
extended comprehensive geriatric consultation, extended midwife-requested genetic assessment, extended special genetic consultation, extended special paediatric consultation, or paediatric neurodevelopmental consultation	180 minutes

2. Detention is *not eligible for payment* in conjunction with diagnostic procedures, obstetrics, and those therapeutic procedures where the fee includes an assessment (e.g. non-*IOP* surgery).

3. Detention is *not eligible for payment* for time spent waiting.

4. For the purposes of calculation of time units payable for detention, the start time commences after the minimum time required for the assessment or consultation listed in the table has passed.

ASSESSMENTS

5. K001 is *not eligible for payment* for same patient same day as A190, A191, A192 A195, A197, A198, A695, A795 or A895.

Claims submission instructions:
Claims for detention are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

ASSESSMENTS

DETENTION-IN-AMBULANCE

Definition/Required elements of service:

Detention-in-Ambulance is payable for constant attendance with a patient in an ambulance, to provide all aspects of care to the patient. Time is calculated only for that period during which the physician is in constant attendance with the patient in the ambulance. The service includes an initial examination and ongoing monitoring of the patient's condition and all interventions, except in those circumstances in which the Schedule provides for separate or additional payment for the intervention.

K101	Ground ambulance transfer with patient per quarter hour or part thereof	42.10
K111	Air ambulance transfer with patient per quarter hour or part thereof	126.40
K112	Return trip without patient to place of origin following air or ground ambulance transfer, per half hour or major part thereof	25.05

Claims submission instruction:

Claims for Detention-in-Ambulance are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
K101 is not applicable to attendance in a vehicle other than an ambulance, in which case K001 may apply.]

DETENTION FOR THE TRANSPORT OF DONOR ORGANS

Definition/Required elements of service:

Detention for the Transport of Donor Organs is payable for time travelling to and from a donor centre (excluding time spent in the donor centre) for the purpose of collecting and transporting to the recipient hospital (a) donor organ(s), including fresh bone being harvested.

K102	Per quarter hour or part thereof (not eligible for payment with K001)	20.20

Claims submission instruction:

Claims for Detention for the Transport of Donor Organs are assessed by a *medical consultant* on an IC basis and require the submission of a written explanation.

[Commentary:
Claims will be adjudicated on the basis of the most time-efficient means of travel to and from a donor centre.]

NEWBORN CARE

Definition/Required elements of service:

Newborn care is the routine care of a well *newborn* for up to the first ten days of life in hospital or *home* and includes an initial general assessment and subsequent assessments, as may be indicated, and instructions to the caregiver(s) regarding the *newborn*'s health care.

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

ACUTE CARE HOSPITAL – NON-EMERGENCY IN-PATIENT SERVICES ("C" PREFIX SERVICES)

A. Admission Assessment – General Requirements

Definition:

a. An admission assessment is the initial assessment of the patient rendered for the purpose of admitting a patient to hospital.

b. The admitting physician is the physician who renders the admission assessment.

Payment rules:

1. Except as outlined below in paragraph 3, 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 consultation, general or medical specific or specific assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.

2. Except as outlined below in paragraph 3, if 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 re-assessment or specific re-assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.

3. When a hospital in-patient is transferred from one physician to another physician, only one consultation, general or specific assessment or reassessment is eligible for payment per patient admission. The amount eligible for payment for services in excess of this limit will be adjusted to a lesser assessment fee. An additional admission assessment is *not eligible for payment* when a hospital inpatient is transferred from one physician to another physician within the same hospital.

Admission Assessments by Specialists:

When a patient has been assessed by a *specialist* in the emergency room (ER) or out-patient department (OPD) and that physician renders a service described as a consultation, specific assessment, or medical specific assessment and subsequently admits the patient to hospital, the initial consultation, specific, or medical specific assessment constitutes the admission assessment.

When a patient has been assessed by a *specialist* in the ER or OPD, and that physician renders any other assessment other than those listed in the paragraph immediately above, and that physician subsequently admits the patient to hospital, an admission assessment is eligible for payment in addition to the initial assessment, if each service is rendered separately.

[Commentary:
In accordance with the surgical preamble, a hospital admission assessment by the surgeon is *not eligible for payment*, unless it is the "major pre-operative visit" (i.e., the consultation or assessment which may be claimed when the decision to operate is made and the operation is scheduled).]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Admission Assessments by General and Family Practitioners:

When a patient has been assessed by a general or family practitioner in the emergency room (ER) or out-patient department (OPD) and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital, the initial consultation, general assessment, general re-assessment constitutes the admission assessment.

When a patient has been assessed by a general or family practitioner in the ER or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, 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.

Payment rules:

A933/C933/C003/C004 are *not eligible for payment* for an admission assessment for an elective surgery patient when a pre-operative assessment has been rendered to the same patient within 30 days of admission by the same physician.

Admission Assessments by General and Family Practitioners in an Emergency Department Funded under an Emergency Department Alternative Funding Agreement:

When a patient has been assessed by the patient's general or family practitioner in an emergency room and that physician subsequently admits the patient to hospital, the General/Family Physician Emergency Department Assessment constitutes the admission assessment if the physician remains the *most responsible physician* for the patient.

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Admission Assessments by Emergency Physicians:

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital as the *most responsible physician* or that physician is asked to perform the admission assessment (even though the patient is admitted under a different *most responsible physician*), the initial consultation, general assessment, or general re-assessment constitutes the admission assessment.

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, and subsequently renders the admission assessment, (even if the patient is admitted under a different *most responsible physician*), the admission assessment is payable as C004, in addition to the initial assessment, if both services are rendered separately.

Admission Assessment by the Most Responsible Physician (MRP) Premium

E082 Admission assessment by the MRP, to admission assessment ..... add 30%

Payment rules:

1. E082 is *only eligible for payment* once per patient per hospital admission.

2. E082 is *only eligible for payment*:

a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or

b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.

3. E082 is *not eligible for payment* for transfers within the same hospital.

4. E082 is not applicable to any other service or premium.

[Commentary:

1. E082 is *only eligible for payment* when the admitting physician is the *MRP*. If the *MRP* does not render the admission assessment, E082 is *not eligible for payment* for any service rendered by any physician during that hospital admission.

2. E082 is *not eligible for payment* for a patient admitted for obstetrical delivery or for a *newborn*.

3. E082 is not applicable for any consultation or assessment related to day surgery.]

B. Subsequent Visit

Definition:

A subsequent visit is any routine assessment in hospital following the hospital admission assessment.

Attendance at Surgery: If, in the interest of the patient, the referring physician is asked to be present by the patient or the *patient's representative*, but does not assist at the procedure, the attendance at surgery by the referring physician constitutes a hospital subsequent visit.

Multidisciplinary care: Except where a single service for a team of physicians is listed in this Schedule (e.g. the *week*ly 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.

Payment rules:

1. Except in the circumstances outlined in paragraphs 2 and 3, or when a patient is referred from one physician to another (see Claims submission instruction below), subsequent visits are limited to one per patient, per day for the first 5 *week*s after admission, 3 visits per *week* from 6 to 13 *week*s after admission, and 6 visits per *month* after 13 *week*s. Services in excess of the limit are *not eligible for payment*.
2. After 5 *week*s of hospitalization, any assessment in hospital required as a result of an acute intercurrent illness in excess of the *week*ly or *month*ly limits set out above constitutes C121 – "additional visit due to intercurrent illness". The *week*ly or *month*ly limits set out above do not apply to additional visits due to intercurrent illness.
3. Pediatric subsequent visits (C262) are limited to one per patient, per *day* for the duration of the admission.
4. When a physician is already in the hospital and assesses one of his/her own patients or patients transferred to his/her care, the service constitutes a subsequent visit. If a physician assesses another physician's patient on an emergency basis, the General Listings ("A" prefix) apply.

Claims submission instruction:

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.

[Commentary:
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.]

C. Subsequent visit by the Most Responsible Physician (MRP)

Subsequent visit by the MRP – day following the hospital admission assessment (C122)

Definition:

Subsequent visit by the *MRP* - day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Subsequent visit by the MRP – second day following the hospital admission assessment (C123)

Definition:

Subsequent visit by the *MRP* - second day following the hospital admission assessment is payable to the physician identified as the patient's *MRP* for rendering a subsequent visit on this day.

Payment rules:

1. C122, C123 are limited to a maximum of one each per hospital admission.

   [Commentary:
   C122, C123 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be payable at a lesser visit fee.]

2. C122, C123 are *not eligible for payment*:
   - **a.** when rendered to the same patient the same day as C124 (Subsequent visit by the *MRP* - day of discharge);
   - **b.** for a patient admitted for obstetrical delivery or *newborn* care; or
   - **c.** for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

3. C122, C123 are not payable for a subsequent visit rendered by a surgeon to a hospital in-patient following non-Z prefix surgery.

   [Commentary:
   The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

4. When a patient is transferred to another physician within the same hospital during either of these days, C122 or C123 are only payable to the physician who was the *MRP* for the majority of the day.

5. When a patient is transferred to another physician at a different hospital, the day of transfer shall be deemed for payment purposes to be the day of admission.

6. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For first and second subsequent visits by the *MRP* following transfer from an Intensive Care Area (C142, C143), see General Preamble page GP46.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

Subsequent visit by the MRP - day of discharge (C124)

Definition/Required elements of service:

Subsequent visit by the *MRP* – day of discharge is payable to the physician identified as the *MRP* for rendering a subsequent visit on the day of discharge, and, in addition, requires completion of the discharge summary by the physician within 48 hours of discharge, arranging for follow-up of the patient (as appropriate) and prescription of discharge medications if any.

The discharge summary must include as a minimum the following information:

- **a.** reason for admission;
- **b.** procedures performed during the hospitalization;
- **c.** discharge diagnosis; and
- **d.** medications on discharge.

Payment rules:

1. C124 is only payable to the *MRP* and limited to one service per hospital admission.

2. C124 is *not eligible for payment* under any of the following circumstances:

- **a.** The patient was discharged within 48 hours of admission to hospital (calculated from the actual date of admission to hospital);
- **b.** The admission was for obstetrical delivery unless the mother required admission to an ICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **c.** The admission was for *newborn* care unless the *infant* was admitted to a NICU, with subsequent transfer and discharge from another unit within the hospital during the hospital stay;
- **d.** For transfers within the same hospital; or
- **e.** For discharges directly from a NICU or ICU where NICU or ICU critical care per diem services were rendered the same day.

[Commentary:

In the case of conflicting claims for this service, the physician to whom the patient has rostered (virtual or actual) may receive the payment for the service.]

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

D. First subsequent visit by the MRP following transfer from an Intensive Care Area

First subsequent visit by the MRP following transfer from an Intensive Care Area (C142)

Definition:

First subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Second subsequent visit by the MRP following transfer from an Intensive Care Area (C143)

Definition:

Second subsequent visit by the *MRP* following patient's transfer from an Intensive Care Area (including Neonatal Intensive Care) where the patient was receiving Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services immediately prior to the time of the transfer to an acute care hospital bed in the same hospital.

Payment rules:

1. C142, C143 are limited to a maximum of one each per hospital admission.

   [Commentary:
   1. C142, C143 are only payable for visits rendered by the *MRP*. Services rendered by physicians who are not the *MRP* may be eligible for payment at a lesser visit fee.
   2. C142 or C143 are *not eligible for payment* for visits rendered to patients who were in an Intensive Care Area only for monitoring purposes.]

2. C142, C143 are *not eligible for payment* to the same physician who rendered Critical Care, Ventilatory Support, Comprehensive Care or Neonatal Intensive Care services prior to the patient's transfer.

3. Only one of C122 or C142 is eligible for payment for the same patient during the same hospital admission. Only one of C123 or C143 is eligible for payment for the same patient during the same hospital admission.

   [Commentary:
   For Subsequent visit by the *MRP* – first and second day following the hospital admission assessment (C122, C123), see General Preamble page GP44.]

4. C142, C143 are *not eligible for payment*:
   - **a.** when rendered to the same patient the same day as C124 (Subsequent visit by the *MRP* – day of discharge), or
   - **b.** for any visit rendered by a surgeon during the 2 days prior to non-Z prefix surgery.

5. C142, C143 are not payable for visits rendered by a surgeon to a hospital in-patient in the first two *week*s following non-Z prefix surgery.

   [Commentary:
   The first and second post-operative visits by the surgeon to a hospital in-patient following non-Z prefix surgery constitute post-operative visits payable at the appropriate specialty specific subsequent visit fee.]

6. When a patient is transferred to another physician within the same hospital, C142 or C143 are only payable to the physician who was the *MRP* for the majority of the day of the transfer.

E. Subsequent visit and palliative care visit by the MRP premium

E083 Subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982..... add 30%

E084 Saturday, Sunday or *Holiday* subsequent visit by the MRP, to subsequent visits and C122, C123, C124, C142, C143, C882 or C982.....Add 45%

Payment rules:

1. E084 is *only eligible for payment* for subsequent visits provided on Saturdays, Sundays and *holidays*.

2. Only one of E083 or E084 is *eligible for payment* per patient per *day*.

3. E084 is *only eligible for payment* when the MRP is from one of the following specialties: 00 (Family Practice and Practice in General), 02 (Dermatology), 07 (Geriatrics), 12 (Emergency Medicine), 13 (Internal Medicine),15 (Endocrinology & Metabolism), 16 (Nephrology), 18 (Neurology), 19 (Psychiatry), 22 (Genetics), 26 (Paediatrics), 28 (Pathology), 31 (Physical Medicine), 34 (Radiation Oncology), 41 (Gastroenterology), 44 (Medical Oncology), 46 (Infectious Disease), 47 (Respiratory Disease), 48 (Rheumatology), 60 (Cardiology), 61 (Haematology), 62 (Clinical Immunology).

4. E083 or E084 are *only eligible for payment*:

- **a.** if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services; or
- **b.** where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be eligible for payment to the physician had he or she not received any such direct or indirect remuneration.

5. E083 or E084 are *not eligible for payment* for *palliative care* visits to patients in designated *palliative care* beds in Long-Term Care Institutions.

6. E083 or E084 are not applicable to any other service or premium.

[Commentary:

1. E083 or E084 are *only eligible for payment* with subsequent visits and *palliative care* visits rendered by the *MRP*.

2. Examples of subsequent visits eligible for payment with E083 or E084 are C002, C007, C009, C132, C137, C139, C032, C037 or C039.

3. E083 or E084 are *not eligible for payment* with C121 additional visits for intercurrent illness.]

F. Concurrent Care

Definition/Required elements of service:

Concurrent care is any routine assessment rendered in hospital by the consultant following the consultant's first major assessment of the patient when the family physician remains the *most responsible physician* but the latter requests continued directive care by the consultant.

Payment rules:

Claims for concurrent care are limited to 4 per *week* during the first *week* of concurrent care, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.

G. Supportive Care

Definition:

Supportive care is any routine visit rendered in hospital by the family physician who is not actively treating the case where:

- **a.** the patient is under the care of another physician;
- **b.** the supportive care is rendered at the request of the patient or family; and
- **c.** the care is provided for purposes of liaison or reassurance.

Payment rules:

Claims for supportive care are limited to 4 per *week* during the first *week* of supportive care, determined from the date of the first supportive visit, and 2 claims per *week* thereafter. Services in excess of this limit are *not eligible for payment*.

AGE-BASED FEE PREMIUMS

1. Despite any other provision in this Schedule, the amount payable for the following services rendered on or after October 1, 2009 to an insured person who falls into the age group described in the Age Group column of the following Age Premium Table is increased by the percentage specified in Percentage Increase column opposite the Age Group:

a. A consultation, limited consultation or repeat consultation rendered by a *specialist*, as those services are defined in this *Schedule*.

b. A surgical procedure listed in Parts K to Z inclusive of this *Schedule*.

c. Basic and time unit surgical assistant services listed in Parts K to Z inclusive of this *Schedule*.

age premium table

Item	Age Group	Percentage Increase
1	Less than 30 days of age	30%
2	At least 30 days but less than one year of age	25%
3	At least one year but less than two years of age	20%
4	At least two years but less than five years of age	15%
5	At least five years but less than 16 years of age	10%

2. Despite any other provision in this *Schedule*, the amount payable for the following services rendered on or after October 1, 2009 to an insured person who is at least 65 years of age, as those services are defined in this *Schedule*, is increased by 15 per cent:

a. A general assessment (A003, C003, C903, W102, W109 or W903);

b. A general re-assessment (A004, C004, W004);

c. An intermediate assessment (A007);

d. A focused practice assessment (A917, A927, A937, A947, A957 or A967);

e. A periodic health visit (K132).