Ontario

Ministry of Health

bulletin

Ontario Health Insurance Plan
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General Manager

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4203	January 1987	District Office Medical Consultant
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SUMMARY — MEDICAL ADMINISTRATIVE POLICIES

This is a summary of significant OHIP administrative and medical policies, the majority of which have appeared in previous OHIP Bulletins.

For the purpose of this summary 'Schedule of Benefits' refers to the April 1st 1986 publication.

1. General Administrative Policies and Procedures:

a) All physicians' claims must be submitted on one of the appropriate OHIP Claim Cards or on Magnetic Tape or diskette. The cards are available in regular or "pre-coded" format for pay physician or pay subscriber claims.

b) The correct subscriber address must be shown on all claims.

c) Accounts (claims and inquiries) must be received by OHIP within six months of date of service to be eligible for payment to physician or subscriber. (Health Insurance Act, Section 23(2), OHIP Bulletin #4007, page 2, August 1972).

d) Claims for consultations, referred laboratory medicine and other referred diagnostic procedures require the OHIP physician number of the referring physician.

e) The claim must be on the claim card bearing the identification of the physician actually rendering the service. The exceptions are:

(1) where prior approval for temporary "locum" status has been granted, (Schedule of Benefits, Preamble paragraph B.52)

(2) diagnostic radiology procedures rendered in hospital which may be claimed on the cards of the Head of the Department of Radiology. (Note: This exception does not extend to services not listed in the Diagnostic Radiology section of the OHIP Schedule of Benefits , even though such services may be rendered through a Department of Radiology [Schedule of Benefits Preamble, Diagnostic Radiology]).

f) The Ontario Health Insurance Plan is able to accept most claims submissions on magnetic tape or diskette. Physicians should apply to their local District Office for complete details. (Bulletin #4130 January 1980, see also page 7 , item 4b. of this communication).

g) Claims received by OHIP by the 10th of any month will be processed for payment by the 15th of the following month. (OHIP Bulletin #4033, February 1974, page 1).

As of September 1, 1985 Canada Post's new "Return to Sender" postal regulations are in effect. Any mail with insufficient postage will not be delivered but returned to the sender, who will in turn be required to add the additional postage and remail the material.

OHIP Offices/les bureaux d'OHIP

Barrie 30 Poyntz St. L4M 3P2

Hamilton 119 King St. W. PO Box 2112 L8N 3Z9

Kenora 100 Main St. S. P9N 1S9

Kingston 1055 Princess St., Ste. 401 PO Box 9000 K7L 5A9

Kitchener 235 King St. E. 1st Floor N2G 4N5

London 227 Queens Ave PO Box 5700 N6A 4L6

Mississauga 201 City Centre Dr. PO Box 7020, Station A L5A 3M1

Oshawa Executive Tower, Oshawa Centre 419 King St. W. L1J 7J2

Ottawa 75 Albert St. K1P 5Y9

Owen Sound 1043A Second Ave. E. N4K 2H8

Peterborough 139 George St. N. K9J 3G6

St. Catharines 59 Church St 3rd Floor L2R 3C3

Sarnia 452 Christina St. N. N7T 5W4

Sault Ste. Marie 205 McNabb St. Suite 205 P6B 1Y3

Sudbury 199 Larch St., 8th Floor P3E 5R1

Thunder Bay 435 James St. S. PO Box 5000 P7C 5G6

Timmins 38 Pine St. N., Ste. 110 P4N 6K6

Toronto 2195 Yonge St. PO Box 1700, Station A M5W 1G9

Toronto Special Services Unit 7 Overlea Blvd. M4H 1A8

Windsor 1427 Ouellette Ave N8X 1K1

Head Office PO Box 38 Kingston K7L 5J2

Please note that 19 OHIP offices around the province will accept hand delivery of claims. Most offices have provision for 24 hour a day drop-off of claims. Please refer to the District and Satellite Office address list on the last page of this bulletin. (Bulletin #4194 September 1985).

h) Statutory holidays for billing purposes, in addition to Saturdays and Sundays, include:

New Year's Day	Canada Day	Remembrance Day
Good Friday	Civic Holiday	Christmas Day
Easter Monday	Labour Day	Boxing Day
Victoria Day	Thanksgiving	

If any of these holidays falls on a Saturday or Sunday, at the physician's discretion, either the Friday before or the Monday following will be recognized as the holiday. (Schedule of Benefits Preamble, paragraph B.43(c).

i) The physician claim card contains two check boxes following the hospital/institution number, to indicate whether the service was rendered to an "in-patient" or "outpatient". The Ontario Health Insurance Plan collects statistics on services rendered in three different settings:

(1) Institution in-patient
(2) Institution out-patient
(3) Other, including office and home.

Services rendered to a patient in more than one of the above settings require a claim card for each setting.

j) The admission date is required on claims for hospital visits.

k) The hospital/institution number is required on claims for all services rendered in hospital/institution.

l) Claims for all services, including hospital and institutional care, must show the *actual* dates on which these services are rendered.

m) Claims for assistants' and anaesthetists' services must show the following:

(1) number of basic units

(2) number of time units and, for services extending beyond two hours duration, the actual time spent assisting, or rendering anaesthesia must be shown

(3) fee claimed (Schedule of Benefits Preamble, paragraphs B.36 and B.37)

(4) if claim is for second assistant or anaesthetist, this should be indicated on claim card. (Schedule of Benefits Preamble, paragraph B.36 (e)).

n) Claims for newborn and low birth weight care should also specify day, month, and year of birth in the diagnostic/description portion of the claim card.

o) Claims for transplants should be submitted for both donor and recipient components under the OHIP number of recipient, if possible. (OHIP Bulletin #4065, Sept 8th 1975)

p) **Payment of Elective Surgical Procedures not available in Ontario** — Appendix C, Schedule of Benefits which supersedes Bulletins #4185 (June 1984) and #4183 (March 1983)

BENEFITS OUTSIDE ONTARIO

Section 59 of Regulation 452 of Revised Regulations of Ontario 1980 made under the Health Insurance Act states in part (subsection (ii):

"The amount payable by the Plan for an insured service rendered by a physician outside Ontario to an insured person on or after the first day of April 1986, is the lesser of,
(a) the amount actually billed by the physician; or

(b) the amount set out opposite the service in Schedule 15 or 48.3 cents multiplied by the applicable individual unit value for such service set out opposite the service in Schedule l6, as the case may be (Laboratory Medicine)."

However, under Code R991 payment will be made at the usual and customary fee paid by insurers in the place where the service was rendered, provided that all of the following conditions are met:

1) the insured service is a surgical or other complex medical procedure;
2) the procedure is generally accepted within Ontario as medical treatment for the insured person's condition;
3) the procedure is not performed in Ontario;
4) the insured person is referred by a physician in Ontario to the physician outside Ontario who will perform the procedure;
5) the insured person departs from Ontario for the express purpose of having the procedure performed;
6) prior written approval has been obtained from the Plan.

The referring physician is requested to contact OHIP(either the Medical Consultant at the District level or the Chief of Claims Payment Policy, Professional Services Branch, 2nd Floor, 49 Place d'Armes, Kingston, Ontario K7L 5J3) if possible, prior to the referral of the patient and certainly prior to the surgery.

OHIP will then define as clearly as possible both the patient's and the Plan's financial responsibilities before the procedure takes place.

Payment of Services to Alberta Residents — OHIP Bulletin #4188, November 1985 (Revision):

The Ontario Health Insurance Plan has been asked by the Alberta Health Care Insurance Plan to advise Ontario health care providers that Alberta issues a new Health Insurance card annually.

This card is issued each year for all known residents of Alberta. The card is effective from July 1st in any year, to and including June 30th in the following year. Current coverage is indicated by the benefit period printed in the upper right corner.

It is important when providing services to Alberta residents that Health Care Providers check for a valid card before agreeing to submit a claim on the inter-provincial claim form to the Alberta Health Care Insurance Plan for direct payment.

An Alberta patient who does not hold a valid health insurance card is personally responsible for payment.

Supplies of the inter-provincial Standard Out-of-Province Claim form are available on request from your local District Office. (OHIP Bulletin #4195, September 1985).

Payment for Services to Yukon Residents — OHIP Bulletin #4189, May 1985:

Effective April 1, 1985, the Yukon Health Care and Hospital Insurance Plan will accept responsibility for payment of insured medical services provided to individuals who present a valid health care identification card in the new format.

The new card is blue and carries an effective and expiry date. "Senior" status is denoted by an additional heading "PHARMACARE". Claim submission on the approved "Standard Out-of-Province Claim" form is expected.

It is important when providing services to Yukon residents that a physician check for a valid card before agreeing to submit a claim on the inter-provincial form to the Yukon Health Care Insurance Plan for direct payment by the Yukon Plan.

A Yukon resident who does not present a valid health insurance card in the new format is responsible for payment for physician and/or hospital services since the claim will not be honoured by the Yukon Plan.

Supplies of the "Standard Out-of-Province Claim" form are available upon request from your local District Office. (OHIP Bulletin #4195, September 1985).

q) **Provision of Supplies, etc. by Hospitals to Outpatients**

Regulation 452 pursuant to the Health Insurance Act (1972) allows hospitals to issue certain equipment, supplies and medication to outpatients under specific circumstances (see Section 39 of Reg. 452). All such issues must be prescribed by a physician on the hospital staff. The circumstances are associated with:

(1) The use of renal dialysis equipment, etc., in the home by patients who are suitably trained. This benefit extends to all public hospitals in Canada. Furthermore, OHIP will pay for dialysis services rendered by private clinics established for that purpose outside Canada (Section 62 of Reg. 452); (OHIP Bulletin #4139, June 1980);

(2) The use of hyperalimentation equipment, etc., provided by hospitals in Ontario; and,

(3) The provision of supplies, etc., by hospitals in Ontario to haemophiliacs for emergency treatment of haemorrhage.

r) To prevent the submission of ineligible claims, it is requested that the OHIP Identification Card be checked for correct surname, and effective date of coverage. Patients should be asked about any change in their OHIP status which might result in coverage under a new number.

s) Claims for patients whose coverage has lapsed will be paid until Code J8 ("coverage not in effect — future claims will not be paid") appears on the Remittance Advice. Services provided on, or after the 20th of the month in which J8 appears, will be rejected. Claims in this category include:
- Service date after termination of contract — J2
- Dependent not covered under this contract — K7
- Enrolled — premiums unpaid — J5 (OHIP Bulletin 4034 Feb.19th 1974).

Exceptions to the Code J8 payment privilege are as follows — i.e. No payment.

- Invalid OHIP Number
- Service date before Effective date of Coverage
- Dependent Child over the age of 21 years
- OHIP Number registered under a different surname
- Holder not covered under OHIP number which only insures dependents.

t) Claims must be submitted to the Plan for insured services provided to insured residents as a result of automobile and other accidents, except for industrial accidents covered by Workers' Compensation Board. However, medical services provided at the request of the legal profession, insurance companies or other third parties, are *not* benefits, and should be billed to the party requesting such services. The exception to this is listed on page 6 of this Bulletin, paragraph 3(f).

u) Participating physicians, who employ other participating physicians on salary, may register their group with OHIP as "Dr. X and Associate(s)". In this case, separate claim cards will be provided to each physician, but payment will be made by a single cheque made out to "Dr. X and Associate(s)". Application for registration of such a group should be made to the appropriate OHIP District Office. (OHIP Bulletin 4016 March 14 1973)

*Each physician remains responsible for the payment received by the group from OHIP for services rendered by the individual physician.

v) **Locum Tenens** — (Schedule of Benefits Preamble, paragraph B.52)

(1) Must replace employing physician who must be absent from practice

(2) Must replace the employing physician for a continuous period up to a maximum of 12 weeks, with an extension on request for a further 6 weeks.

(3) Must be same specialty as the employing physician.

(4) Must be licensed by College of Physicians and Surgeons of Ontario in a category of licence that allows him or her to practise independently, without supervision.

(5) Prior notification must be given to OHIP of name and OHIP physician number and/or licence number of the locum tenens and the exact dates of employment, together with an authorization from the locum tenens to make payment for his or her services to the employer.

If these conditions are met,the locum may sign the employing physician's claim cards.

If any of the above conditions are *not* met, the physicians involved must submit claims to OHIP on his or her own claim cards.

w) **Service Verification (OHIP Bulletin #4018, April 1973):**

The following policies apply to verification letters:

(1) No verification letters will be sent to subscribers for services related to:

Abortions
Male or Female Sterilization
Treatment for Venereal Disease. (OHIP Bulletin #4116, February 1979)

(2) If there are special circumstances in which it is not in the patient's interest that a specific visit or procedure (other than the above) be the subject of a verification letter, the physician should note on that claim card, "NO VERIFICATION PLEASE" and initial the notation. This is not to be used as a routine.

x) *Confidentiality of Patient Records* (OHIP Bulletin #4107, June 1978)

A number of physicians and practitioners use billing agents to prepare their claim cards for submission to the Ontario Health Insurance Plan. Ensuring the confidentiality of patient records is the responsibility of the physician or practitioner, until such time as the claim card is received by the Plan. Physicians and practitioners should, therefore, satisfy themselves that adequate controls are maintained by their billing agents, to protect the confidentiality of patient records.

A number of situations have been reported in which parcels or envelopes containing claim cards have split open in post offices. Your co-operation is requested in restricting bulk, and ensuring that all parcels and evelopes are adequately secured. In addition, claim cards delivered by hand to the OHIP District Offices should be delivered to the mailrooms of the District Offices during working hours, or after hours, be deposited *inside* the special boxes provided at the entrances to the OHIP offices. In some cases, boxes of claim cards have been left in public areas outside the OHIP offices.

2. Direct OHIP Billing for Services Rendered in Public Hospitals and Certain Other Designated Facilities

Changes to Regulation 452 that occurred in 1980 and 1983 permit the direct billing to OHIP for services provided by opted-out physicians to insured persons in an outpatient or other clinical department of a public hospital. Similarly, direct billing is permissible for services rendered to insured persons in certain chronic or extended care facilities, psychiatric and mental health facilities, and in mobile vision and hearing facilities as detailed in Section 67(5),3,4 and 5 of Regulation 452, Health Insurance Act.

The following stipulations apply to such billing:

a) the physician providing the service(s) must be a member of an associate medical group registered with the Plan;

b) the accounts for such services must be submitted directly to the Plan; and,

c) the group and the physician must accept the payment as constituting payment in full for the services rendered.

At present, the following policies apply to registration of "associate medical groups" for submission of claims for insured services in a public hospital.

(1) Physicians providing services in an emergency department may register one group per hospital. This group may include physicians from any specialty.

(2) Groups may be registered for each physician specialty including general practice, but no more than one group per specialty per hospital may be registered. Any service rendered by a physician in a hospital, may be billed through his registered specialty group. It is possible to register a group of one, where there is only one physician in a given specialty.

(3) Where there are very few specialists, it is possible to register several specialties in a single group, to facilitate administration.

(4) Each physician remains responsible for the payment received by the group from OHIP for services rendered by the individual physician.

3. Medical Payment Policy

a) *Time and Frequency Limitations on Assessments* Consultations (full and otherwise) and assessments (complete or otherwise) have time and frequency limitations which must be followed if payment for such services are claimed from OHIP. These limitations are described in detail in the OHIP Schedule of Benefits Preamble. (Paragraphs B.1(p), B.2, B.3, B.4, B.11)

b) Attention is drawn to several recent changes in the definitions of assessments and consultations.

(1) *Intermediate Assessment:* This is a benefit applicable *only* to primary care services, i.e., general practice and paediatrics. (Schedule of Benefits, Preamble paragraph B.7)

(2) *Partial Assessment:* All specialties other than general practice and paediatrics may claim this benefit. It replaces the previous specific reassessment and minor assessment designations for less than comprehensive and/or follow-up evaluatins and advice. (Schedule of Benefits, Preamble paragraph B.6)

(3) *Specific Re-Assessment* is now confined to the assessment upon admission to hospital when the patient has been seen prior to admission for the same illness. It is only claimed in the case of surgical admissions when the procedure is designated "IOP". (Schedule of Benefits, Preamble paragraph B.5)

(4) *Special Surgical Consultation:* may apply when a surgeon provides all the components of a regular consultation but is required to spend at least fifty minutes with the patient (exclusive of any tests) in consultation because of the very complex, obscure or serious nature of the problem. Such Consultations may be claimed on an Independent Consideration (I.C.) basis as described in Schedule of Benefits Preamble, paragraphs B.1(o)and B.32.

(5) *Mini Assessment:* Applies when a physician examines and/or treats a patient for a completely unrelated problem in addition to the examination/treatment of a W.C.B. related problem (for which W.C.B. is charged a minor assessment) during the same office visit. (Schedule of Benefits Preamble, paragraph B.10).

c) *Examinations in preparation for dental surgery under general anaesthesia*, carried out before or after admission to hospital should be coded 903A, along with the applicable prefix. Such examinations will be considered the same as any other office service, and will be subject to OHIP policy for assessments, and re-assessments. (Schedule of Benefits Preamble, paragraph B.16).

OHIP no longer requires that a dental diagnosis be stated on the claim card. Indicate the reason for the assessment (e.g. "Pre-operative Dental Assessment").

d) Detention time is limited to services provided under *exceptional* circumstances, when the physician is required to spend considerable extra time in active treatment of the patient (see Preamble, paragraph B.46, to Schedule of Benefits). In every case the claim must be substantiated by an explanation on the claim card, or in an accompanying letter. If this is not done, the claim will be routinely rejected.

e) The following apply in billing for psychotherapy:

In order to qualify for a psychotherapy claim, a minimum of twenty minutes must be spent with the patient. (Schedule of Benefits Preamble, paragraph B.19).

When psychotherapy extends beyond thirty minutes. the major part (16 minutes) of the next half hour must be spent with the patient to qualify for an additional half hour fee. Similarly, after an hour of psychotherapy, the major part (16 minutes) of the next half hour, must be spent to qualify for an additional half hour fee, and so on.

Psychotherapy may not be claimed by more than one physician for the same patient at the same time.

f) *Investigation of Alleged Sexual Assault K018 and K02l* Complete Documentation and examination are required on both medical and legal grounds.

(1) Documentation is that which is required by the offices of the Provincial Attorney General and Solicitor General.
Claims for rendering this complex investigation are honoured by OHIP who, in turn is reimbursed in part,by the two ministries (OHIP Bulletin #4153 Apr.29 1981)

(2) Kits which contain the appropriate testing equipment for the examination of Sexual Assault victims plus information concerning the documentation procedure are available at most hospitals.

A special visit premium may be claimed in addition to K018 and K021 if appropriate. Treatment of medical problems arising from the sexual assault may be claimed in addition.

(3) Claims for K018 and K021 when the patient has no OHIP coverage: (OHIP Bulletin 4157 July 1981)

OHIP will accept claims for K018 and K021 when the patient has no OHIP coverage. Medical problems treated at that time and the additional fees incurred will also be honoured. However, follow-up medical care at a later date will be paid in accordance with the usual OHIP payment policy set out on page 4 of this Bulletin, paragraphs (r) to (s).

g) **Special Visits and Procedures** — (See Preamble, paragraph B.43, to Schedule of Benefits).

(1) A visit initiated by the patient which necessitates travel by the physician from one location to another in order to see the patient.

(2) Only one type of special visit premium can be claimed per patient per visit.

(3) If a hospital makes quarters available to a physician in the same building or its environs in order to facilitate visits to the hospital, particularly at night, these visits are not to be considered as special visits.

(4) If a physician sees an additional patient at home or in the emergency department while making the initial special visit to a patient, that additional patient qualifies for a reduced special visit fee (see Schedule of Benefits Preamble, paragraph B.43(i) to (m)).

(5) *Emergency Surgical Procedures*

(i) *E409* Non-elective surgical procedures. Obstetrics, clinical procedures associated with Diagnostic Radiological examinations or detention while in attendance with patients in an ambulance that starts between 5:00 p.m. and midnight, or on Saturdays, Sundays and Holidays, increase the procedural fee by 30%. (Schedule of Benefits paragraph B.47)

(ii) *E410* For the procedures listed above that start between midnight and 7:00 a.m., increase the procedural fee by 50% [Preamble, paragraph B.47] (Note: See Schedule of Benefits, Obstetrics Preamble, paragraph 15, for restrictions on claiming these benefits for obstetrics).

Complete Obstetrical Care

An obstetrical claim card is available on request from the OHIP District Office which may be used for all services connected with normal obstetrics. If complications occur during pregnancy that require additional visits, further claims should be submitted on regular claim cards, giving details. This not to be used for individual visits. (OHIP Bulletin #4177, August 1983).

h) *Physician on Duty in Emergency Department*: include the fee listings for minor and multiple systems assessments and re-assessments during regular and premium hours rendered by the physician on duty. Any physician on duty in the emergency department should claim these fees regardless of his/her specialty. (Schedule of Benefits Preamble, paragraph B.40)

The listings under the heading "Emergency Department — Physician on Duty" are meant to apply to those circumstances wherein either emergency or other physicians have elected or are required to be physically and continuously present in the Emergency Department or environs for an arranged designated period of time. In addition to applying to full or part time emergency room physicians who work pre-arranged shifts, these listings also apply to the services rendered by physicians who provide on-call emergency room coverage for designated periods of time and limit the services they provide, in the community serviced by the hospital, predominantly to emergency room coverage. When special visits are rendered by such physicians, A and K codes may be charged for the first patient seen:
a) for up to a maximum of two special visits after 8:00 a.m. and up to 5:00 p.m.;
b) for up to a maximum of three special visits after 5:00 p.m. and up to midnight;
c) for the number of special visits rendered after midnight and up to 8:00 a.m.
When an on call physician practising in the area elects to be continously present in the Emergency Department or environs for an arranged designated period of time because the volume of patients requires it, e.g. during a busy holiday period, the fees under Emergency Department — Physician on Duty (H101, H103, H104, etc.) should be charged after the patients responsible for the initial special visit have been examined and/or treated (and charged for under the A and K codes). (Schedule of Benefits Preamble, paragraph B.40)

When an emergency physician is required to make a special visit to the Emergency Department prior to or after his/her regular arranged designated period of time on duty, he/she may charge the appropriate fee under the General Listings plus the applicable special visit premium for the first patient assessed; all subsequent patients assessed during this visit to the hospital should be billed under the Emergency Department — Physician on Duty listings.

When a physician is on duty in the Emergency Department, sees a patient and admits the patient to hospital, this physician may claim a minor or multiple systems assessment depending on the service initially provided. Either the patient's attending physician or the emergency department physician (but not both) may render and claim the hospital admission assessment. If the emergency department physician (instead of the attending physician) provides the admission general assessment, he/she may claim a general re-assessment (C004) as well as the initial assessment provided both services are actually rendered separately. (OHIP Schedule of Benefits Preamble, paragraph B.40)

i) *Emergency Department Equivalent:* (Schedule of Benefits, Preamble paragraph B.41)

An Emergency Department Equivalent is an office or other place (other than a hospital emergency department) in which a physician renders services as part of an emergency service being made available to the community.

"Emergency Department Equivalent" includes a place used by a physician to render services exclusively to the office practice patients of one or more physicians outside the office hours of those physicians if the place is open for patients to attend.

A place is an Emergency Department Equivalent only during the period of time that the emergency service is being made available.

A place may be an Emergency Department Equivalent notwithstanding that the physicians rendering services therein are not continuously present and only attend on call.

A physician may add a premium of 30% (E030) to the appropriate General Listings for services provided in an Emergency Department Equivalent if

1) the services were rendered on a Saturday, Sunday or holiday ("holiday" is defined in the Preamble paragraph B.43(c) Schedule of Benefits)
2) the services were rendered on the day they were first requested; and,
3) the services were rendered for the purpose of dealing with an emergency.

j) *Regular Office Hours at Night or on Saturdays, Sundays or Holidays*

No special visit premiums may be charged. (OHIP Bulletin #4137, May 21 1980)

k) *Elective Home Visit* (Schedule of Benefits Preamble, paragraph B.43(c))

This is a visit deemed to be medically necessary by the physician without a specific request from the patient.

These visits should be claimed under the special visit premium B990, even if the visit takes place at night or on a Saturday, Sunday or Holiday.

l) *Visit for Procedure:* when the sole reason for an office visit is the performance of a certain procedure, the listed benefit for the procedure will apply. (See Diagnostic and Therapeutic Procedures Preamble for exceptions). When procedures are carried out in the office, emergency or outpatient department on an elective basis, special visit fees should not be claimed in addition to the procedural fee. When procedure(s) are carried out by a physician's employee(s) under the direct supervision of the physician in his office, the usual claims may be made for procedure(s) which are generally and historically accepted as those which may be carried out by the nurse or other medical assistant in the employ of the physician. "Procedures" in this context do not include such services as assessments, consultations, psychotherapy, counselling, etc. Direct supervision requires that during the procedure the physician be physically present in the office or clinic at which the service is rendered. While this does not preclude the physician from being otherwise occupied he must be in personal attendance to ensure that procedures are being performed competently and he must at all times be available immediately to approve, modify or otherwise intervene in a procedure as required in the best interests of the patient. (Schedule of Benefits, Preamble paragraph B.23)

m) *G481 Haemoglobin Screen*

This includes the fee for haematocrit as well, if done in conjunction with haemoglobin. (OHIP Bulletin # 4162, page 10 item 3)

n) *Terminal Care (in hospital)* applies to one designated physician responsible for the care of a terminally ill patient suffering from malignant disease.

Terminal care will be deemed to start when there is no aggressive treatment of the underlying disease process, and care is directed to maintaining the comfort of the patient until death occurs.

Terminal care should be claimed retroactively after death on the basis of hospital visits actually rendered for a period not to exceed four weeks prior to death.

Terminal care visit fees as described above do not apply when unexpected death occurs after prolonged hospitalization for another diagnosis unrelated to the cause of death. (Schedule of Benefits Preamble, paragraph B.31).

4. General Administrative Policies

The following visits or procedures do *not* require a diagnostic code. (OHIP Bulletin #4120, July 1979)

A) The procedures of laboratory medicine, nuclear medicine in vivo, diagnostic radiology, radiation oncology, pulmonary function and diagnostic ultrasound.

B) Newborn baby care in hospital and/or home.

C) Annual health examinations, all types.

D) Anaesthesia services and assisting at surgery.

E) The individual services R077A and Z540A.

F) Normal prenatal care, delivery or postnatal care and attendance at labour and delivery.

G) In the "Diagnostic and Therapeutic Procedures" section of the Schedule of Benefits, all fee schedule codes except those listed under Critical Care.

H) All immunizations and vaccinations.

b) *Magnetic Tape — Changes to Update Data Processing*

Increase densities from 800 B.P.I. to 1600 B.P.I. or 6250 B.P.I. A second and third tape may be submitted at same time if necessary, but each tape must end with trailer record. The 1600 B.P.I. tapes should be limited to a maximum of 29,000 records per tape and the 6250 B.P.I. tapes should be limited to a maximum of 200,000 records per tape. For more information on the technical requirements for magnetic tape input, please contact the technical services area in your local District Office.

Claims submission on 5 1/4" flexible diskettes has been acceptable since May 1st, 1984 (OHIP Bulletin #4181, March, 1984).

The technical specifications are:

5 1/4" flexible diskette

— double sided, double density OR
— single sided, double density
— ASC II data content on input and output
— soft sectored
— MS DOS format

Physicians and practitioners who wish to submit claims on diskette may apply to their local District Office Technical Services area.

c) *Twice Monthly Payment to Physicians*

Physicians who receive payment directly from OHIP will be eligible to receive payments twice monthly, if application is made to the OHIP District Office.

The interim payment will be mailed for receipt by the last working day of the month and will be 50% (or less if requested) of your income from the Plan for a previous 12-month period ending in November each year. The second payment will be the actual approved payment for claims submitted by the 10th of the previous month less the interim payment and will be mailed for receipt by the 15th of the following month. Special arrangements may be made for new physicians joining OHIP. The amount of the interim payment is reviewed annually. (OHIP Bulletin #4127, November 1979).

Direct bank deposit is also available.

Short Practice Profile for General/Family Physicians — (OHIP Bulletin #4199, April 1986)

OHIP, in co-operation with the Ontario Medical Association and the College of Physicians and Surgeons of Ontario, has developed a short practice profile for general/family physicians.

The profile will be available annually, and will reflect payments made by OHIP for physician's services for the latest fiscal year for which data is available (April 1st to March 31st). The first mailing for the 1984/1985 fiscal year took place in May of 1986 and will be distributed as soon as the data becomes available, each year thereafter.

In order to condense the profile to a one-page format, selected codes that make up the majority of claims for general/family practice are listed as well as the total services for each month.

An explanatory letter which gives more detailed information on the content and derivation of the data accompanies each profile.

d) *Returned Subscriber Cheques*

OHIP cheques to subscribers are frequently returned by Canada Post because of incorrect subscriber address. This can be avoided by careful updating of addresses and their proper transcription. The postal code should appear on all claims submitted, whether pay physician or pay subscriber. (OHIP Bulletin # 4194 September 1985)

e) *Veterans*

Services rendered to disabled veterans that are related to a pensionable disability should be claimed from Veterans Affairs Canada. (OHIP Bulletin #4147, February, 1981).

Limitations by Regulation

a) Insured medical services are limited to services which are medically necessary, which are listed in the current OHIP Schedule of Benefits, and which are not specifically excluded by legislation or regulation. A list of specific exclusions is contained in Appendix A to the Preamble of the OHIP Schedule of Benefits.

b) Mammography and Thermography are recognized as a benefit of the Plan only when a patient is referred by a physician for further investigation deemed by that physician to be necessary as a result of clinical examination. The Plan will not accept for payment, claims for routine chest x-rays done in conjunction with mammography, and/or, thermography. (OHIP Bulletin #4031, November 1973).

c) Post Mastectomy Reconstructive Surgery, including the insertion of prostheses, is a benefit of the Ontario Health Insurance Plan, subsequent to either total or partial mastectomy (as listed in the Schedule of Benefits).

Reconstructive breast surgery is also a benefit following prophylactic complete bilateral mastectomies. Such treatment is covered by the Plan where appropriate medical indications have been determined by the physician. (OHIP Bulletin #4096, June, 1977).

d) Anastomosis of Fallopian Tubes, and Vasa Deferentia, previously interrupted surgically for sterilization purpose, are benefits of the Plan. (OHIP Bulletin #4106, May 26 1978)

e) *Sterilization under age 16* — Health Insurance Act Regulation 452 Section 55 — Under the age of 16 the following procedures rendered outside Ontario will not be insured services — vasectomy, hysterectomy and tubal ligation for sterilization. This regulation does not apply where the surgeon or attending physician believes the operation is medically necessary for the protection of the physical health of the insured person. (OHIP Bulletin #4144, November, 1980).

f) Insertion of Testicular Prosthesis is a benefit of the Plan. (OHIP Bulletin #4111, November, 1978).

g) *Excision of Benign Lesions — refers to conditions such as Naevi, Keratoses, Spider Naevi, Papillomata, Neurofibroma*

(1) Face or Neck. Benefit of OHIP.

(2) Other Anatomical Areas. Not normally a benefit of OHIP if removed for alteration of appearance only. Removal of very large lesions in patients less than 18 years of age is a benefit of OHIP.

Authorization not required but a statement of the reason for removal must accompany the claim. (For further details, see Schedule of Benefits, Preamble Appendix D.).

h) *Ontario Drug Benefit Plan*

In addition to the drugs listed in the Drug Benefit Formulary patients, who are eligible for coverage by the Ontario Drug Benefit Plan, may obtain prescribed non-formulary drugs at no charge, if the prescriber obtains special authorization by contacting Ontario Drug Benefit, P.O. Box 68, Kingston, Ontario K7L 5K1 — Telephone (613) 548-6590 or (416) 965-6699 or 1-800-267-0966 (excepting places with an area code of 807).

Dental Surgical

a) A specified list of procedures are insured services and are listed in the OHIP Schedule of Benefits for Dentists, dated July 25, 1986. Hospitalization of the patient is necessary for the performance of the service. The procedures must be:

(i) performed in an approved hospital; and

(ii) performed by a dental surgeon who is a member of the hospital staff.

Hospital and anaesthetists' charges for the above services are covered. When a medical condition necessitates admission to hospital to perform other dental procedures (Section III Schedule of Benefits) that would usually be performed in a dental office, prior authorization for payment must be obtained from OHIP. (OHIP Bulletins #4075, May, 1976 and #4083, November, 1976).

Dental procedures listed in Section III of the OHIP Schedule of Benefits for dentists are:

1. Removal of erupted teeth;
2. Removal of impacted teeth;
3. Removal of residual roots
4. Frenectomies;
5. Alveoloplasties;
6. Cysts

The medical reasons for performance of Section III dental procedures in hospital are as follows:

1. Unstable angina on active treatment.
2. Unstable, significantly elevated hypertension on active treatment.
3. Other forms of active cardiac disease under active treatment including situations involving extractions prior to cardiac surgery.
4. Active lung disease or asthma on current intensive therapy.
5. Mental illness or incompetence.
6. Cerebral palsy or other incapacitating neurological illness.
7. Disability due to Cerebrovascular Accident.
8. Disability due to Myocardial Infarction.
9. Insulin dependent diabetes requiring close medical monitoring.
10. Clinical conditions requiring steroid therapy.
11. Allergy to local anaesthesia.
12. Haemophilia or other bleeding diathesis.
13. Epilepsy.
14. Disability due to age.
15. Alzheimer's disease.
16. Hepatitis B and Non A.B.
17. A.I.D.S.
18. Post-radiation necrosis or sepsis.
19. Pre-radiation of head and neck.

Other conditions for which hospitalization may be necessary will be given independent consideration.

8. Other Payment Policies

a) When anaesthesia is provided for a dental or oral surgeon, and the surgical procedure is also listed in the current Physicians' Schedule of Benefits, the number of basic units which should be claimed is that of the procedure listed in the current OHIP Schedule of Benefits, the number of basic units should be determined as indicated in the Preamble, part B, paragraph 37 (1) of the April 1986 OHIP Schedule of Benefits.

b) All physicians should apply to their District OHIP Office for authorization of proposed surgery, prior to performing any procedure which may fall outside of OHIP coverage. Included in those procedures for which request must be submitted before the procedure is performed are:

(1) Augmentation mammoplasty
(2) Blepharoplasty
(3) Dermabrasion
(4) Epilation of hair
(5) Facelift
(6) Hair transplant
(7) Panniculectomy (Lipectomy)
(8) Reduction mammoplasty
(9) Rhinoplasty or Septorhinoplasty
(10) Scar revision other than face or neck
(11) Tattoo removal
(12) Keloids and benign lesions other than face or neck
(13) Outstanding ears (N.A.B. for patients over 18 years of age).

c) Surgery solely to alter or restore appearance is not a benefit of OHIP except under circumstances listed in Appendix D, paragraph 3.

d) *Family Planning* (OHIP Bulletin #4046 Aug.1974)

An initial visit to a specialist, of a transferred or walk-in patient for the purposes of family planning, should be charged at the specific assessment benefit and not as counselling. A partial or minor assessment may be charged for a repeat visit, or for a transferral for insertion of intrauterine device. Claims should indicate family planning as the diagnosis.

e) Independent consideration may be given by OHIP only to those items marked "I.C.", in the OHIP Schedule of Benefits. Claims rendered under I.C. must include a specific charge along with an explanation of that charge. In relation to surgical procedures, independent consideration may be given for additional hospital visits when supported by statements of medical necessity, or complications. (Schedule of Benefits Preamble, paragraph B.32).

f) When claiming for consultations, and/or visits which precede surgical procedures, physicians should document all visits made, but indicate "no charge" for those included in the definition of a surgical procedure, as contained in the Surgical Preamble, paragraph (1) of the April 1986 OHIP Schedule of Benefits.

g) Benefits for most surgical procedures no longer include the major pre-operative visit after January 1st, 1980. (Schedule of Benefits Surgical Preamble, paragraph (1))

h) *Multiple Surgery Rules*

(1) If more than one operative procedure (Non-I.O.P.) is performed by the same surgeon at the same time and/or under the same anaesthetic or within 14 days during the same hospitalization for the same condition, the benefit shall be the full benefit for the major procedure, plus 85% of the lesser procedure or procedures. (OHIP Schedule of Benefits Surgical Preamble, paragraph (5))

(2) Paragraph (1) does not apply to many of the E-code "add-ons".

There are two main categories of "E" — CODE "ADD-ONS". (OHIP Bulletin #4122, July 1979).

(i) *CATEGORY ONE* — For those procedures which *DO NOT* have Independent Listing.

These "E" codes are *SURCHARGES* which modify other Listings:

— Surcharge for *METHOD* (e.g. Bone Graft) — (E552) Add

— Surcharge for *LOCATION* (e.g. Private Office) — (E542) Add

— Surcharge for *DIFFICULTY* (e.g. Comp. Fract.) (E556) Add

— Surcharge for *RECURRENCE* (e.g. Recurr. Hernia) (E725) Add

IN MULTIPLE SURGICAL PROCEDURES, E Codes of this Category *ARE* subject to the same reduction as the procedures which they modify.

(ii) *CATEGORY TWO* — For those procedures which *DO* have Independent Listing.

These "E" codes represent a *REDUCTION* of the listed benefit for the procedures, when the procedures are performed in conjunction with other Specific Procedures.

— Reduction for *QUANTITY* (e.g. Mult. Metacarp. Fract.) (E559)

— Reduction for *ASSOCIATION* (e.g. Int. Mamm. Art. Impl.) (E652)

— Reduction for *MULTIPLE PROCEDURES* (e.g. Gastrostomy) (E707)

IN MULTIPLE SURGICAL PROCEDURES, E codes of this category are *NOT* subject to any further reduction. (OHIP Bulletin #4122, July 1979)

i) G700 may not be claimed by a diagnostic facility controlled directly, or indirectly by a physician *who has examined (or is about to examine)* the patient and referred the patient to such diagnostic facility. G700 is not payable to hospital departments. (Schedule of Benefits, Diagnostic and Therapeutic Procedures Preamble).

j) Diagnostic and Therapeutic Services rendered in hospital,

1) The term diagnostic and therapeutic services relates to those services as set out in the OHIP Schedule of Benefits that have a technical and professional component and the following services that have a professional component only:

— Radiation Oncology (Therapeutic Radiology)
— Computerized Axial Tomography
— Magnetic Resonance Imaging.

2) With the exception of Computerized Axial Tomography (see #j(6) below), Diagnostic and Therapeutic services rendered to hospital inpatients should not be billed to the Plan as these are the responsibility of the hospital.

3) Laboratory Services that are listed in the Laboratory Medicine section of the Schedule of Benefits, including the professional fees listed in the L800 series, should not be billed to OHIP if the services are provided in a hospital.

4) Other Diagnostic and Therapeutic services rendered to hospital outpatients should be billed to the Plan by the appropriate department registered with the Plan.

5) The technical and professional components of procedures performed on outpatients must both be claimed on the same claim card by the appropriate hospital department. The hospital department *should not* claim the technical component, and the physician the professional component.

6) The professional services listed in the OHIP Schedule of Benefits for Computerized Axial Tomography may be billed, as an exception to the rule, for both inpatient and outpatient services.

(OHIP Bulletin 4070, Dec. 1975 plus revisions)

k) *Necessary Nursing Services*

Insured hospital patients are entitled to all nursing services required to meet their treatment needs. How these needs are to be met is the responsibility of the nurse-in-charge of the Nursing Department.

A physician who decides that a patient requires additional nursing services, should discuss this with the nurse-in-charge. The Nursing Department will decide (1) whether the patient's needs can be met by either reallocation or augmentation of existing staff and (2) the assignment of such staff to ensure the most effective service. Only required nursing as arranged and reimbursed through the hospital is an insured service. Therefore, the cost of private duty nurses, hired directly by the physician, patient, or other person is the responsibility of the patient. (OHIP Bulletin #4097, July 1977).

l) OHIP payments are made only for the coded items appearing in the OHIP Schedule of Benefits. However, since the advice of the Ontario Medical Association is sought with regard to additions and deletions to this Schedule, physicians interested in establishing listings for new procedures, should direct their inquiries to the Tariff Committee of the appropriate Section of the Ontario Medical Association. When new listings are recommended by the Section and the Central Tariff Committee, these items are then subject to Health Ministry approval for benefit status. (OHIP Bulletin #4106 May 26 1978)

9. Laboratory Services

a) *Laboratory Tests in Physicians' Offices*
Physicians who personally perform laboratory tests for the exclusive purpose of diagnosing or treating their own patients, do not require a laboratory licence to perform such tests.

Fourteen of the more common such laboratory tests have been listed as "G" codes in the Diagnostic and Therapeutic section of the Schedule. These codes must be claimed and not the corresponding "L" codes which can only be claimed by a licensed laboratory. There may be, in exceptional circumstances, a test perfomed that is not listed in the Diagnostic and Therapeutic section. Under these circumstances, "L" codes from the Laboratory Medicine section may be used.

b) All medical laboratories in Ontario require a laboratory licence. (OHIP Bulletins #4014, 4019 and 4029, 1973).

c) Payment for an insured service performed by a licensed laboratory may only be made to the licensee of the laboratory performing the service. (OHIP Bulletin #4022, May 1973).

d) Services referred from hospital laboratories to licensed non-hospital laboratories should be billed directly to the referring hospital. Claims for such services may not be submitted to OHIP by the laboratory performing the service. (OHIP Bulletin #4089, February, 1977).

e) OHIP cannot make payments for laboratory tests on specimens sent outside Ontario, or processed in non-licensed facilities. (OHIP Bulletin #4022, May 1973).

f) Serologic tests for the diagnosis of venereal disease may only be performed in Public Health Laboratories or hospitals licensed to perform these tests. However, the patient documentation and handling fee, code L700A, may now be billed to the Plan if VDRL is the only test requested. No private laboratory may perform serologic tests for venereal diseases. (OHIP Bulletin #4025, July, 1973).

g) OHIP payments are 100 percent of the fees listed in the OHIP Schedule of Benefits or as modified by it's Preambles and Appendices. (OHIP Bulletin 4106 May 1978)

h) *Date of Laboratory Service*
A standard date of laboratory service is defined as the date the specimen arrives at the laboratory. (OHIP Bulletin #4135, April 1980).

i) *Laboratory Requisition Form*

(1) All requisitions for laboratory tests by licensed non-hospital laboratories, must be on a standard requisitiion form, provided by OHIP. These forms must be used as an OHIP claim card by the billing laboratories. Tests referred to a secondary laboratory must have the same date of service as the original requisition. The reference laboratory is not eligible to claim L700. (OHIP Bulletins #4079, 4080 August 1976, 4087 Dec. 1976, 4089 Feb. 1977).

(2) *Delegation of Signing Authority* — (OHIP Bulletins #4084, November, 1976 and #4089, February 1977)

(i) A physician requesting laboratory tests, may delegate someone other than an owner or employee of a laboratory to complete and sign the lab requisition form on his/her behalf.

(ii) To assure an audit trail, the name of the person or persons so authorized at any given time, must be recorded in the physician's office and available to an auditor if requested.

(iii) A rubber stamp of the physician's name may be used, but only in conjunction with the initial or signature of the person to whom signing authority has been delegated.

This delegation may apply to a nursing home or similar institution. In such instances, the name of the person must be on file in the nursing home.

It should be noted that the physician is legally responsible for the actions of any person so delegated for the above purpose.

(3) In cases where the Laboratory Director's personal signature is required on the laboratory requisition/claim form, OHIP will accept the signature of a physician, acting as a locum, during the temporary absence of the Laboratory Director. In such cases, OHIP must receive prior notification in which the name, OHIP registration number, and specimen signature of the locum are provided, and the exact dates of the locum arrangement are stated.

(4) Shaded areas are for the use of the laboratory only. However, when the physician draws the specimen, and sends only the specimen to the laboratory, it is necessary for the physician to enter the patient information on the top shaded portion of the requisition, to enable the laboratory to bill for its service.

(5) If a test requisitioned by a physician has a code entered beside it in the shaded "code" column, OHIP accepts this as an indication that the test has been performed by the laboratory, and is being billed to OHIP. Tests that are referred to another laboratory should have "REF" entered beside them in the shaded "code" column. Tests that are not being billed as individual tests, because they were completed on multi-channel automated equipment, should have "MC" entered beside them in the "code" column as an indication that they are included in the multi-channel billing, coded in the "laboratory use only" portion of the requisition/claim form.

(6) The area on the laboratory requisition and claim form entitled "Clinical Problems, Medication, etc.", is for the use of the requisitioning physician in communicating special instructions, etc., to the laboratory. The use of this space is optional, and any information entered will be ignored by OHIP for purposes of processing the claim from the laboratory.

(7) Physicians are reminded that the terminology of the OHIP Schedule of Benefits should be used when requisitioning tests, to prevent confusion in determining the exact test(s) required.

(8) Laboratories have been instructed to return illegible or incorrectly completed forms to the requisitioning physician, since they will not otherwise be able to bill for their services.

j) Laboratories performing tests on automated equipment must claim the lesser benefit of either the individual test(s) or the automated equipment.

Maximum number of units which may be claimed for any number of tests represented by the following codes will be 40 LMS units per patient, per day. (OHIP Bulletin #4125, July 1979).

L005	L061	L194	L223	L252
L030	L067	L204	L225	
L045	L111	L208	L226	
L053	L191	L222	L251	

k) *Repeat Tests*

(1) For repeat tests, the initial order from the physician must state the frequency of the repeat tests (weekly, monthly, etc.). (OHIP Bulletin #4080, August 1976).

(2) A test repeated on the same day, by the same laboratory, must be billed on the same requisition form.

(3) OHIP will not accept repeat tests more than six months after the first test was performed. A new requisition will, therefore, be required every six months, if a repeat test is to be continued.

l) OHIP will return any requisitions not submitted according to the requirements specified. (OHIP Bulletin #4084, November 1976).

m) Regulations made under the Health Disciplines Act specify that physicians must retain details of the investigation ordered and its results for six years. This is the same for any medical record. (OHIP Bulletin #4084, November, 1976).

n) *Claims Rejection*

In addition to the normal claim rejection for reasons of missing, incorrect, and/or, illegible header information, laboratory claims will be rejected by all OHIP District Offices if:

(1) The same service code appears more than once (e.g. in main body of form and also under "laboratory use only").

(2) Requisitioning physician's name or number is missing.

(3) Billing laboratory's name, address and number are not provided.

(4) The tests ordered by the physician are precoded.

(5) Referring laboratory number is missing on tests referred from one laboratory to another, and submitted by the latter laboratory.

(6) Signature of requisitioning physician or his authorized delegate is missing, *unless* one of the following explanations appears in the "Requisitioning Physician's Signature" area on the claim document, in lieu of the signature:

(i) "Repeat Test — original . . . (date)". The date on which the original test was performed *must* be quoted.

(ii) "Referred Test(s)".

(iii) "Cytology Test(s)".

(iv) "Original Contaminated".

(v) "Re-submission — Original Sent . . . (date)". The date on which original claim was submitted must be provided.

(vi) "Delayed — original . . . (date)". In situations where some tests are performed, but others are held over, because a new specimen is required, the laboratory may create an internally generated form for the billing of the latter tests, quoting the date on which the first tests were performed.

(vii) In cases where one requisition form does not have space for all the tests to be billed, a second requisition should be attached. All necessary claim information such as patient details, referring physician's name and number, etc. must be provided on both forms.

(viii) *L640 — Claims for Rapid Screening Tests for Streptococcus Type A Bacteria* — (OHIP Bulletin #4191, May 1985)

A number of kits are now on the market for screening Streptococcus Type A bacteria. If this test is performed in a physician's office or a private laboratory, L640 is the appropriate code to claim.

However, if a laboratory does the screening and then proceeds to a culture, code L640 should not be claimed in addition to the culture code.

(ix) "Emergency Test(s)"

Claims for such tests must be signed personally by the Laboratory Director, as must all claims which have tests added by the Laboratory Director. Unsigned laboratory requisition forms covering routine telephone orders have been received from some laboratories. Such orders must be confirmed by a signed requisition from the physician to enable the laboratory to submit a claim to OHIP. (OHIP Bulletin #4089, February 1977).

(x) *Routine Add-on Laboratory Tests*

A Medical Director of a Laboratory may, with justification, add further appropriate tests and claim for them. These must be personally signed for by the Medical Director.

Some routine "add-ons" need not be signed for each time, as long as the Medical Director has issued a dated, signed directive to the laboratory staff and this is kept on file. Routine "add-ons" are classified as:

CONDITION	**ADDITIONAL TEST WARRANTED**
Positive L319	L319 or L919 if additional tests are done by secondary laboratory
Positive L482	L471 and/or L472
Positive L471 or L472	L481
Positive L500	L501
Positive L500 (for antithyroglobulin antibody or antithyroid microsomal antibody)	L501 (for either or both these antibodies) L900 if additional screen is performed by secondary laboratory
Positive L660	L661
L625 Requested	L653
Appropriate organism isolated L650 requested	L654
Pathogen isolated in culture	L636
B-haemolytic strep isolated in culture	L636 or L638

(OHIP Bulletins #4135, April 1980; #4155, May 1981).

(xi) *L473 — Parallel Titration* — Includes:

1. Antibody screen on current sample.
2. Antibody identification on current sample.
3. Antibody titres on previous current samples L471-L472 may be claimed as well if the development of a new antibody (or antibodies) occurs and necessitates the formation of additional panels of different, or more specific, antigen composition.

   Where new antibodies are shown in the current sample, it is also justifiable to genotype the patient's cells for the corresponding antigens, using code L494.

(xii) *Glucose Tolerance Test*

A standard glucose tolerance test for diabetes is performed over 2 hours, and includes 5 blood glucose and 1 urine glucose determination. (L104). (Laboratory Medicine Preamble, item 4).

If the patient is pregnant, only 4 blood glucose specimens should be taken at hourly intervals. (L103).

(xiii) *Licensed Private Laboratories*

Services coded L800-L899 are physician services. Medical Director's 6 digit number and laboratory's 4 digit number are combined to create the group registration number, and must be on all claims for these codes.

o) *Laboratory Claim Resubmissions and Enquiries* — (OHIP Bulletin #4099, August, 1977)

If items have been omitted from any claim accounted for on a remittance advice, the laboratory should submit a new claim for the missed item(s). In lieu of the requisitioning physician's signature, the original claim number must be quoted. This provides a satisfactory audit trail.

The same procedure will apply to any claim disallowed for eligibility reasons (e.g., "Q8: Lab not licensed to perform this test on date of service" or following "J8: coverage not in effect services provided on or after the 20th of this month, will not be paid, unless subscriber takes corrective action") and where the problem has subsequently been resolved.

Enquiries regarding under-payments/over-payments other than the above must be submitted on a Remittance Advice Inquiry Form.

OHIP DISTRICT OFFICES:

TORONTO — 2195 Yonge Street, Toronto, Ontario M4S 2B2
Telephone: (416) 440-4400

HAMILTON — 119 King Street West, Hamilton, Ontario L8P 4T9
Telephone: (416) 521-7100

MISSISSAUGA — 201 City Centre Dr.,Mississauga, Ontario L5B 2T4
Telephone: (416) 896-6000

OSHAWA — 419 King St. West, Oshawa, Ontario L1J 7J2
Telephone: (416) 434-3701

LONDON — 227 Queen's Avenue, London, Ontario N6A 1J8
Telephone: (519) 433-4561

OTTAWA — 75 Albert Street, Ottawa, Ontario K1P 5Y9
Telephone: (613) 237-9100

SUDBURY — 199 Larch Street, 8th Fl., Sudbury, Ontario P3E 5R1
Telephone: (705) 675-4245

KINGSTON — 1055 Princess Street, Kingston, Ontario K7L 5A9
Telephone: (613) 545-4400

THUNDER BAY — 435 James Street,S., Thunder Bay, Ontario P7E 6E3
Telephone: (807) 475-1423

OHIP SATELLITE OFFICES:

BARRIE — 30 Poyntz Street, Barrie, Ontario L4M 3P2
Telephone: (705) 726-0326
KENORA — 100 Main Street South, Kenora, Ontario P9N 1S9
Telephone: (807) 468-9554
KITCHENER — 235 King Street East, Kitchener, Ontario N2J 4N5
Telephone: (519) 745-8421
OWEN SOUND — 1043A Second Avenue East,Owen Sound,Ontario N4K 2H8
Telephone: (519) 376-6447
PETERBOROUGH — 139 George Street North,Peterborough Ont. K9J 3G6
Telephone: (705) 743-2140
ST.CATHARINE'S — 59 Church Street, St.Catharine's Ont.L2R 3C3
Telephone: (416) 682-6658
SARNIA — 452 Christina Street North, Sarnia, Ontario N7T 5W4
Telephone: (519) 337-3667

SAULT STE MARIE — 205 McNabb Street, Sault Ste.Marie,Ont P6B 1Y3
Telephone: (705) 759-8598
TIMMINS — 38 Pine Street North, Timmins, Ontario P4N 6K6
Telephone: (705) 267-1164
WINDSOR — 1427 Ouellette Avenue, Windsor, Ontario N8X 1K1
Telephone: (519) 258-7560