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Understanding the Schedule of Benefits

This educational module introduces the Schedule of Benefits for Physician Services (the Schedule) and provides an overview of how to determine the most appropriate fee codes to claim for specific services.

This resource is most appropriate for physicians who are entering practice in Ontario and describes how general and specific sections of the Schedule inform correct billing practices. Examples provided span multiple specialties and practice settings in order to illustrate common principles.

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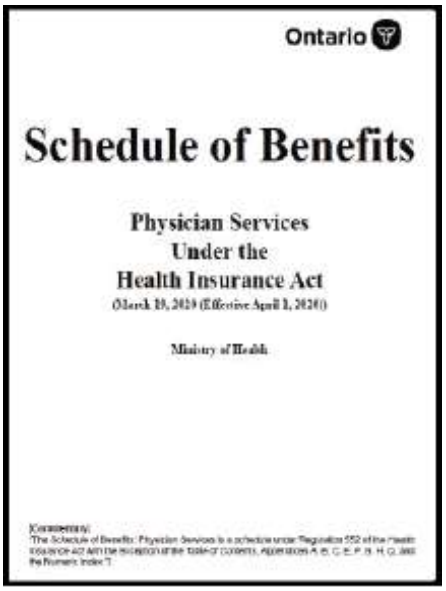
Objectives

Upon completion of this module, the learner should be able to:

1. Describe the purpose of the Schedule of Benefits for Physician Services.
2. Discuss the relationship between the Schedule of Benefits for Physician Services, the *Health Insurance Act* and regulations to the *Health Insurance Act*.
3. Identify how general and specific sections of the Schedule of Benefits for Physician Services inform correct billing practices.
4. Use the Schedule of Benefits for Physicians Services to determine the most appropriate fee code(s) to claim for a specific service.

Introduction


Ontario

Schedule of Benefits

Physician Services
Under the
Health Insurance Act

Ministry of Health

The Schedule of Benefits for Physician Services (the Schedule) is part of *Regulation 552* under *the Health Insurance Act*. It lists insured physician services that can be paid by the Ontario Health Insurance Plan (OHIP) including: patient visits (consultations, assessments, interviews, mental health services), diagnostic and therapeutic procedures, surgical services as well as other miscellaneous services (for example multidisciplinary case-conferences, physician/nurse practitioner-to-physician e-consultation, etc).

The Schedule outlines criteria that must be met for specific services to be paid. This includes definitions, required elements of service, payment rules, claims submission instructions, notes and other text. **Commentary [**which is framed in square brackets**]** is also provided as helpful additional information.

Tip: The Schedule posted on the Ministry of Health website (MOH) is the most current version; physicians must always refer to the current version of the Schedule in order to ensure that the services rendered are in accordance with the payment rules in effect at the time the service was rendered.

Glossary of select terms used in the module

Common elements

The components that are included in the payment for all insured physician services. The common elements are listed in the General Preamble.

Constituent elements

Payment for an insured service includes compensation for performing any applicable common and specific elements of the service, as well as the skill, time and responsibility involved in performing the service. All elements taken together are referred to as the constituent elements of a service.

Independent operative procedures (IOP)

Payment for surgical procedural codes without a Z prefix include pre/post operative care. (although first and second-day visits and day of discharge visits may be separately claimed by the Most Responsible Physician (MRP)), whereas surgical procedural codes with a Z prefix are independent operative procedures denoted throughout the Schedule as an IOP.

Payment Rule

A payment rule specifies a condition that must be met for a listed service to be insured. These are variously titled in the Schedule including: payment rule, medical records requirement, note, etc.

Specific elements

Components that only apply to specific groups of services. The General Preamble lists specific elements that apply to some groups of services (for example assessments). However, specific elements for other groups of services may be listed in the additional preambles throughout the Schedule (for example the Surgical Preamble).

Tip: Additional definitions can be found in the General Preamble. These are identified by italic font in the body of the Schedule.

Legal and regulatory framework

The *Health Insurance Act* provides the authority to list services which are insured. *Regulation 552* of the *Health Insurance Act* references the Schedule as the defined list of insured services. *Section 24* of *Regulation 552* provides exceptions when a listed service is not insured. Services listed in the Schedule are paid to physicians with a valid OHIP billing number, when they are medically necessary for the patient (who is eligible for OHIP coverage) and any and all listed terms and conditions are met. The Schedule is law except for sections marked as commentary, and most of the appendices (except for Appendix D to the Schedule which is included in law through *Regulation 552).*

Q: How can I suggest a change to the Schedule (adding or deleting a fee code; revising or clarifying language)?

A: Additions, deletions, fee changes, or other modifications to the Schedule, are made by the MOH following consultation with the Ontario Medical Association (OMA). An application for a modification to the Schedule or a new fee related to a new therapy or procedure should be submitted by the appropriate section(s) of the OMA to be considered by a bilateral committee consisting of MOH and OMA members. **Any change to the Schedule must be approved through the formal legislative process and requires government cabinet approval.**

Uninsured services

Some services are specifically listed as uninsured in *Section 24* of *Regulation 552* of the *Health Insurance Act*, such as a service that is solely for the purpose of altering or restoring appearance or a treatment for a medical condition that is generally accepted within Ontario as experimental. Examinations or procedures for the purpose of a research or survey program are also not insured services, except if the assessment is conducted to determine if an insured

person is suitable for such a program (see *Section 24* of *Regulation 552* under of the *Health Insurance Act*-this is provided as Appendix A of the Schedule).

Other services may be uninsured depending on the circumstances. An example of a service which is uninsured in limited circumstances is psychotherapy, which is uninsured where it is a requirement for the patient to obtain a diploma or degree or to fulfill a course of study. Other examples of commonly uninsured services include missed appointments or procedures, circumcision except if medically necessary, and certain services rendered and documents and forms completed in connection with non-medically necessary requests (for example life insurance application).

Medical records

Section 17.4 of the *Health Insurance Act* requires that all physicians make and maintain medical records as may be necessary to establish whether:

1. An insured service was rendered to an insured person.
2. The insured service for which the account was submitted accurately represents the service provided.
3. The service was medically necessary.
4. The service was therapeutically necessary.

Certain services are only eligible for payment if specific medical record requirements, as listed in the Schedule, have been met. For example, umbilical hernia repair when done in conjunction with other abdominal surgery (E764A) is only eligible for payment for services related to a pre-existing umbilical hernia that is documented in the patient's permanent medical record prior to the service being provided.

The MOH may review payments made by OHIP to a physician. *Section 17.3* of the *Health Insurance Act* requires all physicians to provide medical records to the General Manager of OHIP upon request. The MOH must be able to determine from your medical records that the requirements in the *Health Insurance Act* have been met, including that the all fee code requirements in the Schedule for the service rendered were rendered personally by the physician or by an individual delegated to perform them where such delegation is authorized in accordance with the Schedule requirements for delegated services.

For time-based codes, the time when the insured services started and ended must be documented on the patient's medical records.

Organization of the Schedule

1. Preambles

The General Preamble is an essential reference for billing questions. It includes general payment rules for all physicians, as well as definitions, required elements for particular services and details about specific categories of services and premiums.

The preambles for groups of services at the beginning of certain sections of the Schedule include additional specific elements and definitions that are elements of services listed in that section or for that group of services. For example, the Surgical Preamble lists specific elements that are considered elements of all surgical services listed in the Schedule, differentiates independent operative procedures (IOP) from non-IOPs, and lists the terms and conditions specific to surgeons/surgical services.

The Surgical Preamble has its own section within the Schedule, however its content applies to all services described as surgical procedures throughout the Schedule, therefore it is helpful to read the Surgical Preamble prior to the specific provisions of the surgical procedure with this in mind.

2. Consultations and visits

This section outlines fee codes and associated payment rules for patient visits. These include all types of consultations and subsequent visits listed by specialty as well as counselling, psychotherapy and interviews. Physicians should select the most appropriate fee code from the section associated with their specialty designation unless they are practicing outside of their specialty, in which case they may use fee codes from the Family Practice and Practice in General section.

3. Specialty Sections

The next set of sections lists fee codes related to specific specialties and non-surgical procedures including:

a. Nuclear Medicine
b. Positron Emission Tomography (PET)
c. Radiation Oncology
d. Diagnostic Radiology
e. Clinical Procedures associated with Diagnostic Radiological Examinations
f. Magnetic Resonance Imaging (MRI)
g. Diagnostic Ultrasound
h. Pulmonary Function Studies
i. Diagnostic and Therapeutic Procedures
j. Obstetrics

4. Surgical Procedures

This section includes a preamble (applicable to all surgical procedures) as well as sub-sections for groupings of surgical procedures (some with their own specific preambles) including:

a. Integumentary System
b. Musculoskeletal System
c. Respiratory System
d. Cardiovascular
e. Haematic and Lymphatic
f. Digestive System
g. Urogenital and Urinary
h. Male Genital
i. Female Genital
j. Endocrine
k. Neurological
l. Ocular and Aural
m. Spinal

Note that unlike the Consultations and Visits section, fee codes within the Surgical Procedures section are not generally limited to physicians with a specific specialty designation.

5. Appendices

Most appendices are for information only; only Appendix D is included in law through *Regulation 552.*

Fee schedule codes and naming conventions

Each service in the Schedule is defined by a unique fee schedule code.

1. Consultations and assessments
    a. The prefix usually differentiates the service location. The A prefix must be used when submitting a claim for consultations and assessments except in the following situations when the codes listed below must be used:
        i. C = acute care hospital, non-emergency in-patient services
        ii. W = long term care institution, non-emergency in-patient services
        iii. H1xx = emergency room patient, services rendered by a physician on duty
        iv. H3xx = rehabilitation unit – services rendered by a specialist in Physical Medicine
    b. The first two numbers indicate the physician specialty (with the exception of those in the format 9x), for example: 00 = GP, 13 = internal medicine.
    c. The third number indicates the type of service:
        i. 3 = general or specific assessment
        ii. 5 = consultation

For example:

A135 =

Out-patient Internal Medicine Consultation

(Prefix A – Out-patient; first two numbers 13 – Internal Medicine; third number -Consultation)

Suffixes*: These have different meanings depending on the type of fee schedule code they are used with.

a. Diagnostic tests

   i. B: indicates a technical fee. This provides compensation for the cost of equipment, personnel, supplies as well as performing the procedure. This may be variously referred to as a T fee or H fee.
   ii. C: indicates a professional fee. This provides compensation for test interpretation and other professional elements rendered by a physician.

b. Surgical procedures

   i. A: surgeon
   ii. B: surgical assistant
   iii. C: anaesthesiologist

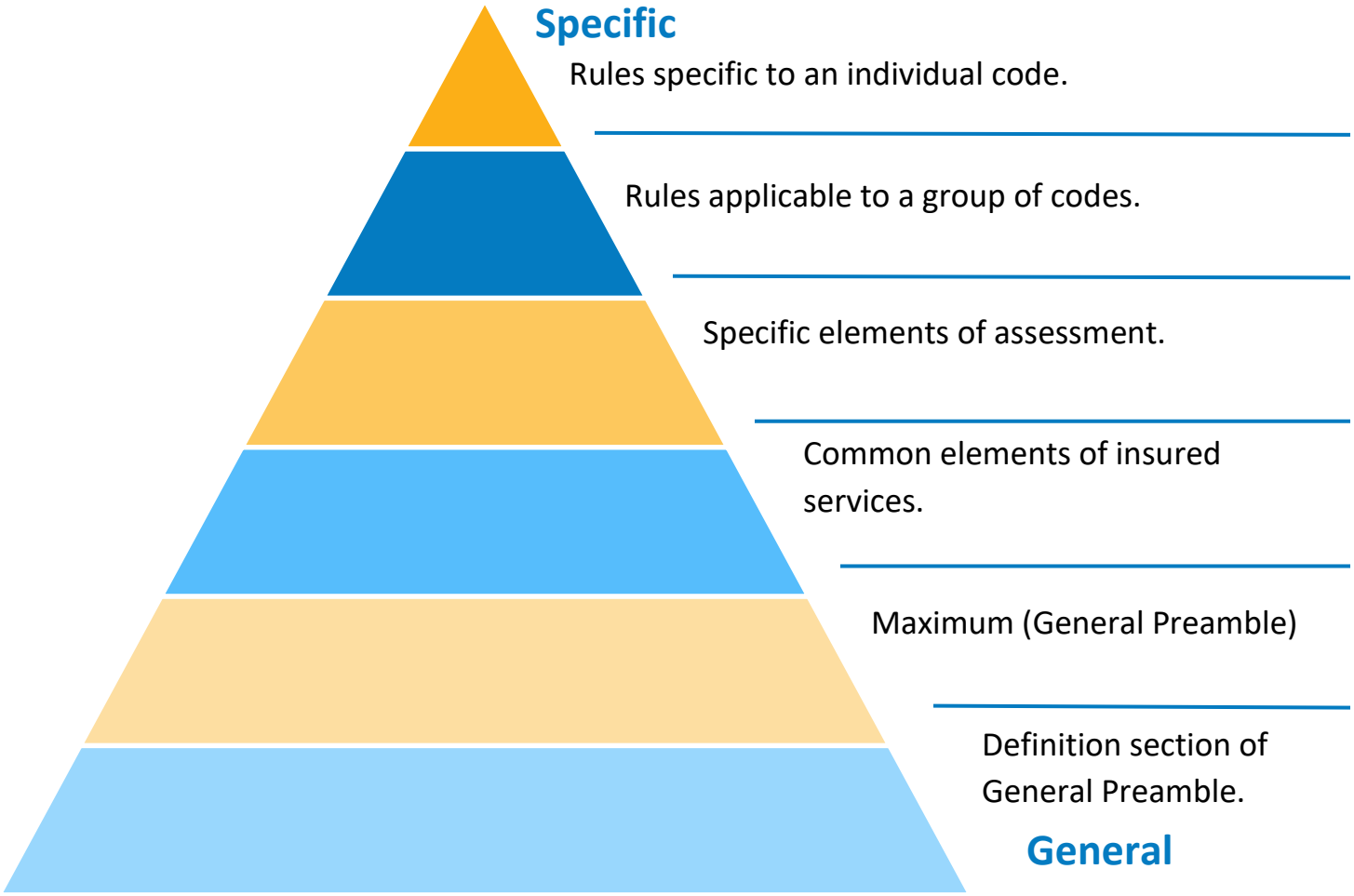
c. Other services (for example, assessments, consultations, counselling, etc.) should be submitted with an A suffix.

*__Note__: All fee codes must be submitted as a five (5) character code including the appropriate suffix.

How the Schedule works

The Schedule should be applied in its entirety and not based on an individual service description or listing alone. In order to understand a fee code, you must consider all the elements in the Schedule in order, from general listings of characteristics of services to the specific individual fee code requirements. You may also need to consider all fee code descriptions within a group of services to select the one that matches the service that was rendered.

To understand the Schedule, it is important to understand the hierarchy embedded within the document (illustrated below). Specific provisions related to individual fee codes (fee code description, for example: intermediate assessment) overrule the general provisions (constituent elements of the service, maximums in the General Preamble, and definitions in the General Preamble), therefore it is helpful to read the Schedule from general to specific provisions with this in mind.



Example: Understanding the differences between different types of assessment

- The Schedule includes three levels of assessment – general, intermediate, and minor assessment (see General Preamble).
- Patients may present to their physician for an evaluation with a large variety of clinical conditions. The level of assessment that a physician may need to perform is determined by an individual patient's circumstances. The hierarchy of general, intermediate and minor assessments is based on the medical approach to diagnosis which utilizes an anatomical or organ system framework.

Description	General Assessment	Intermediate Assessment	Minor Assessment
Fee Code	**A003**	**A007**	**A001**
Location of Service	A place other than in a patient's home	Not specified, use for General Practice and Practice in General when C/W/H codes not applicable	
Includes	**History** • of presenting complaint • family medical history • past medical history • social history • functional inquiry into all body parts and systems and **Physical examination:** • all body parts and systems except for breast/genital/rectal examination where not medically indicated or refused • may include a detailed examination of one or more parts or systems	**History** • of presenting complaint(s) • inquiry concerning the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function and • physical examination: • of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function	**One of the following:** • a brief history and examination of the affected part or region or related to a mental or emotional disorder or • brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis

Check your understanding:

1. The Schedule is best described as:
   a. a billing guide for physicians with an OHIP billing number
   b. a list of insured services that can be paid by OHIP
   c. an appendix to the *Health Insurance Act,* but not a legal document
   d. a guide to appropriate clinical practice in Ontario

2. In order to be eligible for payment by OHIP, a service must always be:
   a. provided personally by a physician
   b. described in the medical literature
   c. medically necessary
   d. listed in the Health Insurance Act

3. The content in the General Preamble is applicable to:
   a. General Practitioners
   b. General Surgeons
   c. General Internal Medicine Specialists
   d. all Physicians

4. Which of the following are required for a new service to be insured by OHIP:
   a. that the new service **is not** experimental
   b. bilateral agreement from the MOH and OMA
   c. approval by cabinet
   d. all of the above

5. A Family Physician sees a 75-year-old patient in follow up for monitoring of chronic diabetes mellitus. The physician should select the appropriate code(s) from the Consultations and Visits section, sub-section:

   a. Family Practice and Practice in General
   b. Endocrinology and Metabolism
   c. Geriatrics
   d. may select from any of these sub-sections

6. A General Surgeon provides counselling to a patient recently diagnosed with breast cancer. The physician should select the appropriate code(s) from the Consultations and Visits section, sub-section:

   a. Family Practice and Practice in General
   b. General Surgery
   c. Psychiatry
   d. may select from any of these sub-sections

7. An orthopaedic surgeon assesses an infant at risk for hip dysplasia. Following a clinical assessment, the physician orders an ultrasound scan which is performed several days later and confirms that the child's hips are normal. The physician calls the patient's mother to advise her of this result. In addition to the original consultation (A065A), the physician may claim:

   a. A064A – partial assessment
   b. A001A – minor assessment
   c. K080A – minor virtual assessment
   d. None of the above

8. A complex house call assessment (A900) is only payable if the medical record supports that an intermediate assessment was performed and:
   a. the visit was a minimum of 50 minutes in length
   b. the patient was a frail elderly or housebound patient
   c. the visit was initiated by the patient or their representative
   d. includes a written request for the visit from a second physician

9. A rheumatologist assesses a patient with severe rheumatoid arthritis affecting multiple joints and performs aspiration of four (4) complex joints. The physician may claim:
   a. G328A x 4
   b. G328A x 1 and G329A x 3
   c. G328A x 1 and G329A x 2
   d. G329A x 4

Check your understanding online

Check your understanding online. Answer these questions in an online version of the quiz. Get your score and feedback on your answers at: Check your understanding: Understanding the Schedule of Benefits for Physician Services.

More information

- Visit the Resources for Physicians page on the ministry website.
- Sign up to have OHIP Announcements sent to you by email to be notified of new educational modules and billing resources. OHIP Announcements are updates from the ministry related to system outages, scheduled maintenance, announcements of new services and OHIP claims office moves or closures.
- You can find INFOBulletins on the ministry's website or sign up to have INFOBulletins sent to you by email. INFOBulletins are communications from the ministry that inform you of changes in payment, policy, programs and software.
- If you have any questions, please contact Inquiry Services, Service Support Contact Centre (SSCC) by email or by calling 1 800 262-6524.
- Visit the OMA website or contact the OMA by email or by calling: 1-800-268-7215.

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The information provided in this educational resource is based on the April 1, 2020 Schedule of Benefits for Physician Services (Schedule). While the MOH makes every effort to ensure that this educational resource accurately reflects the law, the *Health Insurance Act* (*HIA*) and Regulations are the definitive authority in this regard and must be relied upon by physicians. Changes in statutes, regulations or other laws may affect the accuracy or currency of the guidance provided for in this educational resource. In the event of a discrepancy between this educational resource and the *HIA*, its Regulations and/or Schedule, the text of the *HIA*, Regulations and/or Schedule prevail.