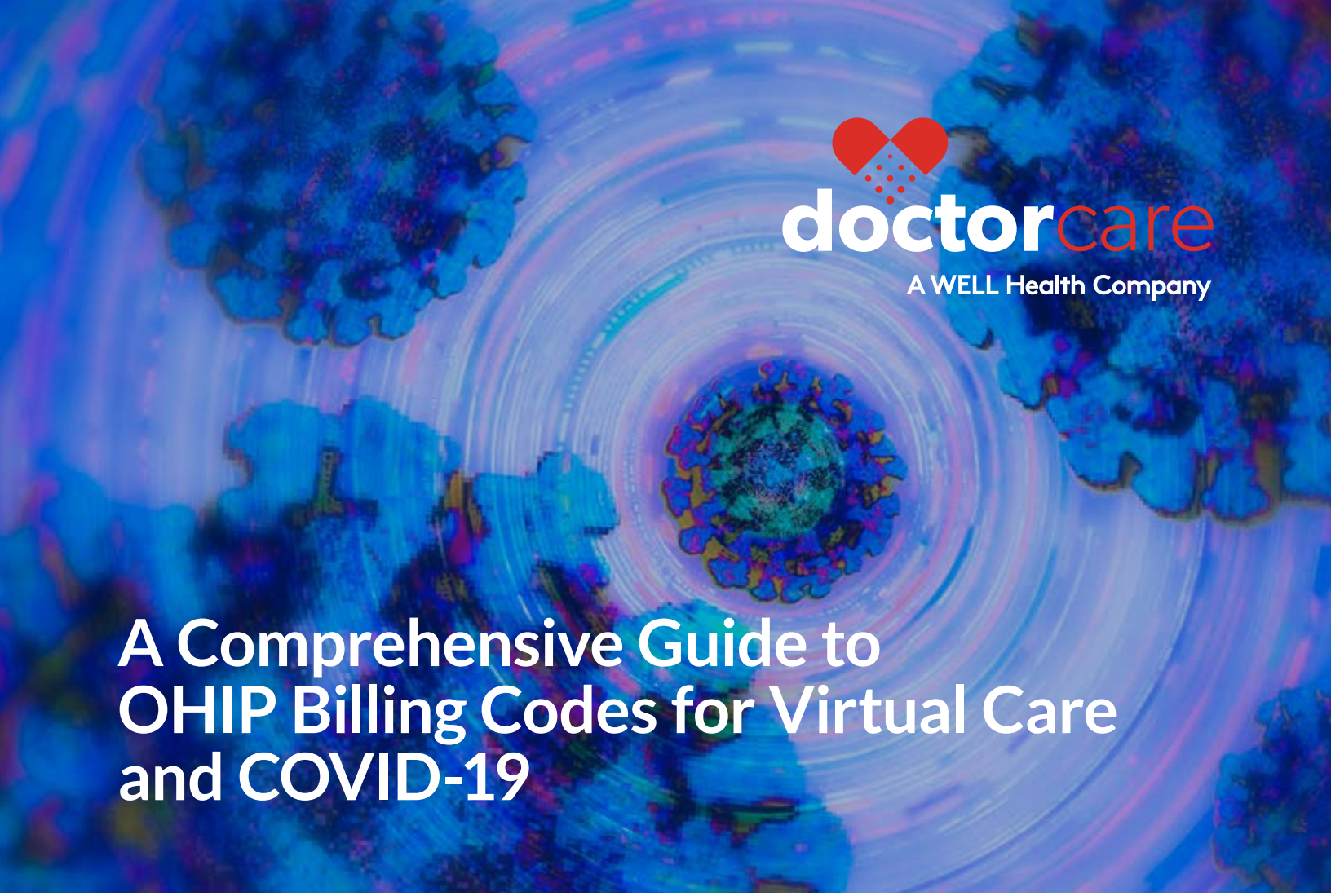


doctorcare
A WELL Health Company

A Comprehensive Guide to OHIP Billing Codes for Virtual Care and COVID-19

Over the past year, the MOH has made numerous updates and changes to OHIP billing codes to address challenges related to the COVID-19 pandemic. We have seen that the volume and frequency of changes have been hard on physicians trying to keep up and manage their billings and practice.

In this ebook, we will summarize the most recent updates on the codes relating to virtual care and COVID-19 and share some tips on how to best bill those fee codes to ensure you are getting paid for the care you are providing.

We have broken the post out into six sections:

- 1. OHIP Virtual Care Billing Codes
- 2. COVID-19 Diagnostic Codes
- 3. COVID-19 Vaccine Fee Codes
- 4. COVID-19 Sessional Fee Codes
- 5. COVID-19 Modifier Payment for AGMPs
- 6. COVID-19 Premiums and Management Fees

1. OHIP Virtual Care Billing Codes

On March 14, 2020 the MOH and OMA created four temporary OHIP billing codes in the schedule of benefits to facilitate telemedicine and virtual care. While these fee codes are not limited to COVID-19 screening or COVID-19 patients, they have been put into place in an effort to reduce the risk of disease spread by keeping people at home and out of doctors' offices.

On April 4, 2021, the MOH announced an extension on the four primary virtual care codes until September 30, 2021 and introduced a new set of virtual fee codes for palliative care.

PRIMARY VIRTUAL CARE CODES

Fee Code	Description	Value
K080	Minor assessment of a patient by telephone or video or advice or information by telephone or video to a patient's representative regarding health maintenance, diagnosis, treatment and/or prognosis.	$23.75
K081	1. Intermediate assessment of a patient by telephone or video, or advice or information by telephone or video to a patient's representative regarding health maintenance, diagnosis, treatment and/or prognosis, if the service lasts a minimum of 10 minutes; or 2. Psychotherapy, psychiatric or primary mental health care, counselling or interview conducted by telephone or video, if the service lasts a minimum of 10 minutes.	$36.85
K082	Psychotherapy, psychiatric or primary mental health care counselling or Interview conducted by telephone or video per unit (unit means half hour or major part thereof)	$67.75
K083	Specialist Consultations and Visits by telephone or video payable in increments of $5. K083 essentially allows you to bill all your usual fee code amounts for telephone or video assessments.	$5

SOME TIPS:

- You can bill the Q012 after-hours premium against K080, K081, and K082 when appropriate.
- Services must be documented on the patient's medical record (including the start and stop times) or the service is not eligible for payments.
- These codes will not contribute to Outside Use.
- K080, K081, and K082 are insured when the service was initiated by the patient or the patient's representative and the service is personally rendered by the physician.
- These fees will not contribute to the Fee-For-Service-Hard-Cap.

These OHIP virtual care billing codes are considered in-basket. For FHO/FHN physicians, they will be paid at the shadow billing rate for rostered patients, and full fee-for-service rate for non-rostered patients.

NEW PALLIATIVE CARE VIRTUAL CODES

Fee Code	Description	Value
K092	Virtual Palliative Care Consultation – Telephone	$159.20
K093	Virtual Palliative Care Consultation – Video	$159.20
K094	Virtual Palliative Care Support – Telephone	$72.15
K095	Virtual Palliative Care Support – Video	$72.15

NOTES:

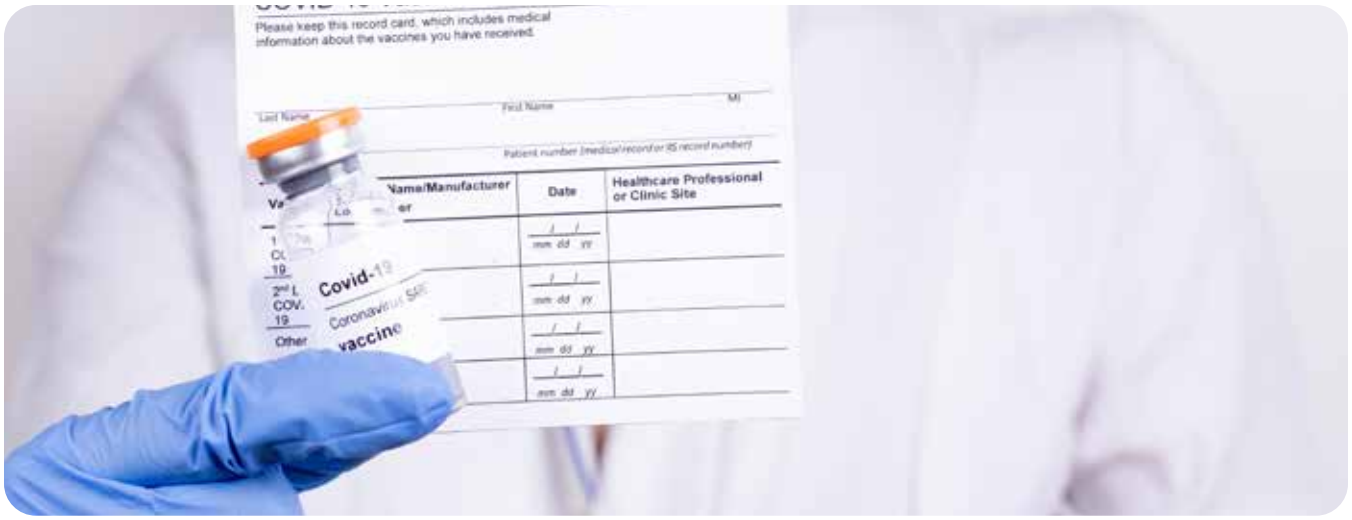
- K092 and K093 are considered special palliative care consultations while the K094 and K095 are considered palliative care support fee codes.
- K092 and K093 are requested when the need for specialized management for palliative care requires the physician spend a minimum of 50 minutes with the patient and/or patient's representative/family in consultation by video or telephone (the majority of time must be spent in consultation with the patient).
- In addition to the general requirements for a consultation, the K092 and K093 fee codes includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling, and consideration of appropriate community services, where indicated.
- The K094 and K095 are time-based services payable for providing pain and symptom management, emotional support and counselling to patients receiving palliative care (by video or telephone). They are payable in increments of ½ hour (or major part thereof).

Please note: While the payment for the provision of services associated with the palliative care virtual codes is effective March 14, 2021, system changes required to process payment are planned for May 2021. The MOH requests that physicians wait to submit claims for these codes until further notice.

We have created a Quick Reference Guide of all the virtual care billing codes.
You can download it here.

2. COVID-19 Diagnostic Code

A new diagnostic code, 080 with the description Coronavirus has been created to be used when the primary purpose for the service is treating patients with a suspected or confirmed case of COVID-19 whether in patient, by telephone, or video. This code can be used for all inpatients with COVID-19 as well as any emergency patients.



3. COVID-19 Vaccine Fee Codes

On March 6, 2021, the MOH announced new fee codes to support the vaccine roll out. There are three specific codes that you can bill for administering the COVID-19 vaccine.

Fee Code	Description	Value
G593	**COVID-19 vaccine** Payable for the administration of each dose of vaccine when multiple doses are required to complete the initial vaccination series.	$13
Q593	**Sole visit premium COVID-19 PEM** Eligible for payment with the G593 "COVID-19 vaccine" when delivery of COVID-19 vaccination is the sole reason for the patients visit.	$5.60
Q007	**COVID-19 vaccine patient facilitation fee** Where a Public Health Unit or the province formally requests a physician or physicians to contact patients to assist in the registering/booking of their patients' COVID-19 vaccination or to provide direct assistance in completing patient consent or other documentation. Can only be billed once per patient for as long as the Ministerial Order for G593 is in effect.	$6

NOTES:

- G593 is not eligible for payment for subsequent booster COVID-19 vaccination doses.
- G593 is not eligible for the FHG Comprehensive Care Premium (10%).
- G593 and Q593 will be out of basket in all primary care patient enrolment models.
- Q007 is not payable where are physician only provides general information regarding how to access or register a vaccination.
- Q007 is not payable when the physician administers the vaccine to the patient and claims G593.

Please note: primary care providers working in Assessment Centres are not eligible to claim the G593, Q593 and Q007 codes during the same time-period they are working in a Ministry designated COVID-19 Assessment Centres.

We have created a quick reference guide for the COVID-19 vaccine fee codes.
You can download it here.

4. COVID-19 Sessional Fee Codes

Two new sessional OHIP fee codes have been announced for physicians supporting vaccination services at hospitals or public health units (PHU) coordinated by COVID-19 Assessment Centres. All services rendered on or after December 14, 2020 at hospital or public health unit (PHU) coordinated COVID-19 vaccination sites are eligible for payment with the H409 and H410 fee codes.

Fee Code	Description	Value
H409	COVID-19 Sessional Unit-per one-hour period, or major Part thereof	$170
H410	COVID-19 Sessional Unit-per one-hour period, or major part thereof on Saturdays, Sundays, holidays or Monday to Friday afterhours (5pm-7am)	$220

For information on how to bill for codes H409 and H410, read our full blog here.

5. COVID-19 Modifier Payment for AGMPs

REACTIVATION OF THE E405A

The MOH has reactivated fee schedule code (FSC) 'E405A-Hospital Complexity Modifier', eligible for payment for eligible services between October 1, 2020 and September 30, 2021.

- E405A should only be billed for patients who are COVID-19 positive or who are treated as at risk of being COVID-19 positive under local hospital policy.
- This FSC can only be billed for providing general anesthesia and for performing certain procedures which are listed in 'Appendix A-Complete List of Eligible AGMPs'.
- E405A will be paid at 30% of the fee paid value (fee approved for shadow billed claims) of the applicable services for the same patient, same physician on the same day.

NEW E404A MODIFIER FOR AGMPS OUTSIDE OF HOSPITAL

The Ministry has implemented a new, temporary 30% modifier payment for eligible AGMPs performed outside of hospitals between October 1, 2020 and September 30, 2021.

The new temporary modifier is only eligible for payment when the AGMP meets all three of the following criteria:

- Is performed outside of a hospital.
- Is commenced between the hours of 7am and 5pm on weekdays.
- Is rendered to a patient who is COVID-19 positive as confirmed by laboratory testing, or at risk of being COVID-19 positive as documented in the medical record.

There has also been an expansion of the list of eligible AGMPs.
Download the complete list here.

6. COVID-19 Premiums and Management Fees

On April 9, 2021, the MOH announced extensions to the temporary payments for selected premiums and management fees.

K083 PREMIUMS

For specialists providing K083 services, the premiums listed below will be eligible for payments until September 30, 2021.

Applicable Premium	Descriptor	Premium
Age-Based fee premiums	Less than 30 days of age	30%
Age-Based fee premiums	At least 30 days but less than one year of age	25%
Age-Based fee premiums	At least one year but less than two years of age	15%
Age-Based fee premiums	At least two years but less than five years of age	15%
Age-Based premiums	At least five years but less than 16 years of age	10%
Internal Medicine Office Assessment Premium		12%
E078	Chronic Disease Assessment Premium	50%
E060	Post renal transplant assessment premium	25%
K630	Psychiatric consultation extension	$113.70
K187	Acute post-discharge community psychiatric care	15%
K188	High risk community psychiatric care	15%
K189	Urgent community psychiatric follow-up	$216.30

SOME TIPS:

The K083 Premiums are payable when all the conditions in the Schedule that apply to the premiums for services rendered in-person are met, other than for a direct physical encounter with the patient.

For the purpose of K083 services that include K083 Premiums payments, the total increments eligible for payment is equal to the fee listed in the Schedule for the appropriate service, plus the value of the applicable K083 Premium(s), rounded to the nearest $5, divided by 5.

K082 FOCUSED PRACTICE PSYCHOTHERAPY PREMIUM

The application of the existing focused practice psychotherapy premium for eligible physicians that relates to in-person psychotherapy to psychotherapy provided by phone or video using the K082 virtual care K-code is now enabled for the period of March 14, 2021 to September 30, 2021.

K082 for psychotherapy will be included as a service for which the amount payable to an eligible physician shall be automatically increased by 17% for the focused practice psychotherapy premium. K082 for psychiatric or primary mental health care, counselling, or interviews are not included as services to which this premium applies.

While the K082 Focused Practice Psychotherapy Premium is effective from March 14, 2021, premium payments for claims with service dates for the period of March 14, 2021 to September 30, 2021 will not be made until Spring 2022 to accommodate the six month claims submission window.

FAMILY HEALTH GROUP (FHG) PHYSICIANS 10% PREMIUM

Effective March 14, 2021 payment of the temporary FHG 10% premium with virtual care K-code services (K080, K081, and K082) is being extended until September 30, 2021. This premium will be paid automatically to FHG physicians rendering these virtual care K-code services to enrolled/assigned patients.

MANAGEMENT FEES FOR SERVICES BY TELEPHONE OR VIDEO

Effective March 14, 2021 the Schedule is being amended to temporarily permit K080, K081, K082 and K083 to be included as a consultation or assessment for the purposes of meeting the requirements for payment of the applicable management fee(s) listed in the Management Fees for Services by Telephone or Video, until September 30, 2021. There are eight management fees that can be claimed:

Equivalent Fee Code	Descriptor	Value
K045	Endocrinology & Metab/Internal Med-Diabetes management by a specialist-annual	$75
K046	Endocrinology & Metab/Internal Med-Diabetes team management-annual	$115
K119	Paediatrics-Paediatric developmental assessment incentive-annual	$115.10
K481	Rheumatology-Rheumatoid arthritis management by a specialist-annual	$75
Q040	GP/FP-Diabetes management incentive-annual	$60
K682	Opiod Agonist Maintenance Program monthly management fee-intensive, per month	$45
K683	Opiod Agonist Maintenance Program monthly management fee-maintanence, per month	$38
K684	Opiod Agonist Maintenance Program-team premium, per month, to K682 and K683 add	$6

Please note: The Long-Term Care (LTC) and Nursing Home Management Fee (W010) where patient care is delivered virtually is already payable with documentation of virtual visits in the patient's chart. Physicians have been eligible for payment for W010 for virtual care since March 14, 2020 and will continue to be able to bill for this management fee when appropriate.

AFTER HOURS PROCEDURE PREMIUMS

In response to the backlog of surgeries and other procedures that have been delayed due to COVID-19, the MOH has made an order to temporarily revise the current payment criteria for physicians to receive a premium when performing after-hours surgeries or other procedures listed in the Schedule of Benefits. The After Hours Procedure Premiums will be eligible for payment until November 28, 2021.

PHYSICIAN – OTHER THAN AN EMERGENCY DEPARTMENT PHYSICIAN

Fee Code	Description
E409	Evenings (17:00h-24:00h) Monday to Friday or daytime and Evenings on Saturdays, Sundays, Holidays-increase the procedural fee(s) by 50%.
E410	Nights (00:00h-07:00h)-increase the procedural fee(s) by 75%.

EMERGENCY DEPARTMENT PHYSICIAN

Fee Code	Description
E412	Evenings (17:00h-24:00h) Monday to Friday or daytime and evenings on Saturdays, Sundays, Holidays-increase the procedural fee(s) by 20%.
E413	Nights (00:00h-07:00h)-increase the procedural fee(s) by 40%.

NOTES:

- E409/E410 is not payable for a procedure rendered by an Emergency Department Physician.
- E412/E413 is only payable for a procedure rendered by an Emergency Department Physician who at the time the service was rendered is required to submit claims using “H” prefix emergency services.

We have created a quick reference guide for the After-Hours Procedure Premiums.
You can download it here.

COVID-19 CRITICAL CARE PREMIUMS

The MOH has introduced a new COVID-19 temporary 30% premium (E415A) for life threatening critical care services G521, G522 and G523, in lieu of hospital hourly Protective or Pre-Emptive Code Blue Teams funding, for the period of October 1, 2020 to September 30, 2021.

Please note: Fee codes K080A, K081A, K082A, K083A, K084A, G040A, G041A, G042A, G043A, E405A, E404A and E415A are exempt from stale date processing until June 30, 2021.

The speed and frequency of changes in billing codes can create confusion and missed billing opportunities and errors. DoctorCare is in frequent contact with the MOH can help you stay on top of your billings and minimize errors. To learn more about how we can help, contact us today.