OMA
ONTARIO MEDICAL ASSOCIATION

OHIP Payments for Palliative Care Services

Quick Reference Guide

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Quick Reference Guide[1]: OHIP Payments for Palliative Care Services

The purpose of this reference guide is to provide a general overview on the payment rules for palliative care services billed to OHIP. The OHIP Schedule of Benefits[2] (the "Schedule") lists a range of fees for many services provided to patients with palliative care needs. This *Guide* provides guidance to physicians on how to bill OHIP for palliative care services rendered in various care settings. Although this *Guide* is most relevant to physicians working in fee-for-service models, it has applicability to those required to submit "shadow billing". Family physicians working within one of the primary care models are advised to review the details of their contract to understand what palliative care services are eligible for payment in various settings (e.g., services "in and out of basket").

The guide is broken down into the following parts:

(A) How does the Schedule define palliative care?
(B) Special Palliative Care Consultation
(C) Palliative Care Case Management fee
(D) Telephone Management of Palliative Care fee
(E) Office visits for palliative care
(F) Home visits for palliative care
(G) Hospital and long-term care palliative care visits
(H) Case Conferences
(I) Physician/Nurse practitioner Telephone Consultation and E-Consultation
(J) Palliative Care Special Premium Bonus
(K) Family physicians in patient enrolment models

A. How does the Schedule define palliative care?

The OHIP Schedule defines palliative care as,

> "*care provided to a terminally ill patient in the final year of life where the decision has been made that there will be no aggressive treatment of the underlying disease and care is to be directed to maintaining the comfort of the patient until death occurs*".[3]

While many patients receiving palliative care are dying of cancer, palliative care is a service that could be rendered to patients who are dying of any number of chronic or terminal illnesses (e.g. AIDS, heart disease, muscular dystrophy, etc.).

[1] **Disclaimer**: Every effort has been made to ensure that the contents of this Guide are accurate. Members should, however, be aware that the laws, regulations and other agreements may change over time. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of applicable Regulations with the Government of Ontario including but not limited to the Ministry of Health and Long-Term Care (MOHLTC), and the College of Physicians and Surgeons of Ontario (CPSO). Members are advised that the ultimate authority in matters of interpretation and payment of insured services (as well as determination of what constitutes an uninsured service) are in the purview of the government. Members are advised to request updated billing information and interpretations – in writing – by contacting their regional OHIP office

[2] OHIP Schedule of Benefits, Physician Services, May 1, 2015 (http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html).

[3] OHIP Schedule of Benefits (SOB), May 2015, page GP4

Not every patient will require or be eligible for palliative care services in their final year of life. For example, a patient residing in a long-term care facility may be nearing end of life, but not dying of a terminal illness requiring comfort measures. The intention of the palliative care fee codes in the OHIP Schedule is that they are to be applied to patients in accordance with the OHIP Schedule's definition for palliative care.

B: Special Palliative Care Consultation

A special palliative care consultation[4] is a consultation requested because of the need for specialized management for palliative care where the physician spends a minimum of 50 minutes with the patient and/or patient's representative/family in consultation (majority of time must be spent in consultation with the patient). In addition to the general requirements for a consultation, the service includes a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counseling and consideration of appropriate community services, where indicated.

When the duration of a special palliative care consultation (A945 or C945) exceeds 50 minutes, one or more units of K023[5] (Palliative care support) are eligible for payment in addition to A945 or C945, provided that the minimum time requirements for K023 are met. **Start and stop times must be recorded in the patient's permanent medical record**.

Special Palliative Care Consultation (Office, home, OPD)	A945	$144.75
Special Palliative Care Consultation (Hospital)	C945	$144.75
Palliative Care Support (>20 min.)	K023	$62.75

In cases where the palliative care consultation does not meet the minimum 50 minute time requirement, then a regular consultation fee may be eligible for payment (A005, C005 or W105).

C: Palliative Care Case Management Fee

The palliative care case management fee[6] is payment for a service rendered for providing supervision of palliative care to a patient for a period of one week, commencing at midnight Sunday, and includes the following specific elements:

a) monitoring the condition of a patient including ordering tests and interpreting test results;

b) discussion with and providing telephone advice to the patient, patient's family or patient's representative(s) even if initiated by the patient, patient's family or patient's representative(s);

c) arranging for assessments, procedures or therapy and coordinating community and hospital care including but not limited to urgent rescue palliative radiation therapy or chemotherapy, blood transfusions, paracentesis/thoracentesis, intravenous or subcutaneous therapy;

[4] OHIP SOB, May 2015, page A1
[5] OHIP SOB, May 2015, page A34
[6] OHIP SOB, May 2015, page J82

d) providing premises, equipment, supplies and personnel for all elements of the service.

Palliative Care Case Management	G512	$62.75

Payment rules that apply to the palliative case management fee include:

1. The service is only eligible for payment when rendered by the physician most responsible for the patient's care, or by a physician substituting for this physician.
2. G511, K071 or K072 are not eligible for payment to any physician when rendered during a week that G512 is rendered.
3. G512 is limited to a maximum of one per week (Monday to Sunday inclusive) per patient and, in the instance a patient is transferred from one most responsible physician to another, is only eligible for payment to the physician who rendered the service the majority of the week.
4. In the event of the death of the patient or where care commences on any day of the week, G512 is eligible for payment even if the service was not provided for the entire week.

- ✓ The Palliative Care Case Management code G512 is billed weekly by the physician most responsible for the patient's palliative care, or by a physician substituting for this physician.
- ✓ The patient may be seeing other physicians but the primary provider will be responsible and "first call" for the patient's palliative care needs.
- ✓ In situations where the most responsible physician (MRP) needs to refer to a palliative care specialist, the MRP may still be eligible to claim G512 if the Schedule requirements have been fulfilled.
- ✓ G512 can be billed for up to one year.
- ✓ The patient can be in any location – home, hospital, LTC, etc.
- ✓ Services such as telephone management of palliative care (G511) and home care application/supervision (K070/K071) are not separately billable services when a physician has claimed G512 for the time period in which those services have occurred.
- ✓ Services not excluded in payment rule #2 such as assessments, subsequent visit fees, W010, K023, special visit premiums etc. remain eligible for payment when rendered with G512.

D: Telephone Management of Palliative Care

The palliative care telephone management fee[7] is payment for the provision by telephone of medical advice, direction or information at the request of the patient, patient's relative(s), patient's representative or other caregiver(s), regarding a patient receiving palliative care at home. The service must be rendered personally by the physician and is eligible for payment only when a dated summary of the telephone call is recorded in the patient's medical record.

[7] OHIP SOB, May 2015, page J81

- ✓ Telephone Management of Palliative Care (G511) is limited to a maximum of two services per week.
- ✓ G511 is not eligible for payment if rendered the same day as a consultation, assessment, time-based service or other visit by the same physician.
- ✓ G511 is only eligible for payment when rendered by the MRP for the patient's care, or by a physician substituting for the MRP.

Telephone Management of Palliative Care (per call)	G511	$17.75

E: Office visits for palliative care

Visits that are less than 20 minutes in length are billed according to the usual family practice fee codes; i.e., bill the applicable fee code that best reflects the service rendered. If the visit is 20 minutes or greater and is directed at providing pain and symptom management, emotional support and counseling the Palliative Care Support (K023)[8] code may be billed. Much like the counseling codes, this is a time-based code that is billed in number of units.

When meeting with relatives of a terminally ill patient for the purpose of developing an awareness of modalities for treatment of the patient and/or his or her prognosis, this visit may be eligible to be billed as Counseling of Relatives (K015).[9] This is, again, a time-based service greater than 20 minutes and billed in units. **Please note that K015 requires that the appointment be pre-booked.**

Start and stop times must be recorded in the patient's permanent medical record when billing K023 and K015.

- ✓ The Palliative Care Support code (K023) and Counseling of Relatives (K015) are billed like counseling codes in 30 minute increments.
- ✓ Where more than one unit is claimed, each preceding unit must be a full 30 minutes and the additional unit is 'major part thereof' or 16 additional minutes of care. For example, a 50 minute visit would be billed as K023 x 2.
- ✓ Refer to page GP37 in the General Preamble of the OHIP Schedule for more information on calculating time units.

Palliative Care Support	K023	$62.75
Counseling of Relatives (scheduled visit)	K015	$62.75

[8] OHIP SOB, May 2015, pages A34, GP5, GP37
[9] OHIP SOB, May 2015, pages A15, GP5, GP37-GP40

F: Home visits for palliative care

Home visits for the purpose of providing palliative care are often eligible to be billed with special visit premiums (SVPs)[10] [11]; See Table 1 on page 6 for listing of applicable SVP codes. SVPs are broken down into two components; (1) the travel premium and (2) the first person seen premium. Both premiums are billed with the appropriate assessment fee.

If the visit is greater than 20 minutes, Palliative Care Support (K023) may be eligible as an alternative to an assessment fee. If the visit is less than 20 minutes, then bill a house call assessment fee (A901 *House call assessment* or A900 *Complex house call assessment*)[12], which is a service that satisfies, at minimum, all of the requirements of an intermediate assessment.[13] Note that the Complex house call assessment (A900)[14], requires that the patient be considered a frail, elderly patient or a housebound patient (please refer to the OHIP Schedule for complete definition and payment rules).

For pronouncement of death in the home, bill the appropriate special visit premium code(s) as above, and Pronouncement of death in the home (A902).[15] If the physician completes the death certificate after death has been pronounced by another provider (nurse or physician), bill Certification of death (A771).[16]

When completing an application for home care services or providing home care supervision to a CCAC, the following fees may be eligible for payment[17]:

- K070 for home care application
- K071 for acute home care supervision (first 8 weeks)
- K072 for chronic home care supervision (after 8th week)

Physicians providing ongoing care to a palliative care patient at home should consider their eligibility to bill G512 Palliative Care Case Management or G511 Telephone Management of Palliative Care. Note that K071, K072 and G511 are not eligible for payment when G512 is billed.

Palliative Care Support (>20 min.)	K023	$62.75
Housecall Assessment (< 20 min.)	A901	$45.15
Complex Housecall Assessment	A900	$45.15
Pronouncement of death in the home (includes death certificate)	A902	$45.15
Certification of death (Completion of death certificate alone)	A771	$20.60
Telephone Management of Palliative Care	G511	$17.75
Home care application	K070	$31.75
Acute home care supervision	K071	$21.40
Chronic home care supervision	K072	$21.40

[10] OHIP SOB, May 2015, pages GP44-GP52
[11] For additional information on billing Special Visit Premiums, refer to Education and Prevention Committee Interpretive Bulletin Vol.7, No. 1: https://www.oma.org/Resources/Documents/0701EPC_Bulletin.pdf
[12] OHIP SOB, May 2015, page A3
[13] OHIP SOB, May 2015, page GP18
[14] OHIP SOB, May 2015, page A3
[15] OHIP SOB, May 2015, page A3
[16] OHIP SOB, May 2015, page A5
[17] OHIP SOB, May 2015, page A40

Table 1: Special Visit Premiums: Palliative Care Home Visit[18]

	Weekdays Daytime (07:00-17:00)	Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours	Evenings (17:00-24:00) Monday through Friday	Sat., Sun. and Holidays (07:00-24:00)	Nights (00:00-07:00)
Travel Premium	$36.40 B966	$36.40 B966	$36.40 B966	$36.40 B966	$36.40 B966
First person seen	$82.50 B998	$82.50 B998	$82.50 B998	$82.50 B998	$110.00 B997
Maximums (per time period)					
Travel Premiums	unlimited	unlimited	unlimited	unlimited	unlimited
First person seen	unlimited	unlimited	unlimited	unlimited	unlimited

G: Hospital and long-term care palliative care visits

For hospital inpatients, MRP subsequent visit fees C122, C123 and C124 may be eligible for payment by the most responsible physician (MRP); please refer to the OHIP Schedule for complete definition and payment rules.[19] On day 2 and 3 following an admission, C122 and C123 may be billed. For discharging the inpatient from hospital, C124[20] may be billed for rendering a subsequent visit on the day of discharge and completing the discharge summary.

Hospital visits to palliative care patients that are less than 20 minutes should be billed as a Palliative Care subsequent visit – C882 (for GPs) and C982 (for specialists).[21] **These codes do not have the weekly service limits associated with other subsequent visit fees (e.g., the after six weeks of care weekly maximum service limits)**. If the visit is 20 minutes or greater and is directed at providing pain and symptom management, emotional support and counseling then the Palliative Care Support fee (K023) could be billed.

When the admission assessment and subsequent hospital visit (including palliative care visits) is rendered by the patient's MRP in an acute care hospital, the MRP may be eligible to bill MRP premium codes E082 (MRP Admission assessment premium) and/or E083 (MRP subsequent visit premium) in addition to the admission assessment or subsequent visit codes (including C122,

[18] OHIP SOB, May 2015, page GP51
[19] OHIP SOB, May 2015, pages GP29 and GP30.
[20] OHIP SOB, May 2015, page GP30
[21] OHIP SOB, May 2015, pages GP34, A9; For C982, refer to appropriate Specialist listing in Section A of the SOB

C123 and C124), when all of the service requirements have been met; please refer to the OHIP Schedule for complete definition and payment rules.[22]

For palliative care visits in a Long-Term Care (LTC) institute, the applicable palliative care fee depends on the type of LTC facility. For patients in a Chronic Care or Convalescent Hospital, bill W882 or W982, as appropriate. For patients in a Nursing home or home for the aged, bill W872 or W972, as appropriate. Please note that W872 and W972 are not eligible for payment if W010 (Monthly Management of a Nursing Home or Home for the Aged Patient) has been billed on the patient in the same month.

If a patient is in a designated palliative care bed, regardless of the type of facility, claims are to be submitted as C882 or C982, as appropriate. [23]

For pronouncement of death in hospital with completion of the death certificate bill C777 and for completion of the death certificate alone bill C771. [24] For pronouncement of death in a LTC facility (regardless of type of facility) with completion of the death certificate bill W777 and for completion of the death certificate alone bill W771. [25]

MRP subsequent visits – day 2 & 3	C122, C123	$58.80
MRP subsequent visit – day of discharge (not for deceased patients)	C124	$58.80
Palliative Care Assessment (<20 min) – GP, acute care	C882	$31.00
Palliative Care Assessment (<20 min) – Specialist, acute care	C982	$31.00
Palliative Care Assessment (<20 min) – GP, Chronic care/ Convalescent	W882	$31.00
Palliative Care Assessment (<20 min) – Specialist, Chronic care/ Convalescent	W982	$31.00
Palliative Care Assessment (<20 min) – GP, Nursing home/home for the aged	W872	$31.00
Palliative Care Assessment (<20 min) – Specialist, Nursing home/home for the aged	W972	$31.00
Palliative Care Support (>20 min.)	K023	$62.75
Hospital Admission Assessment by the MRP - Premium	E082	Add 30%
Hospital Subsequent Visit by the MRP - Premium	E083	Add 30%
Pronouncement of death	C/W777	$33.70
Certification of death (Completion of death certificate alone)	C/W771	$20.60

[22] OHIP SOB, May 2015, pages GP27 and GP32.
[23] OHIP SOB, May 2015, pages GP34.
[24] OHIP SOB, May 2015, pages GP18, A5, A9
[25] OHIP SOB, May 2015, pages GP18, A5, A14

Special visits to hospital or LTC for the purpose of providing palliative care are often eligible to be billed with special visit premiums (SVPs)[26] [27]; see Table 2 on page 8 for listing of applicable SVP codes. As noted above, special visit premiums are broken down into two components; (1) the travel premium and (2) the person premium. Both the travel code and the first person and additional person(s) seen codes are billed with the appropriate assessment fee.

If the visit is greater than 20 minutes, Palliative Care Support (K023) may be eligible as an alternative to an assessment fee. If the visit is less than 20 minutes, then bill appropriate assessment fee that best reflects the service rendered (e.g., A007 Intermediate assessment fee). In cases where you are called to the hospital or LTC for pronouncement of death, bill the applicable SVP codes and A777 (not C777 or W777).

Table 2: Special Visit Premiums: Hospital and LTC inpatient Visit[28]

	Weekdays Daytime (07:00-17:00)	**Weekdays Daytime (07:00-17:00) with Sacrifice of Office Hours**	**Evenings (17:00-24:00) Monday through Friday**	**Sat., Sun. and Holidays (07:00-24:00)**	**Nights (00:00-07:00)**
Travel Premium	$36.40 C/W960	$36.40 C/W961	$36.40 C/W962	$36.40 C/W963	$36.40 C/W964
First person seen	$20.00 C/W990	$40.00 C/W992	$60.00 C/W994	$75.00 C986 W998	$100.00 C/W996
Additional person(s) seen	$20.00 C/W991	$40.00 C/W993	$60.00 C/W995	$75.00 C987 W999	$100.00 C/W997
Maximums (per time period)					
Travel Premiums	2	2	2	6	unlimited
Persons seen (first person & add'l person(s))	10	10	10	20	unlimited

* "C" prefix designates hospital inpatient SVP and "W" prefix designates LTC inpatient SVP.

[26] OHIP SOB, May 2015, pages GP44-GP52
[27] For additional information on billing Special Visit Premiums, refer to Education and Prevention Committee Interpretive Bulletin Vol.7, No. 1: https://www.oma.org/Resources/Documents/0701EPC_Bulletin.pdf
[28] OHIP SOB, May 2015, page GP49

H: Case Conferences

There are a number of fees codes that apply to case conferences[29] [30] involving members of a care team. The general requirements of a case conference are:

- a pre-scheduled meeting conducted for the purpose of discussing and directing the management of an individual patient
- must be conducted by personal attendance, videoconference or by telephone
- must involve at least 2 other participants (eligible participants may vary by type of case conference)
- at least one of the physician participants is the physician most responsible for the care of the patient
- A record of the conference must be recorded with start and stop times and the list of attendees
- Billing is in 10 minute increments with a maximum of 8 units and a maximum of 4 conferences annually, per patient, per physician.

Multidisciplinary cancer conferences (MCC), which are case conferences specific to the discussion and management of one or more cancer patients, must meet the minimum standards established by Cancer Care Ontario.

Refer to the OHIP Schedule for a complete list of the different types of case conferences[31], the associated requirements and payment rules.

Hospital Inpatient Case Conference - acute, chronic or rehab (per unit)	K121	$31.35
Outpatient Palliative Case Conference (per unit)	K700	$31.35
Multidisciplinary Cancer Conferences (per patient)	K708	$31.35
Long-term care/CCAC case conference (per unit)	K124	$31.35
Convalescent care program case conference (per unit)	K706	$31.35

I: Physician/Nurse Practitioner to Physician Telephone Consultation and E-Consultation

Physician/nurse practitioner (NP) to physician telephone consultation[32] [33] is a service where the referring physician or NP, requests the opinion of a physician (the "consultant physician") by telephone who is competent to give advice in the particular field because of the complexity,

[29] OHIP SOB, May 2015, pages A20-A28
[30] For additional information on billing for Case Conferences, refer to Education and Prevention Committee Interpretive Bulletin Vol.9, No. 3: https://www.oma.org/Resources/Documents/0903EPC_Bulletin.pdf
[31] OHIP SOB, May 2015, pages A20-A28
[32] For additional information on billing for Case Conferences, refer to Education and Prevention Committee Interpretive Bulletin Vol.9, No. 2: https://www.oma.org/Resources/Documents/0902EPC_Bulletin.pdf
[33] OHIP SOB, May 2015, pages A29-A30

seriousness, or obscurity of the case. The referring physician/NP initiates the telephone consultation with the intention of continuing the care, treatment and management of the patient. When the purpose of the telephone discussion is to arrange for transfer of the patient's care to any physician, the service is not eligible for billing. A record of the consultation must be kept by the physician(s) who submits a claim for the service.[34]

Physician/NP to physician e-consultation[35] is a similar service to the physician/NP to physician telephone consultation except that both the request and opinion are sent by electronic means through a secure server. This service is only eligible for payment if the consultant physician has provided an opinion and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the e-consultation request.

Physician/NP to Physician Telephone Consultation – Referring Physician	K730	$31.35
Physician/NP to Physician Telephone Consultation – Consultant Physician	K731	$40.45
Physician/NP to Physician E-Consultation – Referring Physician	K738	$16.00
Physician/NP to Physician E-Consultation – Consultant Physician	K739	$20.50

* Note physician/NP to physician telephone consultation rendered by physicians on duty in the emergency department or hospital urgent care clinic are to bill K734 when the referring physician and K731 when the consultant physician.

J: Palliative Care Special Premium Bonus:

Physicians may be eligible to receive the annual Palliative Care Special Premium Bonus. The following fee schedule codes will accumulate to Palliative Care special premium thresholds for enrolled and non-enrolled patients: K023, C882, A945, C945, W882, W872, B997 and B998.

In order to receive the Premium payment, a physician must reach the following thresholds:

Bonus Level	**Level A**	**Level C**
Necessary annual criteria	4 or more patients served	10 or more patients served
Annual Bonus	$2,000	$5,000

Please note:

(i) all family physicians are eligible for the level "A" bonus; and
(ii) only PEM physicians are eligible for the level "C" bonus.

[34] See 'Medical record requirements', OHIP SOB, May 2015, pages A30 and A33
[35] OHIP SOB, May 2015, pages A33-A34

K: Family Physicians in Patient Enrollment Models

The following are some billing considerations specific to Patient Enrollment Models (PEMs):

Fee Code	Description	In Basket
A900	Complex house call assessment	FHO
A901	House Call assessment	FHO
A945	Special palliative care consultation	X
B966	Palliative Care Home Visit - Travel Premium	FHO
B998	Palliative Care Home Visit - First Person See Premium	X
C945	Special palliative care consultation - Non Emergency Hospital In-Patient Services	X
C882	Subsequent visits by the MRP following transfer from an Intensive Care Area - Palliative Care	FHO
W872	Subsequent visits - Nursing home or home for the aged - Palliative Care	X
W882	Subsequent visits - Chronic care or convalescent hospital - Palliative Care	X
K023	Palliative Care Support	X
K700	Palliative care out-patient case conference	FHO / FHN

This document was prepared by the OMA's Economics, Research & Analytics department. Questions can be forwarded to economics@oma.org.