



January 2016 Edition

Physician's Guide to Uninsured Services

A Guide for Ontario Physicians — Billing for Uninsured Services

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 and between editions of this *Guide*. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of the applicable Third Party 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.

Quick Reference List

2016 OMA Physician's Guide to Uninsured Services

The fees noted in the list below are for the completion of the form/report only, with the exception of the 'Insurance Medical Examination'. An assessment fee may also be applicable, when an assessment is required to complete the form/report and when that same assessment is not medically necessary.

Multiplier		Page
2016 Multiplier for Uninsured Services: 2.14		13
Miscellaneous	Suggested Rate	Page
Establishing an Hourly Rate	At physician's discretion	13 - 14
Charges for Copying/Transmission of Medical Records :		
(a) Copying	(a) \$30 (first 20 pages) + \$0.25 per page thereafter	15 - 17
(b) Out-of-pocket disbursements (where applicable)	(b) At cost	
(c) Physician review of records (where applicable)	(c) Physician's hourly rate	
Completion of form physicals for schools, camps, pre-school, daycare, university or other educational institution	\$26.35	21
Completion of form physicals for pre-employment certification of fitness/fitness clubs or hospital/nursing home employee	\$35.20	21
Back to work note Sick note Daycare note (free of communicable disease)	\$18.10	21
Insurance Certificate OCF- 3 Disability Certificate	\$134.65	22
Insurance Certificate OCF-18 Treatment Plan	\$134.65	22
Insurance Certificate OCF-19 Determination of Catastrophic Impairment	\$110.50	22
Insurance Certificate OCF-23 Treatment Confirmation	\$133.60	22
Attending Physician's Statement	\$134.60	23, 42
Insurance Medical Examination (fee includes assessment and report)	\$219.80	23, 42
Revenue Canada, Federal Disability Tax Credit	\$44.95	22
Canada Pension Plan (CPP) Disability Medical Report Form	(up to) \$85.00	23
Canada Pension Plan (CPP) Narrative Medical Report	(up to) \$150.00	23

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I. INTRODUCTION

This *Guide* provides guidance to physicians on third party requested services, other uninsured services, suggested fees, relevant policies and interpretation of relevant regulations applying to such services. Wherever possible, specific issues will be highlighted for members and reference information will be provided for those members wishing to further research the specific issue at hand.

Uninsured medical services are not covered by the Ontario Health Insurance Plan (OHIP) and may be charged directly to the patient (or third party) at the discretion of the physician. Physicians should inform the patient or the person(s) financially responsible about such charges prior to rendering the service and should make an appropriate record (as required) of the uninsured services they provide.

In this Guide,

“Insured Services” means services covered by the Ontario Health Insurance Plan (OHIP);

“Uninsured Services” means services which are not “insured services”;

“Third Party” means a person other than the patient;

“Third Party Services” means any service requested by a Third Party or which is in whole or in part necessary¹ for the production or completion of a document or transmission of information to satisfy the requirements of a Third Party.²

Physicians must bill for insured services at the rates set out in the OHIP Schedule of Benefits. They may not bill any amount in excess of these rates. Physicians may select the rate they bill for uninsured services, unless they are otherwise prohibited from doing so. This *Guide* suggests rates and fees for uninsured services which physicians may choose to charge. The rates and fees suggested in this *Guide* apply to uninsured services of “average” complexity and are intended to offer assistance in establishing appropriate and practice-specific billing rates. Physicians however are not required to charge the rates suggested in this *Guide*.

Please note that Regulation 856/93 under the *Medicine Act*, states that it is professional misconduct to

- i. *“Charging a fee that is excessive in relation to the services performed”* (Section 1(1) 21),
- or
- ii. *“Charging a fee for a service that exceeds the fee set out in the then current schedule of fees published by the Ontario Medical Association without informing the patient, before the service is performed, of the excess amount that will be charged”* (Section 1(1) 22).

¹ Including an annual health exam.

² See for example s.24(1), para 8, 8.1 and 8.2 of O.Reg. 552 under the *Health Insurance Act*.

II. THE DIRECT BILLING PROCESS

General Guidelines for the Direct Billing Process

There are some practical guidelines physicians can follow when billing a patient directly for uninsured services, to help make the process as comfortable and efficient as possible. In order to establish an office policy on billing for uninsured services, physicians should first determine:

- Those services for which patients will be directly billed;
- The fees attached to those services³;
- Any exemptions, such as for seniors or those on fixed-incomes;
- Bookkeeping and collection procedures.

Examples of some common uninsured services include:

- Missed appointments or procedures if less than 24 hours notice has been given (an exception being psychotherapy practices where a reasonable written agreement exists between the patient and physician).
- A service that is solely for the purpose of altering or restoring appearance.
- Providing a prescription to an insured person if the person or person's personal representative requests the prescription and no concomitant insured service is provided.
- Completion of third party reports and forms (please see [Section IV](#) of this *Guide*)

Please note that Section 24 of Regulation 552 under the *Health Insurance Act* precludes a physician from billing a patient or third party:

- For keeping or maintaining appropriate physician records;
- For conferring with, or providing advice, direction, information, or records to physicians or other professionals concerned with the health of the insured person;
- For obtaining consents or delivering written consents; and/or
- An annual administrative or any other fee associated with office overhead costs (including but not limited to the cost of computerizing billings, storage of patient medical records, time spent arranging appropriate follow-up care for insured services, etc.).

A physician's office policy on direct billing for uninsured services must be specific and detailed so that it is fully understood by staff and patients. It should also allow sufficient flexibility to adapt to unique or unexpected circumstances that may be encountered. Once an office policy has been established, it should be put in writing and distributed to staff. When billing directly for services provided, physicians should:

1. Establish and maintain a simple and clear office policy and procedure for direct billing;
2. Inform staff of this policy and procedure and keep them apprised of any changes;
3. Maintain up-to-date accounts;
4. Collect payment from patients at the point of service as often as possible;
5. Follow-up in an orderly and consistent manner;
6. Always discuss fees with the patient before providing the service.

³ Not all fees are up to the physician's discretion (e.g. WSIB services).

II. THE DIRECT BILLING PROCESS

Physicians should familiarize themselves with pertinent College of Physician and Surgeons of Ontario (CPSO) policies⁴, such as,

- Policy #2-12, Third Party Reports, and
- Policy #3-10, Block Fees and Uninsured Services

Additional information on developing an uninsured services billing program can be found in the following Ontario Medical Review (OMR) articles:

1. OMR, February 2010, Vol. 77, No. 2, *Does your uninsured services program need a “check-up”?*, by Jonathan Marcus, MD, CCFP
2. OMR, September 2010, Vol. 77, No. 8, *Tools to support your uninsured services program: point-of-service terminal facilitates “real-time” payment, enhanced practice efficiency*, by Jonathan Marcus, MD, CCFP
3. OMR, May 2011, Vol. 78, No. 5, *Communicating your uninsured services policy to patients: strategies to avoid confusion, misunderstandings*, by Rohan Mathai

Patients and their ability to pay for services

There are some instances where patients claim economic hardship and an inability to comply with the fees they are charged for the uninsured services rendered. It is important for OMA members to realize that rates in this *Guide* are *suggested* rates. When calculating fees, physicians should consider the financial burden that such charges might place on the patient and should decide whether it is appropriate to reduce, waive or allow flexibility based on these considerations as applied to the circumstances of each case. The Canadian Medical Association’s Code of Ethics (2004) states under Paragraph 16 that “*an ethical physician will consider, in determining professional fees, both the nature of the service provided and the ability of the patient to pay, and will be prepared to discuss the fee with the patient.*”

Furthermore, the Medicine Act prohibits physicians from “*charging a fee that is excessive in relation to the services performed*” (Section 1(1) 21).⁵

Timeliness of response

The College of Physicians and Surgeons of Ontario (CPSO) Third Party Reports policy states that physicians should complete and submit third party reports within **60 days**, unless a timeline for these activities has been specified by legislation or a specific legal requirement.⁶ If physicians are unable to comply with this timeframe, either due to the complexity of the report, or for another appropriate reason, physicians should discuss the matter with the third party and reach an agreement for a reasonable extension.⁷

⁴ CPSO policies are available on the CPSO website at <http://www.cpso.on.ca/policies/policies/default.aspx?id=1778>

⁵ http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_930856_e.htm

⁶ The Personal Health Information Protection Act specifies that an individual has a right of access to a record of personal health information and that the health information custodian shall give the response required as soon as possible in the circumstances but no later than 30 days after receiving the request (unless a time extension has been put in place). Full details of this legislation can be accessed: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

⁷ CPSO Third Party Reports policy: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1658>

II. THE DIRECT BILLING PROCESS

Code of Ethics

The responsibilities of an ethical physician to the patient are stated in the Code of Ethics (revised by the Canadian Medical Association in 2004) and include the following:

An ethical physician will: *“provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.”* (Paragraph 37)

In addition, Section 1.17 of Ontario Regulation 856/93 made under the Medicine Act, 1991 states that it may be considered professional misconduct to fail *“without reasonable cause to provide a report or certificate relating to an examination or treatment performed by the member to the patient or his or her authorized representative within a reasonable time after the patient or his or her authorized representative has requested such a report or certificate.”* Therefore, a physician asked to prepare a report for a patient or third party must do so, and must submit that report within a reasonable time. The College states in its policy on Third Party Reports that a reasonable period of time is within 60 days.⁸

⁸ *Ibid.*

II. THE DIRECT BILLING PROCESS

Block Fee Billing

A block fee is defined as a flat fee charged by a physician for a predetermined set of uninsured services during a predetermined period of time (no less than three months and no more than one year). Not all physicians are in a position to charge a block fee due to the nature of their practice and specialty. Physicians are not required to offer a block fee option but can rather charge patients on a fee-for-service basis for uninsured services. Physicians who do choose to offer a block fee must also offer uninsured services separately at individual costs to patients. Patients cannot be required to pay a block fee.

The College of Physicians and Surgeons of Ontario (CPSO) policy on block fees states that physicians may use third party companies to assist them to administer a block fee or payment for uninsured services. Any communication to patients should identify the fact that a third party was involved. Third parties who are asked to administer block fees or payment for uninsured services are acting on the physician's behalf. Physicians are responsible for ensuring these companies adhere to the same standards required of physicians.

The policy also states that patient decisions regarding payment for uninsured services must not affect their ability to access health care services. Physicians must not:

- Require that patients pay a block fee before accessing an insured service;
- Offer to treat patients preferentially because they agree to pay a block fee;
- Terminate a patient or refuse to accept a new patient because that individual chooses not to pay a block fee.

The CPSO policy should be reviewed in detail before a physician constructs a block fee billing system. The policy can be found online at: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1612>.

The OMA's Practice Management and Advisory Service, within the OMA's Health System Programs department, provides information packages on implementing a block or annual fee program, if requested. Contact the department directly at practicemanagement@oma.org.

II. THE DIRECT BILLING PROCESS

Keeping Patients Informed

Many patients are surprised to discover that not all of their medical needs are covered under the Ontario Health Insurance Plan (OHIP), and that they must pay their provider directly for certain uninsured services. This misunderstanding can lead to situations that are frustrating and uncomfortable for both the patient and physician, as well as medical office staff — particularly if the patient learns about the cost after the service has been rendered.⁹ To prevent this from occurring, there are strategies that can be employed to make billing and collecting payment for uninsured services more efficient.

- Always discuss the fees and, where applicable, expected completion date with the patient/third party **in advance of providing the services**.
- Clearly display in the patient waiting area a sign (refer to [Appendix II](#)) and an itemized list of those third party services offered.
- If physicians charge patients for uninsured services, the CPSO states that a list of fees should be made available to the patient. This list must be available regardless of whether the fee will be paid on an individual per service basis or in the context of a block fee.¹⁰
- Discuss fees when the patient books an appointment for an uninsured service.
- Have patients sign a letter of acknowledgement
- When invoicing patients/third party, be sure the invoice and services have been itemized. It is considered professional misconduct for failing to itemize an account for professional services, if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services, or if the account includes a commercial laboratory fee.¹¹ In addition, physicians should issue receipts for all cash payments and ensure that these transactions are properly documented.
- Publish a pamphlet that outlines the office's direct billing process and other information. This pamphlet need not be a complicated and costly publication, however, it should reflect a physician's professionalism, and information should be presented in a clear and concise fashion.
- Don't hesitate to contact the third party (or the patient, where applicable) requesting information in the event the request is unclear, or if the request is unreasonable. It's not unusual for a third party to request a "copy of the patient's file" when in reality, the third party is looking for a specific piece of information. This saves the physician from performing unnecessary work and results in a more manageable fee to the requesting party. (Note that both the patient and the receiving physician/party should be consulted to be sure that providing a specific piece of information or a summary of the record is acceptable in lieu of the entire medical record). Refer to [Appendix II](#) for a set of sample letters that may be of assistance.
- Consider arranging a payment plan with the patient that aligns with their financial means.

⁹ OMR, May 2011, Vol. 78, No. 5, *Communicating your uninsured services policy to patients: strategies to avoid confusion, misunderstandings*, by Rohan Mathai

¹⁰ CPSO Block Fees and Uninsured Services policy: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1612>

¹¹ http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_930856_e.htm

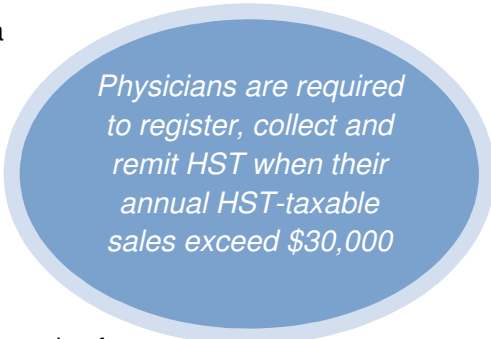
II. THE DIRECT BILLING PROCESS

Application of HST to Uninsured Services

General Information

Physicians who are HST registered are required to charge and collect tax at a rate of 13% on any taxable supplies (other than zero-rated supplies or exempt supplies) of goods and services they supply in the province of Ontario.

All physicians, whether registered or not, are required to pay HST at a rate of 13% on the purchase cost of most of their supplies (other than payments to employees). Physicians are required to register, collect and remit HST when their annual HST-taxable sales exceed \$30,000. For those physicians not exceeding this amount, HST registration is voluntary. Members should be aware that once registered as collectors and remitters of HST, they must continue to file reports even if the HST falls below the \$30,000 threshold.



Physicians are required to register, collect and remit HST when their annual HST-taxable sales exceed \$30,000

Consequently, if a physician retires or significantly reduces his or her supply of HST-taxable services, he or she will have to formally de-register as a HST remitter to be able to cease providing monthly reports to the Canada Revenue Agency (CRA).

It is suggested physicians consult with an accountant prior to registering for HST.

Amendments to the Excise Tax Act

The Excise Tax Act was amended as of March 21, 2013 to clarify that a supply that is not a “qualifying health care supply” is deemed not to be an exempt “health care service”.¹² A “qualifying health care supply” is defined to mean “a supply of property or a service that is made for the purpose of:

- (a) maintaining health,
- (b) preventing disease,
- (c) treating, relieving or remediating an injury, illness, disorder or disability,
- (d) assisting (other than financially) an individual in coping with an injury, illness, disorder or disability, or
- (e) providing palliative health care”.¹³

CRA states that the intent of these changes was to clarify that GST/HST “applies to reports, examinations and other services that are not performed for the purpose of the protection, maintenance or restoration of the health of a person or for palliative care.” (see <http://www.budget.gc.ca/2013/doc/plan/anx2-eng.html>) While further clarifications continue to be sought from the CRA, the CRA has indicated that where the primary purpose of a supply is the protection, maintenance, or restoration of health, the supply will be exempt from HST. A supply may have a dual purpose (e.g. an exam whose purpose is both to promote

¹² Excise Tax Act, Schedule V, Part II, s.1.2.

¹³ Excise Tax Act, Schedule V, Part II, s.1.

II. THE DIRECT BILLING PROCESS

health as well as to provide information for a financial form), but the health benefit cannot be incidental or ancillary to the primary purpose.

We acknowledge that this is confusing, and continue to seek direction from the CRA on this matter. Physicians are encouraged to contact their accountant to obtain clarification on individual concerns.

HST and Uninsured Services: General Guidelines

The information contained in this section is only a general guideline. For the most accurate information pertaining to HST please contact the CRA¹⁴ or consult with your accountant and/or tax lawyer.

As indicated above, certain services physicians charge for as uninsured services will attract HST. Generally, if the primary purpose of a service is NOT to protect, maintain or restore health, HST will be payable. For example, an IME which is carried out solely for the purpose of filling out financial forms will attract HST.

The following uninsured services have, in the past, been considered by the CRA to be subject to HST and are likely to continue to be subject to HST:

- Cosmetic surgical procedures and all related medical services
- Medical Reports based on chart review
- Block & Annual Fees
- Witness fees for court appearances¹⁵
- Medical examinations for which the primary purpose is not motivated by the protection, maintenance, or restoration of health.

The CRA has, in the past, considered the following uninsured services to be HST exempt, and is likely to continue to consider these services to be exempt:

- Consultative, diagnostic, treatment or other health care service by a physician to an individual¹⁶, including:
 - Executive medical assessments carried out for the purpose of health care for the patient
 - Prescription renewal without a visit.
- Preparation and transfer of Medical Records,
- Medical Reports upon patients or upon a person who the physician has examined including the following provided that the exam also has the purpose of promoting, protecting or maintaining health:
 - Employment and pre-employment examinations/reports
 - Immigration examination/reports
 - Employer Back to Work/Timely Return to Work/Modified Employment forms
 - Treatment Plan (Form OCF-18)

¹⁴ <http://www.cra-arc.gc.ca/menu-eng.html>

¹⁵ Page 3, GST Memorandum 300-4-2.

¹⁶ Excise Tax Act, Schedule V, Part II, s.5.

III. SUGGESTED FEES FOR UNINSURED SERVICES

There are several ways a physician can calculate their rates and fees for uninsured services (including those requested by third parties).

In calculating fees for uninsured services, the physician should take into consideration, as circumstances dictate, some or all of the following factors:

- a. Nature and complexity of the matter;
- b. Experience and expertise of the physician;
- c. Time spent with and/or on behalf of the patient; and
- d. The cost of materials not included in the fees for insured services.

Refer to the *OMA Schedule of Fees* for guidance and suggested fees. The OMA Schedule of Fees is based on a fee multiplier applied against the **May 1, 2014** OHIP Schedule of Benefits. **The 2016 multiplier is 2.14**¹⁷. Any fee listed in the **May 1, 2014** OHIP Schedule of Benefits can be multiplied by **2.14** to obtain the **OMA suggested fee for the service**¹⁸.

Further, this *Guide* contains suggested fees for a number of more common forms and services that are typically requested by third parties. However, there are forms, reports and services that are not specified, and in these cases physicians can use one of the following methodologies to establish an appropriate fee.

1. **At the Physician's Cost:**

Defined as the actual, direct or invoice cost (including applicable taxes) incurred by the physician, plus a reasonable mark-up to account for secretarial and other indirect costs. Examples of services that are often billed at the physician's cost:

- Toll charges for long-distance telephone calls.
- Preparing/providing a drug, antigen, antiserum or other substances used for treatment (but not used to facilitate the procedure/examination).¹⁹
- Preparing or providing a device that is not implanted by means of an incision and that is used for therapeutic purposes (e.g., IUD). Exceptions to this are if the device is used to permit or facilitate a procedure or examination, or if the device is a cast for which there is a fee listed in the OHIP Schedule of Benefits, in which case the patient cannot be charged a fee.

2. **Establish an Hourly Rate**

In the absence of a specific fee recommendation for an uninsured service, physicians can consider establishing an hourly rate to assist in determining the appropriate fee. Given the diversity of physician

¹⁷ The methodology used to adjust the multiplier on an annual basis does not account for the mandatory OHIP payment discount.

¹⁸ If members do not have access to the May 1, 2014 OHIP Schedule, the alternative is to consult directly with the 2016 OMA Schedule of Fees to obtain the calculated uninsured rates.

¹⁹ Please refer to CPSO 'Dispensing Drugs Policy' for additional details on the College's expectations of physicians who dispense drugs. Note that physicians have an obligation to advise patients of alternatives to the types of drugs, or other substances, that are being prepared or provided to the patient for a fee by the physician, if such alternatives exist. This may also extend to informing patients about services or mechanisms, such as Ontario Drug Benefit Plan, that are available to patients and may reduce or eliminate the patient's costs. Physicians should issue receipts in such circumstances.

III. SUGGESTED FEES FOR UNINSURED SERVICES

practices and nature of uninsured services provided, **the OMA does not have a suggested hourly rate.** As such, it is incumbent upon the physician to establish their own hourly rate.

When developing an hourly rate, the factors described above should be taken into account. As described in Section VIII: Scale of Grading and Remuneration (page 31), the average net part-time employment hourly rate is calculated to be **\$350**. This figure was calculated based on survey information gathered by the Committee on Economics in 2004.

The following **example**²⁰ illustrates one way to determine an hourly rate based on an individual's gross annual income. A possible source for annual gross income could be from your annual income tax statement.

	Item	Calculation
A	Annual gross earnings:	
	Annual gross OHIP payments (e.g. FFS, primary care, Specialist AFA/AFP models):	\$500,000
	Annual income from other sources (e.g., WSIB, stipends, salaries, alternate funding arrangements)	\$50,000
	Other annual income (e.g., uninsured third party billings)	\$50,000
	Total annual gross earnings:	\$600,000
B	Working days per year: (52 weeks x 5 days/week less 25 days of vacation and 10 statutory holidays)	225
C	Income generating hours (paid hours/day): (9 hours in practice less 2 hours of unpaid non-clinical activity per working day)	7
D [=B x C]	Annual paid hours: (225 days x 7 hours/day)	1,575
E [=A / D]	Hourly rate: (\$600,000/1,575 hours)	\$380.95

Another **example** of determining an hourly rate is to use an average day's income divided by the hours worked. Members may also consider adjusting their calculated hourly rate using the multiplier (see page 14).

The examples cited above do not take the following into account: a physician's training, experience & expertise, medico-legal & personal risks, plus opportunity costs, among other factors which could increase the complexity of the work.

In establishing an hourly rate, physicians are free to use a methodology of their choice and are not limited to the examples in this Guide.

While the OMA does not have a suggested hourly rate, we advise physicians that it is important to consider whether the rate being charged is excessive. It is considered professional misconduct to charge a fee that is excessive in relation to the services being provided (Section 21, Ontario Regulation 856/93).

²⁰ All figures used in the example are for illustration purposes only; members should modify accordingly to reflect their average income, workday, working days/year, etc.

III. SUGGESTED FEES FOR UNINSURED SERVICES

Suggested Charges for Providing Copies of Medical Records

General Information

The provision of copies of patient medical records is an uninsured service. Physicians **cannot charge a fee** for providing copies of their medical records, **unless** they first give the individual **an estimate** of the fee that will be charged.²¹

Sometimes the physician must review the records before providing copies of them to the patient. If this is necessary, the physician may charge professional fees for his or her review.

Note that copies of medical records should only be provided to a third party with the necessary authorization, which may include consent from the patient or the patient's representative, a Court Order, or where required or permitted by law.

Please refer to [Appendix II](#) for a sample letter to the patient informing them of the applicable fee charges.

*Suggested charges for providing copies of patient medical records include a **sum of the following**:*

(1) Copying costs (\$30 for the first 20 pages and \$0.25 per page thereafter);

(2) Out-of-pocket disbursements;

(3) Professional review (billed at the physician's hourly rate).

A. Suggested Charges for Providing Copies of Medical Records

There are **two** elements to the charge for providing printed copies of medical records:

1. Cost of the Provision of the Copy of Medical Records

The OMA recommends physicians charge \$30.00 for the first 20 pages and \$0.25 per page thereafter for the reasonable cost of copying, printing, reproducing or transmitting medical records, including electronic medical records (EMR), when the EMR (or portions of) are printed on paper²². This amount includes clerical labour costs, equipment lease or amortization costs, print volume fees, toner and paper costs, secure electronic storage media costs, equipment maintenance costs, office lease costs for equipment and secure record storage space and other costs of a similar nature.

2. Out-of-pocket Disbursements

In addition to the actual copying or printing costs, the physician may charge for any out-of-pocket disbursements directly related to the request for the provision of copies of the medical records. Examples of such disbursements include fees for the retrieval of the medical record from storage, postage, courier and/or long-distance fax charges for delivering the records to the patient.

²¹ *Personal Health Information Protection Act, s.54(10).*

²² When the record can be transferred without any associated cost via secure email or other electronic transfer, the fee associated with paper records would not apply (professional review may still apply, at the physician's hourly rate). In situations where there is a charge from the vendor to transfer a record, this cost could be passed on to the patient.

III. SUGGESTED FEES FOR UNINSURED SERVICES

B. Professional Review

Sometimes it will be necessary for the physician to review the patient's medical records before providing copies. For example, if the patient requests copies of only certain portions of his records (e.g. those records related to a specified motor vehicle accident), it may be necessary for the physician to review the chart to separate the requested records from the rest of the chart. If the patient's charts include services of a **psychiatric nature**, the physician must be extremely diligent when reviewing the type of information prior to providing a copy. Given the unique, intimate and sensitive nature of psychiatric records, this would entail above-average time on the part of the physician.

Further, a physician may refuse to provide a copy of all or portions of a medical record if he or she is of the opinion that access to those portions of the medical record could reasonably be expected to,

- i. result in a risk of serious harm to the treatment or recovery of the patient or a risk of serious bodily harm to the patient or another person,
- ii. lead to the identification of a person who was required by law to provide information in the record to the physician, or
- iii. lead to the identification of a person who provided information in the record to the physician explicitly or implicitly in confidence if the physician considers it appropriate in the circumstances that the identity of the person be kept confidential.²³

This professional review of the medical record is an uninsured service. The physician may charge the patient/third party for this service. The OMA recommends that the physician charge for this service using his or her hourly rate, keeping in mind that the fee charged should be reasonable.

Transfer of Medical Records

General Information

Generally speaking, physicians must always keep the original copies of their medical records.²⁴ Only copies of the records should be transferred to others. When charging fees for the transfer of medical records, patients must be informed, **in advance**, that this is an uninsured service (not covered by OHIP) and given an estimate of the cost of the transfer. Suggested fees for transferring copies of a patient's medical record are described above under "*Suggested Charges for Providing Copies of Medical Records*".

Sometimes a physician may be of the opinion that a copy of the patient's entire chart is not necessary. For example, it contains information that is of nominal value, is out-dated or is no longer relevant, to understand the patient's current medical condition. In this situation, the physician may suggest to cull the unnecessary information from the chart. If agreed to, the physician may charge a professional fee for his or her review and culling of the patient's medical records. Consent of both the patient and the receiving physician are required when preparing a summary of the records rather than providing a copy of the whole record.

²³ Personal Health Information Protection Act, s.52(1)(e).
²⁴ See s.19, O. Reg. 114/94 under the *Medicine Act*.

III. SUGGESTED FEES FOR UNINSURED SERVICES

Prepayment of the fee for transfer of medical records may be requested when, in the best judgement of the treating physician, the patient's health and safety will not be put at risk if the records are not transferred. For additional information, please refer to the CPSO's policy statement on Medical Records.²⁵

Please refer to [Appendix II](#) for a sample letter to the patient informing them of the applicable fee charges.

Physician Relocation/Closing of Practice: Transfer of Medical Records

When a physician relocates or closes a practice, patients should be contacted to determine if they wish to have their records transferred elsewhere. In instances where patients ask for transfer to a specific location, there can be a charge for the transfer of records. In situations where departing physicians transfer all records to a new practice, there should be no charge to patients unless the patients contact the new practice to request that copies of the records be transferred to a different physician of their choice.

Immunization as an Uninsured Service

Immunization for communicable diseases endemic to Canada is considered an insured service whereas immunization rendered solely for the purpose of travel is not an insured service.

Pre-departure travel medicine services rendered solely for the purpose of travel outside Canada are not covered by OHIP. This includes assessments, counselling or administration of vaccines or drugs for prevention of communicable diseases not endemic to Canada. In addition, the cost of the drugs/serum in these cases is billable to the patient directly.²⁶

Additional information on immunization and other services relating to travel outside Canada can be found in Education and Prevention Committee (EPC) Interpretive Bulletin, Volume 5, No.1. EPC Interpretive Bulletins are available online at: <https://www.oma.org/Resources/Pages/EPCbulletins.aspx>

²⁵ <http://cpso.on.ca/policies/policies/default.aspx?ID=1686>

²⁶ Ministry of Health and Long-Term Care, OHIP Bulletin # 4317, July 30, 1998;
<http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4317/bul4317b.aspx>

III. SUGGESTED FEES FOR UNINSURED SERVICES

TB Mantoux Testing

The fees applicable to TB testing depend on the service(s) being provided. Please consult the OHIP Schedule of Benefits for a complete list of assessment and injection codes and the associated payment rules. If a physician is billing on an uninsured basis, refer to page 14 of this Guide for information on calculating fees for uninsured clinical services.

There are three general categories of TB Mantoux testing requests. They are as follows:

1. If a Ministry of Health program, such as the Public Health Department requests a TB test and a completed form/report, then both the test and completion of the form/report cannot be billed to the patient. Use of the publicly funded Tubersol is permitted in these cases. Only the appropriate OHIP fees can be claimed (e.g., A001 for the visit/assessment and G372 for the injection or G373 if the test is the sole reason for the visit²⁷).
2. If a TB test is requested by a patient, for admission or continuation in a day care or pre-school program or a school, community college, university or other educational institution or program as evidence of immunization status²⁸, then the TB test is insured by OHIP. This includes situations where a student requires a TB test for his/her work placement (e.g. co-op program, internship, etc.). The request must come from the educational institution and documentation must be provided that confirms the work placement is a required component of the student's curriculum. Use of the publicly funded Tubersol is permitted in these cases.
3. If a TB test is requested solely for employment purposes then the test and the completion of the form is uninsured and can be billed to the patient or third party. Use of the publicly funded Tubersol is **not** permitted in these cases.

For additional information on when it is appropriate to bill OHIP for TB testing, please consult the Health Insurance Act, Reg. 552, Section 24 (1.1) 3, 4, 5, 6.

Please note that serum provided by the government is not to be used for uninsured TB testing. When uninsured testing is performed, the serum should be either

- (i) Acquired by the physician and sold to the patient at a direct cost (with reasonable mark-up to account for any indirect costs (e.g., storage, administrative, etc.)), or
- (ii) Acquired by the patient from the pharmacy, via prescription provided by the physician.

²⁷ When the patient returns for a second visit in order for the physician to assess any possible skin reaction, the fee for this interpretation is included in the previously claimed G372 or G373 code.

²⁸ The only way to assess 'immunization status' is to perform a TB test. Immunization status represents both active and passive (via contact) immunization.

III. SUGGESTED FEES FOR UNINSURED SERVICES

Other Uninsured Services

The following services are not insured benefits of OHIP and may be billed directly to patients. This list is not exhaustive. In addition to the services listed below, any service provided by a physician, laboratory or hospital that supports an uninsured service is not an insured benefit. No claims to OHIP should be made for consultations, assessments, counselling, diagnostic investigations (e.g., ultrasound, laboratory tests), et al. that are in support of an uninsured service such as cosmetic surgery, reversal of sterilization, uninsured in vitro fertilization, etc.

Note: Travelling time and mileage charges are non-insured and may be charged directly to patients when visits are made by physicians to see patients outside their normal area of practice. This is defined as the greater of either 8 kilometres or 15 minutes in one direction, from a physician's usual location of practice. **Based on the recommendation by the OMA Rural Medicine Forum, the suggested fee for uninsured travel is \$60 per 30 minutes (or \$120/hour).**

Consultations and Assessments

- Family Practice and Practice in General

Patient interview for practice admission	\$92.35
(Note: patient interview refers to a patient conducted interview of a physician)	
Dispensing service fee ²⁹ (The dispensing service fee is not intended to apply to the provision of drug samples to patients but only where there is a recorded purchase of a supply of drugs)	\$14.75
Certification of incompetence (financial) including assessment to determine incompetence	\$280.40

Consultations and Assessments

- Paediatrics

Pre-adoption examination and evaluation for Children's Aid Society	\$201.10
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Consultations and Assessments

- Psychiatry

Specific assessment with report to referring agency	\$306.15
Therapeutic supervision with any paramedical organization (health education, correction and other community resources)	\$292.10
Appearance before Advisory Review Board or Review Board – per ½ hour or major part thereof	\$152.70

²⁹ Please refer to CPSO 'Dispensing Drugs Policy' for additional details on the College's expectations of physicians who dispense drugs. Note that physicians have an obligation to advise patients of alternatives to the types of drugs, or other substances, that are being prepared or provided to the patient for a fee by the physician, if such alternatives exist. This may also extend to informing patients about services or mechanisms, such as Ontario Drug Benefit Plan, that are available to patients and may reduce or eliminate the patient's costs. Physicians should issue receipts in such circumstances.

III. SUGGESTED FEES FOR UNINSURED SERVICES

Certification of incompetence (financial) including assessment to determine incompetence	\$280.40
Preparation and attendance at Board of Review (plus \$90.14 per half hour in addition for time in excess of three hours)	\$926.75
Completion of forms/procedures dictated by the Mental Health Act	Independent Consideration
Certification procedures regarding management of estate	Independent Consideration

The Role of the Primary Care Physician in Timely Return to Work

In some situations, the physician may assume the role of the Timely Return to Work (TRTW) Coordinator for the provision of services associated with a timely return to work program for the individual employee. The TRTW coordinator works with the employer and the employee/patient to assist in developing and overseeing a timely return work program that is individualized to the employee and meets the requirements of the employer.

The TRTW coordinator assumes the primary responsibility for compiling medical information together with the employee's workplace and job functions information, which may include a formal ergonomic assessment, if appropriate, and provides advice concerning the limitations, restrictions and modifications that may be necessary to accommodate the employee in a timely return to work program. This role might also include a review of the workplace policies and collective agreements to which the employee may have agreed and/or a detailed review of the pre-morbid work history (e.g., chronic absenteeism, difficulty with co-workers).

If the physician assumes the role of TRTW Coordinator, then he or she should bill the requesting third party based on the physician's established hourly rate (refer to page 14), or in some other manner, provided that the rate to be charged to the employer is agreed upon in advance, regardless of how the rate is calculated.

For additional information on the role of TRTW Coordinator, please refer to the OMA's policy paper "*The Role of the Primary Care Physician in Timely Return to Work*", which is available on the OMA's website at: <https://www.oma.org/Resources/Documents/2009PCPandTimelyReturn.pdf>

Refer to [Appendix III](#) for a summary of recommendations from the OMA's policy paper.

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

The following list represents a sample of forms that exist in the public domain. The suggested rates are based on the average time and complexity of completing a typical form. As such, physicians may use their discretion in adjusting the fee charged on a case by case basis to better reflect the time and complexity of completing an individual form. For example, the fee charged may be based on the physician's hourly rate.

Uninsured Report Forms	Suggested Fee
Completion of Forms for:	
Schools/Camps	\$26.35
Admission to Day-care, preschool, university (including out of province and international universities) or any other educational institution	\$26.35
Pre-employment Certification of Fitness/Fitness Clubs	\$35.20
Hospital/Nursing Home Employees	\$35.20
Completion of Licensing Forms/Certificates:	
Drivers Medical Examination	\$53.95
Civil Aviation Medical Examination Report 26-0010E(001004)	<i>At the physician's hourly rate</i>
Pilots License Validation 26-0055(01-91)	<i>At the physician's hourly rate</i>
Completion of Work and School Related Forms/Notes:	
Back to Work Notes/Sick notes	\$18.10
Certificate of freedom from communicable disease	\$18.10

*For third party requested forms or reports, **an appropriate assessment fee may be charged** in addition to the fee charged for completion of the form/report, when the assessment is not medically necessary*

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

Uninsured Report Forms

Suggested Fee

Statutory Accident Benefits Schedule Claim Forms:

An **appropriate assessment fee** may be charged in addition to the insurance form/certificate fee when an assessment is necessary to obtain relevant information needed to complete the insurance form/certificate. Refer to page 14 'Setting Fees for Uninsured Services' for additional information on calculating assessment rates.

#OCF-3	Disability Certificate	\$134.65
#OCF-18	Treatment Plan	\$134.65
#OCF-19	Determination of Catastrophic Impairment	\$110.50
#OCF-23	Treatment Confirmation	\$133.60

The Financial Commission of Ontario's (FSCO) "Professional Services Guideline"³⁰ outlines the maximum expenses payable by automobile insurers under the Statutory Accident Benefits Schedule (SABS) for the services provided by health care professionals/providers listed in the Guideline.

The SABS Guideline does not apply to physicians (physicians were excluded from the Guideline). Therefore, the amounts payable are to be determined and agreed to by both parties involved and are **not** subject to the maximum rates listed in the Guideline.

Insurance Forms:

Travel Cancellation Insurance Form	\$36.05
Life Insurance Death Certificate	\$44.95
Medical Certificate for Employment Insurance Compassionate Care Benefits	\$51.10

Other Forms/Certificates:

Revenue Canada, Federal Disability Tax Credit	\$44.95
Children's Aid Society (CAS) Application for Prospective Foster Parent	\$53.95
Medical Certificate Employment Insurance Sickness Benefits INS5140	\$27.05

³⁰ <http://www.fSCO.gov.on.ca/en/auto/autobulletins/2013/Documents/a-03-13-1.pdf>

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

Life and Health Insurance Report and Assessment Fees

Several versions of life and health insurance forms exist, originating from different sources/different insurance companies. Where members' fees are expected to vary from the suggested fee listed below, it is recommended that members communicate this to the insurance companies prior to providing the service.

For a general description of the specific forms/reports listed below, and whether or not a medical examination/assessment is recommended in order to complete the form/report refer to [Appendix IV](#).

Attending Physician's Statement	\$134.60
System-Specific or Disease Specific Questionnaire	\$89.70
System-Specific Examination	\$107.75
Insurance Medical Examination	\$219.80
Clarification Report	\$362.20/hour
Full Narrative Report	\$362.20/hour
Independent Medical Examination	<i>Independent Consideration</i>

Canada Pension Plan (CPP) Forms

CPP form fees are paid by Service Canada as per the amounts listed below. The physician's hourly rate can be used when balance billing for CPP forms/services (refer to page 14 for information on establishing an hourly rate).

Service Canada will pay "up to" the fees listed below. If a physician's fees are higher than the fees listed below, then patients are responsible for covering any extra costs.

There are two distinctly different types of CPP forms the federal government will pay for:

- (i) **The Disability Medical Report Form** (up to) \$85.00
- (ii) **The Narrative Medical Report** (up to) \$150.00

The Narrative Medical Reports are usually initiated by correspondence from staff at the Income Securities Branch of Human Resources and Skills Development Canada.

The narrative reports require:

- Medical history
- The date of onset of each medical condition
- An examination of findings
- Various excerpts of consultation reports (including identification of consultants)
- Diagnosis
- Copies of test results
- Prognosis
- Course of future action

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

Upon receipt of a physician's invoice and confirmation that the individual concerned has submitted an application, Service Canada will reimburse:

- Up to \$85 for the initial medical report;
- Up to \$25 for the reassessment medical report;
- Up to \$50 for the "Scannable Impairment Evaluation";
- Up to \$25 for the "Medical Report – Recurrence of the Same Medical Problem"; and
- Up to \$150 (depending on complexity and time required for completion) if Service Canada medical adjudicators request other information in the form of a narrative report.

For additional information, please contact Service Canada at 1.800.277.9914 or review the Frequently Asked Questions on the Service Canada website:

<http://www.servicecanada.gc.ca/eng/services/pensions/cpp/disability/benefit/health-prof.shtml>

Unremunerated Report Forms

There are a number of exemptions when charging for the completion of a third party report form. The following list contains some of the common forms that a physician is **not** permitted to charge for its completion³¹:

- Application for Accessible Parking Permit
- Transit forms for the Disabled
- Permanent Resident Card Forms
- Request for Birth Certificate Forms
- Children's Aid Society Forms (on behalf of a child)
- Canadian Passport Application³²
- Ministry of Health and Long-Term Care Forms (e.g., Limited Use, Assistive Devices, etc.)³³

³¹ Section 24, Regulation 552 of the *Health Insurance Act*; please refer to:
http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_e.htm

³² Physicians are not obligated to serve as guarantors. Patients requesting a physician to be a guarantor should be made aware that the form 'Statutory Declaration in Lieu of Guarantor' is available for persons without an eligible guarantor.

³³ Some exceptions apply when a specific code is listed in the OHIP Schedule of Benefits (ie: Home Care Application Fees [K070, K071, K072], Northern Health Travel Grant Application Form [K036], Ontario Hep. C Assistance forms [K026, K027], Long-Term Care Application Form [K038], etc.).

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

Reports Requested by Employers and Other Issues Related to Workplace Safety & Insurance

Workplace Safety & Insurance Board (WSIB)

Injuries that arise out of and in the course of the patient's employment are insured by WSIB³⁴ and not OHIP. OHIP processes these claims on behalf of WSIB. When a patient claims WSIB benefits, the physician must provide the Board such information relating to the patient as the Board may require.³⁵ For a list of the WSIB report forms and their associated fees, contact WSIB at 1.800.569.7919 or visit the website at: <http://www.wsib.on.ca>

Sometimes patients elect to not claim WSIB benefits and ask their physicians to not report the work-related injuries to the WSIB and to bill their services to OHIP. When this occurs, **physicians must,**

a) respect their patient's request and not report the injury to WSIB, but

b) refuse to bill their medical services to OHIP

Physicians cannot report workplace injuries to the WSIB unless the patient is **claiming benefits from WSIB**³⁶ or the **patient consents** to such a report being made. Disclosing patient information without statutory authorization or the patient's consent is professional misconduct under the *Medicine Act* and a violation of the *Personal Health Information Protection Act*.

All Medical services that a patient "**is entitled to claim from WSIB**" (regardless of whether the patient "claims" such benefits) are "not insured" by OHIP.³⁷ Hence, all medical services for injuries arising out of and in the course of the patient's employment may not be billed to OHIP. Hence, these are **uninsured services which must be billed to the patient directly.**

Employer-Specific Forms for Worker Injuries

The injured patient **or the employer** may request the physician complete the WSIB's Functional Abilities Form "**FAF**". Physicians are required by the WSIB Act to complete the FAF on request of either the patient **or the employer**.³⁸ The patient's consent is not required to provide the FAF at the employer's request. The fee for the completion of this form is charged to the WSIB.

Sometimes employers ask that the worker's physician provide a report or complete a different form relating to the worker's ability to early return to work or modified return to work. These forms are not to be confused with the WSIB's FAF form. To complete such a report or other form, the **patient's consent is required**. Completion of such forms and any related assessments and/or tests is an uninsured service and should be charged to the patient or, where the request is made directly by the employer, to the employer.

³⁴ Section 13, *Workplace Safety and Insurance Act*.

³⁵ Section 37(1), *Workplace Safety and Insurance Act*.

³⁶ Authorized by s.37(1) of the *Workplace Safety and Insurance Act*.

³⁷ Section 11.2(2) *Health Insurance Act*.

³⁸ Section 37(3).

V. INTERPROVINCIAL RECIPROCAL BILLING OF MEDICAL CLAIMS

The Reciprocal Medical Billing System (RMBS) may be used to bill for services rendered by physicians or private medical labs to a patient insured under another Canadian provincial health coverage plan, **excluding Quebec**.

The arrangement allows Ontario physicians who voluntarily participate to bill OHIP directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan. Participation is voluntary; physicians who do not wish to participate in this arrangement are free to bill the patient directly using the OMA suggested fees³⁹. Participating physicians will receive payment at the OHIP Schedule of Benefits rates and must accept the payment as payment in full.

Instructions on how to submit electronic reciprocal claims can be found in the OHIP Online Resource Manual for Physicians (Section 4, pages 4-6 – 4-8):

http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html

If physicians do not wish to bill electronically, the following form can be used to make a claim. Completed forms should be submitted to a physician's designated OHIP Claims Office:

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-4421-84~2/\\$File/4421-84.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetFileAttach/014-4421-84~2/$File/4421-84.pdf)

Patients without a valid health card

If the out-of-province patient does not present a valid health card, the patient should be considered uninsured and billed directly for services. In these situations, it is acceptable bill using the OMA suggested fees. If it is not possible to bill the patient directly, a completed Out-of-Province Claim form can be sent to the patient's home province to obtain payment:

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-0000-80~5/\\$File/0000-80E_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-0000-80~5/$File/0000-80E_.pdf)

Patients from Quebec

Physicians are advised to bill Quebec patients directly using the OMA suggested fees. If it is not possible to bill the patient directly, a completed Out-of-Province Claim form can be sent to the patient's home province to obtain payment:

[http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-0000-80~5/\\$File/0000-80E_.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-0000-80~5/$File/0000-80E_.pdf)

Excluded Services

There are a number of services that are excluded from the reciprocal agreement (but are not necessarily OHIP benefits) that should be billed directly to the non-resident patient. A listing of these services can be found in the OHIP Online Resource Manual for Physicians (Section 4, pages 4-7 – 4-8):

http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html

³⁹ The decision to participate in the reciprocal billing arrangement can be made on a case-by-case basis.

VI. BILLING FOR REFUGEES (INTERIM FEDERAL HEALTH PROGRAM)

The **Interim Federal Health Program (IFHP)** provides limited, temporary coverage of costs related to health care for specific categories of people, including protected persons, refugee claimants, rejected refugee claimants and other specific groups. The IFHP provides several types of coverage:

- Health care coverage;
- Expanded health care coverage;
- Public health or public safety health care coverage;
- Coverage for persons detained under the Immigration and Refugee Protection Act (IRPA); and
- Coverage of the cost for immigration medical examinations

The program is funded by Citizenship and Immigration Canada (CIC) and administered by Medavie Blue Cross. The fee policy for IFHP has changed; **fees are no longer paid at the OMA rate, instead, physicians are reimbursed at OHIP rates.**

Health care providers are required to verify patients' IFHP eligibility (which includes the patient's coverage type and the service requested) with Medavie Blue Cross before providing the service because the patient's eligibility may cease or coverage can be modified without notice should their immigration status change. A date printed in the 'valid until' date field of the patient's Interim Federal Health Certificate of Eligibility is not significant proof of eligibility.

For additional information about the IFHP, types of coverage and how to register as a provider, refer to the IFHP Provider Portal: <https://provider.medavie.bluecross.ca/>

The Ontario Temporary Health Program (OTHP) was implemented in January 2014 to address gaps in health care coverage for refugee claimants and rejected refugee claimants. Additional information about OTHP can be found: <http://www.health.gov.on.ca/en/pro/programs/othp/>

General inquiries re: IFHP and OTHP can be made directly to Medavie Blue Cross:

By email: CIC_Inquiry@medavie.bluecross.ca

By phone: 1.888.614.1880

VII. MEDICAL-LEGAL ACTIVITIES

The Preparation of Medical-Legal Reports

Medical-legal reports are essential to the legal process of adjudicating claims for personal injury. A well prepared medical-legal report will contribute significantly to the proper and just resolution of a claim for personal injury, expedite the process, reduce cost and frequently obviate the necessity of a court appearance by the physician.

Confidentiality

Given that the relationship between a patient and a physician is one of highest confidentiality, a physician should insist on being provided with a valid and adequate written consent to the release of medical information. The CPSO states in its policy on Third Party Reports that the physician is responsible for obtaining the patient's consent to disclose personal health information to third parties such as lawyers.⁴⁰ Therefore, physicians should confirm consent with patients whose representatives request medico-legal reports or other personal health information. The CPSO strongly advises physicians to document that consent has been obtained.

Physicians as Witnesses

Non-Treating (Retained) Physicians: Expert Witnesses

Non-treating physicians are often approached by lawyers or the Crown to testify as an expert witness and usually have never seen the patient prior to being contacted. After agreeing to act in such a capacity, physicians may examine the patient so as to establish an expert opinion regarding matters such as the patient's injuries or standards of previously provided medical care. The fees payable to an expert witness are a matter for negotiation between the expert witness and the lawyer seeking the expertise. In addition to a compensation arrangement for time spent in the courtroom, **physicians should not neglect to agree on a fee, in advance, for reports that may be produced as well as travel time and other expenses incurred in the process of acting as expert witnesses. Whenever possible, it is recommended that physicians seek agreement on their fees in writing.**

A non-treating physician is under no obligation to agree to act as an expert witness. The expert witness will rarely receive a subpoena or summons to attend in court since he or she has agreed to act as an expert in advance, and has secured satisfactory remuneration for this expertise. When testifying in court, the expert witness is usually given a set of facts, which closely resemble the actual case, and is then asked hypothetical questions based on those facts. The expert witness will provide a professional opinion based on the examination of the patient, the medical records, and knowledge of similar previous cases.

- **Fees for Civil Lawsuits or Administrative Bodies**

In these lawsuits, an expert's fees are a matter of negotiation between the expert and the lawyer for a party. The only limit is that these fees not be excessive in relation to the services provided by the expert witness.

- **Fees for Expert Witnesses in Criminal Cases**

In these lawsuits, expert witness fees are a matter of agreement between the expert witness and the Crown attorney or defense lawyer. Experts are paid in accordance with a predetermined schedule of fees

⁴⁰ CPSO Third Party Reports policy: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1658>

VII. MEDICAL-LEGAL ACTIVITIES

set by the Ministry of the Attorney General. However, there is nothing that prevents expert witnesses from seeking reimbursement above these amounts.

For more information on fees for expert witnesses, please contact the Ministry of the Attorney General: 416.326.2220 or 1.800.518.7901 or <http://www.attorneygeneral.jus.gov.on.ca/english/>

Treating Physicians

Treating physicians will typically be served with a subpoena or a Summons to Witness to appear in court or before an administrative body and would be subject to arrest, detention, and ordered to pay costs that have arisen for failing to attend if properly served. A physician may only be excused from responding to a summons if ordered so by the presiding judge. The court will only excuse or adjourn the attendance date of a witness for drastic reasons, such as serious illness of the physician, a death in the immediate family, or absence from the country. The physician must have a representative attend in court to explain the absence and the particular circumstances, or have received prior approval not to attend from the party that subpoenaed the physician. Previously scheduled surgical obligations or appointments will generally not be viewed by a court as a reason to excuse a physician.

The party who issued the summons to the treating physician to testify in court is only obliged to pay the physician the daily attendance fee in accordance to the rules that regulate the procedures of that particular trial or hearing, such as the Rules of Civil Procedure, The Family Law Rules, and the Interim Rules of Practice and Procedure of the Financial Services Commission of Ontario. The Tariff also lists the appropriate travel allowance, and the appropriate overnight accommodation and meal allowance, if applicable. Please note that the amounts listed in the Tariff may vary from year to year. The updated Rules of Civil Procedure can be found at:

<http://www.canlii.org/en/on/laws/regu/rro-1990-reg-194/latest/rro-1990-reg-194.html>

Attendance money actually paid to a witness who is entitled to attendance money, to be calculated as follows:

1. Attendance allowance for each day of necessary attendance: \$50

2. Travel allowance, where the hearing or examination is held,

(a) In a city or town in which the witness resides, \$3 for each day of necessary attendance;

(b) Within 300 kilometres of where the witness resides, 24¢ a kilometre each way between his or her residence and the place of hearing or examination;

(c) More than 300 kilometres from where the witness resides, the minimum return air fare plus 24¢ a kilometre each way from his or her residence to the airport and from the airport to the place of hearing or examination.

In the event a physician is served with a summons or subpoena, the physician should contact the Canadian Medical Protective Association (CMPA) for advice as a matter of professional conduct at 1.613.725.2000 or 1.800.267.6522 (toll free) or via email feedback@cmpa.org (accepts general inquiries).

VII. MEDICAL-LEGAL ACTIVITIES

3. Overnight accommodation and meal allowance, where the witness resides elsewhere than the place of hearing or examination and is required to remain overnight, for each overnight stay: \$75

Treating physicians will often be called or summoned as witnesses where they were the first party to see or treat the patient. An example would be a case where a physician saw and treated a patient in the emergency room or was the patient's family doctor and was treating a particular injury or condition. The witness in these cases would generally be asked the facts about the treatment and/or prognosis regarding the patient's health.

There is no question that, occasionally, the boundary between a treating physician and a retained expert witness becomes blurred. In instances where a physician has provided ongoing care for a patient, a lawyer may request further examination and diagnostic testing as well as an extensive report and an opinion concerning the patient's recovery, in addition to testimony in court. Some of these services could be considered to be those of a retained expert witness.

In such cases, the physician should request compensation as an expert witness. The lawyer requesting such services may argue that these are matters inextricably linked to the witness role as the treating physician and refuse to pay. In these cases, the physician who has been previously served with a summons or subpoena is still legally obligated to attend court and provide all the relevant documentation and testimony. The physician should consult in advance with the particular lawyer requesting attendance in court in order to arrive at a mutually agreeable attendance fee. However, it must be pointed out that, in this case, it is conceivable that the physician may only receive the minimum payment (as stated above) for attendance in court. The physician would be entitled to payment for the production of any medical-legal reports prepared in the matter.

VIII. 2016 SCALE OF GRADING AND REMUNERATION

Effective January 1, 2016, the Scale of Remuneration for Salaried Physicians is as follows:

Classification of Salaried Physicians

Because of the variety of groupings used at federal, provincial and municipal levels, and in private industry, it has been felt wise to define the various levels as shown below. A level can then be fitted to the appropriate rank within the service or company.

Applicable to a physician who:

Level I

- Has a limited amount of postgraduate or practical experience.
- May be responsible to a more senior physician.
- Would be promotable to Level II as soon as the necessary experience and skills have been obtained.

Level II

- Has 2-5 years of postgraduate experience, including training or experience in the type of work involved.
- Has a position of responsibility which may involve supervision of the work of other health-care professionals.

Level III

- Has 5-10 years of postgraduate experience which could include (a) a higher qualification in a related specialty, or (b) approximately 5 years of training or experience in the particular field of work, or (c) at least 5 years of experience in the organization in which he or she is working.
- Usually has a supervisory position with either full-time or part-time health-care professionals and others working for him or her.
- May work independently because of the highly specialized kind of work being done.

Level IV

- Has greater responsibilities than those required for Level III.
- Has senior administrative and/or clinical responsibilities.

Level V

- Holds the most senior medical post in an organization or department, is responsible for all medical staff in the organization, and may have responsibility for other health-care professionals.
- Has senior administrative responsibility, up to and including the post of chief executive officer.

VIII. 2016 SCALE OF GRADING AND REMUNERATION

Salary Ranges

It is expected that annual increments would be made within the following ranges to reflect increased value to the employer and increases in the cost of living. The salaries quoted below are to be considered as exclusive of fringe benefits.

Level	Minimum
Level I	\$171,904
Level II	\$277,625
Level III	\$285,061
Level IV	\$297,827
Level V	\$337,859

Salaries should be modified under the following circumstances:

1. Where no provision is made for superannuation, the salary should be adjusted to compensate for this.
2. The possession of a specialist qualification (which is being utilized in the execution of the post) should be recognized by an additional sum over and above the figures quoted.
3. Regional variations in salary due to a special cost of living consideration should be recognized by an adjustment to the maximum rate.

Salaried physicians should be entitled to a minimum of the following: one month's vacation, one week leave for continuing education in addition to the vacation allowance, and 11 statutory holidays.

Employers should be encouraged to pay the membership fees necessary for a physician to remain in good standing with his or her profession (e.g., College of Physicians and Surgeons of Ontario, Canadian Medical Protective Association, Ontario Medical Association, Canadian Medical Association, etc.)

Part-Time Employment: (Industrial, Public Health, etc.).....**net per hour \$351⁴¹**

As a point of clarification, the Part-Time Employment rate of return represents a "net" rate, indicating that it is "net" of any expenses of practice or overhead costs that the physician might incur as a result of employment.

As responsibility and nature of the programs vary, there should be negotiation between the physician and the employing organization. The above figure is a recommended average rate.

⁴¹ This figure is subject to an annual fee adjustment calculated using a methodology that was established in 2005 by the OMA's Central Tariff Committee and subsequently approved by OMA Council.

IX. ADDITIONAL SOURCES OF INFORMATION

Ontario Medical Association	www.oma.org 416.599.2580, toll free 1.800.268.7215 Fax: 416.599.9309
College of Physicians and Surgeons of Ontario <ul style="list-style-type: none"> • General inquiries..... • Physician advisory services..... 	www.cpso.on.ca 416.967.2603, toll free 1.800.268.7096 416.967.2606, toll free 1.800.268.7096, ext 606
Royal College of Physicians and Surgeons	www.rcpsc.medical.org Fax: 613.730.8830, toll free 1.800.668.3740
Workplace Safety & Insurance Board <ul style="list-style-type: none"> • Health Professionals Access Line..... • Billing Hotline (payment enquiry)..... 	www.wsib.on.ca 416.344.4526, toll free 1.800.569.7919 1.800.668.9958, fax 1.888.313.7373
Ministry of Health and Long-Term Care: <ul style="list-style-type: none"> • Client Support (for complex claims billing and payment inquiries) • Claims Adjustment (assessment, approval, adjustment or denial of medical claims)..... • Operational Support (provider registration) 	www.health.gov.on.ca 1.800.262.6524 or SSContactCentre.MOH@ontario.ca Hamilton: 1.888.630.8066 or 905.521.7100 Toronto: 1.855.645.1282 or 416.314.7770 Oshawa: 1.855.250.3696 or 905.576.2870 ProviderRegistration.MOH@ontario.ca
Canadian Medical Association	www.cma.ca 1.613.731.9331, toll free 1.800.267.9703
Canadian Medical Protective Association	www.cmpa-acpm.ca 1.613.725.2000, Toll free 1.800.267.6522 Fax: 1.613.725.1300 Tel: 1.877.763.1300
Ontario Hospital Association	www.oha.ca 416.205.1300
Ontario Telemedicine Network	www.otn.ca General
Canada Revenue Agency	www.cra-arc.gc.ca/menu-e.html
Auto Insurance Accident Claim Forms	www.fsco.gov.on.ca
Federal Forms	www.servicecanada.gc.ca/eng/online/index.shtml
Section on General & Family Practice	http://sgfpnet.com/
Veteran Affairs Canada, Providers Info Guide	http://www.veterans.gc.ca/eng/services/information-for/health-care-providers

APPENDIX I: FREQUENTLY ASKED QUESTIONS

1. What is the OMA multiplier and how do I use it to determine a fee for an uninsured service?

The multiplier is a tool to convert an OHIP fee into an uninsured fee (also known as the OMA rate). The OHIP fees listed in the current OHIP Schedule of Benefits can be multiplied by 2.14 to obtain the rate that applies when the service/procedure is rendered on an uninsured basis.

Example:

- OHIP rate for A007 is \$33.70
- $\$33.70 \times 2.14 = \72.11 (\$72.15, rounded up to the nickel)
- \$72.15 is the suggested fee for an intermediate assessment when rendered on an uninsured basis

2. A patient made an appointment for the purpose of having insurance forms completed. The insurance forms requested information on the patient's health status. In order for me to adequately comment on the patient's current health, I needed to assess the patient. Is the assessment billable to OHIP?

No, the assessment is not medically necessary because it was performed for the sole purpose of providing information to the insurance provider. The assessment should be billed to the insurance company, along with the fee for the form.

3. What should I bill for an assessment that was rendered for the purposes of completing a third party form?

In this case, the assessment is an uninsured service. The fee claimed will depend on the service rendered, similar to when physicians bill OHIP for an assessment. If the elements provided meet the requirements of a general assessment, then the suggested uninsured rate for A003 General Assessment is $A003 \$77.20 \times 2.14 = \165.25 (\$165.21, rounded up to the nickel). To view the required elements for each level of assessment, refer to the OHIP Schedule of Benefits General Preamble, pages GP12-GP22: http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

4. I was asked to complete a form for a patient and the form is not listed in this Guide. How much should I bill for this service?

If there is a form that does have a suggested fee, and is similar in length, complexity and/or effort, a physician could simply apply that rate to the form that does not have a specific suggested fee. Another option is to apply the physician's hourly rate to the service and use that as a guideline.

5. A patient has requested an electronic copy of their medical record (on a CD or portable storage device, for example). How do I bill the patient for this?

Provision of records is about cost recovery. For paper records, the cost is the sum of (1) cost rate of photocopying, (2) out of pocket disbursements and (3) physician review at the hourly rate (see page 16). For the provision of records on a CD or portable storage device, a physician could charge for their expenses (cost of the blank CD or the cost of the blank portable storage device, etc.) plus any out of pocket disbursements and their hourly rate for any necessary physician review of the record.

APPENDIX I: FREQUENTLY ASKED QUESTIONS

- 6. I have had patients who are insistent on having a Pap smear more frequently than every 33 months. Can the patient be billed for the Pap smears that are performed outside of the OHIP Schedule of Benefits guidelines? If so, how much should the patient be billed?**

If the patient wants a Pap smear performed more frequently or for reasons not stipulated in the new OHIP Schedule of Benefits payment rules, then the service would not be covered by OHIP and charging the patient directly is acceptable. If an uninsured Pap smear is performed, then the physician should collect payment for G365 if it is not included in the patient visit and for E430 if the service was provided outside of the hospital. If a medically necessary assessment unrelated to the Pap smear is provided at the same time, then that should be billed to OHIP using the appropriate assessment fee. If the Pap smear was the sole reason for the patient visit, then G700 may also be billed to the patient. (Reminder: the uninsured fees for G365, E430, G700, etc. are calculated by multiplying the current OHIP fee by the OMA multiplier; see page 14).

- 7. I recently performed a TB test on a patient who required it by their new employer (a hospital). My colleagues all agreed that this was an uninsured service and I billed it as such. I have another patient coming to see me for a TB test, as she requires it in order to begin her internship at a hospital. Does this mean the service is uninsured because it is for employment purposes?**

An 'internship' suggests that this employment is a curriculum requirement for an academic program, which would mean the TB test is insured by OHIP. In order to make a claim to OHIP for this service, the request must come from the educational institution and documentation must be provided by the patient that confirms the work placement is a required component of the student's curriculum.

Additional questions?

Send them directly to uninsuredservices@oma.org

APPENDIX II: SAMPLE LETTERS AND MESSAGING

Sample Patient Information Letter re: Office Policy on Uninsured Services

Insert Physician Name, Office/Clinic Logo and Address, Date, etc.

Dear Patient:

This information sheet is our latest attempt to keep you informed of changes in our office policy. For your information, OHIP does *not* pay for all services that you request from your doctor(s). Services that OHIP does not pay for are called “*non-insured or uninsured services*” and it is illegal and fraudulent for doctors to bill OHIP for them. In order to maintain the financial viability of our practice and ensure prompt service, it is necessary (and *legal*) for our practice to charge for these services.

Every effort has been made to account for most of the commonly requested services in this information sheet. If the uninsured service you are requesting is not listed below, please communicate this to me or my office staff for further clarification. To help speed up our service, please let my office staff know when you are making your appointment that you are requesting a service that is in the list below *or* a service for which you have been charged in the past by my office or another doctor’s office.

The fees contained in the list below are based on the Ontario Medical Association’s suggested fees as found in the **INSERT APPROPRIATE YEAR** edition of the OMA *Physician’s Guide to Uninsured Services*.

All uninsured services must be paid in full when rendered. You have the right to receive a receipt and my office staff will provide you with one upon settlement of your account. Should you be unable to pay for the uninsured service at the time it is provided, please let my office staff know when and how you intend to settle your outstanding account. We will make every effort possible to assist you in the settlement of your outstanding account. Please note that our office accepts cheques, credit card and Interac payments. Where applicable, a charge of **\$XX.XX** for personal cheques that are returned N.S.F. by financial institutions will be added to a patient’s account. Thank you for your co-operation.

Please acknowledge receipt and acceptance of the above office policy by signing below and returning the detachable portion by either fax, mail, email or in person to my office (*insert fax number and/or email address*). Should you have any further questions, please contact (*insert name of office staff person*) at my office phone number.

Sincerely

Physician’s signature _____

Physician’s name _____

Insert list of uninsured services and office charges

I agree with the above policy and terms/conditions..

Patient’s Signature _____

Patient’s Name _____

Date signed _____

APPENDIX II: SAMPLE LETTERS AND MESSAGING

Sample Confirmation Letter of Third Party Request

Insert Physician Office/Clinic Logo, Name, Address, etc., here

Date

Dear (Insert Name of Third Party)

Re: *Request on Behalf of Patient X Received in my Office on (insert date)*

I am in receipt of your request for the completion of a *(insert name of form)* on behalf of patient X.

This letter is intended to inform you of my usual and customary fee for the completion of this *(insert name of Form or Report here)*, which is based on the Ontario Medical Association's suggested rate listed in the *(insert year)* edition of the *Physicians' Guide to Uninsured Services*.

Based on the preceding, I estimate that the fee for the completion of this *(insert name of Report or Form)* to be \$Y.00. This figure assumes no extraordinary complexity and/or follow-up information requests from your company. Should such follow-up work be required, additional estimates will be provided in a similar fashion.

An invoice will be sent to you along with the completed Form/Report. Our office policy for payment of such Reports/Forms is 30 days from the invoice date. After 30 days, an interest rate of ___% (compounded monthly) equivalent to a daily rate of ___% will be applied to your outstanding charges. The Annual rate of interest is ___%.

Please acknowledge receipt and acceptance of this estimate and policy by signing below and returning it to our office wither by mail, email *(insert address if applicable)* or by *(insert fax number)*. Should you have any further questions please contact *(insert name of office staff person)* at my office phone number quoting the patent's name.

Sincerely

Billing Physician's signature _____

Billing Physician's name _____

I agree with the above estimate and terms/conditions of payment.

Third Party's Signature _____

Third Party's Name _____

Date signed _____

APPENDIX II: SAMPLE LETTERS AND MESSAGING

Sample Letter for Patient Requested Copying or Transmission of Medical Records

Insert Physician Office/Clinic Logo, Name, Address etc here

Date

Dear Patient

I have received your request to transfer a copy of your medical records to [Dr. Requesting's name]

I will be happy to comply with your request. Please be advised that the cost of this service is not covered by your health insurance and you are responsible for the cost of the physician chart review (if applicable), duplication, and transfer of your records. Please note that, by law, your original record must be kept in this office for at least 10 years after your last professional visit. To assist your new physician, I suggest that you choose one of the two following options.

Please circle the number of the option you choose:

1. I will be happy to prepare a summary of your medical history and include your most recent and significant laboratory results as well as all applicable consultation and hospital reports. This summary is, in my opinion, the most useful to your new doctor, but should be confirmed with them as an acceptable alternative to transferring the entire record. Please notify us, in writing, if you want us to exclude any information.

The charge for this service is \$ _____

2. Alternatively, we can also copy the complete chart. The charge for this is based on the following *Provincial Medical Association Suggested Charges*:

- Individual chart (1 – 20 pages): \$ 30.00
- Each additional page at a rate of \$0.25 per page: \$ _____
- Professional Review (time x physician hourly rate): \$ _____

Your chart has [number of] pages. The charge will be \$ _____

Please indicate your choice of payment option with a check mark and return this form to our office.

- Payment included with this consent form. Your chart will be sent directly on to your new doctor.
- Payment not included with consent form. Our office will notify you when the records are ready. You will send payment and we will forward the record on.
- When your chart is ready, we will notify you and you will come to the office to pick up your record and settle your account.
- Our office will notify you when we have sent the record to your new doctor so you can send in payment.
- Cancel the chart transfer.

Signature (Patient) _____

Date: _____

Source: Adaptation of form, courtesy of: Dr. Thomas R. Faloon, CCFP, FCFP, Ottawa. *Canadian Family Physician* 2002; 48:564,566.

Note: [1] The above form was developed and published for Canada-wide usage. [2] In keeping with CPSO Policy #4-12 regarding "Medical Records" specifically the section on "Patient Requests Transfer", prepayment of the fee for a transfer of medical records may be requested when, in the best judgment of the treating physician, the patient's health and safety will not be put at risk if the records are not transferred. For additional information please review the CPSO policy statement on Medical Records.

APPENDIX II: SAMPLE LETTERS AND MESSAGING

Sample Third Party Invoice

Insert Physician Office/Clinic Logo, Name, Address etc here

Bill to: Third Party Name
Third Party Address
Third Party Phone and Fax Numbers

Invoice Number: _____

Invoice Date: _____

Payment Terms: In full within ____ days of invoice date

Re: Patient's Name
Patient's Date of Birth
Requested Form/Report/Activity
Date of Requested Form/Report/Activity

Payment Due Date: \$ _____

Dear (*Insert Contact Name of Third Party*):

Attached please find the requested Form/Report/Activity on (*insert date*). As per the estimate and your agreement (*attach copy of faxed Agreement – see Attachment 1 above*) the itemized final cost is \$_____.

- insert form/report/activity cost based on OMA suggested rate and/or hourly rate multiplied by the time necessary to complete activity
- insert associated costs (copying, courier etc)

The total cost is \$_____. Please remit your cheque payable to _____ by the payment due date noted above in order to avoid late payment charges.

Thank you for your business and cooperation.

Sincerely,

Billing Physician's Signature _____

Billing Physician's Name _____

Insert Late Payment Office Policy for Outstanding Accounts.

New OMA Uninsured Services Poster



The Ontario Health Insurance Plan (OHIP) provides coverage for a vast majority of physician services; however, there are some services that are not covered.

Physicians are pleased to offer these valuable services; however, the responsibility for payment lies with the patient or the third party requesting the service.

Quality health care, medical advice and timely access are priorities that Ontario's physicians intend to honour. Speak with your physician for more information about other health care services that are not covered by OHIP.



EXAMPLES OF SERVICES NOT COVERED BY OHIP

Medical Services

- Routine eye examinations for patients 20 - 64 yrs of age
- Examinations/diagnostic tests necessary to satisfy requirements requested by employers, insurance companies, government agencies, etc.
- Pre-adoption examinations
- Prescription renewals without a visit
- Travel medicine advice and services for travelling outside of Canada
- Telephone advice if initiated by the patient
- Cosmetic procedures and related examinations and diagnostic tests

Completion of Forms and Medical Records

- Medical/legal reports
- Federal government forms
- Certificates for the purpose of travel, immigration, employment, etc.
- Driver's/aviation medical exam and other licensing forms/certificates
- Insurance forms, reports and certificates, such as:
 - Disability certificate
 - Treatment plan
 - Insurance medical examination reports
- Completion of work and school related forms/notes, such as:
 - Sick or back-to-work notes
 - Admission to day care/schools/recreational
 - Employer requested reports/forms (e.g., form physicals)

Administrative Services

- Copying medical records, reports and letters at the patient's request
- Transfer or summary of medical records at the patient's request
- Missed appointments without sufficient notice

Block Fees

A block fee is defined as an optional flat fee charged by a physician for a predetermined set of services not covered by OHIP for a specific period of time. Not all physicians offer a block fee due to the nature of their practice and charge for each uninsured service when rendered. Speak to your physician for more information on block fees.

Please note that some exceptions may apply.

The OMA has created a new Uninsured Services poster to help physicians educate patients about uninsured medical and administrative services, as well as block fees.

Developed by OMA Economics, Research and Analytics, in consultation with the OMA's Uninsured Services Committee, the poster provides some clear and common examples of those services not covered by OHIP.

The poster is an updated version of the "Message to Patients" document that was presented in past editions of the Guide.

This poster is intended for display in patient waiting rooms, public seating areas or other high-traffic settings.

For OMA Members only:
To receive a free copy of the 11" x 17" colour poster by mail, or a PDF copy by email, please send an email with your complete mailing address to: uninsuredservices@oma.org.

APPENDIX III: SUMMARY OF RECOMMENDATIONS ON THE PHYSICIAN ROLE IN TIMELY RETURN TO WORK

For additional information on the role of TRTW Coordinator, please refer to the OMA's policy paper "*The Role of the Primary Care Physician in Timely Return to Work*", which is available on the OMA's website at: <https://www.oma.org/Resources/Documents/2009PCPandTimelyReturn.pdf>

The summary of recommendations is as follows:

Third Party Requests for information:

- 1) We recommend that third party requests for medical information and services be distinctly separated into two streams:
 - a. Requests for medical documentation of illness, disease, injury or disability for the purposes of entitlement to disability benefits (refer to CPSO's policy on "Third Party Reports") and;
 - b. Requests for information and services related to returning a patient to work, such as functional assessments, reviewing job descriptions, consulting with supervisors, workplace interviews, assessing barriers to return to work, prescribing restrictions and modifications to the job (herein collectively referred to as "RTW Services").
- 2) We recommend that when a third party requests information for (a) entitlement to disability benefits or (b) returning a patient to work that:
 - a. Separate patient consent be obtained for each request for medical information.
 - b. Patient consent be considered time limited and that repeat requests for information fall within a reasonable time of the original receipt of patient consent.
- 3) We recommend the development of educational sessions to support physicians in understanding their CPSO obligations regarding third party requests and to support those physicians who wish to assume the role of the timely return to work coordinator.
- 4) We recommend that patients not be required to assume the costs of third party requests for services related to the certification of disability.
- 5) We recommend that patients not be required to assume the costs of services related to a timely return to work program. The OMA believes that the employer/insurer should assume the cost and payment for the services related to a timely return to work program as well as for the services related to the certification of the disability.

APPENDIX IV: ADDITIONAL INFORMATION ON LIFE AND HEALTH INSURANCE REPORTS

Attending Physician's Statement

Fee: \$134.60

Insurance companies request completion of this form after clients have applied for insurance coverage and have provided the company with information on their medical history and other biographic data. This form is usually sent directly to the physician, accompanied by the patient's signed consent form, and is a request for historical medical information directly from the patient's medical charts. The physician's findings, treatment, and opinion recorded following a patient's visits for significant medical problems are requested.

In these instances, insurance companies do not generally require a medical assessment to be performed on the patient since this is not a request for information on the current health status of the patient. The insurance company may request relevant copies of lab test results and/or electrocardiograms.

In the event the patient is making a disability claim, the insurance company may require a medical assessment and up-to-date information on the health status of the patient. The assessment is insured and billable to OHIP, *if in the opinion of the physician the service is medically necessary*. Completion of the report remains uninsured and is billable to the patient or third party.

System-Specific or Disease-Specific Questionnaire

Fee: \$89.70

This form is usually sent directly to the physician along with the patient's signed consent form. The questionnaire will ask for specific details related to a patient's medical condition. For example, in the case of a patient with diabetes, past blood sugar readings, treatment given, control details, etc., would be requested. Unless specifically requested, a medical assessment is not required to complete this form since it is not a request for a report on the patient's current medical status.

Systems-Specific Examination

Fee: \$107.75

This is a request by the insurance company for an assessment that includes a single system medical history and examination. This would include a review of the pertinent medical history relating to the system, a system-specific examination, and the completion of the corresponding form.

Insurance Medical Examination

Fee: \$219.80

This is a request by the insurance company for a general physical examination and the completion of the accompanying form, which usually includes questions making up a functional inquiry, a past history of the patient's health status, and the results of the physical examination.

Clarification Report

Fee: \$362.20/hr

This report is usually requested directly from the physician in order to adjudicate a claim. It involves answering specific questions to clarify information about medical and administrative details previously submitted to the insurance company. A medical examination is not usually required unless specifically requested by the insurance company.

APPENDIX IV: ADDITIONAL INFORMATION ON LIFE AND HEALTH INSURANCE REPORTS

Full Narrative Report

Fee: \$362.20/hr

This report is usually requested by the insurance company in order for the physician to answer detailed questions to clarify information about medical and administrative details. This is quite common in cases of prolonged or complex disability (e.g., chronic fatigue syndrome) or psychiatric illness and/or in cases that involve multiple healthcare specialists and treatment modalities. It is usually requested in a letter-type format, and insurance companies usually require that copies of appropriate test results and consultation reports also be included with the response. A medical examination is not usually required unless specifically requested by the insurance company.

Independent Medical Examination

Fee: Independent Consideration

Usually contracted between a physician and insurance company; fees and scope of assessment are usually discussed in advance with the physician based on the insurance company's requirements.

