Virtual Care Telephone and Video Codes
Frequently Asked Questions

Last updated: August 7, 2020

1. **When are these codes effective?**

   March 14, 2020

   The new phone/video and assessment centre codes became effective March 14. Effective May 1st, physicians can now submit claims for the new phone/video and assessment centre codes. Previously, physicians were instructed to hold their claims until the system is ready.

   InfoBulletins are available at:
   http://health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4745.aspx
   http://health.gov.on.ca/en/pro/programs/ohip/bulletins/11000/bul11229.aspx
   http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4755.aspx

2. **Which physicians are eligible to bill these fee codes and which are not? Can a physician in a patient enrolment model provide them to non-rostered patients? Can a fee-for-service physician provide them to any patient?**

   All General and Family Practitioners are eligible to bill K080, K081 and K082 to any patient. Specialists are eligible to bill K083.

   For FHO/FHN provision of services to non-rostered patients, the application of the Hard Cap ceiling for these services will not be enforced.

   K081 and K082 fee codes are largely intended for primary care providers. The K083 fee code provides a mechanism for specialist physicians to bill an amount for telephone or video services that is approximately equal to the amount that would be claimed for an equivalent in-person consultation or assessment.

   Please note that K083A can only be billed by specialists, as claims submitted by physicians with specialty code '00' will be rejected.

   Although it is expected that most specialist providers will utilize the K083 fee code for services rendered by telephone or video, there is no restriction that prevents specialists from alternatively billing K081 and K082 fee codes.

   Providers should bill the most appropriate fee code for the service rendered.

3. **Will these codes impact Access Bonus?**

   The ministry has agreed that K080, K081 and K082 will not contribute to outside use. Options to implement this complex system change are being investigated. If the ministry is unable to

prevent these codes from attributing to outside use in the short term, the ministry will undertake a review of services provided during the period that these temporary K-prefix codes are in effect, remove the financial impact of outside use, and recalculate any Access Bonus payments for this period.

4. **Is the FHG 10% Premium applicable to the new telephone codes for enrolled patients?**

   Yes, the FHG 10% premium will be automatically paid to physicians on virtual care K-code services provided to enrolled patients.

   The applicable FHG premiums for K-code claims previously submitted will be adjusted automatically through the Medical Claims Adjustment (MADJ) process at a future date, retroactive to March 14, 2020. More information will be provided in a future OHIP INFOBulletin.

5. **Can Q012/Q016/Q017/Q018 after hour premiums be billed in conjunction with these?**

   Yes, after hours premiums Q012, Q016, Q017 and Q018 can be applied to these codes as appropriate for rostered patients. However, virtual visits do not qualify for special visit premiums.

6. **Can K082 be used for K023 - Palliative care support and other similar codes such as K022 - HIV primary care, K037 – Fibromyalgia/chronic fatigue syndrome care, etc.?**

   Yes, these services could be captured by the K080 – K082 code closest to the type of services provided.

7. **What about other fee codes in the Consults and Visits in the Family Practice & Practice in General (00) section?**

   The K080-K082 have been described broadly enough to capture the types of services that we would expect physicians to be providing to meet patient need during this pandemic.

8. **Is there specific technology for phone or video that needs to be used to bill these codes? Can we use Skype or other video conferencing apps to see patients?**

   There are no specific technologies required. The OMA's virtual care one-pager provides quick-reference overview of the virtual care platforms you can use to provide care to patients during this COVID-19 pandemic. Please refer to Question 8's answer for important information with respect to patient consent to provide these services.

9. **Is there anything I should do with respect to patient authorizations to provide these services by phone or video?**

   Unless you are using virtual care technologies where consent from the patient is handled at sign-up, you should ask patients for their consent.

   Information vetted by OMA and OntarioMD legal teams and the CMPA has been created to make

this easier. OMA Legal has prepared a short paragraph statement and information to provide to patients to initiate a Virtual Care patient encounter which has also been vetted by the CMPA here.

The Information and Privacy Commissioner of Ontario (IPC) has published a "Notice to the Public" addressing privacy matters during the exceptional circumstances of the emergency. Specifically, the IPC has acknowledged the need for the health sector to use phone, text, email, and other messaging services including the use of technologies not normally used for business during the crisis. This guidance is available at https://www.ipc.on.ca/newsrelease/ipc-closure-during-covid-19-outbreak/

10. **Can I bill these codes for virtual care services via email and text messaging?**

    Email and text messaging are not billable services. However, consider the right type of contact, for the right patient, at the right time, for the right problem. Video conferencing and phone calls are payable under the fee codes, but email and texts to patients may also be useful for care, even if not discretely funded.

11. **What is meant by the stipulation that "*the service is initiated by the patient or the patient's representative*"?**

    - **Does this mean that if WE call the patient then it won't be billable?**

    This would be dependent upon the situation. If, for example, the patient had an appointment that was rescheduled as a telephone or video appointment, then providing the service over phone/vide would still meet the payment requirements of the new temporary fees.

    If you are scheduling a follow-up appointment (e.g., to discuss test results of a prior appointment) and this follow-up appointment is rendered by telephone or video, then this would also meet the payment requirements of the new temporary fees.

    For clarity, please note these codes are not for calling or rescheduling appointments, but are for the provision of the medical advice only. We continue to advocate for ways that doctors can manage their small businesses, including expenses and staff.

    K080, K081 and K082 must be initiated by the patient or the patient's representative. Patient's representative is defined in the Schedule of Benefits for Physician Services (the Schedule) as the legal representative of the patient.

    The services described above as K080, K081 and K082 are insured when the following conditions are met:

    1. The service was initiated by the patient or the patient's representative;
    2. The service is personally rendered by the physician.

    To be eligible for payment, the telephone or video service must have emanated from the patient's need or desire to receive a health service. This would typically be identifiable by the

patient's attendance/availability for a pre-booked encounter, or the fact that the patient has engaged the provider for the purpose of obtaining a health service.

Administrative staff may co-ordinate appointments and organize care in a manner analogous to in-person encounters without violating this condition. Similarly, medically necessary follow-up services may be organized by the provider (or by their staff) without violating the condition.

Consultations, which arise from requests from other providers, would not violate the condition in so far as the patient would have assented to the referral as part of their discussion with the referring provider.

Fundamentally, the "patient initiated" condition has been applied to the temporary k-prefix fee codes as a prohibition against physician solicitated-services or the billing of services that would not have occurred within the physician's "in-person" practice. For example, a physician-initiated call to "check-in" on a patient would not be eligible for payment, nor would any telephone calls or video encounters conducted for administrative purposes (such as to inform patients of clinic closures or the availability of remote services).

Services are not eligible for payment when initiated by the physician (or the physician's staff) without a clear and medically necessary reason for doing so. For example, the communication of normal lab work, unless medically necessary (in so far as the clinical management of the patient is altered) should not be billed.

Physician-initiated communication to provide advice or guidance regarding a previously rendered service is also not separately eligible billable. A common example of this would occur when a patient is provided with a prescription along with instruction to fill it only upon receipt of a positive test result. The call to inform the patient of the test result is not eligible for payment as it would be considered a Specific Element of the initial (refer to: item F, GP 11, Schedule of Benefits).

As a general rule, the provider should consider whether the remote encounter would have occurred in their "in-person" practice. In circumstances where an in-person encounter would not have taken place, it is unlikely that a claim for a temporary k-prefix code could be supported.

- **For patients in a Long Term-Care (LTC) or Complex Continuing Care (CCC) facility, does "patient's representative" include inter-professional team members, such as nursing staff?**

Yes, inter-professional team members such as nursing staff would be considered a "patient's representative" for the purposes of initiating a telephone or video visit with a patient in a LTC or CCC.

12. **We have pre-existing clinics with patients – many of which we can call or do virtually but cannot be cancelled or delayed. Our members would like to use the new codes to have telephone encounters during this period of crisis to avoid physical interaction and patients**

visiting the hospital where the vast majority of our practices sit. The rules say that the encounter must be initiated by a patient or patient rep. Does this mean we can't use these codes for our current clinics?

Pre-booked appointments rescheduled as telephone or virtually appointments would still meet the payment requirements for the new temporary codes, as the initial appointment was initiated by the patient or patient's representative.

For clarity, please note these codes are not for calling or rescheduling appointments, but are for the provision of the medical advice only. We continue to advocate for ways that doctors can manage their small businesses, including expenses and staff.

13. **Can K080 be billed for simply rescheduling a patient's appointment?**

    No, these codes are not for calling or rescheduling appointments, but are for the provision of the medical advice only. We continue to advocate for ways that doctors can manage their small businesses, including expenses and staff.

14. **Can you please clarify how specialists are to bill K083 Specialist consultation or visit by telephone or video payable in increments of $5.00?**

    - Given the differential rates across specialties, specialists will bill the value of the equivalent face-to-face code in $5 increments.
    - Any visit within the "Consultations and Visits" section of the OHIP Schedule of Benefits is applicable if it is a service that can be provided by video or phone
    - The applicable units for the K083 claim submission are derived by selecting the fee code that best reflects the service rendered, rounding the fee value to the nearest $5 and then dividing by 5.

    Example:
    - A448 Medical Oncologist Partial Assessment fee is $38.05
    - Round to the nearest $5 is $40.00.
    - Divide $40 by 5 to derive units (40/5 = 8 units).
    - K083 claim submission would be 8 units with a fee payment of $40 (8 units x $5).

15. **Is K083 limited to just "Consultation" type visits, or also for other types of assessments, such as "Partial Assessment", "Medical Specific Assessment", etc.?**

    K083 is not limited to consultations and can be billed for other types of visits, such as a partial assessments, medical specific assessments and subsequent visits to hospital inpatients. Any visit within the "Consultations and Visits" section of the Schedule of Benefits is applicable if it is a service that can be provided by video or phone. In situations where the service is not described in their specialty's fee code listing (e.g., K013 counselling or K002 interview), then the other codes (K080, K081 and K082) may be eligible for payment. Providers should bill the most appropriate fee code for the service rendered.

K083 is a unit based fee code that pays $5 per unit. The applicable units are derived by selected the fee code that best reflects the service rendered and dividing its fee value rounded to the nearest $5 by 5. For example, a partial assessment rendered by a Medical Oncologist (A448 - $38.05) would calculate applicable K083 units by dividing $40 by $5 = 8 units. Thus, the claim submission would be for 8 units and a fee of $40.

16. I am a specialist. Do I need to record start and stop times to bill code K083?

While the OMA's position is that start and stop times are not required except when billed in place of a time based fee code, the Ministry has stated that physicians should document start and stop times for all Kxxx codes.

17. Are all 4 codes (K080, K081, K082, and K083) available for use by all specialties, or are some limited (e.g. just for GP's, just for specialists)

K080, K081 and K082 are for use by GP/FPs; Specialists are to use K083.

K083 is not limited to consultations and can be billed for other types of visits, such as a partial assessments, medical specific assessments and subsequent visits to hospital inpatients. Any visit within the "Consultations and Visits" section of the Schedule of Benefits is applicable if it is a service that can be provided by video or phone. In situations where the service is not described in their specialty's fee code listing (e.g., K013 counselling or K002 interview), then the other codes (K080, K081 and K082) may be eligible for payment.

Providers should bill the most appropriate fee code for the service rendered.

18. As a psychiatrist, if I see patients for 2 units of individual psychotherapy (K197A) what billing will OHIP allow for telephone visits? Do I bill with K082? Is there a cap? Occasionally a patient may be seen longer.

As a specialist, this would be billed as K083. Calculation of applicable units would be done in a similar manner as other services billed as K083 – i.e., divide total fee value rounded to nearest $5 by 5 to calculate applicable units and then multiply units by $5. For example, 2 units of K197 = $160.60 ($80.30 x2) and when rounded to the nearest $5 is $160. Dividing by 5 results in 32 units. 32 units multiplied by $5 results in a total fee payment of $160. As there are no limits on K197 in the OHIP Schedule, the same payment rules applies to K083.

19. Are specialists' premiums that would normally be eligible for payment also be applicable to the temporary fee codes, such as age premiums and E078 Chronic disease assessment premium?

Yes, if a specialist premium was eligible for payment, such as E078 and age premiums, then it is still applicable. The exception being that virtual visits do not qualify for special visit premiums.

Physicians can now submit claims, including any previously unsubmitted claims for services provided on or after March 14, 2020, for the equivalent specialist premiums by adding the eligible premium to the fee for the appropriate service and submitting a claim for the sum of the service and premium using K083. Additional details can be found in OHIP INFOBulletin #4764.

For the purpose of these K083 claims and premium payments, the total increments eligible for payment is equal to the fee listed in the Schedule for the appropriate service, plus the value of the applicable equivalent premium(s), rounded to the nearest $5, divided by 5.

Example 1:

- A183 Neurology Medical Specific Assessment fee is $79.80
- E078 calculated fee is $39.90
- Total fee amount is $119.70
- Round to the nearest $5 is $120
- Divide $120 by 5 to derive units (120/5 = 24 units)
- K083 claim submission would be 24 units with a fee payment of $120 (24 units x $5)

Example 2:

- A Paediatrician renders a consultation to a patient aged less than 30 days (age premium < 30 days = add 30%)
- A265 Paediatric Consultation fee is $175.40
- Age premium (age premium < 30 days = add 30%) calculated fee is $52.62
- Total fee amount is $228.02
- Round to the nearest $5 is $230
- Divide $230 by 5 to derive units (230/5 = 46 units)
- K083 claim submission would be 46 units with a fee payment of $230 (46 units x $5).

Please note: where a physician has **previously submitted claims** for payments under K083, which did **not** include the value of any applicable specialist premiums, physicians will have to wait to submit claims for the equivalent specialist premiums until further notice from the ministry. A new code will be launched to allow for retroactive payment that will require OHIP computer programming, with the intention being to aim for the October 2020 RA. More information will be provided in a future OMA member update and INFOBulletin.

Claims submitted through OTNinvite should be submitted in the usual manner using the appropriate fee code(s) and any applicable automated premiums (e.g., age premiums, Focus Practice Psychotherapy Premium) will continue to be applied automatically to the payment.

20. Are the special visit premiums eligible for payment in addition to the virtual care visit fee (first person seen, additional person seen)?

No, virtual visits do not qualify for special visit premiums.

21. Are diagnostic codes needed to bill K080 – K083?

Yes, diagnostic codes are required. In addition, a new diagnostic code (080 Coronavirus) should be used when treating patients with suspected or confirmed COVID-19 and/or when treating a patient by telephone/video for suspected or confirmed COVID-19

22. How should I bill for video visits via OTNinvite?

If you currently provide service through OTNinvite – you can continue to bill as usual. If you are new to using OTNinvite or using telephone or one of the other platforms – you can use the new temporary Kxxx codes, as detailed in the table below. For more information on billing for OTNinvite within the Ontario Virtual Care Program, please see the OMA's Virtual Care Working Group FAQ.

Physician Virtual Care Platform Use	Billing Codes
Currently using OTNinvite (PEM physician providing virtual care to rostered patients/GP focus practice designated physician/specialist)	Can continue to bill as usual with the Ontario Virtual Care Program codes (see Virtual Care Billing Information Manual for details)[1]
New to using OTNinvite (any physician)	Bill the new temporary K codes[2]
Using phone or non-OTN video visit technology	Bill the new temporary K codes

[1] Temporary K codes can be used if preferred

[2] Physicians who are new to OTNinvite and eligible to bill under the Ontario Virtual Care Program – PEM physicians with rostered patients, GP focus practice designated physicians, and specialists – can choose to bill the virtual care program codes (see Virtual Care Billing Information Manual for details) if preferred, by completing the billing registration form.

For eligible physicians billing the Ontario Virtual Care Program codes for a virtual visit conducted using OTN, the following codes must be submitted or the claim will be rejected:

- The appropriate OHIP Schedule fee code for the clinical care provided;
- A virtual care program B-code (B103A for a hosted video visit OR B203A for a direct-to-patient video visit); and
- The Service Location Identifier (SLI) set to "OTN".

For physicians billing the K codes for a virtual visit conducted using OTN, the OHIP Schedule fee code, virtual care program B-code or SLI set to "OTN" should not be submitted. If submitted, the claim will be rejected. Only the appropriate temporary K code should be billed.

23. Instead of sessional fee of $170/hr, can I bill FFS for patients seen in Assessment Centre?

No, physicians who work in Assessment Centres, will receive an hourly sessional payment for this coverage; no other insured services are eligible for payment. Services provided in Assessment Centres cannot be billed as fee-for-service or shadow billed.

24. How are claims submitted for the H409 and H410 sessional fees?

H409 and H410 claims must be submitted as follows:

- H409 and H410 must be billed with the unique group number assigned to each individual Assessment Centre;
- The health number field must be left blank;
- The version code field must be left blank;
- The birth date field must be left blank; and
- The claim must specify the fee, as calculated by the physician.

25. Will there be any compensation provided to physicians who are unable to provide clinical services to patients, either because of office closures/reduction in OR time or because they themselves are quarantined?

OMA has raised this important issue with the government pointing to previous Income Stabilization agreements in place during SARS. The government has agreed to start discussions with the OMA on income stabilization and physician compensation matters in response to the COVID 19 pandemic and we will keep members appraised of results of these discussions.

26. Can a family physician and/or GPs with a focus practice bill K083 when doing a consultation?

No, the Ministry has advised and agreed that "for physicians performing palliative care and long-term care services, K082 can be billed in units for time spent providing those consultations and visits". In the OMA's view, this means that you can bill two K082s if you spend 46 minutes with a patient, and three if you spend 76 minutes.

As well, in the OMA's view, applying this same approach, family physicians providing any other virtual consultation services (e.g., care of the elderly, women's health) can also submit K082 virtual claims, based on the units of time spent providing the consultation.

Please note that the time requirements apply and your record keeping must reflect this.

27. As a GP/FP, how do I bill for group psychotherapy?

The current language of K082 does not limit to individual psychotherapy, it simply state "*psychotherapy, psychiatric or primary mental health care, counselling or interview conducted by telephone or video …*" and, as such it could be billed for group psychotherapy. The idea being that a single K082 claim would be made for the entire group in a similar manner as K040 Group counselling and not billed per member like the group psychotherapy fees.

Note that GP focus practice designated physicians and PEM physicians providing virtual care to rostered patients are eligible to register with OTN and bill OHIP Schedule fee codes through OTN. Claims would be submitted in the usual manner except you would modify the OHIP claim submission by,

(1) including the applicable virtual care program B-code; and

(2) setting the Service Location Identifier (SLI) to "OTN".

Any applicable automated premiums (e.g., Focus Practice Psychotherapy Premium) would continue to be applied automatically to the OTN payment and medical record requirements for payment purposes (e.g., start and stop times) would follow the OHIP Schedule payment rules.

For additional information on virtual care, including the Ministry's Virtual Care Billing Information Manual and details on registering with OTN, please visit our webpage: https://www.oma.org/VirtualCare.

28. Will virtual visits count towards annual and monthly management fees such as, K045 Diabetes management by a specialist and Q040 Diabetes management incentive?

Claims submitted through OTNinvite using applicable fee codes already count toward minimum annual service requirements.

The relevant virtual care K-code services will be deemed to contribute towards the accumulations or limits for the corresponding consultations, assessments, and visits in the Schedule payment rules for the management fees listed below. This includes situations where the Schedule payment rules are met through a combination of the relevant in-person or virtual care services.

An equivalent management fee will be implemented to pay physicians for eligible management fees; management fees are not payable under K083. As such, **physicians will have to wait to submit claims** until further notification from the ministry that will advise on the process and code to submit such claims.

Please note:

- Where the Schedule requires that specific element(s) of physical examination(s) be completed for the year that the Management Fee is claimed (e.g. foot examination in diabetic patients), an in-person physical examination(s) must take place in order for physicians to qualify for payment equivalent to the management fee. All other payment requirements in the Schedule that are applicable to insured services also apply to these services. For these payments, virtual care K-codes will be accepted as meeting the requirements for listed consultations, assessments or visits in the Schedule.
- K083 claim submissions must not include any management fee amounts; the management fees are not eligible for payment using K083.

Applicable Monthly and Annual Management Fees

Equivalent Fee Code	Descriptor	Value

K045	Endocrinology & Metab/Internal Med - Diabetes management by a specialist - annual	$75.00
K046	Endocrinology & Metab/Internal Med - Diabetes team management - annual	$115.00
K119	Paediatrics - Paediatric developmental assessment incentive - annual	$115.10
K481	Rheumatology - Rheumatoid arthritis management by a specialist - annual	$75.00
Q040	GP/FP - Diabetes management incentive - annual	$60.00
K682	Opioid Agonist Maintenance Program monthly management fee - intensive, per month	$45.00
K683	Opioid Agonist Maintenance Program monthly management fee - maintenance, per month	$38.00
K684	Opioid Agonist Maintenance Program - team premium, per month, to K682 or K683 add	$6.00

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

29. How do we bill for out of province patients (excluding Quebec)?

Physicians should continue to use existing billing methods for patients who have Canadian provincial health insurance coverage (e.g. BC, AB etc.), and for those who have federal coverage (e.g. Interim Federal Health).

30. How should physicians bill for seeing Quebec patients virtually, since Quebec does not have a reciprocal billing arrangement with Ontario?

Physicians rendering virtual services to Quebec patients should bill RAMQ directly using the "Out of Province Claim for Physician Services" form using Ontario's virtual care codes. Within the "Diagnosis and other remarks" section of the form, note that the service was delivered virtually as per COVID-19 distancing standards.

Ottawa and area physicians who are already registered to bill electronically using codes 15773 and 15765 should continue to do so and should indicate in the notes that the service was rendered at a distance because of COVID-19.

31. The new billing codes are "in the basket" however on weekends and holidays A888 is billed with Q012 which are "out of the basket"? Will the new codes also be out of basket when billed on weekends?

The OMA has raised this question with the government and we will keep members appraised of results of these discussions.

32. Does billing the new K-codes on the weekend precludes physicians from billing A888?

No, as the telephone/video service is being rendered in place of the A888 service, it would be acceptable to bill both A888 (for in person visits) and the new time based K-codes (for virtual person visits) on the same day.

33. Does OHIP cover conversations with patients by e-mail, when physicians provide the same level of advice and service as they would have by other virtual means?

No, the provision of services by e-mail is not covered by OHIP. The new temporary Kxxx codes only reimburse physicians for services rendered by telephone or video.

34. With the new exemption on expired health cards, what should we be doing with regard to billings for these patients? Will the MOH allow them to be submitted normally, or will they need to be logged and submitted at a later date?

Most of the recently expired and expiring photo health cards remain valid and can continue to be used for accessing insured and publicly-funded health services.

Providers are encouraged to continue to validate health cards at each point of service using ministry health card validation mechanisms to ensure the health card remains valid.

If the expired cards remain valid, physicians should submit their billings for those health card numbers using the typical claims submission process.

The ministry has suspended the mandatory conversion of the red and white health cards at this time. As such, red and white health cards that remain valid and belong to the person presenting it may be also be accepted for insured and publicly-funded health services. Again, providers are encouraged to validate the card at each visit to ensure it remains valid for billing purposes.

35. Does the original code that would have been billed by specialists have to be recorded in the note?

In additional to the usual medical record requirements, for record keeping and administrative purposes, we recommend the provider should document the analogous “in-person” fee code that was utilized in the calculation of units for the K083 claim as a precaution for post-payment audit purposes.

36. What about supervision of residents?

Yes, a physician who supervises a medical trainee who renders these services is eligible to be

paid for the insured service as if the supervising physician performed the service personally, subject to any terms, conditions and limitations found in the Schedule.

INFOBulletin 4745 refers to services being rendered by the physician. This is not meant to change current teaching practices or how billing for supervision occurs, this is to ensure services that were not previously 'delegatable' to others are not now delegated using these codes (for example, to nurses or other health care professionals). If a resident provides a service that would otherwise be billable and now provides that service on the phone instead, the supervisor would bill for that service using the K083 guidelines as provided (within the usual Supervision of Postgraduate Medical Trainees guidelines).

37. Can the new fee codes K087, K088, K089 be used for providing care to uninsured persons via telephone or video?

Yes, these codes will be payable for services rendered to uninsured patients in-person, by telephone or by video.

38. What is the effective date of the new fee codes K087, K088 and K089 for provision of care to uninsured persons?

These temporary codes are effective March 21, 2020, however system changes will be implemented over the coming weeks to process these payments. Physicians can now bill for these codes effective May 1 retroactive to March 21, 2020. Further details can be found here: http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4756.aspx

39. Can I bill these codes (K087, K088 and K089) for non-Covid 19 patients?

Yes, Services funded through these temporary fee codes are not limited to those required to diagnose and treat COVID-19.

40. Can I bill these fee codes (K087, K088 and K089) to provide services to patients in another province?

No, physicians should continue to use existing billing methods for patients who have Canadian provincial health insurance coverage (e.g. BC, QC etc), and for those who have federal coverage (e.g. Interim Federal Health).

41. Are these fee codes (K087, K088 and K089) eligible for payment to specialists?

Yes, these fee codes can be billed by both family physicians and specialists.

42. How are claims submitted for K087, K088 and K089?

- The health number field must be left blank;
- The version code field must be left blank;

- The birth date field must be left blank; and
- The claim must specify the fee, as calculated by the physician.

When submitting claims for K087, K088, K089, the fee billed on the claim should equal the value of the fee code multiplied by the total number of patients served during the same day.

For example, if K087 is claimed for 3 patients seen during the same day, the fee billed should be $71.25 (3 x $23.75). Likewise, for K089, which is a time-based code, the claim for K089 will be the total number of units for all patients seen during the same day.

43. Can I delegate elements of a virtual care visit to my own personal staff (e.g., Physician Assistant or Nurse), in a similar manner that I've done for in-person visits, and still bill the new virtual care fees?

Yes, elements of an assessment could be delegated to a non-physician (e.g., Physician Assistant (PA), Nurse and Nurse Practitioner (NP)). However, in order to bill OHIP or through OTN, the physician must personally render the service and meet applicable payment requirements (e.g., time requirements for K081, K082, etc.), which would include as a minimum, a history (or confirm with the patient the relevant history obtained by the PA, nurse or NP), performance of any necessary examination and communication of the diagnosis and/or treatment plan. Of course, this would all need to be recorded in the patient's medical record.

44. Can I bill a consultation if a full physical examination is not done?

Physicians will need to use their discretion, as some health concerns can be addressed with virtual care alone, but in some cases the need for physical examination or an in-person visit cannot be replaced. In these cases, it should be explained to the patient that virtual care is not a substitute and that an in-person visit is necessary in order to perform a physical examination (see answer to question 8 for additional information).

45. What can be billed for prescription renewals over the phone?

If speaking to a pharmacy about a prescription renewal, nothing has changed; OHIP cannot be billed for this service (it remains uninsured). If speaking to a patient over the phone about their prescription, then K080, K081 (GPs) or K083 (specialists) may be eligible for payment.

46. Can the new temporary fee codes (K080, K081, K082 and K083) be used for WSIB claims?

The OMA has confirmed with the Workers Safety and Insurance Board (WSIB) that WSIB insured patients are eligible for the new temporary telephone and video codes K080 – K083. We are continuing to work with the WSIB to ensure all changes to the Schedule of Benefits will be available to WSIB patients.

47. How should physicians should submit claims for providing virtual care services to, Military personnel; and Refugees?

Medavie Blue Cross has made the necessary updates and added the temporary codes (K080 – K083) introduced by OHIP as outlined in the InfoBulletin issued March 13, 2020 to their systems for claims adjudication and processing purposes. As such, they are requesting physicians in Ontario use these temporary codes (K080 – K083) when submitting claims to ensure accuracy of the information on file for claims processed for both Military Personnel and Refugee patients.

Note, Medavie Blue Cross understands there may be some added complexities with claims for Refugees, and as such, are working with Immigration, Refugees and Citizenship Canada (IRCC) to provide additional information to health care providers in the coming weeks.

48. Application of FFS Hard Cap

As specified in INFOBulletin 11229, the application of the FFS Hard Cap will not be enforced. We have confirmed that this is also true for physicians practicing on the NGEP and the I.S. model.

49. Do 'virtual visits" count towards W010 visit requirements

W010 LTC monthly management fees in nursing homes would continue to be payable with documentation of virtual visits in the patient's chart. As with in-person visits, virtual visits would not be payable under K-codes in the same month as the W010 is billed.

50. Are there limits imposed on the number of claims that can be submitted for the temporary Kxxx codes?

The temporary Kxxx codes are intended to mirror in-person visits, which are subject to reasonable service maximums. Accordingly, similar service maximums have been applied to the temporary K-prefix codes. In circumstances where service maximums are exceeded, physicians may submit their claim for manual review.

For example, as with in-person encounters, it would be uncommon for a physician to bill for more than one assessment or consultation service for the same patient on the same date of service. The described rule prevents automatic payment of possibly ineligible service claims.

In circumstances where the physician believes that multiple services rendered on the same day are eligible for separate payment, they should submit the claim for manual review.