Ontario

Assessments and consultations

This guide will assist you in identifying the specific elements of assessments and consultations, recognize when limits apply, and create awareness of common billing errors. It will help you determine if a consultation is eligible for payment and to select the most appropriate fee code for specific patient assessment scenarios.

> The Ministry of Health (MOH) and the Ontario Medical Association (OMA) have jointly prepared this educational resource to provide general advice and guidance to physicians on specific billing matters.
>
> OMA Ontario Medical Association   Ontario

Table of contents

Objectives

Common billing errors related to assessment and consultation

Family practice/practice in general versus specialist assessments/consultation codes

Key features of specific types of assessments

Additional features of consultations

Limits for consultations

Case examples

May counselling or primary mental health be claimed in addition to a consultation or assessment?

More information

Help us improve our learning modules

Objectives

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

1. Identify the specific elements of assessments and consultations.
2. Determine if a consultation is eligible for payment.
3. Select the most appropriate fee code for a specific patient assessment scenario.
4. Recognize when limits apply to specific assessment and consultation services.
5. Identify common billing errors associated with assessments and consultations.

Common billing errors related to assessments and consultations

- Claiming an assessment or consultation code that does not match the clinical service described in the medical record.
- Claiming an assessment when only providing results or other information to the patient which are considered a constituent element of the original service.
- Claiming an assessment in association with another service where the combination is not eligible for payment.
- Claiming a consultation in the absence of referral as described in the schedule.
- Claiming a consultation when assuming routine transfer of care.

Family practice and practice in general versus specialist assessment and consultation codes

Family physicians should use the visit codes from the Family Practice and Practice in General section of the Schedule (Pages A1-A63).

This section of the schedule includes some categories of services that may be claimed by all physicians when provided in accordance with Schedule provisions and payment rules (e.g. counselling, interviews, etc.).

Specialists (as defined in the General Preamble) should use the visit fee codes from the section of the Schedule associated with their specialty. If specialists are providing insured services that do not fall within the scope of their specialty practice, then fee codes from the Family Practice and Practice in General section should be used.

- For example, if a paediatrician assesses a parent of one of their patients, they should use an assessment code from the Family Practice and Practice in General section rather than a Paediatrics fee code.

Assessments

Assessments are direct physical encounters with a patient in which **a history and physical exam is performed**. There are several types of assessments all of which include the common elements of insured services, specific elements for assessments in the General Preamble as well as any additional required elements listed in association with a particular type of patient visit. Assessments must be personally provided by the physician to be insured under OHIP.

Additional specific elements of assessments	Comments
Other inquiry carried out to arrive at an opinion as to the nature of the patient’s condition	Before/during or after the encounter that included the physical examination
Performing any procedure during same encounter as the physical examination (e.g. obtaining specimens, diagnostic/therapeutic or surgical services).	If a procedure is separately listed in the Schedule with a fee that is payable in conjunction with an assessment, this may be claimed in addition to the assessment.
Making arrangements for any related assessments, procedures or therapy.	n/a
Interpretation of results	n/a
Making arrangements for follow-up care	n/a
Discussion with/providing advice/information to the patient or the patient’s representative	• whether by telephone or otherwise • on matters related to the service • if professionally appropriate, reporting results of related procedures/assessments prior to the next insured service
Monitoring the condition of the patient and intervening when medically indicated	Until the next insured service is provided
Providing premises, equipment, supplies, and personnel for the specific elements of the service.	Except for any aspect performed in a hospital or nursing home

Note: The General Preamble defines a *12-month period* as any period of 12 consecutive month (distinct from a *calendar year*, which is the period from January 01 to December 31) which is relevant to determining whether claims for some repeat Consults or Assessments are eligible for payment.

Consultations

A consultation is an assessment requested (in writing) by a referring physician or nurse practitioner who has professional knowledge of the patient and identifies the consultant physician as competent to give advice because of the complexity, seriousness or obscurity of the patient case or because another opinion is requested by the patient or the patient's representative.

Additional specific elements of consultations	Comments
General, specific or medical specific assessment	Except where otherwise specified
Review of all relevant data	n/a
Written report to the referring provider	Including findings, opinions and recommendations
A copy of the consultation request*, signed by the referring physician or nurse practitioner	• Must be kept in the physician medical record or the common medical record of the institution where the consultation occurs. • The consultation request must identify the consultation by name and the referring provider by name and billing number and must include the patient name and health number. • The consultation request must include information relevant to the referral and specify the service(s) required. • In the absence of a written request, the amount payable for the consultation shall be reduced to the amount payable for an assessment.

Note: Consultations may not be requested exclusively by a medical trainee; they must be signed by the referring physician or NP.

Examples of patient visits that do not meet payment criteria as consultation:

- When a patient requests additional consultation(s) from a different physician of the same specialty for the same condition, it is the responsibility of the referring health care provider to determine if requests for multiple consultations for the same condition are medically necessary – if not, these services are uninsured.
- Consultations are not eligible to be paid when a patient presents him or herself to a consultant's office without a referral from his or her primary physician or the patient simply asks his or her primary physician for the name of a specialist and the patient approaches the specialist directly.
- When a hospital in-patient is transferred from one physician to another physician, only one consultation, general or specific assessment or reassessment is eligible for payment per patient admission. The amount eligible for payment for services in excess of this limit will be adjusted to a lesser assessment fee.

Key features of specific types of assessments

(see General Preamble for full details)

Key Features	General Assessment	General Re-Assessment	Minor Assessment	Intermediate Assessment**
Location / type of physician	Rendered at a place other than in a patient's home; GP/FPs and specialist not providing a specialist service	Rendered at a place other than in a patient's home; GP/FPs and specialist not providing a specialist service	GP/FPs and specialist not providing a specialist service	GP/FPs and specialist not providing a specialist service
History and Physical examination/ other elements	Full history* **AND** Examination of all body parts and systems except for breast, genital or rectal examination where not medically indicated or refused.	Includes all the services listed for a general assessment, with the exception of the patient's history, which need not include all the details already obtained in the original assessment.	Brief history and examination of the affected part or region or related to a mental or emotional disorder; **AND/OR** Brief advice or information regarding health maintenance, diagnosis, treatment **AND/OR** prognosis	History of the presenting complaint(s), inquiry Concerning, **AND** Examination of the affected part(s), region(s), system(s), or mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.
Limits	One per patient per physician per 12 months period unless one of following applies: • The 2nd assessment is clearly different and unrelated to the diagnosis made at the time of the first general assessment. • At least 90 days have elapsed since the date of the last general assessment and the 2nd assessment is a hospital admission assessment.	Two per patient per physician per 12-month period unless rendered for a hospital admission.	n/a	n/a

* A full history must include all of the following elements: history of the presenting complaint, family medical history, past medical history, social history, functional inquiry into all body parts and system.

** An intermediate assessment requires a more extensive examination than a minor assessment.

Key Features	Complex Medical Specific Re-Assessment	Level 1 Paediatric Assessment	Level 2 Paediatric Assessment **	Partial Assessment	Specific Assessment and Medical Specific Assessment	Specific Re-assessment and Medical Specific Re-Assessment
Type of physician	Specialist physicians	Paediatricians	Paediatricians	Specialist physicians	Specialist physicians	Specialist physicians
History and Physical examination/ other elements	Includes all the services listed for a medical specific re-assessment. The physician must provide a report in writing to the patient's primary care physician.	Brief history and examination of the affected part or region or related to a mental or emotional disorder, **OR** Brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis	History of the presenting complaint(s), inquiry concerning, **AND** Examination of the affected part(s), region(s), system(s), and mental or emotional disorder as needed to make a diagnosis, exclude disease, and/or assess function.	History of the presenting complaint Physical exam necessary to evaluate the presenting complaint	Full history of the presenting complaint Detailed examination of the affected part(s), region(s), or system(s) needed to make a diagnosis, and/or exclude disease, and/or assess function	Relevant history and physical of one or more systems
Limits	Any combination of medical specific assessments and complex medical specific re-assessments are limited to 4 per patient per physician per 12-month period.	n/a	n/a	n/a	One per patient per physician per 12 months period unless one of following applies: The 2nd assessment is clearly different and unrelated to the diagnosis made at the time of the first general assessment. At least 90 days have elapsed since the date of the last general assessment and the 2nd assessment is a hospital admission assessment.	Two per patient per physician per 12-month period unless rendered for a hospital admission.

** A Level 2 paediatric assessment also includes well baby care which is a periodic assessment of a well newborn/infant during the first two years of life including complete examination with weight and measurements, and instruction to the parent(s) or the patient's representative regarding health care.

Additional features of consultation

(see General Preamble for full details)

Additional Features	Repeat consultation	Limited consultation	Emergency Department physician consultation	Special surgical consultation
Location (if specified)/ type of physician	Specialist physicians	All non-specialist physicians and some specialist physicians	Emergency medicine specialists and non-specialist physicians working in the Emergency Department. The service must be provided in the Emergency Department.	Surgical specialists
Definition	Additional consultation rendered by the same consultant for the same presenting problem following care rendered to the patient by another physician in the interval following the initial consultation but preceding the repeat consultation	**Specialist physicians:** A consultation which is less demanding and requires substantially less of the physician's time than the full consultation. Same requirements as a full consultation. **Any physician who is not a specialist:** Same services as a specific assessment.	Must include all elements of a consultation. The ER report constitutes adequate documentation of the written report as long as the rendering of all constituent elements of a consultation is clearly documented and that a copy of the ER report is sent to the referring physician or nurse practitioner.	Must include all elements of a regular consultation and require the surgeon to devote **at least 50 minutes** exclusively to the consultation with the patient, excluding any time devoted to other services or procedures for which an amount is payable in addition to the consultation.
Referral requirements	New written request by the referring physician or nurse practitioner	Written request by referring physician or nurse practitioner	Written request by referring physician or nurse practitioner who may not be another ER physician in the same hospital.	Written request by referring physician or nurse practitioner

Limits for consultations

Specific payment rules apply when a physician provides more than one consultation* to a patient with a 24-month period as outlined in the General Preamble and summarized in the table below. Consultations in excess of the described limits will be adjusted to a lesser assessment.

1st consultation – all locations	2nd consultation	Location of 2nd consultation	May claim 2nd service as	Comment
Diagnosis “A”	Diagnosis “A”	All locations except hospital inpatient or Emergency Department	Repeat consultation	Must meet the requirements of a repeat consultation
Diagnosis “A”	Diagnosis “A”	Hospital inpatient or Emergency Department	Repeat consultation	Second service must meet the requirements of a repeat consultation and is rendered within 12 months of the first consultation.
Diagnosis “A”	Diagnosis “A”	Hospital inpatient or Emergency Department	Consultation	Second service must meet the requirements of a consultation and is rendered more than 12 months but less than 24 months following the first consultation.
Diagnosis “A”	Diagnosis “B”	All locations	Consultation	Second service must meet the requirements of a consultation, is rendered within 24 months of first service, and represents a clearly defined unrelated diagnosis to the first diagnosis (“A”).

* Applicable to all consultations, including time-based and age-specific consultation services (e.g. special, extended and comprehensive consultations) but not repeat consultations.

Case examples

Scenario 1:

Mr. Joelle sees Dr. Farid, a GP concerned about a painful left red eye. Dr. Farid refers Mr. Joelle to Dr. Aya (an ophthalmologist) and provides a signed letter describing the reason for the consultation as well as the patient's name, health number and contact information.

Dr. Aya reviews the referral letter and then assesses Mr. Joelle, conducting a specific assessment. He diagnoses glaucoma and recommends appropriate treatment and follow-up to the patient. Dr. Aya proves a written report to Dr. Farid outlining his findings, conclusions and recommendations. What fee code is eligible for payment to Dr. Aya?

- As Dr. Aya has fulfilled the payment requirements for a consultation, A235 is eligible for payment.

Scenario 2

Mrs. Joelle (also a patient of Dr. Farid) accompanies her husband to a follow-up visit with Dr. Aya. She mentions to the ophthalmologist in passing that she is concerned about drooping of her upper eyelids which are making it difficult to read. As Dr. Aya has had a cancellation in his clinic schedule, he offers to assess her problem and performs an appropriate history and physical examination and determines that she would benefit from formal visual field testing and consideration of blepharoplasty. Is it appropriate for Dr. Aya to claim a consultation for this assessment?

- **No**. As there has been no written request from a referring family physician or nurse practitioner, a consultation is not eligible for payment. Dr. Aya may claim the assessment that best describes the clinical encounter, which is a specific assessment.

Scenario 2b

Following Dr. Aya's assessment, Mrs. Joelle calls her family physician and requests that he send a letter requesting that the ophthalmologist assess her drooping eyelids. Once Dr. Aya receives the request, is it appropriate for him to claim the previous visit as a consultation?

- **No**. Written requests for consultation must precede the consultation and may not be provided retroactively.

Scenario 3

Mr. Joelle slips on ice and fractures his left ankle. He is assessed in the Emergency Department and referred to Dr. Legault, the Orthopaedic Surgeon on-call, who provides a consultation and personally applies a below knee cast for treatment of the undisplaced fracture. In total, Dr. Legault spends 50 minutes with Mr. Joelle providing these services including 10 minutes applying the cast. He documents the start and stop times of his visit in the patient medical record. Does the described clinical encounter meet payment criteria as a special surgical consult (A935)?

- **No**. While Dr. Legault has provided all the elements of a consultation, a special surgical consultation (A935) requires that the physician spend a minimum of 50 minutes with the patient, *exclusive of time required for any other billable service*. Dr. Legault should claim A065 for the consultation (40 minutes) and F074 for the fracture treatment (which took 10 minutes).

Scenario 4

Dr. Legault continues to see Mr. Joelle periodically over the next 3 months as the fracture heals and Mr. Joelle progresses through rehabilitation. Six months later, Dr. Farid sends a written referral request to Dr. Legault asking him to assess Mr. Joelle's shoulder which has been stiff and painful since the original fall. Dr. Legault assesses Mr. Joelle in clinic, diagnoses a rotator cuff tear and recommends surgical treatment. He provides a report to Dr. Farid. What fee code is eligible for payment to Dr. Legault?

- As the patient's concern relates to a different diagnosis from the first consultation, and Dr. Farid has fulfilled the payment requirements for a **consultation, A065 is eligible for payment.**

Scenario 5a

Dr. Marron, a family physician whose background includes several years experience working in rural emergency medicine performing minor surgical procedures, is working at an urgent care centre. She receives a call from a colleague working at a neighbouring family practice who asks her to see a patient with a complex laceration that requires suturing. The referring physician does not have the equipment in his clinic or expertise to perform the laceration repair and sends a consult note. Dr. Marron assesses the patient, focusing on the injury and sutures the laceration and dictates a report back to the referring physician. In addition to the procedure code for the laceration, what is the most appropriate assessment for Dr. Marron to claim?

- Dr. Marron should claim A905 for a limited consultation.

Scenario 5b

If in addition to the laceration, the patient had hit her head requiring a full history and physical examination. What is the most appropriate assessment for Dr. Marron to claim in addition to the laceration repair?

- Dr. Marron should claim A005 for a consultation instead of A905

May counselling or primary mental health care be claimed in addition to a consultation or assessment?

As described previously, discussion with/providing advice/information to the patient or the patient's representative is a specific element of all assessments and may not be claimed separately as counselling. For example, when a physician initiates medical treatment for hypertension and spends time providing information about the disease as well as treatment options lifestyle modifications and medication, this discussion is included in the fee for the appropriate assessment (A007 in the case of a Family Physician) and may not be claimed as a separate educational dialogue.

For a visit to be claimed as K013/K033, in addition to the time and pre-booking requirements, the visit should be dedicated solely to an educational dialogue with a physician. This would include a service is rendered for the purpose of developing awareness of the patient's

problems or situation and of modalities for prevention and/or treatment, and to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention. Counselling may also include the appropriate inquires (including obtaining a patient history, and a brief physical examination) carried out in order to arrive at an opinion as to the nature of the patient's condition (whether such inquiry takes place before, during or after the encounter during which the therapy or other interaction takes place); any appropriate procedure(s), related service(s), and/or follow-up care.

Note: That when a physician provides primary mental health care (e.g. K005) in conjunction with another assessment provided during the same visit where there are clearly different diagnoses for the two services, this may be claimed in addition to the assessment fee.

Note: That the time units submitted when claiming K005 should only reflect time spent providing primary mental health care.

Scenario 6

Dr. Santorini is working in her office when one of her patients arrives as a walk-in having had a quarrel with his partner. The patient is quite distraught and has sustained some minor self-inflicted cuts to one wrist as well as contusions to his head where he banged it against a wall. He freely admits to anger issues, is not suicidal or homicidal and states that he acted impulsively.

Scenario 6a

Dr. Santorini assesses the patient's injuries (examines the lacerations, performs relevant neurologic and musculoskeletal examinations), sutures on one of the minor cuts to his arm and provides education about wound care and monitoring for concerns related to the minor head trauma. In addition to claiming an assessment (A007) and laceration repair (Z176) fee codes, is it appropriate for Dr. Santorini to claim K013 for the education that was provided?

- **No**. Providing advice and information related to the assessment and procedure described above are specific elements of these fee codes and may not be claimed separately.

Scenario 6b

In this scenario, in addition to the services described previously, Dr. Santorini assesses the patient and concludes the patient has maladaptive behaviour patterns and recommends some anger management strategies. She documents start and stop times of this discussion which required 25 minutes. Is it appropriate for Dr. Santorini to claim K005 for the primary mental health care that was provided?

- **Yes**. Dr. Santorini may claim K005 x 1 unit for the primary mental health care provided in addition to A007 and Z176. In order to identify that these services relate to clearly different diagnoses, Dr. Santorini selects appropriate and distinct diagnostic codes for the A007/Z176 (959 - Trauma) and for the K005 (300 - Anxiety). It should be noted that the additional primary mental health fee code is only eligible to be claimed if provided consecutively to the other assessment and procedure rather than concurrently.

Scenario 7a

Mrs. Hutton is a 55-year-old woman with hypertension who attends her physician's (Dr. Scott) office for a regularly scheduled follow-up of her chronic condition. Dr. Scott performs a focused history and physical to assess his patient's symptoms, disease control and identify any problems or complications. As part of the visit, Dr. Scott provides education about diet and lifestyle interventions to optimize disease control. What is/are the most appropriate fee codes to claim for this visit?

- Dr. Scott may claim A007 for an intermediate assessment (which includes the described educational counselling). It is not appropriate to claim an additional fee code for counselling.

Scenario 7b

Mrs. Hutton returns for a scheduled follow up visit. Once Dr. Scott has reevaluated her blood pressure, she identifies that she has many questions and visit becomes an educational dialogue that lasts 30 minutes. What is/are the most appropriate fee codes to claim for this visit?

- The answer depends on the service that was provided during the appointment. A time threshold alone should not be used to classify an appointment as counselling.

- If this scheduled appointment meets the Schedule criteria for counselling - an educational dialogue rendered for the purpose of developing awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information in respect of diagnosis, treatment, health maintenance and prevention – including the time requirements, then K013 may be claimed. In this case, it is not appropriate to claim an additional fee code for an assessment.
- Note that advice given to a patient that would ordinarily constitute part of a consultation, assessment, or other treatment, is included as a common or constituent element of the other service and does not constitute counselling.

More information

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

Help us improve our learning modules

Please take this quick, online survey on the Assessments and consultations learning module.

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