Billing for Coordinated Care Planning:
A Guide for Family Practice and Practice in General

For full definitions, payment rules and medical record requirements, please refer to the current Ontario Health Insurance Plan Schedule of Benefits, http://www.health.gov.on.ca/en/pro/programs/ohip/sob/ (see disclaimer below).

The following information is not an exhaustive list, but merely a guide for Family Physicians who may/are billing for services rendered associated with Coordinated Care Planning:

CASE CONFERENCES

*A **CASE CONFERENCE** is a pre-scheduled meeting, conducted for the purpose of discussing and directing the management of an individual patient.*

A case conference:

a. Must be conducted in-person, by videoconference or by telephone

b. Must involve at least 3 eligible participants (the physician most responsible for the care of the patient and at least 2 other participants that include physicians, regulated social workers, and/or regulated health professionals.

***Note:** Case conferences for educational purposes, such as rounds, journal club, group learning sessions or continuing professional development or any meeting where the conference is not for the purposes of discussing and directing the management of an individual patient is not a case conference.*

Hospital In-Patient Case Conference	K121	$31.31/unit	Case Conferences are time-based services calculated in time units of 10-minute increments. The minimum time required is based upon consecutive time spent participating in the case conference, as follows: 1 unit – 10 minutes; 5 units – 46 minutes 2 units – 16 minutes; 6 units – 56 minutes 3 units – 26 minutes; 7 units – 66 minutes 4 units – 36 minutes; 8 units – 76 minutes **Additional Details:** For Paediatric Out-Patient Case Conference, personnel employed by an accredited centre of Children's Mental Health Ontario may be included in the other 2 participants. For Mental Health Out-Patient Case Conference, personnel employed by a mental health community agency funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC) may be included in the other 2 participants. Is only eligible for payment when the physician most responsible has a specialty designation in Psychiatry. For Bariatric Out-Patient Case Conference, personnel employed by a Bariatric Regional Assessment and Treatment Centre may be included in the other 2 participants.	A22-A28
Palliative Care Out-patient Case Conference	K700	$31.35/unit		
Paediatric Out-Patient case conference	K704	$31.35/unit		
Chronic Pain Out-Patient Case Conference	K707	$31.35/unit		
Mental Health Out-Patient Case Conference	K701	$31.35/unit		
Bariatric Out-Patient Case Conference	K702	$31.35/unit		
Geriatric Out-Patient Case Conference	K703	$31.35/unit		
Long-Term Care/Home & Community Care (HCC) Case Conference	K124	$31.35/unit		
Long-Term Care – High risk Patient Case Conference	K705	$31.35/unit		

<table>
<tr><td>Convalescent Care Program Case Conference</td><td>K708</td><td>$31.35/unit</td><td>For Geriatric Out-Patient Case Conference is only eligible for payment when the patient is at least 65 years of age or less than 65 years of age with dementia, and when a Specialist in Geriatrics, or a physician with an exemption to access bonus impact in Care of the Elderly from MOHLTC is participating

For the Long-Term Care – High Risk Patient Case Conference, personnel of HCC may be included in the other 2 participants.

For Convalescent Care Program Case Conference, personnel of the Convalescent Care program funded by the Ontario MOHLTC may be included in the other 2 participants.

All eligible participants must be involved or about to become involved in the care of the patient. For each type of case conference, there is a maximum of 4 services per patient, per physician, per 12 month period and a maximum of 8 units per patient, per physician, per 12 month period.</td><td></td></tr>
<tr><td colspan="5">CONSULTATIONS AND VISITS</td></tr>
<tr><td colspan="5">INTERVIEWS are not eligible for payment when the information being obtained is part of the history normally included in the consultation or assessment of the patient. The interview must be a booked, separate appointment lasting at least 20 minutes.</td></tr>
<tr><td>Interviews with relatives or person authorized to make a treatment decision</td><td>K002</td><td>$62.75/unit</td><td rowspan="3">Interviews are calculated and payable in time units of 30 minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient (or patient’s representative) and the physician in-person is as follows:

<table><tr><td>1 unit</td><td>20 minutes</td><td>5 units</td><td>136 minutes</td></tr><tr><td>2 units</td><td>46 minutes</td><td>6 units</td><td>166 minutes</td></tr><tr><td>3 units</td><td>76 minutes</td><td>7 units</td><td>196 minutes</td></tr><tr><td>4 units</td><td>106 minutes</td><td>8 units</td><td>228 minutes</td></tr></table>
Additional Details:
Interviews with relatives or person authorized to make a treatment decision on behalf of the patient in keeping with the Health Care Consent Act.

Interviews with CAS or legal guardian on behalf of the patient in accordance with the Health Care Consent Act conducted for the purpose other than obtaining consent.

Diagnostic interview and/or counselling with child and/or parent for psychological problem or learning disabilities.</td><td rowspan="3">GP42 & A19</td></tr>
<tr><td>Interviews with Children’s Aid Society (CAS) or legal guardian</td><td>K003</td><td>$62.75/unit</td></tr>
<tr><td>Diagnostic interview and/or counselling with child and/or parent</td><td>K008</td><td>$62.75/unit</td></tr>
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			KOO2 is only eligible for payment if the physician can demonstrate that the purpose of the interview is not for the sole purpose of obtaining consent. *K002/K003 are claimed using the patient's health number and diagnosis. These listing apply to situations were medically necessary information cannot be obtained from or given to the patient or guardian (e.g., due to illness, incompetence, etc.)* *K008 is claimed using the child's health number. Psychological testing is not an insured service.*	
Complex House Call Assessment	A900	$45.15	Primary care service rendered in a patient's home to a patient that is considered a frail elderly patient or a housebound patient. Eligible for payment for first person seen during a single visit to same location.	A3
Telephone Consultation (Referring Physician)	K730	$31.35/unit	Requires at least 10 minutes of patient-related discussion and start and stop times must be documented. Maximum one (1) service per patient per day. Consultant physician has provided an opinion and/or recommendations for patient treatment and/or management. There is a separate billing code for Consultant Physician, see A29.	A29
E-Consultation (Referring Physician)	K738	$16.00/unit	Must be sent by electronic means through a secure server. Consultant physician has provided an opinion and/or recommendations for patient treatment and/or management within thirty (30) days from the date of the request. Maximum of one (1) service per patient per day. Maximum of six (6) services per patient, per physician, per 12 month period and 400 services per physician, per 12 month period. For details on the requirements around documenting e-consultations and telephone consultations, please see the Schedule of Benefits. There is a separate billing code for Consultant Physician, see A33.	A29
Home Care Application	K070	$31.75	Service provided by most responsible physician for completion or submission of an HCC application on behalf of a patient. Limited to one (1) per home care admission per patient. Not eligible if patient currently receiving homecare.	A40
Acute Home care Supervision	K071	$21.40	Service provided by most responsible physician for personally providing medical advice, direction or information to HCC staff or HCC contractor on behalf of a patient. Acute Home Care Supervision applies in the first 8 weeks following admission to home care program. Limited to a maximum of two (2) services per patient per week for 8 weeks but only one (1) service per patient, per physician, per week.	
Chronic Home Care Supervision	K072	$21.40		

			Chronic Home Care Supervision applies after the 8th week following admission to home care program. Limited to a maximum of four (4) services per patient, per month but only two (2) services per patient, per physician, per month.	

***Disclaimer**: While every effort has been made to ensure that the contents of this guide are accurate, individuals should be aware that information contained within the OHIP Schedule of Benefits often change over time. Health Links assumes no responsibility for any discrepancies of differences of interpretation that the MOHLTC may have with the contents of this guide. Individuals are advised that the ultimate authority in matters of interpretation and payment are in the purview of the MOHLTC and, as such, members should request updated information and interpretations from the OHIP Schedule of Benefits or their local MOHLTC office.*