Ministry of Health and Long-Term Care

Resource Manual for Physicians

Ministry of Health and Long-Term Care

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Ontario

Resource Manual
for Physicians

This manual is a general summary provided for information purposes only. All efforts are made to ensure the accuracy of this manual; however, it may contain errors and/or omissions. Users are cautioned against reliance on the contents without confirming the accuracy, completeness, reliability and currency of the information provided herein.

Physicians, hospitals, and other health care providers are directed to review the *Health Insurance Act* and Regulation 552 (including the Schedules under that regulation) for the complete text of the provisions (www.e-laws.gov.on.ca). In the event of a conflict or inconsistency between this manual and the applicable legislation and/or regulations, the legislation and/or regulations prevail.

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Current as of October 2017

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PHYSICIAN REGISTRATION

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1. PHYSICIAN REGISTRATION

1.1 Overview

You must register with the Ministry of Health and Long-Term Care (the ministry) in order to receive an Ontario Health Insurance Plan (OHIP) billing number to submit claims for insured services. If you are interested in alternate payment methods, please refer to Section 6 – General Information.

In order to apply for an OHIP billing number with the ministry you must hold a valid certificate with the College of Physicians and Surgeons of Ontario (CPSO) and you must have an Ontario practice address.

Mandatory Address Reporting

All physicians are required under Ontario Regulation 57/97 of the *Health Insurance Act* to provide in writing to the ministry, an address for every place they regularly provide insured services in Ontario to insured persons.

Where multiple addresses exist, the physician should identify which address is the primary practice site where possible. In addition to each address, physicians must indicate whether services are provided as a locum tenens and/or provided as delegated procedures carried out under direct supervision of the physician.

Provisions governing delegated procedures can be found in the General Preamble section of the Schedule of Benefits located at:

http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/genpre.pdf

Practice addresses are not considered personal information and may be disclosed upon request and as such, it is recommended that your residential address not be provided.

The ministry may require supporting documentation to validate your address information and may request information on any other practice addresses. In addition, you may be contacted to verify and/or update your address data currently on file with the ministry.

1.2 Questions and Answers

What kind of certificate is required from the CPSO in order to bill the ministry?

In order to bill the ministry you must hold one of the following valid types of certificate from the CPSO:

- Independent Practice
- Academic
- Supervised Practice of Short Duration
- Restricted

How do I get an OHIP billing number?

You must complete the "*Registration for Regulated Health Professionals" form* (3384-83) and return to the ministry for processing. Please submit by one of the following methods:

- scanning original and sending by email: ProviderRegistration.MOH@ontario.ca **Or**
- Faxing original to (613)-545-5848 **Or**
- Mailing original to:

Ministry of Health and Long-Term Care
Claims Services Branch
Provider Registry Unit
PO Box 68
Kingston, ON K7L 5K1

For More Information

Call the **Service Support Contact Centre (SSCC)** at:
1-800 262-6524

Hours of operation: 8:00am - 5:00pm

When the form is approved and processed, you will receive a letter from the ministry with your assigned OHIP billing number and the effective date.

How do I get a form?

The form is available online at:

http://www.health.gov.on.ca/en/pro/forms/ohip_fm.aspx

I've graduated, have my independent practice certificate and am working now. Can I work while waiting for my billing number to be issued and bill retroactively?

When you have been assigned a billing number, you may bill retroactively up to six months prior to receiving your billing number but no earlier than the effective date of your certificate.

Now that I have my billing number how do I go about submitting claims?

Your claims must be submitted by electronic data transfer in accordance with Ontario Regulation 552, Section 38.3 of the *Health Insurance Act*.

Refer to Section 4 – Claims Submission for information on how to submit your claims.

Who do I report my address change to?

You must submit your address changes, in writing, to:

Ministry of Health and Long-Term Care
Claims Services Branch
Provider Registry Unit
PO Box 68
Kingston, ON K7L 5T3 **Or**

by email:

ProviderRegistration.MOH@ontario.ca **Or**

Fax to (613)-545-5848

The ministry will need at least 30 business days advance notice of the change.

If I work as a locum may I use the employing physician billing number?

No, you must submit claims using your own billing number. However, refer to the "Delegated Procedure" section of the General Preamble of the Schedule of Benefits for Physician Services for billing of delegated procedures in a locum tenens located at:

http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/genpre.pdf

PHYSICIAN PAYMENT – SCHEDULE OF BENEFITS FOR PHYSICIAN SERVICES

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2. Physician Payment – Schedule of Benefits for Physician Services

2.1 Overview

The Ministry of Health and Long-Term Care (ministry) makes payments for services insured by the Ontario Health Insurance Plan (OHIP) in accordance with the payment requirements listed in the Schedule of Benefits for Physician Services (Schedule). The Schedule lists approximately 6,000 physician services and includes extensive preambles and notes that provide detailed conditions for payment of insured services. The Schedule is a document incorporated by reference into Regulation 552 under the *Health Insurance Act* (HIA) and is amended only by regulation change. The HIA, specifically Section 24 of Regulation 552, also contains a listing of explicitly uninsured services and should be read in conjunction with the Schedule and the rest of Regulation 552.

Changes to the Schedule include the addition of new services, deletion of obsolete services and redefinition of existing services. Individual physicians who wish to propose changes may submit proposals to the Physician Services Payment Committee through the appropriate clinical section of the OMA.

The HIA stipulates that only medically necessary services are insured. Sometimes, a service may be either insured or uninsured depending on the medical indications for the service. For some services, specific indications have been explicitly included as conditions for payment in the fee code definition. The physician must ensure that the appropriate indications are documented in the patient's medical record in order to satisfy the payment requirements.

For many procedures that may be considered cosmetic, the Schedule requires that the physician obtain prior approval from the ministry (i.e. complete the Request for Approval of Payment for Proposed Surgery form (0691-84)). Such requirements are described either in notes adjacent to applicable fee codes or in Appendix D of the Schedule.

The ministry regularly makes INFOBulletins available on the ministry public internet site. INFOBulletins offer information on payment, program or policy changes with regard to the Schedule and/or other payment information. Some INFOBulletins are mailed to physicians; however this practice is changing and increasingly INFOBulletins are only being posted electronically (see link at end of this section).

Separate fee schedules also exist for other practitioners, medical laboratories (licensed under the Laboratory and Specimen Collection Centre Licensing Act) and independent health facilities (licensed under the Independent Health Facilities Act).

2.2 General Preamble

Note:

*This is intended to be a **brief overview** of the critical elements within the General Preamble, and not a substitute for the actual document.*

The first section of the Schedule is the "General Preamble". The General Preamble provides details about billing requirements for all physicians. The **Definitions** section of the General Preamble lists general definitions of key terms and phrases used in the Schedule. Information regarding a number of topics is provided under **General Information**. This is followed by the **Constituent and Common Elements of Insured Services** and the **Specific Elements of Assessments.** The next sections provide information on **Consultations** and **Assessments** followed by the section regarding services provided only in **Hospitals and Other Institutions**. The next section focuses on psychotherapy, counselling, and related services, followed by a similar review of services that involve interviews. The remaining sections include information on delegated procedures (with regard to payment by OHIP), age-based premiums, special visit premiums, surgical assistants' services, anaesthesiologists services, other premiums, emergency department sessional fees and emergency department alternative funding agreements.

In addition to the information provided in the General Preamble, it is necessary to review service specific information provided elsewhere in the Schedule to have a complete understanding of the requirements for a particular service.

The following is an overview of the issues and information contained within the General Preamble that may guide you in a more detailed examination of the General Preamble.

Note:

In the event of a conflict between this overview and the full text of the General Preamble, the General Preamble prevails. You are expected to be familiar with all the relevant provisions of the General Preamble and applicable legislation and regulations. All claims for payment will be determined in accordance with the Schedule and not with this overview. For specific details and definitions, refer specifically to the General Preamble.

Common and Constituent Elements

All insured services include the skill, time and responsibility involved in performing the service. Unless otherwise specifically stated in the Schedule, the elements that are common to all insured services include:

- Being available to provide **follow-up** insured services to the patient or making arrangements for coverage when you are not available.
- Making any arrangements for **appointment(s)** involving the insured service.

- Obtaining and **reviewing information** (including taking history) to make the appropriate decisions to perform elements of the service.
- Obtaining **consents** or delivering written consents.
- Keeping and maintaining appropriate **medical records.**
- Providing any **medical prescriptions**, except where the request for this service is initiated by the patient (or their representative) and no insured service is provided.
- Preparing or submitting **documents**, **records** or **information** for use in programs administered by the ministry.
- Conferring with or providing advice, direction, information or records to physicians and other professional associated with the health and development of the patient.
- Providing **premises, equipment**, **supplies** and **personnel** for the service.

Please refer to the General Preamble for the full text.

Assessments and Consultations

For all services that are described as **assessments**, or as including assessments, the following is a list of the **specific elements**, in addition to the common elements:

- Direct **physical encounter** with the patient including any appropriate physical examination and ongoing monitoring of the patient's condition where indicated. These services **cannot** be delegated.
- Other **inquiry,** including patient history, carried out in order to arrive at any opinion as to the nature of the patient's condition, appropriate procedures, related services and/or follow-up care which may be required.
- Performing any procedure(s) during the same encounter as the physical examination unless separately listed in the Schedule and payable in addition to the assessment (examples include obtaining specimens, preparing the patient, interpreting results).
- Making **arrangements** for related assessments, procedures, therapy, interpreting results and appropriate follow-up care.
- Discussion with and providing **advice** and **information,** including prescribing therapy to the patient (or their representative) by telephone or otherwise on matters related to the service and when appropriate, to convey the results of a related procedure prior to future patient visit (e.g. it would not normally be necessary to schedule a second visit with a patient to review the results from a diagnostic test such as a throat swab; however, if an examination such as an exercise stress test was ordered in the first appointment, then it may be necessary to have the patient return for a second appointment to discuss the results and the second appointment would accordingly be an insured service for which a claim could be submitted).

- When medically indicated, monitoring the condition of the patient and intervening until the next insured service is provided.
- Providing the premises, equipment, supplies and personnel for the specific elements of the service (except for those performed in a hospital or nursing home).

Please refer to the General Preamble for the full text.

Annual limits may apply to various codes, including individual consultation and assessment codes.

A **consultation** (e.g. A135 for Internal Medicine) is a service provided upon a **written request** from a referring physician, who, in light of his or her professional knowledge of the patient, requests the opinion of another physician competent to give advice in this field or because another opinion was requested by the patient (or their representative). The consultant must perform a general or specific assessment, including the review of all relevant data. The consultant physician must submit his or her findings, opinions, and recommendations **in writing** to the referring physician. A copy of the written request must be maintained in the consulting physician's medical record except in the case of a consultation which occurs in a hospital, nursing home, long-term care facility where common patient medical records are maintained. In such cases, the written request may be kept in the common medical record.

In the absence of a written request, the amount payable for the consultation shall be reduced to the amount payable for an assessment. A consultation is not to be claimed as such:

- When a patient presents him or herself to a consultant's office without a referral from his or her primary physician; or,
- When the patient simply asks his or her primary physician for the name of a specialist and the patient approaches the specialist directly (refer to Bulletin 4318).

A **repeat consultation** (e.g. A136 for Internal Medicine) is an additional consultation rendered by the same consultant regarding the same problem, following care rendered to the patient by another physician following the initial consultation. If a consultant asks a patient to return for a later examination, this visit is not a repeat consultation.

A **limited consultation** (e.g., A435 for Internal Medicine) involves all elements of a full consultation, but requires substantially less of the physician's time than a full consultation. For example, when a physician sees a patient in consultation for a plantar wart a limited consultation code would be appropriate.

The Education and Prevention Committee (EPC), a joint committee of the ministry and the OMA, has published an EPC Interpretive Bulletin on the topic of consultations (Bulletin Volume 4, No. 4 titled "Referrals for Consultation" – see link at end of this section).

A **general assessment** (A003) is a family practice service provided somewhere other than the patient's home and includes a full history (including medical, family and social history) and except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts.

A **periodic health visit** is a general assessment of an individual who has no apparent physical or mental illness and which takes place after the second birthday. It may include instructions to the patient and/or parents regarding health care. A periodic health visit should be claimed as follows:

- **Family Practice and Practice in General**

  K017 – child after second birthday

  K130 – adolescent

  K131 – adult aged 18-64

  K132 – adult 65 years of age and older

- **Paediatrics**

  K267 – child age 2 to 11 years (no diagnostic code required)

  K269 – adolescent age 12 to 17 years (no diagnostic code required)

A periodic health visit is limited to one per patient per year by any one physician.

A **general re-assessment** (A004) is a family practice code that includes all of the services included in a general assessment, with the exception of the patient's history (which need not include all the details already obtained in the original assessment).

A **minor assessment** (A001) includes a brief history and examination of the affected part, region or disorder and/or brief advice or information regarding health maintenance, diagnosis, treatment, and/or prognosis. For example, seeing a patient with a simple skin rash or conjunctivitis would be billed as a minor assessment. This is a family practice code but should also be billed by specialists practicing outside of their specialty and/or in a primary care practice setting.

An **intermediate assessment** (A007) is a primary care service that requires a more extensive examination than a minor assessment. It also requires a history of the presenting complaint(s), inquiry concerning and examination of the affected part(s), region(s), system(s) or mental and emotional disorder as needed to make a diagnosis, exclude a disease and or assess function. This is a family practice code but should also be billed by specialists practicing outside of their specialty and/or in a primary care practice setting.

Non-emergency Acute Care Hospital In-patient Services

Non-emergency acute care hospital in-patient services include consultations and assessments rendered to admitted patients on a non-emergency basis and utilize the "C" prefix code. This includes, but is not limited to **admission assessments**, **subsequent visits, concurrent care**, and **supportive care**.

Emergency Department - Emergency Physician on Duty

Emergency Department – Emergency Physician on Duty: There are specific "H" prefix listings (H1-codes) for consultations, multiple systems assessments, minor assessments, comprehensive assessments and re-assessments rendered by the physician on duty in the Emergency Room. Any physician on duty or on-call in the emergency department should use these fee codes unless a special visit is required. If a special visit is required to the Emergency Department (e.g., the physician is called from home to make a special visit to see a patient in the Emergency Department and must travel to the hospital), the appropriate 'A' prefix fee code should be claimed for the first patient assessed (in addition to the special visit premium code(s)).

If the emergency department physician on call (or off duty) is already in the hospital or hospital environs a special visit premium cannot be billed when the physician is called to the Emergency Department. See the section on 'Special Visit Premiums' below for more information.

Psychotherapy and Counselling Services

Psychotherapy (K007) is treatment for mental illness, behavioral maladaptations or emotional problems, in which a physician deliberately establishes a professional relationship with a patient for the purpose of removing or modifying existing symptoms attributed to the problem.

Individual counselling (K013, K033) is defined as a patient visit dedicated solely to an educational dialogue between the patient and a physician. Advice provided to a patient that would ordinarily constitute part of a consultation, assessment or other treatment, is included as a common or constituent element of such other service, and does not constitute counselling in this context. If the patient does not have a pre-booked appointment, the amount payable for this service will be adjusted to a lesser assessment fee.

Delegated Procedure

A **Delegated Procedure** is a procedure carried out by a physician's employee where the service remains insured if certain conditions are met. Procedures in this context do not include such services as assessments, consultations, psychotherapy, counselling, etc. One of the requirements (with few exceptions) is for "direct supervision", that is, the physician must be physically present in the office or clinic at which the service is rendered. For more information including payment rules for delegated procedures, refer to the 'Delegated Procedure' section of the General Preamble.

The EPC has also published an EPC Interpretive Bulletin on the topic of payment for delegated procedures (Volume 9, No. 1 titled "Payment Requirements for Delegated Services" – see link at the end of this section).

Special Visit Premiums

Special visit premiums may be payable when a physician is required to make a medically necessary visit to a patient at a specific location. Special visits are generally non-elective; however, if a special visit is required at the patient's home, the visit may be non-elective or elective.

A **non-elective visit** is one that is initiated by a patient or by an individual on behalf of the patient (e.g. nurse) for the purpose of rendering a non-elective service.

An **elective home visit** is a visit to a patient's home deemed medically necessary by the physician, initiated by the physician and carried out at a time convenient to the physician.

The General Preamble contains several tables, each representing a different location for a special visit (e.g. long-term care institution, patient's home, hospital in-patient, etc.). Please refer to the table representing the location of the special visit to determine the appropriate fee code(s).

Special visits may have two components:

1. A travel component; and/or
2. A person seen component (first person seen and additional person(s) seen).

The travel component of a special visit requires the physician to travel from one location to another to see the patient (e.g., from home to the hospital). Travel from one location of a hospital facility/complex to another location within the same facility/complex does not qualify for the travel premium (even if they are separate buildings).

In order for the first person seen premium to be eligible for payment, the physician must meet the requirement for travel. Additional persons seen may also qualify for a premium if there is a need to see other patients on a non-elective basis at the same location as part of the same visit. The travel component is not payable for additional persons seen at the same location.

Full payment rules and requirements, including the medical record requirements, are listed in the General Preamble under 'Special Visit Premiums'.

The EPC published an EPC Interpretive Bulletin on the topic of special visit premiums (Volume 7, No. 1 titled "Special Visit Premiums" - see link at the end of this section).

Other than a hospital or long-term care facility, special visits do not apply when rendered in a place that is open for patients to attend (e.g., walk-in clinic). Patients seen during office hours held on nights or Saturdays, Sundays, or holidays do not qualify for any of the special visit premiums.

Surgical Assistants' Services

The **Surgical Assistants' Services** section of the General Preamble provides a list of specific elements for assistance at surgery as well as information regarding these services.

Appendix H of the Schedule contains a chart to assist in determining the number of assistant time units for billing purposes.

The EPC published an EPC Interpretive Bulletin on the topic of surgical assistants' services (Volume 8, No. 3 titled "Surgical Assistant Services" - see link at the end of this section).

Anesthesiologists' Services

The anesthesiologists' section of the General Preamble provides a list of specific elements for anesthesiologists' services as well as information regarding these services.

Appendix H of the Schedule contains a chart to assist in determining the number of anaesthesia time units for billing purposes.

For further details or clarification regarding any of these topics, please refer to the Schedule or contact your local OHIP office.

2.3 Schedule of Benefits Appendices

There are several appendices found at the end of the Schedule. With the exception of **Appendix D**, these appendices do not form part of the Schedule; however, they do contain information that may be helpful. Regulations, such as those excerpted within the appendices are subject to change. Physicians are reminded to acquaint themselves with the current text of these regulations.

Appendix included as part of the Schedule:

Appendix D - This section contains information regarding the criteria for OHIP coverage for surgical procedures that are for the purpose of altering or restoring appearance, including surface pathology and sub-surface pathology.

Appendices as attachments to the Schedule:

Appendix A – Provides an on-line reference and link to Section 24 of Regulation 552 under the HIA.

Appendix B – Provides on-line references and links to Regulation 114/94 relating to **Conflict of Interest** and **Records** in accordance with the Medicine Act, 1991.

Appendix C – Information on Benefits Outside Ontario as well as Interprovincial Reciprocal Billing of Medical Claims.

Appendix F – Services set out here are not “insured services” within the meaning of the HIA but are paid by the ministry, acting as a paying agent on behalf of the Ministry of Community and Social Services (MCSS), the Ministry of the Attorney General, the Ministry of the Community and Correctional Services, and the Workplace Safety and Insurance Board (WSIB). This appendix includes a list of important forms for physicians relating to the **MCSS Ontario Disability Support Program** and **MCSS Ontario Works Program.**

Appendix G – Provides on-line references and links to medical record requirements as found in the Medicine Act, 1991 and the HIA.

Appendix H – Table listing the number of units payable based on the duration of time spent rendering anaesthesia or surgical assistant services.

Appendix Q – Provides descriptions and information for ‘Q’ prefix codes for primary care models.

Following the Appendices, you will find **the Alpha Numeric Index.**

2.4 Links to on-line documents

Use the following links to access on-line documents referenced in this section:

The Schedule:

http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

INFOBulletins (also formerly published as Bulletins):

http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

EPC Interpretive Bulletins are published in the Ontario Medical Review and also available on the OMA's public site at:

https://www.oma.org/Resources/Pages/EPCbulletins.aspx

Note:

Schedule page references may not be current in all EPC Interpretive Bulletins as they reflect content in the version of the Schedule stated in the Bulletin. Other Schedule changes may also have taken effect since publication and the current version of the Schedule should always be consulted for accuracy of payment rules.

PAYMENT INTEGRITY

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Ontario

3. Payment integrity

3.1 Overview

The Ministry of Health and Long-Term Care (ministry) is committed to providing information to assist physicians in receiving the payment to which they are entitled for insured services provided to insured persons in Ontario. To achieve that, the ministry works with individual physicians to resolve any questions that arise and to try to reach a mutual understanding of the appropriate fee codes to submit for the services provided.

The appropriate fee codes to be submitted to OHIP are determined by the payment requirements set out in the *Health Insurance Act* (HIA) and Regulation 552, including the Schedule of Benefits for Physician Services (Schedule). To ensure prompt payment, submitted claims are paid on an honour system after being processed through computerized checks. These initial checks and resulting payment do not necessarily mean that all payment requirements have been met.

Under the authority of Section 18 of the HIA, the ministry's Payment Integrity Unit conducts post-payment reviews of physicians' claims payments as a component of measures that contribute to accountability for the use of OHIP funds.

In accordance with the HIA, the Commitment to the Future of Medicare Act (CFMA) and the Independent Health Facilities Act (IHFA), the ministry also investigates potential circumstances of unauthorized payments or charges for insured services (extra-billing) or for access to insured services (queue-jumping).

3.2 Review Processes

The ministry reviews, on a post-payment basis, concerns that were reported externally (e.g. from the public or an external organization), or identified internally (e.g. from a local OHIP Claims processing office, or the OHIP Fraud Hotline) related to a provider or group to determine the appropriateness of a physician's claims and resulting payments.

In addition, the ministry conducts province wide reviews of payment issues and interacts with identified physicians to validate adherence to the Schedule and to account for the use of OHIP funds.

The authority and the process by which possible instances of unauthorized payments are investigated and resolved are set out in the CFMA, IHFA and regulations. For more information, these Acts and regulations are available on the government website at *Health Insurance Act*.

3.3 Possible Actions

Actions which may result from these ministry post-payment reviews include:

- Education
- Records review/audit
- Confirmation Letters
- Recovery
- Referral to the Physician Payment Review Board (PPRB)
- Referral to the Accounting Policy and Financial Reporting Branch (for investigation of potential fraud and possible referral to the Ontario Provincial Police (OPP) for investigation)
- Referral to the College of Physicians and Surgeons of Ontario for investigation of potential professional misconduct or patient safety concerns.

Actions which may result from a CFMA investigation include:

- Education
- Reimbursement of unauthorized payments to patients
- Provincial Offences charges

Education

One of the functions of the ministry is to educate and assist physicians in correctly billing OHIP for services provided. Individual education letters to physicians are often sent after a general review of a physician's claims to OHIP or after review of records. The ministry also conducts general billing studies through the Provider Education Program (PEP). PEP studies generally involve letters to a number of physicians setting out information regarding a specific fee code or fee codes in the Schedule. PEP letters can be sent by the ministry or by the Education and Prevention (EPC) Committee (a joint committee of the ministry and the OMA). Finally, the ministry educates physicians through the publication of INFOBulletins and EPC Interpretive Bulletins.

Records Review/Audit

The ministry may request medical records from a physician to better understand the claims submitted for the services provided. The authority for such a request is set out in Sections 37 and 37.1 of the HIA. Section 29 of the HIA deems the disclosure of this information to the ministry to be authorized by the insured persons. Medical records must support the claims submitted by demonstrating that an insured service was provided to an insured person; that the claim submitted represented the service provided; and that the service was medically necessary. As such, a records review is used to verify that a service was provided and the appropriate fee was claimed.

Confirmation letters

In some cases, the ministry may send letters to patients asking them to confirm whether they received a specific service from a physician on a specific day. Where patients are unsure or state that no visit occurred on the specific day, the ministry may conduct a closer review of the physician's claims. Confirmation letters serve a basic accountability function for the ministry to the public.

Recovery

When analysis of a physician's claims indicates that an amount is owing to OHIP, the physician may be asked in writing to reimburse OHIP. If the physician does not agree that an amount is owing, or disagrees with the amount calculated, the matter may be referred to the Physician Payment Review Board.

In addition, the Payment Correction List sets out circumstances in which the General Manager of OHIP may take action on physician claims. This list is available on the internet at:

http://www.health.gov.on.ca/english/providers/program/ohip/sob/payment_correction_list.html

Referral to the Physician Payment Review Board (PPRB)

In situations where there is disagreement between the ministry and the physician as the result of a payment concern, audit or review under the HIA, the concern may be referred by the ministry or the physician to the PPRB for review.

Physicians referred to the PPRB by the ministry will be notified and will have the opportunity to make representations (either in person or through independent counsel) at the board.

Referral to the Accounting Policy and Financial Reporting Branch

In situations where there is a concern of fraudulent billing, the Payment Integrity unit or the CFMA program area may refer the concern to the Risk Management and Fraud Control unit of the ministry. This unit reviews the concern and makes a determination on whether to forward to the OPP Anti-Rackets Unit for possible criminal investigation.

Referral to the College of Physicians and Surgeons of Ontario (CPSO)

In some cases, information obtained during an audit of a physician's accounts (e.g. review of records) or during a CFMA investigation may give cause for the ministry to refer the matter to the CPSO as required under Section 38(4) of the HIA.

4

CLAIMS SUBMISSION

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4. CLAIMS SUBMISSION

4.1 Overview

This section provides an overview of the claims submission process, including:

- method of submitting claims
- process to submit claims
- submission of claims
- reports
- reconciliation and payment
- inquiries

4.2 Method of Submitting Claims

All claims must be submitted through medical claims electronic data transfer (MC EDT) in accordance with Regulation 552, Section 38.3 of the *Health Insurance Act* (HIA).

Medical Claims Electronic Data Transfer (MC EDT)

The MC EDT is a secure web-enabled service that offers a:

- simple user interface (web page) with basic upload and download functions using an internet connection; and
- a web service for complete automation and integration with Electronic Medical Record (EMR)/Clinic Management System (CMS) software or billing software systems.

The web page is **not** intended for use with automated programs or scripts. The MC EDT web page is suitable for those with a low number of daily file uploads. File uploads and downloads are a manual process and cannot be scripted or integrated with a systems interface.

Users of the web service will require third party software/vendor to develop a fully automated system to submit and receive files. The MC EDT Technical Specifications for the web service is located on the ministry website at:

http://www.health.gov.on.ca/english/providers/pub/pub_menus/pub_ohip.html

Some of the key benefits of the MC EDT service include:

- Secure user authentication;
- Ability to designate access to administrative staff, third party agents or other health care providers, to act on your behalf for the submission and/or reconciliation of claim files;
- Additional electronic reports.

The MC EDT service is available 24 hours a day, seven days a week with the exception of weekly scheduled system maintenance on Sunday mornings between the hours of 1:00 am and 5:00 am and Wednesday mornings between the hours of 5:00 am to 8:00 am.

The MC EDT service currently supports the following file types:

- Medical Claims
- Stale Dated Claims
- Overnight Batch Eligibility Checking (OBEC)

For further information on MC EDT and how to register, refer to the MC EDT Reference Manual located at:

http://www.health.gov.on.ca/en/pro/publications/ohip/docs/mc_edt_reference_manual.pdf

4.3 Process to Submit Claims

Claim files must be submitted in a specific file format as outlined in the Technical Specifications-Interface to Health Care Systems manual.

You should contact a software vendor to determine the most appropriate hardware and billing software that would meet your needs based on your business practices and technical capabilities. All hardware and software must conform to the specifications as contained in the Technical Specifications-Interface to Health Care Systems manual.

4.4 Submission of Claims

There are three types of claims a physician will submit:

- Health (HCP)
- Workplace Safety Insurance Board (WSIB)
- Reciprocal Medical Billing (RMB)

HCP Claim

Health claims are claims for services rendered by physicians or private medical labs to a patient with Ontario health insurance coverage.

- Payment program “HCP”
- Payee - “P” for pay provider
- Payee - “S” for pay patient

Note: *Payee is dependent on whether you opted in or opted out when you registered.*

WSIB Claim

Workplace Safety and Insurance Board (WSIB) (formerly Workers' Compensation Board (WCB)) claims are for services rendered to patients with Ontario health insurance coverage who have work related injuries.

- Payment program is WCB
- Payee is "P" for pay provider
- If the patient is assessed for a non-WCB related problem during a WCB visit (minor assessment only), A008A (Mini Assessment) may be payable. Refer to the Schedule of Benefits, sections General Preamble and Consultations and Visits
- A008A cannot be billed on the same claim as the WCB service. It must be billed on a separate HCP claim. A008A can be billed only when the WSIB claim is for A001A
- If the physician bills any service on a WCB claim other than a minor or partial assessment, no other assessment can be submitted as an HCP claim.

Note: Other than the payment program, the information required to bill is the same as for HCP claims.

The following services are excluded from WCB submissions to the ministry:

- Service codes prefixed by "T" or "V"
- Lab services provided by private medical laboratory facilities
- Services provided by hospital diagnostic departments
- Services rendered to patients registered in other Canadian provincial plans
- Services rendered by out-of-province physicians
- Fee schedule codes: A008, K018, K021, K051, K053, K061, P004, P006
- Charges for completion of form, such as M640 (must be billed directly to WSIB)
- Services provided by OPTED-OUT health care providers

RMB Claim

Reciprocal Medical Billing claims are submitted to bill for services rendered by physicians to a patient insured under another Canadian provincial/territorial health coverage plan, **excluding Quebec**.

- Payment program - RMB
- Payee - P for pay provider

Note: *Except for the section on patient information all other areas are identical to those on the regular HCP claim*.

When treating an out-of-province (OOP) resident, view their health card. If there is an expiry date on the card and the card has expired, do not submit a reciprocal claim. In such a case, the patient is responsible for any charges. The physician must provide the patient with a detailed form/invoice of services and charges so the patient can seek reimbursement from their home province.

Patient Information

Province	Two letter code representing the province of the patient's registration
Registration Number	Assigned to the patient in his or her province of residence (may be up to 12 characters without any spaces or special characters)
Date of Birth	YYYYMMDD format (e.g., 19491225)
Patient's Surname	Up to 13 characters of the patient's last name
Payment Program	Must be RMB (if unable to change this field, physicians should contact their software provider for instructions)
Payee	Must be P for pay provider
Patient's First Name	Up to six characters of the patient's first name
Sex	1 (male) or 2 (female)

Participation in the Reciprocal Medical Billing System (RMBS) is voluntary; however, participation is recommended when an OOP resident presents a valid health card from their jurisdiction of residence. This ensures payment under the Ontario Schedule of Benefits for Physician Services rate.

Other options for payment include:

- Submitting a paper claim directly to the patient's home plan (e.g., QC); or
- Charging the patient directly (e.g., those with an expired health card)

Physicians who do not submit through the RMBS and who bill the patient's home ministry or who bill the patient directly can use the standard "Out of Province Claim for Physician Services" form (0000-80) available online at:

http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?openform&ENV=WWE&NO=014-0000-80

If payment is received directly from a patient, in addition to a detailed invoice of the services provided, (e.g., the form above or some other invoice listing the services and charges) please ensure the patient is provided with proof of payment; so that they can seek reimbursement from their home plan.

The following services are excluded from RMB and should be billed directly to the non-resident patient (or to the non-resident's home province/territory if prior approval has been granted by the home province/territory):

- Surgery for alteration of appearance (cosmetic surgery)
- Sex reassignment surgery
- Surgery for reversal of sterilization
- Routine periodic health examinations including routine eye examinations
- Lithotripsy for gall bladder stones
- Treatment of port wine stains on other than the face or neck, regardless of the mode of treatment
- Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
- Services to persons covered by other agencies (e.g., Armed Forces, Workplace Safety and Insurance Board, Department of Veterans' Affairs, Correctional Services of Canada [Federal penitentiaries])
- Services requested by a third party
- Team conference(s)
- Genetic screening and other genetic investigation, including DNA probes
- Procedures still in the experimental/developmental phase
- Anaesthetic services and surgical assistant services associated with all of the above
- Services required by the Ministry of Community and Social Services and the Ministry of Attorney General or the Solicitor General
- PET scans and Gamma Knife Radiosurgery
- Telemedicine services

Note: *The patient may be eligible for reimbursement by his or her own provincial/territorial plan*.

Coding Requirements

Fee Schedule Codes are located in the ministry Schedule of Benefits for Physician Services. In addition, the following information will assist with the submission of claims:

- Diagnostic Codes
- Services Requiring Diagnostic Codes

Cut-Off Date for Claims Submission

The ministry operates on a monthly processing cycle. Submissions received by the 18th of the month will typically be processed for approval the following month. When the 18th falls on a weekend or holiday, the deadline will be extended to the next business day.

MC EDT submissions received after the 18th may not be approved until the next monthly processing cycle (i.e. submissions received on Nov 18th will appear on the December RA, submissions received after Nov 18th may not appear until the January RA).

Claims must contain complete, valid and accurate information in order to be processed on time. Claims requiring internal review by ministry staff may have payment delayed

The ministry recommends daily or weekly submissions of claims to ensure timely adjudication of claims files and to aid in the subsequent reconciliation of rejected claims.

Resubmission of Unpaid Claims

In accordance with regulation under the *HIA*, all claims must be submitted within six months of the date of service. This includes original and resubmitted claims (i.e. corrected). Claims submitted more than six months following the date of service are termed "stale dated" claims.

Claims Requiring Documentation

The manual review indicator is a field in your medical claims billing software which allows you to inform the ministry that special attention such as supporting documentation is required to process a specific claim.

Supporting documentation should be electronically submitted to the ministry using **eSubmit** or faxed to your claims processing office when the claim is submitted:

http://www.health.gov.on.ca/en/pro/programs/ohip/claimsoffice/default.aspx

Supporting documentation may include documents such as an operative report/clinical notes, or a "Claims Flagged for Manual Review" form (2404-84). The reasons for submitting this form as supporting documentation are listed on the form. This form is not required if using eSubmit to supply supporting documentation to the ministry.

A "Request for Approval of Payment for Proposed Surgery" form (0691-84) is another supporting document; however, it is to be submitted to your claims processing office prior to the service being rendered.

The form is available at:

http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?openform&ENV=WWE&NO=014-0691-84

Special Notes about "Claims Flagged for Manual Review" form:

Do **not** use the "Claims Flagged for Manual Review" for

- Stale-dated claims
- Inquiries (overpayment, underpayment, non-payment)
- Procedures that require prior approval

- E409A/E410A, E400B/E400C and E401B/E401C

Use this form for:

- duplicate service code claimed for the same date, different time
- claim resubmitted with a requested operative report
- statement from operating surgeon substantiating 2 surgical assistants
- suppression of service verification
- specific services which you want to be manually reviewed by the ministry
- out-of-province referring provider information (e.g. name and address)
- statement from operating surgeon to substantiate claim for M400B assistant fee when no basic fee is listed
- anesthetic or assistant claims where total units exceed “99” – see Data Link (93-004) Divisional Communication, August 1993
- A “Request for Approval of Payment for Proposed Surgery” form (0691-84) is another supporting document; however, it is to be faxed to your claims processing office prior to the service being rendered. This form is available at:

http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?openform&%20ENV=WWE&NO=014-0691-84

4.5 Reports

The following reports are sent electronically from the ministry. Only reports applicable to your practice will be sent to you. All reports must be retrieved (downloaded) for review or appropriate action.

File Reject Message

A File Reject Message notifies you if the ministry has rejected an entire claims file. This report is usually sent within a few hours of the ministry receiving your claims submission.

Batch Edit Report

A Batch Edit Report notifies you of the acceptance or rejection of claims batches. This report is usually sent within 24 hours of the ministry receiving your claims submission. If claims are uploaded on a weekend, holiday or at month end, the Batch Edit Report is delivered on the next claims processing day.

Claims Error Report

Claims submitted may be rejected for a variety of error conditions. Each file submission processed by the ministry will generate an Error Report (if applicable), therefore, several error reports may be received throughout the month based on the frequency of claims submissions. Claims rejected to an Error Report are automatically deleted from the payment stream. Rejected claims must be corrected and resubmitted to be processed for payment.

A Claims Error Report provides a list of rejected claims and the appropriate error codes or error report message for each claim. Error codes may be reported at the header level of a claim and/or at the item level. Rejected claims may have more than one error code or error report message assigned (refer to section – Error Codes or Error Report Messages for further detailed explanation of the possible error codes).

The Error Code is a three-character alpha/numeric code. The first character is an alpha and denotes the type of reject as follows:

- V Validity Error (applies to HCP/WCB/RMB payment programs)
- A Assessment Error (applies to HCP/WCB/RMB payment programs)
- E Eligibility Error (applies to HCP/WCB/RMB payment programs)
- R Reciprocal Medical Billing (RMB) Specific Errors

A rejected claims item may be internally re-routed to the Error Report by the ministry and will include an error report message. The error report message is generated to provide more detailed information as to why the claim is being returned. Error report messages appear directly below the related claim item (refer to section – Error Report Messages).

Rejected claims shown on the Error Reports are returned during the processing month. The corrected information should be resubmitted immediately. If the resubmitted information is received prior to the 18th of the same month, the claim can be processed for payment in the same billing cycle. Claims must be resubmitted within six months of the date of service to avoid being rejected as a stale dated claim.

Claims Error Reports should be retained on file in your office to assist in monthly payment reconciliations. If claims are not approved for payment on your monthly Remittance Advice Report (RA), then check your Error Report for that month to determine if the claim was rejected and needs to be submitted again.

A Claims Error Report is usually sent within 48 hours of claims file submission. If claims are uploaded on a weekend, holiday or at month end, the Error Report is delivered on the next claims processing day.

Split Claims Error Report

The Split Error Report is only available to physicians affiliated with a primary care group.

This report summarizes an individual physician's rejected claims that were submitted under the group number. A list of rejected claims and the appropriate error codes for each claim will appear on the report (refer to section – Error Codes).

Remittance Advice Report (RA)

An RA is a monthly statement of approved claims. You will receive your RA between the 5th and 7th of the month following the successful submission and processing of your claims.

Your RA is issued before you receive your payment on the 15th business day of each month.

Group RA Split/Extract

The group RA Split/Extract is only available to individual physicians within a Family Health Network (FHN) for reconciliation of their own claims.

The FHN primary care groups operate over a wide area of separate physical locations and every physician in a FHN may have a different billing package and submit claims from individual locations. The RA Split/Extract contains a FHN physician's own claim details only.

OBEC Response File

OBEC is a Health Card Validation (HCV) method that enables health care professionals to verify the eligibility of a patient's health number/version code before a health service is provided. A formatted file of health numbers/version codes can be sent to the ministry for processing and eligibility is verified against the ministry's database based on the date the file is submitted.

OBEC files received by the ministry by 4:00 pm are processed overnight and the response file will be sent to your MC EDT account by 7:00 am the following morning.

Governance Reports

Governance Reports are only sent to groups that provide specialty services in a hospital or an academic health sciences centre within specific communities. The following reports are generated monthly and sent to the MC EDT account for the governance at time of registration with the ministry.

- Academic Health Science Centre (AHSC) Governance Reports
- Northern Specialist Alternate Payment Program Governance Reports

Primary Care Reports

The following enrolment/consent reports are only sent to primary care physicians.

Enrolment/Consent Outside Use Report

Outside Use is a core service that is provided to enrolled patients by any family physician who is not affiliated with the patient's primary care group. The report includes outside use details for each physician within a specific primary care group to assist in the calculation of their Access Bonus payment.

Enrolment/Consent Patient Summary Report

This report is a summary of patient enrolment activity to date. The report includes total number of members, breaks down total numbers into member status (e.g. assigned, enrolled, pre-members) and unconfirmed total.

4.6 Reconciliation and Payment

Your RA may contain codes that indicate when a service has been reduced or disallowed because of medical rules which control the payment of claims (refer to section – Explanatory Codes).

Inquiries on your RA should be submitted within four months from the date of the RA on which the claim appears.

Information updates will be transmitted via the message facility of the monthly RA. It is important that your reconciliation software allows you to read information displayed in the RA message facility. Please read all communications to ensure you are up-to-date on topics relevant to your practice. Copies of communications should be kept for reference.

4.7 Inquiries

- Inquiries regarding underpayments must be made within four months of the date of the RA on which the payment appears and should include information/documentation to support the inquiry/request.
- Inquiries can be submitted electronically to the ministry using eSubmit; or mailed/faxed to your claims processing office using a "Remittance Advice Inquiry" form (0918-84). This form is available online at:

http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?openform&ENV=WWE&NO=014-0918-84

- The ministry may determine that the decision is its final payment decision at any stage of the inquiry process.

  If the payment decision has **not** been identified as final, the physician may continue the inquiry process by providing new information or documentation in a timely manner to support the ministry's review of the claim(s). This may continue so long as there is meaningful dialogue between the physician and the ministry (i.e., new documentation/information is provided). A new RAI should **not** be submitted.

- Where a physician disagrees with the ministry's final payment decision, a hearing by the Physician Payment Review Board may be requested. This request must be made within 20 business days from the time the response is sent by the ministry or a payment decision letter from the ministry (whichever is later).
- For RAIs submissions using eSubmit, RA responses are available under the MC EDT service. Select the option to download reports. These documents are displayed with a File Type of "General Communication".

Note: *inquiries related to overpayments or correcting a claim (e.g., incorrect health number, service date, diagnostic code, service not provided) can be submitted using eSubmit or on an RAI form. These should be submitted within four months of the date of the RA; however they may still be considered after this time.*

4.8 Province/Territory Codes

PROVINCE/TERRITORY	PROVINCE CODE	FORMAT
ALBERTA • Prior to June 1/94, 11 numerics	AB	9 numerics - individual registration (effective June 1/94)
BRITISH COLUMBIA	BC	10 numerics - individual registration (effective Jan. 1/91)
MANITOBA • Prior to Apr 1/05, 6 numerics	MB	9 numerics – individual registration (effective Apr. 1/05)
NEWFOUNDLAND/LABRADOR	NL	12 numerics - individual registration
NEW BRUNSWICK	NB	9 numerics - individual registration
NORTHWEST TERRITORIES	NT	8 characters - individual registration One alpha (N, D, M or T and 7 numerics)
NOVA SCOTIA • Prior to Jan. 1/94, 11 numerics (Family Based)	NS	10 numerics - individual registration (effective Jan. 1/94)
PRINCE EDWARD ISLAND	PE	8 numerics (SIN) - individual registration
SASKATCHEWAN SK	SK	9 numerics - individual registration (effective April 1/91)
TERRITORY OF NUNAVUT	NU	9 numerics - individual registration (effective April 1/99)
YUKON	YT	9 numerics - individual registration

4.9 Error Codes

Error Code – Description(s) – "A" Codes

A1A Outside Service Period

A2A Patient is underage or overage for this service code

A2B This service is not normally performed for this sex. Please check your records.

A3E No such service code for date of service

A3F No fee exists for this service code on this date of service

A3G Fee Billed Low – Check

A3L Other New Pt Fee Already Pd

A34 Multiple duplicate claims

A4D Invalid specialty for this service code

AC1 Maximum reached – resubmit alternate fsc

AC4 A valid referring/requisitioning health care provider number must be present for this service code.

Referring number is 722900-744292 (Nurse Practitioner) and

FSC are not any of the five following:

- Laboratory Services (L***)
- Cardiology codes G310, G313, G700
- Physiotherapy Code
- Xray - X codes
- Ultra Sound Codes - J code

AD9 Premium not allowed alone

ADF Corresponding Procedure Invalid, Omitted or Paid at zero

AH8 Hospital and/or Admission date is missing or invalid. - Invalid Adm Dte/Hosp No

AHF Concurrent or Supportive Care Same Period

AM1 Service Limit Exceeded

AMR Minimum service requirements have not been met

ARF Missing Physician Referring Number

ARP Referring Physician # Required

ASP Not Allowed With Surgical Procedure

Error Code – Description(s) – "C" and "D" Codes

CNA Counselling Not Allowed

Error Code – Description(s) – "E" Codes

EF1 IHF number not approved for billing on the date specified
EF2 IHF not licensed or grandfathered to bill FSC on the date specified
EF3 Insured services are excluded from IHF billings
EF4 Provider is not approved to bill IHF fee on date specified
EF5 IHF practitioner 991000 is not allowed to bill insured services
EF7 Referring physician number is required for the IHF fee billed
EF8 'I' service codes are exclusive to IHFs
EF9 Mobile site number required
EG1 Group not Eligible
EH1 Srv. Date <Elig. Eff. Date
EH2 Mismatched Version Code
EH4 Srv. Date > Elig. End Date
EH5 Srv. Dt. Not in Elig. Period
EH6 Eligibility Terminated – Deceased
EH9 HN Not Activated
ENP Invalid FSC for NP
EPA Network billing not approved
EPC Patient not rostered/rostered to another Network
EPF Enrlmt Date Mismatch
EPP Incorrect Code for Eligibility (Ontario Works/Ontario Disability Support Program)
EPS Patient Not Elig for Prog
EP1 Enrlmt Trans Not Allowed
EP2 Not for Enrol/Re Enrol
EP3 Check Srv Dte / Enrol Dte
EP4 Enrolmnt Restriction
EP5 Incorrect FSC for Grp Typ
EP6 HN Not Activated
EQ1 Practitioner not registered with OHIP - Clinic/Dr Not on File

EQ2 Specialty code is inactive or not registered on date of service

EQ3 Health care provider is registered as OPTED-IN for date of service – claim submitted as Pay Patient

EQ4 Health care provider is registered as OPTED-OUT for date of service – claim submitted as Pay Provider

EQ5 Lab inactive for service date

EQ6 Referring/requisitioning health care provider number is not registered with the Ministry of Health

EQ9 Lab No. not on File

EQB Solo health care provider number is not actively registered with the Ministry of Health on this date of service

Practitioner number is Midwife (700000 - 722899) referral only

Claims submitted by Chiropractors using their CSN

EQC Group number is not registered with the Ministry of Health.

EQD Group number is not actively registered with the Ministry of Health on this date of service

EQE Health care provider is not registered with the Ministry of Health as an affiliate of this group on date of service

EQF Health care provider is not actively registered with the Ministry of Health as an affiliate of this group on date of service

EQG Referring laboratory is not registered with the Ministry of Health

EQJ New Graduate bills New Patient fee (q013) or Physician (not a new graduate) bills new Graduate – New Patient fee (Q033) - Pract. Not Elig. On S/D

EQK A100 billed with a specialty code other than 00. - MNI Does not Meet Criteria

EQL A100 billed with a speciality code other than 00 or billed by provider with any EDAFA group number. - Phy Not Eligible to Claim

EQM Not Registered for Use

EQN Reg Usage Err on S/D

EQP Enrolment Type Not Eligible

EQS Provider does not have a sub-specialty of PSY. - Pract Criteria Not Met

ERF Referring physician number is currently ineligible for referrals

ESD APP group affiliation on service date

ESF A non-encounter service claim submitted by a physician not eligible to bill FSC

ESH If a claim is submitted by a Mental Health Sessional Group for a code other than K400A, reject the claim to the error report. - Not Elig. For Blank HN

ESN If health number is on the claim for K400A- No HN required for FSC. Invalid Blank HN Claim

ET1 The telemedicine billing is submitted by a physician who is not registered as a Telemedicine physician. - Not Reg for Telemedicine

ET4 The telemedicine billing does not include a telemedicine premium code (B100, B101, B102, B200, B201, B202) - Telemed Fee code missing

ET5 The telemedicine billing is submitted with a telemedicine premium/tracking code but the SLI code is not 'OTN' or is not present. - Telemed SLI Missing/Invld

Error Code – Description(s) – "H" and "P" Codes

HCC Not on Health Care Connect (HCC) database - Not Eligible

On HCC database but not Complex-Vulnerable

On HCC database but not in 'referred to' status

HCE Patient enrolled to billing physician but later than 3 months from the "referred to" date on Health Care Connect database - Enrolment after 3 Months

PAA To ensure the smoking cessation initial discussion fee (E079) has been paid within 365 days prior to the smoking cessation counseling fee (Q042) or the smoking cessation follow up fee (K039) - No Initial Fee Prev. Pd.

PA1 Physician Assistant (PA) Pilot claim submissions may contain one or more PA Tracking FSC's but other OHIP insured service FSCs are not allowed on the same claim. - Invalid PA Srv

PA2 Physician Assistant Pilot (PA) claim submissions with the PA as the submitting physician must identify the solo billing number of the supervising physician in the "Refer Physician" field. - Invalid PA Claim

PA3 The physician and/or referring physician fields on the PA Pilot claim submission contain billing numbers which are not affiliated to the PA Pilot group number. Not registered for PA

PA4 PA Registrn on S/D Err

PA5 PA Affiliation Error

PA6 PA Affil'n on S/D Err

Error Code – Description(s) – "R" and "T" Codes

R01 Missing HSN

R02 Invalid HSN

R03 Invalid/Missing Province Code

R04 Service Excluded from RMBS

R05 Provincial code is 'ON' (Ontario) which is not valid for RMBS

R06 Wrong Provider for RMBS

R07 Invalid Pay Type for RMBS

R08 Invalid Referral Number

R09 Claim Header 2 Missing - RMB

TM1 Dup Telemed Claim, Same patient (uninsured)

TM2 Can't Bill with MSD/CNC AP

TM3 Service not Telemedicine Payable

TM4 Non Telemed Claim paid for same patient

TM5 Telemed Claim Paid for same patient

TM6 Registration not in effect on Service Date

TM7 Dental Service not eligible for Telemedicine

TM8 Not eligible for Store FD

Error Code – Description(s) – "V" Codes

V02 Invalid Region Code

V05 Error - Clm No/Serv Date

V06 Incorrect Clinic Code

V07 Invalid Pract. Number

V08 Invalid Specialty Code

- Specialty code is missing/not 2 numerics
- Not a valid specialty code
- Specialty code is 27 and provider number is not 599993
- Specialty code is 90 and provider number is not 991000
- Specialty code is 49, 50, 51, 52, 53, 54, 55, 70 and 71 and the health care provider number does not begin with 4
- Specialty code is 56 and health care provider number does not begin with 80 or 81
- Specialty code is 57 and health care provider number does not begin with 86 or 839985
- Specialty code is 58 and health care provider number does not begin with 87
- Specialty code is 59 and health care provider number does not begin with 88 or 89 or not in range 830000 – 839984
- Specialty code is 80 or 81 and health care provider number does not begin with 82

V09 Invalid Referral Number

V10 Patient's last name is missing/not alphabetic (A - Z)

First field position is blank

RMB claim only

V12 Patient's first name is missing/not alphabetic (A - Z)

First field position is blank

RMB claim only

V13 Patient's date of birth is missing/invalid format

Month not in the range of 01 – 12

Not 8 numerics (new MRI format)

Day is outside acceptable range for month

V14 Patient sex must be '1' (male) or '2' (female)

RMB claim only

V16 Unacceptable Diagnostic Code

Not numeric

Health care provider number is 82XXXX and diagnostic code is not 4 numerics or is 3 numerics and not 070, 072, 880 or 971

Fee schedule code is G423, G424 and diagnostic code is not 360, 371 or 376

V17 Payee must be 'P' (Provider) or 'S' (Patient)

V18 In-patient admission date is not 8 numerics

Month of admission is not in the range of 01 - 12

Day of admission is outside the acceptable range for month

In-patient admission date is later than Ministry of Health system run date

V19 Invalid Chrio Diagnostic Code

V20 Service code is A007, patient is over 2 years old and diagnostic code is '916' or service code is A003 and the patient is under 16 years old and the diagnostic code is '917'

V21 Diagnostic Code Required

V22 Invalid Diagnostic Code

V23 Check No. Of Services

V28 Invalid Hospital Number

V29 Invalid In-Out-Pat-Ind

V30 FSC/DX Code Combination NAB

V31 Missing any of the following: group number, health care provider number, specialty code

V34 Service code begins with ‘V1’ and health care provider number does not begin with 88 or 89, or in range 830000 - 839984 (and the reverse of this condition)

Service code begins with ‘V2’ and health care provider number does not begin with 86 or is 839985 (and the reverse of this condition)

Service code begins with ‘V3’ and health care provider number does not begin with 87 (and the reverse of this condition)

Service code begins with ‘V4’ and health care provider number does not begin with 80, 81, 84 or 85 (and the reverse of this condition)

Service code begins with ‘V8’ and health care provider number does not begin with 82 (and the reverse of this condition)

Service code begins with ‘T’ and health care provider number does not begin with 4, excluding fee schedule codes J99-- (and the reverse of this condition)

Service code begins with ‘H4’ and health number is not a sessional reference number

V35 Invalid OOP/OOC Service

V36 Check input criteria required for sessional billing

V39 Number of items exceeds the maximum (99)

V40 Service code is missing

Service code is not in the format ANNNA where:

A is alphabetic (A - Z)

NNN is numeric (001 - 999)

A is alphabetic (A - C)

V41 Fee submitted is missing/not 6 numerics

Fee submitted is not in the range ‘000000’ - ‘500000’ ($$$$cc)

V42 Number of services is missing/not 2 numerics

Number of services is not in the range ‘01 - 99’

V47 Fee submitted is not evenly divisible (to the cent) by the number of services

V50 Service Date Pre Initial Visit

V51 Invalid location code - must be blank or four numerics. If present, must be valid based on MOHLTC Residency Code Manual

V53 Invalid FSC-Magnetic Tape/Disk

V62 Invalid service location indicator – assigned when a Service Location Indicator (SLI) code included with a hospital diagnostic service billing from a participating

hospital physician/group is not of the five valid SLI codes (HDS, HED, HIP, HOP or HRP)

V63 Referring Laboratory Number must start with 5 (5###)

V64 Missing service location indicator – assigned when a hospital diagnostic service is billed by a participating hospital physician/group but a service location indicator code was not included

V65 Missing master number – assigned when SLI code HDS, HED, HIP, HOP or HRP is included with a diagnostic service billing from a participating hospital physician/group but a master number was not included

V66 Missing admission date – assigned when SLI code HIP is included with a diagnostic service billing from a participating hospital physician/group but an admission date was not included

V67 Missing master number and admission date – assigned when a SLI code HIP is included with a diagnostic service billing from a participating hospital/group but a master number and admission date were both not included

V68 Incorrect service location indicator – assigned when a diagnostic service is billed from a participating hospital physician/group with a master number and admission date but the SLI code is not HIP

V69 Serv Dte Invalid for SLI

V70 Date of service is greater than the file/batch creation date

V71 Invalid Dental Master No.

V98 Wrong Preventive Care Date of Service

Error Code – Description(s) – Other "V" Codes

VHB No HN Req'd for FSC

VH0 Header 2 and HN Present

VH1 Health Number is Invalid

VH2 HN is Missing

VH3 Invalid Payment Program

VH4 Invalid Version Code

VH5 OHIP # Required for Service Date

VH6 Mixed Service Dates

VH7 HN and OHIP # on Same Claim

VH8 No Match on DOB with HN

VH9 HN Not Reg'd with MOH

VJ5	Date of Service is missing/not 8 numerics
	Month is not in the range 01 - 12
	Day is outside acceptable range for month
	Date of Service is greater than Ministry of Health system run date
VJ7	Stale-dated Claim
VJ8	Stale-dated Claim Encounter
VS1	Invalid SEAMO Prvdr Code
VS2	Invalid Venue Type
VS3	Invalid Clinic Number
VS4	Invalid Healthcare Item
VS5	Invalid IP/OP Indicator
VS6	Invalid HC Item Cde Fmt
VW1	Invalid WCB Service

4.10 Error Report Messages

Error Report Message – Description(s) – Numeric Codes

02 Incorrect District code 0 Correct & resubmit

03 Date of service does not match OP report - correct & resubmit

04 Special Visit premium payable only when submitting with FSC from the general listings

05 No receipt of supporting documentation requested by MOH

09 Fee Schedule Code(s) used is not correct. Please resubmit using appropriate code(s) from OHIP Schedule of Benefits

10 Resubmit as RMB Claim

11 Bill Patient or Quebec Medicare

12 Please advise Patient to contact MOH re eligibility /card status/address

13 Service date is prior to newborn's date of birth

14 Fee billed low – check for current SOB fee

15 No. of Services exceed Maximum allowed

16 Cannot be claimed alone/service date mismatch

17 E409/E410 N/A – Resubmit with appropriate assist/anaesthetic premium codes

18 Resubmit with man review indicator and provide supporting documentation for two assistants

19 Resubmit with manual review indicator and forward copy of OP Report

20 Resubmit with manual review documentation i.e. consultation report/Hospital Records

21 Records indicate patient deceased/ Please clarify or confirm.

22 Code submitted requires prior approval

23 Hospital visits claimed by more than one physician – please clarify role in patient's care

24 Claims appearing on previous RA's as Over/Under Payments should not be resubmitted; please use inquiry form for payment adjustment requests.

25 Incomplete newborn registration – have parent/guardian contact MOH

26 One house call assessment (A901) allowed per visit. Please resubmit claim with appropriate service code

27 This duplication submission is being returned; Original submission currently on file pending medical consultant adjudication

28 Resubmit with manual review indicator with written explanation for detention. Total time spent with patient including consultation/assessment indicated.

29 Discrepancy between claim and documentation. Resubmit claim and documentation.

4.11 Explanatory Codes

Explanatory Code – Description(s) – Numeric Codes

30 Service is not a benefit of OHIP

31 Not a valid network service

32 OHIP records show service(s) on this day claimed previously

35 OHIP records show this service rendered has been claimed previously (used on Pay Practitioner duplicate claims)

36 OHIP records show service has been rendered by another Practitioner, Group, Lab

37 Effective April 1, 1993 the listed benefit for this code is 0 LMS units

40 Service or related service allowed only once for same patient

41 FSC Billed – No Evidence In Supporting Documentation Provided

42 FSC Billed Included in Other Procedure

45 Specialty code restriction on FSC

46 Paid Per 2nd Review By MA

47 Not Paid Per 2nd Review By MA

48 Paid as submitted - clinical records may be requested for verification purposes

49 Paid according to the average fee for this service. Independent consideration will be given if clinical records/operative reports presented.

50 Paid in accordance with the Schedule of Benefits

51 Fee Schedule Code changed in accordance with Schedule of Benefits

52 Fee-for-service assessed by medical consultant

53 Fee allowed according to appropriate item in a previous Schedule of Benefits

54 Interim payment - claim under review

55 Deduction is an adjustment on an earlier account

56 Claim under review

57 This payment is an adjustment on an earlier account

58 Claimed by another physician within group

59 Practitioner's notification - WCB claims

60 Not a benefit of the Reciprocal Medical Billing Agreement

62 Claim assessed by Assessment Officer

66 Reduced per APP Funding Contract

69 Elective Services Paid At 75% Of OHIP Schedule of Rates

70 OHIP records show corresponding procedure(s) on this day claimed previously by another physician

80 Technical fee adjustment for hospitals

Explanatory Code – Description(s) – "C" and "D" Codes

AP	This payment is in accordance with legislation. If you disagree with the payment, you may appeal to the General Manager
C1	Allowed as repeat/limited consultation/midwife-requested emergency assessment
C2	Allowed at re-assessment fee
C3	Allowed at minor assessment fee
C4	Consultation not allowed with this service - paid as assessment
C5	Allowed as multiple systems assessment
C6	Allowed as Type 2 admission assessment
C7	An admission assessment (C003A) or general re-assessment (C004A) may not be claimed by any physician within 30 days following a pre-dental/pre-operative assessment
C8	Payment reduced to geriatric consultation fee – maximum number of comprehensive geriatric consultations has been reached
C9	Allowed as in-patient interim admission orders – initial assessment already claimed by other physician
D1	Allowed as repeat procedure - initial procedure previously claimed
D2	Additional procedures allowed at 50%
D3	Not allowed in addition to visit fee
D4	Procedure allowed at 50% with visit
D5	Procedure already allowed - visit fee adjusted
D6	Limit of payment for this procedure reached
D7	Not allowed in addition to other procedure
D8	Allowed with specific procedures only
D9	Not allowed to a hospital department
DA	Maximum for this procedure reached - paid as repeat/chronic procedure
DB	Other dialysis procedure already paid
DC	Procedure paid previously not allowed in addition to this procedure – fee adjusted to pay the difference
DD	Not allowed as diagnostic code is unrelated to original eye exam
DE	Lab tests already paid - visit fee adjusted
DF	Corresponding fee code was not billed or paid at zero
DG	Diagnostic/Miscellaneous services for hospital patients are not payable on a fee-for-service basis in the Hospital Global budget.

DH	Ventilatory support allowed with Haemodialysis
DL	Allowed as laboratory tests in private office
DM	Paid/disallowed in accordance with MOH policy regarding an Emergency Department Equivalent
DN	Allowed as pudenal block in addition to procedure - as per stated OHIP policy
DP	Procedure paid previously allowed at 50% in addition to this procedure - fee adjusted to pay the difference
DR	Self-Referred Diagnostic Services Payable at 50%
DS	Not allowed – mutually exclusive code billed
DT	In-patient technical fee not allowed
DV	Service is included in Monthly Management Fee for LTC patients
DX	Diagnostic code not eligible with FSC

Explanatory Code – Description(s) – "E", "F" and "G" Codes

E1	Service date prior to start of eligibility
E2	Incorrect version code for service date
E3	Version Code not on File for HN
E4	Service date after the eligibility termination date
E5	Service date not within an eligible period
E6	Service Date after Eligibility End Date – Eligibility Terminated as MOH Records Indicate Patient Deceased
E9	Service Date after Eligibiliy End Date – Eligibility Terminated Due to no Response to Notice to Register
EA	Service date is not within an eligible period - services provided on or after the 20th of this month will not be paid unless eligibility status changes
EB	Coding added/changed in accordance with Schedule of Benefits
EE	Assessment Allowed at Full Fee For Patient Proceeding to Hospital
EF	Incorrect version code - services provided on or after the 20th of this month will not be paid unless the current version code is provided
EV	Check health card for current version code
F1	Additional fractures/dislocations allowed at 85%
F2	Allowed in accordance with transferred care
F3	Previous attempted reductions (open or closed) allowed at 85%
F5	Two weeks aftercare included in fracture fee

F6	Allowed as Minor/Partial Assessment
FF	Additional payment for the claim shown
G1	Other critical/comprehensive care already paid
GF	Coverage lapsed - bill patient for future claims

Explanatory Code – Description(s) – "H", "I" and "J" Codes

H1	Admission assessment or ER assessment already paid
H2	Allowed as subsequent visit - initial visit previously claimed
H3	Maximum fee allowed per week after 5th week
H4	Maximum fee allowed per week after 6th week to pediatricians
H5	Maximum fee allowed per month after the 13th week
H6	Allowed as supportive or concurrent care
H7	Allowed as chronic care
H8	Hospital number and/or admission date required for in-hospital service
H9	Concurrent care already claimed by another doctor
HA	Admission assessment claimed by another physician - hospital visit fee applied
HB	Subsequent Visit Already Paid Same Day
HF	Concurrent or supportive care already claimed in period
HM	Invalid master number used on date of service
I2	Service is globally funded
I3	FSC is not on the IHF licence profile for the date specified
I4	Records show service has been rendered by another Practitioner, Group or IHF
I5	Service is globally funded and FSC is not on IHF licence profile
I6	Premium not applicable
I7	Claim date does not match patient enrolment date
I8	Confirmation not received
I9	Payment not applicable/expired
J1	Service Date is Before the Effective Date of OHIP Coverage
J2	Service Date is After the Termination of Coverage Date
J3	Approved for stale dated processing
J5	Coverage Applied For; Premiums Not Yet Paid
J7	Claim submitted six months after service date

J8 Coverage Not In Effect; Services Provided On Or After The 20th Of This Month Will Not Be Paid Unless Subscriber Takes Corrective Action

J9 Coverage Reinstated. Submit Claims Routinely

Explanatory Code – Description(s) – "L" and "M" Codes

L1 This service paid to another laboratory

L2 Not allowed to medical Laboratory Director

L3 Not allowed in addition to other laboratory procedure(s)

L4 Not allowed to attending physicians

L5 Not allowed in addition to other procedure paid to another laboratory

L6 Procedure paid previously to another laboratory, not allowed in addition this procedure - fee adjusted to pay the difference

L7 Not allowed - referred specimen

L8 Not to be claimed with prenatal/fetal assessment

L9 Laboratory services for hospital in-patients or out-patients are not payable on a fee-for-service basis - included in the hospital global budget

LA Lab service is funded by special Lab Agreement

LS Paid in accordance to special Lab Agreement

M1 Maximum fee allowed or maximum number of service has been reached same/any provider

M2 Maximum allowance for radiographic examination(s) by one or more practitioners

M3 Maximum fee allowed for prenatal care

M4 Maximum fee allowed for these services by one or more practitioners has been reached

M5 Monthly maximum has been reached

M6 Maximum fee allowed for special visit premium - additional patient seen

MA Maximum number of sessions has been reached

MC Maximum number of case conferences has been reached in a 12 month period

MD Daily maximum has been exceeded

MN Maximum number of occipital nerve block sessions has been reached

MR Minimum service requirements have not been met

MS Maximum allowed for sleep studies in a specific period by one or more physicians has been reached

MX Maximum of 2 arthroscopy "R" codes with E595 has been reached

MU Maximum Units Exceeded

MW Maximum Number of Weeks has elapsed since payment of initial service

MY Yearly maximum has been exceeded

Explanatory Code – Description(s) – "O", "P" "Q" and "R" Codes

O1 Fee for obstetric care apportioned

O2 Previous prenatal care already claimed

O3 Previous prenatal care already claimed by another doctor

O4 Office visits relating to pregnancy and claimed prior to delivery included in obstetric fee

O5 Not allowed in addition to delivery

O6 Medical induction/stimulation of labour allowed once per pregnancy

O7 Allowed as subsequent prenatal visit - initial prenatal visit already claimed

O8 Allowed once per pregnancy

O9 Not allowed in addition to post-natal care

P2 Maximum fee allowed for low birth weight care

P3 Maximum fee allowed for newborn care

P4 Fee for newborn care/low birth weight care is not billable with neonatal intensive care

P5 Over-age for paediatric rates of payment

P6 Over-age for well-baby care

P8 HCC GT 3 months

P9 Complex New patient

PM Minimum roster size not met

Q7 No fee allowed for treatment of immediate family

Q8 Lab not licensed to perform this test on date of service

R1 Only one health exam allowed in a twelve-month period

R2 10 Well Baby Visits Allowed Up To Two Years Of Age

R3 One Well Child Exam (Age 2-5 Years) Allowed Within A12 Month Period

RD Duplicate, paid in RMBS

Explanatory Code – Description(s) – "S" and "T" Codes

S1 Bilateral surgery, one stage, allowed at 85% higher than unilateral

S2	Bilateral surgery, two stage, allowed at 85% higher than unilateral
S3	Second surgical procedure allowed at 85%
S4	Procedure fee reduced when paid with related surgery or anaesthetic
S5	Not allowed in addition to major surgical fee
S6	Allowed as subsequent procedure - initial procedure previously claimed
S7	Normal pre-operative and post-operative care included in surgical fee
S9	Initial Procedure Not Found
SA	Surgical procedure allowed at consultation fee
SB	Normal pre-operative visit included in surgical fee - visit fee previously paid - surgical fee adjusted
SC	Not allowed, major pre-operative visit already claimed
SD	Not allowed, Team/Assist Fee already claimed
SE	Major pre-operative visit previously paid and admission assessment previously paid - surgery fee reduced by the admission assessment
SF	Most Responsible Physician visit not allowed during post-operative period – surgical fee adjusted
SV	MRP visit not allowed during post-operative period – fee reduced to subsequent visit fee
SX	ICU Per Diem code Paid To Another Physician, MRP Premium Not Allowed
T1	Fee allowed according to surgery claim

Explanatory Code – Description(s) – "V", "W" and "X" Codes

V1	Allowed as repeat assessment - initial assessment previously claimed
V2	Allowed as extra patient seen in the home
V3	Not allowed in addition to procedural fee
V4	Date of service was not a Saturday, Sunday or statutory holiday
V5	Only one OVA allowed within a 12-month period for age 19 and under, or 65 and over - and one within 24 months for age 20 - 64
V6	Allowed as minor assessment - initial assessment already claimed
V7	Allowed at medical/specific re-assessment fee
V8	This service paid at lower fee as per stated OHIP policy
V9	Only one initial office visit allowed within a twelve-month period
VA	Procedure fee reduced - consultation/visit fees not allowed in addition
VB	Additional OVA is allowed once within the second year for patients aged 20-64, following a periodic OVA
VC	Procedure Paid Previously Not Allowed In Addition To Visit Fee. Fee Adjusted To Pay The Difference
VG	Only one geriatric general assessment premium per patient per 12-month period
VM	Oculo-visual minor assessment is allowed within 12 consecutive months following a major eye exam
VP	Allowed with special visit only
VS	Date of service was a Saturday, Sunday or statutory holiday
VX	Complexity premium not applicable to visit fee
W4	Warning: - service location indicator code missing
X2	G.I. tract includes cine and video tape
X3	G.I. tract includes survey film of abdomen
X4	Only one BMD allowed within a 36 month period for a low risk patient
X5	Only one BMD allowed within a 12 month period for a high risk patient
X6	Only one BMD allowed within a 60 month period for a low risk patient

4.12 Specialty Codes

This is a list of specialties or disciplines recognized by the Royal College of Physicians and Surgeons of Canada relevant to services covered by the Ministry of Health and Long-Term Care.

Specialty Code - Physician – Specialty or Discipline

00	Family Practice and Practice in General
01	Anaesthesia
02	Dermatology
03	General Surgery
04	Neurosurgery
05	Community Medicine
06	Orthopaedic Surgery
07	Geriatrics
08	Plastic Surgery
09	Cardiovascular and Thoracic Surgery
12	Emergency Medicine
13	Internal Medicine
15	Endocrinology
16	Nephrology
17	Vascular Surgery
18	Neurology
19	Psychiatry
20	Obstetrics and Gynaecology
22	Genetics
23	Ophthalmology
24	Otolaryngolgy
26	Paediatrics
27	Non-Physician Lab Director
28	Laboratory Medicine
29	Microbiology
30	Clinical Biochemistry
31	Physical Medicine

33	Diagnostic Radiology
34	Therapeutic Radiology
35	Urology
41	Gastroenterology
44	Medical Oncology
46	Infectious Disease
47	Respiratory Disease
48	Rheumatology
56	Optometrists
58	Chiropodists
60	Cardiology
61	Haematology
62	Clinical Immunology
63	Nuclear Medicine
64	Thoracic Surgery
70	Oral Radiology
71	Prosthodontics
85	Alternate Health Professionals
86	Generic Referral
99	RMBS OOP/OOC

Specialty Code - Dental – Specialty or Discipline

49	Dental Surgery
50	Oral Surgery
51	Orthodontics
52	Paedodontics
53	Periodontics
54	Oral Pathology
55	Endodontics

Specialty Code - Practitioner – Specialty or Discipline

56	Optometry
58	Chiropody (Podiatry)
80	Private Physiotherapy Facility (Approved to Provide Home Treatment Only)
81	Private Physiotherapy Facility (Approved to Provide Office/Home Treatment)

Specialty Code - Other – Specialty or Discipline

27	Non-medical Laboratory Director (Provider Number Must Be 599993)
75	Midwife (Referral Only)
76	Nurse Practitioner
85	Alternate Health Care Profession
90	IHF Non-Medical Practitioner (Provider Number Must Be 991000)

4.13 Diagnostic Codes

Diagnosis (Starts with "A") – Description(s) – Code

Abdominal	Pain, Masses	787
	Adhesions	560
Abortion	Advice	895
	Complete, Incomplete	634
	Missed	632
	Therapeutic	635
	Threatened	640
Abrasions		919
Abruptio Placenta		641
Abscess	Anal or Rectal Regions	566
	Bartholin's Gland	616
	Brain	349
	Breast	611
	Dental	525
	Fallopian Tube, Ovary or Tubo-ovarian	614
	Pilonidal Tissue, Other	682
	Skin and Subcutaneous	685
	Urinary System	590
Acariasis		133
Acne		706
	Rosacea	695
	Vulgaris	706
Acromegaly		253
Actinomycotic Infection		039
Addison's Disease		255
Adenitis Cervical		289
Adentis - see Lymphadenitis		
Acute		683
Adenoids, Chronic Infection		474

Adenoma Parathyroid		259
Adjustment Reaction		309
Adrenogenital Syndrome		255
Adverse Effects	Of Drugs and Medications, including allergy, overdose, reactions	977
	Or Other Chemicals (e.g., lead pesticides and venomous bites)	989
	Of Surgical And Medical Care (e.g., wound infection, wound disruption, other iatrogenic disease)	994
	Of Physical Factors (e.g., heat, cold, frostbite, pressure)	998
Agammaglobulinemia		279
Aged Parent Problem		900
Agranulocytosis		288
A.I.D.S.	Acquired Immune Deficiency Syndrome	042
A.I.D.S. (A.R.C.)	Acquired Immune Deficiency Syndrome Related Complex	043
Alcoholic Psychosis		291
Alcoholism		303
Allergy	Bronchitis	493
	Drugs and Medication	977
	Rhinitis	477
Alopecia		704
Alveolitis, Oral Cavity		525
Alveolitis, Lung		518
Amblyopia		368
Amoebiasis		006
Amenorrhea		626
Amino-acid – Acid Metabolism Disorder		270
Amputation, Traumatic	Lower Limb(s)	894
	Upper Limb(s)	884
Anal	Fissure, Fistula	565
	Stricture	569
Anaphylaxis		995

Anemia	Aplastic	284
	Hemolytic, acquired excluding hemolytic disease of newborn	283
	Hemoytic, Hereditary	282
	Iron Deficiency	280
	Pernicious	281
	Sickle Cell	282
	Other Anemias	285
Aneurysm, Aortic (non-syphilitic)		441
Aneurysm, Others		447
Angina, Ludwig's		529
Angina Pectoris		413
Angina, Vincent's		136
Ankylosing Spondylitis		720
Ankylosis, Joint		718
Annual Health Examination: Adolescent/Adult		917
Anorexia		787
Anorexia Nervosa		307
Anuria		788
Anxiety Neurosis		300
Aphakia		360
Appendicitis, Acute	With or without abscess or peritonitis	540
Arrythmias, Cardiac, Other		427
Arteriosclerosis	Cerebral with psychoses	298
	Generalized	440
Arteriosclerotic Cerebrovascular Disease, Chronic		437
Arteriosclerotic Heart Disease (A.S.H.D.) Without Symptoms		412
Arteritis, Temporal		446
Arthralgia		781
Arthritis	Osteo	715
	Pygenic	711
	Rheumatoid	714

Traumatic 716
Arthrogryposis (Contracture of Joint) 728
Asbestosis 501
Ascites 787
Asphyxia 799
Asthma 493
Astigmatism 367
Astroblastoma 191
Astrocytoma 191
Ataxia 780
Atelectasis 518
Atherosclerosis 440
Athlete's Foot 110
Atrial Fibrillation, Flutter 427
Autism 299
Automated Visual Field AVF test 918

Diagnosis (Starts with "B") – Description(s) – Code

Baker's Cyst 727
Basal Cell Carcinoma 173
Battered Child 899
Bed Sore 707
Bee Sting 989
Behavior Disorders of Childhood and Adolescence 313
Bell's Palsy 351
Bends 994
Benign Prostatic Hypertrophy (B.P.H.) 600
Birth Trauma 767
Bites, Non-venomous 919
Bites, Venomous 989
Bleeding Post-menopausal 627
Rectal 569

Blepharitis		373
Blindness		369
Blood Poisoning		038
Boil		680
Botulism		136
Bradycardia		427
Branchial Cyst		744
Bronchiectasis		494
Bronchitis	Acute	466
	Allergic	493
	Chronic	491
Brucellosis		023
Bruises		919
Buerger's Disease		443
Bullet Wound	If open wound use code for appropriate area – see Open Wounds	
	If internal injury use	869
Bunion		727
Burns	Thermal or Chemical	949
Bursitis		727

Diagnosis (Starts with "C") – Description(s) – Code

Calculus (Stone)	Bile Duct	576
	Bladder	592
	Kidney	592
	Lacrimal Duct	368
	Liver	573
	Prostate	592
	Salivary Glands	527
	Ureter	592
Calluses		700
Candidiasis		112
Canker Sore		528

Carbuncle 680
Cardiac Arrest 427
Cardiospasm 530
Carpal Tunnel Syndrone 739
Cartilage Tear 718
Cataract Congenita 744
Excluding Diabetic or Congenital 366
Carcinoma In Situ Breast 233
Digestive Organs 230
Genito-urinary System 233
Skin 232
Respiratory System 231
Other 234
Celiac Disease 579
Cellulitis 682
Cephalgia 780
Cephalo-pelvic Disproportion 653
Cerebral Degenerations, Other 331
Cerebral Haemorrhage 432
Cerebral Ischaemia, Transient 435
Cerebral Palsy 343
Cerbro-vascular Accident, Acute (C.V.A.) 436
Cerrebral Thrombosis 436
Cerumen in Ear 388
Cervical Dysplasia 622
Cervical Erosion 622
Cervical Hyperplasia 752
Cervicitis 616
During Pregnancy 646
Chalazion 373
Chicken Pox 052
Child Abuse, Child Neglect 899

Childhood Psychosis 299
Cholecystitis without Gallstones 575
Cholelithiasis (Gallstones) With or Without Cholecystitis 574
Chorea 392
Chorioretinitis 363
Choroiditis 363
Chronic Fatigue Syndrome 795
Circumcision, Newborn 609
Cirrhosis Liver, Alcoholic, Biliary 571
Claudication, Intermittent 443
Claustrophobia 300
Cleft Palate, Lip 749
Club Foot 754
Coagulation Defects 286
Coarctation of Aorta 747
Coccydynia 724
Cold, Common 460
Cold Sore 054
Colic, Renal 788
Colitis Mucus 564
Ulcerative 556
Colon Spastic, Irritable 564
Colon Positive Fecal Occult Blood 545
Colon Surveillance 546
Colon Family History of Colon Cancer 547
Colon Screening 548
Compression of Umbilical Cord 762
Concussion 850
Conduction Disorders, Other 426
Condyloma 099
Condylomata Accuminata 079
Congenital Anomalies Autosomal, Chromosomal 758

Circulatory System 747
Digestive System 751
Ear, Face, Neck 744
Eye 743
Genital Organs 752
Heart 746
Limbs 755
Musculoskeletal System 756
Nose and Respiratory System 748
Pylorus, Mouth, Esophagus, and Stomach 750
Sex Chromosomes 758
Urinary System 753
Congestive Heart Failure 428
Conjunctiva Disorders (e.g., Conjuntivitis) 372
Conn's Syndrome 255
Constipation 564
Contraceptive Advice 895
Contusions 919
Convulsions 780
Cord Prolapse 762
Corneal Ulcer 370
Corns 700
Coronary Artery Disease, Chronic, Without Symptoms 412
Coronary Insufficiency, Acute 413
Coronary Thrombosis 410
Cough 786
Coxsackie Pleurodynia 074
Cramps of Leg 781
Cretinism 243
Crohn's Disease 555
Croup 464
Cushing's Syndrome 255

C.V.A.	Cerebrovascular Accident	436
Cyst	Baker's	727
	Bartholin's Gland	616
	Bone	213
	Branchial	745
	Breast	610
	Dental	525
	Dermoid	228
	Hydatid All Sites	122
	Lip (mucocele)	210
	Ovarian	220
	Pilonidal	685
	Renal	223
	Sebaceous	706
	Urachal	753
Cystic Fibrosis		277
Cystic Disease, Chronic or	Cystic Mastitis	610
Cystinuria		270
Cystitis		595
	During Pregnancy	634
Cystocele		618

Diagnosis (Starts with “D”) – Description(s) – Code

Dacrocystitis		375
Deafness, All Types		389
Decubitus Ulcer		707
Deficiency	Mental	319
	Iron	280
	Nutritional, Vitamin	269
Dehydration		277
Delirium Tremens		291
Delivery	Normal	650

	With Other Complications	669
	With Placenta Praevia, Abruptio Placenta	641
Dementia	Senile, Presenile	290
Dental Caries		521
Depression, Reactive		300
Depressive or Other Non-psychotic Disorder, Not Classified Elsewhere		311
Dermatitis	Allergic, Atopic	691
	Contact	692
	Neuro	691
	Seborrheic	690
Dermatomyositis		710
Detachment, Retinal		361
Deviated Nasal Septum		470
Diabetes Mellitus (Including Complications)		250
Diabetes Mellitus with Ocular Complications		248
Diabetes Insipidus		253
Diaper Rash		691
Diarrhea		009
Difficulty at Work		905
Diphtheria		032
Diplopia		368
Disease	Addison's	255
	A.I.D.S	042
	Arteriosclerotic	437
	Arteriosclerotic Heart	412
	Bacterial	040
	Buerger's	443
	Breast Cystic, Chronic	610
	Bright's	580
	Christmas	286
	Crohn's	555
	De Quervaine's	727

	Duchennes	099
	Graves	242
	Hansen's	030
	Hashimoto	245
	Hemolytic of Newborn	773
	Hirchsprung's Megacolon	751
	Hodgkin's	201
	Huntington's Chorea	349
	Hypertensive Heart	402
	Hypertensive Renal	403
	Ischaemic Heart	413
	Legg Perthes	732
	Lung, Other	518
	Marie Strumpell	720
	Meniere's	386
	Motor Neurone	349
	Osgood-Schlatter	732
	Paget's - of bone	731
	Parkinson's	332
	Pelvic - inflammatory, chronic (P.I.D.)	614
	Peripheral Vascular (P.V.D.)	443
	Raynaud's	519
	Respiratory System, other	398
	Still's	714
	Tay-Sachs	330
	Venereal	099
	Viral, Arthropod-borne	066
Dislocation	Elbow	832
	Finger	834
	Other	839
	Recurrent	718
	Shoulder	831

Diverticulitis	or Diverticulosis of small or large intestine	562
Divorce		901
Dizziness		780
Down's Syndrome		758
Drug Addiction, Dependence		304
Drug Overdose		977
Drug Psychosis		292
Duodenal Ulcer, With or Without Haemorrhage or Perforation		532
Dupuytren's Contracture		728
Dwarfism		253
Dysentery	Amoebic	006
Dysfunction	Ovarian	256
	Pituitary Gland	253
	Sexual	306
Dyslalia		315
Dyslexia		315
Dysmenorrhea		625
Dyspareunia		625
Dyspepsia		536
Dysphagia		787
Dysplasia, Cervical		622
Dyspnea		786
Dystrophy, Muscular		359
Dysuria		786

Diagnosis (Starts with “E”) – Description(s) – Code

Echinococcosis	122
Eclampsia	642
Economic Problems	897
Ectopic Pregnancy	633
Ectropion	374
Eczema	691

Edema	Not yet diagnosed	785
Educational Problems		902
Embolism	Post-partum pulmonary	677
	Pulmonary	415
Emphysema		492
Encephalitis		323
	Viral, Mosquito Borne	062
Encephalomyelitis		323
Encephalopathy, Hypertensive		437
Endocarditis		429
Endometriosis		617
	Acute or Chronic	615
Enteritis	Regional	555
	Gastro	009
Enterocele		618
Entropion		374
Enuresis	Mental Disorder	307
Eospinophilia		288
Epididymitis		604
Epiglottitis, Acute		464
Epilepsy		345
Epistaxis		786
Erosion, Cervical		622
Erysipelas		035
Erythema, Multiforme or Nodosum		695
Esophagitis		530
Eustachian Tube Disorders		381
Eye Disorders, Other		379
Eyelid Disorders, Other		374

Diagnosis (Starts with "F") – Description(s) – Code

Facial Nerve Disorders		351
False Labour		644
Family Disruption		901
Family Planning		895
Fanconi Sydrome		270
Fever	Glandular	075
	Hay	477
	Rheumatic with or without Endocarditis, Myocarditis or Pericarditis	391
	Scarlet	034
	Typhoid	002
Fibrillation		427
Fibro-adenosis of Breast		610
Fibrosis	Cystic	277
	Pulmonary	515
Fissure, Anal		565
Fistula, Anal		565
Flat Foot		734
Flutter, Atrial or Ventricular		427
Food Poisoning		005
Foreign Body	Eye or other tissues	930
Fractures, Fracture-dislocation		
	Ankle	824
	Carpal Bones	814
	Clavicle	810
	Facial Bones	802
	Femur	821
	Fibula	823
	Humerus	812
	Metacarpals	815
	Pelvis	808

Phalanges 816
Radius 813
Ribs 807
Skull 803
Spontaneous 733
Tibia 823
Ulna 813
Vertebral Column with spinal cord damage 806
Vertebral Column without spinal cord damage 805
Other 829
Frigidity 302
Frostbite 994
Fungus - See Mycoses Furunculosis 680

Diagnosis (Starts with "G") – Description(s) – Code

Gallstones (Calculus) Cholelithiasis, with or without Cholecystitis 574
Ganglion 727
Gastric Ulcer 531
Gastritis 535
Gastro-enteritis and Gastro-enteritis, Viral 009
German Measles (Rubella) 056
Gingivitis 523
Glandular Fever 075
Glaucoma 365
Glmerulonephritis, Acute 580
Glossitis 529
Goitre Exophthalmic 242
Nontoxic Nodular 241
Simple Thyroid 240
Gonococcal Infections 098
Gout 274
Granuloma, Pyogenic 686

Gynecomastia 611

Diagnosis (Starts with "H") – Description(s) – Code

Habit Spasms 307
Haemorrhage, Eye 379
Haemorrhage, Intracranial 432
Haemorrhage in Early Pregnancy 640
Haemorrhage, Post-Partum 666
Haemorrhagic Conditions, Other 287
Haemorrhoids 455
Halitosis 787
Hallux Valgus or Varus 735
Hammer Toe 735
Hansen's Disease (Leprosy) 030
Hay Fever 477
Headache (Cephalgia) Migraine 346
Tension 307
Except tension and migraine 780
Heart Blocks 426
Heartburn 787
Heart Disease, All Other Forms 429
Heart Failure, Congestive 428
Helminthiases 128
Hemangioma 228
Hematemesis 787
Hematuria 599
Hemiplegia 599
Hemolytic Anemia, Hereditary 282
Hemolytic Disease of Newborn 773
Hemophilia 286
Hemoptysis 786
Hepatitis 070

Hernia	Femoral, umbilical, ventral, diaphragmatic or hiatus hernia with obstruction	552
	Femoral, umbilical, ventral, diaphragmatic or hiatus hernia without obstruction	553
	Inguinal with or without obstruction	550
Herpes Genitalis		099
Herpes Simplex		054
Herpes Zoster		053
Hiccough		787
High Birthweight Infant		766
High Myopia	Greater than 9 diopters, irregular astigmatism resulting from post-corneal grafting or corneal scarring from disease	371
Hirsutism		709
Histoplasmosis		115
Hives		708
Hodgkin's Disease		201
Hunner's Ulcer		595
Hyaline Membrane Disease		769
Hydrocele		603
Hydrocephalus		742
Hydronephrosis		591
Hyperactive Child		314
Hyperaldosteronism		255
Hypercalcemia		259
Hyperchlorhydria		536
Hypercholesterolemia		272
Hyperemesis Gravidarum		643
Hyperkeratosis		701
Hyperkinetic Syndrome of Childhood		314
Hypermenorrhea		626
Hypermentropia		367
Hyperopia		367
Hyperplasia	Adrenal	259

	Endometrial	621
Hypertension, Essential		401
Hypertensive Encephalopathy		437
Hypertensive Heart Disease		402
Hypertensive Renal Disease		403
Hypertensive Retinopathy		362
Hyperthyroidism		242
Hypertrophy	Benign Prostatic (B.P.H.)	600
	Breast	611
	Tonsils, Adenoids	575
Hyperventilation		786
Hypochlorhydria		536
Hypogammaglobulinemia		279
Hypoglycemia		259
Hypomenorrhea		626
Hypotension		447
Hypothyroidism	Acquired	244
	Congential	243
Hysteria		300

Diagnosis (Starts with "I") – Description(s) – Code

Ileitis, Regional		555
Ileus, Paralytic		560
Illegitimacy		903
Immunity Disorders		279
Immunization	All types	896
Impaction of Intestine		560
Impetigo		684
Imprisonment		906
Incontinence of Urine		788
Indigestion		536
Inertia, Uterine		661

Infarction	Myocardial Acute	410
	Myocardial Old, Without Symptoms	412
	Pulmonary	415
Infection	Actinomycotic	098
	Gonococcal	039
	Intracranial	298
	Meningococcal	036
	Monilia all sites	112
	Nipple, Post-partum, Salmonella	003
	Other Human Immunodeficiency Virus Infection	044
	Tonsils, Adenoids Chronic	474
	Trichomonas Vaginalis	131
	Tuberculous, Primary, Including Recent Positive T.B. Skin Test Conversion	010
	Upper Respiratory	460
	Wound	998
Infertility		628
Infestation	Pinworm	127
	Tapeworm - all types	123
Influenza		147
Ingrown Nail		703
Inguinal Hernia with or without Obstruction		550
Injury	Head	854
	Internal to Organ	869
	Superficial	919
	Other	959
In-laws Problem		900
Insufficiency	Acute Coronary	413
	Mitral	394
Intertrigo		695
Intervertebral Disc Disorders		722
Intussusception		560

Iritis 364
Irregular Astigmatism Resulting from post corneal grafting or corneal scarring from disease 371
Ischaemic Heart Disease, Acute 413
Ischamia, Transient Cerebral 435
Itchy Condition, Other 698

Diagnosis (Starts with "J") – Description(s) – Code

Jaundice 787
Joint Ankylosis 718
Arthrogryposis 728
Contracture 718
Derangement, Loose Bodies 718
Pain 781
Swelling, Masses 781
Tuberculosis 015
Other Disease of 739
Keloid 701
Keratitis 370
Keratoconus 376
Klinefelter's Syndrome 758

Diagnosis (Starts with "K") – Description(s) – Code

Korsakov's Psychosis 291
Kyphosis 737

Diagnosis (Starts with "L") – Description(s) – Code

Labyrinthitis 386
Laceration Perineal 664
Except Limbs 879
Lower Limb(s) 894
Upper Limb(s) 884
Lactic Acidosis 259
Laryngitis, Acute 464

Legg-perthes Disease 732
Leiomyoma 218
Legal Problems 906
Leprosy (Hansen's Disease) 030
Leukoplakia Oral Mucosa 528
Tongue 529
Lice, Head or Body 132
Lipoid Metabolism Disorder 272
Lipoma 214
Lipoprotein Disorders 272
Lips, Diseases of 528
Litigation 906
Lordosis 737
Low Birthweight Infant 765
Low Vision 369
Ludwig's Angina 529
Lumbago 724
Lumbar Strain 724
Lupus Erythematosus 695
Lupus Erythematosus Disseminated 710
Lymphadenitis Acute 683
Lymphangioma 228
Lymphangitis 457
Lymphedema 457
Lymphosarcoma 200

Diagnosis (Starts with “M”) – Description(s) – Code

Macrognathism 524
Malabsorption Syndrome 579
Malaria 136
Malnutrition, Unspecified 263
Malocclusion 524

Malpresentation		652
Manic Depressive Psychosis		296
Marie-Strumpell Spondylitis		720
Marital Difficulties		898
Masses	Circulatory System	785
	Respiratory System	786
	Digestive System	787
	Genito-urinary System	788
Mastitis	Cystic	610
	Post-partum	675
Mastoiditis		383
Measles		055
	German, Rubella	056
Melancholia, Involutional		296
Melena		787
Meniere's Disease		386
Meningioma (Benign)		225
Meningitis	Bacterial, Central Nervous System	320
	Due to Other Organisms	321
	Enterovirus	047
	Infectious	036
Menigocele		741
Meningococcal Infection		036
Meningomyelocele		741
Meniscus or Cartilage Tear		718
Menopause		627
Menorrhagia		626
Menstruation Disorders		626
Mental Deficiency, Retardation		319
Mesenteric Artery Occlusion		557
Metabolic Disorders, Other		277
Metrorrhagia		626

Micrognathism		524
Migraine		346
Mitral Insufficiency or Stenosis		394
Mole		216
Monilia Infection, All Sites		112
Mononucleosis, Infectious		075
Monoplegia		349
Motor Neurone Disease		349
Motor Retardation		315
Multiple Pregnancy		651
Multiple Sclerosis		340
Mumps		072
Muscle Spasms		728
Muscular Dystrophy		359
Muscular Rheumatism		729
Myasthenia Gravis		358
Mycoses, All Types		117
Myocarditis	Artherosclerotic	429
	Rheumatic	391
	Coxsackie	074
Myocardial Infarction	Acute	410
	Old	412
Myoneural Disorders		367
Myopia		367
Myositis		729
Myxedema		244

Diagnosis (Starts with “N”) – Description(s) – Code

Naevus, Pigmented	216
Narcolepsy	349
Nasal Polyp	471
Nasopharyingitis, Acute	460

Nausea		787
Neck Sprain/Strain		847
Neoplasm (Benign)	Bladder	223
	Bone	213
	Brain	225
	Breast	217
	Cartilage	213
	Cervical Polyp	218
	Connective and other soft tissue	215
	Dermato Fibroma	216
	Digestive System, other parts	230
	Eye	224
	Genital Organs, female, other	221
	Genital Organs, male, other	222
	Hemangioma	228
	Intrathoracic Organs	212
	Kidney	223
	Leiomyoma	218
	Lip	210
	Lipoma	214
	Lymphangioma	228
	Oral Cavity	210
	Other Endocrine Glands/related structures	227
	Ovary, e.g. Ovarian Cyst	220
	Peripheral Nerves	225
	Peritoneum	211
	Pharynx	210
	Respiratory System	212
	Seborrheic Wart	216
	Skin	216
	Spinal Cord	225
	Thyroid	226

	Ureter	223
	Uterine Fibroid	218
	Other	229
Neoplasm (Malignant)	Anus	154
	Astroblastoma, Astrocytoma	191
	Basal Cell	173
	Bladder	188
	Bone	170
	Brain	191
	Breast, Female	174
	Broad, Ligament	183
	Bronchus	162
	Cancer, Multiple Sites	199
	Carcinomatosis	198
	Cervix	180
	Connective and other soft tissue	171
	Cranial Nerves	192
	Esophagus	150
	Eye	190
	Fallopian Tube	183
	Gallbladder and Extra Hepatic Bile Ducts	156
	Genital Organs, female, other	184
	Genital Organs, male, other	187
	Gum	143
	Hodgkin's Disease	201
	Hypopharynx	148
	Kidney	189
	Large Intestine Excluding Rectum	153
	Larynx	161
	Leukemia, Lymphatic, Lymphocytic, Lymphoid	204
	Leukemia, Monocytic	206

Leukemia, myeloid including granulocytic and myelogenous 205
Leukemia, other types 208
Leukemia, plasma cell 203
Lip 140
Liver, primary malignancy (not secondary spread or metastatic) 155
Lung 162
Lymphoid and Histiocytic Tissue, other 202
Lymphosarcoma 200
Major Salivary Glands 142
Male Breast 175
Melanoma of Skin 172
Metastic Disease, secondary spread 199
Mouth, Floor of 144
Multiple Myeloma 203
Nasal Cavities, middle ear and accessory sinuses 160
Nasopharynx 147
Oropharynx 146
Other Endocrine Glands and related structures 194
Other and ill-defined sites within the digestive organs and peritoneum 159
Other and ill-defined sites within the lip, oral cavity and pharynx 149
Other and ill-defined sites 195
Other and unspecified parts of mouth 145
Other sites within the respiratory system and intrathoracic organs 165
Other Specified Leukaemia 207
Ovary 183
Pancreas 157
Placenta 181
Pleura 163
Prostate 185

Recto Sigmoid 154
Rectum 154
Reticulosarcoma 200
Retroperitoneum and Peritoneum 158
Secondary Cancer 198
Secondary Neoplasm of Lymph Nodes 196
Secondary Neoplasm of Respiratory and Digestive System 197
Skin Malignancies, other 173
Small Intestine, including duodenum 152
Spinal Cord 192
Stomach 151
Testis 186
Thymus, Heart and Mediastinum 164
Thyroid 193
Tongue 141
Urinary Organs, other 189
Uterus, body of 182
Uterus, part unspecified 179
Vagina 184
Vulva 184
Other Malignant Tumours 199
Neoplasm Unspecified (e.g., Polycythemia Vera) 239
Neoplasm Of Uncertain Behaviour
Digestive and Respiratory Systems 235
Endocrine Glands and Nervous System 237
Genitourinary Organs 236
Other and Unspecified Sites and Tissues 238
Nephrotic Syndrome 581
Neuralgia, Trigeminal 350
Neurasthenia 300
Neuritis, Idiopathic Peripheral 356
Neuritis, Optic 377

Neurodermatitis 691
Neurosis Anxiety, Obessive Compulsive 300
Neutropenia 288
Nocturia 788
Non-psychotic Disorder Not Classified Elsewhere 311
Nutritional and Vitamin Deficiencies 269

Diagnosis (Starts with "O") – Description(s) – Code

Obesity 278
Obsessive Compulsive Neurosis 300
Obsessive Compulsive Personality 301
Obstipation 564
Obstructed Labour 660
Obstruction Esophagus 530
Intestine 560
Lacrimal Duct 375
Obstructive Pulmonary Disease
Chronic, other 496
Occupational Problems Unemployment, difficulty at work 905
Oligomenorrhea 626
Oligouria 786
Onychogryposis 703
Oophoritis Acute or chronic 614
Open Wounds Except Limbs 879
Lower Limb(s) 894
Upper Limb(s) 884
Orchitis 604
Osgood-Schlatter Disease 732
Osteitis Deformans 731
Osteoarthritis 715
Osteochondritis, Osteochondritis Dissecans 732
Osteomyelitis 730
Osteoporosis 730

Otitis Externa 380
Otitis Media, Serous 381
Otitis Media, Suppurative 382
Otosclerosis 387
Ovarian Dysfunction Failure 256
Overdose, Drug 977

Diagnosis (Starts with "P") – Description(s) – Code

Pain Abdominal 787
Chest 785
Joint, Leg, Muscle 781
Palsy Bell's 351
Cerebral 343
Pancreas Endocrine Disorders 251
Paralysis, Facial 351
Paralytic Ileus 560
Paranoid Personality Disorder 301
Paranoid States 297
Paraphimosis 605
Paraplegia 349
Paratyphoid Fever 002
Parathyroid Gland Disorders 252
Parent-child Problems (e.g., Child Abuse, Battered Child, Child Neglect) 899
Parkinson's Disease 332
Paronychia 686
Paroxysmal Tachycardia 427
Patent Ductus Arteriosus 747
Pediculosis 132
Pelvic Inflammatory Disease (P.I.D.) 614
Performation of Tympanic Membrane 384
Pericarditis 429
Perinatal Morbidity & Mortality, Due to Complications of Labour or Delivery 763

Perinatal Disorders of Digestive System 777
Periodontal Disease 523
Peripheral Vascular Disease 443
Peritonitis, With Or Without Abscess 567
Personality Disorder (e.g., Obsessive Compulsive) 301
Paranoid 301
Schizoid 301
Pertussis 033
Pes Planus 734
Pharyngitis 460
Phimosis 605
Phlebitis 451
P.I.D. Pelvic Inflammatory Disease 614
During Pregnancy 646
Pilonidal Cyst or Abscess 685
Pinworm Infestation 127
Pituitary Gland Dysfunction 253
Placenta Previa 641
Pleurisy With or Without Effusion 511
Tuberculosis 012
Pleurodynia, Bronholm's Disease 074
Pneumonia, All Types 486
Pneumothorax, Spontaneous or Tension 512
Poisoning Food 005
Blood 038
Poliomyelitis, Acute 045
Polyarteritis Nodosa 446
Polycythemia Vera 239
Polycystic Ovaries 256
Polymyalgia Rheumatic 725
Polymyositis 710
Polyp Anal or Rectal 569

	Cervical	219
	Nasal	471
Porphyria		277
Positive Conversion of T.B. Skin Test		010
Postmaturity		766
Pre-eclampsia (P.E.T.)		642
Pregnancy	Abnormality Bony Pelvis	653
	Anemia of	646
	Ectopic	633
	Foetal Distress	656
	Multiple	651
	Other complications (e.g., Vulvitis, Vaginitis, Cervicitis, Pyelitis)	646
	Premature Rupture of Membranes	658
	Prolonged Pregnancy (post dates/post maturity pregnancy)	645
	Cystitis	646
	Uncomplicated	650
Premature Labour		644
Prematurity		765
Premenstrual Tension		625
Presbyopia		367
Presenile Dementia		290
Problems	Aged Parent(s)	900
	Economic	897
	Educational	902
	Family Disruption, Divorce	901
	Illegitimacy	903
	In-laws	900
	Legal Problems, Litigation, Imprisonment	906
	Occupational, Unemployment, Difficulty at Work	905
	Parent/child (e.g., child-abuse, battered child, child neglect)	899

	Social Maladjustment	904
	Other problems of social adjustment	909
Prognathism		524
Prolapse	Rectal	569
	Umbilical Cord	762
	Uterine	618
Prolonged Labour		662
Prostatitis		601
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Diseases of Blood and Blood-Forming Organs:
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Cystocele, rectocele, urethrocele, enterocele, uterine prolapse 618
Retroversion of uterus, endometrial hyperplasia, other disorders of uteru 621
Cervical erosion, cervical dysplasia 622
Stricture or stenosis of vagina 623
Dyspareunia, dysmenorrhea, premenstrual tension, stress incontinence 625
Disorders of menstruation 626
Menopause, post-menopausal bleeding 627
Infertility 628
Other disorders of female genital organs 629
Signs and Symptoms Not Yet Diagnosed:
Renal colic, urinary retention, nocturia, masses 788

Complications of Pregnancy, Childbirth and the Puerperium

Missed abortion 632
Ectopic pregnancy 633
Incomplete abortion, complete abortion 634
Therapeutic abortion 635
Threatened abortion, haemorrhage in early pregnancy 640
Abruptio placentae, placenta praevia 641
Pre-eclampsia, eclampsia, toxaemia 642
Vomiting, hyperemesis gravidarum 643
False labour, threatened labour 644
Prolonged pregnancy 645
Other complications of pregnancy (e.g., vulvitis, vaginitis, cervicitis, pyelitis, cystitis) 646
Normal delivery, uncomplicated pregnancy 650
Multiple pregnancy 651
Unusual position of fetus, malpresentation 652
Cephalo-pelvic disproportion 653
Foetal distress 656
Premature rupture of membrane 658
Obstructed labour 660
Uterine inertia 661
Prolonged labour 662
Perineal lacerations 664
Post-Partum haemorrhage 666
Retained placenta 667
Delivery with other complications 669
Post-Partum thrombophlebitis 671
Post-Partum mastitis or nipple infection 675
Post-Partum pulmonary 677

Diseases of the Skin and Subcutaneous Tissue

Infections
- Boil, carbuncle, furunculosis 680
- Cellulitis, abscess 682
- Acute lymphadenitis 683
- Impetigo 684
- Pilonidal cyst or abscess 685
- Pyoderma, pyogenic granuloma, other local infections 686

Other Inflammatory Conditions:
- Seborrheic dermatitis 690
- Eczema, atopic dermatitis, neurodermatitis 691
- Contact dermatitis 692
- Erythema multiforme, erythema nodosum, acne, rosacea, lupus erythematosus, intertrigo 695
- Psoriasis 696
- Pruritus ani, other itchy conditions 698

Other Diseases of Skin and Subcutaneous Tissue:
- Corns, calluses 700
- Hyperkeratosis, scleroderma, keloid 701
- Ingrown nail, onychogryposis 703
- Alopecia 704
- Acne, acne vulgaris, sebaceous cyst 706
- Debcubitus ulcer, bed sore 707
- Allergic urticaria 708
- Other disorders of skin and subcutaneous tissue 709

Diseases of Muscoloskeletal System and Connective Tissue

Desseminated lupus erythematosus, generalized scleroderma, dermatomyositis, polymostitis 710
Pyogenic arthritis 711
Rheumatoid arthritis, Still's disease 714
Osteoarthritis 715
Traumatic arthritis 716
Joint derangement, recurrent dislocation, ankylosis, meniscus or cartilage tear, loose body in joint 718
Ankylosing spondylitis 720
Sero- negative Spondyloarthropathies 721
Intervertebral disc disorders 722
Lumbar strain, lumbago, coccydynia, sciatica 724
Synovitis, tenosynovitis, bursitis, bunion, ganglion 727
Dupuytren's contracture 728
Fibrositis, myositis, muscular rheumatism 729
Osteomyelitis 730
Osteitis deformans, Paget's disease of bone 731
Osteochondritis, Legg-Perthes disease, Osgood-Schlatter disease, osteochondritis dissecans 732
Osteoporosis, spontaneous fracture, other disorders of bone and cartilage 733
Flat foot, pes planus 734
Hallux valgus, hallux varus, hammer toe 735
Scoliosis, kyphosis, lordosis 737
Other diseases of musculoskeletal system and connective tissue 739

Signs and Symptoms Not Yet Diagnosed:

Leg cramps, leg pain, muscle pain, joint pain, arthralgia, joint swelling, masses 781

Congenital Anomalies

Congenital Anomalies	Spina bifida, with or without hydrocephalus, meningocele, meningomyelocele	741
	Hydrocephalus	742
	Congenital anomalies of eye	743
	Congenital anomalies of ear, face, and neck	744
	Transposition of great vessels, tetralogy of Fallot, ventricular septal defect, atrial septal defect	745
	Other congenital anomalies of heart	746
	Patent ductus arteriosus, coarctation of aorta, pulmonary artery stenosis, other anomalies of circulatory system	747
	Congenital anomalies of nose and respiratory system	748
	Cleft palate, cleft lip	749
	Other congenital anomalies of mouth esophagus, stomach and pylorus	750
	Digestive system	751
	Genital organs	752
	Urinary system	753
	Club foot	754
	Other congenital anomalies of limbs	755
	Other musculoskeletal anomalies	756
	Chromosomal anomalies (e.g., Down's syndrome, other autosomal anomalies, Klinefelter's syndrome, Turner's syndrome, other anomalies of sex chromosomes)	758
	Other congenital anomalies	759

Perinatal Morbidity and Mortality

	Compression of umbilical cord, prolapsed cord	762
	Due to complications of labour or delivery	763
	Prematurity, low-birth weight infant	765
	Postmaturity, high-birth weight infant	766
	Birth trauma	767

Hyaline membrane disease, respiratory distress syndrome 769
Hemolytic disease of newborn..... 773
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Other conditions of fetus or newborn..... 779

Symptoms, Signs and Ill-Defined Conditions

Non-specific Abnormal Findings:
Non-specific findings on examination of blood 790
Non-specific findings on examination of urine 791
Chronic fatigue syndrome 795
Other non-specific abnormal findings 796
Senility, senescence..... 797
Sudden death, cause unknown 798
Other ill-defined conditions..... 799

Accidents, Poisonings and Violence

Fractures and Fracture-dislocations: Facial bones 802
Skull 803
Vertebral column - without spinal cord damage..... 805
Vertebral column - with spinal cord damage 806
Ribs 807
Pelvis..... 808
Clavicle..... 810
Humerus..... 812
Radius and/or ulna 813
Carpal bones 814
Metacarpals..... 815
Phalanges - foot or hand 816
Femur..... 821
Tibia and/or fibula..... 823
Ankle 824
Other fractures 829

Dislocations	Shoulder	831
	Elbow	832
	Finger	834
	Other dislocations	839
Sprains, Strains and Other Trauma:		
	Shoulder, upper arm	840
	Wrist, hand, fingers	842
	Knee, leg	844
	Ankle, foot, toes	845
	Neck, low back, coccyx	847
	Other sprains and strains	848
	Concussion	850
	Other head injuries	854
	Internal injuries to organ(s)	869
	Lacerations, open wounds - except limbs	879
	Lacerations, open wounds, traumatic amputations - upper limb(s)	884
	Lacerations, open wounds, traumatic amputations - lower limb(s)	894
	Automated Visual Field (AVF) test	918
	Abrasions, bruises, contusions and other superficial injury including non-venomous bites	919
	Foreign body in eye, or other tissues	930
	Burns - thermal or chemical	949
	Other injuries or trauma	959
Adverse Effects	Of drugs and medications - including allergy, overdose, reactions	977
	Of other chemicals (e.g., lead, pesticides, and venomous bites)	989
	Of physical factors (e.g., heat, cold, frostbite, pressure)	994
	Of surgical and medical care (e.g., wound infection, wound disruption, other iatrogenic disease)	998

Supplementary Classifications

Family Planning	Family planning, contraceptive advice, advice on sterilization or abortion	895
Immunization	Immunization - all types	896
	Pentavalent (DPT POLIO/ACT HIB)	960
	DPT Polio	961
	DT	962
	MMR (Measles, Mumps, Rubella)	963
	Hepatitis B	964
	TD Polio	965
	TD (Adults and aged 7 years and older)	966
	Influenza	967
	Pneumococcal	968
	Other Immunization – Not Defined	969
Social, Marital and Family Problems:		
	Economic problems	897
	Marital difficulties	898
	Parent-child problems (e.g., child-abuse, battered child, child neglect)	899
	Problems with aged parents or in-laws	900
	Family disruption, divorce	901
	Educational problems	902
	Illegitimacy	903
	Social maladjustment	904
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	Legal problems, litigation, imprisonment	906
	Other problems of social adjustment	909
Other	Well baby care	916
	Annual health examination adolescent/adult Well Vision Care	917

Physiotherapy

Operations on the Musculoskeletal System:

Osteotomy 893
Excision Bunion 894
Excision of Bone Partial 897
Excision of Bone Complete (e.g., Patellectomy) 898
Excision or Destruction of Intervertebral Disc Excision of Semilunar Cartilage of Knee 923
Synovectomy 924
Spinal Fusion 930
Arthrodesis of Foot and Ankle 931
Arthrodesis of Other Joints 932
Arthroplasty of Foot and Toe 933
Arthroplasty of Knee and Ankle (e.g., Hauser Repair) 934
Total Hip Replacement 935
Other Arthroplasty of Hip 936
Incision of Muscle, Tendon, Fascia, and Bursa of Hand 940
Division of Muscle, Tendon, and Fascia of Hand 941
Suture of Muscle, Tendon, and Fascia of Hand 944
Transplantation of Muscle and Tendon of Hand 945

Other Acceptable Diagnosis:

Gait Training or CrutchWalking Instruction (acceptable for a 1 visit treatment only) 072
Perceptual Motor Testing or Perceptual Motor Assessment of Dysfunction 070
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Post-Partum Observation 971

Common Diagnostic Codes

Arthritis	Osteo-degenerative	7159
	Cervical	7210
	Gouty	7120
	Rheumatic	7149
	Non-specified Acute	7169
	Non-specified Chronic	7150
Bells Palsy		3510
Bursitis		7310
Calcaneal	Spur	7267
	Bone	7269
Calcium	Bursa	7278
	Joint	7198
Capsulitis		7260
Cervical Disc Disease		7224
Cervical Strain		8470
Chest Disease		5199
Chondromalacia		7177
Compression Fracture - Cervical		7220
Contusion Knee		9241
Dislocated Shoulder		8310
Epicondylitis		7263
Fibrositis		7290
Frozen Shoulder		7260
Fracture	Ankle (closed)	8248
	Humerus (unspecified)	8122
	Leg	8270
	Vertebra	8058
	Wrist	8140
Gout		2740
Hamstring - Tendon		8409
Headache		7840

Injury	Elbow	9593
	Shoulder	9592
Kyphosis (acquired)		7371
Lumbago		7242
Lumbar Disc Disease (degenerative)		7251
Lumbar Strain		8472
Lymphedema		4579
Muscle Spasm		7288
Muscle Strain		8489
Myositis Plain and Trauma		7291
Neuralgia (unspecified)		7292
Pagets Disease		7310
Pain	Arch	7295
	Back (posterial)	7245
	Back (low)	7242
	Neck	7231
Plantar Fascitis		7287
Pelvis Inflammatory Disease/Salpingitis		6142
PVD		4439
Rheumatism (muscle)		7290
Sacro-iliac Strain - Hip		8439
Scoliosis (unspecified)		7379
Spondylolisthese		7561
Strained	Ankle	8450
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4.14 Questions and Answers

What is the monthly cut-off for claims submission and when will I receive payment?

The ministry operates on a monthly processing cycle. Submissions received by the 18th of the month will typically be processed for approval the following month. When the 18th falls on a weekend or holiday, the deadline will be extended to the next business day. MC EDT submissions received after the 18th may not be approved until the next monthly processing cycle (i.e. submissions received on Nov 18th will appear on the December RA, submissions received after Nov 18th may not appear until the January RA).

My software program includes a field for "Manual Review Indicator". What is it and when would I use it?

For most claims, this field would be blank; however, if the claim requires special consideration (e.g., two identical services billed same day), a Y indicator should be entered in this field. If Y is used, the claim will be flagged for internal manual reviewed and adjudication.

Supporting documentation must be sent to the ministry so that it can be matched to the claim submission. The documentation can be submitted electronically using **eSubmit**, or faxed to your claims processing office.

If you select to fax, the "Claims Flagged for Manual Review" form (2404-84) must be completed. This form indicates the information that is required for claims submitted with a Y indicator. This information is to be included in the supporting documentation as well. The form and supporting documentation should be faxed to your claims processing office:

http://www.health.gov.on.ca/en/pro/programs/ohip/claimsoffice/default.aspx:

When claims are submitted, how do I get notified of submission errors?

Claim errors are listed on your Claims Error Report which will be sent to you within 48 hours after the file submission. Errors reported must be corrected and resubmitted in order for payment to be made. Error reports should be retained in order to track claims that may not appear on the next RA.

When is a claim considered stale dated?

Claims must be submitted within six months of the service date. Claims submitted more than six months after the service has been rendered will not be accepted for payment unless there are extenuating circumstances as defined by ministry policy.

How do I inquire about a claim that has been overpaid/underpaid?

Inquiries regarding overpayments or underpayments should be made within four months of the RA on which the payment appears. Inquiries can be electronically submitted to the ministry using eSubmit or faxed to your claims processing office on a "Remittance Advice Inquiry" form (0918-84).

The form is available online at:

http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?openform&ENV=WWE&NO=014-0918-84.

5

REGISTRATION FOR ONTARIO HEALTH INSURANCE COVERAGE

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Ontario

5. REGISTRATION FOR ONTARIO HEALTH INSURANCE COVERAGE

5.1 Client Registration Overview

Typically, to obtain Ontario health insurance coverage initially or to reactivate OHIP coverage and be issued an Ontario health card, eligible residents over the age of 16 must apply in person at a ServiceOntario centre.

To receive Ontario health insurance coverage, each eligible resident must apply and substantiate basic personal information by providing documentary proof of his or her Canadian citizenship/immigration status, residency within Ontario and identity.

Information on each registered person is collected by means of a standard registration form issued by the ministry and stored as electronic data on the Registered Persons Data Base (RPDB). Every eligible person who applies for Ontario health insurance coverage is assigned a permanent and unique health number.

People 16 years of age and older must register in person to provide their signature and to have their photo taken. There may be exemptions from photo and/or signature requirements for medical or other reasons.

Upon approval for Ontario health insurance coverage, client registration and identification information is entered onto the ministry's RPDB. The insured person is issued a plastic health card bearing his or her photo, signature, name, health number and version code, date of birth, and validity period. In most cases, when a change in information is made or the card is reported lost, stolen, damaged or not received, a replacement card will be issued with the same health number and a new version code.

People with a valid health card and eligibility can obtain insured medical and hospital services, prescription drugs (for a limited population group) and prove entitlement to various other provincially funded health services and benefits.

The RPDB is used in various ministry-processing systems to verify eligibility for services. A significant use of the data is in the fee-for-service medical claims system where claims can be paid to the provider if the patient has eligibility and a valid health card.

5.2 Eligibility Overview

Every applicant who is determined to be eligible for Ontario health insurance coverage becomes an insured person and is issued a health card. To receive insured services, the insured person must present his or her health card upon the request of the health care provider. The health card must be returned to the ministry or destroyed when it is no longer valid.

All personal information including personal health information, stored by the ministry is protected by the Personal Health Information Protection Act (PHIPA). Every registered person should ensure the information on his or her registration record in the ministry's RPDB is up-to-date. Maintaining the accuracy of the information in the RPDB is essential for ensuring ongoing eligibility for Ontario health insurance coverage.

Eligibility policies are based on the Regulation 552 of the Health Insurance Act (HIA) and the Canada Health Act.

To be eligible for Ontario health insurance coverage, a person must:

- have Canadian Citizenship or other immigration status as listed in the regulation;
- make his/her primary place of residence in Ontario; and
- be physically present in Ontario for 153 days in any given 12-month period.

In addition, most new and returning applicants for OHIP coverage must also be physically present in Ontario for at least 153 of the first 183 days after establishing residence in the province (exceptions are noted in Regulation 552).

Most eligible new or returning residents are subject to a 3-month waiting period prior to the effective date of coverage.

Visitors to the province, those who have their primary place of residence outside Ontario, tourists and transients are not eligible for Ontario health insurance coverage.

An OHIP-eligible resident can be away from Ontario for up to 7 months in each 12-month period and still maintain their OHIP coverage.

In addition, Regulation 552 of the HIA includes provisions for maintaining OHIP coverage during specific types of longer temporary absences out of the country provided certain requirements are met.

It is the responsibility of every insured person to report, within 30 days of its occurrence, a change in the information that was used to establish his or her entitlement to be or continue to be an insured person.

Regulation 552 also notes that a person may be asked to submit any information, evidence or documents necessary to determine a person's entitlement for OHIP, whether the person is applying to be an insured person for the first time or seeking to re-establish coverage.

Participation in the Ontario health plan is voluntary; however, coverage of residents with another health insurance policy for services that would be insured within Ontario is prohibited.

5.3 Health Cards

Each eligible resident in the province of Ontario may apply to be an insured person to receive provincially funded insured health services covered by the Ontario Health Insurance Plan (OHIP). A health card is provided to the insured person to present to the health services provider at each visit for an insured health service.

Health Cards for Newborns

The registration of newborns through hospitals is usually completed using the Ontario Health Coverage Infant Registration form. The registration form, completed by the parent, is forwarded by the birthing hospital to the ministry for processing. Until the child's health card is mailed to the parents, the parent will have a record of the child's health number preprinted on the registration form's tear-off strip.

There are two types of Ontario health cards in circulation - the photo health card and the red and white health card.

Health services providers should continue to validate all health cards at the time of service using existing validation processes.

Both the photo and the red and white health cards remain acceptable as proof of entitlement to medically necessary insured health services providing the card is valid and belongs to the person presenting the card. All health cards contain a magnetic stripe that contains the unique 10-digit lifetime identification number, known as a health number which is assigned to all eligible Ontario residents.

Variations of each of these health cards are detailed below.

Photo Health Card

The photo health card, introduced in February 1995, represented a government action to protect the integrity of the health care system and to preserve it for the future. The photo health card contains several security features as illustrated in the examples that follow.

Since 1995, additional security features have been added to the photo health card to make it more tamperproof and counterfeit resistant.

The photo health card is a green plastic card with the front of the card depicting a trillium and bearing the insured person's name, 10-digit personal health number and version code, date of birth, sex (on cards issued prior to June 2016 only), cards issue and expiry date, the person's photo and signature (unless a photo and signature exemption has been granted or the person is under 16 years of age).

There are multiple variations of the photo health cards in circulation.

Black and White Photo Health Card (no Sex Designation) - Description

- This is the only photo health card that is currently being produced.
- It is considered acceptable as proof of OHIP coverage if it was issued after June 13, 2016 (see Bulletin 4671).
- The following changes were made to this version of the card:
    - The front of the health card will no longer display the individual's sex designation; however it is available for retrieval from the magnetic stripe of the health card (the information is still required to be entered on the OHIP database).
    - No changes have been made to the back of the black and white photo health card.

Black and White Photo Health Card (no Sex Designation)

Secondary Photo
Greyscale of primary photo
Secondary signature
Redundant data

Security Background

Variable Microprint

Trillium Image
Optical variable ink added in top right corner on the card front.
New trillium image changes colour from magenta to gold when card is tilted.

Primary Photo
Primary photo of the card holder is now black and white image
Holographic image is removed.

Bearer Related Data
Laser engraved into card material

Tactile Features
Apparent to touch and feel without any special tool
Ontario trillium logo unique to Ministry of Health and Long-Term Care
Primary signature, health card number

Bearer Related Data
Donor information

Magnetic Stripe

Stock Control Number

Variable Microprint

2-D Barcode Encoding specific amount of data
Machine readable

Black and White Photo Health Card - Description

- It is considered acceptable as proof of OHIP coverage if it was issued between January 8, 2014 to June 13, 2016 (see Bulletin 4621).
- The following changes were made to this version of the card:

    - The primary photo of the card holder is a black and white image.
    - The holographic images previously seen covering the primary photo have been removed.
    - Optical variable ink was added in the top right corner on the card front. The trillium image changes colour from magenta to gold when the card is tilted.
    - The old provincial logo in the bottom right corner on the card front was replaced with a tactile image of the new provincial stylized logo.
    - Both the English and French text on the back of the card was updated as to reflect how to request a change of address on the Ontario health card.

Black and White Photo Health Card

Secondary Photo
Greyscale of primary photo
Secondary signature
Redundant data

Trillium Image
Optical variable ink added in top right corner on the card front.
New trillium image changes colour from magenta to gold when card is tilted.

Security Background

Variable Microprint

Primary Photo
Primary photo of the card holder is black and white image. Holographic image is removed.

Bearer Related Data
Laser engraved into card material

Tactile Features
Apparent to touch and feel without any special tool
Ontario trillium logo unique to Ministry of Health and Long-Term Care

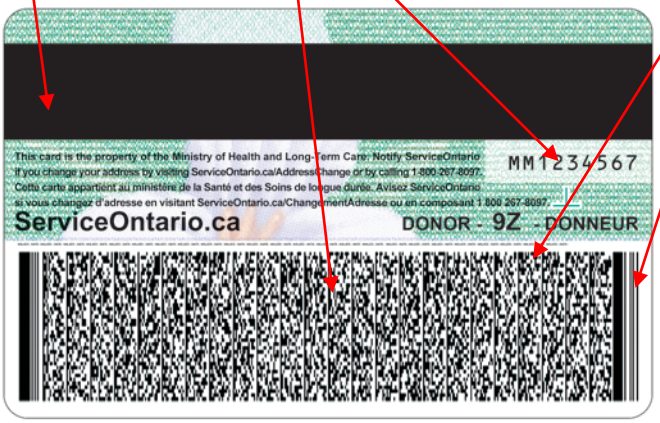
Magnetic Stripe
Primary signature, health card number

Stock Control Number

Bearer Related Data
Donor information

Variable Microprint

2-D Barcode Encoding specific amount of data Machine readable



Colour Photo Health Card - Description

The enhanced photo health card was introduced in November 2007 (see Bulletin 4460, November 30, 2007) with additional and improved security features (e.g. holograph images, laser printing, etc.). Unlike the standard photo health card, the residential address does not appear on the back of the card.

Enhanced photo health cards produced since November 2007 include the following security features:

- A security background on the front and the back of the card which uses mechanisms similar to those used for currency;
- A smaller photograph and signature, printed in shades of gray on the right hand side of the card;
- A holographic overlay, printed over the colour photograph;
- The name as shown on the face on the card is printed in very small (microprint) text on the front and the back of the card;
- The health number, version code and Ontario trillium logo have slightly raised print (tactile printing); and
- Additional enhancements which cannot be identified for security reasons.

Colour Photo Health Card

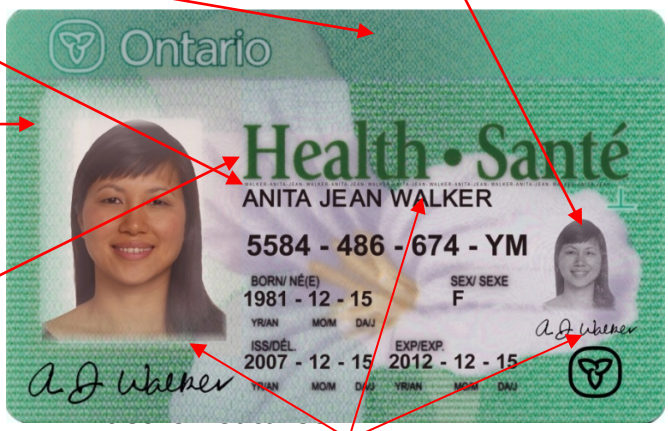
Secondary Photo
Greyscale of primary photo
Secondary signature
Redundant data

Security Background

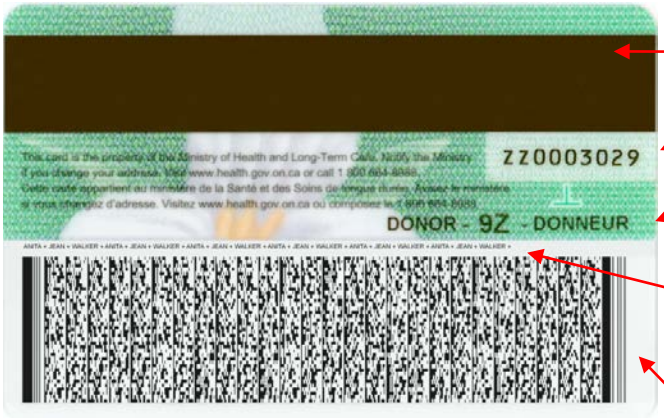
Variable Microprint

Primary Photo
Thermal transfer of colour photo protected with holographic overlay
Overlapping portrait edge and security background

Bearer Related Data
Laser engraved into card material



Apparent to touch and feel without any special tool
Ontario trillium logo unique to Ministry of Health and Long-Term Care
Primary signature, health card number



Magnetic Stripe

Stock Control Number

Bearer Related Data
Donor information

Variable Microprint

2-D Barcode
Encoding specific amount of data
Machine readable

Standard Photo Health Card - Description

- The standard photo health card was introduced by the Ministry of Health and Long-Term Care (MOHLTC) in 1995 to replace the red and white health card.
- The implementation of the photo card introduced more security to the health card with the purpose of discouraging individuals from sharing cards or using cards that did not belong to them.
- The trusted registration process and health card renewal cycle were implemented in conjunction with the photo health card; this process requires that residents apply in person to confirm that they continue to meet the OHIP eligibility requirements.
- The initial standard photo health card included the cardholder's residential address on the back of the card.

Standard Photo Health Card

This predecessor to the enhanced photo health card does not have all the security features introduced for the enhanced photo health card. The other main difference is the presence of the client's address on the photo health card.

Rainbow Printing
A sophisticated printing technique to prevent counterfeiting

Holographic Overlay
Another security feature to prevent counterfeiting

Trillium
Ontario's official flower

Photo
Digitized and printed right on the card for added security

Health Number and Version Code
A unique number for each Ontario resident

Signature
Digitized and printed right on the card to prevent counterfeiting

Date of Birth
In year-month-day order

Card issue and expiry dates
To show when it is time to renew

Micro printing
Another enhanced security feature

Card Statement
Responsibility as the holder of a Health Card

Magnetic Stripe
So health care providers can check that cards are valid

Organ Donor Code
Reflects organ and/or tissue donation wishes upon death

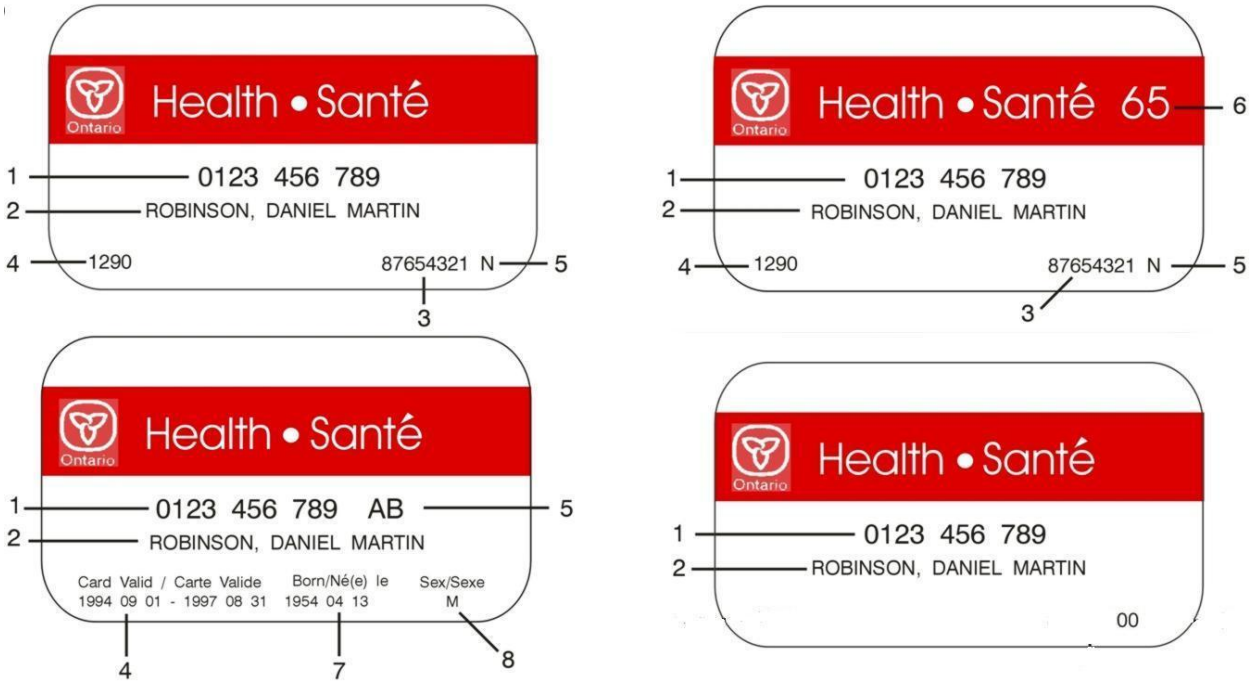
Bar Code
So health care providers can check that cards are valid

Red and White Health Card - Description

In 1990, the ministry introduced individual health numbers and issued new red and white health cards to all eligible residents of Ontario. Those over the age of 65 were issued a red and white health card displaying “65” on the face of the card.

There are four versions of the plastic red and white health card currently in circulation.

All of the following red and white health card types are acceptable. Each displays the 10-digit personal health number, the insured person’s name and version code **if applicable.**



1 Health number

2 Name

3 OHIP number

4 Expiry date of coverage (month/year) – not displayed on most red and white cards

5 Version code – on replacement cards only

6 Health 65 Indicator – signifies eligibility for Ontario Drug Benefit

7 Date of Birth

8 Sex

5.4 Health Card Validation

Health Card Validation (HCV) allows a health care provider to access the ministry's Registered Person Database (RPDB) to determine if a patient's health number and version code are valid when presented at the point of service.

Why Validate?

HCV provides decision-making information at the time of service and allow a health care provider or organization to:

- Verify patient data;
- Reduce eligibility claim rejects by ensuring a client is eligible for service prior to service delivery;
- Reduce version code claim rejects associated with incorrect version codes;
- Receive the most recent oculo-visual assessment, bone mineral density measurement or sleep study date of service (currently only available by the Interactive Voice Response method); and
- Reduce health care fraud by eliminating service to ineligible clients and by visually confirming HCV response information with client at the point of service; for example, gender, date of birth.

Types of Health Card Validation

There are various HCV methods available that provide access to the ministry's RPDB. Health care providers may review each of the methods to determine which most appropriately meets their needs based on current business practices and technical capabilities.

To register for HCV and for further information on HCV methods, please refer to the Health Card Validation Reference Manual at:

http://www.health.gov.on.ca/english/providers/pub/ohip/ohipvalid_manual/ohipvalid_manual_mn.html

5.5 Health number Release

The ministry recognizes that patients may not always present for health services with the most recent health card information including the most recent version code.

If a provider cannot reasonably obtain the health card information from the patient or from existing records, the ministry, through ServiceOntario, has escalation processes to provide health numbers and version codes directly to providers. There is both a form based process as well as a 24x7 ServiceOntario Help Desk that offers providers accelerated release of health numbers/version codes. The 24x7 process is the preferred method as the ministry has undertaken a reduction in the amount of physical transferral of health numbers via mail.

The Health Number Release form facilitates claims payment by allowing providers access to health numbers and/or version codes if clients cannot produce their health card or if their health card was invalid at the time of service.

For access to the 24x7 ServiceOntario Help Desk services, providers must first sign up for the service. To begin this process, an email containing the provider's name and OHIP billing number can be sent to 24x7@ontario.ca. Please note that this service is only provided to recognized Ontario Health Information Custodians (as defined in the PHIPA).

The Health Number Release form (# 1265-84) is available for downloading at:

http://www.forms.ssb.gov.on.ca

Note: A person's health number and version code is considered "personal health information" under the PHIPA.

5.6 Questions and Answers

Is there a waiting period for OHIP coverage?

Most new applicants for coverage as well as former residents returning to Ontario to live permanently (after being out of the country for more than seven months) have a three-month waiting period before coverage begins. There are some exceptions, such as newborns, military family members and some migrant farm workers.

Is there an eligibility review and appeal process?

A person may request a review of any decision made by ServiceOntario (with regard to his or her eligibility for Ontario health insurance coverage or their health card) to the OHIP Eligibility Review Committee and/or to the Health Services Appeal and Review Board (HSARB).

Individuals should contact a ServiceOntario centre for information about the review and appeal process.

What does my patient need to do to obtain a photo health card?

Your patient will be asked to provide proof of:

- Canadian citizenship or other OHIP-eligible immigration status; and
- Residency in Ontario; and
- Identity.

Please advise your patient to visit the ministry website for document requirements at: https://www.ontario.ca/ or contact the ServiceOntario Infoline at:

1-866-532-3161

Patients holding a red and white health card are asking me if they need to obtain a new photo health card. Should I be telling them to visit a ServiceOntario office and request a photo health card?

The Ministry continues to encourage red and white health cardholders to switch to the more secure photo health card – it is a more secure health card and can protect patients against fraud.

All versions of the photo health card and the standard red and white health card remain acceptable for insured health services as long as they are valid and belong to the individual. You should continue to validate all health cards at the time of service using existing validation processes.

There is no fee for patients to change their health card from their old red and white health card to the new photo health card.

If their health card has been lost, stolen, damaged or if they need to change their personal information, they will need to re-register for a photo health card. Please advise them to visit the ministry's website at:

https://www.ontario.ca/ or they may call the ServiceOntario, Infoline at

1-866-532-3161 for more information.

What is the ministry's policy on "good faith" payments?

In the past, in situations where the provider could not determine an eligibility problem by looking at the health card, claims were paid until such time as the provider had been notified by the ministry via the provider's monthly "Remittance Advice".

Refer to Bulletins 4303 and 4305 for further information

http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bulletin_4000_mn.html

Should I ask my patients to present their health cards every time they require insured health services?

Yes, it is recommended that you ask your patients to present their health cards each time they visit you. You will then be able to determine quickly if they are eligible for insured health services using any of the HCV methods available.

What is a health card version code?

The version code is a randomly generated alpha-code used with the health number to identify the status of a health card. The version code is used to uniquely identify a health card. It is important for health card validation to identify whether a health card is currently valid. This is an important feature of the anti-fraud strategy should a health card be reported lost or stolen. Whenever your patient receives a replacement card, the health number remains the same but the version code changes and automatically renders the previous health card invalid.

A version code may be one or two letters. Not all red and white health cards have version codes. A red and white health card without a version code may be valid. You should ensure the card is valid each time a patient receives services.

Should I bill my patients for medical services if they do not have their health card when they visit me?

If your patient does not have their health card with them and they advise you that they have not been issued a new health card since their last visit, you

should look up their health number and version code on your records. If the record is found, you should use one of the HCV methods available to check eligibility and health card status. If you cannot determine if your patient is eligible, you may:

- require the patient to pay for service until their eligibility is confirmed;
- request the patient complete a "Health Number Release" form to allow the ministry to release the health number and version code;
- hold the claim until the confirmation of eligibility is received; or
- contact the 24x7 ServiceOntario Help Desk to determine the patient's correct health number and version code.

The Health Number Release form (#1265-84) is available at:

http://www.forms.ssb.gov.on.ca

You should discuss these options with your patient. If you charge a patient who later is proven to be covered by OHIP (eligible) at the time of service, then you are required to reimburse the patient the full amount charged.

What happens if my patient does not have their health card and they need insured health services in an emergency?

The patient can sign a Health Number Release form (see link above), or the hospital may call the ServiceOntario 24x7 Help Desk. The patient cannot be refused emergency medical treatment.

Can I charge for completing a Health Number Release form?

No.

My patient has lost his or her red and white health card but cannot appear at an office for medical reasons.

When a patient has a medical condition that prevents him or her from appearing in person at a ServiceOntario office to re-register for a photo health card, the patient can apply for an exemption for the photo/signature requirement. To assist the patient in this process you must complete the Declaration of Health Care Provider portion of the Exemption Request form (#3164-84 available from your ServiceOntario centre). The patient/representative is responsible for completing the other sections and mailing or delivering the form to the ministry.

No fee can be charged to either the patient or the ministry for the completion of the form.

My patient has presented a Transaction Record to me to obtain medical services. Is this acceptable?

A Transaction Record with the version code of the new card is issued to clients during their visit to a ServiceOntario centre to process their new/replacement photo health card. The Transaction Record is to be used to obtain medical services prior to receipt of their new photo health card. The health number and version code should be validated using HCV methods to ensure the patient has OHIP eligibility and a valid health card.

My patient went to a ServiceOntario centre to renew his or her photo health card but has not received a new health card. The patient has presented their previous health card with a hole punched in it as well as a transaction record that does not have a version code indicated on it. Is this acceptable?

A Transaction Record without a version code or a hole-punched health card indicates that a health card has been issued, but the new version code is not active yet. A claim should be submitted under the old version code on the hole-punched health card.

What should I do if I suspect that one of my patients is no longer living in the province and returns to Ontario only when in need of medical services?

Physicians and other prescribed persons are now required by law to report certain incidents of suspected or detected OHIP fraud. Providers may call the ministry's Fraud Report Line at 1 800 265-4230 or report in writing by email to:

ReportOHIPFraud.MOH@ontario.ca

How should my patients advise the ministry if they change their address?

There are three ways to update their address:

1. Access the ServiceOntario website and update online at:

   https://www.indcoi.serviceontario.ca/WebChannel/?lang=en

2. Obtain a Change of Address form (#1057-82) and return it by mail. This form is available on the ministry's OHIP forms website at:

   http://www.forms.ssb.gov.on.ca

   or from any ServiceOntario centre.

3. Send a letter to a ServiceOntario centre. The letter must include the patient's full name, health number, telephone number, current address, and their new address including postal code.

Note:

It is important that the ministry always has the patient's current address on record. The ministry appreciates your assistance in reminding patients that they must notify the ministry of any change in address information.

My patients often advise me that they are going to be travelling outside of Canada and inquire about out-of-country health care services. What should I tell them?

The Ontario Health Insurance Plan (OHIP) only covers emergency health services out-of-country at very limited rates. For example, an outpatient visit to a U.S. emergency room may cost thousands of dollars for the duration of your patient's care, however OHIP will only reimburse up to a total of $50.00 CDN per day for this service regardless of the severity of the situation. **If your patient plans to travel outside of Ontario, it is strongly recommended they obtain additional private medical insurance and fully understand what the policy covers**.

Patients should be referred to the ministry's "OHIP Out of Country Services" webpage for out-of-country information:

http://www.health.gov.on.ca/en/public/programs/ohip/outofcountry/

6

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Ontario

6. GENERAL INFORMATION

6.1 Acts (Legislation)

Acts administered by the Ministry of Health and Long-Term Care are:

- Alcoholism and Drug Addiction Research Foundation Act
- Ambulance Act
- Cancer Act
- Charitable Institutions Act
- Commitment to the Future of Medicare Act, 2004
- Community Psychiatric Hospitals Act
- Developmental Services Act (long-term care programs and services only)
- Drug and Pharmacies Regulation Act
- Drug Interchangeability and Dispensing Fee Act
- Drugless Practitioners Act
- Elderly Persons Centres Act
- Expanded Nursing Services for Patients Act
- Fluoridation Act
- Healing Arts Radiation Protection Act
- Health Care Consent Act
- Health Facilities Special Orders Act
- Health Insurance Act
- Health Protection and Promotion Act
- Homemakers and Nurses Services Act
- Homes for Retarded Persons Act (long-term care programs and services only)
- Homes for Special Care Act
- Homes for the Aged and Rest Homes Act
- Human Tissue Gift Act (to be renamed Trillium Gift of Life Network Act)
- Immunization of School Pupils Act
- Independent Health Facilities Act
- Laboratories and Specimen Collection Centres Licensing Act
- Local Health Systems Integration Act, 2006
- Long Term Care Act, 1994
- Long-Term Care Homes Act, 2007
- Mental Health Act
- Mental Hospitals Act
- Ministry of Community and Social Services Act (Sections 11.1 and 12 re: long-term care programs and services only)

Acts (Legislation) (Continued)

- Ministry of Health Act
- Ministry of Health Appeal and Review Board Act, 1998
- Municipal Health Services Act
- Nursing Homes Act
- Ontario Disability Support Program Act, 1997 (long-term care programs and services only)
- Ontario Drug Benefit Act
- Ontario Medical Association Dues Act, 1991
- Ontario Mental Health Foundation Act
- Ontario Works Act, 1997 (long-term care and services act only)
- Personal Health Information Protection Act
- Private Hospitals Act
- Public Hospitals Act
- Regulated Health Professions Act, 1991
- Audiology and Speech Language Act, 1991
- Chiropody Act, 1991
- Chiropractic Act, 1991
- Dental Hygiene Act, 1991
- Dental Technology Act, 1991
- Dentistry Act, 1991
- Denturism Act, 1991
- Dietetics Act, 1991
- Massage Therapy Act, 1991
- Medical Laboratory Technology Act, 1991
- Medical Radiation Technology Act, 1991
- Medicine Act, 1991
- Midwifery Act, 1991
- Nursing Act, 1991
- Occupational Therapy Act, 1991
- Opticianry Act, 1991
- Optometry Act, 1991
- Pharmacy Act, 1991
- Physiotherapy Act, 1991
- Psychology Act, 1991
- Respiratory Therapy Act, 1991
- Substitute Decisions Act, 1991
- Tobacco Control Act, 1994
- University of Ottawa Heart Institute Act, 1999

Major statutes relevant to the Ministry of Health and Long-Term Care but not administered by the ministry are:

- Canada Health Act
- Freedom of Information and Protection of Privacy Act

Copies of these and other Acts and Regulations are available on the E-law website or you may purchase a copy from the Ontario Government Book Store.

6.2 Local Health Integration Networks

Local Health Integration Networks (LHIN) has responsibility for:

- Public and private hospitals (including divested Provincial Psychiatric Hospitals)
- Community Care Access Centres
- Community Support Service Organizations
- Mental Health and Addiction Agencies
- Community Health Centres
- Long-Term Services Homes

For more information refer to:

http://www.health.gov.on.ca/en/common/system/services/default.aspx

http://www.lhins.on.ca

6.3 Emergency Health Services

Ontario's Emergency Health Services (EHS) system is a series of interrelated land and air emergency medical services and programs designed to provide timely response and pre-hospital care. The Emergency Health Services Branch achieves this by:

Overseeing air and land ambulance services, as well as the communications centres responsible for dispatching those ambulance services;

Managing and regulating the land ambulance services provided by upper tier municipalities and District Social Services Administration Board, as well as providing administrative, operational, and technical support of ambulance services;

Establishing standards for the management, operation, and use of ambulance services and assuring compliance with those standards;

Maintaining close working relationships with the municipalities and designated delivery agents responsible for the proper provision of land ambulance services; with health care providers and facilities; with ambulance communications centres, and with other ministries and system stakeholders;

Monitoring, inspecting and evaluating ambulance services and investigating complaints respecting ambulance service delivery.

For more information refer to:

www.health.gov.on.ca/english/public/program/ehs/ehs_mn.html

www.health.gov.on.ca/english/providers/program/ambul/ehs_mn.html

6.4 Assistive Devices Program

The objective of The Assistive Devices Program (ADP) is to financially assist Ontario residents with long term physical disabilities to obtain basic, competitively priced, and personalized assistive devices appropriate for the individual's needs and essential for independent living. ADP includes the home oxygen program.

Devices covered by the program are intended to give people increased independence and control over their lives. They may allow them to avoid costly institutional settings and remain in a community living arrangement.

For more information refer to:

www.health.gov.on.ca/english/providers/program/adp/adp_mn.html

6.5 Community Care Access Centres

Community Care Access Centres coordinate services for seniors, people with disabilities and people who need health care services in the community to help them live independently in their own homes for as long as possible. Staff at the centres, provide information and coordinate professional, personal support and homemaking services for people living in their own homes and for school children with special needs, and make arrangements for admission to long-term care facilities.

For more information refer to:

http://www.health.gov.on.ca/en/common/system/services/ccac/

http://oaccac.com/

http://healthcareathome.ca/

6.6 Cancer Care Ontario

Cancer Care Ontario is an umbrella organization that steers and coordinates Ontario's cancer services and prevention efforts. Cancer Care Ontario releases standards and guidelines for care, services provided, prevention methods, wait time lists and information on breast, cervical and colorectal screening.

For more information refer to:

http://www.cancercare.on.ca

6.7 Ontario Drug Benefit Programs

Through the Ontario Drug Benefit Program, the Ministry of Health and Long-Term Care covers most of the cost of prescription drug products listed in the Ontario Drug Benefit (ODB) Formulary. The following people, who are Ontario residents and have valid Ontario health insurance (OHIP), are eligible for drug coverage under the ODB Program:

- people 65 years of age and older;
- residents of long-term care facilities;
- residents of Homes for Special Care;
- people receiving professional services under the Home Care program;
- Trillium Drug Program recipients.

For more information refer to:

http://health.gov.on.ca/en/public/programs/drugs/programs/odb/odb.aspx

http://www.health.gov.on.ca/en/public/programs/drugs/programs/odb/opdp_trillium.aspx

6.8 Ontario Family Health Networks

Ontario has become a national leader in primary care reform with the introduction of Family Health Networks, the expansion of nurse practitioners, and the strengthened role of Community Health Centres and Health Service Organizations.

For more information refer to:

http://www.health.gov.on.ca/en/pro/programs/fht/

6.9 Underserviced Area Program

The Underserviced Area Program (UAP) is one of a number of supports provided by the ministry to help underserviced communities recruit and retain health professionals.

The UAP was established in 1969 to respond to the need for more health professionals in Northern Ontario. It has gradually expanded its role to address the issue of health human resources in southern communities.

The program is administered by Health Care Programs Division, North Region Branch, to enhance access to health care services in designated rural and remote areas of the province, which have difficulty attracting and retaining health care professionals. It offers a variety of components aimed at attracting and retaining health care providers to underserviced areas in Ontario. In order to access the UAP's recruitment and retention benefits, a community must be designated as underserviced.

For more information refer to:

http://www.health.gov.on.ca/english/providers/program/uap/uap_mn.html

6.10 Academic Health Science Centre / Alternate Funding Plan

An Academic Health Science Centre (AHSC) is the coming together of medical staff that holds both privileges at the teaching hospital and an academic appointment from the university; fully affiliated teaching hospital(s); and a university with a faculty of health sciences or a school of medicine. The function of an AHSC is to provide education, research and clinical services.

An AHSC Alternative Funding Plan (AFP) is a contract between academic physicians, teaching hospitals, universities, the Ontario Medical Association (OMA) and the Ministry of Health and Long-Term Care (MOHLTC) that sets out non-fee-for-service funding for a range of services and which aligns the interests of the parties by merging multiple funding sources for the remuneration of involved medical staff for clinical service, education, research and associated administration.

In exchange for the merger of funding sources, the parties of an AFP agree to meet a comprehensive set of deliverables in clinical service, education, research and associated administration.

6.11 Homes for Special Care

The Homes for Special Care (HSC) Program was established in 1964 to provide long-term and permanent residential care to persons discharged from Provincial Psychiatric Hospitals (PPH) who require supervision or assistance with activities of daily living. The program encourages community living by offering a housing alternative to institutional care.

For more information refer to:

http://www.health.gov.on.ca/english/providers/program/hsc/hsc_mn.html