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Ministry of Health
Ministry of Long-Term Care

Ontario Health Insurance Plan

INFOBulletin

Virtual Health Care in Ontario

Introduction of the new virtual care model in the Ontario health care system

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To: All physicians
Category: Physician Services; Primary Health Care Services
Written by: Negotiations Branch, Physician and Provider Services Division
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Contents

Virtual Care - Background and Resources

The Ministry of Health (ministry) and the Ontario Medical Association (OMA) have been working together to implement the 2021 Physician Services Agreement (PSA).

Effective December 1, 2022, the Schedule of Benefits <https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf> (the Schedule) has been amended to reflect the new virtual care funding framework, as set out in the PSA and communicated in INFOBulletin 221002 <https://health.gov.on.ca/en/pro/programs/ohip/bulletins/redux/bul221002.aspx> .

The new virtual care model is only applicable to service dates on or after December 1, 2022. For virtual services rendered prior to December 1, 2022, providers may continue to bill using the temporary COVID-19 K-codes and/or through the Ontario Virtual Care Program.

Education and Prevention Committee (EPC) Billing Briefs are prepared jointly by the ministry and the OMA. They provide general advice and guidance to physicians on OHIP billing matters.

You can find EPC Billing Briefs in the Resources for Physicians <https://www.health.gov.on.ca/en/pro/programs/ohip/> page of the ministry's website.

EPC Billing Briefs are now available for:

- Virtual Care 1: Comprehensive and Limited Virtual Care Services <https://www.health.gov.on.ca/en/pro/programs/ohip/billing_briefs/virtual_care_services.aspx>
- Virtual Care 2: Terms and Conditions <https://www.health.gov.on.ca/en/pro/programs/ohip/billing_briefs/virtual_care_services_tc.aspx>

COVID-19 Virtual Care K-Codes

The existing K080A-K083A and K092A-K095A virtual care K-codes will be ended on November 30, 2022. Claims submitted with a service date of December 1, 2022, or later will reject to the provider's error report with error code 'A3E - No Such F.S Code'.

Modality Indicators

Effective December 1, 2022, physicians will continue to use the K300A (Video) or K301A (Telephone) modality indicators to identify the technology used to deliver the service when claiming comprehensive virtual care services. These fee codes must be submitted on the same claim using the same service date as the eligible insured virtual service.

If a claim has both a Video and Telephone modality on a matching service date, the claim will reject to the provider's error report with new error code 'AT1 - Only One Modality Allowed'.

The modality indicators cannot be claimed alone. If a K300A or K301A is submitted as the sole code on a service date, it will reject to the provider's error report with error code 'AD8 - Not Allowed Alone'.

For new virtual care claims with service dates on or after December 1, 2022, the tracking codes K300A and K301A will pay at $0.00 and now be processed with an explanatory code of '30'.

Claims submitted for the temporary COVID-19 virtual K-codes with service dates prior to December 1, 2022, will continue to have the K300A and K301A processed with an explanatory code of '33'.

Eligible Providers and Payment Programs

Virtual services can be claimed for the eligible insured services listed in Appendix J <https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=819> of the Schedule and can be provided under payment programs Health Claims Payment (HCP) and Workplace Safety and Insurance Board (WCB).

Providers with a billing number in the range of 010009 to 333798 and 333800 to 398999 are eligible to submit virtual care claims.

Optometrists, podiatrists, and dental surgeons are not eligible to submit claims for physician virtual care services under this new virtual care model.

At the time of service, both the patient and provider must be physically present in Ontario for insured in-province services to be eligible for payment.

Virtual care services are not eligible to be submitted through Reciprocal Medical Billing (RMB). RMB claims submitted with a K300A or K301A will reject to the provider's error report with error code 'R04 - Service Excluded from RMBS'.

Options for payment for Out-of-Province patients who receive an eligible virtual service within the province of Ontario by an Ontario physician include:

- Submitting a paper claim directly to the patient's home plan (e.g., QC); or
- Charging the patient directly

Physicians can use the standard "Out of Province Claim for Physician Services" form (0000-80) *<https://forms.mgcs.gov.on.ca/dataset/014-0000-80>* .

If payment is received directly from a patient, in addition to a detailed invoice of the services provided, (i.e., 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.

Registered Third Party Billing Agencies (RTPBA) are not eligible to submit claims for virtual care services. RTPBAs submitting claims with the K300A or K301A will reject to the provider's error report.

Patient-Physician Relationship

To submit comprehensive virtual care services for payment under the new virtual care payment structure, physicians must establish a patient-physician relationship prior to submitting applicable Fee Schedule Codes (FSCs).

The definition and criteria of a patient-physician relationship can be found in the Schedule under the Virtual Care Services section titled Existing/Ongoing Patient-Physician Relationship *<https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=198* . This is also further discussed in EPC Billing Brief Virtual Care 1: Comprehensive and Limited Virtual Care Services *<https://www.health.gov.on.ca/en/pro/programs/ohip/billing_briefs/virtual_care_services.aspx>* .

Comprehensive Virtual Care Services

Comprehensive virtual care services are video and/or telephone services insured and payable under existing or new FSCs listed in Appendix J, Section 1 *<https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=819* of the Schedule. Appendix J also indicates the eligible modality for each service.

Comprehensive virtual care services must be rendered in the context of an existing/ongoing patient-physician relationship *<https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=198* and meet the criteria as defined in the Schedule.

Virtual care services billed as comprehensive services that do not meet the patient-physician relationship criteria will reject to the provider's error report with new error code 'AT3 - No Pat-Phys Relationship'. These may be resubmitted as limited virtual services if appropriate conditions are met.

New Comprehensive Virtual Care Services

The following new comprehensive virtual care FSCs are effective December 1, 2022, and are only eligible for payment when rendered by video:

Table A: New comprehensive virtual care services effective December 1, 2022

Fee Code	Service Descriptor	Modality
A814A	Midwife or Aboriginal Midwife-Requested Assessment (MAMRA) by Video	Video
A817A	Midwife or Aboriginal Midwife-Requested Special Assessment (MAMRSA) by Video	Video
A818A	Midwife or Aboriginal Midwife-Requested Anaesthesia Assessment (MAMRAA) by Video	Video
A010A	GP Focused practice consultation by Video	Video
A011A	GP Focused practice repeat consultation by Video	Video
A906A	GP Focused practice limited consultation by Video	Video

A913A	GP Focused practice special consultation by Video	Video
A914A	GP Focused practice comprehensive consultation by Video	Video

If the new virtual care services above are claimed without the required K300A video modality indicator, the claim will reject to the provider's error report with new error code 'AT2 - Must Include Vid Modality'.

The A814A, A817A, and A818A require a valid midwife or aboriginal midwife referral number. Claims that do not include a valid referral number will reject to the provider's error report with error code 'AC4 - Unacceptable Ref. No.'.

The A010A, A011A, A906A, A913A, and A914A can only be billed by a GP Focused Practice Physician or a physician who is eligible for the focused practice psychotherapy premium as defined in the Schedule. When billed by providers who are ineligible, these codes will reject to the provider's error report with error code 'ESF - Not Elig to Bill FSC'.

If a GP Focus Practice Designated physician has their Focus Practice designation ended retroactively prior to the service date of a previously approved A010A, A011A, A906A, A913A, or A914A claim, the claim will be reprocessed and paid at $0.00 with new explanatory code 'B3 - Patient-Physician Relationship Requirements Not Met'.

As per the Schedule, if more than one MAMRA (A813A or A814A), MAMRSA (A815A or A817A), or MAMRAA (A816A or A818A) of the same type are billed for the same patient, same service date, by the same provider, the following outcome will occur:

- If the in-person service was paid first, the virtual care service will be paid at $0.00 with new explanatory code 'B4 - Virtual Service not allowed in addition to In-Person Equivalent Service'.
- If the new virtual care service was paid first, the in-person service will be paid at $0.00 with new explanatory code 'B5 - In-Person Service Not Allowed in Addition to Virtual Equivalent Service'.
- If both are submitted on the same claim with the video modality indicator and the same service date, the in-person service will be paid at $0.00 with new explanatory code 'B8 - Service Not Eligible for Payment Virtually' and the virtual services will be adjudicated for payment where eligible.

If a GP Focused Practice Physician is claiming the new GP Focused Practice virtual video services to the same patient on the same service date as an in-person service, consultation (A010 or A005), repeat consultation (A011 or A006), limited consultation (A906 or A905), special consultation (A913 or A911), or comprehensive consultation (A914 or A912) the following outcome will occur:

- If the in-person service was paid first, the virtual care service will be paid at $0.00 with new explanatory code 'B4 - Virtual Service not allowed in addition to In-Person Equivalent Service'.
- If the new virtual care service was paid first, the in-person service will be paid at $0.00 with new explanatory code 'B5 - In-Person Service Not Allowed in Addition to Virtual Equivalent Service'.
- If both are submitted on the same claim with the video modality indicator and the same service date, the in-person service will be paid at $0.00 with new explanatory code 'B8 - Service Not Eligible for Payment Virtually' and the virtual services will be adjudicated for payment where eligible.

New Limited Virtual Care Services

The following limited virtual care services are new video and telephone services insured and payable outside of an existing/ongoing patient-physician relationship. Limited virtual care services can be found in the Schedule in Appendix J, Section 2.

Table B: Limited Virtual Care Services effective December 1, 2022

Fee Code	Descriptor	Modality
A101A	Limited virtual care service - video	Video

A102A	Limited virtual care service - phone	Phone

The limited virtual care services will not establish a patient-physician relationship as they are provided outside the context of an Existing/Ongoing Patient-Physician Relationship.

The A101A and A102A limited virtual care services require a valid diagnostic code on the claim.

The A101A and A102A limited virtual care services do not require a K300A or K301A modality indicator. However, if one of the modality code indicators is submitted with an A101A or A102A, the claim will not reject and will be adjudicated for payment where eligible.

Both A101A and A102A cannot be billed on the same day, by the same provider for the same patient. If they are submitted on the same claim, or one has already been paid subsequent limited virtual care services beyond the first will be paid at $0.00 with new explanatory code 'B6 - Limited Virtual Care Service Already Paid'.

If it is medically necessary to provide two or more limited virtual care services on the same day to the same patient, the provider can submit subsequent claim(s) flagged for manual review and provide supporting documentation.

The A101A and A102A will not contribute as qualifying services/minimum service requirements for payment of premiums and management fees, including the following:

- K045A - Endocrinology & Metab/Internal Med-Diabetes management by a specialist-annual
- K046A - Endocrinology & Metab/Internal Med-Diabetes team management-annual
- K119A - Paediatrics-Paediatric developmental assessment incentive-annual
- K481A - Rheumatology-Rheumatoid arthritis management by a specialist-annual
- K682A - Opioid Agonist Maintenance Program monthly management fee-intensive, per month
- K683A - Opioid Agonist Maintenance Program monthly management fee-maintenance, per month
- K684A - Opioid Agonist Maintenance Program-team premium, per month, to K682A or K683A add

Primary Care

Included/Core Services

The new virtual care FSCs A010A, A011A, A814A, A817A, A818A, A906A, A913A, A914A, A101A, and A102A have been added as included/core services for all primary care models.

Approved claims for enrolled patients will be paid at $0.00 with an I2 explanatory code and compensated at the shadow billing rate where appropriate for each model. Family Health Group (FHG) and Comprehensive Care Model (CCM) physicians will be paid Fee-For-Service (FFS).

If a provider's affiliation or a patient enrolment status is changed retroactively, any previously submitted virtual care claims will be re-processed to determine if payment remains valid based on the patient-physician relationship requirements. If the patient-physician relationship criteria are no longer met after a virtual care claim was previously paid, the virtual care service will be adjusted and approved and paid at $0.00 with new explanatory code 'B3 - Patient-Physician Relationship Requirements Not Met'.

Outside Use

Primary care core services provided virtually, where eligible, will contribute to outside use for the enrolling physician when provided to an enrolled patient by a general practitioner outside of the patient's group at the rate paid for the virtual service.

GP Focused Practice Physicians providing virtual care services to enrolled patients will continue to be exempt from contributing to the enrolling physicians' Outside Use, where eligible.

The new A010A, A011A, A906A, A913A, and A914A GP Focus Practice designated services will also be exempt from Outside Use.

After-Hours

Primary care after-hours services provided virtually, where eligible, will continue to be payable using the existing after-hours premium or tracking codes. This includes:

- Q012A for FHG, Family Health Network (FHN), Family Health Organization (FHO), Group Health Centre (GHC), Blended Salary Model (BSM), Rural and Northern Physicians Group Agreement (RNPGA), St. Joseph's Health Centre (SJHC), Weeneebayko Area Health Authority (WAHA) physicians

- Q016A for CCM physicians
- Q017A for GP Focused Practice (GPFP) HIV physicians
- Q018A for GPFP Care of the Elderly 1 physicians
- Q091A for Toronto Palliative Care Associates (TPCA) and GP Focused Palliative Care (GPFPC) physicians

After-hours codes must be submitted on the same claim as the eligible virtual service and modality indicator to be eligible for payment.

The new A101A and A102A limited virtual care services <https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=199> are not eligible for after-hours premiums.

TPCA and GPFPC physicians do not need to include the Special Visit Premium on eligible virtual After-Hours claims to be eligible for the premium payment.

Thresholds (Hard Cap and After-Hours)

Primary care core services provided virtually, where eligible, to non-enrolled patients will accumulate to the physicians FFS Hard Cap or After-Hours Thresholds as per existing rules of the model.

Alternate Payment Plan/Alternate Funding Plan

Virtual care services provided by physicians billing under an Alternate Payment Program (APP) and Alternate Funding Plan (AFP) will be paid according to their agreements. Claims for shadow-billing group will be paid at $0.00 with an I2 explanatory code and paid the applicable shadow-billing rate and flow through payments.

Premiums, Management Fees, and Special Premiums

Premiums

In addition to the primary care after-hours premiums identified above, the premiums and management fees eligible under virtual care are identified in the Schedule under the heading Virtual Care Services - Premium and Management Fees <https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=206> as well as in Appendix Q <https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=832>. These premiums are payable when providing eligible comprehensive virtual care services and when the necessary Schedule requirements have been met.

Where premiums require an accompanying/qualifying comprehensive virtual care service to be eligible for payment, it is strongly recommended the premium is billed on the same claim with the eligible virtual service for accurate adjudication. If billed separately from eligible virtual services, payment may not be correct.

If a comprehensive virtual service has been submitted separately and the premium is allowed to be submitted separately, then the premium can be submitted on a separate claim with a matching modality indicator.

Additionally, a Remittance Advice Inquiry (RAI) can always be submitted to correct any claim that was incorrectly submitted or paid.

Examples:

1. A163A and E060A provided virtually via video should be billed on the same claim and same service date along with the K300A.
2. A007A was submitted with a K301A telephone modality indicator. Later, it was discovered the E079A premium was not added to the claim. E079A with a matching K301A can subsequently be submitted with the same service date as the A007A.
3. A007A was provided to an enrolled patient via video after-hours by a Family Health Organization (FHO) physician. It should be submitted with a K300A and a Q012A after-hours premium on the same claim.
4. A007A was provided to an enrolled patient via telephone after-hours by a FHO physician, it should be submitted with a K301A and the Q012A. However, it was discovered that the Q012A was missed. An RAI must be submitted to correct the claim as Primary Care After-Hours premiums must be billed on the same claim to be eligible for payment.

Management Fees

Eligible comprehensive virtual care services will contribute to eligible management fees listed in the Virtual Care Services section of the Schedule, with the following additional criteria:

1. A virtual 'K030A - Diabetic management assessment' service is only payable if an in-person K030A has been billed in the preceding 12 months by the same physician.
   - If an in-person K030A is not found in the preceding 12 months, the virtual K030A will be approved at $0.00 with new explanatory code 'B8 - Service Not Eligible for Payment Virtually'.

2. The 'Q040A - Diabetes management incentive' is only payable if at least one of the required K030A services by the same physician were provided in-person.
   - If an in-person K030A is not found in the preceding 12 months, the virtual Q040A will be approved at $0.00 with explanatory code 'MR - Minimum Service Requirements Have Not Been Met'.
   - Q040A cannot be submitted with the K300A and K301A modality indicators.

3. A007A provided virtually is not eligible for the Q014A and Q015A Newborn Care Episodic Fee.
4. The 'W010A - Monthly management fee' is not eligible to be billed virtually. The requirements of W010A remain the same and must be provided in-person. If the W010A is billed with a modality indicator, it will be approved at $0.00 with new explanatory code 'B8 - Service Not Eligible for Payment Virtually'.

Special Premiums

Where existing requirements are met, eligible comprehensive virtual care services and FSCs identified in Appendix J, Section 1 and Appendix Q of the Schedule billed virtually will contribute to eligible Special Premiums as follows:

1. Q020A and Q021A billed with a modality indicator will contribute to the Primary Care-Serious Mental Illness (PC-SMI) Special Premium
2. C010A billed with a modality indicator will contribute to the Hospital Special Premium

Additional Information for Claim Submission and Payment of Virtual Care Services

All existing payment rules and restrictions for the services listed in Appendix J of the Schedule will apply to claims with services submitted with a virtual care modality indicator.

A full listing of new error and explanatory codes can be found in Appendix A of this INFOBulletin.

In-Person and Virtual Services to the Same Patient

In-person services should not be billed with any modality indicators.

If an in-person service was rendered on the same service date as a virtual care service by the same physician to the same patient, the services must be submitted on separate claims to ensure proper adjudication and payment of the claim.

In-person and virtual care services provided to a patient on the same service date and submitted on the same claim will result in the in-person services being adjudicated as though they were virtual services due to the presence of the K300A or K301A.

In-person and virtual care services provided to a patient on different service dates can be submitted on the same claim and will be processed accordingly for payment where eligible.

In-person services ineligible for virtual care accidentally submitted with a modality indicator and paid at $0.00 with explanatory code 'B8 - Service Not Eligible for Payment Virtually' can be resubmitted for payment without a modality indicator.

Multiple virtual care services delivered to the same patient, on the same service date, may be submitted on the same claim with one modality indicator providing those services were delivered via the same modality. If different modalities were utilized to deliver the virtual services, they will need to be submitted on separate claims. If medically necessary, subsequent claims for the same service date may need to be flagged for manual review with supporting documentation if regular payment rules are preventing payment where eligible.

Payment Rates for Virtual Care

Approved comprehensive virtual care services provided by video are payable at the corresponding in-person rate set out in the Schedule.

As detailed in the Schedule under the payment rules in the Virtual Care Services <https://www.health.gov.on.ca/en/pro/programs/ohip/sob/physserv/sob_master_20221201.pdf#page=202 section, approved comprehensive virtual care services provided by telephone are payable at 85% of the corresponding in-person rate in the Schedule (rounded to the nearest 5 cents). Except for the following services provided by telephone, which are payable at 95% of the corresponding in-person rate in the Schedule (rounded to the nearest 5 cents):

- K005A - Primary Mental Health
- K007A - GP Psychotherapy
- K197A - Individual Out-Patient Psychotherapy
- K198A - Outpatient Psychiatric Care

Telephone claims adjusted to pay at the 85% or 95% rate will be accompanied by new explanatory code 'B2 - Paid in accordance with the OHIP Schedule of Benefits for Telephone Virtual Care Services'.

In some cases, the 'B2' explanatory code may be overwritten with other informational explanatory codes as necessary. These claims may still be paid at the Schedule rate for telephone services depending on the payment circumstances. An example of this is claim adjustments accompanied by explanatory code '57 - This payment is an adjustment on an earlier account'.

Please note that claims for comprehensive virtual care services should be submitted using the in-person fee value, regardless of whether the service is rendered by video or telephone. Payments for telephone services will be automatically paid at the rate in the Schedule.

Additional Claim Processing and Error Handling

Claims submitted with a modality indicator that only contain services not eligible for payment when rendered virtually (services that are not listed in Appendix J of the Schedule) will be paid at $0.00 with new explanatory code 'B8 - Service Not Eligible for Payment Virtually'.

Claims submitted with a K301A Telephone modality for services that are only eligible for payment when delivered by Video (as identified in Appendix J of the Schedule) will be paid at $0.00 with new explanatory code 'B1 - Service Not Eligible for Payment When Delivered by Telephone'.

Comprehensive virtual care services and limited virtual care services are not payable for the same patient, same service date, by the same physician. If both are claimed the following outcomes will occur:

- If a comprehensive virtual care service was paid first, the incoming limited virtual care service will be approved at $0.00 with new explanatory code 'B7 - Comprehensive Virtual Care Service Already Paid'.
- If a limited virtual care service was paid first, the comprehensive virtual care service may:
  - Be rejected depending on the virtual service that was submitted, i.e. counselling services not allowed in addition to assessments.
  - Be reduced by the value of the paid limited virtual care service with explanatory code 'DC - Procedure paid previously not allowed in addition to this procedure - fee adjusted to pay the difference'. If the total fee paid would be reduced to zero or less, the comprehensive virtual care service will be approved at $0.00 with explanatory code 'D7 - Not Allowed in Addition to Other Procedure'.

Claims submitted with a modality indicator which contain services that are eligible to be provided virtually as well as services not eligible for payment when rendered virtually (those not listed in Appendix J of the Schedule) all on the same service date will have the non-virtual care eligible services approved at $0.00 with new explanatory code 'B8 - Service Not Eligible for Payment Virtually'. Allowable virtual care premiums will be processed where eligible and will not receive the B8 explanatory code.

Examples:

- Claim A
  Item 1: A007A with a service date of 2023-01-01
  Item 2: K300A with a service date of 2023-01-01
  Item 3: A007A with a service date of 2023-01-20
  Item 4: C010A with a service date of 2023-02-01
  Item 5: K300A with a service date of 2023-02-01

Outcome: All claims will be processed for payment where eligible

- Claim B
  Item 1: A007A with a service date of 2023-01-01
  Item 2: K300A with a service date of 2023-01-01
  Item 3: G538A with a service date of 2023-01-20
  Item 4: K300A with a service date of 2023-01-20
  Item 5: C010A with a service date of 2023-02-01

  Outcome: The G538A will be approved at nil with a B8 Explanatory Code. The remaining claim items will be processed for payment where eligible.

- Claim C
  Item 1: A007A with a service date of 2023-01-01
  Item 2: K300A with a service date of 2023-01-01
  Item 3: G538A with a service date of 2023-01-20
  Item 4: K300A with a service date of 2023-01-20
  Item 5: A007A with a service date of 2023-01-20
  Item 6: C007A with a service date of 2023-02-01

  Outcome: The G538A will be approved at nil with the explanatory code B8. The remaining claim items including the A007A with a service date of 2023-01-20 will be processed for payment where eligible.

Special Visit Premiums are not eligible to be billed virtually. A Special Visit Premium billed with a modality indicator will be approved at $0.00 with new explanatory code 'B8 - Service Not Eligible for Payment Virtually'.

Existing Indirect Services

Existing indirect services (not in-person) already in the Schedule will continue to be eligible for payment, as normal, where existing requirements for payment are met. These services do not require a virtual care modality indicator.

The following is a list of the services that fall under this category:

- G063A - Initiation of outpatient continuous nerve block infusion
- G064A - Management and supervision of outpatient continuous nerve block infusion or outpatient palliative epidural infusion
- G098A - Transfusion support weekly fee
- G100A - Haemophilia infusion weekly fee
- G101A - Home/self-care ventilation weekly fee
- G271A - Anticoagulant supervision
- G334A - Telephone supervisory fee for ovulation induction with human menopausal gonadotropins or gonadotropin-releasing hormone (not eligible for payment same day as visit), to a maximum of 10 per cycle)
- G382A - Supervision of chemotherapy
- G388A - Management of special oral chemotherapy, for malignant disease
- G500A - Diabetes monthly management - month in which insulin injections (2 or more daily) or insulin by pump is initiated; or month in which initial assessment by a specialist of a diabetic patient treated with insulin injections (2 or more daily) or insulin by pump occurs, 1 or more
- G511A - Telephone management regarding a patient receiving palliative care at home
- G512A - Weekly palliative care case management fee
- G514A/G520A - Diabetes monthly management - each additional month (1-3 contacts); or each additional month (4+ contacts)
- G860A-G866A - Chronic dialysis weekly team fee
- K313A - Physiatric management
- K034A - Telephone reporting - specified reportable disease to a MOH
- K071A - Acute home care supervision (first 8 weeks)
- K072A - Chronic home care supervision (after 8th week)
- K077A - Geriatric telephone support
- K090A/K091A - Pre-op and post-op medical management of bariatric surgery
- K480A - Physician to allied professional telephone consultation (rheumatology)
- K708A/K709A/K710A - Multidisciplinary cancer conferences

- K121A/K700A/K704A/K701A/K702A/K703A/K707A/K124A/K705A/K706A - Case conferences
- K730A/K731A/K734A/K735A - Physician/NP to physician telephone consultations
- K732A/K733A/K736A/K737A - Critical telephone consultation
- K738A/K739A - E-consultations
- U025A/U023A/U026A/U021A/U235A/U233A/U236A/U231A - E-assessments

Tracking Codes

The following tracking codes are permissible with a virtual service and a modality indicator on the same claim, same service date, for the same patient.

- Q006A - Frail Elderly Patient
- Q011A - Tracking code for Pap Smear
- Q020A - Tracking code for Bipolar Disorder
- Q021A - Tracking code for Schizophrenia
- Q130A - Influenza tracking code
- Q131A - Mammogram tracking code
- Q132A - Childhood immunization tracking code
- Q133A - Colorectal screening tracking code
- Q140A - Pap Smear exclusion
- Q141A - Mammogram exclusion
- Q142A - Colorectal exclusion

If a claim is submitted with a tracking code not in the list above on the same service date as a modality indicator, the claim will reject to the physician's error report with new error code 'AT4 - Modality Not Allowed'.

Ontario Virtual Care Program (OVCP)/Telemedicine (OTN)

The use of OVCP/Telemedicine B-prefix FSCs within OVCP will be ended on November 30, 2022, in alignment with the previously communicated ending of the OVCP video visit claims submission and payment option INFOBulletin 221102 *<https://health.gov.on.ca/en/pro/programs/ohip/bulletins/redux/bul221102.aspx>* .

Claims submitted with a service date after November 30, 2022, with:

- the 'OTN' Service Location Indicator (SLI) will reject to the provider's error report with new error code 'V73 - OTN SLI No Longer Active'; and/or
- an OVCP B-prefix code (e.g., B203A) will reject to the provider's error report with error code 'A3E - No Such F.S. Code'. *****

***Please note** B103A will remain available as a tracking code within the OHIP insured framework for video services rendered at patient host sites, for use where this has been required by a separate agreement.

Keywords/Tags

OHIP; Virtual Care; Video; Telephone; Virtual; Virtual Visits; Ontario Virtual Care Program; OVCP; Telemedicine; OTN; COVID-19; K-Codes; K300A; K301A; Physician Services Agreement; Physicians; Providers

Contact Information

Do you have questions about this INFOBulletin? Email the Service Support Contact Centre *<mailto:SSContactCentre.MOH@ontario.ca>* or call 1-800-262-6524.

Find INFOBulletins online on the Ministry of Health website. *<http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/>*

Appendix A - List of New Virtual Care Error and Explanatory Codes

Error Codes
AT1 - Only One Modality Allowed
AT2 - Must Include Vid Modality
AT3 - No Pat-Phys Relationship

AT4 - Modality Not Allowed
V73 - OTN SLI No Longer Active

Explanatory Codes
B1 - Service Not Eligible for Payment When Delivered by Telephone
B2 - Paid in accordance with the OHIP Schedule of Benefits for Telephone Virtual Care Services'
B3 - Patient-Physician Relationship Requirements Not Met
B4 - Virtual Service not allowed in addition to In-Person Equivalent Service
B5 - In-Person Service Not Allowed in Addition to Virtual Equivalent Service
B6 - Limited Virtual Care Service Already Paid
B7 - Comprehensive Virtual Care Service Already Paid
B8 - Service Not Eligible for Payment Virtually

For More Information

Call **ServiceOntario**, INFOline at:
1–866–532–3161 <*tel:+1–866–532–3161*> (Toll–free)
In Toronto, (416) 314–5518 <*tel:416–314–5518*>
TTY 1–800–387–5559 <*tel:+1–800–387–5559*> .
In Toronto, TTY (416)327–4282 <*tel:416–327–4282*>
Hours of operation: Monday to Friday, 8:30am – 5:00pm