OMA
ONTARIO MEDICAL ASSOCIATION

January 2011 Edition

Physician's Guide to Third Party and Other Uninsured Services

A Guide for Ontario Physicians — Billing for Uninsured Services

Dedicated to Doctors. Committed to Patients.

Disclaimer: Every effort has been made to ensure that the contents of this *Guide* are accurate. Members should, however, be aware that the laws, regulations and other agreements may change over time and between editions of this *Guide*. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of the applicable Third Party Regulations with the Government of Ontario including but not limited to the Ministry of Health and Long-Term Care (MOHLTC), and the College of Physicians and Surgeons of Ontario (CPSO). Members are advised that the ultimate authority in matters of interpretation and payment of insured services (as well as determination of what constitutes an uninsured service) are in the purview of the government. Members are advised to request updated billing information and interpretations – in writing – from medical consultants at their local MOHLTC office or the Provider Services Branch of the MOHLTC.

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Introduction

This *Guide* is dedicated to providing OMA members with guidance on uninsured and third party requested services, suggested fees, relevant policies and interpretation of relevant Regulations applying to such services. Wherever possible, specific issues will be highlighted for members and reference information will be provided for those members wishing to further research the specific issue at hand.

Uninsured medical services are not covered by the Ontario Health Insurance Plan (OHIP) and may be charged directly to the patient or third party at the discretion of the physician. Third Party services are defined as any service (including an annual health exam) received by a patient who, in whole or in part, is necessary for the production or completion of a document or transmission of information to satisfy the requirements of a party other than the patient. [Note: "transmission of information" also includes situations in which physicians provide information to their patients during the medical assessments. The medical assessments are considered third party requests when patients use this information to complete a third party requested form].

The definition of Third Party Services along with descriptions and excerpts of the applicable Regulations can be found online: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_e.htm#bk9

Suggested rates contained in this *Guide* apply to uninsured services of "average" complexity and are intended to offer assistance in establishing appropriate and practice-specific billing rates. Physicians should, however, use their discretion on how much they wish their fees to deviate from the OMA suggested rates - depending on the complexity of the particular uninsured services in question.

According to Regulation 856/93 under the *Medicine Act,* it is professional misconduct to charge a *"fee for a service that exceeds the fee set out in the then current schedule of fees published by the Ontario Medical Association without informing the patient, before the service is performed, of the excess amount that will be charged".* (Section 1(1) 22)

The OMA Schedule of Fees now applies a multiplier to the amount payable for each OHIP fee code to calculate the amount payable for the clinical service if it was uninsured. The OMA recommends that physicians charge the fee calculated by this process for uninsured services. Physicians may charge more for their uninsured clinical services, but should be aware that it is professional misconduct to,

1) Charge a fee that is excessive in relation to the services performed, and

2) Charge a fee for a service that exceeds the fee set out in the then current Schedule of Fees published without informing the patient, before the service is performed, of the excess amount that will be charged.

(See section 1(1) paragraph 21 and 22 O. Reg. 856/93 under the Medicine Act – see http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_930856_e.htm)

Please note that the majority of the information provided to physicians in this *Guide*, unless otherwise specifically noted, does **not** apply to WSIB Claims and requested Reports which are captured under the Workplace Safety and Insurance Act 1996, formerly the WCB Act.

I. Fee Setting for Uninsured Services

Calculating Fees for Uninsured Services

Using the Multiplier:

The OMA Economics Department developed a multiplier that allows a physician to calculate a fee for an uninsured service rendered based on the fees listed in the OHIP Schedule of Benefits.

2011 multiplier = 1.99

Effective April 1, 2011, any fee listed in the OHIP Schedule of Benefits can be multiplied by **1.99** to obtain the **OMA suggested fee for the service or procedure**. Prior to April 1, 2011, physicians should continue to use the previous multiplier: **1.98.**

The multiplier is calculated based on the premise that the rates currently paid for medical services under the provincial health care plan are not reflective of what the rates would be in an "open market". Therefore, this calculation will assist in the determination of a reasonable rate for an uninsured medical service that reflects current market conditions.

The rates calculated represent medical services of "average" complexity and, as such, physicians should modify their charges accordingly when the complexity and time for the medical service deviate from those of the "average" service, provided that there is a compliance with the Medicine Act.

Setting Fees for Uninsured Services

This *Guide* contains suggested fees for a number of more common forms and services that are typically requested by third parties. There are a number of forms, reports and services that are not specified, and in these cases physicians can use one of the following methodologies to establish the appropriate fee:

1. ***At the Physician's Cost:*** Defined as the actual, direct or invoice cost (including applicable taxes) incurred by the physician, plus a reasonable mark-up to account for secretarial and other indirect costs.

2. ***Independent Consideration:*** Defined as an "acceptable professional rate", taking into account the following factors:

    a. Nature and complexity of the matter;
    b. Experience and expertise of the physician;
    c. Time spent with and/or on behalf of the patient; and
    d. The cost of materials not included in the fees for insured services.

3. ***Establish an Hourly Rate***

In the absence of a specific fee recommendation for an uninsured service, physicians could consider establishing an hourly rate to assist in determining the appropriate fee. Given the diversity of physician practices and nature of uninsured services provided, the OMA does not have a suggested hourly rate. As such, it is incumbent upon the physician to establish their own hourly rate.

Appendix I provides an example on how an hourly rate can be derived based on an individual physician's annual gross income.

As described in **Part VI** of this Guide (Scale of Grading and Remuneration), the average net part-time employment hourly rate for General and Family Practitioners and Specialists is calculated to be **$321/hour**. This figure was calculated based on survey information gathered by the Committee on Economics in 2004.

Examples of Common Uninsured Services

The Health Insurance Act (Reg. 552, 1990) specifies a number of services rendered by physicians or practitioners that are not insured services and are not part of the insured services unless they are specifically listed as an insured service or as part of an insured service in the OHIP Schedule of Benefits.

Examples of services that are often billed at the physician's cost:

- Toll charges for long-distance telephone calls.
- Preparing/providing a drug, antigen, antiserum or other substances used for treatment (but not used to facilitate the procedure/examination).
- Preparing or providing a device that is not implanted by means of an incision and that is used for therapeutic purposes (e.g., IUD). Exceptions to this are if the device is used to permit or facilitate a procedure or examination, or if the device is a cast for which there is a fee listed in the OHIP Schedule of Benefits, in which case the patient cannot be charged a fee.

Examples of services often billed on an independent consideration basis:

- Missed appointments or procedures if less than 24-hours notice has been given (an exception being psychotherapy practices where a reasonable written agreement exists between the patient and physician).
- A service that is solely for the purpose of altering or restoring appearance.
- Providing a prescription to an insured person if the person or person's personal representative requests the prescription and no concomitant insured service is provided.
- Travelling to visit an insured person outside the usual area of medical practice, which is defined by the Ontario Medical Association as greater than 8 kilometres or 15 minutes of travel.

For the direct source of the applicable Regulations outlining which services are deemed to be uninsured, please refer to Section 24, Regulation 552 Revised Regulation of Ontario, 1990, under the Health Insurance Act: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_e.htm#BK8

Additional services that are not considered insured benefits of OHIP are listed in **Appendix II** (refer to page 28).

Definition of Third Party Services

In addition to outlining services deemed uninsured, the Health Insurance Act (Reg. 552, 1990) also defines third party services as any service (including an annual health exam) received by a patient, which in whole or in part is necessary for the production or completion of a document or transmission of information to satisfy the requirements of a party other than the patient.

Physicians cannot bill OHIP but may charge patients or a third party wherever possible, in the event that they are aware the information provided to the patient during the medical assessment will be used by the patient at a later date to complete a third party requested form. In the event a physician has billed OHIP prior to learning the service pertains to a third party request, the OHIP claim must be reversed, allowing for the physician to bill the appropriate party (patient, third party).

Nothing in the third party regulation allows a physician to bill:

(a) For keeping or maintaining appropriate physician records;

(b) For conferring with, or providing advice, direction, information, or records to physicians or other professionals concerned with the health of the insured person;

(c) For obtaining consents or delivering written consents; and/or

(d) An annual administrative or any other fee associated with office overhead costs (including but not limited to the cost of computerizing billings, storage of patient medical records, time spent arranging appropriate follow-up care for insured services, etc.).

Please refer to Section 24, Regulation 552 Revised Regulation of Ontario, 1990, under the Health Insurance Act for additional information on third party requested services or documents: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_e.htm#BK8

Block Fee Billing

A block fee is defined as a flat fee charged by a physician for a predetermined set of uninsured services during a pre-determined period of time (no less than three months and no more than a year). While not all physicians are in a position to charge a block fee due to the nature of their practice and specialty, it is also true that no physician preferring to charge on an uninsured fee-for-service basis is required to offer a block fee option.

Physicians may also enter into an annual fee arrangement with third parties for the provision of third party requested services.

The College of Physicians and Surgeons of Ontario (CPSO) has a policy on block fees which should be reviewed in detail before a physician constructs a block fee billing system. The policy can be found online at: http://www.cpso.on.ca/policies/policies/default.aspx?ID=1612.

The OMA's Practice Management and Advisory Service also provides information packages on implementing a block or annual fee program, as well as specific professional guidance if requested. Please visit the website at https://www.oma.org/Member/Programs/Practice/Pages/default.aspx or contact the department directly at Practiceadvisory@oma.org.

II. The Direct Billing Process

There are some practical guidelines physicians can follow when billing a patient directly, to help make the process as comfortable and efficient as possible.

Physician skill and expertise are valuable

It is common for some physicians to render uninsured services without billing for them, which is not common practice for professionals in other sectors of business. Anything that requires a physician's signature is a professional service and confers the right to charge for it.

Be cognizant of ethical considerations

When calculating fees, physicians should consider the financial burden such charges might place on the patient, and be prepared to reduce or waive fees based on these considerations.

General Guidelines for the Direct Billing Process

In order to establish an office policy on billing for uninsured services, physicians should first determine:

- Those services for which patients will be directly billed;
- The fees attached to those services;
- Any exemptions, such as seniors or those on fixed-incomes;
- Bookkeeping and collection procedures.

A physician's office policy on direct billing must be specific and detailed so that it is fully understood by staff and patients. At the same time, it should allow sufficient flexibility to adapt to any unique or unexpected circumstances that may be encountered.

Keep in mind the College of Physicians and Surgeons of Ontario (CPSO) Third Party Reports policy states the following:

"In order to avoid unnecessary delays in process, which often have significant impact for the patient/individual, reports should be provided to third parties within **60 days**, unless other arrangements are made. If additional time is required to prepare an appropriate report, due to complexity or other appropriate reasons, this should be discussed with the third party."

This policy can be found on the CPSO website at:
http://www.cpso.on.ca/policies/policies/default.aspx?ID=1658

Patients and their ability to pay for services

There are some instances where patients claim economic hardship and an inability to comply with the fees they are charged by doctors for the transfer of the records. It is important for OMA members to realize that rates in this *Guide* are *suggested* rates and that they should use their judgment in reducing the fees in instances of financial hardship. In fact, the Canadian Medical Association's Code of Ethics (2004) clearly states under Paragraph 16 that "*an ethical physician will consider, in determining professional fees, both the nature of the service provided and* ***the ability of the patient to pay*** *(emphasis added), and will be prepared to discuss the fee with the patient.*"

Furthermore, the Medicine Act prohibits physicians from *"charging a fee that is excessive in relation to the services performed"* (Section 1(1) 21). This information can be found online at: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_930856_e.htm

Keeping Patients Informed

Most difficulties between a physician and patient arise from a lack of clear communication. Many patients don't realize that there are some services the government doesn't pay for. Staff should ensure that patients are informed about uninsured services and the direct billing policy **in advance of providing services**.

The following are a few suggestions on informing patients about direct billing:

- Clearly display in the patient waiting area a sign (refer to **Appendix III**, on page 30) and an itemized list of those third party services offered.
- Discuss fees when the patient books an appointment for an uninsured service.
- Mention fees before providing the uninsured service.
- Consider publishing a pamphlet that contains the office's general information and direct billing information. Keep in mind that this pamphlet need not be a complicated and costly publication, however, it should reflect a physician's professionalism, and information should be presented in a clear and concise fashion.

Patients should be well informed regarding what services are uninsured and the cost associated with them. To avoid any misunderstanding and future patient claims to the contrary, the OMA suggests that upon informing the patients of the charges, the physician (or office staff) obtain a simple acknowledgment/consent that they have been advised of the charge for uninsured services, when the fee charged is of a significant amount.

Billing for Services and Collecting Payment

There are strategies that can be employed to make billing and collecting payment for uninsured services more efficient:

- Always discuss the fees and expected completion date with the patient/third party prior to performing the service.

- Don't hesitate to contact the third party (or the patient, where applicable) requesting information in the event the request is unclear, or if the request is unreasonable. It's not unusual for a third party to request a "copy of the patient's file" when in reality, the third party is looking for a specific piece of information. This saves the physician from performing unnecessary work and results in a more manageable fee to the requesting party. Refer to **Appendix III** (refer to page 30) for a set of sample letters that may be of assistance.

- Consider arranging a payment plan with the patient that aligns with their financial means.

Application of HST to Uninsured Services

General Information

Physicians who are HST registered are required to charge and collect tax at a rate of 13% on any taxable supplies (other than zero-rated supplies or exempt supplies) of goods and services they supply in the province of Ontario.

All physicians, whether registered or not, are required to pay HST at a rate of 13% on the purchase cost of most of their supplies (other than labour).

Physicians are required to register, collect and remit HST when their annual HST-taxable sales exceed $30,000.

For those physicians not exceeding this amount, HST registration is voluntary. Members should be aware that once registered as collectors and remitters of HST, they must continue to file reports even if the HST falls below the $30,000 threshold. Consequently, if a physician retires or significantly reduces his or her supply of HST-taxable services, he or she will have to formally de-register as a HST remitter to be able to cease providing monthly reports to the Canada Revenue Agency.

Additional Information about HST

The information contained in this section is only a general guideline. For the most accurate and up-to-date information pertaining to HST please contact the Canada Revenue Agency (CRA) toll-free at 1-800-959-8287 or refer to the CRA website at: http://www.cra-arc.gc.ca/tx/bsnss/tpcs/gst-tps/menu-eng.html or consult with your accountant and/or tax lawyer.

HST and Uninsured Services: General Guidelines

The following uninsured services are considered by the Canada Revenue Agency to be subject to HST:

- Cosmetic surgical procedures and all related medical services.
- Medical Reports upon a person who is not a patient of the physician or the physician has not examined i.e. based upon chart review only,[1]
- Block & Annual Fees
- Witness fees for court appearances[2]

The Canada Revenue Agency considers the following uninsured services to be HST exempt:

- Consultative, diagnostic, treatment or other health care service by a physician to an individual,[3] including,
  - Executive medical assessments,
  - Prescription renewal over phone.
- Preparation and transfer of Medical Records,
- Medical Reports upon patients or upon a person who the physician has examined including,
  - Employment and pre-employment examinations/reports,
  - Immigration examinations/reports,
  - Employer Back to Work/Timely Return to Work/Modified Employment forms,
  - Treatment Plan (Form OCF-18/59).

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[1] CRA Policy P-248 applies to "Independent Medical *Examinations*". It appears that this policy does not apply where there is no "examination" and hence no "physician-patient relationship" established.

[2] Page 3, GST Memorandum 300-4-2.

[3] Excise Tax Act, Schedule V, Part II, s.5.

III. Suggested Fees for Uninsured Services and Forms

Please refer to Appendix IV for a summary listing of common services, forms and letters physicians are often requested to provide/complete, and their corresponding fees.

Suggested Charges for Copying Medical Records

General Information

Copies of medical records should only be provided with the consent of the patient or a court order. The provision of a copy of patient medical records is an uninsured service. Physicians are ***prohibited from charging*** a fee for providing copies of their medical records, ***unless*** they first give the individual ***an estimate*** of the fee that will be charged.[4] Please refer to **Appendix III** for a sample letter to the patient informing them of the applicable

In addition, sometimes the physician must review the records before providing copies of them to the patient. If this is necessary, the physician may charge professional fees for his or her review.

A. Suggested Charges for Providing Copies of Medical Records

There are two elements to the charge for the providing a copy of medical records:

1. cost of the provision of the copy, and
2. out-of-pocket disbursements incurred by the physician related to the provision of the copies.

1. Cost of Provision of the Copy of Medical Records

The OMA recommends physician charge $30.00 + $0.25 per page for each page over 20 pages for the reasonable cost of copying, printing, reproducing or transmitting medical records. This amount includes clerical labour costs, equipment lease or amortization costs, print volume fees, toner and paper costs, electronic storage media costs, equipment maintenance costs, office lease costs for equipment and record storage space and other costs of similar nature.

2. Out-of-pocket Disbursements Related to the Provision of the Copy

In addition to the costs described above, the physician may charge any out-of-pocket disbursements that he or she incurs that are directly related to the request for the provision of copies of the medical records. Examples of such disbursements include charges for the retrieval of the medical record from storage, postage, courier, long-distance fax charges and other charges of similar nature.

B. Professional Review

Sometimes it will be necessary for the physician to review the patient's medical records before providing copies. For example, if the patient requests copies of only certain portions of his records (e.g. those records related to a specified motor vehicle accident), it may be necessary for the physician to review the chart to separate the requested records from the rest of the chart. Further, a physician may refuse to

[4] *Personal Health Information Protection Act*, s.54(10).

provide a copy of all or portions of a medical record if he or she is of the opinion that access to those portions of the medical record could reasonably be expected to,

> (i) result in a risk of serious harm to the treatment or recovery of the patient or a risk of serious bodily harm to the patient or another person,
>
> (ii) lead to the identification of a person who was required by law to provide information in the record to the physician, or
>
> (iii) lead to the identification of a person who provided information in the record to the physician explicitly or implicitly in confidence if the physician considers it appropriate in the circumstances that the identity of the person be kept confidential.[5]

This professional review of the medical record is an uninsured service. The physician may charge the patient for this service. The OMA recommends that the physician charge for this service using his or her hourly rate.

Suggested Charges for Transfer of Medical Records

General Information

Generally speaking, physicians must always keep the original copies of their medical records.[6] Only copies of their medical records should be transferred to other persons.

When charging fees for the transfer of medical records, patients must be informed, ***in advance***, that this is an uninsured service (not covered by OHIP) and given an estimate of the cost of the transfer. Please refer to **Appendix III** (refer to page 30) for a sample letter to the patient informing them of the applicable fee charges.

Prepayment of the fee for a transfer of medical records may be requested when, in the best judgement of the treating physician, the patient's health and safety will not be put at risk if the records are not transferred until payment is received. For additional information, please refer to the CPSO's policy statement on Medical Records, which is available online at: http://www.cpso.on.ca/Policies/medical%20records/medicalrec7.htm.

Charges for Transfer of Medical Records

A physician may charge the following charges for the transfer of Medical Records:

1. Copying charges (see above - **"Suggested Charges for Copying Medical Records")**, and
2. Professional Review or Summary of Medical Records.

On occasion, a physician may be of the view that the new physician will not need a copy of the patient's entire chart e.g. it contains information that is of nominal value, is out-dated or is no longer relevant, or that a short summary of portions of the chart would suffice, for the recipient to understand the patient's current medical condition. In this situation, the physician may, with the patient's consent, cull the unnecessary information from the chart and/or prepare a brief summary of the medical records. In these circumstances, the physician may charge the patient for his or her professional services.

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5 Personal Health Information Protection Act, s.52(1)(e).

6 See s.19, O. Reg. 114/94 under the *Medicine Act*.

Physician Relocation/Closing of Practice: Transfer of Medical Records

The Ministry of Health and Long-Term Care advises that physicians are entitled to charge for the transfer of records when the transfer (performed at the request of their patients) is due to the physician relocating or leaving the practice. In these instances it is advisable that patients be contacted, either in writing or verbally, and asked whether they wish to have their records transferred to a specific practice.

In instances where patients give approval of transfer to a specific location, there can be a charge for the transfer of records. In situations where physicians, because of their relocation or leaving practice, transfer all records to a new practice there should be no charge to patients unless the latter contact the new practice and request that copies of the records be transferred to a different physician of their choice.

Suggested Charges for Uninsured Clinical Services

Rates for services rendered in uninsured circumstances should be calculated using the OHIP Schedule of Benefits as a template. To reflect uninsured rates, the OHIP fee should be increased by **1.99** (ie: current OHIP rate x **1.99** = OMA rate).

The rates calculated represent medical services of "average" complexity and, as such, physicians should modify their charges accordingly when the complexity and time for the medical service deviate from those of the "average" service.

Example:

The OHIP rate for A007 is $33.10 (October 2010 rate). The fee applicable in uninsured circumstances is equal to:

33.10 x 1.99 = $65.87

Suggested Charges for Uninsured Reports and Forms

For third party requested services, physicians can generally charge for the completion of a report in addition to the appropriate assessment fee.

This list represents only a sample of forms that exist in the public domain. **Note: Where there is no suggested fee for a specific form a physician encounters, the OMA suggests billing the third party for the time required to perform the service using the OMA's established hourly rate (refer to page 7).**

In the event a form has not been specifically listed in this *Guide*, a fee can be calculated based on the OMA hourly rate, which amounts to $8.55/minute.

Uninsured Report Forms		Suggested Fee
Completion of Form Physicals for:		
Schools/Camps		$24.55
Admission to Day-care, preschool, university or any other educational institution		$24.55
Pre-employment Certification of Fitness/Fitness Clubs		$32.75
Hospital/Nursing Home Employees		$32.75
Completion of Licensing Forms/Certificates:		
Drivers Medical Examination (FLRC80)		$49.15
Civil Aviation Medical Examination Report 26-0010E(001004)		$81.85
Pilots License Validation 26-0055(01-91)		$16.40
Administrative License Suspension Appellant Medical Information Form		$40.20
Completion of Work and School Related Forms/Notes:		
Back to Work Notes/Sick notes		$16.40
Federal Employee Absence Notes		$24.55
Day Care Note (free of communicable disease)		$16.40
Insurance Certificates:		
Please note: An appropriate assessment fee can be charged in addition to the insurance form/certificate fee when an assessment is necessary to obtain relevant information needed to complete the insurance form/certificate. Refer to page 14 'Suggested Charges for Uninsured Clinical Services' for additional information on calculating assessment rates.		
#OCF-18	Treatment Plan	$122.85
#OCF-3	Disability Certificate	$122.85
#OCF-19	Determination of Catastrophic Impairment	$100.75
-	Travel Cancellation Insurance Form	$32.75
-	Life Insurance Death Certificate	$40.95
-	Medical Certificate for Employment Insurance Compassionate Care Benefits	$46.55
Government Forms:		
Citizen and Immigration Canada Medical Report for Immigration		$122.85
CPP Disability Medical Report Form *		$122.85
Request for Medical Information re: Applicants to Canadian Armed Forces		$96.40
Central Collection Service Request for Physician's Information		$122.85
Revenue Canada, Federal Disability Tax Credit		$40.95
Auto Sales Tax Rebate Form		$32.80
* *Please see 'Canada Pension Plan (CPP) Forms on page 17*		
Other Certificates:		
Children's Aid Society (CAS) Application for Prospective Foster Parent		$49.15
Medical Certificate Employment Insurance Sickness Benefits INS5140		$24.55

Unremunerated Report Forms

There are a number of exemptions when charging for the completion of a third party report form. The following list contains some of the common forms that a physician is **not** permitted to charge a patient for its completion:

- Application for Accessible Parking Permit
- Transit forms for the Disabled
- Permanent Resident Card Forms
- Request for Birth Certificate Forms
- Children's Aid Society Forms (on behalf of a child)
- Canadian Passport Application
- Ministry of Health and Long-Term Care Forms (e.g., Limited Use, Assistive Devices, etc.)*

** Some exceptions apply when a specific code is listed in the OHIP Schedule of Benefits (ie: Home Care Application Fees [K070, K071, K072], Northern Health Travel Grant Application Form [K036], Ontario Hep. C Assistance forms [K026, K027], Long-Term Care Application Form [K038], etc.).*

Source: Section 24, Regulation 552 of the *Health Insurance Act*; please refer to: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_e.htm#BK8

Immunization as an Uninsured Service

Immunization for communicable diseases endemic to Canada is considered an insured service. Immunization that is obtained solely for the purpose of travel is not an insured service.

Pre-departure travel medicine services that travellers obtain solely for the purpose of travel outside Canada are not covered by OHIP. This includes assessments, counselling or administration of vaccines or drugs for prevention of communicable diseases not endemic to Canada. In addition, the cost of the drugs/serum in these cases is billable to the patient directly.

Source: Ministry of Health and Long-Term Care, OHIP Bulletin # 4317, July 30, 1998.
http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4317b.html

For additional information on immunization and other services relating to travel outside Canada, please refer to the Education and Prevention Committee Interpretive Bulletin, Volume 5, No.1 available online: http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/epc/pdf/epc_bulletin_022107v5_1.pdf

TB Mantoux Testing

If a Ministry of Health program, such as the Public Health Department (for example) requests a TB test and a completed form/report, then both the test and completion of the form/report cannot be billed to the patient. Only the appropriate OHIP fees can be claimed (e.g., A001 for the visit/assessment and G372 for the injection).

If a TB test is requested by a patient, as evidence of immunization status*, for admission or continuation in a day care or pre-school program or a school, community college, university or other educational institution or program as evidence of immunization status (for example), then the TB test is insured by OHIP. However, the completion and transmission of a form/report is uninsured and cannot be billed to OHIP.

* The only way to assess 'immunization status' is to perform a TB test.

If a TB test is requested solely for employment purposes (e.g., a hospital), then the test and the completion of the form is uninsured and can be billed to the patient or third party.

For additional information on when it is appropriate to bill OHIP for TB testing, please consult the Health Insurance Act, Reg. 552, Section 24 (1.1) 3, 4, 5, 6.

Please note that serum provided by the government is not to be used for uninsured TB testing. When uninsured testing is performed, the serum should be either

(i) Acquired by the physician and sold to the patient at a direct cost (with reasonable mark-up to account for any indirect costs (e.g., storage, administrative, etc.)

or

(ii) Acquired by the patient from the pharmacy, via prescription provided by the physician.

(Source: Section 24, Regulation 552 of the *Health Insurance Act*; please refer to: http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900552_e.htm#BK8)

Reports Requested by Employers and Other Issues Related to Workplace Safety & Insurance

Workplace Safety & Insurance Board (WSIB)

There are occasions where patients ask physicians not to report work-related injuries to the WSIB but to bill these to OHIP instead. ***Physicians are reminded that billing a WSIB covered medical service to OHIP is fraudulent and results in significant cost-shifting to the OHIP pool.*** On the other hand, reporting an injury to the WSIB against the patient's desire could be construed as an act of professional misconduct by breaching the confidentiality provision of the Medicine Act.

In instances where the patient insists that the injury not be reported to the WSIB, it is recommended that the physician bill the patient directly for the cost of the medical services.

For a list of the WSIB report forms and their associated fees, contact WSIB at 1.800.569.7919 or visit the website at: http://www.wsib.on.ca/wsib/wsibsite.nsf/public/homepage.

Employer-Specific Forms for Worker Injuries

There are instances where employers ask that workers injured in the workplace to get their physicians to complete an employer-specific form related to early return to work or modified return to work.

Completion of such forms and any related assessments and/or tests is an uninsured service and should be charged to the patient or, where possible, the employer.

These forms are not to be confused with the corresponding Workplace Safety & Insurance Board (WSIB) forms which command a fee payable by the WSIB.

The Role of the Primary Care Physician in Timely Return to Work

In some situations, the physician may assume the role of the Timely Return to Work (TRTW) Coordinator for the provision of services associated with a timely return to work program for the individual employee. The TRTW coordinator works with the employer and the employee/patient to assist in developing and overseeing a timely return work program that is individualized to the employee and meets the requirements of the employer.

The TRTW coordinator assumes the primary responsibility for compiling medical information together with the employee's workplace and job functions information, which may include a formal ergonomic assessment, if appropriate, and provides advice concerning the limitations, restrictions and modifications that may be necessary to accommodate the employee in a timely return to work program. This role might also include a review of the workplace policies and collective agreements to which the employee may have agreed and/or a detailed review of the pre-morbid work history (e.g., chronic absenteeism, difficulty with co-workers).

If the physician assumes the role of TRTW Coordinator, then he or she should bill the requesting third party based, on the OMA's suggested hourly rate (refer to page 7), or in some other manner, provided that the rate to be charged to the employer is agreed upon in advance, regardless of how the rate is calculated.

For additional information on the role of TRTW Coordinator, please refer to the OMA's policy paper "*The Role of the Primary Care Physician in Timely Return to Work*", which is available on the OMA's website at: https://www.oma.org/Resources/Documents/2009PCPandTimelyReturn.pdf

Please refer to **Appendix V** (refer to page 37) for a summary of recommendations from the OMA's policy paper.

Life and Health Insurance Report and Assessment Fees

There are numerous life and health insurance forms as well as numerous versions of similarly titled categories of insurance forms belonging to different companies. Where members' fees are expected to vary from the suggested fee listed below, it is recommended that members communicate this to the insurance companies prior to providing the service.

Please refer to **Appendix VI** (refer to page 38) for a general description of the specific forms/reports listed below, and whether a medical examination/assessment is recommended to complete the form/report.

Attending Physician's Statement	$122.80
System-Specific or Disease Specific Questionnaire	$81.85
Insurance Medical Examination	$200.55
System-Specific Examination	$98.25
Clarification Report	$331.05/hour
Full Narrative Report	$331.05/hour
Independent Medical Examination	Independent Consideration

Canada Pension Plan (CPP) Forms

The fees listed for CPP forms are paid by Service Canada as per the amounts listed below. **If a physician's fees are higher than the fees listed below, then patients are responsible for covering any extra costs**. OMA suggested rates should be used as guidance when balance billing for CPP forms/services (refer to page 7 for suggested hourly rates).

There are two distinctly different types of CPP forms the federal government will pay for:

(i) The Disability Medical Report Form $85.00

(ii) The Narrative Medical Report (up to) $150.00

The Narrative Medical Reports are usually initiated by correspondence from staff at the Income Securities Branch of Human Resources and Skills Development Canada.

The narrative reports require:

- Medical history
- The date of onset of each medical condition
- An examination of findings
- Various excerpts of consultation reports (including identification of consultants)
- Diagnosis
- Copies of test results
- Prognosis
- Course of future action

Upon receipt of a physician's invoice and confirmation that the individual concerned has submitted an application, Service Canada will reimburse:

- Up to $85 for the initial medical report;
- Up to $25 for the reassessment medical report;
- Up to $50 for the "Scannable Impairment Evaluation";
- $25 for the "Medical Report – Recurrence of the Same Medical Problem"; and
- Up to $150 (depending on complexity and time required for completion) if Service Canada medical adjudicators request other information in the form of a narrative report.

For additional information, please contact Service Canada at 1-800-277-9914 or review the Frequently Asked Questions on the Service Canada website http://www.rhdcc-hrsdc.gc.ca/eng/isp/cpp/partners.shtml#f

IV. Interprovincial Reciprocal Billing of Medical Claims

The Reciprocal Medical Billing System (RMBS) is used to bill for services rendered by physicians or private medical labs to a patient insured under another Canadian provincial health coverage plan, excluding Quebec. This reciprocal billing arrangement between Ontario and all provinces and territories except Quebec came into effect on April 1, 1988.

The arrangement allows Ontario physicians who voluntarily participate to bill OHIP directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan. Participation is voluntary. Participating physicians will receive payment at the OHIP Schedule of Benefits rates and must accept the payment as payment in full. The agreement includes services rendered by private medical laboratories and private diagnostic facilities but does not include diagnostic services rendered in a hospital setting.

Instructions on how to submit claims can be found in the OHIP Online Resource Manual for Physicians (Section 4, page 4-7):
http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html

There are a number of services that are excluded from the reciprocal agreement (but are not necessarily OHIP benefits) that should be billed directly to the non-resident patient. A listing of these services can be found in the OHIP Online Resource Manual for Physicians (Section 4, page 4-9):
http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html

For treatment of patients from Quebec, physicians are advised to **bill the patient directly.** Alternatively, the Out-of-Province Claim for Physician Services form can be used to obtain a reimbursement. Physicians are to submit the completed form directly to the Régie de l'assurance maladie du Québec.

The Out-of-Province Claim for Physician Services form can also be used for physicians not participating in RMBS, or for claims for RMB excluded services that are OHIP benefit. Physicians are to submit the completed form to the Ottawa claims processing office: 75 Albert Street, Ottawa, Ontario, K1P 5Y9.

A copy of the Out-of-Province Claim for Physician Services form can be found on the Ministry of Health and Long-Term Care website at:
http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/GetAttachDocs/014-0000-80~5/$File/0000-80E_.pdf

V. Medical-Legal Activities

The Preparation of Medical-Legal Reports

Medical-legal reports are essential to the legal process of adjudicating claims for personal injury. A well prepared medical legal report will contribute significantly to the proper and just resolution of a claim for personal injury, expedite the process, reduce cost and frequently obviate the necessity of a court appearance by the physician.

Confidentiality

Given that the relationship between a patient and a physician is one of highest confidentiality, a physician should insist on being provided with a valid and adequate written consent to the release of medical information. While the very request for medical information by a lawyer or firm professing to be retained by the patient may be considered as an adequate consent of the patient, it is recommended that the lawyer requesting the information provide the physician with not only a clear statement as to the lawyer's representation of the patient but also a valid and adequate consent of the patient. It is the lawyer's responsibility to provide the physician with such consent.

Code of Ethics

The responsibilities of an ethical physician to the patient are stated in the Code of Ethics (revised by the Canadian Medical Association in 2004) and include the following:

An ethical physician will: “provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others." (Paragraph 37)

This is reinforced by Section 1.17 of Ontario Regulation 856/93 made under the Medicine Act, 1991 which defines professional misconduct to include: "failing without reasonable cause to provide a report or certificate relating to an examination or treatment performed by the member to the patient or his or her authorized representative within a reasonable time after the patient or his or her authorized representative has requested such a report or certificate."

Physicians as Expert Witnesses

Non-Treating (Retained) Physicians as Witnesses

Non-treating physicians are often approached by lawyers or the Crown to testify as an expert witness and usually have never seen the patient prior to being contacted. After agreeing to act in such a capacity, physicians may examine the patient so as to establish an expert opinion regarding matters such as the patient's injuries or standards of previously provided medical care. The fees payable to an expert witness are a matter for negotiation between the expert witness and the lawyer seeking the expertise. In addition to a compensation arrangement for time spent in the courtroom, **physicians should not neglect to agree on a fee, in advance, for reports that may be produced as well as travel time and other expenses incurred in the process of acting as expert witnesses**. **Whenever possible, it is recommended that physicians seek agreement on their fees in writing.**

A non-treating physician is under no obligation to agree to act as an expert witness. The expert witness will rarely receive a subpoena or summons to attend in court since he or she has agreed to act as an expert in advance, and has secured satisfactory remuneration for this expertise. When testifying in court, the expert witness is usually given a set of facts, which closely resemble the actual case, and is then asked hypothetical questions based on those facts. The expert witness will provide a professional opinion based on the examination of the patient, the medical records, and knowledge of similar previous cases.

- Fees for Civil Lawsuits or Administrative Bodies

In these lawsuits, an expert's fees are a matter of negotiation between the expert and the Crown attorney or defense lawyer. The only limit is that these fees not be excessive in relation to the services provided by the expert witness.

- Fees for Expert Witnesses in Criminal Cases

In these lawsuits, expert witness fees are a matter of agreement between the expert witness and the Crown attorney or defense lawyer. The Ministry of the Attorney General generally pays experts in accordance with the schedule of fees below. However, there is nothing that prevents expert witnesses from seeking reimbursement above these amounts.

For more information on fees for expert witnesses, please contact the Ministry of the Attorney General: 416.326.2220 or 1.800.518.7901 or http://www.attorneygeneral.jus.gov.on.ca/english/

Treating Physicians as Witnesses

Treating physicians will typically be served with a subpoena or a Summons to Witness to appear in court or before an administrative body and would be subject to arrest, detention, and ordered to pay costs that have arisen for failing to attend if properly served. A physician may only be excused from responding to a summons if ordered so by the presiding judge. The court will only excuse or adjourn the attendance date of a witness for drastic reasons, such as serious illness of the physician, a death in the immediate family, or absence from the country. The physician must have a representative attend in court to explain the absence and the particular circumstances, or have received prior approval not to attend from the party that subpoenaed the physician. Previously scheduled surgical obligations or appointments will generally not be viewed by a court as a reason to excuse a physician.

The party who issued the summons to the treating physician to testify in court is only obliged to pay the physician the daily attendance fee in accordance to the rules that regulate the procedures of that particular trial or hearing, such as the Rules of Civil Procedure, The Family Law Rules, and the Interim Rules of Practice and Procedure of the Financial Services Commission of Ontario. The Tariff also lists the appropriate travel allowance, and the appropriate overnight accommodation and meal allowance, if applicable. Please note that the amounts listed in the Tariff may vary from year to year. The updated Rules of Civil Procedure can be found at: http://www.canlii.org/en/on/laws/regu/rro-1990-reg-194/latest/rro-1990-reg-194.html

Attendance money actually paid to a witness who is entitled to attendance money, to be calculated as follows:

1. **Attendance allowance for each day of necessary attendance: $50**

2. **Travel allowance, where the hearing or examination is held,**

   (a) In a city or town in which the witness resides, $3 for each day of necessary attendance;

   (b) Within 300 kilometres of where the witness resides, 24¢ a kilometre each way between his or her residence and the place of hearing or examination;

(c) More than 300 kilometres from where the witness resides, the minimum return air fare plus 24¢ a kilometre each way from his or her residence to the airport and from the airport to the place of hearing or examination.

3. Overnight accommodation and meal allowance, where the witness resides elsewhere than the place of hearing or examination and is required to remain overnight, for each overnight stay: $75

Treating physicians will often be called or summoned as witnesses where they were the first party to see or treat the patient. An example would be a case where a physician saw and treated a patient in the emergency room or was the patient's family doctor and was treating a particular injury or condition. The witness in these cases would generally be asked the facts about the treatment and/or prognosis regarding the patient's health.

There is no question that, occasionally, the boundary between a treating physician and a retained expert witness becomes blurred. In instances where a physician has provided ongoing care for a patient, a lawyer may request further examination and diagnostic testing as well as an extensive report and an opinion concerning the patient's recovery, in addition to testimony in court. Some of these services could be considered to be those of a retained expert witness.

In such cases, the physician should request compensation as an expert witness. The lawyer requesting such services may argue that these are matters inextricably linked to the witness role as the treating physician and refuse to pay. In these cases, the physician who has been previously served with a summons or subpoena is still legally obligated to attend court and provide all the relevant documentation and testimony. The physician should consult in advance with the particular lawyer requesting attendance in court in order to arrive at a mutually agreeable attendance fee. However, it must be pointed out that, in this case, it is conceivable that the physician may only receive the minimum payment (as stated above) for attendance in court. The physician would be entitled to payment for the production of any medical-legal reports prepared in the matter.

In the event a physician is served with a summons or subpoena, the physician should contact the Canadian Medical Protective Association (CMPA) for advice as a matter of professional conduct at 1.613.725.2000 or 1.800.267.6522 (toll free) or via email feedback@cmpa.org (accepts general inquires).

2011 Scale of Grading and Remuneration of Salaried Physicians

Effective January 1, 2011, the Scale of Remuneration for Salaried Physicians is as follows:

Classification of Salaried Physicians

Because of the variety of groupings used at federal, provincial and municipal levels, and in private industry, it has been felt wise to define the various levels as shown below. A level can then be fitted to the appropriate rank within the service or company.

Applicable to a physician who:

Level I

- Has a limited amount of postgraduate or practical experience.
- May be responsible to a more senior physician.
- Would be promotable to Level II as soon as the necessary experience and skills have been obtained.

Level II

- Has 2-5 years of postgraduate experience, including training or experience in the type of work involved.
- Has a position of responsibility which may involve supervision of the work of other health-care professionals.

Level III

- Has 5-10 years of postgraduate experience which could include (a) a higher qualification in a related specialty, or (b) approximately 5 years of training or experience in the particular field of work, or (c) at least 5 years of experience in the organization in which he or she is working.
- Usually has a supervisory position with either full-time or part-time health-care professionals and others working for him or her.
- May work independently because of the highly specialized kind of work being done.

Level IV

- Has greater responsibilities than those required for Level III.
- Has senior administrative and/or clinical responsibilities.

Level V

- Holds the most senior medical post in an organization or department, is responsible for all medical staff in the organization, and may have responsibility for other health-care professionals.
- Has senior administrative responsibility, up to and including the post of chief executive officer.

Salary Ranges

It is expected that annual increments would be made within the following ranges to reflect increased value to the employer and increases in the cost of living. The salaries quoted below are to be considered as exclusive of fringe benefits.

Level	Minimum
Level I	$156,959
Level II	$253,488
Level III	$260,278
Level IV	$271,934
Level V	$308,486

Salaries should be modified under the following circumstances:

1. Where no provision is made for superannuation, the salary should be adjusted to compensate for this.

2. The possession of a specialist qualification (which is being utilized in the execution of the post) should be recognized by an additional sum over and above the figures quoted.

3. Regional variations in salary due to a special cost of living consideration should be recognized by an adjustment to the maximum rate.

Salaried physicians should be entitled to a minimum of the following: one month's vacation, one week leave for continuing education in addition to the vacation allowance, and 11 statutory holidays.

Employers should be encouraged to pay the membership fees necessary for a physician to remain in good standing with his or her profession (e.g., College of Physicians and Surgeons of Ontario, Canadian Medical Protective Association, Ontario Medical Association, Canadian Medical Association, etc.)

Part-Time Employment: (Industrial, Public Health, etc.).....**net per hour $321**

As a point of clarification, the Part-Time Employment rate of return represents a "net" rate, indicating that it is "net" of any expenses of practice or overhead costs that the physician might incur as a result of employment. As responsibility and nature of the programs vary, there should be negotiation between the physician and the employing organization. The above figure is a recommended average rate.

VII. Additional Sources of Information

Ontario Medical Association	www.oma.org 416.599.2580, toll free 1.800.268.7215 Fax: 416.599.9309
College of Physicians and Surgeons of Ontario • General inquiries…… • Physician advisory services……	www.cpso.on.ca 416.967.2600, toll free 1.800.268.7096 416.967.2603 416.967.2606, toll free 1.800.268.7096, ext 606
Royal College of Physicians and Surgeons	www.rcpsc.medical.org Fax: 613.730.8830, toll free 1.800.668.3740
Workplace Safety & Insurance Board • Website for physicians…….. • Health Professionals Access Line……... • Billing Hotline (payment enquiry)……	www.wsib.on.ca www.wsib.on.ca/wsib/wsibsite.nsf/public/HealthProfessionals 416.344.4526, toll free 1.800.569.7919 1.800.668.9958, fax 1.888.313.7373
Ministry of Health and Long-Term Care Branches: • Provider Services …….. • Drug Programs …….. • Public Health …….. • Primary Care Team …….. • Billing Inquiries……	www.health.gov.on.ca 613.548.6561 416.327.8109 416.327.4300 416.327.8443, toll free 1.866.766.0266 email: physicianscheduleinquiries@moh.gov.on.ca
Ministry of Health and Long-Term Care, OHIP Bulletins	www.health.gov.on.ca/english/providers/program/ohip/bulletins
Canadian Medical Association	www.cma.ca 1.613.731.9331, toll free 1.800.267.9703
Canadian Medical Protective Association	www.cmpa-acpm.ca 1.613.725.2000, toll free 1.800.267.6522 Fax: 1. 613.725.1300 tel:1.877.763.1300
Ontario Hospital Association	www.oha.ca 416.205.1300
Ontario College of Family Physicians	www.ocfp.ca 416.867.9646
Canada Revenue Agency	www.cra-arc.gc.ca/menu-e.html
Auto Insurance Accident Claim Forms	www.fsco.gov.on.ca
Federal Forms	www.servicecanada.gc.ca/eng/online/index.shtml
Family Practice Section	www.familydoctorsofontario.com
Government of Ontario Directory	www.serviceontario.ca
Veteran Affairs Canada, Providers Info Guide	www.vac-acc.gc.ca/providers
ICD 10 Codes	http://secure.cihi.ca
Interim Federal Health Program • Customer Service……..	www.fasadmin.com 1.800.770.2998

Appendix I: Establishing an Hourly Rate

The following **example** illustrates one way to determine an hourly rate based on an individual's gross annual income. A possible source for annual gross earnings could be from your annual income tax statement.

	Item	Calculation
A	*Annual gross earning:* *Annual gross OHIP billings[1]:* *Annual income from other sources[2] (e.g., WSIB, stipends, alternate funding arrangements)* *Other annual income[2] (e.g., uninsured third party billings)* ***Total annual gross earnings:***	 $352,800 $20,000 $20,000 ***$392,800***
B	*Working days per year[3]:* (52 weeks x 5 days/week less 30 days vacation and holidays)	230
C	*Income generating hours[2]* (paid hours/day)*:* (9 hours in practice less 2 hours of unpaid non-clinical activity per working day)	7
D [=B x C]	*Annual paid* hours*:* (230 days x 7 hours/day)	1,610
E [=A / D]	***Hourly rate:*** ($392,800/1,610 hours)	***$243.98***

Notes:

1. Average annual gross OHIP billings figure was based on Average Gross OHIP Professional Billings by Ontario Physicians whose professional OHIP billings were greater than $100,000 for Fiscal Year 2009/10.
2. This figure is for illustration purposes only. Members should modify accordingly to reflect their average workday.
3. Word days per year was calculated based on 30 days vacation and 10 statutory holidays.

Appendix II: Selected Services Not Insured by OHIP

The following services are ones which are not insured benefits of OHIP. These services may be billed directly to patients. This list is not exhaustive. In addition to the services listed below, any service provided by a physician, laboratory or hospital that supports an uninsured service is not an insured benefit. No claims to OHIP should be made for consultations, assessments, counselling, diagnostic investigations (e.g., ultrasound, laboratory tests), et al. that are in support of an uninsured service such as cosmetic surgery, reversal of sterilization, uninsured in vitro fertilization, etc.

Please note:
Travelling Time and Mileage Charges are non-insured and may be charged directly to patients when visits are made by physicians to see patients outside their normal area of practice. This is defined as the greater of either 8 kilometres or 15 minutes in one direction, from a physician's usual location of practice.

Consultations and Assessments
Family Practice and Practice in General

Patient interview for practice admission	**$84.20**
(Note: patient interview refers to a patient conducted interview of a physician)	
Dispensing service fee (The dispensing service fee is not intended to apply to the provision of drug samples to patients but only where there is a recorded purchase of a supply of drugs)	**$13.30**
Certification of incompetence (financial) including assessment to determine incompetence	**$255.90**

Consultations and Assessments
Obstetrics & Gynaecology

Emergency telephone consultation	**$49.55**

The emergency telephone consultation may be billed if the following conditions are met:

- A physician (the "consultant"), as a result of an emergency situation, is requested by a physician via telephone to provide an opinion via telephone regarding a patient.
- There is no associated patient contact by the consultant either before or after the telephone call.
- The call originates from a hospital other than the consultant's own.
- The call is fully documented by the consultant.
- A written report is subsequently provided by the consultant to the referring physician.

Consultations and Assessments
Paediatrics

Pre-adoption examination and evaluation for Children's Aid Society	**$183.50**

Consultations and Assessments
Psychiatry

Specific assessment with report to referring agency	**$279.35**

Therapeutic supervision with any paramedical organization (health education, correction and other community resources)	**$266.55**
Appearance before Advisory Review Board or Review Board – per ½ hour or major part thereof	**$139.35**
Certification of incompetence (financial) including assessment to determine incompetence	**$255.90**
Preparation and attendance at Board of Review (plus $90.14 per half hour in addition for time in excess of three hours)	**$846.05**
Completion of forms and procedures dictated by the Mental Health Act	**Independent Consideration**
Certification procedures regarding management of estate	**Independent Consideration**

Pulmonary Function Studies

Functional Residual Capacity – Carbon monoxide diffusing capacity by steady state at rest	**$28.60 (technical fee)** **$21.65 (professional fee)**
Sputum induction – Transdiaphragmatic pressure measurement	**$137.90 (technical fee)** **$117.35 (professional fee)**
Sputum induction – Isocyanate Challenge Test (WCB cases)	**$488.60 (technical fee)** **$266.55 (professional fee)**

Diagnostic and Therapeutic Procedures

Epilation of facial hairs – technical component	**Independent Consideration**
Acupuncture i.e. including insertion of needle(s) into specifically elected point(s) combined with manual, electrical or thermal stimulation of the needle(s) for the management of pain, performed by a physician	**$22.00**

Operations on the Integumentary System, Skin and Subcutaneous Tissue

Comedones, acne pustules, milia	-ten or fewer	**$9.50**
	-eleven or more	**$33.20**
Acne scar revision - Punch grafting – Two to ten punch grafts, each		**$29.65**

Surgical Procedures

Circumcision – newborn (complete care, not for physical symptomatology)	**$172.20**
Tubal patency reconstruction (any surgical technique) after previous tubal occlusion procedure	**$1,376.75**

Appendix III: Sample Letters and Signage

Sample Patient Information Letter re: Office Policy on Uninsured Services

Insert Physician Name, Office/Clinic Logo and Address etc.

Date

Dear Patient:

This information sheet is our latest attempt to keep you informed of changes in our office policy. For your information, OHIP does *not* pay for all services that you request from your doctor(s). Services that OHIP does not pay for are called *"non-insured or uninsured services"* and it is illegal and fraudulent for doctors to bill OHIP for them. In order to maintain the financial viability of our practice and ensure prompt service, it is necessary (and *legal*) for our practice to charge for these services.

Every effort has been made to account for most of the commonly requested services in this information sheet. If the uninsured service you are requesting is not listed below, I ask that you communicate this to me or my office staff for further clarification. It would also help us speed up our service, if you would let my office staff know when you are making your appointment that you are either requesting a service that is in the list below *or* a service for which you have been charged in the past by my office or another doctor's office.

The fees contained in the list below are based on the Ontario Medical Association's suggested fees as found in the ***INSERT APPROPRIATE YEAR*** edition of the OMA *Physician's Guide to Third Party and Other Uninsured Services*.

All uninsured services must be paid in full when rendered. You have the right to receive a receipt and my office staff will provide you with one upon settlement of your account.

Should you be unable to pay for the uninsured service at the time it is provided, please let my office staff know when and how you intend to settle your outstanding account. We will make every effort possible to assist you in the settlement of your outstanding account. Please note that our office accepts cheques, credit card and Interac payments. Where applicable, a charge of $20 for personal cheques that are returned N.S.F. by financial institutions will be added to a patient's account. Thank you for your co-operation.

Physician Signature _____

Physician's Name _____

Insert list of uninsured services and office charges

Sample Confirmation Letter of Third Party Request

Insert Physician Office/Clinic Logo, Name, Address, etc., here

Date

Dear (Insert Name of Third Party)

Re: *Request on Behalf of Patient X Received in my Office on (insert date)*

I am in receipt of your request for the completion of a (*insert name of form*) on behalf of patient X.

This letter is intended to inform you of my usual and customary fee for the completion of this (*insert name of Form or Report here*), which is based on the Ontario Medical Association's suggested rate contained in the (*insert year*) edition of the *Physicians' Guide to Third Party and Other Uninsured Services*.

Based on the preceding, I estimate that the fee for the completion of this *(insert name of Report or Form*) to be *$Y.00.* This figure assumes no extraordinary complexity and/or follow-up information requests from your company. Should such follow-up work be required, additional estimates will be provided in a similar fashion.

An invoice will be sent to you along with the completed Form/Report. Our office policy for payment of such Reports/Forms is 30 days from the invoice date. After 30 days, an interest rate of ___% (compounded monthly) equivalent to a daily rate of ___% will be applied to your outstanding charges. The Annual rate of interest is ___%.

Please acknowledge receipt and acceptance of the above estimate and office policy by photocopying this letter, signing below and mailing and/or faxing it to my office (*insert fax number).* Should you have any further questions please contact (*insert name of office staff person*) at my office phone number quoting the patent's name.

Sincerely

Billing Physician's signature _____

Billing Physician's name _____

I agree with the above estimate and terms/conditions of payment.

Third Party's Signature _____

Third Party's Name _____

Date signed _____

Sample Letter for Patient Requested Transfer of Medical Records

Insert Physician Office/Clinic Logo, Name, Address etc here

Date

Dear Patient

I have received your request to transfer a copy of your medical records to [*Dr. Requesting's name*]

I will be happy to comply with your request. Please be advised that the cost of this service is not covered by your health insurance. Therefore, you will be responsible for the cost of the physician chart review, duplication, and transfer of your records. Please note that, by law, your original record must be kept in this office for at least 10 years after your last professional visit. To assist your new physician, I suggest that you choose one of the two following options.

Please circle the number of the option you choose:

1. I will be happy to prepare a summary of your medical history and include your most recent and significant laboratory results as well as all applicable consultation and hospital reports. This summary is, in my opinion, the most useful to your new doctor. Please notify us, in writing, if you want us to exclude any information.

The charge for this service is $_____

2. Alternatively, we can also photocopy the complete chart. The charge for this is based on the following *Provincial Medical Association Suggested Charges*:

   - Individual chart (1 – 5 pages): $_____
   - Each additional page (up to 50 pages): $_____
   - Each additional page (over 50 pages): $_____

Your chart has [number of] pages. The charge will be $_____

Please indicate your choice of payment option with a check mark and return this form to our office.

☐ Cheque included with this consent form. Your chart will be sent directly on to your new doctor.
☐ Cheque not included with consent form. Our office will notify you when the records are ready. You will send payment and we will forward the record on.
☐ When your chart is ready, we will notify you and you will come to the office to pick up your record and settle your account.
☐ Our office will notify you when we have sent the record to your new doctor so you can send in payment.
☐ Cancel the chart transfer.

Signature (Patient) _____

Date: _____

Source: Courtesy of: Dr. Thomas R. Faloon, CCFP, FCFP, Ottawa. *Canadian Family Physician* 2002; 48564,566.

Note: [1] The above form was developed and published for Canada-wide usage. [2] In keeping with CPSO Policy #5-05 regarding "Medical Records" specifically the section on "Patient Requests Transfer", prepayment of the fee for a transfer of medical records may be requested when, in the best judgment of the treating physician, the patient's health and safety will not be put at risk if the records are not transferred. For additional information please review the CPSO policy statement on Medical Records.

Sample Third Party Invoice

Insert Physician Office/Clinic Logo, Name, Address etc here

Bill to: Third Party Name
Third Party Address
Third Party Phone and Fax Numbers

Invoice Number: _____

Invoice Date: _____

Payment Terms: In full within ____ days of invoice date

Re: Patient's Name
Patient's Date of Birth
Requested Form/Report/Activity
Date of Requested Form/Report/Activity

Payment Due Date: $_____

Dear (*Insert Contact Name of Third Party*):

Attached please find the requested Form/Report/Activity on (*insert date*). As per the estimate and your agreement (*attach copy of faxed Agreement – see Attachment 1 above*) the itemized final cost is $_____.

- insert form/report/activity cost based on OMA suggested rate and/or hourly rate multiplied by the time necessary to complete activity
- insert associated costs (photocopying, courier etc)

The total cost is $_____. Please remit your cheque payable to _____ by the payment due date noted above in order to avoid late payment charges.

Thank you for your business and cooperation.

Sincerely,

Billing Physician's Signature _____

Billing Physician's Name _____

Insert Late Payment Office Policy for Outstanding Accounts.

OMA
ONTARIO MEDICAL ASSOCIATION

Message to Patients

Are you aware that not all of the services that your physician provides to you are insured through OHIP and that your physician can request a payment from you for those services?

Listed below are examples of some of the services that you could be charged for.

Non-Medical Services

- **Chart transfer or summary of your medical records,** at your request.
- **Writing reports and filling out forms**.
  Examples:
  Licensing, insurance forms
  Federal Government forms
  Sick notes or back-to-work notes
  Medical/Legal reports
  Form Physicals
  Employer requested reports
- **Missed Appointments** without sufficient notice given.
- **Long distance telephone charges**

Medical Services Not Insured by OHIP

- **Cosmetic procedures** including related consultations and diagnostic tests.
- **Routine eye examinations** for patients aged 20 to 64
- **Acupuncture**
- **Pre-departure travel medicine services** for those travelling outside of Canada
- **Assessments/diagnostic tests** required solely for the completion of reports, forms or licenses
- **Medical advice** given via the telephone and telephone prescription renewals

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Block Fees may be offered as an option in place of some of the above non-OHIP covered services. Quality health-care, medical advice and timely access are priorities Ontario's physicians intend to honour. Speak to your physician about other health-care services that are not insured by OHIP, and the fees that you may be charged.

Please note that some exceptions may apply

Appendix IV: Uninsured Forms and Services (Index)

Forms/Service	Suggested Minimum Fee	Refer to Page in Guide	Notes
Please note: An appropriate assessment fee can be charged in addition to a fee for the completion of a form/certificate/report when an assessment is necessary to obtain relevant information needed to complete the form/certificate/report. Refer to page 14 'Suggested Charges for Uninsured Clinical Services' for additional information on calculating assessment rates.			
Part-time Hourly Rates			
• Net	$321.00/hr	6,7	
Completion of Form Physicals for:			
• Schools • Camps • Pre-employment Certification of Fitness • Fitness Clubs • Hospital/Nursing Home Employees	$24.55 $24.55 $32.75 $32.75 $32.75	15	
Completion of Licensing Forms/Certificates:			
• Drivers Medical Examination (FLRC80)	$49.15	15	
Work and School Related Forms/Notes			
• Back to Work Notes • Sick Notes • Day Care Note (free of communicable disease)	$16.40 $16.40 $16.40	15	
Insurance Certificates and Reports			
• Treatment Plan, form #OCF-18 • Disability Certificate, form #OCF-3 • Determination of Catastrophic Impairment #OCF-19 • Travel Cancellation Insurance Form • Life Insurance Death Certificate • Medical Certificate for Employment Insurance Compassionate Care Benefits	$122.85 $122.85 $100.75 $32.75 $40.95 $46.55	15	
• Children's' Aid Society (CAS) Application Form for Prospective Foster Parent • Medical Certificate Employment Insurance Sickness Benefits INS5140	$49.15 $24.55	15	➢ Bill parent(s) for the form

Forms/Service	Suggested Minimum Fee	Refer to Page in *Guide*	Notes
• Attending Physician's Statement	$122.80	19, 39	➢ Usually no assessment required; additional charge for copies of lab tests/records
• System or Disease Specific Questionnaire	$81.85	19, 39	➢ Usually no assessment required
• Insurance Medical Examination	$200.55	19, 39	➢ Fee includes general assessment and form
• Systems Specific Examination	$98.25	19, 39	➢ Includes single system assessment plus simple form
• Clarification Report	$331.05/hr	19, 39	
• Full Narrative Report	$331.05/hr	19, 40	
• Independent Medical Examination	Charge hourly rate	19, 40	➢ Independent Consideration between physician and insurance company
Federal CPP Program			
• Disability Medical Report Form	$85.00	19	
• Narrative reports (medical history)	$150.00	19	
Miscellaneous			
• Missed appointments		7	Fee at physician's discretion
• Photocopying			Fee at physician's discretion

Appendix V: Summary of Recommendations on the Physician Role in Timely Return to Work

For additional information on the role of TRTW Coordinator, please refer to the OMA's policy paper "*The Role of the Primary Care Physician in Timely Return to Work*", which is available on the OMA's website at: https://www.oma.org/Resources/Documents/2009PCPandTimelyReturn.pdf

The summary of recommendations is as follows:

Third Party Requests for information:

1) We recommend that third party requests for medical information and services be distinctly separated into two streams:

a. **Requests for medical documentation of illness, disease, injury or disability for the purposes of entitlement to disability benefits (as per CPSO) and;**
b. **Requests for information and services related to returning a patient to work, such as functional assessments, reviewing job descriptions, consulting with supervisors, workplace interviews, assessing barriers to return to work, prescribing restrictions and modifications to the job (herein collectively referred to as "RTW Services").**

2) We recommend that when a third party requests information for (a) entitlement to disability benefits or (b) returning a patient to work that:

a. **Separate patient consent be obtained for each request for medical information.**

b. **Patient consent be considered time limited and that repeat requests for information fall within a reasonable time of the original receipt of patient consent.**

3) We recommend the development of educational sessions to support physicians in understanding their CPSO obligations regarding third party requests and to support those physicians who wish to assume the role of the timely return to work coordinator.

4) We recommend that patients not be required to assume the costs of third party requests for services related to the certification of disability.

5) **We recommend that patients not be required to assume the costs of services related to a timely return to work program. The OMA believes that the employer/insurer should assume the cost and payment for the services related to a timely return to work program as well as for the services related to the certification of the disability.**

Appendix VI: Additional on Life and Health insurance Reports Information

Attending Physician's Statement
Fee: $122.80

Insurance companies request completion of this form after clients have applied for insurance coverage and have provided the company with information on their medical history and other biographic data. This form is usually sent directly to the physician, accompanied by the patient's signed consent form, and is a request for historical medical information directly from the patient's medical charts. The physician's findings, treatment, and opinion recorded following a patient's visits for significant medical problems are requested.

In these instances, insurance companies do not generally require a medical assessment to be performed on the patient since this is not a request for information on the current health status of the patient. The insurance company may request relevant copies of lab test results and/or electrocardiograms.

In the event the patient is making a disability claim, the insurance company may require a medical assessment and up-to-date information on the health status of the patient. The assessment is insured and billable to OHIP, ***if in the opinion of the physician the service is medically necessary.*** Completion of the report remains uninsured and is billable to the patient or third party.

System-Specific or Disease-Specific Questionnaire
Fee: $81.85

This form is usually sent directly to the physician along with the patient's signed consent form. The questionnaire will ask for specific details related to a patient's medical condition. For example, in the case of a patient with diabetes, past blood sugar readings, treatment given, control details, etc., would be requested. Unless specifically requested, a medical assessment is not required to complete this form since it is not a request for a report on the patient's current medical status.

Insurance Medical Examination
Fee: $200.55

This is a request by the insurance company for a general physical examination and the completion of the accompanying form, which usually includes questions making up a functional inquiry, a past history of the patient's health status, and the results of the physical examination.

Systems-Specific Examination
Fee: $98.25

This is a request by the insurance company for an assessment that includes a single system medical history and examination. This would include a review of the pertinent medical history relating to the system, a system-specific examination, and the completion of the corresponding form.

Clarification Report
Fee: $331.05/hr

This report is usually requested directly from the physician in order to adjudicate a claim. It involves answering specific questions to clarify information about medical and administrative details previously submitted to the insurance company. A medical examination is not usually required unless specifically requested by the insurance company.

Full Narrative Report
Fee: $331.05/hr

This report is usually requested by the insurance company in order for the physician to answer detailed questions to clarify information about medical and administrative details. This is quite common in cases of prolonged or complex disability (e.g., chronic fatigue syndrome) or psychiatric illness. It is usually requested in a letter-type format, and insurance companies usually require that copies of appropriate test results and consultation reports also be included with the response. A medical examination is not usually required unless specifically requested by the insurance company.

Independent Medical Examination
Fee: Independent Consideration

Usually contracted between a physician and insurance company; fees are usually discussed in advance with the physician based on the insurance company's requirements.

Please forward any questions and/or suggestions for the next edition of this Guide to:

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