

**PHYSICIAN'S GUIDE TO
THIRD PARTY
AND OTHER UNINSURED SERVICES**

ONTARIO MEDICAL ASSOCIATION

January 2007 Edition



January 1, 2007

Dear Colleagues:

It is with great pleasure that I offer you the new and improved edition of the OMA's *Physician's Guide to Third Party and Other Uninsured Services*.

The 2007 edition of the *Guide* includes text boxes that highlight some of our recommendations on how to improve revenue generation, as well as pitfalls that members should avoid when dealing with uninsured services. This should improve both the user friendliness of the *Guide* and make it more relevant in our practices.

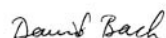
A new summary table that includes all uninsured services listed in this *Guide* can be found in Appendix I. This will make it simpler for members to refer to specific services or form fees without going through the entire *Guide*. The relevant fees and recommendations will continue to appear in the appropriate section of the *Guide*. Furthermore, example forms that can be modified according to member practices (as well as accessed electronically through the electronic version of this *Guide* on our Association website www.oma.org) have been added in the Appendices. In addition, legal information and references that previously tended to overshadow recommendations and messages in the main body of the *Guide* have now been moved to the Appendix section. Members wanting to find the source of the recommendations in the *Guide* can refer to the Appendices with the legal background and relevant references.

Our information suggests that some members are not taking advantage of all the possibilities related to charging for third party and uninsured services – which leads to an unnecessary and preventable revenue loss in members' practices. It is my hope that this edition of the *Guide* will provide information to our members that will help them maximize their revenue potential.

Your Association has also set up a dedicated e-mail address (thirdpartyguide@oma.org) for direct member comments, feedback and suggestions on improving our next edition. I ask that you take advantage of this opportunity and communicate with us via this e-mail address. Alternatively, you may write to us by using the address that appears on the last page (before the Appendices) of this *Guide*.

I hope that you find our efforts helpful in your practices and that you will find this edition of the *Guide* an indispensable tool in negotiating uninsured services in your practices.

Sincerely,

A handwritten signature in cursive script that reads "David Bach".

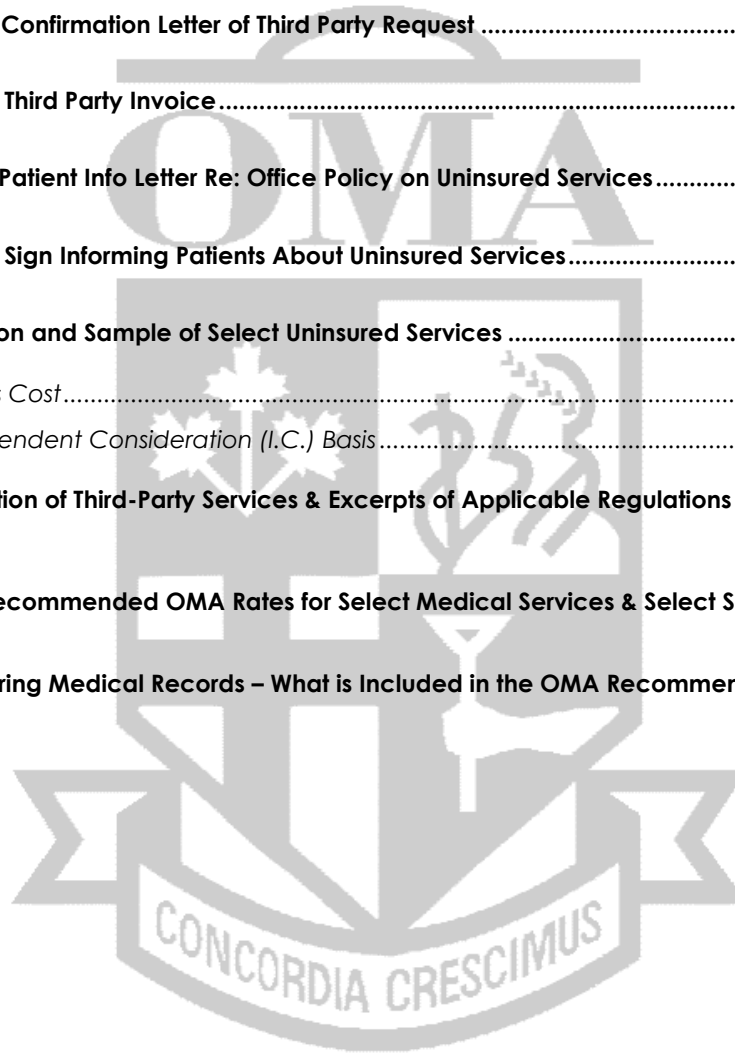
Dr. David Bach, President

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 Ministry of Health and Long Term Care (MOHLTC) and the College of Physicians and Surgeons (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 in Kingston.

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PHYSICIAN'S GUIDE TO THIRD PARTY AND OTHER UNINSURED SERVICES

January 2007 Edition

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. Physicians should, whenever possible, inform the patient or the person(s) financially responsible about such charges prior to rendering the service and should make an appropriate record (as required) of the uninsured services they provide. For a list of **uninsured services** that are commonly encountered, please **refer to Appendix VII** of this *Guide*. In addition to the preceding list, the definition of Third Party Services along with descriptions and excerpts of the applicable Regulations (the latter are also found online at:

http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900552_e.htm#BK9) are in Appendix VIII of this *Guide*.

Frequently, members are called upon to provide medical services to residents of the United States and other countries. According to the *Medicine Act* (online source: http://www.e-laws.gov.on.ca/DBLaws/Regs/English/930856_e.htm) 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) Furthermore, the Act prohibits physicians from "charging a fee that is excessive in relation to the services performed" (Section 1(1) 21). To avoid any misunderstanding and future patient claims to the contrary, the OMA recommends that patients be informed of the charges and OMA recommended rates and either sign a simple consent form that they have been advised of such charges or, in the very least, an acknowledgement that they have been advised of the charge for the uninsured services.

This 2007 Edition of the *Guide* has been significantly revised to improve its user friendliness and applicability to member practices. Recommended 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 recommended rates - depending on the complexity of the particular uninsured services in question.

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. Calculating Fees for Third-Party and Other Uninsured Services

There are several ways physicians can calculate their rates and fees for uninsured services (including those requested by third parties).

- Where possible, physicians providing uninsured services may wish to refer to the *OMA Schedule of Fees* for guidance and recommendations. In recommending rates, the OMA Schedule of Fees uses some or all of the following factors, as circumstances dictate:

Note: The exception to these methods of calculating recommended rates for uninsured services is referred to in Appendix VII. Under I. Definition of Uninsured Services "at Physician's Cost"

- 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;
- D. The cost of materials not included in the fees for insured services.

1. Establishing An Hourly Rate

In the absence of a specific fee recommendation for a rendered uninsured service, physicians should consider calculating the **hourly rate** and using this in their invoice. There are two approaches to setting an hourly rate:

Approach #1

One approach to setting your fees for uninsured services, including third-party services, is according to the time required to provide a particular service. This can be achieved by establishing an hourly rate based on your annual gross earnings.

➤ **Note:** Any hourly rate calculated using a physician's earnings is primarily based on earnings derived from the provision of insured services (gross OHIP billings). At the time of publication of this Guide, **OMA recommended rates were approximately 93% higher than OHIP rates. As such, the hourly rate calculated should reflect the uninsured nature of the particular services provided.** Further, the particular expertise of the physician providing the uninsured report/service should be taken into consideration.

The following **example** illustrates one way to determine an hourly rate:

	Item	Calculation
A	Annual gross OHIP billings: (Please note that when using OHIP income this should be income <u>before</u> any applicable thresholds)	\$230,000
B	Converted gross OHIP billings: (\$230,000 x 1.93)	\$443,900
C	Other annual income: (E.g., third party billings at OMA recommended rates)	\$20,000
D [B + C]	Total annual gross earnings: (\$443,900 + \$20,000)	\$463,900

E	Working days per year: (52 weeks x 5 days/week less 30 days vacation & holidays)	230 working days
F	Income generating hours ¹ : (9 hours in practice less 2 hours of unpaid non-clinical activity per working day)	7 paid hours/day
G [=E x F]	Annual paid hours ² : (231 days x 7 hours/day)	1,617 paid hours
H [=D x G]	Hourly rate: (\$459,300/1,610 hours)	\$288.14/hour

Notes:

- Members will need to carefully estimate the hours (on **average**) they work per day. These will certainly vary depending on the specific practice. The hours used in box F above are only an *example* and should be modified according to the members' average workday.
- In calculating the Annual paid hours per year used in Box G, the assumption used in the above example is that the member takes 4 weeks of holidays and the 9 statutory holidays listed in the OHIP Schedule of Benefits (*page GP3 of the April 1, 2006 edition*).

Approach #2

In establishing an hourly rate, physicians may also be guided by the part-time hourly rate shown in the Scale of Grading and Remuneration listed in the OMA Schedule of Fees. The recommended "gross" minimum part-time hourly rate for the 2007 calendar year is \$441.00/hr.

For physicians not responsible for providing their own regular practice expenses, the recommended minimum hourly rate is "\$276.00/hr net" of expenses.

➤ **Note:** *In certain situations, physicians experiencing a high volume of requests for uninsured services from certain employers/third parties, they may wish to enter into a contractual arrangement to provide these services at a predetermined rate/flat fee for a select period of time.*

II. Specific Recommended Fees for Uninsured Services & Forms

The following tables provide **examples** of select medical services, common reports and the associated OMA-suggested fees. The fees are presented to help physicians determine appropriate charges for third party and other uninsured services.

Members should be aware that all recommended rates for medical services are effective April 1, 2007. Recommended rates for form fees are effective January 1, 2007. To access recommended rates for medical services prior to April 1, 2007 please consult the 2006 edition of this Guide, the 2006 OMA Schedule of Fees or contact the OMA's Department of Economics.

1. Consultations and Visits

The OMA Schedule of Fees lists recommended fees that may and should be used by members as the basis for determining their fees when charging for uninsured medical services. The listed recommended fees are meant to 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. Given the large number of medical services and specialties that are involved in providing uninsured services, only a select representative number of recommended fees can be found in Appendix IX.

Did you know????? That, in many cases you can charge not only for the completion of an uninsured form but also for the medical assessment used to complete the form. For example, a family doctor performing an annual health exam used in the completion of an MOT Driver License Renewal or Application may bill for the A003 (\$123.05) plus the recommended fee for the form (\$42.24) for a total of \$165.29

Physicians providing Psychotherapy, Hypnotherapy and any form of Counselling, Primary Mental Health, Paediatric Adolescent, and Psychiatric Care by telephone, other electronic communications or in the physical absence of the patient (or patient's relative or patient representative as the case may be) are not insured services unless otherwise specifically listed in the Schedule (source: page GP 36, April 1, 2006 MOHLTC Schedule of Benefits). Members rendering such services should consult the specific OMA recommended rates in Appendix IX of this Guide or the 2007 OMA Schedule of Fees.

2. Example Uninsured Services

The following Table illustrates a sample of select uninsured services that physicians encounter in their practices. There are several tables throughout this Guide that highlights such services and uninsured form fees. **Appendix I provides a summary Table of all such services listed in this Guide.**

Service	OMA Fee
• Dispensing Service Fee (not to apply to provision of drug samples, only where there is recorded purchase of drugs).....	\$11.41
• Electrocardiogram for insurance companies (technical component only, no interpretation required).....	\$15.10
• Venipuncture (performed for insurance companies - sole purpose of visit).....	\$23.63
• Psychiatric telephone consultation by psychiatrist.....	\$287.34
• Psychiatric care/Psychotherapy by psychiatrist by telephone.....	\$121.05
• Diagnostic interview and/or counselling with child/parent for testing per 1/2 hour (K003).....	\$107.93
• Maximal Stress Electrocardiogram for insurance companies (technical component only, no interpretation required).....	\$169.04
• Certification of incompetence (financial) including assessment to determine incompetence (K624).....	\$220.17
• TB Mantoux Test (A composite fee consisting of a minor assessment fee and an injection fee. Patients would be responsible for the cost of the serum.).....	\$41.83

3. Immunization as an Uninsured Service

There are some instances where immunization is not an insured service. Patients receiving uninsured immunization may be charged for the service and the cost of the serum. Members should note that the Ministry of Health and Long Term Care also advises that immunization received solely for the purpose of travel outside Canada is an uninsured service (see Appendix VII, paragraph x **OR** MOHLTC Bulletin #4317, July 30, 1998 – direct link: <http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/4000/bul4317b.html>). Only immunization for communicable diseases endemic to Canada is an insured service.

4. Recommended Charges for the Transfer of Medical Records

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 II** for a sample letter to the patient informing them of the applicable fee charges.

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 refer to the CPSO’s policy statement on Medical Records, which is available on the CPSO’s website at:

<http://www.cpso.on.ca/Policies/medical%20records/medicalrec7.htm>.

Are You Aware That ?? Most Patients think that a Transfer of records involves the transfer of the doctor’s original records?

The OMA recommended minimum fee charges for the transfer of medical records (which includes making copies of the medical records) for an individual is **\$35.36 for pages 1-5 and \$1.37 per page thereafter** when the transfer of records occurs at the request of the patient because the care of the patient is being transferred at the request of the patient or the patient’s representative. **Please note** that these suggested rates can be altered at the discretion of the attending physician.

In situations where the patient’s charts include services of a psychiatric nature, the physician must be extremely diligent when reviewing the type of information that is transferred; this entails above average time on the part of the physician. The recommended fee for the transfer of such records is **\$47.30 for pages 1-5 and \$1.90 per page thereafter**.

➤ **Note:** The Ministry of Health and Long Term Care has also advised 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.

There are some instances where patients claim economic hardship and inability to comply with the fees they are charged by doctors for the transfer of the records. It is important for our members to realize that the OMA rates are *recommended* rates and that they (or their office staff) should use their judgement 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."

Did You Know That ?? Most patients (or Third Parties) believe that a transfer of medical records only involves photocopying and that this is no different than the photocopying services provided by large office supply companies or small retailers. For a complete list of physician and staff actions involved in the 'transfer' of medical records, please see Appendix X. Members should use this list to explain the cost of the requested transfer.

5. Uninsured Report Forms

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

The following suggested fees were developed with the assistance of representatives of the relevant OMA Sections and Forms Committee. This is only a sample of forms that exist in the public domain. **Where there is no recommended fee for a specific form a physician encounters, the OMA suggests billing the third party for the time required to perform the service; i.e., hourly rate** (please refer to the Section of this Guide on "Establishing an Hourly Rate").

Uninsured Report Forms	Suggested Fee
Completion of Form Physicals for:	
• Schools	\$21.10
• Camps	\$21.10
• Pre-employment Certification of Fitness	\$28.15
• Fitness Clubs	\$28.15
• Hospital/Nursing Home Employees	\$28.15
Completion of Licensing Forms/Certificates:	
• Drivers Medical Examination (FLRC80)	\$42.24
• Pilots Civil Aviation; form 26-0010(0890)	\$70.42
• Pilots License Validation 26-0055(01-91)	\$14.07
• Administrative License Suspension Appellant Medical Information Form	\$34.53
Completion of Work & School Related Forms/Notes:	
• Back to Work Notes	\$14.07
• Sick Notes	\$14.07
• Federal Employee Absence Notes; blue form	\$21.10
• Day Care Note (free of communicable disease)	\$14.07
Insurance Certificates:	
• Treatment Plan, form #OCF-18	\$105.65
• Disability Certificate, form #OCF-3	\$105.65
• Certificate of Health Practitioner, form #OCF-8	\$34.53

• Determination of Catastrophic Impairment #OCF-19/59	\$86.67
• Approval of an Assessment or Examination #OCF-22	\$105.65
• Travel Cancellation Insurance Form	\$28.15
• Life Insurance Death Certificate	\$35.21
• Medical Certificate for Employment Insurance Compassionate Care Benefits	\$40.01

Government Forms:

• Citizenship and Immigration Canada Medical Report for Immigration	\$105.65
• CPP Disability Medical Report Form (The federal government pays \$65 for completion of this form, physicians may bill patients for the remainder of the fee.)	\$105.65
• Request for Medical Information Regarding Applicants to Canadian Armed Forces	\$82.89
• Central Collection Service Request for Physician's Information	\$105.65
• Revenue Canada, Federal Disability Tax Credit	\$35.21
• Auto Sales Tax Rebate Form	\$28.17

Other Certificates:

• Children's Aid Society (CAS) Application Form for Prospective Foster Parent	\$42.24
• UIC Disability/Maternity Certificate INS2019	\$21.10

6. Unremunerated Report Forms

As per **Appendix VIII** of this *Guide*, there are a number of exemptions when charging for the completion of a third party report form. The following list (**source:** Section 24, Regulation 552 of the *Health Insurance Act*) contains some of the more common forms (along with the applicable paragraph in the Regulation) that a physician is not permitted to charge a patient for its completion:

- Application for Accessible Parking Permit form [*paragraph (1.1) 3 viii*]
- Transit forms for the Disabled [*paragraph (1.1) 3 viii*]
- Permanent Resident Card Forms
- Request for Birth Certificates
- Children's Aid Society Forms child [*paragraph (1.1) 3vi*]
- Canadian Passport Application
- Ministry of Health and Long-Term Care Forms (E.g., Limited Use, Assistive Devices, etc.) [*paragraph (1.1) 3 iii*]. **Note:** Some exceptions apply – see 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 (**to be introduced April 1, 2007**) etc.

7. Canada Pension Plan (CPP) Forms

There are two distinctly different types of CPP forms that the federal government pays for.

- i. The Disability Medical Report Form, which commands a \$65 fee

- ii. The Narrative Medical Reports for which the federal government pays up to \$150.00. Narrative Medical Reports are not the same as the Disability Medical Report Forms and are usually initiated by correspondence from staff of the Income Securities Programs Branch of Human Resources Development Canada.

Are you aware that ???? You may charge patients over and above the fees payable by the federal government under the CPP program. Use the OMA recommended rates as guidance when 'balance billing' for CPP forms/services. If required, the cost of the associated medical assessment should also be charged to the patient.

The narrative reports will require a medical history, the date of onset of each medical condition, an examination of findings, various excerpts of consultation reports (including identification of the consultants), diagnosis, copies of tests, a prognosis and course of future action. The federal government will reimburse physicians according to the following scale for narrative reports:

Service	Fee
➤ Photocopied information from the patient's chart and/or a short statement/paragraph (completed in less than 15 minutes)	\$25.00
➤ Short narrative typed reply involving chart review and medical report preparation (up to one full page and 15-20 minutes time)	\$50.00
➤ Full narrative typed report that is more complex to review and prepare (at least two pages and 40-45 minutes time)	\$100.00
➤ Detailed and complete typed report that involves a more extensive chart review and medical report preparation (3 or more pages, 60 minutes time)	\$150.00

Note: *There is nothing preventing physicians from seeking reimbursement beyond the rates and fees payable by the federal government under the CPP (or any other federal government program for that matter). Members are also reminded that they may charge patients for the cost of the associated assessments when necessary and indicated in order to complete the requested federal forms. OMA recommended rates should be used as a guideline when seeking the appropriate assessment fee – **example OMA rates for select specialties appear in Appendix IX.***

8. Life and Health Insurance Uninsured 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. In what follows, a general description of the specific form and a recommended fee will be provided. Where members' fees are expected to vary from the recommended fee, it is recommended that members communicate this to the insurance companies requesting the form.

- **Attending Physician's Statement** **Fee: \$105.61**

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.

Note: 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. As per Section II, item (f) of this guide, 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. For additional information please consult Section 24, paragraph (1.2) of the regulations at: <http://www.elaws.gov.on.ca/DBLaws/Regs/English/900552e.htm#BK9>.

▪ **System or Disease Specific Questionnaire** **Fee: \$70.42**

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: \$172.53**

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: \$84.52**

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: \$284.81/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: \$284.81/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.

9. Block Fees

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 that offer a block fee plan, however, **must** also offer patients the option of paying on a per uninsured service basis.

In its November 2004 policy update, the College of Physicians and Surgeons of Ontario (CPSO) offers some important points that physicians must keep in mind when implementing a block fee policy in their offices:

- Physicians should provide their patients choosing NOT to enrol in their block fee plan with a written statement of the fees charged for uninsured services in their practices.
- Physicians are advised to secure a written consent to the payment option chosen by the patient and to maintain this consent as part of the patient's record.
- In cases where patients opt for the block fee option, they must be given the opportunity to change their original choice within a week of their initial decision – at which point they become eligible to be charged on a per-service basis.
- Preferential treatment may not be offered to patients who prefer one option over the other.

The CPSO also recommends that, when offering their patients the block fee option, physicians should inform them in the following manner:

“Most of your medical needs are covered by the Ontario Health Insurance Plan (OHIP). There are, however, some services that are not covered. You can be charged for these services one by one, or you can be charged a block fee which would cover all the services which are not paid by OHIP for periods of time not less than three months or more than 12 months. The College of Physicians and Surgeons of Ontario has set out rules, which doctors must follow if they wish to charge block fees. These are:

- An annual/block fee must be identified as a fee for uninsured services for a period of not less than three months and not more than one year.
- The services covered by this fee must be clearly stated, in writing, and understood by the patient.
- The patient must be advised of the amount of the individual charges.
- The patient must be given the option of paying individual charges for the uninsured services as they are rendered.
- The decision as to whether or not to elect this form of payment must be the patient's, and must not be a condition of the patient being accepted by the doctor.

- The patient must be given a copy of this policy statement and indicate their acceptance of paying for uninsured services in this manner before being billed an annual fee.
- Fees for the service of being available to render a service cannot be charged in advance and are not to be included in annual fees".

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

For an information package on implementing a block or annual fee program, please contact either the OMA's Department of Economics or Professional Services. For a review of the CPSO policy, please go to <http://www.cpso.on.ca/Policies/blockfees.htm>.

10. Reports Requested by Employers and Other Issues Related to Workers' Compensation

There are instances where employers ask that workers injured in the workplace get their physicians to complete employer-specific forms 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 and Insurance Board (WSIB) forms which command a fee payable by the WSIB.

For a list of the WSIB report forms and their associated fees contact WSIB at 1-800-569-7919 or visit their website at www.wsib.on.ca

There are also 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 WSIB covered medical services 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 physician bill the patient directly for the cost of the medical services.

III. The Application of GST to Uninsured Services - Some Guidelines

Summary Table of GST and Uninsured Services

SERVICE	GST	NO GST
Block & Annual Fees	✓	
Medical Legal Reports	✓	
Independent Medical Evaluations (IMEs)		✓
System or Disease specific questionnaires		✓
Clarification Report	✓	
Treatment Plan (Form OCF-18/59)		✓
Disability Certificate	✓	
CPP Disability Reports	✓	
Expert Medical Opinion	✓	
Review of Medical Documentation for 3 rd party	✓	
Management Fees Paid by Physicians	✓	
Cosmetic surgical/medical procedures	✓	
Employer back to work/Timely Return to Work forms		✓
Prep. & Transfer of Medical Records		✓
Executive Medical Assessments		✓
Employment/pre-employment exams and associated forms		✓
Immigration Examinations and Reports		✓
Prescription renewal over phone		✓

1. Advance GST Rulings versus GST Application Rulings

The Canada Revenue Agency offers two types of rulings concerning the application of GST: "advance GST rulings" and "GST application rulings". Both are provided free of charge.

- An **Advance GST Ruling** is a written statement provided by the Canada Revenue Agency to a registrant or other person, stating how Canada Revenue Agency (CRA) will interpret specific provisions of Part IX of the Excise Tax Act with respect to supplies, actions, transactions, or series of transactions, which the person is contemplating. This ruling refers to specific persons, specific transactions and specific time periods within which the transaction must be completed. Consequently, a request that relates to a hypothetical situation cannot be viewed as a request for an advance GST ruling. Physicians often have questions regarding the application of GST in a particular instance. If they are asking for an interpretation that specifically relates to a proposed activity or set of activities, then they should request an Advance GST Ruling and all necessary facts should be provided.
- A **GST Application Ruling** provides the CRA's position on specific provisions of the legislation as they relate to a clearly defined factual situation of a particular person. Generally, GST application rulings relate to ongoing transactions and do not specify time limits.

Physicians should also note that they are required to register, collect and remit GST when their annual GST-taxable sales and revenues exceed \$30,000. For those physicians not exceeding this amount, GST registration is voluntary. Physicians should note that the following information on which uninsured services attract the application of GST does not constitute official advance GST rulings and is provided for information purposes.

Note: Members should be aware that once registered as collectors and remitters of GST, they must continue to file reports even if the GST falls below the \$30,000 threshold. Consequently, even if physicians retires or significantly reduce GST-taxable services, they would have to formally *de-register* as a GST remitter otherwise GST and monthly reports would continue to be required.

2. GST and Block/Annual Fees

Block or Annual fees (described in Section II.9 of this *Guide*) are considered taxable supplies since, at the time they are billed and paid for by the patient, there are no specific services being provided. These fees are similar to an insurance premium and ensure the right to a future service(s), the exact nature of which is (are) not predetermined.

3. GST and Medical Legal Reports

Medical legal reports are statements of fact and/or opinions regarding the physical/mental condition of a patient pertaining to an occurrence (e.g. automobile accident). Such reports are considered to be taxable supplies and attract GST, even if there has been an examination of the patient required to complete a medical legal form.

The only exception is in instances where the medical examination is an insured service for which a claim is submitted to (and paid for by) the Ministry of Health and Long-Term Care. In such a case, the medical service is tax exempt (pursuant to Section 9 of Part II of Schedule V of the Excise Tax Act) and is considered a separate supply from the medical legal report.

4. GST and Independent Medical Evaluations (IME)

Independent Medical Evaluations are conducted on the request of a third party, such as an insurance company or a lawyer, by a physician who did not have a previous relationship with the individual. IMEs are contracted between the physician and a third party with fees being agreed upon in advance.

Canada Revenue Agency's(CRA) GST/HST Policy Statement P-248, issued September 21,2006 ("p-248), defines an IME as "service of providing an expert opinion contained in a written report that is prepared by a medical practitioner acting in the course of the practice of medicine (physician). This expert opinion is supplied by the physician or by the operator of a health care facility. These expert opinions are supplied to a third party regarding the future and ongoing medical or health care treatment of an individual who is of interest to the third party. A third party is any person or organization other than the supplier or the individual, such as an insurance company, lawyer, tribunal or government. The supplier submits a report to the third party responding to a set of questions posed by the third party about the individual. In most cases, the expert opinion involves a meeting between the supplier and the individual as the supplier may be required to interview or examine the individual. The expert opinion is not an insured service under any provincial or territorial health insurance plan".
(On line source:<http://www.cra-grc.gc.ca/E/pub/gll/p-248/p-248-3.html>)

P-248 states that the provision of IME services are not subject to GST under the Excise Tax Act (*the "Act"*) when:

- IME services are rendered to a patient of the "health care facility" (in accordance with section 2 of Part II of the Act, which exempts institutional health care services made by the operator of a health care facility if the service is rendered to a patient or resident of the facility, except for cosmetic, non-medicinal services for purposes.)
- IME services are provided by a physician in the course of the practice of medicine (in accordance with section 5 of Part II of the Act which exempts services by a physician of a consultative, diagnostic, treatment or other health care service rendered except for cosmetic, non-medicinal services for purposes); and
- Services are provided for the purpose of an independent assessment (in accordance with section 7 of Part II of Schedule V, which exempts several health related non-medicinal services).

P-248, reverses the previous position taken by the CRA in an issued interpretation letter which stated that GST exemptions for services related to IMEs were extremely limited to specific situations. As a result of P-248 the exemption of GST for IME services has been expanded significantly. If a physician is unsure if a certain service relating to an IME is exempt from GST, it is advisable to review P-248 or to consult with an accountant.

5. GST and Insurance Forms

- **System or disease-specific questionnaires**

This is an insurance form that is usually sent to a physician (along with a signed consent form) asking for specific details related to a patient's medical condition. According to the CRA, this report prepared by the physician for the purpose of determining eligibility for insurance coverage is exempt from the GST.

- **Clarification Report**

Generally a medical examination is not required when an insurance company requests such a report. According to the CRA, such reports are subject to the GST.

- **Treatment Plan (Form OCF-18/59)**

This type of report is completed to determine the present health status of an individual, and to either rule out, confirm or recommend a necessary treatment modality. Since physicians will involve themselves in consultative, diagnostic or other health care services in order to assess the patient's health status and recommend appropriate treatment plans, this report is exempt from the application of the GST (pursuant to Section 5 of Part II of Schedule V to the Excise Tax Act).

- **Disability Certificate (Form OCF-3 – formerly OCF3/59)**

In completing this form (which is requested by the insurance company in the event of disability claims or legal action) physicians are not required to examine patients since this has already occurred in the context of previously assessing and treating the patient. In cases where there is a medical examination performed, it is solely for the purpose of confirming physical/mental pathology as a result of the previous incident. Consequently, such certificates are subject to the GST.

- **CPP Disability Reports/Disability Tax Reports**

For the same reason as the previous certificate, such reports are subject to the GST.

6. GST and Other Uninsured Services

The following uninsured services are considered by the Canada Revenue Agency to attract application of the GST:

- i. Review of documentation and provision of expert opinion by physicians
- ii. Management fees paid by physicians for administrative services, use of facilities, equipment, etc.
- iii. Surgical services and all related medical services that are provided for cosmetic purposes

The Canada Revenue Agency consider the following uninsured services GST exempt:

- i. Employer generated return to work/modified employment/timely return to work forms
- ii. Preparation and transfer of medical records at the request of the patient or his/her representative
- iii. Provision of a prescription to an insured patient at the request of the patient (or his/her representative) and no concomitant insured service is provided
- iv. Executive medical assessments
- v. Employment and pre-employment examinations/reports
- vi. Immigration examinations/reports

For more information regarding the GST you can call the Canada Revenue Agency toll-free at 1-800-959-8287 or refer to their website at: <http://www.cra-arc.gc.ca/menu-e.html>.

IV. 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.

1. 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 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.

2. 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:

Note: According to the College of Physicians and Surgeons of Ontario (CPSO Policy #8-02): "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, due to complexity or other appropriate reasons, this should be discussed with the third party."

"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."

V. Physicians as Expert Witnesses

1. Non-Treating (Retained) Physicians

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/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.

i. 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 defence lawyer. The only limit is that these fees not be excessive in relation to the services provided by the expert witness.

ii. 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 defence lawyer. The Ministry of the Attorney General generally pays experts in accordance with the below schedule of fees. However, **there is nothing that prevents expert witnesses from seeking reimbursement above these amounts.**

The Ministry of the Attorney General schedule of fees is as follows:

A.	Travel Time	\$45/hr
B.	Preparation, Interviews, Consultations	
	▪ GPs and family physicians	\$90/hr
	▪ other specialists	\$100/hr
C.	Witness Fee - Hourly Rate	
	▪ GPs and family physicians	\$110/hr
	▪ other specialists	\$125/hr
D.	Witness Fee - Half Day Rate	
	▪ GPs and family physicians	\$300
	▪ other specialists	\$325
E.	Witness Fee - Whole Day Rate	
	▪ GPs and family physicians	\$600
	▪ other specialists	\$650

2. Treating Physicians

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.

Tariff 'A' of the Rules of Civil Procedure state that the daily attendance allowance for a witness is \$50.00

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 medico-legal reports prepared in the matter.

VI. The Direct Billing Process

1. Some Practical Guidelines

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

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.

When billing directly for services provided, physicians should:

1. Establish and maintain a simple and clear office policy and procedure for direct billing;
2. Inform staff of this policy and procedure and keep them apprised of any changes;
3. Maintain up-to-date accounts;
4. Collect payment from patients at the point of service as often as possible;
5. Follow-up in an orderly and consistent manner;
6. Always discuss fees with the patient before providing the service.

Note: In the event physicians are unable to collect the fees charged for uninsured services they might wish to resort to the Small Claims Court system or employ the services of a collection agency. For more information please contact the OMA's Legal Department.

To establish a consistent office policy, physicians should first determine:

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

A physician's office policy on direct billing must be specific and detailed so that staff and patients fully and clearly understand it. At the same time, it should allow sufficient flexibility to adapt to any unique or unexpected circumstances that may be encountered. Once an office policy has been established, it should be put in writing and distributed to staff.

2. Keeping Patients Well-Informed

Most difficulties between a physician and patient arise from a lack of clear communication. Many patients simply don't realize that there are some services government doesn't pay for, and they may become upset when presented with a bill. To prevent this from happening, physicians and their staff must ensure that patients are well informed about uninsured services and the direct billing policy **well in advance of receiving treatment**.

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

1. Clearly display in your patient waiting area a sign (*refer to Appendix III, pg 27*) and an itemized list of those third-party services you offer.
2. Discuss fees when the patient books an appointment for an uninsured service.
3. Mention fees before you provide the uninsured service.
4. Provide an information pamphlet to the patient that includes:
 - General information (e.g., office hours, telephone hours, after-hours procedures, prescription refill instructions)
 - Direct billing information (e.g., services that are directly billed by you and not insured by government, procedures for third-party claim forms).

Keep in mind that this pamphlet need not be a complicated and costly publication. However, it should reflect your professionalism, and information should be presented in a clear and concise fashion.

3. Charging Interest on Unpaid Accounts - Some Guidelines

Quite often physicians encounter instances whereby accounts relating to third party uninsured services remain unpaid in spite of recovery efforts or are paid on a delayed basis. Physicians are reminded that they are entitled to charge interest on unpaid/delayed accounts. There are, however, certain guidelines that physicians should keep in mind when exercising this option:

- i. If an invoice to pay is directed to the patient **without explicit mention of interest payable on late payment** then, in accordance with section 128 of the *Courts of Justice Act* (Ontario), physicians may not charge a rate exceeding the Bank of Canada rate (rounded to the nearest tenth).
- ii. If an invoice to pay claims interest for late payment, the courts have determined (section 4 of the *Interest Act of Canada*) that "no interest exceeding the rate of 5% per annum shall be chargeable, payable or recoverable on any part of the principal money **unless the contract contains an express statement of yearly rate**" (emphasis added). In other words, a statement of only a monthly rate of interest is not sufficient if members wish to charge an annual rate exceeding 5%.
- iii. Physicians who include mention of late payment interest charges in their submitted invoices (specifically mentioning the annual rate) may charge up to an annual effective interest rate of 60%. Anyone entering into an agreement or receiving payment of a greater rate of interest could be found guilty of a criminal offence under section 347(1) of the *Criminal Code*.

VII. Useful Contact Information

Ontario Medical Association	www.oma.org 416-599-2580, toll free 1-800-268-7215 Fax: 416-599-9309
College of Physicians & Surgeons • 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 & Surgeons	www.rcpsc.medical.org Fax: 613-730-8830, 1-800-668-3740
Workplace Safety & Insurance Board • Downloadable forms.....	www.wsib.on.ca 416-344-4526, toll free 1-800-569-7919
Ministry of Health & Long Term Care Branches: • Provider Services • Drug Programs • Public Health • Primary Care Team	www.gov.on.ca 613-548-6561 416-327-8109 416-327-4300 416-327-8443, toll free 1-866-766-0266
Canadian Medical Association	www.cma.ca 1-613-731-9331, toll free 1-800-267-9703
Canadian Medical Protective Assoc • Medico-legal/general inquiries • Membership.....	www.cmpa-acpm.ca 1-613-725-2000, toll free 1-800-267-6522 Fax: 613-725-1300 tel:1-877-763-1300 613-725-1300
Ontario Hospital Association	www.oha.ca 416-867-9646
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.gc.ca/form/e-services_e.html
Family Practice Section	www.familydoctorsofontario.com
Government of Ontario Telephone Online Directory	www.serviceontario.ca



OMIA

If you have any suggestions for the next edition of this Guide,
please forward them in writing to:

**Department of Economics
Ontario Medical Association
525 University Avenue, Suite 200
Toronto, Ontario M5G 2K7**

OR

Via e-mail to : thirdpartyguide@oma.org

Appendix I: Uninsured Forms and Services At a Glance

Forms/Service	Suggested Minimum Fee	Reference Page in Guide	Notes
<p>Note: For third party requested services, physicians can generally charge for the completion of a report in addition to the appropriate assessment fee.</p>			
<p>Part-time Hourly Rates:</p> <ul style="list-style-type: none"> • Net • Gross 	<p>\$276.00/hr \$441.00/hr</p>	7-8	
<p>Transfer of Medical Records</p>	<p>\$35.36 \$1.37</p>	9-10	<ul style="list-style-type: none"> ➤ Pages 1-5 ➤ each page thereafter
<p>Transfer of Medical Records (for <u>psychiatric/mental health</u> patients)</p>	<p>\$47.30 \$1.90</p>	10	<ul style="list-style-type: none"> ➤ Pages 1-5 ➤ each page thereafter
<p>Completion of Form Physicals for:</p> <ul style="list-style-type: none"> • Schools • Camps • Pre-employment Certification of Fitness • Fitness Clubs • Hospital/Nursing Home Employees 	<p>\$21.10 \$21.10 \$28.15 \$28.15 \$28.15</p>	11	
<p>Completion of Licensing Forms/Certificates:</p> <ul style="list-style-type: none"> • Drivers Medical Examination (FLRC80) 	\$42.24	11	
<p>Electrocardiogram for insurance companies (technical component only, no interpretation required)</p>	\$15.10	9	
<p>Venipuncture (performed for insurance companies - sole purpose of visit)</p>	\$23.63	9	
<p>Maximal Stress Electrocardiogram for insurance companies (technical component only, no interpretation required)</p>	\$169.04	9	
<p>Dispensing Service Fee (not to apply to provision of drug samples, only where there is recorded purchase of drugs)</p>	\$11.41	9	
<p>Completion of Work & School Related Forms/Notes:</p> <ul style="list-style-type: none"> • Back to Work Notes • Sick Notes • Day Care Note (free of communicable disease) 	<p>\$14.07 \$14.07 \$14.07</p>	11	

Appendix I: Uninsured Forms and Services At a Glance - Continued

Forms/Service	Suggested Minimum Fee	Reference Page in Guide	Notes
<p>Note: For third party requested services, physicians can generally charge for the completion of a report in addition to the appropriate assessment fee.</p>			
<p>Insurance Certificates & Reports</p>			
<ul style="list-style-type: none"> • Treatment Plan, form #OCF-18 • Disability Certificate, form #OCF-3 • Certificate of Health Practitioner, form #OCF-8 • Determination of Catastrophic Impairment #OCF-19/59 • Approval of an Assessment or Examination #OCF-22 • Travel Cancellation Insurance Form • Life Insurance Death Certificate • Medical Certificate for Employment Insurance Compassionate Care Benefits 	<p>\$105.65</p> <p>\$105.65</p> <p>\$34.53</p> <p>\$86.67</p> <p>\$105.65</p> <p>\$28.15</p> <p>\$35.24</p> <p>\$34.67</p>	11	
<ul style="list-style-type: none"> • Children's' Aid Society (CAS) Application Form for Prospective Foster Parent • UIC Disability/Maternity Certificate INS2019 	<p>\$42.24</p> <p>\$21.10</p>	12	<p>➤ Bill parent(s) for the form</p>
<ul style="list-style-type: none"> • Attending Physician's Statement 	\$105.61	13	<p>➤ Usually no assessment required; additional charge for copies of lab tests/records</p>
<ul style="list-style-type: none"> • System or Disease Specific Questionnaire 	\$70.42	14	<p>➤ Usually no assessment required</p>
<ul style="list-style-type: none"> • Insurance Medical Examination 	\$172.53	14	<p>➤ Fee includes general assessment and form</p>
<ul style="list-style-type: none"> • Systems Specific Examination 	\$84.52	14	<p>➤ Includes single system assessment plus simple form</p>
<ul style="list-style-type: none"> • Clarification Report 	\$284.81/hr	14	
<ul style="list-style-type: none"> • Full Narrative Report 	\$284.81/hr	14	
<ul style="list-style-type: none"> • Independent Medical Examination 	Charge hourly rate	14	<p>➤ Independent Consideration between physician and insurance company</p>
<ul style="list-style-type: none"> • TB Mantoux Test (A composite fee consisting of a minor assessment fee and an injection fee. Patients would be responsible for the cost of the serum.) 	\$41.83	9	
<ul style="list-style-type: none"> • Psychiatric care/Psychotherapy by psychiatrist by telephone • Psychiatric telephone consultation by psychiatrist 	<p>\$121.05</p> <p>\$287.34</p>	9	

Appendix I: Uninsured Forms and Services At a Glance - Continued

Forms/Letters	Suggested Minimum Fee	Reference Page	Notes
<i>Federal CPP Program</i>			
• Disability Medical Report Form	\$65.00	12	
• Narrative reports (medical history)	\$150.00	13	
• Photocopied info for narrative report less than 15 minutes	\$25.00	13	
• Short narrative typed report typed 15-20 minutes	\$50.00	13	
• Full narrative typed report 40-45 minutes typed	\$100.00	13	
• Detailed and complete typed report, 60 minutes	\$150.00	13	
<i>3rd Party Forms – Bill to Patient</i>			
• Admission to Day care	\$21.10		
• Admission to Pre-School	\$21.10	11	
• Admission to School	\$21.10	11	
• Admission to Community College	\$21.10	11	
• Admission to University	\$21.10	11	
• Admission to Other Educational Institutes	\$21.10	11	
<i>3rd Party Services Billable to OHIP</i>			
• Return to Day Care (OHIP Visit Fee)			* Form completion at Physician's discretion
• Return to Pre- School (OHIP Visit Fee)			* Form completion at Physician's discretion

Appendix II: Sample Letter for Patient Requested Transfer of Medical Records

Dr. [Responder's name], address, phone number, fax number,
(e-mail address if appropriate)

Date: _____

Dear [Patient Name] _____

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 two options.

Please circle the number 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 Recommended 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.

Your preferred phone number for contact is (000) 000-000.

- 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 of Patient _____ **Date:** _____

Yours truly [signature of Dr. Responder]

Source: Courtesy of: Dr. Thomas R. Faloon, CCFP FCFP, Ottawa. Canadian Family Physician 2002; 48:564,566.

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 addition information please review the CPSO policy statement on Medical Records.

Appendix III: Sample Confirmation Letter of Third Party Request

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

Dear (Insert Name of Third Party here)

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

I am in receipt of your request for the completion of a (insert name of form here) 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 recommended rate contained in the (insert year here) 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 here) 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 2% (compounded monthly) equivalent to a daily rate of ____ % will be applied to your outstanding charges.

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 here). Should you have any further questions please contact (insert name of office staff person here) at my office phone number quoting the patient's name.

Sincerely

Billing Physician's signature here
Billing Physician's name here

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

Third Party's Signature _____
Third Party's Name _____
Date signed _____

Appendix IV: Sample Third Party Invoice

Insert Billing Physician's Office/Clinic Logo, Name, Practice Address etc. Here

Bill to: Third Party Name Third Party Address Third Party Phone & Fax Number	Invoice Number: _____ Invoice Date: _____ Payment Terms: <i>In full within __ days of Invoice Date</i>
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 here)*. 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 recommended rate and/or hourly rate multiplied by the time necessary to complete activity
- insert associated costs (photocopying, courier etc0

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 here

Appendix V: Sample Patient Info Letter Re: Office Policy on Uninsured Services

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

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 recommended fees as found in the **INSERT APPROPRIATE YEAR HERE** edition of the OMA'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 \$20.00 for personal cheques that are returned N.S.F. by financial institutions will be added to patients' accounts. Thank you for your cooperation.

Physician Signature _____

Physician's Name _____

Insert list of uninsured services and office charges here



Message to Patients

Did you know that OHIP does not pay for all of the services your doctor provides to you? Physicians can request payment from patients for the services that are not covered by OHIP.

Listed below are some examples of physician services that you can be charged for, by your doctor:

NON-MEDICAL SERVICES

(some exceptions may apply)

- * **Transferred copies or a summary of your medical records**, at your request, when changing doctors or when your doctor is relocating or leaving the practice
- * **Writing reports and filling out forms.** Examples of such forms are:
 - * Licensing / insurance forms
 - * Federal Government (Canada Pension Plan, immigration, etc.) forms
 - * Sick or back-to-work notes
 - * Medical legal reports
 - * Employer-requested reports
 - * Recreational camp forms
- * **Missed appointments** without sufficient notice
- * **Long distance telephone** and facsimile toll charges

SOME MEDICAL SERVICES THAT ARE NOT COVERED BY OHIP:

(some exceptions may apply)

- * **Cosmetic procedures** (including some related consultations and diagnostic tests)
- * **Acupuncture**
- * **Pre-departure Travel Medicine Services** for the purpose of traveling outside of Canada
- * **Routine eye examinations** for patients who request more than the regulated amount covered by OHIP
- * **Examinations / diagnostic tests** required for the completion of documents such as reports, forms and licenses
- * **Medical advice** over the telephone or call-in prescription renewal orders to the pharmacist

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 doctor about other health care services that are not insured by OHIP and of the fees you may be charged.

Appendix VII: Definition and Sample of Select Uninsured Services

Uninsured medical services are not covered by the Ontario Health Insurance Plan (OHIP) and may be charged directly to patient at the discretion of the physician. Physicians should, whenever possible, inform the patient or the person financially responsible about such charges prior to treatment and should make an appropriate record (as required) of the uninsured services they provide.

The following is a list of uninsured services that are commonly charged by physicians at present time. The list is not exhaustive. For additional information, please refer to Appendices B and D of the Ministry of Health's Schedule of Benefits.

For the direct source of the applicable Regulations outlining which services are deemed to be uninsured, please go to Section 24 of the Regulations found at http://www.e-laws.gov.on.ca/DBLaws/Regs/English/900552_e.htm#BK9

1. **At Physician's Cost**

This is 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.

- (a) **Preparation and transfer of an insured person's health records** when this is done because the care of the person is being transferred at the request of the person or person's representative. In addition to the office overhead, the physician may charge for his or her time in preparing the information for transfer → (see section on *Transfer of Medical Records in this Guide for further guidance and information*).
- (b) Toll charges for long-distance telephone calls.
- (c) Preparing or providing a device that is not implanted by means of an incision and that is used for therapeutic purposes, e.g. an I.U.D. 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 Schedule of Benefits, in which case the patient cannot be charged a fee.
- (d) Preparing or providing:
 - i. a drug, antigen, antiserum or other substances used for treatment that is not used to facilitate a procedure or examination;
 - ii. a drug to promote ovulation.

2. **On An Independent Consideration (I.C.) Basis**

Independent consideration is defined as an acceptable professional rate, taking into account factors and using the guidance offered in Section I of this Guide. Examples include:

- (a) **Missed appointments or procedures** if less than twenty-four hours notice of cancellation has been given by the patient. An exception to the twenty-four hour notice exists for psychotherapy practices where a reasonable written agreement exists between the patient and the physician.

➤ **Note:** Practically speaking, this is one of the hardest fees to collect from patients. Physicians should make this policy clear at the time new patients are taken on and should set either a) a flat fee for all missed office visit/assessment or b) charge on the basis of the specific type of visit/procedure missed. In either case, members should note that even if the appointment missed would have otherwise been insured by OHIP, it becomes uninsured once the appointment is missed and, consequently, OMA recommended fees may be used to determine the amount that may be charged.

- (b) **A service that is solely for the purpose of altering or restoring appearance.**
- (c) **Advice given by telephone** to an insured person at the request of the person or the person's representative unless advice by telephone is specifically listed as an insured service or part of an insured service in the Schedule of Benefits, such as G271 anti-coagulant supervision and G382 supervision of chemotherapy.
- **Note: The MOHLTC Schedule of Benefits lists the following as a Specific Element of an insured service and, consequently, may not be charged to patients:**
- "Discussion with, and providing advice and information, including prescribing therapy to the patient or the patient's representative(s), whether by telephone or otherwise, on matters related to:
1. the service; and
 2. in circumstances in which it would be professionally appropriate that results can be reported upon prior to any further patient visit, the results of related procedure(s) and/or assessment." (source: Item F., 2006 Schedule of Benefits, page GP15)
- (d) **Providing a prescription to an insured person** if the person or the person's personal representative requests the prescription and no concomitant insured service is provided.
- (e) **Travelling to visit an insured person outside the usual area of medical practice**, which is defined by the Ontario Medical Association as the greatest of eight (8) kilometres or fifteen (15) minutes of travel.
- (f) **An interview or case conference** regarding the care of an insured person under the Ontario Health Insurance Act that:
- i. lasts more than 20 minutes
 - ii. includes a professional none of whose services are insured services **and**
 - iii. occurs at a place other than a hospital
- Note:** Code K121 Case Conference (2006 OHIP fee \$51.70 per half hr. unit) is an example of a case conference that **is** insured (since it must be provided to an hospital inpatient, lasts more than 20 minutes and involves medical/paramedical personnel).
- (g) **An anaesthetic service rendered by a physician in connection with,**
- i. a service rendered by a practitioner that is provided outside a hospital, **or**
 - ii. a dental service that is not insured, is provided in a hospital **and** involves only the removal of impacted teeth.
- (h) A service rendered to a person who is 20 or more years of age and less than 65 years of age that is rendered solely for the purpose of refraction.
- (i) **The fitting of contact lenses** other than for:
- i. aphakia;
 - ii. myopia greater than nine diopters;
 - iii. irregular astigmatism resulting from post corneal grafting or corneal scarring from disease; or
 - iv. keratoconus.
- (j) The fitting or evaluation of hearing aids and tinnitus maskers.
- (k) Treatment for a medical condition that is generally accepted within Ontario as experimental.

- (l) An acupuncture procedure.
- (m) Circumcision, except if medically necessary.
- (n) Reversal of sterilization.
- (o) ***In vitro fertilization other than the first three treatment cycles*** of in vitro fertilization that are intended to address infertility due to complete bilateral anatomical fallopian tube blockage that did not result from sterilization.
- (p) Destruction of hair follicles.
- (q) ***Certain surface and sub-surface pathology*** (such as select trauma scars, keloids, benign lesions, etc, see → preamble of the Ministry of Health and Long Term Care *Schedule of Benefits, Appendix D pages 2D to 8D*).
- (r) Sex re-assignment surgery.
- (s) Psychological testing.
- (t) Psychotherapy that is a requirement for the patient to obtain a diploma or degree or to fulfil a course of study.
- (u) ***Counselling, therapy or any other service rendered for the purpose of weight loss*** for the benefit of a patient other than a patient,
 - i. who has a medical condition that is attributable to, or aggravated by excess weight, or
 - ii. who suffers from obesity (defined as a person whose body mass index is greater than 27) and whose obesity puts the patient at an increased risk of developing a medical condition that is attributable to, or aggravated by, excess weight.
- (v) An examination or procedure for the purpose of a research or survey program other than an assessment that is necessary to determine if an insured person is suitable for the program.
- (w) A service or treatment, including immunization or the administration of any drug, rendered to an insured person in connection with, and for the sole purpose of, travelling to a country outside Canada.
- (x) Occupational, environmental, corporate and organizational medicine services; including environmental, medical, occupational, security or other health risk assessments, workplace audits; health promotion and illness prevention initiatives, disability management and return to work programmes; collaboration with other professionals and client representatives; and other associated and incidental services.

Appendix VIII: Definition of Third-Party Services & Excerpts of Applicable Regulations (Section 24, Reg 552 of the Health Insurance Act)

The current regulations define 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.

- Note: (Physicians cannot bill OHIP but may charge patients – or the third party wherever possible – in the event that they are aware that 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.) Third party services may also be provided directly to a business or organization, and there need not be a specific patient involved.

Except where noted under **Exemptions**, the following third-party services are uninsured, when the service or document relates to:

- (a) Admission to, or continued attendance in, a day care, pre-school program or school, community college, university or other educational institution or program [paragraph (8.2) i];

Exemptions – (i.e., the medical services are insured and the appropriate visit fee can be billed to OHIP):

- Providing a service to enable a patient to return to day care or pre-school, **if in the opinion of the physician the service is medically necessary** [paragraph (1.2) 2.]. Note that the report produced from the service remains uninsured and is billable to the patient or third party; and
 - Providing a service, completing a document, or transmitting information that is required as evidence of immunization status for admission or continued attendance in a day care or pre-school program or a school, community college, university or other educational institution or program. [paragraph (1.1) 3 vii]
- (b) Admission or continued attendance in a camp, recreational/athletic program, association, or club [paragraph (8.2) ii];
- (c) Application for, or the continuation of, insurance coverage (e.g. taking out a life, disability or other insurance policy) [paragraph (8.2) iii];
- (d) Application for, or the continuation of, a license (e.g. pilot, driver's and other licenses) [paragraph (8.2) iv];
- (e) Entering or maintaining a contract [paragraph (8.2) v];
- (f) An entitlement to benefits, including insurance benefits or benefits under a pension plan (e.g. private or CPP disability benefits [paragraph (8.2) vi]);

Exemptions – (i.e., the services are insured and the appropriate visit fee can be billed to OHIP):

- Providing a service to enable a patient to receive disability or sickness benefits, **if in the opinion of the physician the service is medically necessary** [paragraph (1.2) 1.]. Note that the report produced from the service remains uninsured and is billable to the patient or third party.

- (g) Obtaining employment (e.g. pre-employment medical examinations) or maintaining employment (e.g. annual/periodic medicals) [paragraph (8.2) vii].
- Exemptions** – (i.e., the services are insured and the appropriate visit fee can be billed to OHIP):
- Providing a service relating to a patient's fitness to continue employment, **if in the opinion of the physician the service is medically necessary** [paragraph (1.2) 3]. Note that the report produced from the service remains uninsured and is billable to the patient or third party.
- (h) An absence from, or return to work [paragraph (8.2) viii];
- Exemptions** – (i.e., the services are insured and the appropriate visit fee can be billed to OHIP):
- Providing a service relating to a patient's absence or return to work, **if in the opinion of the physician the service is medically necessary** [paragraph (1.2) 4]. Note that the report produced from the service remains uninsured and is billable to the patient or third party.
- (i) Legal proceedings [paragraph (8.2) ix];
- Exemptions** – (i.e., the services are insured and the appropriate visit fee can be billed to OHIP):
- Providing a service relating to legal proceedings **if in the opinion of the physician the service is medically necessary** [paragraph (1.2) 5]. Note that the report produced from the service remains uninsured and is billable to the patient or third party;
 - Providing an examination and producing or completing documents or transmitting information under the Mental Health Act, or for the purpose of an investigation of an alleged sexual assault in accordance with requirements of the Ministry of the Attorney General and the Ministry of the Solicitor General [paragraph (1.1) 6]
- (j) Required by legislation of any government or to receive anything under, or to satisfy a condition under, any legislation or program of government [paragraph (8.1)];
- Exemptions** – (i.e., the services are insured and the appropriate visit fee can be billed to OHIP):
- Providing a service and producing or completing a document, or transmitting information that is:
 - i. Required to be admitted to (or receive health services in) a hospital or nursing home or home under the Homes for the Aged and Rest Homes Act, a home for mentally handicapped under the Retarded Persons Act, or a charitable institution under the Charitable Institutions Act [paragraph (1.1) 3i];
 - ii. Required in relation to an annual health exam of a patient resident in a facility defined in i) [paragraph (1.1) 3ii];
 - iii. Required to receive anything under a Ministry of Health and Long Term Care administered program [paragraph (1.1) 3 iii];
 - iv. Required to receive welfare or social assistance benefits provided by a government or employment supports under Part III of the *Ontario Disability Support Program Act, 1997*, [paragraph (1.1) 3 iv];

- v. Required by a health facility under the Independent Health Facilities Act [paragraph (1.1) 3v];
- vi. Respecting the health status of a child [paragraph (1.1) 3vi] who:
 - (a) Is in the supervision/care/custody/control of the Children's Aid Society;
 - (b) Resides in a place of secure custody, a place of open custody or a place of temporary detention, within the meaning of Part IV of the Child and Family Services Act; or
 - (c) Resides in a children's residence licensed under Part IX of the Child and Family Services Act.

➤ **Note:** This exemption does not apply to medical services and the resulting reports generated at the request of the Children's Aid Society to determine eligibility as a foster parent.

- vii. Required as evidence of disability, or for the purposes of eligibility for a benefit, related to transportation under any legislation or government program [paragraph (1.1) 3 viii].
- viii. Required to obtain consents to perform insured services [paragraph (1.1) 3 ix].

(k) A service provided by a laboratory, physician or hospital that supports one of the above services (excluding the noted exemptions) is also an uninsured service [paragraph (1.1) 4].

➤ **Note:** Physicians are reminded that they may not bill for the following services that are constituent elements of insured medical services. This list is not exhaustive; for a complete list of the common and specific elements of insured services that physicians cannot bill as uninsured services, please refer to the April 1, 2006 edition of the *OHIP Schedule of Benefits General Preamble pages GP 13-15*.

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

- (a) For keeping or maintaining appropriate physician records [paragraph (1.1) 1].
- (b) For conferring with, or providing advice, direction, information, or records to physicians or other professionals concerned with the health of the insured person [paragraph (1.1) 2].
- (c) For obtaining consents or delivering written consents [paragraph (1.1) 3 ix].
- (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 medical care for insured services etc.)

**Appendix IX: 2007 Recommended OMA Rates for Select
Medical Services & Select Specialties***

General and Family Practice	Code	OMA Fee
• Consultation	A005	\$117.04
• General Assessment	A003	\$115.80
• Intermediate Assessment	A007	\$58.48
• Minor Assessment	A001	\$37.03
• Housecall Assessment	A901	\$87.20
• Annual Health Examination - child after second birthday	K017	\$63.34
• Individual Psychotherapy	K007	\$107.94
• Primary Mental Health Care	K005	\$107.94
• Counselling	K013	\$107.94
Cardiology		
• Consultation	A605	\$240.34
• General Assessment	A603	\$122.24
Dermatology		
• Consultation	A025	\$114.05
• Specific Assessment	A023	\$81.26
Internal Medicine		
• Consultation	A135	\$240.34
• General Assessment	A133	\$122.24
Ophthalmology		
• Consultation	A235	\$124.60
• Special Surgical Consultation	A935	\$240.34
• Specific Assessment	A233	\$88.45
Orthopaedic Surgery		
• Consultation	A065	\$120.24
• Special Surgical Consultation	A935	\$240.34
• Specific Assessment	A063	\$83.20
Paediatrics		
• Consultation	A265	\$240.34
• General Assessment	A263	\$122.24
• Intermediate Assessment/Well Baby Care	A007	\$58.48
• Annual Health Exam (ages 2-11)	K267	\$63.33
• Annual Health Exam (ages 12-17)	K269	\$109.87

* Only select OMA recommended rates for select specialties are reproduced in this Appendix. For a complete list of OMA fees, please consult the 2007 Edition of the OMA Schedule of Fees available directly through the OMA or its website (www.oma.org) or contact the OMA's Department of Economics.

**Appendix IX: 2007 Recommended OMA Rates for Select
Medical Services & Select Specialties* (Continued)**

Psychiatry	Code	OMA Fee
• Consultation	A195	\$287.34
• Geriatric Psychiatry Consultation	A795	\$360.40
• Specific Assessment with Report to Referring Agency	--	\$240.34
• Psychiatric Care (outpatient – per ½ hour)	K198	\$121.05
• Psychiatric Care (inpatient – per ½ hour)	K199	\$133.14
• Psychotherapy outpatient/inpatient – per ½ hr.)	K197/K190	\$121.05

* Only select OMA recommended rates for select specialties are reproduced in this Appendix. For a complete list of OMA fees, please consult the 2007 Edition of the OMA Schedule of Fees available directly through the OMA or its website (www.oma.org) or contact the OMA's Department of Economics.

Appendix X: Transferring Medical Records – What is Included in the OMA Recommended Fee

The function of transferring medical records includes a variety of activities in addition to the simple act of photocopying medical records. The following is an example of the activities performed by the physician and/or the practice's office staff when the transfer of medical records is related to a transfer of care of the patient:

- The physician from which the patient is transferring receives the request and makes sure that the proper authorization form is included and signed by the patient(s).
- The physician reviews the chart, estimates the cost of the transfer. In some instances and with the patient's permission, the physician may decide which parts of the records are necessary to be photocopied and transferred. While this is time consuming it ultimately saves the patient from having to pay for the transfer of many years worth of trivial and no longer relevant medical information.
- The physician's office staff communicates with the patient and explains that there will be a charge for the transfer of records and quotes the estimated rate. The physician asks the patient to sign and return a form acknowledging the quoted charge and that they are financially responsible for settling the account following the transfer (Please refer to Appendix II for a sample letter).
- The importance of appropriate communication with patients prior to the initiation of the transfer must be stressed. Patients must be informed, in advance, that the transfer of medical records is an uninsured service (not covered by OHIP) and given an estimate of the cost of the transfer.

Members should be aware that patients quite often do not realize that the originals of their charts are never transferred rather these remain in the physician's practice for a minimum of 10 years.

- Once the form is received from the patient, the chart is reviewed (if this hasn't previously occurred), or the relevant areas of the chart that have been selected by the physician are photocopied.

It is important to note that staff may have to remove the chart from the premises to get it copied, or in the event the office has access to a photocopier, the office staff person will have to copy the relevant pages (while ensuring that the original chart remains in order). It is important to also understand that photocopying a chart during office practice hours is disruptive to office administration and even more so when staff have to leave the premises.

- The original chart is returned to an area of the office records that contains the inactive files and is stored for at least ten years after the date of the last entry in the record, or until ten years after the day on which the patient reached or would have reached the age of eighteen years (according to the CPSO requirements).
- The physician transfers the copy of the chart (either directly to the patient in a sealed envelope) or by mail.