

Physician's Guide to Third-Party & Other Uninsured Services 2003 Edition

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The following physician guide provides a brief outline of uninsured services and suggested fees, with particular attention to third-party services. This guide is intended to offer assistance in establishing appropriate billing rates. However, physicians should use their discretion on whether or not to charge above or below these suggested rates. (Note: 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 WCB Act).

I. Definition of Uninsured Services

Uninsured medical services are not covered by the Ontario Health Insurance Plan (OHIP) and may be charged directly to patients 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 provided.

Following is a list of uninsured services that are commonly charged by physicians at present. The list is not exhaustive.

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. Toll charges for long-distance telephone calls.
- b. Preparing or providing a device that is not implanted by means of an incision and that is used for therapeutic purposes, e.g., an IUD. Exceptions to this are if the device is used to permit or facilitate a procedure or examination, or if the device is a cast for which there is a fee listed in the Schedule of Benefits, in which case the patient cannot be charged a fee.
- c. The costs associated with the application of fibreglass casts outside hospital.
- 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.
- e. 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.

2. On An Independent Consideration (IC) Basis

Independent consideration is defined as an acceptable professional rate, taking into account factors noted in Section III of this

guide.

- a. Missed appointments or procedures if less than 24-hours notice of cancellation has been given by the patient. An exception to the 24-hour notice exists for psychotherapy practices where a reasonable written agreement exists between the patient and the physician.
- b. A service that is solely for the purpose of altering or restoring appearance, except where the service is specifically listed as an insured service or part of an insured service in the Schedule of Benefits.
- 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.
- 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 greater of eight (8) kilometres or fifteen (15) minutes of travel.
- f. An interview or case conference in respect of an insured person that lasts more than 20 minutes and includes a professional - none of whose services are insured services.
- g. An anesthetic service rendered by a physician in connection with a service rendered by a practitioner that is provided outside a hospital, or in connection with a dental service that is not insured, and is provided in a hospital involving only the removal of impacted teeth.
- h. 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.
- i. An acupuncture procedure.
- j. Psychological testing.
- k. A service that is part of a group-screening program.
 - l. 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.
- m. Treatment for a medical condition that is generally accepted within Ontario as experimental.
- n. Psychotherapy that is a requirement for the patient to obtain a diploma or degree or to fulfil a course of study.
- o. Circumcision, except if medically necessary.
- p. Reversal of sterilization.
- q. 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.
- r. Destruction of hair follicles.
- s. 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, pages 2D to 8D).
- t. 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.
- u. 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.
- v. Sex re-assignment surgery.
- w. The fitting or evaluation of hearing aids and tinnitus maskers.

II. Third-Party Services

The current regulations define third-party services as any service (including an annual health exam) received by a patient that 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.)

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, school, community college, university or other educational institution;

Exemptions (i.e. medical services insured by 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 (the report produced from the service remains uninsured);
- providing a service, completing a document, or transmitting information that is required as evidence of immunization status for admission or continued attendance in day care or pre-school program or a school, community college, university or other educational institution or program.

- b. Admission or continued attendance in a camp, recreational/athletic program, association, or club.

- c. Application for, or the continuation of, insurance coverage (e.g., taking out a life, disability or other insurance policy).

- d. Application for, or the continuation of, a licence (e.g., pilot, driver's and other licences).

- e. Entering or maintaining a contract.

- f. An entitlement to benefits, including insurance benefits or benefits under a pension plan (e.g., private or CPP disability benefits);

Exemptions (i.e. medical services insured by 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 (the report form produced from the service remains uninsured).

- g. Obtaining employment (e.g., pre-employment medical examinations) or maintaining employment (e.g., annual/ periodic medicals);

Exemptions (i.e. medical services insured by 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 (the report form produced from the service remains uninsured).

- h. An absence from, or return to, work;

Exemptions (i.e. medical services insured by OHIP):

- providing a service relating to a patient's absence from, or return to, work, if in the opinion of the physician the service is medically necessary (the report form produced from the service remains uninsured).

- i. Legal proceedings;

Exemptions (i.e. medical services insured by OHIP):

- providing a service relating to legal proceedings if in the opinion of the physician the service is medically necessary (the report form produced from the service remains uninsured).
- 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.

- j. Required by legislation of any government or to receive anything under, or to satisfy a condition under, any legislation or program of government;

Exemptions (i.e. medical services insured by 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.
 - ii. required in relation to an annual health exam of a patient resident in a facility defined in i).
 - iii. required to receive anything under a Ministry of Health and Long-Term Care-administered program.
 - iv. required to receive welfare/social assistance benefits provided by government or vocational rehabilitation (Vocational Rehabilitation Services Act).
 - v. required by a health facility under the Independent Health Facilities Act.
 - vi. respecting the health status of a child who: is in the supervision/care/custody/control of the Children's Aid Society; 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 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.

- viii. required to obtain consents to perform insured services.
- 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.

Nothing in the third-party regulation allows physicians to bill:

Physicians are reminded that they may not bill for the following services that are considered to be constituent elements of the insured medical services (for a complete list of the common elements of insured services that physicians cannot bill as uninsured services see pages iii-v in the Preamble of the Ministry of Health and Long-Term Care Schedule of Benefits).

- a. For keeping or maintaining appropriate physician records.
- b. For conferring with, or providing advice, direction, information, or records to physicians or other professionals concerned with the health of the insured person.
- c. For obtaining consents or delivering written consents.
- 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.)

III. Calculating Fees for Third-Party and Other Uninsured Services

In calculating fees for uninsured services, including third-party services, but excepting the services described in Section 1 under "At Physician's Cost," the physician should take into consideration, as circumstances dictate, some or all of the following factors:

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

Alternatively, physicians providing uninsured services, including third-party services, may wish to refer to the OMA Schedule of Fees, which takes into consideration the above factors for specific items, to determine fees to be charged. Another approach includes setting an hourly rate (see page viii of this guide). In addition to physicians charging an annual fee to patients for uninsured services (including third-party services), physicians may enter into annual financial contractual arrangements directly with third parties for the provision of third-party-requested services and the completion of the corresponding forms.

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

Note: All recommended rates for medical services are effective April 1, 2003. Recommended rates for form fees are effective immediately. For recommended rates for medical services prior to April 1, 2003, please consult the 2002 edition of this guide, the 2001 OMA Schedule of Fees, or contact the OMA Economics Department.

a. Consultations and Visits

(Uninsured when provided in connection with third-party services as described in Section II of this guide)

General and Family Practice		
	Code	OMA Fee
Consultation	A005	\$98.37
General Assessment	A003	97.32
Intermediate Assessment	A007	49.15
Minor Assessment	A001	31.13
Annual Health Examination - child after second birthday	K017	53.23

b. (b) Other Relevant Uninsured Services

	OMA Fee
Dispensing Service Fee (not to apply to provision of drug samples, only where there is recorded purchase of drugs)	\$ 9.60
Electrocardiogram for insurance companies (technical component only, no interpretation required)	12.70

Venipuncture (performed for insurance companies - sole purpose of visit)	19.88
Diagnostic interview and/or counselling with child/parent for testing per 1/2 hour (K003)	90.71
Maximal Stress Electrocardiogram for insurance companies (technical component only, no interpretation required)	142.08
Certification of incompetence (financial) including assessment to determine incompetence (K624)	185.04
TB Mantoux Test N.B. This is a composite fee consisting of a minor assessment fee and an injection fee. Patients would be responsible for the cost of the serum.	35.16

c. Immunization as an Uninsured Service

There are some instances where immunization is not an insured service. The Ministry of Health and Long-Term Care considers influenza immunization to be an insured service for all persons in Ontario over six months of age. 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. Only immunization for communicable diseases endemic to Canada is an insured service.

At the time of publication of this guide, a program was initiated by the Ministry of Health and Long-Term Care to ensure all school children are immunized for hepatitis B. The Ministry advises that, as a result of this commitment, immunization for hepatitis B is considered an insured service.

d. Recommended Charges For Photocopying and/or The Transfer Of Medical Records

The recommended minimum transfer of medical records charge for an individual (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) is **\$29.60** for pages 1-5 and **\$1.17** for each page thereafter. These suggested rates can be altered at the discretion of the acting 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 **\$39.77** for pages 1-5 and **\$1.60** 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 instances 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.**

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 physician'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 (which involves locating the chart and going through the records).
- 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 the form acknowledging the quoted charge and that they are financially responsible for settling the account following the transfer.
- 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 physicians 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 moreso when staff have to leave the premises.

- **The chart is returned to an area of the office records that contains the inactive files and is stored for at least 10 years after the date of the last entry in the record, or until 10 years after the day on which the patient reached or would have reached the age of 18 years (according to the CPSO requirements).**
- The physician transfers the copy of the chart (either directly to the patient in a sealed envelope, mails it, or places it in the new doctor's mailbox, if this is convenient).

The importance of appropriate communication with patients **prior to the initiation of the transfer** must be stressed. Patients should be informed, **in advance, that the transfer of medical records is an uninsured service and is, consequently, not covered by OHIP. Further, 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.** Where possible, an estimate of the cost of the transfer should be disclosed to patients **in advance**.

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 members to realize that the OMA rates **are recommended rates and that they (or their office staff) should use their judgment in reducing the fees in instances of financial hardship.** In fact, the Canadian Medical Association Code of Ethics (April 1990) clearly states under Article 24 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.

e. Uninsured Report Forms

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

The following suggested fees were developed with the assistance of representatives of the relevant OMA clinical sections. **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 - see section (i) below).**

	<u>Suggested Fee</u>
Completion of Form Physicals for:	
Schools	\$17.75
Camps	17.75
Pre-employment Certification of Fitness	23.67
Fitness Clubs	23.67
Hospital/Nursing Home Employees	23.67
Completion of Licensing Forms/Certificates:	
Drivers Medical Examination (FLRC80)	\$35.51
Pilots Civil Aviation; form 26-0010(0890)	59.19
Pilots Licence Validation 26-0055(01-91)(Physicians may consider not charging for signing this certificate when done in conjunction with the Pilot's Civil Aviation form 26-0010(0890)	11.84
Administrative Licence Suspension Appellant Medical Information Form	29.03
Completion of Work & School-Related Forms/Notes:	
Back-to-Work Notes	\$11.84
Sick Notes	11.84
Federal Employee Absence Notes; blue form	17.75
Day Care Note (free of communicable disease)	11.84
Insurance Certificates:	
Treatment Plan, form #OCF-18/59	\$88.80
Disability Certificate, form #OCF-3/59 (former Health Practitioner's Certificate)	88.80
Certificate of Health Practitioner, form #OCF-8	29.03
Travel Cancellation Insurance Form	23.67
Life Insurance Death Certificate	29.60

Government Forms	
Citizenship and Immigration Canada Medical Report for Immigration	\$88.80
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.)	88.80
Request for Medical Information Regarding Applicants to Canadian Armed Forces	69.68
Central Collection Service Request for Physician's Information	88.80
Revenue Canada, Federal Disability Tax Credit	29.60
Auto Sales Tax Rebate Form	23.67
Other Certificates:	
Childrens' Aid Society (CAS) Application Form for Prospective Foster Parent	\$35.51
UIC Disability/Maternity Certificate INS2019	17.75

f. 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 (effective April 1, 1997).
- ii. The Narrative Medical Reports, for which the federal government pays **up to \$150**. 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. 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:**

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 that prevents physicians from seeking reimbursement above these amounts and billing patients the balance of any amount over and above these fees. Physicians are reminded that they may charge patients for the cost of medical assessments associated with the preparation of the preceding documents required by the federal government.

g. Life and Health Insurance Uninsured Report 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: \$88.79

Completion of this form is requested by insurance companies 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 be performed on the patient since this is not a request for information on the current health status of the patient. (Note: this is not the case in the event the patient is putting in a disability claim, in which case the insurance company may require a medical assessment and up-to-date information on the health status of the patient; please consult the Ministry of Health and Long-Term Care Schedule of Benefits Appendix A, page 4A, point 1.2.1.) Relevant copies of lab test results and/or electrocardiograms may be requested by the insurance company.

System or Disease-Specific Questionnaire Fee: \$59.19

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, e.g., 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: \$145.00

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: \$71.04

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: \$236.80/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: \$236.80/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 (such as 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 Fee: Independent Examination 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.

h. Establishing An Hourly Rate

There are several approaches that can be used when setting fees for uninsured services.

Approach #1

One approach to setting 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. The following example illustrates one way to determine an hourly rate:

Example

Annual gross income (Please note that, when using OHIP income, this should be income before thresholds are applied.)	\$300,000
Working days/year: 52 weeks x 5 days/week less 30 days vacation and holidays	230 working days
Income-generating hours: 9 hours in practice, less 2 hours of (paid clinical time) unpaid non-clinical activity per working day	7 paid hours per day
Annual paid hours: 230 days x 7 hours/day	1,610 paid hours

Example

Hourly rate: \$300,000/1,610 hours	\$186.30 per hour
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Important Note: Any hourly rate calculated using a physician's earnings is primarily based on earnings derived from the provision of insured services. Consequently, the hourly rate calculated in the preceding example should be modified upward to reflect the uninsured nature of the particular services provided, as well as particular expertise of the physician providing the uninsured report/service. (At the time of publication of this guide, OMA recommended rates are approximately 71 per cent higher than OHIP rates.)

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 part-time hourly rate for the **2003 calendar year is \$200.00 net of associated expenses.**

Physicians with regular office practices can use a sessional gross hourly rate to account for office overhead costs they incur while working on a sessional basis. **This would require adjusting the net hourly rate of \$200.00 upward to account for the individual physician's overhead costs.**

i. Block and Annual Fees

In June 1995, the Ontario Divisional Court struck down the ban in s.1(1) Paragraph 23 of Regulation 856/93 under the Medicine Act, 1991 on the charging of annual fees by physicians. As a result, it is not unlawful for physicians to charge their patients an annual fee that covers the delivery of uninsured services.

The College of Physicians and Surgeons of Ontario (CPSO) 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). But there are 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:

1. 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.
2. The services covered by this fee must be clearly stated, in writing, and understood by the patient.
3. The patient must be advised of the amount of the individual charges.
4. The patient must be given the option of paying individual charges for the uninsured services as they are rendered.
5. 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.
6. 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.
7. 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."

(An example of a sample letter on annual fees that may be sent to patients, as well as a general example of which fees are covered and not covered in a specific clinic, appear in the April 1996 edition of the Ontario Medical Review, pp. 27-29).

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

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

There are instances where employers ask that workers injured in the workplace request 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 WSIB report forms and their associated fees, contact WSIB at 1-800-569-7919.**

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. It is recommended that

physicians bill patients for the cost of the medical services in instances that they insist the injury not be reported to the WSIB. **Moreover, for these instances where patients insist that the WSIB not be notified, it is recommended that physicians ask that patients sign a form acknowledging that they release the physician of any future liability for future health complications related to the particular injury.**

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

Changes to the Ministry of Health and Long-Term Care Schedule of Benefits, along with the increasing number of physicians charging patients for uninsured medical services and reports/ forms, has necessitated the introduction of a specific section in this guide dedicated to the application of the Goods and Services Tax (GST) to such services.

a. **Advance GST Rulings versus GST Application Rulings**

Canada Customs and Revenue Agency (formerly Revenue Canada) 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 Canada Customs and Revenue Agency to a registrant or other person, stating how Canada Customs and Revenue Agency 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.

A **GST Application Ruling** provides Canada Customs and Revenue Agency'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 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.

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.

b. **GST and Block/Annual Fees**

Block or Annual fees (described in Section III (j) 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.

c. **GST and Medical Legal Reports**

Generally, such reports are requested in instances of ongoing or potential legal action and are a statement of fact of 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 the GST, even if there has been an examination of the patient required to complete the medical legal form. The only exception is in instances where the medical examination is an insured service for which a claim is submitted (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.

d. **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 Canada Customs and Revenue Agency, this report prepared by the physician for the purpose of determining eligibility for insurance coverage is exempt from the GST.

○ **Independent Medical Examination (IME)**

This is usually contracted between an independent physician and the insurance company, with fees being discussed in advance based on the insurance company's requirements. According to Canada Customs and Revenue Agency, IMEs are

similar in tax status to medical legal reports as there is no intent to render health care to the individual patient and are, consequently, subject to the GST.

○ **Clarification Report**

Generally, a medical examination is not required when such a report is requested by an insurance company. According to Canada Customs and Revenue Agency, 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-3/59)**

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.

e. **GST and Other Uninsured Services**

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

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

The following uninsured services are considered GST exempt by Canada Customs and Revenue Agency:

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

To obtain further information regarding the GST, contact Canada Customs and Revenue toll-free at 1-800-959-8287, or visit the Canada Customs and Revenue Web site (www.ccr.gc.ca).

V. 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.

a. **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 a consent.

b. **Code of Ethics**

The responsibilities of an ethical physician to the patient are stated in the Code of Ethics issued by the Canadian Medical Association in April 1990, and include the following:

"An ethical physician, will, upon a patient's request, supply the information that is required to enable the patient to receive any benefits to which the patient may be entitled" (Section 9)

This is reinforced by Section 1.17 of Ontario Regulation 856/93 made under the Medicine Act, 1991, which defines professional misconduct to include:

"Failing without reasonable cause to provide a report or certificate relating to an examination or treatment performed by the member to the patient or his or her authorized representative within a reasonable time after the patient or his or her authorized representative has requested such a report or certificate."

VI. Physicians as Expert Witnesses

a. Non-Treating (Retained) Physicians

Non-treating physicians are often approached by lawyers or the Crown to testify as expert witnesses, and usually have never seen the patient prior to being contacted. After agreeing to act in such a capacity, physicians may examine the patient so as to establish an expert opinion regarding matters such as the patient's injuries, or standards of previously provided medical care.

The fees payable to an expert witness are a matter for negotiation between the expert witness and the lawyer seeking the expertise. In addition to a compensation arrangement for time spent in the courtroom, physicians should not neglect to agree on a fee, **in advance**, for reports that may be produced, as well as travel time and other expenses incurred in the process of acting as expert witnesses. **Whenever possible, it is recommended that physicians seek agreement on their fees, in writing.**

A non-treating physician is under no obligation to agree to act as an expert witness.

The expert witness will rarely receive a subpoena or summons to attend in court since he or she has agreed to act as an expert in advance and has secured satisfactory remuneration for this expertise.

When testifying in court, the expert witness is usually given a set of facts which closely resemble the actual case and is then asked hypothetical questions based on those facts. The expert witness will provide a professional opinion based on the examination of the patient, the medical records, and knowledge of similar previous cases.

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 defense 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

Similarly, in these instances, 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 a schedule of fees. There is nothing that prevents expert witnesses from seeking reimbursement above these amounts. **The OMA has suggested a rate for both general practitioners and specialists of \$200 per hour, or \$800 per half day, and \$1,600 per whole day. Arrangements should, however, be made prior to agreeing to act as an expert witness. The Ministry of the Attorney General fee schedule does not apply to those expert witnesses retained by the defence.**

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

b. **Treating Physicians**

Treating physicians will typically be served with a subpoena or 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 risen 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 summons the treating physician to testify in court is only obliged to pay the physician the daily attendance fee (approximately \$50.00), the appropriate travel allowance, and the appropriate overnight accommodation and meal allowance, if applicable. These rates are prescribed in the Rules of Civil Procedure, and may vary annually. There is no reason, however, that the physician cannot attempt to receive a more reasonable compensation for lost time. The degree of success in this area will, of course, vary.

Treating physicians will often be called or summonsed 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.**

VII. The Direct Billing Process

a. **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:

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

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

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

A physician's office policy on direct billing must be specific and detailed so that 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.

b. **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:

- Clearly display in the patient waiting area the poster and guide on third-party services.
- Discuss fees when the patient books an appointment for an uninsured service.
- Mention fees before providing the uninsured service.
- Provide an information pamphlet to the patient that includes:
 - general information (i.e. office hours, telephone hours, after-hours procedures, prescription refill instructions).
 - direct billing information (i.e. services that are directly billed by the physician and not insured by government, procedures for third-party claim forms). It is not advisable to list fees, since they will require periodic updating.

(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.)

c. **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:

- 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).
- 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 five per cent 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.**" In other words, a statement of only a monthly rate of interest is not sufficient if members wish to charge an annual rate exceeding five per cent.
- 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 per cent. Anyone entering into an agreement or receiving payment of a greater interest could be found guilty of a criminal offence under section 347(1) of the Criminal Code.

VIII. Collecting Unpaid Charges - Small Claims Court

In the event physicians are unable to collect the fees charged for uninsured services, they may wish to resort to the small claims court system. When considering this option, physicians are reminded that:

- In order to initiate a small claims court claim, one must obtain a statutory form from the local court.
- One must hire his or her own process server or bailiff to serve the claim.
- The court now requires a payment of \$100 to set the action down for trial either as a defended or undefended matter. This is similar to what happens in the Superior Court of Justice, formerly known as the Ontario Court (General Division).
- The limit for a small claims court judgment is \$10,000, plus pre-judgment interest and (costs in excess of the limit must be foregone in order to receive a small claims court judgment).

- Once the claim has been issued, the debtor has 20 days within which to file a defence, measured from the date of service. Assuming a defence is filed, then the physician will be notified of the trial date by the court office.
 - The appropriate (geographically) small claims court must be selected for the issuance of the claim. Each court has a limited geographical jurisdiction. With the exception of the City of Toronto (which is divided into two districts - the Toronto Small Claims Court and the North York Small Claims Court) selection of the appropriate court is straightforward. Physicians should contact any small claims court office if they are unsure of the correct jurisdiction.
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If you have any suggestions for the next edition of this guide, please forward them in writing to:

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