OHIP Billing Information for Telemedicine Services [1]

October 2019

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[1] *Please note that:*

- *OTN does not endorse these billing processes as appropriate when "non-telemedicine" services are claimed to OHIP.*
- *This billing manual is under revision and will be re-issued in the near future.*

OHIP Billing Information for Telemedicine Services
October 2019

1. Overview

The purpose of this document is to outline information specific to submitting billings for telemedicine services (i.e. video visits) and premium/tracking fee codes via the Ontario Health Insurance Plan (OHIP) claims processing system.

Unless otherwise specified in this document, the existing rules and procedures that apply to OHIP claims submissions will apply when submitting telemedicine billings to OHIP.

2. Registration

- **Telemedicine Registration**: Physicians must sign and complete a Registration Form to be registered as a telemedicine provider with the Ministry of Health. Registration forms are available and processed through the Ontario Telemedicine Network (OTN).

- **OHIP Telemedicine Billing Privileges**: Physicians submitting telemedicine billings to OHIP must have completed and signed the Registration Form on the date of the telemedicine service in order to bill OHIP.

3. Billing Information and Requirements

- **Technical Specifications**: Current OHIP claims submission instructions identified in the "Technical Specification Interface to Health Systems Manual" apply in the submission of telemedicine billings and is available at: http://www.health.gov.on.ca/en/pro/publications/ohip/docs/techspec_interface_hcsm.pdf.

- **Service Location Indicator:** Telemedicine billings must include a Service Location Identifier (SLI) code of "OTN" to indicate that a consult was done through telemedicine. Contact your billing software vendor to confirm where this is to be entered.

  a) The SLI code must be in field positions 59-62 of the Claim Header-1 Machine Readable Input Record;

  b) The SLI code must be left justified; and

  c) The SLI code must be the three alpha characters OTN.

  If your billing software vendor set up the billing data entry to coincide with the field numbering listed in the OHIP Technical Specification Manual, then the SLI Code would be entered after the "manual review indicator" flag which is field position 58 of the Claim Header-1 record.

- **Premium/Tracking Fee Codes:** Telemedicine billings must include one applicable Telemedicine Premium Fee Code or the Telemedicine Store Forward Tracking code:

  - **Premium Fee Codes:**

    B100A: $35.00 First Telemedicine Patient Encounter premium
    B200A: $15.00 Subsequent Telemedicine Patient Encounter premium

    B101A: $35.00 First Cancelled/Missed Telemedicine Patient Encounter premium*****
    B201A: $15.00 Subsequent Missed/Cancelled Telemedicine Patient Encounter premium*

    B102A: $35.00 First Technical Difficulties Abandoned Patient Encounter premium*****

B202A: $15.00 Subsequent Technical Difficulties Abandoned Patient Encounter premium*****

***** Services cannot be billed in addition to the premiums for a missed, cancelled, or abandoned session.

- **Tracking Fee Code:** B099A: $0.00 Tracking Code for "Store Forward" Telemedicine Services.

- **Fee Service Codes:** Telemedicine billings can include fee service codes listed in the OHIP Schedule of Benefits for Physicians services but must **not** include services that have been identified as being excluded from the telemedicine program.

4. Excluded Telemedicine Services Fee Codes

Billing any of the excluded telemedicine codes under telemedicine would cause payments to reject.

The following fee service codes and ranges of fee service codes listed in the OHIP Schedule of Benefits are not billable as telemedicine services:

- Surgical services with a fee code prefix of D, E, (Except E078 and E079), F, M, N, P (Except P003, P004 and P005), R, S, and T and ending with an A or C suffix.

- G104A, G111A, G121A, G140A, G143A, G146A, G149A, G152A, G153, G154, G167A, G174A, G181A, G209A, G284A, G308, G310A, G311A, G315A, G316A, G372A, G373A, G414A, G416A, G434A, G440A, G441A, G442A, G443A, G445A, G448A, G451A, G455A, G466A, G491A, G505A, G506A, G508A, G519A, G538A, G540A, G542A, G544A, G554A, G560A, G566A, G570A, G574A, G577A, G590A, G651A, G652A, G654A, G655A, G661A, G682A, G683A, G684A, G685A, G686A, G687A, G688A, G689A, G692A, G693A, G815A, G850A, G851A, G852A, G853A, G854A, G855A, G856A, G857A, and G858A.

- All J and Y prefixed fee codes with A, B or C suffixes (J***A, J***B, J***C, Y***A, Y***B, Y***C).

- Form fee codes listed in the Schedule of Benefits and Schedule F: K050A, K051A, K052A, K053A, K054A, K055A, K065A, K066A, K053, K061, K623, K624, K629, K035, K036, K038, K027, K031, K070, K620. Physicians can complete these forms either before or after the telemedicine session and should submit the bills through the regular OHIP claims process. Although these service codes are excluded as billable telemedicine services, they are eligible for payment through other programs. (Please see Questions # 6 and # 7 in the "General Billing Questions" section on page 10 of this document for instructions on billing for forms when they are associated with a telemedicine service).

- All laboratory fee codes with a prefix of "L" (L***). These codes should only be billed by physicians for services performed for their own patients in their own offices. These codes are eligible for payment through OHIP, not telemedicine.

- All X prefixed fee codes with B or C suffixes (X***B, X***C).

Disclaimer: This list of telemedicine excluded fee codes is current as of September 2011 and will be updated in the near future.

Note that where a physician provides a telemedicine consultation and also renders services for the same patient that are excluded from telemedicine but are OHIP eligible (e.g. form fees and lab codes), two claims should be submitted; the telemedicine consultation should be billed through the telemedicine billing process (i.e. using the "OTN" SLI Code), while the OHIP eligible service that is excluded from telemedicine, should be billed through the regular OHIP claims process.

5. Billing Requirements Summary

- **Telemedicine billings submitted to OHIP for processing and payment:**
  a) Must be from a physician approved by the ministry as eligible to render telemedicine services and registered with the ministry for billing privileges;
  b) Must be for services rendered where both the physician and the patient are in attendance via an approved OTN video solution and be physically located in Ontario during the health encounter;
  c) Must include the "OTN" Service Location Indicator Code;
  d) Must include the applicable telemedicine premium fee code or tracking code;
  e) Must **not** include fee codes for excluded telemedicine services.

6. Manual Review

- **When does a physician have to use the "Manual Review" indicator with telemedicine billings?**

  Generally, the "manual review" indicator is only required in very limited circumstances to ensure that certain valid telemedicine billings do not get rejected because of some existing OHIP processing rules or if special consideration is required. Telemedicine billings will need to be flagged for "manual review" and supporting documentation, in the form of a written explanation, will need to be provided in the following circumstances:

  1. A telemedicine service and an OHIP service that is not an excluded telemedicine service have been rendered by the same physician to the same patient on the same date of service.*****
  2. A Store Forward telemedicine service and a telemedicine session service or an OHIP service that is not an excluded telemedicine service have been rendered by the same physician to the same patient on the same date of service.
  3. An excluded telemedicine service has been rendered via an approved OTN video solution.
  4. If a second telemedicine session was provided to the same patient on the same day for valid clinical reasons, then the telemedicine billing should be submitted with the Manual Review indicator set to "Y" (Yes) and written explanation provided for adjudication purposes.

When asking for a manual review, if you are submitting two separate claims (one through the regular OHIP process and the other through the telemedicine billing process), put the request for a manual review on the claim submitted through the telemedicine billing process.

***Note:** If a telemedicine service and an OHIP service that is an excluded telemedicine service have been rendered by the same physician to the same patient on the same date of service, then a manual review is **not** required.

7. Payment Processing and Reporting

- **Payment Processing**: As with regular OHIP claims, the telemedicine billings must be received and processed by OHIP within six months from the date of service. Telemedicine billings will be processed per the existing OHIP monthly claims assessment schedule and paid on the 15th day of the following month.
- **Remittance Advice**: As per existing OHIP processes, detailed claims payment information for approved telemedicine billings will be reported on the physician's solo or the group Remittance Advice (RA) using the reports and formats that are currently present within the OHIP claims processing system.
- **Telemedicine Payment Report**: In addition to the claim details on the monthly RA, a summary of the telemedicine payments will be also reported on the RA. The RA telemedicine report will be titled "Ontario Telemedicine Network Service Location" and include the dollar value of the telemedicine services and the telemedicine premium payments for the RA reporting period and a fiscal year-to-date total.
- A summary of the telemedicine payments is also reported on the RA under the heading "Ontario Telemedicine Network Service Location". The telemedicine RA report includes the dollar value of the telemedicine services and the telemedicine premium payments for the RA reporting period and a fiscal year-to-date total.
- **Third Party Adjustments**: Any third party adjustments that are applicable to a physician's OHIP remittance, such as per a Court Order, will also apply to the physician's telemedicine payment.

8. Summary of Error Conditions/Explanatory Code Messages

- There are eleven error conditions applicable to telemedicine billings:
  1) ET1: Provider Not Registered for Telemedicine Program;
  2) ET4: Telemedicine Premium/Tracking Code Missing;
  3) ET5: Telemedicine SLI Code Missing or Invalid;
  4) TM1: Duplicate Telemedicine Claim for Same Patient;
  5) TM2: Service Not Billable for Missed/Cancelled/Abandoned Appointment;
  6) TM3: Service Not Payable Under Telemedicine Program;
  7) TM4: Non-Telemedicine Claim Already Paid for This Patient;
  8) TM5: Telemedicine Claim Already Paid for This Patient;
  9) TM6: Telemedicine Registration Not in Effect on Service Date;

10) TM7: Dental Services Not Payable Under Telemedicine Program; and
11) TM8: Provider Not Eligible for Store Forward Telemedicine Services.

- The Explanatory Code MA (Maximum Number of Sessions has been Reached) will be issued if a second $35.00 first patient encounter premium (B100A, B101A, B102A) is billed on the same date of service.

9. Details for Handling Error Conditions/Explanatory Code Messages

Error Condition Codes

The following new error conditions are applicable to the processing and assessment of telemedicine billings and related conditions.

1) ET1: Provider Not Registered for Telemedicine Program

ET1 Description: The "ET1" error code will be issued and the entire claim will be returned to the physician's/dentist's error report if a telemedicine billing is submitted by a physician/dentist who is not registered as eligible to bill for telemedicine services.

ET1 Corrective Action: Contact OTN to request a Registration Form. If a Registration Form was already completed, signed, and submitted, contact OTN to confirm the status. The ET1 rejected telemedicine billings can be re-submitted when OTN acknowledges that the physician's/dentist's Registration Form has been received and processed.

2) ET4: Telemedicine Premium/Tracking Code Missing

ET4 Description: The "ET4" error code will be issued and the entire claim will be returned to the physician's/dentist's error report if a billing includes the "OTN" Service Location Indicator code but does not include the telemedicine tracking code for Store Forward (B099A) or a valid telemedicine premium code (B100A, B101A, B102A, B200A, B201A, B202A).

ET4 Corrective Action: If the billing is for telemedicine services then the billing should be resubmitted with an applicable telemedicine premium/tracking fee code. If the billing is not for telemedicine services then the billing should be resubmitted without the "OTN" SLI code.

3) ET5: Telemedicine SLI Code Missing or Invalid

ET5 Description: The "ET5" error code will be issued and the entire claim will be returned to the physician's/dentist's error report if the telemedicine tracking code for Store Forward (B099A) or a telemedicine premium code (B100A, B101A, B102A, B200A, B201A, B202A) is billed but the Service Location Indicator code is not present on the billing or if present is not "OTN".

ET5 Corrective Action: If the billing is for telemedicine services then the billing should be resubmitted with the "OTN" SLI code. If the billing is not for telemedicine services, then the billing should be resubmitted without the telemedicine premium/tracking code.

4) TM1: Duplicate Telemedicine Claim for Same Patient

TM1 Description: The "TM1" error code will be issued and the entire claim will be returned to the physician's/dentist's error report if:

a) a second telemedicine billing is submitted by the same physician/dentist for the same patient on the same date of service; or

b) there is more than one telemedicine tracking and/or premium fee code on the same billing; or

c) if the duplicate billing was submitted in error; or

d) if the duplicate billing was intentional because a second telemedicine session was provided to the same patient on the same day for valid clinical reasons.

TM1 Corrective Action:

a) The physician/dentist should confirm if the original or duplicate telemedicine billing is for the wrong patient.

   1) If the duplicate billing is for the wrong patient, then the billing should be resubmitted with the correct patient's Health Number.

   2) If the duplicate billing was submitted in error, no further action is required. However, if it is intentional because a second telemedicine session was provided to the same patient on the same day for valid clinical reasons, then the rejected telemedicine billing should be resubmitted with the Manual Review indicator set to "Y" (Yes) and written explanation provided for adjudication purposes.

b) Resubmit the telemedicine billing with only one premium/tracking code.

5) TM2: Service Not Billable for Missed/Cancelled/Abandoned Appointment

TM2 description: The "TM2" error code will be issued and the entire claim will be returned to the physician's/dentist's error report if a telemedicine billing is submitted with a missed, cancelled or abandoned premium fee code (B101A, B102A, B201A, or B202A) and the billing also includes a fee service code. Services cannot be billed with these telemedicine premiums as it is assumed that the services could not be rendered because the patient was not present or the session was abandoned due to technical difficulties.

TM2 Corrective Action: If an incorrect premium fee code was billed, the physician/dentist should correct and resubmit the billing. If no services were rendered due to the missed, cancelled, or abandoned telemedicine appointment, the billing should be resubmitted for only the applicable premium and the service(s) removed. If there were some technical difficulties but the downtime did not prevent the provision of services, then the billing should be resubmitted with the B100A, B200A, or B099A fee code as applicable and the service(s) should be billed using the appropriate OHIP service code(s).

6) TM3: Service Not Payable Under Telemedicine Program

TM3 Description: The "TM3" error code will be issued and the entire claim will be rejected and returned on the physician's error report if a telemedicine billing includes services that are not payable as telemedicine services.

TM3 Corrective Action: If the fee service code included with the telemedicine billing is incorrect, then the billing can be resubmitted with the correct fee service code. If the fee service code is correct but is a telemedicine excluded service, the physician should resubmit the billing with the Manual Review indicator set to "Y" (Yes) and provide written explanation for adjudication purposes. If the excluded service was rendered to the patient per a face-to-face encounter

outside of the telemedicine session, the physician can claim the service in a separate billing without the telemedicine premium and without the OTN SLI code for payment by OHIP.

7) TM4: Non-Telemedicine Claim Already Paid for This Patient

TM4 Description: The "TM4" error code will be issued and the entire claim will be rejected and returned on the physician's/dentist's error report if a telemedicine billing is submitted and a payment for a non-telemedicine claim for an eligible telemedicine service was already made to the same physician for the same patient on the same date of service.

TM4 Corrective Action: If the previous non-telemedicine claim was incorrect and should have been a telemedicine billing, the physician/dentist will need to request an adjustment be processed by OHIP through existing claims adjustment procedures. If the non-telemedicine claim and telemedicine billing are correct because the physician in fact rendered both services on the same day in both telemedicine and non-telemedicine settings, then the rejected telemedicine billing should be resubmitted with the Manual Review indicator set to "Y" (Yes) and written explanation provided for adjudication purposes.

8) TM5: Telemedicine Claim Already Paid for This Patient

TM5 Description: The "TM5" error code will be issued and the entire claim will be rejected and returned on the physician's/dentist's error report if a non-telemedicine claim is submitted and a payment for a telemedicine billing was already made to the same physician/dentist for the same patient on the same date of service. (This error condition will not apply if the non-telemedicine claim is for services that are excluded from the telemedicine program.)

TM5 Corrective Action: If the non-telemedicine claim was submitted for services omitted from the telemedicine billing then the physician/dentist will have to request an adjustment be processed by OHIP through existing claims adjustment procedures to amend the original telemedicine billing. If the non- telemedicine claim and telemedicine billing are correct because the physician/dentist in fact rendered both services on the same day in both telemedicine and non-telemedicine settings, then the rejected non- telemedicine billing should be resubmitted with the Manual Review indicator set to "Y" (Yes) and written explanation provided for adjudication purposes.

9) TM6: Telemedicine Registration Not in Effect on Service Date

TM6 Description: The "TM6" error code will be issued and the entire claim will be rejected and returned on the physician's/dentist's error report if the service date of a telemedicine billing is prior to the physician's/dentist's telemedicine registration effective date or after the physician's/dentist's telemedicine registration end date.

TM6 Corrective Action: If the date of service is incorrect, the physician/dentist should correct the date of service and resubmit the telemedicine billing. If the date of service is correct, the physician/dentist should contact OHIP and OTN to confirm the telemedicine registration effective date and/or end date as applicable. The rejected billing can then be resubmitted when OTN has confirmed with the physician/dentist that the telemedicine registration effective and/or end date has been amended.

10) TM7: Dental Services Not Payable Under Telemedicine Program

TM7 Description: The "TM7" error code will be issued and the entire claim will be rejected and returned on the dentist's error report if the service is not payable under the telemedicine program.

TM7 Corrective Action: The dentist will need to confirm if the correct fee service code was billed with the telemedicine claim and take appropriate action.

11) TM8: Provider Not Eligible for Store Forward Telemedicine Services

TM8 Description: The "TM8" error code will be issued and the entire claim will be rejected and returned on the dentist's error report as Provider not Eligible for Store Forward Telemedicine Services.

TM8 Corrective Action: The dentist should confirm that the correct telemedicine premium/tracking fee code was billed. Dentists are not eligible to bill the B099A telemedicine tracking code as the patient must be present during the consultation.

Existing Explanatory Codes

MA: Maximum Number of Sessions has been Reached

MA Description: The existing Explanatory Code MA (Maximum Number of Sessions has been Reached) will be issued with the physician's/dentist's Remittance Advice if a second $35.00 first patient encounter premium fee code (B100A, B101A, or B102A) is billed by the same physician/dentist on the same date of service. The premium will be paid at zero dollars but the other services of the telemedicine billing will be paid as billed (subject to other claims payment processing rules).

MA Corrective Action: The physician/dentist will have to request an adjustment be processed by OHIP through existing claims adjustment procedures to amend the MA payment to add the applicable B200A, 201A, or B202A subsequent patient premium to obtain the $15.00 premium payment.

10. General Billing Questions

Question # 1: *How many times per day can a physician bill B100A, B101A, B102A, first patient encounter premiums? For example, can B100A be claimed if a consult is done in the morning, afternoon and late afternoon, or with different cities or different cameras? Can B100A be billed for the first patient and B101A for the second patient if the second appointment is cancelled?*

Answer: An individual physician may only bill the B100A, B101A, B102A premium for the first telemedicine patient seen each day and **only once** each day. All other consultations taking place that day through telemedicine, wherever the patients and physician may be, or whether or not the appointment is missed/cancelled or abandoned, must be billed with the B200A, B201A, B202A subsequent patient encounter premiums as applicable.

Question # 2: *If a consulting physician provides consultation from a telemedicine studio that is within a hospital, should the consulting physician include the hospital's Master Number on the telemedicine billing?*

Answer: No, consulting physicians do not need to include the hospital Master Number on the telemedicine billing when providing the consultation from a hospital-based telemedicine site. The hospital's Master Number would only be required if the participating patient was an in-patient of the hospital where the telemedicine consultation took place.

***NOTE**:* All telemedicine billings from dentists must include the hospital Master Number of the hospital where the dentist was located when rendering the dental service via telemedicine.

Question # 3: *If a patient attends a telemedicine studio that is within a hospital, should the consulting physician include the hospital's Master Number on the telemedicine billing?*

Answer: No, the hospital Master Number is not required on the telemedicine billing if the patient is simply attending the hospital to use the telemedicine equipment and the Master Number would only be required if the patient was an in-patient of the hospital or the service was rendered by a dentist.

Question # 4: *Can radiologists submit telemedicine billings?*

Answer: No, radiologists cannot bill telemedicine services as radiology services are covered by OHIP.

Question # 5: *If a family doctor attends a telemedicine consultation with his/her patient who is being treated by an oncologist for cancer, reviews the treatment options offered by the oncologist with the patient immediately after the session ends and decides on a course of action, can the family doctor bill A007 for the face-to-face visit (paid by OHIP) and the applicable telemedicine premium fee code for the videoconference?*

Answer: The family doctor will need to submit two separate billings for the services rendered. Billing A would be the usual face-to-face format to bill OHIP for the A007 assessment fee. Billing B would include the "OTN" Service Location Indicator code and the applicable telemedicine premium fee code and will need to include a "manual review" indicator and written explanation to alert OHIP that there has not been a billing error and to honour the telemedicine premium billing.

Question # 6: *If a patient travels 150 km to their closest telemedicine studio to see a cardiologist who is 500 km away and the cardiologist provides the telemedicine consult and completes the consultant section of the travel grant form, does the cardiologist bill this all on one claim?*

Answer: No, two billings are required. One will be a telemedicine services billing with the "OTN" SLI code and will include the applicable telemedicine premium fee code and consultation fee code. The second will be for completing the travel grant form and will be billed as a regular OHIP billing. The "manual review" indicator is <u>not</u> required for either billing because the travel grant form completion is an excluded telemedicine service.

Question # 7: *Are two billings required when a patient sees a pediatrician and the pediatrician bills a telemedicine premium and the consultation where the pediatrician is required to complete a form based on the findings of the consultation and there is an OHIP billable fee for completing the form?*

Answer: Yes, two billings are required, one will be a telemedicine services billing with the OTN SLI code and will include the applicable telemedicine premium fee code and consultation fee code. The second will be for completing the form and will be billed as a regular OHIP billing. The "manual review" indicator is <u>not</u> required for either billing because the form completion is an excluded telemedicine service.

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Question # 8: *How should a doctor bill when he/she completes a Store Forward service as well as a telemedicine consultation on the same patient on the same day?*

Answer: If billed together the billing will be rejected as TM1 and if billed separately both billings will reject as TM1 as it will be considered a duplicate. To ensure payment, the Store Forward service and the telemedicine consultation service must be billed as separate telemedicine billings and include the "manual review" indicator on one of the claims with a written explanation to alert OHIP that there has not been a billing error.

Who do I contact if I have any questions?

For further billing related inquiries, please contact the Service Support Contact Centre at: 1-800-262-6524 or SSContactCentre.MOH@ontario.ca.

For specific questions about conducting video visits, please contact: info@otn.ca.