OHIP Billing: Long-Term Care

Quick Reference Guide

This short guide will help you understand how to bill for long-term care (LTC) patients in Ontario.

How do you roster LTC patients?

To roster LTC patients, bill the rostering code Q202. If a patient was rostered previously with Q200 from the same doctor, Q202 will override it. If they were rostered with another doctor, the patient would need to be derostered first.

What are the W-prefix services?

These services apply to patients in chronic care hospitals, convalescent hospitals, nursing homes, homes for the aged and designated chronic or convalescent care beds in hospitals other than patients in designated palliative care beds - "W" prefix services.

What are the billing codes for consultations and assessments for LTC?

Here is an extensive list of consultation and assessment codes that physicians can expect to bill. For more information on the requirements of consultations and assessments, download our Assessments and Consultation guide here.

Consultations

Fee Code	Description	Value
W105	Consultation	$87.75
W911	Special family consultation	$150.70
W912	Comprehensive family consultation	$226.05
W106	Repeat consultation	$45.90

Assessments

Fee Code	Description	Value
W102*	Type 1 – day of admission	$69.35
W104	Type 2 – day two of admission	$20.60
W107	Type 3 – day three of admission	$30.70
W109	Periodic health visit	$70.50
W777	Intermediate assessment – pronouncement of death	$37.95

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W771	Certification of death	$20.60
W004	General re-assessment of patient in nursing home	$38.35
W903	Pre-dental/pre-operative general assessment	$65.05
W904	Pre-dental/pre-operative assessment	$33.70

*If the physician has rendered a consultation, general assessment, or general re-assessment of the patient prior to admission, the amount payable for the service will be adjusted to a lesser fee.

What are the different subsequent LTC visits?

A subsequent visit is any routine assessment following the patient's admission to a long-term care institution.

Fee Code	Description	Value
W010A*	Monthly management fee	$115.25
W003A	Nursing home or home for the aged - first two subsequent visits per patient per month	$34.10
W008A	Additional subsequent visits for nursing home patients (max two per patient per month)	$34.10
W872A	Palliative care for a patient in a nursing home	$34.10
W121A	Additional visits due to intercurrent illness	$34.10

Note: The admission date of the patient must be provided on the claim for all W-prefix services or the service is not eligible for payment.

Tip: Billing W010 when the patient is rostered with Q200 will result in the claim being unpaid. Making sure the patient is either rostered with Q202 or not rostered at all (billing fee-for-service) will ensure payment of W010.

Considerations for W010 – Monthly Management Fee

When a physician bills their first W010 for a long-term care patient, they cannot bill individual visits (W003, W008, etc.) within 11 months of billing a W010. This rule is outlined on page GP52, point #6. Doing this will result in a **DV explanatory error-** " Service is included in Monthly Management Fee for Long-Term Care," and the following visits will not be paid.

If the physician decides to bill individual visits instead, they can submit a Remittance Advice Inquiry for the first W010 in that 11-month period to be removed, or you can resubmit for a W010 (which will be reduced by the amount of the first W-visit code paid).

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What codes do you bill for counselling a LTC patient?

Fee Code	Description	Value
K002	Interview with relatives	$70.10
K013	Counselling – individual care – first three units of K013 and K040 combined per patient per provider per 12-month period (per unit)	$70.10
K033	Counselling – individual care – first three units of K013 and K040 combined per patient per provider per 12-month period (per unit)	$49.35
K015	Counselling of relatives for palliative patient – 1 or more persons	$70.10

Note: You cannot bill counselling (ex. K013) on the same bill as an assessment with the same diagnostic code, they need to be on separate claims and need to have different and unrelated diagnostic codes.

What are the special visit premiums that can be billed for LTC visits?

Premium	Weekdays Daytime	Weekdays Daytime - Sacrifice of Office Hours	Evenings Monday through Friday	Sat., Sun. and Holidays	Nights
Time	07:00-17:00	07:00-17:00	17:00-24:00	07:00-24:00	00:00-07:00
Travel Premium	W960 $36.40 Max. 2	W961 $36.40 Max. 2	W962 $36.40 Max. 2	W963 $36.40 Max. 6	W964 $36.40 Unlimited
First person seen	W990 $20 Max. 10	W992 $40 Max. 10	W994 $60 Max. 10	W998 $75 Max. 20	W996 $100 Unlimited
Additional person(s) seen	W991 $20 Max. 10	W993 $40 Max. 10	W995 $60 Max. 10	W999 $75 Max. 20	W997 $100 Unlimited

Note: When billing Special Visit Premiums, since their purpose is for **non-elective visits** only, **W-prefix** consultations and assessments are **not eligible** to be billed in conjunction with special visit premiums. Only A-prefix assessments can be billed with special visit premiums.

For example, codes like W105, W102, W106 are not eligible to be billed with special visit premiums since they fall under elective visits. Elective visits indicate that a physician follows a schedule and/or is scheduled to see those patients on a regular basis.