OHIP Billing: Time-Based Codes

Quick Reference Guide

This guide will provide you with key information on the different time-based billing codes commonly used in Ontario.

Challenge	DoctorCare Best Practices and Recommendations
What are the different time-based codes?	**Time-Based Assessment Codes**

Fee Code	Description	Value
K005	Primary Mental Health Care - Individual Care	$70.10 / unit
K007	Psychotherapy - Individual Care	$70.10 / unit
K019	Psychotherapy - Group Care (2 people)	$35.10 / unit
K013	Counselling (first 3 units)	$70.10 / unit
K033	Counselling (after billing >3 units of K013/year)	$49.35 / unit
K040	Group Counselling (2 or more people)	$70.10 / unit
K041	Group Counselling (after billing >3 units of K040/year)	$50.20 / unit
K016	Genetic Assessment	$74.05 / unit
K022	HIV Primary Care	$70.10 / unit
K023	Palliative Care Support	$74.70 / unit
K028	STD Management	$70.10 / unit
K029	Insulin Therapy Support (ITS)	$70.10 / unit
K037	Fibromyalgia/Encephalomyelitis Care	$70.10 / unit

How are units calculated?

The time-based codes are calculated and payable in time units of 30-minute increments. In calculating the time unit(s), the minimum time required in direct contact with the patient and the physician in person is as follows:

#Units	#Minimum time
1 unit	20 minutes
2 units	46 minutes
3 units	76 minutes (1h 16m)
4 units	106 minutes (1h 46m)
5 units	136 minutes (2h 16m)
6 units	166 minutes (2h 46m)
7 units	196 minutes (3h 16m)
8 units	226 minutes (3h 46m)

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Example	A physician spends 47 minutes providing knowledge and information to a patient who had just been diagnosed with heart failure. The patient comes back again a month later for another counselling session about the same medical condition for 50 minutes. What code do you bill? **K013 – Counselling (first 3 units) x1** **K033 – Counselling (>3 units) x1** Because the physician provided 4 units of counselling with this patient, you would bill the K013 for the first 3 units and then K033 for the fourth unit.
What are the payment rules for the time-based codes?	**Primary Mental Health Care- Individual Care (K005)** Primary mental health care are services encompassing any combination or form of assessment/treatment by a physician for mental illness, behavioural maladaptations, and/or other problems assumed to be of an emotional nature, where there is consideration of the patient's biological and psychosocial functioning. **Payment Rule** • K005 is not to be billed in conjunction with other consultations and visits rendered by a physician during the same patient visit unless there are clearly different diagnoses for both services. **Psychotherapy - Individual Care & Group Care (K007 / K019)** Psychotherapy is any form of treatment for mental illness and/or other problems that are assumed to be of an emotional nature, where a physician establishes a professional relationship with a patient with the purpose of removing or modifying existing symptoms and of promoting positive personality growth and development. **Payment Rule** • Psychotherapy may not be claimed when provided in conjunction with a consultation or other assessments rendered by a physician during the same patient visit unless there are clearly defined different diagnoses for the two services. **Counselling - Individual Care & Group Care (K013 / K033 / K040 / K041)** Counselling is a patient visit dedicated solely to an educational dialogue with a physician. This service is for the purpose of developing awareness of the patient's problems or situation and of modalities for prevention and/or treatment, and to provide advice and information. **Payment Rules** • Other than the codes listed on GP58 in the Schedule of Benefits, no other services are eligible for payment when rendered by the same physician the same day as any type of counselling service. • If the patient does not have a pre-booked appointment, the amount payable for this service will be adjusted to a lesser assessment fee.

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What are the payment rules for the time-based codes?	**Genetic Assessment (K016)** A genetic assessment is for the purpose of interviewing the appropriate family members, collection and assessment of adequate clinical and genetic data to make a diagnosis and assessment of the risk to persons seeking advice. **Payment Rule** • This service is limited to 4 units per patient per day. **HIV Primary Care (K022)** Primary care of patients infected with HIV includes any combination of common and specific elements of any insured service listed under “Family Practice & Practice In General” in the “Consultations and Visits” section of the Schedule of Benefits. **Payment Rule** • When a physician submits a claim for any other consultation or visit to the same patient on the same day for which the physician submits a claim for HIV Primary Care, the HIV Primary Care service is included (in addition to the common elements) as a specific element of the other insured service. **Palliative Care Support (K023)** Palliative care support is a time-based service payable for providing pain and symptom management, emotional support and counselling to patients receiving palliative care. **Payment Rules** • With the exception of A945/C945, any other services listed under the "Family Practice & Practice in General" in the "Consultations and Visits" section of the Schedule of Benefits are not eligible for payment when billed with this service. • Start and stop times must be recorded in the patient's permanent medical record or the service will be adjusted to a lesser paying fee. **STD Management (K028)** Sexually transmitted disease (STD) or potential blood-borne pathogen management is for the purpose of providing assessment and counselling to a patient suspected of having a STD or to a patient with a potential blood-borne pathogen. **Payment Rules** • K028 is not eligible for payment when billed with any consultation, assessment or visit by the same physician on the same day. • K028 is limited to a maximum of two units per patient per physician per day and four units per patient, per physician, per year.

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What are the payment rules for the time-based codes?	**Insulin Therapy Support (K029)** ITS is for the purpose of providing assessment, support and counselling to patients on intensive insulin therapy requiring at least 3 injections *per day* or using an infusion pump. **Payment Rule** • Maximum 6 units payable per patient, per physician, per year. **Fibromyalgia/Myalgic Encephalomyelitis Care (K037)** Fibromyalgia/Myalgic Encephalomyelitis Care is defined as providing care to patients with Fibromyalgia or Myalgic Encephalomyelitis. **Payment Rule** • No other consultation, assessment, visit or time-based service is eligible to be billed on the same day as K037 to the same patient by the same physician.