OHIP Billing: Paediatric NICU/ICU Codes

Quick Reference Guide

This short guide will help you understand how to bill for patients in the NICU and ICU in Ontario.

What is Neonatal Intensive Care?

In the world of newborn care, some infants require specialized attention that goes beyond routine check-ups. Neonatal Intensive Care is a service rendered by a physician for being in constant or periodic attendance during a one-day period to provide all aspects of care to the Intensive Care Area patients.

These services include an initial consultation or assessment, subsequent assessments, including the ongoing monitoring of the patient's condition and the following procedures listed in Section J34 in the Schedule of Benefits

What are the different levels of Neonatal Intensive Care?

There are three levels of neonatal intensive care depending on the procedures performed:

Level A - Full life support, including monitoring (either invasive or non-invasive), ventilatory support and parenteral alimentation (all modalities), which includes codes:

Fee Code	Description	Value
G600	1ST day	$376.05
G601	2nd day and onwards	$187.95
G603*	Neonatal low volume intensive care - payable in lieu of G600 or G604 if sole newborn to maximum of 25 services per physician per fiscal year	$546.00
G604	Neonatal low birth weight intensive care - payable in lieu of G600 or G603 for newborn less than 750 grams in weight or 26 weeks gestational age	$536.95

***If the physician has maxed out on the 25 services per fiscal year, they would resort to billing G600.**

Level B - Intensive care, including monitoring (invasive or non-invasive), oxygen administration and intravenous therapy, but without ventilatory support:

Fee Code	Description	Value
G610	1st day	$258.05
G611	2nd day onwards	$129.00

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Level C - Intermediate care, including one or more of oxygen administration, non-invasive monitoring or gavage feeding:

Fee code	Description	Value
G620	1st day	$162.95
G621	2nd day onwards	$65.05

Note: if a patient moves from one level to another on the same day, you can't charge a “day one” fee code for the subsequent level; it would need to be billed as a “day two and onward” fee code.

In the situation where the patient is transferred from one hospital to another on the same day, the receiving physician will need to submit a manual review. Billing twice the same code for the same patient on the same day will result in an error, and the claim will not be paid.

Special visit premiums cannot be billed with NICU/ICU codes, as the doctor oversees the patient for the whole day.

It is also important to note that only a single doctor is allowed to bill these codes for a single patient per day. If another doctor is taking over the patient's care due to a shift change, the doctors must coordinate to determine how billing will be managed.

Example

Let’s look at a common scenario to understand how to rectify the situation:
The paediatrician was on call from 8 p.m. to 8 a.m. the following day. If the patient was admitted at 12:01 a.m., this admission is considered part of Day 1. Both doctors (one on call until 8 a.m. and the other starting at 8 a.m.) may want to bill for Day 1.

However, the second doctor, starting their shift at 8 a.m., cannot charge for Day 2, as the admission occurred during the same day. To resolve this issue, the doctors should decide who will bill for “Day 1” and who will charge for a consult at a reduced fee.

What are the ICU/NICU premiums?

During emergency care, there are the ICU/NICU premiums, added on to specific fee codes:

Fee Code	Description	Value
G556	ICU/NICU admission assessment is an initial visit rendered during nighttime (00:00-07:00), to G400, G405, G557, G600, G603, G604, G610 or G620	$136.40
C101*	For each patient seen on a visit to ICU or CCU (subject to the exceptions set out below)	$9.10

* Not eligible for payment with Supportive Care or with Critical Care, Ventilatory Care, Comprehensive Care, Acquired Brain Injury Management or Neonatal Intensive Care where team fees are claimed. Also, payable alone when no other separate fee is payable for the service provided in the ICU or CCU (e.g. post-operative care by the surgeon).

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Out of NICU/ICU Billing

The patient's journey of care doesn't end when they leave the ICU/NICU. When a patient has been transferred outside of the ICU/NICU, the MRP will continue to monitor their condition until they are discharged from the hospital.

When the patient has been transferred out of the ICU/NICU, here are the codes that the physician would bill:

Fee Code	Description	Value
C142	1st subsequent visit following transfer from ICU/NICU by the MRP	$61.15
C143	2nd subsequent visit following transfer from ICU/NICU by the MRP	$61.15
E083	Subsequent visit by the MRP add-on premium	30%
E084	Saturday, Sunday and Holiday subsequent visit by the MRP add-on premium	40%

Here is what the paediatrician's billing would look like for a patient out of the ICU/NICU:

Day 1 out of NICU/ICU: 1st subsequent visit following the transfer from ICU/NICU by the MRP (C142) + Subsequent visit by the MRP add-on premium (E083/E084)

Day 2 out of NICU/ICU: 2nd subsequent visit following transfer from ICU/NICU by the MRP (C143) + Subsequent visit by the MRP add-on premium (E083/E084)

Exception to C142/C143: If C122 (First day following admission assessment) or C123 (Second day following admission assessment) have been previously charged for the same hospital stay, then C142 and C143 will not apply. Only one of C122/C142 or C123/C143 allowed per hospital stay.

For example, a patient is admitted on day one to the paediatric floor, and the following day a physician charged C122 and C123 on the third day. If the patient's condition declines and they are transferred to the ICU, then C142/C143 cannot be charged and would instead use the regular subsequent visit codes (C262).