

OHIP Billing: Hospital Billing Codes

Quick Reference Guide

This quick reference guide will provide you with key information on hospital billing codes, and how to bill for services performed in the hospital by Ontario physicians.

Hospital Admission Assessment by the MRP

When a patient has been seen for an admission assessment or consultation (C005, C003, C933, etc.), the Most Responsible Physician (MRP) can add E082 to their claim in addition to the assessment fee.

Fee Code	Fee Description	Value
E082	Add on to admission assessment by MRP	30% of fee code

Hospital Consultation Codes

Hospital inpatient consultation codes follow the same requirements as their A-prefix equivalent (A005, A911, A905, etc.), and are paid out at 100% of the service fee (out-of-basket).

Fee Code	Fee Description	Value
C005	Consultation	\$87.90
C911	Special family and general practice consultation (minimum 50 mins.)	\$150.70
C912	Comprehensive family and general practice consultation (minimum 75 mins.)	\$226.05
C905	Limited consultation	\$74.25
C006	Repeat consultation	\$45.90

Hospital Assessment Codes

Hospital inpatient assessment codes follow the same requirements as their A-prefix equivalent (A003, A004, etc.), and are paid out at 100% of the service fee (out-of-basket).



Fee Code	Fee Description	Value
C003	General assessment	\$87.35
C004	General re-assessment	\$38.35
C933	On-call admission assessment	\$79.90
C904	Pre-dental/pre-operative assessment	\$33.70

Forms and Home Care Supervision

The following codes are for the completion of applications and forms regarding home and long-term care, as well as supervision.

Fee Code	Fee Description	Value
K070	Home care application	\$31.75
K038	Completion of LTC health report form	\$45.15
K071	Acute home care supervision (first 8 weeks following admission to homecare program)	\$21.40
K072	Chronic home care supervision (after 8 th week following admission to home care program)	\$21.40

Billing and Payment Rules:

- K070 must be rendered by the MRP and is limited to one per home care admission per patient.

Subsequent Visits

Subsequent visit codes are for any routine assessment in the hospital following the admission assessment.

Fee Code	Fee Description	Value
C122	Day following the hospital admission assessment	\$61.15
C123	Second day following the hospital assessment	\$61.15
C002	First five weeks - per visit	\$34.10
C007	Sixth to thirteenth week inclusive - per visit	\$34.10
C009	After thirteenth week - per visit	\$34.10
C124*	Day of discharge	\$61.15

*Note: C124 cannot be billed on the second day.



Recommendations:

- If you are the Most Responsible Physician (MRP) and bill a subsequent visit on a Saturday, Sunday or holiday, add billing code **E084- Subsequent or palliative visit by the MRP (check Schedule of Benefits for qualifying specialties).**
- If you are the Most Responsible Physician (MRP) and bill a subsequent visit on a weekday, add billing code **E083- Subsequent or palliative visit by the MRP.**

Billing and Payment Rules:

- All C-prefix codes require an admission date and master/facility number included in the claim or it will come back as the following error: **AH8-Hospital and/or Admission date is missing or invalid.**

Counselling and Conference

The following codes are for the counselling and conference for the admitted patient.

Fee Code	Fee Description	Value
K002	Interview with relatives	\$70.10
K013	Individual counselling	\$70.10
K015	Counselling of relatives - on behalf of catastrophically or terminally ill patient	\$70.10
K121	Hospital In-patient conference (max 4 units per patient, per doctor, per year)	\$32.45

Other Visits

The following codes are any additional visits that physicians can bill for inpatient services.

Fee Code	Fee Description	Value
C121	Additional visits due to intercurrent illness	\$34.10
C008	Concurrent care	\$34.10
C010	Supportive care	\$34.10

Billing and Payment Rules:

- **C121** - After 5 weeks of hospitalization, any assessment required as a result of an acute intercurrent illness constitutes as C121.
- **C008** – This code is for any routine assessment by the consultant after the consultant's first major assessment of the patient when the family physician remains the MRP.
- **C010** – This code is for any routine visit rendered in a hospital by the family physician who is not actively treating the case.



Hospital In-Patient Special Visit Premium

Premium	Weekdays Daytime	Weekdays Daytime - Sacrifice of Office Hours	Evenings Monday through Friday	Saturday, Sunday 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	C960 \$36.40	C961 \$36.40	C962 \$36.40	C963 \$36.40	C964 \$36.40
First person seen	C990 \$20.00	C992 \$40.00	C994 \$60.00	C986 \$75.00	C996 \$100.00
Additional person(s) seen	C991 \$20.00	C993 \$40.00	C995 \$60.00	C987 \$75.00	C997 \$100.00

Note: When billing Special Visit Premiums, bill with **A-prefix** consultations or assessments. C-prefix consultations and assessments are **not** eligible to be billed in conjunction with special visit premiums.

Emergency Department Special Visit Premium

Premium	Weekdays Daytime	Weekdays Daytime - Sacrifice of Office Hours	Evenings Monday through Friday	Saturday, Sunday 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	K960 \$36.40	K961 \$36.40	K962 \$36.40	K963 \$36.40	K964 \$36.40
First person seen	K990 \$20.00	K992 \$40.00	K994 \$60.00	K998 \$75.00	K996 \$100.00
Additional person(s) seen	K991 \$20.00	K993 \$40.00	K995 \$60.00	K999 \$75.00	K997 \$100.00

Note: When billing Special Visit Premiums, bill with **A-prefix** consultations or assessments. C-prefix consultations and assessments are **not** eligible to be billed in conjunction with special visit premiums.