OHIP Payments for Addiction Medicine Services

Quick Reference Guide

Economics, Policy & Research

OMA
ONTARIO MEDICAL ASSOCIATION

OHIP Payments for Addiction Medicine Services
Quick Reference Guide[1]

The purpose of this reference guide is to provide a general overview on the payment rules for billing for addiction medicine services. The full definitions, payment rules and medical record requirements of the services described in this guide are detailed in the OHIP Schedule of Benefits[2] (the "Schedule").

The guide contains the following sections:

(A) A680/C680 Substance Abuse - Initial Assessment
(B) K680 Substance Abuse - Extended Assessment
(C) Monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP)
(D) Focused Practice Assessments (FPA)
(E) B103 Opioid Agonist Therapy
(F) Point of Care Drug Tests
(G) GP focused practice Designation- Addiction medicine

A: A680/C680 Substance Abuse - Initial Assessment

The OHIP Schedule defines the Substance Abuse - Initial Assessment as "an assessment where the physician spends a minimum of 50 minutes of personal contact assessing a patient related to substance abuse *with or without* the patient's relative(s) *or patient's representative*, exclusive of time spent rendering any other service to the patient. This service is *only eligible for payment* to the physician intending to subsequently render treatment of the patient's substance abuse"[3].

The elements of the service must include:

i. A complete history of illicit drug use, abuse and dependence, ensuring that a DSM diagnosis is recorded for each problematic drug;
ii. A complete addiction medicine history;
iii. Past medical history;
iv. Family history;
v. Psychosocial history, including education;
vi. Review of systems;
vii. A focused physical examination, when indicated;
viii. Assessment/diagnosis including a DSM diagnosis for each problematic drug;
ix. Review of treatment options;
x. Formulation of a treatment plan;
xi. Communication with the patient and/or family to obtain information for the assessment as well as for support staff working in the treatment environment;
xii. Communication with previous care providers, including family doctors, as necessary.

[1]**Disclaimer**: Every effort has been made to ensure that the contents of this Guide are accurate. Members should, however, be aware that the laws, regulations and other agreements may change over time. The Ontario Medical Association assumes no responsibility for any discrepancies or differences of interpretation of applicable Regulations with the Government of Ontario including but not limited to the Ministry of Health (MOH), and the College of Physicians and Surgeons of Ontario (CPSO). Members are advised that the ultimate authority in matters of interpretation and payment of insured services (as well as determination of what constitutes an uninsured service) are in the purview of the government. Members are advised to request updated billing information and interpretations – in writing – by contacting their regional OHIP office.

[2]OHIP Schedule of Benefits, Physician Services, February 20, 2024 (effective April 1, 2024) (https://www.ontario.ca/files/2024-08/moh-schedule-benefit-2024-08-30.pdf)

[3] OHIP Schedule, page A57

Fee Code	Descriptor	Fee
A680	Initial assessment – substance abuse	$144.75
C680	Initial assessment – substance abuse – subject to the same conditions as A680	$144.75

Payment rules that apply to the Initial assessment-substance abuse include:

1. If A680 is not pre-booked at least one day before the service is rendered, the service is not eligible for payment.
2. A680 is limited to one per patient per physician except in circumstances where a 12-month period has elapsed since the most recent insured service rendered to the patient by the same physician.
3. A680 is limited to a maximum of two per patient per 12-month period.
4. A680 is not eligible for payment for the assessment of substance abuse related to smoking cessation.[4]
5. Any insured service rendered to the patient before October 1, 2010, by the physician submitting a claim for A680/C680 for the same patient and paid as an insured service under the Health Insurance Act constitutes an "Initial Assessment - Substance abuse" service and is deemed to have been rendered on October 1, 2010.

Important Notes:

- Start and stop times of the service must be recorded in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser assessment fee.
- A DSM diagnosis must be recorded in relation to each problematic substance in the patient's permanent medical record or the amount payable for the service will be adjusted to a lesser assessment fee.
- Relevant information obtained in the provision of all elements of the service must be recorded in the medical record or the amount payable for the service will be adjusted to lesser assessment fee.

B: K680 Substance Abuse - Extended Assessment

A substance abuse - extended assessment is the service for providing care to patients receiving therapy for substance abuse. The service has the same specific elements as an assessment. For detailed information on specific elements of Assessments, please refer to the schedule[5].

Fee Code	Descriptor	Fee
K680	Substance abuse - extended assessment (per unit)	$70.10

Payment rules that apply to the Substance abuse - extended assessment (per unit) include:

1. K680 is a time-based service with time calculated based on units. Unit means ½ hour or major part thereof – see General Preamble GP7, GP55 for definitions and time-keeping requirements.
2. No other consultation, assessment, visit or time-based service is eligible for payment when rendered the same day as K680 to the same patient by the same physician.
3. K680 is not eligible for payment for management of smoking cessation (See K039 – smoking cessation).

[4] For assessment services related to smoking cessation, see general listings, A957, K039 and E079 services, as applicable in the Schedule of Benefits.
[5] OHIP Schedule, page A59

Important Note:

- Start and stop times must be recorded in the patient's permanent medical record or payment will be adjusted to reflect the service documented in the medical record.

C: Monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP)[5]

The OHIP Schedule defines the Monthly management of a patient in an Opioid Agonist Maintenance Program (OAMP) is the one-month management and supervision of a patient receiving opioid agonist treatment by the physician most responsible for the management and supervision of that patient when rendered in accordance with the definitions and payment rules described below.

The monthly management of a patient in an OAMP is only eligible for payment to a physician who has an active general exemption for methadone maintenance treatment for opioid dependence pursuant to *Section 56 of the Controlled Drugs and Substances Act 1996.*

This service includes the following specific elements:

- All medication reviews, adjusting the dose of the opioid agonist therapy, and where appropriate, prescribing additional therapy, and discussions with pharmacists;
- With the exception of all physician to physician telephone consultation services, discussion with, and providing advice and information to the patient, patient's relative(s), patient's representative or other caregiver(s), in person, by telephone or otherwise, on matters related to the service, regardless of identity of person initiating discussion; and
- All discussions in respect of the patient's opioid dependency, except where the discussion is payable as a separate service.

Fee Code	Descriptor	Fee
K682	**Opioid Agonist Maintenance Program monthly management fee - intensive, per month** is the service for management of an OAMP patient receiving an opioid agonist where the physician renders at least two (2) required services in the month.	$45.00
K683	**Opioid Agonist Maintenance Program monthly management fee - maintenance, per month** is the service for management of an OAMP patient receiving an opioid agonist where the physician renders one (1) required service in the month.	$38.00
K684	**Opioid Agonist Maintenance Program - team premium, per month, to K682 or K683…(add)** is the service for management of an OAMP patient receiving an opioid agonist where: **i.** the physician most responsible for the OAMP management of the patient provides one of K682 or K683 in the month and supervises members of the OAMP management team; **ii.** the OAMP management team consists of the physician most responsible for the OAMP treatment and at least two other non-physician members who have successfully completed a training program in addiction medicine that includes opioid agonist management; **iii.** the OAMP management team members provides at least one in-person therapeutic encounter with the patient in the month for which the service is payable; and **iv.** the therapeutic encounter is not primarily for the purpose of urine testing or the provision of a prescription.	$6.00

The definitions are outlined below:
Required services are:

i. a consultation, assessment or visit from the Consultation and Visits section of his Schedule; or
ii. a K-prefix time-based service excluding group services and case conferences.

A service primarily for the purpose of providing a prescription does not constitute a required service and does not count towards the minimum requirements of K682 or K683.

Payment rules:

1. K682, K683 and K684 are only eligible for payment to the physician most responsible for the patient's OAMP for the applicable month.
2. K684 is only eligible for payment when all required patient encounters are documented in the medical record.
3. K682 is limited to a maximum of six services per patient per 12-month period
4. A maximum of one of K682 or K683 is eligible for payment per patient per month any physician.
5. In circumstances where the administration of an opioid agonist is delegated to another qualified health professional, K682 and K683 are only eligible for payment if the physician can demonstrate that he/she has received a delegation exemption from the CPSO.

Important Notes:

- OAMP monthly management fees may be claimed for a patient enrolled in a treatment program using methadone or buprenorphine. Claims for K683, K682 and K684 are payable only after the minimum requirements have been rendered for the month.
- In circumstances where the physician most responsible for the patient's OAMP is temporarily absent and/or the patient is transferred to another physician in any month, the physicians should determine who is the physician most responsible for the purposes of claim submission and payment. In the event that more than one claim is submitted for the same patient for the same month, only the first claim submitted is eligible for payment.
- The CPSO Methadone Maintenance Treatment Program Standards and Clinical Guidelines may be found at the CPSO website[6].

D: Focused Practice Assessments

FPA is an assessment rendered by a GP/FP physician, unless otherwise specified, with additional training and/or experience in sport medicine, allergy, pain management, sleep medicine, addiction medicine (including methadone) or care of the elderly (age 65 or older). The assessment must satisfy, at a minimum, all of the requirements of an intermediate assessment.[7]

Fee Code	Descriptor	Fee
A957	Addiction medicine FPA	$37.95

Payment rules:

- No other consultation, assessment, visit or counselling service is eligible for payment when rendered the same day as one of A917, A927, A937, A947, A957 or A967 to the same patient by the same physician.

[6] CPSO website link: http://www.cpso.on.ca
[7] OHIP Schedule, page A7

- E079 is not eligible for payment with any FPA
- A957 may also be billed by a specialist with additional training and/or experience in addiction medicine (including methadone).

Important Notes:

- Despite any other provision in the Schedule, the amount payable for a focused practice assessment (A917, A927, A937, A947, A957 or A967) services to an insured person who is at least 65 years of age, as those services are defined in the Schedule, is increased by 15 per cent. This premium will automatically pay when a claim is submitted for a focused practice assessment where the patient is 65 years of age or older.
- Physicians should be prepared to provide to the ministry documentation demonstrating training and/or experience on request.

E: B103 Opioid Agonist Therapy

The Ontario Virtual Care Program (previously called the Telemedicine Program) has now issued new billing codes for Hosted Video Visits and Direct-to-Patient Video Visits, which provide further detail on the Virtual Care Program changes announced on November 15, 2019, INFOBulletin 4731[8].

Tracking fee code

Fee Code	Descriptor	Fee
B103A	Hosted video visit - patient attending at a patient host site	$0.00

- Synchronous video visits with a patient who is physically located and supported at a patient host site during the clinical encounter.

Please note: The B103 is eligible for a $15 Temporary Premium Mitigation Payment (TPMP) for OAT patients only. Billing the B103 for non-OAT patients will not result in payment but should not lead to claim rejections. Payment is triggered on a per-patient basis when a monthly K682/K683 is billed. Any physician (not just the MRP) who submits the K682/K683 can bill the B103 if they provide A680, A957, or K680 OAT services via telemedicine. Additionally, the B103 must include the "K300A" telemedicine modality indicator.

B103A will remain available as a tracking code within the OHIP insured framework for video services rendered at patient host sites, for use where this has been required by a separate agreement.[9]

F: Point of Care Drug Tests[10]

A laboratory service (“test”) set out in Laboratory Medicine in Physician’s Office section is an insured service eligible for payment only when rendered by a physician (“the original physician”), or by a physician substituting for the original physician, who performs the test in the original physician’s own office for the physician’s own patient.[11]

[8] INFOBulletin 4750
[9] INFOBulletin 221203
[10] OHIP Schedule, page J67
[11] OHIP Schedule, page J6

Tests listed under "Point of care drug testing" are payable to those physicians where point of care testing is necessary for their practice.

Please note:

1. Fee codes listed in the separate Schedule of Benefits for Laboratory Services apply only to services provided by private laboratories licensed under the Laboratory and Specimen Collection Centre Licensing Act.
2. Any service listed in this section is not insured when rendered to support in-vitro fertilization services or artificial insemination services. See Regulation 552 section 24(1) paragraph 23 and 29 under the Act.
3. Laboratory services are only eligible for payment if the result of the test(s), the physician's interpretation of the results of the test(s) and the treatment decision based on the test results are documented in the patient's permanent medical record.

Fee Code	Descriptor	Fee
G041	Target drug testing, urine, qualitative or quantitative (per test)	$3.70
G042	Target drug testing, urine, qualitative or quantitative (per test)	$2.50
G040	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse (per test)	$15.00
G043	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse (per test)	$7.50
G039	Creatinine	$1.03

Payment Rules:

1. For the purposes of opioid agonist maintenance treatment, G040, G042, G041 and G043 are only eligible for payment to a physician who has an active general exemption for methadone maintenance treatment or chronic pain treatment with methadone pursuant to Section 56 of the Controlled Drugs and Substances Act 1996.
2. G040 and G041 are limited to a maximum of five (5) services per patient (any combination) per month to any physician when K682 or K683 is payable.
3. G042 and G043 are limited to a maximum of four (4) services per patient (any combination) per month to any physician when K682 or K683 is payable.
4. Any combination of G040, G041, G042 and G043 is limited to a maximum of three (3) services per patient per month for management of a patient with chronic pain, an addiction, or receiving opioid agonist treatment program where K682 or K683 is not payable in the month for the same patient to any physician.
5. G040, G041, G042 and G043 are not eligible for payment unless K623 or K624 or a consultation, assessment or time–based service involving a direct physical encounter with the patient is payable in the same month to the same physician rendering the G040, G041, G042 or G043 service.
6. G039 is limited to a maximum of two (2) tests per patient per week, any physician.
7. G039 is only eligible for payment when rendered to rule out urine tampering.
8. Only one of G040, G041, G042 or G043 is eligible for payment per urine sample.

Important Notes:

- G041 and G042 are tests for a specific drug of abuse.

- Drugs of abuse may include any of the following: alcohol, methadone, methadone metabolite, morphine, a synthetic or semi-synthetic opiate, cocaine, benzodiazepines, amphetamines, methamphetamines, cannabinoids, barbiturates or any other drug of abuse.

G: GP Focused Practice Designation- Addiction Medicine

GP Focused Practice Physician means, for the purpose of eligibility to provide a focused practice consultation by Video (A010, A011, A906, A913, A914), a physician who has been designated by the bi-lateral MOH-OMA GP Focused Practice Review Committee or a physician who is eligible for the focused practice psychotherapy premium. All GP Focused Practice Designation physicians are eligible to use the codes listed below. For more information, please refer to the schedule.[12]

Fee Code	Descriptor	Fee
A010	GP focused practice consultation by Video	$87.90
A011	GP focused practice repeat consultation by Video	$45.90
A906	GP focused practice limited consultation by Video	$73.25
A913	GP focused practice special consultation by Video	$150.70
A914	GP focused practice comprehensive consultation by Video	$226.05

Please see below for information on a list of fee schedule and diagnostic codes that will be exempt from a Harmonized Model physician's Access Bonus when billed by a physician with the Addiction Medicine GP Focused Practice Designation. This list may be revised should discussions at the GP Focused Practice Review Committee result in changes.[13]

The fee schedule and diagnostic codes on the provided list will not impact the Access Bonus of all Harmonized Models. While we recognize that some of the codes included on the list may currently not impact Access Bonus in some models, the lists were designed for use in all models and were therefore purposefully more broadly defined.

Please note: the diagnostic codes provided for most designations will be exempt from Access Bonus when billed with any fee schedule code, not just the fee schedule codes provided.

Addiction Medicine	
Fee Schedule Code	**Description**
A957A	FOCUSED PRACTICE ASSESSMENT - ADDICTION MEDICINE
G010A	D./T. PROC - LAB.MED. - URINALYSIS - ONE OR MORE PARTS.W/0.MICRO.
G039A	CREATININE
G040A	DRUGS OF ABUSE SCREEN, URINE, MUST INCLUDE AT A MINIMUM OPIATES, COCAINE, CANNABINOIDS, BENZODIAZEPINES AND BARBITUATES
G041A	TARGET DRUG TESTING, URINE, QUALITATIVE OR QUANTITATIVE
Diagnostic Code	**Description**
303	ALCOHOLISM
304	DRUG DEPENDENCE, DRUG ADDICTION

[12] OHIP Schedule, page A63, A68

[13] GP FOCUSED PRACTICE DESIGNATION -POLICY AND PROGRAM OVERVIEW (https://www.oma.org/siteassets/oma/media/pagetree/pps/starting/gp-focused/gp-focus-package-overview.pdf)

OHIP Payments for Addiction Medicine Services: Quick Reference for OHIP Billing[14]

Substance Abuse Assessments		
A680	Initial assessment – substance abuse	$144.75
C680	Initial assessment – substance abuse (subject to same conditions as A680)	$144.75
K680	Substance abuse – extended assessment (per unit)	$70.10
Monthly Management of a Patient in an Opioid Agonist Maintenance Program (OAMP)		
K682	OAMP monthly management fee – intensive, per month	$45.00
K683	OAMP monthly management fee – maintenance, per month	$38.00
K684	OAMP – team premium, per month, to K682 or K683	$6.00
Point of Care Drug Testing		
G041	Target drug testing, urine, qualitative or quantitative (per test)	$3.70
G042	Target drug testing, urine, qualitative or quantitative (per test)	$2.50
G040	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse (per test)	$15.00
G043	Drugs of abuse screen, urine, must include testing for at least four drugs of abuse (per test)	$7.50
G039	Creatinine	$1.03
GP Focused Practice Designation – Addiction Medicine		
A957	Addiction medicine focused practice assessment	$37.95
A010	GP focused practice consultation by Video	$87.90
A011	GP focused practice repeat consultation by Video	$45.90
A906	GP focused practice limited consultation by Video	$73.25
A913	GP focused practice special consultation by Video	$150.70
A914	GP focused practice comprehensive consultation by Video	$226.05
A010	GP focused practice consultation by Video	$87.90

Document compiled by the OMA's Economics, Policy & Research department
Please forward questions to economics@oma.org

[14] Please note that the information contained in this resource is strictly for general reference and may not address all possible billing scenarios that may arise or all possible billing codes. The information included may not contain all payment rules and/or medical record requirements. Physicians are to select the most appropriate service code, which best represents the service provided.