

January 2022 Edition

Physician's Guide to Uninsured Services

A Guide for Ontario Physicians



Dedicated to Doctors
Committed to Patients

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 and between editions of this *Guide*. The Ontario Medical Association (OMA) assumes no responsibility for any discrepancies or differences of interpretation of the applicable Third Party 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.

QUICK REFERENCE LIST¹

Multiplier	Page	
2022 Multiplier for Uninsured Services: 2.50²	13	
Miscellaneous	Suggested Rate	
Page	Page	
Establishing an Hourly Rate	At physician's discretion	13 - 15
Charges for Reproduction/Transmission of Medical Records ³ :	(a) \$30 (first 20 pages) + \$0.25 per page thereafter	16 - 18
(a) Copying/printing; or	(b) \$30.00	
(b) Electronic transfer; and	(c) \$45 per 15 minutes, after first 15 minutes	
(c) Physician review of records (where applicable)		
Completion of documentation/forms for physicals for schools, camps, pre-school, daycare, university/educational institutions	\$31.50	25
Completion of documentation/forms for physicals for pre-employment certification of fitness/fitness clubs or hospital/nursing home employee	\$42.00	25
Back to work note, sick note or daycare note (free of communicable disease)	\$22.00	25
Insurance Certificate OCF- 3 Disability Certificate	\$160.00	26
Insurance Certificate OCF-18 Treatment Plan	\$160.00	26
Insurance Certificate OCF-19 Determination of Catastrophic Impairment	\$132.00	26
Insurance Certificate OCF-23 Treatment Confirmation	\$159.00	26
Attending Physician's Statement	\$160.00	26, 51
Insurance Medical Examination (assessment and report)	\$260.00	26, 51
CRA Disability Tax Credit Certificate (form T2201)	\$83.00	25
Medical Report for a CPP Disability Benefit (SCISP-2519)	(up to) \$85.00	27
CPP Narrative Medical Report	(up to) \$150.00	27

¹ The fees noted in the list below are for the completion of the form/report only, with the exception of the 'Insurance Medical Examination'. An assessment fee may also be applicable, when an assessment is required to complete the form/report and when that same assessment is not medically necessary.

² The OMA Schedule of Fees is based on the multiplier as applied against the current OHIP Schedule of Benefits.

³ Refer to pages 16-18 for important information on cases that have come before the Information and Privacy Commissioner of Ontario (IPC) with respect to complaints made against physicians under the Personal Health Information Protection Act (PHIPA) regarding photocopying charges.

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I. INTRODUCTION

This *Guide* provides guidance to physicians on third party requested services, other uninsured services, suggested fees, relevant policies and interpretation of relevant regulations applying to such services. Wherever possible, specific issues will be highlighted for members and reference information will be provided for those members wishing to further research the specific issue at hand.

In this Guide,

“Insured Services” means services covered by the Ontario Health Insurance Plan (OHIP);

“Uninsured Services” means services which are not “insured services”;

“Third Party” means a person other than the patient;

“Third Party Services” means any service requested by a Third Party or which is in whole or in part necessary⁴ for the production or completion of a document or transmission of information to satisfy the requirements of a Third Party.⁵

Physicians must bill for insured services at the rates set out in the OHIP Schedule of Benefits. They may not bill any amount in excess of these rates. Physicians may select the rate they bill for uninsured services, unless they are otherwise prohibited from doing so. This *Guide* suggests rates and fees for uninsured services which physicians may choose to charge. The rates and fees suggested in this *Guide* apply to uninsured services of “average” complexity and are intended to offer assistance in establishing appropriate and practice-specific billing rates. Physicians however are not required to charge the rates suggested in this *Guide*.

Note that Regulation 856/93 under the *Medicine Act*, states that the following is professional misconduct:

- i. *“Charging a fee that is excessive in relation to the services performed”* (Section 1(1) 21),
or
- ii. *“Charging a fee for a service that exceeds the fee set out in the then current schedule of fees published by the Ontario Medical Association without informing the patient, before the service is performed, of the excess amount that will be charged”* (Section 1(1) 22).

⁴ Including an annual health exam.

⁵ See for example s.24(1), para 8, 8.1 and 8.2 of O.Reg. 552 under the Health Insurance Act, <https://www.ontario.ca/laws/regulation/900552#BK9>

II. THE DIRECT BILLING PROCESS

General Guidelines for the Direct Billing Process

There are some practical guidelines physicians can follow when billing a patient directly for uninsured services, to help make the process as comfortable and efficient as possible. In order to establish an office policy on billing for uninsured services, physicians should first determine:

- Those services for which patients will be directly billed;
- The fees attached to those services⁶;
- Any exemptions, such as for seniors or those on fixed-incomes;
- Bookkeeping and collection procedures.

Examples of some common uninsured services include:

- Missed appointments or procedures if less than 24 hours notice has been given (an exception being psychotherapy practices where a reasonable written agreement exists between the patient and physician).
- A service that is solely for the purpose of altering or restoring appearance.
- Providing a prescription to an insured person if the person or person's personal representative requests the prescription and no concomitant insured service is provided.
- Completion of third party reports and forms (see [Section IV](#) of this *Guide*)

Note that Section 24 of Regulation 552 under the *Health Insurance Act* precludes a physician from billing a patient or third party:

- For keeping or maintaining appropriate physician records;
- For conferring with, or providing advice, direction, information, or records to physicians or other professionals concerned with the health of the insured person;
- For obtaining consents or delivering written consents; and/or
- An annual administrative or any other fee associated with office overhead costs (including but not limited to the cost of computerizing billings, storage of patient medical records, time spent arranging appropriate follow-up care for insured services, etc.).

A physician's office policy on direct billing for uninsured services must be specific and detailed so that it is fully understood by staff and patients. It should also allow sufficient flexibility to adapt to unique or

⁶ Not all fees are up to the physician's discretion (e.g. WSIB services).

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unexpected circumstances that may be encountered. Once an office policy has been established, it should be put in writing and distributed to staff. When billing directly for services provided, physicians should:

1. Establish and maintain a simple and clear office policy and procedure for direct billing;
2. Inform staff of this policy and procedure and keep them apprised of any changes;
3. Always discuss fees with the patient before providing the service;
4. Collect payment from patients at the point of service as often as possible;
5. Maintain up-to-date accounts.

Physicians should familiarize themselves with pertinent College of Physician and Surgeons of Ontario (CPSO) policies⁷, such as,

- ▶ Third Party Reports, and
- ▶ Uninsured Services: Billing and Block Fees

Information on developing an uninsured services billing program can be found in the following Ontario Medical Review (OMR) articles⁸:

1. OMR, February 2010, Vol. 77, No. 2, *Does your uninsured services program need a “check-up”?*, by Jonathan Marcus, MD, CCFP
2. OMR, September 2010, Vol. 77, No. 8, *Tools to support your uninsured services program: point-of-service terminal facilitates “real-time” payment, enhanced practice efficiency*, by Jonathan Marcus, MD, CCFP
3. OMR, May 2011, Vol. 78, No. 5, *Communicating your uninsured services policy to patients: strategies to avoid confusion, misunderstandings*, by Rohan Mathai

An additional OMA resource titled *Implementing an Uninsured Services Program* is available for download on the OMA website.⁹

Patients and their ability to pay for services

There are some instances where patients claim economic hardship and an inability to comply with the fees they are charged for the uninsured services rendered. It is important for OMA members to realize that rates in this *Guide* are *suggested* rates. When calculating fees, consider the financial burden that

⁷ CPSO policies are available on the CPSO website at <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies>

⁸ <https://www.oma.org/member/newsroom/ontario-medical-review2/>

⁹ <https://www.oma.org/uploadedfiles/oma/media/member/mappedpdfs/multiple-top-level/implementing-an-uninsured-services-program-november-2018-final.pdf/>

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such charges might place on the patient and whether it is appropriate to reduce, waive or allow flexibility based on these considerations as applied to the circumstances of each case. The Canadian Medical Association's Code of Ethics (2004) states under Paragraph 16 that "*an ethical physician will consider, in determining professional fees, both the nature of the service provided and the ability of the patient to pay, and will be prepared to discuss the fee with the patient.*" Furthermore, the Medicine Act prohibits physicians from "*charging a fee that is excessive in relation to the services performed*" (Section 1(1) 21).¹⁰

Collecting Fees

Physicians may take action to collect fees owed to them, which may include physicians or their office staff contacting patients or hiring a third party (i.e., collection agency) to assist in the process. Physicians who are considering ending the physician-patient relationship due to an outstanding balance must comply with the expectations set out in the CPSO's Ending the Physician-Patient Relationship policy.¹¹

Timeliness of response

The CPSO Third Party Reports policy states that physicians should complete and submit third party reports within **45 days**, unless a timeline for these activities has been specified by legislation or a specific legal requirement.¹² If physicians are unable to comply with this timeframe, either due to the complexity of the report, or for another appropriate reason, physicians should discuss the matter with the third party and reach an agreement for a reasonable extension.¹³

Code of Ethics

The responsibilities of an ethical physician to the patient are stated in the Code of Ethics (revised by the Canadian Medical Association in 2004) and include the following:

An ethical physician will: "*provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.*" (Paragraph 37)

In addition, Section 1.17 of Ontario Regulation 856/93 made under the Medicine Act, 1991 states that it may be considered professional misconduct to fail "*without reasonable cause to provide a report or certificate relating to an examination or treatment performed by the member to the patient or his or her authorized representative within a reasonable time after the patient or his or her authorized representative has requested such a report or certificate.*"

¹⁰ http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_930856_e.htm

¹¹ <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Ending-the-Physician-Patient-Relationship>

¹² The Personal Health Information Protection Act specifies that an individual has a right of access to a record of personal health information and that the health information custodian shall give the response required as soon as possible in the circumstances but no later than 30 days after receiving the request (unless a time extension has been put in place). Full details of this legislation can be accessed: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm

¹³ CPSO Third Party Reports policy: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Third-Party-Medical-Reports>

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Block Fee Billing

A block fee is defined as a flat fee charged by a physician for a predetermined set of uninsured services during a predetermined period of time (no less than three months and no more than one year). Not all physicians are in a position to charge a block fee due to the nature of their practice and specialty. Physicians are not required to offer a block fee option; patients can be charged on a fee-for-service basis for uninsured services. Physicians who do choose to offer a block fee must also offer uninsured services separately at individual costs to patients. Patients cannot be required to pay a block fee.

The CPSO policy on block fees¹⁴ states that physicians may use third party companies to assist them to administer a block fee or payment for uninsured services. Any communication to patients should identify the fact that a third party was involved. Third parties who are asked to administer block fees or payment for uninsured services are acting on the physician's behalf. Physicians are responsible for ensuring these companies adhere to the same standards required of physicians.

The policy also states that patient decisions regarding payment for uninsured services must not affect their ability to access health care services. Physicians must not:

- Require that patients pay a block fee before accessing an insured service;
- Offer to treat patients preferentially because they agree to pay a block fee;
- Terminate a patient or refuse to accept a new patient because that individual chooses not to pay a block fee.

For additional information, refer to the OMA reference guide "Implementing an Uninsured Services Program: A Guide for Physicians"¹⁵ for a general overview on how to implement an efficient and effective Uninsured Services Program in a physician office, including relevant policies and interpretation of regulations applicable to the implementation of such programs.

¹⁴ <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Uninsured-Services-Billing-and-Block-Fees>

¹⁵ <https://www.oma.org/uploadedfiles/oma/media/member/mappedpdfs/multiple-top-level/implementing-an-uninsured-services-program-november-2018-final.pdf/>

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Keeping Patients Informed

Many patients are surprised to discover that not all of their medical needs are covered under the Ontario Health Insurance Plan (OHIP), and that they must pay their provider directly for certain uninsured services. This misunderstanding can lead to situations that are frustrating and uncomfortable for both the patient and physician, as well as medical office staff — particularly if the patient learns about the cost after the service has been rendered.¹⁶ To prevent this from occurring, there are strategies that can be employed to make billing and collecting payment for uninsured services more efficient.

- Always discuss the fees and, where applicable, an expected completion date with the patient/third party in advance of providing the services.
- If physicians charge patients for uninsured services, the CPSO states that a list of fees should be made available to the patient. This list must be available regardless of whether the fee will be paid on a per service basis or in the context of a block fee.¹⁷ Consider displaying a list in the patient waiting area.
- Have patients sign a letter of acknowledgement, confirming that they have been informed of, and understand the uninsured services policy.
- When invoicing patients/third party, be sure the services have been itemized. It is considered professional misconduct for failing to itemize an account for professional services, if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services, or if the account includes a commercial laboratory fee.¹⁸ In addition, physicians should issue receipts for all cash payments and ensure that these transactions are properly documented.
- Don't hesitate to contact the third party (or the patient, where applicable) requesting information in the event the request is unclear, or if the request is unreasonable. It's not unusual for a third party to request a "copy of the patient's file" when in reality, the third party is looking for a specific piece of information. This saves the physician from performing unnecessary work and results in a more manageable fee to the requesting party.
- Consider arranging a payment plan with the patient that aligns with their financial means.

Refer to [Appendix II](#) for sample messaging and letters that may be of assistance.

¹⁶ OMR, May 2011, Vol. 78, No. 5, *Communicating your uninsured services policy to patients: strategies to avoid confusion, misunderstandings*, by Rohan Mathai

¹⁷ CPSO Uninsured Services: Billing and Block Fees policy: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Uninsured-Services-Billing-and-Block-Fees>

¹⁸ http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_930856_e.htm

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Application of HST to Uninsured Services

Physicians who are HST registered are required to charge and collect tax at a rate of 13% on any taxable supplies (other than zero-rated supplies or exempt supplies) of goods and services they supply in the province of Ontario.

All physicians, whether registered or not, are required to pay HST at a rate of 13% on the purchase cost of most of their supplies (other than payments to employees). For those physicians not exceeding \$30,000 in taxable sales, HST registration is voluntary. Members should be aware that once registered as collectors and remitters of HST, they must continue to file reports even if the HST falls below the \$30,000 threshold.

Physicians are required to register, collect and remit HST when their annual HST-taxable sales exceed \$30,000.

Consequently, if a physician retires or significantly reduces his or her supply of HST-taxable services, he or she will have to formally de-register as a HST remitter to be able to cease providing monthly reports to the Canada Revenue Agency (CRA). **It is suggested physicians consult with an accountant prior to registering for HST.**

Amendments to the Excise Tax Act

The Excise Tax Act was amended as of March 21, 2013 to clarify that a supply that is not a “qualifying health care supply” is deemed not to be an exempt “health care service”.¹⁹ A “qualifying health care supply” is defined to mean “a supply of property or a service that is made for the purpose of:

- (a) maintaining health,
- (b) preventing disease,
- (c) treating, relieving or remediating an injury, illness, disorder or disability,
- (d) assisting (other than financially) an individual in coping with an injury, illness, disorder or disability, or
- (e) providing palliative health care”.²⁰

CRA states that the intent of these changes was to clarify that GST/HST “applies to reports, examinations and other services that are not performed for the purpose of the protection, maintenance or restoration of the health of a person or for palliative care.”²¹ While further clarifications continue to be sought from the CRA, the CRA has indicated that where the primary purpose of a supply is the protection, maintenance, or restoration of health, the supply will be exempt from HST. A supply may have a dual purpose (e.g. an

¹⁹ Excise Tax Act, Schedule V, Part II, s.1.2.

²⁰ Excise Tax Act, Schedule V, Part II, s.1.

²¹ <http://www.budget.gc.ca/2013/doc/plan/anx2-eng.html>

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Physicians are encouraged to contact the CRA or their accountant to obtain clarification on individual concerns.

exam whose purpose is both to promote health as well as to provide information for a financial form), but the health benefit cannot be incidental or ancillary to the primary purpose.

HST and Uninsured Services: General Guidelines

The information contained in this section is only a general guideline. For the most accurate information pertaining to HST, contact the CRA or consult with your accountant and/or tax lawyer.

As indicated above, certain services physicians charge for as uninsured services will attract HST. Generally, if the primary purpose of a service is NOT to protect, maintain or restore health, HST will be payable. For example, an IME which is carried out solely for the purpose of filling out financial forms will attract HST.

The following uninsured services have, in the past, been considered by the CRA to be subject or exempt to/from HST and are likely to continue to be categorized as such:

Services subject to HST
<ul style="list-style-type: none">• Cosmetic surgical procedures and all related medical services• Medical reports based on chart review• Block/annual fees• Witness fees for court appearances²²• Medical examinations for which the primary purpose is not motivated by the protection, maintenance, or restoration of health
Services exempt from HST
<ul style="list-style-type: none">• Consultative, diagnostic, treatment or other health care service provided by a physician to an individual²³, including:<ul style="list-style-type: none">• Executive medical assessments carried out for the purpose of health care for the patient• Prescription renewal without a visit• Preparation and transfer of medical records• Medical reports upon patients or upon a person who the physician has examined including the following provided that the exam has the purpose of promoting, protecting or maintaining health:<ul style="list-style-type: none">• Employment and pre-employment examinations/reports• Immigration examination/reports• Employer back to work/timely return to work/modified employment forms• Treatment Plan (insurance form OCF-18)

²² Page 3, GST Memorandum 300-4-2

²³ Excise Tax Act, Schedule V, Part II, s.5.

III. SUGGESTED FEES FOR UNINSURED SERVICES

There are several ways a physician can calculate their rates and fees for uninsured services (including those requested by third parties).

In calculating fees for uninsured services, the physician should take into consideration, as circumstances dictate, some or all of the following factors:

- (a) Nature and complexity of the matter;
- (b) Experience and expertise of the physician;
- (c) Time spent with and/or on behalf of the patient; and
- (d) The cost of materials not included in the fees for insured services.

This *Guide* contains suggested fees for a number of more common forms and services that are typically requested by third parties. However, there are forms, reports and services that are not specified, and in these cases physicians can use one of the following methodologies to establish an appropriate fee.

1. At the Physician's Cost:

Defined as the actual, direct or invoice cost (including applicable taxes) incurred by the physician, plus a reasonable mark-up to account for secretarial and other indirect costs. Examples of services that are often billed at the physician's cost:

- Toll charges for long-distance telephone calls.
- Preparing/providing a drug, antigen, antiserum or other substances used for treatment (but not used to facilitate the procedure/examination).²⁴
- Preparing or providing a device that is not implanted by means of an incision and that is used for therapeutic purposes (e.g., IUD).

Exceptions to this are if the device is used to permit or facilitate a procedure or examination, or if the device is a cast for which there is a fee listed in the OHIP Schedule of Benefits, in which case the patient cannot be charged a fee.

Refer to the OMA Schedule of Fees (SOF) for suggested fees for clinical services. The OMA SOF is based on a fee multiplier applied to the current OHIP Schedule of Benefits.

The 2022 multiplier is 2.50.²⁵ Any fee listed in the current OHIP Schedule of Benefits can be multiplied by 2.50 to obtain the OMA suggested fee for the service.

²⁴ Please refer to CPSO 'Dispensing Drugs Policy' (<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Dispensing-Drugs>) for additional details on the College's expectations of physicians who dispense drugs. Note that physicians have an obligation to advise patients of alternatives to the types of drugs, or other substances, that are being prepared or provided to the patient for a fee by the physician, if such alternatives exist. This may also extend to informing patients about services or mechanisms, such as Ontario Drug Benefit Plan, that are available to patients and may reduce or eliminate the patient's costs. Physicians should issue receipts in such circumstances.

²⁵ An explanation on how the annual adjustments to the multiplier and the suggested fees for uninsured services is on the OMA website: <https://www.oma.org/member/practice-professional-support/billing/billing-fee-codes/billing-for-uninsured-services/>

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2. Establish an Hourly Rate

In the absence of a specific fee recommendation for an uninsured service, physicians can consider establishing an hourly rate to assist in determining the appropriate fee. Given the diversity of physician practices and nature of uninsured services provided, the OMA does not have a suggested hourly rate. As such, it is incumbent upon the physician to establish their own hourly rate.

The OMA does not recommend a standard, suggested hourly rate that applies to all physicians.

The following **example**²⁶ illustrates one way to determine an hourly rate based on an individual’s gross annual income. A possible source for annual gross income could be from your annual income tax statement.

	Item	Calculation
A	Annual gross earnings: Annual gross OHIP payments (e.g. FFS, primary care, Specialist AFA/AFP models): Annual income from other sources (e.g., WSIB, stipends, salaries, alternate funding arrangements) Other annual income (e.g., uninsured third party billings) Total annual gross earnings:	\$310,000 \$25,000 \$25,000 \$360,000
B	Working days per year: (52 weeks x 5 days/week less 25 days of vacation and 10 statutory holidays)	225
C	Hours of work per day	9
D [=B x C]	Annual paid hours: (225 days x 9 hours/day)	2,025
E [=A / D]	Hourly rate: (\$360,000/2,025 hours)	\$177.78
F	Hourly rate – adjusted by OMA multiplier (2.50) (\$177.78 x 2.50)	\$445

Another **example** of determining an hourly rate is to use an average day’s income divided by the hours worked.

²⁶ All figures used in the example are for illustration purposes only; members using this methodology should modify accordingly to reflect their average income, workday, working days/year, etc.

III. SUGGESTED FEES FOR UNINSURED SERVICES

The examples cited in this *Guide* do not take the following into account: a physician's training, experience, expertise, medico-legal and personal risks, plus opportunity costs, among other factors which could increase the complexity of the work.

In establishing an hourly rate, physicians are free to use a methodology of their choice and are not limited to the examples in this Guide.

While the OMA does not have a standard, suggested hourly rate, physicians are advised that it is important to consider whether the rate being charged is excessive. It is considered professional misconduct to charge a fee that is excessive in relation to the services being provided.²⁷

Physician Remuneration for Meetings and Committee Work

In situations where physicians are participating in meetings and/or Committee work for agencies and organizations, conducted outside of their routine practice, physicians can use their discretion in deciding rates for remuneration. Note that hospital by-laws or employment contracts may contain a requirement for physician participation and/or prevent such billing.

If looking for specific suggestions, physicians could use their hourly rate or the OMA's honoraria policy²⁸ as a guideline.

Refer to [Appendix II](#) for a sample letter and invoice physicians can use when collecting payment for these activities.

²⁷ (Section 21, Ontario Regulation 856/93); <https://www.ontario.ca/laws/regulation/930856>

²⁸ <https://www.oma.org/uploadedfiles/oma/media/member/membermappedpdfs/your-association/2020-financial-matters-policy.pdf>

III. SUGGESTED FEES FOR UNINSURED SERVICES

Suggested Charges for Providing Copies of Medical Records

General Information

The provision of copies of patient medical records to the patient or third party is an uninsured service. Physicians cannot charge a fee for providing copies of medical records, unless they first give the individual an estimate of the fee that will be charged.²⁹

Note that copies of medical records should only be provided to a third party such as a lawyer or insurance company with the necessary authorization. This may include consent from the patient or the patient's representative, a Court Order, or where required or permitted by law.

Refer to [Appendix II](#) for a sample letter to the patient informing them of the applicable fee charges.

Throughout this section, please keep in mind it refers only to the copy and transfer of medical records.

Cost of the Provision of the Copy of Medical Records

Several cases decided before the Information Privacy Commissioner (IPC) have held that physicians may charge **\$30 for the first 20 pages and \$0.25 per page thereafter** (which includes the first 15 minutes of professional review) for the reasonable cost of copying, printing, reproducing or transmitting medical records, including electronic medical records (EMR), when the EMR (or portions of) are printed on paper. All other record reproduction methods should be charged for at cost.

This amount quoted above includes clerical labour costs, equipment lease or amortization costs, print volume fees, toner and paper costs, secure electronic storage media costs, equipment maintenance costs, office lease costs for equipment, secure record storage space and other costs of a similar nature. It also includes postage by regular mail.

When the record can be transferred without any associated cost via secure email or other electronic transfer, the fee recommended by the IPC is **\$30.00**. The OMA recommends that all record transfer be done electronically wherever possible. Alternatively, the records may be posted by regular mail marked confidential on the envelope; sent by secure fax; or handed directly to the patient or their legal representative. If the physician and patient agree to another method of transfer—for example, courier—the physician may charge the patient at cost.

As indicated above, this refers only to the copy and transfer of medical records at the request of the patient and/or a third party.

²⁹ *Personal Health Information Protection Act*, s.54(10).

III. SUGGESTED FEES FOR UNINSURED SERVICES

Professional Review of the Medical Record

It is recommended that the physician review the patient's medical records before providing copies. This allows the physician to pull the relevant portions of the chart to fulfill the request and avoid providing any records that are unnecessary or put the patient's privacy at risk. This is especially important when the record is being released to a third party such as an insurance company. A review also permits the physician to ensure there is no sensitive third-party information contained within the record, and that the record does not require any updates in the form of late entries. Reviewing the record helps the physician avoid potential complaints with the CPSO; however, it is not required by law.

If the patient's charts include services of a psychiatric nature, the physician should exercise especial diligence when reviewing the information prior to providing a copy. Given the unique, intimate and sensitive nature of psychiatric records, this may entail above-average time on the part of the physician. Further, a physician may refuse to provide a copy of all or portions of a medical record if he or she is of the opinion that access to those portions of the medical record could reasonably be expected to,

- result in a risk of serious harm to the treatment or recovery of the patient or a risk of serious bodily harm to the patient or another person,
- lead to the identification of a person who was required by law to provide information in the record to the physician, or
- lead to the identification of a person who provided information in the record to the physician explicitly or implicitly in confidence if the physician considers it appropriate in the circumstances that the identity of the person be kept confidential.³⁰

Any review of a record should be documented and properly docketed. In other words, the physician should explain what they reviewed the record for, any findings or concerns, and how much time was spent. The manner in which a physician is permitted to charge for this review is outlined below.

The Role of the Information and Privacy Commissioner (IPC) on Fees Charged

In the past, the OMA recommended physicians charge for out-of-pocket disbursements (at cost) and the professional review of the medical record (at the physician's own hourly rate) in addition to the costs for copying or reproducing the record.

The IPC does not support these additional charges.

The OMA strongly disagrees with the IPC and believes that the review of the record is significant work that should be appropriately remunerated. A fee of \$30 which includes 15 minutes of professional review with sufficient risk involved in charging for additional professional review time, is insufficient and

³⁰ Personal Health Information Protection Act, s.52(1)(e).

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unacceptable. However, the OMA has challenged this before adjudicators of the IPC and all challenges were unsuccessful. The OMA continues to advocate for physicians on this matter.

Under PHIPA, it is *possible* for a physician to request additional fees for review above and beyond 15 minutes **if the other party is informed ahead of time and agrees**. However, if the other party does not agree, the matter would need to be escalated to the IPC for review; in the interim, the physician risks a complaint to the CPSO if they fail to turn over the record.

The OMA recommends the following approach:

- Prior to reviewing the record, submit an invoice that includes review past the first 15 minutes **if needed**. Ensure this review is carefully documented in terms of docketed time; if possible, use the audit logs in an electronic medical record to docket. The IPC recommends a fee of \$45 per additional 15 minutes³¹ which the OMA strongly suggests physicians adhere to in order to avoid triggering an IPC complaint. However, if agreed upon, a physician is not prohibited from charging their hourly rate. This should be documented in writing.
- If the party refuses to pay the amount invoiced, the physician can consider what is reasonable and what the party is able to pay. If the physician believes the amount to be fair and reasonable, and the other party refuses to pay, the matter may be escalated to the IPC. In such a case, we recommend contacting OMA Legal or another legal representative.

As indicated above, these recommendations speak only to review for the purpose of copying and transferring medical records. Reviewing records for other purposes is outside of scope for this section. Reviewing records for other purposes—for example, professional consultation—is addressed on page 14 of this Guide.

³¹ The rate of \$45 per 15 minutes of professional review is related solely to the review required to release copies of medical records and that this limitation does not apply to any professional review of records that might be necessary for the preparation of third party reports, which may be billed at the physician's hourly rate, as outlined on page 14.

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Transfer of Medical Records at Patient Request

General Information

Generally speaking, physicians must always keep the original copies of their medical records.³² Only copies of the records should be transferred to others. When charging fees for the transfer of medical records, patients must be informed, in advance, that this is an uninsured service (not insured by OHIP) and given an estimate of the cost of the transfer.

Sometimes a physician may be of the opinion that a copy of the patient's entire chart is not necessary. For example, it contains information that is of nominal value, is out-dated or is no longer relevant, to the patient's current medical condition. In this situation, the physician may suggest to cull the unnecessary information from the chart. If agreed to, the physician may charge a professional fee for his or her review and culling of the patient's medical records. Consent of both the patient and the receiving physician are required when preparing a summary of the records rather than providing a copy of the whole record.

Prepayment of the fee for transfer of medical records may be requested when, in the best judgement of the treating physician, the patient's health and safety will not be put at risk if the records are not transferred. For additional information, refer to the CPSO's policy statement on Medical Records.³³

Refer to [Appendix II](#) for a sample letter to the patient informing them of the applicable fee charges.

Physician Relocation/Closing of Practice: Transfer of Medical Records

When a physician relocates or closes a practice, patients should be contacted to determine if they wish to have their records transferred elsewhere. In instances where patients ask for transfer to a specific location, there can be a charge for the transfer of records. In situations where departing physicians transfer all records to a new practice, there should be no charge to patients unless the patients contact the new practice to request that copies of the records be transferred to a different physician of their choice.

Immunization as an Uninsured Service

Immunization for communicable diseases endemic to Canada is considered an insured service whereas immunization rendered solely for the purpose of travel is not an insured service. Pre-departure travel medicine services rendered solely for the purpose of travel outside Canada are not covered by OHIP. This includes assessments, counselling or administration of vaccines or drugs for prevention of

³² See s.19, O. Reg. 114/94 under the *Medicine Act*.

³³ <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Medical-Records>

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communicable diseases not endemic to Canada. In addition, the cost of the drugs/vaccine in these cases is billable to the patient directly.³⁴ Additional information on immunization and other services relating to travel outside Canada can be found in Education and Prevention Committee (EPC) Interpretive Bulletin, Volume 5, No.1.³⁵

Immunization and TB Mantoux Testing

Whether immunization and TB Mantoux testing for proof of immunization status are insured or not is dependent upon the purpose for the test. Likewise, the applicable fees billable are dependent upon the service(s) rendered.³⁶ There are four general categories of immunization/TB testing requests for proof of immunization status:

1. If a Ministry of Health program requests an immunization/TB test and completion of a form/report (e.g., Public Health Department requests a TB test), then both the test and completion of the form/report cannot be billed to the patient. However, the appropriate OHIP fees can be billed to OHIP, such as the applicable assessment and immunization test fees. For a TB test, this may include A001 or A007 for the visit/assessment and G372 for the injection or G373 if the test is the sole reason for the visit.³⁷
2. If an immunization/TB test is requested by a patient for admission or continuation in a day care or pre-school program or a school, community college, university or other educational institution or program as evidence of immunization status, or the test is required to satisfy a condition of being admitted to a Long Term Care facility, then the test and completion of an immunization status form/report are insured by OHIP. This includes situations where a student requires a test for a work placement (e.g. co-op program, internship, etc.) and is a required component of the student's curriculum.

For insured tests, publicly-funded tuberculin skin test solution (brand name: Tubersol®), used to administer the TB skin test, can be acquired through local public health units.

³⁴ Ministry of Health, OHIP Bulletin # 4317, July 30, 1998;
<http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4317/bul4317b.aspx>

³⁵ https://www.oma.org/uploadedfiles/oma/media/public/0501epc_bulletin.pdf

³⁶ Refer to the OHIP Schedule of Benefits for fees and the associated payment rules. If a physician is billing on an uninsured basis, refer to page 13 of this Guide for additional information on calculating fees for uninsured clinical services.

³⁷ When the patient returns for a second visit in order for the physician to assess any possible skin reaction, the fee for this interpretation is included in the previously claimed G372 or G373 code.

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3. If a physician determines that an immunization/TB test is medically necessary and the service is received wholly or partly for the production or completion of a document or the transmission of information that relates to any of the circumstances below³⁸, then the TB test is insured. The immunization form/report is not insured.

- The receipt of disability or sickness benefits or the satisfaction of a condition relating to the disability or sickness benefits;
- Return to a day care or pre-school program, after a temporary absence;
- A condition relating to the fitness to continue employment other than a condition that requires an examination or assessment to be conducted on an annual or other periodic basis;
- An absence from or return to work;
- Legal proceedings.

Unless for travel purposes, the administration of a vaccine is an insured service, even if the vaccine is not publicly funded.

4. If an immunization/TB test is requested solely for employment purposes (requested solely as a condition for obtaining employment or required by an employer on a periodic basis), then the test and the completion of the form/report is uninsured and can be billed to the patient or third party.

Tubersol provided by the government is for insured tests and not to be used for uninsured TB tests.³⁹ When uninsured testing is performed, Tubersol should be either acquired by the physician or sold to the patient at a direct cost with reasonable mark-up⁴⁰ or acquired by the patient from the pharmacy, via prescription provided by the physician. For additional information on when it is appropriate to bill OHIP for immunization and TB testing, consult the HIA, Reg. 552, s. 24 (1), 24(1.1) and 24(1.2)⁴¹ and OHIP Bulletin #4692 Tuberculosis (TB) skin test.⁴²

³⁸ As per section 24(1.2) of Regulation 552 under the Health Insurance Act

³⁹ The Ministry's Population and Public Health Division is currently undertaking a review of the guidelines pertaining to the use of publicly funded Tubersol. Note that this information is subject to change.

⁴⁰ Reasonable mark-up should account for any indirect costs (e.g., storage, administrative, etc.).

⁴¹ <https://www.ontario.ca/laws/regulation/900552#BK9>

⁴² <http://www.health.gov.on.ca/en/pro/programs/ohip/bulletins/4000/bul4692.pdf>

III. SUGGESTED FEES FOR UNINSURED SERVICES

Patient Ability/Fitness to Operate Motor Vehicle

In Ontario, all drivers are required to meet basic medical and vision standards to operate a motor vehicle. This may result in requests from the Ministry of Transportation (MOT), via the patient, for a physician to provide a medical assessment, vision assessment, medical report and/or the completion of forms. The list below represents services that might be requested.

If the services requested are required as evidence of disability so that the patient can be eligible for a benefit related to transportation (under any legislation, program or government), then the services are insured (including any necessary assessment), and the patient cannot be charged.⁴³

Example: A physician renders a general assessment and urinalysis in order to complete the drivers medical examination form. The OMA suggested fee is \$211.15 + \$5.35 + \$65.00 = \$281.50.

Forms:		2022 OMA Fee
	Drivers medical examination form	\$65.00
Assessments:		
A007	Intermediate Assessment	\$92.15
A003	General Assessment	\$211.15
Axxx	Medical Specific Assessment	Fees vary
Axxx	Partial Assessment	Fees vary
A233	Ophthalmology Specific Assessment	\$144.25
Visual assessments:		
A110 / A112	Periodic oculo-visual assessment (by a General/Family practitioner)	\$122.25
A115	Major eye examination	\$127.75
A237 / A239	Periodic oculo-visual assessment (by an Ophthalmologist)	\$141.50
G814	Orthoptic examination	\$62.50
Other services:		
G857	Visual fields - kinetic (with permanent record) – technical component	\$11.40
G436	Visual fields - kinetic (with permanent record) – professional component	\$36.25
G858	Visual fields – static – technical component	\$34.40
G432	Visual fields – static – professional component	\$67.40
G010	Urinalysis – without microscopy	\$5.35

The completion of any associated forms or reports (including follow-up forms/reports) would be an additional charge and it is recommended that physicians use their own hourly rate to determine the fee.

⁴³ s.24(1), (1.1) paragraph 3(viii), O. Reg. 552 under the Health Insurance Act; <https://www.ontario.ca/laws/regulation/900552#BK9>

III. SUGGESTED FEES FOR UNINSURED SERVICES

Other Uninsured Services

The following services are not insured benefits of OHIP and may be billed directly to patients. This list is not exhaustive. In addition to the services listed below, any service provided by a physician, laboratory or hospital that supports an uninsured service is not an insured benefit. No claims to OHIP should be made for consultations, assessments, counselling, diagnostic investigations (e.g., ultrasound, laboratory tests), et al. that are in support of an uninsured service such as cosmetic surgery, reversal of sterilization, uninsured in vitro fertilization, etc.

Note: Travelling time and mileage charges⁴⁴ are not insured and may be charged directly to patients when visits are made by **physicians to see patients outside their normal area of practice.** This is defined as the greater of either 8 kilometres or 15 minutes in one direction, from a physician's usual location of practice.

The suggested fee for uninsured travel is \$75 per 30 minutes (\$150/hour), plus mileage at the CRA reasonable per-km allowance.

Consultations and Assessments - Family Practice and Practice in General

Patient interview for practice admission **\$110.00**

(Note: patient interview refers to a patient conducted interview of a physician)

Dispensing service fee⁴⁵ **\$17.50**

(The dispensing service fee is not intended to apply to the provision of drug samples to patients but only where there is a recorded purchase of a supply of drugs)

Certification of incompetence (financial) including assessment to determine incompetence **\$331.00**

Consultations and Assessments - Paediatrics

Pre-adoption examination and evaluation for Children's Aid Society **\$237.00**

⁴⁴ It is recommended that the mileage charges are based on the CRA reasonable per-kilometre allowance: <https://www.canada.ca/en/revenue-agency/services/tax/businesses/topics/payroll/benefits-allowances/automobile/automobile-motor-vehicle-allowances/reasonable-kilometre-allowance.html>

⁴⁵ Refer to CPSO 'Dispensing Drugs Policy' (<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Dispensing-Drugs>) for additional details on the College's expectations of physicians who dispense drugs. Note that physicians have an obligation to advise patients of alternatives to the types of drugs, or other substances, that are being prepared or provided to the patient for a fee by the physician, if such alternatives exist. This may also extend to informing patients about services or mechanisms, such as Ontario Drug Benefit Plan, that are available to patients and may reduce or eliminate the patient's costs. Physicians should issue receipts in such circumstances.

III. SUGGESTED FEES FOR UNINSURED SERVICES

Consultations and Assessments - Psychiatry

Specific assessment with report to referring agency	\$362.00
Therapeutic supervision with any paramedical organization (health education, correction and other community resources)	\$345.00
Appearance before Advisory Review Board or Review Board – per ½ hour or major part thereof	\$181.00
Certification of incompetence (financial) including assessment to determine incompetence	\$331.00
Preparation and attendance at Board of Review (plus \$90.14 per half hour in addition for time in excess of three hours)	\$1090.00
Completion of forms/procedures dictated by the Mental Health Act	Independent Consideration
Certification procedures regarding management of estate	Independent Consideration

The Role of the Primary Care Physician in Timely Return to Work

In some situations, the physician may assume the role of the Timely Return to Work (TRTW) coordinator for the provision of services associated with a timely return to work program for the individual employee. The TRTW coordinator works with the employer and the employee/patient to assist in developing and overseeing a timely return work program that is individualized to the employee and meets the requirements of the employer.

The TRTW coordinator assumes the primary responsibility for compiling medical information together with the employee's workplace and job functions information, to provide advice concerning the limitations, restrictions and modifications that may be necessary to accommodate the employee in a timely return to work program. This role might also include a review of the workplace policies and collective agreements to which the employee may have agreed and/or a detailed review of the pre-morbid work history (e.g., chronic absenteeism, difficulty with co-workers).

Physicians assuming the role of TRTW Coordinator should bill the requesting third party based on the physician's established hourly rate, or in some other manner, provided that the rate to be charged to the employer is agreed upon in advance. [Appendix III](#) contains a summary of recommendations from the OMA's policy paper "The Role of the Primary Care Physician in Timely Return to Work".⁴⁶

⁴⁶ <https://www.oma.org/uploadedfiles/oma/media/member/membermappedpdfs/practice-professional-support/primary-care/timely-return-to-work-2008-primary-care.pdf/>

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

The following list represents a sample of forms that exist in the public domain. The suggested rates are based on the average time and complexity of completing a typical form. As such, physicians may use their discretion in adjusting the fee charged on a case by case basis to better reflect the time and complexity of completing an individual form. For example, the fee charged may be based on the physician's hourly rate.

For third party requested forms or reports, an appropriate assessment fee may be charged in addition to the fee charged for completion of the form/report, when the assessment is not medically necessary.

Uninsured Report Forms	Suggested Fee (For form only)
Completion of forms associated with patient physicals:	
Schools/Camps	\$31.50
Admission to day-care, preschool, university (including out of province and international universities)	\$31.50
Pre-employment certification of fitness/fitness clubs	\$42.00
Hospital/Nursing home employees	\$42.00
Completion of licensing forms/certificates:	
Drivers medical examination form	\$65.00
Civil aviation medical examination report 26-0010E(001004)	Physician's hourly rate
Sick notes and other work or school related forms/notes	
Sick notes (includes return to work/school notes)	\$22.00
Fitness to work notes ⁴⁷	Independent Consideration
Certificate of freedom from communicable disease	\$22.00
Other forms/certificates;	
CRA Disability Tax Credit Certificate (form T2201)	\$83.00
Children's Aid Society (CAS) application for prospective foster parent	\$65.00
Medical certificate employment insurance sickness benefits INS5140	\$44.00
Miscellaneous insurance forms:	
Travel cancellation insurance form	\$42.75
Life insurance death certificate	\$54.00
Medical certificate for employment insurance compassionate care benefits	\$62.00

⁴⁷ The fee for a "sick note \$22.00" above is intended to be a brief note. Fitness to work represents a more comprehensive service that might require a detailed explanation about a patient's current capabilities and ongoing management, in the context of being fit for employment.

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

The following forms are specific to Statutory Accident Benefits Schedule claims. **An appropriate assessment fee may be charged** in addition to the insurance form/certificate fee when an assessment is necessary to obtain relevant information needed to complete the insurance form/certificate.

Uninsured Report Forms	Suggested Fee
Statutory Accident Benefits Schedule claims.	
OCF-3 Disability Certificate	\$160.00
OCF-18 Treatment Plan	\$160.00
OCF-19 Determination of Catastrophic Impairment	\$132.00
OCF-23 Treatment Confirmation	\$159.00

The Financial Commission of Ontario's (FSCO) "Professional Services Guideline"⁴⁸ outlines the maximum expenses payable by automobile insurers under the Statutory Accident Benefits Schedule (SABS) for the services provided by health care professionals/providers listed in the Guideline. The SABS Guideline **does not apply to physicians** (physicians were excluded from the Guideline). Therefore, the amounts payable are to be determined and agreed to by both parties involved and are not subject to the maximum rates listed in the Guideline.

Life and Health Insurance Report and Assessment Fees

Several versions of life and health insurance forms exist, originating from different sources/insurance companies. Where members' fees are expected to vary from the suggested fee listed below, it is recommended that members communicate this to the insurance companies prior to providing the service.

Reports and Assessments	Suggested Fee
Attending Physician's Statement	\$160.00
System-Specific or Disease Specific Questionnaire	\$107.00
System-Specific Examination	\$129.00
Insurance Medical Examination	\$260.00
Clarification Report	\$429.00/hour
Full Narrative Report	\$429.00/hour
Independent Medical Examination	Independent Consideration

Refer to [Appendix IV](#) for a general description of these services and whether an examination/assessment is recommended in order to complete the form/report.

⁴⁸ <https://www.fSCO.gov.on.ca/en/auto/autobulletins/2014/Documents/a-08-14-1.pdf>

IV. SUGGESTED FEES FOR UNINSURED REPORTS AND FORMS

Canada Pension Plan (CPP) Forms

CPP form fees are paid by Service Canada as per the amounts listed below. The physician's hourly rate can be used when balance billing for CPP forms/services.

Service Canada will pay up to \$85.00 for the Medical Report for CPP Disability Benefit and up to \$150.00 for the Narrative Medical Report. If a physician's fees are higher, then patients are responsible for covering any extra costs.

There are two distinctly different types of CPP forms the federal government will pay for:

- (i) **Medical Report for a CPP Disability Benefit (SCISP-2519) (up to) \$85.00**
- (ii) **The Narrative Medical Report (up to) \$150.00**

The Narrative Medical Reports are usually initiated by correspondence from staff at the Income Securities Branch of Human Resources and Skills Development Canada.

The narrative reports require:

- Medical history
- The date of onset of each medical condition
- An examination of findings
- Various excerpts of consultation reports (including identification of consultants)
- Diagnosis
- Copies of test results
- Prognosis
- Course of future action

Upon receipt of a physician's invoice and confirmation that the individual concerned has submitted an application, Service Canada will reimburse **up to**:

- \$85 for the Initial Medical Report (ISP2519);
- \$85 for the Terminal Illness Medical Attestation for a Disability Benefit under the Canada Pension Plan (ISP2530B)
- \$25 for the Reassessment Medical Report (ISP2509);
- \$50 for the Scannable Impairment Evaluation (IMPAIR);
- \$25 for the Medical Report – Recurrence of the Same Medical Problem (ISP2525); and
- \$150 if Service Canada medical adjudicators request other information in the form of a narrative report (depending on complexity and time required for completion).

Patients are responsible for covering any extra costs. Fees outlined in this Section are set in consultation with the Canadian Medical Association and are subject to change. Occasionally, physicians may be requested to provide independent medical consultations or functional capacity evaluations during the initial application process, or when determining eligibility. Specialists or functional capacity evaluation facilities are paid directly for these examinations. For additional information, contact Service Canada at 1.800.277.9914 or review the Frequently Asked Questions on the Service Canada website.⁴⁹

⁴⁹ <http://www.servicecanada.gc.ca/eng/services/pensions/cpp/disability/benefit/health-prof.shtml>

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Unremunerated Report Forms

There are a number of exemptions when charging for the completion of a third party report form. The following list contains some of the common forms that a physician is **not** permitted to charge for its completion⁵⁰:

- Application for Accessible Parking Permit
- Accessible Transit Eligibility Application forms
- Children's Aid Society Forms (on behalf of a child)
- Canadian Passport Application⁵¹
- Ministry of Health Forms (e.g., Assistive Devices, etc.)⁵²

Reports Requested by Employers and Other Issues Related to Workplace Safety & Insurance

Workplace Safety & Insurance Board (WSIB)

Injuries that arise out of and in the course of the patient's employment are insured by WSIB⁵³ and not OHIP. OHIP processes these claims on behalf of WSIB. When a patient claims WSIB benefits, the physician must provide the Board such information relating to the patient as the Board may require.⁵⁴ For a list of the WSIB report forms and their associated fees, contact WSIB⁵⁵.

Sometimes patients elect to not claim WSIB benefits and ask their physicians to not report the work-related injuries to the WSIB and to bill their services to OHIP. When this occurs, physicians must respect their patient's request and not report the injury to WSIB, but refuse to bill their medical services to OHIP.

If a patient does not want to report their injury to WSIB, the patient is responsible for the cost of their medical services. Physicians cannot bill these services to OHIP.

⁵⁰ Section 24, Regulation 552 of the *Health Insurance Act*; please refer to: http://www.e-laws.gov.on.ca/html/regis/english/elaws_regs_900552_e.htm

⁵¹ Physicians are not obligated to serve as guarantors. Patients requesting a physician to be a guarantor should be made aware that the form 'Statutory Declaration in Lieu of Guarantor' is available for persons without an eligible guarantor.

⁵² Some exceptions apply when a specific code is listed in the OHIP Schedule of Benefits (i.e.: Home Care Application Fees [K070, K071, K072], Northern Health Travel Grant Application Form [K036], Ontario Hep. C Assistance forms [K026, K027], Long-Term Care Application Form [K038], etc.).

⁵³ Section 13, *Workplace Safety and Insurance Act*.

⁵⁴ Section 37(1), *Workplace Safety and Insurance Act*.

⁵⁵ www.wsib.on.ca

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Physicians cannot report workplace injuries to the WSIB unless the patient is claiming benefits from WSIB⁵⁶ or the patient consents to such a report being made. Disclosing patient information without statutory authorization or the patient's consent is professional misconduct under the *Medicine Act* and a violation of the *Personal Health Information Protection Act*.

All medical services that a patient "is entitled to claim from WSIB" (regardless of whether the patient "claims" such benefits) are "not insured" by OHIP.⁵⁷ All medical services for injuries arising out of and in the course of the patient's employment may not be billed to OHIP. Hence, these are **uninsured services which must be billed to the patient directly**.

If a patient does not want to claim WSIB benefits, they are not required to report their injuries to the WSIB. Physicians cannot report workplace injuries without the patient's consent.

Employer-Specific Forms for Worker Injuries

The injured patient or the employer may request the physician complete the WSIB's Functional Abilities Form (FAF). Physicians are required by the WSIB Act to complete the FAF on request of either the patient or the employer.⁵⁸ The patient's consent is not required to provide the FAF at the employer's request. The fee for the completion of this form is charged to the WSIB.

Sometimes employers ask that the worker's physician provide a report or complete a different form relating to the worker's ability to early return to work or modified return to work. These forms are not to be confused with the WSIB's FAF form. To complete such a report or other form, the **patient's consent is required**. Completion of such forms and any related assessments and/or tests is an uninsured service and should be charged to the patient or, where the request is made directly by the employer, to the employer.

⁵⁶ Authorized by s.37(1) of the *Workplace Safety and Insurance Act*.

⁵⁷ Section 11.2(2) *Health Insurance Act*.

⁵⁸ Section 37(3).

V. INTERPROVINCIAL RECIPROCAL BILLING

The Reciprocal Medical Billing System (RMBS) may be used to bill for services rendered by physicians or private medical labs to a patient insured under another Canadian provincial health coverage plan, **excluding Quebec.**

The arrangement allows Ontario physicians who voluntarily participate to bill OHIP directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan. Participation is voluntary; physicians who do not wish to participate in this arrangement are free to bill the patient directly using the OMA suggested fees.⁵⁹ Participating physicians will receive payment at the OHIP Schedule of Benefits rates and must accept the payment as payment in full.

Patients without a valid health card

If the out-of-province patient does not present a valid health card, the patient should be considered uninsured and billed directly for services. In these situations, it is acceptable to bill using the OMA suggested fees.

Patients from Quebec

Physicians are advised to bill Quebec patients directly using the OMA suggested fees.

Excluded Services

There are services that are excluded from the reciprocal agreement (but are not necessarily OHIP benefits) that should be billed directly to the non-resident patient. A listing of these services can be found in the OHIP Online Resource Manual for Physicians (Section 4, pages 4-7 - 4-8).⁶⁰

Claims Submissions

If a physician chooses not to bill a patient directly, claims can be made electronically through the RMBS. Instructions on how to submit electronic reciprocal claims can be found in the OHIP Online Resource Manual for Physicians (Section 4, pages 4-6 - 4-8). Physicians who do not submit through the RMBS and bill the ministry directly must complete and submit the standard “Out of Province Claim for Physician Services” form (0000-80).⁶¹ This form is also used for claims for residents of Quebec and for RMB excluded services that are OHIP benefits. In the event a physician cannot bill a patient directly for services or through RMBS, this form can be sent to the patient’s home province to obtain payment.

Options to submit claims for patients under another Canadian provincial health plan:

- **Bill the patient directly using OMA rates; or**
- **Submit electronically via RMBS using OHIP rates (excludes Quebec patients); or**
- **Submit a claim to the Ministry using Form 0000-80.**

⁵⁹ The decision to participate in the reciprocal billing arrangement can be made on a case-by-case basis.

⁶⁰ http://www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html

⁶¹ <http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?openform&ENV=WWE&NO=014-0000-80>

VI. BILLING FOR REFUGEES: INTERIM FEDERAL HEALTH PROGRAM

The **Interim Federal Health Program (IFHP)** provides limited, temporary coverage of costs related to health care for specific categories of people, including protected persons, refugee claimants, rejected refugee claimants and other specific groups. The IFHP provides several types of coverage:

- Health care coverage;
- Expanded health care coverage;
- Public health or public safety health care coverage;
- Coverage for persons detained under the Immigration and Refugee Protection Act (IRPA); and
- Coverage of the cost for immigration medical examinations

The program is funded by Citizenship and Immigration Canada (CIC) and administered by Medavie Blue Cross. **Physicians are reimbursed at OHIP rates.**

Health care providers are required to verify patients' IFHP eligibility (which includes the patient's coverage type and the service requested) with Medavie Blue Cross before providing the service because the patient's eligibility may cease or coverage can be modified without notice should their immigration status change. A date printed in the 'valid until' date field of the patient's Interim Federal Health Certificate of Eligibility is not significant proof of eligibility.

For additional information about the IFHP, types of coverage and how to register as a provider, refer to the IFHP Provider Portal⁶².

General inquiries re: IFHP can be made directly to Medavie Blue Cross:

By email: CIC_Inquiry@medavie.bluecross.ca

By phone: 1.888.614.1880

Physicians are not required to participate in the Interim Federal Health Program. If choosing to participate, physicians are not permitted to bill the patients directly.

⁶² <https://www.medaviebc.ca/en/health-professionals>

VII. MEDICAL-LEGAL ACTIVITIES

The Preparation of Medical-Legal Reports

Medical-legal reports are essential to the legal process of adjudicating claims for personal injury. A well prepared medical-legal report will contribute significantly to the proper and just resolution of a claim for personal injury, expedite the process, reduce cost and frequently obviate the necessity of a court appearance by the physician.

Confidentiality

Given that the relationship between a patient and a physician is one of highest confidentiality, a physician should insist on being provided with a valid and adequate written consent to the release of medical information. The CPSO states in its policy on Third Party Reports that the physician is responsible for obtaining the patient's consent to disclose personal health information to third parties such as lawyers.⁶³ Therefore, physicians should confirm consent with patients whose representatives request medico-legal reports or other personal health information. The CPSO strongly advises physicians to document that consent has been obtained.

Physicians as Witnesses

Non-Treating (Retained) Physicians: Expert Witnesses

Non-treating physicians are often approached by lawyers or the Crown to testify as an expert witness and usually have never seen the patient prior to being contacted. After agreeing to act in such a capacity, physicians may examine the patient so as to establish an expert opinion regarding matters such as the patient's injuries or standards of previously provided medical care. The fees payable to an expert witness are a matter for negotiation between the expert witness and the lawyer seeking the expertise. In addition to a compensation arrangement for time spent in the courtroom, **physicians should not neglect to agree on a fee, in advance, for reports that may be produced as well as travel time and other expenses incurred in the process of acting as expert witnesses. Whenever possible, it is recommended that physicians seek agreement on their fees in writing.**

A non-treating physician is under no obligation to agree to act as an expert witness. The expert witness will rarely receive a subpoena or summons to attend in court since he or she has agreed to act as an expert in advance, and has secured satisfactory remuneration for this expertise. When testifying in court, the expert witness is usually given a set of facts, which closely resemble the actual case, and is then asked hypothetical questions based on those facts. The expert witness will provide a professional opinion based on the examination of the patient, the medical records, and knowledge of similar previous cases.

⁶³ CPSO Third Party Reports policy: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Third-Party-Medical-Reports>

VII. MEDICAL-LEGAL ACTIVITIES

- **Fees for Civil Lawsuits or Administrative Bodies**

In these lawsuits, an expert's fees are a matter of negotiation between the expert and the lawyer for a party. The only limit is that these fees not be excessive in relation to the services provided by the expert witness.

- **Fees for Expert Witnesses in Criminal Cases**

In these lawsuits, expert witness fees are a matter of agreement between the expert witness and the Crown attorney or defense lawyer. Experts are paid in accordance with a predetermined schedule of fees set by the Ministry of the Attorney General. However, there is nothing that prevents expert witnesses from seeking reimbursement above these amounts.⁶⁴

Treating Physicians

Treating physicians will typically be served with a subpoena or a Summons to Witness to appear in court or before an administrative body and would be subject to arrest, detention, and ordered to pay costs that have arisen for failing to attend if properly served. A physician may only be excused from responding to a summons if ordered so by the presiding judge. The court will only excuse or adjourn the attendance date of a witness for drastic reasons, such as serious illness of the physician, a death in the immediate family, or absence from the country. The physician must have a representative attend in court to explain the absence and the particular circumstances, or have received prior approval not to attend from the party that subpoenaed the physician. Previously scheduled surgical obligations or appointments will generally not be viewed by a court as a reason to excuse a physician.

The party who issued the summons to the treating physician to testify in court is only obliged to pay the physician the daily attendance fee in accordance to the rules that regulate the procedures of that particular trial or hearing, such as the Rules of Civil Procedure⁶⁵, The Family Law Rules, and the Interim Rules of Practice and Procedure of the Financial Services Commission of Ontario. The Tariff also lists the appropriate travel allowance, and the appropriate overnight accommodation and meal allowance, if applicable. Please note that the amounts listed in the Tariff may vary from year to year.

In the event a physician is served with a summons or subpoena, the physician should immediately contact the Canadian Medical Protective Association (CMPA) for advice as a matter of professional conduct.

⁶⁴ For more information, contact the Ministry of the Attorney General.

⁶⁵ <http://www.canlii.org/en/on/laws/regu/rro-1990-reg-194/latest/rro-1990-reg-194.html>

VII. MEDICAL-LEGAL ACTIVITIES

Attendance money actually paid to a witness who is entitled to attendance money, to be calculated as follows:

1. Attendance allowance for each day of necessary attendance: \$50

2. Travel allowance, where the hearing or examination is held,

(a) In a city or town in which the witness resides, \$3 for each day of necessary attendance;

(b) Within 300 kilometres of where the witness resides, 24¢ a kilometre each way between his or her residence and the place of hearing or examination;

(c) More than 300 kilometres from where the witness resides, the minimum return air fare plus 24¢ a kilometre each way from his or her residence to the airport and from the airport to the place of hearing or examination.

3. Overnight accommodation and meal allowance, where the witness resides elsewhere than the place of hearing or examination and is required to remain overnight, for each overnight stay: \$75

Treating physicians will often be called or summoned as witnesses where they were the first party to see or treat the patient. An example would be a case where a physician saw and treated a patient in the emergency room or was the patient's family doctor and was treating a particular injury or condition. The witness in these cases would generally be asked the facts about the treatment and/or prognosis regarding the patient's health.

There is no question that, occasionally, the boundary between a treating physician and a retained expert witness becomes blurred. In instances where a physician has provided ongoing care for a patient, a lawyer may request further examination and diagnostic testing as well as an extensive report and an opinion concerning the patient's recovery, in addition to testimony in court. Some of these services could be considered to be those of a retained expert witness.

In such cases, the physician should request compensation as an expert witness. The lawyer requesting such services may argue that these are matters inextricably linked to the witness role as the treating physician and refuse to pay. In these cases, the physician who has been previously served with a summons or subpoena is still legally obligated to attend court and provide all the relevant documentation and testimony. The physician should consult in advance with the particular lawyer requesting attendance in court in order to arrive at a mutually agreeable attendance fee. However, it must be pointed out that, in this case, it is conceivable that the physician may only receive the minimum payment (as stated above) for attendance in court. The physician would be entitled to payment for the production of any medical-legal reports prepared in the matter.

VIII. 2022 SCALE OF GRADING AND REMUNERATION

Effective January 1, 2022, the Scale of Remuneration for Salaried Physicians is as follows:

Classification of Salaried Physicians

Because of the variety of groupings used at federal, provincial and municipal levels, and in private industry, it has been felt wise to define the various levels as shown below. A level can then be fitted to the appropriate rank within the service or company.

Applicable to a physician who:

Level I

- ▶ Has a limited amount of postgraduate or practical experience.
- ▶ May be responsible to a more senior physician.
- ▶ Would be promotable to Level II as soon as the necessary experience and skills have been obtained.

Level II

- ▶ Has 2-5 years of postgraduate experience, including training or experience in the type of work involved.
- ▶ Has a position of responsibility which may involve supervision of the work of other health-care professionals.

Level III

- ▶ Has 5-10 years of postgraduate experience which could include (a) a higher qualification in a related specialty, or (b) approximately 5 years of training or experience in the particular field of work, or (c) at least 5 years of experience in the organization in which he or she is working.
- ▶ Usually has a supervisory position with either full-time or part-time health-care professionals and others working for him or her.
- ▶ May work independently because of the highly specialized kind of work being done.

Level IV

- ▶ Has greater responsibilities than those required for Level III.
- ▶ Has senior administrative and/or clinical responsibilities.

Level V

- ▶ Holds the most senior medical post in an organization or department, is responsible for all medical staff in the organization, and may have responsibility for other health-care professionals.
- ▶ Has senior administrative responsibility, up to and including the post of chief executive officer.

VIII. 2022 SCALE OF GRADING AND REMUNERATION

Salary Ranges

It is expected that annual increments would be made within the following ranges to reflect increased value to the employer and increases in the cost of living. The salaries quoted below are to be considered as exclusive of fringe benefits.

Level	Minimum
Level I	\$202,055
Level II	\$326,318
Level III	\$335,058
Level IV	\$350,064
Level V	\$397,117

Salaries should be modified under the following circumstances:

1. Where no provision is made for superannuation, the salary should be adjusted to compensate for this.
2. The possession of a specialist qualification (which is being utilized in the execution of the post) should be recognized by an additional sum over and above the figures quoted.
3. Regional variations in salary due to a special cost of living consideration should be recognized by an adjustment to the maximum rate.

Salaried physicians should be entitled to a minimum of the following: one month's vacation, one week leave for continuing education in addition to the vacation allowance, and 11 statutory holidays.

Employers should be encouraged to pay the membership fees necessary for a physician to remain in good standing with his or her profession (e.g., College of Physicians and Surgeons of Ontario, Canadian Medical Protective Association, Ontario Medical Association, Canadian Medical Association, etc.)

Part-Time Employment: (Industrial, Public Health, etc.) ...net per hour \$413⁶⁶

As a point of clarification, the Part-Time Employment rate of return represents a "net" rate, indicating that it is "net" of any expenses of practice or overhead costs that the physician might incur as a result of employment.

As responsibility and nature of the programs vary, there should be negotiation between the physician and the employing organization. The above figure is a recommended average rate.

⁶⁶ This figure is subject to an annual fee adjustment calculated using a methodology that was established in 2005 by the OMA's Central Tariff Committee and subsequently approved by OMA Council.

APPENDIX I: FREQUENTLY ASKED QUESTIONS

What is the OMA multiplier and how do I use it to determine a fee for an uninsured service?

The multiplier is a tool to convert an OHIP fee into an uninsured fee (also known as the OMA rate). The OHIP fees listed in the current OHIP Schedule of Benefits can be multiplied by 2.50 to obtain the rate that applies when the service/procedure is rendered on an uninsured basis.

A patient made an appointment for the purpose of having insurance forms completed. The insurance forms requested information on the patient's health status. In order for me to adequately comment on the patient's current health, I needed to assess the patient. Is the assessment billable to OHIP?

No, the assessment is not medically necessary because it was performed for the sole purpose of providing information to the insurance provider. The assessment should be billed to the insurance company, along with the fee for the form.

Converting OHIP rates to OMA rates:

A007 = \$36.85 (OHIP)

\$36.85 x 2.50 = \$92.125

Rounded up to the nickel = \$92.15

\$92.15 is the suggested fee for an intermediate assessment rendered on an uninsured basis.

What should I bill for an assessment that was rendered for the purposes of completing a third-party form?

In this case, the assessment is an uninsured service. The fee claimed will depend on the service rendered, similar to when physicians bill OHIP for an assessment. If the elements provided meet the requirements of a general assessment, then the suggested uninsured rate for A003 General Assessment is A003 \$84.45 x 2.50 = \$211.15 (\$211.13, rounded up to the nickel). To view the required elements for each level of assessment, refer to the OHIP Schedule of Benefits General Preamble, pages GP16 - GP39.⁶⁷

I was asked to complete a form for a patient and the form is not listed in this Guide. How much should I bill for this service?

If there is a form that does have a suggested fee, and that form is similar in length, complexity and/or effort as the form without a suggested fee, a physician could simply apply that rate to the form. Another option is to apply the physician's hourly rate to the service and use that as a guideline.

I have had patients who are insistent on having a Pap smear more frequently than every 33 months. Can the patient be billed for the Pap smears that are performed outside of the OHIP Schedule of Benefits guidelines? If so, how much should the patient be billed?

⁶⁷ http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

APPENDIX I: FREQUENTLY ASKED QUESTIONS

If the patient wants a Pap smear performed more frequently or for reasons not stipulated in the new OHIP Schedule of Benefits payment rules, then the service would not be covered by OHIP and charging the patient directly is acceptable. If an uninsured Pap smear is performed, then the physician should collect payment for G365 if it is not included in the patient visit and for E430 if the service was provided outside of the hospital. If a medically necessary assessment unrelated to the Pap smear is provided at the same time, then that should be billed to OHIP using the appropriate assessment fee. If the Pap smear was the sole reason for the patient visit, then G700 may also be billed to the patient. (Reminder: the uninsured fees for G365, E430, G700, etc. are calculated by multiplying the current OHIP fee by the OMA multiplier; see page 13). Note that all lab services in support of an uninsured service are also uninsured.

I recently performed a TB test on a patient who required it by their new employer (a hospital). My colleagues all agreed that this was an uninsured service and I billed it as such. I have another patient coming to see me for a TB test, as she requires it in order to begin her internship at a hospital. Does this mean the service is uninsured because it is for employment purposes?

An ‘internship’ suggests that this employment is a curriculum requirement for an academic program, which would mean the TB test is insured by OHIP. In order to make a claim to OHIP for this service, the request must come from the educational institution and documentation must be provided by the patient that confirms the work placement is a required component of the student’s curriculum.

What is considered reasonable, in terms of charging fees for missed appointments?

It is acceptable to charge patients for missed appointments or procedures if less than 24 hours notice has been given (an exception being psychotherapy practices where a reasonable written agreement exists between the patient and physician). The OMA does not have a standard recommendation for a missed appointment fee, as there are a number of factors that could inform the fee (e.g. geography, specialty, etc.). Once the fee(s) has been set by a physician, the policy should be clearly explained to patients at the time of booking. If possible, the physician should consider having the patient sign a letter acknowledging the office policy.

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE LETTER: Communication to Patient for Missed Appointment (General/Family Physician)

<Insert physician name(s), office/clinic logo, other contact information and date>

Dear <insert>:

Please be advised that you missed a scheduled appointment on <insert date> at <insert time>.

As a courtesy to our office and to the other patients waiting for care, **appointment cancellations require at least one business day’s notice**, except in exceptional circumstances. As per policy, the missed appointment charges are as follows:

Regular appointment	<insert fee>
Extended appointment (e.g. physicals, counselling, etc.)	<insert fee>

The amount owing for your missed appointment is <insert fee>. Payment is required as soon as possible and within <insert time period> of this notice. Payment can be made by contacting the office (<insert payment method(s)>). If your account remains outstanding, you may also be reminded about any outstanding charges at the time of booking or attending new appointments.

If you have concerns about your ability to pay, please speak to our office about what options may be available - we do not intend to cause undue financial hardship, and you will not be denied care on the basis of your ability to pay.

Please be reminded that as per the office policy, patients who have missed <insert number> appointments may be dismissed from the practice, since the time is needed in the care of other patients.

Thank you for your attention to this matter. We hope to hear from you soon.

Should you have any questions, please don’t hesitate to contact the office.

Sincerely

<Insert name and signature>

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE LETTER: Communication to Patient for Missed Appointment (Specialist)

<Insert physician name(s), office/clinic logo, other contact information and date>

Dear <insert>:

Please be advised that you missed a scheduled appointment in our office on <insert date> at <insert time>.

As a courtesy to our office and to the other patients waiting for care, **appointment cancellations require at least one business day's notice**, except in exceptional circumstances. As noted in the policy communicated to you upon booking, the missed appointment charges are as follows:

New consultation	<insert fee>
Follow-up appointment	<insert fee>

The amount owing for your missed appointment is <insert fee>. Payment is required as soon as possible and within <insert time period> of this notice. Payment can be made by contacting the office (<insert payment method(s)>). If your account remains outstanding, you may also be reminded about any outstanding charges at the time of booking or attending new appointments.

Please be reminded that as per our office policy, patients who have missed a new consultation may not be re-booked if the account remains outstanding for payment. If you have missed <insert number> of follow-up appointments, patients may not be re-booked, as time is needed for the care of other patients.

Thank you for your attention to this matter. We hope to hear from you soon.

Should you have any questions, please don't hesitate to contact the office.

Sincerely

<Insert name and signature>

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE LETTER: Office Uninsured Services Policy

<Insert physician name(s), office/clinic logo, other contact information and date>

Dear Patient:

This letter and enclosed information sheet is to notify you of our office policy on uninsured services. OHIP does not pay for all services that patients request from physicians. Services that OHIP does not pay for are called “*uninsured services*” and physicians are prohibited from billing OHIP for these services.

Every effort has been made to account for most of the commonly requested services in the enclosed information sheet. If the uninsured service you require is not listed, please communicate this to me or my office staff for further clarification. To help speed up our service, please let my office staff know when you are booking your appointment that you are requesting a service that appears on the list or a service for which you have been charged in the past by this office or another physician’s office.

The fees contained in the enclosed list are in accordance with the <insert appropriate year> edition of the *OMA Physician’s Guide to Uninsured Services*.

All uninsured services must be paid in full when rendered; office staff will provide a receipt upon settlement of your account. Should you be unable to pay for the uninsured service at the time it is provided, please let my office staff know when and how you intend to settle your outstanding account. We will make every effort possible to assist you in the settlement of your outstanding account. Note that our office accepts <insert payment methods> payments.

Please acknowledge receipt and acceptance of the above office policy by signing below and returning a copy by either fax, mail or in person to my office. Alternatively, you can deliver your acceptance via email to <insert email address>. Should you have any further questions, please contact <insert name of office staff person> at <insert phone number or email>.

I agree with the above policy and terms/conditions

Patient name

Signature

Date

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE LETTER: Patient Requested Copy and/or Transmission of Medical Records

<Insert physician name(s), office/clinic logo, other contact information and date>

PATIENT INFORMATION
Patient Name
Patient DOB

FILE / INVOICE #	DATE

Dear Patient:

I have received your request to **<transfer and/or copy>** your medical records. Please be advised that the cost of this service is not covered by OHIP and you are responsible for the cost of the physician chart review, duplication, and transfer of your records. Note that, by law, your original record must be kept in this office for at least 10 years after your last professional visit.

Consider the following options*:

Please indicate the option of your choice:

Option A: Chart Summary

Summary of medical history, including your most recent and significant laboratory or diagnostic test results as well as all applicable consultation and hospital reports. Please notify, in writing, if you would like any information to be excluded.

Estimated time to complete request: **<insert time estimate>**

Physician hourly rate: **<insert hourly rate>**

Estimated fee: **<insert \$ figure>**

Option B: Entire Chart

Copy and/or transmission of entire chart. The fees are based on the **<insert year>** Ontario Medical Association Physician's Guide to Uninsured Services.

First 20 pages of chart (includes 15 mins of professional review)	\$ _____
Additional pages (\$0.25 per page)	\$ _____

* The fee for option A is recommended to be based on the physician's hourly rate. Option B is based on the recommendations outlined on pages 16-18. This letter is intended to be an example; Option B should be tailored to support the format of a physician office's medical records as well as the format of the reproduced records.

APPENDIX II: SAMPLE LETTERS AND MESSAGING

Professional review (\$45 per 15 mins, after the first 15 minutes):

\$ _____

Estimated fee: <insert \$ figure>

Option C: Customized Option

In the event that options A and B do not meet your specific needs, indicate the documentation and/or information required below. The office will review and contact you with a cost estimate before your request is fulfilled.

Please acknowledge acceptance of this estimate by signing below and returning a copy by fax, mail or via email to <insert email address>. Should you have any further questions, please contact <insert name of office staff person> at <insert phone number or email address>.

Once the work is complete, the office will notify you to settle your account. Upon settlement you will be provided with a copy or the copy will be forwarded to the requested recipient

I agree with the above policy and terms/conditions

Patient name

Signature

Date

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE LETTER: Confirmation of Third Party Request

<Insert physician name(s), office/clinic logo, other contact information and date>

PATIENT INFORMATION
Patient Name
Patient DOB
SERVICE REQUESTED

FILE / INVOICE #	DATE

Dear <Insert name of third party>:

I am in receipt of your request for the completion of the service noted above.

This letter is intended to inform you of my standard fee for the provision of this service, which is based on the Ontario Medical Association's suggested rate listed in the <insert year> edition of the Physician's Guide to Uninsured Services.

The estimated fee for this service is <enter \$ figure (and itemized breakdown, where appropriate)>. This figure assumes no extraordinary complexity and/or follow-up information requests for clarification or additional information. Should such follow-up work be required, additional estimates will be provided in a similar fashion.

An invoice will be sent to you upon completion of the service. <Insert any policy related to timeframe of expected payment and/or interest charges for late payments>

Please acknowledge receipt and acceptance of this estimate and policy by signing below and providing a copy by fax, mail or via email to <insert email address>. Should you have any further questions, please contact <insert name of office staff person> at <insert phone number or email address>.

Sincerely

<Insert name and signature>

I agree with the above estimate and terms/conditions of payment.		
_____	_____	_____
Name	Company/Organization	Date

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE: Third Party Invoice (General)

INVOICE

<Insert physician name(s), office/clinic logo, other contact information and date>

BILL TO
Name
Company/Organization
Street Address
City, Province, Postal Code
Phone Number and Email Address

INVOICE #	DATE

PATIENT INFORMATION
Patient Name
Patient DOB
SERVICE REQUESTED
Description of Requested Form/Report/Service
Date of Requested Form/Report/Service

ITEMIZED DESCRIPTION AND FEE(S) FOR SERVICES	FEE
TOTAL DUE	\$

<Insert applicable payment terms (e.g. in full within # of days of invoice date)>

Additional Comments

If you have any questions about this invoice, please contact <insert name of office staff person> at <insert phone number or email address>.

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE: Third Party Invoice (Copying and/or Transmission of Medical Records)

INVOICE

<Insert physician name(s), office/clinic logo, other contact information and date>

BILL TO
Name
Company/Organization
Street Address
City, Province, Postal Code
Phone Number and Email Address

INVOICE #	DATE

PATIENT INFORMATION
Patient Name
Patient DOB
SERVICE REQUESTED
Copying/Transmission of Medical Records
Date of Request

SUMMARY OF CHARGES	RATE	FEE
Photocopying (# of pages)	\$30 (first 20 pages), \$0.25 per page thereafter	
Physician professional review	\$45 per 15 mins, after the first 15 mins.	
Courier		
TOTAL DUE		\$

<Insert applicable payment terms (e.g. in full within # of days of invoice date)>

Additional Comments

--

If you have any questions about this invoice, please contact <insert name of office staff person> at <insert phone number or email address>.

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE LETTER: Cover letter for Invoicing for Physician Administrative Work

<Insert physician name(s), office/clinic logo, other contact information and date>

Dear <insert>:

This attached invoice is in reference to my participation with **<insert committee, working group, other activity>**. As discussed previously, this work is not an insured service and thus, I am invoicing **<organization>** for my participation.

The fees quoted on the invoice are my own specific professional fees, which take into account my knowledge, expertise, level of experience and cost of forfeiting clinical practice time (where applicable). The fees have been set in accordance with the guidelines published by the Ontario Medical Association (OMA). Refer to the OMA Physician's Guide to Uninsured Services for further information.

Should you have any questions, please don't hesitate to contact me.

Sincerely

<Insert name and signature>

APPENDIX II: SAMPLE LETTERS AND MESSAGING

SAMPLE: Invoice for Physicians Participating in Administrative Work (outside of routine practice)

INVOICE

<Insert physician name(s), office/clinic logo, other contact information and date>

BILL TO
Name
Company/Organization
Street Address
City, Province, Postal Code
Phone Number and Email Address

INVOICE #	DATE

MEETING/ACTIVITY INFORMATION
Description
Date(s)
Location
Role

Refer to "Honorarium Basic Rates" for my personal, professional rates. Time is calculated on an hourly rate rounded to the nearest half hour. All expenses are billed at cost.

HONORARIUM TYPE	DURATION	RATE	FEE
Meeting			
Teleconference			
Travel time			
Other			
EXPENSES			
Air / Bus / Train / Flight			
Automobile	# kms	@ 0.59/km ⁶⁸	
Parking			
Taxi			
Hotel			
Meals			
Other			
TOTAL DUE			\$

<Insert applicable payment terms (e.g. in full within # of days of invoice date)>

HONORARIUM BASIC RATES	BASE HOURLY RATE ⁶⁹		
Participation per year	Up to 15 days	15.5 - 25 days	25 days +
Meetings (attended in person)	\$122.00	\$149.00	\$170.00
Teleconference	\$122.00	\$149.00	\$170.00
Travel	\$122.00	\$149.00	\$170.00

⁶⁸ Based on the current CRA reasonable per-kilometre allowance rate

⁶⁹ Rates used (OMA honoraria rates) are for illustration purposes only.

OMA Uninsured Services Poster



Uninsured Services

What you need to know...

The Ontario Health Insurance Plan (OHIP) provides coverage for a vast majority of physician services; however, there are some services that are not covered.

Physicians are pleased to offer these valuable services; however, the responsibility for payment lies with the patient or the third party requesting the service.

Quality health care, medical advice and timely access are priorities that Ontario's physicians intend to honour. Speak with your physician for more information about other health care services that are not covered by OHIP.



EXAMPLES OF SERVICES NOT COVERED BY OHIP

Medical Services

- Routine eye examinations for patients 20-64 years of age
- Examinations/diagnostic tests necessary to satisfy requirements requested by employers, insurance companies, government agencies, etc.
- Pre-adoption examinations
- Prescription renewals without a visit
- Travel medicine advice and services for travelling outside of Canada
- Telephone advice if initiated by the patient
- Cosmetic procedures and related examinations and diagnostic tests

Completion of Forms and Medical Records

- Medical/legal reports
- Federal government forms
- Certificates for the purpose of travel, immigration, employment, etc.
- Driver's/aviation medical exam and other licensing forms/certificates
- Insurance forms, reports and certificates, such as:
 - Disability certificate
 - Treatment plan
 - Insurance medical examination reports
- Completion of work and school related forms/notes, such as:
 - Sick or back-to-work notes
 - Admission to day care/schools/recreational
 - Employer requested reports/forms (e.g., form physicals)

Administrative Services

- Copying medical records, reports and letters at the patient's request
- Transfer or summary of medical records at the patient's request
- Missed appointments without sufficient notice

Block Fees

A block fee is defined as an optional flat fee charged by a physician for a predetermined set of services not covered by OHIP for a specific period of time. Not all physicians offer a block fee due to the nature of their practice and charge for each uninsured service when rendered. Speak to your physician for more information on block fees.

Please note that some exceptions may apply.

The Uninsured Services poster helps physicians educate patients about uninsured medical and administrative services, as well as block fees.

Developed by OMA Economics, Research & Analytics, in consultation with the OMA's Uninsured Services Committee, the poster provides some clear and common examples of those services not covered by OHIP.

This poster is intended for display in patient waiting rooms, public seating areas or other high-traffic settings.

OMA members:

To receive a free copy of the 11" x 17" colour poster by mail, or a PDF copy by email, please send an email with your complete mailing address to: uninsuredservices@oma.org.

This poster is also available for download at <https://www.oma.org/member/section/practice-&-professional-support/billing-for-uninsured-services?type=topics>

APPENDIX III: SUMMARY OF RECOMMENDATIONS ON THE PHYSICIAN ROLE IN TIMELY RETURN TO WORK

For additional information on the role of TRTW Coordinator, please refer to the OMA's policy paper "*The Role of the Primary Care Physician in Timely Return to Work*", which is available on the OMA's website.⁷⁰

The summary of recommendations is as follows:

Third Party Requests for information:

1. We recommend that third party requests for medical information and services be distinctly separated into two streams:
 - (a) Requests for medical documentation of illness, disease, injury or disability for the purposes of entitlement to disability benefits (refer to CPSO's policy on "Third Party Reports") and;
 - (b) Requests for information and services related to returning a patient to work, such as functional assessments, reviewing job descriptions, consulting with supervisors, workplace interviews, assessing barriers to return to work, prescribing restrictions and modifications to the job (herein collectively referred to as "RTW Services").

2. We recommend that when a third-party requests information for (a) entitlement to disability benefits or (b) returning a patient to work that:
 - (a) Separate patient consent be obtained for each request for medical information.
 - (b) Patient consent be considered time limited and that repeat requests for information fall within a reasonable time of the original receipt of patient consent.

3. We recommend the development of educational sessions to support physicians in understanding their CPSO obligations regarding third party requests and to support those physicians who wish to assume the role of the timely return to work coordinator.

4. We recommend that patients not be required to assume the costs of third party requests for services related to the certification of disability.

5. We recommend that patients not be required to assume the costs of services related to a timely return to work program. The OMA believes that the employer/insurer should assume the cost and payment for the services related to a timely return to work program as well as for the services related to the certification of the disability.

⁷⁰ <https://www.oma.org/uploadedfiles/oma/media/member/membermappedpdfs/practice-professional-support/primary-care/timely-return-to-work-2008-primary-care.pdf/>

APPENDIX IV: ADDITIONAL INFORMATION ON LIFE AND HEALTH INSURANCE REPORTS

Attending Physician's Statement

Fee: \$160.00

Insurance companies request completion of this form after clients have applied for insurance coverage and have provided the company with information on their medical history and other biographic data. This form is usually sent directly to the physician, accompanied by the patient's signed consent form, and is a request for historical medical information directly from the patient's medical charts. The physician's findings, treatment, and opinion recorded following a patient's visits for significant medical problems are requested.

In these instances, insurance companies do not generally require a medical assessment to be performed on the patient since this is not a request for information on the current health status of the patient. The insurance company may request relevant copies of lab test results and/or electrocardiograms.

In the event the patient is making a disability claim, the insurance company may require a medical assessment and up-to-date information on the health status of the patient. The assessment is insured and billable to OHIP, ***if in the opinion of the physician the service is medically necessary.***

Completion of the report remains uninsured and is billable to the patient or third party.

System-Specific or Disease-Specific Questionnaire

Fee: \$107.00

This form is usually sent directly to the physician along with the patient's signed consent form. The questionnaire will ask for specific details related to a patient's medical condition. For example, in the case of a patient with diabetes, past blood sugar readings, treatment given, control details, etc., would be requested. Unless specifically requested, a medical assessment is not required to complete this form since it is not a request for a report on the patient's current medical status.

Systems-Specific Examination

Fee: \$129.00

This is a request by the insurance company for an assessment that includes a single system medical history and examination. This would include a review of the pertinent medical history relating to the system, a system-specific examination, and the completion of the corresponding form.

Insurance Medical Examination

Fee: \$260.00

This is a request by the insurance company for a general physical examination and the completion of the accompanying form, which usually includes questions making up a functional inquiry, a past history of the patient's health status, and the results of the physical examination.

APPENDIX IV: ADDITIONAL INFORMATION ON LIFE AND HEALTH INSURANCE REPORTS

Clarification Report

Fee: \$429.00/hr

This report is often requested directly from the physician in order to adjudicate a claim. It involves answering specific questions to clarify information about medical and administrative details previously submitted to the insurance company. A medical examination is not usually required unless specifically requested by the insurance company.

Full Narrative Report

Fee: \$429.00/hr

This report is requested by the insurance company in order for the physician to answer detailed questions to clarify information about medical and administrative details. This is quite common in cases of prolonged or complex disability (e.g., chronic fatigue syndrome) or psychiatric illness and/or in cases that involve multiple healthcare specialists and treatment modalities. It is generally requested in a letter-type format, and insurance companies often require that copies of appropriate test results and consultation reports also be included with the response. A medical examination is not usually required unless specifically requested by the insurance company.

Independent Medical Examination

Fee: Independent Consideration

This service contracted between a physician and insurance company; fees and scope of assessment are generally discussed in advance with the physician based on the insurance company's requirements.

Please forward any questions and/or suggestions for the next edition of this Guide to:

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