GENERAL PREAMBLE

HOSPITAL AND INSTITUTIONAL CONSULTATIONS AND ASSESSMENTS

ACUTE CARE HOSPITAL – NON-EMERGENCY IN-PATIENT SERVICES (“C” PREFIX SERVICES)

A. Admission Assessment – General Requirements

Definition:

a. An admission assessment is the initial assessment of the patient rendered for the purpose of admitting a patient to hospital.

b. The admitting physician is the physician who renders the admission assessment.

Payment rules:

1. Except as outlined below in paragraph 3, when the admitting physician has not previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a consultation, general or medical specific or specific assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.

2. Except as outlined below in paragraph 3, if the admitting physician has previously assessed the patient for the same presenting illness within 90 days of the admission assessment, the admission assessment constitutes a general re-assessment or specific re-assessment depending on the specialty of the physician, the nature of the service rendered and any applicable payment rules.

3. When a hospital in-patient is transferred from one physician to another physician, only one consultation, general or specific assessment or reassessment is *eligible for payment* per patient admission. The amount *eligible for payment* for services in excess of this limit will be adjusted to a lesser assessment fee. An additional admission assessment is *not eligible for payment* when a hospital inpatient is transferred from one physician to another physician within the same hospital.

Admission Assessments by Specialists:

When a patient has been assessed by a *specialist* in the emergency room (ER) or out-patient department (OPD) and that physician renders a service described as a consultation, specific assessment, or medical specific assessment and subsequently admits the patient to hospital, the initial consultation, specific, or medical specific assessment constitutes the admission assessment.

When a patient has been assessed by a *specialist* in the ER or OPD, and that physician renders any other assessment other than those listed in the paragraph immediately above, and that physician subsequently admits the patient to hospital, an admission assessment is *eligible for payment* in addition to the initial assessment, if each service is rendered separately.

> **[Commentary:**
> In accordance with the surgical preamble, a hospital admission assessment by the surgeon is *not eligible for payment*, unless it is the “major pre-operative visit” (i.e., the consultation or assessment which may be claimed when the decision to operate is made and the operation is scheduled).]

Admission Assessments by General and Family Practitioners:

When a patient has been assessed by a general or family practitioner in the emergency room (ER) or out-patient department (OPD) and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital, the initial consultation, general assessment, general re-assessment constitutes the admission assessment.

When a patient has been assessed by a general or family practitioner in the ER or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, and subsequently admits the patient to hospital, an admission assessment is *eligible for payment* in addition to the initial assessment, if each assessment is rendered separately.

Payment rules:

A933/C933/C003/C004 are *not eligible for payment* for an admission assessment for an elective surgery patient when a pre-operative assessment has been rendered to the same patient within 30 days of admission by the same physician.

Admission Assessments by General and Family Practitioners in an Emergency Department Funded under an Emergency Department Alternative Funding Agreement:

When a patient has been assessed by the patient's general or family practitioner in an emergency room and that physician subsequently admits the patient to hospital, the General/Family Physician Emergency Department Assessment constitutes the admission assessment if the physician remains the *most responsible physician* for the patient.

Admission Assessments by Emergency Physicians:

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders a service described as a consultation, general assessment, or general re-assessment and subsequently admits the patient to hospital as the *most responsible physician* or that physician is asked to perform the admission assessment (even though the patient is admitted under a different *most responsible physician*), the initial consultation, general assessment, or general re-assessment constitutes the admission assessment.

When a patient has been assessed by an emergency physician in the ER or OPD and that physician renders any other assessment other than those listed in the paragraph immediately above, and subsequently renders the admission assessment, (even if the patient is admitted under a different *most responsible physician*), the admission assessment is payable as C004, in addition to the initial assessment, if both services are rendered separately.

Admission Assessment by the Most Responsible Physician (MRP) Premium

E082 Admission assessment by the MRP, to admission assessment .... add 30%

Payment rules:

1. E082 is *only eligible for payment* once per patient per hospital admission.
2. E082 is *only eligible for payment*:
   a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services;

   or

   b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be *eligible for payment* to the physician had he or she not received any such direct or indirect remuneration.
3. E082 is *not eligible for payment* for transfers within the same hospital.
4. E082 is not applicable to any other service or premium.

[Commentary:

1. E082 is *only eligible for payment* when the admitting physician is the *MRP*. If the *MRP* does not render the admission assessment, E082 is *not eligible for payment* for any service rendered by any physician during that hospital admission.
2. E082 is *not eligible for payment* for a patient admitted for obstetrical delivery or for a *newborn*.
3. E082 is not applicable for any consultation or assessment related to *day* surgery.]

E. Subsequent visit and *palliative care* visit by the *MRP* premium

E083 Subsequent visit by the MRP, to subsequent visit, C122, C123, C124, C142, C143, C882 or C982 .... add 30%

Payment rules:

1. E083 is *only eligible for payment* once per patient per *day*.
2. E083 is *only eligible for payment*:
   a. if the physician establishes that he or she does not receive any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services;

      or

   b. where the physician receives any direct or indirect remuneration from a hospital or hospital foundation for rendering in-patient clinical services, if the physician establishes that such remuneration has been reduced by an amount equal to the amount that would be *eligible for payment* to the physician had he or she not received any such direct or indirect remuneration.
3. E083 is *not eligible for payment* for *palliative care* visits to patients in designated *palliative care* beds in Long-Term Care Institutions.
4. E083 is not applicable to any other service or premium.

[Commentary:
E083 is *only eligible for payment* with subsequent visits and *palliative care* visits rendered by the *MRP*.]