Education and Prevention Committee
Interpretive Bulletin

Volume 2, No. 2

Questions and Answers

INTRODUCTION

What is the Education and Prevention Committee (EPC)?

The Ministry of Health and Long-Term Care (MOHLTC) and Ontario Medical Association (OMA) have jointly established the Education and Prevention Committee (EPC). The EPC's primary goal is to educate physicians about submitting OHIP claims that accurately reflect the service provided so that the need for recovery of inappropriately submitted claims is reduced.

What is an Interpretive Bulletin?

In order to achieve this goal, the EPC is developing a number of educational initiatives that are intended to help physicians submit accurate OHIP claims. One of these initiatives is the provision of regular "Interpretive Bulletins." Interpretive Bulletins will be jointly prepared by the Ministry and the OMA. The purpose of these Bulletins will be to provide general advice and guidance to physicians on specific billing matters.

Interpretive Bulletins are provided for education and information purposes only and express the Ministry's and OMA's understanding of the law at the time of publication. The information provided in this Bulletin is based on the July 2003 Schedule of Benefits - Physician Services. While the OMA and Ministry make every effort to ensure that this Bulletin is accurate, the Health Insurance Act and Regulations are the only authority in this regard and should be referred to by physicians. Changes in the statutes, regulations or case law may affect the accuracy or currency of the information provided in this Bulletin.

The EPC will maintain an index of these Bulletins to assist physicians in referring to previously discussed topics.

Questions and Answers

Purpose

The purpose of this Interpretive Bulletin is to answer some specific questions posed to the Committee on billing issues raised in prior Interpretive Bulletins.

Question #1:

This inquiry is in response to the EPC Bulletin entitled "Special Visit Premiums," published in the November 2003 OMR. Please explain the phrase "by the patient or his or her representative," which is found in the Schedule of Benefits section 22 paragraph "a".

Answer:

The word representative does not mean that this is the patient's legal guardian or the individual who possesses Power of Attorney for medical decision-making. A nurse, a physician, a home-care nurse, or even a neighbour could be acting as the representative for the patient and request a

visit by a physician that may qualify for a special visit premium. This phrase is meant to indicate that the request must come from the patient or another individual who has knowledge that the patient requires emergent or non-elective (urgent) medical attention.

Question #2:

Please explain what the appropriate fee service code would be for common clinical problems seen in a general practice. The examples given in the question were upper respiratory tract infections and urinary tract infections.

Answer:

Clinical records serve various purposes. Primarily, the record is for the benefit of the patient. The accuracy and completeness of the record is important for ongoing care. In addition, the record is for the physician's benefit in the event of a patient complaint or lawsuit. Finally, the record must demonstrate that what is claimed to OHIP for payment is correct.

It's not possible to advise that all patients presenting with a urinary tract infection (UTI) should be billed with a specific fee code such as intermediate (A007) or minor assessment (A001). That decision can only be made by the physician attending the patient. However, the medical record must support the fee claimed.

The following presents two scenarios with ultimately the same diagnosis and treatment.

1) A female patient presents with symptoms of frequency, dysuria and hematuria. She advises that she gets frequent urinary tract infections and has been investigated in the past. There is no fever, abdominal pain or flank pain. There is no history of allergies and the patient is not taking any medications. The physician decides that there is no need to perform a detailed examination apart from a dip stick urine, and based on the history and diagnostic test decides to prescribe an antibiotic. The record states "Frequency, dysuria, hematuria for 12 hours. Frequent UTI's on a monthly basis with normal investigations. No fever, no abdominal pain. Examination: Looks well. No flank pain to percussion. WBC's and RBC's 4+."

This would correctly be claimed as a minor assessment (A001) and urinalysis without microscopy (G010).

2) A female patient presents with abdominal pain, fever for two days, chills and shakes. Her last menstrual period was 5 days ago. There is no previous history of same illness. There is no diarrhea or vomiting. There is slight pain with voiding. No history of sore throat, cough or back pain. There is no history of allergies and the patient is not taking any medications. On examination; Chest clear to IPPA, GI - tender suprapubic area, flank pain to percussion L side. No organomegaly, no masses. Pelvic exam, no D/C, no uterine tenderness, no masses. Urinalysis, 4+ RBC, 4+ WBC. Dx Abdominal pain, probable UTI. Rx - antibiotic.

This example shows a greater level of detail in the history and physical examination. A fee for an intermediate assessment (A007) would be appropriate.

General Advice and Guidance

In both instances, for the same clinical problem, the Ministry has found records with the following:

UTI. Rx Amoxil

The record does not aid any reviewer of the medical record in determining what took place during the patient encounter. For payment purposes, the record substantiates that a visit took place, but it does not demonstrate that a more extensive assessment took place. If this record were adjudicated, it could only be paid as a minor assessment (A001).

Question #3:

This inquiry is also in response to the EPC Bulletin published in the November 2003 OMR, entitled "Special Visit Premiums." Please explain the term "non-referred obstetrics" found in the General Preamble, section 22 paragraph "c".

Answer:

To answer this question, one has to look to the requirements for a special visit premium to be claimed. The

description of any fee service code in the Schedule of Benefits must always be read together with the General Preamble, the common and specific elements of services, the preamble and the notes and definitions of a specific section in which the fee service code is found.

The General Preamble, section 22 under paragraph "c", states that "Special visit premiums only apply to non-elective or emergency calls and do not apply to non-referred or transferred obstetrics with the exception of the special visits for obstetrical delivery with sacrifice of office hours for the first patient seen (C989 Obstetrics Listing)." This means that for a woman in labour, a special visit premium does not apply if:

1) you are the most responsible physician
2) a transfer of care has taken place and you have assumed the care of the patient.

There is an exception that if there is a sacrifice of office hours, C989, is eligible for payment even if the care of the patient has been transferred.

For example, if you are called in to see a patient you have seen through the pregnancy, and the patient is in labour, a special visit premium is not eligible for payment unless there is a sacrifice of office hours. In that instance, C989 is eligible for payment. The appropriate After Hours Premium (E409, E410) are eligible for payment in conjunction with the appropriate delivery fee.

If a colleague asks you to follow a patient while they are on holiday, this is a transfer of care. Seeing the patient in the example above, a special visit premium would not apply unless there was a sacrifice of office hours.

If a physician competent to give advice is asked to see a patient in consultation (referred patient) due to the complexity or seriousness of a condition, then the consultant is eligible for payment of a consultation and special visit premium if applicable.

If you are called to see a patient who is 38 weeks pregnant, who is bleeding and she is not in labour, then you are eligible for payment of the appropriate assessment fee and special visit premium. Page K2 of the September 1, 2003 Schedule of Benefits, in the preamble to the Obstetrics section under paragraph three, indicates that illnesses resulting from or associated with pregnancy or false labour requiring added home or hospital visits, shall be claimed on a per visit basis. Therefore, if a complication of pregnancy or false labour arises, then the appropriate visit fee is eligible for payment. This would include a special visit premium if that visit qualifies for a special visit premium.

Your feedback is welcomed and appreciated.

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