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Ministry of Health and Long-Term Care

OMA

Education and Prevention Committee Interpretive Bulletin

Volume 5, No. 4

OHIP Group Billing Number, Referrals for Consultation, Billing of Injections, Chronic Disease Assessment Premium

Questions and Answers — Part B

Introduction

What is the Education and Prevention Committee (EPC)?

The Ministry of Health and Long-Term Care (MOHLTC) and the 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?

Interpretive Bulletins are prepared jointly by the MOHLTC and the OMA to provide general advice and guidance to physicians on specific billing matters. Bulletins are provided for education and information purposes only, and express the MOHLTC'S and OMA's understanding of the law at the time of publication. The information provided in this Bulletin is based on the April 2007 Schedule of Benefits – Physician Services (Schedule). While the OMA and MOHLTC make every effort to ensure that this Bulletin is accurate, the Health Insurance Act (HIA) 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. In the event of a discrepancy between this Bulletin and the HIA or its Regulations and/or Schedule under the Regulations, the text of the HIA, Regulations and/or Schedule, prevail.

EPC Interpretive Bulletins and all other MOHLTC bulletins are available on the Ministry website:
(http://www.health.gov. on.ca/english/providers/program/ohip/bulletins/bulletin_mn.html).

Purpose

The purpose of this Interpretive Bulletin is to share questions and answers submitted by physicians to the Physician Services Committee (PSC) for response by the EPC. As noted at the end of EPC Interpretive Bulletins, the PSC forwards questions anonymously to the EPC which, in turn, provides the answers to the PSC for response to the physician.

Although most of the following questions and answers have been included in their original form, some have been edited, where necessary, to clarify meaning and provide context.

OHIP Group Billing Number

Further information about the OHIP Group Billing Number may be found in EPC Bulletin Vol. 4 No. 2, published in the March 2006 OMR (https://www.oma.org/pcomm/OMR/mar/06maintoc.htm). Note that despite involvement in a group or groups, a physician may still submit claims using only his or her solo billing number for non-group related services provided.

Q1: *Reference was made in the Bulletin on Group Numbers that individual physicians are allowed to have their OHIP payments directed into an account associated with a group they are affiliated with. At this time, we do not have a group, but would like to know how we proceed to create a group account for palliative physicians in our program. We have been under the impression that NEW group accounts were no longer being permitted.*

A1: Physicians asking about obtaining a group number should write to:
Provider Services Branch
Ministry of Health and Long-Term Care
Registry Unit
370 Select Drive
Box 168
Kingston ON K7M 8T4

Note: new group accounts are being assigned. More information is available by writing to the address above.

Q2: *I have received the recent information package on the Group Billing Number. I would like to take the opportunity to ask one question. In the "responsibilities associated with an OHIP billing number" section, I note that it is the legal responsibility of the physician for billings submitted under his or her billing number. However, to my knowledge, we do not receive a listing from OHIP as to what is billed under the number. I assume that since OHIP is directed to pay my billings to me at my address, that all claims are being handled in such a path. If, however, there are claims being made under my number and paid elsewhere, I would have no knowledge of this. In this day, with identity theft occurring, is there a way that OHIP notifies the physician of a list of submitted claims under our billing number for us to verify the claims as legitimate?*

A2: Only those physicians who have signed the appropriate documentation to join a group can have billings paid to that group. If a group attempts to claim for services under an unregistered billing number, those claims are rejected. Therefore, if you have not applied for affiliation with a group, any group that attempts to submit claims using your billing number will not receive payment. Consequently, you would never be accountable for these claims as no payment was received.

If a physician has any solo billings, that physician receives at least once a month, a remittance advice that has details of all claims submitted under his or her solo number, as well as summary information of what has been paid to any group numbers.

If a physician has any concerns about the use of his or her billing number, the physician should contact the local district office.

Q3: *I recently left a group practice and sent a letter to OHIP. Then, when I settled in my new practice a few weeks later, I telephoned OHIP to tell them not to pay any money into the old group account. I was told this cannot be done. If any billings occur with the old group number, it will be processed with that group. Given the above — after having sent something in writing — what is my protection?*

A3: Payment for service would be directed to the group account if the physician was affiliated with the group on the date of service, and, if the group submitted a claim for payment. Hence, all claims billed by the group number will be processed with that group up to the date the physician left the group practice. It is the date of the service, and not the date the physician left the group, that is relevant for payment purposes.

Physicians in a group who wish to end an affiliation with a group may contact their local district office for instruction, or write to:
Provider Services Branch
Ministry of Health and Long-Term Care
Registry Unit
370 Select Drive
Box 168
Kingston ON K7M 8T4

Q4: *How do you track any billing that occurs when you leave the group, i.e. the group back-dates billing to when you were with the group?*

A4: The physician's monthly solo remittance advice contains summary level information of the amount paid to a group on behalf of the physician each month. The information is contained in the group's billing number in your remittance. The group's remittance advice contains the details of each

physician's group billing. When a physician has group billings, he or she may request the information from the group administrator.

Referral for Consultation

Further information on Referrals for Consultation may be found in EPC Bulletin Vol. 4 No. 4, published in the September 2006 OMR (https://www.oma.org/pcomm/OMR/sep/06maintoc.htm).

Q1: *I have a patient who sees a specialist for follow-up visits for a specific condition. My patient has been seeing this specialist for approximately five years for this condition, however, the specialist insists that the patient obtain a new referral for consultation each time he returns to see the specialist. Is this required for OHIP purposes?*

A1: No, a new request for referral is not required for OHIP purposes for a patient who sees a specialist for ongoing/follow-up care. The specialist is eligible for payment of the appropriate assessment (not a consultation) that best describes the service provided at the follow-up visit, even if the specialist has requested a new referral letter.

Q2: *Thank you for allowing me to correspond with you regarding referrals. I am of the understanding that as a specialist office (fertility) that all new patients need a referral to be seen by one of our physicians. That we are doing, but my question is when a patient wants to return to the office after a 12-month lapse, do we require a new referral for their chart? Should no referral be available, the physicians cannot bill a consult fee for the service, but can bill OHIP for an assessment (A203A). Is this correct?*

A2: There is no OHIP requirement that all new patients require a referral. This is a decision of the individual physician whether he or she only sees patients on referral. If the physician sees a patient without the billing requirements of a consultation being fulfilled, then an assessment that describes the service performed may be submitted for payment to OHIP. If the physician sees a patient 12 or more months after the initial consultation visit, a second consultation may only be claimed if the requirements of the Schedule are met. If those requirements are not met, then an assessment that describes the service performed may be submitted for payment to OHIP. A203 may be the appropriate fee to claim, however, the correct fee code to claim is dependent on the service performed. The definition and payment rules for consultations are found in the General Preamble, page GP16, and EPC Bulletin Vol. 4 No. 4.

Billing for Injections

Further information on this topic may be found in EPC Bulletin Vol. 4 No. 3, published in the April 2006 OMR (https:// www.oma.org/pcomm/OMR/apr/06maintoc.htm).

Q1: *I read the billing example in the Interpretive Bulletin of the Education and Prevention Committee, Volume 4, No. 3, published in the OMA Review, April 26, 2006. At the end, you wrote that the physician can bill a G538 for the immunization with visit. In my experience, this is never paid, and the code D7 is given in the remittance advice. As a coincidence, I billed this code for a person for whom I repaired a laceration shortly after this publication. Once again, this was not paid with an explanatory code. Please explain to me this discrepancy?*

A1: Medical rules were changed on November 1, 2006 to allow payment of the injection service.

Note: The injection service may be delegated provided the conditions of delegation, which are listed on page GP42 of the Physician Schedule, are met (i.e. employee of the physician, performed in a private office, etc.).

Chronic Disease Assessment Premium (E078)

Further information on the Chronic Disease Assessment Premium may be found in EPC Bulletin Vol. 5 No. 2, published in the March 2007 OMR (https://www.oma.org/pcomm/OMR/mar/07maintoc.htm).

Guidelines

The Chronic Disease Assessment Premium (E078) is eligible for payment to a designated medical specialist (see page GP21 of the Schedule) under the following conditions:

- Direct assessment or treatment of the chronic condition.
- Assessment of, or treatment of, a complication of the chronic condition or its treatment.
- Assessment of, or treatment of, a chronic condition and an unrelated condition.
- Assessment of, or treatment of, an unrelated condition where the chronic disease must be considered and enters into the management decision of the unrelated condition.
- The diagnosis of the chronic disease has been pre-established and recorded on the patient's medical record.

The premium is not eligible for payment for inpatients of any hospital, patients seen in a long-term care facility, or patients seen in an emergency department.

Q1: *I am a neurologist seeing a diabetic patient for a diabetic neuropathy in follow-up. Can I claim a diagnosis of 250 Diabetes Mellitus and claim E078 on the Partial Assessment code?*

A1: The neurologist is eligible for payment of the premium. Diagnostic code 250 includes complications of diabetes.

Q2: *I am a neurologist seeing a patient with Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) who I am treating with prednisone. The patient also had Diabetes Mellitus. Can I claim a diagnosis of 250 Diabetes Mellitus and claim E078 on the Partial Assessment code?*

A2: Using the guidelines noted above, the neurologist would ask: Is the CIDP a complication of the diabetes? If "yes," the premium is eligible for payment (with diagnostic code 250).

If it were not a complication of the diabetes, the neurologist would then ask: Do I need to assess the diabetes as well? Is my treatment going to affect the treatment of the diabetes?

If the answer to the last two questions were "no," then E078 would not be eligible for payment. However, it appears that in this case, the prednisone treatment will affect management of the diabetes, therefore, the premium is eligible for payment (with diagnostic code 250).

Q3: *I am a neurologist seeing a patient with a stroke. The patient also had Diabetes Mellitus. Can I claim a diagnosis of 250 Diabetes Mellitus and claim E078 on the Partial Assessment code?*

A3: This is similar to Question 2. The neurologist would ask the same type of questions. If the consequences of the stroke are sufficient to reduce the activity of the patient (e.g., the patient is bedridden), then adjustment to the treatment of the diabetes may be required. If such adjustment is required, then the neurologist is eligible for payment of the premium (with diagnostic code 250).

Q4: *I am a cardiologist seeing a patient with Coronary Artery Disease (CAD). The patient also had Diabetes Mellitus. Can I claim a diagnosis of 250 Diabetes Mellitus and claim E078 on the Partial Assessment code?*

A4: This is similar to Question 2. The cardiologist would ask the same type of questions.

Q5: *I am a cardiologist seeing a patient with known CAD for fatigue who happens to have rheumatoid arthritis and hemoglobin of 90. Can I claim a diagnosis of 714 Rheumatoid Arthritis, and claim E078 on the Partial Assessment code?*

A5: No. Assessment and treatment of the CAD is unlikely to directly relate to management of the rheumatoid arthritis.

Your feedback is welcome and appreciated!

The Education and Prevention Committee welcomes your feedback on the Bulletins in order to help ensure that these are effective educational tools. If you have comments on this Bulletin, or suggestions for future Bulletin topics, etc., please submit them in writing to:

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Toronto, Ontario, M5G 2K7
Fax: (416) 340-2961
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Dr. Jane MacNaughton, Co-Chair
Dr. Larry Patrick, Co-Chair
Education and Prevention Committee

Note: The Physician Services Committee Secretariat will anonymously forward all comments/suggestions to the Co-Chairs of the EPC for review and consideration.

For specific inquiries on Schedule interpretation, please submit your questions IN WRITING to:

Provider Services Branch, Physician Schedule Inquiries, 370 Select Drive, P.O. Box 168,
Kingston, Ontario, K7M 8T4