Bulletin

Ontario

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4394	**December 30, 2002**	**Ministry of Health and Long-Term Care Processing Office**
Distribution **Physicians, Hospitals, Clinics, Laboratories**		(See Address Below)

Subject Medical Review Committee Activity

This is the second Bulletin of a bi-annual publication on Directions issued by the Medical Review Committee (MRC). Bulletin #4383 published April 1, 2002, was the first release of information on such Directions.

Under the Health Insurance Act (HIA), the General Manager may refer claims that raise a concern about incorrect billing practices to the MRC. Usually this type of situation requires a detailed review of patient records that the MRC has the legal authority to undertake. A physician may also request that the MRC review a decision of the General Manager under the HIA to require repayment of improper claims.

The MRC is an independent committee administered by the College of Physicians and Surgeons of Ontario (CPSO). The MRC operates at arm's length from both the CPSO and the ministry. The MRC consists of 18 physician members nominated by the CPSO and six members of the public. The Minister of Health and Long-Term Care appoints all members.

The MRC may perform either a panel review or a single-member review. Three physician members and one member of the public conduct panel reviews. Single-member reviews, or "expedited reviews", are conducted by one physician.

The MRC may direct that :

- the General Manager pay the claims as submitted or at a lesser amount, or
- the physician repay all or part of the claims.

MRC directions are binding on the General Manager. Physicians are the only parties who can appeal an MRC direction to the Health Services Review and Appeal Board (HSARB). HSARB directions can be appealed to Divisional Court.

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Office locations

Barrie 30 Poyntz St. L4M 3P2	Hamilton 119 King St. W P.O. Box 2280, Stn. A L8N 4C8	Kenora 220-808 Robertson St. P9N 1X9	Kingston 1055 Princess St. P.O. Box 9000 K7L 5A9	Kitchener Canada Life Square Main Floor 235 King St. E., N2G 4N5	London 217 York St., 5th FloorP.O. Box 5700 Terminal A N6A 1B7	Mississauga 201 City Centre Dr. P.O. Box 7020, Stn. A L5A 3M1
North Bay 101-447 McKeown St. P1B 9S9	Oshawa Exec. Tower, Oshawa Centre. 419 King St. W. P.O. Box 635 L1H 8L4	Ottawa Fuller Building 75 Albert Street K1P 5Y9	Owen Sound 981 2nd Avenue E. N4K 2H5	Peterborough 550 Lansdowne St. W. K9J 8J8	St.Catharines 59 Church St 3rd Floor L2R 3C3	Sarnia 452 Christina St. N. N7T 5W4
Sault Ste. Marie Roberta Bondar Place 70 Foster Dr., Ste. 100 P6A 6V4	Sudbury 199 Larch St., Suite 801 P3E 5R1	Thunder Bay 435 James St. S. , Suite 113 P7E 6T1	Timmins 38 Pine St. N., Ste. 110 P4N 6K6	Toronto 2195 Yonge St. P.O Box 1700 Stn. A M5W 1G9	Windsor 1427 Ouellette Ave. N8X 1K1	Head Office P.O. Box 38 Kingston, ON K7L 5J2

It is important for a physician to realize that he/she is solely accountable for the propriety and accuracy of his/her claims to OHIP. Physicians are legally responsible for ensuring that all claims submitted, including those submitted under a group number (identified to their billing number) reflect the correct fee code(s) for the service(s) that he/she rendered. The ministry may recover money from a physician individually and personally, despite the fact that payment was made to a group account, if that group's claim was made in conjunction with the physician's solo billing number. This applies equally to hospital groups where fees are paid to the individual physician through a group billing number. It is the physician who is legally responsible for the repayment of any incorrect claims submitted, not the hospital.

A claim is properly payable only for a service that a physician personally rendered or personally delegated and supervised in accordance with the requirements of the Schedule of Benefits for Physician Services. This is equally true whether the claim is submitted under a solo or group billing number.

The following chart of MRC directions indicates that the largest percentage of referrals is based on the A007 Intermediate Assessment fee code.

The Schedule of Benefits for Physician Services defines an Intermediate Assessment (A007) and Minor Assessment (A001) as follows :

Intermediate Assessment : is a primary care service rendered by physicians providing general practice or pediatric services and requires a more extensive assessment than a minor assessment. It requires a history of the presenting complaint(s), inquiry concerning and examination of the affected part(s), region(s), or system(s) or mental or emotional disorder as needed to make a diagnosis, exclude disease and/or assess function.

Minor Assessment : is a visit which involves a direct physical encounter with the patient and includes either or both of the following :

1. a brief history and examination of the affected part or region or mental or emotional disorder;
2. brief advice or information regarding health maintenance, diagnosis, treatment and/or prognosis.

The most common reasons cited by the MRC in their directions for the reduction of payment for the Intermediate Assessment are :

- the physician had billed an intermediate assessment for very minor presenting complaints that only warranted an examination of the affected part or region and hence should have been billed as a minor assessment;
- the documentation of the intermediate assessments was often lacking pertinent details of the

patient's history, functional inquiry, and examination rendered.

In addition to the medical record requirements found in section 37.1 of the Health Insurance Act, the CPSO has developed professional guidelines for office medical records. Appendix B of the Schedule of Benefits also contains information on record keeping as specified in sections 18 & 19 of Ontario Regulation 241/94 made under the Medicine Act, 1991.

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Once all appeal rights have been exhausted, the Health Insurance Act authorizes the General Manager of OHIP to publicize information about providers who have been directed by a panel of a Medical or Practitioner Review Committee to repay money received for improper claims. This Bulletin contains the release of this information.

The following information pertains to physicians who appeared before a panel of the Medical Review Committee for a review of services provided on or after May 1, 1996, and who have been directed to repay claims to OHIP as of March 31, 2002, and whose appeal rights have been exhausted.

Specialty/ Practitioner Type :	**Region Where Services Under Review Provided :**	**Region Where Provider Currently Practicing (as of 07/31/01) :**	**Period of Review : mm/dd/ yy**	CODES REVIEWED **Referred to Review Committee**	CODES REVIEWED **Contained in Review Committee Direction**	**Recovery Amount * :**
Family Practice and General Medicine	Central West	Central West	05/01/96 to 7/31/97	A003, A007, J304A, K013	A003, A007, J304A, K013	$53,750.00
Neurology	Central West	Central West	06/01/97 to 05/31/99	A183, A184, A186, A188, A385	A183, A184, A186, A385	$56,627.83
Family Practice and General Practice	Central East	Central East	05/01/96 to 06/30/96	A001, A003, A007, G465, G467	A003, A007	$269.05
Family Practice and General Practice	Central East	Central East	05/01/96 to 07/31/97	A003, A004, A007, K002, K007, K013	A003, A004, A007, K002, K007, K013	$21,250.00
Internal Medicine	Central East	Central East	08/01/96 to 07/31/98	A133, A135	A133, A135	$35,000.00
Anaesthesia	Central East	Central East	05/01/96 to 07/31/96	A013, A014, A015, G123, G216, G219, G223, G227, G228, G231, G235, G238, G273, G384, G385	A013, A015, G123, G216, G219, G223, G227, G228, G231, G235, G238, G273, G384, G385,	$12,714.26
Anaesthesia	Central South	Central South	06/01/97 to 05/31/99	A007, A014, A015, G123, G214, G218, G227, G228, G234, G238, G384, G385	A007, A014, A015, G123, G214, G218, G228, G234, G238, G384, G385	$53,463.28

Internal Medicine	Central East	Central East	07/01/97 to 06/30/99	A133, A134	A133, A134	$99,212.17
Family Practice and General Practice	Central South	Central South	05/01/96 to 01/31/00	A007	A007	$34,218.33
Paediatrics	Central East	Central East	07/01/96 to 06/30/98	A007, A263, A264	A263, A264	$120,747.73
Family Practice and General Practice	Central West	Central West	01/01/98 to 12/31/99	A007	A007	$55,017.26
Internal Medicine	Southwest	Southwest	05/01/96 to 02/28/98	A133, A135	A133	$82,179.43
Family Practice and General Practice	East	East	05/01/96 to 06/30/97	A003, A007, K007, K013	A003, A007, K007, K013	$40,833.33
Paediatrics	Central East	Central East	11/01/96 to 10/31/98	A263, A264, K013	A263, A264, K013	$82,179.43
Paediatrics	Central East	Central East	08/01/96 to 07/31/98	A007, A263, A264	A007, A263, A264	$40,833.33
Family Practice and General Practice	Central West	Central West	05/01/96 to 09/30/96	A003, A007, K007, K013	A003, A007, K007, K013	$16,242.69
Internal Medicine	Central West	Central West	5/01/96 to 09/30/97	A133, A135, A136, G111, G112, G315, G319	A133, A135, A136	$21,250.00
Family Practice and General Practice	Central East	Central East	05/01/96 to 10/31/96	A003, A004, A007, G310, G313, G467, G482, G489, G700, K007	A003, A004, A007, K007	$2,616.85
* The recovery amount includes amounts that pertain to services provided on or after May 1, 1996.						

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Specialty/ Practitioner Type :	**Region Where Services Under Review Provided :**	**Region Where Provider Currently Practicing (as of 07/31/01) :**	**Period of Review : mm/dd/ yy**	CODES REVIEWED **Referred to Review Committee**	CODES REVIEWED **Contained in Review Committee Decision**	**Recovery Amount * :**
Family Practice and General Practice	Central West	Central West	05/01/96 to 02/28/97	A007, K013, W001, W002, W003, W008, W102	A007, K013, W001, W008	$3,567.37
Cardiology	Central West	Central West	01/01/97 to 12/31/98	A603, A604, A605	A603, A604, A605	$52,865.37
Family Practice and General Practice	Central East	Central East	05/01/96 to 07/31/96	A001, A004, A007, A994, A995, G467, G700, K007, K013	A001, A004, A007, A994, A995, G467, K007, K013,	$10,625.00
Internal Medicine	Central South	Central South	05/01/96 to 04/30/98	A133, A134, A135	A133, A134, A135	$105,837.80
Internal Medicine	Central South	Central South	05/01/97 to 04/30/99	A135, A136	A135, A136	$110,000.00
Paediatrics	Central East	Central East	05/01/96 to 09/30/96	A007, A263, A264, A265, A266, K013	A263, A264, A266	$8,333.33
Psychiatry	Central West	Central West	09/01/96 to 08/31/98	A994, A995, K002, K003, K190, K195, K197	A994, A995, K003, K190, K197	$201,352.53
Gastroenterology	Central East	Central East	04/01/97 to 03/31/99	A413, A414, A415, K994, K995	A413, A414, A415, K994, K995	$34,557.30
Family Practice and General Practice	Central South	Central South	05/01/96 to 11/30/96	A003, A004, A007, K007, K013	A003, A004, A007, K007, K013	$2,208.91
Cardiology	Central West	Central West	05/01/96 to 04/30/98	A603, A604	A603, A604	$30,489.44

* The recovery amount includes amounts that pertain to services provided on or after May 1, 1996.

The Medical Review Committee cases noted above involve the referral of 71 different codes for review.

However, it should be noted that of the codes referred for review, some codes were referred much more frequently than other codes. Codes that were more commonly referred include the following :

Code :	Description :	Percentage of Referrals from Cases Noted Above :
A007	Intermediate Assessment/Well Baby Care	57%
K013	Psychotherapy – counseling	33%
A003	General Assessment	30%
K007	Psychotherapy – individual care	23%
A004	General Re-assessment	17%
A133	General Assessment	17%
A135	Consultation	17%

Providers who have questions about claims for a given service are encouraged to contact their District Office and obtain clarification in writing.

More information about the review committee process is contained on the ministry's website: http://www.health.gov.on.ca

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