Bulletin

Ontario

Bulletin Number	Date	Direct inquiries to
4455	**September 5, 2007**	Ministry of Health and Long-Term Care Processing Sites (address below)

Distribution
Physicians, Hospitals, Clinics and Laboratories

Subject: The Payment Correction List (PCL)

The payment correction list is a new component in the revised medical claims review process. The PCL came into effect with recent amendments to the Health Insurance Act following recommendations in Mr. Peter Cory's report on best practices for Ontario.

The PCL is a list of circumstances for which payments are subject to correction.

The initial PCL (attached) was approved by the Medical Services Payment Committee, a joint committee of the Ministry and the Ontario Medical Association (OMA), and will be maintained by the new Joint Committee on the Physician Schedule of Benefits (see Bulletin Number 4449). The PCL is published on the Internet at www.health.gov.on.ca/english/providers/providers_mn.html#ohip.

The PCL process prior to payment

- The General Manager may refuse to pay or pay a reduced amount due to a circumstance listed on the PCL. If the physician disagrees and the issue cannot be resolved with the ministry, he or she may submit a request within 20 business days of receiving notice, to the Transitional Physician Audit Panel (TPAP) to hold a hearing (the Physician Payment Review Board, once it is fully functional, will replace the TPAP).

The PCL process after a payment has been made

- If the General Manager is of the opinion that an amount paid to a physician for a service should not have been paid or should have been paid at a reduced amount due to a circumstance listed on the PCL, the General Manager may give notice to the physician of the circumstance and of the amount the General Manager believes is owing. If the physician disagrees, and the issue cannot be resolved with the ministry, he or she may submit a request within 20 business days of receiving notice, to the Transitional Physician Audit Panel to hold a hearing (the Physician Payment Review Board, once it is fully functional, will replace the TPAP).

The Transitional Physician Audit Panel (TPAP) can be contacted at:

Transitional Physician Audit Panel
151 Bloor Street West, 9th Floor
Toronto ON M5S 2T5

Processing Sites			
Hamilton 119 King Street West, 10th Floor P.O. Box 2280, Stn A L8P 4Y7	**Kingston** 1055 Princess Street, Suite 401 P.O. Box 9000 K7L 5A9	**London** 217 York Street, 5th Floor Station A N6A 5P9	**Mississauga** 201 City Centre Drive Suite 300 L5B 2T4
Oshawa Executive Tower, Oshawa Centre 419 King Street West P.O. Box 635 L1J 7J2	**Ottawa** Fuller Building 75 Albert Street K1P 5Y9	**Sudbury** 199 Larch Street Suite 801 P3E 5R1	**Toronto** 47 Sheppard Avenue East Suite 505 M2N 7E7

Payment Correction List

Restricted practice

- Claim for a service performed while the physician is prohibited from performing such due to a term, condition and/or limitation that has been imposed upon his or her certificate of registration

Deceased patient or deceased physician

- Claim for service performed after date of death of the physician
- Claim for service performed after date of death of the patient, other than:
    - claim for pronouncement of death; or
    - appropriate claim(s) for pathology specimens

Keying and administrative errors

- Exchanging two letters that are side by side on the keyboard where the result is a claim for a fee code normally billed by a different specialty than that of the physician submitting the remittance (e.g., a family medicine practitioner typing an “S007” (resection of mandible surgery) rather than an “A007“)
- Wrong health number, including version code
- Incorrect date of service where such is evident from other claims submitted by the physician
- Claim amount keyed incorrectly by the ministry into the ministry’s Online Claims Correction System (e.g., paid $1,028.00 instead of $128.00)

Billing for hospital inpatients

- For all fee codes that the schedule of benefits prohibits being billed for an admitted patient, between the time a patient is admitted to a hospital and the time a patient is discharged

Prohibited code combinations

- Code combinations expressly prohibited in the schedule of benefits

Errors explicitly acknowledged by a physician

- Where a physician has explicitly acknowledged, in writing, that a claim was incorrect. Comment: this circumstance would provide a convenience for physicians, bypassing the need for the physician to submit the necessary changes in the form of revised claims. Some examples where this has occurred in the past as the result of verification letter inquiry: no service provided; incorrect health number (service provided to another insured patient); incorrect fee code

Duplicate or other prohibited claims submissions

- Second and subsequent claims by the same physician or other physicians for the same service to a patient
- Fee-for-service claims by a physician who is party to an alternative payment plan agreement, for services that are within the scope of the agreement and for which fee-for-service payments are prohibited by the agreement

Circumstances covered by current computerized checks, and the following

- Maximum number of claims per day or year: E411 over limit of 25/year; G603 over limit of 25/year; E101B over limit of 1/day; C989 over limit of 1/day
- Birth-related claim for: female with previous hysterectomy claim; female with previous birth-related claim within 8 months or less; female aged 10 years or younger; female aged 55 or older; male