

INFOBulletin

Keeping health care providers informed of payment, policy or program changes

To: Physicians, Hospitals, Clinics and Laboratories

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Re: Physicians Submitting Claims to OHIP for Medical Services

Preamble

The Ontario Health Insurance Plan (OHIP) frequently encounters billing issues where physicians may have claims submitted under their billing number by a third party that are subsequently determined to be incorrect. This bulletin is to remind physicians they are solely responsible for claims submitted to OHIP. Physicians submitting claims for technical fees have obligations related to the quality and appropriateness of the test.

Purpose of an OHIP Billing Number

The OHIP billing number is necessary in order for a physician to submit claims to OHIP for insured physician services listed in the Schedule of Benefits for Physician Services (Schedule). Submission of claims using a billing number allows the Ministry to calculate and direct payment for claims submitted under the number. Once the OHIP billing number is assigned, it remains in effect until:

- there is a change affecting a physician's license (as notified by the College of Physicians and Surgeons of Ontario [e.g., retirement, death or a practice limitation/restriction]); or
- the physician notifies Provider Registration, in writing, of the intention to cease submitting claims (e.g., retirement, moving out of the province).

Responsibilities associated with the OHIP Billing Number

The Health Insurance Act states that claims submitted in the name of a physician with their billing number, and any payments made on those claims, are deemed to have been:

- submitted personally by the physician;
- paid to the physician personally;
- received by the physician personally; and
- made by and submitted with the consent and knowledge of the physician.

Regardless of who submits a claim, or who receives the payment, you are responsible for all claims submitted and for reconciling all payments made in conjunction with your billing number. For these reasons, you should always be familiar with the claims submitted and the payments made under your billing number, and you should exercise caution when providing your billing number to others.

Note that a locum tenens or another physician filling in for you while you are away must use his or her own billing number (and not yours) for services he or she personally renders. This applies regardless of the payment model you participate in. If he or she incorrectly uses your billing number, you remain responsible to OHIP for those claims (which could include repayment of any incorrectly submitted claims).

How do I know what has been submitted under my OHIP Billing Number?

Every claim submitted to OHIP for payment, and processed by the Ministry's Claims Payment system, appears on either the monthly Remittance Advice (RA) or the Claims Error Report (CER). The RA shows a line-by-line account, and the amount paid for submitted claims. The total amount paid (by cheque or direct deposit) is also shown on the RA. Claims on the CER require correction and resubmission.

Group numbers

A group number is a number issued by the Ministry that allows individual physicians to have their billings associated with a group. A group number is not a billing number. When a claim is submitted with a group number on the claim, the payment is usually made to the group's bank account, if so directed (there are exceptions for some specialist group contracts where, if the contract allows, the payment is directed to the individual physician); however, the individual physician (whose billing number is on the claim) is responsible for the claim.

Some examples where a group number may be used:

- Primary health care models (e.g., Family Health Organization, Family Health Group);
- Alternate Payment Programs (e.g., emergency department alternate funding arrangement, academic health science centres);
- Other hospital or clinical groups where staff may submit billing.

The Ministry does not oversee individual group arrangements. Specifically, the Ministry has no knowledge of how monies are disbursed among physicians affiliated with the group when payment is made to a group bank account. The Ministry provides the group number for directing payment by setting up the affiliation of a physician to a group or groups, however; as previously stated, individual physicians are responsible for all claims and payments made in conjunction with their billing number, including those associated with a group number or directed into a group account. Physicians in a group where payment is directed to the group account may request the detailed listing of their own group billings from the group administrator or lead physician.

Affiliation with a group

If a group agrees to accept a new member, the physician must apply in writing to the Ministry, or in some other documented manner, indicating his or her desire to be part of a group for billing/payment purposes. The required documentation may differ depending on the type of group. For example, a common form for standard groups is the Ministry's Authorization for Group Payment form; however, Primary Care groups or Specialist Physician groups may require different Ministry documentation.

If a physician wishes to terminate a group affiliation for any reason, including retirement, the physician must notify the appropriate Ministry unit or program area (as per the contract) in writing, indicating the specific end date of the affiliation. Physicians should also consult with their group administrator in order to be aware of all consequences when ending their affiliation with a group, especially those that may arise if a recovery of an incorrect payment is required.

Claims for the Technical Component of Diagnostic or Therapeutic Procedures

Technical fees are listed in various diagnostic imaging sections as well as the Diagnostic and Therapeutic Procedures section of the Schedule.

A physician who submits a claim to OHIP for the technical component of a diagnostic or therapeutic procedure is required to render the necessary elements of the service, as described in the relevant section of the Schedule in order for the claim to be payable. This is a requirement whether these procedures are rendered in a public hospital or in a physician's office, regardless of whether these elements are rendered personally by the physician, an employee of the physician, or a hospital employee. For a service to be eligible for payment, the physician is responsible for ensuring that the services are rendered in accordance with professional standards and the requirements of the Schedule.

Technological advances and evolving business practices have led to an expansion of companies offering diagnostic services to physicians. These businesses may not be owned or operated by the physician who is claiming payment from OHIP for the technical component of the services.

Physicians who rely on a third party to provide services to their patients may have minimal involvement in, or control of, the actual operation of the diagnostic test. They may rely on the third party to ensure the quality and appropriateness of the tests. If there is any compromise in meeting the professional standards and/or other requirements of the Schedule, eligibility for payment of these services may be affected.

To be eligible for payment from OHIP, physicians must be able to account for the complete quality assurance process, from data acquisition to reporting and record keeping. Physicians are reminded that submitting a claim to OHIP means that the physician is solely responsible for the accuracy of that claim. After the payment is made, if services are found to not be in compliance with the provisions of the Health Insurance Act, the regulations or the Schedule, the physician remains solely responsible for repayment of the claim to OHIP.

Ministry forms can be found at: http://www.health.gov.on.ca/en/pro/forms/ohip_fm.aspx

Contact information for Provider Registration can be found at:
http://www.health.gov.on.ca/en/pro/publications/ohip/ohip_billing.aspx

The full details of the changes to the Schedule can be found at:
http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html

The Health Insurance Act and associated regulations can be found at:
<http://www.ontario.ca/laws/>

This Bulletin is a general summary provided for information purposes only. Physicians, hospitals, and other health care providers are directed to review the *Health Insurance Act*, Regulation 552, and the Schedules under that regulation, for the complete text of the provisions. You can access this information at www.e-laws.gov.on.ca. In the event of a conflict or inconsistency between this bulletin and the applicable legislation and/or regulations, the legislation and/or regulations prevail.