



Ontario



Education and Prevention Committee Interpretive Bulletin

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Life Threatening Critical Care (G521, G522, G523, G391) and Other Critical Care (G391 and G395)

Introduction

What is the Education and Prevention Committee (EPC)?

The Ministry of Health and Long-Term Care 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 adjustment of inappropriately submitted claims is reduced.

What is an Interpretive Bulletin?

Interpretive Bulletins are prepared jointly by the Ministry and the OMA to provide general advice and guidance to physicians on specific billing matters. They 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 October 1, 2009 Schedule of Benefits — Physician Services (Schedule). While the OMA and Ministry 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 Bulletins and all other Ministry bulletins are available on the Ministry website at: http://www.health.gov.on.ca/english/providers/program/ohip/bulletins/bulletin_mn.html

Purpose

This Bulletin provides information to all physicians on changes to the non per diem critical care fee codes, which can be found on pages J18 through J21 of the October 1, 2009 Schedule.

What is new with regard to the non per diem critical care codes in the Schedule?

a) New terms and definitions of critical care — two classes:

1. "Life threatening emergency situation" is now termed "life threatening critical care."

2. Other resuscitation" is now termed "other critical care."

b) The amount payable for fee codes G521, G522, G523, G391 and G395, have all increased.

c) Start and stop times of the service must be recorded in the patient's medical record/chart in order for the service to

be eligible for payment. However, the final time unit total may include time which is consecutive or non-consecutive.

This topic presents a challenge in providing clear examples to the physician when a certain service could be claimed rather than another. The clinical state of a patient in crisis can change moment by moment. This bulletin is not intended to be prescriptive. The service for which the physician is entitled to payment under the Schedule is determined by the service rendered. To support that claim, the clinical record should clearly document the clinical state of the patient and the services rendered. As with all services, the physician should render the service; look to the schedule to see which fee code most accurately reflects the service(s) rendered; and submit the claim using the appropriate fee code or codes.

If at any point in the future there is a dispute between OHIP and the physician about the claims submitted, the clinical record will assist in settling a dispute. If the dispute is referred to the Physician Payment Review Board, the matter will be reviewed with a board consisting of a peer physician(s).

What is “Life Threatening Critical Care”?

“Life threatening critical care” is care provided to a critically ill or critically injured patient.

For the purpose of these fee codes, critical illness/injury is defined as a condition that acutely impairs one or more vital organ system(s) causing vital organ system failure that will result in a high probability of imminent life threatening deterioration or death. “High probability” requires that there be more than merely a possibility or a risk.

Examples include, but are not limited to, central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure.

The specific fee codes eligible for payment for the provision of “life threatening critical care” services by the first three

physicians are: G521 (first ¼ hour, or part thereof), G523 (second ¼ hour, or part thereof), and G522 (after the first ½ hour, per ¼ hour, or part thereof). For the fourth and subsequent physicians, G391 (per ¼ hour, or part thereof) is eligible for payment.

What is “Other Critical Care”?

“Other critical care” is care provided for a condition where there is potential threat to life or limb such that, without resuscitative intervention by the physician, there is a high probability that the patient will suffer a loss of limb or will require “life threatening critical care.” “High probability” requires that there be more than merely a possibility or a risk.

The specific fee codes eligible for payment for the provision of “other critical care” services are G395 (first ¼ hour) and G391 (each subsequent ¼ hour).

Payment rules

In order for these critical care time-based fee codes to be eligible for payment, the physician must be providing critical care exclusively to the patient, and therefore cannot provide care or any other services to, or with respect to, any other patient during the time that these critical care codes are claimed. If separately billable services are rendered to the patient, the time spent performing these cannot be used when determining the number of units of critical care to bill.

When a physician claims the critical care codes (G521, G522, G523, G391, or G395), the following services are not eligible for payment when claimed for that patient on the same day by the physician:

1. Assessment and ongoing monitoring of the patient’s condition
2. Intravenous lines
3. Cutdowns
4. Arterial and/or venous catheters
5. Central venous pressure lines
6. Endotracheal intubation
7. Tracheal toilet

8. Blood gasses
9. Nasogastric intubation with or without anesthesia, with or without lavage
10. Urinary catheters
11. Pressure infusion sets and pharmacological agents

In addition to the above services, when a physician claims the life threatening critical care codes (G521, G522, G523, or G391 as listed under “life threatening critical care”), the following services are also not eligible for payment when claimed for that patient on the same day by the physician:

1. Defibrillation
2. Cardioversion

How is the time calculated for these critical care codes?

The codes are payable in time units of 15 minutes, or part thereof.

As noted above, the time need not be consecutive. For example, one may provide life threatening critical care to a patient who presents in ventricular flutter. The patient then stabilizes. Some time later, the patient again develops acute ventricular flutter and further life threatening critical care is rendered. To determine the total time units to claim, the physician would add duration of time for both instances when the service was rendered (based on each of the start and stop times, which must be recorded on the patient’s record).

What if critical care per diem codes are claimed?

The codes identified in this bulletin are not payable to a physician when a per diem intensive care area code for critical care, ventilatory support, comprehensive care or neonatal intensive care are paid to the physician for services rendered to the same patient on the same day.

Examples:

Note

The examples are brief and do not provide a complete description of the patient’s clinical presentation or treatment, and are not intended to be used as clinical guidelines or the basis for the fee code that should be billed.

For all examples where critical care is rendered, the patient must either have a life threatening condition (life threatening critical care), or the condition must be imminently deteriorating to the point where there is a high probability that the condition will become life threatening, or that the patient will suffer loss of a limb (other critical care). When determining whether or not critical care is the most appropriate service to be claimed as opposed to the appropriate emergency department assessment (i.e. H prefix code), it is important to consider whether the patient is deteriorating, or whether the nature of the problem leads the physician to reasonably believe there is a high probability of such imminent deterioration.

In contrast, for patients who are clinically stable, the applicable assessment code (based on the service rendered) is the more appropriate service to be claimed (for example, multi-systems assessment [emergency department], or subsequent visit [hospital or nursing home inpatient]). It is understood that at some point, the patient’s clinical status can change such that the patient’s condition is deteriorating and requires critical care.

Note that consultations or assessments rendered before or after provision of critical care may be eligible for payment on a fee-for-service basis, but not when claiming critical care (intensive care area), ventilatory support, comprehensive care, or neonatal intensive per diem fees.

1. Cardiac

Patient with life threatening Acute Coronary Syndrome/STEMI requiring thrombolysis — G521, G522, G523, G391.

2. Neurological

Patient presenting with a stroke or TIA who is clinically stable with a normal workup — appropriate assessment code.

3. Respiratory

Patient with an asthma exacerbation with significant dyspnea, wheeze and tachypnea, who is deteriorating and requires multiple modalities of treatment — G395, G391.

4. Allergy

- (a) Patient with a severe allergic reaction with symptoms or signs of progression and deterioration (for example, significant oral swelling and dyspnea) — G395, G391.
- (b) Patient with life threatening anaphylaxis requiring therapy and/or advanced airway management — G521, G523, G391.

5. Sepsis

- (a) UTI/Pneumonia with a Systemic Inflammatory Response Syndrome (SIRS) where the patient is deteriorating and has a clinical picture of fever, tachycardia, tachypnea and leukocytosis, without shock requiring therapy — G395, G391.
- (b) UTI/Pneumonia (life threatening Sepsis) patient with shock and organ failure requiring aggressive therapy and/or advanced airway management — G521, G522, G523, G391.

6. Trauma

- (a) Trauma (moderate/severe: ISS≤15 in patients aged 16 and older or ≤12 in patients under age 16), patient who is clinically unstable and deteriorating, but without imminent life threatening injuries — G395, G391.
- (b) Trauma (life threatening: ISS>15 in patients aged 16 and older or >12 in patients under age 16) with imminent life threatening injuries and organ failure — G521, G523, G522, G391. Note that the trauma premium E420 is eligible for payment for these patients if the service is rendered on the day of, or within 24 hours of, the trauma.

Note

As with all claims to OHIP, the appropriate fee code is dependent on the individual circumstances of the case and the services rendered. The medical records should support the service(s) claimed and, if audited, would be used to demonstrate that critical care was rendered.

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 or questions on this Bulletin, or suggestions for future Bulletin topics, etc., please submit them in writing to:

Physician Services Committee Secretariat
150 Bloor Street West, 8th Floor
Toronto, Ontario M5S 3C1
Fax: 416.340.2961
E-mail: Secretariat@pscs.ca
Dr. Chester Brown, (Acting) Co-Chair
Dr. Larry Patrick, Co-Chair
Education and Prevention Committee

The PSC 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:

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