



Questions and Answers

relevant to recent EPC Bulletins, including:

*Special Visit Premiums (Vol. 7, No. 1),
Most Responsible Physician Premiums (Vol. 8, No. 1),
and Smoking Cessation (Vol. 8, No. 2)*

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 July 1, 2010 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

The purpose of this Bulletin is to share several questions and answers submitted to the Physician Services Committee (PSC) by physicians for response by the EPC. As noted at the end of EPC 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/or provide additional context.

Special Visit Premiums

Question 1

There have been numerous rejections by OHIP on the billing of these codes during after hours and weekends by myself and others I know.

For example:

You are on-call on the weekend and are called in from home to the hospital to see two or more patients: what are the billing codes for a consultation, plus the special visit premium, plus the travel premium? Similarly, what are the billing codes after 5:00 p.m. during weekdays?

Response 1

The EPC cannot specifically respond to questions on why claims are being rejected. If you have questions about specific services, or why a service may have been rejected, you should contact your local OHIP claims office.

With regard to your questions on what the appropriate fee code(s) would be, the answer would depend on the service(s) rendered (e.g., specialty specific assessment or consultation) and, for the special visit premium(s), the location of where the service is rendered. The following may be helpful:

Location	Table	Schedule Page
Emergency department (non-ED physician)	Table I	GP57
Hospital outpatient	Table II	GP57
Hospital inpatient	Table III	GP58
LTC home	Table IV	GP58
Emergency for ED physician on-call to the ED	Table V	GP59
Home	Table VI	GP60
Palliative care home visit	Table VII	GP61
Physician office	Table VIII	GP61
Other (non-professional setting)	Table IX	GP62

As stated on page GP56, use the "A" prefix assessment fee code from the General Listings when claiming a special visit premium. Specific to physicians on-call for the emergency department, you must also record on the patient's common medical record the time of the request and the reason for the request for attendance. For all other locations, the time the special visit was rendered must be on the patient record.

When travel is required from one location to another (e.g., from home to the hospital), the travel premium may be eligible for payment. A first person seen premium may also be eligible when travel is required, and if additional patients are also seen during that visit, the additional person seen premium may also be eligible for payment (up to the maximum) if a request is made for a special visit to the additional person(s) seen.

An example — assuming you are an internal medicine specialist (13) on-call for the Hospital Inpatients (see Table III): Your first call comes on Saturday at 8:00 a.m. to consult

on a hospital inpatient. You are eligible for the Consultation (A135 for internal medicine), the travel premium and the first person seen (C963 and C986). While there, you are asked to see another patient. You are eligible for the additional person seen (C987). You return home. You are called again on Saturday at 6:30 p.m. to see three patients who have deteriorated that day. Assuming you render the service described by a medical specific assessment, you are eligible for three A133s for the assessments, the travel premium, the first person seen and two additional persons seen (C963, C986 and two C987s).

With regard to your question on which special visit fee codes are eligible for weekdays after 5:00 p.m., please refer to the appropriate table based on the location of the visit.

Question 2

In reading Vol. 7, No. 1 of the Interpretive Bulletin wherein you discussed special visit premiums, I need to know more of the B962. I would very much appreciate further information on this code. I provide in-home service and often have to travel 45 minutes each direction to get to a patient's home. This is a cost-prohibitive service, so this transit fee would be most welcome.

Response 2

EPC Bulletin Vol. 7, No. 1 references the October 1, 2009, version of the Schedule of Benefits for Physician Services, however, a newer version, effective July 1, 2010, now exists. The most current and up-to-date Schedule is always available electronically on the Ministry website at: http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html.

With regard to fee code B962, this is the travel component of the special visit premium for non-elective home visits (evenings, Monday through Friday). A premium may be eligible for payment when you are required to travel from one location to another location (the destination location) in order to see a patient.

See Table VI on page GP60 of the Schedule for the appropriate special visit fee codes for Home visits.

Example 1: If you are making a non-elective visit to a patient's home (e.g., apartment building) and are required to travel from one location to the patient's home to provide the service on an evening from Monday to Friday, you are

eligible for payment of the house call assessment (A901), a special visit premium for the first person seen (B994), and the travel component (B962).

If you see other patients at the same home or multiple-resident dwelling (see the “Note” on page GP60), you are not eligible for payment of the special visit premiums for the other patient(s) seen.

If you see two patients who reside in the same apartment building (whether in the same unit or not) on the same visit, you are only travelling once to the apartment building. Therefore, you are only eligible for one travel premium (B962) and one first person seen premium (B994). You are eligible for the appropriate assessment code for the second person seen (other than a general assessment).

If you must then travel to another location (i.e. not the same home, dwelling or building complex), then you are eligible for the travel premium component, the first person seen and A901. Please note that there is a maximum of two travel premiums (B962) payable for non-elective special visits per day (evenings, Monday through Friday), and a maximum of 10 first person seen premiums (B994) per day. This means that, while you may still be required to travel from one location to another, you cannot claim more than two travel premiums; however, you may still be eligible for the first person seen premium at a new location, provided the requirement to travel from one location to the destination location has been met, and you have not exceeded the maximum.

See Example 1 in the EPC Special Visit Premium Bulletin. You must also record, on the patient’s chart, the time of the special visit in order for the services to be eligible for payment.

Smoking Cessation Counseling (E079 and K039)

Question 1

Re: your excellent explanation for E079 and K039.

But in my practice, as a community cardiologist, more than 10% of my patients do not have a family doctor. Many of my patients still smoke! What code should I use if I do smoking cessation counselling?

Response 1

E079 and K039 are Family/General Practice codes listed on page A25 of the Schedule of Benefits. These services are eligible for payment to the primary care physician most

responsible for the patient’s ongoing care. If you are seeing a patient as a cardiologist and you provide counselling for smoking cessation, you may be eligible for payment of a K013/K033 counselling service, provided the requirements of counselling are met. However, note that counselling codes are not payable in addition to an assessment or consultation.

Question 2

Re: E079 in Bulletin Vol. 8, No. 2.

In Examples 1 and 2, is E079 eligible for payment if the patient seen does not have a family physician to provide ongoing care?

Response 2

No, if a patient does not have a primary care physician who is most responsible for providing ongoing care, the service is not eligible for payment to any physician.

Question 3

I wanted to comment on the Bulletin in the February 2010 OMR regarding E079/K039. I am a practicing family physician and I noticed many of my E079 codes were getting rejected by OHIP. I started covering a walk-in clinic on the weekends, and the front desk told me the other physicians in the walk-in all add an E079 automatically to ALL smokers, regardless of reason for the visit. This annoys me to no end! So, I am the one counselling these patients for 20 to 30 minutes in my office and see them regularly, yet I can’t get reimbursed for it because they went to a walk-in at some point in the last year! I think the E079 and K039 should be for enrolled patients only, that way, walk-in doctors can’t claim it on a five-minute appointment for a cold! The honour-system is obviously not working!

Response 3

Thank you for your comments. Unfortunately, the EPC is not able to address your concerns specifically; however, we will forward your comments to the Medical Services Payment Committee (MSPC), a joint OMA/Ministry committee tasked with, among other things, making recommendations for fee codes and payment requirements. If you would like to make a complaint to the Ministry regarding the specific patients for whom your claims for the smoking cessation services were disallowed and paid at zero with an explanatory code M1 (maximum fee allowed or maximum number of services has been reached by same/any provider), please provide:

- your OHIP billing number; and
 - the health numbers of patients for whom the smoking cessation claims have not been paid, in writing, to: Health Services Branch, Manager, Payment Integrity, 370 Select Drive, P.O. Box 168, Kingston, ON, K7M 8T4.
- Alternatively, a copy of the remittance advice highlighting these unpaid claims may be submitted.

Question 4

For smoking cessation codes, do I have to bill an E079 every 365 days to claim two subsequent K039 that year following each E079? Or can I bill K039 twice a year after billing an E079 once ever?

Response 4

A smoking cessation follow-up visit (K039) is eligible for payment up to two times in the 12-month period following the initial visit (E079). K039 is not eligible for payment, unless an initial discussion has occurred in the 12-month period prior to the claim. The simple answer to your question ("Or can I bill K039 twice a year after billing an E079 once ever?") is no. If the patient continues to smoke, the initial discussion must occur again no sooner than 12 months after the service was last provided.

Most Responsible Physician (MRP) admission assessment and subsequent visit premiums (E382 and E083)

Question 1

I admit a patient for a bladder tumour resection. This is a Z-code. Can I charge E082 on day of admission, and E083 for subsequent hospital visits and discharge?

Response 1

Provided the patient is an inpatient and you are the MRP, and you have rendered the admission assessment and are not receiving additional remuneration for the provision of clinical MRP services (as stipulated on page GP32 and GP37), and provided the patient is not receiving a non Z-code surgical procedure in conjunction with the Z-code procedure, then you are eligible for payment of E082 for the admission assessment and for E083 for the subsequent visits and discharge assessment, provided the services are rendered in accordance with the Schedule.

Question 2

I admit a patient for a prostate resection. This is an S code.

Can I charge E083 for subsequent post-op visits and day of discharge?

Response 2

As stated on page SP1 of the Schedule, for non Z-prefix services, the specialty-specific subsequent visit may be claimed only for the first and second in-hospital post-op visits. The E083 premium may be eligible on the first two post-op visits, provided you are the MRP and are not receiving additional remuneration for the provision of clinical MRP services (as stipulated on page GP37). Similarly, the premium also applies to the discharge assessment, which, if you are the MRP, would be billed as C124.

Question 3

Please take a look at the following scenario and clarify the legitimacy of claiming the E codes:

A hospitalist group works days, Monday to Friday, covering inpatients and getting a weekly stipend. It is clear that when billing the E082 and E083 codes, the group members should expect a decrease in the hospital stipend by the amount of these E codes.

Here's the question:

For any nights and weekends that these physicians work on-call as MRPs (not as hospitalists), they should be able to bill the E082/083 codes just as any other non-hospitalist would, correct? If, on the other hand, these physicians cannot bill these premiums independent of the hospitalist stipend, then why should another internist or family doctor doing call bill these?

Response 3

Fee codes E082 and E083 are premiums for eligible services provided by the Most Responsible Physician. The MRP is defined on page GP4 of the Schedule as "the attending physician who is primarily responsible for the day-to-day care of a hospital inpatient." If a physician receives direct or indirect remuneration from the hospital (or hospital foundation) for rendering inpatient clinical services, then the remuneration must be reduced by at least the amount that would be eligible for payment from the premium. This applies regardless of the time or day that the service is provided. As previously stated, the premium is only eligible for payment to the patient's MRP, therefore, another physician performing on-call duties, who may not be the MRP, is not eligible for payment of the premium.

Your feedback is welcomed 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. Jane MacNaughton, 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