Schedule Changes to Pre-Dental/Pre-Operative Assessments, and Fee Code Z110

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 services provided and that are in compliance with the law.

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 September 1, 2011, 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 are available on the OMA website (http://www.oma.org/Resources/Pages/EPCbulletins.aspx). The Schedule is available on the Ministry website (http://www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html).

Purpose

The purpose of this Interpretive Bulletin is to provide physicians with information on specific changes to the Schedule, which came into effect in 2011.

While there were several changes to the Schedule in 2011, this Bulletin focuses on revisions specific to:

- pre-dental/pre-operative assessments; and
- fee code Z110 (extensive debridement of an onychogryphotic nail involving the removal of multiple laminae).

Pre-Dental/Pre-Operative Assessments

New fee codes for pre-dental/pre-operative assessments rendered by specialists (A904, C904 and W904) were added to the Schedule, effective July 1, 2011. In addition, amendments were made to the pre-dental/pre-operative general assessment (A903, C903 and W903).

A pre-dental/pre-operative assessment, listed on page A3 of the Schedule, is described as the service "required to provide history and physical exam information to the perioperative team that will be assessing suitability for surgery and anaesthesia."

There are separate listings for the pre-dental/pre-operative assessment, depending on the level of assessment rendered and the specialty of the physician. The location of the patient determines the appropriate prefix:

- A903, C903 (non-emergency hospital inpatient), W903 (non-emergency long-term care inpatient) — when a

full general assessment is rendered by the primary care physician in the specialty of general/family practice, pediatrics or emergency medicine; and
- A/C/W904 — when the assessment is rendered by a physician in any other specialty.

Payment Requirements

A/C/W903 require that a full medically necessary general assessment be rendered, the elements of which include a full history, family medical history, an examination of all body parts and systems, and other requirements listed on page GP18.

A/C/W904 require, at a minimum, that a medically necessary partial assessment be rendered, which includes a history of the presenting complaint and the necessary physical examination (see page GP20).

These services are not eligible for payment for filling out a hospital's pre-operative form, unless the payment requirements of the service have been met (i.e., these are not form fees).

Limits and maximums:
- Only one pre-dental/pre-operative assessment is eligible for payment per patient for the same surgical procedure;
- A/C/W904 are not eligible for payment when rendered on the same day as the surgery; and
- A/C/W903 are limited to a maximum of two services per patient per physician over a 12-month period (they also constitute "general assessments" for the purpose of calculating the general assessments limits stated on page GP18).

Note: When a claim for a pre-dental/pre-operative assessment for an individual patient is payable by OHIP, and that patient is subsequently admitted to hospital for elective surgery within 30 days of the pre-dental/pre-operative assessment, the admission general assessment (C003) or a general re-assessment (C004) is not eligible for payment.

The patient's medical record must document the findings of the assessment, and meet the payment requirements for the level of assessment rendered. The assessment must also be personally rendered by a physician and cannot be delegated to a non-physician for OHIP payment purposes.

	A/C/W903	A/C/W904
Assessment required	General Assessment	Partial assessment at a minimum
Eligible specialties	General/Family Practice (00), Emergency Medicine (12), or Pediatrics (26)	All specialties other than 00, 12 or 26
Limits	Maximum of two per patient per physician per 12-month period	Not eligible on day of surgery
	Regarding a patient and his or her surgery: • only one pre-dental/pre-operative assessment is eligible for payment (i.e., one of these six codes); and • only one physician is eligible for payment of a pre-dental/pre-operative assessment.	

Examples

Example 1

Dr. W is a family physician. On October 3, 2011, she performed a pre-operative assessment prior to cataract extraction from Mrs. F's left eye.

Is Dr. W eligible for payment of A903?
Yes, provided the payment requirements are met (including a complete general assessment) and the maximums for general assessments (including A003) for the 12-month period have not been reached. If a complete general assessment is not medically necessary or not performed, a minor or intermediate assessment should be claimed based upon their specific payment requirements.

Example 2

Dr. T, an anesthesiologist, evaluates 78-year-old Mr. B prior to Ministry of Health and Long-Term Care pre-approved day surgery to extract Mr. B's remaining teeth. Is Dr. T eligible for payment of A904 for this service?

If the purpose of Dr. T's evaluation is only to provide the peri-operative team with patient history and physical examination, the evaluation is not on the same day as surgery, and the evaluation is not performed as the pre-anesthetic evaluation that is included in the anesthetic service (see GP70), then A, C or W904 may be eligible for payment, provided the requirements of the pre-dental assessment are met.

If Dr. T is the physician who administers the anesthesia for Mr. B, and the evaluation is performed on the same day as surgery, A904 is not eligible for payment based on the payment rules for A904.

Example 3

Dr. H, a family physician, assesses Mrs. G. on admission for an elective hysterectomy. Is Dr. H eligible for payment of a pre-operative general assessment?

Provided that a pre-operative general assessment has not been performed by Dr. H in the last 30 days, he is eligible for payment of A/C903. However, if Dr. H or any other physician has performed a pre-operative assessment in the last 30 days, that service constitutes the admission assessment, and an additional admission assessment (e.g., C003 or C004) is not eligible for payment.

Example 4

Dr. S, a surgeon, renders a consultation to a patient and recommends surgery at the visit. The information required for the peri-operative team (which includes Dr. S as surgeon) is gathered and documented during the assessment/consultation, thereby satisfying the hospital's requirements for pre-operative paperwork. Is A904 payable in addition to the consultation?

No, A904 is not payable on the same day as a consultation as, in general, only one assessment is eligible for payment to a physician on the same day. In the example above, because the information required to fill out a pre-operative form was obtained during the consultation, a separate service is not payable as A904 is not simply a form fee.

Z110 – Extensive Debridement of an Onychogryphotic Nail, Involving Removal of Multiple Laminae

Effective September 1, 2011, the Schedule was amended to require that the service described by Z110 must be rendered personally by the physician in order to be eligible for payment of the listed fee. If the service is not rendered personally by the physician (e.g., delegated to a non-physician) it remains insured for the patient (which means that the patient cannot be charged), and payable at zero to the physician.

Extensive debridement of an onychogryphotic nail (Z110) may be eligible for payment to a physician who personally removes multiple layers of the onychogryphotic nail. As with all insured services, the patient's medical record must document and support the service claimed. Z110 is not eligible for payment for trimming or clipping of nails. The provision of medically or therapeutically necessary general foot care services that are not separately listed in the Schedule are specific elements of the assessment. See page M19 of the Schedule for the description of Z110.

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 (referencing this Bulletin) to:

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The PSC Secretariat will anonymously forward all EPC Interpretive Bulletin comments, questions or 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:

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