

OHIP BILLING for ANESTHESIOLOGY

(Updated September 13, 2011)

Introduction

Review the SOB (Schedule of Benefits) on line at either the OMA website or the MOHLTC website http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html.

Another good place to look is the Physician Manual, which contains the diagnostic codes, at the website www.health.gov.on.ca/english/providers/pub/ohip/physmanual/physmanual_mn.html.

Read the Preamble of the SOB, paying particular attention to the section for Anesthesia.

The schedule has just been updated July 2011. Updates may occur every 6 months so be vigilant for any increases/changes.

Remember: **everything** we do is billable.

Submit your bills as soon as possible.

Please check to see that the correct date is on the top...with the month in writing rather than numbers.

General Preamble

The Anesthesia unit is currently worth \$15.01.

Most procedures have a minimum basic unit of 7. Some procedures have a basic unit of 6. Cataracts, Endoscopy and Standby have a basic unit of 4.

All anesthesia service codes should have the suffix "C". (This means that the claim is being submitted for the anesthesia component.)

Consultations, assessments and most procedures (except placement of labour epidurals) use suffix "A". All of these claims require a **Diagnostic Code**.

Most consultations and assessments should be claimed using the prefix "A". The prefix "C" should only be used for non-emergency in-patient services.

Note that the HDH is not considered an in-patient hospital and claims using the prefix "C" will be rejected. Thus, **EPACU patient visits** should be billed using A013A/A014A.

Specific Anesthetic Services

Anesthetic service claims (suffix "C") will include:

- Basic units
- Time units
- Add on codes
- After hours premium
- Special visit premium

Time units

- Value for each 15 minute period or part thereof
- During the first hour or less = 1 unit/15 minutes or part of
- After the first hour but before 90 minutes = 2 units/15 minutes or part of
- After 90 minutes = 3 units/15 minutes or part of

After hours premium for anesthetic services (suffix "C")

- Payable when the case starts
- Apply to all anesthetic services, including labor epidurals, using suffix "C"

E400C	Monday to Friday 17:00 – 24:00 Weekends and Holidays 07:00 – 24:00	+ 50%
E401C	Nights 00:00 – 07:00	+75%

After hours premium for major invasive procedures

- Apply to G125A (lumbar epidural), G118A (thoracic epidural), G268A (arterial line), G269A (central line), G211A (endotracheal intubation)

E409A	Monday to Friday 17:00 – 24:00 Weekends and Holidays 07:00 – 24:00	+ 50%
E410A	Nights 00:00 – 07:00	+75%

Special Visit premium for anesthetic services (suffix "C")

- Payable when you are required to make a special visit, *from outside of the hospital*, to provide anesthetic services
- Applicable only to the first patient seen on each special visit

C998C	Monday to Friday 17:00 – 24:00
C985C	Weekends and Holidays 07:00 – 24:00
C999C	Nights 00:00 – 07:00

Special Visit premium for other services (suffix "A")

- Applicable to consultations, assessments and procedures, resuscitation codes
- Excludes patients seen on routine rounds and critical care team fees
- Consists of a travel premium (for travel from outside of the hospital), first person seen premium and additional persons seen (for the same special visit) premium
- First person seen and additional persons seen premiums are eligible even if there is no travel from outside the hospital
- The time when the visit takes place must be documented on the medical record

- Use “A” rather than “C” prefix when submitting codes for consultations and visits (e.g A015A rather than C015A for a consultation)
- For in-patients (KGH):

First Person Seen	
C990A	Monday to Friday 7:00 – 17:00
C994A	Monday to Friday 17:00 – 24:00
C986A	Weekends and Holidays 07:00 – 24:00
C996A	Nights 00:00 – 07:00

Additional Person Seen	
C991A	Monday to Friday 7:00 – 17:00
C995A	Monday to Friday 17:00 – 24:00
C987A	Weekends and Holidays 07:00 – 24:00
C997A	Nights 00:00 – 07:00

Travel Premium	
C960A	Monday to Friday 7:00 – 17:00
C962A	Monday to Friday 17:00 – 24:00
C963A	Weekends and Holidays 07:00 – 24:00
C964A	Nights 00:00 – 07:00

- For patients at HDH and all other outpatients:

First Person Seen	
U990A	Monday to Friday 7:00 – 17:00
U994A	Monday to Friday 17:00 – 24:00
U998A	Weekends and Holidays 07:00 – 24:00
U996A	Nights 00:00 – 07:00

Additional Person Seen	
U991A	Monday to Friday 7:00 – 17:00
U995A	Monday to Friday 17:00 – 24:00
U999A	Weekends and Holidays 07:00 – 24:00
U997A	Nights 00:00 – 07:00

Travel Premium	
U960A	Monday to Friday 7:00 – 17:00
U962A	Monday to Friday 17:00 – 24:00
U963A	Weekends and Holidays 07:00 – 24:00
U964A	Nights 00:00 – 07:00

Cancelled surgery

- If you have seen the patient but not started anything, bill a visit (C012A at KGH, A014A at HDH).
- If you have started the anesthetic but not the surgery, bill E006C B6 plus time (or the basic for the case, if you feel justified).
- If the surgery is started and aborted, bill full procedure codes.

Replacement Anesthetist E005C

- Bill E005C B6 plus time units
- Qualifies for after hours premium based upon the start time of the case
- Qualifies for all premiums

Second Anesthetist E001C

- Bill E001C B6 plus time units
- Qualifies for all premiums

Extra Units

- Can be in addition to any code with base units except cataracts and standby

		<u>Units</u>
E021C	Premature newborn less than 37 weeks	9
E014C*	Newborn	5
E009C*	Infant from 29 days to 1 year	4
E019C*	Child from 1 to 8 years inclusive	2
E007C*	Adult aged 70-79 years inclusive	1
E018C*	Adult 80 years and older	3
E010C	Patient with BMI >45 (must be noted on the chart)	2
E011C	Patient in prone position	4
E024C	Patient in sitting position during surgery, greater than 60 degrees upright	4
E012C	Patient with MHS	5
E022C	ASA 3	4
E017C	ASA 4	10
E016C	ASA 5	20
E020C	ASA E – for ASA 3 or higher and case starts within 24 hours of booking	4
E025C	Massive transfusion >70 ml/kg or 10 units	10
C101A	For patients seen on a visit to ICU or CCU	

*These codes do not need to be submitted because they are automatically added by OHIP

Trauma Premium E420A

- Applies to claims on day of trauma or within 24 hours
- Adds 50% to all consults, resuscitation codes and anesthesia codes
- Requires the ISS score to be “on the medical record” and greater than 15 for an adult
- **Injury Severity Score ISS:** see calculator on www.anesthesia.ca (Links)

Special circumstances

In the following situations, the base units are replaced by the following base units:

		<u>Units</u>
E650C	Cardiopulmonary bypass	28
E645C	Off-pump coronary artery graft	40
E002C	Hypothermia	25
E013C	Relief of acute upper airway obstruction (above carina)	10

Other codes of interest

		<u>Units</u>
G459A	Arterial puncture	
G268A	Arterial cannulation	
G269A	Central venous cannulation	
Z438A	Pulmonary artery catheter	
G211A	Endotracheal intubation for resuscitation	
Z327A	Bronchoscopy for intubation	
Z342A	Bronchoscopy for placement of endobronchial blocker or DLT	
G322A	Insertion of nasogastric tube under anesthesia	
Z540A	Insertion of duodenal feeding tube	
Z437C	Cardioversion	6
G478C	ECT in-patient	6
G479C	ECT out-patient	6
E023C	EUA or cataracts with deep sedation or general anesthesia	6
E003C	Standby – no extra units premiums	4

Resuscitation

Life threatening emergency

- First ¼ hour G521A
- Second ¼ hour G523A
- After first half hour, for every 15 minutes or part thereof G522A

Other resuscitation

- First ¼ hour G395A
- After first ¼ hour, for every 15 minutes or part thereof...G391A

Consultations and Visits

These are coded with A and C prefixes. The “A” prefix is the default choice and should be used in most circumstances. The “C” prefix is reserved for elective, in-hospital services. The HDH is not considered an in-patient hospital and thus all claims with “C” prefix from the HDH will be rejected. **Generally speaking, the only time you should use the “C” prefix is for patients seen routinely on APMS rounds and for visits to OB patients the day following delivery. For all other visits you should use the “A” prefix.**

Consultations (A015A, C105A)

- Requires a written request either in the form of a letter or an order in the patient’s chart
- Requires a written response, either as a letter or in the patient’s chart
- Requires a Diagnostic Code - these can be found in the Physician Manual at the site noted above. Some commonly used codes are attached at the end of this outline.
- The A prefix should be used preferentially (usually paid without difficulty) as most consults are urgent/emergent situations

Repeat Consultation (A016A, C016A)

- Requires all of the above and some element of interval care which changes the situation

- Requires another consult (written)

Limited consultation for Acute Pain Management (A215A)

- Must be requested by another physician
- Is for other than chronic pain or routine post-op pain management (routine is im/sc injections)
- Must perform a specific assessment and submit opinions in writing

Specific Assessment (A013A)

- Requires a full history of presenting problem and focused physical and documentation in chart
- This is the code most often applicable for PACU assessments and EPACU assessments requested due to specific problems

Partial Assessment (A014A)

- Focused history/physical to assess response to treatment or advice
- Same as subsequent visit
- Usual EPACU assessment day of surgery AND morning following surgery

Preoperative or Pre Dental General Assessment (A903A)

- Is a general assessment required prior to surgery under anesthesia in a hospital
- Can be done by anesthesia as long as it is not done on the same day as the surgery
- Does not require a written request or diagnostic code

Detention (K001A per ¼ hour)

- Read preamble
- Not always paid by OHIP so try not to use this

Subsequent Visit (C012A)

- Routine assessment in hospital
- Limited to one/day (day means calendar day)

Physician to Physician Telephone Consultation

- This service includes all services rendered by the consultant physician to provide opinion/advice/recommendations on patient care, treatment and management to the referring physician
- The consultant physician is required to review all relevant data provided by the referring physician
- **K730A** – Referring physician
- **K731A** – Consultant physician

Midwife-Requested Anesthesia Assessment (A816A, C816A)

- Assessment of mother or newborn on written request by midwife

Acute Pain

Neuraxial Blocks

- These can be billed if they are done to provide postoperative pain relief but not if they are the sole anesthetic
- There is no longer a discount if concurrent with a GA, as long as they are intended to provide analgesia for more than 4 hours

G248A	Caudal, single injection
G125A	Caudal/lumbar epidural with catheter
G118A	Thoracic epidural with catheter
G062A	Cervical epidural with catheter

Spinal injection of narcotic G222A

- Duration of action more than 4 hours
- Does not apply to fentanyl or sufentanil (specifically stated)

Nerve Blocks

- Eligible for payment only if intended to provide pain relief for more than 4 hours

Major Plexus Block G260A

- Brachial plexus, lumbar plexus, sacral plexus, deep cervical plexus, or a combined 3-in-1 block which must include the femoral, obturator and lateral femoral cutaneous nerves.
- When a major plexus block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.
- When 2 or more nerve blocks of major and/or minor peripheral nerves that are within the distribution of a major plexus are rendered individually, only G260 is *eligible for payment*.

Major Peripheral Nerve G060A

- A block of one of: radial, median, ulnar, musculocutaneous, **femoral, sciatic, common peroneal and/or tibial**, obturator, suprascapular, pudendal (uni or bilateral), trigeminal or facial nerve;
- **A paravertebral block** – first injection only;
- An **ankle block** (must include 2 or more of the following: deep peroneal, superficial peroneal, posterior tibial, saphenous or sural nerve);
- **A fascia iliaca block.**
- G060 is limited to a maximum of 4 services per patient per physician per *day*.

Minor Peripheral Nerve G061A

- A block of one of: ilioinguinal and/or iliohypogastric, genitofemoral, lateral femoral cutaneous, saphenous, occipital, supraorbital, infraorbital or glossopharyngeal nerve;
- An intercostal block;
- A superficial cervical plexus block;
- **A transversus abdominis plane (TAP) block;**
- **A paravertebral block** – additional injection.
- G061 is limited to a maximum of 4 services per patient per physician per *day*.

- When a minor peripheral nerve block is rendered, additional blocks of one or more nerves within the same nerve distribution are *not eligible for payment*.

Nerve Block Catheter G279A

- Paid in addition to applicable plexus or peripheral nerve block EXCEPT when inserted for femoral 3-in-1(G260)→ bill G060 and G279 in this case

Epidural Blood Patch

- Epidural Blood Patch – **G068A**
- Epidural Blood Patch, injection through existing catheter – **G065A**

Maintenance of continuous catheter infusions for analgesia G247A

- Max 3 visits/day
- After hours premium

E402A	Monday to Friday 17:00 – 24:00 Weekends and Holidays 07:00 – 24:00	+ 40%
E403A	Nights 00:00 – 07:00	+50%

IV PCA

- Initial assessment A215A (acute pain assessment) or A015A(consult)
- Daily visits C012A (once/day) except at HDH, when A014A code should be used
- Consider billing Specific Assessment A013A or Partial Assessment A014A if it is complicated

HDH Arthroplasty

- Please enter patients into APMS system and record their assessment on the computer system

Obstetrical Anesthesia/Analgesia:

Epidural

- Acute Pain assessment A215A (with diagnostic code, suggest 787)
- Insertion of catheter P014C B6
- Maintenance P016C (one unit for each ½ hour, to a max of 12 units)
- After hours premiums apply (E400C, E401C)
- ONLY Premiums for obesity, ASA class, and afterhours premiums can be added
- Add-on for CSE – E111A - can be billed in addition to P014C
- **CANNOT** bill for epidural morphine(G222) with P014C, P016C

Delivery

- Standby or top up E100C (time units only - suggest using the other standby code for MAC)
- Operative delivery (forceps, vacuum) P020C B6
- Repair of tear or extension of episiotomy P028C B6
- PPH, including uterine curettage Z774C B6
- Removal of retained placenta P029C B6

C-Section

- C-section P018C B7 + G222A if intrathecal narcotics (> 4 hrs duration) are given
- Remember to bill C012A for next date (code 650)

IV PCA

- Acute pain assessment (A215A)
- Visits (C012A, only one/day)
- Attendance at delivery (E100C) prn

Neonatal resuscitation

- see Obstetrical Preamble p.K2
- If applicable, can bill full resuscitation codes or intubation plus specific assessment

Cardiac and Critical Care (CVRI):

CVRI patients

- Comprehensive Care - G557A 1st Day
- G558A – 2nd Day intubated
- G401A – 2nd Day not intubated
- **This is an all-inclusive fee to which nothing can be added**

Call back for Cardiac case

- Bill Special Visit premium C998 or C999 + case

TEE

- Specific assessment (A013A) or consult (A015A)
- Second Anesthetist E001C
- TEE probe insertion G580A
- TEE procedure G581A
- Echocardiography interpretation: complete G571A, limited G575A
- Cardiac Doppler procedure G578A (will be rejected if not accompanied by G571A)
- Saline study G579A

Cardiac Surgery

- E650C B28 replaces the basic unit fee for all cases using cardiopulmonary bypass
- E645C B40 for OPCAB

Cataracts and Other Ophthalmologic Procedures under MAC

MAC for cataracts and other ophthalmologic procedures (E137C, E138C, E139C, E140C, E141C, E143C, E144C, E145C, E146C) are not eligible for extra units for ASA status, BMI>45 and age. If you provide deep sedation or general

anesthesia or if you perform a nerve block for the procedure, then bill E023C in place of the usual code. E023C is eligible for extra units for ASA status and age.

Common Diagnostic Codes for Consultation billing:

CAD 412	Diabetes 250
ACS 413	HTN 401
CHF 428	Cirrhosis 571
Arrhythmia 427	Chronic renal failure 585
Other Cardiac 429	Pregnancy 650
PVD 443	Pre-eclampsia 642
COPD 496	Trauma 959
Asthma 493	Shock 785
OSA 786	Anxiety 300
Other Respiratory 398	Pain – Abdominal 787
Osteoarthritis 715	Pain – Chest 785
Rheumatoid Arthritis 714	Pain – Joint, Leg, Muscle 781
CVD 437	
CVA 436	
TIA 435	
Epilepsy 345	
Obesity 278	