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billing briefs
Education and Prevention Committee

Education and Prevention Committee (EPC) Billing Briefs are prepared jointly by the Ministry of Health (MOH) and the Ontario Medical Association (OMA) to provide general advice and guidance to physicians on billing matters.

Submission of Claims for Surgical Procedures – Common Situations Where Manual Review Required

Category: Surgery
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Claims Tips: Examples of surgical claims that should be submitted for manual review. Note that when additional documentation (requested by the MOH) is submitted, the claim must be re-submitted at the same time:

- Duplicate service code claimed for same patient, same date.
- Claim resubmitted with a requested operative report.
- Explanation from operating surgeon substantiating need for two surgical assistants.
- Explanation from operating surgeon to substantiate claim for M400B assistant fee when no basic fee is listed.
- Specific services which you want to be manually reviewed by the MOH.
- Out-of-province referring provider information.

Multiple Procedural Fee Schedule Codes

- Surgeons may wish to provide the operative procedure note as well as other documents that may facilitate adjudication of complex procedures where multiple Schedule of Benefits-Physician Services (Schedule) fee schedule codes are claimed. For example, a copy of the Operating Room nursing record to document surgical start/stop times for time-based billing such as R993 etc.
- For particularly complex or unusual procedures, some surgeons provide a cover letter or annotate the operative procedure note to indicate the portions of the procedure that correspond to specific fee codes.

- Providing full documentation with claim submission minimizes delays in adjudication and payment of claims.

Common concerns that may lead to payment delays or denials

Lack of supporting information for specific fee codes such as (but not limited to):

- Trauma premium (E420)-timeframe related to trauma and correctly calculated Injury Severity Score (ISS) score.
- Acute spinal cord injury premium (E383)-requires timeframe of weakness and American Spinal Injury Association (ASIA) score.
- Morbid obesity premium (E676)-requires documentation of patient Body Mass Index (BMI).
- Start/stop times for time-based fee codes (example, R226, R691/R692/R693, R698, surgical assistant claims during 2-surgeon procedures, complex laceration repair, etc.).
- Advancement/rotation/transposition/Z-plasty flaps-requires size of flap and clear description of type of flap performed.
- Laceration repair or scar reconstruction-requires documentation of length of laceration or scar when relevant repair/reconstruction fee codes claimed.

Unbundling of surgical fee codes

- The surgical benefit includes the generally accepted surgical components of the procedure.
- Unbundling occurs when one or more fee codes are claimed that are a generally accepted component of a surgical procedure performed are claimed in addition to or instead of the fee code for the procedure.
- Please note: physicians are expected to claim the most appropriate fee code for a procedure if described in the Schedule rather than claiming a separate fee code for each constituent element of the procedure.
- The purpose of each service provided as part of the procedure will be examined to determine if that service was a constituent element of the procedure. For example, consider whether the procedure could have been performed without the element. If the answer is no, then that element should not be claimed using a separate fee code even if a fee code exists.
- The surgical benefit includes the generally accepted surgical components of the procedure.

Examples	**Incorrect claim**	**Correct claim**	**Explanation**
Anterior resection/ proctosigmoidectomy	S213A + S312A	S213A	A laparotomy (S312A) is a component of a bowel resection therefore this is included in S213A
Total knee arthroplasty	R441A + R412A	R441A	Arthrotomy (R412A) is a component of a total knee arthroplasty therefore this is included in R441A. Note also that the benefit for total joint replacement also includes denervation of the joint, all

			tenotomies and division and repair of muscle.
Umbilical hernia repair performed at the same time as another abdominal surgery	S332A	E764A	The E- code should be used unless the umbilical hernia repair is a stand-alone procedure
Reconstruction of pseudoarthrosis of radius	R323A + E551A (or any other bone graft fee code) + F033A	R323A	The Surgical Preamble says that the benefit for obtaining a bone graft (E551A in this case) is not to be claimed in cases of pseudoarthrosis repair, fusions or for listings in which bone grafting is included. Additionally, if pseudoarthrosis repair involves fracture stabilization by plate/screws or other internal fixation, this is also included in the pseudoarthrosis fee code and may not be claimed using a FSC for fracture fixation (such as F033A).
Claw toe reconstruction	R471A + R557A	R430A	R430A includes the elements of interphalangeal arthrodesis (R471A) and tendon lengthening (R557A) as well as any associated arthrotomy, debridement or synovectomy.
Nerve block for procedural anesthesia	G224A	Nil	When a nerve block is used for procedural anesthesia, it is considered a component of the surgical fee codes and may not be claimed as G224A even if the block provides postoperative analgesia.
Arthroscopy performed solely to visualize joint surfaces during open reduction and internal fixation of related fracture or dislocation	R688A + F077A	F077A	Arthroscopy is a component of F077A when performed purely for visualization.
Cystoscopy performed following total abdominal hysterectomy to exclude iatrogenic injury	Z606A + S757A	S757A	Cystoscopy is a component of S757A when performed for the purpose described.

Claiming for repair of iatrogenic complications

The listed benefit for a procedure normally includes repair of any iatrogenic complications occurring during the course of the surgery performed by the same

surgeon.
For example:

- Repair of a dural tear that occurs during spinal decompression is considered a component of the decompression and may not be claimed as E382.
- Open reduction and internal fixation of a femoral fracture that occurs during a primary total hip arthroplasty is considered a component of R440 and may not be claimed as F096.
- Division of a nerve (intentional or unintentional) as part of dissection and subsequent repair of nerve.

Fee codes claimed that are not supported by the operative record submitted

- Fee code claimed that is not described in the operative procedure note or that does not meet the requirements of the Schedule description.

Examples	Incorrect claim	Correct claim	Why the fee codes do not apply
Bone from femoral head removed at time of total hip arthroplasty used as bone graft during same procedure	R440A + E552A	R440A	Bone harvest fee codes (E551A and E552A) are not applicable for the re-use of bone excised as part of another procedure being claimed (such as total hip arthroplasty).
Use of allograft bone during total hip arthroplasty	R440A + R200A	R440A + E553A	R200A is a fee code for the harvest of cadaveric bone from an organ donor, it is not eligible for payment for the use of allograft bone during another procedure. The use of allograft (bone bank) bone during a procedure should be claimed as E553A.
Infiltration of local anesthetic around the wound at the end of a procedure	G224A	Nil	Infiltration of local anesthetic is included in all surgical fee codes and does not constitute G224. G224 is defined as follows: • a major or minor peripheral nerve block, major plexus block, neuraxial injection (with or without catheter) or intrapleural block (with or without catheter) for post-operative pain control (with a duration of action more than 4 hours) rendered in conjunction with a procedure which the physician performs on the same patient. With the exception of a bilateral pudendal block (where only one service is eligible for payment), G224A is eligible for payment once

			per region per side where bilateral procedures are performed.
Large pedicle flap	R064A	R080A	• Elevation of a free island flap (R064A) is not the appropriate fee code when a pedicled flap (R080A if the flap is large) is performed, regardless of the complexity of the pedicled flap. • A free island flap requires transplantation of a flap from one anatomic area to another with associated microvascular anastomosis.
Application of a vacuum-assisted (VAC) dressing	E550A	Nil	• E550A is only applicable when a closed irrigation system is used. • A VAC dressing is not considered a closed irrigation system. • Application of a VAC dressing is included in the surgical fee codes.
Spinal fusion from L1-L3	E370A + (E366A x 2)	E370A + E366A	• Each fusion level claimed must include two levels of hardware. • This is a 2 level fusion (L1-L2 and L2-L3) rather than a 3 level fusion. • If this fusion only included hardware in L1 and L3 it would be considered one level and claimed as E370A alone).
Large bowel resection/anastomosis-medical record does not support mechanical obstruction	S177A	S167A	• S177 is only eligible for payment for a one stage intestinal resection and repair in the clinical setting of mechanical intestinal obstruction.
Tubal ligation performed for the purpose of sterilization at the time of c-section	S738A + P018A	S741A + P018A	• S738 is only eligible for payment for unilateral or bilateral salpingectomy or salpingo-oophorectomy. • Tubal ligation/interruption/removal by any method or approach for the purpose of sterilization (including at the time of C-section) should be claimed as S741A.

Claiming for an assessment or consultation on the day of surgery

- A visit on the same day prior to surgery is included in the surgical fee unless it constitutes the major pre-operative visit.
- The major pre-operative visit is defined as the consultation or assessment fee which may be claimed when the decision to operate is made and the operation is scheduled, regardless of the time interval between the major pre-operative visit and surgery.

Keywords/Tags

Adjudication; Manual Review; OHIP Claims; OHIP Payment; Surgery

More Information

EPC Billing Brief: Trauma Premium (E420) *<https://www.health.gov.on.ca/en/pro/programs/ohip/billing_briefs/trauma_premium.aspx>*

Contact Information

For additional information, please visit the Resources for Physicians *<http://www.health.gov.on.ca/en/pro/programs/ohip/>* and the How to Get Help with Billing Questions *<http://www.health.gov.on.ca/en/pro/programs/ohip/docs/billing_questions_help.pdf>* pages on the ministry website.

If you have any billing or claims submission inquiries, please contact the Inquiry Services, Service Support Contact Centre (SSCC) by email *<mailto:sscontactcentre.moh@ontario.ca>* or by calling 1-800-262-6524.

To provide feedback on EPC Billing Briefs, or to suggest topics for future EPC Billing Briefs, send an email *<mailto:info@oma.org>* to the attention of the joint MOH/OMA Education and Prevention Committee.

The Ministry of Health (MOH) and the Ontario Medical Association (OMA) have jointly prepared this educational resource to provide general advice and guidance to physicians on specific billing matters.

The Ministry of Health (MOH) 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 for payment for the insured service provided.

EPC Billing Briefs are prepared jointly by the MOH and the OMA to provide general advice and guidance to physicians on billing matters. EPC Billing Briefs are provided for education and information purposes only. The information provided in this EPC Billing Brief is based on the December 2022 Schedule of Benefits - Physician Services (Schedule).

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