Joint IBC & Coalition Coding Practice FAQ #2

Questions often are raised by facilities and insurers about how certain injuries and treatments should be coded by health care facilities, using Ontario claim forms (OCFs) that are submitted through HCAI. Stakeholders agree that adoption of consistent coding practices is important to improve the reliability of HCDB reports, which will provide stakeholders with a better understanding of the medical and rehabilitation costs in the Ontario automobile insurance health system. This will also facilitate fair adjudication by insurance adjusters. HCDB Coding Practice FAQs are designed to improve stakeholders' ability to use and comprehend ICD-10-CA[1,2], CCI[1,3] and GAP codes.

CAUTION

These FAQs are for guidance purposes only, intended to assist health care facilities and insurers in understanding elements of the injury and intervention codes used on OCFs. The information supplied in this document has no legal or regulatory authority and is not to be relied on as legal advice. Many factors unknown to us may affect the applicability of any statement or comment made in these FAQs to any particular claim. Health care professionals and insurers must continue to evaluate injury claims individually based on the merits of each case. Disagreements related to the use or interpretation of injury and intervention codes will not be resolved by IBC, by the Coalition or by FSCO and should be discussed between the insured person, the insurer and the health practitioner.

GOODS AND SERVICES ARE ADJUDICATED (NOT THE CODE)

All injury and intervention codes transmitted from a provider to an insurer via HCAI are valid codes. Insurer adjudication decisions are not based on the code used by a provider. Adjudication decisions will continue to be informed by the reasonableness and necessity of goods or services for an individual claimant, which are represented by a code. But submission of a valid code representing proposed goods or services will not necessarily result in approval of those goods or services.

[1] ICD-10-CA is based upon the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10). © World Health Organization 1992. All rights reserved.

[2] © ICD-10-CA – Canadian Institute for Health Information

[3] © CCI – 2006 Canadian Institute for Health Information

Coding Practice FAQ #2: How do I invoice x-rays as part of the MIG?

As of November 1, 2012, an amended OCF-21C is in effect which contains amendments to the previous form. These changes include the requirement to use a MIG[4] code when charging fees for delivery of x-ray services.

Background

When a clinic or provider wishes to invoice for MIG4 services that have been approved by an insurer, health providers must use an OCF-21C.

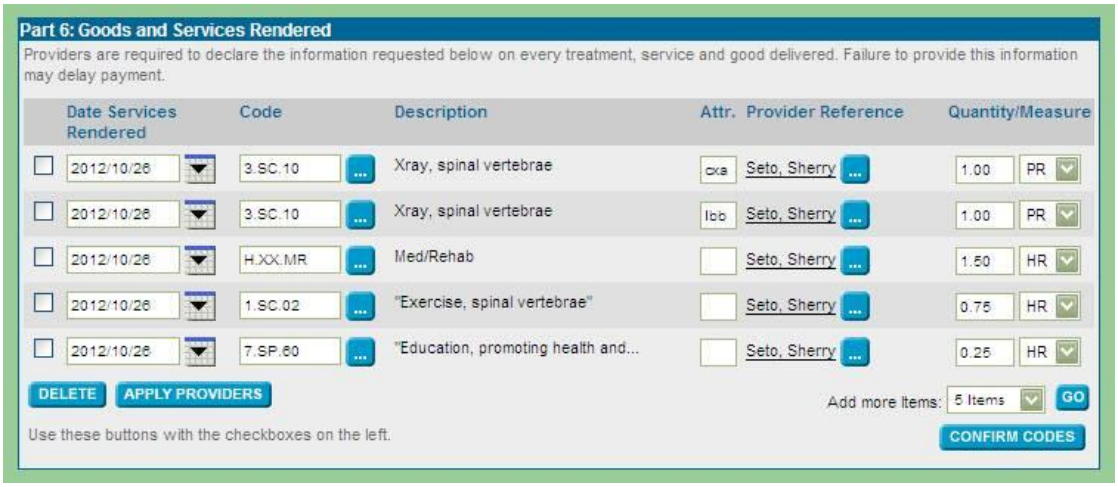
Charges for MIG4 services, including x-ray services, are inserted into Part 7 of the OCF-21C (*Reimbursable Fees within the Minor Injury Guideline or Pre-approved Framework*). As of November 1, 2012, Part 7 of the OCF-21C will only allow providers to select MIG (and PAF) codes (click here to view PAF and MIG codes).

There are no MIG-specific (or PAF) codes that capture x-rays that are authorized in Appendix C of the PAF or MIG.

How should providers invoice fees for x-rays delivered as part of the MIG?

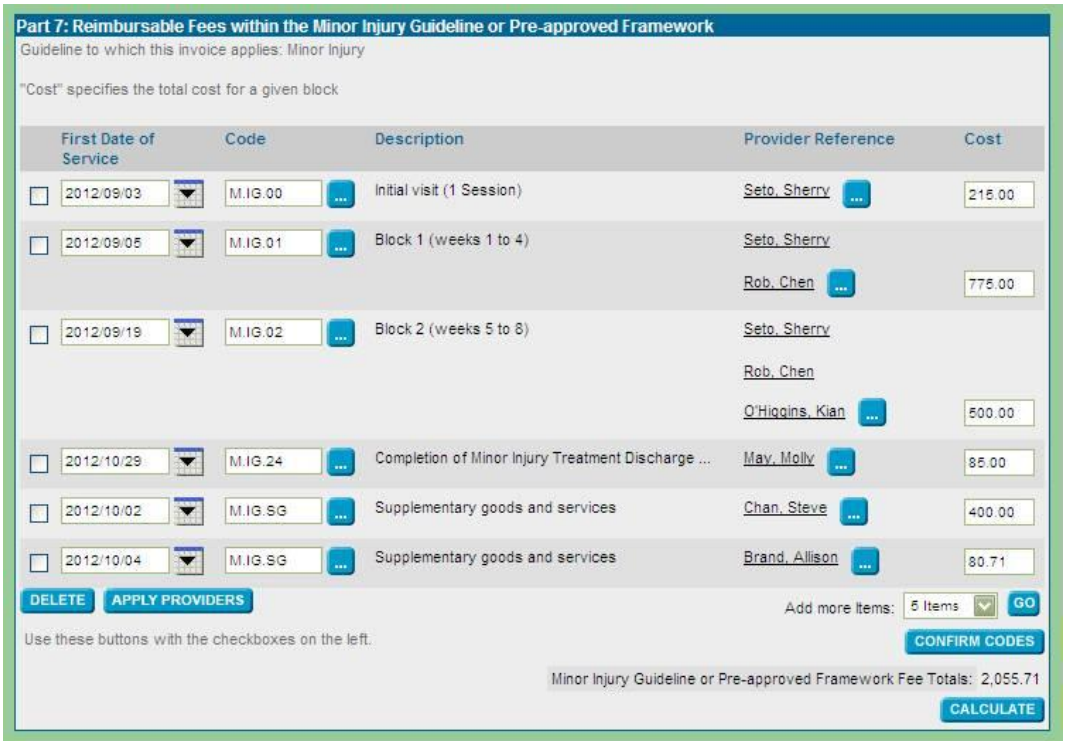
As of November 1, 2012, providers will need to invoice x-rays in Part 7 of the OCF 21-C without using CCI codes. In future, new MIG codes may be introduced to reflect x-rays. The following describes a recommended process for invoicing x-rays as authorized by the MIG4:

1. Part 6 – Goods and Services (see screen shot below)
    a. Part 6 of the OCF-21C asks providers to list all goods and services delivered to the patient on each treatment visit. For example, if a patient attended 12 treatment visits and received 2 types of treatment each visit, there will be 24 line items.
    b. Only use CCI or GAP codes**.**
        i. **Do not use the MIG (M) or PAF (P) block billing codes in Part 6**. MIG and PAF block billing codes should only be used in Part 7.
    c. In Part 6 you may insert the CCI codes for x-ray services along with the appropriate attributes. No fees should be included in this section as they will be listed in Part 7.



[4] If the accident occurred **prior** to September 1, 2010, PAF services and PAF codes should be used.

2. Part 7 – Fees (see screen shot below)
    a. Part 7 is where the provider indicates the fees being charged for MIG4 services. Only MIG (and PAF) codes are available in Part 7 – but there is no MIG or PAF code for x-rays.
    b. If the provider wishes to charge for x-rays authorized in Appendix C of the MIG or of the PAF Guideline:
        i. Select the code MIG.SG[5];
        ii. Enter the amount charged for x-rays; and
        iii. In the "Other Information" section of the OCF-21C, tell the insurer that the line references x-rays.
    c. If an insurer wants to determine which x-rays are being invoiced, it can refer to Part 6.



Question
Can I use two instances of the code MIG.SG in Part 7 of one OCF-21C?

Answer
Yes. But make sure that the adjuster knows that the second instance of MIG.SG reflects x-ray services and not supplementary goods and services. To do this, add a note in "Other Information" explaining that the second instance is for x-rays, the details of which can be viewed in Part 6.

Question
Are insurers required to pay more than $400 under the code MIG.SG?

[5] For accidents prior to September 1, 2010, use the PAF code PWW.SC.

Answer

Insurers are only required to pay up to $400 for *Supplementary Goods and Services*, which is what the code MIG.SG represents. But x-rays are not included in the $400 allotment for supplementary goods and services. The MIG authorizes x-rays in addition to the other MIG charges, within the $3,500 minor injury cap[6]. X-ray charges are set out in Appendix C of the MIG.

Since the CCI codes for x-rays are no longer permitted in Part 7 of the OCF-21C, the use of the code MIG.SG for the purpose of invoicing x-rays should be acceptable to insurers. In other words, some OCF-21Cs may have two lines using the code MIG.SG. And, where appropriate, insurers may be obliged to approve payment in excess of $400 under the MIG.SG code as follows:

1. Up to $400 for supplementary goods and services; PLUS
2. X-rays as authorized in Appendix C of the PAF and MIG.

Question

Can we use Part 8 to invoice for x-rays delivered under the MIG?

Answer

No. Part 8 is only applicable to PAF claims (accidents prior to September 1, 2010) and should not be used for MIG claims (accidents on or after September 1, 2010).

[6] The MIG authorizes up to $2,200 plus x-ray costs. All MIG expenses are deducted from the minor injury cap of $3,500.