Joint IBC and Coalition Coding Practice FAQ #3

Frequently, facilities and insurers ask how certain injuries, problems and treatments should be coded by health care facilities on Ontario Claims Forms (OCFs) that are submitted through HCAI. Stakeholders agree that adoption of consistent coding practices contributes to the reliability of Health Claims Database (HCDB) reports, which inform stakeholders about how the auto insurance health system is working. Consistent coding also helps insurance claim adjusters in the adjudication process. Joint IBC and Coalition Coding Practice FAQs are designed to improve stakeholders' ability to use and comprehend ICD-10-CA[1,2], CCI[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 Insurance Bureau of Canada (IBC), the Coalition or FSCO and should be discussed between the insured person, the insurer and health practitioner.

GOODS AND SERVICES ARE ADJUDICATED (NOT THE CODE)

Insurer adjudication decisions are not based solely 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 codes selected by providers, as well as other information supplied to the insurance claims adjuster about the claimant, his/her injury and treatment recommendations. 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 *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision (ICD-10). World Health Organization, 1992. All rights reserved.
[2] ICD-10-CA – 2014 – Canadian Institute for Health Information.
[3] CCI – 2014 – Canadian Institute for Health Information.

Coding Practice FAQ #3: What the codes do and do not do

This FAQ highlights the fact that the codes used in OCF are not designed to drive adjudication decisions or insurance payment processes.

Standard injury and treatment codes were introduced to Ontario health care providers in the auto insurance system over a decade ago. On June 1, 2015, the standard code sets used in HCAI will be updated from the 2006 to the 2015 code sets (ICD-10-CA and CCI). This is an opportune time to review why the codes are used and clarify that the codes do not affect adjudication or payment of claims.

What is HCAI?

Health Claims for Auto Insurance (HCAI) is managed by HCAI Processing (HCAIP), a not-for-profit Ontario corporation established and funded by the insurance industry and operated by a board of directors that includes representatives of the insurance industry and health care communities.

HCAIP has been designated by the Financial Services Commission of Ontario (FSCO) as the Central Processing Agency for the purposes of fulfilling the role as outlined in the Health Claims for Auto Insurance (HCAI) December 2014 Guideline – Superintendent's Guideline No. 04/14.

IBC has entered into an agreement with FSCO, and subsequently with HCAIP, which operates the HCAI system, to collect Ontario automobile insurance health claims data for statistical purposes. A governance framework has been established governing IBC's access to the automobile insurance health claims data.

To meet the privacy protection requirements stipulated in the Personal Information Protection and Electronic Documents Act (PIPEDA), the data transmitted from HCAIP to the HCDB held by IBC does not include any personal identifying information such as name, address, postal code and other information that might identify an individual claimant. Moreover, it does not include any personal health information.

What do the codes do?

The **HCDB Standard Report** is only possible through the mandatory use of standardized codes that represent injuries and treatment interventions. IBC created the HCDB Standard Report in consultation with the Ontario Ministry of Finance (MOF), FSCO, the Coalition Representing Health Professionals Associations in Ontario Automobile Insurance Services (the Coalition) and insurance companies. The intent is to provide a basic statistical report on a consistent basis over time. Standardized codes, such as the GAP, ICD-10-CA and CCI, allow injury and treatment data to be gathered in the HCDB and presented for publication in the HCDB Standard Reports. The major purpose for the collection of automobile insurance health claims data is to better understand the medical and rehabilitation costs involved in Ontario automobile insurance health claims and the recovery process.

The use of standard injury and intervention codes may help health care providers and insurers to communicate about an insured person's problems and proposed treatment. But, as discussed in the section called "What do the codes *not* do," providers and insurers should not rely solely on the codes as a means of understanding the impact of an injury or problem on the insured person's functional status or need for treatment.

What do the codes *not* do?

HCAI's mandate is only to transmit claim forms (OCF-18, OCF-23 and OCF-21), completed by service providers on behalf of an insured person, to a person's insurer. HCAI also transmits insurer adjudication decisions back to the service provider. **HCAI plays no role in:**

- Adjudication of claims;
- Payment of benefits and expenses; or
- Determination of whether an expense is payable by the insurer or if it is payable through the insured person's medical and/or rehabilitation limits.

While the codes may assist in communication between health providers and insurers about the kinds of injuries sustained and treatments proposed for injured persons, the codes alone are usually insufficient to inform the adjuster about the unique circumstances related to each claimant's injury and his or her treatment needs. For example, if a provider uses the injury code "S72.00" it will inform the adjuster that the claimant has sustained a "Fracture of the upper femoral epiphysis (separation)." But it does not tell the adjuster which leg was fractured. Further, it does not tell the adjuster the extent to which the injury may impact the insured person's ability to function in the short or long term. The claimant's "story" still requires the use of narrative information, which may be added in various sections of a treatment plan. In other words, the use of standard codes by health providers does not eliminate the need for good communication between health providers and insurers.

Who decides which code is the "right" one to use?

The health care practitioner who completes treatment plans and invoices is responsible for deciding which injury or treatment code is the most appropriate code to represent the problems that will be addressed by the goods and services proposed and which intervention codes are most appropriate to represent the goods and services that the health care facility proposes to deliver to the insured person.

Each standardized coding set – GAP, ICD-10-CA and CCI – provides a framework to guide the appropriate selection of codes intended to be used for certain activities. However, it is possible for health care facilities to select a similar or overlapping code for a specific injury or activity. For example, GAP codes beginning with "I" are intended to capture interventions and expenses associated with Insurer Examinations (IEs). While providers are encouraged to use "I" codes when invoicing for IEs, it is possible to use other codes such as the CCI codes. If a provider uses an incorrect code, the adjuster is still responsible for adjudicating based on the goods and services claimed and not solely based on the code used.

Health care providers are encouraged to select codes that best represent the injury and treatment which that treatment provider is addressing. Sub-optimal code selection by service providers may contribute to the margin of error in the HCDB reports[4]. For example, using a CCI code to represent an IE may result in the expense being categorized as a "Provider Initiated Examination" and not as an IE expense within the HCDB report. However – even if the wrong code is used for the IE – the insurer is still responsible for ensuring that the IE expense is not paid from the insured person's medical and/or rehabilitation limits.

Is treatment driven by the injury codes used?

No. Many people may suffer similar injuries that can be coded with the same injury codes. But recovery is predicated by a variety of factors including but not limited to each individual's prior medical history and conditions,

[4] HCDB Standard Report 2014 – H1. Pg 74.

social or economic factors, co-morbidities and timing of treatment. Appropriate treatment for an individual at any given time includes consideration of these factors.

How to learn more about coding

There are a number of resources available for health care providers and insurers who wish to learn more about coding:

1. HCAI Information website: www.hcaiinfo.ca
2. Joint IBC/Coalition Coding FAQs: http://www.ibc.ca/on/auto/crisis-management/claims-process/coding-faqs
3. IBC Coding bulletins: http://www.ibc.ca/on/auto/crisis-management/claims-process/coding-faqs
4. Ontario Health Professional Associations: Contact the relevant health professional association. Some associations have developed specific coding guidance that is relevant to the professional group.