IBC | Insurance Bureau of Canada

Coalition
Coalition of Health Professional Associations in Ontario Automobile Insurance Services

Joint IBC & Coalition Coding Practice FAQ #1

Questions often are raised by facilities and insurers about how certain injuries, problems and treatment should be coded by health care facilities, using OCF claim forms that are submitted through HCAI. Stakeholders agree that adoption of consistent coding practices is important to improve the reliability of HCDB reports, which will inform stakeholders about how the auto insurance health system is working. This will also facilitate fair adjudication by insurance adjusters. HCDB Coding Practice FAQs (CPF) 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 OCF claim forms. 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, the Coalition or by FSCO and should be discussed between the insured person, the insurer and 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 Edition (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 #1: Canadian Classification of Health Interventions Codes (CCI) - Section 7 Codes

The Superintendent's Professional Services Guideline indicates that administrative overhead charges associated with medrehab services are to be included in the hourly rates charged by health care facilities for goods and services.

Expenses related to professional services" as referred to in the SABS and the Professional Services Guideline include all administration costs, overhead, and related costs, fees, expenses, charges and surcharges. Insurers are not liable for any administration or other costs, overhead, fees, expenses, charges or surcharges that have the result of increasing the effective hourly rates, or the maximum fees payable for completing forms, beyond what is permitted under the Professional Services Guideline.[4]

The CCI defines healthcare interventions as follows:
A service performed for or on behalf of a client whose purpose is to improve health, alter or diagnose the course of a disease (condition), or to promote wellness.[5]

Non-overhead Administration

Question

In cases where administrative activities are covered by the SABS, how can these administrative activities be coded?

Answer:

There are circumstances where non-overhead administrative services may be proposed by facilities and approved by insurers, although in some cases they may not be covered under the SABS

Examples:

- Form Completion Fee: When proposing a fee for completion of an OCF 18, the facility would use the code 7SF30LB (Support activity, documentation for claims form).

- Photocopying at request of insurer: If a facility is required to produce a copy of their clinical notes at the request of the insurer, this is an expense (photocopying) that may be payable by the insurer, although it is not covered by the SABS. If approved by the insurer, the facility could use CCI – 7SJ30 (*Clinical documentation - Correspondence, clinical for external party on behalf of client*)

[4] Superintendent's Guideline No. 01/11. Professional Services Guideline.
[5] © CCI – 2006 Canadian Institute for Health Information, pg 4.

Section 7 CCI Codes (Other Healthcare Interventions)

Question

Section 7 CCI Codes imply that certain interventions, which appear administrative in nature, are considered to be health-related interventions. Are Section 7 codes *valid* codes and can they be used on OCF claim forms transmitted through HCAI?

Answer

Section 7 CCI codes are valid and therefore may be transmitted through HCAI on OCF claim forms. Section 7 codes are categorized as *Other Healthcare Interventions* and are defined as follows:

Any other service that cannot be described as obstetrical (fetal), therapeutic or diagnostic, but nevertheless, contributes directly to improve a client's health, alters the course of a health condition or promotes wellness.[5]

All claims for goods and services must be adjudicated on their merits (not based on the code used) and providers should not expect automatic approval of the services represented by the codes shown below. Not all of the services listed are authorized by the SABS in all circumstances (e.g. Case Management is authorized by the SABS only for persons with Catastrophic Impairment). However, in certain circumstances the services listed below may be determined by health care practitioners and/or insurers to be reasonable and necessary to improve an insured person's health after injury in automobile collisions.

Table 1: Activities covered under Section 7

Code	Standard description visible to insurer	Possible health-related interventions represented by code
7SF12	Planning, service	1. Team conferences (*e.g. scheduling and coordinating team members and conducting meeting, etc.)* 2. Care planning 3. Discharge planning *(e.g. communication with hospital staff, CCAC, transportation arrangements, arranging for equipment, etc)* 4. Activity programming
7SF15	Brokerage, service	1. Telephone advice *(e.g. check ins by patient or by provider to follow up health status as an alternative to a full clinical visit)* 2. Health advice 3. Delegation of clinical support activities *(e.g. directing personal support workers and rehabilitation support workers)* 4. Follow up, preventive health care (*e.g. post-surgery home check up*) 5. Case management *(only for persons with catastrophic impairment or non-catastrophic impairment if optional benefits purchased)* 6. Client referral *(e.g. if insurer has approved referral to another health professional)* *May involve initiating or maintaining a collaborative process to assess, plan, implement, coordinate, monitor and/or evaluate the options and services required to meet a client's health care needs*

GAP Codes (click here) for administrative services are listed under the heading *Administrative/Other Services*.
CCI Codes (click here) for administrative health-related interventions as listed in Section 7 of the CCI (click here for CCI)

Health Facility Must Provide Service Details

As shown, the Section 7 codes represent a *group* of several services. The code does not tell the adjuster which specific service is being recommended. Providers need to use the narrative section of the OCF to ensure that an insurer knows what services are proposed and require adjudication. If the insurer doesn't know specifically what service is being proposed, they will not be able to approve it. To learn how to use the narrative parts of OCF, refer to the document called "Coding: Meant to Classify Not Inform Adjudication" available on the HCAI Information website.

Health Care Facilities

Prior to submitting expenses using the codes 7SF12 and 7SF15, certifying health practitioners may wish to ask:

- Will these services contribute directly to improve a client's health, alter the course of a health condition or promote wellness? How will this be measured?

- Have cognitive, physical, emotional or behavioural challenges been communicated to the insurer? Have social, family, environmental or vocational issues been communicated to the insurer?

- Is the insurer aware that the patient is/is not attending regular clinical visits outside the home (if applicable)?

- Have I supplied the insurer with an explanation of why these services are necessary (this must be done on the narrative part of the OCF 18)?
    - Why is a team meeting necessary? Which team members need to be involved? What happens if the team meeting doesn't happen?
    - Why is care planning required in addition to routine treatment planning?
    - Why is discharge planning required? How will the provider supplement the discharge planning supplied by the institution from which the patient is being discharged?
    - Why is activity programming required? Why is it not included as part of the routine treatment planning process?

- Have I explained why these are not services that are a routine part of a treatment visit?

- Have I supplied the insurers with enough information to understand the consequences to the injured person if these services are declined?

Insurers

Prior to approving or declining expenses submitted under Section 7 codes, insurers may want to consider the circumstances of each injured claimant. For example:

- Will these services contribute directly to improve a client's health, alter the course of a health condition or promote wellness? How will this be measured?

- Are there cognitive, physical, emotional or behavioural challenges experienced by the claimant? Are there social, family, environmental or vocational issues that need to be addressed?

- Is there an explanation with details of the services required in the narrative part of the OCF 18; or has the facility contacted me with that information?
    - Will a team meeting with the team members listed help promote better use of medrehab resources and improved recovery?
    - Will care planning as described promote better use of medrehab resources and improved speed or quality of recovery?
    - Is discharge planning required? How will the provider supplement the discharge planning supplied by the institution from which the claimant is being discharged?
    - Is activity programming required? Why is it not included as part of the routine treatment planning process?

- Is it clear that these are not services that are routinely included as part of a treatment visit?

- What are the consequences to the injured person if these services are declined?