INTRODUCTION / PREAMBLE

An understanding of this preamble is essential for the proper interpretation of the Guide

I Overview

This Guide lists by Specialty Section, SMA recommended fees for uninsured medical services. For the purposes of this Guide, uninsured medical services are those which are not paid by the Saskatchewan Medical Services Branch in accord with the Payment Schedule under The Medical Care Insurance Act.

The services may be requested by the patient or by a third party interested in adjudicating the patient's fitness or eligibility for certain benefits. It is inappropriate to bill the Medical Services Branch for uninsured services. The physician is entitled to charge either the patient for the service or the third party requesting the service. An appropriate record should be made of each uninsured service rendered.

The Guide is not binding upon any physician. The Guide should be interpreted from the point of view that it provides a tool for the determination of reasonable relativity between fees for services of average complexity. It is assumed that physicians will, at all times, exercise responsible judgement in establishing their fees.

The basic principle of the Guide is that a physician is entitled to appropriate compensation for services rendered. For circumstances where a fee might cause financial hardship to a patient, the physician may choose to reduce the fee. Alternatively, when unusual time, skill, or attention is required in the management of any condition, the physician is entitled to a greater fee. In either case of individual adjustment, the physician is advised to provide the patient with an explanation.

The Guide is divided into several sections with fee descriptions based as nearly as possible on the descriptions listed in the insured payment schedule. Section A consists of three parts: (A.1) lists rates for general uninsured services and third party requests; (A2) lists services that are negotiated with agencies other than Saskatchewan Health Medical Services Branch; (A3) lists miscellaneous services that correspond with Section A in the insured payment schedule. Other sections of this Guide are organized by specialty, to be consistent with the insured Payment Schedule. This format is not intended to restrict any physician and, therefore, a physician who performs a service listed in another specialty section may base the fee on the units listed in that section.

II Policy Statement on Third Party Requests and Uninsured Services

Most services provided by physicians are insured under *The Medical Care Insurance Act* or paid by other agencies such as the Cancer Foundation, the Workers' Compensation Board, etc. Some services provided by physicians are not insured. To clarify physicians' entitlements and responsibilities in this regard, the Saskatchewan Medical Association maintains that:

1. Physicians have a professional responsibility to expeditiously assist patients in obtaining those benefits to which they are legitimately entitled;

2. Physicians are entitled to reimbursement for the extra time and resources devoted to the provision of medical information to third parties and for providing any uninsured service;

3. Those parties requesting medical information, reports or certificates should be obliged to arrange for appropriate reimbursement;

4. Third parties who request medical information about individuals must be clear as to why they require the information and tailor any forms accordingly after consultation with the SMA about the design of their forms;

5. Third parties requesting information must ensure that the reason for the request is clearly communicated to the physician other than by word of mouth of the patient;

6. When providing medical information, physicians should not be expected to judge whether the subject patient is eligible for the benefits provided by the third party;

7. Physicians should not be considered by third parties as truant officers in dealing with absenteeism;

8. In establishing fees for responses to third party requests and for uninsured services, physicians are guided by, but not bound by, the SMA Guide to Fees;

9. The Association is prepared to facilitate adjudication of disputes over fees charged by physicians for these services.

III Definitions

1. A visit is defined as the service by a physician to, or on behalf of, a patient. When more than one visit is necessary on any given day, the physician is entitled to submit a fee for each service rendered. The physician is entitled to charge appropriately for visit services when rendered in the office, the home, the hospital or wherever the patient may be at the time of the service.

2. Hospital Care is defined as the professional services provided from the time of admission to the time of discharge. Procedures, emergency visits and continuous personal attention prior to, or during hospitalization command additional fees.

3. Consultation applies where a physician who has attended a patient requests the opinion and advice of another physician with respect to the diagnosis and/or management of the patient's current condition. The consultation includes the assessment of the patient, review of the relevant diagnostic data and the submission of a written opinion to the referring physician. No follow-up care by the consultant is assumed to be included in the fee for the consultation.

4. Repeat Consultation is defined as a formal consultation for the same or related condition repeated within 30 days by the same physician. A repeat consultation (service code 11), is only to be billed when it is generated by a new formal request by the referring physician. It should not be used for routine follow-up of the patient for which a partial assessment or subsequent review (service code 5) or follow-up assessment (service code 7) are appropriate.

5. Directive Care applies when the referring physician remains primarily responsible for the patient's care, but, because of the seriousness or complexity of the condition, requests ongoing advice from the consultant during the acute phase of the illness.

6. Multi-disciplinary care is the situation in which the complexity of the care, usually involving more than one diagnosis, requires the services of more than one physician with complementary skills in different fields or practice for adequate care of the patient.

7. Supportive care applies when the responsibility of the patient's care has been temporarily transferred by the referring physician to a consultant but it remains necessary and/or desirable for the referring physician to visit the patient for the purposes of continuity and coordination of care as well as support and reassurance for the patient and the family.

8. Classification Codes

   All procedures listed in the Guide are assigned a classification code as follows:
   D - Diagnostic - none
   0 - Day surgery - includes the day of the procedure
   10 - Day surgery - includes the day of, and 10 days following, the procedure
   42 - Day surgery - includes the day of, and 42 days following, the procedure

9. Fee for Service - means services are to be billed on the basis of the individual appropriate visit or procedure items.

10. By report - means that the bill should be accompanied by a detailed explanation of the circumstances and the services provided.

IV General Guidelines

1. For the purposes of this Guide, a specialist is a physician whose name is listed as a specialist with the Council of the College of Physicians and Surgeons of the Province of Saskatchewan.

2. For physicians who have completed their specialty training and are awaiting placement on the specialist register of the College of Physicians and Surgeons, it is suggested that they base their fees on the fee listed for general practice or on 90% of that listed for the specialist, whichever is the greater.

3. When a general practitioner performs any service listed in a section of the Guide other than Sections A1, A2 and B, H, and J, it is suggested that the fee be based on 90% of the listed fee without an asterisk (*). Codes with an asterisk (*) are considered to be single listed (i.e. the GP and specialist rates are the same).

4. A physician may render a fee only for those services which have been provided or supervised as well as the technical component of procedures performed in the office.

5. A written report for a third party is a separate service for which the physician may render a fee in addition to the fee for the medical service provided.

6. A diagnostic, therapeutic or laboratory procedure performed or supervised by a physician commands a fee in addition to the visit fee unless otherwise stated.

7. When a procedure, either diagnostic or therapeutic, is the sole reason for the visit, it is suggested that the procedure fee alone be charged.

8. When a procedure, either diagnostic or therapeutic, is performed in addition to an unrelated visit service, it is suggested that the charge be the visit fee plus 75 percentage of the procedure fee.

9. If, during any period of hospitalization, a patient develops an acute exacerbation of the illness present on admission, a complication, or an entirely new and unrelated illness, the physician is entitled to charge hospital care as for a new admission.

Surgical Fees

10. The concept of the composite surgical fee includes the base surgical procedure and associated care provided to the patient in hospital following the procedure. All other services provided pre- and post-operatively should be billed separately.

11. For diagnostic procedures related to the surgical procedure and performed by the same surgeon (e.g. cystoscopy, D and C, bronchoscopy, angiography) when done under the same anaesthetic as the surgery or during the hospitalization following surgery, it is suggested that the fee be based on an individually selected percentage of the fees listed.

12. If, during the post-operative period in the hospital, the patient develops a condition directly related to the original disease and requires another operation, it is suggested that the fee be based on an individually selected percentage of the fee(s) listed for the operation performed.

13. If a patient develops a condition unrelated to the original disease while still in hospital, then any procedure performed commands the full fee.

14. When two similar bilateral procedures are done at the same time or during the same admission to hospital, it is suggested that the fee for the second procedure be based on 75 percent of the listed fee unless otherwise listed.

15. When one surgeon performs two or more unrelated procedures at the same time, through the same or separate incisions, it is suggested that the fee for the lesser procedures be based on 75 percent of the listed fee unless otherwise listed.

16. If a surgical procedure for which one fee is listed must be performed by two specialist surgeons, it is suggested that the attending surgeon bill according to the listed units and the second surgeon according to an individually selected percentage of the listed fee.

V OBSERVATIONS ON SELECTED SERVICES

1. Transfer of Medical Charts[1]

Requests for information from the physician's office medical record may come from another physician, from the patient, or from lawyers and other third parties. Each request merits a slightly different approach.

Requests from Physicians

It is rarely essential that a new physician obtain the patient's total file from previous attending physicians because most patients can recount the significant features of their past history. Therefore, a physician's request to another physician should state specifically what information is required, e.g. results of diagnostic procedures, therapeutic measures taken, response to therapy, etc. In such cases, the physician might consider sending a written statement.

However, if a new physician sends a standard blanket request, the previous attending physician has two options:

- send a photocopy or electronic copy of the documents on file, or

[1] For SMA/CPSS jointly developed guidelines, visit: http://www.cps.sk.ca/imis/CPSS/Legislation__ByLaws__Policies_and_Guidelines/Legislation_Content/Policies_and_Guidelines_Content/Transfer_of_Patient_Records.aspx

- send the entire chart and ask the new physician to make copies as needed and then return the original file. (The physician should retain original files for a minimum of six years).

  There would, in most situations, be no charge for sending information to another physician.

Requests from Patients

The Saskatchewan Health Information Protection Act (HIPA) enshrines patients' rights to access their own health information, and allows physicians to charge a "reasonable fee" for this access.

When a patient asks for a copy of the medical record, one option is to suggest that the patient have their new physician ask for specific information. If the patient requests his/her own personal copy (and a growing number of patients are doing so), the physician should provide a photocopy and may charge the patient the fee(s) suggested in this Guide.

Requests from Lawyers

When a lawyer requests a copy of the medical chart, the first step is to ensure that there is a valid consent signed by the patient to be placed on file. The next step is to offer to send a report to answer the lawyer's specific questions.

If that offer is not accepted by the lawyer, send a photocopy of the chart and charge the lawyer as suggested in the SMA Guide to Fees.

It is helpful to remember that such fees are almost always passed on to the patient. The fee(s) charged to lawyers should not exceed what the patient would have been charged for direct access to the information.

The Health Information Protection Act requires that physicians (and other information trustees) respond to information requests in a reasonable time frame. Saskatchewan's Privacy Commissioner has informally defined "within 30 days" as a reasonable amount of time to respond to non urgent requests.

2. Missed Appointments

Charging for missed appointments is not a general occurrence but there are circumstances which would clearly justify such charges. It would be wise to forewarn each patient individually when charges for missed appointments might be contemplated.

3. Renewals of Prescriptions by Telephone

Telephone prescription renewals initiated by a pharmacist are considered to be an insured service (unless provided to a RCMP or other uninsured beneficiary).

Patient-initiated telephone prescription renewals are considered to be uninsured. Practitioners are urged to exercise careful judgement when or if to charge for this service, as it is expected that such charges may come under scrutiny.

As with missed appointments, patients should be forewarned if a charge will be levied.

4. Uninsured Services Provided at the Same Time as Insured Services

It can happen that, while assessing a patient at the request of a third party for an uninsured service, it becomes obvious that the patient requires medical care. Providing necessary medical care would be insured and it would be acceptable to submit a claim to the Medical Services Branch for those services. However, that portion of the service relating to compliance with the third party's request such as completion of a report or certificate remains uninsured. The physician is entitled to charge separately for that.

It is expected that physicians will not charge for any of the following in addition to the insured fees for any medical services provided:

- writing a prescription
- referral note to a colleague
- completion of a standard requisition form for a diagnostic or therapeutic service
- completion of patient records
- charges for any long-distance telephone calls related to referrals to colleagues may be billed to the patient

VI Unlisted Services

When no unit is listed for service and the service cannot be readily compared to one that is listed, the physician may submit a request for a new listing to the SMA Committee on Uninsured Services through the office of the Saskatchewan Medical Association.

VII Disputed Fees

All cases requiring advice regarding a dispute over fees or over the interpretation of this preamble should be referred to the office of the SMA.

VIII Physicians' Guide to Third Party Requests and Uninsured Services

THE DIRECT BILLING PROCESS

1. <u>Ethics of Direct Billing</u>

The Canadian Medical Association's Code of Ethics lists the principles of ethical behaviour for physicians. One of these principles urges physicians to be "...responsible in setting a value on your services".

In this regard, the Code of Ethics states that an ethical physician:

- Will practise in a fashion that is above reproach and will take neither physical, emotional, nor financial advantage of the patient.
- When acting on behalf of a third party will ensure that the patient understands the physician's legal responsibility to the third party before proceeding with the examination.
- Will, upon a patient's request, supply the information that is required to enable the patient to receive any benefits to which the patient may be entitled.
- Will consider, in determining professional fees, both the nature of the service provided and the ability of the patient to pay, and will be prepared to discuss the fee with the patient.

2. Some Practical Guidelines

There are some practical guidelines physicians can follow when billing a patient directly to help make the process as comfortable and efficient as possible.

a) Keep Patients Well-Informed

Always ensure that fees have been discussed with the patient before providing the service. Most difficulties between a physician and patient arise from a lack of clear communication. Many patients simply do not realize that there are some services the government does not pay for and they may become upset when presented with a bill.

To prevent this from happening, physicians and their staff must ensure patients are well-informed about uninsured services and the direct billing policy well in advance of receiving treatment.

The following are a few suggestions on informing patients about direct billing.

- Clearly display in your patient waiting area a poster which outlines your billing policies
- Discuss fees when the patient books an appointment for an uninsured service
- Mention fees before you provide the uninsured service
- Provide patients a fact sheet or pamphlet which includes information on direct billing

b) Maintain simple and clear office policies and procedures for direct billing

To establish consistent office policies, physicians should first determine:

- Those services for which patients will be directly billed
- The fees attached to those services
- Any exemptions, such as low income earners
- Bookkeeping and collection procedures

A physician's office policies on direct billing must be specific and detailed so that staff and patients fully and clearly understand them. At the same time, they should allow sufficient flexibility to adapt to any unique or unexpected circumstances that may be encountered.

Once office polices have been established, they should be put in writing and distributed to staff members of the office staff. Procedures should be in place to apprise staff of any changes to office policies.

To minimize difficulties in direct billing, clinics should also:

- Maintain up-to-date accounts
- Collect payment from patients at the point of service as often as possible
- Follow-up in an orderly and consistent manner

c) Make adjustments for financial burden

When calculating fees, physicians should consider the financial burden such charges might place on the patient and be prepared to adjust fees based on these considerations.