CRITICAL CONDITION GOOD FAITH COVERAGE POLICY

The Critical Condition Good Faith (CCGF) Coverage Policy is provided through the 2017-2022 agreement between the Saskatchewan Medical Association and the Ministry of Health. Physicians may apply for reimbursement if they provided eligible services to Canadian residents with no current provincial coverage.

All eligible physicians are encouraged to take advantage of the coverage policy. Guidelines are given below. Further information may be obtained from the Saskatchewan Medical Association, 201 – 2174 Airport Drive, Saskatoon, Saskatchewan S7L 6M6, telephone 244-2196 or 1-800-667-3781.

Guidelines

Physician Eligibility

To apply, a physician must:

(a) be licensed with the College of Physicians and Surgeons of Saskatchewan under Bylaw 2.4, 2.5, 2.6 or hold a locum license at the time of service.
(b) be a resident in Saskatchewan and be practising on fee-for-service basis in Saskatchewan at the time of service.
(c) be providing eligible insured clinical services to eligible patients at the time of service.

Service Eligibility

The coverage only applies to treatment services provided on or after April 1, 2021, by eligible physicians to eligible patients in-hospital for emergent or urgent acutely critical conditions.

Services for conditions that are terminal but not acutely critical are not considered part of this policy. Treatment provided in clinics in the community is excluded. All services that are not medically required are excluded. Services provided to out-of-country visitors are excluded.

Patient Eligibility

The patient must:

(a) be a resident of Canada; and
(b) be eligible for provincial/territorial coverage at the time of service.

The physician must obtain proof of patient's residency in Canada. For example:
eHealth Supporting Documentation Information.

The physician must validate no Saskatchewan HSN in the Patient Health Registry System (PHRS):
PHRS Log In Page

The physician must validate with Hospital Registry via Shared Client Index (SCI) no current out-of-province HSN for the patient
eHealth Accessweb MIT Login

The dates of confirmation of no provincial/territorial coverage must be documented.

If the patient has an existing HSN or (re)establishes coverage within 180 days, the physician must submit claims to Medical Services Branch (MSB).

The physician is encouraged to advise the patient that if they do not (re)establish coverage within 180 days, they could be invoiced for the services directly.

The physician is encouraged to collect as much information about the patient as possible (e.g. names, aliases, DOB, contact information, next of kin) to facilitate the search in the PHRS or with SCI, and to confirm residency. No patient information should be included as part of this application.

General Information

Physicians interested in accessing the program are encouraged to first read the guidelines and are required to fill out the attached Application form and the Standard Invoice. Based upon this information the SMA will make a determination of eligibility.

The physician must hold billings for 180 days from the date of service before they apply for this coverage.

The SMA may reach out to relevant physician experts (e.g. SMA committees, section representatives) and/or the MSB to obtain feedback about appropriateness of billings.

Physicians may be asked to provide additional information (e.g. OR report) to substantiate their claims on SMA or the Ministry's request.

Exceptions to policy requirements are subject to review by the SMA.

Eligible physicians can invoice the SMA for reimbursement to be paid at Physician Payment Schedule rates applicable at the time of service.

The SMA will make payment by cheque.

Income Tax

Money received from the CCGF program must be declared as income for tax purposes.

SASKATCHEWAN MEDICAL ASSOCIATION
201-2174 Airport Drive • Saskatoon, SK • S7L 6M6
p. 306 244 2196 • f. 306 653 1631 • w. www.sma.sk.ca

APPLICATION FOR REIMBURSEMENT – CRITICAL CONDITION GOOD FAITH PROGRAM

Applicant Information:

Name: _____

Address: _____ Office Phone #: _____

_____ Home Phone #: _____

Postal Code: _____ Email Address: _____

Type of Practice: Fee-for-Service Contract Other Specialty: _____

Authorization for Release of Information

I hereby authorize SMA to share information provided as part of this application with other stakeholders (i.e. clinic/hospital, Ministry of Health, SMA committees, section representatives etc.) for the purpose of determining eligibility for reimbursement under the Critical Condition Good Faith Coverage Policy.

Signature: _____ Date: _____

Declaration

I hereby certify that:	Initials
✓ I was licensed with CPSS, was a resident of Saskatchewan and was practicing on fee-for-service basis in Saskatchewan or held a locum license at the time of service as per the CCGF Guidelines.	
✓ I have validated that the services provided as described on the Standard Invoice match the definition as per the CCGF Guidelines.	
✓ I have held the billings for 180 days from the date of service before submitting this application.	
✓ I have validated during this 180-days hold:	
o that the patient had proof of residence and was eligible for provincial/territorial coverage in Canada (i.e. not an out-of-country visitor status) at the time of service; and	
o that there was no current Saskatchewan HSN for this patient; and	
o that there was no current out-of-province HSN for this patient.	
✓ The information provided in this application is true and accurate.	
✓ I will abide by the terms of the SMA's Critical Condition Good Faith Coverage Policy.	
✓ I am not receiving reimbursement for these services from any other party.	

Signature: _____ Date: _____

Return to:
Critical Care Good Faith Coverage Policy
Email: economics@sma.sk.ca
Fax: 1-306-653-1631

STANDARD INVOICE – CRITICAL CONDITION GOOD FAITH COVERAGE

In order for this invoice to be considered for payment, all of the eligibility requirements must be met. Supportive documentation must be available to the SMA and the Ministry of Health upon request.

Confirmation date of no SK HSN	01 (DD)	09 (MM)	21 (YY)	Confirmation date of no OOP HSN	01 (DD)	09 (MM)	21 (YY)

SERVICES PROVIDED (Please do not include patient's private information, such as name, HSN, DOB etc.)

Short description of the case: Anesthesia for closure of abdomen following ruptured Aortic Aneurysm. Patient did not know their coverage had expired. I checked later and they still did not renew their coverage.						
Date of Service:			**ICD-9 Diagnostic Code:**	**Name of the Facility:**	**Start time:**	**End time:**
01 (DD)	04 (MM)	2021 (YYYY)	00.0	RUH	18:30	20:30

Referring Physician		**Names of other physicians involved:**	**Location of Service Indicator (Inpatient-2,B,K; ER-9)**
Name:	**#:**		
John Smith	1234	Anna Dough	B

Please use rates from the Payment Schedule for Insured Services Provided by Physician applicable at the date of service.

No. of Units	**Fee Code**	**Rate, $$**	**Sub-total before premiums, $$**	**Premiums,$$**			**Total with premiums, $$**	**Comments** (e.g. explain service or premiums)
				Location of Service (aka Time of Day)	**Age**	**Weight**		
1	502H	34.00	34.00	17.00			51.00	Weekday after 5 pm
8	503H	52.20	417.60	208.80			626.40	Weekday after 5 pm
						Grand Total =	**677.40**	

For internal SMA use only

	Initials	**Recommendation**	**Comments**
SMA staff:			
Section Rep:			
EC Rep:			
TC Rep:			

STANDARD INVOICE – CRITICAL CONDITION GOOD FAITH COVERAGE

In order for this invoice to be considered for payment, all of the eligibility requirements must be met. Supportive documentation must be available to the SMA and the Ministry of Health upon request.

Confirmation date of no SK HSN | | | | DD MM YY

Confirmation date of no OOP HSN | | | | DD MM YY

SERVICES PROVIDED (Please do not include patient's private information, such as name, HSN, DOB etc.)

Short description of the case:					
Date of Service:			**ICD-9 Diagnostic Code:**	**Name of the Facility:**	**Start time:**	**End time:**
DD	MM	YYYY				

Referring Physician		**Names of other physicians involved:**	**Location of Service Indicator (Inpatient-2,B,K; ER-9)**
Name:	**#:**		

Please use rates from the Payment Schedule for Insured Services Provided by Physician applicable at the date of service.

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				Location of Service (aka Time of Day)	**Age**	**Weight**		
			Grand Total =					

For internal SMA use only

	Initials	**Recommendation**	**Comments**
SMA staff:			
Section Rep:			
EC Rep:			
TC Rep:			