CORRECT CLAIMS FAQ

Attendance at delivery

Q. What is the appropriate billing for attendance at a delivery?

A. If you are requested to attend at a delivery due to your special expertise, the appropriate billing is a consultation fee (9B for Family Practitioners or 9C for Pediatricians). Otherwise, a family physician should bill a complete assessment (3B). If newborn resuscitation is required, physicians are now eligible to bill the Emergency Resuscitation codes listed in Section A of the Payment Schedule (220A to 223A).

Please note that you cannot bill an assessment/consultation during the same time frame as the resuscitation service (double billing). An assessment/consultation can be billed if it is provided at a separate and/or adjacent time.

For Family Practitioners concerned about MSB rejection of their 9B claims, we suggest noting in the comment section of your claim the words "Requested to Attend at Delivery."

Q. Can two family physicians ever bill for the same delivery? For example, one physician bills 42P, and the other bills 41P.

A. Sometimes. This can be allowed when a family physician with special expertise in obstetrics is called in to take over a delivery. What constitutes special expertise? If the "consulting" family physician participates in a Specialist Emergency Coverage rotation for obstetrics, it's automatically allowed. All other cases must be submitted to MSB with an acceptable explanatory report.

Billing for Casts/Backslabs

Q. If I apply a backslab to immobilize a fracture, can this be billed as a cast application?

A. Yes. It is appropriate to bill for a cast in circumstances where a backslab is used to immobilize a fracture. This would not apply to the use of prefabricated splints but only in circumstances where a molded cast is applied.

Billing More Than One Agency

Q. During a visit for a work-related injury, the patient asked me to assess an unrelated and insured medical condition. Can I bill more than one agency for a single patient visit?

A. Sometimes. The Medical Services Branch has a linkage to WCB, and will automatically reject dual claims. However, there are clearly some circumstances where such dual claims are appropriate. Physicians often combine multiple unrelated services for the convenience of the patient (for example, to minimize a rural patient's travel time). In such cases, the physician should bill the Medical Services Branch "by report," briefly explaining the services provided.

Cardioversion (Code 42D)

Q. Can I bill Code 42D (cardiac arrhythmia cardioversion) for drug induced cardioversion?

A. No. Code 42D is confined to the use of electro-cardioversion. The treatment of cardioversion utilizing medications should be billed utilizing the appropriate visit fee codes.

COVID-19 Immunization

Q. How do I bill for COVID-19 immunizations?

A. There are two options for billing depending on the service provided:

1. If the patient is seen by the physician for an assessment and/or evaluation first, then bill the appropriate visit fee only. (Immunizations done at the time of a visit are included in the visit fee.)

2. If the patient did not require evaluation or assessment and the only service provided was the immunization (by either the physician or a nurse), code 161A is the correct billing code and fee

It is appropriate to bill the patient directly for the cost of the vaccine if not provided free-of-charge by Public Health.

Botox Injections

Q. One of our clinic's nurses has the appropriate training to do Botox injections, and works under the direct supervision of a physician. Is it acceptable to bill for the Botox injections that she performs?

A. No. The current Botox codes are professional fees based upon physicians' rates of payment for the time, effort, and training required for the procedures. As such, it would not be appropriate to bill for work performed by clinic staff.

Admission of Patients to Alcohol/Drug Rehabilitation Centre

Q. I have been asked to do a history and physical and complete a form for a patient prior to admission to an addiction/rehabilitation centre. Is this an insured service, and what is the appropriate fee to charge?

A. All pre-admission complete assessments are insured, even if requested by a third party addiction centre. Family physicians should bill for this service using code 3B. The form is considered to be part of the medical record for the visit, and is therefore included in the 3B billing code.

Counselling Relatives

Q. Can I bill for counselling relatives about one of my patients when the patient is not in attendance?

A. Yes. The Payment Schedule allows for reimbursement to physicians for counseling family members. The appropriate code to bill for this service is codes 40B and 41B. To be eligible to bill this service, the counselling must be provided during a pre-booked separate appointment at which time a medical record is generated. It is expected that this would normally occur in circumstances where the relative has a serious or complex problem. As noted in the Payment Schedule, routine briefing and advice to relatives is considered to be part of the visit service fees.

Correct Ways to Claim for Various Forms

Q. What are the correct ways to claim for the various forms requested by:

1. **Screening Program for Breast Cancer**
2. **Program for Prevention of Cervical Cancer**
3. **Colorectal Cancer Screening Program**
4. **Saskatchewan Cancer Agency request for follow-up of registered cancer patient**

A. All four of these requests are now covered under the 56A fee code (Report Requested by Cancer Agency or Cancer Screening Program). To ensure payment, it's important to use the following diagnostic codes:

Requesting Program/Agency	**Diagnostic Code(s)**
Screening Program for Breast Cancer	Z51
Program for Prevention of Cervical Cancer	Z52
Colorectal Cancer Screening Program	Z53
Saskatchewan Cancer Agency request for follow-up of registered cancer patient	140-234

Practitioner Telephone Consultations

Q. Are family practitioners eligible to bill code 769A or 762A (major and minor telephone assessment and advice)?

A. Only those family practitioners who are recognized as providing specialty services under the Specialist On Call Coverage Program are eligible to bill these codes.

First Visit for Chelation Therapy

Q. Is the first visit by a patient to determine whether or not they are a candidate for chelation therapy an insured service or not?

A. Any visit for the sole purpose of determining suitability for an uninsured treatment modality such as chelation is considered an uninsured service and should, therefore, be billed directly to the patient.

Flu Shots

Q. How do I bill for flu shots?

A. There are two options for billing depending on the service provided:

1. If the patient is seen by the physician for assessment and/or evaluation first, then bill the appropriate visit fee only. (Immunizations done at the time of a visit are included in the visit fee.)

2. If the patient did not require evaluation or assessment and the only service provided was the immunization (by either the physician or a nurse), code 161A is the correct billing code and fee.

It is appropriate to bill the patient directly for the cost of the vaccine if not provided free-of-charge by Public Health.

Forms for Adoption

Q. I have been asked to complete an examination and report for adoption by Christian Counselling Services. Can I bill for this service and, if so, what is the appropriate code?

A. This service is considered to be an insured service and is covered by the Medical Services Branch of Saskatchewan Health. The appropriate code for this service is 37A, since Christian Counselling is acting as an agent for Social Services for the purpose of adoptions.

Hospital Discharge Fee (Code 725A)

Q. When can I bill the hospital discharge fee (code 725A)?

A. Almost any time your hospital in-patients are discharged. From discussions with the Medical Services Branch, we understand that a significant number of these are not currently billed. If your patient has been admitted for at least 24 hours, and you are responsible for discharging the patient, you can bill this fee on the day of discharge.

For obstetrical cases, you are entitled to bill separately for mother and infant. The code also applies in circumstances where an in-patient is transferred to another hospital/facility or when an in-patient has died. Also, note that this service is payable only once per discharge.

You may also bill this fee if the patient was admitted to a Health Centre for at least 24 hours as a short-term acute care patient. Appendix B of the Payment Schedule has some further details.

Letter of Referral

Q. Am I required to provide a letter of referral to a specialist for routine follow up for an ongoing problem?

A. No. If a follow up is recommended or planned by a specialist and it is done as part of a regular follow for an ongoing problem, this visit should be billed as a "visit" and does not require a referral letter from the family physician to facilitate that encounter. If more than a year has elapsed, but the condition requires regular yearly follow up, a consultation can be billed by the specialist without a referral letter from the family physician.

Monitoring Anticoagulant Therapy

Q. Can I bill code 763A for monitoring anticoagulant therapy if I do not see or call the patient that month?

A. Yes. Code 763A is paid for monitoring anticoagulant therapy. It is generally expected that physicians have an arrangement with their patients to call them should they require adjustment in their anticoagulant dosage or repeat testing. It is understood that physicians may not need to call their patients some months if their INR level is stable and no change is required. The fee is still payable in these circumstances so long as the patient is being actively monitored and supervised on a consistent basis.

MS, Alzheimer, and Ankylosing Spondylitis EDS Forms

Q. What is the appropriate billing for filling out MS, Alzheimer, and Ankylosing Spondylitis EDS forms?

A. For Multiple Scleroses EDS, code 153A can be billed once per year for filling out the request form. This fee is for the form only. The assessment is considered part of the visit service, and you may bill the appropriate consultation or visit fee in addition.

Alzheimer EDS is paid through two separate fees. Code 154A is used for the initial application, while follow-up status reports by phone or fax may be billed using code 155A. Again, these codes do not include the assessment, which should be billed using the appropriate consultation or visit fees.

Ankylosing Spondylitis EDS forms can be billed using code 156A. These EDS requests can be made either by family physicians or specialists.

Newborn Care

Q. What is the appropriate billing for newborn care?

A. For a Family Practitioner or Paediatrician, the appropriate billing is usually a Complete Assessment (3B or 3C) as it is expected one will fully assess the infant, followed by regular hospital care fees (25B to 28B) for each day the baby remains in hospital.

A consultation (9B or 9C) rather than a complete assessment may be charged if newborn care is provided on a specific request from the delivering physician, and not as part of a shared call arrangement.

Nursing Home Fees

Q. I used to bill 626A for routine nursing home visits. What do I bill for these visits now?

A. The old nursing home visit code has been modernized and replaced with Special Care Home Management fee codes (627A, 628A, 629A) effective April 1, 2020.
For more information, please visit this page: Payment Schedule Modernization

Surcharge – Removal of Moles

Q. I've arranged to remove a patient's moles tomorrow after hours in the hospital emergency room. Can I bill a surcharge for this work?

A. No, surcharges are only billable for unscheduled emergency work. The preamble to the surcharge section also states that payment will be made only if the call is "initiated by the patient, or someone other than the physician, on the patient's behalf."

Request for Medical Information

Q. When Saskatchewan Community Resources and Employment (formerly the Department of Social Services) requests a report on a patient, I usually bill code 20A for this service. I recently received a similar request from a First Nations Band who administers social assistance for its members. Who should I bill for completing the report?

A. All requests for medical information relating to social assistance are considered uninsured third party requests. In the case of Saskatchewan Community Resources and Employment, the Medical Services Branch has agreed to act as the paying agent when you complete a form and bill code 20A. No similar arrangement exists with First Nations Bands, so you should bill the Band directly for the service.

Requests Respecting Social Assistance Clients

Q. I frequently receive requests directly from Social Assistance clients requesting a note to justify increased social services benefits. These clients often advise that they were told to request a note by their social workers. Is there a proper form for these requests and who is responsible for payment?

A. Income security workers for Social Services have been advised that their clients should take a Medical Report Form (Form SSS 1092) to the physician when requesting medical information to support a social assistance claim. The form should indicate the reason for the request and should

contain all of the relevant information. Physicians are under no obligation to provide information on a prescription pad or note.

The Department of Social Services uses the medical report to assess a client's eligibility for social assistance, as well as requirements for medically related items such as special diets.

There is a fee code listed in the Payment Schedule for this service (Code 20A). This code pays for the completion of a Social Services form and can be billed directly to the Medical Services Plan.

SGI Driver Medical Review

Q. I've heard there have been some changes to drivers' medicals. How should I bill for them?

A. In April, a new non-co-payment fee was introduced for medicals requested by the SGI Driver Medical Review Unit. The new 74A fee code replaced the previous 72A at almost twice the rate. It is no longer appropriate to bill the patient extra for this service.

Payment for a commercial driver's medical continues to be the full responsibility of the patient. This fee includes the patient assessment (if necessary) and completion of the form. The new code 805A can be found on page A4 of the guide.

SGI has recently indicated that a large number of commercial drivers' medicals have been billed in error using code 74A. It is important that billing staff understand the difference between regular and commercial drivers' medicals; otherwise, the clinic will be presented after-the-fact with an SGI invoice for overpayment, and will have to track down and seek payment from the patient.

Specialist Counselling Fees

Q. I am a specialist who sometimes holds counselling sessions with patients. Why is there no specialist counselling fee?

A. While counselling fee codes were introduced by the Section of Family Practice and reside in the "B" Section of the Payment Schedule, they are available to any fee-for-service physician (GP or Specialist) who needs them. Please note that counselling must occur in a booked separate appointment and be fully documented in the medical record. There is a maximum of 30 minutes for third-party counselling (counselling family members regarding a patient) that is billable with these codes. Page B.2 in the Payment Schedule offers further details.

Surcharges for Call Back to Emergency

Q. When I am on call I find it more convenient to remain in the hospital. When I am called to emergency will I be eligible to bill an initial surcharge?

A. No. Tariff recognized that there are circumstances where it is more convenient or appropriate for a physician to remain in the hospital when on call. In the opinion of Tariff, however, an initial surcharge can only be billed in circumstances where the physician actually travels to see the patient. In circumstances where the physician remains within the hospital, it is not appropriate to bill an initial surcharge. It would, however, be appropriate to bill an extra patient seen

surcharges for subsequent patients seen after 5:00 p.m. and on weekends. It is also acceptable to bill premiums for these services.

Suture Removal for 10-Day Procedures/Surgical Fee Unbundling

Q. I have heard that I can now bill for post-operative visits and suture removal, even if I performed the surgical procedure. How should I bill these?

A. Post operative visits (except for those in hospital) can now be billed following any 10 or 42 day surgical procedure, regardless of who performed the surgery. Family physicians and cognitive specialists would generally bill using a partial assessment fee (e.g. 5B). Surgeons would generally use their follow-up assessment code (e.g. 7L).

Suture removal can also be billed following these procedures, using code 898L (for example, if your partner puts sutures in, you can now bill to remove them). When billed with a visit, the suture removal fee is automatically reduced to 75 percent.