GENERAL SERVICES

		Fee
	Procedures	
	Additional payments for diagnostic service excluding ECG's, 0, 10 or 42 day operative procedures performed on patients under one (1) year of age are automatically calculated and paid as explained in Section A, Paediatric Age Supplement for Procedural Fees.	
20A	Report requested by Saskatchewan Social Services to determine employability, rehabilitation potential, level of care, or other specified reason. The 20A and other associated visits and laboratory codes should be submitted with a diagnostic code of Z90 (Examination - Third Party Request from Saskatchewan Social Services) This code is locked with 20A in the Payment Schedule.	$31.50 *
37A	Examination and Report required for adoption -- child or parent or for a person becoming a foster parent -- a diagnostic code of V70 must be used	$129.00
39A	Rape victim (suspected or actual) -- includes medical history, examination, counselling, all medical documentation and initial treatment	$952.00 *
40A	Child abuse victim (suspected or actual) -- includes medical history, history of abuse obtained from social worker, police, parents or other individuals, examination, investigation and referral as necessary, counselling and treatment, medical documentation of findings and management	$630.00 *
	Foetal Alcohol Spectrum Disorder Assessment	
41A	FASD assessment and diagnosis -- per 15 minutes or major portion -- (max of 12 units per patient)	$83.40 *
	Clinical evaluation of the patient, review of information and consultation with other providers (verbal and written) for the purpose of Foetal Alcohol Spectrum Disorder (FASD) - assessment and diagnosis.	
	Includes a review of: -- birth and prenatal history; -- medical and surgical histories, including psychiatric and psychological reports; -- detailed family history focusing on genetic conditions which cause brain dysfunction; -- social history, including any social services records, pre-sentence reports, risk assessments, etc.	
	Limited to physicians with appropriate training and expertise in FASD assessment, including: -- geneticists with expertise in diagnosing birth defects; -- developmental paediatricians; -- any physician with training from a recognized training centre for FASD diagnosis (examples University of Washington, Seattle Washington; Lakeland Centre for Foetal Alcohol Syndrome, Cold lake Alberta; and the Motherisk Centre, Toronto).	

		Fee
	The physician should keep appropriate documentation of time and place. Physicians who intend to provide this service should apply to the SMA Tariff Committee to be considered eligible to bill MSB for this service. (This code is not to be used for third party uninsured requests for assessment such as requests from Saskatchewan Justice and others).	
56A	Report requested by Cancer Agency or Cancer Screening Program The following 4 forms are covered under this fee code: 1) Saskatchewan Cancer Agency request for follow-up of registered cancer patient - must be billed with a diagnositic code from 140 to 234 2) Program for the Prevention of Cervical Cancer - must be billed with diagnostic code Z52 3) Screening Program for Breast Cancer - must be billed with diagnostic code Z51 4) Colorectal Cancer Screening Program - must be billed with diagnostic code Z53	$27.00 *
60A	Required physician reporting forms The following form is covered under this fee code: 1) Physician Reporting Form for West Nile cases - must be billed with diagnostic code 066	$26.40
	Exceptional Drug Status	
153A	Multiple Sclerosis - payment for the completion and submission of the initial and yearly documentation required by the Saskatchewan Drug Program (SDP) to determine eligibility for Exceptional Drug Status (EDS) in the treatment of Multiple Sclerosis. Only one fee is payable every twelve months. Applicable visit fees may be submitted concurrently	$60.80 *
154A	Alzheimers Disease - payment for the completion and submission of the initial documentation required by the SDP to determine eligibility for Exceptional Drug Status (EDS) in the treatment of Alzheimers Disease. Follow-up status reports required by the Drug Program can be done by phone or fax and are billable using code 155A. Application visit fees may be submitted concurrently	$60.80 *
155A	Alzheimers Disease - follow-up status reports required by the SDP by phone or fax. Applicable visit fees may be submitted concurrently	$24.20 *
156A	Anklosing Spondylitis - payment for the completion and submission of the initial and renewal application form required by the Saskatchewan Drug Plan (SDP)	$60.80 *

		Fee
	to determine eligibility for Exceptional Drug Status (EDS) in the treatment of Ankylosing Spondylitis. Only one fee is payable every twelve months. Applicable visit fee may be submitted concurrently	
	Third party counselling for the provision of Medical Assistance in Dying (MAID) services provided by a willing practitioner 1. Billable on a third party basis when a family member, caregiver, relative, friend, spouse, etc is counselled because of the patient's request for Medical Assistance in Dying (MAID) services. 2. Third party counselling is billable to a maximum of 3 hours per day per patient. More than 3 hours is billable by report with a comment on the electronic claim with the total duration of time spent. 3. Third party counselling claims should be submitted in the name of the patient requesting MAID services (not the family member, relative, caregiver, etc). 4. Diagnosis must be Z37 (third party counselling, MAID). 5. May be billed by any physician. 6. Surcharges are not payable (815A-839A). 7. Per "Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record.	
80A	Third Party Counselling – first 15 minutes, includes a) History review; d) Intervention; b) Counselling; e) Record of service provided c) Educational dialogue; f) Time spent counselling	$75.00
81A	Third Party Counselling – next 15 minutes or major portion thereof	$75.00
	Specified Forms	
752A	SSCN prioritization form completion and submission to SSCN	$23.40 *
753A	Physician completion and submission of an application filed with the court under the *Mandatory Testing and Disclosure (Bodily Substances) Act* - by report	$32.00 *
909A	Initiating protocol for the discontinuance of life-support systems following certification of brain death	$61.80 *
100A	Collection of blood from donor for transfusion	$32.60 *
101A	Phlebotomy for therapeutic reason e.g. polycythemia	$32.60 *
107A	Insertion of IV by physician where a nurse or health care worker is unavailable or unable to start the IV - if procedure is longer than 15 minutes, bill as 918A with explanation	$45.00 *
108A	Venipuncture - peripheral or central (jugular) for blood collection or phlebotomy by physician where a nurse or health care worker is unavailable or unable to perform the task	$45.00 *
	Injections -- medication extra	
110A	-- intramuscular or subcutaneous - (included in visit)	$32.60 *
111A	-- direct intravenous injection of medication (Not for	$32.60 *

		Fee
	injection into IV tubing nor for initiation if IV)	
112A	-- arterial puncture	$32.60 *
113A	Hyposensitization injections -- each -- included in visit maximum 3 units per session -- up to 9 units per session for venom desensitization	$13.90 *
114A	IVP/IVC injection when performed in the absence of a radiologist	$32.60 *
115A	Aspiration and/or injection of ganglion	$59.60 *
116A	Insertion of subcutaneous contraceptive implant	$91.80 *
117A	Removal of subcutaneous contraceptive implant	$125.00 *
118A	Pessary -- Initial fitting or review	$44.00 *
	Bladder catheterization	
120A	-- urethral	$13.90 *
121A	-- other than urethral	$21.00 *
122A	Peritoneal lavage	$210.00 *
123A	Insertion of I.U.D.	$102.00 *
125A	Paracentesis or diagnostic tap -- thorax or abdomen	$153.00 *
126A	Pericardial aspiration - by any method (17 years of age and older)	$336.00 *
130A	Pericardial aspiration - by any method (under 17 years of age)	$314.00 *
127A	Lumbar puncture	$126.00 *
128A	Gastric lavage	$38.50 *
129A	Percutaneous manipulations of gallstone(s)	$504.00 *
131A	Submission of Papanicolau smear (females only)	$40.00 *
132A	Relief of faecal impaction -- under general anaesthetic	$147.70 *
133A	Pleural punch biopsy -- with or without thoracentesis	$77.00 *
134A	Insertion of central venous catheter	$124.00 *
135A	Insertion of central venous catheter in infant	$248.00 *
136A	-- under general anaesthesia or IV sedation (includes post-op recovery)	$326.40 *
	Insertion of arterial line for measurement of systemic pressures - unilateral or bilateral	
140A	-- adult	$79.80 *
141A	-- child	$248.00 *
137A	Anoscopy	$15.50
150A	Physiotherapy procedures including heat or light lamps, traction -- per treatment	$8.60 *
925A	Intravenous chemotherapy or remicade treatment treatment	$40.70 *
	Communicable disease service	
160A	-- diagnostic skin tests (e.g. Schick	$6.40 *

		Fee
	test; Dick test) -- each	
161A	-- immunization -- per injection (included in visit)	$32.60 *
162A	-- vaccination and reading	$32.60 *
	Allergy Diagnosis (Testing)	
170A	Scratch test (inhalant-ingestant) - each -- maximum 35 units per annum	$4.30 *
	Patch test (contact dermatoses)	
171A	-- each -- maximum 50 units per annum	$6.40 *
	Intradermal test	
172A	-- each -- maximum 20 units per annum	$7.80 *
	Test for phototoxic or photoallergic reaction under controlled ultraviolet light source (e.g. hot quartz mercury vapor lamp or Wood's Blak-Ray light)	
173A	-- each -- maximum 30 units per annum	$8.40 *
174A	Allergy Challenge--patient challenged with an antigen in a graded fashion (repeated spirometry 600D-603D or 610D to 613D can be billed maximum 3 tests) (per complete 15 minute period)	$43.00
	For hyposensitization -- See service code 113A	
	Total Parenteral Nutrition When provided by other than the attending physician or surgeon **Note**: This service is included in visit/hospital care when provided by the attending physician or surgeon	
182A	-- consultation and initial set up including CVP line	$270.70 *
183A	-- subsequent care per day	$31.00 *
184A	-- outpatient TPN supervision not payable with visit (max 2 per week)	$31.40 *
	Botox Injections Botox fees below are intended for use in the relief of symptoms resulting from dystonias and other neuromuscular spasticity problems and hyhidrosis.	
	Entitlement to bill botulinum toxin injection codes is limited to Ophthalmologists, Otolaryngologists, Orthopaedic Surgeons, Physiatrists, Internists, Neurologists, Plastic Surgeons, General Surgeons, Urologists, Gynaecologists, Anaesthetists and Dermatologists. Others with appropriate training experience may apply to the Saskatchewan Medical Association Tariff Committee for entitlement.	

GENERAL SERVICES

		Fee
	Only one code from the Botox schedule is billable per patient contact. Botox injections include any EMG control and additional injections within 42 days.	
190A	Blepharospasm	$379.00
191A	Hemifacial spasm	$379.00
192A	Extraocular muscle(s) for strabismus or spastic dysphonia -- one or more muscles -- unilateral or bilateral (previously 473S)	$458.00
193A	Multiple muscle -- bilateral	$504.00
194A	Multiple muscle -- unilateral	$380.00
195A	Single muscle -- bilateral	$189.00
196A	Single muscle -- unilateral	$126.00
197A	Rectal spasm, anal fissure	$127.00
	Endoscopy for achalasia etc. -- see endoscopic codes - Section L.	
198A	Hyperhidrosis -- per side (left or right armpit) - to intiate billing, two physicians must have diagnosed the patient with hyperhidrosis (e.g. referring physician and consultant, or two family physicians with the second physician confirming the diagnosis)	$230.00
199A	Botox Injection of Detrusor Muscle via cystoscopy for neurogenic or non-neurogenic overactive bladder	$379.00
	Specimen collection and referral -- to be sent for a special test, when it is the only charge made	
	Urine	
204A	Collection and referral of specimen(s)	$11.40 *
	Blood	
205A	Collection and referral of specimen(s)	$11.40 *
	Other	
206A	Collection and referral of specimen(s)	$11.40 *
	Bone Marrow	
207A	-- aspiration	$97.40 *
208A	-- aspiration and needle biopsy	$152.00 *
209A	-- interpretation	$64.20 *
210A	Examination of blood smear and written clinical report -- by internist or paediatrician with special training in haematology	$40.10
	Cardiac Catheterization	
300A	-- right heart catheterization - to include catheter insertion and any or all of RA, RV, PA, and PAW pressures. Not to be billed during a routine coronary angiogram	$295.30 *
303A	-- left -- retrograde includes catheter insertion and LV and AO pressures	$344.50 *
304A	-- transeptal	$380.90 *
306A	Transvenous endocardial biopsy (right or left) -- independent procedure	$673.00
307A	-- when done in conjunction with any	$204.00

GENERAL SERVICES

		Fee
	catheterization procedure, add	
310A	Dye and/or thermodilution curve studies includes all curves obtained from a patient regardless of method	$190.50 *
311A	Oximetry	$190.50 *
312A	HIS bundle electrocardiography -- sinus node recovery time	$295.30
612A	Complete electrophysiological cardiac studies with drug intervention	$843.20
613A	Endocardial mapping	$541.40
614A	Intracardiac electrocardiography and/or atrial pacing	$215.10
316A	Insertion and measurements with Swan Ganz Catheter - to include all pressures, dye or thermodilution curves, recordings and interpretation	$319.90

Echocardiography

Echocardiography is an insured service when it is provided by a physician who is listed by the College of Physicians and Surgeons of Saskatchewan as having qualified to receive payment. Technical service is only billed if the physician owns the instrument. Multiple echocardiograms on a patient, except Doppler studies for patients under 17 years of age, by same physician or clinic within a period of one year are paid at a reduced rate. The first interpretation is paid at 100%: the second at 50%; third and fourth at 25%, and for the remainder no fee is payable. The technical fees are paid at 100%. The first echo of any type performed starts the series for that patient. Subsequent echos of any type are billed at the reduced rates. Although the physician may not be present for the entire exam, it is expected that he/she will be readily available when tests are being done. Serial Echocardiograms provided to patients receiving cardio-toxic onocology medications at the request of the Cancer Agency will be considered for payment at 100% for the first test in that 12 month period and each additional exam by report at 100%.

Example:

Apr. 30, 2004 Interpretation of M Mode & 2 dimensional echocardiogram - claim 321A.

May 15, 2004 Interpretation of M Mode & 2 dimensional echocardiogram - claim 521A.

July 12, 2004 Interpretation of M Mode, 2 dimensional & doppler echocardiogram - claim 533A.

Feb. 2, 2005 Technical & interpretation of M Mode & 2 dimensional echocardiogram - claim 530A and 531A.

March 6, 2005 Interpretation of M Mode & 2 dimensional echocardiogram - No fee payable.

May 4, 2005 Interpretation of M Mode & 2 dimensional echocardiogram (start of new series) - claim 321A.

	M Mode and Two - Dimensional same day	
320A	-- technical (first)	$154.10
520A	-- technical (second)	$107.00
530A	-- technical (third and fourth, each)	$107.00
321A	-- interpretation (first)	$160.50
521A	-- interpretation (second)	$80.30
531A	-- interpretation (third and fourth, each)	$39.60
	Doppler study, including M Mode plus two-dimensional studies on same day	
322A	-- technical (first) -- 17 years of age and older	$196.90
522A	-- technical (second) -- 17 years of age and older	$154.00
532A	-- technical (third and fourth, each) -- 17 years of	$154.00

		Fee
	age and older	
556A	-- technical -- under 17 years	$154.00
323A	-- interpretation (first) -- adult	$258.90
523A	-- interpretation (second) -- 17 years of age and older	$154.00
533A	-- interpretation (third and fourth, each) -- 17 years of age and older	$110.00
557A	-- interpretation -- under 17 years of age	$220.00
535A	-- technical for serial echocardiograms of patients receiving cardiotoxic oncology medication (second and subsequent)	$154.00
536A	-- interpretation for serial echocardiograms of patients receiving cardiotoxic oncology medication (second and subsequent)	$220.00
	Transoesophageal echocardiogram - to include insertion of transducer and interpretation. Within one year at same office or institution. The first and second transoesophageal echoes are paid at 100%, the third is paid at 25% and for remainder no fee can be charged.	
324A	-- first and second	$336.00
534A	-- third	$84.00
	Codes 443A to 447A, 545A, 548A and 648A are not for use by Radiologists - see Section X.	
	Angiography	
443A	-- angiocardiography -- right and/or left side	$258.90 *
444A	-- extremities, percutaneous -- unilateral	$198.00 *
	Aortography	
445A	-- any method when sole procedure	$301.70 *
446A	-- with selective catheterization of each additional artery to a maximum of 3, add	$44.90 *
545A	--when done as part of 447A and/or 443A or 145C, add	$138.00 *
	Coronary Angiography to include right	
447A	and left coronaries	$461.20 *
548A	-- with selective catheterization of venous and/or arterial bypass grafts each to a maximum of 3, add	$163.00 *
648A	-- with ergonovine stimulation, add	$160.50 *
	Clinical procedures listed below associated with diagnostic radiology may be charged in addition to those listed in Section X.	
331A	Intracoronary thrombolytic therapy	$1,409.20
	Transluminal angioplasty	
328A	-- coronary	$1,132.10
329A	-- each additional stenosis (maximum one per arterial branch)	$572.50
330A	-- peripheral	$469.00
332A	-- pulmonary valve or artery	$1,125.60

GENERAL SERVICES

		Fee
333A	-- pulmonary valve or artery where followed by corrective surgery within 24 hours	$572.50
334A	-- Aorta or aortic valve	$1,125.60
335A	-- insertion of coronary artery stent(s) associated with 328A (any number), add	$440.80
336A	-- subclavian artery	$479.00

Note: Post-angioplasty care for elective procedures (328A, 329A, 334A and 493A) is included in the payment for these procedures.

Procedures under fluoroscopic, C.T. or Ultrasound guidance are found in Section X.

Procedures under fluoroscopic, C.T. or Ultrasonic guidance

406A	Percutaneous nephrostomy with nephrogram	$628.00
407A	Manipulation of peritoneal dialysis catheter	$114.00 *
460A	Non-palpable breast lesion - needle localization provided by surgeon	$104.00 *
412A	Percutaneous fallopian tube cannulation and dilatation -- with selective salpingography, unilateral or bilateral	$255.00
463A	Injection of a sinus tract	$107.00
403A	Percutaneous intra-abdominal drainage	$384.00
462A	Sialography	$129.00 *
661A	Percutaneous insertion of pleural catheter for closed chest drainage	$182.00

Continuous Personal Attendance

The benefit payment is all inclusive, for medically required personal attendance given continuously by a physician, where no other item in the SMA Fee Guide applies. Certain procedures can be billed during a period of 918A, 926A-928A, 220A-226A in the same manner as they can be billed during a period of 335H-339H. (For example if closed chest drainage takes 15 minutes, code 95L can be billed but that 15 minutes should not also be billed as a 918A).

These codes infer that a physician is continually present at a patient's bedside.

Code 918A is not paid for maternity cases.

For intensive care in ICU or CCU -- see Section H.

For a claim to be processed, the physician must provide details of:
I) the clinical condition neccesitating continuous attendance;
ii) the treatment or care provided;
iii) time when continuous attendance on patient started and was completed.

May be billed with applicable surcharge where appropriate.

918A	Continuous personal attendance -- per 1/4 hour or major portion thereof (see requirements above)	$86.20

Indirect Patient Care = Emergency Situations = Emergency Department

		Fee
	This payment is for emergency situations in emergency departments where physician time is spent exclusively on any of the following aspects of patient care: (i) arranging hospital admission or transfer of the patient to another acute care facility (ii) arranging laboratory and diagnostic imaging services (iii) arranging the patient's surgical team (iv) coordinating acillary medical staff This code is billable on the same day as countinous personal attendance (918A) and emergency resuscitation codes (220A-226A), provided that the time periods do not overlap. It is also billable following minor assessments, major assessments and consultations. The physician cannot bill for other work during the same time as this service is being billed. This code may only be billed by general practitioners. For a claim to be processed, the physician must provide details of: (i) the patient's clinical condition (ii) the type of care being arranged (iii) the time when indirect patient care was started and was completed May be submitted with appropriate surcharge where applicable	
919A	Indirect patient care -- per 15 minutes or major portion thereof (see reporting requirements above)	$61.20

Physicians accompanying a patient on transfer by ambulance from one locale to another

These service codes are all inclusive, for medically required attendance during patient transfer by ambulance. Certain procedures can be billed during a period of 926A-928A in the same manner as they can be billed during a period of 335H-339H (see Section H). (For example if closed chest drainage takes 15 minutes, code 95L can be billed but that 15 minutes should not also be billed as a 926A or 927A). It may be billed with the apropriate emergency or special call surcharge.

For a claim to be processed, the physician must provide details of:
(i) the clinical condition necessitating continuous attendance
(ii) the treatment or care provided
(iii) time when continuous attendance on patient started and was completed

926A	Outbound journey with patient only -- per 15 minutes or major portion thereof	$98.00
927A	Homeward or return journey with or without patient -- per 15 minutes or major portion thereof	$56.20
928A	Standby at destination while patient is transferred to receiving physician (max of 4 units) -- per 15 minutes or major portion thereof	$63.00 *
725A	**Hospital discharge & documentation** (payable once per discharge of formally admitted hospital in-patients to the physician responsible for discharging patient -- must be a location of service 2 and billed on the date of discharge from the hospital)	$25.00 *

Emergency Resuscitation - "Code" Situations

Life Threatening Emergency Situation - Being in constant attendance for the

		Fee
	time billed to provide resuscitation in an emergency situation (cardiac arrest, multiple systems major trauma, cardio respiratory failure, resuscitation of newborn, severe shock, coma). The specific elements are those of an assessment, including immediate crisis related examination, on going monitoring of the patient's condition and the usual resuscitative procedures as required: defibrillation, cardioversion, cutdowns, intravenous lines, arterial and/or venous catheters, pressure infusion sets and pharmacological agents, urinary catheters, CVP lines, blood gases, nasogastric tubes, endotracheal intubation and tracheal toilet. Time is to be measured as the period of constant attendance excluding time required for any separately billable intervention (service). If a physician starts billing codes 220A to 223A, the resuscitation should finish with this series of codes.	
	Amount payable per physician per **life threatening emergency** situation for the first two physicians for which a claim is submitted and paid	
220A	- first 15 minutes	$204.00
221A	- second 15 minutes	$102.00
222A	- after first 30 minutes (per 15 minutes or major portion thereof)	$92.60
223A	Amount payable per physician per life threatening emergency for third and subsequent physicians for which a claim is submitted and paid -- per 15 minutes or major portion thereof	$92.60
	Other Resuscitation - is different from Life Threatening Emergency Situation only in that it applies to providing resuscitation in emergency situations other than listed above and only includes the following resuscitative procedures: cutdowns, intravenous lines, arterial and/or venous catheters pressure infusion sets and pharmacological agents, urinary catheters, CVP lines, blood gases, nasogastric tubes, with or without lavage, and tracheal toilet. Time is to be measured as the period of constant attendance excluding time required for any separately billable intervention (service). If a physician starts billing codes 224A to 226A, the resuscitation should finish with this series of codes.	
	Amount payable per physician per **Other Resuscitation** for the first two physicians for which a claim is submitted and paid	
224A	- first 15 minutes	$102.00
225A	- after first 15 minutes (per 15 minutes or major major portion thereof)	$92.60
226A	Amount payable per physician per other resuscitation for the third and subsequent physicians for which a claim is submitted and paid -- per 15 minutes or major portion thereof	$92.60
	Consultation or assessment rendered before or after provision of resuscitative care or neonatal intensive care may be claimed on a fee-for-service basis but not when claiming Intensive (Critical, Ventilatory or Comprehensive) Care per diem fees. When claiming Critical, Ventilatory, or Comprehensive Care per diem fees, no other Intensive Care codes may be claimed by the same physician(s).	
	SPECIAL CALL SERVICES AND SURCHARGES	

SECTION A.4:

GENERAL SERVICES

Fee

A. Preamble

I. Payment for a special call will be made only if the call is initiated by the patient, or someone other than the physician, on the patient's behalf.

II. Special call payments are claimable for where a physician attends a patient on a priority basis, and the visit causes a degree of disruption of work or of out of hours activity, and travel (except in the case of additional patients seen). When more than one patient is attended,

the surcharge for "additional patient" would apply. Please note - you cannot bill for additional patients seen from 8 a.m. to 5 p.m. weekdays. Payment for a special call does not apply where a physician is specially called to another location in the hospital when he is already in the building.

Surcharges may apply to a service at
a) the patient's home;
b) hospital out-patient or emergency department;
c) Special Care Home;
d) physician's office when the physician is called back from some other place;
e) other locations.

III. Payment will be made for the examination and/or procedure provided plus the appropriate surcharge.

IV. Where a surcharge is billed in connection with a major surgical procedure, fracture, dislocation or delivery, one surcharge is billable per case per physician.

V. Special call services are categorized by time of day.

VI. "Weekend" refers to the period from 5:00 p.m. on Friday to midnight on Sunday. "Statutory Holiday" refers to the entire 24 hour period of the specific day.

VII. The statutory holidays in each year are: January 1, Good Friday, Family Day (3rd Monday in February), Victoria Day, July 1, first Monday in August, Labour Day, Thanksgiving Day, Remembrance Day, Christmas and Boxing Day. If any of these days fall on Saturday or Sunday, they will be observed as stated in the Physician's Newsletter.

B. Special Calls

I. Weekdays

815A	Surcharge -- 8 a.m. to 5 p.m.	$77.40 *
817A	Surcharge -- first patient seen -- 5 p.m. to midnight **(Monday - Thursday)**	$113.00 *
837A	Surcharge -- each additional patient seen -- 5 p.m. to midnight **(Monday - Thursday)**	$56.00 *
819A	Surcharge -- first patient seen -- Midnight to 8 a.m.	$264.00 *
839A	Surcharge -- each additional patient seen -- Midnight to 8 a.m.	$76.00 *

II. Weekends and Statutory Holidays (or designated days)

816A	Surcharge -- first patient seen -- 8 a.m. to 5 p.m.	$102.00 *
836A	Surcharge -- each additional patient seen -- 8 a.m. to 5 p.m.	$51.00 *
818A	Surcharge -- first patient seen -- 5 p.m. to Midnight **(Friday to Sunday)**	$138.00 *

		Fee
838A	Surcharge -- each additional patient seen -- 5 p.m. to Midnight **(Friday to Sunday)**	$68.80 *
819A	Surcharge -- first patient seen -- Midnight to 8 a.m.	$264.00 *
839A	Surcharge -- each additional patient seen - Midnight to 8 a.m.	$76.00 *

III. Emergency -- day or night -- any day

721A -- Surcharge, in addition to payment for an appropriate assessment and/or procedure — $178.00 *

This surcharge is payable where a physician travels to respond immediately to a stat call involving a life-threatening situation, provides immediate care and arranges for the patient's emergency admission as a hospital in-patient.

On occasions where the factors in bold type pertain except that emergency admission to hospital is not required, e.g. hypoglycemic shock, the physician is expected to provide an explanation for billing this service code.

Note: Surcharge 721A is not payable when the patient is already hospitalized. Surcharge is not payable in addition to other surcharges.

C. Surcharges are NOT billed in the following circumstances:

(a) Where by prior arrangement, a patient may go to the out-patient department of a hospital, in lieu of an office visit;
(b) Special call initiated by the physician (except the house call surcharges 615A or 915A);
(c) With another surcharge: 615A, 700A, 701A, 721A, 815A, 816A, 817A, 818A, 819A, 836A, 837A, 838A, 839A, or 915A.
(d) With codes 41A, 80A, 81A, 153A-155A, 184A, 190A-199A, 600A, 626A, 680A, 681A, 708A-718A, 725A, 726A, 727A, 753A, 761A-769A, 790A-795A, 770A, 52B-53B, 57B, 60B-62B, 64B-68B, 200B, 205B, 206B, 207B, 30D, 31D, 32D, 130D, 131D, 145D, 278D, 279D, 281D-291D, 320D, 43E, 400H-424H, 667H, 80J, 81J, 278K, 279K, 31M, 260P and 300T. These codes include all services rendered as well as any travel;
(e) With hospital day care items, e.g. 25 to 28 section B to T, 35B;
(f) With emergency medicine visits (73B & 85B);
(g) SGI Medical Driver Fitness and Review (codes 70A to 74A);
(h) Extra patient surcharges are not billed with codes 335H to 339H. Initial patient surcharges billed only once per patient per day.

Statutory Holiday Hospital Care Surcharge

700A Premium payable for hospital care visit (25 to 28 B to T) or new born care visit (30, 31, 32 B or C) made on a statutory holiday (day in lieu if stat is weekend). — $20.00 *

Bill as 700A in addition to the hospital care day code. The 700A should be billed at the same time as the hospital care visit.

701A **Saturday and Sunday Hospital Care Surcharge** — $20.00

This charge is payable when a hospital care visit (25 to 28 B to T; 35B) is made on a Saturday or Sunday. Billed in addition to the hospital care visit, it should be billed at the same time as the hospital care visit.

House Calls - Not Specially Called - Surcharges

GENERAL SERVICES

		Fee
615A	House Call -- follow-up visit, not specially called - surcharge	$46.20 *
915A	House Call -- home care of cancer patient registered by the Saskatchewan Cancer Foundation - surcharge	$46.20 *

Payment will be made for the examination and/or procedure provided plus either of the surcharges 615A or 915A. Per “Documentation Requirements for the Purposes of Billing” the time and location of service must be documented in the medical record.

The intent of payment under surcharge codes 615A and 915A is for a visit to a patient at home (not special care or nursing homes), where the visit is not initiated by the patient but where the physician judges that a visit is required, e.g. a follow-up visit for a condition seen previously, or a periodic visit for a chronic condition as in the case of a house-bound patient.

Routine Nursing Home Visit
The fee is for a visit to a long term care facility on a routine basis to evaluate the patient's condition and to provide advice as necessary to the patient and/or the nursing staff concerning the management of the patient. The physician must either see and assess the patient or review the patient's history and condition with nursing staff. The physician needs to be able to verify that the visit occurred.

626A	**Routine Nursing Home Visit**	$60.00 *

This fee is for a visit made on a routine basis to evaluate the patient's condition and to provide advice as necessary to the patient and/or the nursing staff concerning the management of the patient. The physician must either see and assess the patient or review the patient's history and condition with nursing staff. The physician needs to be able to verify that the visit occurred.

GENERAL SERVICES

Fee

Patients in:
1. Special care homes as defined in The Facility Designation Regulations for patients receiving:
a. Convalescent care
b. Long-term care or long-stay care
c. Palliative care
d. Respite Care
2. Hospitals* or health centres as defined in The Facility Designation Regulations for patients receiving:
a. Convalescent care
b. Long-term care or long-stay care
c. Palliative care
d. Respite Care
e. Level 4 care
*Community, northern, regional, provincial, rehabilitation or district as defined by The Facility Designation Regulations.
Personal Care Homes as defined in The Personal Care Homes Act remain excluded from payment under this code.
Legislation can be found at the following links:
http://www.qp.gov.sk.ca/documents/English/Regulations/Regulations/R8-2R6.pdf
http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/P6-01.pdf

Geriatric Assessment Unit

600A Payment for assessment of patients attending Geriatric Assessment/Rehabilitation Unit
Physician must be physically present to consult and review patients as necessary. Documentation required for significant change orders only -- two per patient per 7 day period. $24.20 *

Group Counselling (instruction time only)

1. Group Counselling of 5 or more patients where the objective is to provide medical expertise regarding the patients' condition, to be billed in the name of one patient.
2. Claim must include a note or comment indicating the number of patients involved and the topic.
Per “Documentation Requirements for the Purposes of Billing”, all time-based codes must have the start and stop times recorded.

680A -- initial 15 minutes $119.00 *
681A -- additional complete 15 minute units (to a maximum of 3 units) $119.00 *

Paediatric Age Supplement for Procedural Fees

• This supplement includes all diagnostic, 0, 10 or 42 day procedure(s) including applicable section W and X code, surgical assistant and anesthetic payment (codes 94H to 161H, 220H & 500H to 505H).
• This supplement excludes ECGS (30D, 31D, 32D).

900A Patients less than 31 days of age, add 50 percent -- maximum of $1,500
901A Patients less than 91 days of age but older than 30 days, add 25 percent -- maximum of $1,500
902 A Patients less than 1 year of age but older than 90 days, add 10 percent -- maximum of $1,000

Note: Paediatric Supplements are based on the value of the diagnostic service, 0, 10, or 42 day procedure(s), surgical assist payment and the anaesthetic payment (codes 500H to 505H only) (excluding all premiums and surcharges).

Fee

Paediatric Weight Supplement for Procedural Fees

• This supplement includes all diagnostic, 0, 10 or 42 day procedure(s) including applicable section W and X codes in the case of the attending physician; the surgical assist payment in the case of the surgical assistant; and the anesthetic payment (codes 500H to 505H only) in the case of the anesthetist.
• This supplement excludes ECGS (30D, 31D, 32D).
• You are required to submit the following codes to obtain the weight supplement:

893A Patients greater than 30 days of age, less than 91 days and less than 3kg in body weight --add 25%, maximum of $1,500
894A Patients greater than 90 days of age and less than 3kg in body weight -- add 40%, maximum of $1,500
895A Patients greater than 90 days of age and less than 6kg in body weight -- add 15%, maximum of $1,500

Note: Paediatric Weight Supplements are based on the value of the procedures listed above. In all cases time of day premiums and surcharges are excluded from the calculation of the supplement. If applicable bill as one of the above codes with the correct calculated value (amount to be paid times the appropriate percentage) and indicate the weight of the patient in a comment.

Paediatric Age Supplements for visits with patients 0 to 5 years of age

1. These supplements provide the physician with increased compensation when he provides an eligible visit service for a patient under 6 years of age.
2. Eligible visit services include codes 3 to 11 sections C to T inclusive, 3B, 4B, 5B, 9B, 11B, 15B, 73B, 85B, 38G, 39G, 14K, 15K, 12S, 9X and 10X. Other serivces are not eligible for this supplement.

896A Visit supplement for patient 2 to 5 years of age - additional 20 percent
898A Visit supplement for patients less than 2 years of age - additional 35 percent

Specialist Visit Supplement for patients 65 years of age and older

1. These supplements provide the physician with increased compensation when providing an eligible visit service for a patient 75 years or age or older.
2. Eligible visit services include codes 3__, 5__, 7__, 8__, 9__, 10__ and 11__ in sections C to T and 14K and 15K. Any other services are not eligible for this supplement.

905A Visit supplement for patients 65 to 74 years of age - additional 15 percent
906A Visit supplement for patients 75 years of age and older - additional 25 percent

Note: Specialist Age Supplements are based on the value of the visit excluding other premiums and surcharges.

OUT-OF-HOURS PREMIUMS -- (to be referred to as a premium)

1. Premiums

(a) The premium provides the physician with increased compensation when they performs most services in a non-office environment initiated between the hours of 5:00 p.m. and 7:00 a.m., weekends or on a statutory holiday.
(b) Services starting in the time period from 5:00 p.m. to midnight and 7:00 a.m. through midnight for weekends and statutory holidays qualify for a 50% premium. **Use billing code 897A.**

(c) Services starting in the time period from midnight to 7:00 a.m. (including weekends) or anytime on a statutory holiday qualify for a 100% premium. **Use billing code 899A**.

2. All services are eligible for premiums except for:
(a) hospital visits (25 to 28B to T, 700A, 52B, 53B);
(b) surcharges, e.g. 815 to 839A, 615A, 721A, 915A;
(c) emergency room coverage services, e.g. 708-718A;
(d) special care homes and nursing home code, ie. 626A;
(e) lab services;
(f) services always done in the office, e.g. 320A, 322A, 520A, 522A, 530A, 532A, 535A, 556A, 4B, 207B, 4C, 30D, 32D, 50D, 54D, 65D, 142D, 267D, 269D, 271D, 276D, 320D, 401D, 13G, 897L, 899L, 31M, 260P, 261P, 330P, 338P, 438P, 439P, 109Q, 29R, 402R, 404R, 406R, 40S, 45S, 301S, 653S, 582S, 96T, 300T, 443T.
(g) other services 41A, 65A, 70A-74A, 153A-156A, 184A, 190A-199A, 600A, 680A, 681A, 725A, 726A, 727A, 732A, 734A, 752A, 753A, 761A-769A, 790A-795A, 60B-62B, 64B-68B, 145D, 121D, 123D, 124D, 128D-132D, 278D, 279D, 281D-291D, 300D, 500D, 501D, 43E, 400H-424H, 540H, 545H, 580H, 585H, 80J, 81J, 278K, 279K, 679K, 580L, 180M, 492N-494N, 580P, 581P, 400R, 500R.

3. Services must start in the time period 5:00 p.m. to 7:00 a.m. or anytime on a weekend or statutory holiday to qualify for the premium. The time period for determining the applicability of premiums for surgical services is based on the anaesthetic start time.

4. Premium for obstetrical delivery is paid if the time of delivery falls between 5:00 p.m. and 7:00 a.m. or anytime on a weekend or statutory holiday. A premium for repair of 3rd degree and 4th degree tears is paid if the delivery qualified for out-of-hours premium.

5. The premium will apply to time units (e.g. H and J codes) extending beyond 7:00 a.m. as long as the service began within the 5:00 p.m. to 7:00 a.m. time period, or anytime on a weekend or statutory holiday.

6. A premium starting before midnight (5:00 p.m. to midnight) and running into the next day should be billed at the before midnight rate.

7. The current rates are 50% for 5:00 p.m. to midnight (including weekends and stat holidays 7:00 a.m. to 5:00 p.m.) and 100% for midnight to 7:00 a.m.

After-Hours-Clinic Premium

1. The after-hours-clinic premium provides the physician with increased compensation when he performs most services in a office location outside the hours of 7:00 a.m. And 7:00 p.m. weekdays.

2. The premium applies to scheduled or unscheduled after-hours-clinic work.

3. This premium is restricted to general practice physicians in Moose Jaw, Prince Albert, Regina, Saskatoon, Balgonie, Clavet, Dalmeny, Emerald Park, Langham, Lumsden, Martensville, Pense, Pilot Butte, Warman, White City, Lloydminister, North Battleford, Swift

Current and Yorkton.

4. The service must be provided in an office location to be eligible. Services not eligible for an after-hours-clinic premium include:
(a) hospital visits (25 to 28B to T, 35B, 700A, 52B, 53B)
(b) surcharges, e.g. 815 to 839A, 615A, 721A, 915A
(c) emergency room coverage serviced, i.e. 708A to 718A
(d) special care homes and nursing home code, i.e. 626A
(e) lab services
(f) services always done in the hospital, e.g. 184A, 600A, 725A, 726A, 727A, 732A, 734A, 121D, 123D, 124D, 128D-132D, 278D, 279D, 281D-291D, 500D, 43E, 400H-424H, 540H, 545H, 580H, 585H, 80J, 81J, 278K, 279K, 679K, 580L, 180M, 580P, 581P, 400R, 500R
(g) SGI 70A, 71A, 74A
(h) other services 57B, 60B, 61B, 62B, 763A, 764A, 765A, 767A, 768A

5. When an after-hours-clinic premium applies to these services at an office location they must be billed with a location of service of F (after-hours-clinic).

6. Effective June 1, 2011 the rate is 10% for weekdays 7:00 p.m. To 7:00 a.m., weekends and statutory holidays. For this premium "Weekend" refers to the period from 7:00 p.m. on Friday to midnight on Sunday. "Statutory Holiday" refers to the entire 24-hour period of the specific day. **Use billing code 904A**

Telephone Calls/Facsimile/E-mail

(for prescription renewals see codes 794A-795A)

Telephone call initiated by allied health care personnel to discuss patient care and management - maximum of one per patient per day (codes 790A to 795A)

Allied health care personnel includes, but is not limited to:

- -- Home care coordinators
- -- Registered and licenced practical nurses
- -- VON
- -- Public health nurses
- -- Psychiatric nurses
- -- Mental health workers
- -- Physiotherapists
- -- Occuptional therapists
- -- Respiratory Therapists
- -- Ambulance Paramedics
- -- Social workers
- -- Psychologists
- -- School teachers/counsellors
- -- Pharamacists
- -- Private care home shift supervision

- -- Physicians, optometrists, dentists and chiropractors are not considered allied health care personnel, per “Definitions”.
- -- Payment is for telephone conversations initiated by allied health care workers.
- -- All calls must be recorded on the patient's chart, including the name and professional capacity of the health care worker involved and the advice given.
- -- No claim may be made for telephone calls in which only a physician proxy, e.g. nurse or clerk, speaks with the allied health care personnel.
- -- This code is for circumstances where it's necessary for the pharmacist to discuss the care of the patient and is not for prescription renewal, clarifying illegible prescription or switching to a generic form of a drug.
- -- No claim may be made for telephone calls regarding patients in hospital receiving acute care.

Fee

-- This service is not intended to cover calls insured as part of the Emergency room coverage codes (708A to 716A in the MSB Payment Schedule).
-- This service is intended to compensate the physician for unexpected interruptions to the physician's normal practice routine.
-- Where the allied health worker requests information or advice by facsimile transmission or electronic mail, the physician may respond by telephone, fax or electronic mail and submit a claim for this request.

-- Only one of codes 790A-795A should be billed per day.

On behalf of nursing home patients

790A Phone/Fax/E-mail -- Not payable in addition to any other payment for the same date of service $25.00 *

On behalf of all other patients

791A Phone/Fax/email -- Not payable in addition to any other payment for the same date of service $25.00 *

Telephone Calls/Facsimile/E-mail on behalf of a palliative patient

This code is billable for patients designated as palliative by their Regional Health Authority or by the Saskatchewan Drug Plan.

Billing is restricted to telephone calls, facsimile or email initiated by allied health care personnel, or telephone calls from the patient's designated family representatives.

Allied health care personnel includes, but is not limited to: Home Care Coordinators; Registered and Licenced Practical Nurses; VON; Public Health Nurses; Psychiatric Nurses; Mehtal health workers; Physiotherapists; Occupational Therapists; Respiratory Therapists; Ambulance Paramedics; Social Workers; Psychologists; School Teachers/Counsellors; Pharmacists; Private care home shift supervisor.

-- Home care coordinators
-- Registered and licenced practical nurses
-- VON
-- Public health nurses
-- Psychiatric nurses
-- Mental health workers
-- Physiotherapists
-- Occuptional therapists
-- Respiratory Therapists
-- Ambulance Paramedics
-- Social workers
-- Psychologists
-- School teachers/counsellors
-- Pharamacists
-- Private care home shift supervision

Physicians, optometrists, dentists and chiropractors are not considered allied health care personnel, per “Definitions”.

No claim may be made for telephone calls in which only a physician proxy, e.g. nurse or clerk, speaks with the allied health care personnel or family members. No claim may be made for telephone calls regarding patients in hospital receiving acute care.

Where the allied health personnel requests information or advice by facsimile, e-mail, or other electronic means, the physician may respond by telephone, facsimile, e-mail, or other electronic means. Contacts from the patient's family representative are restricted to telephone calls.

All interactions must be recorded on the patient's chart, including the name and professional capacity of the allied health care personnel involved and the advice given.

This code is for circumstances where it's necessary for the pharmacist to discuss the

		Fee
	care of the patient and is not for prescription renewal, clarifying illegible prescription or switching to a generic form of a drug. A maximum of three contacts are payable per day. Codes 790A and 791A are not billiable for this patient on the day this code is billed.	
793A	Telephone calls/facsimile/e-mail on behalf of palliative patient	$40.00
	Prescription renewal by telephone call, facsimile, e-mail or other electronic means Telephone call pharmacist initiated for the purpose of refilling a prescription	
	Prescription Renewal Phone Call	
794A	Phone call -- Not payable in addition to any other payment for the same date of service	$10.00 *
	Prescription Renewal Fax/E-mail	
795A	Fax call -- Not payable in addition to any other payment for the same date of service	$10.00 *
	Remote Telephone call from Primary Health Nurse/Triage Nurse in another community	
761A	Not payable in addition to any other payment for the same date of service (max per day - 1 call per patient) Additional calls or visits will only be paid by report. Payment is restricted to telephone conversations initiated by remote primary health nurse/triage nurse seeking advice about the management of a patient **All Calls** must be recorded on the patient's chart including the name of the primary health nurse/triage nurse involved	$50.00 *
	Remote Consultations Between Physicians Major Telephone Assessment and Advice	
769A	includes: pertinent family history, patient history, history of presenting complaint, discussion with referring physician of functional enquiry and examination of all parts and systems, review of laboratory and/ or other data, diagnosis/ assessment record and written submission of the consultant's opinion and recommendations to the referring doctor, but without the consulting physician seeing the patient If the patient is subsequently seen within 42 days for care or assessment, the physician would be unable to claim for a consultation, but could claim for a complete or initial assessment, depending upon the service provided	$101.00

SECTION A.4:

GENERAL SERVICES

		Fee
	Minor Telephone Assessment and Advice	
762A	includes: history review, history of presenting complaint, discussion of patient condition/ management and advice to referring physician but without the consulting physician seeing the patient A written opinion is not necessary for this fee. However, the referring physician's name, patient Information, the diagnosis and the advice given must be recorded. Where a General Practitioner requests information or advice by facsimilie transmission or electronic mail, the Specialist may respond by telephone, fax or electronic mail and submit a claim for this service	$50.00
770A	**Monitoring Home Parenteral Antimicrobial Intravenous Therapy – by telephone** 1. Payable for management of antimicrobial agents prescribed for administration at home through parenteral home intravenous programs. 2. Only payable to specialists recognized by the College of Physicians and Surgeons of Saskatchewan as being Infectious Disease specialists (both adult and pediatric) 3. Payable once per calendar week per patient; ie: only one physician is able to bill on the same patient per week. 4. This service is not eligible for premiums or surcharges. 5. This payment stops when the active treatment protocol ends. 6. Includes: a) monitoring the condition of a patient regarding antimicrobial therapy; b) ordering blood tests; c) interpreting the results; d) inquiry into possible complications; and, e) adjusting the dosage of the antimicrobial therapy. 7. Visit services for each patient contact would be paid per usual. 8. A record of the information and the physician's advice must be included in the patient's chart.	$50.00
	Monitoring Anticoagulant Therapy	
763A	Monitoring anticoagulant therapy by telephone, per month -- monitoring the condition of a patient with respect to anticoagulant therapy, including ordering blood tests, interpreting the results, inquiry into possible complications and adjusting the dosage of the anticoagulant therapy. Max patient per month (only one physician can be paid for each month)	$26.00 *
	Management of Diabetes Monthly fees for monitoring and managing patients with insulin-dependent diabetes. Includes monitoring patient's condition, blood sugars and insulin levels; ordering and interpreting any necessary tests; adjusting insulin dosage as necessary. The fees are only payable for months during which the	

		Fee
	patient has sent information to the physician (by phone, fax, e-mail or other electronic means) that requires a change in the patient's drug or insulin therapy. The physician must review the information personally (not billable if review undertaken by nurse or diabetes educator).	
	Only one physician may bill these codes for any given patient in any one month. A record of the information and the physician's advice must be included in the patient's chart.	
764A	Patients with Type 2 Diabetes on Insulin, per month	$46.20 *
765A	Patients with Type 1 Diabetes on Insulin, per month	$92.80 *
	Patients with Type 1 Diabetes on Insulin Pump	
766A	-- first 12 months, per month	$142.00 *
767A	-- after 12 months, per month	$92.80 *
768A	Pregnant Patients with Diabetes (Type 1 or 2) on insulin, per month	$139.00 *
	Telemedicine Supplement with Direct Interactive Video Link with the Patient	
732A	Initial daily supplement for any patient attended to using an approved telemedicine video link (maximum of one per day for all patients)	$62.80 *
734A	Subsequent daily supplement for additional patients attended to using an approved telemedicine video link - Payable in addition to appropriate visit codes only. Premiums and special call surcharges do not apply to these telemedicine codes. - On site assistant may be needed to assist with the on site aspects of the assessment (examination).	$25.00 *
	Telemedicine Technical Standby	
729A	-- for each 15 minutes, or major portion thereof (max 30 minutes)	$62.80 *
	Only applies if telemedicine service is delayed or interrupted for technical reasons. - No other service can be provided or billed in this interval. - Paid by report. (Please detail the nature of the problem and its resolution). - The time is calculated from the beginning to the end of the technical delay.	
	General Practice Assistant Service. Only applies if a general practitioner is required at the referring end, to assist with essential physical assessment without which the specialist service would be ineffective.	

		Fee
	- The time is calculated from the beginning to the end of the personal attendance. - No other service can be provided or billed in this interval. - Intervals of more than 30 minutes must include an explanation.	
	General Practitioner Assistant	
728A	-- for each 15 minutes, or major portion thereof	$62.80
	Video Case Conference Must be a formal scheduled session with an approved out-of-province referral centre. A single video case conference fee billed in the name of one patient covers all the patients reviewed during that videoconference. The physician should keep appropriate documentation of time and place. Entitlement to bill video case conference codes is limited to physicians who have applied to and been granted approval by the Saskatchewan Medical Association Tariff Committee.	
726A	First 15 minutes	$105.00 *
727A	-- subsequent 15 minutes, or major portion	$72.00 *