SECTION B:

GENERAL PRACTICE

		Fee
	General Practice Visits	
	Visit age supplement for patients 55 years of age and older: 1. These supplements provide the physician with increased compensation when providing an eligible visit service for a patient over 54 years of age. 2. Eligible visit services include codes 3B, 5B, 9B, 11B and 15B. Any other services are not eligible for this supplement.	
100B	for patients 55 to 64 years of age	15 percent
101B	for patients 65 to 74 years of age	25 percent
102B	for patients 75 years of age and older	35 percent
	NOTE: General Practice Age Supplements are based on the value of the visit excluding other premiums and surcharges.	
3B	**Complete assessment** -- includes: pertinent family history, patient history, history of presenting complaint, functional enquiry, examination of all parts and systems, assessment, diagnosis, necessary treatment, advice to patient and record of service provided	$134.00
5B	**Partial assessment or subsequent visit** --includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), assessment, diagnosis, necessary treatment, advice to the patient and record of service provided	$70.00
4B	**Well baby care in office** -- refers to the periodic office visits during the first year of life of a healthy infant and includes the necessary weights and measurements, examination and instruction to the parent regarding health care	$72.80
8B	**Pre-natal visit** after the first visit for maternity care or post-natal office visit	$72.80
9B	**Consultation** -- includes all visits necessary, history and examination, review of laboratory and/or other data and written submission of the consultant's opinion and recommendations to the referring doctor	$150.00
11B	-- repeat consultation A formal consultation for the same or related condition repeated within 90 days by the same physician. Repeat consultation 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 either service code '5' "partial assessment or subsequent review" or service code '7' "follow-up assessment" are appropriate.	$72.80
15B	**Pre-operative assessment** -- includes: pertinent family and social history, patient history, functional enquiry, examination of all relevant parts and systems,	$133.00

Fee

completion of required forms and advice to the patient as necessary (payable only to physicians other than the attending surgeon)
Where this service is provided by the same physician within 30 days of a complete assessment it should be billed as a partial assessment.

Counselling

1. Counselling is where the physician engages with the patient on an individual basis, where the goal of the physician and patient is to become aware of the patient's problems or situation and of the modalities for prevention and/or treatment

2. Counselling can also include an educational dialogue with the patient regarding prevention/health promotion, early detection of health problems, environmental issues related to the patient's health and occupational health and safety.

3. It is recognized that techniques may include hypnosis.

4. Payment for this service implies that it is a discrete service provided by the physician personally.

5. It is not a substitute for a visit involving a complete or partial examination or assessment.

6. This code is not to be used simply because an assessment and/or treatment took 15 minutes or longer, such as in the case of multiple complaints

Third party counselling:

1. NOTE: Third party counselling for the provision of Medical Assistance in Dying (MAID) related services are billable under service codes 80A/81A.

2. It is payable on a third party basis when a family member is counselled because of the patient's serious and complex problem.

3. It is not payable for routine briefing or advice to relatives, which is considered part of the visit service fee.

4. Third party counselling must be provided at a booked separate appointment.

5. Third party counselling claims are subject to a maximum of 30 minutes and should be submitted in the counselled individual's name.

6. Diagnosis must be confirmed or the diagnostic code Z84 must be indicated.

7. May be billed by any physician.

Code	Description	Fee
40B	Counselling -- first 15 minutes, includes: a) history review; b) counselling,; c) educational dialogue; d) intervention; e) record of service provided, and; f) time spent counselling.	$75.00
41B	-- next subsequent 15 minutes or major portion thereof	$75.00

Fee

Hepatitis C - Monthly stipend for overseeing treatment

Monthly stipend for managing the treatment of patients with a confirmed diagnosis of Hepatitis C. The fees are payable for months in which treatment is provided according to recognized protocols for Hepatitis C.

Only one physician may bill this code per month. Patient contacts would continue to be paid as visit services. This fee is not eligible for premiums or surcharges. This payment stops when the active treatment protocol ends.

57B	Each month	$102.00

Palliative Hospital Care*
Palliative hospital care is billable by the physician responsible for the in-hospital care of patients designated as palliative by their Regional Health Authority or the Saskatchewan Drug Plan. Hospital care includes all of the routine services required to manage in hospital care.

Additional services provided as a result of an acute episode may be payable with an explanation. An assessment or consultation may not be billed when palliative hospital care is transferred to another physician. This code cannot be billed on the same day as regular hospital care (25B to 28B).

35B	- per diem *payable on day of admission	

Spinal Pathway
The Spinal Pathway code provides payment to physicians for the time they spend completing and recording a spinal assessment algorithm using the approved Spinal Pathway form.

200B	Spinal pathways # physicians that have completed the Saskatchewan Spine Pathways Course, "Assessment and Management of Low Back Pain" are eligible to bill this code. This code may be billed once per acute or chronic episode that requires completing the Spinal Pathway form and algorithm.	$30.00

Chronic Pain Management

Entitlement Criteria: Chronic Pain Management initial and follow-up pain assessments (205B, 206B) are payable to general practitioners who have applied to and have been granted approval from the Saskatchewan Medical Association Tariff Committee.
Approval will be based upon a combination of the following criteria: proof of expertise in chronic pain management (examples of proof must include at least two of the following: education, training, experience and references), AND a letter of recommendation from the College of Physicians and Surgeons of Saskatchewan based upon information from the Prescription Review Program and Quality of Care Department.
For the purposes of billing, 205B and 206B are payable on the date that the approval from the SMA Tariff Committee is granted to the general practitioner.

This assessment is payable to general practitioners once per patient every 5 years where a minimum of 45 minutes is spent on the following:

• Complete medical assessment and documentation of: medical history, psychiatric history, family history, allergy and intolerance history, pertinent physical examination, pertinent past medical investigations and treatments, pain diagnosis and type (nociceptive, neuropathic, mixed, central).
• Pain diagram, brief pain inventory and the DN4 Neuropathic Pain questionnaire.
• Addiction Screening including opioid risk tool score (ORT).
• Current psychological evaluation including one or more of the following tools: Beck's Inventory, Hospital Anxiety and Depression Score (HADS), PHQ-9 or equivalent, or the Pain Catastrophizing

Fee

score (PCS).
• Medication history including current medications (with verification by accessing the Pharmaceutical Information Program) and past medications trialed for the pain condition.
• Opioid Use Agreement/Informed Consent and Urine Drug Test (UDT) if opioids are considered.
• Initial education on chronic pain as a disease and self-management.
The required documents can be found on the SMA website (www.sma.sk.ca), or an equivalent EMR checklist system can be used.

205B	Chronic Pain Management - Initial Assessment	$408.00 #
206B	Chronic Pain - Follow-up Assessment	$140.00

HIV/AIDS – Primary Care Management

HIV/AIDS management is payable to general practitioners responsible for the primary care of patients with a diagnosis of HIV/AIDS once per patient every 90 days for the following:
a) Review of medication and/or antiviral therapy; and
b) Review and/or ordering of diagnostic and/or screening tests, such as lab work, (ie: CD4 counts, viral loads), tuberculosis, vaccinations, chest x-rays, hepatitis screening, etc; and
c) Completion of approved flow sheets/templates with care consistent with approved guidelines; and
d) Assessment of vital signs, weight, and body mass index (BMI), noting any abnormalities and/or changes in general appearance, body habitus, physical well-being, frailty, and mobility; and
e) Review of current and past medical history, any relevant changes in social or family history, current functional inquiry and review of systems; and
f) Review and management of any relevant underlying co-morbid conditions; and
g) Review and evaluation of any substance or alcohol use; and
h) Review of any psychosocial implications or factors; and
i) Patient education and/or counselling regarding HIV/AIDS care.

• Visits in excess of quarterly (90-day) limits would be billed using other applicable fee codes (ie: partial assessment (5B)) when all criteria of those codes are met.
• Per “Documentation Requirements for the Purposes of Billing”, the documentation must demonstrate that all of the above components were performed.
• No time-of-day premiums are eligible except in-office premium “F”; and
• No surcharges/special calls are billable, as this is considered a prearranged service.

207B	**HIV/AIDS – Primary Care Management**	$147.20

Case Conference
Must be a formal scheduled session. A single conference fee billed in the name of

Code	Description	Fee
	one patient covers all the patients reviewed at that conference. Use 43B if case conference is part of Home Care Program. A maximum of two case conferences per patient per year is billable. The physician should keep appropriate documentation of time and place.	
42B	-- per conference (not patient) first 30 minutes or part thereof	$138.00
43B	-- per home care conference (not patient) first 30 minutes or part thereof	$138.00
44B	-- add to 42B or 43B for each additional 15 minutes or part thereof	$63.00
	Hospital Care*	
	(Payable on day of admission)	
25B	-- first 10 days, per day	$69.80
26B	-- 11-20 days, per day	$69.80
27B	-- 21-30 days, per day	$69.80
28B	-- thereafter, per day	$69.80

Note: for hospital discharge by physician, see code 725A.
*Payable on day of admission.

25B may be billed for short-term acute care patients who are admitted to a Health Centre in the same manner as an acute care hospital. Physicians may not use this option to cover new admissions for long-term care patients.

Supportive Care
Supportive Care is billable by the patient's family physician for inpatient visits to patients formally admitted to hospital under a specialist where it is necessary and/or prudent for the family physician to visit the patient to:
- -- promote continuity of care;
- -- reassure the patient and liaise with the family;
- -- become aware of the specialist's current and future treatment recommendations;
- -- facilitate the continuing management of the patient in the community following discharge.

Note: This service must be documented in the patient's file (hospital chart). This service is not payable in addition to a case conference billed for the same patient on the same day or in conjunction with any surcharge or premium. Cases where the patient has spent less than 24 hours as a hospital in-patient will only be paid if this service has not been paid in the preceeding 30 days. Services in excess of six per year per patient are to be billed by report.

Services in excess of six per discrete hospital admission per patient are to be billed by report which means the claim must be accompanied by a detailed explanation of the circumstances. Payment will be assessed on the basis of the explanation.

Code	Description	Fee
52B	Initial Visit (to be billed once per admission - otherwise 53B)	$82.60
53B	Subsequent Visits - to be billed during the patient's stay as a hospital in-patient up to a maximum of once per week (i.e. 53B is not billable within 6 days of another 53B)	$82.60
	METHADONE - Monthly stipend for overseeing methadone management	

GENERAL PRACTICE

		Fee
60B	First 3 months - per patient (lifetime maximum)	$100.00
61B	Second 3 months - per patient (lifetime maximum)	$80.00
62B	Thereafter - per patient	$50.00

-- No restarts in the payment program, i.e. if the patient leaves the program and then at a later date re-enters the program, his payment would resume at the same level as when he/she opted out.

-- Only one physician will be paid the monthly stipend. Change of physician does not affect level of payment.

-- Visits for each patient contact would be paid as at present (5B's or 40B's) in addition to monthly stipend.

-- Not eligible for premiums or surcharges.

-- Entitlement to these monthly stipends is limited to physicians who:

1. Have a current valid license to prescribe methadone for addiction.

2. Are actively supervising the patient's continuing use of methadone or buprenorphine/naloxone (Suboxone) within the provincial methadone program.

Note: This payment stops when the patient stops taking methadone.

Chronic Disease Management

Chronic disease management (CDM) fees are designed to encourage the use of accepted clinical care pathways to optimize the patient management. CDM fees are billable only for patients with a confirmed diagnosis of diabetes mellitus, coronary artery disease, congestive heart failure or chronic obstructive pulmonary disease (COPD) who require ongoing longitudinal care management of these diseases.

CDM fees are billable only once per patient, every 90 days. To initiate billing of these codes, the physician's first CDM fee claim for the patient must include the comment: "will be providing ongoing care to the patient". Subsequent (after 90 days) CDM fee claims must be consecutive and continuous for the same patient/same physician or clinic and will not require a comment.

An SMA-approved flow sheet must be completed and care must be consistent with approved guidelines. The approved flow sheets are available on the SMA website.

Electronically available equivalent CDM tracking systems (e.g., Electronic Medical Records) that interface with the Chronic Disease Management Toolkit are also eligible.

The CDM fee includes a patient visit that involves at least 15 minutes of physician time. Visits in excess of one every 90 days, or involving less than 15 minutes of time, should be billed using appropriate visit codes (e.g., code 5B).

If the patient has more than one of these conditions, they will be dealt with at the same visit. An approved flow sheet must be completed for each condition and at least 5 minutes of additional time per condition will be spent.

63B	Examination and certification of need for psychiatric examination pursuant to <u>The Mental Health Services Act</u> with completion of Form A	$147.70

Note: Code 63B does not apply to examination, certification or decertification for mental incompetence/competence under the Mentally Disordered Persons Act. Accounts for those services should be submitted to the office of the Public Trustee.

		Fee
64B	Visit and quarterly review of chronic disease -- base fee	$70.00
	Plus add one or more of the following fees for chronic conditions assessed during the visit:	
65B	Diabetes -- add (billable for the following diagnostic codes: 250)	$70.00
66B	Coronary heart disease -- add (billable for the following diagnostic codes: 410-414 inclusive)	$70.00
67B	Congestive heart failure -- add (billable for the following diagnostic codes: 425, 428, 429)	$70.00
68B	COPD -- add (billable for the following diagnostic codes: 490, 491, 492, 496, 518, 519)	$70.00

As an example, if a patient has coronary artery disease, the physician can bill fee 64B and 66B. When a physician sees a patient with more than one chronic disease (e.g., diabetes and coronary artery disease), he/she would bill fee 64B, 65B, and 66B for a total of $167.70.

Emergency Medicine - Visits

The following listings apply to services provided by scheduled on-site emergency physicians providing services in hospital emergency departments.

- -- Surcharges are not payable with these codes.
- -- Other procedures and visits shall be billed using the General Practice codes and fees as listed in the various sections.
- -- Physicians (e.g. on call) who choose to attend their patients in the Emergency Department but who are not the designated emergency physicians as defined above, shall not bill these service codes but shall use the appropriate General Practice codes (i.e. 3B to 5B). Physicians scheduled to work in hospital emergency departments on a call-in basis as opposed to an on-site basis shall not bill these services but shall use the appropriate General Practice codes. These services are not to be used for free standing treatment centres or non-hospital emergency clinics.

Visit age supplement for patients 55 years of age and older:

1. These supplements provide the physician with increased compensation when providing an eligible visit service for a patient over 54 year of age.
2. Eligible visit services include codes 9B, 11B, 15B, 73B and 85B. Any other services are not eligible for this supplement.

100B	for patients 55 to 64 years of age	15 percent
101B	for patients 65 to 74 years of age	25 percent
102B	for patients 75 years of age and older	35 percent

NOTE: Emergency Medicine Age Supplements are based on the value of the visit excluding other premiums and surcharges

73B	**Complete assessment** -- includes: pertinent family history, patient history, history of present complaint, functional enquiry, examination of all parts and systems, diagnosis --assessment, necessary treatment, advice to the patient and record of the service provided	$138.00

SECTION B:

GENERAL PRACTICE

Code	Description	Fee
85B	**Partial assessment or subsequent visit** -- includes: history review, history of presenting complaint, functional enquiry, examination of affected part(s) or system(s), diagnosis -- assessment, necessary treatment, advice to the patient and record of the service provided Payment for patients 0-5 years of age are automatically applied. See Section A - Paediatric Visit Age Supplement for details	$71.00