PREAMBLE TO THE TARIFF OF FEES

1. INTRODUCTION

The following outlines the policy of the Department of Health and Social Services of Prince Edward Island in the assessment of claims for basic health services provided to entitled persons under the *Hospitals Act* and *Health Services Payment Act* of Prince Edward Island. The assessment rules shall be subject to continual review and shall be amended from time to time by the Department in the light of experience in the operation of the P.E.I. Medical Insurance Plan, hereinafter referred to as "the Plan." In the event of a conflict between the assessment rules and this preamble, this preamble shall prevail.

The Preamble to the Tariff of Fees is deemed to form part of the regulations, but in the case of a conflict between any provision of the preamble, the regulations or the Act, the provision of the Act or the regulations shall prevail.

2. GENERAL CONSIDERATIONS

As a general overall policy, the Tariff of Fees should be applied in accordance with commonly established practices in the billing of patients prior to the introduction of the *Hospitals Act* and *Health Services Payment Act.*

The term "he" shall be considered gender neutral throughout the tariff.

Electronic Submission of Claims - All claims must be submitted in an electronic form within three (3) months from the date of the service.

3. ACCEPTANCE OF TARIFF

For the purpose of payment for services under the Department of Health and Social Services Plan, physicians shall claim 100% of the Tariff of Fees and the accepted claims shall be paid at the tariff established by the Department of Health and Social Services in accordance with Section 4 (b) of the *Act*.

A participating physician may not charge an amount above the Tariff of Fees.

4. PARTICIPATION OF PHYSICIANS

All physicians practicing in Prince Edward Island are considered to be participating physicians under the Act, unless they opt out in accordance with Section 10.1(1)(2) of the Act. Consequently, accounts for basic health services provided to entitled persons are to be submitted to, and shall be paid by, the Department of Health and Social Services.

4.A. Election to Opt Out

A physician may opt out of the Plan by notice in writing to the Department as provided for under Section 10(1)(2) of the *Health Services Payment Act.*

4.B. Patient Claim Information

A physician who has elected to opt out is non-participating, and therefore cannot be paid by the Department of Health & Social Services directly for his services. He is required, however, to provide the resident with the required information, in a form acceptable to the Plan, for the resident to make a claim against the Department of Health & Social Services. The payment shall be made directly to the resident in an amount not exceeding the approved tariff for the insured service or, the amount of the physician s claim, whichever is the lesser.

4.C. Election to Participate

A physician may opt back into the Plan by application in writing to the Department of Health & Social Services as provided for under subsection 8.4 of the Act.

4.D. Selective Service(s) Opting Out

4.D.1 Procedure to Become Non-Participating Physician

Opted-in physicians may elect to opt out for any given patient for the total management of the condition under care, including any complications which may develop; for a series of services for which a composite fee applies, or for which the fees are inter-related, the physician would have to either opt in or opt out for the entire series of services.

4.D.2 Submission and Payment of Claims for Opted-Out Patients or Services

If the opted-in physician wishes to opt out for a particular patient or a particular service, he may, as at present, submit his claim to the Department of Health and Social Services on behalf of the patient. The patient shall then receive payment from the Department as per the Tariff of Fees.

4.D.3 Notification by Participating Physician of Opted-Out Services

The following procedures must be strictly adhered to in the case of any patient of a participating physician for whom the physician has elected to opt out:

(i) The physician must inform the patient prior to the rendering of the service that he or she shall be billed directly for the service(s) being rendered;

(ii) The physician must sign the claim and report thereon the amount being charged to the patient, i.e. total amount charged.

5. PAYMENT AT SPECIALIST RATES

Under the Plan, insured services provided by specialists shall only be payable at the rate listed for visits under that particular specialty when the service provided is within the field of the specialty concerned. If such services are not considered to be within the specialty field, payment shall be made at Family Practice rates. Specialist rates are only payable when the physician is on the Specialist register with the College of Physicians and Surgeons of Prince Edward Island.

6. MEDICAL NECESSITY

The Health Services Payment Act requires that only those services that are medically necessary shall be considered eligible for payment. If, in the opinion of the physician, a service is medically necessary, he may submit his claim for payment. Where a physician considers that a service rendered to an entitled person is not medically required, he may charge the patient for the service. Where the Department is in doubt as to the medical necessity of a service provided to an entitled person, the claim may be referred to the Medical Advisory Committee for a recommendation.

6.A. Services Rendered Without Medical Supervision

The Department of Health and Social Services shall consider for payment only those claims for services, which are carried out by, or under the direction of, a physician.

Fees are allowed to cover payment for professional services only and not the cost of materials or supplies used.

7. INDEPENDENT CONSIDERATION (fee code 9999)

Independent Consideration shall be given under one of the following conditions:

(i) Where a fee is listed as Independent Consideration in the Tariff of Fees.
(ii) When requested by a physician (An explanatory note must accompany the claim).
(iii) When a service is claimed which is not listed in the Tariff of Fees.

For operative procedures, the anesthetic start and stop times must be recorded on the patient chart and on the claim.

8. EMERGENCY VISIT DEFINITION

An emergency visit refers to a situation where the demands of the patient and/or the physician's interpretation of the condition is such that he responds immediately at the sacrifice of regular office hours or routine medical practice. The need for immediate response is the intended controlling feature. Immediate attendance because of a personal choice or availability of physician is not considered an emergency visit. Urgent visits for acute or chronic conditions, which do not interfere with routine medical practice do not constitute an emergency visit. The premium fee (xx94) for emergency visits shall be added to the regular fee. Time of day must be indicated on the claim.

9. HEALTH PROMOTION COUNSELING

Counseling patients and/or relatives in providing advice, encouragement, and direction for health care topics is an insured service. Included are lipid or dietary counseling, AIDS advice, smoking cessation, healthy heart advice, prenatal psychosocial assessment, etc. Fee codes for counseling are not to be used in addition to office visit. This service is payable in blocks of fifteen (15) minutes or major portion thereof.

10. OFFICE VISIT CODES

Office visit codes refer to services provided by a physician to a patient for diagnosis and/or treatment in the office, and shall generally be limited to one per physician per patient per day. In situations where two or more members of the same family attend a physician's office on the same day, each patient shall be treated as a separate individual for the purpose of claims submitted**.**

10.A. Consultation (fee codes xx60)

A consultation refers to a written request by one physician for an opinion from another physician competent to provide advice when the patient's condition, due to its complexity, obscurity, or seriousness of the case, necessitates an expert opinion. No consultation fee shall be claimed unless the consultation has been requested by the attending physician. The arranging of an appointment by a physician, any other person, or organization, does not qualify as a consultation in and of itself.

Consultations requested by patients, their representatives, or a third party acting on their behalf, do not qualify as consultations payable under the Plan.

The referral must be initiated by a physician, or a Resident licensed by the College of Physicians and Surgeons of Prince Edward Island.

Discussion of a case by telephone or by letter between two physicians does not qualify as a consultation and is therefore not payable under the Plan.

The referring physician must forward a written request for a consultation, which should include a description of the presenting complaint, the treatment undertaken (if any) and any relevant diagnostic test findings and patient information.

The consulting physician must show the name of the referring physician in the appropriate section on his claim and must retain a copy of the written request for consultation, signed by the referring physician in the patient chart. He must also submit his findings along with recommendations for further care, in writing, to the referring physician.

10.B. Consultation by a Family Physician (fee code 0160)

A consultation by a family physician requires that the consultant obtain a relevant history and perform a relevant physical examination, review pertinent x-ray films, laboratory or other data and submit his opinion and recommendation in writing to the referring physician. The patient should return to the referring physician for continuing care. The condition of the patient as justified by the diagnosis is the control mechanism for paying for such consults between family

physicians. Trivial or minor problems shall result in the consult being reduced to an office visit or rejected on grounds of "not medically necessary." Information on the claim must substantiate necessity of consult between family physicians.

10.C. **Repeat Consultation** (fee codes xx62)

A repeat consultation shall be a re-assessment for the same or related illness, or complication thereof, within 30 days of the initial consultation. A repeat consultation shall contain all the required elements of a consultation and implies that some interval care has been delivered by the referring physician prior to the request for a repeat consultation. Situations where a consulting physician requests a patient to return at a later date for an assessment does not qualify as a repeat consultation as there has been no written and signed referral by the attending physician.

10.D. **Comprehensive Office Visit** (fee codes xx10)

A comprehensive office visit (formerly complete office examination/initial office visit) is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient’s complaint(s) or medical condition. A comprehensive office visit shall comprise of a full history, which includes a history of the presenting complaint as well as past medical history, a full functional inquiry, a detailed examination of relevant body systems, a recommendation for treatment and all the relevant advice related to the presenting complaint. A record of the findings and advice to the patient shall be considered part of the examination.

A comprehensive office visit may not be claimed within 30 days of a previous visit for the same complaint or medical condition. Visits provided within a 30-day period for the same condition or complication should be claimed as a limited office visit.

With regard to specialists,

(i) fee codes xx10 shall be billed where the patient has been initially referred for consultation and a subsequent visit relates to the same diagnosis, and

(ii) these visits can be billed to a maximum of four times within a twelve-month period. If additional such visits are required, a comment on the claim shall be required.

10.E. **Limited Office Visit** (fee codes xx13)

A limited office visit (formerly regional office examination/subsequent office visit) is a service rendered to a patient who presents with one or more complaints that require the physician to take a brief history of the presenting complaint(s), examine the affected part, region, or system, and provide a corresponding diagnosis and recommendation for treatment and/or care. The limited office visit is less involved than the comprehensive visit in terms of the functional inquiry, physical examination and documentation of the prior history.

A limited office visit may be claimed when the physician performs a limited assessment for a new condition or when monitoring or providing treatment of an established condition. Generally, payment shall be limited to no more than one office visit per patient per physician per day, except in cases where it is medically necessary in the physician's opinion to render a repeat office

visit on the same day, and such medical necessity is documented both on the patient's chart, and as a comment on the electronic claims submission.

Office visit codes may not be claimed by a physician who has performed a major surgical procedure in the previous 30 days where the visit is related to the surgery performed. In the case of fractures and/or dislocations, the stated fee shall cover treatment including that related to the care of the fracture for a period of 45 days following the procedure**.**

10.F. Complete Re-examination by a Medical Specialist (fee codes xx63)

When a referred patient is seen in consultation for the first time and, when the nature and complexity of the referring problem requires a follow-up examination with complete re-examination, this shall be paid regardless of the interval between initial consultation and subsequent visit(s).

10.G. Annual Health Examination

An annual health examination for the detection of disease conditions at an early stage before symptoms appear is regarded as a basic health service and may be claimed no more than once in a calendar year. A diagnosis must not be indicated on a claim for an annual health exam. If a diagnosis is indicated, the physician should claim for a complete examination.

10.G.1 Procedures in Addition to Annual Health Examination

Physicians may bill either an annual health exam or a procedure, whichever is greater. This excludes a Pap test (code 2008 or code 2001), which is payable in addition to an annual health exam**.** The insertion of an intra-uterine contraceptive device (Fee Code 6939) shall be paid at one-half the regular fee if inserted at the same time as an annual health exam.

10.H. Emergency Services in a Physician's Office

A physician who makes an unscheduled, non-elective, emergency visit to his office after regular office hours shall be entitled to claim the emergency office visit fee, providing a special trip to the office is necessary. The diagnosis/treatment/comment indicated on the claim must justify the service on an emergency basis. Time of visit must be specified on the claim. Additional patients seen during this special trip may be claimed at the normal office visit rate.

10.I. Continuing Care at a Specialist's Office

A specialist may charge his Specialty rates, as established in the tariff, when the patient is referred by a physician for continuing care. The service being rendered must be within the field in which the specialist is certified by the College of Physicians and Surgeons of Prince Edward Island, otherwise the Family Practice rate shall apply.

11. HOSPITAL VISIT CODES

Hospital visit codes are limited to medical services rendered to an entitled person formally admitted to hospital for diagnostic tests and/or treatment. All initial visits, consultations and procedures must be supported by documentation. Routine daily visits by the attending physician need documentation only if the patient condition warrants.

11.A. Hospital Consultation

A hospital consultation refers to a written request by one physician for an opinion from another physician competent to provide advice when the patient's condition, due to its complexity, obscurity, or seriousness of the case, necessitates an expert opinion. No consultation fee shall be claimed unless the consultation has been requested by the attending physician.

The referral must be initiated by a physician or a Resident licensed by the College of Physicians and Surgeons of Prince Edward Island.

Discussion of a case by telephone or by letter between two physicians does not qualify as a consultation and is therefore not payable under the Plan.

A written request for a consultation, signed by the referring physician, must appear on the patient's chart, on the emergency department record, or on the hospital order sheet.

The consulting physician must show the name of the referring physician in the appropriate section on his claim. The consultant must also document his findings, along with recommendations for further care, on the patient's chart.

Where a family physician maintains day-to-day responsibility for care, and requests only a consultation, the family physician shall charge on a per visit basis, and the consultant shall charge a consultant's fee.

11.A.1 Consultations Required by Hospitals

Consultations required by statute or hospital regulations are allowable benefits and are billable to the Plan.

11.A.2 Consultation by Specialist Prior to Intensive Care

(i) **Consultation Only**: Where a consultation is requested by the attending physician without transfer, the usual consultation fee shall be paid.

(ii) **Consultation and Transfer of Care**: Where a consultation is requested by the attending physician, and where, as a result of the findings of the consultation, the patient is subsequently transferred to the care of the consultant, both the consultant fee and subsequent daily visit fee shall be allowed.

(iii) **Transfer of Care**: Where the attending physician transfers a patient to the care of a consultant, but does not request a consultation, only the fee for visits shall be allowed.

11.B. Complete Examination in Hospital / Initial Hospital Visit (fee codes xx30)

A complete hospital examination cannot be billed by the attending physician until the physician has personally seen the patient and documented the History and Physical on the chart. Any daily hospital care, including acceptance of responsibility of care from the admitting physician prior to the complete examination, may be claimed as a subsequent hospital visit.

11.B.1 Initial Visit - Unassigned ("orphan") patient

An unassigned patient is a patient who does not have a regular family physician, or whose regular family physician does not have admitting privileges in the hospital where the patient has been admitted. This tariff cannot be claimed for newborns. This tariff also does not apply to patients whose regular family physician, with admitting privileges in the hospital where the patient is to be admitted, is temporarily unavailable due to vacation, illness, bereavement or CME, for less than four (4) weeks. This fee is payable in addition to the initial hospital visit fee. This fee code is applicable to family physicians only.

11.C. Other Hospital Visits

11.C.1 Concurrent Care

This refers to a situation where medical indication requires the services of more than one physician for adequate care of the patient on the same day. The physicians concerned shall have supplementary skills in different fields of practice, and each submits his separate account for the services rendered to the patient. Medical necessity for the requirement of multiple physicians must be established and noted on the claim and the patient chart.

Team procedures are not considered to be Concurrent Care when a team fee is listed in the Schedule of Fees.

11.C.2 Continuing Care and Supportive Care

(a) In medical cases of unusual severity, the responsibility for the day-to-day continuing care of the patient may be transferred from the attending physician to the consultant for a period of time. The consultant should charge, in addition to his consultation fee, his day-to-day continuing care on a per visit basis at the specialty rate listed for his specialty.

(b) Supportive Care is defined as a Limited Visit provided by the family physician in a situation where the responsibility for the medical and surgical care of a registered hospital in-patient has temporarily been transferred to a consultant. Effective September 1, 2004, up to seven (7) visits can be claimed for supportive care while the patient is in hospital.

11.C.3 Directive Care

Directive care by a consultant may be claimed only in cases where the condition of the patient requires this special service and where the attending physician specifically requests the consultant to provide this service, and documents this request on the patient's chart. In such cases, both physicians may claim on a per visit basis.

11.C.4 Convalescent Care in Community Hospitals

During the period when patients are transferred to local community hospitals for convalescent care, the family physician may bill under fee code 0145/0144 for the entire stay.

11.C.5 Intensive Care / Critical Care

Critical care fees (fee codes xx95, xx96, xx97, xx98, xx02) apply to the daily care of critically ill and potentially unstable patients who require intensive monitoring and treatment in a designated, approved intensive care area. Critical care fees include initial consultation and assessment and daily management of the patient, including the following procedures, as required: insertion of intravenous lines, arterial and central venous catheters, pressure infusion sets and pharmacological agents, securing and interpretation of blood gases, oximetry, endotracheal intubation, tracheal toilet, artificial ventilation and all necessary measures for respiratory support.

The following critical care services may be claimed in addition to the daily critical care fee codes: Swan-Ganz catheter insertion, transvenous pacemaker insertion, chest tube insertion, cardioversion, renal dialysis, and detention.

Critical care fees are payable to the physician in charge of the daily management of the patient. Other physicians who become involved in the patient's care may charge the appropriate consultation, visit or procedure fees, including Concurrent Care as defined in 11.C.1.

Critical care fees do not apply when stable, non-critically ill patients are admitted to an intensive care area for cardiac rhythm monitoring or observation alone, or when patients who were critically ill no longer require intensive care, but remain in the intensive care area after a transfer order is written because of lack of beds elsewhere in the hospital. Critical care fees can be claimed up to and including the day the patient is medically suitable for transfer from the intensive care area. Intermediate/Progressive Care (fee code 0501) applies to the care of stabilized non-critically ill patients in an intensive care area, which may be an Intensive Care Unit, Coronary Care Unit, Progressive Care Unit, or Intermediate Care Unit.

Documentation including physical assessments, changes to patient symptoms, interpretation of necessary tests, and management plan on a daily basis is required to support billing these codes.

First day critical care codes require time of day when requesting after-hours premiums.

11.C.6 Visits Prior to Surgery

(i) Visit By a Surgeon Prior to Surgery

A visit by a surgeon other than a consultation within a day of the operation by the same surgeon for the same illness may not be claimed, as this is considered to be included in the surgical fee. However, consideration may be given in special cases where sufficient documentation is provided.

(ii) Visit By Attending Physician Prior to Surgery

An attending physician may carry out hospital investigations prior to referring a patient to a Surgeon, and shall be entitled to submit claims for his services up to the time of referral. He shall only be entitled to submit claims beyond this time if he continues to be responsible for a condition not related to the surgery.

11.C.7 Visit Prior to Surgical Assist

A physician who submits a claim for a visit to an entitled person at home, in the office, or in the emergency department, and later on the same day assists at an operation, shall be allowed the fee for the visit in addition to the assistant's fee. The visit shall not be payable, however, if the physician concerned is also the surgeon performing the operation on the patient.

11.C.8 Multiple Physicians

A physician must indicate on his claim each day he has actually seen the patient in hospital. Generally, only one physician shall be paid for one hospital visit per patient per day. Any claim involving more than one hospital visit per day or the attendance of two physicians on the same day should be accompanied by an explanatory note.

In cases where a physician is temporarily replacing the attending physician, the attending physician shall not claim for the visits that are rendered by the replacement physician.

11.C.9 Discharge Fee

A hospital Discharge Fee may be claimed by the physician (either a family physician or a specialist when a patient is admitted for non-surgical hospitalization) who performs the activities in discharging a hospital in-patient. These activities include, as necessary, the completion of the patient’s chart, discharge summary, writing prescriptions for the patient, providing discharge instructions to the patient and arranging for follow-up care of the patient.

The fee is not payable where surgery or fracture care is provided in a hospital setting unless a patient is transferred to a family physician for follow-up care after surgery/fracture care. In this case, the family physician may claim the discharge fee if the family physician performs the discharge duties. This fee cannot be claimed by the operating surgeon in association with any surgical code being billed, or for immediate post-partum care.

A hospital visit fee may be claimed in addition to the discharge fee where a hospital visit is provided on the same day.

11.D. Detention

11.D.1 Definition of Detention

"Detention Time" is defined as the time in excess of half an hour spent by the physician in actually examining or treating a patient; the time so spent constitutes detention time only when

the time is spent by the physician exclusively, continuously, and when physically present with the patient in respect of whom detention time is charged.

Detention does not commence until after the first half hour of service. In cases where consultations are billed for the same patient, detention does not begin until after the first hour for the specialty groups of internal medicine, pediatrics, psychiatry and physiatry. For all other specialty groups, detention starts one-half hour after the beginning of the consultation. Claims submitted must include sufficient documentation and time spent justifying the charge for Detention. This service is payable in blocks of fifteen (15) minutes or major portion thereof.

11.D.2 Detention for Ambulance Transport of Patients

When a physician has accepted the responsibility of transporting a patient from one location to another, the physician shall be paid detention during time of travel from this location back to original site. Claims should have a comment record, indicating the length of time of the detention and any other information that would assist in adjudicating the claim.

11.D.3 Special Call Requiring Detention (fee codes xx76)
(Hospitalized inpatients only)

Where a physician on duty in the Emergency Department is called to the floor to see/treat an inpatient, payment shall be made on a detention basis with actual time spent indicated on claim. Time of day must also be indicated on the chart.

11.D.4 Call-back for hospitalized in-patient (fee codes xx70)

Where a consultation or a visit fee is charged and the physician is called back on the same day to provide further medical care, detention shall begin immediately.

11.D.5 Special Detention - Radiology (fee code 8871)

Between 18:00 and 08:00 hours and on Saturdays, Sundays and holidays, detention for radiologists shall begin when the radiologist arrives at the hospital. If more than one patient is seen, detention may be claimed for the first patient only.

11.E. Hospital Emergency Department Visits

Physicians attending patients in the Emergency Department (ED) of a hospital shall claim under the appropriate ED code in the applicable section of the Tariff of Fees.

Emergency Department visits are categorized by both the time of day and the level of complexity of the encounter.

11.E.1 Time of Day

"Day" applies to visits between the hours of 08:00 and 18:00.
"Night" applies to visits between the hours of 18:00 and 08:00 the following day
"Weekend" applies to visits between the hours of 18:00 Friday and 08:00 Monday.

11.E.2 Level of Complexity

(a) Level I - Limited visit

A Level I Emergency Department visit (limited visit) is a service rendered to a patient who presents to the Emergency Department with a single condition requiring only a brief history of the presenting complaint, examination of the affected part, region or system, review of any required laboratory and/or imaging studies, and treatments.

(b) Level II - Comprehensive Visit

A Level II Emergency Department visit (comprehensive visit) is an in-depth evaluation of a patient necessitated by the seriousness, complexity, or obscurity of the patient's complaint(s) or medical condition. A comprehensive visit shall comprise of a full history, a full functional inquiry, and a detailed examination of relevant body systems. It shall also include a review of any required laboratory and/or imaging studies, and the initiation of appropriate treatment.

A comprehensive visit may also be claimed for those patients whose illness or injury requires prolonged observation, continuous therapy and/or multiple reassessment(s).

A comprehensive visit may be claimed, when appropriate, when a patient is seen in the Emergency Department for the first time that day by that physician. Return visits for the same condition on the same or following day by the same physician should be claimed as a limited visit.

Reassessment by physician on duty in the Emergency Department is the service provided when, at least two hours after the original assessment or re-assessment is completed (including appropriate investigation and treatment), a subsequent assessment indicates that further provision of care and/or investigation is required and performed. Reassessments are not to be claimed for discharge assessments, nor when the patient is admitted by the physician on duty in the Emergency Department, nor when this assessment leads directly to referral for consultation. A maximum of three reassessments may be claimed per patient per day with a maximum of two reassessments per physician per patient per day. A reassessment shall be paid at the same rate as a limited visit.

(c) Level III - Resuscitation/critical care visit

A Level III Emergency Department visit (resuscitation/critical care visit) pertains to the management of a life-threatening illness or injury which requires immediate evaluation and emergent intervention/treatment by the emergency physician. Emergency conditions necessitating Level III care would include resuscitation of cardiac arrest, multiple trauma, cardio-respiratory failure, shock, coma, cardiac arrhythmias with hemodynamic compromise, hypothermia, and other immediately life-threatening situations.

A resuscitation/critical care visit shall include an immediate crisis-related examination and the usual resuscitative interventions as required, such as defibrillation, cardioversion, intravenous lines, cutdowns, arterial and/or central venous catheters, arterial puncture for blood gases, insertion of nasogastric tubes with or without lavage, endotracheal intubation and tracheal toilet,

and the use and monitoring by the emergency physician of pharmacologic agents such as inotropic, vasopressor, and thrombolytic drugs.

Payment for Level III care is based on the amount of time spent by the physician in constant attendance with a critically-ill patient in a life-threatening emergency situation. As in other detention-based care, after-hours premiums are applicable to Level III care.

Since emergency situations can occur anywhere in the hospital, resuscitation care is not restricted to emergency departments or emergency physicians, although it is expected that the physician in charge of the resuscitation shall normally be the physician on duty in the Emergency Department.

Because resuscitation situations often require the services of more than one physician at the same time, Level III care may be billed by up to three physicians per life-threatening emergency situation, when required. The attending physician shall document the need for more than one (1) physician.

11.E.3 Return Visits

When the patient has been discharged from the emergency department and returns the same day unexpectedly, another visit by a different physician may be claimed.

11.E.4 Multiple Physicians

The routine transfer of care between emergency physicians at the change of shift shall not generate a new visit fee. However, in the event of a significant deterioration in a patient's status that medically requires both a new examination and modification of the treatment plan, then the appropriate visit fee item may be claimed.

11.E.5 Medical conditions treated in addition to minor surgical procedures

Patients may present, for example, with a laceration requiring suture repair and also require treatment of an unassociated, unrelated illness or injury. Both a visit fee (Level I, II, or III) and the procedural fee may be billed. In the event that a Level I, II, or III visit fee is medically required and billed, the greater fee shall be paid in full and the lesser at 50 percent.

Patients may also present with an emergency medical condition associated with a laceration (e.g. syncope with a scalp laceration or seizure disorder with a facial laceration). Again, both the appropriate visit fee (Level I, II, III) and a procedural fee may be billed. The greater fee shall be paid in full and the lesser fee at 50 percent.

12. OTHER VISIT CODES

This category includes visit codes relating to visits in the Home, Long Term Care Institutions, Nursing Homes, etc.

12.A. Home Visit

Refers to services rendered other than at the physician's office and may include calls in which a patient is seen at the site of onset of illness or injury. Frequency of visits shall usually not exceed one per patient per day by the same physician except in unusual circumstances, in which case the physician should provide a suitable explanation on his claim.

12.A.1 Additional Patients Seen

Refers to an additional member of the same family, or person living in the same household or institution, examined and treated during a home visit.

12.A.2 Additional Fee for Emergency House Call (Fee codes xx25)

This fee applies between the hours of 08:00 and 18:00 only, in addition to the corresponding home visit or procedure.

12.B. Palliative Care

12.B.1 Palliative Care Consultation

A palliative care consultation must fulfill the normal requirements of a consultation, and include a psychosocial assessment, comprehensive review of pharmacotherapy, appropriate counselling and, where indicated, consideration of appropriate community services. A minimum of 50 minutes must be spent with the patient by a designated physician with recognized training and expertise in palliative care.

12.B.2 Repeat Palliative Care Consultation

A repeat Palliative Care Consultation shall be a reassessment for the same or related illness or complication thereof, within 30 days of the initial Palliative Care Consultation. A repeat consultation shall contain all the required elements of a Palliative Care Consultation and implies that some interval care has been delivered by the referring physician prior to the request for a repeat consultation. Situations where a consulting physician requests a patient to return at a later date for an assessment do not qualify as a repeat consultation as there has been no written and signed referral by the attending physician.

12.B.3 Palliative Care Telephone Call

Physicians may bill for telephone calls initiated by allied health professionals, in which the physician provides advice and direction regarding a palliative home care patient. The patient must be in a formal palliative home care program, and the claim must be supported by documentation on the patient’s chart. Limit of three claims per patient per week.

12.B.4 Palliative Home Care Admission

This fee is applicable only to patients admitted to a formal palliative home care program. It is applicable anywhere in the Province and is not limited to designated palliative care physicians.

12.C. PACS Telephone Consultation

This service is restricted to orthopedic surgeons who provide PACS-based telephone advice to physicians, and includes history review, history of presenting complaint, direct review of PACS imaging studies, discussion of patient condition/management, and advice to the referring physician, but without the consulting physician seeing the patient. Documentation must include a written submission of the consultant's opinion and recommendations to the referring physician. This service cannot be billed if the orthopedic surgeon sees the patient and bills an orthopedic consultation within 3 days of the telephone consultation. The Department or a Health Authority shall not be required to provide PACS outside the hospital.

12.D On-Call Retainer Fees

12.D.1 Speciality Services

One (1) specialist or other physician as applicable from each of the following clinical areas shall be entitled to a daily on-call retainer for providing twenty-four (24) hour coverage to each of the listed hospitals or provincial service, as the case may be:

Queen Elizabeth Hospital
Internal Medicine, Surgery, Anesthesia, Pediatrics, OBGYN, Orthopedics, Ophthalmology, Urology, Plastic Surgery, Oncology and Surgical Assistant

Prince County Hospital
Internal Medicine, Surgery, Anesthesia, OBGYN and Pediatrics.

Provincial
ENT, Diagnostic Imaging.

12.D.2 Payment of Retainer

Payment of retainer is contingent upon the following conditions being met:

(i) provision of twenty-four (24) hours per day, seven (7) days per week continuous coverage for each listed specialty;

(ii) the specialty commits to provide coverage for not less than a period of one (1) calendar month, except that in the event there are fewer than three (3) physicians practicing in a particular specialty, each physician must provide no less than one (1) day in three (3) coverage, i.e. a minimum of ten (10) days per month with a minimum of 30% being provided on Saturdays, Sundays, and holidays;

(iii) the physician is responsible to an emergency department, and is available to respond to a request by emergency medical staff to attend to a patient emergency;

(iv) the physician's name appears on an established hospital call schedule;

(v) the physician shall be entitled to bill fee-for-service in addition to the on-call retainer for all services rendered when on-call; and

(vi) the physician is not otherwise compensated through another contractual arrangement for on-call coverage.

13. PREMIUM FEES

13.A After-Hours Premiums

The following paragraphs show the charges applicable to physician services when provided on an emergency basis within defined hours. The rules regarding the application of After-Hours Premium for Emergency Services are as follows:

13A.1 Application of Premium

Where at least two thirds of a service rendered falls within a premium period, the premium rate applicable to that period shall apply for the entire service. In all other cases, the service must be billed at the lower rate.

13.A.2 Surgical Start Time

For billing purposes, the start time of surgical procedures is determined by the recorded anaesthetic start time.

13.A.3 After-Hours Premium for Emergency Situations Only.

After hours premiums refer to emergency situations and are not to be billed when the time the service is rendered is for the convenience of the physician.

Physicians are required to include on the comment record the date and time of the emergency situation. An E Indicator is required.

13.A.4 After-Hours Premium for Emergency Service (18:00-24:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, home visits, community care facility visits, diagnostic and therapeutic procedures, and detention rendered on an emergency basis during the hours of 18:00 to midnight shall be paid at normal fees plus 25%. Time and E indicator must be shown on claim.

13.A.5 After-Hours Premium for Emergency Service (24:00-08:00)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anaesthesia services, home visits, community care facility visits, diagnostic and therapeutic procedures, and detention rendered on an emergency basis during the hours of midnight to 08:00 shall be paid at normal fee plus 100%. Time and E indicator must be shown on claim.

13.A.6 First Patient Seen after Midnight (fee code 9902)

Fee code 9902 applies to the first patient seen after midnight by family physicians who provide emergency house calls, with the exception of nursing home visits, and also applies to family physicians who render emergency office visits in the community of Crapaud only. This tariff is payable at a rate of $200 no more than once per day, and requires documentation including necessity for any detention claimed

13.A.7 After-Hours Premium for Emergency Service (08:00-18:00) (Saturdays, Sundays, Holidays)

Consultations, surgical procedures, assists for surgical procedures, deliveries, anesthesia services, home visits, community care facility visits**,** diagnostic and therapeutic procedures**,** and detention rendered on an emergency basis during the hours 08:00 to 18:00 on Saturdays, Sundays and holidays shall be paid normal fees plus 25%. E indicator must be shown on claim.

13.B. Geriatric Premium - Family Physicians Only

A geriatric premium shall apply to Family Physician office visit codes 0110, 0113, 0160, 0162 and 2231 for patients 75 years of age and over, in accordance with the schedule for implementation of such premium as follows:

April 1, 2005	5%
October 1, 2005	10%
April 1, 2006	15%
October 1, 2006	25%

14. PSYCHIATRIC SERVICES

14.A. Psychotherapy

Psychotherapy is defined as a procedure carried out by a physician to treat mental, emotional and psychosomatic illness through a therapeutic relationship with the patient in an individual, group or family setting. Psychotherapy always entails continuing medical diagnostic evaluation and responsibility and may be carried out in conjunction with drugs and other treatment(s) (e.g. ECT). Psychotherapy assumes that the psychological and physical components of an illness are intertwined and that at any point in the disease process, psychological symptoms and signs may give rise to, substitute for, or run concurrently with physical symptoms and signs and vice versa.

This service is payable in blocks of fifteen (15) minutes or major portion thereof.

14.B. Certification for Admission to a Psychiatric Facility

Medical examinations required in connection with the certification of an entitled person to a mental institution or alcohol/drug treatment facility are acceptable as a benefit under the Plan (fee code 2800). A visit is not payable in addition to the certification examination.

14.C. Limitation

Where a claim is submitted for psychotherapy provided to an entitled person, no claim shall be accepted for a subsequent visit by a physician on the same day unless it is medically necessary and for an unrelated cause.

14.D. Psychotherapy Services in Hospital by Family Physician

A family physician may claim for psychotherapy in hospital**.**

14.E. Group Psychotherapy & Diagnostic/Therapeutic Interview

Billings must include PHN & DOB for each patient involved.

14.F. Hospital In-Patients under Attending Care of Psychiatrist

Fee code 0146 is payable to the family physician if a complete medical assessment is requested by the psychiatrist.

In addition, Supportive Care may be billed to a maximum of seven (7) visits during a hospital stay. The diagnosis may be the same or related for supportive care.

If the family physician is requested by the psychiatrist to see the patient for a physical condition, then Concurrent Care would apply (fee code 0142).

14.G. Case Management Conference

A Case Management Conference is a scheduled, multi-disciplinary meeting with other professionals for the purpose of discussing a treatment, management or intervention plan for the patient(s). The patient(s) and/or family members may or may not be present at the conference. This service is payable in blocks of fifteen (15) minutes or major portion thereof.

14.H. Diagnostic and Therapeutic Interview

A diagnostic and therapeutic interview is a scheduled interview with a patient and/or a patient's family or other persons who may have relevant information about the patient's circumstances for the purpose of obtaining a collateral history and discussing a treatment, management or intervention plan for the patient. The patient may or may not be present during the interview. This service is payable in blocks of fifteen (15) minutes or major portion thereof. This fee may be billed by psychiatry, pediatrics, internal medicine and family practice. This fee may also be billed by surgical specialties if the diagnosis is related to cancer.

14.I. Mental Health Crisis Care

Mental health crisis care is an unscheduled and unanticipated visit to a family physician by a patient who exhibits mental distress that requires immediate attention. This fee may be billed only once per patient per physician every six months

This service is payable in blocks of fifteen (15) minutes or major portion thereof.

15. SURGICAL SERVICES

The fee for surgical procedures shall include the customary pre and post-operative care as deemed necessary by the operating surgeon for a period of up to 30 days post-operatively or two office visits if necessary for the follow-up examination subsequent to discharge from hospital.

In cases where a surgeon is the primary physician responsible for critically-ill patients in an ICU, the surgeon shall be allowed to bill applicable Critical Care codes (0595-0598). However, these fees would not be applicable if another physician e.g. an internist is also charging Critical Care (0595-0598) rates. (Ref. Section 12.C.5.)

15.A. Pre-Operative Consultation and Investigation

A consultation by a surgeon which subsequently leads to surgery shall be paid in addition to the procedural fee, as long as the documentation requirements for consultations in Sections 11.A. or 12.A. are met.

In unusually complicated cases requiring prolonged preoperative care, visit fees may be claimed by the surgeon and must be accompanied by an adequate explanation.

15.B. Post-Operative Period

The normal post-operative period is deemed to be 30 days for all surgical procedures except fractures and dislocations where the normal post-operative period is 45 days.

15.C. Procedures During Visits

Surgical procedures performed in the course of a home visit may be charged in addition to the fee for the visit but if performed in connection with an office call, only procedure fees shall be charged if it was the primary reason for the visit. A procedural fee may be charged in addition to the office visit fee when the condition requiring the procedure was not the primary reason for the visit. Explanation must be provided clearly indicating there is no relationship between these two services.

15.D. Cosmetic Surgery (See PRIOR APPROVAL Section 29 & Preamble Appendix C)

15.E. SURGICAL PROCEDURES

15E.1 Role Codes

Role Codes #24, #25, #26 and #27 apply when the attending surgeon identifies the need for a qualified actively practicing second surgeon to assist in a procedure because of the second surgeon's expertise in a specific area. Prior approval is required for non-emergency cases, explaining the requirement for a second surgeon.

#10 Surgeon billing 100% of tariff

#11 Surgeon billing 65% of tariff - applies to surgeries performed by the same surgeon through different incisions under the same anaesthetic.

#12 Surgeon billing 50% of tariff - applies to surgeries performed by the same surgeon through the same incision under the same anaesthetic.

#21 Assistant billing 30% of surgeon's claim where **surgeon has billed 100%** of tariff (surgeon role #10).

#22 Assistant billing 30% of surgeon's claim where **surgeon has billed 65%** of tariff (surgeon role #11).

#23 Assistant billing 30% of surgeon's claim where **surgeon has billed 50%** of tariff (surgeon role #12).

#24 Assistant billing 50% of surgeon's claim where **surgeon has billed 100%** of tariff (surgeon role #10).

#25 Assistant billing 50% of surgeon's claim where **surgeon has billed 65**% of tariff (surgeon role #11).

#26 Assistant billing 50% of surgeon's claim where **surgeon has billed 50%** of tariff (surgeon role #12).

#27 Assistant billing 75% of surgeon's claim where an **intra-operative consultation** has occurred. (Ref 15.E.5.(c))

15.E.2 Similar Procedures Done Concurrently

When two similar procedures, e.g. sutures, are done at one time, the charge for the second procedure should be 50% of the listed fee, or as indicated in the schedule. When done at an interval under a separate anaesthetic, the full fee shall apply.

15.E.3 Multiple Procedures Through Same Incision

When more than one operative procedure is performed by the same surgeon through the same incision and under the same anaesthetic, the full fee shall be charged for the major procedure, and 50% the listed fee for the second procedure, except where such combined operations are specified in the schedule. This does not apply where an appendix or ovarian cyst is removed incidentally during an operation, for which no additional payment shall be made. Oophorectomy performed at the time of hysterectomy is billable only if ovarian pathology is present, at a rate of 25% for each ovary.

15.E.4 Multiple Procedures Through Separate Incisions

When procedures are done by one surgeon through separate incisions under one anaesthetic, the charge for the lesser procedure should be 65% of the listed fee.

15.E.5 Separate Surgeons

(a) Different Procedures

When different operative procedures are done by two different surgeons under the same anaesthetic for different conditions, the fee shall be 100% of the listed fee for each condition.

(b) Same Procedure

Where the attending surgeon identifies the need for a qualified actively practicing second surgeon to assist in a procedure because of the second surgeon's expertise in a specific area, the second surgeon shall be paid at 50% of the attending surgeon's fee. Prior approval is required for non-emergency cases, explaining the requirement for a second surgeon.

(c) Intra-operative Consultations

When the attending physician identifies the need for a consultation from a qualified actively practicing second surgeon, during an operation in progress, the second surgeon shall be paid a separate consultation fee.

If the second surgeon assumes responsibility for the surgery, he shall be paid the surgical fee but not the consultation. The original surgeon shall be paid an assistant fee at 75% (Role Code #27). The original assistant (now the second assistant) shall continue to be paid at 30% (Role Code #21).

If the second surgeon becomes an assistant, the second surgeon shall be paid a separate consultation fee and an assistant's fee paid at 50% (Role code # 24). The original surgeon shall be paid for the operation at 100% (Role Code #10). The original assistant (now the second assistant) shall continue to be paid at 30% (Role Code #21).

15.E.6 Subsequent Operation

When a subsequent operation becomes necessary during the same hospitalization because of complications, or for a new or different condition developing during the same hospitalization, full fee shall be paid for procedures listed in the surgical schedule, which are performed because of complications.

15.E.7 Procedure Done in Stages

Where operative procedures are normally performed in stages, the full fee may be claimed for each procedure.

15.E.8 Pre-operative Diagnostic Procedures

Diagnostic procedures carried out prior to surgery shall be eligible for payment according to the Schedule.

15.E.9 Surgical Procedures Performed in Ambulatory Settings

Surgical procedures that can be safely and appropriately performed in an approved ambulatory setting (i.e., a hospital setting approved by a Health Authority or a non-hospital setting approved by the Department) shall be paid at the same rate as if the procedure had been performed in a hospital operating room.

16. SURGICAL ASSISTANTS

16.A. Minor Surgical Procedure

The necessity of a surgical assistant for a minor surgical procedure shall be left to the discretion of the surgeon. On occasion, explanations may be required.

16.B. Schedule of Rates

A surgical assistant shall render a separate claim for his services in accordance with the following:

(1) 30% of the fee listed for the procedure

(2) When a second assistant is required by the surgeon, he may claim a fee as if he were the first assistant. Necessity of the second assistant must be indicated on the surgeon's claim and the Department of Health and Social Services has been assured that the requirement for a second assistant shall be a low frequency item

(3) Surgical assists must be identified with Role Code No. 21, 22, 23, 24, 25, 26 or 27 as applicable on the claim

16.C. Concurrent Care Limitations

When an Assistant's fee is claimed, the physician may not claim for Concurrent or Supportive Care unless he is caring for a disease or condition not related to the surgical procedure at which he assisted.

17. FRACTURE CARE

17.A. Definitions

Open reduction shall mean the reduction of a fracture by an operative procedure and is intended to include exposure of the fracture site with fixation as indicated.

Closed reduction shall mean the reduction of a fracture by non-operative methods with the aid of local or general anesthesia.

No reduction shall mean treatment of a fracture by any method other than that designated above.

17. B. Composite Fee

The fees listed for fractures are intended to cover the treatment of the fracture including any necessary after care, e.g. physiotherapy supervision, exercises, cast changes, etc., for a period of forty five (45) days. Where aftercare cannot be provided by the initial surgeon, the subsequent treating physician is entitled to claim for a cast change when required.

17.C. Immobilization

Immobilization in a plaster cast or splint is not a prerequisite for claiming a fee for fractures.

17.D. Compound Fractures

The fee for compound fractures and/or compound dislocations shall be the fee for the appropriate fracture or dislocation plus 50%.

If an open reduction is performed, the fee for the open reduction shall apply.

17.E. Separate Surgeons

If different surgeons treat different fractures on the same patient at the same time, each surgeon shall be entitled to full fees for the initial fracture and 50% fees for subsequent fractures treated.

17.F. Repeated Closed Reductions

When repeated closed reductions are carried out by one surgeon for the same fracture, then the listed fee for that fracture shall apply to the first reduction and 50% for each subsequent reduction. In cases where two closed reductions are done for one fracture, the tariff should be half the usual fee for the first reduction when done by the same surgeon. When the subsequent reduction is done by a different surgeon, the full fee should apply in each case.

17.G. Closed Reduction followed by Open Reduction

Where one surgeon performs a closed reduction of a fracture and later has to perform an open reduction, then the fee shall be 50% for the closed reduction and 100% for the open reduction.

17.H. Multiple Fractures

In multiple fractures, the fee for the major fracture requiring open reduction, plus 50% of the fee for the minor fractures requiring cast or closed reduction, shall apply.

17.I. Second Surgeon

When it becomes necessary for a second surgeon to perform a reduction, the full fee shall apply for this procedure. The first physician in this case shall be entitled to 100% of the fee for the closed reduction.

18. ANESTHESIA SERVICES

18.A. Anesthesia Fees

Anesthesia fees are payable only when the anesthetic is personally administered by a physician other than the surgeon, assistant surgeon or obstetrician and who remains in constant attendance during the procedure for the sole purpose of rendering an anesthetic service.

An anesthesia fee is for professional services only and includes:

18.B. Pre-Anesthesia Evaluation

Pre-anesthesia evaluation of the patient as an anesthetic risk, ordering of pre-medication as indicated, administration of all types of anesthesia, fluids or blood incidental to anesthesia or surgical procedure and immediate post-anesthetic supervision.

18.C. Supportive and Resuscitation Measures

Immediate supportive and resuscitation measures in the operating room and/or the recovery ward as indicated by the patient's condition.

18.D. Complication

Treatment of any complication arising from anesthesia within 48 hours.

18.E. Anesthesia Detention Fee

Anesthesia detention fees apply when an anesthetist is called and is personally present as a stand by to render anesthetic services.

18.F. Anesthesia for a Normal Delivery

Anesthesia for a normal delivery is an allowable service providing it was medically necessary in the opinion of the attending physician.

18.G. Anesthesia Outside Hospital

Claims for anesthetic services by a physician outside hospital shall be considered for payment only in an emergency or disaster situation.

18.H. Cancelled Surgery

This fee code (0266) is claimed when an anesthetist makes a pre-operative visit to a patient whose surgery is subsequently cancelled. If the anesthetist administers anesthesia within 7 days from the visit, this fee code is not payable; if anesthesia is administered by a different anesthetist, then the fee is payable.

18.I. Definition Beginning and End of Anesthesia

Anesthesia time begins, with the exception of ECT cases, ten (10) minutes prior to the patient's arrival in the operation room to allow for informed consent and preparation of equipment and ends when the anesthetist is no longer in personal attendance (when the patient may be safely placed under the customary post-operative supervision).

19. OBSTETRICAL SERVICES

Obstetrical care includes initial visit, prenatal visits and necessary laboratory tests, delivery, post- partum care in hospital and postnatal visit. All composite obstetrical fees have been eliminated in favor of individual fees for services rendered.

19.A. Prenatal Visits

These are visits to a physician s office prior to delivery of the infant. These are usually monthly visits but may be more frequent in the last three months. Claims should be submitted on a regular basis and not held until delivery takes place.

19.B. Delivery

This usually refers to the time in hospital while labor proceeds to the delivery of the infant.

Where a failed operative (forceps) delivery leads to C-section by the same physician, the C-section fee code 6004 is payable at 100% and failed operation (forceps) delivery 6007 is payable at 50%.

Fee code 0004 is to be claimed if the general practitioner has attended a difficult labor and/or attended difficult delivery or cesarean section.

19.C. In-Hospital Post-partum Care

This refers to the immediate care following delivery of the baby while the mother is still in hospital.

19.D. Postnatal Visit

This usually occurs about 6 weeks following the delivery and shall include a pelvic examination. Therefore, the postnatal period is defined as approximately 6 weeks.

19.E. Multiple Pregnancy

Second and additional deliveries shall be claimed at 50% of delivery fee.

19.F. Outpatient Assessment for Complications of Pregnancy/Labour

This tariff can be billed where a patient presents to hospital with a complication of pregnancy or labour after 20 weeks gestation by dates. An obstetrician may bill this tariff without a consultation request, provided the physician has not seen the patient within the prior 30 days. The service must include all the components of a major consultation with the appropriate chart documentation.

20. PAEDIATRIC SERVICES

20.A. Newborn Care

Newborn care refers to routine care of a well baby during the first ten (10) days including complete examination and necessary parental advice.

Premature infant means an infant weighing 5 ½ lbs. (2500 grams) or less at birth.

Fee code 1136 applies to attendance at maternal delivery and shall include the consult. Fee code 1160, a pediatric consult, may not be billed on the same day as 1136 unless a comment is provided. Fee code 1136 may be billed in addition to fee codes 1145, 1148 or 1150 (Pediatric Intensive Care).

20.B. Well Baby Care

Well baby care refers to periodic office visits to a maximum of nine visits of a healthy baby for routine supervision and development and any parental instructions required. Well baby care may be claimed only until the patient reaches his/her first birthday. Claims billed under well baby care after the first birthday shall be paid as office visits and a diagnosis shall be necessary.

20.C. Child Care

Pediatrics shall include the care of children up to their 16th birthday.

20.D. Patients 16 and over

Consultations for those patients 16 years of age and over shall be considered if accompanied by an explanation.

20.E. Pediatric Critical Care

Fee Code 1154 can be billed for pediatric patients who are ill enough to require critical care, which includes constant nursing care, continuous cardio-respiratory monitoring and intravenous therapy. This code can be billed regardless of whether the patient is in ICU or in a designated

room on the pediatric floor with specialized nursing care. Appropriate documentation must be on the chart.

21. DIAGNOSTIC AND THERAPEUTIC PROCEDURES

When a Diagnostic and Therapeutic Procedure is claimed at the same time as a visit or consultation fee, both fees are payable in full, except when such procedure is the sole reason for the patient's attendance.

21.A. Provision of Surgical Dressing in Physician's Office

Change of Surgical Dressing in a physician's office may be claimed under Tariff of Fees fee code 2010 in Diagnostic and Therapeutic Procedures whether rendered by the physician or his staff.

21.B. Multiple Venepunctures

When a diagnostic test requires multiple venepunctures, up to five (5) venepunctures (fee code 2238) in one day may be billed if an appropriate comment is included.

21.C. Pelvic Examination

Pap smear with or without pelvic examination (fee code 2008) or pelvic examination only (fee code 2001) may be billed in conjunction with any visit other than an obstetrical or gynecological consultation.

21.D. Urodynamic Studies

No more than four (4) urodynamic study fee codes may be billed per patient per visit.

21.E. Skin Lesions

Generally, removal of skin lesions for cosmetic purposes is not an insured service. However, the following conditions are insured services:

(a) The removal of malignant lesions or lesions recognized as presenting a significant risk of producing malignant lesions. Examples are neurofibromatosis (Von Recklinghausen's disease), keratoses in chronic dialysis patients.

(b) The removal of non-malignant skin lesions, which because of their location or size, result in recurring bleeding or recurring infections not amenable to non-surgical management.

21.F. Injections

21.F.1. Injections of Vitamin B12 for Pernicious Anemia

Injections of B12 shall not be paid more frequently than once every four (4) weeks after the first two weeks of such treatment.

21.G.2. Subsequent Injections on the Same Visit

An additional amount shall not be allowed for subsequent injections on the same visit unless the patient develops a reaction at the time of the visit requiring further treatment. This is in accordance with the wording of the Tariff of Fees, fee code 2009.

21.G.3. Injection of Joints

Where two or more joints are injected on the same visit, 65% (as per surgical rules) of the usual fee shall be allowed for the second and subsequent procedures.

22. LABORATORY SERVICES

22.A. Fees

The tariff fees listed under Laboratory Medicine are applicable to those physicians recognized by the College of Physicians and Surgeons of P.E.I. as specialists in the relevant branch of Laboratory Medicine.

The fees listed include the professional component only. Technological and other ancillary components are not included, nor are the costs of necessary premises, equipment or materials.

The fees listed are separate from, and in addition to, any supervisory fee or salary, which may be negotiated between a physician and a hospital or other health authority, unless otherwise mutually agreed.

22.B. Autopsies

A complete autopsy consists of dissection of the chest, abdomen, and head. A limited autopsy consists of dissection of a particular region with exclusion of other areas (e.g., dissection of the chest and abdomen, with exclusion of the head).

22.C. Cytology

Cytology fees are applicable to those cases requiring diagnosis after screening by a cytotechnologist or those cases requiring screening by a pathologist as part of an accepted and recognized quality control program.

23. MISCELLANEOUS

23.A. Time Limit - Submission of Claims

Subsection 19.1 of the *Health Services Payment Act Regulations* states in part that “a physician who renders a basic health service to an entitled person shall submit his claim for service within three (3) months of the date on which the service was rendered in such form and manner as the Department may prescribe.”

23.B. Time Limit - Surgical/Obstetrical Claims

The time period allowed before a surgical procedure becomes outdated for billing purposes shall begin on the date on which the major procedure was performed.

23.C. Time Limit - Claims on Extended Care Patients

Claims for services rendered to extended care patients and obstetrical patients should be submitted at appropriate intervals to ensure that no period greater than the allowable time elapses between the provision of a service and the date the corresponding claim is received at the Department of Health & Social Services

23.D. Time Limit - Submission of Appeals

Physicians appealing a reduction or rejection of a claim also are required to submit their appeal prior to the expiry of the allowable time period from the date the claim appeared on a payment statement. Failure to do so shall result in the appeal being declared "stale dated" and not reviewed.

23.E. Maximum Visit

When there are more than 10 non-hospital visits in 90 days to the same physician, a comment record is required to substantiate payment of the claim.

24. UNINSURED SERVICES / Examinations Requested by a Third Party

Section 1(d)(I) (D) of the *Health Services Payment Act Regulations* states that “examinations required in connection with employment, insurance, admission to an educational institution or camp, procurement of a passport or visa or legal proceedings, or any similar examination at the request of a third party are excluded as Basic Health Services.”

Included in the above would be services and examinations rendered at the request of the following groups:

a. Insurance companies

b. Educational institutions

c. Employers

d. Youth groups, e.g. Scouts Canada, Cadet Services of Canada

e. Various summer camps

f. Office of the Attorney General - PEI (e.g., court requests, jury duty exemption)

g. Workers' Compensation Board of any province or territory

h. Veterans Affairs Canada (incl. RCMP)

i. Citizenship and Immigration - Canada - e.g., Visa Purposes

j. Federal, Provincial or Municipal Governments

k. Physical Examination For Adoption Purposes

l. Advice and Injection for Out of Country Travel

m. National Defense Canada

Claims for discussion of a patient's condition with another member of the family, other than for psychotherapy or diagnostic/therapeutic interview, shall not be accepted as an insured service.

25. SERVICES OF SALARIED PHYSICIANS

Claims from salaried physicians for medical services provided in the normal course of their employment shall be accepted for information only, however payment shall not be made.

26. HOLIDAYS

For the purpose of the Tariff of Fees, the following days are designated holidays:

New Year's Day

Good Friday

Easter Monday

Victoria Day

Canada Day

Labor Day

Thanksgiving

Remembrance Day

Christmas Day

Boxing Day

Christmas Eve Afternoon (12 noon)

Floating holiday
- Lobster Carnival Day for Prince County
- Gold Cup and Saucer Day for Queens & Kings Counties

When a statutory holiday falls on a Saturday or Sunday and when such statutory holiday is celebrated on a subsequent weekday, holiday rates shall apply for services rendered on an emergency basis on that designated weekday.

Holidays are considered to begin at 08:00 hrs on the day of the holiday (or designated holiday), and end at 08:00 hrs the following morning.

27. INTERPROVINCIAL RECIPROCAL BILLING OF MEDICAL CLAIMS

On April 1, 1988 a reciprocal billing arrangement for physician's medical claims came into effect between Prince Edward Island and all provinces and territories except Quebec.

The arrangement allows Prince Edward Island physicians to bill the Department directly for services rendered to eligible Canadian residents other than residents covered by the Quebec Plan.

28. WORKERS' COMPENSATION BOARD CLAIMS

Where a patient receives services for a WCB-related complaint and at the same visit, receives a service for an unrelated diagnosis, both services may be billed to the respective paying agencies.

29. PRIOR APPROVAL

All physician referrals made for non-emergency out-of-province/out-of-country physician or hospital services must receive prior approval from the Department of Health and Social Services. Prior approval is not necessary in the case of emergency transfers but an emergency out-of-province referral request must still be reported on a claim to the Department using the appropriate out-of-province referral fee code. Failure to obtain prior or emergency approval shall result in the patient/parent being held responsible for the total costs of the services. Preamble Appendix D outlines the policy/procedures for the out-of-province referral program. Such prior approval is valid for a period of one (1) year.

30. AUDIT PROCESS

An audit process is defined in the *Health Services Payment Act and Regulations* which charges the Department of Health and Social Services with the responsibility to ensure accountability for expenditures on basic health services.