Alternate Level of Care (ALC) Designation in Acute Care

Billing Information Sheet

Insured Services, Medical Services Branch

1.	GENERAL INFORMATION
	With the exception of patients designated as awaiting long term care placement, the patient designation (i.e. ALC) should not impact billing practices. The focus of billing is related to the condition of the patient, and the medical services provided by the physician. As care needs vary, and medical services provided by a physician are not always required daily, reasonable billing and judgment based on the services provided is required when billing.
	Alternate Level of Care (ALC) is defined as: A patient who is occupying a bed in an acute facility and does not require the intensity of resources/services provided in that care setting and is, therefore, designated ALC. The below is a general summary of the Fee Codes eligible for billing for patients designated ALC, however physicians must be mindful to bill for services that pertain to the individual patient's clinical condition and circumstance.
	The Saskatchewan Medical Care Insurance Act (SMCIA) (and associated regulations), provide the legislative framework by which services provided to patients are eligible for payment. Section 14(1) of SMCIA indicates that "…services that are medically required services provided in Saskatchewan by a physician are insured services." Payment is made for the service provided under the appropriate Physician Payment Schedule Fee Codes, if the descriptor criterion of the service is met.
	Care of acute or ALC patients may be managed by a General Practitioner or a Specialist. Eligible fee codes will vary depending on the patients' clinical needs and the services provided. Any physician can bill fee codes listed in the "A" section of the Payment Schedule. The Assessment rules contained in the Payment Schedule apply to all services provided and billed.