Outpatient and Inpatient Services

Provided to Residents of Other Provinces, and Territories

Medical Services Branch
Reference Manual for Hospitals

Effective: **April 1, 2023**
Section: **Finance**
Replaces: **Policy Statements 128 and 129 dated March 27, 1998**
Statement No: **128**

Saskatchewan

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Introduction

The purpose of this manual is to provide hospital reciprocal billing program administrators in Saskatchewan health care facilities with a reference document outlining the policies, guidelines and processes for inter-provincial/territorial hospital billing claims for insured in-patient and out-patient hospital services. The application of these policies, guidelines and processes is referred to as “the reciprocal billing arrangement”. Oversight of the reciprocal billing arrangement is provided by the Interprovincial Health Insurance Agreements Coordinating Committee (IHIACC).

Recent Changes to Reciprocal Billing

Mental Health Facilities

Effective April 1 2023, select mental health facilities are able to reciprocally bill inpatientper diem rates for the provision of emergency mental health services.Refer to IHIACC’s in-patient per diem rate sheets for a list of facilities andassociated rates.

X-ray with cardiac catheterization

Effective April 1 2023, a separate out-patient rate was added for patients receiving an x-ray with cardiac catheterization. Refer to IHIACC’s out-patient rate sheets code 21 or 71.

Eligibility for Benefits

The aim of the *Canada Health Act* is to ensure that all eligible residents of Canada have reasonable access to insured health services on a prepaid basis, without charges related to the provision of insured services.

If there are eligibility issues with a patient's health card, he/she should contact their provincial/territorial beneficiary registration office to resolve any potential beneficiary entitlement concerns.

Persons who move to take up permanent residency in another province/territory are responsible for informing their current provincial/territorial health care insurance plan that they are leaving and to register with the health care insurance plan of their new province or territory.

Jurisdictions should encourage persons to register with the health insurance plan of their new province/territory of residence within three months of establishing residency in another jurisdiction.

Refer to **Appendix I** of this manual for Provincial/Territorial Ministry of Health contact information.

Persons entering Canada with a work visa for a specific province/territory, may be provided temporary coverage for insured health services (e.g., a unique health card), for use in that province/territory only. These persons are not eligible under the reciprocal billing arrangement and are responsible for health care expenses incurred in other jurisdictions. For reciprocal billing purposes, jurisdictions should not accept health cards, other than those shown in **Appendix H**.

Some provincial/territorial health insurance plans require persons to contact their health ministry for coverage during a period of extended temporary absence from the province/territory. In cases of temporary moves between jurisdictions for employment/educational leave and/or vacation, the patient's province/territory of residence may be responsible for coverage up to one year (depending on the expiry date of the patient's health card). Some jurisdictions may provide extended coverage beyond one year. Patients should be encouraged to contact their provincial/territorial health ministry for details on coverage during temporary absences.

Persons Excluded from Benefits Under Reciprocal Billing

Persons excluded under the *Act* include members of the Canadian Forces and persons serving a term of imprisonment within a federal penitentiary. The Government of Canada provides coverage to the groups through separate federal programs.

Eligible Facilities

In-patient and out-patient hospital services that are eligible for reciprocal billing must be provided in a facility identified and approved by IHIACC to do so.3

Services Excluded from the Reciprocal Billing Arrangement

The reciprocal billing arrangement for in-patient and out-patient insured hospital services only applies to those services identified by IHIACC as insured by all provincial/territorial health insurance plans. A number of health care services have been identified as uninsured by all or some provinces/territories and are therefore excluded from the reciprocal billing arrangement.

Claims for excluded services cannot be billed through the reciprocal billing arrangement. Unless other bilateral arrangements are made for the payment of excluded services, costs for these hospital services are the patient's responsibility, and should be billed directly to the patient by the hospital.

A number of provinces provide coverage for some of the excluded services listed below. The home plan of the patient may be contacted for information concerning possible coverage and the proper method of billing. SEE **APPENDIX I** FOR INFORMATION ON CONTACTING THE HEALTH PLANS OF OTHER PROVINCES AND TERRITORIES. The cost of any service provided which is excluded in the patient's home province or territory should be collected directly from the patient.

Services Not Covered

The following services are excluded from the reciprocal billing arrangement for Outpatient, Inpatient and physician accounts:

- Surgery for alteration of appearance (cosmetic surgery)
- Sex reassignment surgery / gender confirming surgery
- Surgery for reversal of sterilization
- Routine periodic health examinations including routine eye examinations
- In-vitro fertilization, artificial insemination
- Lithotripsy for gall bladder stones
- PET Scans (Except for selected medical indications. Please refer to the out-patient rate sheets for a list of billable PET-CT scans)
- Gamma Knife Radiosurgery
- Brachytherapy
- Sleep labs
- Virtual Health / Telemedicine
- Islet cell transplantation
- Magnetoencephalography (MEG) Scan
- CAR-T cell therapy
- All dental services, except medically necessary oral surgery (e.g., disease of the jaw or injury of the jaw) performed in hospital

  Note: A dental service provided by a physician is not an excluded service.
- Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy
- Genetic screening and other genetic investigations, including DNA probes

- The treatment of port-wine stains on other than the face or neck, regardless of the modality of treatment
- Procedures still in the experimental/developmental/clinical research phase
- Anaesthetic services and surgical assistant services associated with all of the foregoing
- Services to persons covered by other agencies: Canadian Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services Canada (Federal penitentiaries)
- Services requested by a "third party"
- Team conference(s)

Other Excluded Services

- Prescription drugs administered outside the hospital setting
- Take home pharmacy (with the exception of the provision of drugs under out-patient service code 56 & 57
- Home Care
- Charges for hostel care

Quebec, Ontario and New Brunswick do not provide coverage for patients who visit hospitals solely for the administration of drugs, vaccines, sera or biological products.

Excluded Ambulance Services

Air and road ambulance services provided to out-of-province/territory residents are not considered insured health care services by most provincial and territorial health insurance plans. As such, ambulance services are not covered under the reciprocal billing arrangement.

The payment for out-of-province ambulance services is the responsibility of the patient. Charges for out-of-province/territory ambulance services can range from several hundred dollars for ground ambulance services, to several thousand dollars for air ambulance services. Therefore, residents should be encouraged to contact their provincial/territorial ministry of health for information regarding coverage for out-of-province ambulance services before leaving their province/territory of residence.

Under special circumstances, transfers by ground ambulance from one hospital to another hospital for diagnostic and therapeutic services are covered under the reciprocal billing arrangement. REFERENCE PAGE 24.

Services Provided to Non-Residents of Canada

Health regions should charge 3 times the reciprocal billing rate for all hospital services provided to non-Canadian residents. This includes all inpatient per diems, outpatient services, high cost procedures, bone marrow and stem cell transplant services and well newborn per diems.

For up to date information regarding the policy for health services provided to non-residents of Canada, please visit Section #7 on the website http://www.saskatchewan.ca/residents/health/prescription-drug-plans-and-health-coverage/health-benefits-coverage/out-of-province-and-out-of-canada-coverage#patients-visiting-saskatchewan-from-out-of-canada

Responsibility of the Federal Government or the Workers' Compensation Board

Do not bill through the reciprocal billing arrangement accounts for which Veterans Affairs Canada, the Saskatchewan penitentiary, the Workers' Compensation Board or the Armed Forces are responsible. These agencies are to be billed directly. SEE **APPENDIX B**.

Outpatient Services Provided to Residents of Other Provinces and Territories

An outpatient is an individual who has been officially accepted by a hospital and receives one or more health services without being admitted as an in patient, whose personally identifiable data is recorded in the registration or information system of the organization and to whom a unique identifier is assigned to record and track services.

Multiple outpatient services provided on the same day

- When two or more out-patient activities (service codes 51 to 62, 65 to 71) are provided to the same patient on the same day at the same hospital, regardless of whether the patient was discharged and/or readmitted to the same hospital on the same day, only one out-patient activity can be billed by the hospital (i.e., the one incurring the highest cost).
- When service codes 51 or 68, 69, 70 and 13 are provided to the same patient, at the same hospital, on the same date of service, the hospital can bill for both services.
- If you are billing an outpatient visit that occurred just before midnight (patient did not leave hospital) and the patient required a diagnostic procedure (e.g., a CT Scan) during the same visit, only the greater is payable. In this example, the CT Scan is payable but not the outpatient visit.
- If a patient is seen as an out-patient at two different facilities on the same day, both facilities can bill the applicable out-patient rate.

Patients Receiving Outpatient and Inpatient Services on the Same Day

- A hospital can bill an Out-patient rate (service code 51-67) and an In-patient rate for the same day, as long as the patient is not a registered in-patient at the time the out-patient service is provided.

  Rules of application:

  - No out-patient services can be billed during the time a patient is admitted as an in-patient.
  - If a patient receives an out-patient service and is later admitted to the same hospital on an in-patient basis on the same day, the hospital can bill for both the out-patient service and the in-patient stay for that day (i.e., the admission date and the date of out-patient service are the same).
  - If a patient receives outpatient services while admitted as an in-patient, the hospital cannot bill for the outpatient services. In these instances the cost of the outpatient services are included in the in-patient per diem rates.
  - If a patient is admitted as an in-patient at facility ‘A’ and is sent to another facility ‘B’ for an out-patient service and returns to facility ‘A’ as an in-patient, facility ‘A’ can bill for an in-patient stay and facility ‘B’ can bill for an out-patient visit.
  - Outpatient services provided prior to admission, or after discharge, may be billed.

Transfers from one hospital to another hospital

- If a patient receives an outpatient service from one hospital and is transferred to another hospital for admission, the hospital providing the outpatient service can bill for this service. The hospital providing the in-patient services may bill at its standard ward or ICU rate, as applicable.

Outpatient leaves before being seen

- If a patient is registered at a hospital as an outpatient and leaves before being seen by a physician or receiving treatment, a standard outpatient visit may be billed.

Cost of supplies

- The rates listed for outpatient services include the cost of supplies normally used in any procedure, but do not include supplies for use by patients after leaving the hospital.
- Appliances, splints, crutches and canes are excluded from the outpatient rates. These items are the responsibility of the patient and should be charged to the patient.

Refer to the rate sheet used by your jurisdiction for more details regarding the rules of application.

Billing for Laboratory Services

Outpatient claims for lab services may be submitted for services provided to eligible out of province patients who are registered as an outpatient and receive lab services in publicly funded hospitals.

Outpatient claims for lab services may be submitted for specimens referred to a publicly funded hospital lab for laboratory tests, but where the patient is not present. For the referred-in laboratory specimen, this is a composite fee for all specimens in relation to one patient.

If lab services in addition to another outpatient activity are provided to the same patient on the same day at the same hospital only one outpatient service can be billed by the hospital (i.e.: the one service with the highest rate).

If lab services are provided to an eligible out of province patient at a hospital and a specimen is referred to another hospital for further laboratory testing for the same patient, both facilities can bill an outpatient claim for lab services provided, using their respective facility numbers.

Laboratory services provided to an eligible out of province patient who is not registered as an outpatient in a hospital or are provided at a private lab are not eligible for reciprocal billing under the hospital reciprocal agreements. However, specimen referred for further laboratory testing for the same patient, can be billed through the hospital reciprocal agreements by the hospital receiving them.

Schedule of Outpatient Rates Applicable to Residents of Other Provinces and Territories

Interprovincial/territorial Reciprocal Billing – Out-Patient Rates For Billing Services Provided in QC, MB, SK, AB, BC and NU * Effective for Visits on or After April 1, 2023

Rates Include Some Physician Compensation Paid Outside the Hospital in Addition to Physician Compensation Paid Directly by the Hospital (see rule #2)

Service Code	Description	Rate ($)
51	Standard Out-patient Visit, including select discrete high cost diagnostic imaging procedures. Excludes specific services identified within other service codes. See note #8.	361
52	Day care surgery single rate code retired. See codes 68 to 70.	
53	Hemodialysis	573
54	Computerized Tomography (CT)	710
55	Outpatient Laboratory and all other Diagnostic Imaging procedures not specifically listed elsewhere in this schedule of service codes. Includes general radiography, mammography, outpatient laboratory, and referred-in laboratory specimens except for those identified as High Cost Outpatient Laboratory Service Code 65. See note #9.	160
56	Chemotherapy drugs totaling less than $1,000: Bill a visit fee of $361 PLUS the actual acquisition cost of the drugs. No invoice is required. Use code 66 for drug costs totaling $1,000 or more. See note #10.	
57	Cyclosporine/Tacrolimus/AZT/Activase/Erythropoietin/Growth Hormone therapy visit: **$287 plus the actual drug costs**.	
58	Extracorporeal Shock Wave Lithotripsy (ESWL) - Lithotripsy for stones within the gallbladder are excluded.	1,582
61	Magnetic Resonance Imaging (MRI)	676
62	Radiotherapy Services	639
63	Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/PCI with stents/endovascular coils: the invoiced price of the device (invoice required) in addition to the rate applicable to either the Standard Out-patient Visit or Day Care Surgery. In order to bill code 63 the device(s) must total $1,000 or more. See note #11.	
65	High Cost Laboratory for laboratory services not specifically listed elsewhere in this schedule of service codes, and **above $160** the rate provided in the host province's schedule of benefits for laboratory medicine applies; or in the absence of a scheduled rate, an amount that is negotiated between the provincial plans (Genetic screening is excluded).	
66	Chemotherapy drugs totaling $1,000 or greater: Bill a visit fee of $361 PLUS the actual acquisition cost of the drugs. Invoice is required. Prior approval must be obtained for drugs over $5,000. See notes 10 and 12.	
67	PET-CT Scan. See note #13.	1,613
68	Day Care Surgery – Low. See note #14.	1,198
69	Day Care Surgery – Medium. See note #14.	4,222
70	Day Care Surgery – High. See note #14.	15,321
71	X-ray with Cardiac Catheterization	1,813

* Jurisdictions must submit a request and rationale to the RRWG for review, if there is a need to change the set of rates (fees-included or fees-excluded) that they will be using province wide. The request must be received no later than May 30th of the year prior to the date of the change.

Rules of Application for Billing Out-Patient Services

1. Where applicable rates have been established based on an accumulation of costs reflective of the billing rule of one bill per patient per hospital per day.
2. All rates are composite charges that include physician fees for non-invasive procedures and necessary diagnostic interpretations. Physician fees for non-invasive procedures and necessary diagnostic interpretations CANNOT be billed in addition to the rates listed herein. Other physician compensation, for services not paid directly by the hospital, should be billed separately through Medical Reciprocal Billing or separate arrangement with Quebec.
   Invasive procedures include surgeries requiring incisions and other procedures where there would be insertion into the body. Such as endoscopic retrograde cholangiopancreatography (ERCP), endoscopy with biopsy, cardiac catheterization or certain interventional radiology procedures. Whereas a medical procedure is defined as non-invasive when there is no break in the skin.
3. When two or more out-patient activities (service codes 51 to 62, 65 to 70) are provided to the same patient on the same day at the same hospital, regardless of whether the patient was discharged and/or readmitted to the same hospital on the same day, only one out-patient activity can be billed by the hospital (i.e., the one incurring the highest cost).
4. An out-patient charge can be billed on the same day of in-patient admission or discharge from the same hospital, as long as the patient is not a registered in-patient at the hospital at the time of service.
5. If a patient receives out-patient services while admitted as an in-patient the hospital cannot bill for the out-patient services. In these instances the cost of the out-patient services are included in the in-patient per diem rates.
6. If a patient is registered at a hospital as an out-patient and leaves before being seen by a physician or receiving treatment, code 51 may be billed.
7. If a patient is seen as an out-patient at two different facilities on the same day, both facilities can bill the applicable out-patient rate.
8. An out-patient is an individual who has been officially accepted by a hospital and receives one or more health services without being admitted as an inpatient; and whose personal identifiable data is recorded in the registration or information system of the organization and to whom a unique identifier is assigned to record and track services.

Select discrete high cost diagnostic imaging procedures include the following:

- Nuclear medicine - diagnostic images and treatment procedures using radiopharmaceuticals. Includes single photon emission computed tomography (SPECT). Excludes nuclear medicine scans superimposed on images from modalities such as CT or MRI (e.g. SPECT/CT) which have their own service codes.
- Fluoroscopy – an imaging technique to obtain real-time moving images of a patient through a fluoroscope, developed from the capture of external ionizing radiation on a fluorescent screen.
- Ultrasound - the production of a visual record of body tissues by means of high frequency sound waves.
- Interventional/Angiography Studies - the use of radiant energy from x-ray equipment during interventional and angiography studies. These radiographic techniques use minimally invasive methods and imaging guidance to perform studies that replace conventional surgery such as diagnostic arteriography, renal and peripheral vascular interventions, biliary, venous access procedures and embolization.

9. For the referred-in laboratory specimen this is a composite fee for all specimens in relation to one patient referred to an institution for laboratory tests but where the patient is not present.

   General radiography refers to the use of radiant energy from x-ray equipment for general diagnostic purposes. Mammography involves taking an x-ray of breast tissue for screening and/or diagnostic purposes

10. Chemotherapy drugs are all drugs used to treat cancer including monoclonal antibodies, tyrosine kinase inhibitors, angiogenesis inhibitors etc.

11. Cardiac pacemakers and/or defibrillators (any type)/cochlear implants/stents/endovascular coils:

    Cardiac pacemakers and/or defibrillators (any type)

    Refers to cardiac devices. Does not include temporary pacemakers or artificial heart.

    CCI codes:

    Percutaneous transluminal [transvenous] approach or approach NOS:

    - 1.HZ.53.GR-NM single chamber rate responsive pacemaker
    - 1.HZ.53.GR-NK dual chamber rate responsive pacemaker
    - 1.HZ.53.GR-NL fixed rate pacemaker
    - 1.HZ.53.GR-FS cardioverter/defibrillator
    - 1.HZ.53.GR-FR cardiac resynchronization therapy pacemaker
    - 1.HZ.53.GR-FU cardiac resynchronization therapy defibrillator

    Percutaneous approach (to tunnel subcutaneously):

    - 1.HZ.53.HN-FS Implantation of internal device, heart NEC cardioverter/defibrillator [AICD]

    Open (thoracotomy) approach:

    - 1.HZ.53.LA-NM single chamber rate responsive pacemaker
    - 1.HZ.53.LA-NK dual chamber rate responsive pacemaker
    - 1.HZ.53.LA-NL fixed rate pacemaker
    - 1.HZ.53.LA-FS cardioverter/defibrillator
    - 1.HZ.53.LA-FR cardiac resynchronization therapy pacemaker
    - 1.HZ.53.LA-FU cardiac resynchronization therapy defibrillator

    Open Subxiphoid approach:

    - 1.HZ.53.QA-NM single chamber rate responsive pacemaker
    - 1.HZ.53.QA-NK dual chamber rate responsive pacemaker
    - 1.HZ.53.QA-NL fixed rate pacemaker

Combined open (thoracotomy) approach and percutaneous transluminal (transvenous) approach:

- 1.HZ.53.SY-FS cardioverter/defibrillator

- 1.HZ.53.SY-FR cardiac resynchronization therapy pacemaker

- 1.HZ.53.SY-FU cardiac resynchronization therapy defibrillator

Cochlear Implants:

CCI codes:

- 1.DM.53.LA-LK Implantation of internal device, cochlea, of single channel cochlear implant

- 1.DM.53.LA-LL Implantation of internal device, cochlea, of multi-channel cochlear implant

Category does not include reposition of an existing, previously placed implant (1.DM.54.^^)

PCI (Percutaneous Coronary Intervention) with Stents (including drug eluting stents):

CCI codes:

- 1.IJ.50.GQ-NR Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using (endovascular) stent only

- 1.IJ.50.GQ-OA Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using balloon or cutting balloon dilator with (endovascular) stent- 1.IJ.50.GQ-OB Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using laser (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GQ-OE Dilation, coronary arteries percutaneous transluminal approach [e.g. with angioplasty alone] using ultrasound (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GU-OA Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using balloon or cutting balloon dilator with (endovascular) stent

- 1.IJ.50.GU-OB Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using laser (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GU-OE Dilation, coronary arteries percutaneous transluminal approach with thrombectomy using ultrasound (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GT-OA Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using balloon or cutting balloon dilator with (endovascular) stent

- 1.IJ.50.GT-OB Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using laser (and balloon) dilator with (endovascular) stent

- 1.IJ.50.GT-OE Dilation, coronary arteries percutaneous transluminal approach with atherectomy [e.g. rotational, directional, extraction catheter, laser] using ultrasound (and balloon) dilator with (endovascular) stent

Stent Grafts:

Stent graft procedure is a procedure that uses percutaneous transluminal approach and (endovascular) stent with synthetic graft. EVAR related CCI codes are excluded from this procedure group.

CCI codes:

-1.IM.80.GQ-NR-N - Repair, pulmonary artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue [e.g. stent graft].

-1.JK.80.GQ-NR-N - Repair, subclavian artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue (e.g. stent graft).

-1.KE.80.GQ-NR-N - Repair, abdominal arteries NEC, using percutaneous transluminal (arterial) approach and (endovascular) stent graft [e.g. snorkel stent graft].

-1.KG.56.GQ-NR-N - Removal of foreign body, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft]

1.KG.80.GQ-NR-N - Repair, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft].

1.KT.80.GQ-NR-N - Repair, vessels of the pelvis, perineum and gluteal region using percutaneous transluminal (arterial) approach and (endovascular) stent graft.

Endovascular Coiling:

Endovascular coiling or endovascular embolization, is a surgical treatment for cerebral aneurysms. This is intended to prevent rupture in unruptured aneurysms, and rebleeding in ruptured aneurysms. The treatment uses detachable coils made of platinum that are inserted into the aneurysm using the microcatheter.

CCI codes

-1.JW.51.GQ-GE - Occlusion, intracranial vessels, percutaneous transluminal (arterial) approach using [detachable] coils.

12. Claims submitted with Code 66 must be accompanied by a hospital invoice that must identify the patient (name, health number, date of administration) and the cost of the drugs used in the visit. Prior approval **must be obtained** for chemotherapy drugs with a cost greater than $5,000. Hospitals should be informed that treatment should not take place until prior approval has been obtained. Hospitals should follow usual prior approval processes to request prior approval from the home Ministry.

    Only one prior approval request is needed for patients that require multiple visits. Hospitals should indicate on the prior-approval request that repeat visits are required.

    In emergency situations, where prior approval cannot be obtained in a timely manner, chemotherapy drugs can be reciprocally billed without prior approval. The host province must notify the home province in writing and provide a rationale as to why prior-approval could not be requested, an adjustment can be requested if no rationale is provided.

13. A PET-CT scan can be billed under the following clinical indications only:

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
ESOPHAGEAL CANCER	Staging prior to surgery; for baseline staging assessment of those patients diagnosed with esophageal cancer being considered for curative therapy and/or repeat PET-CT scan on completion of pre-operative/ neoadjuvant therapy, prior to surgery	**C15.–** *Malignant neoplasm of oesophagus*	3.**.70.CJ
COLORECTAL CANCER	Staging for potentially resectable recurrences (including rising CEA); where recurrent disease is suspected on the basis of an elevated and/or rising carcinoembryronic antigen (CEA) level(s) during follow-up after surgical resection but standard imaging tests are negative or equivocal PET-CT for apparent limited metastatic disease, such as organ-restricted liver or lung metastases, or limited nodal metastases (at presentation or follow-up) who are being considered for radical intent therapy, such as ablation, radiotherapy, or surgery. PET-CT should be considered prior to chemotherapy where the identification of occult metastases prior to resection or chemotherapy may render resection inappropriate or may alter a patient's management; or 6 weeks post chemotherapy	**C18.–** *Malignant neoplasm of colon* **C19** - *Malignant neoplasm of rectosigmoid junction* **C20** - *Malignant neoplasm of rectum* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs* **R76.8** - *Other specified abnormal immunological findings in serum*	3.**.70.CJ
GYNECOLOGICAL CANCER	Staging locally advanced cervical cancer; PET-CT for patients with locally advanced cancer of the cervix (+/- endometrial cancer) with positive or equivocal pelvic lymph nodes as assessed by PET-CT Re-staging prior to consideration of pelvic exenteration; PET-CT for patients with recurrent gynecologic malignancies under consideration for radical salvage surgery	**C51.–** *Malignant neoplasm of vulva* **C52** - *Malignant neoplasm of vagina* **C53.–** *Malignant neoplasm of cervix uteri* **C54.–** *Malignant neoplasm of corpus uteri* **C55** - *Malignant neoplasm of uterus, part unspecified* **C56.–** *Malignant neoplasm of ovary* **C57.–** *Malignant neoplasm of other and unspecified female genital organs* **C58** - *Malignant neoplasm of placenta* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes*	3.**.70.CJ
HEAD AND NECK	Diagnosis of the primary site; for the evaluation of metastatic squamous cell carcinoma in neck nodes when the primary disease site is unknown after standard radiologic and clinical investigation For the staging on nasopharyngeal cancer PET-CT to assess patients with N1, N2, or N3 metastatic squamous cell carcinoma of the head and neck, after chemoradiation, who have residual neck nodes of 1.5cm or greater on re-staging PET-CT performed 10-12 weeks post therapy	**C00.–** *Malignant neoplasm of lip* **C01** - *Malignant neoplasm of base of tongue* **C02.–** *Malignant neoplasm of other and unspecified parts of tongue* **C03.–** *Malignant neoplasm of gum* **C04.–** *Malignant neoplasm of floor of mouth* **C05.–** *Malignant neoplasm of palate* **C06.–** *Malignant neoplasm of other and unspecified parts of mouth* **C07** - *Malignant neoplasm of parotid gland* **C08.–** *Malignant neoplasm of other and unspecified major salivary glands* **C09.–** *Malignant neoplasm of tonsil* **C10.–** *Malignant neoplasm of oropharynx* **C11.–** *Malignant neoplasm of nasopharynx* **C12** - *Malignant neoplasm of pyriform sinus* **C13.–** *Malignant neoplasm of hypopharynx*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
	Staging of patients with of locally advanced (N1, N2, or N3) malignancies of the head and neck	**C14.–** *Malignant neoplasm of other and ill-defined sites in the lip, oral cavity and pharynx* **C30.0 –** *Malignant neoplasm of nasal cavity* **C31.–** *Malignant neoplasm of accessory sinuses* **C32.–** *Malignant neoplasm of larynx* **C41.–** *Malignant neoplasm of bone and articular cartilage of other and unspecified sites* **C49.0 -** *Malignant neoplasm of connective and soft tissue of head, face and neck* **C69.5 -** *Malignant neoplasm lacrimal gland & duct* **C76.0** - *Malignant neoplasm of head, face and neck* **C77.0** - *Secondary malignant neoplasm lymph nodes of head, face and neck*	
MELANOMA	Staging in node positive disease for whom radical surgery is planned; for the staging of melanoma patients with localized "high risk" tumours with potentially resectable disease; or for the evaluation of patients with melanoma and isolated metastasis at the time of recurrence when metastectomy is being contemplated	**C43.–** *Malignant melanoma of skin* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs* **C79.–** *Secondary malignant neoplasm of other and unspecified sites*	3.**.70.CJ
LUNG	Solitary Pulmonary Nodule (SPN) (solid or semi-solid, excluding GGN), undiagnosed in patients at high risk from TTNB; SPN: a lung nodule for which a diagnosis could not be established by a needle biopsy due to unsuccessful attempted needle biopsy; the SPN is inaccessible to needle biopsy; or the existence of a contra-indication to the use of needle biopsy	**C34.–** *Malignant neoplasm of bronchus and lung* **C77.–** *Secondary and unspecified malignant neoplasm of lymph nodes* **C78.–** *Secondary malignant neoplasm of respiratory and digestive organs* **C79.–** *Secondary malignant neoplasm of other and unspecified sites* **J98.4 -** *Other disorders of lung*	3.**.70.CJ
	For initial staging of patients being considered for potentially curative therapy based on negative standard imaging tests; OR for staging of patients with locoregional recurrence, after primary treatment, being considered for definitive salvage therapy		
	Initial staging, restaging, recurrent disease or multiple primaries being considered for potentially curative therapy		
	For staging of patients with locoregional recurrence, after primary treatment, being considered for definitive salvage therapy		
	Staging if limited stage disease is suspected and may be indicated for limited use in radiation treatment planning in patients with small cell lung cancer; Small cell lung cancer: limited disease small cell lung cancer where combined modality therapy with chemotherapy and radiotherapy is being considered		
LYMPHOMA	Baseline staging of patients with aggressive lymphomas being considered for curative intent treatment; for the baseline staging of patients with indolent lymphomas being considered for aggressive/curative therapy	**C81.–** *Hodgkin lymphoma* **C82.–** *Follicular lymphoma* **C83.–** *Non-follicular lymphoma* **C84.–** *Mature T/NK-cell lymphomas* **C85.–** *Other and unspecified types of non-Hodgkin lymphoma*	3.**.70.CJ

CANCER TYPE	CLINICAL INDICATION	ICD-10-CA Codes for Cancer Type	CCI Codes
	Evaluation of residual mass(es) following chemotherapy in a patient with Hodgkin's or non-Hodgkin's lymphoma when further potentially curative therapy (such as radiation or stem cell transplantation) is being considered;	**C86.–** *Other specified types of T/NK-cell lymphoma* **C88.4–** *Extranodal marginal zone B-cell lymphoma of mucosa-associated lymphoid tissue [MALT-lymphoma]*	
	Assessment of response in Hodgkin's lymphoma after two (2) or three (3) cycles of chemotherapy, when chemotherapy is being considered as the definitive single modality therapy		
TESTICULAR CANCER	Evaluation of residual mass; Germ cell tumours: where persistent disease is suspected on the basis of the presence of a residual mass after primary treatment for seminoma when curartive surgical resection is being considered	**C62.–** *Malignant neoplasm of testis*	3.**.70.CJ
	Germ cell tumours: where recurrent disease is suspected on the basis of elevated tumour marker(s) - (beta human chorionic gonadotrophin (HCG) and/or alpha fetoprotein) and standard imaging tests are negative		
THYROID CARCINOMA	Detection of suspected recurrence based on rising TG with negative Iodine-131 scan; where recurrent or persistent disease is suspected on the basis of an elevated and/or rising thyroglobulin level(s) but standard imaging studies, including I-131 scan and/or neck ultrasound, are negative or equivocal	**C73** - *Malignant neoplasm of thyroid gland*	3.**.70.CJ

14. A day care surgery patient is one who has been pre-booked and registered to receive services from a functional centre that is equipped and staffed to provide day surgery (e.g. an operating room, an endoscopy suite, a cardiac catheterization lab).

    Code 68, 69 and 70 claims must include a corresponding CCI code. Code 68, 69 and 70 claims that are missing or provide an invalid CCI code are subject to IHIACC's adjustment process. I.e., the home jurisdiction pays the claim as billed and, after submitting an adjustment to the host jurisdiction, the host jurisdiction must pay back the claim amount to the home jurisdiction if a proper CCI code cannot be identified.

    CIHI produces a day care surgery rate lookup table, which provides the corresponding day care surgery rate after a CCI code is entered. If the CCI code provided does not have a corresponding day care surgery rate, the service cannot be billed as a day care surgery.

    If a hospital has questions related to the classification of services, the hospital should inform their provincial/territorial Ministry who may contact CIHI for advice regarding the appropriate code/rate to bill.

How to bill for chemotherapy drugs (codes 56 and 66):

	Scenario 1		Scenario 2		Scenario 3	
	Drug	Cost ($)	Drug	Cost ($)	Drug	Cost ($)
Examples:						
Chemo drugs provided to the patient:						
August 14, 2022	Fluorouracil	14.22	Fluorouracil	14.22	Fluorouracil	14.22
August 14, 2022	Trastuzumab	4,968.00	Trastuzumab	4,968.00	Cyclophosphamide	45.10
August 14, 2022		--	Epirubicin	93.39	Epirubicin	93.39
STEP 1 - Determining service code, invoice and prior approval requirements						
Total drug costs used to determine: what code to bill, if an invoice is required and if prior approval is required:		4,982.22		5,075.61		152.71
Billing code used (code 56 under $1,000 or code 66 if $1,000 or over)		66		66		56
Invoice required (total is $1,000 or more)		YES		YES		NO
Prior approval required (total is over $5,000) *		NO		YES		NO
STEP 2 - Determining the amount to claim						
Visit Amount (out-patient code 51)		361.00		361.00		361.00
Total Cost Claimed (total drugs + visit amount)		5,343.22		5,436.61		513.71

Prior-approval requests and invoices should never include the number of units (vials, tablets, dosage, etc.).

How to bill for laboratory services:

Scenarios	Cost = or < $142	Cost > $142
A. Referred in specimen	Code 55	Code 65
B. Patient presents at lab with referral from outside the hospital	Code 55	Code 65
C. Patient seen at emergency/outpatient department and presents at lab on the same day	Code 51	Bill code 51 if the laboratory service cost $361 or less. Bill code 65 if the laboratory service cost more than $361. Only one service code can be billed (see rule 3).
D. Patient seen at emergency/outpatient department and presents at lab on a different day	Code 51 for emergency department visit and code 55 for lab	Code 51 for emergency department visit and code 65 for lab

Procedure for Billing Outpatient Services Provided to Residents of Other Provinces and Territories through the Reciprocal Billing Arrangement

SEE **APPENDIX A** FOR AN ILLUSTRATION OF A COMPLETED MONTHLY STATEMENT OF OUTPATIENT SERVICES PROVIDED TO RESIDENTS OF ANOTHER PROVINCE OR TERRITORY.

1. Request proof of coverage from the patient. **SEE APPENDIX H** FOR ILLUSTRATIONS OF THE HEALTH SERVICES CARD OF EACH PROVINCE AND TERRITORY. Patients are not required to sign a declaration of hospital insurance coverage. If the patient is unable to provide a current health services card, collect the account directly from the patient. The patient may then apply to their home province or territory for reimbursement.
2. Bill insured services through the reciprocal billing form "Out of Province Out-patient Services", Health H19-364.
3. Complete a separate statement for each province or territory whose residents receive outpatient services in the reporting month.
4. Record the patient's health services number and expiry date (if present) from the health services card.
    - If the card only displays a year and month (e.g., 2019/12) it is valid until the end of the month shown on the card, unless otherwise determined by the health care plan of the patient's province/territory of residence.
5. Record the full name of the patient, the date of birth and sex. Use the indicators "M" for male,"F" for female or . For married Quebec residents, provide birth surname.
6. Record the date on which the service was provided. Record dates in the year, month, day sequence using two numeric digits in each column (eg) April 15, 2002 should be recorded as 02/04/15.
7. Indicate the type of service provided by entering the appropriate code according to the schedule on pages 2 and 3 in the service code column and the corresponding amount in the Cost per Service column.
8. Record the ICD-10-CA diagnostic code and appropriate CCI intervention code if it is a day care surgery service code 68, 69 or 70.
9. An authorized hospital employee must sign each page of all statements, certifying that the health services card of the patients have been examined and the address in each case appears on the hospital records.
10. Adjustments
    - In order to request an adjustment, please fax your written request which indicates the specific details pertaining to the claim and the reason for an adjustment. This information should be faxed to 306-798-0582.
11. Forward part 1 (original) of all statements to Claims Analysis Unit, Medical Services Branch,
12. 3475 Albert Street, Regina, S4S 6X6. Retain part 2 in the hospital records. The Medical Services Branch (MSB) reimburses Regional Health Authorities on a monthly basis and recovers these payments from the responsible provincial or territorial health department.
13. Hospitals may be required to provide additional information such as the patient's address, if it is requested by the province of origin.
14. Paylists
    - The reason for an adjustment is indicated on the paylist following the amount. **SEE APPENDIX G** FOR THE ADJUSTMENT REASON CODES.

Inpatient Services Provided to Residents of Other Provinces and Territories

Hospitals are responsible for collecting the information required for the processing of reciprocal hospital claims. If authorization of a reciprocal claim is rejected due to inadequate information collection by the hospital seeking reimbursement, the hospital is not entitled to bill insured patients directly or to refer the account to a collection agency. These claims must be written off and absorbed within the hospital's budget.

Declaration of In-Patient Hospital Insurance Coverage Form

In accordance with the reciprocal billing arrangement, a Declaration of Hospital Insurance Coverage Form **must be completed** by the out-of-province patient for all In-patient hospital claims. The form provides patient contact information and identifies which province/territory is responsible for health care coverage. However, it is not a substitute for the presentation and validation of a valid health card.

How to Process the Declaration of Hospital Insurance Coverage Form

SEE **APPENDIX C** FOR AN ILLUSTRATION OF A COMPLETED FORM.

1. The patient should present at the time of admission, a current health services card issued by the home province. Record the patient's health services number and health card expiry date (if present), which is displayed on the identification card, accurately on the declaration form in the areas labeled "Health Insurance Number" and "Date of Expiry" respectively. SEE **APPENDIX H** FOR ILLUSTRATIONS OF THE HEALTH SERVICES CARD OF EACH PROVINCE AND TERRITORY.

2. The declaration form must be completed in detail, including the signature of the patient, a parent or another responsible party, at the time of admission. If the patient is unable to sign a declaration form because of their medical condition, the signature of a relative or travelling companion who is able to certify that the patient is a permanent resident at the address recorded on the declaration is acceptable. If it is not possible to obtain an acceptable signature, an authorized hospital employee (e.g., administrator, registered nurse) may sign the form on the patient's behalf with an explanation of the reason for their signature.

3. Submit the original completed declaration to MSB (Medical Services Branch), attached to a completed Out of Province Beneficiary Hospital Admission-Separation Record form at the time of discharge, death or transfer of the patient. The copy of the declaration is to be retained in the hospital records.

Procedure for Billing Inpatient Services Provided to Residents of Other Provinces and Territories through the Reciprocal Billing Arrangement

SEE **APPENDIX A** FOR AN ILLUSTRATION OF A COMPLETED MONTHLY STATEMENT OF OUTPATIENT SERVICES PROVIDED TO RESIDENTS OF ANOTHER PROVINCE OR TERRITORY.

1. At the time of admission of a patient who is a resident of another Province or territory:

    a) Read the information on the Billing Checklist. SEE **APPENDIX D**.

    b) Request the patient to present a current health services card issued by the home province or territory.

    c) Record the patient's health services number and health card expiry date (if present) on a Declaration of Hospital Insurance Coverage form. SEE **APPENDIX H** FOR ILLUSTRATIONS OF THE HEALTH SERVICES CARD OF EACH PROVINCE AND TERRITORY.
        - If the card only displays a year and month (e.g., 2019/12) it is valid until the end of the month shown on the card, unless otherwise determined by the health care plan of the patient's province/territory of residence.

    d) Have the patient complete the Declaration of Hospital Insurance Coverage form. Ensure that the declaration is signed by the patient, the parent or another responsible party.

2. Retain both copies of the declaration until the patient is discharged or until the patient has been hospitalized for thirty consecutive days. REFER TO ITEM 2 ON PAGE 19, PERTAINING TO INTERIM BILLINGS FOR LONG STAY PATIENTS. (A LONG STAY PATIENT IS ONE WHO HAS BEEN HOSPITALIZED FOR 30 CONSECUTIVE DAYS.) A time limit of one year from date of discharge is allowed for submissions of accounts to the other Plan (so allow MSB about 2 months for complete processing). Accounts not billed within this time limit may **not** be billed to the patient or a collection agency.

3. If the patient is unable to provide satisfactory proof of coverage from the home province, the patient will be held responsible for payment of the cost of hospitalization.

4. At the time of discharge:

    a) Submit a completed Out of Province Beneficiary Hospital Admission – Separation Record form (Health OOP-AS1 or Health OOP-AS2) to MSB.

    b) Record the name of the responsible province or territory and the patient's health services number and health card expiry date (if present) from the Declaration of Hospital Insurance Coverage form in the designated area on the Hospital Admission-Separation Record form. REFER TO **APPENDIX E** FOR AN ILLUSTRATION OF A COMPLETED OUT OF PROVINCE BENEFICIARY HOSPITAL ADMISSION-SEPARATION RECORD form.

    c) Submit the original completed Declaration of Hospital Insurance Coverage form along with the Out of Province Beneficiary Hospital Admission-Separation Record. Retain a copy of the declaration in the hospital records.

d) Report the discharge of a long stay patient in accordance with instructions outlined in item 2 below.

e) When the statements are complete, send the Declaration and Out of Province Beneficiary Hospital Admission-Separation forms to MSB. MSB reimburses the Saskatchewan Health Authority at the established rates and recovers the payments from the other plans.

5. Accident or Injury Report

No longer required.

Rules of Application

1. In-patient admission and discharge date

When submitting claims for standard ward, ICU or well newborn in-patient stays, the per diem hospital rate is multiplied by the number of days of hospitalization, less one day – the discharge date. If a patient is admitted and discharged on the same date, that date is considered as one in-patient day stay.

With the exception of long-term in-patient stays, claims for hospital admissions should be submitted when the patient is discharged.

2. In-patient stay exceeding 30 days

Hospitals providing services to an out-of-province/territory patient must notify their own provincial/territorial health insurance plan, by the 30th day of a patient's in-patient stay, if the patient requires a continuous in-patient stay of more than 30 days. Hospitals must provide updates on the patient's status every subsequent 30th day of a continuous in-patient stay (i.e., notification on day 30, day 60, day 90 etc.). The host province/territory health insurance plan should notify the home province/territory health insurance plan in the same manner (i.e., on day 30, day 60, day 90, etc.).

In addition to specifically **notifying** the home jurisdiction of long-term in-patient stays, hospitals should complete and submit an interim billing to MSB on an Out of Province Beneficiary Hospital Admission – Separation Record form with an original Declaration of Hospital Insurance Coverage form.

The completed Out of Province Beneficiary Hospital Admission – Separation Record forms should be submitted to MSB at 30-day intervals until the patient is discharged or transferred, noting continuous stay.

Example: Patient admitted January 15th and discharged July 12th

Claim order	Date entered for "admission date" on claim	Date entered for the "separation date/discharge" date on the billing claim
1	January 15	March 1
2	March 1	April 1
3	April 1	May1
4	May 1	June 1
5	June 1	July 1
6	July 1	July 12

Although the patient is not actually/physically discharged, a discharge date is required on the hospital claim so that it won't be rejected by IT systems.

The billing policy above does not apply to bone marrow/stem cell transplant rates. These rates are inclusive of long term hospital stays.

3. Same day out-patient/in-patient billings

A hospital can bill an out-patient rate and an in-patient rate for the same day, as long as the patient is not a registered in-patient at the time the out-patient service is provided.

Rules of application:

- No out-patient services can be billed during the time a patient is admitted as an in-patient.
- If a patient receives an out-patient service and is later admitted to the same hospital on an in-patient basis on the same day, the hospital can bill for both the out-patient service and the in-patient stay for that day (i.e., the admission date and the date of out-patient service are the same).
- If a patient is discharged from the hospital and is provided an out-patient service at the same hospital on the same day, the hospital can bill for the out-patient service (i.e., the discharge date and the date of the out-patient service are the same).
- If a patient is admitted as an in-patient at facility 'A' and is sent to another facility 'B' for an out-patient service and returns to facility 'A' as an in-patient, facility 'A' can bill for an in-patient stay and facility 'B' can bill for an out-patient visit.

4. In-patient stay spanning two fiscal years

   When an in-patient stay extends over two fiscal years and the authorized rate has changed during the period, the hospital must bill the portion of the stay occurring in each fiscal year at the respective year's rate.

   The scenarios described below will assist in calculating claim amounts when there is a rate change during an in-patient's stay that extends over two fiscal years. A fiscal year runs from April 1 to March 31. As two different rates are used, two different claim lines must be submitted.

   The following examples demonstrate the billing concept:

   a. Standard Ward/ICU rate change on the date of discharge
   Example:
   Admission date: March 31, 2019
   Discharge date: April 1, 2019 = 1 In-patient day
   Old ward rate: April 1, 2018 to March 31, 2019 = $722.00
   New ward rate: April 1, 2019 = $745.00

   Enter all required claim submission data with admission date March 31, 2019 and discharge date April 1, 2019. The amount claimed is $722.00 because the discharge date is not paid.

   b. Standard Ward/ICU rate change during the In-patient stay
   Example:
   Admission date: March 29, 2019
   Discharge date: April 2, 2019 = 4 in-patient days
   Old ward rate: April 1, 2018 to March 31, 2019 = $722.00
   New ward rate: April 1, 2019 = $745.00

   Complete two claims:

   Claim 1: Enter all required claim submission data, with admission date March 29, 2019 and discharge date April 1, 2019. Total claimed would be $2,166.00 (old ward rate $722.00 x 3 days).

   Claim 2: Repeat the required data, but with admission date April 1, 2019 and discharge date April 2, 2019. Total claimed would be $745.00 (new ward rate $745.00 x 1 day).

5. Patient released on a pass

   When an out-of-province/territory patient is released from the hospital on a temporary pass and the bed is being retained for that patient, the hospital can bill for the period during which the bed was retained, to a maximum of 72 hours (three in-patient days).

6. Transfers from one hospital to another hospital

   If a patient is admitted to one hospital, then transferred to another hospital on the same day, both hospitals can bill the applicable in- patient rate(s) for the date of transfer.

If a patient received an out-patient service from one hospital and was then transferred to another hospital for admission, the hospital providing the out-patient service can bill the out-patient rate for that service. The hospital providing the in-patient service can bill the applicable in-patient rate(s).

When an out-of-province patient is transferred by ground ambulance from one hospital to another hospital for diagnostic or therapeutic services and the patient returns to the first hospital within 24 hours, the cost of the transfer is included within the per diem rate(s) of the first hospital and the patient should not be billed for the ambulance service.

When an out-of-province patient is transferred by means of transport other than ground ambulance from one hospital to another hospital for diagnostic or therapeutic services and the patient returns to the first hospital within 24 hours the cost of the transfer is the patient's responsibility.

When an out-of-province patient is transferred from one hospital to another hospital on the same day, both hospitals can bill the applicable in-patient rate(s) for the date of transfer.

In-Patient Hospital Split (ICU & Ward) Per Diem Rates for Reciprocal Billing

Saskatchewan Health has implemented split per diem rates (ICU & Ward) for in-patient reciprocal billing when services are provided to residents of other Canadian provinces and territories. Facilities that bill both standard ward and ICU per diem rates are assigned two unique facility ID numbers. One facility ID number corresponds to the standard ward per diem rate and the second facility ID number corresponds to the ICU per diem rate. The concept of split per diem rates provides facilities with the ability to recover costs of in-patient stays in a more reasonable and equitable manner for the level of care provided.

General Rule: If a patient is admitted and discharged from hospital within 24 hours, that time in hospital is considered as one in-patient day stay regardless of billing by hours and minutes. However, to claim an ICU day for a hospital stay of less than 24 hours, the entire stay must be in ICU.

Here are the **guidelines for calculation and billing of the ICU/Ward days** split:

Note that all the reciprocal billing claims for ICU and Ward rates will have to be submitted using separate claim forms as shown in the attached samples.

1. Calculate total days of hospitalization (i.e., discharge date – admit date, less one)

2. Calculate the total number of ICU days by following the steps below:
   - Step 1: Calculate total ICU hours.
   - Step 2: Calculate the number of ICU days by dividing the total hours calculated in step 1 by 24 (i.e., total ICU hours/24).
   - Step 3: If the remainder of hours calculated in step 2 is greater than or equal to 12 hours, round up one day. If the remainder is less than 12 hours, round down.

   Example:
   If total ICU hours = 100, then number of ICU days = 4.17 (100/24). The remainder (0.17) represents 4 hours, therefore total ICU days equals 4.

3. Calculate ward days (i.e., total days of hospitalization – ICU days = ward days)

4. Note ICU starting date = admit date

Remaining ICU days, if any, are listed as if they occurred immediately after the admit date. For example, if the admit date was April 1 and there were four days in ICU then report ICU days as April 1, 2, 3 and 4.

Example:

- Patient is admitted September 1 and is discharged September 10. Billing should be completed as follows:
  - **ICU**
    Admit date: September 1, 20xx
    Discharge from ICU unit: September 5, 20xx
    Total days billed: 4 days ICU

  - **Ward**
    Admit date: September 5, 20xx
    Discharge from hospital: September 10, 20xx
    Minus 1 day for discharge date
    Total days billed: 5 days

Hospital billing clerks should determine appropriate billings for ICU and ward for submissions based on the above rules, that is, one claim for ICU and one claim for Ward, using the appropriate facility number for each. The discharge date of the first unit would be the admit date of the second unit.

Interprovincial Billing for Newborns

Effective April 1, 2023, for a healthy newborn, bill $1,167.00 per day with the appropriate diagnostic code for the first 30 days; thereafter, the applicable in-patient per diem rate should be billed. Well newborns are defined as those newborns that receive care under the diagnostic code Z38** series ONLY.

For a newborn diagnosed as "unwell" the hospital can bill the authorized combined, standard ward and/or ICU per diem rate with the applicable diagnostic code. When a newborn receives standard ward patient care, the authorized standard ward per diem rate may be billed. When a newborn receives care in an intensive care unit, the authorized intensive care unit per diem rate may be billed. The well newborn rate is not billed when the authorized standard ward and/or the intensive care unit per diem rate is billed.

Note: The mother and the newborn are treated as separate patients and therefore a separate claim should be submitted for each based on their condition (i.e., as standard ward patient, ICU patient, etc.).

Claims for **newborns and for babies up to three months of age** may be submitted using their mother's out-of-province registration number. Claims for babies over three months of age must be submitted using the baby's out-of-province registration number.

Hospitals must encourage the out-of-province parent(s) of a newborn to apply immediately for health coverage for their infant. Out-of-province parents need to contact their home province of residence as soon as possible to discuss requirements to register their infant, and to complete the process to obtain a health card/number.

The table below provides guidance on how to bill for newborn patients based on their condition and the billing methodology of the hospital (i.e., combined rate or split ward/ICU rate).

Billing Rules for Newborns					
		"Well" newborn	**"Unwell" newborn**		
			Level of Care Received		
			Standard ward care only	**ICU care only**	**Both standard ward and ICU care**
Billing Methodology	**Combined rate**	well newborn rate X number of days	combined rate per diem X number of days		
	Split standard ward/ICU rate	well newborn rate X number of days	standard ward care per diem rate X number of days	ICU per diem rate X number of days	***Standard ward and ICU ward stays must be billed on separate claims:*** standard ward care per diem rate X number of days ICU per diem rate X

Baby is stillborn: If the baby is stillborn, the hospital can only claim for the mother.

Adoption of Newborn to Mothers who are Residents of Other Provinces or Territories

A hospital claim should not be made for a newborn who is being placed for adoption or placed with an adoption agency within the host province/territory. In these cases the province or territory where the newborn is being put up for adoption is responsible for the newborn's health care costs.

A newborn of a mother, who is a resident of another province or territory, when placed for adoption in Saskatchewan, is granted Saskatchewan coverage from the date of birth.

Submit the mother's account through the reciprocal billing arrangement in accordance with item 2 above. If a newborn is being placed for adoption, the first 7 days of care following birth are Saskatchewan responsibility.

If the newborn is still in hospital on the 8th and subsequent days for non-medical reasons, (i.e, awaiting placement), these days should be billed to the Department of Social Services at the newborn rate in effect at that time.

If the newborn's stay in hospital is due to medical necessity, all days of care provided are accepted as Saskatchewan's responsibility.

Babies born via surrogate:

A surrogate is defined as a woman who has entered into an arrangement with another party, i.e., the intended parent(s), to carry a fetus(es) to term, with the intent of surrendering the newborn(s) at birth to the intended parent(s).

The term "surrogate" may be defined differently in each province/territory; therefore, the home province/territory of the "surrogate" should be contacted directly.

In the case where a baby is born via a surrogate, the expectation is that the intended province/territory of residence of the newborn is responsible for providing date-of-birth coverage. If the newborn's registration with the health insurance plan of the intended province/territory of residence is delayed pending the provision of required documentation (e.g., documents demonstrating legal parentage), the expectation is that coverage will be back-dated to date-of-birth, once the required documentation has been received. Onus is on the intended parent(s) to provide the documentation required to register the newborn with the provincial/territorial health insurance plan of residence, as soon as possible.

If the intended parent(s) abandon the newborn (i.e., do not honor the surrogacy agreement) coverage for the newborn follows the surrogate.

If the newborn is abandoned by all parties involved, the province/territory where the newborn is resident at the time the abandonment occurred is responsible for first-day coverage.

The above guidelines do not apply to Quebec because "any agreement whereby a woman undertakes to procreate or carry a child for another person is absolutely null" (Civil Code of Quebec, article 541). In all cases, Quebec relies on legal documents that demonstrate family relationship to determine the eligibility of newborns. Thus, the infant could be retroactively eligible for coverage depending on the document provided.

Special Implant/Device Add-on Costs - In-patient

Please refer to the following list of implant/device add-on 300 code rate sheets for the associated rules of application which can be billed at invoice cost in addition to the in-patient per diem rates, if certain criteria are met.

300 codes should **NOT** be billed in addition to any other rates, other than in-patient per diems. High cost 100 codes include implant/device costs that are backed out of the in-patient per diem rates. The costs associated with providing implants/devices on an out-patient basis are recovered through the application of out-patient rates.

Other in-patient implant/device costs are captured within the in-patient per diem rates. Therefore, the application of in-patient per diem rates enables the cost of other implants/devices to be recovered over a patient's length of hospital stay.

Interprovincial Billing Special Implant/Device Add-on Costs - In-patient

Effective for Interventions on or After April 1, 2023

For special implants/devices listed under the code 300 series: Where the total invoice cost of the implants/devices is under $2,000, only the per diem is billable. Where the total invoice cost of the implants/devices is $2,000 or greater, the invoice cost may be billed in addition to the associated in-patient per-diem for the hospital and a copy of the supplier invoice must be provided to the home jurisdiction. If individual items inserted during the procedure (e.g. – implant, device, mesh, pins, screws etc.) cost less than $500, supporting documentation (facility invoice or other) may be submitted in place of a supplier invoice. See the table at the end of this document for billing scenario examples.

Service Code	Description	CCI Codes
310	Cochlear implants	- 1.DM.53.LA-LK Implantation of internal device, cochlea of single channel cochlear implant - 1.DM.53.LA-LL Implantation of internal device, cochlea of multi-channel cochlear implant
311	Cardiac pacemakers and/or defibrillators (any type) ICD etc	Percutaneous transluminal [transvenous] approach or approach NOS: - 1.HZ.53.GR-NM single chamber rate responsive pacemaker - 1.HZ.53.GR-NK dual chamber rate responsive pacemaker - 1.HZ.53.GR-NL fixed rate pacemaker - 1.HZ.53.GR-FS cardioverter/defibrillator - 1.HZ.53.GR-FR cardiac resynchronization therapy pacemaker - 1.HZ.53.GR-FU cardiac resynchronization therapy defibrillator Percutaneous approach (to tunnel subcutaneously): - 1.HZ.53.HN-FS Implantation of internal device, heart NEC cardioverter/defibrillator [AICD]. Open (thoracotomy) approach: - 1.HZ.53.LA-NM single chamber rate responsive pacemaker - 1.HZ.53.LA-NK dual chamber rate responsive pacemaker - 1.HZ.53.LA-NL fixed rate pacemaker - 1.HZ.53.LA-FS cardioverter/defibrillator - 1.HZ.53.LA-FR cardiac resynchronization therapy pacemaker - 1.HZ.53.LA-FU cardiac resynchronization therapy defibrillator Open Subxiphoid approach: - 1.HZ.53.QA-NM single chamber rate responsive pacemaker - 1.HZ.53.QA-NK dual chamber rate responsive pacemaker - 1.HZ.53.QA-NL fixed rate pacemaker Combined open (thoracotomy) approach and percutaneous transluminal (transvenous) approach: - 1.HZ.53.SY-FS cardioverter/defibrillator - 1.HZ.53.SY-FR cardiac resynchronization therapy pacemaker - 1.HZ.53.SY-FU cardiac resynchronization therapy defibrillator
312	Aortic valve (aka TAVI). Implantation of xenograft aortic valve replacement without excision of native valve, via transcatheter approach.	-1.HV.80.GQ-XX-L Repair, aortic valve percutaneous transluminal (transcatheter) arterial approach using xenograft tissue valve [e.g. bovine or porcine tissue] - 1.HV.80.GR-XX-L Repair, aortic valve percutaneous transluminal (transcatheter) (transseptal) venous approach using xenograft tissue valve [e.g. bovine or porcine tissue] -1.HV.80.ST-XX-L Repair, aortic valve closed heart technique (transapical) (transcatheter) using xenograft tissue valve [e.g. bovine or porcine tissue] Notes: The CIHI Classifications and Terminologies staff has advised Health Canada that the IHIACC approved service code 312 Aortic valve CCI codes are the most suitable to describe this procedure and confirm a Grade 1 match (best fit). The CCI classification is designed to categorise procedures for analysis and it is not always possible to identify a procedure uniquely.

313	Ventricular assist device. VAD includes the mechanical pump (all forms: external, implanted or paracorporeal), implant kit, external controller with backup, main AC power source with patient cables, batteries, charger, DC adapter for car, monitor to communicate information regarding VAD function and to enable program setting changes to VAD controller, and necessary accessories including cannulae and circuits specific to the device, blood flow Doppler, water proof VAD shower bag, vests, battery holster and belts.	- 1.HP.53.GP-QP Implantation of internal device, ventricle, of ventricular assist pump using percutaneous transluminal approach [e.g. Impella] - 1.HP.53.LA-QP Implantation of internal device, ventricle, of ventricular assist pump using open approach [e.g. HeartMate, Novacor] The codes assigned include the following, in CCI: Insertion, biventricular assist device [BiVAD] Insertion, left ventricular assist device [LVAD] Insertion, right ventricular assist device [RVAD] Insertion, ventricular assist device [VAD] that for long-term therapy [e.g. destination therapy] that for short-term therapy [e.g. bridge-to-transplant or bridge-to-recovery therapy] The assigned codes do not include adjustment, repositioning or removal of VADs
314	Abdominal aorta knitted grafts, stents	- 1.KA.57.LA-XX-A Extraction, abdominal aorta using open approach and (widening) autograft - 1.KA.80.GQ-NR-N Repair, abdominal aorta using percutaneous transluminal (arterial) approach and (endovascular) stent graft - 1.KA.80.LA-XX-N Repair, abdominal aorta using open approach with synthetic material [e.g. Teflon felt, Dacron, Nylon, Orlon] - 1.KA.76.MZ-XX-N Knitted graft, Spiral-z iliac stent, reliant stent graft.
315	Cranium screws, wires, mesh, plates used in release/repair	- 1.EA.72.LA-NW Release, cranium open approach using plate, screw device (with/without wire or mesh) no tissue used (in the release) - 1.EA.72.LA-NW-A Release, cranium open approach using plate, screw device (with/without wire or mesh) with autograft - 1.EA.72.LA-NW-Q Release, cranium open approach using plate, screw device (with/without wire or mesh) with combined sources of tissue [e.g. graft and flap] - 1.EA.72.LA-NW-G Release, cranium open approach using plate, screw device (with/without wire or mesh) with pedicled flap [pericranial flap] - 1.EA.72.LA-KD Release, cranium open approach using wire or mesh only no tissue used (in the release) - 1.EA.72.LA-KD-A Release, cranium open approach using wire or mesh only with autograft - 1.EA.72.LA-KD-Q Release, cranium open approach using wire or mesh only with combined sources of tissue [e.g. graft and flap] - 1.EA.72.LA-KD-G Release, cranium open approach using wire or mesh only with pedicled flap [pericranial flap]
316	Implantation, thalamus and basal ganglia, of electrodes using burr hole approach	- 1.AE.53.SE-JA Implantation of internal device, thalamus and basal ganglia of electrodes [e.g. recording, stimulating] using burr hole approach.

317	Artificial knee used in bilateral and unilateral revision/replacement	Single component: 1.VG.53.LA-PM-N Implantation of internal device, knee joint, knee joint with synthetic material (e.g. bone paste, cement,) single component prosthetic device 1.VG.53.LA-PM Implantation of internal device, knee joint, knee joint uncemented single component prosthetic device 1.VG.53.LA-PM-A Implantation of internal device knee joint with bone autograft single component prosthetic device 1.VG.53.LA-PM-K Implantation of internal device, knee joint, knee joint with bone homograft single component prosthetic device 1.VG.53.LA-PM-Q Implantation of internal device, knee joint, knee joint with combined sources of tissue (e.g. bone graft, cement, paste) single component prosthetic device Dual component: 1.VG.53.LA-PN-N Implantation of internal device, knee joint, knee joint with synthetic material (e.g. bone paste, cement,) dual component prosthetic device 1.VG.53.LA-PN Implantation of internal device, knee joint uncemented using dual component prosthetic device1.VG.53.LA-PN-A Implantation of internal device, knee joint, knee joint with bone autograft dual component prosthetic device 1.VG.53.LA-PN-K Implantation of internal device, knee joint, knee joint with bone homograft dual component prosthetic device 1.VG.53.LA-PN-Q Implantation of internal device, knee joint, knee joint with combined sources of tissue (e.g. bone graft, cement, paste) dual component prosthetic device Tri component: 1.VG.53.LA-PP-N Implantation of internal device, knee joint, knee joint with synthetic material (e.g. bone paste, cement,) tri component prosthetic device 1.VG.53.LA-PP Implantation of internal device, knee joint, knee joint uncemented tri component prosthetic device 1.VG.53.LA-PP-K Implantation of internal device, knee joint, knee joint with bone homograft tri component prosthetic device .1VG.53.LA-PP-A Implantation of internal device, knee joint, knee joint with bone autograft tri component prosthetic device 1.VG.53.LA-PP-Q Implantation of internal device, knee joint, knee joint with combined sources of tissue (e.g. bone graft, cement, paste) tri component prosthetic device Partial component : 1.VG.53.LA-PR Implantation of internal device, knee joint uncemented partial component [e.g. tibial liner (insert) alone] The host jurisdiction does not need to record the status attribute.
318	Spinal fixation/fusion rods, grafts, screws	- 1.SA.74.^^ Fixation, atlas and axis (all codes) - 1.SA.75.^^ Fusion, atlas and axis (all codes) - 1.SC.74.^^ Fixation, spinal vertebrae and - 1.SC.75.^^ Fusion, spinal vertebrae EXCLUDING codes with device qualifier XX meaning ‘no device used.
319	Artificial hip used in unilateral replacement (excludes bilateral and revised)	- 1.VA.53.^^ with the exception of 1.VA.53.LA-SL-N which is the implantation of a cement spacer only If an invoice is requested, a note should be added to the invoice that indicates the status and location attribute (status attribute of ‘P’ (primary) and a location attribute of either ‘L’ for left or ‘R’ for right).

320	Artificial shoulder used in shoulder revision/replacement	1TA53LAPM, 1TA53LAPMA, 1TA53LAPMK, 1TA53LAPMN, 1TA53LAPMQ, 1TA53LAPN, 1TA53LAPNA, 1TA53LAPNK, 1TA53LAPNN, 1TA53LAPNQ, 1TA53LAPQ, 1TA53LAPQA, 1TA53LAPQK, 1TA53LAPQN, 1TA53LAPQQ, 1TA53LASLN, 1TA53LAPR If an invoice is requested, a note should be added to the invoice that indicates the status attribute of 'R' (revision).
321	Stent grafts Stent graft procedure is a procedure that uses percutaneous transluminal approach and (endovascular) stent with synthetic graft. EVAR related CCI codes are excluded from this procedure group.	-1.IM.80.GQ-NR-N - Repair, pulmonary artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue [e.g. stent graft]. -1.JK.80.GQ-NR-N - Repair, subclavian artery, using percutaneous transluminal approach and (endovascular) stent with synthetic tissue (e.g. stent graft). -1.KE.80.GQ-NR-N - Repair, abdominal arteries NEC, using percutaneous transluminal (arterial) approach and (endovascular) stent graft [e.g. snorkel stent graft]. -1.KG.56.GQ-NR-N - Removal of foreign body, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft]. -1.KG.80.GQ-NR-N - Repair, arteries of leg NEC using percutaneous transluminal approach and (endovascular) stent with synthetic graft [e.g. stent graft]. -1.KT.80.GQ-NR-N - Repair, vessels of the pelvis, perineum and gluteal region using percutaneous transluminal (arterial) approach and (endovascular) stent graft.
322	Expandable stent graft used in endovascular aneurysm repairs (EVAR) Endovascular aneurysm repair or endovascular aortic repair (EVAR) is a type of endovascular surgery used to treat an abdominal aortic aneurysm. The procedure involves the placement of an expandable stent graft within the aorta to treat the aortic disease without surgically opening or removing part of the aorta.	1ID80GQNRR, 1ID80GQNRN, 1KA80GQNRR , 1KA50GQOA
323	Transcatheter pulmonary valve Pulmonary valve treatment is a procedure wherein an artificial heart valve is delivered via catheter through the cardiovascular system. The catheter is inserted into the patient's femoral vein through a small access site. The catheter which holds the valve is placed in the vein and guided into the patient's heart. Once the valve is in the right position, the balloons are inflated and the valve expands into place and blood will flow between the patient's right ventricle and lungs.	1.HT.80.GP-XX-L Repair, pulmonary valve percutaneous transluminal approach using xenograft

How to bill for implants/devices:

Item	Scenario 1		Scenario 2		Scenario 3	
	Cost ($)	**Information Required on Invoice**	**Cost ($)**	**Information Required on Invoice**	**Cost ($)**	**Information Required on Invoice**
Mesh	200	Not applicable	200	Facility Cost	200	Facility Cost
Screw 1	550	Not applicable	300	Facility Cost	500	Supplier Cost
Screw 2	200	Not applicable	200	Facility Cost	200	Facility Cost
Wire	0		400	Facility Cost	200	Facility Cost
Pacemaker	1,000	Not applicable	1,000	Supplier Cost	1,000	Supplier Cost
Total	**1,950**		**2,100**		**2,100**	
Billable Amount:	**Per Diem Only**		**2,100**		**2,100**	
Accompanying Invoice Needed:	**None**		**- 1 facility generated invoice listing: mesh, screw 1, screw 2 and wire - supplier generated invoice for: pacemaker**		**- 1 facility generated invoice listing: mesh, screw 2 and wire. - if items from different supplier separate supplier invoices for: screw 1, pacemaker - if items from same supplier, one supplier invoice for: screw 1, pacemaker**	

Facility Generated Invoice:

If any specific component used during a procedure (e.g. a screw) has a unit cost of less than $500.00 (e.g. $120.00 each), regardless of how many may be used, it is acceptable to list this information on one facility generated invoice. Additionally; any other components costing less than $500.00 each; regardless of how many are used; can be added onto the same facility generated invoice.

Supplier Generated Invoice:

If any specific component used during a procedure (e.g. pacemaker) has a unit cost of $500.00 or more (e.g. $510.00 each), regardless of how many may be used, it is acceptable to identify this component on the respective supplier invoice. Additionally; any other components with a cost of $500.00 or more each; regardless of how many are used; should be identified on the respective supplier invoice.

High Cost Procedures

High cost procedures include:

- Organ Procurement (service codes 99 and 100)
- Vital organ transplants (service codes 101 to 108)
- Bone marrow and stem cell transplants (service codes 600 to 607)

Costs associated with high cost procedures that do not have a separate code but have been identified by IHIACC as meeting reciprocal billing eligibility requirements (e.g., complex ablation which is insured by all jurisdictions and not on excluded services list etc.) are included within the in-patient per diem rates and therefore should not be billed separately.

NOTE: Only those high cost procedures identified below are covered under the reciprocal billing arrangement. For high cost procedures that fall outside the reciprocal billing arrangement, facilities may wish to contact the patients' home jurisdiction regarding possible coverage and the proper billing method. Where possible, the request should be made prior to the service being provided. SEE **APPENDIX I** FOR INFORMATION ON CONTACTING THE HEALTH PLANS OF OTHER PROVINCES AND TERRITORIES.

Interprovincial Billing Rates for Designated High Cost Transplants

Effective for Discharges on or After April 1, 2023

Organ Transplants (Service codes 99-108)

Service Code	Description	Rate ($)
99	In-Country Organ Procurement	31,780
100	Out-of-Country Organ Procurement: The actual out-of-country procurement costs can be billed. An invoice must accompany the reciprocal billing claim.	
101	Heart	26,085
102	Heart & Lung	28,550
103	Lung	21,113
104	Liver	18,892
106	Kidney	10,053
108	Kidney & Pancreas	12,439

Rules of Application for Organ Transplants

1. Any individual organ transplant (example: heart and kidney) may be billed at the authorized rate during a patient stay. This includes a repeat transplant of the same organ for the same patient.
2. Rates represent the hospital cost associated with the day of the transplant including the cost of the transplant itself. The appropriate in-patient per diem Ward/ICU rate may be billed for the length of the patient stay minus 1 day for the day of transplant.
3. Each outpatient visit separate from any inpatient stay associated with the high cost procedure may be billed at the authorized interprovincial outpatient rate.
4. Procurement is defined as all costs associated with the acquisition, storage, shipment and maintenance of the organ to be transplanted. Procurement includes the hospital and medical cost of maintaining the donor.
5. The recipient's home province/territory is responsible for the associated in-country and out-of-country procurement costs in all cases.
6. In-country and out-of-country procurement costs are not included within the rates. Therefore, code 99 or 100 should be billed to recoup the cost of organ procurement.
7. An additional amount may be billed when an artificial heart is implanted as an interim step prior to a natural heart transplant.
8. A province/territory may bill the transplant patient's province/territory of residence for the provision of donor testing or preparation services using the transplant recipient's health card number. The province/territory providing the donor testing or preparation services may bill the transplant patient's province/territory regardless of whether the donor tests positive or negative for transplantation.
9. Transplants listed on this rate schedule represent those high cost transplants for which a separate rate has been approved. For transplants that are not listed herein, only the per diem rate can be billed.

Billing Scenarios for High Cost Organ Transplants

	Scenario 1		Scenario 2		Scenario 3	
		Cost ($)		Cost ($)		Cost ($)
Examples:						
Organ Transplant Type:	Heart		Heart		Lung	
Admission Date:	2023/04/01		2023/08/15		2023/08/01	
Discharge Date:	2023/04/10		2023/09/28		2023/09/10	
HCP Date:	2023/04/02		2023/08/18		2023/08/08	
Ward Rate:	$1,108		$1,108		$1,108	
ICU Rate:	$5,432		$5,432		$5,432	
STEP 1 - Determining Length of Stay Cost						
Total Days (minus the day of transplant & discharge date)	8		43		39	
# of Ward Days	0	$0	19	$21,052	15	$16,620
# of ICU Days	8	$43,456	24	$130,368	24	$130,368

STEP 2 – Apply Block Rate for HCP						
Transplant block Rate	Code 101	$26,085	Code 101	$26,085	Code 103	$21,113
STEP 3 – Determine if Artificial Heart required						
Was an artificial heart implanted prior to natural heart transplant?	No		Yes		N/A	
Cost of Artificial Heart				$95,000	N/A	
STEP 4 – Determine procurement cost						
In-country Organ Procurement	Yes	$31,780	No		Yes	$31,780
Out-of-Country Organ Procurement	No		Yes	$20,000	No	
STEP 5 – Confirm billing codes & amounts to claim						
Total Per Diem Cost Claimed (Ward + ICU)		**$43,456**		**$151,420**		**$146,988**
HCP Claimed	**Code 101**	**$26,085**	**Code 101**	**$26,085**	**Code 103**	**$21,113**
Procurement Cost Claimed	**Code 99**	**$31,780**	**Code 100**	**$20,000**	**Code 99**	**$31,780**
Artificial Heart Claimed	**-**	**-**		**$95,000**	**-**	**-**

Note: When submitting claims for standard ward or ICU in-patient stays, the per diem hospital rate is multiplied by the number of days hospitalized, less two days – one for the transplant and one for the discharge date.

Organ Transplants and Procurement – service codes 99 to 108

- Effective April 1, 2019, IHIACC approved the implementation of a new billing model for high cost organ transplant service codes 101 to 108. The new billing model is a mixed model compromised of a block rate for the day the procedure is performed including the cost of the transplant itself, and the approved Ward and/or ICU rate is billed for the length of the patient stay minus the day of the transplant.
    - The per diem hospital rate is multiplied by the number of days hospitalized, less two days – one for the transplant and one for the discharge date.

- Under the previous billing model, the high cost organ transplant rates were block rates that included not only the cost associated with the transplant; but also the costs associated with an entire in-patient stay, admission to discharge, during which the transplant occurred.

- If an organ is acquired, **service code 99** (In-Country Procurement) or **service code 100** (Out-of-Country Organ Procurement) should be billed in addition to service code 101 to 108.
    - For service code 100, a copy of the invoice must be submitted for the out of country procurement with the claim. If the invoice is not provided, the claim is refused.

Billing service code 101 to 108 spanning a Ward and ICU stay and/or with an artificial heart

- The rates for transplant services codes 101 to 108 represent the hospital cost associated with the day of the transplant itself. The appropriate in-patient per diem Ward/ICU rate of the hospital performing the transplant may be billed for the length of the patient stay minus 1 day for the day of transplant. **Two claim lines** must be submitted when these procedures are performed.
    - The first claim line identifies the per diem information.
    - The second claim line identifies the high cost procedure information.

- If an organ is acquired, service code 99 (In-Country Procurement) or service code 100 (Out-of-Country Organ Procurement) is billed in addition to service code 101 to 108. Three claim lines must be submitted. Enter all the patient identification details on all three claim lines

  For service code 100, submit a copy of the invoice for the out of country procurement with the claim. If the invoice is not provided, the claim is refused.
    - Two claims must be submitted when the hospitalization spans a Ward and ICU stay.
    - An additional amount can also be billed when an artificial heart is implanted as an interim step prior to a natural heart transplant.

Billing when transplant recipient passes away during organ transplant

- If the organ transplant recipient passes away during the surgery, the day of the transplant and day of discharge are the same. Codes 101 to 108 can be billed for the day of the transplant.

  Scenario: During the transplant surgery, recipient passes away on the operating table.

Admission date:	April 5, 2023
Transplant date:	April 7, 2023
Date of death:	April 7, 2023

    - As the date of death occurred on April 7th, this would also be considered the discharge date for billing purposes.

    - On the claim line that identifies the per diem information for the length of patient stay from admission to date of death:
        - Complete all required fields with an admission date of April 5, 2023 and a discharge date of April 7, 2023 at the 2023/2024 approved rate; minus 1 day for the date of discharge.
        - Complete all required fields using the applicable high cost organ transplant code (101 to 108) at the listed rate with a date of transplant of April 7, 2023.

Billing when patient's eligibility changes during hospitalization

- When a transplant recipient's eligibility changes during the in-patient stay; the jurisdiction covering the patient is responsible for the cost of the in-patient stay up to or following the eligibility change.

  For the solid organ transplant, the jurisdiction covering the patient on the day of transplant is responsible for the costs of the transplant.

Scenario: Patient's eligibility changes during hospitalization for lung transplant.

- Individual moves from jurisdiction A to jurisdiction B on April 15, 2023.
- Individual applies for coverage in jurisdiction B which will be effective on July 1, 2023.
- Individual is admitted into hospital in jurisdiction B on May 1, 2023 for lung transplant.
- Transplant occurs on May 3, 2023.
- Patient is discharged on July 15, 2023.

As the lung transplant occurred while the individual was covered under jurisdiction A, jurisdiction A is responsible for the cost of the transplant. The hospital in jurisdiction B would submit two claim lines:

On the claim line that identifies the per diem information for the length of patient stay from admission to date of eligibility change:

- Jurisdiction B would complete all required fields with an admission date of May 1, 2023 and a discharge date of July 1, 2023 at the 2023/2024 approved rate; minus 1 day for the date of discharge.
- Jurisdiction B would complete all required fields using the applicable high cost organ transplant code (101 to 108) at the listed rate with a date of transplant of May 3, 2023.

Following the eligibility change on July 15, 2023 Jurisdiction B will be responsible for the cost of the in-patient stay from July 15, 2023 to the discharge date of July 30, 2023.

Out-of-Province/Out-of-Country Living Donor

Out-of-Province/Territory Living Donor

Blood testing markers and other tests to determine if the donor is a match are typically done to determine compatibility. These tests should be done on a living donor before they arrive at the host jurisdiction.

Scenario and rules for living donor in jurisdiction A traveling to transplant recipient's home province jurisdiction B where transplant occurs:

1. Living donor in jurisdiction A undergoes testing in jurisdiction A to determine compatibility.
   - Costs are billed reciprocally under the transplant recipient's health number by jurisdiction A to jurisdiction B.

2. Living donor arrives in jurisdiction B. Further testing occurs, the organ is harvested and the organ transplant occurs.
   - All costs are the responsibility of jurisdiction B.

3. Other pre or post donor transplant care
   - Emergency post-transplant care services related to complications arising from the transplant are covered by jurisdiction B. Emergency services **not** related to the transplant are reciprocally billed under the donors health number by jurisdiction B to jurisdiction A.

Scenario and rules for living donor from jurisdiction A and recipient from jurisdiction B travelling to jurisdiction C for the transplant:

1. Living donor in jurisdiction A undergoes testing in jurisdiction A to determine compatibility.
    - These costs are billed reciprocally under the transplant recipient's health number by jurisdiction A to jurisdiction B.

2. Living donor and recipient arrive in jurisdiction C. Further testing occurs, the organ is harvested and the organ transplant occurs.
    - All costs are billed reciprocally under the transplant recipient's health number by jurisdiction C to jurisdiction B.

3. Other pre or post donor transplant care
    - Emergency post-transplant care services related to complications arising from the transplant are billed under the recipients health number by jurisdiction C to jurisdiction B. Emergency services **not** related to the transplant are reciprocally billed under the donors health number by jurisdiction C to jurisdiction A.

Out of Country Living Donor

Preliminary testing for an out of country living donor is done in the donor's home country before they arrive in the jurisdiction where the transplant will occur.

Scenario and rules for an out-of-country living donor and Canadian transplant recipient from jurisdiction A travelling to the host jurisdiction B for the transplant:

1. Living donor preliminary testing is performed in the country of origin and donor travels to jurisdiction B for transplant.
    - Any costs incurred by jurisdiction B are documented by jurisdiction B and later billed to jurisdiction A.

2. Living donor and recipient arrive in jurisdiction B. Further testing occurs, the organ is harvested and the organ transplant occurs.
    - All costs, including preliminary testing are billed reciprocally under the transplant recipient's health number by jurisdiction B to jurisdiction A.

3. Other pre or post transplant care
    - Emergency post-transplant care services related to complications arising from the transplant are billed under the recipients health number by jurisdiction B to jurisdiction A. Emergency services **not** related to the transplant are the responsibility of the donor.

Once the living donor arrives in the host province all costs fall under the hospital budget, which would be reciprocally billable as procurement costs under the transplant recipient's Health Number. No post-transplant costs (costs not related to the procurement) are eligible for Reciprocal Billing. The out-of-country living donor or their secondary insurer is responsible for the post-transplant costs.

Bone Marrow / Stem Cell Transplants

Effective for Discharges on or after April 1, 2023

Service Code	Service Category	Maximum Length of Stay (MLOS)	Basic Block Rate ($)	Add-on Standard High Cost Per Diem over MLOS ($)
600	Acquisition costs (outside Canada) includes Monoclonal Antibody		Invoice Cost	Invoice Cost
601	Adult Autologous <72 hour discharge		36,689	
602	Paediatric Autologous <72 hour discharge		44,025	
603	Adult Autologous >72 hour	16 days	82,555	3,058
604	Paediatric Autologous >72 hour	13 days	110,072	5,502
605	Adult Allogeneic excl. matched unrelated donor (MUD) patients	25 days	189,976	3,266
606	Paediatric Allogeneic	25 days	235,229	5,912
607	Adult Allogeneic MUD patients	25 days	229,318	3,266

Some bone marrow / stem cell rates are block rates inclusive of a certain length of in-patient stay. These block rates are billed based on the date of discharge regardless if services were provided over two fiscal years.

Rules of Application for Bone Marrow / Stem Cell Transplants

1. Any inpatient stay, separate and distinct from an admission for a bone marrow/stem cell transplant (i.e. for pre-procedure assessment, stabilization, etc.), will be billed at the authorized per diem rate of the hospital.

2. Each outpatient visit will be billed at the authorized interprovincial outpatient rate.

3. Each block rate includes all facility costs associated with a single transplant episode including inpatient and diagnostic costs. For purposes of calculating the Maximum Length of Stay, the inpatient stay includes the date of admission but not the date of discharge.

4. The Add-on Standard High Cost Per Diem can be billed for inpatient days in excess of the Maximum Length of Stay during the inpatient admission in which the transplant was performed.

5. Acquisition Costs:
   a) When bone marrow/stem cell is acquired within Canada, the costs are included in the block rate. The transplant centre is responsible for paying the acquisition cost.

b) When bone marrow/stem cell is acquired from outside Canada, the actual invoice cost paid by the transplant centre can be billed to the recipient's home province. The actual invoice must accompany the reciprocal billing claim.

6. Cases discharged within 72 hours from date of procedure are to be billed at the 72-hour discharge (adult or paediatric) rate by the hospital which performed the transplant service.

7. Paediatric refers to person 17 years of age and under.

8. Persons who are discharged and develop complications related to a bone marrow or stem cell transplant, may be re-admitted for inpatient stays at the authorized per diem rate of the hospital and not the Add-on Standard High Cost Per Diem.

9. Any repeat inpatient stay for the same patient for a repeat bone marrow or stem cell transplant will be treated as a new case and will be billable as described in these Rules.

10. With the exception of acquisition costs in 5(b), claims for bone marrow/stem cell transplants must be billed as a complete claim at the time of discharge.

11. Diagnostic coding is mandatory and should indicate the principle cause or final diagnosis of the transplant case.

12. Bone marrow/stem cell transplants performed as part of clinical trials or for diagnoses for which the treatment is still considered experimental are not eligible for reciprocal billing.

Billing when patient's eligibility changes during hospitalization for Bone Marrow / Stem Cell Transplants

- For interprovincial bone marrow / stem cell rates, the cost of the service is to be shared between the jurisdictions on a pro-rated basis whereby the jurisdiction covering the patient on the day of hospitalization is responsible for the costs up to the eligibility change.

  Scenario
  - Resident moves from jurisdiction A to jurisdiction B
  - Applies for coverage in jurisdiction B which will be effective on March 10
  - Is admitted into hospital in jurisdiction B on March 5 for Adult Allogeneic MUD
  - Transplant occurs on March 10
  - Is discharged on March 15

  Billing For the scenario above:

  - Jurisdiction A responsible for care from March 5 to March 9
  - Jurisdiction B responsible for care from March 10 to March 15

- **The policy above applies to the <u>bone marrow / stem cell rates</u> only**. I.e., if the patient is admitted prior to or after the transplant under a separate admission/discharge, then the jurisdiction responsible for coverage on those days is responsible for payment of the separate in-patient stay.

For bone marrow/stem cell transplants where admission is longer than the Maximum Length of Stay (MLOS):

1. Calculate the daily rate of the transplant costs:
    a) For bone marrow/stem cell transplants, this is the (block rate plus the add-on costs for the additional days past the MLOS)/number of days admitted less 1 day.
2. Multiply the daily rate by the number of days the patient was eligible under the former jurisdiction's coverage.
3. Submit the pro-rated amount and provide letter/documentation stating the change in eligibility and the calculation.

For bone marrow/stem cell transplants where admission and discharge are less than or equal to the MLOS:

1. Calculate the pro-rated percentage
2. Submit the pro-rated amount and provide letter/documentation stating the change in eligibility and the calculation.

Scenario

- Resident moves from jurisdiction A to jurisdiction B
- Applies for coverage in jurisdiction B which will be effective on March 10
- Is admitted into hospital in jurisdiction B on March 5 for Adult Allogeneic MUD
- Transplant occurs on March 10
- Is discharged on March 15

Billing For the scenario above:

- Jurisdiction A responsible for care from March 5 to March 9
- Jurisdiction B responsible for care from March 10 to March 15

The host and home jurisdictions will agree how the above noted rate apportionment should be accommodated within their respective billing systems (either by original rate recalculation or billing adjustment etc.).

The policy above applies to the bone marrow / stem cell rates only. I.e., if the patient is admitted prior to or after the transplant under a separate admission/discharge, then the jurisdiction responsible for coverage on those days is responsible for payment of the separate in-patient.

Time Limit for Submission of Claims

Hospitals are responsible for collecting the information required for the processing of reciprocal hospital claims. A time limit of one year from the date of discharge is allowed for submission of accounts. For any accounts older than 12 months, the hospital should seek approval for extension of the time limit for submission from the beneficiary's province. Accounts not billed within this timeframe or a claim is rejected due to inadequate information collection by the hospital seeking reimbursement, the hospital is not entitled to bill insured patients directly or to refer the account to a collection agency. These claims must be written off and absorbed within the hospital's budget.

Workers Compensation Board Claims

After a WCB denial letter is received, hospitals have 12 months from the date of the WCB denial letter to submit a claim/adjustment. If the claim/adjustment is not submitted within 12 months of the date of the denial letter, the hospital must absorb the cost and cannot charge the patient. The WCB denial letter must be provided to the patient's province/territory of residence with the claim/adjustment.

Appendices

Saskatchewan Health
Medical Services Branch

3475 Albert Street
Regina, Saskatchewan
S4S 6X6

Out of Province Beneficiary Out-patient Services

Hospital Name and Location	Hospital Number	Page of
Maple Creek Hospital	098	1 | 1

Province of Origin	Code	Period Ending
Nova Scotia		August 2002

	Plan Registration Number	Health Card Expiry Date (YYYY MM DD)	Patient's Surname	Given Name	Initial	Date of Birth (YY MM DD)	Sex	Date of Service (YY MM DD)	Serv. Code	Cost per Service
1	0001 899 908	2002 12 31	Smith	Sally		45 05 17	F	02 08 02	01	110 00
	Diagnosis	ICD-10-CA Diagnostic Code	Intervention	CCI Intervention Code						
2	0001 902 202	2002 12 31	Jones	Tommy		88 08 22	M	02 07 31	02	400 00
	periapical abscess with sinus	K04.7	extract tooth forceps	1.FE.57.JA-						
3		YYYY MM DD				YY MM DD		YY MM DD		
4		YYYY MM DD				YY MM DD		YY MM DD		
5		YYYY MM DD				YY MM DD		YY MM DD		
6		YYYY MM DD				YY MM DD		YY MM DD		
7		YYYY MM DD				YY MM DD		YY MM DD		
8		YYYY MM DD				YY MM DD		YY MM DD		

Hospital Certification:

I certify that Health Insurance Identification Cards of the patients listed above have been examined and the address in each case appears on the hospital records.

Total Cost of Services ▶

Control Reference Number

Authorized Signature

Date

Health OOP-OP
(09/2002)

Appendix B: Instructions for Billing Other Agencies

Workers' Compensation Board

Hospital services provided to persons whose injuries were work related, should be billed to the Workers' Compensation board. The established rate applies. Invoices should be sent to:

Workers' Compensation Board (306) 787-4370
200-1881 Scarth Street
Regina SK S4P 4L1

Veterans Affairs Canada (VAC)

Veterans Affairs Canada will accept responsibility for payment of the public ward charges if a beneficiary is being treated for a pensionable disability.

If a patient is identified as Veterans Affairs Canada responsibility at the time of admission:

a) Contact Veterans Affairs Canada who will determine the veterans eligibility for inpatient services.

   If eligible for inpatient services (Program 05) complete a Hospital Services form (behind page 18) and submit it to:

   Veterans Affairs Canada (204) 983-2860
   Prairie Regional Office
   Treatment Benefits
   P.O. Box 6050
   Winnipeg MB R3C 4G5

b) If the veteran is eligible for benefits under the 14 TAPS (Treatment Accounts Processing System) programs, he or she will be issued a Client I.D. card.

   Prescription Drugs (Program 10)
   Medical Supplies (Program 07)
   Aids for Daily Living (Program 01)

   Contact Alberta Blue Cross for billing procedure:

   Alberta Blue Cross (780) 498-8100
   10009-108 Street Edmonton AB T5J 3C5

   A supply of claim forms can be obtained by contacting Alberta Blue Cross.

Royal Canadian Mounted Police

As of April 1, 2013 members of the Royal Canadian Mounted Police are eligible for a Saskatchewan health services card and receive the same basic health coverage as other Saskatchewan residents. All services provided to regular RCMP members should be billed to Medical Services Branch using their Saskatchewan health services number.

Services provided to members of the Royal Canadian Mounted Police who are stationed outside of Saskatchewan should also be billed reciprocally per protocol for out-of-province coverage for members of the general public.

For RCMP members who are confirmed to require care as a result of work-related injury, they are to be billed directly, as those claims will be paid to them through their Blue Cross coverage. Blue Cross requires the following patient information be provided:

1. Full Name
2. Date of Service
3. Diagnosis
4. Blue Cross Number of the RCMP member

Canadian Armed Forces (CAF)

The Canadian Armed Forces have made changes to the rates they pay for hospital services provided to their members. Claims must be submitted directly to Medavie Blue Cross. See the attached link to access the Resources for Health Professionals and appropriate Payment Schedules.

https://www.medaviebc.ca/en/health-professionals/resources

Federal Penitentiary

Services provided to inmates of the Saskatchewan Penitentiary should be billed at the daily established rate to:

Saskatchewan Penitentiary (306) 953-6295
Business Office
Box 160
Prince Albert SK S6V 5R6

Attention: Assistant Warden

Appendix C: Declaration of Hospital Insurance Coverage Form

Saskatchewan Health
Medical Services Plan

DECLARATION OF HOSPITAL INSURANCE COVERAGE
In-patient Interprovincial Agreement

Chart No. 006121

PATIENT IDENTIFICATION (Provide information as shown on Health Insurance Card)

Surname	Given Name(s)	Initials	Date of Birth (Year Month Day)
Smith	John	D.	1960 04 01

Address registered with Province of Coverage (R.R.#, Number and Street, Apartment No.): 9999-58th Street NW

Sex: Male [X] Female [ ]

City, Town, Village	Postal Code	Current Telephone Number (Area Code)
Calgary, Alberta	T1V3C4	(403) 594-0123

PROVINCE OF COVERAGE: Alberta
Health Insurance Number: 12345-6789
Date of Effectiveness (Year Month Day):
Date of Expiry (Year Month Day):

TO BE COMPLETED IF PATIENT IS TEMPORARILY PRESENT IN HOST PROVINCE

Temporary Address in Host Province *if available* (R.R.#, Number and Street, Apt. No., City, Town, Village)	Province	Postal Code	Telephone Number (Area Code)
1234 Avenue C North Saskatoon	SK	S7K3M5	(306) 244-1234

Reason for entitlement to insured in-patient hospital services from Province of Coverage:

- [X] Vacation/In Transit
- [ ] Study: _____ (Name of Educational Institution)
- [ ] Medical Referral
- [ ] Temporary Employment/Business
- [ ] Other: _____ (Please Specify)

ANTICIPATED DURATION OF STAY
FROM (Year Month Day): 2002 02 05
TO (Year Month Day): 2002 02 28

- [ ] Awaiting Eligibility for Coverage in the Province *(other than Host Province)* of _____ Date registered with new Health Insurance Plan: ____/____ (Year Month)

Address (R.R.#, Number and Street, Apt. No., City, Town, Village) | Postal Code | Telephone Number (Area Code) ( ) -

TO BE COMPLETED IF PATIENT HAS MADE A PERMANENT MOVE TO HOST PROVINCE

Permanent Address in Host Province (R.R.#, Number and Street, Apt. No., City, Town, Village) | Province | Postal Code | Telephone Number (Area Code) ( ) -

Last Address in Former Province (R.R.#, Number and Street, Apt. No., City, Town, Village) | Province | Postal Code | Former Telephone Number (Area Code) ( ) -

Date of Departure from Province of Coverage (Year Month Day):

- [ ] Date of Arrival OR
- [ ] Date of Establishing Residence in Host Province (Year Month Day):

HOSPITAL

Name	Location	HOSPITAL NUMBER
Saskatoon City Hospital	Saskatoon	140

Additional Information:

Admission/Separation Number: 1135012
Date of Admission (Year Month Day): 2002 02 12

DECLARATION OF PATIENT or REPRESENTATIVE

I hereby declare conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the *Canada Evidence Act* that I am entitled (or I declare on behalf of the patient that he/she is entitled) to insured hospital services from the Province of Coverage.

Signature of Person making Declaration | **Signature of Authorized Hospital Representative** | Date

Name of Declarant if other than Patient *(Please Print)*

Relationship to Patient *(Please specify if other than Parent/Guardian)*

- [ ] Parent/Guardian

Address of Declarant if other than Patient (R.R.#, Number and Street, Apt. No., City, Town, Village, Province) | Postal Code | Former Telephone Number (Area Code) ( ) -

- [ ] Same as Patient

Note: Send Part 1 to Saskatchewan Health Benefits and Inquiries Section, 3475 Albert St., Regina, Sask. S4S 6X6
Part 2 Retain for your records.

Health 19-8
03/98

Appendix D: Hospital Reciprocal Administrative Requirements Billing Check List

HOSPITAL RECIPROCAL ADMINISTRATIVE REQUIREMENTS

BILLING CHECK LIST

PATIENT IDENTIFICATION

- Health care card must be valid for date of service; check for effective and expiry date(s).

  NOTE: Health care card MUST be presented by the patient. If no card is presented, the patient is responsible for payment or contact another family member to provide the provincial/territorial health card information.

- Registration number MUST be carefully recorded.

- Record patient's full name, and date of birth as shown on the health care card.

- Record the patient's home (out of province) address, including postal code as shown on the health care card, when applicable.

- Record the patient's telephone number, including the area code.

DECLARATION OF HOSPITAL INSURANCE COVERAGE FORM

- If the patient is being admitted as an inpatient, the Declaration of Hospital Insurance Coverage Form must be **signed** and duly completed in full as follows:

  - Patient's full name as shown on the health care card;
  - Patient's date of birth;
  - Patient's address including postal code (temporary host province address or permanent home province address);
  - Plan registration number, including expiry date as shown on the health care card;
    - If the card only displays a year and month (e.g., 2019/12) it is valid until the end of the month shown on the card, unless otherwise determined by the health care plan of the patient's province/territory of residence.
  - Telephone number, including area code;
  - Reason for absence from home province, i.e., vacation, medical referral, attending University;
  - **THE FORM MUST BE SIGNED BY THE PATIENT/GUARDIAN/OTHER FAMILY MEMBER/OR PATIENT REPRESENTATIVE.**

FAILURE OF THE PATIENT TO PROVIDE THE NECESSARY INFORMATION WILL RESULT IN PAYMENT OF THE ACCOUNT BEING THE PATIENT'S RESPONSIBILITY.

Appendix E: Out of Province Beneficiary Hospital Admission- Separation Record

Saskatchewan Health
Medical Services Branch

Out of Province Beneficiary
Hospital Admission - Separation Record

Hospital Information		Admission Number	Chart Number
Name of Hospital	Hospital Code Number		
Royal University Hospital	142	02112671	865458

Patient Information

Last Name	First Name	Initial	Health Services Number	Health Card Expiry Date	Prov. Code (MSB Use Only)
Brown	John	D.	123456	2002 12 31	

Address	City/Town	Province	Postal Code
P.O. Box 1234	Swan River	Manitoba	R0L 1Z0

Gender	Birthdate (Day / Month / Year)	Telephone	Nearest Relative or Friend, Parent or Guardian	Telephone
[X] Male [ ] Female	15 / 09 / 96	(204) 736-2345	Jane Brown	(204) 736-2345

Admission and Separation Information

Ward Number	Admission Date / Time (Day / Month / Year / Time)	Discharge Date / Time (Day / Month / Year / Time)	Days Stay	Per Diem Rate
214	12 / 02 / 02 / 14:00	15 / 02 / 02 / 16:00	3	[X] Adult/Child [ ] New Born

Type of Discharge

[X] 1. Medical Discharge [ ] 2. Discharge without Medical Authorization [ ] 3. Death with Autopsy
[ ] 4. Death without Autopsy [ ] 5. Transfer [ ] 6. Continuous Stay

Transferred to: _____ (Name of Hospital)

Diagnoses Information

Description	ICD-10-CA Diagnostic Code
Primary Diagnosis: Acute ulcerative appendicitis	K 35.9
Secondary Diagnosis	
Additional Diagnosis	

Intervention Information

Description	CCI Code	Day	Month	Year	High Cost Procedures: Service Code	High Cost Procedures: Expected Cost
Most Major Intervention: Appendectomy	1.NV.8 9.DA--	13	02	02		
Secondary Intervention						
Additional Intervention						

Certified that the above patient received the services indicated.

_____
Authorized Hospital Officer

Saskatchewan Health Control Reference Number

Note: Send Part 1 to Saskatchewan Health Benefits and Inquiries Section, 3475 Albert St., Regina, Sask. S4S 6X6
Retain Parts 2 and 3 for your records.

Health OOP-AS1
(09/2002)

Appendix F: Selected Operations (CCI codes) on the Cardiovascular System

Selected Operations (CCI codes) on the Cardiovascular System

For services provided on or after April 1, 2011, jurisdictions can no longer bill cardiovascular add- on procedure rates previously listed under the 500 code series. This attachment has been deleted.

Appendix G: Adjustment Reason Codes

Adjustment Reason Code	Description
800	PLAN REGISTRATION NUMBER IS INVALID/BLANK; DOES NOT PASS CHECK DIGIT
801	PATIENT NOT REGISTERED; IF IN-PATIENT, PROVIDE A COMPLETED DECLARATION FORM
802	DEPENDENT NOT ON MASTER FILE/DATABASE
803	PATIENT'S COVERAGE NOT EFFECTIVE FOR DATE OF
804	PATIENT'S COVERAGE EXPIRED PRIOR TO DATE OF SERVICE
805	DATE OF ADMISSION PRIOR TO PLAN REGISTRATION EFFECTIVE DATE; PROVIDE A COMPLETED DECLARATION FORM
806	DATE OF ADMISSION AFTER PLAN REGISTRATION TERMINATION DATE; PROVIDE A COMPLETED DECLARATION FORM
807	INCOMPLETE PATIENT INFORMATION ON DECLARATION FORM
808	PATIENT'S/PARENT'S/GUARDIAN'S/REPRESENTATIVE'S SIGNATURE MISSING ON DECLARATION FORM
809	PATIENT REGISTERED IN ANOTHER PROVINCE
810	PATIENT'S HEALTH CARE CARD EXPIRED; DATE OF
811	PROVIDE A DECLARATION FORM
812	DECLARATION FORM INCOMPLETE, ADJUSTMENT GRANTED
813	DECLARATION FORM NOT RECEIVED REQUESTING ADJUSTMENT
814	NO RESPONSE RECEIVED TO PREVIOUS REQUEST
815	REQUEST CLOSED - CLAIM RECEIVED AND ADJUSTED
816	REQUEST CLOSED - RULE NO LONGER APPLIES
817	INVALID ADJUSTMENT REFERENCE INDICATOR
818	INVALID/BLANK DECEASED INDICATOR
819	INVALID/BLANK OUT OF PROVINCE REGISTRATION NUMBER EXPIRY DATE
820	ADMISSION/SEPARATION DATE MUST BE BLANK
821	INVALID CODING SCHEME TYPE CODE
822	INVALID SECOND VISIT CODE
823	INVALID/BLANK CITY NAME/PROVINCE
824	SERVICE CODE NOT EFFECTIVE FOR DATE OF SERVICE
825	INVALID/BLANK PATIENT'S SURNAME/GIVEN NAME
826	INVALID/BLANK PATIENT'S ADDRESS/POSTAL CODE
827	INVALID/BLANK PATIENT'S DATE OF BIRTH
828	INVALID/BLANK PATIENT'S GENDER CODE

Adjustment Reason Code	Description
829	INVALID/BLANK DIAGNOSTIC CODE(S)
830	INVALID/BLANK PROCEDURE CODE
831	INVALID/BLANK HIGH COST PROCEDURE CODE
832	INVALID/BLANK OUTPATIENT SERVICE CODE
833	INVALID/BLANK ADMISSION DATE
834	INVALID/BLANK DISCHARGE DATE
835	INVALID/BLANK OUTPATIENT SERVICE DATE
836	INVALID/BLANK HIGH COST PROCEDURE DATE(S)
837	INVALID/BLANK WARD RATE
838	INVALID/BLANK OUTPATIENT RATE
839	INVALID/BLANK HIGH COST PROCEDURE RATE(S)
840	HIGH COST PROCEDURE CODE SUPPLIED WITHOUT A
841	PATIENT DISCHARGED WITHIN 48HRS OF HIGH COST PROCEDURE
842	INVALID/BLANK HOSPITAL NUMBER
843	ORIGINAL PRACTITIONER IDENTIFIER/SPECIALTY CODE/NUMBER OF CALLS/PAY TO CODE/SERVICE END DATE ARE NOT APPLICABLE FOR HOSPITAL RECIPROCAL
844	INVALID/BLANK SUBMISSION TYPE (INPATIENT /OUTPATIENT) SEGMENT
845	HIGH COST PROCEDURE DATE/OVERRIDE AMOUNT MUST BE BLANK IF NO HIGH COST PROCEDURE CODE
846	INVALID CODE SCHEME
847	INVALID ACCIDENT CODE/INDICATOR/CONTINUOUS STAY TYPE
848	INVALID/BLANK ADJUSTMENT AMOUNT
849	INVALID ADJUSTMENT REASON INDICATOR
850	DUPLICATE OUTPATIENT CLAIMS, SAME HOSPITAL
851	DUPLICATE INPATIENT TO OUTPATIENT, SAME HOSPITAL
852	DUPLICATE INPATIENT CLAIMS, SAME HOSPITAL
853	OVERLAPPING SERVICE/ADMISSION DATES
854	CLAIM OVER ONE YEAR OLD
855	ADJUSTMENT REQUEST OVER THE 18 MONTH TIME LIMIT
856	EXCLUDED SERVICE
857	INCORRECT AMOUNT BILLED
858	PRIOR APPROVAL REQUIRED FOR SERVICE PROVIDED
859	SECOND OUTPATIENT VISIT CLAIMED; A SECOND VISIT CANNOT BE RB.
860	OTHER REASON; (PROVINCE/TERRITORY PROVIDE
861	PATIENT MUST BE 18 YEARS OF AGE OR OLDER FOR PROCEDURE

Adjustment Reason Code	Description
862	MAXIMUM NUMBER OF SERVICES REACHED
863	MULTIPLE OUTPATIENT SERVICES SAME HOSPITAL
864	DUPLICATE CLAIM
865	ADMISSION/SERVICE/BILLING DATE LESS THAN BIRTH DATE
866	BILLING END DATE MUST BE EQUAL OR GREATER THAN BILLING START DATE
867	SEPARATION MUST BE EQUAL OR GREATER THAN ADMISSION DATE
868	INVALID CLAIM/HIGH COST PROCEDURE OVERRIDE AMOUNT
869	SERVICE EVENT TYPE MUST BE 'I' OR 'O' FOR HREC CLAIM TYPE
870	ADMISSION/SERVICE DATE PRIOR TO 'NU' (NUNAVUT) EFFECTIVE DATE
873	DECLARATION RECEIVED
874	ADDRESS CANNOT BE SPECIFIED WITH OUTPATIENT CLAIMS
875	INVALID STAY TYPE
876	SEPARATION DATE CANNOT BE SPECIFIED WITH OUTPATIENT CLAIMS
877	SERVICE START DATE CANNOT BE SPECIFIED WITH INPATIENT CLAIMS
878	SERVICE CODE EFFECTIVE DATE INVALID

Appendix H: Provincial Health Cards

Appendix I: Provincial and Territorial Health Plans Contact Information

Newfoundland and Labrador
Department of Health
Audit and Claims Integrity
Confederation Building, 1st Floor, West Block
P.O. Box 8700
St. John's, Newfoundland and Labrador
A1B 4J6
Telephone: 709-729-3108
Fax: 709-729-1918

Prince Edward Island
Out-of-Province Coordinator
Medical Affairs
PO Box 2000
16 Garfield Street,
Charlottetown, PE, C1A 7N8
Telephone: (902) 368.6516
Fax: (902) 620.3072

Nova Scotia
Nova Scotia Medical Services Insurance (MSI)
PO Box 500
Halifax, NS B3J 2S1
Telephone: (902) 496-7011
Toll Free: 1-866-553-0585
Fax: (902) 490-2275

New Brunswick
New Brunswick Medicare
Eligibility and Claims
520 King Street 4th Floor
Fredericton, NB E3B 6G3
Telephone: 506-453-8275
Fax: 506-457-3547

Quebec
Regie de l'assurance-maladie du Quebec
1125, chemin Saint-Louis (30)
Sillery, (Quebec) G1S 1E7
Telephone: (613) 783-4420
FAX: (613) 237-3246

Ontario
Ministry of Health and Long-Term Care
Health Services Branch, Provider Payment Programs
Negotiations and Accountability Management Division
370 Select Drive, P.O. Box 168
Kingston, ON K7M 8T4
Tel: 613 536 3061
Fax: 613 536 3184

Manitoba
Manitoba Health
Hospital Abstract / Reciprocal Billing
300 Carlton Street
Winnipeg, MB R3B 3M9
Telephone: 204-786-7362 or 204-786-7303
Fax: 204-772-2248

Saskatchewan
Saskatchewan Ministry of Health
Medical Services Branch
Claims Analysis Unit
3475 Albert Street
Regina, SK S4S 6X6
Telephone: 306-787-3475
Fax: 306-798-0582

Alberta
Hospital Reciprocal Billing Unit
Alberta Health and Wellness
PO box 1360 Stn Main
Edmonton, AB T5J 2N3
Telephone: 780-427-1479
Fax: 780-422-1958

British Columbia
Ministry of Health
Out-of-Province Claims
2-1, 1515 Blanshard Street
Victoria, BC V8W 3C8
Telephone: 250-952-1334
Fax: 250-952-1940

Yukon Territory
Insured Health and Hearing Branch
Department of Health & Social Services
Government of Yukon
H-2 Box 2703
Whitehorse YT Y1A 2C6.
Telephone: 867-667-5202
Fax: 867-393-6486

Northwest Territories
Manager of Health Care Eligibility and Insurance Programs
Health Services Administration
Bag Service #9
Inuvik, NT X0E 0T0
Toll Free: 1-800-661-0830 Ext. 17
Fax #: 867-777-3197

Nunavut
Health Insurance Programs
Box 889
Rankin Inlet, NU X0C 0G0
Phone: 867-645-8002
Fax: 867-645-8092