

**October 1, 2014**

# **PAYMENT SCHEDULE**

**For Insured Services Provided by an Optometrist  
Supplementary Health, Family Health Benefits & Seniors' Income  
Plan Programs**

**Supplementary Health, Family Health Benefits & Seniors' Income Plan Programs  
Payment Schedule  
For Insured Services Provided by an Optometrist**

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		April 1, 2013	April 1, 2014	Oct 1, 2014	April 1, 2015
2U	<b>Routine examination of the eyes</b>	\$55.40	\$55.40	\$55.40	\$56.50
	<ul style="list-style-type: none"> <li>a) case history;</li> <li>b) visual acuity;</li> <li>c) external examination;</li> <li>d) assessment of extraocular muscles;</li> <li>e) convergence testing;</li> <li>f) pupil response;</li> <li>g) accommodation;</li> <li>h) examination of cornea, lens, media, fundus;</li> <li>i) determination of refractive error or change;</li> <li>j) instruction, information, and advice to the patient with respect to the status of his vision and its future management; and</li> <li>k) provision of the necessary spectacle prescription.</li> </ul>				

Eligibility is limited to:

- 1 service per 24-month period for beneficiaries 18-64 years of age, and
- 1 service per 12-month period for beneficiaries over 64 years of age.

4U	<b>Repeat routine examination of the eyes</b>	\$55.40	\$55.40	\$55.40	\$56.50
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An additional routine examination of the eyes within the time limits of a routine examination ("2U" above) or annual examination for patients with diabetes ("22U"), as listed in the October 1, 2014 Payment Schedule for Insured Services Provided by an Optometrist. This service is payable when the optometrist furnishes the Ministry of Health with evidence satisfactory to the Minister that special circumstances required the service be provided.

Eligibility is limited to beneficiaries over 17 years of age.

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	<b>April 1, 2013</b>	<b>April 1, 2014</b>	<b>Oct 1, 2014</b>	<b>April 1, 2015</b>
<p>12U <b>Partial examination (other than assessment of Ocular Urgencies and Emergencies)</b></p> <p>An examination of the eyes requested by the patient that includes patient history; functional enquiry, examination and assessment; diagnosis, record and necessary advice to the patient.</p> <p>A partial examination service is not a covered service when:</p> <p>a) routine examination of the eyes or annual examination for patients with diabetes that was an insured service, was provided to the beneficiary within the preceding ninety consecutive days, unless the optometrist furnishes the Ministry of Health with evidence satisfactory to the Minister that special medical circumstances required that the partial examination service be provided; or</p> <p>b) it relates to the provision or wearing of contact lenses.</p> <p>Eligibility is limited to beneficiaries over 17 years of age.</p>	<b>\$27.20</b>	<b>\$27.20</b>	<b>\$27.20</b>	<b>\$27.70</b>
<p>21U <b>Tonometry – the measurement of eye tension with a tonometer</b></p> <p>Eligibility is limited to beneficiaries over 17 years of age.</p>	<b>\$14.40</b>	<b>\$14.40</b>	<b>\$14.40</b>	<b>\$14.70</b>

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	<b>April 1, 2013</b>	<b>April 1, 2014</b>	<b>Oct 1, 2014</b>	<b>April 1, 2015</b>
<b>40U Visual Field Testing (Screening or Threshold)</b>	---	---	\$30.00	\$30.60

Eligibility is limited to beneficiaries:

- a) with Supplementary Health Coverage,
- b) with Family Health Benefits Coverage, and
- c) over 64 years of age with Seniors' Income Program

Eligibility is limited to:

- 1 service per 12-month period for beneficiaries under the age of 18,
- 1 service per 24-month period for beneficiaries 18-64 years of age, and
- 1 service per 12-month period for beneficiaries over 64 years of age.

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**SUBMISSION OF ACCOUNTS**

**1. Time Limit for Submission of Accounts**

An examination of the eyes initiated by the patient or upon referral from another doctor for the following acute disorders of the anterior segment:

The Ministry of Health must receive accounts for insured services within six months of the date of service to be eligible for payment under *The Saskatchewan Medical Care Insurance Act*

The six months period of time may be extended to twelve months by the Ministry of Health if it is determined that the delay was due to factors beyond the control of the person presenting the account. Claims returned to the optometrist should be corrected as necessary and sent back to Medical Services Branch (MSB), Ministry of Health within 30 days; this will be strictly enforced once a claim becomes 5 months old. The submission time period applies to all persons submitting accounts to The Ministry of Health

In cases where beneficiaries are billed directly, *The Saskatchewan Medical Care Insurance Act* requires the beneficiary be provided with an itemized statement within six months following the date of service to enable them to claim payment from the Ministry of Health. As long as the beneficiary is provided with a statement of account in time, the Act does not restrict the practitioner's right to collect the account from the beneficiary. If the practitioner does not provide the statement in time, the right to collect the account from the beneficiary is lost

**2. Form of Account:**

**Standard Claim Submission**

The Ministry of Health may make payment for insured services provided to a beneficiary on an account being presented, containing the following information:

- a) patient's name in full;
- b) patient's Health Services Number;
- c) patient's month and year of birth, and sex;
- d) diagnosis or diagnostic code;
- e) where service is provided in Saskatchewan, service code corresponding to procedure or treatment performed;
- f) date of each service;
- g) amount charged for each service provided;
- h) additional remarks if nature of service was unusual;
- i) name and signature (not required if claim is submitted by computer) of person providing service;
- j) name or number of referring physician where applicable

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3. **Method of Submission**

Claims may be submitted in electronic or paper format. Rates for payment for claims submitted electronically are those set out in the payment schedule. Rates for payment for claims submitted in paper format will be \$2.00 less than the amount set out in the payment schedule to offset costs associated with manually processing such claims

For assistance in establishing electronic claims submission, please contact Medical Services Branch, **Operations and Client Services Unit** at 787-3473 or fax 787-3761.

**ASSESSMENT RULES**

1. **General:**

Claims for insured services submitted by any method (mode) of billing are subject to the assessment rules. This applies even in the event of claims being received under different modes of billing (e.g. mode 6 – billed directly to MSB, mode 3 – billed directly to the beneficiary) for all services to a patient on the same day.

The relationship of the current service to prior or subsequent services may result in a payment amount that differs from the payment listed in the Payment Schedule.

A previous payment may be adjusted due to the subsequent submission of a claim for a related service.

Where a claim is returned or the payment is different from the amount billed, an Explanatory Code, of two letters ie: SA, is used to indicate the reason. A list of the Explanatory Codes is appended to this section.

When a request is made for an explanation or outline of circumstances in order to assess a claim, the Ministry of Health shall determine whether the explanation is acceptable.

No payment is made for a report or other information required to assess or review an account.

2. **Visits:**

Any claim submitted for a second visit on the same date of service or within the time limitation period by either the same optometrist or another in the same clinic, should state the reason for the second visit, the time and service provided.

An optometrist may not claim for an insured service provided to himself, his spouse, or dependent.

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**2U -- ROUTINE EXAMINATION OF THE EYES\***

1. A routine examination of the eyes is a covered service when the Minister has not made a previous payment to any optometrist or physician for the same service provided to the same beneficiary within the eligibility time and age limit.
2. A routine examination of the eyes is not a covered service where it is provided:
  - a) within the post-operative care period following major eye surgery by a physician or optometrist in the same clinic;
  - b) at the request of a third party, e.g., to complete a certificate or report;
  - c) in respect of the provision of safety glasses for employment purposes.

**4U -- REPEAT ROUTINE EXAMINATION OF THE EYES \***

1. A repeat routine examination of the eyes is a repeat or an additional routine examination of the eyes (2U) performed within the age/time limit for 2U.
2. A repeat routine examination of the eyes is a repeat performed within the time limit for 22U (Annual Examination for Patients with Diabetes) – as listed in the October 1, 2014 Payment Schedule for Insured Services by an Optometrist.
3. The claim will be rejected if no explanation is provided.
4. The claim will be paid if:
  - a) the patient was referred by a physician or public health nurse;
  - b) visual changes associated with a refractive error of .5D for sphere or cylinder or an axis change of 10° or more (per eye).
5. Claims will be individually assessed for such conditions as:
  - Albinism
  - Cataract Aphakia
  - Diabetes
  - Glaucoma
  - Keratoconus
  - Macular degeneration
  - Marked Corneal Dystrophy
  - Patients at high risk, high RX +/- 8.00D
  - Postoperative Cataract Surgery with or without intraocular lens
  - Syphilis
  - Tuberculosis



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6. Diagnosis and referral of an acute or non-acute ocular or intraocular pathological condition where a total eye assessment is appropriate.

**12U -- PARTIAL EXAMINATION**

1. This represents any covered visit service to an optometrist other than a 2U, 4U, 21U, 15U 16U, or 22U service.
2. There are no time limits except when 12U is billed within 90 days following a 2U, 4U, 21U, 22U service. If billed within 90 days, special consideration will be given to a 12U billed for an unrelated condition or on referral of the patient by a physician or public health nurse.
3. Special consideration may be given to a 12U billing in accordance with Repeat Routine Examination of the Eyes (4U), items 3 and 4, or where a complete eye assessment or Ocular Urgency or Emergency (15U) assessment are inappropriate.
4. A 12U may also be billed in respect of the following medical conditions:

Amblyopic children; and  
Retinal detachment.

*\*Note:* When a third party identifies a potential vision deficiency of a qualified beneficiary, and all other applicable conditions of a Routine Examination (2U), Repeat Routine Examination (4U), or Annual Examination for Patients with Diabetes (22U) apply, the service is an insured service and is to be billed as such. The completion of any special forms and/or reports may be directly charged to the beneficiary

**21U -- TONOMETRY**

1. Eligibility is limited to beneficiaries over 17 years of age.

**40U – VISUAL FIELD TESTING (SCREENING OR THRESHOLD)**

1. Routine/baseline screening is not a benefit.

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**EXPLANATORY CODES**

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Patient Identification

A plastic "Health Services Card" for registered beneficiaries is sent every third year, expiring December 31, 2011 and every third year thereafter, to their last reported postal address. Coverage depends on registration. Notification of changes is the beneficiary's responsibility.

The Health Services Card shows: the effective and ending coverage dates, Health Services Number, name, sex, month, and year of birth.

Health Registration, Phone: 1-800-667-7551 or 787-3251, 11<sup>th</sup> Avenue, Regina, S4P 0J5, should be notified of:

- a) Change of address;
- b) Registration errors, ie: name, sex, or date of birth;
- c) Changes in family.

All accounts should be sent to the Medical Services Branch (MSB), the Ministry of Health.

Residents who are members of the Canadian Forces or inmates of the Federal Penitentiaries are not provided with health care coverage under MSB. Their spouses and dependents, resident in Saskatchewan, must be registered for coverage.

The alphabetic code listed in the payment file/list, reject file or returned claim identifies the related explanation.

- AA Not Registered -- no record of this person under this number. Please check the patient's Health Services Card expiry date.
- AB Patient does not appear to be covered for this date of service. If you can resubmit with the patient's correct address, we will determine if the patient was covered.
- AC Registered as opposite sex -- please check the Health Services Card.
- AD Incorrect Health Services Number -- use the number shown on this payment file/list for future claims.
- AE Incorrect date of birth -- please use the date of birth shown on the Health Services Card.
- AF Please review this claim, the Health Services Number is inconsistent with the name, sex or birth date on the Health Services Card.
- AH Please review this claim. Our records indicate that the beneficiary registered under this number died prior to the date of service.

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- AL Please check the date of service. This claim was received at MSB prior to the date of service indicated on the claim.
- AM A letter sent to this patient by Health Registration regarding the validation renewal stickers has been returned. This patient will not have coverage after this coming January 31. When you again attend to this patient, please advise him/her to immediately contact Health Registration at 1-800-667-7551 or 787-3251 to have their coverage updated. Please ignore this message if the patient now has the new sticker.
- AN The coverage for this patient has been terminated in accordance with his/her Canadian Immigration Authorization. All attempts to contact the patient have been unsuccessful.

The date of service on the claim is after the termination date on the Health Services Card. In order to have the Health Services coverage updated, he/she should immediately contact Health Registration, 11<sup>th</sup> Avenue, Regina, S4P 0J5.

- AO A letter sent to this Saskatchewan patient by Health Registration has been returned. Therefore, the patient's coverage has been terminated. On your next contact with this patient, please advise the patient to immediately contact Health Registration at 1-800-667-7551 or 787-3251 to have their coverage updated.
- AP The 9-digit Health Services Number is incorrectly recorded. Please recheck your files and/or the patient's Health Services Card.
- AR Patient not registered for coverage on this date of service. Please check the effective and expiry dates on the Health Services Card.
- If the patient is a resident, he/she should immediately contact Health Registration, phone: 1-800-667-7551 or 787-3251, 11<sup>th</sup> Avenue, Regina, S4P 0J5, in order to have coverage updated. If resubmitting, please indicate the current address.

General

- AS Your account had to be split for processing. Payment for the listed services was approved based on the Ministry of Health Payment Schedule (additional cheques may be issued).
- AT A 2U, 4U, 12U, 15U, 16U, 22U, 31U, 34U, 35U, 36U, 37U, or 38U service code seems inappropriate for the diagnosis.
- AU To assist our Medical Consultants in the assessment of this service please resubmit a claim form with a letter indicating the reason for providing the service.
- AV This service is not insured
- AX A Medical Consultant has reviewed this claim. The circumstances described are not considered sufficient to warrant payment.
- AY Assessed by a Medical Consultant.
- AZ Please refer to correspondence.

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- BA Duplicate payment has been made, for a similar service provided on the same day, to the same optometrist.
- BB Possible duplication of a similar service has been paid to you or to another optometrist in your clinic. If no duplication, please resubmit with a note in the "Remarks" area, on the back of the claim form or a comment record in the automated claim submission.
- BC Duplicate -- same clinic -- payment has been made to another optometrist in your clinic for a similar service on the same day.
- BD The beneficiary has been paid, based on the claim previously submitted.
- BG Billed less than Listed Payment -- appropriate payment for the date of service has been approved.
- BK Payment based on the service code and related payment approved by MSB.
- BN You were asked for additional information to assess this claim, no reply received -- without this information, the claim cannot be processed.
- BO Service Code and/or Payment approved -- is based on your description of the service.
- BP Payment adjustment based on:  
(a) Your resubmission, or  
(b) Our review of assessment.
- BQ** The service code and/or amount submitted are incorrect. Please review and resubmit
- BR** Invalid service code -- please review.
- BW Billed more than Listed Payment -- appropriate payment for the date of service has been approved.
- BZ Payment is based on the amount payable to a Saskatchewan optometrist providing the same service.
- DD Please verify date(s) of service and resubmit
- FD** This service code is listed as a bilateral procedure. Therefore, only one (1) is payable per patient contact.
- JP This claim is being rejected because this service has been billed and paid to another provider of service.
- FM** Approved only with specified services as listed in the Payment Schedule.
- KQ Post-Operative Visit following major eye surgery is an inclusion within the payment to the surgeon in the same clinic.

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- SA 2U or 4U -- a previous examination was provided to this beneficiary by yourself or another optometrist or physician within the designated time span:
- 18-64 years - Minimum Time - 24 months  
All other ages - Minimum Time - 12 months
- If resubmitting, please indicate:
1. Previous and current refractive errors.
  2. Any medical factors necessitating current examination.
  3. Name of referring physician if patient referred.
- SB A 2U or 4U has been paid to you or another optometrist during the interval between the dates given on your claim for your previous and current eye examination.
- SD 12U is not approved when a 2U, 4U, 15U, 16U or 22U has been paid within the preceding 90 days unless indicated for an unrelated condition
- SE 21U is payable only:
1. With an insured 2U or 4U service and
  2. For a beneficiary 18 years of age or older.
- SF The maximum number of services has been exceeded for a 15U or 16U; a 15U or 16U cannot be provided within 30 days of a 2U, 4U, 12U or 22U.
- SG The factors indicated have been reviewed and are not considered sufficient to warrant payment of a second refraction within the designated time span.
- SH 31U is payable:
1. One service per 12-month period.
  2. All Saskatchewan beneficiaries, subject to assessment rules.
- SI 34U is only payable with an insured 15U or 16U service.
- SJ 22U – a previous examination was provided to this beneficiary by yourself/another optometrist/physician within the designated time span. All ages – Minimum Time – 12 months.
- SK 35U, 36U, 37U, 38U are payable only with an insured 22U service.
- SL 35U, 36U, 37U, 38U – approved only once within a period of 12 consecutive months for the same physician or clinic.

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SS Coverage for examination of the eyes is limited to those under the age of 18, Social Assistance recipients nominated to receive Supplementary Health benefits, recipients of Family Health Plan benefits and seniors receiving the Saskatchewan Income Plan supplement. According to our information, the patient is not eligible for coverage.

SX Insufficient information given to process your claim. Please resubmit with a more complete explanation of service(s) provided. If this was a post-surgical visit, indicate nature of surgery, date and name of surgeon.

Non-Insured Services

CA Examinations or services to provide certificates or reports requested by a third party are not insured, e.g., for:

Attendance at camps	Insurance
Employment	Judicial purposes
Employment insurance programs	Motor vehicle or other licenses (see 23U)
Participation in Sports	

CB The following are not insured:

Advice by telephone	Eye glasses (fitting, frames or lens)
Appliances (Prostheses)	Medication
Committee or advisory service	Secretarial or a reporting fee
Contractual service for a Testimony in court government department or agency	Travel by an optometrist

CE Non-Registered Provider of Service -- a service is not insured by MSB if it was provided by an optometrist or a graduate student who is not registered with or licensed by the appropriate agency of the province, state or country in which he practices

CF Date of Insurability -- not insured on the date it was provided.

CG Optometrist billing for his immediate Family -- a service is not insured when provided by an optometrist to himself or any member of his immediate family. Reference: Regulations under the Medical Care Insurance Act.

CH These services appear to be the responsibility of the Department of Veteran's Affairs (DVA). Please send the appropriate form to DVA, Treatment Benefit Unit, Box 6050, Winnipeg, Manitoba, R3C 4G5. If they do not accept responsibility, DVA will forward the claim to MSB.

CI The service provided cannot be paid for an out-of-province beneficiary; there is no reciprocal billing process for optometric claims

CM Claims received more than six months after the date of service. If factors beyond your control prevented submission within six months, please resubmit with an explanation.

A resubmitted claim must be returned within one month to MSB. The resubmitted claim must include the original claim number and the date of original submission. Reference: Medical Care Insurance Act, Section 14A and Related Regulations.

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- CN Claims received more than twelve months after the date of service cannot be accepted for any reason. Reference: Medical Care Insurance Act, Section 14A and Related Regulations.
- CS Department of Veterans' Affairs has advised MSB that they have paid you for this service.
- CT Workers' Compensation Board (WCB) has advised MSB that they have paid you for this service.
- CW These services appear to be the responsibility of WCB. Please submit a claim to the WCB at Suite 200 – 1881 Scarth Street, Regina, S4P 4L1. If they do not accept responsibility, WCB will forward the claim back to you. If the claim has not yet been paid, please submit a claim to MSB with a comment "Not WCB" followed by the date rejected by WCB.
- CZ Services in relation to the wearing or provision of contact lenses other than a routine eye refraction (2U, 4U) are not insured.

Incomplete or Incorrect Claims

- YA Patient's Name -- please clarify the full name
- YB Registration -- indicate the complete 9 digit Health Services Number.
- YC Date of Birth -- indicate the month and year of birth recorded on the Health Services Card.
- YD Family Head -- please indicate the full name and address.
- YF THE SIGNATURE BLOCK on this claim is completed differently than what you previously indicated to MSB.

The acceptable methods are:

1. Personal Signature
2. Impress a rubber stamp facsimile of the optometrist's signature
3. Impress a rubber stamp of the optometrist's name in capital letters.
4. Hand print the optometrist's name in capital letters.
5. Delegate a member of the staff to personally sign on the optometrist's behalf.

Prior to resubmission, please complete the signature block by either:

- a) your previously designated method of signing; or
- b) personal signature.

If you wish to change your previously designated method of signing claims, you must advise MSB in writing of the specific acceptable method you intend to use in the future.

- YI Clarification -- please clarify the item(s) circled on the claim or recheck the entire claim.
- YJ Diagnosis -- please clarify.
- YK Code and fee -- please indicate the service code and amount charged for each service.

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- YL Date of Service -- please indicate the proper day, month, and year.
- YP The clinic number is invalid for the submitted dates of service. Please review the clinic number and the dates of service.
- YR Please clarify the name and initials of the Optometrist who provided the service.
- YS Referring Physician -- we are unable to identify the indicated referring physician. The circled numeric indicates the information required:
1. the initials, or
  2. the surname and initials, or
  3. the location of his practice on the date of referral.
- ZA The patient identity information on the claim (month or year of birth, sex or surname) does not correspond to information on the Health Services Card. Please check the Health Services Card, make the claim corrections and resubmit
- ZC The submitted claim contains invalid data other than patient information data, e.g. September 31, a 13th month, a lower case alphabetic character, a partially blank field as HSN, a space in the birth date, the submitted fee at zero dollars, etc.
- ZD The dates of service or month of birth are invalid. The date of service may be greater than the date of computer processing. A claim cannot have two months of service.
- ZF The optometrist is not eligible to submit for services on the indicated date of service.
- ZH Please check the date of service on this claim because it conflicts with previously paid services. If you resubmit without changes, please indicate "Date of Service is Proper" on the comment record or in the remarks area of the claim form.
- ZL The submitted referring doctor number is invalid. Please check the referring doctor name and number.
- ZM The claim contains an invalid diagnostic code according to the International Classification of Diseases - 9th Revision. Please check the diagnosis, diagnostic code and table of invalid codes.
- ZN MSB has received multiple claims with the same clinic, doctor, claim and Health Services Number. One of the claims is being processed in the system; all other claims with the same claim number are being returned.
- ZP An invalid mode of payment has been used on this claim.
- ZS The claim was submitted as a Professional Corporation (PC) claim; however, no PC information has been received or the PC claim is not valid on this date.
- ZT Please refer to the comment record(s) being returned by MSB for a more detailed explanation.
- ZW The direct input claim cannot be processed. Please resubmit on a regular claim form.

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ZY The direct input claim cannot be processed. Please resubmit with comments or an explanation of the service provided. If a more detailed explanation is required, it should be submitted and attached to a regular claim form.