“Base” and “Add” Service Codes

Billing Information Sheet

Insured Services, Medical Services Branch

1.	TIPS FOR BILLING
a)	The Physician Payment Schedule outlines what is expected for each service code. **In order for an “add” code to be eligible for payment, it must be submitted with the required “base” code in the same claim (same claim number)**.
b)	**Do not submit an “add” service code on a separate claim (different claim numbers) as the “base” code, even if both are submitted in the same payment run.** *It may be necessary to contact your software vendor to assist you with entering your claims correctly in your system.*
c)	Any “add” service code submitted without the corresponding “base” code will be rejected with the following explanatory codes: **QE** – This service code must be billed in conjunction with a base code. Please review the Payment Schedule and code descriptor. Resubmit your amended claim in the next billing cycle. **FM** – Approved only with specified services as listed in the Payment Schedule.
2.	**EXAMPLES OF “BASE” AND “ADD” SERVICE CODES**
a)	**Counselling 40B/41B** Counselling is considered a “visit” service and consists of a ‘base code’ (40B) and ‘add’ code (41B). The 40B may be billed alone, but the add code 41B cannot be billed alone or with any other visit service. For example: • **5B + 41B on the same claim –** The 5B and 41B cannot be billed together. The 41B can only be billed in conjunction with a 40B. • **41B on its own –** The 41B is going to be rejected explanatory code **QE.**
b)	**Psychiatric Care – Patient not admitted to a hospital or health care centre** 110E -- minimum of 15 minutes 111E -- each subsequent 15 minutes or major part thereof to a maximum of 5, bill units **Correct Billing:** Claim No. 10001 – 110E and 111E **Incorrect Billing:** Claim No. 10001 – 111E Claim No. 10002 – 110E

c)	**Ophthalmology Add Codes** When submitting for ophthalmology cases where a service code (i.e. 535S / 651S / 579S) is dependent on submission with a specific code, please submit these codes on the same claim (same claim number) not on separate claims to avoid rejections or processing delays. **Correct Billings:** Patient A: Claim No. 10001 7S, follow-up assessment **34S, visual field screening** **651S, add to 34S** Patient B: Claim No. 10002 9S, Consultation 32S, Tension -- measured with a tonometer – bilateral **170S, Retinal tear -- complete treatment by diathermy, cryosurgery or laser** **181S, Laser Technical Components – add to 170S** Claim No. 10003 664S, Indirect ophthalmoscopy 653S, Fundus or Slit Lamp Photography, tech. 652S, Fundus or Slit Lamp Photography, prof. 582S, Optical Coherence Tomography (OCT), tech. 581S, Optical Coherence Tomography (OCT), prof. 580S, Corneal pachymetry **Incorrect Billings:** Patient A: Claim No. 10001 **651S, add to 34S** Claim No. 10002 7S, follow-up assessment **34S, visual field screening** Patient B: Claim No. 10003 664S, Indirect ophthalmoscopy 653S, Fundus or Slit Lamp Photography, tech. 652S, Fundus or Slit Lamp Photography, prof. 582S, Optical Coherence Tomography (OCT), tech. 581S, Optical Coherence Tomography (OCT), prof. 580S, Corneal pachymetry **181S, Laser Technical Components – add to 170S** Claim No. 10004 **170S, Retinal tear -- complete treatment by diathermy, cryosurgery or laser** 009S, Consultation 032S, Tension -- measured with a tonometer – bilateral