PAYMENT SCHEDULE

For Insured Services Provided by an Optometrist

February 1, 2022

		2021 Rate	2015 Rate
2U	**Routine examination of the eyes** a) case history; b) visual acuity; c) external examination; d) assessment of extraocular muscles; e) convergence testing; f) pupil response; g) accommodation; h) examination of cornea, lens, media, fundus; g) determination of refractive error or change; i) instruction, information, and advice to the patient with respect to the status of his vision and its future management j) provision of the necessary spectacle prescription Eligibility is limited to: - one service per 12-month period for beneficiaries under 18 years of age.	$60.00	$56.50
4U	**Repeat routine examination of the eyes** 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"). 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 under 18 years of age.	$60.00	$56.50

		2021 Rate	2015 Rate
12U	**Partial examination** **(other than assessment of Ocular Urgencies and Emergencies)** 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. A partial examination service is not a covered service when: a) routine examination of the eyes or annual examination for patients with diabetes as an insured service, was provided to the beneficiary within the preceding 90 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 b) it relates to the provision or wearing of contact lenses. Eligibility is limited to: - beneficiaries under 18 years of age.	$28.80	$27.70

		2021 Rate	2015 Rate
15U	**Initial Assessment of Ocular Urgencies and Emergencies** An examination of the eyes initiated by the patient or upon referral from another doctor for the following acute disorders of the anterior segment: 364 Anterior uveitis 372 Conjunctivitis 379 Episcleritis 373 Inflammatory/infectious disorders of the lids (i.e., blepharitis, chalazion, hordeolum, cysts) 375 Inflammatory/infectious disorders of lacrimal system (i.e.,epiphora, canaliculitis, dacryocystitis) 370 Keratitis 918 Ocular injury / foreign body 921 Ocular injury / foreign body 930 Ocular injury / foreign body 374 Other diseases of the eyelid 379 Other diseases of the eye 376 Preseptal Cellulitis 379 Scleritis 372 Subconjunctival hemorrhage 371 Symptomatic corneal dystrophies Initial Assessment of Ocular Urgencies and Emergencies, continued Includes: - pertinent family & patient history; - history of presenting complaint; - functional inquiry; - examination and assessment; - diagnosis - necessary treatment; and - advice to patient. <u>Eligibility:</u> All Saskatchewan beneficiaries, subject to assessment rules.	$49.20	$47.30

		2021 Rate	2015 Rate
16U	**Follow-up Assessment of Ocular Urgencies and Emergencies** Follow-up examination of the eyes as clinically required for the conditions noted under Initial Assessment of Ocular Urgencies and Emergencies Includes: – history review; – functional enquiry; – examination; – reassessment; – diagnosis; – patient record; – necessary treatment; and – advice to patient. Eligibility: All Saskatchewan beneficiaries, subject to assessment rules.	$34.75	$33.40
22U	**Annual eye examination for patients with diabetes** a) case history; b) visual acuity; c) external examination; d) assessment of extraocular muscles e) convergence testing; f) pupil response; g) accommodation; h) examination of cornea, lens, media, fundus; i) determination of refractive error or change; j) instruction, information, and advice to the patient with respect to the status of his vision and its future management k) provision of the necessary spectacle prescription Eligibility: All Saskatchewan beneficiaries, subject to assessment rules. Limited to one service per 12 month period.	$60.00	$56.50
23U	**Examination and Report of Visual Functions** Requested by SGI for the assessment of the patient's ability to operate a motor vehicle. This service is paid by Medical Services Branch (MSB) on an agency basis.	$42.45	$40.80

		2021 Rate	2015 Rate
31U	**Tonometry in conjunction with annual examination for patients with diabetes**	$15.30	$14.70
34U	**Tonometry in conjunction with assessment of Ocular Urgencies/ Emergencies**	$15.30	$14.70
35U	**Optical Coherence Tomography (OCT) – bilateral – professional fee** **In conjunction with annual examination for patients with diabetes** Not to be used for routine screening of patients and limit of one per year when billed for the management of diabetes.	$21.20	$20.40
36U	**Optical Coherence Tomography (OCT) – bilateral – technical fee** **In conjunction with annual examination for patients with diabetes** Not to be used for routine screening of patients and limit of one per year when billed for the management of diabetes.	$21.20	$20.40
37U	**Photography – bilateral – professional fee** **In conjunction with annual examination for patients with diabetes**	$6.35	$6.10
38U	**Photography – bilateral – technical fee** **In conjunction with annual examination for patients with diabetes**	$6.35	$6.10
40U	**40U Visual Field Testing (Screening or Threshold) for use in conjunction with 91U High Risk Medication Consultation** Billable for patients a) of any age, on hydroxychloroquine only. Eligibility is limited to: - one service per 12-month period for beneficiaries on hydroxychloroquine, when billed in conjunction with a 91U.	$31.80	--

		2021 Rate	2015 Rate
91U	**High Risk Medication Consultation** Eligibility is limited to: - beneficiaries currently taking hydroxychloroquine or pentosan polysulfate. **No age limit.** **Billable once in 365 days, including any eligible added services – refer to Assessment Rules.**	$49.20	--
92U	**Junior Idiopathic Arthritis Consultation** Eligibility is limited to: - beneficiaries under 18 years of age, with a diagnosis of JIA (ICD-9 714), when referred by a rheumatologist. Enter the referring physician's billing number in the 'referred from' field. **Billable once in 365 days, including any eligible added service – refer to Assessment Rules.** **Referral from OOP rheumatologist for Saskatchewan beneficiaries accepted – refer to Assessment Rules.**	$49.20	--
115U	**Cycloplegic Retinoscopy – bilateral – Under age 11** Eligibility is limited to: - beneficiaries under age 11 – refer to Assessment Rules. Standard Guidelines for indications for use of cycloplegia in children are as follows: ➢ Suspected latent hyperopia ➢ Amblyopia (one or both eyes has reduced vision and is not correctable to 20/20 acuity) ➢ Anisometropia (a significant difference in refractive error between the eyes) ➢ Suspected pseudomyopia ➢ Accommodation spasm ➢ Esotropia or esophoria ➢ Suspected malingering ➢ Variable and inconsistent endpoint refraction ➢ Uncooperative/non-communicative patients	$31.20	--

		2021 Rate	2015 Rate
116U	**Cycloplegic Retinoscopy – bilateral – Aged 11 to 17** Eligibility is limited to: - beneficiaries **aged 11 to 17, only in very limited circumstances, such as cognitive function or physical disability, comment required** – refer to Assessment rules. Standard Guidelines for indications for use of cycloplegia in children are as follows: • Suspected latent hyperopia • Amblyopia (one or both eyes has reduced vision and is not correctable to 20/20 acuity) • Anisometropia (a significant difference in refractive error between the eyes) • Suspected pseudomyopia • Accommodation spasm • Esotropia or esophoria • Suspected malingering • Variable and inconsistent endpoint refraction • Uncooperative/non-communicative patients	$31.20	--
131U	**Post Cataract Surgical Care – Initial Visit – Left Eye** Optometrists are to work in concert with ophthalmologists regarding patient sharing; the focus of these services is on rural and senior patients, but there are no limits on age or location. Billable only upon referral from ophthalmologist. Billable only with ICD-9 Code 366. Billable **once** per eye during the post-operative window of 1 day to 365 days.	$49.20	--
132U	**Post Cataract Surgical Care – Initial Visit – Right Eye** Optometrists are to work in concert with ophthalmologists regarding patient sharing; the focus of these services is on rural and senior patients, but there are no limits on age or location. Billable only upon referral from ophthalmologist. Billable only with ICD-9 Code 366. Billable **once** per eye during the post-operative window of 1 day to 365 days.	$49.20	--

		2021 Rate	2015 Rate
133U	**Post Cataract Surgical Care – Subsequent Visit – Left Eye** Billable only subsequent to a 131U. Billable twice per left eye during the post-operative window of 2 days to 365 days. Billable with OCT only in limited cases with retinal swelling, or macular edema, either cystoid or diabetic. Billable only by referral from ophthalmologist.	$34.75	--
134U	**Post Cataract Surgical Care – Subsequent Visit – Right Eye** Billable only subsequent to a 132U. Billable twice per right eye during the post-operative window of 2 days to 365 days. Billable with OCT only in limited cases with retinal swelling, or macular edema, either cystoid or diabetic. Billable only by referral from ophthalmologist.	$34.75	--
135U	**Optical Coherence Tomography (OCT) – Professional fee – bilateral** **In conjunction with Post Cataract Surgical Care – Initial Or Subsequent Visit** Not to be used for routine screening of patients and only eligible when billed in conjunction with Post Cataract Surgical Care Initial Visit 131U or 132U or Subsequent Visit 133U or 134U.	$21.20	--
136U	**Optical Coherence Tomography (OCT)– Technical fee – bilateral** **In conjunction with Post Cataract Surgical Care – Initial Visit or Subsequent Visit** Not to be used for routine screening of patients and only eligible when billed in conjunction with Post Cataract Surgical Care Initial Visit 131U or 132U or Subsequent Visit 133U or 134U.	$21.20	--
137U	**Tonometry – Bilateral** **In conjunction with Post Cataract Surgical Care – Initial or Subsequent Visit** Not to be used for routine screening of patients and only eligible when billed in conjunction with Post Cataract Surgical Care Initial Visit 131U or 132U or Subsequent Visit 133U or 134U.	$15.30	

		2021 Rate	2015 Rate
190U	**Optical Coherence Tomography (OCT) – Professional fee – bilateral** **In conjunction with High Risk Medication Consultation 91U** Not to be used for routine screening of patients and limit of one per 365 days when billed in conjunction with High Risk Medication Consultation.	$21.20	--
191U	**Optical Coherence Tomography (OCT) – Technical fee – bilateral** **In conjunction with High Risk Medication Consultation 91U** Not to be used for routine screening of patients and limit of one per 365 days when billed in conjunction with High Risk Medication Consultation.	$21.20	--
192U	**Tonometry – bilateral – In conjunction with Junior Idiopathic Arthritis Consultation 92U**	$15.30	--
810U	**Virtual Care – Optometrist Assessment of Ocular Urgencies and Emergencies via telephone or secure videoconference.** If an in-person follow-up is required for the same patient for the same condition within 7 days of the 810U, the in-person visit must be billed as a 16U.	$31.85	

SUPPLEMENTARY HEALTH INSURED SERVICES

THE FOLLOWING SERVICE CODES ARE FOR PATIENTS WHO RECEIVE SUPPLEMENTARY HEALTH, FAMILY HEALTH BENEFITS, OR SENIORS' INCOME PLAN BENEFITS ONLY

		2021 Rate	2015 Rate
2U	**Routine examination of the eyes**	$60.00	$56.50

a) case history;
b) visual acuity;
c) external examination;
d) assessment of extraocular muscles;
e) convergence testing;
f) pupil response;
g) accommodation;
h) examination of cornea, lens, media, fundus;
g) determination of refractive error or change;
i) instruction, information, and advice to the patient with respect to the status of his vision and its future management
j) provision of the necessary spectacle prescription

Eligibility is limited to:

- one service per 24-month period for **Supplementary Health, Family Health Benefits & Seniors' Income Plan** beneficiaries 18-64 years, and
- one service per 12-month period for **Supplementary Health, Family Health Benefits & Seniors' Income Plan** beneficiaries over 64 years of age .

4U	**Repeat routine examination of the eyes**	$60.00	$56.50

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"). 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:

- Supplementary Health, Family Health Benefits & Seniors' Income Plan beneficiaries over 17 years of age

		2021 Rate	2015 Rate
12U	**Partial examination** **(other than assessment of Ocular Urgencies and Emergencies)** 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. A partial examination service is not a covered service when: a) routine examination of the eyes or annual examination for patients with diabetes as an insured service, was provided to the beneficiary within the preceding 90 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 b) it relates to the provision or wearing of contact lenses. Eligibility is limited to: - Supplementary Health, Family Health Benefits & Seniors' Income Plan beneficiaries over 17 years of age.	$28.80	$27.70
21U	**Tonometry -** The measurement of eye tension with a tonometer. Eligibility is limited to: - Supplementary Health, Family Health Benefits & Seniors' Income Plan beneficiaries over 17 years of age.	$15.30	$14.70
40U	**40U Visual Field Testing (Screening or Threshold)** Billable for patients 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: - one service per 12-month period for beneficiaries under the age of 18, - one service per 24-month period for beneficiaries 18-64 years of age, and - one service per 12-month period for beneficiaries over 64 years of age.	$31.80	$30.60

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 12 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 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

3. **Method of Submission**

Claims may be submitted in electronic or paper format. A reduced rate of payment may be applied to claims submitted in paper format. The amount of such a reduction to paper claims will be determined by the Ministry of Health after consultation with the Association.

For assistance in establishing electronic claims submission, please contact MSB, Operations and Client Services Unit at 306-787-3473 or fax 306-787-3761.

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.

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.

When billed for Supplementary Health, Family Health Benefits and Seniors' Income Plan program patients, eligibility is limited to beneficiaries over 17 years of age.

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 age/time limit for 22U.

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 l0° 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

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

When billed for Supplementary Health, Family Health Benefits and Seniors' Income Plan program patients, eligibility is limited to beneficiaries over 17 years of age as follows:

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

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 or 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

   When billed for Supplementary Health, Family Health Benefits and Seniors' Income Plan program patients, eligibility is limited to beneficiaries over 17 years of age.

15U -- INITIAL ASSESSMENT OF OCULAR URGENCIES AND EMERGENCIES

1. Payable on a self-referred basis or on referral of the patient by a physician or public health nurse.

2. Where the patient is referred to a physician for further assessment or treatment, the name of the physician referred to must be included in the claim submission.

16U -- FOLLOW-UP ASSESSMENT OF OCULAR URGENCIES AND EMERGENCIES

1. Where the patient is referred to a physician for further assessment or treatment, the name of the physician referred to must be included in the claim submission.

21U **TONOMETRY** for Supplementary Health, Family Health Benefits & Seniors' Income Plan Programs patients only.
Eligibility is limited to beneficiaries over 17 years of age.

22U – ANNUAL EXAMINATION FOR PATIENTS WITH DIABETES *

1. An annual examination for patient with diabetes is a covered service when the Minister has not made a previous payment to any optometrist or physician for the same service to the same beneficiary within the eligibility time.

   Payable when billed for the management of diabetes and submitted with a diagnostic code of 250 (Diabetes Mellitus).

2. An annual examination for patients with diabetes is not a covered service where it is provided:
   a) within the post-operative period following major eye surgery by a physician or optometrist in the same clinic;

   b) at the request of a third party, eg. to complete a certificate or report;

   c) in respect of the provision of safety glasses for employment purposes.

31U – TONOMETRY IN CONJUNCTION WITH ANNUAL EXAMINATION FOR PATIENTS WITH DIABETES

1. Payable when billed for the management of diabetes and in conjunction with an insured 22U service and submitted with a diagnostic code of 250 (Diabetes Mellitus).

   Eligibility:
   All Saskatchewan beneficiaries, subject to assessment rules.
   Limited to one service per 12 month period.

34U – TONOMETRY IN CONJUNCTION WITH ASSESSMENT OF OCULAR URGENCIES/EMERGENCIES

1. Payable when billed in conjunction with an insured 15U (Initial Assessment of Ocular Urgencies/Emergencies) or 16U (Follow-Up Assessment of Ocular Urgencies/Emergencies).

   Eligibility:
   All Saskatchewan beneficiaries, subject to assessment rules.

35U – OPTICAL COHERENCE TOMOGRAPHY (OCT) – BILATERAL – PROFESSIONAL FEE

1. Payable when billed for the management of diabetes and in conjunction with an insured 22U service and submitted with a diagnostic code of 250 (Diabetes Mellitus).

   Eligibility:
   All Saskatchewan beneficiaries, subject to assessment rules.
   Limited to one service per 12 month period.

36U – OPTICAL COHERENCE TOMOGRAPHY (OCT) – BILATERAL – TECHNICAL FEE

1. Payable when billed for the management of diabetes and in conjunction with an insured 22U service and submitted with a diagnostic code of 250 (Diabetes Mellitus).

   Eligibility:
   All Saskatchewan beneficiaries, subject to assessment rules.
   Limited to one service per 12 month period.

37U – PHOTOGRAPHY – BILATERAL – PROFESSIONAL FEE

1. Payable when billed for the management of diabetes and in conjunction with an insured 22U service and submitted with a diagnostic code of 250 (Diabetes Mellitus).

   Eligibility:

   All Saskatchewan beneficiaries, subject to assessment rules.
   Limited to one service per 12 month period.

38U – PHOTOGRAPHY – BILATERAL – TECHNICAL FEE

1. Payable when billed for the management of diabetes and in conjunction with an insured 22U service and submitted with a diagnostic code of 250 (Diabetes Mellitus).

   Eligibility:

   All Saskatchewan beneficiaries, subject to assessment rules.
   Limited to one service per 12 month period.

40U VISUAL FIELD TESTING (SCREENING OR THRESHOLD)

1. Routine/baseline screening is not a benefit.
   Eligibility is limited to beneficiaries:

   a) with Supplementary Health Coverage,
   b) with Family Health Benefits Coverage,
   c) over 64 years of age with Seniors' Income Program, and
   d) of any age, regardless of coverage, on hydroxychloroquine.

   Eligibility is limited to:
   - one service per 12-month period for beneficiaries under the age of 18,
   - one service per 24-month period for beneficiaries 18-64 years of age,
   - one service per 12-month period for beneficiaries over 64 years of age, and
   - one service per 12-month period for all beneficiaries on hydroxychloroquine, when billed in conjunction with a 91U .

91U – HIGH RISK MEDICATION CONSULTATION

Eligibility is limited to:

- beneficiaries currently taking hydroxychloroquine or pentosan polysulfate.

A comment indicating which medication must accompany the claim; if the claim is missing the medication information or the medication is not on the approved list, service is not eligible for payment.

Additional services allowed when medically required:
Beneficiaries on hydroxychloroquine:

1. OCT professional and technical codes 190U and 191U
2. Visual Field Test 40U.

Beneficiaries on pentosan polysulfate):

1. OCT professional and technical codes 190U and 191U.

Referrals:
Beneficiaries on hydroxychloroquine:

- Referred from a GP or IM Specialist/Rheumatologist. Enter the physician's billing number in the 'referred from' field.

Beneficiaries on pentosan polysulfate:

- No referral required.

No age limit.

Billable once in 365 days, including any eligible added services.

92U – JUNIOR IDIOPATHIC ARTHRITIS CONSULTATION

Eligibility is limited to:

- beneficiaries under 18 years of age, with a diagnosis of JIA (ICD-9 714), when referred by a rheumatologist. Enter the referring Saskatchewan physician's billing number in the 'referred from' field. Out of province (OOP) beneficiaries must pay out of pocket.

Referrals from OOP rheumatologists for Saskatchewan beneficiaries accepted. Use the following billing number in the 'referred from' field:

OUT OF PROVINCE REFERRING DOCTOR NUMBERS

When the referring doctor is located outside Saskatchewan, please indicate the doctor's name and province on the comments record (max. 77 characters) and code the claim's referring doctor number to the appropriate province below.

Alberta	9908
British Columbia	9909
Manitoba	9907
Ontario	9906
Quebec	9905
Other Provinces	9900

Additional services allowed when medically required:

1. Tonometry in conjunction with JIA Consultation 192U.

Billable once in 365 days, including any eligible added service.

115U – CYCLOPLEGIC RETINOSCOPY – BILATERAL – UNDER AGE 11

Billable with a 2U, 4U, or 12U; current frequency limits apply.

Eligibility is limited to:

- beneficiaries under age 11.

Standard Guidelines for indications for use of cycloplegia in children are as follows:

- Suspected latent hyperopia
- Amblyopia (one or both eyes has reduced vision and is not correctable to 20/20 acuity)
- Anisometropia (a significant difference in refractive error between the eyes)
- Suspected pseudomyopia
- Accommodation spasm
- Esotropia or esophoria
- Suspected malingering
- Variable and inconsistent endpoint refraction
- Uncooperative/non-communicative patients

116U – CYCLOPLEGIC RETINOSCOPY – BILATERAL – AGED 11 TO 17

Billable with a 2U, 4U, or 12U; current frequency limits apply.
Eligibility is limited to:

- beneficiaries **aged 11 to 17, only in very limited circumstances, such as cognitive function or physical disability, comment required**. Comment must include:
  1. Cognitive Impairment, AND/OR
  2. Physical Impairment, AND
  3. Primary suspected condition or indication for cycloplegia listed below.

Standard Guidelines for indications for use of cycloplegia in children are as follows:

- Suspected latent hyperopia
- Amblyopia (one or both eyes has reduced vision and is not correctable to 20/20 acuity)
- Anisometropia (a significant difference in refractive error between the eyes)
- Suspected pseudomyopia
- Accommodation spasm
- Esotropia or esophoria
- Suspected malingering
- Variable and inconsistent endpoint refraction
- Uncooperative/non-communicative patients

131U – POST CATARACT SURGICAL CARE – INITIAL VISIT – LEFT EYE

Optometrists are to work in concert with ophthalmologists regarding patient sharing; the focus of these services is on rural and senior patients, but there are no limits on age or location.

Billable only upon referral from ophthalmologist. Enter the referring physician's billing number in the 'referred from' field.

Billable only with ICD-9 Code 366.

Billable once per eye during the post-operative window of **1 day to 365 days**.

132U POST CATARACT SURGICAL CARE – INITIAL VISIT – RIGHT EYE

Optometrists are to work in concert with ophthalmologists regarding patient sharing; the focus of these services is on rural and senior patients, but there are no limits on age or location.

Billable once per eye during the post-operative window of 1 day to 365 days.

Billable only upon referral from ophthalmologist; enter the referring physician's billing number in the 'referred from' field.

Billable only with ICD-9 Code 366.

133U – POST CATARACT SURGICAL CARE – SUBSEQUENT VISIT – LEFT EYE

Subsequent to a **131U**. Billable twice per left eye during the post-operative window of 2 days to 365 days.

Billable with OCT only in limited cases with retinal swelling, or macular edema, either cystoid or diabetic.

Billable only by referral from ophthalmologist; enter referring ophthalmologist's billing number in the "referred from" field.

Billable only with ICD-9 Code 366.

134U – POST CATARACT SURGICAL CARE – SUBSEQUENT VISIT – RIGHT EYE

Subsequent to a **132U**. Billable twice per right eye during the post-operative window of 2 days to 365 days.

Billable with OCT only in limited cases with retinal swelling, or macular edema, either cystoid or diabetic.

Billable only by referral from ophthalmologist; enter referring ophthalmologist's billing number in the "referred from" field.

Billable only with ICD-9 Code 366.

135U - OPTICAL COHERENCE TOMOGRAPHY (OCT) – PROFESSIONAL FEE - BILATERAL
In conjunction with Post Cataract Surgical Care Initial or Subsequent Visits

Not to be used for routine screening of patients.
Limit of three per eye in 365 days when billed in conjunction with Post Cataract Surgical Care Initial Visit **131U or 132U** or Subsequent Visit **133U or 134U**.
If both eyes have cataract surgery within 365 days, limit to 6 in 365 days from date of surgery.

136U – OPTICAL COHERENCE TOMOGRAPHY (OCT) – TECHNICAL FEE– BILATERAL
Billable only in conjunction with Post Cataract Surgical Care Initial or Subsequent Visit

Not to be used for routine screening of patients.
Limit of three per eye in 365 days when billed in conjunction with Post Cataract Surgical Care Initial Visit **131U or 132U** or Subsequent Visit **133U or 134U**.
If both eyes have cataract surgery within 365 days, limit to 6 per 365 days from date of surgery.

137U – TONOMETRY – BILATERAL – In conjunction with Post Cataract Surgical Care Initial or Subsequent Visits, codes 131U, 132U, 133U, or 134U

Not to be used for routine screening of patients.
Limit of three per eye in 365 days when billed in conjunction with Post Cataract Surgical Care Initial Visit **131U or 132U** or Subsequent Visit **133U or 134U.**

190U – OPTICAL COHERENCE TOMOGRAPHY (OCT) – PROFESSIONAL FEE – BILATERAL

Billable only in conjunction with High Risk Medication Consultation 91U. Not to be used for routine screening of patients.
Limit of one per 365 days when billed in conjunction with High Risk Medication Consultation.

191U – OPTICAL COHERENCE TOMOGRAPHY (OCT)– TECHNICAL FEE – BILATERAL

Billable only in conjunction with High Risk Medication Consultation 91U. Not to be used for routine screening of patients.
Limit of one per 365 days when billed in conjunction with High Risk Medication Consultation.

192U **TONOMETRY – BILATERAL – In conjunction with Junior Idiopathic Arthritis Consultation 92U**
Limited to beneficiaries under 18 years of age, with a diagnosis of JIA (ICD-9 714), when referred by a rheumatologist.
Limit of one per 365 days when billed in conjunction with JIA Consultation**.**

810U **Virtual Care – Optometrist Assessment of Ocular Urgencies and Emergencies via telephone or secure videoconference.**
If an in-person follow-up is required for the same patient for the same condition within 7 days of the 810U, the in-person visit must be billed as a 16U.

EXPLANATORY CODES

Patient Identification

A plastic "Health Services Card" for registered beneficiaries is sent every third year, expiring December 31, 2023 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 306-787-3251, 2130 11th 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, the Ministry of Health.

Residents who are members of the Canadian Forces and 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.

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 them to immediately contact Health Registration at 1-800-667-7551 or 306-787-3251 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 their 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, 2130 11th 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 306-787-3251 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, they should immediately contact Health Registration, phone: 1-800-667-7551 or 306-787-3251, 2130 11th Avenue, Regina, S4P 0J5, in order to have their 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 the Ministry of Health Payment Schedule (additional cheques may be issued).

AT Diagnosis and Payment Schedule item are not compatible.

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
1. Please refer to correspondence sent to the optometrist or clinic. If you have questions, please contact Physician Claims Inquiries; or
2. This code may have been rejected as a procedure that is “normally only provided once” (ie: total bilateral thyroidectomy) or only repeated after a reasonable interval (ie: delivery), please verify your service code with report if applicable.

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.

BP The service code and/or amount submitted are incorrect. Please review and resubmit

BQ Invalid service code -- please review.

BR Billed more than Listed Payment -- appropriate payment for the date of service has been approved.

BT Approved at the maximum amount consistent with your description of the service provided.

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.

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. For beneficiaries 18 years of age or older, with an insured 2U or 4U service and
2. For a Supplementary Health, Family Health Benefits & Seniors' Income Plan Programs beneficiary 17 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 period only:
1. One service per 12 month period; and
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.

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

CB The following are not insured:

Advice by telephone
Appliances (Prostheses)
Committee or advisory service
Contractual service for a government department or agency
Eye glasses (fitting, frames or lens)
Medication
Secretarial or a reporting fee
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.

CN Claims received more than 12 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.

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.

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.