

INSURED SERVICES TARIFF

APPROVED BY THE MINISTER OF HEALTH AND SOCIAL SERVICES


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Preamble to the Insured Services Tariff for Physicians

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A Purpose and Structure of the Preamble

A.1 The preamble to the Insured Services Tariff for Physician Services (the “Schedule”) assists medical practitioners in the Northwest Territories in submitting appropriate claims for the provision of insured medical services. The preamble provides the billing rules under which the services are claimed; these rules are a roadmap designed to clarify the use of the Schedule.

A.2 In some instances, a specialty-specific preamble is also provided (see Section G); if there is an inadvertent conflict between a specialty-specific preamble and any other section of the Schedule, the interpretation of the specialty-specific preamble shall prevail.

A.3 The preamble is divided into six interdependent sections:

- B Introduction to the Preamble
- C Administrative Items
- D Definitions
- E Types of Services
- F Premiums
- G Specialty-Specific Preambles

A.4 Two appendices further support the Schedule:

- H New Service Item Committee
- I Updating and Maintenance of the Schedule

B Introduction to the Preamble

- B.1** All benefits listed in the Schedule, except where specific exceptions are identified, must include the following as part of the service being claimed; payment for these inherent components is included in the listed fees:
- a. Direct face-to-face encounter with the patient by the medical practitioner, appropriate physical examination when pertinent to the service and ongoing monitoring of the patient's condition during the encounter, where indicated. (For exceptions to this rule, refer to Section E.2, Telehealth Services).
 - b. Any inquiry of the patient or other source, including review of available medical records, necessary to arrive at an opinion as to the nature and history of the patient's condition.
 - c. Appropriate care for the patient's condition, as specifically listed in the Schedule for the service and as traditionally and historically expected for the service rendered.
 - d. Arranging for any related assessments, procedures, and therapy as may be appropriate, and interpreting the results, except where separate listings are applicable to these services.
 - e. Arranging for any follow-up care that may be appropriate.
 - f. Discussion with and providing advice and information to the patient or the patient's representative(s) regarding the patient's condition and recommended therapy, including advice as to the results of any related assessments, procedures and/or therapy which may have been arranged. No additional claims may be made for such advice and discussion, or for the provision of prescriptions and/or laboratory requisitions, unless the patient's medical condition indicates that the patient should be seen and assessed again by the medical practitioner in order to receive such advice.
 - g. Making and maintaining an adequate medical record of the encounter that supports appropriately the service being claimed. A service for which an adequate medical record has not been recorded and retained is considered not to be complete and is not a benefit.

- B.2** Where a benefit in the Schedule is stated to be payable by **assessment**, the value of that benefit will be assessed by the Director of Medical Care Services with consideration of what is fair and equitable in the clinical circumstances.
- B.3** It is not possible to interpret accurately the fee service codes or to submit appropriate claims using those codes without an understanding of the Preamble.

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C Administrative Items

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C.1 Fees Payable by the Schedule

- a. A payment schedule for insured medical services provided by medical practitioners is established under the *Act* and is referenced in master agreements between the Government of the Northwest Territories (GNWT) and the Northwest Territories Medical Association (NWTMA). Benefits payable under the *Act* are limited to services which are medically required for the diagnosis and/or treatment of a patient, which are not excluded by legislation or regulation, and which are rendered personally by medical practitioners or by others delegated to perform them if compliant with the policies of the Department of Health and Social Services (DHSS) on delegated services.
- b. Services requested or required by a third party for other than medical requirements are not insured or payable under the *Act*. Services, such as consultations, laboratory investigations, anaesthesia, and surgical assistance, rendered solely in association with other services which are not benefits also are not considered benefits of the Schedule, except in special circumstances as approved by the Minister of Health and Social Services.

C.2 Setting and Modification of Fees

- a. Additions, deletions, fee changes, or other modifications to the Schedule are the responsibility of the DHSS, with due consideration of consultation with the NWTMA and the recommendation(s) of the New Service Item Committee (NSIC).
- b. The structure, mandate, and processes of the NSIC are provided as an appendix, namely Section G, to this preamble.
- c. The processes of the updating and maintenance of the Schedule are provided as an appendix, namely Section H, to this preamble.

C.3 Services Not Listed in the Schedule

Services not listed in the Schedule must not be billed to the DHSS under other listings. Medical practitioners who wish to have modifications to the Schedule should submit their proposals to the NWTMA for subsequent consideration by the NSIC and the DHSS. Interim listings may be designated by the DHSS for new procedures or other services for a limited period of time to allow definitive listings to be established, if appropriate.

C.4 Exceptional Circumstances

When a medical practitioner satisfies the Director by means of supporting evidence, that a procedure has involved unusual complications or has required the exercise of an unusual degree of skill, care, responsibility, or an unusual amount of time, the Director may allow a benefit greater than the benefit approved in the Schedule.

C.5 Insured Services Rendered Outside of Canada

Subject to the provisions of *Exceptional Circumstances*, the benefits payable in respect of insured services shall not exceed the benefits listed in the Schedule

for services rendered within the Northwest Territories. The Director may pay benefits in respect of insured services rendered outside of Canada, where:

- a. The insured and required medical treatment is not available within Canada and the patient has been referred to a medical practitioner outside of Canada with the prior approval of the Director, or
- b. In the opinion of the Director, circumstances exist which warrant medical treatment outside of Canada. This may include personal reimbursement for insured services received while on vacation; such personal reimbursement is limited to the value indicated in the Schedule. That notwithstanding, the benefits payable under these circumstances, as authorized by the Director, may exceed the benefits prescribed in the Schedule.

C.6 Reciprocal Claims

All provinces, and territories, except Quebec, have entered an agreement to pay for insured services provided to residents of other provinces when a patient presents with a valid provincial health registration card. However, the services listed below are exempt from this agreement and should be billed directly to the non-resident patient.

Medical practitioner services excluded under the inter-provincial agreements for the reciprocal processing of out-of-province medical claims are, as follows:

- a. Surgery for alteration of appearance (cosmetic surgery)
- b. Gender-reassignment surgery
- c. Surgery for reversal of sterilization
- d. Therapeutic abortions
- e. Routine periodic health examinations including routine eye examinations
- f. In-vitro fertilization, artificial insemination
- g. Acupuncture, acupressure, transcutaneous electro-nerve stimulation (TENS), moxibustion, biofeedback, hypnotherapy

- h. Services to persons covered by other agencies: RCMP, Armed Forces, Workers' Compensation Board, Department of Veterans Affairs, Correctional Services of Canada (Federal Penitentiaries)
- i. Services requested by a "Third Party"
- j. Team conference(s)
- k. Genetic screening and other genetic investigation, including DNA probes
- l. Procedures still in the experimental/developmental phase
- m. Anaesthetic services and surgical assistant services associated with all of the foregoing.

The services on this list may or may not be reimbursed by the home province. The patient should make enquires of that home province after direct payment to the Northwest Territories medical practitioner.

C.7 Medical Travel for Insured Services Outside of Northwest Territories

- a. The Director may pay benefits for medical travel in respect of insured services rendered in Canada but outside of Northwest Territories, where the insured and required medical treatment is not available within Northwest Territories and the patient has been referred to a medical practitioner outside of Northwest Territories with the prior approval of the Director or, in the opinion of the Director, circumstances exist which warrant medical treatment outside of Northwest Territories.
- b. For clarity, benefits for medical travel will be paid according to the GNWT policy on medical travel and with the explicit authorization of the Director.

C.8 Adequate Medical Records of an Insured Benefit

A medical record of a benefit in the Schedule is considered adequate when it contains all information which may be designated or implied in the Schedule for the service, and when another medical practitioner of the same specialty, who is unfamiliar with both the patient and the attending medical practitioner, would be

able to readily determine the following from that record and/or the patient's medical records from previous encounters:

- a. Date and location of the service
- b. Identification of the patient and the attending medical practitioner
- c. Presenting complaint(s) and presenting symptoms and signs, including their history
- d. All pertinent previous history including pertinent family history
- e. The relevant results, both negative and positive, of a systematic enquiry pertinent to the patient's problem(s)
- f. Identification of the extent of the physical examination including pertinent positive and negative findings
- g. Results of any investigations carried out during the encounter
- h. Summation of the problem and plan of management

C.9 Uninsured Medical Services

Benefits shall not be paid for:

- a. Medical-legal services, including:
 - i. Examinations performed at the request of third parties in connection with legal proceedings
 - ii. The giving of evidence by a medical practitioner in legal proceedings, or
 - iii. The preparation of reports or other documents relating to the results of a medical practitioner's examination for use in legal proceedings or otherwise and whether requested by the medical practitioner's patient or by a third party
- b. Examinations required for the use of third parties including examinations required for:
 - i. Drivers' licenses

- ii. Pre-school or university
 - iii. Attendance at a camp
 - iv. Employment requirements
- c. Services not medically required including, but not limited to, the completion of sick leave forms
- d. Group immunization
- e. In vitro-fertilization
- f. Services provided by a medical practitioner to his or her own family
- g. Telephone advice or prescriptions given over the telephone
- h. Surgery for cosmetic purposes except where medically required
- i. Dental services other than oral surgery as set out in the approved tariff
- j. Dressings, drugs, vaccines, biologicals and related materials, eyeglasses and special appliances, plaster, surgical appliances or special bandages
- k. Treatments rendered in the course of chiropractics, physiotherapy, podiatry or any other practice ordinarily carried on by persons who are not medical practitioners
- l. Optometry services
- m. Mileage charges
- n. Laboratory or x-ray services performed in a facility not approved by the Director
- o. Services that a person is eligible to receive under
 - i. A statute of any other province or territory
 - ii. Any law of a jurisdiction outside the Territories relating to workers' compensation, and
 - iii. Any statute of the Parliament of Canada
- p. Routine annual check-up where there is no definable diagnosis, except where a patient has attained 65 years of age or is less than 10 years of age
- q. Services not provided by or under the supervision of a medical practitioner

C.10 Specialist Benefits

- a. Only those medical practitioners who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada may claim specialist benefits for assessments.

- b. Specialist benefits for procedures may be claimed by those medical practitioners who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada and by other medical practitioners who perform specialist procedures as General Practitioners granted credentials by a health authority or hospital to perform such procedures.
- c. Specialists who have received a specialist certificate recognized by a College of Physicians and Surgeons in Canada may claim for procedures other than those generally accepted as within the scope of their specialty training, when granted credentials by a health authority or hospital to perform such procedures.

C.11 Inclusive Services and Fees

Some services listed in the Schedule have fees that are specifically intended to cover multiple services over extended time periods. Examples include most surgical procedures, critical care per diem listings, and some obstetrical listings. The preambles and Schedule are explicit where these intentions occur.

C.12 Medical Research

Costs of medical services (such as examinations by medical practitioners, laboratory procedures, other diagnostic procedures) that are provided solely for the purposes of research or experimentation are not the responsibility of the patient or DHSS. However, it is recognized that medical research may involve what is generally considered to be accepted therapies or procedures, and the fact that a therapy or procedure is performed as part of a research study or protocol does not preclude it from being an insured service. In the situation where therapies or procedures are part of a research study, only those reasonable costs customarily related to routine and accepted care of a patient's problem will be considered insurable; additional services carried out specifically for the purposes of the research are not the responsibility of DHSS.

C.13 Experimental Medicine

- a. Costs of medical services that are provided for the purpose of what is considered to be experimental medicine are not the responsibility of the patient or DHSS.
- b. New procedures and therapies not performed elsewhere and which involve a radical departure from the customary approaches to a medical problem, are considered to be experimental medicine. Services related to such experimental medicine are not chargeable to DHSS.
- c. New therapies and procedures which have been described elsewhere may or may not be deemed by the Director of Medical Insurance to be experimental medicine for the purposes of determining eligibility for payment by DHSS.
- d. Where such a new therapy or procedure is being introduced into Northwest Territories and the medical practitioners performing the new therapy or procedure wish to have a new fee item inserted in to the fee schedule to cover the new therapy or procedure, the process describing the New Service Item Committee (See Appendix G) must be followed.
- e. When a new therapy or procedure is being performed outside Northwest Territories, a patient or patient advocate may request that the services associated with this new therapy or procedure be considered insured services by DHSS. The Director of Medical Insurance, utilizing information obtained from various sources, such as medical practitioners, the NWTMA, or evidence-based research, will review the situation. If it is determined that the new therapy or procedure is experimental, then the cost of medical services provided for this type of medical care will not be the responsibility of DHSS. If it is considered that the therapy or procedure is not experimental, the cost of medical services associated with this treatment will be evaluated by the DHSS to determine if it is an insured service in the Northwest Territories.

- f. If procedures are accepted as no longer being experimental, they may be considered as an insured benefit in the Schedule on an interim basis and will be reviewed again within five years.

C.14 Services to Family and Household Members

- a. Services are not benefits of the Schedule if a medical practitioner provides them to the following members of the medical practitioner's family:
 - i. a spouse,
 - ii. a son or daughter,
 - iii. a step-son or step-daughter,
 - iv. a parent or step-parent,
 - v. a mother-in-law or a father-in-law,
 - vi. a grandparent,
 - vii. a grandchild, or
 - viii. a brother or sister
- b. Services are not benefits of the Schedule if a medical practitioner provides them to a member of the same household as the medical practitioner.

D Definitions

Please note that definitions of specific types of medical assessments and services are provided in the corresponding section of the Preamble.

Act

Medical Care Act

age categories

Premature baby – 2,500 grams or less at birth

Newborn or Neonate – from birth up to, and including, 28 days of age

Infant – from 29 days up to, and including, 12 months of age

Child – from 1 year up to, and including, 15 years of age

antenatal care

Pregnancy-related visits from the time of confirmation of pregnancy to delivery

(same as prenatal)

dental surgeon

A person lawfully entitled to practise operative dentistry

DHSS

Department of Health and Social Services of the Government of the Northwest Territories

emergency department physician

Either a medical practitioner who is a specialist in emergency medicine or a medical practitioner who is physically and continuously present in the Emergency Department or its environs for a scheduled, designated period of time

For purposes of providing consultation services upon referral from a physician not providing services in the same Emergency Department, the

emergency department physician is recognized as FRCP (EM), CCFP (EM), or ABEM

holiday

The list of dates designated as statutory holidays will be issued annually by the DHSS and will reflect those dates identified in the Human Resource Manual under section 813.5

home

Patient's place of residence, including a multiple resident dwelling or single location that shares a common external building entrance, other than a hospital or long-term care institution

independent consideration

A process for assessing the value of services where a value is not listed in the *Insured Service Tariff*

intensive care unit

Special areas recognized and funded by the DHSS to provide high intensity care

medical advisor

A licensed physician designated as the medical advisor by the DHSS

office

The location where a physician is practising his or her profession, whether in a physician's home, in a hospital, in an institution, or in other facilities or buildings

palliative care

Care provided to a terminally ill patient during the final year of life, where a decision has been made that there will be no aggressive treatment of the underlying disease, and care is directed to maintaining the comfort of the patient until death occurs

participating province

A province or territory in which there is a health care insurance plan in respect of which a contribution is payable under the *Canada Health Act*

postnatal care

A single visit performed approximately 6 weeks following delivery for the purpose of assessment and advice to the mother

postpartum care

Inpatient hospital visits to the mother following delivery

premium

A fee that may be claimed by a physician in addition to the fee for an insured medical service, outlined in the tariff, and in situations described in Section F of the preamble

prenatal care

See antenatal care

professional fee

A fee able to be claimed by a registered medical practitioner for providing an insured medical service, other than an identified and insured technical fee that supports the equipment used for that service

referral

A request from one practitioner to another practitioner to render a service with respect to a specific patient; typically the service is one or more of a consultation, a laboratory procedure, or other diagnostic test, or specific surgical or medical treatment

specialist

A medical practitioner who is a certificant or a fellow of the Royal College of Physicians and Surgeons of Canada, and is licensed to practice in the Northwest Territories as a specialist

technical fee

A fee able to be claimed in support of equipment used to provide an insured medical service for which a professional fee can be billed

third party

A person or organization other than the patient, his/her agent, or MSP that is requesting and/or assuming financial responsibility for a medical or medically related service

transferral

The transfer of responsibility from one medical practitioner to another for the care of patient, temporarily or permanently

This is distinguished from a referral, and normally does not provide the basis for billing a consultation; the exception is that, when the complexity or severity of illness necessitates that accepting the transferral requires an initial chart review and physical examination, a limited or full consultation may be medically necessary and is requested by the transferring medical practitioner

time categories

12-month period – any period of twelve consecutive months

Calendar year – the period from January 1 to December 31

Day – a calendar day

Fiscal year – from April 1 of one year to March 31 of the following year

Month – a calendar month

Week – any period of 7 consecutive days

uninsured service

A service that is not prescribed as insured by the DHSS

visit

A service rendered by a medical practitioner to a patient for diagnosis or treatment or both in the office, home, hospital, or elsewhere

E Types of Services

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E.1 Introduction

- a. Where services are provided to the same patient by the same medical practitioner, or by another medical practitioner within the same clinic, major first visit benefits, including consultation benefits, shall not be paid more frequently than once in each six months.
- b. The 6-month limitation does not apply to a major consultation by a specialist in Internal Medicine if that consultation is for a referred service that differs from the previous consultation.
- c. A consultation for a referred medical service may be claimed on the same day as a procedure in an office, clinic, or hospital, performed subsequent to that consultation.
- d. When a patient is seen by a medical practitioner for the sole purpose of receiving

- an injection or undergoing a procedure for which the benefit is less than that approved for a visit, the visit benefit shall not be paid.
- e. Claims for special visits to an Emergency or Outpatient Department must indicate the actual time the patient was seen by the medical practitioner in the outpatient department.

E.2 Telehealth and Teleconference Services

- a. “Telehealth Services” are defined as a medical practitioner delivering a health service provided to a patient at a Health Authority approved, publicly funded telehealth program, and live image transmission of those images to a receiving medical practitioner at another approved site, through the use of video technology.
- b. “Video technology” means the recording, reproducing, and broadcasting of live visual images utilizing a direct interactive video link with a patient. In order for payment to be made, the patient must be in attendance at the sending site at the time of the video capture. Only those services that are designated as telehealth services may be claimed; other services/procedures require face-to-face encounters.
- c. Telehealth services are payable only when patients are informed and are provided opportunity to agree to services rendered using this modality.
- d. “Telehealth examination” means an examination of a patient by the consultant at the receiving site using “telehealth services” as defined above.
- e. In those cases where a specialist service requires a general practitioner at the patient’s site to assist with the essential physical assessment, without which the specialist service would be ineffective, the specialist must indicate the requirement in the medical record.
- f. Where a receiving medical practitioner, after having provided a telehealth consultation service to a patient, decides s/he must examine the patient in

- person, the medical practitioner should claim the subsequent visit as a limited consultation, unless more than 6 months has passed since the telehealth consultation.
- g. Where a telehealth service is interrupted for technical failure, and is not able to be resumed within a reasonable period of time, and therefore is unable to be completed, the receiving medical practitioner should submit a claim under the appropriate miscellaneous code for independent consideration with appropriate substantiating information.
 - h. Video technology services are generally payable once per patient/per day/per medical practitioner. Information regarding the medical necessity and times of additional services should accompany related claims.
 - i. Teleconference services may originate from a nurse practitioner, home care nurse, public health nurse, or midwife in a community health centre with no resident physician and directed to a medical practitioner, or from a physician in a community health centre outside of Yellowknife and directed to a specialist.

E.3 Electrocardiography

Interpretation of an electrocardiogram may be claimed only by medical practitioners who have been accredited by a College of Physicians and Surgeons in Canada to provide such services.

E.4 Consultation

- a. A consultation applies when a medical practitioner, or a health care practitioner (midwife, for obstetrical or neonatal related consultations; nurse practitioner; optometrist, for ophthalmology consultations; oral/dental surgeon, for diseases of mastication; community nurse), in the light of his/her professional knowledge of the patient and because of the complexity, obscurity, or seriousness of the case, requests the opinion of a medical practitioner competent to give advice in this field.

- b. The referring physician is expected to provide the consulting physician with a letter of referral that includes the reason for the request and the relevant background information on the patient.
- c. The service includes the initial services of a consultant necessary to enable the consultant to prepare and render a written report, including his/her findings, opinions, and recommendations, to the referring practitioner. A consultation must not be claimed unless the attending practitioner specifically requested it and unless the written report is rendered. It is expected that a written report will be generated by the medical practitioner providing the consultation within 2 weeks of the date-of-service. In exceptional circumstances, when beyond the consultant's control, a delay of up to 4 weeks is acceptable.
- d. When a consultation is followed by a procedure performed by the consultant, a benefit shall be paid for both the consultation and the procedure.
- e. A benefit for continuing care shall be paid to a consultant following a consultation where the continuing care is provided by the consultant at the request of the referring medical practitioner.
- f. Where the benefits for continuing care by a consultant are applicable, a benefit for insured services provided by the referring medical practitioner after the consultation shall only be paid to the referring medical practitioner after the full responsibility for the care of the patient has been returned to the referring medical practitioner, unless the complexity of the clinical needs of the patient require the services of the referring medical practitioner in addition to those of the consultant.
- g. A consultation for the same diagnosis is not normally payable as a full consultation unless an interval of at least six months has passed since the consultant has last billed any visit for the patient; a **limited consultation** may be payable within the six month interval, if medically necessary.

- h. A **minor** or **repeat consultation** requires all of the components expected of a full consultation for that specialty but is less demanding and normally requires substantially less of the medical practitioner's time than a full consultation.
- i. It is expected that a minor or repeat consultation, when medically necessary, will be billed as part of continuing care, and that a full consultation is not billed simply because of the passage of time.
- j. A new and unrelated diagnosis can be billed as a full consultation without regard to the passage of time since the consultant has last billed any visit for the patient.
- k. Once a consultation has been rendered and the written report submitted to the referring practitioner, this aspect of the care of the patient normally is returned to the referring practitioner; however, if by mutual agreement between the consultant and the referring practitioner, the complexities of the case are felt to be such that its management should remain for a time in the hands of the consultant, the consultant should claim for continuing care according to the Schedule pertaining to the specialty.
- l. Where the care of this aspect of the case has been transferred, except for a patient in hospital, the referring practitioner generally should not charge for this aspect of the patient's care unless and until the full responsibility is returned to him/her; for hospitalized patients, supportive care may apply.
- m. Continuing care by a specialist, following consultation, normally is paid at the specialist rates; however, continuing care requires that a written update of the patient's condition and care be appropriately reported to the referring practitioner at least every six months, until the responsibility for this aspect of the patient's care is returned to the referring practitioner.

E.5 Counseling

- a. Counseling is defined as the discussion with the patient, caregiver, spouse, or relative about a medical condition which is recognized as difficult by the medical

- profession or over which the patient is having significant emotional distress, including the management of malignant disease. Counseling, to be claimed as such, must not be delegated and must last at least 20 minutes.
- b. Counseling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the counseling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counseling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns. Nor are the counseling codes generally applicable to the explanation of the results of diagnostic tests. A counseling service cannot be claimed for a time in excess of 90 minutes.
 - c. Group counseling fee items apply only when two or more patients are provided counseling in a group session lasting 60 minutes or more, but not greater than 90 minutes. The group counseling fee items are not applicable when there is a discussion with the patient in the presence of a caregiver, spouse, or relative when the patient is the only person requiring medical care. In those situations, only the applicable individual counseling fee item could be billed, using that patient's personal health number.
 - d. Group counseling fee items are not billable for each person in the group. Claims should be submitted under the name of only one of the beneficiaries, with the names of the other patients attending the session listed in the note record. Times should be included with billings for group counseling fee items.
 - e. A claim for greater than 90 minutes counseling in any single session or day requires assessment by the medical advisor.
 - f. Claims for counseling to non-psychiatric patients and in excess of 5 sessions annually require assessment by the medical advisor.

E.6 Referral and Transferral

- a. A **referral** is defined as a request from one practitioner to another practitioner to render a service with respect to a specific patient. Such service usually would be a consultation, a laboratory procedure or other diagnostic test, or specific surgical or medical treatment.
- b. When the medical practitioner to whom a patient has been referred makes further referrals to other medical practitioners, it is the usual practice that the original referring medical practitioner be informed of these further referrals.
- c. A **transferral**, as distinguished from a referral, involves the transfer of responsibility for the care of the patient temporarily or permanently. Thus, when one medical practitioner is going off call or leaving on holidays and is unable to continue to treat his/her cases, medical practitioners who are substituting for that medical practitioner should consider that the patients have been temporarily transferred (not referred) to their care.
- d. The medical practitioner to whom a patient has been transferred normally should **not** bill a consultation for that patient. However, when the complexity or severity of the illness requires that the medical practitioner accepting the transfer reviews the records of the patient and examines the patient, a limited or full consultation may be billed when specifically requested by the transferring medical practitioner.

E.7 House Visits

- a. A house visit is considered necessary and may be billed only when the patient cannot practically attend a medical practitioner and the patient's complaint indicates a serious or potentially serious medical problem that requires a medical practitioner's attendance in order to determine appropriate management.
- b. If a house visit is determined to be necessary and is initiated by the patient during the medical practitioner's regular office hours, the house visit should be billed as a home visit irrespective of when the service is rendered. Service

charges do not apply to pre-booked house visits rendered after regular office hours.

- c. The necessity and detail and the time of the visit should be documented in the patient's clinical record

E.8 Hospital Care

- a. Where an outpatient visit results in the admission of a patient to a hospital the maximum benefit paid is that of a first visit when not seen in house or office.
- b. An in-hospital admission examination may be claimed when a patient is admitted to an acute care hospital for medical care rendered by a general practitioner. The service also may be applicable when a medical practitioner is required to perform an admission examination prior to a hospital service being delivered by a health care practitioner (e.g., a dental surgeon). The hospital admission examination listing is not applicable when a patient has been admitted for surgery or when a patient is admitted for care rendered by a specialist. This service is applicable only once per patient per hospitalization and is in lieu of a "hospital visit" on the day it is rendered. This service includes all of the components of a complete examination.
- c. A subsequent hospital visit is the routine monitoring and/or examination(s) that are medically required following a patient's admission to an acute care hospital. Payments for subsequent hospital visits are usually limited to one per patient per day for a period up to 30 days; however, it is not the intent of the Schedule that subsequent visit fees be claimed for every day a patient is in hospital unless the visits are medically required and unless a medical practitioner visits the patient each day.
- d. If it is medically required for a patient to be visited more than once per day at any time, or daily beyond the initial 30-day period, an explanation should be submitted with the claim and consideration will be given.

- e. If a surgeon who is not resident in the Northwest Territories provides surgical services in the Northwest Territories and is unable to render the usual post-operative care, the medical practitioner who performs the post-operative services for the patient may claim for necessary hospital visits.
- f. For those medical cases where the medical indications are of such complexity that the concurrent services of more than one medical practitioner are required for the adequate care of a patient, subsequent visits should be claimed as **concurrent care** by each medical practitioner, as required for that care.
- g. Where a case has been referred and the referring medical practitioner no longer is in charge of the patient's care, but for which continued liaison with the family and/or reassurance of the patient is necessary while the patient is hospitalized, **supportive care** may be claimed by the referring medical practitioner. Payments for supportive care are limited to one visit for every day of hospitalization for the first ten days and, thereafter, one supportive care visit for every seven days of hospitalization.
- h. **Newborn care in hospital** is the routine care of a well baby up to 10 days of age and includes an initial complete assessment and examination and all subsequent visits as may be appropriate, including instructions to the parent(s) and/or the patient's representative(s) regarding health care. Newborn well baby care in hospital normally is not payable to more than one medical practitioner for the same patient; however, when a well baby is transferred to another hospital, because of the mother's state of health, separate claims for newborn care when rendered by a different medical practitioner at each hospital may be made.
- i. When visits are required to patients in long-term-care institutions, such as nursing homes, intermediate care facilities, extended care units, rehabilitation facilities, chronic care facilities, convalescent care facilities and personal care facilities, whether or not any of these facilities are situated on the campus of an acute care facility, claims may be made to a maximum of one visit every two weeks. It is not sufficient, however, for the medical practitioner simply to review the patient's chart. A face-to-face patient/medical practitioner encounter must be made. For acute concurrent illnesses or exacerbation of original illness requiring

institutional visits beyond the foregoing limitations, additional institutional visits may be claimed with accompanying written explanation.

E.9 Designated Procedures

- a. When a patient enters a hospital and undergoes a procedure for which no booking was made in advance, and where the procedure is indicated in the Insured Services Tariff with the notation "+", benefits shall be paid for:
 - i. Visits before and after the day on which the procedure is performed,
 - ii. Visits on the day on which the procedure is performed, and
 - iii. The procedure
- b. When a patient attends at a medical practitioner's office or clinic and undergoes a procedure for which no booking was made in advance, and where the procedure is indicated in the Insured Services Tariff with the notation "+", benefits shall be paid for the procedure and either:
 - i. The visit on the day on which the procedure is performed, or
 - ii. Consultation on the day on which the procedure is performed

E.10 Emergency Detention Time

- c. Benefits for emergency detention time shall be paid to a medical practitioner for the time s/he is medically required to personally and continuously attend and treat an illness or injury of an emergency nature.
- d. Illness of an emergency nature includes mental or emotional disorders.
- e. No medical detention time benefit shall be paid to a medical practitioner unless the medical practitioner submits, in writing, a simple explanation of the activity and the time spent in performing the activity.
- f. Medical detention time shall not apply to:

- i. Counseling or psychotherapy;
 - ii. Waiting for results of laboratory or x-ray examinations;
 - iii. Giving advice to family members of the patient or to the patient;
 - iv. Waiting for a family medical practitioner or consultant;
 - v. Service provided in the office in conjunction with routine visits, except when it is documented that an emergency existed; or
 - vi. Medivac detention time described in section E.11.
- g. Where a visit benefit is claimed, the medical detention time benefit does not apply until 2 hours after the start of the visit.
- h. The maximum time for which benefits are payable as medical detention is seven hours.

E.11 Medivac Detention Time

- a. Medivac detention time shall be paid to a medical practitioner for the time s/he is medically required to personally and continuously attend a patient being transported by surface or air ambulance.
- b. No medivac detention time benefit shall be paid to a medical practitioner unless the medical practitioner submits, in writing, a simple explanation of the activity and the time spent in performing the activity.
- c. Where a patient is being transported from a medical facility to another medical facility, medivac detention time begins when the patient is discharged from the medical facility and ends when the patient is admitted to the receiving medical facility.
- d. Where a patient who has not been admitted to a medical facility is being transported to a medical facility, medivac detention time begins when the medical practitioner begins to prepare the patient for transportation to a medical facility and ends when the patient is admitted to the facility.

- e. Where a medical practitioner has to travel outside his or her community to reach a patient, medivac detention time includes the time the medical practitioner spends in reaching the patient.
- f. The maximum time for which medivac detention time benefits are payable is 12 hours.
- g. Return travel time, or time stranded, shall be paid to a medical practitioner who is out of his or her community as a direct result of an emergency medivac for the time the medical practitioner spends in returning home, or is stranded outside his or her community after the completion of the medivac.
- h. No benefit for return travel or time stranded shall be paid to a medical practitioner unless the medical practitioner submits, in writing, the times for the beginning and end of the period the medical practitioner claims under this benefit.
- i. The maximum time for which return travel or time stranded benefits are payable is five hours per day.

E.12 Cosmetic Procedures

- a. Surgery to alleviate significant physical symptoms or to restore or to improve function to any area altered by disease, trauma, or congenital deformity normally is a benefit of the Schedule.
- b. Surgery solely to alter or restore appearance is not considered medically necessary and is not a benefit of the Schedule.

E.13 Surgical Assisting

- a. Where the surgical assistant is also the attending physician requesting the surgical consultation that leads to provision of a procedure, he or she shall be

- entitled to claim either the emergency benefit or the admission benefit in addition to the assisting benefit.
- b. Claims for surgical assisting must indicate the lesser of the actual operating time from induction of anaesthesia to skin closure, or the total time of attendance by the medical practitioner; assisting time shall not exceed the anaesthetic time.
 - c. Premiums payable for a surgical procedure apply equally to the payment for surgical assisting.
 - d. Procedures for which surgical assisting benefits are not payable are:
 - i. Minor cutaneous and subcutaneous tumors and biopsies
 - ii. D and C, minor gynecological procedures
 - iii. Anal fissure, ischiorectal abscess, anal and rectal polypi
 - iv. Abscesses, except for major abscesses
 - v. Endoscopic procedures and examinations
 - vi. Transfusions
 - vii. Closed reductions of fractures, except femur, tibia, radius and ulna
 - viii. Application of plaster casts, orthopaedic appliances and manipulations
 - ix. Ingrown toenails
 - x. Minor plastic surgery, such as stamp graft, dermabrasion
 - xi. Thoracentesis and closed drainage
 - xii. Arteriography
 - xiii. Tympanoplasty, fenestration
 - xiv. Tonsillectomy and adenoidectomy
 - xv. Vasectomy
 - xvi. Submucous resection, rhinoplasty
 - xvii. A-V shunt
 - xviii. Release carpal tunnel
 - e. Procedures for which surgical assisting benefits may be required sometimes and are payable by assessment are:
 - i. Phalangeal and digital amputations
 - ii. Ganglion wrist

- iii. Excisional breast biopsy
- iv. Simple fistula
- v. Hemorrhoidectomy
- vi. Bunionectomy
- vii. Mastoidectomy
- viii. Open reduction of fractured finger
- ix. Hammer toe repair
- x. Morton's neuroma

A claim for discretionary surgical assisting benefits, as listed herein, requires an explanatory letter from the surgeon, applicable to that claim.

F Premiums

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F.1 Eligibility for Callbacks

Callbacks are based on a special visit in response to a request for a service and the performance of service. This premium can apply to the provision of a consultation or a procedure, but not to both when the consultation leads to the procedure within the designated times.

F.2 General Practice Callbacks

For General Practice, callback premiums are available for hospital visits to Emergency and Outpatient Departments, as follows:

- a. When specially called from home or office:

CB-001 \$115.00

- b. When specially called from home or office, with patient assessment

CB-002 \$60.00

F.3 Consultations and Procedures Callbacks

For consultations and procedures rendered by medical and surgical specialists and General Practice Anaesthetists, callback premiums may be claimed, as follows:

- a. When specially called from home or office:

CB-003 \$175.00

- b. When specially called from home or office, with patient assessment

CB-004 \$100.00

F.4 Consultations and Procedures After Hours Premiums

- a. After hours premiums may be claimed for the provision of non-elective consultations, surgical and anaesthetic procedures in the operating room, and obstetrical deliveries.
- b. The after-hours premiums are based on the time of day that an eligible non-elective service is initiated, applying the following codes and percentage increases to the submitted claim:

- i. 18:00 to 00:00
AH-001 50%
- ii. 00:00 to 07:00
AH-002 75%

F.5 Body Mass Index Premium

For surgical and anaesthetic services that are performed in the operating room, a body mass index (BMI) modifier may be claimed if the BMI exceeds 40. The premium is an additional 20% applied to the surgical, anaesthetic, and surgical assistant fees, using the code **BP-001**.

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G Specialty-Specific Preambles

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G.1 Surgical Specialties

a. Payment for Pre-operative and Post-operative Care

- i. Benefits for surgical procedures, other than an obstetrical procedure, listed in the Insured Services Tariff and valued at greater than \$193.00 include compensation for post-operative care for a period of 14 days following the procedure.
- ii. Notwithstanding subsection G.1.a.i, additional benefit may be claimed for services required to deal with a complication to the procedure or, when unusual clinical circumstances require that additional medical services are provided, the additional services are not part of the inclusive fee and may be claimed separately.
- iii. When a surgeon does not provide the major portion of the post-operative care during the period of 14 days following the procedure, the benefit for the procedure shall be assessed by the medical advisor and paid at a lesser rate than the procedural rate listed in the Insured Services Tariff.
- iv. When a medical practitioner other than the surgeon provides the major portion of the post-operative care during the period of 14 days following the procedure, the benefit paid to that medical practitioner shall be based on the number of hospital, home, or office visits provided to that patient.
- v. Hospital care provided prior to a procedure may be claimed on the basis of first and subsequent visits by the medical practitioner who performed the surgery or by a different medical practitioner providing such care.

b. Multiple Surgical Procedures

- i. When two or more similar surgical procedures, including bilateral procedures, are performed at one time, the procedure with the greater

listed fee may be claimed in full and the fees for the additional procedures are reduced to 75%, unless otherwise indicated in the Schedule.

- ii. When two or more different procedures are performed through separate incisions under the same anaesthetic, and repositioning or re-draping of the patient or more than one separately draped surgical operating field is medically or surgically required (because of the nature of the procedure and/or the safety of the patient), both procedures may be claimed in full, unless otherwise indicated in the Schedule.
- iii. When multiple related surgical procedures are performed through one incision, payment will be made for the major procedure only.
- iv. Secondary surgical procedures, including those performed for post-operative complications, by the same surgeon for the same or related condition, shall be paid at 75% of the listed benefit for the secondary procedure. That notwithstanding, when an emergency procedure is followed by a procedure intended conclusively to stabilize the condition of the patient, then each procedure may be claimed in full.
- v. When two procedures are performed under the same anaesthetic by two surgeons and both procedures are within the competence of either one of the surgeons, the total surgical fee claimed should be no greater than that which would be payable if both procedures had been performed by one surgeon plus one fee for surgical assisting.

c. Abandoned Surgical Procedures

Surgical procedures that are abandoned before completion will be given independent consideration and paid in accordance with the services performed.

d. Diagnostic Surgical Procedures

Payment rules for diagnostic surgical procedures vary according to the site of service and the listed benefit value for the procedure. These are summarized in the following table:

Site of Service	Benefit of \$192.99 or less	Benefit of \$193.00 or more
Hospital	Benefit shall be paid for the procedure and visits before and after the day on which the procedure is performed	Benefit shall be paid for the procedure and visits before the day on which the procedure is performed
Office or Clinic	Benefit shall be paid for the procedure or the visit on the day of the procedure	Benefit shall be paid for visits before the day on which the procedure is performed and either the procedure or the visit on the day of the procedure

G.2 Obstetrics

- a. The obstetrical benefit includes services provided for minor prenatal and minor coincidental medical conditions occurring during the pregnancy.
- b. The obstetrical benefit does not include claims made for visits for unrelated major medical conditions, which may be claimed separately.

- c. The obstetrical benefit includes minor postnatal conditions and contraceptive advice.

G.3 Paediatrics

a. When a Paediatrician Provides Care for a Premature or Newborn Infant

- i. Newborn care on the date of birth and the date of discharge may be claimed when a healthy newborn has been referred to a Paediatrician by a medical practitioner; a consultation may not be claimed in this circumstance.
- ii. If it becomes apparent that, while in the care of the Paediatrician, the newborn is ill, then the appropriate consultation benefit shall be paid and benefits shall be paid for the appropriate number of hospital days involved.
- iii. When consultation with another specialist is requested by the Paediatrician, a consultation benefit shall be paid to the specialist.
- iv. Claims for routine care and care for minor complications of a premature infant shall be paid as a minor or repeat consultation for the initial visit and in accordance with the approved tariff for subsequent daily care benefits.

b. When a Medical Practitioner other than a Paediatrician Provides Care for a Premature or Newborn Infant

- i. Where a consultation is required, the referring physician may claim the benefit for newborn assessment on the day of birth and the consultant shall be paid a consultation benefit.

- ii. When the ongoing care of the newborn is transferred to a consultant, the attending medical practitioner shall be paid by assessment, based on medical necessity.
- iii. The routine care of, or the care for minor complications of, a healthy premature infant shall be paid in accordance with the approved tariff for daily hospital care.

c. Subsequent Office Visit of a Newborn Infant

- i. When a medical practitioner has already claimed benefits for each of the delivery and postnatal care, newborn care on the day of birth, and newborn care on the day of discharge:
 - No benefit shall be paid for a subsequent office visit if the newborn is well.
 - A subsequent visit benefit shall be paid if the newborn is sick..
 - Subsequent to the initial post-partum visit, claims may be made for whatever benefit items are appropriate for the care provided.
- ii. When a medical practitioner has received a benefit only for newborn care on the day of birth, and newborn care on the day of discharge, an office benefit may be claimed for a first visit not requiring a general assessment and subsequent visits, whether the newborn is ill or well.

G.4 Orthopaedic Surgery – Fractures

- a. When a medical practitioner attempts a closed reduction of fracture unsuccessfully and finds it necessary to transfer the patient into the care of another medical practitioner, the initial benefit may be claimed at 50% of the listed benefit.

- b. A medical practitioner receiving a transferred patient after an initial unsuccessful closed reduction of a fracture may claim the full benefit for the final reduction.
- c. A medical practitioner performing an open reduction after his/her initial unsuccessful closed reduction of a fracture shall claim only the benefit for the open reduction.
- d. Rigid immobilization of a fracture that does not require a closed reduction may be claimed at 50% of the listed benefit for the closed reduction.
- e. Closed reduction of a compound fracture may be claimed at 150% of the listed benefit.

G.5 Psychiatry

- a. Individual psychotherapy or counseling may be claimed when the intent of the encounter is the therapy of one individual.
- b. Group psychotherapy may be claimed when all members of the group, present at the encounter, are receiving therapy in the session.
- c. Individual counseling by a general practitioner may be claimed only where an appointment is specifically for the purpose of psychotherapy.

G.6 Anaesthesia

- a. An anaesthesia benefit is based on the time between the induction of anaesthesia and when the attendance of the anaesthetist is no longer required, and an additional benefit that reflects the nature of the procedure.
- b. For the purpose of assessment of anaesthetic benefits, each anaesthetic procedure shall be considered as a separate and complete procedure.

- c. The listed benefit is for professional services including pre - anaesthesia evaluation and **post-anaesthetic** follow-up and all immediate supportive measures.
- d. In special cases where more than one anaesthetist is considered necessary by the Department in the interests of the patient, the benefit payable to the second anaesthetist may not exceed 75% of the benefit otherwise prescribed for the procedure.
- e. If multiple surgical procedures are provided to a patient under a single anaesthetic, the principles, which apply to the payment of surgeons, are applicable to the payment of anaesthetic benefits.
- f. For diagnostic and therapeutic anaesthetic procedures, the anaesthetic benefit is for professional services and excludes the cost of materials but includes examination, **post-treatment** observation, and **follow-up**; consultations, when requested, may be charged in addition to nerve block procedures.
- g. Claims submitted for general anaesthesia must include the services provided, the duration of the anaesthesia, the fee code and its descriptor.
- h. Where the anaesthetist is the medical practitioner in attendance of a patient, and consultation by a surgeon, the anaesthetist is entitled to claim either:
 - i. The emergency benefit or the admission benefit, and
 - ii. The anaesthetic benefit, if applicable
- i. In addition to the entitlement to claim the anaesthetic benefit, the anaesthetist may claim
 - i. The admission benefit, where the anaesthetist is the

- admitting medical practitioner, and
- ii. The daily care benefit, where the anaesthetist has been providing daily care prior to surgery

G.7 Critical Care

- a. **Life threatening critical care** is care to a critically ill or injured patient, where the illness or injury acutely impairs one more vital organ systems and results in imminent life threatening deterioration in the patient's conditions, or makes such deterioration highly probable. This can include, but is not limited to central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.
- b. Life threatening critical care is time-based and includes the following services that are not eligible to be claimed when rendered to the same patient by the same physician on the same day:
 - i. Assessment and ongoing monitoring of the patient's condition
 - ii. Intravenous lines
 - iii. Cutdowns
 - iv. Arterial and/or venous catheters
 - v. Central venous pressure lines
 - vi. Endotracheal intubation
 - vii. Tracheal toilet
 - viii. Blood gases
 - ix. Nasogastric intubation with/without anaesthesia with/without lavage
 - x. Urinary catheterization
 - xi. Pressure infusion sets and pharmacological agents
 - xii. Defibrillation
 - xiii. Cardioversion
- c. The time claimed for life threatening critical care may be consecutive or non-consecutive, but must be spent fully devoted to the care of the

patient. It cannot be claimed for the services of a physician on the same day for which the physician claims a per diem fee for critical care in the intensive care unit, ventilatory support, or comprehensive care.

- d. **Other critical care** is a service rendered for resuscitation, assessment, and related procedures, other than those described as life threatening critical care but where there is a potential threat to life and limb such that the medical care is necessary to prevent the loss of limb or the requirement for life threatening care.
- e. Other critical care is time-based and includes the following services that are not eligible to be claimed when rendered to the same patient by the same physician on the same day:
 - i. Assessment and ongoing monitoring of the patient's condition
 - ii. Intravenous lines
 - iii. Cutdowns
 - iv. Arterial and/or venous catheters
 - v. Central venous pressure lines
 - vi. Endotracheal intubation
 - vii. Tracheal toilet
 - viii. Blood gases
 - ix. Nasogastric intubation with/without anaesthesia with/without lavage
 - x. Urinary catheterization
 - xi. Pressure infusion sets and pharmacological agents
- f. **Critical care per diem** claims apply per patient treated by the physician-in-charge of a patient in the intensive care unit and reflect the number of days the patient has received such care.
- g. Critical care per diem charges can be any of Critical Care, Ventilatory Support, or Comprehensive Care (both Critical Care and Ventilatory

Support); when claimed, no other critical care codes may be used by the same physician.

- h. **Critical Care** is the provision by a physician of all aspects of the care of a critically ill patient in the intensive care unit, excluding Ventilatory Support.
- i. **Ventilatory Support** is the provision of ventilatory care to a critically ill patient in the intensive care unit, including initial consultation and assessment, peripheral intravenous lines, endotracheal intubation with positive pressure ventilation, insertion of arterial and central venous lines, tracheal toilet, use of artificial ventilator, and the interpretation of all related laboratory testing.
- j. **Comprehensive Care** is the provision of both Critical Care and Ventilatory Support to a critically ill patient in the intensive care unit.
- k. Physicians other than those providing Critical Care or Comprehensive Care may claim consultation, visit, or procedural fees not listed as part of critical care. If Ventilatory Care is the only service provided by one physician, another may claim Critical Care fees or the appropriate consultation, visit, or procedural fees.
- l. The critical care per diem fees should not be claimed for stabilized patients or for those patients who are in the intensive care unit for the purpose of monitoring.

G.8 Emergency Medicine

- a. The schedule of services for Emergency Medicine apply only to assessments and procedures rendered by the emergency physician(s) who are on duty and on-site in the emergency department.

- b. The time designations for assessments and procedures in the emergency department are, as follows:
- i. Day 08:00 – 18:00
 - ii. Evening 18:00 – 24:00
 - iii. Night 24:00 – 08:00
 - iv. Weekend and Holiday services are defined as occurring from 08:00 to 24:00 on a Saturday, Sunday, or statutory holiday
- c. When not specific to the emergency department, procedures shall be claimed using the appropriate service codes designated in other specialty sections of the Schedule, providing that the emergency physician has the appropriate credentials and privileges to provide these services.
- d. **Level I** visits in the emergency department are defined as a level of service pertaining to the evaluation and treatment of a single condition requiring a short history, examination, and treatment; it shall include review of related laboratory tests and x-rays. This visit level shall pertain, as well, to patients not meeting the criteria for Level II or Level III care.
- e. **Level II** visits in the emergency department pertain to the evaluation of a medical condition that necessitates a detailed medical history and physical examination of three or more regions; it shall include review of related laboratory tests and x-rays, and the initiation of appropriate treatment. This visit level shall pertain, as well, to those patients whose illness or injury requires prolonged observation, continuous therapy, and multiple reassessments.
- f. **Level III** visits in the emergency department pertain to the evaluation of a patient with serious multiple or complex medical problem(s) which can be obscure and which require a detailed and comprehensive

history and complete physical examination; it shall include review of related laboratory tests and x-rays, and the initiation of appropriate treatment, in addition to discussions with the patient, family members, and other physicians.

- g. **Critical care** visits in the emergency department are defined as **life threatening critical care** and **other critical care** in section G.7 of this preamble.
- h. **Medivac preparation** of a patient includes those assessments and interventions required after the decision to transport a seriously ill patient is confirmed by the receiving hospital.

H Appendix: New Service Item Committee

- H.1** The New Service Item Committee (NSIC) is a joint committee constituted by representatives of the Northwest Territories Medical Association (NWTMA) and the Department of Health and Social Services (DHSS) of the Government of the Northwest Territories (GNWT).
- H.2** The mandate of the NSIC is to recommend to the Minister of Health and Social Services (the "Minister") the inclusion of new insured medical services in the Insured Services Tariff (the "Schedule"), as published by the GNWT.
- H.3** Implementation of the recommendations of the NSIC requires the approval of the Deputy Minister of Health and Social Services (if the recommendation is not cost neutral) or the Director of Health Services Administration (if the recommendation is cost neutral).
- H.4** All recommendations of the NSIC will incorporate proposed billing rules around a new service item, including but not limited to site of service, eligible specialty(ies), anaesthesia units (where applicable), and associated eligible premiums.
- H.5** The NWTMA shall appointment two physicians to serve on the NSIC with the following responsibilities:
- a. Chair the NSIC
 - b. Receive new service items requests from clinical specialty representatives of the NWTMA, or from the DHSS
 - c. Set the agenda and provide items for discussion at NSIC meetings, with input from the DHSS
 - d. Provide liaison between the NSIC and the originator of a proposal, clarifying related issues and reporting results of the committee deliberations
 - e. Work with DHSS staff in developing billing rules for a recommended new service item

- H.6** The Director, Health Services Administration of the DHSS shall appoint two GNWT representatives to serve on the NSIC with the following responsibilities:
- a. Organize materials for the DHSS representatives
 - b. Document and collate NWTMA and DHSS proposals
 - c. Document and collate actions and correspondence on each new service item under consideration by the NSIC
 - d. Prepare relevant utilization data on each new service item under consideration by the NSIC
 - e. Prepare a cost impact analysis on each new service item under consideration by the NSIC
 - f. Where required, obtain an independent clinical perspective on a new service item that is under consideration, and provide that perspective for consideration by the NSIC
 - g. Provide liaison between the NSIC and Deputy, or the delegate of the Deputy, clarifying related issues and reporting results of the committee deliberations
 - h. Where required, undertake environmental scans across the country concerning the items being considered by the NSIC, including but not limited to codes for the specific services, insured benefits, service volumes, and associated descriptions of the service
 - i. Work with the NWTMA in developing billing rules for a recommended new service item
- H.7** The CEO of the Stanton Territorial Health Authority shall appoint two hospital representatives to serve on the NSIC with the following responsibilities:
- a. Provide the perspective of hospital services
 - b. Provide the perspective of other health authorities, where applicable
 - c. Where required, provide technology expertise and advice to the NSIC

H.8 Following is the process that guides the activities of the NSIC:

- a. The NWTMA, DHSS, or the health authorities, using a standard New Service Item Request Form, can submit a request for a new service item to the Chair of the NSIC.
- b. When a physician contacts the DHSS Medical Advisor and requests to be paid through Independent Consideration (IC) for a new service which does not have a specific code for it in the Insured Services Tariff, the Medical Advisor or Consultant may assign an interim value for the service and advise the physician to bill the service/procedure as an IC, using a manual payment form. It is then incumbent upon the physician to ensure there is a New Service Item Request Form completed and sent to the NWTMA within six months. If no formal request has been received by the NWTMA and the DHSS notified of the request, payment of the service through IC will be discontinued.
- c. DHSS documents and collates proposals, actions, and correspondence that relate to potential new service items, under consideration by the NSIC
- d. The Chair of the NSIC, after consultation with the Director, Health Services Administration, will call a meeting of the NSIC and provide all available documentation prior to that meeting; the documentation includes that provided by both the NWTMA and the DHSS
- e. Requests for a new service item are duly considered by the NSIC with respect to merit, validity, completeness, cost, and perceived benefit. If the NSIC determines that there are necessary clarifications or extra information required, the Chair, on behalf of the NSIC, will undertake to contact the appropriate resource for such clarification or extra information
- f. NSIC decisions are based on consensus, and could be any of the following: acceptance, as submitted; acceptance, with adjustments; rejection; or referral
- g. NSIC decisions are communicated to the originator of the proposal for a response. If the decision is acceptance of the requested item and the originator is in agreement with the conditions on which the NSIC has based its decision, the matter can move forward to the next step; if however, the requestor does not accept the decision, the issue may be brought back to the NSIC for further discussion and possible adjustment.

- h. Once both the NSIC and the originator of the proposal accept the documented decision, the NSIC will submit the new service item for consideration by the Deputy, or delegate, or the Director, Health Services Administration, depending on the financial implications of the decision. This submission will include the supporting documents available to the NSIC, including the recommended billing rules.

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I Appendix: Updating and Maintenance of the Schedule

- I.1** Updating and maintenance of the Insured Services Tariff (the “Schedule”) is essential to reflecting care and to its continuing relevance to government and to physicians. Further, technology advances can necessitate revision to a fee service code and its constituent elements.
- I.2** Updating and maintenance of the Schedule can include any or all of:
- a. Adding a code
 - b. Deleting a code
 - c. Changing the value of a code
 - d. Modifying a code descriptor, a billing rule, or a payment rule
- I.3** Responsibility for updating and maintenance of the Schedule rests with the Department of Health and Social Services (DHSS), and can include consultation and advice from the Northwest Territories Medical Association (NWTMA).
- I.4** Decision-making requires clearly articulated objectives and goals that are explicit, reasonable, and objective. Outcome measures should target the needs of patients, providers, and the payer.
- I.5** Evaluating the efficacy of the process of updating and maintenance of the Schedule requires identification of goals, measuring the outcome against those goals, and timeliness.
- I.6** The three sources of codes for annual review are:
- a. New code approved through the process established by the New Service Item Committee (NSIC)
 - b. Codes submitted for consideration by either the DHSS or the NWTMA
 - c. A further total of fifty codes selected randomly from the top fifteen codes, by service volume, for each clinical specialty

- I.7** Each review will include a relativity assessment and determination of the impact of technology on the provision of the service.
- I.8** The relativity assessment will be the basis of valuating a new code or modifying the value of an existing code. The basis of the relativity assessment is the derivation of intensity and its measurement against an existing intensity rating. The existing intensity rating will be that of an anchor code for each specialty; the anchor code can be either a procedure or an assessment that is performed commonly and is easily understood.
- I.9** The intensity rating is a derived relative value for the code. These ratings have been calculated for most commonly used codes in the Northwest Territories; each will be confirmed for the anchor services. The service being evaluated will measure relative value as a function of knowledge and judgment, technical skills, communication skills, and risk and stress. These components of physician work and the typical time required to perform a service will be derived from consultation with the NWTMA and external resources, as required.
- I.10** Therefore, the valuation formula is, as follows:

$$V_1 = V_2 (I_1 / I_2)$$

where

V_1	is	calculated value for the new or assessed code
V_2	is	existing value for anchor code
I_1	is	intensity rating for the new or assessed code
I_2	is	intensity rating for anchor code

where

I	is	sum of 1-7 ratings for each of knowledge and judgment, technical skills, communication skills, and risk and stress, multiplied by the average time required for the service
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