doctorcare
A WELL Health Company

Release 6 Changes

Quick Reference Guide

This short guide will provide you with key information on the release 6 changes for fee schedule codes K229, R766, and R767. These changes were implemented January 1, 2021 with an effective date of April 1, 2020.

Challenge	DoctorCare Best Practices and Recommendations
What are the updated requirements to the K229 fee code?	**K229A – Complex genetic test interpretation** K229A is restricted to physician specialists in genetics and/or specialists with a Fellow of the Canadian College of Medical Geneticists (FCCMG) designation. Updated requirements for billing fee code K229: • K229A may be submitted for up to two services per patient, per physician, per 365 days. • If a claim is submitted for more than two services, it will be paid at $0 with explanatory 'M1-Maximum number of services has been reached' on the providers Remittance Advice RA. • K229A must be submitted by a provider who has also submitted a claim for a consultation or genetic care service for the same patient. • If a claim for K229A is submitted and there is no consultation or genetic care service on history, the claim will pay at $0 with explanatory code 'DF-Corresponding fee code has not been claimed or was approved at zero'.
What are the two new fee schedule codes?	There are two new fee schedule codes: R766A and R767A. • **R766A**: In-situ saphenous vein arterial bypass-tibial-two Vascular Surgeons-first surgeon. • **R767A:** In-situ saphenous vein arterial bypass-tibial-two Vascular Surgeons-second surgeon.
What are the requirements for fee codes R766 and R767?	Requirements for billing codes R766 and R767 • Fee codes are only eligible for payment to a physician that is a vascular surgeon with a specialty designation in General Surgery (03) or Vascular Surgery (17). • Fee codes are not eligible for payment with R804A. • If a claim is submitted for R766A/B and/or R767A with R804A on the same claim, the R804A will pay and the R766A/B and/or R767A will be paid at $0 with explanatory code 'D7 Not allowed in addition to other procedure'.

Challenge	DoctorCare Best Practices and Recommendations
What are the requirements for fee codes R766 and R767? (continued)	Requirements for billing codes R766 and R767 (continued) • If a claim is submitted for R766A/B and R767A for the same patient, same physician, same service date, the R766A/B will pay and R767A will be paid at $0 with explanatory code 'D7 Not allowed in addition to other procedure'. • If a claim for R766A/B is submitted and there exists on history a R767A that has been previously paid for the same patient, same surgeon and same service date, the incoming claim will be paid at $0 with explanatory code 'D7 Not allowed in addition to other procedure'. • If a claim for R767A is submitted and there exists on history a R766A/B that has been previously paid for the same patient, same surgeon and same service date, the incoming claim will be paid at $0 with explanatory code 'D7 Not allowed in addition to other procedure'. • Surgical assistant units associated with R766 are only eligible for payment to one physician. • R766C is eligible for automated anaesthesia age premiums. • R766C-Anaesthesiologists are eligible to bill extra units listed on page GP95 of the Schedule. • If a claim is submitted for R767B/C it will be rejected to the providers error report with error code 'A3F-No Fee for Service'.
What are the new rules for Medical Claims Adjustments (MADJ) for fee codes R766 and R767?	New rules for Medical Claims Adjustments (MADJ) • Claims already submitted for R766A and R767A with service dates between April 1, 2020 and December 31, 2020 that were previously paid were subject to the MADJ. If necessary, these claims were adjusted in accordance with the changes to the Schedule of Benefits for Physician Services effective April 1, 2020. • Adjustments will appear on the February 2021 Remittance Advice RA. • Please note that during the MADJ process, the claims processing system selects an entire claim for reprocessing. • A single claim can include multiple fee schedule codes and all codes will be reprocessed. • Claims that were reprocessed with no change in payment will appear on the Remittance Advice RA with explanatory code '55-This deduction is an adjustment on an earlier account' and '57-This payment is an adjustment on an earlier account'. These two transactions will net to zero with no payment impact but will report on the Remittance Advice for reconciliation purposes.