Billing Bulletin

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IMPORTANT HEALTH WEBSITE LINKS

All Medical Services Branch Payment Schedules, Newsletters, Operations Bulletin, Billing Bulletins, Billing Information Sheets and forms are available at:
https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx

PAPER COPIES OF THE PAYMENT SCHEDULE, BILLING BULLETIN AND OPERATIONS BULLETIN

Medical Services Branch does not provide paper copies of the Physician Payment Schedule, the Billing Bulletin or the Operations Bulletin. The Physicians' Newsletter continues to be mailed out. Copies of these documents can be found at the website link above.

General Billing Inquiries

Direct all general billing inquiries to:

Claims Analysis Unit
Phone: 306-787-3454
Fax: 306-798-0582

Physician Audit Inquiries

Direct all physician audit inquiries to:

Policy, Governance and Audit Unit
Phone: 306-787-0496
Fax: 306-787-3761
Email: MSBPaymentsandAudit@health.gov.sk.ca

NEW Billing Resources

There are new billing resources available on the website. These documents will be provided to all new physicians upon registering with Medical Services Branch. They are also available for download or viewing at the above link. They cover topics such as physician billing obligations, documentation requirements, payment integrity (audit), requesting changes to the Payment Schedule, and the Joint Medical Professional Review Committee.

Saskatchewan

GENERAL

PHYSICIAN BILLING OBLIGATIONS: Physicians are personally responsible for all billings submitted under their Medical Services Branch-assigned billing number. Billing staff must be supervised and billings must be reviewed prior to submission for payment.

All physicians who are receiving direct payment through the publically funded system have signed a Direct Payment Agreement with MSB. This agreement stipulates the manner in which services must be submitted for payment and all physicians must be aware of their responsibilities.

We appreciate physicians' ongoing efforts and cooperation in ensuring that the service codes they submit to the Ministry for payment meet the requirements as set out in the Physician Payment Schedule, their Direct Payment Agreement and *The Saskatchewan Medical Care Insurance Act*.

Statutory Holidays for the Purposes of Billing Statutory Holiday Premiums and/or Surcharges

Please be advised that statutory holidays for the purposes of billing any type of premium or surcharge/special service(s) are per the Government observed/designated holidays listed below, and may be different than the Saskatchewan Health Authority designated holidays.

HOLIDAY	ACTUAL DATE	OBSERVED/BILLED ON
Victoria Day	Monday May 20, 2019	Monday May 20, 2019
Canada Day	Monday July 1, 2019	Monday July 1, 2019
Saskatchewan Day	Monday August 5, 2019	Monday August 5, 2019
Labor Day	Monday September 2, 2019	Monday September 2, 2019
Thanksgiving	Monday October 14, 2019	Monday October 14, 2019
Remembrance Day	Monday November 11, 2019	Monday November 11, 2019
Christmas Day	Wednesday December 25, 2019	Wednesday December 25, 2019
Boxing Day	Thursday December 26, 2019	Thursday December 26, 2019

NEW Request for Review of Claims Assessment Form

Please be advised, the ***"Request for Review of Claims Assessment Form"*** has been modernized to assist physicians and clinics with their inquiries. The form must be filled completely and indicate the nature of your request. This new form is available on our website, link as on page 1.

Out-of-Country Coverage - Tips on Submitting a Prior Approval Request for Coverage to the Ministry of Health

The Ministry of Health ***does cover the cost of some elective medical services*** provided out of country. ***Coverage is only considered in exceptional circumstances and under certain conditions:***

- ***Refer to The Physician Payment Schedule (page 9) for the requirements***;
- A Saskatchewan listed specialist, within whose field of practice the required service lies, should submit the prior approval request to the Ministry;
- The request must be provided to the Ministry ***BEFORE*** the patient is referred for treatment out of the country;
- Include information regarding the ***urgency level*** of the prior approval request, based upon the clinical condition of the patient;
- ***Clearly describe*** what out-of-country SPECIFIC SERVICE/TREATMENT is being requested.
    - Generally speaking, it is not sufficient to request a "detailed assessment", "comprehensive multi-disciplinary assessment" or "further follow up";
- ***It is the physicians responsibility*** to clearly DETAIL and confirm the service being requested is NOT available in Canada and, where possible, include information on consultations and/or outcomes of those consultations with other Canadian specialist physicians, centres of excellence or specialty hospitals which were exhausted prior to the consideration of any services outside of the country;

- Submitting a request for prior approval ***does not guarantee an approval for funding***. The Ministry bases all adjudications on current legislation and the medical and clinical information provided by the requesting specialist.

- ***Following adjudication*** of the prior approval request, the outcome of the Ministry's review is provided in writing to the specialist physician who made the prior approval request.

- ***It is the responsibility of the specialist physician to follow-up with the patient*** regarding the outcome of the request and the patient's plan for ongoing care.

Top 5 Billing Issues - Identified by the JMPRC

The Joint Medical Professional Review Committee (JMPRC) is responsible for reviewing the billing patterns of Saskatchewan physicians. Based on the results of the JMPRC's investigation, the Committee has the authority to order a recovery of monies if they determine that the Minister has paid monies inappropriately. ***The top 5 billing issues as identified by the JMPRC are as follows:***

1. **Documentation – substandard (inadequate, incomplete and inaccurate):**
    a. Partial assessments (5B);
    b. Complete assessments (3B);
    c. Counseling (40B/41B);
    d. Chronic Disease Management flow sheets (64B-68B);
    e. Inappropriate use of EMR templates.

2. **Frequency of non-medically required partial assessments (5B) and/or counseling services (40B/41B):**

    Contributing factors**:**
    a. Lack of prescription management;
    b. Lack of practice management;
    c. Lack of anticoagulation management;
    d. Lack of documented follow-up instructions to the patient;
    e. Routine injections billed as visits;
    f. Uninsured services billed as visits;
    g. Billed with prescheduled minor procedures such as plantar warts.

3. **Frequency of faxed prescription renewals (794A, 795A):**

    Contributing factors**:**
    a. Lack of prescription management;
    b. Lack of practice management.

4. **Frequency of faxes/telephone calls for nursing home patients (790A, 791A, 794A, 795A):**

    It is expected that if a physician is attending a designated special care home facility on a regular basis, that all necessary routine and/or chronic/long-term/ongoing services such as chronic medication refills, ordering lab work, reviewing test results, advising nursing staff, etc, would be included in the fee for the 626A. It is expected that these services would be done in conjunction with the weekly visit and not done through multiple billings of services such as 790A, 791A, 794A, or 795A etc.

5. **Billing for services that were not provided:**
    a. Patient was not seen, service billed in error;
    b. Deliberate misbilling.

SECTION A - GENERAL SERVICES

794A, 795A – Prescription Renewal by Telephone Call, Facsimile, Email or Other Electronic Means

Physicians are reminded of the appropriate billing of prescription renewal codes. This item has been identified by the Joint Medical Professional Review Committee (JMPRC) and MSB as being a high volume inappropriately billed service.

- This service code **cannot be billed** as a routine practice or to authorize repeat prescriptions for which long term repeats would more properly have been authorized at the time of writing of the initial prescription at the time of the patient's visit.
- This service code **cannot be billed** to verify or clarify dosages on prescriptions, or when the physician's instructions are unclear or illegible.
- This service code **cannot be billed** for ordering prescriptions (such as injectables) in advance of a scheduled procedure or contacting the patient regarding dosage changes (ie: INR monitoring).

Prescription renewals can only be billed when extenuating circumstances exist, such as patients who could not attend a scheduled three or six-month follow-up, or a patient that has relocated and needs refills on chronic medications until a new physician can be established.

It is the physician's responsibility to manage prescriptions appropriately and ensure that the patient has enough renewals to last until the next scheduled visit. Regardless of an individual pharmacy's pattern of practice, simply complying with each and every request that originates from a pharmacy is not considered an adequate explanation. **Using pharmacy-initiated faxes to manage medications is inappropriate.** Not providing appropriate prescriptions at the time of visits leads to unnecessary faxed requests being billed to Medical Services Branch.

Special Care Home (nursing home) patients – if a physician is seeing a patient in a designated special care home facility and billing routine nursing home services (626A) on a regular basis, it is expected that adequate, long-term chronic medication refills will be provided during the weekly visit to the facility. Medical Services Branch would not expect to see this service billed for nursing home patients except in exceptional circumstances.

The vast majority of physicians referred to the *JMPRC* have an issue with inappropriate billing of faxed prescription renewals, which has resulted in recovery of monies.

790A/791A - Telephone Calls/Facsimile/Email Initiated by Allied Health Care Personnel to Discuss Patient Care and Management

Payment is restricted to telephone calls, facsimile or email initiated by allied health care personnel. Physicians, optometrists, dentists and chiropractors are not considered allied health care personnel, per "Definitions" in the Physician Payment Schedule.

These codes are not payable for contacting the patient (ie: providing advice regarding INR monitoring dosage changes; follicle tracking results) or providing advice to facility staff between visits on conditions that need to be addressed on a routine basis that should otherwise be covered during these visits, like prescription renewals, minor ailments, medication reviews etc. Please refer to 790A/791A in the Physician Payment Schedule for full listed criteria and documentation requirements.

815A- 839A – Surcharges and Special Calls

Surcharges/special calls or "callbacks/call outs", as they are sometimes referred to, are an additional service code that is payable to physicians who are specially called to see a patient. The intent of the surcharge codes (815A-839A) is to compensate physicians for *unforeseen* medical urgencies that may arise, and when the physician attends to the patient on a priority basis, the visit causes a degree of disruption of work or of out-of-hours activity and travel.

Family practice physicians with extended hours and walk-in clinics during regularly scheduled operating hours (whether 5 p.m. or later) utilizing surcharges to manage patient volumes and physician availability is not an appropriate use of surcharges. ***Surcharge codes are not an acceptable management tool in this instance.***

Surcharges and special calls are sometimes confused with "premium location" payments. MSB also pays a "premium" via the location code if a physician attends to a patient between certain hours on certain days of the week. The next section will provide education on premium locations.

PREMIUM LOCATIONS - TIPS FOR SUBMITTING

Premium locations provide compensation for a physician who attends a patient between certain hours on certain days of the week.

Non-premium (8:00am – 5:00pm weekdays)	1	Office
	2	Hospital inpatient
	3	Hospital outpatient
	4	Home
	5	Other
	6	Location not indicated
	7	Emergency Room Physicians

Premium (50%) locations (5:00pm – midnight weekdays, 7:00am – midnight STAT holidays, 7:00am – midnight weekends)	B C D E	Inpatient Outpatient Home Other
Premium (100%) locations (Midnight to 7:00am)	K M P T	Inpatient Outpatient Home Other
Office Premium (10%) (office location 7:00pm – 7:00am)	F	Office

You can bill mixed locations on the same claim IF they are the same premium or non-premium amount. (e.g., you can bill 2, 3, and 1 all on the same claim or "B" and "C" on the same claim because they will both generate a 50% premium.

Examples:

A) "B" and "K" cannot be billed on the same claims
Reason: Location "B" generates a 50% premium and "K" generates a 100% premium.

B) "1" and "C" cannot be used on the same claim
Reason: Location "1" is a non-premium location and "C" is a 50% premium location.

Other Surcharge/Special Call Information

- Surcharges are intended to compensate physicians ***for travel to a separate location*** – it cannot be billed if a physician goes from one location in the same building (hospital) to another.
- It is to compensate for a call-out on an ***urgent basis to attend on a priority basis*** and is not intended to be used ***where the physician defers the visit to a later time for his/her convenience***.
- ***Times need to be recorded*** on the medical record and documentation also needs to ***support the medical necessity*** of the call-out, the location traveled from and to, and verify the degree of disruption of work or out-of-hours activity.
- The surcharge is not intended for cases where the physician goes home and then returns and resumes work after hours ***on a scheduled basis.***
- Surcharges are not to be billed for pre-arranged services that were ***scheduled at previous visits***, even if the physician has to travel to another location to do these.

Substitution of Fee Codes

Per the Physician Payment Schedule, if a specific service code for the service rendered is listed in the Payment Schedule, that fee code must be used in claiming for the service, without substitution. When a physician service is not listed in the Payment Schedule, the physician should write Medical Services Branch to request advice on the correct submission of the account: 3475 Albert Street, Regina SK, S4S 6X6 or fax 306-787-3761.

Your correspondence must outline:

- The nature and description of the service;
- The frequency of the service;
- The length of time spent performing the service; and
- The suggested fee and rationale.

SECTION B - GENERAL PRACTICE

5B - Partial Assessments - With Prearranged Minor Procedures

Physicians are reminded that when a minor procedure is pre-planned and agreed upon by the patient, but scheduled for another time, it is not always **medically required** to re-evaluate the area of interest and bill for another partial assessment at the time the procedure is performed.

Booking procedures to be done electively and billing additional partial assessments routinely at time of the procedure is not appropriate. If a **medically required** reason exists at the time of the procedure, it should be appropriately documented and meet the billing requirements of the code.

Examples of minor procedures would be wart treatments (877L-879L), ablation of lesions (603L-605L), excision of lesions (857L-860L) etc.

5B - Partial Assessments – Documentation Requirements

One of the most common issues identified by the Joint Medical Professional Review Committee (JMPRC) is the lack of documentation and clinical content to support the medical necessity or frequency of partial assessment billings.

Physicians are expected to document each patient visit in accordance with accepted standards of care and guidelines for medical record-keeping, which align with the Physician Payment Schedule

billing requirements. Acceptable documentation for a partial assessment includes an accurate and complete account of each patient visit including information and clinical content such as:

- history appropriate to the patient's presenting concerns to establish medical necessity of the visit;
- any relevant past medical history, drug reactions, current medication, allergies and active health problems;
- physical examination pertinent to the patient's medical concern;
- diagnosis and assessment to determine if the investigation of the patient's medical condition should include ordering laboratory tests, diagnostic imaging, a referral to a consultant or other investigatory methods; and
- treatment, including medication name, dose and length of prescription, investigations, and follow-up instructions to the patient.

5B - Partial Assessments – Billed for routine injections (110A, 161A, 381M, etc)

Physicians should be aware that injection-associated services can lead to the increased billing frequency of inappropriate and non-medically required patient visits, such as partial assessments (5B). If a patient, for example, attends for a routine injection that is being received on an ongoing basis (such as weekly, biweekly, monthly etc), it would generally not be medically required to perform the components of a partial assessment each and every time.

Should there be a situation where the patient presents for a different clinical condition that requires management, or the current condition associated with the injections needs to be revaluated, the documentation ***must support the medical necessity and include all of the documentation requirements.***

55B - Partial Assessments and Specialist Wait Times in Saskatchewan

Patient referral to a specialist?

Use CODE 55B (instead of 5B)

The 55B billing code enables the health system to measure and report how long patients are waiting to see a specialist. Use of 55B has been more than doubled since 2012. The goal is to increase the use of this code (where appropriate) to be able to report specialist wait times similar to the Saskatchewan Specialist Directory.

Statistics	2012-13	2017-18	% increase
Number of 55B services	17,646	41,285	134%
Number of physicians who used 55B	532	697	31%

Ask your billing clerks to use the 55B when a referral is being arranged.

Has the 5B doctor's visit resulted in a referral to a specialist?

USE 55B CODE (Instead of 5B)

WHEN A PARTIAL ASSESSMENT LEADS TO A REFERRAL, USE THE 55B BILLING CODE
The 55B code is for use by General Practitioners and Family Physicians only.

FOR MORE INFORMATION, please contact Mr. Bhooman Bodani at the Medical Services Branch. Email: bbodani@health.gov.sk.ca Phone: 306-787-8936 or fax: 306-787-0023

40B, 41B - Counseling Services – Tips for Billing

Counseling is considered a "visit" service and consists of a '***base code'*** (40B) and '***add'*** code(s) (41B). The 40B may be billed alone, but the add code 41B cannot be billed alone or with any other visit service.

Examples:

A) 5B + 41B on the same claim **(X)**

The 5B & 41B cannot be billed together. Only a 41B can be billed in conjunction with a 40B.

B) 40B + 41B + 41B on same claim, separate lines of service. **(X)**

41B should be billed with "units" (number of services). If billed on separate lines of service, the 2nd 41B will be considered a duplicate "BA" until further clarification is received.

Please be advised, counseling codes are not a substitute for a lengthy visit service simply because an assessment was greater than 15 minutes or multiple complaints were addressed that "took longer than usual".

All documentation requirements must be met and the start and stop times must be recorded in the medical record.

64B, 65B-68B - Chronic Disease Management – Tips For Billing

Chronic Disease Management (CDM) fees are billable once per patient every 90 days. CDM services must be submitted with a base code of 64B and should be accompanied by one of the 'add' codes of 65B-68B. Subsequent CDM claims must be consecutive and continuous for the same patient by the same physician or clinic. If the visit is in excess of one every 90 days, or the visit involved less than 15 minutes of physician time, the service should be submitted as a partial assessment (5B) **pending all the billing criteria for a 5B is met.**

65B-68B is "add" codes to the base code of 64B. The add code cannot be paid without a 64B. 65B-68B cannot be billed in conjunction with a 5B visit service code. The Claims Analysis Unit has identified a high volume of inappropriately billed CDM service codes which are billed in erroneously.

Examples:

A) 5B + 64B/65B on the same claim. **(X)**

The 5B will be rejected "DA". Only one visit type service is approved during a single patient contact.

B) 5B + 65B on the same claim. **(X)**

The 65B should not be billed without the 64B base code. The 5B should not have been billed on this claim.

SECTION P – OBSTETRICS AND GYNECOLOGY

31P - Tubal Insufflation or Hysterosalpingogram or Sonohysterogram

The service code for sonohysterogram (31P) is intended to be a stand-alone, primary procedure and includes other ultrasound guidance for the provision of confirming catheter placement. Additional diagnostic ultrasound codes may be payable in addition to the 31P if they are medically required and for unrelated reasons.

SECTION S – OPHTHALMOLOGY

110S - Abscess, Incision and Drainage (Orbit)

Service code 110S is only billable for incision and drainage of an abscess ***of the orbit (eye)***. Please ensure that abscesses of other body sites are billed under the applicable service codes (ie: 850L – Incision and drainage of abscess, etc. - Integumentary system).