PAYMENT SCHEDULE

For Insured Services Provided by a Dentist or a Dentist Holding a Specialist License

April 1, 2019

Saskatchewan

DEFINITIONS

1. **Insured Service**

   A service listed in the Payment Schedule, provided by a dentist to a beneficiary (services for orthodontic care of cleft palate are insured only when the beneficiary is referred by a physician or another dentist).

2. **Referral**

   A referral for other than a consultation is the complete transfer of responsibility for an insured service to a dentist by a physician or another dentist.

3. **Specialist**

   A dentist whose name is on the list of dentists maintained by the College of Dental Surgeons of Saskatchewan and who has been formally advised to the Medical Services Plan, Saskatchewan Health as being entitled to receive payment at specialist rates

4. **Classification**

   Designates the time span applied by the Assessment Rules to other services in arriving at an appropriate payment.

   a) **"0" Day** – the day of the procedure.
   b) **"10" Day** – the day of and ten days following the procedure.
   c) **"42" Day** – the day of and forty-two days following the procedure.

5. **By Report**

   a) The claim must be made on one of the regular claim forms (not by automated submission) and must be accompanied by a detailed explanation of the circumstances and the services provided.
   b) Payment will be assessed on the basis of the information provided. An estimated appropriate fee may be provided.

6. **Hospital**

   A hospital as defined in *The Hospital Standards Act*.

7. **Clinic**

   The arrangement whereby two or more dentists are practising their profession, records and histories of the patients of those dentists are being maintained, and each of those dentists has access to those records and histories.

8. **Composite Fee**

   A fee which includes payment for more than one service (usually one major service and a number of minor services associated with the treatment of one condition).

9. **Mode of Payment**

   The method by which Medical Services Branch, Saskatchewan Ministry of Health (MSB) makes payment for services, i.e.:

   a) Mode 1 – Paid directly by MSB to the provider of service.
   b) Mode 3 – Paid to beneficiary.

SERVICES BILLABLE BY ENTITLEMENT

In order for a dentist or dental specialist to commence billing for a service that is stated "by entitlement", prior approval must be sought through the College of Dental Surgeons of Saskatchewan (CDSS), then received and approved by Medical Services Branch. The CDSS is responsible to submit to MSB the names of dentists or dental specialists and the effective date they approve for entitlement to bill these "by entitlement" services, and:

a) The effective date is the date the request was approved by the CDSS.
b) The effective date cannot pre-date the original request by the dentist or dental specialist.
c) If the effective date is older than 6 months when received by MSB, any billable service dates cannot exceed 6 months.
    - Accounts for insured services must be received by the Ministry of Health within six months following the date of service to be eligible for payment under *The Medical Care Insurance Act*.

REQUIREMENTS:

MSB requires the following information be provided for each member of the list provided by CDSS:

1. Proof of request;
2. Proof of approval by CDSS with the date approval was granted to the dentist or dental specialist by the CDSS; and
3. Copies of all pertinent documents pertaining to the dentist's or dental specialist's credentials that support the approval.

PATIENT IDENTIFICATION

A plastic "Health Services Card" for registered beneficiaries is sent every third year, to their last reported address. Coverage depends on registration. Notification of changes are the beneficiary's responsibility.

The Health Services Card shows: the effective and ending coverage dates, Health Services Number, name, sex and month and year of birth.

Saskatchewan Health Registration, 2130 11th Avenue, Regina, SK, S4P 0J5, should be notified of:

a) change of address,
b) registration errors, e.g. name, sex or date of birth,
c) changes in family.

All accounts should be sent to Medical Services Branch, Saskatchewan Ministry of Health (MSB).

Residents who are members of the Canadian Forces and inmates of the Federal Penitentiaries are not provided with health care coverage under MSB. Their spouses and dependents, residing in Saskatchewan, must be registered for coverage.

ASSESSMENT RULES

General

1. Payment for an insured service is based on the appropriate Payment Schedule item in accordance with applicable assessment rules.

2. When unusual time, skill or attention is required in the management of any insured service is satisfactorily explained, payment may be made in excess of the amount indicated by the application of the Payment Schedule. By Report.

Oral and Maxillofacial Surgery

Surgical Assistance

1. Calculation of payment to a surgical assistant is based on the time between the induction of anaesthesia and when continuous attendance by assistant is no longer required. When no anaesthetic is administered, the time is calculated from the beginning to the end of the procedure.

2. Payment for the services of assistants during surgery will be made only for those surgical procedures that are generally considered to justify the service.

3. A dentist may only be paid for surgical or assist services in relation to either a single surgical procedure or a series of procedures under the same anaesthesia. When he/she acts in more than one capacity, payment is approved for only the higher priced services.

Anesthesia

1. The listed payment for the procedure includes anaesthesia (local only; excludes sedation or general anesthesia) by the surgeon or surgical assistant.

ASSESSMENT RULES Continued

Surgery

1. Payment for the following services are included within the listed payment for the procedure:

   A. Surgeon or another dentist in the same clinic:

      a) diagnostic procedures related to the surgical procedures except 195Z paid at 75% with other surgical procedures;
      b) application of pins, splints, dressings, or bone graft substitutes.

   B. The surgeon or any dentist who practice:

      a) procedures for the control of hemorrhage within 24 hours of surgery;
      b) visit services for the same or a closely related condition during the normal period of post-operative care;
      c) The tightening or cleaning of dental wiring and the removal of dental wiring, pins, splints or dressings; operative removal of screws, wires, and plates is not included in the procedure.

2. Materials are not insured services. The costs of any materials used are not included in the fee. The costs of NAM materials, lab fees, and tapes are to be invoiced to MSB for payment by DPEBB.

3. The listed composite payment includes total pre-operative, operative and post-operative care. When more than one practitioner provides services for the care of a beneficiary which is included within the composite payment, details of the services provided by each practitioner must be supplied with his/her claim.

4. The payment includes all manipulations and fixation media* to achieve and maintain satisfactory healing during the normal post-operative period.

   *NOTE: Interdental wiring in accordance with the Payment Schedule.

5. When more than one procedure is carried out under the same anesthesia the higher priced procedure is assessed on the basis of 100% of the listed payment and the additional procedures are assessed on the basis of 75% of the listed payments, except where the procedures are listed by fractional components (e.g. “per” quadrant), in which case the assessment is on the basis of the full payment (100%) for each component.

6. A second surgical procedure during the post-operative period of an earlier related procedure is assessed on the basis of 75% of the listed payment, except where the procedure is listed by fractional components.

Consultations, Follow-up Examinations, and Assessments

1. a) A 200Z consultation is insured only in conjunction with an insured oral surgery service and requires a referring dentist or physician.

   b) A "follow-up examination" is insured only in conjunction with an insured oral surgery service.

   c) A 400Z Dental Assessment is insured when provided in the absence of insured dental services. The 400Z requires a request by another dentist of a physician, or referral by a physician or dentist, and cannot be billed with a surcharge.

2. When for same or related condition, a dentist provides:

   a) a consultation on the same day or within 90 days prior to or 90 days after another consultation by the same dentist, the second consultation will be converted to a follow-up examination.

   b) a consultation on the same day or within 42 days after a follow-up examination by the same dentist, the consultation will be converted to a follow-up examination.

NAM Treatment of Infant Cleft Lip and Palate

Patient must be referred by physician, dentist, or Cleft Lip and Palate Clinic, with a diagnostic code of 749.

Orthodontic Care for Cleft Palate

1. Patient must be referred by either: a physician, a dentist, or a Cleft Palate Clinic.

2. 52Z, 54Z, 64Z, 66Z
   Treatment maximums apply per patient regardless of the number of dentists participating in the total care.

Note that starting on page 7, the classification (Class) of the procedures has been supplied.

FEE CODES

Code	Description of Service	Specialist	Dentist	Class
	ORAL AND MAXILLOFACIAL SURGERY			
87Z	Fracture of alveolus (including debridement, teeth removal or repositioning, splinting and fixation of segment of fracture)	219.30		42
	Fractures of the facial bone – mandible			
94Z	Closed reduction with intermaxillary fixation – including interdental and intermaxillary wiring	410.05		42
95Z	Open reduction of single fracture – excluding interdental or intermaxillary wiring	426.35		42
96Z	Multiple compound or comminuted fractures – excluding interdental or intermaxillary wiring	505.90		42
97Z	Condylar fracture – open reduction – excluding interdental or intermaxillary wiring	715.00		42
	Code 94Z may be billed at 100% in conjunction with 95Z, 96Z or 97Z if interdental or intermaxillary wiring is performed			
	Fractures of the facial bone – maxilla/zygoma			
98Z	Displaced – closed reduction	410.05		42
99Z	Open reduction with internal fixation	489.60		42
100Z	Malar bone and zygomatic arch open elevation or temporal approach (Gillies)	410.05		42
101Z	Complete facial smash with cranial/facial separation, complicated, open reduction, multiple surgical approaches, internal fixation, wiring teeth, etc. – by report	By Report		
	Interdental wiring			
108Z	Removal of interdental and/or intermaxillary wiring and/or arch bar – different surgeon – office procedure	43.95		
109Z	Operative removal of any number of screws or wires – per operative site	96.90		10
110Z	Operative removal of plates (including screws and wires) – 110Z includes the removal of screws and wires and, therefore, is not billable with 109Z	255.00		10

Code	Description of Service	Specialist	Dentist	Class
	Surgical Assisting Calculation of the payment to a surgical assistant is based on the time between the induction of anaesthesia and when continuous attendance by the surgical assistant is no longer required.			
112Z	– First hour or any part thereof	128.50		
113Z	– Each additional fifteen minutes or part thereof	34.70		
	The following procedures because of their complexity may require the services of two specialist surgeons. Where the second surgeon's involvement is more than routine assistance in the procedure, he/she may bill 1/2 of the surgeon's payment or the standard assist codes, whichever is greater. Eligible services include the following: • Temporomandibular joint reconstruction including a gap arthroplasty, costochondral joint reconstruction or artificial joint reconstruction; • Congenital skeletal malocclusion including Lefort I osteotomy in conjunction with a bilateral sagittal osteotomy; • Facial smash reconstruction including open reduction of two of the following structures: mandible, maxilla, zygoma. This could include a bicoronal flap approach.			
117Z	Payment based on first surgeon's assessed claim	½ of first surgeon's claim		
	Periodontal surgery/prosthetic surgery			
129Z	Frenectomy – lingual or labial • Maximum of 2 per patient per lifetime.	93.85	78.54	10
130Z	Edentulous patients – tuberosity reduction – unilateral	166.25		42
131Z	Edentulous patients – tuberosity reduction – bilateral	327.40		42
134Z	Torus Palatinus – Excision	326.40		42
135Z	Torus Mandibularis – Unilateral – Excision	193.80		42
136Z	Torus Mandibularis, – Bilateral, – Excision	337.60		42
149Z	**Periodontal Surgery, Gingivectomy** The procedure by which gingival deformities are reshaped and reduced to create normal and functional form, when the pocket is uncomplicated by extension into the underlying bone. • Per quadrant; • Specialist periodontist or other dental specialist by report; • Maximum of 4 per lifetime; • Not to be used for surgical exposure of teeth for orthodontic purposes; • For patients age 18 and under, claim must be submitted by report with a copy of the referral letter.	207.05		42

Code	Description of Service	Specialist	Dentist	Class
150Z	Alveoplasty per quadrant (not in conjunction with extraction)	99.95		42
151Z	Patients with an edentulous alveolus – dental ridge reconstruction with sulcus deepening without grafting utilizing bone graft substitute (not included) • Per arch. • X-ray may be required for assessment.	292.75		42
152Z	Patients with an edentulous alveolus – dental ridge construction and sulcus deepening without skin or bone graft • Per arch. • X-ray may be required for assessment.	289.70		42
153Z	Patients with an edentulous alveolus – dental ridge reconstruction and/or sulcus deepening including the application of skin, mucosal or bone graft • Per arch. • X-ray may be required for assessment.	519.20		42
	Lacerations – suturing			
	Intraoral			
156Z	– Up to 2.5 cm	51.70	43.95	10
157Z	– Each additional 2.5 cm or part thereof	25.70	21.85	10
	Extraoral			
158Z	– Facial lacerations up to 5 cm	125.45		10
159Z	– Each additional 2.5 cm or part thereof	62.65		10
	Dental abscess/maxillofacial space abscess – Total care – Cannot be claimed in conjunction with 166Z, 167Z, 168Z or 169Z			
162Z	Intraoral – limit one per arch	57.10	48.75	10
163Z	Extraoral – office procedure	115.25		10
164Z	Patient under general anaesthetic – by report	By Report		10
	Cysts of dental origin – Intraoral approach only – Radiographs may be requested			
166Z	Under 1 cm	49.55		42
167Z	1 to 2.5 cm in diameter	158.10		42
168Z	Over 2.5 cm to 5 cm in diameter	278.45		42
169Z	> 5 cm – by report, including x-ray(s)	By Report		42
	Intraoral Biopsy			
170Z	Soft tissue	83.65	71.40	D
171Z	Bone – Not to be claimed in conjunction with 134Z, 135Z, 136Z, 150Z, 151Z, 152Z, 153Z, 174Z.	141.80	121.40	D

Code	Description of Service	Specialist	Dentist	Class
	Oroantral fistula			
174Z	Repair of oroantral fistula (excludes bone grafting)	398.80		
175Z	Caldwell Luc operation – maxillary sinus (excludes bone grafting)	351.90		
	Operative removal of duct stone			
176Z	Submandibular	156.05		42
177Z	Parotid	274.40		42
178Z	Ranula – floor of mouth – simple (marsupialization)	167.30		42
179Z	Ranula – floor of mouth – complicated (and/or removal of sublingual gland)	398.80		42
	Temporomandibular joint dysfunction			
183Z	Uncomplicated – closed reduction	91.80	78.55	10
184Z	Uncomplicated – closed reduction under general anaesthetic	133.60		10
185Z	Temporomandibular dislocation – open reduction – unilateral	473.30		10
186Z	Coronoidectomy for trismus	350.90		42
187Z	Eminectomy or zygomatic arch osteotomy for chronic dislocation	491.65		42
188Z	Meniscoplasty	629.35		42
189Z	Condylectomy	664.00		42
190Z	Meniscectomy	707.90		42
191Z	Costochondral graft for condylar replacement	664.00		42
192Z	Meniscectomy with implant, add	117.30		42
193Z	Gap arthroplasty for ankylosis	628.30		42
194Z	Condylectomy with joint prosthesis with or without glenoid fossa prosthesis	1,331.10		42
195Z	Arthroscopy – diagnostic – paid 75% when done with other surgical procedures	292.75		D
196Z	Arthroscopic meniscus and joint repair – with alloplastic material – includes arthroscopy	590.60		42
197Z	Arthrocentesis with or without injection of medications	66.40		0
198Z	Arthroscopy – therapeutic – including lysis and lavage – therapeutic inspection	334.55		0
210Z	Incision, excision or ablation of cranial nerve	239.70		42
211Z	Injection of cranial nerve for destruction (trigeminal neuralgia)	133.60		42

Code	Description of Service	Specialist	Dentist	Class
	Orthognathic Procedures			
	Orthognathic fees do not include: • Pre-operative radiography; • Records; • Intra-operative splints; or, • The model surgery needed to fabricate splints.			
229Z	Osteotomy to include: • Open condylar oblique osteotomy; • Ramus or sagittal split osteotomy; • Intra or extraoral; • Bilateral (includes interdental or intermaxillary wiring)	1,331.10		42
230Z	LeFort I osteotomy of maxilla – one segment	1,331.10		42
231Z	– including application of bone graft	1,479.00		42
232Z	– including harvesting and application of bone	1,676.90		42
235Z	LeFort I osteotomy of maxilla – two segments	1,467.80		42
236Z	– including application of bone graft	1,609.55		42
237Z	– including harvesting and application of bone graft	1,812.55		42
238Z	LeFort I osteotomy – cleft palate	1,729.90		42
239Z	LeFort I osteotomy – cleft palate – closure of alveolar cleft sites and oral/nasal fistula	1,995.10		42
240Z	Submucous septorhinoplasty	289.70		42
245Z	Alveolar bone grafting and closure of oroantral fistula with reconstruction of nasal floor	664.00		42
246Z	Symphyseal narrowing osteotomy of the mandible	473.30		42
247Z	Symphyseal narrowing osteotomy with bone graft	651.80		42
248Z	Surgically assisted rapid palatal expansion	531.40		42
249Z	Distraction osteogenesis to widen the mandible	531.40		42
250Z	Harvesting of autogenous bone graft for use by oral and maxillofacial surgeon – by second surgeon	292.75		42
251Z	Harvesting by same surgeon, add	200.95		42
252Z	Application of bone graft. To be used in special circumstances where not included in combined surgical/bone graft procedures – by report	292.75		42

Code	Description of Service	Specialist	Dentist	Class
	Dental Extractions **			
300Z	Consultation in conjunction with an insured dental extraction service – payable when submitted with a copy of the Cancer Agency Referral Letter attached.	106.10	49.05	
	Extractions – payable when submitted with a copy of the Cancer Agency Referral Letter attached.			
301Z	– first tooth in each quadrant	113.20	96.90	
302Z	– subsequent teeth in each quadrant – per tooth	64.25	64.25	

****Payment of claims for dental extractions may be made where:**

a) The extraction of teeth is necessary to be performed prior to the provision of heart surgery services, prior to or following services for chronic renal disease, prior to or following head and neck cancer services or services for total joint replacement by prosthesis, or,

b) As a result of cancer radiation treatment within fifteen years where the patient has followed the recommended guidelines of the radiation oncologist and of the dentist in relation to recommended dental hygiene and care; or,

c) Prior to stem cell transplants; **and**,

d) The beneficiary is referred to the dentist by a specialist in the field of practice in which the services lie; **and**,

e) The specialist recommends that payment be made for the service.

	Adjunctive Services		
200Z	Consultation in conjunction with an insured oral and maxillofacial surgery service, includes: • All visits necessary; • History and examination; • Review of laboratory and/or other data; and, • Written submission of the consultant's opinion and recommendations to the referring doctor.	66.40	
202Z	Follow-up examination related to an insured oral and maxillofacial surgery service or previous consultation (200Z) includes: • History review; • Examination; • Record; • Treatment; and, • Advice to patient.	26.85	

Code	Description of Service	Specialist	Dentist	Class
203Z	Emergency Surcharge – day or night – any day – requires supporting documentation This surcharge is payable where an oral and maxillofacial surgeon: • Travels to respond immediately to a stat call involving a life – threatening situation; • Provides immediate care; and, • Arranges for the patient's emergency admission as a hospital in-patient. • It is in addition to payment for an appropriate assessment and/or procedure.	49.35		
204Z	BMI Supplement – General surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height [m]2) greater than 40 a) Maximum of one 204Z supplement per patient per day; Supplement 204Z may be billed by dental specialists with insured dental procedures done in the operating room.	163.20		
400Z	**Dental Assessment** A Dental Assessment is payable when provided in person, by a dental specialist who has been granted entitlement, and the assessment service results in the dental specialist not billing an insured service, and the dental assessment is: a) Required and requested to enable another medical or dental specialist to perform a service; or b) In limited cases, as requested by an ER physician, where a patient requires medically necessary urgent or emergent dental specialty assessment, i.e. infection or trauma; or, c) In very limited special cases related to medical co-morbidity, the patient is seen by an entitled dental specialist in-hospital or in-clinic for assessment. Dental assessment is billable only by entitlement. See p. 3 for entitlement criteria and process. Insured services that are billed in conjunction with a Dental Assessment will not be payable within the 42 day period, except by report. Dental assessments are not payable if referral is for routine dental treatment, i.e.: • Restorative; • Prosthetic; • For periodontal reasons; or, • For routine extractions.	89.70		

Code	Description of Service	Specialist	Dentist	Class
	Nasoalveolar Molding (NAM) Treatment of Large Cleft Lip and Palate Payable by entitlement only.			
20Z	Unilateral Large Cleft Lip and Palate Assessment – Initial NAM Assessment and Start up • To determine if NAM treatment is warranted and viable; if viable, all services associated with preparation of device, insertion, and fitting. Payable only once per patient up to age 12 months.	350.00		
21Z	Unilateral Large Cleft Lip and Palate NAM Treatment – Initial Adjustment Visit • Payable only once per patient upon initiation in infants up to age 12 months and with a diagnostic code of 749 cleft lip and palate.	111.00		
22Z	Unilateral Large Cleft Lip and Palate NAM Treatment – Subsequent Adjustment Visit • Payable to a maximum of 23 times per patient and with a diagnostic code of 749 cleft lip and palate; patient age may exceed 12 months.	111.00		
30Z	Bilateral Large Cleft Lip and Palate Assessment – Initial NAM Assessment and Start up • To determine if NAM treatment is warranted and viable; if viable, all services associated with preparation of device, insertion, and fitting. Payable only once per patient up to age 12 months.	350.00		
31Z	Bilateral Large Cleft Lip and Palate NAM Device and Treatment – Initial Adjustment Visit • Payable only once per patient up to age 12 months and with a diagnostic code of 749 cleft lip and palate.	173.00		
32Z	Bilateral Large Cleft Lip and Palate NAM Device and Treatment – Subsequent Adjustment Visit • Payable to a maximum of 23 times per patient and with a diagnostic code of 749 cleft lip and palate; patient age may exceed 12 months.	173.00		

Code	Description of Service	Specialist	Dentist	Class
	Orthodontic Care of Cleft Palate			
	Orthodontic Care – Infant, With Cleft Palate			
	Initial Oculo-Instrumental Examination of an infant to determine if treatment is warranted.			
38Z	– in office or while Dentist in hospital	39.90		
39Z	– special visit to hospital required	53.15		
40Z	Preparation and Fitting of a Prosthetic appliance for infant • Age less than 2 years. • Includes all post-procedural visits related to the appliance. • Per appliance (maximum 5 appliances per infant).	334.55		
	Initial Expansion & Anterior Alignment (up to 12 years of age)			
46Z	Initial Oculo-Instrumental Examination to determine if treatment is warranted (maximum 2)	51.40		
48Z	**Diagnostic Phase**: • Complete orthodontic examination; • Diagnostic models; • Panorex film; • Facial & profile photographs; • Cephalogram; and, • Treatment planning	378.40		
50Z	**Starting Fee**: Placement of fixed or removable appliances	600.80		
52Z	**Active Treatment:** • All visits necessary to review progress, change or adjust appliances. • Visit fee to a maximum of 14. • Visits beyond 14 “by report” to a maximum of 24.	149.95		
53Z	**Placement of retainer** at the completion of initial phase of treatment	214.20		
54Z	**Retention Treatment:** • 2 visits per year to a maximum of 6. • All visits necessary to ensure retention of desired occlusion of teeth and relationship of facial bones.	60.10		

Code	Description of Service	Specialist	Dentist	Class
	Orthodontic Care of Cleft Palate			
	Final Alignment (Approximate age 9 years to 16 years); Retention Treatment (Age 9 years to 21 years)			
47Z	Examination to determine if treatment is warranted (one per 12 months – maximum 3)	51.40		
49Z	**Diagnostic Phase**: • Complete orthodontic examination; • Diagnostic models; • Panorex film; • Facial & profile photographs; • Cephalogram; and, • Treatment planning	378.40		
60Z	Starting Fee – upper Arch – placement of fixed appliance	467.15		
62Z	Starting Fee – both Arches (cannot be combined with 60Z)	1,199.50		
64Z	**Active Treatment**: • All visits necessary to review progress and adjust bands. • Visit fee to a maximum of 30. • Beyond 30 visits "by report" to a maximum of 36 visits.	184.60		
65Z	Placement of retainer at the completion of final phase of treatment	214.20		
66Z	**Retention Treatment**: • 2 visits per year to a maximum of 6. • All visits necessary to ensure retention of desired occlusion of teeth and relationship of facial bones.	60.10		

Notes:

1. The payment for orthodontic treatment under this Schedule is limited to insured persons with a **cleft of the hard palate**. The orthodontic services must be necessary and consequential to the cleft palate. Treatment under this Schedule does not include clefts affecting only the soft palate or lip.

2. Consideration will be given to extending the orthodontic services in this Schedule to insured persons with severe congenital cranial-facial anomalies other than cleft palate. The orthodontic services must be necessary and consequential to the diagnosed congenital abnormalities.

   Payment for any orthodontic services for congenital anomalies other than cleft palate requires prior approval by the Medical Services Plan. Orthodontists must submit a treatment plan, full records (models, Panorex, encephalogram, photographs or slides), and a list of the codes they wish to bill under the treatment plan.

3. Dental reconstruction to replace missing or deformed teeth due to cleft palate or other congenital anomalies are **not insured services**. Dental reconstruction includes, by way of examples, crown and bridges; partial dentures; osseo-integrated implants.

EXPLANATORY CODES
PATIENT IDENTIFICATION

The alphabetic code listed on the payment file/list, reject file or returned claim identifies the related explanation.

AA Not registered – no record of this person under this number. Please recheck the Health Services Card.

AC Incorrect sex indicated on claim – Medical Services Branch (MSB) has paid this claim. Please use the sex shown on the Health Services Card for future claims.

AD Incorrect Health Services Number – use the number shown on this payment file/list for future claims.

AE Incorrect date of birth – please use the date of birth shown on the Health Services Card. Please use the date of birth as shown on the Health Services Card for future claims.

AF Please review this claim. The Health Services Number is inconsistent with the name, sex or birth date on the Health Services Card.

AH Please review this claim. Our records indicate that the beneficiary registered under this number died prior to the date of service.

AL Please check the date of service. This claim was received at MSB prior to the date of service indicated on the claim.

AM A letter sent to this patient by Health Registries regarding the validation renewal stickers has been returned. This patient will not have coverage after January 31. When you next attend to this patient, please advise him/her to immediately contact Health Registration at 1-800-667-7551 or 306-787-3251 to have their coverage updated. Please ignore this message if the patient now has a new expiry sticker.

AO A letter sent to this patient by the Ministry of Health has been returned. Therefore, the patient's coverage has been terminated. On your next contact with this patient, please advise the patient to immediately contact Health Registries at 1-800-667-7551 or 306-787-3251 to have their coverage updated.

AP The 9-digit Health Services Number is incorrectly recorded. Please recheck your files and/or the patient's Health Services Card.

EXPLANATORY CODES

AR Patient not registered for coverage on this date of service. Please check the effective and expiry dates on the Health Services Card.

If the Patient is a resident, he/she should immediately contact Health Registries, 1-800-667-7551, 2130 11th Avenue, Regina, SK, S4P 0J5, in order to have coverage updated. If resubmitting, please indicate the current address.

AS Your account had to be split for processing. Payment for the listed services was approved based on the Saskatchewan Ministry of Health Payment Schedule (additional cheques may be issued).

AT Diagnosis and Payment Schedule item are not compatible.

AU To assist our Dental Consultant in the assessment of this service; please submit a request for review of claims assessment form with a copy of the operative report, medical record, or a descriptive letter.

AV This service is not insured.

AW This Payment Schedule service code applies to a certain location of service; the location of service you submitted is not compatible.

AX A Dental Consultant has reviewed this claim. The factors described are not considered sufficient to warrant additional payment. If there are further relevant details, please resubmit with the additional information.

AY Assessed by a Dental Consultant.

AZ Please refer to correspondence.

GENERAL

BA Duplicate – same dentist – payment has been made for the same service provided on the same day. Please check your records for a duplicate payment and only resubmit the claim if the service has not been previously submitted and paid.

BB Possible duplication of a payment for a similar service. If no duplication, please resubmit with a note in the "Remarks" area, on the back of a claim form or a comment record in the automated claim submission.

BC Duplicate – same clinic – payment has been made to another dentist in your clinic for a similar service on the same day. Please check your records for a duplicate payment and only resubmit the claim if the service has not been previously submitted and paid.

BD The beneficiary has been paid for a similar service provided on the same day.

BE The age of the patient is inconsistent with the description of the payment schedule.

BG This Payment Schedule service code was submitted at less than the listed rate.

a) If this claim has been returned to you, please correct and submit at the current rate.
b) If this claim has been adjusted by Ministry Officials, the appropriate rate for the date of service has been approved.

EXPLANATORY CODES

BH Payment Approved at:
1) Listed rate for a specialist in your specialty.
2) Equivalent service code and fee listed in your specialty.

Re: Definition of "Specialist".

BJ Unreferred patient – payment for this item can only be made if the patient was referred and the 4-digit referring practitioner number is indicated in the appropriate field. Please re-submit:
a) If referred, with the 4-digit referring practitioner or Cleft Palate Clinic in the appropriate field;
b) If unreferred, using appropriate code and fee.

BK The current service code you submitted is inconsistent with previously paid services.

BN You were asked for additional information to assess this claim, no reply received - without this information, the claim cannot be processed

BO The approved service code and payment is based on your description of the service.

BP Payment adjustment based on:
a) Your resubmission;
b) Our review of assessment; or,
c) Information received on Review of Claim Assessment form.

BQ The service code and/or amount submitted may be incorrect. Please review and resubmit.

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

BV Payment based on the appropriate service code and amount listed for the date provided.

BW Billed more than the listed payment – appropriate payment for the date of service has been approved.

BZ Payment is based on the amount payable to a Saskatchewan dentist in the same specialty providing the same or similar service.

EXPLANATORY CODES
SERVICES NOT INSURED BY MINISTRY OF HEALTH

CB Materials & other services – e.g.:

Advice by telephone	Drugs
Anesthetic materials	Secretarial or reporting fee(s)
Appliances (Prostheses)	Surgical supplies
Dressing or Medication	Tray service

CD Extraction of teeth is not an insured service **except** when :

a) The extraction of teeth is necessary to be performed prior to the provision of heart surgery services, services for chronic renal disease, prior to or following head and neck cancer services or services for total joint replacement by prosthesis, or in conjunction with Cleft lip and Palate repair/grafting/orthodontic realignment or,
b) As a result of cancer radiation treatment within five years where the patient has followed the recommended guidelines of the radiation oncologist and of the dentist in relation to recommended dental hygiene and care; or,
c) Prior to stem cell transplants; and,
d) The beneficiary is referred to the dentist by a specialist in the field of practice in which the services lie; and,
e) The specialist recommends that payment be made for the service.

CE A service by a dentist who is not registered with the College of Dental Surgeons of Saskatchewan on the date the service was provided.

CF This service code is not valid for this date, because it is either:

a) Prior to implementation; or
b) After deletion from the Payment Schedule.

CG **Dentist Billing – Own Family**

Payment is not approved for services provided by a dentist to himself, his spouse or any of his dependents. (Ref: Regulations under *The Saskatchewan Medical Care Insurance Act*).

CH These services appear to be the responsibility of the Department of Veteran's Affairs (D.V.A.). Please send the appropriate form to D.V.A., Treatment Benefit Unit, Box 6050, Winnipeg, MB, R3C 4G5. If they do not accept responsibility, please resubmit the claim electronically with the comment “Not responsibility of DVA”.

EXPLANATORY CODES

CM Claims received more than six months after the date of service. If factors beyond your control prevented submission within six months, the following details must be received in writing addressed to the Manager, Claims Unit (fax: 306-798-0582):

a) List of claims for which you are requesting the time limit approval.
b) Service codes and dollar amounts.
c) Number of patients.
d) Dates of service.
e) Circumstances for the delay in submitting your accounts.
f) Date of submission.

A resubmitted claim must be returned within one month. Resubmitted claims must include original claim number and the date of the original submission.

CN Claims received more than twelve months after the date of service cannot be accepted for any reason.

CU Payment is only approved for those dentists listed by the College of Dental Surgeons of Saskatchewan as having qualified to receive payment for this service.

CW These services appear to be the responsibility of the Workers' Compensation Board (WCB). Please submit a claim to the WCB at Suite 200 - 1881 Scarth Street, Regina, S4P 4L1. If they do not accept responsibility, WCB will forward the claim to you. If the claim has not yet been paid, please submit an automated claim to MSB with a comment "Not WCB" followed by the date submitted to and rejected by WCB.

MISCELLANEOUS

DD Please verify date(s) of service and resubmit.

EN A 200Z is not payable unless it is provided in conjunction with an insured oral surgery service.

FH Service is not insured as it was provided outside a hospital.

GC To assist the Dental Consultant in the assessment of this service, please submit orthodontic treatment plan, photos of full records, and a list of the codes you wish to bill under the treatment plan. The Practitioner should not start billing active treatments until Medical Services has reviewed the records.

JA Payment for an assistant is not approved for this procedure unless special circumstances satisfactory to the Ministry of Health are described. Please provide details and resubmit your claim.

JC Payment is to be based on the induction of anesthetic to when the surgical assistant is no longer required – payment has been adjusted based on billed anesthetic time.

JN Considered an inclusion within the payment for a more major procedure.

JO Paid in accordance with assessment rules for two or more procedures performed on the same day by the same dentist, another dentist in the same clinic or part of the surgical team.

EXPLANATORY CODES

JQ Paid at the maximum listed for these multiple procedures. Re: Payment Schedule item.

JW Paid as a repeat procedure within the designated post-operative period.

KA An inclusion in payment for the procedure when provided by the same dentist or another dentist in the same clinic.

KH Only the greater payment is approved when a dentist acts in more than one capacity, e.g., anesthetist, assistant or surgeon.

KO Pre-operative care in hospital is included in the payment for a "10" or "42" day surgical procedure.
Re: Assessment Rules – "Surgery Rule 3."

KQ Visit services for the same or a closely related condition during the normal period of post-operative care for a "10" or "42" day procedure are included in payment for or the procedure, when provided by the surgeon or any dentist.
Re: Assessment Rule – Surgery #1B.

XA Radiology is only approved to a dentist certified by the College of Dental Surgeons of Saskatchewan as being a Specialist in Oral Radiology.

XF Maximum Exceeded – The beneficiary's payment history indicates that the services provided would, with this service, exceed the Payment Schedule maximum.

INCOMPLETE CLAIMS

YA Patient's name – please clarify the full name.

YB Registration – indicate the complete 9 digit Health Services Number as recorded on the Health Services Card.

YC Date of Birth – indicate the month and year of birth recorded on the Health Services Card.

YD Family head – please indicate the full name and address.

EXPLANATORY CODES

YF THE SIGNATURE BLOCK on this claim is completed differently than what you previously indicated to MSB.

The acceptable methods are:
1. Personal signature.
2. Impress a rubber stamp facsimile of the practitioner's signature.
3. Impress a rubber stamp of the practitioner's name in capital letters.
4. Hand print the practitioner's name in capital letters.
5. Delegate a member of the staff to personally sign on the practitioner's behalf.

Prior to resubmission, please complete the signature block by either:
a) Your previously designated method of signing; or
b) Personal signature.

If you wish to change your previously designated method of signing on claims, you must advise MSB in writing of the specific acceptable method you intend to use in the future.

YG Beneficiary identification – If we have inaccurately identified your patient, please make the required correction and resubmit it. If there is doubt as to the correct identification, please check the patient's Health Services Card.

YH Diagnosis – please indicate the diagnosis.

YI Please clarify the item(s) circled on the claim or recheck the entire claim.

YK Please indicate the service code and amount charged for each service.

YL Date of service -- please indicate the proper day, month and year.

YP The clinic number is invalid for the submitted dates of service. Please review the dates of service and clinic number.

YR Please clarify the name and initials of the dentist who provided each service.

YS We are unable to identify who referred the patient. A referring practitioner's name either has not been supplied, or if a name is present on the claim, he or she cannot be located in our listing of active Saskatchewan practitioners. If the patient was referred, please resubmit the claim with the full name of the practitioner and the location of his or her practice.

YU Your claim has been returned because of the omission of one or both of the following items:
a) Designation of the operative procedure,
b) The total time when additional time is billed.

ZA The patient identity information on the claim (month or year of birth, sex or surname) does not correspond to information on the Health Services Card. Please check the Health Services Card, make the claim corrections and resubmit.

EXPLANATORY CODES

ZC The submitted claim contains invalid data other than patient identification data, e.g. September 31, the submitted fee at zero dollars, the 13 month, a lower case alpha character, a partially blank field as HSN, wrong location of service, a service not allowed for premiums, etc.

ZD The dates of service or month of birth are invalid. The date of service may be greater than the date of computer processing or there are two months of service on 50 records with the same claim number.

ZF The doctor is not eligible to submit for services on the indicated dates of service.

ZH Please check the date of service on the claim because it conflicts with previously paid services. If you resubmit without changes, please indicate "Date of Service is Proper" on the comment record or in the remarks area of the claim form.

ZL The submitted referring doctor number is invalid or an invalid referring doctor number has been used for a non-cancer diagnosis. Please check the referring doctor name and number

ZM The claim contains an invalid diagnostic code according to the International Classification of Diseases – 9th Revision. Please check the diagnosis, diagnostic code and table of invalid codes

ZN The Ministry of Health has received multiple claims with the same clinic, doctor, claim and Health Services Number. One of the claims is being processed; all other claims with the same claim number are being returned.

ZP An invalid mode of payment has been used on the claim.

ZS This claim was submitted as a Professional Corporation (PC) claim; however, no PC information has been received or the PC claim is not valid on this date.

ZT Please refer to the comment record(s) being returned by MSB for a more detailed explanation.

ZW The direct input claim cannot be processed. Please resubmit on a regular claim form.

ZY The direct input claim cannot be processed. Please resubmit with comments or an explanation of the service provided. If an operative report or a detailed explanation is required, it should be submitted and attached to a regular claim form.