Ministry of
Health

SASKATCHEWAN HEALTH

PAYMENT SCHEDULE FOR INSURED SERVICES

PROVIDED BY A DENTIST OR A DENTIST HOLDING A SPECIALIST LICENCE

April 1, 2010

MEDICAL SERVICES PLAN
PAYMENT SCHEDULE FOR INSURED SERVICES PROVIDED BY A DENTIST OR A DENTIST HOLDING A SPECIALIST LICENCE

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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 a 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.

MEDICAL SERVICES PLAN
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April 1, 2010

ORAL AND MAXILLOFACIAL SURGERY

Code	Description of Service	Specialist	Dentist
087Z	Fracture of alveolus (including debridement, teeth removal or repositioning, splinting and fixation of segment of fracture)	$215.00	
	Fractures of the facial bone – mandible		
094Z	Closed reduction with intermaxillary fixation including interdental and intermaxillary wiring	402.00	
095Z	Open reduction of single fracture, **excluding** interdental or intermaxillary wiring	418.00	
096Z	Multiple compound or comminuted fractures – **excluding** interdental or intermaxillary wiring	496.00	
097Z	Condylar fracture – open reduction – **excluding** interdental or intermaxillary wiring	701.00	
	Code 094Z may be billed at 100% in conjunction with 095Z, 096Z or 097Z if interdental or intermaxillary wiring is performed		
	Fractures of the facial bone – maxilla/zygoma		
098Z	Displaced – closed reduction	402.00	
099Z	Open reduction with internal fixation	480.00	
100Z	Malar bone and zygomatic arch open elevation or temporal approach (Gillies)	402.00	
101Z	Complete facial smash with cranial/facial separation, complicated, open reduction, multiple surgical approaches, internal fixation, wiring teeth, etc. – by report	By Report	

Code	Description of Service	Specialist	Dentist
Interdental wiring			
108Z	Removal of interdental and/or intermaxillary wiring and/or arch bar – different surgeon – office procedure	43.10	
109Z	Operative removal of any number of screws or wires per operative site	95.00	
110Z	Operative removal of plates (including screws and wires) 110Z includes the removal of screws and wires and therefore is not billable with 109Z	250.00	

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	126.00
113Z	Each additional fifteen minutes or part thereof	34.00

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. The services considered for this billing option 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	1/2 of first surgeon's claim

Periodontal surgery/prosthetic surgery

129Z	Frenectomy – lingual or labial (maximum of 2 per patient)	92.00	77.00
130Z	Edentulous patients – tuberosity reduction – unilateral	163.00	
131Z	Edentulous patients – tuberosity reduction – bilateral	321.00	
134Z	Torus Palatinus – Excision	320.00	
135Z	Torus Mandibularis – Unilateral – Excision	190.00	
136Z	Torus Mandibularis, Bilateral, Excision	331.00	

Code	Description of Service	Specialist	Dentist
Periodontal surgery/prosthetic surgery (continued)			
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.	203.00	
150Z	Alveoplasty per quadrant (not in conjunction with extraction).	98.00	
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.	287.00	
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.	284.00	
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.	509.00	
Lacerations – suturing			
Intraoral -			
156Z	Up to 2.5 cm	50.70	43.10
157Z	Each additional 2.5 cm or part thereof	25.20	21.40
Extraoral -			
158Z	Facial lacerations up to 5 cm	123.00	
159Z	Each additional 2.5 cm or part thereof	61.40	
Dental abscess/maxillofacial space abscess – total care (Cannot be claimed in conjunction with 166Z, 167Z, 168Z or 169Z)			
162Z	Intraoral – limit one per arch	56.00	47.80
163Z	Extraoral – office procedure	113.00	
164Z	Patient under general anaesthetic – by report	By Report	

Code	Description of Service	Specialist	Dentist
Cysts of dental origin – intraoral approach only – radiographs may be requested			
166Z	Under 1 cm	48.60	
167Z	1 to 2.5 cm in diameter	155.00	
168Z	Over 2.5 cm to 5 cm in diameter	273.00	
169Z	> 5 cm – by report, including x-ray(s)	By Report	
Intraoral biopsy			
170Z	Soft tissue	82.00	70.00
171Z	Bone – Not to be claimed in conjunction with 134Z, 135Z, 136Z, 150Z, 151Z, 152Z, 153Z, 174Z.	139.00	119.00
Oroantral fistula			
174Z	Repair of oroantral fistula (excludes bone grafting)	391.00	
175Z	Caldwell Luc operation – maxillary sinus (excludes bone grafting)	345.00	
Operative removal of duct stone			
176Z	Submandibular	153.00	
177Z	Parotid	269.00	
178Z	Ranula – floor of mouth – simple (marsupialization)	164.00	
179Z	Ranula – floor of mouth – complicated (and/or removal of sublingual gland)	391.00	
Temporomandibular joint dysfunction			
183Z	Uncomplicated – closed reduction	90.00	77.00
184Z	Uncomplicated – closed reduction under general anaesthetic	131.00	
185Z	Temporomandibular dislocation – open reduction – unilateral	464.00	
186Z	Coronoidectomy for trismus	344.00	
187Z	Eminectomy or zygomatic arch osteotomy for chronic dislocation	482.00	
188Z	Meniscoplasty	617.00	
189Z	Condylectomy	651.00	
190Z	Meniscectomy	694.00	
191Z	Costochondral graft for condylar replacement	651.00	
192Z	Meniscectomy with implant, add -	115.00	

Code	Description of Service	Specialist	Dentist
Temporomandibular joint dysfunction (continued)			
193Z	Gap arthroplasty for ankylosis	616.00	
194Z	Condylectomy with joint prosthesis with or without glenoid fossa prosthesis	1,305.00	
195Z	Arthroscopy – diagnostic – paid 75% when done with other surgical procedures	287.00	
196Z	Arthroscopic meniscus and joint repair – (with alloplastic material – includes arthroscopy)	579.00	
197Z	Arthrocentesis with or without injection of medications	65.10	
198Z	Arthroscopy – therapeutic – including lysis and lavage – therapeutic inspection	328.00	
210Z	Incision, excision or ablation of cranial nerve	235.00	
211Z	Injection of cranial nerve for destruction (trigeminal neuralgia)	131.00	
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 extra oral – bilateral (includes interdental or intermaxillary wiring)	1,305.00	
230Z	LeFort I osteotomy of maxilla – one segment	1,305.00	
231Z	- including application of bone graft	1,450.00	
232Z	- including harvesting and application of bone graft	1,644.00	
235Z	LeFort I osteotomy of maxilla – two segments	1,439.00	
236Z	- including application of bone graft	1,578.00	
237Z	- including harvesting and application of bone graft	1,777.00	
238Z	LeFort I osteotomy – cleft palate	1,696.00	
239Z	LeFort I osteotomy – cleft palate – closure of alveolar cleft sites and oral/nasal fistula	1,956.00	
240Z	Submucous septorhinoplasty	284.00	
245Z	Alveolar bone grafting and closure of oroantral fistula with reconstruction of nasal floor	651.00	
246Z	Symphyseal narrowing osteotomy of the mandible	464.00	
247Z	Symphyseal narrowing osteotomy with bone graft	639.00	
248Z	Surgically assisted rapid palatal expansion	521.00	
249Z	Distraction osteogenesis to widen the mandible	521.00	
250Z	Harvesting of autogenous bone graft for use by oral and maxillofacial surgeon – by second surgeon	287.00	
251Z	Harvesting by same surgeon add:	197.00	

Code	Description of Service	Specialist	Dentist
Orthognathic procedures (continued)			
252Z	Application of bone graft. To be used in special circumstances where not included in combined surgical/bone graft procedures. BY REPORT.	287.00	
Dental extractions**			
300Z	Consultation in conjunction with an insured dental extraction service	104.00	48.10
	Extractions:		
301Z	- first tooth in each quadrant	111.00	95.00
302Z	- subsequent teeth in each quadrant – per tooth	63.00	63.00

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

a) the extraction of teeth is necessary to be performed before the provision of heart surgery services, services for chronic renal disease, head and neck cancer services or services for total joint replacement by prosthesis; and
b) the beneficiary is referred to the dentist by a specialist in the field of practice in which the services lie; and
c) 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.	65.10	
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.	26.30	
203Z	Emergency Surcharge – day or night – any day 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 arrange for the patient's emergency admission as a hospital in-patient. It is in addition to payment for an appropriate assessment and/or procedure.	48.40	

Code	Description of Service	Specialist	Dentist
Adjunctive Services (continued)			
204Z	BMI Supplement – General surgery supplement for patients with a Body Mass Index, (Weight [kg]/Height $[m]^2$) greater than 40 - 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	160.00	
752Z	SSCN Forms – SSCN prioritization form completion and submission to SSCN in conjunction with an insured oral and maxillofacial surgery service.	10.60	10.60

ORTHODONTIC CARE OF CLEFT PALATE

Code	Description of Service	Specialist	Dentist
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	39.10	
39Z	- special visit to hospital required	52.10	
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)	328.00	
INITIAL EXPANSION & ANTERIOR ALIGNMENT (up to 12 years of age)			
46Z	Initial Oculo-Instrumental Examination – to determine if treatment is warranted (maximum 2)	50.40	
48Z	Diagnostic Phase: Complete Orthodontic Examination, diagnostic models, panorex film, facial & profile photographs, cephalogram and treatment planning	371.00	
50Z	Starting Fee: Placement of fixed or removable appliances	589.00	
52Z	Active Treatment: All visits necessary to review progress, change or adjust appliances. Visit fee to a maximum of 14 (beyond 14 by Report to a maximum of 24).	147.00	
53Z	Placement of retainer at the completion of initial phase of treatment	210.00	
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.	58.90	

ORTHODONTIC CARE OF CLEFT PALATE

Code	Description of Service	Specialist	Dentist
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)	50.40	
49Z	Diagnostic Phase: Complete orthodontic examination, diagnostic models, panorex film, facial & profile photographs, cephalogram and treatment planning	371.00	
60Z	Starting Fee – upper Arch – placement of fixed appliance	458.00	
62Z	Starting Fee – Both Arches (cannot be combined with 60Z)	1,176.00	
64Z	Active Treatment: All visits necessary to review progress and adjust bands. Visit fee to a maximum of 30 (beyond 30 by Report to a maximum of 36 visits).	181.00	
65Z	Placement of retainer at the completion of final phase of treatment	210.00	
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	58.90	

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.

ASSESSMENT RULES

Ex. Code

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. — JA

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. — KH

Anaesthesia

1. The listed payment for the procedure includes anaesthesia (any type) by the surgeon or surgical assistant.

Ex. Code

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: KA

      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: KQ

      a) procedures for the control of haemorrhage 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. The costs of any materials used are not included in the payment. CB

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 payments included all manipulations and fixation media* to achieve and maintain satisfactory healing during the normal post-operative period. KQ

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

5. When more than one procedure is carried out under the same anaesthesia 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 for each component. JO

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. JW

Ex. Code

Consultations and Follow-up Examinations

1. (a) A consultation is insured only in conjunction with an insured oral surgery service. EN

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

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. BK

   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. BK

Orthodontic Care for Cleft Palate

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

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

DEFINITIONS

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.

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).

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

Mode 1 -- Paid directly by MSB to the provider of service.
Mode 3 -- Paid to beneficiary.

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.

Specialist - a dentist whose name is on the list of dentists maintained by the College of Dental Surgeons of Saskatchewan and MSB has been formally advised by the College as being entitled to receive payment at specialist rates.

PATIENT IDENTIFICATION

A plastic "Health Services Card" for registered beneficiaries is sent every third year, expiring December 31, 2011 and every third year thereafter, 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, 1942 Hamilton Street, Regina, S4P 2C5 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 MSB.

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

The alphabetic code listed 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.

AB Patient does not appear to be covered for this date of service. If you can resubmit with the patient's correct address, we will determine if the patient was covered.

AC Registered as opposite sex -- please check the Health Services Card.

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

AE Incorrect date of birth -- please use the date of birth shown on the Health Services Card.

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

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

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

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

AO A letter sent to this patient by Sask. 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 Sask. Health at 1-800-667-7551 to have their coverage updated.

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

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

If the Patient is a resident, he/she should immediately contact Health Registration, (1-800-667-7551) 1942 Hamilton Street, Regina, S4P 2C5, in order to have coverage updated. If resubmitting, please indicate the current address.

GENERAL

AS Your account had to be split for processing. Payment for the listed services was approved based on the Saskatchewan 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 claim form with a copy of the operative report or a descriptive letter.

AV This service is not insured.

AW This Payment Schedule item applies only to a particular location of service (refer to Payment Schedule).

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.

BA Duplicate -- same dentist -- payment has been made for same service provided on the same day.

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 same service on the same day.

BD The beneficiary has been paid, based on the claim previously submitted.

BG Billed less than the listed payment -- appropriate payment for the date of service has been approved.

BH Only a "specialist" is entitled to payment at the specialist rates.
Re: Definition of "Specialist".

BJ Unreferred patient -- if this patient was referred, please resubmit with the full name of the referring physician, dentist or Cleft Palate Clinic referral.

BK Payment based on the service code and related payment approved by the MSB.

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, or
(b) our review of assessment.

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.

SERVICES NOT INSURED BY MSB

CB Materials & other services -- e.g.:

Advice by telephone	Drugs
Anaesthetic 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 provided by a dentist prior to heart surgery, the treatment of chronic renal disease or services for total joint replacement by prosthesis.

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 (DVA). Please send the appropriate form to DVA, Treatment Benefit Unit, Box 6050, Winnipeg, R3C 4G5. If they do not accept responsibility DVA will forward the claim to MSB.

CM Claims received more than six months after the date of service. If factors beyond your control prevented submission within six months, please resubmit with an explanation.

A resubmitted claim must be returned within one month. 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 Worker's 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 back to you. If the claim has not yet been paid, please submit a claim to MSB with a comment "NOT WCB" followed by the date rejected by WCB.

MISCELLANEOUS

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

EN A consultation 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.

JA Payment for an assistant is not approved for this procedure unless special circumstances satisfactory to MSB are described.

JC Time designated exceeds the related anaesthetic 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.

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

JW Paid as a repeat procedure.

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., anaesthetist, assistant or surgeon.

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

KQ Related visits or services during the designated post-operative period are included in payment for 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.

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.

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

YS We are unable to identify who referred the patient. The circled numeric indicates the information required:

(1) the initials,
(2) the surname and initials,
(3) the location of his/her practice on the date of referral.

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.

ZC The submitted claim contains invalid data other than patient identification data, e.g. September 31, the submitted fee at zero dollars, the 13th month, a lower case surname, a partially blank field as HSN, 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 Saskatchewan 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.