Operations Bulletin

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IMPORTANT HEALTH WEBSITE LINKS HAVE CHANGED

With the implementation of the new Government website on February 1, 2015, important links have changed.

The new Government of Saskatchewan website is www.saskatchewan.ca.

Providers Section:
All Medical Services Branch Payment Schedules, Newsletters and Operations' Bulletins are available at the link below:

http://www.saskatchewan.ca/government/health-care-administration-and-provider-resources

Forms:
All Medical Services Branch forms are available at the link below:

http://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/ministry-of-health-forms

This link includes the following forms:

- Direct Deposit request
- Income Statement request
- Review of Claims Assessment
- Medical Statement request
- Physician Profile request
- Practitioner Change request
- Professional Corporation request
- New Clinic Request application
- Prior Approval Request Form – abdominal panniculectomy
- Electronic Remittance Application
- Health Provider Questionnaire

Government of Saskatchewan

STATUTORY HOLIDAYS TO JUNE 2017

HOLIDAY	ACTUAL DATE	OBSERVED ON	SUBMISSION DATE IMPACT	PAYMENT DATE IMPACT
Thanksgiving	Monday October 10, 2016	Monday October 10, 2016	None	None
Remembrance Day	Friday November 11, 2016	Friday November 11, 2016	None	Run jg: Moved to Tuesday November 15
Christmas Day	Sunday December 25, 2016	Tuesday December 27, 2016	None	Run jj: Moved to Wednesday December 28
Boxing Day	Monday December 26, 2016	Monday December 26, 2016	None	Run jj: Moved to Wednesday December 28
New Year's Day	Sunday January 1, 2017	Monday January 2, 2017	None	None.
Family Day	Monday February 20, 2017	Monday February 20, 2017	None	Run jn: Moved to Tuesday February 21
Good Friday	Friday April 14, 2017	Friday April 14, 2017	None	None
Victoria Day	Monday May 22, 2017	Monday May 22, 2017	None	None
Canada Day	Saturday July 1, 2017	Monday July 3, 2017	None	None
Saskatchewan Day	Monday August 7, 2017	Monday August 7, 2017	None	Run jz: Moved to Tuesday August 8.

Please note that any changes to the run schedule will be communicated via the ICS message window and pay lists. Please check the ICS service website periodically for important messages regarding payment or run information.

PRINTED COPIES OF THE PAYMENT SCHEDULE – NO LONGER AVAILABLE

Please be advised that after October 1, 2015, Medical Services Branch no longer provides printed copies of the Physician Payment Schedule. The Physicians' Newsletter and Operations Bulletin will continue to be mailed out. Copies of the Payment Schedule can be found on the website and link on page 1 of this newsletter.

INCOME STATEMENTS

Effective January 1, 2014, prepayment is required for all income statement requests at a charge of $18.00 annually. Payment must accompany your request form. The Physician Request for Income Statement form can be found under the forms link on page 1.

PHYSICIAN PROFILE REQUEST FORM

Physician profiles represent a summary of services for which the Ministry of Health has made payment to a physician and a comparison to the group average for physicians in the same type of practice. To request a copy of your profile, please access the Physician Profile Request form under the forms section on the website (link on page 1). Please see Physician Payment Schedule page 35 for payment information.

ELECTRONIC REMITTANCES

Effective August 1st, 2015, Medical Services Branch and the Ministry of Finance offer electronic remittance. Electronic remittance allows physicians and clinics to receive an email that outlines payment information rather than a physical direct deposit advice or payment notification. Physicians and clinics benefit from using electronic remittance, as it improves accuracy and timeliness of recording revenue, and because payment information is sent prior to funds being deposited.

To Sign Up

To sign up for electronic remittance please download and fill in the appropriate Electronic Remittance Application form (multiple physicians or single physician) which can be found at:

http://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/ministry-of-health-forms#medical-services-branch-forms

Completed forms and inquiries related to electronic remittances can be directed to:
AccountingUnitMSB@health.gov.sk.ca

ROYAL CANADIAN MOUNTED POLICE (RCMP) HEALTH COVERAGE

As of April 1, 2013, all members of the RCMP were eligible for Saskatchewan Health coverage. However, RCMP members are not eligible for Workers' Compensation coverage. All RCMP members who are confirmed to require care as a result of a work-related injury, are to be billed directly, as those claims will be paid to them through their Blue Cross coverage.

Blue Cross requires that the following information be provided:

- Full name
- Date of service
- Diagnosis
- Blue Cross number of the RCMP member

IMPORTANT REMINDER REGARDING TIME LIMIT FOR SUBMISSION OF ACCOUNTS

The Saskatchewan Medical Care Insurance Payment Regulations, 1994 Section 11 (1) states that accounts for payment must be received in the period of six consecutive months immediately following the provision of the insured service. Section 11 (2) clearly describes that extension to the six-month time limit is by rare exception and for reasons beyond the control of the practitioner.

Claims returned to the physician should be corrected and sent back to Medical Services Branch within 30 days; this will be strictly enforced once a claim becomes 5 months old.

IMPORTANT:

PLEASE NOTE: The maintenance of appropriate office billing records, training and monitoring of billing staff, reconciliation of accounts submitted compared to accounts paid, establishment of appropriate internal controls in the conduct of the business of medical practice and working directly with vendors to ensure that systems are configured appropriately in order to meet the business needs, are all items that fall within the direct control and responsibility of the physician.

IMPORTANT REMINDER FOR ONLINE CLAIM SUBMISSIONS

This is a reminder to review the validation and return reports that are available on the Ministry's Internet Claims Submission (ICS) service website. Your EMR program or billing application may not relay these reports automatically from ICS. These reports will provide you with information about the status of your claims.

Even if your billing system identifies that your claims were **submitted**, it does not confirm that the file was received by the Medical Services Branch (MSB). To ensure your submission was successfully submitted to MSB it is recommended that you review your ICS ***"validation report"***. This report contains totals for each clinic/doctor number that was submitted in the run for payment and/or any errors found in your submission prior to the bi-weekly Tuesday claims run.

***If you do not receive an ICS *"validation report"* immediately after your claims submission you must follow up with MSB to investigate the issue as this indicates there is a problem with the receipt of your submission.**

It is also important for you to pick up your ***"return.txt"*** file from the ICS website starting on the Wednesday following the Tuesday run. This file contains the pay list records and any returned or rejected claims. Use this report to reconcile your accounts.

You can access the ICS website by going online to ***https://ics.ehealthsask.ca/***

VERIFICATION OF HEALTH COVERAGE

Effective January 1, 2013, Medical Services Branch no longer verifies beneficiary health coverage information by phone or fax. Physicians (licensed to practice in Saskatchewan) who wish to verify the validity of a patient's health coverage are required to request access to the online Person Health Registration System Viewer (PHRS Viewer). To learn more about PHRS viewer, please contact eHealth Saskatchewan at 306-337-0600 or toll free at 1-888-316-7446 or by email at servicedesk@ehealthsask.ca

GENDER NEUTRAL HEALTH CARDS

Please be advised that some Canadian Provinces are changing how they display the sex and gender information on their provincial health cards. The most recent example of this change was that of Ontario on June 13, 2016. Health cards produced in Ontario after this date no longer have the sex designation visible on the card (which was previously visible to the right of the birth date on an older photo health card). Citizens of Ontario will be able to mark their gender as "X" instead of "M" or "F" for male or female. The change doesn't affect the card's validity and it continues to function in the same way.

Payment for insured services provided to out-of-province patients, with the exception of Quebec, may be made by the Ministry of Health upon an account being presented. The claim must contain pertinent information including the patient's name in full, the patient's Health Service Number, the patient's month and year of birth, and sex, the location of service, etc. For a full list of required information, please refer to page 25 and 26 of the October 1, 2016, Physician Payment Schedule. The sex indicator is a required field on the physician claims billing system and can only be male or female.

Please note that other Canadian provinces have made or are considering making this change to their health cards as well. Absence of the sex indicator or any of the other critical information listed above on a reciprocal claim will affect processing. **It is imperative that, if any of this information is not displayed on a patient's provincial health card, that the clinic personnel collect the information as required.**

It is recommended that a photo copy of the front and back of the health card be taken and kept on the patient's file.

OUT-OF-PROVINCE SERVICES NOT COVERED BY MEDICAL SERVICES BRANCH

Please be advised that the following services are not covered by MSB:

- Mental health;
- Alcohol and drug addictions;
- Problem gambling;
- Acquired brain injury; and
- Rehabilitation services.

If you have a patient that requires these services out of province, approval must be obtained from Community Care Branch of the Ministry of Health prior to the patient receiving services. Requests for out-of-province assessment or treatment can only be accepted from Regional Health Authorities.

For more information on how to access community based services in your area, contact your local health region or call 306-787-3479.

UNINSURED SERVICES REQUESTED BY OTHER PROVIDERS

It has recently come to our attention that some physicians are ordering laboratory tests on behalf of uninsured providers (e.g. Naturopaths, Homeopaths, etc.).

The Saskatchewan Medical Care Insurance Act and associated Regulations outline the circumstances under which laboratory testing is insured through the public system. A physician ordering on behalf of an uninsured provider (i.e. Naturopath) is not an insured service.

As outlined in *The Saskatchewan Medical Care Insurance Act* and associated Regulations, if an insured service is provided in conjunction with an uninsured service, both services are uninsured and the patient is responsible for the cost. For example, if a patient sees a physician for the sole purpose of requesting uninsured services (laboratory testing from a Naturopath) both the visit and any testing order are uninsured and the patient is responsible for those costs. The Ministry would recover payment for services if it was billed for the situation as described above.

As these services are uninsured, it would be inappropriate for physicians to be ordering laboratory tests from another provider through the insured health system, when they have not examined and independently determined that the tests are clinically appropriate. There is a process in place for patients to receive uninsured laboratory services which should be followed in these circumstances.

BILLING REMINDERS

REMOTE CONSULTATION BETWEEN PHYSICIANS - 769A/762A

As outlined in the Physician Payment Schedule, service codes 769A and 762A are to be used for remote consultations "between physicians", which means it is a doctor-to-doctor consultation only. Therefore, it is not a billable service if it is between a nurse/nurse practitioner and a doctor.

There are existing codes in the Physician Payment Schedule that remunerate physicians for discussions related to patient care and management when initiated by nurse practitioners (NPs) and pharmacists:

- 790A and 791A (both NPs and pharmacists); and
- 761A (NPs).

EMERGENCY SURCHARGE - 721A

Please be advised that service code 721A is considered a special call/surcharge similar to codes 815A to 839A.

- Only one (1) special call/surcharge is billable per patient contact and 721A cannot be billed in addition to codes 815A to 839A.

ROUTINE INJECTIONS

Ministry officials have been reviewing the use of injection codes 110A and 161A to evaluate if the service delivered by the physician is supported in terms of the billings submitted.

The results of this review have revealed that a large volume of injection services have been billed inappropriately as visit services (5B).

The Saskatchewan Medical Care Insurance Act states that in order for a service provided in Saskatchewan by a physician to be deemed insured it must be medically required.

In order to bill for a 5B service:

a) It must be medically required; and
b) All payment schedule criteria must be performed and documented.

- For routine injections such as flu shots, B12, testosterone, iron, Depo-Provera, etc., if only the injection is being provided, then a 110A or 161A should be billed, not a 5B.
- Typically, it would not be medically required to bill a 5B for each injection visit.

COMPLEX/EXTENDED PEDIATRIC CONSULTATIONS - 12C/13C

Please be advised that service codes 12C/13C are billable for specific medical conditions only, as negotiated with the Saskatchewan Medical Association Tariff Committee.

- These service codes are not billable for patients with any medical condition that is not defined as complex neurodevelopmental, complex behavioural or complex psychiatric. Infants presenting with "developmental concerns" where a formal diagnosis of a "complex neurodevelopmental" condition has not been made are also not eligible.

- These service codes are not billable when a pediatric consultation for conditions other than those listed above takes longer than 45 minutes and would normally be billed as 9C.

- The full 45 minutes of time must be spent and documented in the patient record as per the Payment Schedule descriptor.

CLOSED CHEST DRAINAGE – 95L

Service code 95L is typically payable if it is being done as a stand-alone procedure or post-surgery due to a complication. This code is not payable with another major surgical procedure as it is considered an inclusion within the payment for a more major procedure.

EXPLANATORY CODE 'AU'

If a claim is returned with an explanatory code of 'AU', please submit a **"Request for Review of Claims Assessment"** form with a copy of the operative report, medical record or a descriptive letter. Please also ensure that the **run code and claim number are included**. If an operative report is being submitted, it must contain surgical start and end times. These claims should **not** be resubmitted electronically.

Please ensure that you have read the descriptor for each service code and bill accordingly.

It is the responsibility of the physician to ensure that the appropriate service code is submitted for the service that was provided. We appreciate your ongoing efforts and cooperation in ensuring that the service codes you submit to the Ministry for payment meet the requirements as set out in the Physician Payment Schedule and *The Saskatchewan Medical Care Insurance Act*.

Billing Questions?

For all general billing inquiries please contact the Claims Unit at 306-787-3454

PARTIAL ASSESSMENTS THAT RESULT IN A REFERRAL TO A SPECIALIST – 55B

WHEN A PARTIAL ASSESSMENT LEADS TO A REFERRAL, USE THE 55B BILLING CODE

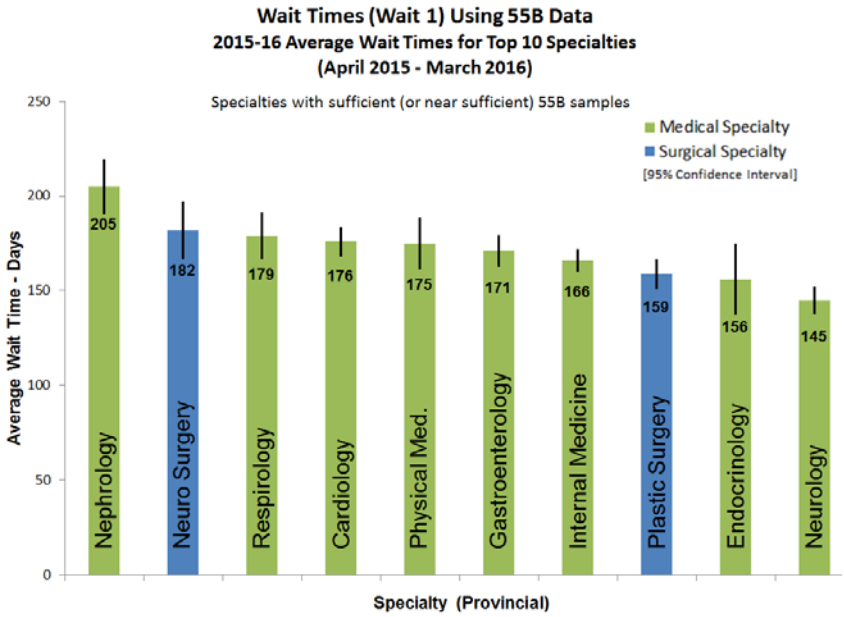
The 55B billing code is to be used in place of a 5B billing code in those cases when the patient visit resulted in a referral to a specialist. It is to be used independently - instead of the 5B, not in addition to other billed codes such as the 5B or the 3B.

This code is for use by General Practitioners/Family Physicians only.

USING THE 55B BILLING CODE HELPS MEASURE SPECIALIST WAIT TIMES

Unlike surgery wait times, no simple method existed to estimate with confidence how long patients were waiting before a specialist appointment (Wait 1). The billing code for partial assessments (Code 5B) was the most frequently used billing code that involved referrals to a specialist. However, if a patient had several partial assessment visits, there was no simple way to confirm which one resulted in a referral. Using 55B code indicates the start of the patient's wait, which can later be paired with the specialist visit to measure the wait time.

WAIT TIMES MEASURED USING 55B WILL BE ACCURATE



Researchers at the University of Western Ontario's Department of Statistics and Actuarial Sciences confirmed that measuring samples of specialist wait times using the 55B billing code provides an accurate estimate of a specialist's wait times, even though some referrals are made using other codes. Current utilization of 55B code has provided sufficient samples to measure patient wait times aggregated at the specialty level.

FOR MORE INFORMATION, please contact Mr. Bhooman Bodani at the Strategic Priorities Branch. Email: bbodani@health.gov.sk.ca Phone: (306) 787-8936 or Fax: (306) 787-0023