Billing Bulletin

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IMPORTANT HEALTH WEBSITE LINKS

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

CONTACT INFORMATION HAS CHANGED

For inquiries related to the following areas, the contact numbers have changed:

- Physician Billing Inquiries
- Claims Processing Support Inquiries
- Physician Billing Education Inquiries

Please contact the Business Support Desk at 1-800-605-2965 where your call will be routed to the appropriate area for support. The Business Support Desk is open Monday to Friday, 8:00 a.m. to 5:00 p.m. Please be advised that we are closed evenings, weekends and on Government of Saskatchewan observed statutory holidays.

For **physician audit and professional review inquiries,** the contact information remains the same:
Policy, Governance and Audit Unit
Fax: 306-787-3761
Email: MSBPaymentsandAudit@health.gov.sk.ca

BILLING RESOURCES & BILLING INFORMATION SHEETS

There are important billing resources available on the eHealth website. These documents are provided to all new physicians upon registering with Medical Services Branch (MSB). They are also available for download or viewing at the above link. Physicians should ensure that they avail themselves of this important information.

ONLINE BILLING COURSE

Please note that the online billing course is temporarily unavailable. MSB looks forward to launching a new course at a future date.

CUSTOMER PORTAL TRAINING AND EDUCATION

For training related to the new claims processing system and customer portal, please visit: https://www.ehealthsask.ca/services/CustomerPortal/Pages/Training

STATUTORY HOLIDAYS FOR THE PURPOSES OF BILLING TIME-OF-DAY PREMIUMS AND/OR SPECIAL CALL/SURCHARGES:

Please be advised that statutory holidays for **the purposes of billing** any type of time-of-day premium or special call/surcharge are according to the Government's observed/designated holidays listed below and may be different than the Saskatchewan Health Authority designated holidays.

HOLIDAY	ACTUAL DATE	OBSERVED/BILLED ON
Good Friday	April 18, 2025	April 18, 2025
Victoria Day	May 19, 2025	May 19, 2025
Canada Day	July 1, 2025	July 1, 2025
Saskatchewan Day	August 4, 2025	August 4, 2025
Labor Day	September 1, 2025	September 1, 2025
Thanksgiving Day	October 13, 2025	October 13, 2025
***Note: For the purposes of billing there is no statutory holiday observed on the Monday following Good Friday.**		

AUDIT & INVESTIGATIONS

JOINT MEDICAL PROFESSIONAL REVIEW COMMITTEE (JMPRC)

The JMPRC is a legislated, ***physician peer-review committee*** with two (2) physicians appointed by each of the Saskatchewan Medical Association, the College of Physicians and Surgeons of Saskatchewan and the Ministry of Health.

The JMPRC is responsible for ***reviewing a physician's pattern of medical practice associated with billing***. The Committee has the authority to review a physician's billings over a 15-month period, request copies of medical records, and interview physicians with respect to their pattern of medical practice. If a physician's pattern of medical practice is deemed to be unacceptable by the JMPRC, it has the legislative authority to order a physician to repay monies to the government.

Summary of All Monies Ordered to be Recovered

The following is a summary of all monies ordered to be repaid by physicians due to inappropriate billings and/or an inappropriate pattern of medical practice in the last three fiscal years (April 1 to March 31):

Fiscal Year	Total Amount Ordered to be Recovered	No. of physicians	Average Recovery per Physician
2022-23	$2,567,089	10	$256,709
2023-24	$1,343,271	7	$191,896
2024-25	$1,616,820	9	$179,646

To learn more about the JMPRC, you can access the billing information sheet here: JMPRC Billing Information Sheet

BILLING AUDITS AND INVESTIGATIONS

Medical Services Branch has a legislative obligation to protect taxpayer funded services and ensure that the use of these funds is appropriate and aligns with existing legislation. Minimizing loss and ensuring government accountability to a publicly funded system are key.

The use of routine audits are an effective method used to deter and identify the potential misuse and overuse of public funds. Eliminating and deterring inappropriate billings that have minimal evidence of a patient benefit or cost-effectiveness can reduce potential harm to patients and excessive costs to the publicly funded system. This, in turn, leaves more money available to potentially address unmet health care needs and to ensure the best possible distribution of public resources.

Billing audits and investigations can be initiated in a variety of ways. MSB undertakes routine audits on a regular basis, but investigations can also be initiated through inquiries and **complaints from physicians or other members of the public.**

The following is a list of ROUTINE AUDITS that PGA conducts on a bi-weekly, monthly or quarterly basis:

The following routine audits have been undertaken in 2025:

- **Partial assessment (5B) billed for injection service (110A/161A)**
  - Confirming medical necessity of the partial assessment
- **Partial (5B) and complete assessments (3B) billed for uninsured third-party requests**
  - Services resubmitted that were previously rejected with a third-party request diagnosis (Z12)
- **Multiple surcharges (815A) billed in a day by the same doctor**
  - Ensuring physicians are only billing the surcharge for the first patient seen

- **Remote consultation between physicians (769A & 762A)**
  - Verifying that the specialist is "remote" from the referring physician and that documentation meets all criteria from the Payment Schedule
- **House call surcharge (615A)**
  - Confirming medical necessity and appropriateness of the surcharge
- **Prescription renewal by fax/email (795A)**
  - Confirming the medical necessity and appropriateness of the service
- **Chronic Disease Management (CDM) – 64B-68B**
  - Ensuring that CDM flow sheets are complete and start and stop times are recorded with appropriate length of time spent
- **Location of Service Premiums – "E", "P" & "T"**
  - Confirming the correctness of the "LOS" billed

Material being submitted as a result of a routine audit (all explanatory codes in the Routine Audit and Recovery section of the Payment Schedule) should be forwarded to Policy, Governance and Audit (PGA) directly at MSBPaymentsandAudit@health.gov.sk.ca

If physicians or other members of the public have potential concerns about a physician's billing practices, they are encouraged to contact Policy, Governance and Audit at: MSBPaymentsAndAudit@health.gov.sk.ca

To learn more about physician audits, you can access the information sheets here:

Routine Audit Billing Information Sheet

Payment Integrity (Audit) Billing Information Sheet

REFERRALS TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN (CPSS)

Medical Services Branch would like to make physicians aware that any potential inappropriate billing issues identified by MSB may be referred to the College of Physicians and Surgeons of Saskatchewan (CPSS) for further investigation and possible disciplinary action.

Physicians have an obligation pursuant to *The Medical Professional Act, 1981 (section (46))* and the CPSS' Code of Ethics (7.1) to ensure that the billings they submit for payment are appropriate and align with legislation. In some circumstances, physicians may be disciplined by the College pursuant to section (46) of the *Act*.

In October 2024, the CPSS issued a guidance document related to billing. The document can be found on the CPSS website under "Physicians" → "Law and Guidance" → "Guidance to the Profession" or at the following link: CPSS Guidance Document

GENERAL

PROLOTHERAPY

Please be advised that **prolotherapy** is not an insured service and cannot be billed under any service code, including nerve block or injection codes.

OPEN TREATMENT OF UNUNITED FRACTURES

Payment for an open fracture treatment which remains ununited after the designated post-operative period is compensated at 150% of the Payment Schedule item for primary open reduction. These claims require a comment (i.e. "ununited fracture") to be processed accordingly.

SECTION A – GENERAL SERVICES

20A – MINISTRY OF SOCIAL SERVICES RESPORT

For a 20A service code to be processed, any additional claim items billed in conjunction **must** include diagnostic code Z90. If a claim is submitted with an ineligible service code or without the correct diagnostic code the claim will be rejected with explanatory code CZ.

162A – VACCINATION & READING

Please be advised that this service code **cannot be used for pneumovax, flu shots, or any other injection/vaccination** service that does not involve a reading. A recent routine audit has found a large number of these services being billed inappropriately in circumstances that should have been billed as 161A (immunization per injection, included in visit) or 110A (subcutaneous or intramuscular injection).

204A, 205A, 206A – SPECIMEN COLLECTION AND REFERRAL

As a reminder to physicians, effective October 1, 2024, specimen collection and referrals are billable on the same day as most other services, including visits. This change was made to assist physicians in offsetting the costs associated with operating on-site laboratory or phlebotomy services.

725A – HOSPITAL DISCHARGE AND DOCUMENTATION

If you receive an explanatory code "YT - Please resubmit the claim indicating the hospital admission and discharge dates" resubmit your claim with a comment indicating the patient admission and discharge date for your claim to be considered for payment.

762A – MINOR TELEPHONE ASSESSMENT

Physicians are reminded that **all listed criteria must be documented in the medical record** regarding a history review, history of presenting complaint, and discussion of patient condition/management and recommendations to the referring physician.

794A & 795A – PRESCRIPTION RENEWAL BY TELEPHONE CALL, FACSIMILE, EMAIL OR OTHER ELECTRONIC MEANS

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

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

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

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

SECTION B – GENERAL PRACTICE

805B - VIRTUAL PARTIAL ASSESSMENTS (805B) FOR ROUTINE TEST RESULTS

As a reminder, notification of normal test results is not billable under this service code. Under the heading "Virtual Care Services", Assessment Rule 9. b):

Virtual cares services are not payable for:

- *notification of normal test results*
- *notification of office, referral or other appointments*
- *"triaging" of patients, or, any other administrative tasks*
- *telephone calls to/from patients in an acute care setting*
- *phone calls to request/obtain sick notes*
- *form completions and other third-party requests*

- *phone calls to obtain or provide updates on behalf of the patient related to referrals/tests/procedures*
- *for consultations with other providers (physicians, allied health care professionals) on behalf/request of the patient.*

For other eligible services and conditions, all listed components must be documented and medical necessity must be established. **The intent behind this service code is to facilitate a partial assessment (5B) via video or telephonic means.** It is not simply a "telephone call" to or from a patient.

SECTION H – ANESTHESIA

506H/507H – DENTAL ANESTHESIA – Comment may be required for payment

Physicians are reminded that dental anesthetic is an insured service when:

- The anesthesia service is provided to a person under age 14, or;
- The anesthesia service is classified as an insured service (oral and maxillofacial surgery) under the Saskatchewan Health plan, or;
- The anesthesia service is medically necessary for other dental procedures. For MSB to assess the medical necessity of your claim, you **must include a comment** indicating the specific medical diagnosis concerning the patient (i.e. Autism, Cerebral Palsy, Dementia, etc.).

SECTION J – SURGICAL ASSISTING

50J – SPECIALIST O/R STANDY

Physicians are reminded that the marking of the wound incision prior to the start of the operation does fulfill the criteria for specialist standby.

For example, the plastic surgeon marking the breast incision prior to the general surgeons start and then waiting to complete the reconstruction would not be considered billable under this service code.

SECTION L – GENERAL SURGERY (MINOR PROCEDURES)

5B WITH 898L – PARTIAL ASSESSMENT OR SUBSEQUENT VISIT WITH REMOVAL OF SUTURES AND/OR STAPLES

Physicians are reminded that for the routine removal of sutures, the procedure alone would be most appropriately billed.

In circumstances where the removal of sutures is billed in conjunction with a partial assessment, the visit **must establish medical necessity** and **all partial assessment criteria must be met.** There would be no medical reason to bill a partial assessment unless an active medical reason exists.

This applies to all scheduled or preplanned minor procedures.

SECTION N – PLASTIC SURGERY

400N billed with 244N – SUBCUTANEOUS TISSUE SPACE EXPANDER -- IMPLANTATION

Physicians are reminded that 244N (Free graft, full thickness, other -- more than 10 sq. cm.), billed in conjunction with 400N, (Subcutaneous tissue space expander – implantation) is not eligible for payment.

This is considered to be an inappropriate substitution of codes.

The insertion of a commercial product [ALLODERM] does not constitute a full thickness skin graft.

420N – VACUUM ASSISTED WOUND MANAGEMENT – WHEN SET-UP COMPLETED BY A PHYSICIAN

The use of the Prevena dressing does not fulfill the requirements of this code and cannot be billed using service code 420N.

SECTION S – OPHTHALMOLOGY

580S – CORNEAL PACHYMETRY (REPEAT BY REPORT ONLY) – BILATERAL

Physicians are reminded that in order for a 580S to be considered for payment:

- Must include a report, the report must be attached within 90 days of receiving a claim rejection with explanatory code GC.
- The diagnostic code indicated on the claim **must** match the diagnosis in the report provided.
- The diagnostic code submitted must be an eligible for a repeat.

SERVICE CODES BILLABLE WITH UNITS

A reminder that the following service codes are billable with a maximum of two units: 131S/132S/133S/136S/180S/181S/182S/522S/573S/650S/673S/674S/675S. These service codes are **not** eligible to be used with the bilateral indicator.

SECTION W – DIAGNOSTIC ULTRASOUND

DUPLICATE 16W OR 17W

When billing for 16W twice or a 17W twice the second eye is not billable if it is done for comparison purposes. Claims submitted with the same service code twice will require a comment indicating the service is for the second eye and **not** for comparison purposes.