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

All physicians should ensure that they avail themselves of this important information. New physicians will receive a copy of the Billing Resources and Billing Information Sheets.

CONTACT INFORMATION

For MSB inquiries related to physician registration, claims processing, physician education, physician billing or payment related inquires please contact our Business Support Desk at 1-800-605-2965 Monday – Friday 8:00-5:00pm.

Please be advised that we are closed evenings, weekends and on Government of Saskatchewan observed statutory holidays.

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

ONLINE BILLING COURSE

The online billing course is temporarily unavailable as a new version is currently under development. MSB looks forward to launching a new redesigned course in 2026.

CUSTOMER PORTAL TRAINING AND EDUCATION

For training and information related to the Claims Processing System (CPS) and Customer Portal (CP), 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
Thanksgiving	October 13, 2025	October 13, 2025
Remembrance Day	November 11, 2025	November 11, 2025
Christmas Day	December 25, 2025	December 25, 2025
Boxing Day	December 26, 2025	December 26, 2025
New Year's Day	January 1, 2026	January 1, 2026
Family Day	February 16, 2026	February 16, 2026
Good Friday	April 3, 2026	April 3, 2026
***Note: For the purposes of billing there is no statutory holiday observed on the Monday following Good Friday.**		

IMPORTANT INFORMATION

TIME LIMIT FOR CLAIM SUBMISSIONS

Great News! Due to the Claims Processing System stabilization work, the submission of claims and the backlog of pended claims have resumed to normal processing times.

Effective **October 1, 2025,** the Ministry will require any claim submissions exceeding the 6-month time limit to follow the legislated requirements of notification/rationale in writing for any delayed submissions. The details pertaining to time limit can be found in the Payment Schedule under the Time Limit Preamble and the explanatory code CM.

ACTION REQUIRED:

- Please ensure all claims for services provided on or before April 1, 2025, are submitted prior to October 1, 2025.
- Please ensure you are actioning and/or correcting any rejected claims within 30 days. If the 30-days will exceed the 6-month time limit, please include a comment in your claims resubmission for assessment to occur. Exceptions may include explanatory codes: AU, RA-RZ and WCB or PHRS claims.

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.

Right to Appeal

Pursuant to *The Saskatchewan Medical Care Insurance Act*, physicians have the right to appeal the JMPRC's decisions to the Court of King's Bench.

Decisions of the Court are posted publicly on the Canadian Legal Information Institute (CANLII) website.

What is CANLII?

CanLII is a non-profit organization founded in 2001 by the Federation of Law Societies of Canada on behalf of its 14-member law societies. Its mandate is to provide efficient and open online access to judicial decisions and legislative documents. By doing so, CanLII supports members of the legal profession in the performance of their duties while providing the public with permanent open access to laws and legal decisions from all Canadian jurisdictions.

Links to Past Decisions

The CanLII.org website provides access to court judgments from all Canadian courts, including the Supreme Court of Canada, federal courts, and the courts in all Canada's provinces and territories. CanLII.org also contains decisions from many federal and provincial administrative tribunals.

To find past JMPRC decisions, please navigate to: Saskatchewan - Court of King's Bench for Saskatchewan | CanLII and use search word "JMPRC".

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

BILLING AUDITS AND INVESTIGATIONS

The Medical Services Branch has a legislative mandate to safeguard the integrity of publicly funded health services and to ensure that expenditures are consistent with applicable legislation and policy. A central component of this mandate is to promote accountability in the use of public funds and to minimize inappropriate or inaccurate billings.

Routine audits are an established mechanism for supporting these objectives. They serve both to confirm compliance with billing requirements and to deter practices that may result in overpayments or misuse of public funds. By ensuring that claims are accurate, complete, and consistent with the Payment Schedule and related requirements, the Branch can protect the sustainability of the publicly funded system and support the equitable distribution of resources.

Billing audits and investigations can be initiated in a variety of ways. Routine audits are undertaken 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 in circumstances where the service may have more appropriately been billed as the injection only
- **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 surcharges for the first patient seen
  - Ensuring that the physician attended on a priority basis, the visit caused a degree of disruption of work or of out-of-hours activity and travel
  - Ensuring that the physician was not already in the building when the call was initiated
- **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 to ensure that it is not being billed for routine prescheduled visits to a patient’s residence (i.e. retirement village, personal care home)

- **Prescription renewal by fax/email (795A)**
  - Confirming the medical necessity and appropriateness of the service to ensure that they are not being billed for the routine management of medications
- **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 and to ensure that the location was not an office, outpatient or inpatient facility
- **Surcharges billed with 13I (Interpretation of telephonic rhythm strips and/or ECGs by cardiologist with prompt response and advice to the referring physician on immediate case management)**
  - Ensuring the appropriateness of the surcharge, as 13I services are telephonic communications and there is no travel involved

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

RESUBMITTING OF REJECTED AUDIT CLAIMS
Please be advised, when claims are rejected with explan code 'RA' to 'RZ', please do not resubmit a new claim. Only submit the requested document appended to the original claim.

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 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

COVID-19/FLU SHOT CLINICS

Please by advised, when a COVID-19 or flu shot clinic is being held, these injection services should be billed as follows:

Flu shots → 161A
Covid 19 injections → 505A

As a reminder, Covid 19 injections are **only payable when performed personally by the physician** or a medical learner under the physician's supervision in accordance with the "Services Supervised by a Physician". For more information, the billing information sheet can be accessed here:

https://www.sma.sk.ca/wp-content/uploads/2022/05/2022.05.01-Final-3.0-Billing-Info-May-1-2022.pdf

CONSULTATIONS AND REPEAT CONSULTATIONS

To be eligible for payment, consultations and/or repeat consultations must:

- Be formally requested by an eligible referring practitioner;
- Fulfill all the criteria in the descriptor of the code as listed in the Payment Schedule.

If a formal request did not occur or if a patient is recalled for a follow-up visit you must bill the appropriate visit service (initial or follow-up).

EXPLANATORY CODES AA and ZA

Rejected claims with explanatory codes AA or ZA refer to the patient's demographic information **not** matching the Personal Health Registry System (PHRS). Please refer to PHRS to ensure the patient details included on your claim are accurate and that the patient is active in PHRS. Complete any changes required and resubmit your claim for processing.

TIME-BASED CODES

One of the major purposes of providing physicians with time-based billing codes is to accurately reflect and compensate for the time and complexity involved in patient care, especially when services go beyond standard assessments or procedures.

Some medical encounters, such as counseling, mental health support, chronic disease management, or complex care planning, may not involve many procedures, but may require significant physician time. Time-based codes ensure these services are properly valued. By recognizing time-intensive interactions, such as those needed for elderly or multi-morbid patients, physicians are encouraged to provide thorough care without financial disincentive.

Mandatory Component:

Because the key component associated with time-based services is the "time", it is mandatory to document both the start and stop times in the medical record. Please be aware some service codes also require the physician to submit the start and stop times on the claim when submitted for payment.

Properly and accurately recording the time spent with the patient ensures transparency, supports the accuracy of the clinical record, and verifies that the billed time aligns with the service provided. **Failure to document or report this information accurately as required may result in claim rejections, audits, or repayment obligations.**

Time-based service codes are frequently audited and reviewed to ensure that this information is documented appropriately.

Common Misinterpretations

The Ministry has identified several scenarios that are commonly misinterpreted or misapplied in clinical billing practices. These areas of concern include:

- **Documentation of Start and Stop Times**: Start and stop times must be explicitly recorded in the patient record using actual clock times (e.g., "1:04 p.m. to 1:47 p.m."), rather than a duration only (e.g., "43 minutes").
- **Basis for Start and Stop Times**: Times must reflect the actual duration of the clinical encounter and time spend providing patient care and should not be based on automatically generated EMR appointment times or booking templates.

  Note that both the Ministry and the College of Physicians and Surgeons of Saskatchewan recommend that physicians avoid using EMR features that auto-populate start and stop times based on the appointment time.
- **Calculation of Total Time:** The total time billed must align with the requirements of the applicable code, including the correct application of time thresholds such as "a major portion thereof."

- **Trigger for Counselling Codes:** The presence of a psychiatric diagnosis (e.g., anxiety, depression) alone does not automatically justify the use of counselling codes. The billing must reflect the nature and content of the clinical service provided, consistent with the criteria set out in the Payment Schedule.

These clarifications are intended to support appropriate billing practices and ensure that claims align with both clinical documentation and service code criteria requirements.

SECTION A – GENERAL SERVICES

627A, 628A – SPECIAL CARE HOME MANAGEMENT

These codes are only eligible for payment:

- Once every **14 days.**
- By **one** physician who is the most responsible physician
  - If the care of a patient has been transferred, the new physician claim must have a comment indicating they are assuming care with the effective date
- Physicians are responsible for knowing which patients they are most responsible for and to ensure they cease all billings once a patient's care has been transferred.
- If submitting a claim for a patient currently under another physician's care, a comment is required, please refer to page 84 in the Payment Schedule.

941A – NON-CLINICAL OR ADMINISTRATIVE WORK FOR MAID SERVICES

For the 941A service code to be processed, the claim must be submitted with:

- Start and Stop times in the applicable field on the claim record.
- An approved diagnostic code : Z31, Z32, Z33, Z34 or Z36.
- A comment indicating the non-clinical work required for MAiD services.

SECTION B – GENERAL PRACTICE

52B, 53B – SUPPORTIVE CARE

Regina and Saskatoon are currently the only approved hospitalist sites for supportive care. The referring physician for supportive care must be located in Regina or Saskatoon or your claim will be rejected.

14B – SPECIALIZED ASSESSMENT AND WRITTEN REPORT INVOLVING A NURSE PRACTITIONER REFERRAL

Effective October 1, 2025, 14B is billable by physicians with approved entitlement for specialized assessments related to the physician's additional post-graduate training/qualifications in one or more of the following categories:

- General Practice-Anesthesia
- General Practice-Obstetrics
- General Practice-General Surgery
- Allergy
- Sports Medicine
- Addictions Medicine
- Dermatology
- Palliative Care
- Pediatric psychiatry: General Practitioners with entitlement to bill Advanced Primary Health Care for Pediatric Patients – Psychiatric Care (163B/164B)
- Chronic pain: General Practitioners with entitlement to bill Pain Clinic codes (201H-205H).

14B is not billable on patients who are on the physician's roster or if the physician is already the most responsible physician (MRP) for the patient at the time of referral.

14B may only be billed by physicians with entitlement when a patient is referred by a nurse practitioner for a specialized assessment related to the physician's approved post-graduate training/qualifications.

- **Entitlement to bill 14B is limited to physicians with approved post-graduate training/ qualifications in the abovementioned categories.**

- **Relevant training/qualifications are those listed under the physician's College of Physician and Surgeons of Saskatchewan (CPSS) profile under any of the following headings: Post graduate training, Qualifications, Specialty, Field of Practice. Entitlement is effective the date of approval and cannot be backdated.**

Physicians with additional post-graduate training or qualifications in the abovementioned categories **not** listed on their CPSS profile who are providing (or intend to provide) eligible referred specialized services may submit an application form with their credentials to the Saskatchewan Medical Association (SMA) Tariff Committee (tariff@sma.sk.ca) for consideration to be approved by MSB & the SMA for entitlement.

SECTION D – INTERNAL MEDICINE

31D – ELECTROCARDIOGRAM OR PHONOCARDIOGRAM – INTERPRETATION ONLY

Physicians are reminded that interpretations must be billed using the date and location where the original service (tracing) was performed. It is not appropriate to hold batches of tracings for later interpretation in order to generate additional time-of-day premiums.

SECTION H – ANESTHESIA

585H – OPERATIVE PREMIUM FOR COMPLEXITY AND RISK

While some degree of risk to life or limb is inherent in any surgical procedure, the intent of this service code is more specific. It is restricted to circumstances in which the underlying injury or condition itself poses a significant risk to life if the procedure is not performed on an emergency or expedited basis. The seriousness of the condition, rather than the general risks associated with surgery, is the determining factor in the appropriate use of this code.

Accordingly, per the Payment Schedule, 585H can only be billed in the following circumstances:

1. Where there is recognition and agreement between the surgeon and the anesthetist that undue delay in surgical treatment would pose a **significant risk to life or a major body part.**

2. Multiple trauma involving at least 2 of the following:

    a) Abdominal injury requiring laparotomy;
    b) Thoracic injury requiring chest tube or thoracotomy
    c) Head injury with GCS less than 9;
    d) Fracture of cervical spine, pelvis, femur, proximal tibia or humerus;
    e) Burns to more than 30% of the body surface.

SECTION P – OBSTETRICS AND GYNECOLOGY

218P – COMPLICATIONS OF PREGNANCY

When billing this service code **by report**, physicians must indicate the condition for which 218P is being claimed in the comment section of the claim and attach the delivery record as supporting documentation.

333P – REMOVAL OF INTRAUTERINE DEVICE UNDER GENERAL ANESTHESIA OR IV SEDATION – WHEN ONLY PROCEDURE DONE

Please note that 333P is considered a composite/all-inclusive code. No other P section procedure codes are billable in addition to 333P.

SECTION S – OPHTHALMOLOGY

136S,181S - SERVICES BILLABLE WITH UNITS

When submitting claims for 136S or 181S please ensure you include the appropriate units required.

If these services are done **bilaterally**, on the same day, rather than create a new claim, simply include the appropriate units for the bilateral service.

SECTION W – DIAGNOSTIC ULTRASOUND

33W – LIMITED ABDOMINAL ULTRASOUND

Follow-up abdominal ultrasounds including, but not limited to, monitoring of specific organs/quadrants within the abdomen, hepatocellular carcinoma (HCC) screening/ongoing monitoring of liver cirrhosis **must be billed under 33W.**