GUIDANCE TO THE PROFESSION

Referrals to the CPSS from the JMPRC regarding billing concerns

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INTRODUCTION

Guidance from the College provides information to express or clarify the College's view on a particular matter. It is intended as guidance for physicians in areas where research and current practice are evolving or changing rapidly, the implementation of processes and procedures may be premature, or it is timely to communicate the College's stance on an issue before a bylaw, policy, or professional guideline is developed. It is available on the College's website under Guidance to the Profession.

EXECUTIVE SUMMARY

The College of Physicians and Surgeons of Saskatchewan (CPSS) has developed a Guidance document that addresses critical issues identified in referrals from the Joint Medical Professional Review Committee (JMPRC) to the CPSS. The document outlines key concerns related to billing practices, medical record-keeping, and patient care management that have become recurrent patterns.

Key points covered in this document include:

1. Recurring concerns identified by the JMPRC
2. Physicians' responsibility for billing submissions, even when delegated
3. Guidelines for billing third-party and uninsured services
4. The importance of maintaining accurate and unaltered medical records
5. Standards for adequate medical record-keeping
6. Proper use of prepopulated templates and macros in electronic medical records
7. Requirements for documenting time-based codes
8. Appropriate use of Chronic Disease Management (CDM) codes

9. Avoiding upcoding of services
10. Managing the frequency of non-medically required services
11. Judicious use of investigations and examinations
12. Appropriate billing of virtual care codes
13. Ethical considerations regarding billing for services not provided

The document also provides educational recommendations and resources to help physicians improve their practices in these areas. By addressing these concerns, we aim to enhance the quality of patient care, ensure regulatory compliance, and maintain the integrity of the healthcare system.

Physicians are encouraged to review this guidance carefully and implement the recommended practices to avoid potential JMPRC reviews and referrals to the College.

REFERRALS TO THE CPSS FROM THE JMPRC REGARDING BILLING CONCERNS

The College of Physicians and Surgeons of Saskatchewan (CPSS) recently had a meeting with the Joint Medical Professional Review Committee (JMPRC), and the two other stakeholder organizations namely Medical Services Branch (MSB) and the Saskatchewan Medical Association (SMA). During this meeting, the high volume of referrals from the JMPRC to the CPSS was discussed.

While the College will collaborate with the SMA and MSB in considering options to assist physicians with billing education, we have elaborated this document to address several critical issues identified in referrals to the College that are forming a pattern of concerns.

Although the College does not usually get involved in any billing related issues or advice, these recurrent findings are integral to maintaining the highest standards of patient care and ensuring compliance with regulatory requirements.

1. Recurring Concerns

As discussed below, the Joint Medical Professional Review Committee (JMPRC) has encountered frequent instances of recurrent issues prompting reassessment and referral to the College. This creates the perception that physicians may not be paying adequate attention to certain issues and misapplication of certain codes. It is crucial to ensure that each billing code accurately reflects the services provided and that any patterns of misuse are promptly addressed.

2. Responsibility for Billing Submissions

Physicians who delegate the submission of their billings must remember that the Automated Claims Submission and Direct Payment Agreement (DPA) with the Medical Services Branch (MSB) holds them personally responsible for these actions, regardless of who submits the billings. It is imperative that physicians who have signed this contract review and verify all submissions to ensure accuracy and compliance.

3. Billing for Third-Party and Uninsured Services

Inappropriate billing for third-party and uninsured services is frequently encountered and often leads to reassessment by the JMPRC and referral to the College. Ensure that billing for such services is accurately documented and justified.

The MSB Payment Schedule includes a detailed list of services that are uninsured under the heading "*Services Not Insured by the Ministry of Health";* this includes, but is not limited to, the Worker's Compensation Board (WCB), Department of Veterans' Affairs pensionable disability, Saskatchewan Government Insurance (SGI), and examinations or services to provide a medical report or certificate required for the information of a third party etc.

Cosmetic services that are uninsured in Saskatchewan, such as removal of benign skin lesions or warts for purely cosmetic purposes, cannot be billed to MSB. Physicians can charge patients directly for these uninsured services. There are some therapies and treatments that are not insured regardless of whether the service is deemed to be 'cosmetic' or not, which includes such services as ablation of seborrheic keratosis or treatment of warts other than plantar or genital.

4. Alteration and Creation of Medical Records

Physicians should not alter or create medical records when requested by agencies such as the College or JMPRC, as doing so would constitute falsification of records and a breach of professional ethics. Medical records serve as legal documents that provide an accurate account of a patient's medical history, treatment, and care.

Modifying or fabricating records after the fact, especially in response to external inquiries or complaints, undermines the integrity and credibility of these records.

Such actions could be perceived as an attempt to conceal information or misrepresent events, which is considered unprofessional conduct and may have serious consequences, including disciplinary action.

Physicians must maintain contemporaneous, accurate and complete medical records at all times, and any amendments should be properly documented and justified based on factual errors or omissions.

5. Inadequate Medical Record Keeping

Inadequate medical record keeping which fails to meet the standards of the College and MSB is a common issue in almost all JMPRC referrals to the College. Thorough and accurate documentation is essential for patient care, regulatory compliance, and legal protection. The College's regulatory bylaw 23.1, Medical Records clearly sets out the expectations for medical record-keeping, and is applied by the JMPRC as well as the Practice Enhancement Program (PEP).

Documentation requirements for the purpose of billing are outlined in the MSB Payment Schedule.

6. Use of Prepopulated Templates and Macros

The inappropriate, inaccurate, and incorrect use of prepopulated templates and macros poses a critical concern for patient safety. These practices often fail to convey the medical necessity of visits and are a common cause for reassessment by the JMPRC and referrals to the College. In addition, the use of these pre-populated templates without verifying the entries may convey inaccurate information, with significant medicolegal and patient care

repercussions. An article in the 2022 DocTalk newsletter titled "EMR Template Use – Timesaver or Potential Pitfall?" provides more information.

7. Time-Based Codes Documentation

The use of time-based codes without proper documentation of the time spent providing services is a significant issue that almost always leads to a College referral. As a requirement of the payment schedule, real-time start and stop times of physician to patient interaction must be recorded accurately to justify the billing of these codes. Physicians should avoid using EMR features that auto-populate start and stop times based on the appointment time.

Examples include counselling codes, chronic disease management (CDM) visits with an associated flowsheet, psychiatric services, chronic pain management, etc. [Per the MSB Payment Schedule "*Documentation Requirements for the Purposes of Billing", all time-based codes must have the start and stop times documented in the medical record*.]

8. Inappropriate Use of Chronic Disease Management (CDM) Codes

CDM fees are designed to support physicians in providing ongoing, evidence-informed care for patients with certain chronic diseases. The intent is to ensure longitudinal management and optimal patient outcomes for patients with confirmed diagnoses of Diabetes Mellitus, Coronary Artery Disease, Heart Failure, and Chronic Obstructive Pulmonary Disease (COPD). It is important to recognize that:

- The CDM fee includes a patient visit that involves at least 15 minutes of physician time.
- A patient CDM flow sheet approved by the Saskatchewan Medical Association (SMA) must be completed and care must be consistent with approved guidelines.
- These flowsheets must be completed adequately for verification that all required aspects of care were addressed at the visit.
- CDM fees are billable only for patients with confirmed diagnoses.
- If more than one qualifying chronic condition is managed at the same visit, an approved patient CDM flow sheet must be completed for each condition, and the physician must spend at least 5 minutes of additional time per condition.
- As noted above, all time-based codes must have the start and stop times documented in the medical record.

9. Upcoding of Services

Upcoding occurs when a physician submits billing codes for a more expensive service or procedure than was actually performed. This practice results in higher payment by MSB than is justified for the services provided. Upcoding can occur intentionally or unintentionally, but it is considered fraudulent and unethical. Here are a few common examples of upcoding:

a. Billing for a more complex service instead of a simple one: A physician might bill for a comprehensive medical exam (3B) when only a partial assessment (5B) was conducted, or might bill for an initial consultation (9-codes) instead of a repeat consultation (11-codes) or follow-up visit.

b. Using time-based counseling codes in place of the more appropriate 5B code when addressing complex issues that require prolonged patient-physician interactions. The 5B code is specifically designed to capture the intricacies and depth of care involved in such cases, ensuring accurate documentation and appropriate compensation for the services rendered. In some JMPRC-referred cases, there are concerns that billing for counselling occurs without any evidence that appropriate counselling was provided. A longer 5B visit does not qualify for counselling codes.

c. Misrepresenting procedures: A minor surgical procedure might be billed as a more complicated surgery, thereby attracting a higher payment. Examples include biopsies (100F/101F) upcoded to excisional codes (857L, 863L, etc.), and the length of lacerations sutured not appropriately measured and overestimated.

d. Time-Based Services: Claiming that a longer duration was spent on a service than actually was, such as billing for an hour-long consultation when only a 15-minute session occurred, or billing time-based service codes when a partial examination or assessment was conducted and took longer than 15 minutes.

e. Misapplication of codes for services such as faxes or phone calls from pharmacies to refill medications (794A/795A), instead upcoding to 'discussing patient care and management' codes (790A/791A).

f. Billing a visit code when the intent of the visit and the service performed was only an injection such as vaccinations or B12 injections, without any supporting documentation to establish that an additional medically required service was provided.

10. Frequency of "Non-medically required" or "Not clinically indicated" Services

The concept of inadequate practice management by physicians involves several key issues that can lead to an unacceptably high frequency of non-medically required patient visits and associated billing.

"Medically required" typically refers to services that are necessary/essential for the diagnosis, treatment, or prevention of illness or injury. This aligns with the concept of medical necessity, which involves services that a physician would provide to a patient based on prudent clinical judgment. These services must be deemed necessary for the patient's well-being based on medical evidence and standards of care.

"Clinically indicated" generally means that a service or procedure is appropriate for a specific patient's condition based on current medical standards and the physician's professional assessment. It considers clinical judgment and the necessity for an action or intervention based on the situation.

These terms are closely related and often overlap, but they are not necessarily inter-changeable:

- "Medically required" focuses on the overall necessity of a service.
- "Clinically indicated" emphasizes the appropriateness of a service for a specific patient's situation.

Some examples include:

- Inadequate Follow-Up Advice

  When physicians do not provide clear and comprehensive follow-up instructions to patients, it can result in patients making unnecessary return visits. For instance, if a physician fails to specify when a patient should seek further medical attention or what symptoms to watch for, patients may return to the clinic out of uncertainty or anxiety, even when it is not medically necessary. This can create a

backlog of appointments and lead to increased billing for visits that could have been avoided with proper guidance and advice.

- Insufficient Prescription Renewals

  Prescriptions that are only issued for short durations or without adequate refills can force patients to return to the clinic more frequently than clinically necessary just to renew their medications. This practice not only inconveniences patients but also increases the volume of appointments and associated billing. For example, a chronic condition like hypertension or diabetes typically requires long-term medication management. If patients must return every month or so for a prescription renewal, it adds unnecessary strain on healthcare resources. There is no definitive standard in Canada for the duration or authorized refills of prescriptions for chronic stable conditions. However, while there is some variation across provinces, the generally accepted standard in Canada for prescribing medications for chronic stable conditions involves issuing prescriptions for durations of up to 90 days, with possible extensions to 12 months in stable cases, accompanied by appropriate authorized refills and follow-up plans. It is essential for physicians to apply clinical judgment, ensure appropriate monitoring, and provide adequate patient education. Frequent and medically unnecessary use of 795A noted by the JMPRC could be avoided by better prescription management with appropriate prescribing durations for chronic medications.

- Inappropriate Call-Backs

  Scheduling routine follow-up visits for issues that could be managed through patient self-monitoring or remote consultation can lead to excessive patient visits. For instance, asking patients to return to review normal test results or for minor conditions that do not require in-person evaluation can result in overutilization of the medical system. This practice increases the frequency of visits and inflates billing without adding significant value to patient care.

- Billing inappropriately for visits associated with prescheduled minor procedures.

  Billing for non-medically required partial assessments (5B) associated with prescheduled minor procedures raises concerns about potential overutilization and inappropriate billing. Routinely billing a 5B for initially assessing conditions like plantar warts, and then billing additional 5Bs for follow-ups without documented justification, could be considered excessive. Similarly, billing a 5B for assessing a joint prior to an injection procedure, providing a prescription, and then again billing the partial assessment fee on top of the procedure fee, may not meet the criteria for medical necessity. These practices warrant scrutiny to ensure billing aligns with regulations and policies aimed at preventing unnecessary insured services billings.

- Billing for follow-up assessments (7-codes) on the day of an electively scheduled surgery.

  Billing for non-medically required or not clinically indicated follow-up assessments is a frequent source of concern raised by the JMPRC in referrals to the College. These codes may be appropriately applied when considered medically required and clinically indicated, for example when:

  - It addresses a material change in the patient's condition that could affect surgical outcomes.
  - It allows for reassessment of risks and benefits based on new information.
  - It ensures patient safety by confirming the appropriateness of the planned procedure given changed circumstances.

The CPSS would expect that, when an assessment is billed in these circumstances:

1) The follow-up consultation is documented in the patient's medical record.
2) The rationale/clinical indication for the additional assessment is stated and justified.
3) The assessment adheres to professional standards and ethical guidelines for patient care.

It is important to note that the JMPRC indicates that routine preoperative visits would not typically qualify as follow-up assessments. This billing approach should be reserved for cases where there is a clear medical necessity and clinical indication for a reassessment due to significant changes in the patient's condition or new information that could impact the surgery or surgical planning.

11. Inappropriate or outdated investigations and examinations

The "annual physical examination" with associated bloodwork is generally not recommended for asymptomatic adults in Canada. The current standard of care is to provide preventive health services based on age, risk factors, and needs, rather than routine annual comprehensive exams.

- The Canadian Task Force on Preventive Health Care has consistently recommended against routine annual physical exams for asymptomatic adults, as the evidence shows they do not improve health outcomes or reduce morbidity and mortality. Instead, they advise periodic preventive health visits focused on age-appropriate screening and counseling.
- The College of Family Physicians of Canada (CFPC) supports its members' professional judgment in determining the necessity of periodic exams, rather than mandating annual physicals. They note the lack of evidence for benefit from annual exams in asymptomatic patients.
- The public health plans of several provinces, including British Columbia, Nova Scotia, New Brunswick, and Newfoundland and Labrador, no longer cover routine annual physicals for asymptomatic adults. Other provinces like Ontario have moved away from comprehensive annual exams to more targeted "personalized health reviews."

Outdated or unnecessary testing, including but not limited to routine ECGs, urine dipsticks at each visit, and spot glucose tests for patients who already monitor their glucose levels at home, are often considered non-medically required based on current best evidence for disease management. Some general examples include:

- Routine ECGs: For asymptomatic patients without a family history or known heart disease, routine ECGs do not generally provide useful diagnostic information and rarely change clinical management. Current guidelines suggest that routine ECGs are not necessary for low-risk patients as they do not improve outcomes and can lead to unnecessary follow-up testing and anxiety.
- Urine Dipsticks: Routine urine dipstick tests at every visit are not typically necessary unless there are specific symptoms or risk factors suggesting a urinary tract infection or renal issue. For most patients, especially those without symptoms, these tests do not provide meaningful clinical information and do not contribute to better disease management.
- Spot Glucose Tests: For diabetic patients who regularly monitor their blood glucose levels at home, spot glucose tests during clinic visits do not add value. Home monitoring provides more comprehensive data over time; this is more useful for managing diabetes than isolated glucose measurements taken during office visits.

Some of the reasons these are not recommended follow:

- Risk of False Positives and Overdiagnosis: Frequent and unnecessary testing increases the likelihood of false positive results, leading to overdiagnosis and unnecessary anxiety for patients. This can also trigger a cascade of further unnecessary tests and treatments, which do not benefit the patient and can cause harm.
- Inefficiency and Resource Wastage: Unnecessary tests consume healthcare resources that could be better utilized for patients with a genuine need for those tests. This inefficiency contributes to higher healthcare costs without improving patient outcomes.
- Guidelines and Evidence-Based Practice: Current clinical guidelines and evidence-based practices discourage routine use of these tests without specific indications.
- Patient-Centered Care: Unnecessary testing can undermine patient-centered care by shifting focus away from meaningful patient interactions and comprehensive management plans. Instead, time and resources are better spent on personalized care that addresses patients' individual needs and conditions based on current best evidence.

  Avoiding outdated or unnecessary tests aligns with the principles of Choosing Wisely, an initiative aimed at promoting conversations between clinicians and patients to reduce unnecessary tests and procedures. It ensures that healthcare practices are based on current evidence, improve patient outcomes, and use resources efficiently.

12. Billing of Virtual Care Codes

The JMPRC has observed excessive and inappropriate billing of virtual care codes, often with little or no medical necessity. It is essential to judiciously determine whether a telephone discussion with a patient justifies billing as a medically required assessment.

It is crucial that virtual care is not used indiscriminately for the nonmedically required services that generate billings, as this would be considered a violation of ethical standards. Virtual care service codes should only be utilized when it is medically required, clinically appropriate, and in the best interest of the patient's care needs.

By carefully considering these factors, physicians can optimize the judicious use of virtual care while upholding professional standards, acting in their patients' best interests, and avoiding inappropriate billing practices.

13. Billing for services not provided

Billing for services not personally performed or without proper documentation raises significant ethical and professional concerns for physicians in Saskatchewan.

The College's Regulatory Bylaws and Code of Ethics explicitly prohibit such practices, which could be considered fraud or professional misconduct.

With the exception of a limited number of services that may be provided under the supervision of a physician (see "Services Supervised By A Physician" in MSB Payment Schedule), physicians must only bill for insured services they have directly provided and adequately documented in the patient's medical record. Billing for services not rendered, or lacking documentation to substantiate the service, violates the core principles of integrity, accountability, and professionalism expected of the medical profession.

Such actions undermine public trust and could result in disciplinary action.

EDUCATIONAL RECOMMENDATIONS

Based on discussions with the JMPRC and identified in College referrals, the following key issues have been identified for educational communication to physicians:

a) Definitions, Assessment Rules, and Billing Criteria

- Payment Schedules, Billing Bulletins and Information Sheets on Health Care Resources for Physicians

b) Appropriate, Adequate, and Complete Documentation

- CPSS Regulatory Bylaw 23.1 for medical records.

c) Standard Guidelines for Follow-Up Care

Examples include:

- Canadian Task Force on Preventive Health Care (CTFPHC)

  The CTFPHC provides guidelines on preventive health care, including screening and follow-up intervals for various conditions. Their guidelines are based on systematic reviews of the evidence and are intended to help primary care providers make informed decisions.

- Canadian Diabetes Association (CDA)

  The CDA provides comprehensive guidelines for the management of diabetes, including follow-up care.

- Hypertension Canada

  Hypertension Canada publishes guidelines for the diagnosis, risk assessment, prevention, and treatment of hypertension.

- Canadian Cardiovascular Society (CCS)

  The CCS provides guidelines for the management of cardiovascular diseases, including heart failure and coronary artery disease.

- Chronic Disease Management (CDM) Flowsheets

  The CDM program in Saskatchewan has developed chronic disease management flowsheets for conditions like chronic obstructive pulmonary disease, Diabetes, Coronary Artery Diseases, and congestive heart failure.

- Cancer Care Guidelines

  Organizations like the Canadian Cancer Society and the Saskatchewan Cancer Agency provide follow-up care guidelines for various types of cancer.

- Best Practices and Evidence-Based Medicine

  General best practice guidelines, such as those provided by the College of Family Physicians of Canada (CFPC), incorporate regular updates on the latest evidence to guide follow-up care.

d) Targeted Patient Instructions

The Canadian Medical Protective Association (CMPA) provides guidelines and advice to physicians on best practices for follow-up care. These guidelines emphasize the importance of clear communication, proper documentation, and patient safety.

e) Judicious Access to Healthcare Services

Physicians in Saskatchewan play a critical role in managing judicious access to healthcare services. By adhering to evidence-based guidelines, optimizing diagnostic testing, effectively managing follow-ups, engaging patients, leveraging technology, coordinating care, efficiently managing practice operations, and participating in continuous quality improvement, physicians can ensure that patients receive necessary and appropriate care. This approach helps to balance the demand on healthcare resources, improve patient outcomes, and maintain the sustainability of the healthcare system. Resources like the Canadian Institute for Health Information (CIHI) provide data and reports that can inform physicians about healthcare utilization patterns and areas for improvement in judicious access.

f) Use of EMR Templates and Macros

The use of EMR templates and macros can be a double-edged sword for physicians. While they can improve efficiency and standardize documentation, overreliance on them can lead to inaccurate, incomplete, or irrelevant information being included in patient records. This raises concerns about patient safety, medicolegal risks, and potential billing infractions.

Physicians can access educational resources on the judicious use of EMR templates and macros through various channels:

- The Canadian Medical Protective Association (CMPA) provides risk management guidance, including best practices for EMR documentation.
- The College of Family Physicians of Canada (CFPC) offers practice tools, guidelines, and continuing professional development programs that cover EMR optimization and documentation standards.
- The Royal College of Physicians and Surgeons of Canada's CanMEDS framework emphasizes the role of physicians as scholars and advocates for quality improvement, which includes appropriate EMR use.
- The SMA EMR team can provide assistance, and often collaborate with EMR vendors to provide training resources specific to Saskatchewan physicians.

g) Virtual Care

Physicians can access information and education on the judicious use of virtual care from the following sources:

- Virtual Care Services preamble is included in the Assessment Rules of the Payment Schedule on the Health Care Resources for Physicians.
- The Canadian Medical Association (CMA) has developed a Virtual Care Playbook that provides guidance on best practices, standards, and considerations for implementing and optimizing virtual care services.
- The College of Family Physicians of Canada (CFPC) offers virtual care resources, including webinars, toolkits, and practice guidelines, to support family physicians in delivering high-quality virtual care.
- The Royal College of Physicians and Surgeons of Canada (RCPSC) has incorporated virtual care competencies into its CanMEDS framework and provides educational resources for specialists on appropriate virtual care delivery.

- Academic institutions such as the College of Medicine CME department and Saskatchewan Health Authority may offer continuing professional development programs, workshops, or courses focused on virtual care best practices, including appropriate use cases and patient selection criteria.
- Professional medical journals, conferences, and online resources from organizations like the Canadian Medical Protective Association (CMPA) can provide guidance on medico-legal considerations and risk management strategies for virtual care.

By accessing reputable sources, physicians can stay informed about the latest evidence-based practices, regulatory requirements, and ethical considerations surrounding the judicious use of virtual care, ensuring it aligns with providing high-quality, patient-centered care while mitigating potential risks and inappropriate billing practices.

CONCLUDING COMMENTS

We appreciate your attention to these critical issues and your commitment to maintaining the highest standards of patient care. By addressing these concerns, we can improve the quality of care provided to patients, ensure patient safety, ensure compliance with MSB and College expectations, and of course, avoid a JMPRC review and possible referral to the College.

The College does not provide direct billing advice. Any questions should be directed to the Medical Services Branch for guidance.

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Sincerely,

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