Billing Bulletin

Billing Bulletin No. 1
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IMPORTANT HEALTH WEBSITE LINKS

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

PAPER COPIES OF THE PAYMENT SCHEDULE, BILLING BULLETIN AND OPERATIONS BULLETIN

Medical Services Branch does not provide paper copies of the Physician Payment Schedule, the Billing Bulletin or the Operations Bulletin. The Physicians' Newsletter continues to be mailed out. Copies of these documents can be found at the website link above.

GENERAL BILLING INQUIRIES

All general billing inquiries should be directed to the Claims Analysis Unit at:

Phone: 306-787-3454
Fax: 306-798-0582

PHYSICIAN AUDIT INQUIRIES

All physician audit inquiries should be directed to the Policy, Governance and Audit Unit at:

Phone: 306-787-0496
Fax: 306-787-3761
Email: MSBPaymentsandAudit@health.gov.sk.ca

Government of Saskatchewan

PHYSICIAN BILLING OBLIGATIONS:

Physicians are personally responsible for all billings submitted under their billing number, billing staff should be supervised, and that billings should be reviewed prior to submission.

All physicians who are receiving direct payment through the publically funded system have signed a Direct Payment Agreement with MSB. This agreement stipulates the manner in which services must be submitted for payment and all physicians should be aware of their responsibilities.

We appreciate physicians' ongoing efforts and cooperation in ensuring that the service codes they submit to the Ministry for payment meet the requirements as set out in the Physician Payment Schedule, their Direct Payment Agreement and *The Saskatchewan Medical Care Insurance Act*.

SERVICES BILLABLE BY ENTITLEMENT OR BY APPROVAL

If a service code is listed as "by entitlement" or "by approval", the physician must request and receive approval **PRIOR** to billing. Effective dates cannot be retroactive or "back-dated". Please see Payment Schedule "Services Billable by Entitlement or by Approval" for more information.

STATUTORY HOLIDAYS FOR THE PURPOSES OF BILLING STATUTORY HOLIDAY PREMIUMS AND/OR OR SURCHARGES

Please be advised that statutory holidays for the purposes of billing any type of premium or surcharge/special service(s) are per the Government observed/designated holidays listed below, and may be different than the Saskatchewan Health Authority designated holidays.

HOLIDAY	ACTUAL DATE	OBSERVED/BILLED ON
Thanksgiving	Monday, October 8, 2018	Monday, October 8, 2018
Remembrance Day	Sunday, November 11, 2018	Monday, November 12, 2018
Christmas Day	Tuesday, December 25, 2018	Tuesday, December 25, 2018
Boxing Day	Wednesday, December 26, 2018	Wednesday. December 26, 2018
New Year's Day	Tuesday January 1, 2019	Tuesday January 1, 2019
Family Day	Monday February 18, 201	Monday February 18, 2019
Good Friday	Friday April 19, 2019	Friday April 19, 2019
	Note: Government does not observe an Easter Monday statutory holiday	
Victoria Day	Monday May 20, 2019	Monday May 20, 2019

CONCURRENT HOSPITAL CARE REQUIREMENTS

Payment for concurrent hospital care by more than one physician may be approved only after the ***Ministry of Health is provided with satisfactory explanations*** that care by more than one physician was required. The physician must indicate rationale if due to complexity of condition – even when care provided by another physician in the same specialty.

DOCUMENTATION REQUIREMENTS FOR THE PURPOSES OF BILLING

Documentation is an integral and fundamental component of a medical service. An adequate record will ***enhance quality and accountability,*** and ***provide protection*** *for the physician*, the patient and the Ministry.

This is the only way to support that the service you provided was medically required and met the billing requirements.

The Payment Schedule describes what is expected for each billing code. In order for a service to be eligible for payment, the record must reflect that the entire requirement for payment has been fulfilled.

Documentation requirements ***for the purposes of billing*** may be different than documentation requirements for ***clinical*** **or** ***medical-legal*** **purposes.**

It is the physician's responsibility to know the difference.

- ✓ **For the purposes of billing** --- refer to the Physician Payment Schedule.
- ✓ **For clinical or medical-legal purposes** --- refer to the College of Physicians and Surgeons of Saskatchewan bylaws or the Canadian Medical Protective Association (CMPA) website.

Tips when using EMR templates or macros:

As an example, it is often seen through audit that physical exams will often leave questions about whether all of the factors of the physical exam that were documented were actually performed.

The reason for this is that there can be many components that were documented as "normal" when the patient had known pathology.

This occurs because the physician has not gone back and changed his "normal exam" template to reflect what was actually done. ***This calls into question the reliability of the documentation.***

SECTION A - GENERAL SERVICES

110A, 161A, ETC - SERVICES ASSOCIATED WITH INJECTIONS

Physicians should be aware that injection-associated codes can lead to increased billing frequency of inappropriate patient visits. If a patient, for example, attends for a routine injection that is being received on a monthly basis, it would generally not be associated with a visit code.

Should there be a situation where the patient presents for a different problem, and this is managed by the physician, the documentation must include all of the requirements for a visit and must be documented as such.

190A – 198A - BOTOX

A recent routine audit has identified a large volume of inappropriately billed Botox injection service codes related to pelvic pain.

The listed service codes for Botox (190A-198A) are not insured for any condition other than those listed as approved per the Physicians Payment Schedule. Any other use of Botox requires written prior approval of MSB and the Saskatchewan Medical Association (SMA). Botox for **pelvic pain** and **migraines** are uninsured services.

763A – 768A, ETC – SERVICES ASSOCIATED WITH MONITORING OF RESULTS

Physicians should be aware that monthly 'monitoring' codes such as the 763-768A include documentation, and that the payment includes and will compensate for any associated services like faxing prescriptions or communicating with a pharmacist/nursing home, the patient etc.

Physicians also need to be reminded that 763A for INR monitoring is intended to decrease the inappropriate frequency of patient visits, meaning that the patient does not need to attend the physician's office on a routine, scheduled basis to have their anticoagulants adjusted.

918A, 919A, and 220A-226A - TIPS FOR SUBMITTING

For a claim to be processed, the physician must provide the 3 criteria as stated within the Physician Payment Schedule. As an example, the 220A-226A requires: the clinical condition necessitating continuous attendance, AND treatment or care provided, AND time when attendance on patient started and completed. The comment line may be used to provide this information. i.e. "***Respiratory distress, CPR, airway stabilization, 0800-0930***". If the billing criteria is not met, the claim will be rejected with explanatory code "DR". To avoid delays in processing, please provide the appropriate comment with submission(s).

SECTION B - GENERAL PRACTICE

9B - CONSULTATION SERVICES BILLED BY GENERAL PRACTITIONERS

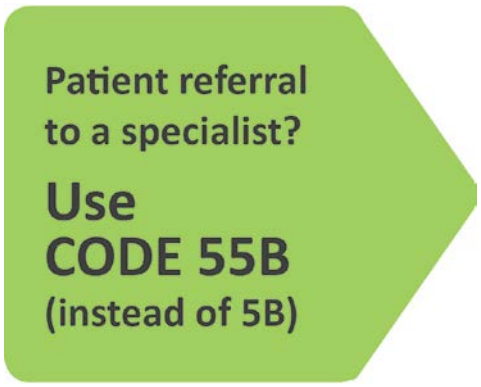
This service applies where a physician, having examined the patient, formally requests the opinion and advice of another physician because of the ***complexity, obscurity or seriousness*** of the current condition or conditions involved. This service must also include a written recommendation and opinion back to the referring physician.

MSB has recently identified many consultation services being billed by general practitioners 'on referral' from another general practitioner for routine services that would typically be within the scope of general practice such as prenatal care, pap smears, plantar warts, etc. It is not appropriate in these circumstances to bill for a consultation (9B).

64B- 68B - CHRONIC DISEASE MANAGEMENT

Chronic Disease Management (CDM) fees are billable once per patient every 90 days. CDM services must be submitted with a base code of 64B and should be accompanied by one of the 'add' codes of 65B-68B. Subsequent CDM claims must be consecutive and continuous for the same patient by the same physician or clinic. If the visit is in excess of one every 90 days, or the visit involved less than 15 minutes of physician time, the service should be submitted as a partial assessment (5B) **pending all the billing criteria for a 5B is met.**

55B - PARTIAL ASSESSMENTS AND SPECIALIST WAIT TIMES IN SASKATCHEWAN



The 55B billing code enables the health system to measure and report how long patients are waiting to see a specialist.

Use of 55B has been more than doubled since 2012. The goal is to increase the use of this code (where appropriate) to be able to report specialist wait times similar to the Saskatchewan Specialist Directory.

Facts

2012-13 (First Year)		2017-18
17,646	# of 55B Services (134% increase)	**41,285**
532	Physicians used 55B (31% increase)	**697**

Ask your billing clerks to use the 55B when a referral is being arranged.

Has the 5B doctor's visit resulted in a referral to a specialist?

USE 55B CODE
(Instead of 5B)

WHEN A PARTIAL ASSESSMENT LEADS TO A REFERRAL, USE THE 55B BILLING CODE
The 55B code is for use by General Practitioners and Family Physicians only.

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.

SECTION D – INTERNAL MEDICINE

200D-207D, 214D, 216D - ENDOCRINE TESTING

The listed fee codes 200D-207D, 214D, 216D are physician services billable only when personally performed by the physician. MSB's has the authority to pay for physician services and if the responsible of performing the service is delegated, it must meet the criteria for "Services Supervised by a Physician".

Endocrine testing services are not billable to MSB when the physician simply ordered and/or interpreted the test(s), but the test itself was performed by someone other than the physician, (ie: nursing staff, hospital staff).

SECTION H - ICU

400H – 404H - INTENSIVE CARE UNIT BILLED WITH ECGS

ICU care codes are inclusive of all other procedures/visits/ diagnostics done while the patient is in the ICU. An ECG (31D) is not payable by the same doctor on the same day except on the first day and the time indicates the 31D is prior to ICU admission. Otherwise, the 31D will be rejected with explanatory "DP".

SECTION J – SURGICAL ASSISTING

80J, 81J - SURGICAL ASSISTANCE

80J and 81J are for office-based physicians who earn less than 50% of their income submitted and paid through the MSB billing system from surgical assisting. They are billable for scheduled surgeries performed between 8:00 am and 5:00 pm, Monday to Friday only.

They should not be billed for weekends or with premium locations.

SECTION L – GENERAL SURGERY

83L, 854L, 110S - EXCISION OF TUMOR OR BIOPSY (BREAST), MUSCLE BIOPSY AND ABSCESS, INCISION AND DRAINAGE (ORBIT)

A recent routine audit has identified a large volume of inappropriately billed service codes (83L, 854L, 110S).

Please ensure that all abscesses and biopsies are billed under the applicable service codes pertaining to the **specific body site/area** for which it applies and the procedure performed. Pay particular attention when entering the first few letters of a key word to auto-select the service code from your billing software.

For general practitioners, these codes are billable "by report" only.

700L - SURGICAL DEBRIDEMENT

Surgical debridement is a time-based code billable "by report". MSB requires start and stop time and details of the procedure to be provided. MSB will only pay this code for 'debridement'. You may use the comment line on your claim to submit information 'by report'.

SECTION M – ORTHOPEDIC SURGERY

380M – 382M - ARTHROCENTESIS- PUNCTURE FOR ASPIRATION OF JOINT AND/OR INJECTION OF MEDICATION

Arthrocentesis codes are considered inclusions in a major surgery same day, by same physician. Codes 380M – 382M will be rejected with explanatory code "JN" in these circumstances.

SECTION P – OBSTETRICS AND GYNECOLOGY

50P, 250P - THERAPEUTIC ABORTIONS – SURGICAL VS. MEDICAL

Codes 50P (first trimester) and 250P (second trimester) are designated as '42-day' surgical procedures and can only be billed for the provision of performing **surgical** abortions.

Prescribing or administering pharmaceutical agents such as ***Mifegymiso*** are included in the visit service and there is no additional billing.

SECTION S – OPHTHALMOLOGY

TIPS FOR OPHTHALMOLOGY "ADD" CODES (OR ANY "ADD" CODES)

When submitting for ophthalmology cases where a service code (i.e, 535S / 651S / 579S) is dependent on submission with a specific code, please submit these codes on the same claim to avoid delays in reimbursement. Otherwise, the claim may fail for manual handing and delay your payment. For example:

Correct:

Claim No. – Seq. No.	Service codes
10002-0	7S, follow-up assessment
10002-1	34S, visual field screening
10002-2	651S, add to 34S

Incorrect:

Claim No. – Seq. No.	Service codes
10001-0	651S, add to 34S
10002-0	7S, follow-up assessment
10002-1	34S, visual field screening