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 at:
https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx

CONTACT INFORMATION

Physician Billing Inquiries
Direct all physician billing inquiries to:
Phone: 306-787-3454
Fax: 306-798-0582

Claims Processing Support Inquiries
Direct all claims submission & processing inquiries to:
Phone: 306-787-0182 or 306-787-3470
Fax: 306-798-0582

Physician Audit Inquiries
Direct all physician audit and professional review inquiries to:
Policy, Governance and Audit Unit
Phone: 306-787-0496
Fax: 306-787-3761
Email: MSBPaymentsandAudit@health.gov.sk.ca

Physician Billing Education Inquiries
Direct all physician education and online billing course inquiries to:
Insured Services Officer
Phone: 306-787-9011

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.

FREE ONLINE BILLING COURSE:

MSB offers an online billing course that outlines the process involved in the billing cycle. The course is appropriate for beginners, as well as those with more advanced billing knowledge and is designed to be flexible. Start and stop at your leisure! Your progress will be saved for you to resume when convenient. Depending on the participant's knowledge, the course may take between hours or days to complete.

HOW TO GET STARTED:

1. Go to the following link: **https://msbonlinebillingcourse.litmos.com/self-signup/**
2. Enter the required information and use the following code: **OLBC**
3. You will need to complete a basic User Profile upon signup, requiring only an email address for your User Name and a valid password, consisting of the following criteria:
    - Minimum of 8 characters
    - 1 upper case
    - 1 lower case
    - 1 number
    - 1 special character

To start the course, you will be presented with a list of the modules under the course, along with a button to “Start the Learning Path”. You can choose to start at the top and work to the bottom or click on any module in the sequence. Alternatively, you can exit the module you are working on at any time (using the **orange** ‘exit’ button in the right corner) and come back later or you can move onto another module of your choice.

You will require a current Physicians Payment Schedule to facilitate you in the course, which can be found at this link: **https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx**

Once you have completed the signup process, use the following link to re-enter the site with your new credentials: **https://msbonlinebillingcourse.litmos.com**

If you have any questions regarding the Online Billing Course, please contact 306-787-9011.

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	Monday October 10, 2022	Monday October 10, 2022
Remembrance Day	Friday November 11, 2022	Friday November 11, 2022
Christmas	Sunday December 25, 2022	Friday December 23, 2022
Boxing Day	Monday December 26, 2022	Monday December 26, 2022
New Year's Eve	Sunday January 1, 2023	Monday January 2, 2023
Family Day	Monday February 20, 2023	Monday February 20, 2023
Good Friday	Friday April 7, 2023	Friday April 7, 2023
Note: For the purposes of billing, there is no statutory holiday observed on Easter Monday.		

ARE YOU CERTIFIED A SUB-SPECIALIST?

To become a recognized sub-specialist with the Medical Services Branch (MSB) you must provide confirmation from the College of Physicians and Surgeons of Saskatchewan. Please contact cpssreg@cps.sk.ca with proof of credentials and indication you have passed your examination and they will review the sub-specialty. If approved, you will receive a specialty letter from the College.

The Medical Services Branch will only update your physician profile upon receipt of your specialty letter from the College.

For further inquiry, please contact:

College of Physicians & Surgeons of Saskatchewan
101-2174 Airport Drive
SASKATOON SK S7L 6M6
T: 306-244-7355

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***. It 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, the JMPRC has the legislative authority to order a physician to repay monies to the government.

Did you know that the JMPRC has the authority to apply an "additional amount" to be repaid by the physician?

Pursuant to subsection 49.2 (7) of the *Act*, the JMPRC has the authority to apply an "additional amount" ***up to a maximum of $50,000*** – this is over-and-above the "reassessment" ordered by the JMPRC specifically related to inappropriately paid services.

Some factors that the JMPRC considers when opting to apply the additional amount are:

- Any undue delays caused by the physician during the course of the review; and/or
- A physician's cooperation and forthrightness during the course of the review; and/or
- A physician's previous interactions with the JMPRC; and/or
- A physician's failure to ensure that any inappropriate, erroneous, uninsured, or non-medically required services were not billed to the publicly funded system; and/or,
- A physician's failure to abide by their direct payment agreement with Medical Services Branch.

In 2021-22, the JMPRC ordered additional amounts totaling $198,500 from 10 physicians.

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 3 fiscal years (April 1 to March 31):

Fiscal Year	Amount Ordered to be Recovered	No. of physicians	Average Recovery per Physician
2019-20	$1,783,770	8	$222,971
2020-21	$2,035,232	7	$290,747
2021-22	$2,002,408	10	$198,500

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 tax-payer 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 wide variety of ways. MSB undertakes routine audits on a regular basis, but investigations can also be initiated through inquiries and **complaints from the public.**

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 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*.

GENERAL

HEALTH COVERAGE OUTSIDE OF SASKATCHEWAN

If you are considering referring a patient for services outside of Saskatchewan, prior approval is required for payment of any services that are not eligible to be billed reciprocally.

For prior approval requests, a Saskatchewan specialist in the relevant specialty must provide a written request with their explicit clinical recommendation to the Medical Services Branch within the Ministry of Health, or the Saskatchewan Cancer Agency. The written prior approval request, including costs, must:

- Clearly describe the **clinical circumstances** of the case that make it exceptional.
- Clearly describe the **service(s) being requested.**
- State – to the best of the specialist's knowledge – **that the service(s) are not available anywhere in Saskatchewan**.

For additional information, please review the **Information Sheets for Out of Province and Out of Country** coverage on the eHealth website or review Page 9 and 10 of the current Physician Payment Schedule.

https://www.ehealthsask.ca/services/resources/Pages/Health-Coverage.aspx

OVERUSE AND MISUSE OF DIAGNOSTIC TESTS

The ordering and performing of diagnostic tests should align with best practice guidelines, established clinical protocols, and accepted standards of care.

MSB often identifies patterns of practice whereby physicians bill certain laboratory tests, ECGs, chest x-rays, and audiograms in association with annual or periodic health exams when there is no demonstrable clinical indication or medical necessity. **Physicians are reminded that insured service are those that are medically required and tests that are not clinically indicated should not be billed to the public system.**

Medical Services Branch recommends that physicians familiarize themselves with the website *Choosing Wisely Canada (CWC)* at http://www.choosingwiselycanada.org/, which is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make appropriate choices to ensure high-quality care.

Medical Services Branch thanks physicians for the important role they play in reducing instances of unnecessary care, unnecessary treatments, and the unnecessary performing and ordering of testing. Eliminating ineffective or unnecessary services that have minimal evidence of a patient benefit or cost-effectiveness could reduce potential harm to patients and excess costs to our publicly funded health system - leaving more money available to potentially address unmet health care needs and to ensure the best possible distribution of public resources.

FOLLOW-UP ASSESSMENTS BILLED ON SAME DAY AS MAJOR (42-DAY) PROCEDURES

Physicians are reminded that all services billed to the publicly funded system must be medically required and must meet all documentation requirements listed in the Physician Payment Schedule.

When the patient has been prebooked for surgery which will occur in the future, a follow-up visit can only be billed on the day of surgery **if it is medically required**, **clinically indicated**, and **all Payment Schedule components** have been **performed and documented.**

Follow-up assessments contain the following components:

a) **history review;**
b) **functional enquiry;**
c) **examination;**
d) **reassessment;**
e) **necessary treatment;**
f) **advice to the patient; and,**
g) **record of service provided.**

In circumstances where Medical Services Branch has reviewed the documentation and has deemed that it does not support that all components have been performed and documented, or that there was no demonstrable medical necessity or clinical indication to perform a follow-up assessment, **then the payment will be recovered.**

REMOVAL OF INTRAUTERINE DEVICES (IUDs)

Removal of IUDs are considered an inclusion in the visit service. There is no other service code payable for the removal of IUDs**.** For clarity, service codes 872L or 873L (removal of foreign bodies) is not billable/payable for this purpose.

SUBSTITUTION OF CODES

Physicians are reminded that substitution of codes is **not allowable** under *The Saskatchewan Medical Care Insurance Act*, its supporting regulations and the Physician Payment Schedule. If you are unclear on the appropriate code to submit for payment or if there is no existing code:

1. Physicians can write to the Medical Services Branch to request advice on the correct submission of codes; and/or

2. Physicians can make a request to the Saskatchewan Medical Association (SMA) tariff committee to request a change to the Payment Schedule, including the implementation of new service codes.

Please see page 7 and 8 in the Physician Payment Schedule for more information related to services that are not listed in the Physician Payment Schedule.

INPATIENT TRANSFER OF CARE

During a period of inpatient care, where there is a change of attending physician or when a physician has been asked to 'take over the care' of a patient at the request of another physician, the new physician is not entitled to bill a consultation or any other visit service such as a complete, initial, partial or follow-up assessment. The billing is to be as if there was a continuation of care under the same physician. The physician taking over the care of an inpatient is entitled to bill the appropriate hospital or ICU service code(s) upon assuming care.

A consultation or other visit service may only be billed when the service is medically required and all of the Payment Schedule requirements are met. If a consultation or visit service code is utilized inappropriately simply for routine transfer of care, the claim submitted shall be rejected with "ET" explanatory code.

INCREASED CLAIMS VOLUMES

As a result of increased claims volumes, and in order to assist Medical Services Branch in processing your claims in a timely manner, until further notice, we are requesting that you:

- ✓ **Please wait for a minimum of two (2) payment runs if you have not received any information regarding the status of the claims submitted.**
- ✓ **For any claims that have not yet been adjudicated by MSB, please do not resubmit electronically or use the Request for Review of Claims Assessment form.**

MEDICAL CONSULTANT INQUIRIES

As per page 33 of the Physician Payment Schedule, if a physician does not agree with the results of a Review of Claims Assessment, a further review by a Medical Consultant must be requested in writing with the requisite information provided. Telephone inquiries or emails will not initiate a review by the Medical Consultant.

Please send your written request, along with the requisite information to:

Medical Consultant, Medical Services Branch
Ministry of Health
3475 Albert Street Regina, Saskatchewan S4S 6X6
or fax to: 306-798-1124

811B-T - REPEAT CONSULTATIONS - PROVIDED VIA TELEPHONE OR SECURE VIDEOCONFERENCE

Repeat virtual consultations (811B-T) are only to be billed when it is generated by a new formal request by the referring physician and should not be used for routine virtual follow-up of the patient for which the 'Virtual Partial Assessment or Subsequent Virtual Visit' or 'Virtual Follow-Up Assessment' is appropriate.

For clarification, if a patient is formally re-referred for the same or related condition within 90 days of a formal consultation, a repeat consultation can be billed; however, all subsequent visits billed for routine follow-up of the patient should be billed as the appropriate service code for partial assessment or subsequent visit (e.g., 5C) or follow-up assessment (e.g., 7M).

If the patient is formally referred for an unrelated condition within 90 days of another consultation, by the same physician, the second consultation will be converted to a complete/initial assessment.

It is not considered appropriate billing practice to bill all subsequent visits billed for the routine follow-up of the patient after an initial consultation as repeat consultations simply because the patient was initially formally referred for consultation.

SECTION A – GENERAL SERVICES

190A-199A - BOTOX SERVICES MUST BE PERFORMED BY PHYSICIANS PERSONALLY

In order for Botox codes to be billed to the publicly funded system, they must have been performed by the physician personally. **Botox services delegated to a nurse or other staff person cannot be billed to Medical Services Branch.**

There are only limited circumstances under which a physician can bill for a service that they did not personally perform.

This information can be found in the Physician Payment Schedule under the heading "**Services Supervised by a Physician**".

As a reminder – Botox for migraines is NOT an insured service and cannot be billed under these service codes. Patients should be advised of this prior to receiving the service.

615A – HOUSE CALL SURCHARGES

Travelling to see patients in their home and generating house call surcharges must be based on medical necessity and not because of convenience, courtesy, or preference by the patient or physician when no medical necessity for the travel to the patient's home exists.

If it is a physician's preference or private arrangement with a group home or private care home to travel to the home as a matter of convenience or as a courtesy, then it would not be the responsibility of the public system to compensate a physician for doing so when no valid medical reason is present. Physicians are able to attend these homes should they choose to as a matter of courtesy and convenience to the residents, but no additional payment would apply.

627A, 628A, 629A - SPECIAL CARE HOME MANAGEMENT (SCHM)

For routine continuous management of patients in special care homes there is a maximum of one (1) payment by any physician every 14 days for either indirect or direct care. For the purpose of Special Care Home Management, non-urgent patient care excludes special calls (i.e. urgent/emergent). Where a physician visits a patient on a special call basis, payment will be at the special call rates depending upon the time of day. **If the SCHM service does not fulfill these criteria, it will be rejected with BK explan code.**

VIRTUAL CARE SERVICES cannot be billed for routine services payable under SCHM. **Virtual care billingsfor services included in SCHM will be rejected with BK explan code.** Virtual care services for urgent/emergent patient care are payable in addition to SCHM.

769A/762A - REMOTE CONSULTATION BETWEEN PHYSICIANS

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.

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)**

For adjudication purposes, "Remote" Consultations between physicians pertains to the locale (i.e., distance) where two physicians **(typically a general practitioner and a specialist),** are situated. It is **not** intended to define method or means of transmission (e.g., cell phone or other devices).

SECTION H – ANESTHESIA

96H-97H – NERVE BLOCKS – TRIGGER POINT INJECTIONS

As a reminder to physicians, only one additional unit of trigger point injections are payable for a total of two (2) trigger point injections. **As stated in the descriptor**:

> **Instances where more than two injections are required will be reviewed at the request of the physician, upon receipt of an explanation of the circumstances.**

Simply providing an explanation that multiple trigger points were performed is not a sufficient explanation. Physicians must outline the exceptional circumstances under which multiple trigger point injections were performed.

SECTION L – GENERAL SURGERY

883L – TRIMMING OF TOENAILS, CORNS OR CALLUSES

Service code 883L is not billable in conjunction with plantar wart cryotherapy codes (877L-879L). This code is not intended to be paid for shaving or paring callused skin around a plantar wart site. That is considered an inclusion in the plantar wart cryotherapy codes.

SECTION N – PLASTIC SURGERY

120N – BURNS - SURGICAL DEBRIDEMENT AND/OR DRESSINGS

Please be advised that service code **120N is payable at 100%** when billed with or without a visit service. **EMR systems should be updated to reflect this**. It is not reduced to 75% per the multiple procedure rules – see Multiple Services – General Assessment Rules, item (2) – "procedures with possible unit values are paid at the listed fee". Items 2 (a) and 2 (b) do not apply.

SECTION R – UROLOGY

65R-67R – CIRCUMCISIONS

Medical Services Branch has the authority to pay physicians for medically required services pursuant to *The Saskatchewan Medical Care Insurance Act* subsection 14 (1). Circumcisions are only payable when medically required and clinically indicated. They are not payable for routine newborn circumcisions or for religious, cultural, cosmetic or other elective reasons.

The patient should be advised ahead of time that all costs associated with the service are the responsibility of the patient.

SECTION S – OPHTHALMOLOGY

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

When submitting for ophthalmology cases where a service code is dependent on submission with a specific code (i.e., 535S / 651S / 579S), 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

SECTION W – ULTRASOUND

POINT-OF-CARE ULTRASOUND

Point-of-Care Ultrasound (POCUS) is an ultrasound examination provided and performed at the 'point-of-care' as an adjunct to the physical examination to identify or clarify the presence or absence (uncertainty) of a limited number of specific findings. **POCUS is not payable under any ultrasound service code in the Payment Schedule.** See description in the Payment Schedule under "Definitions".

A Billing Information Sheet is available to assist physicians and their billing staff. It can be found at: https://www.ehealthsask.ca/services/resources/establish-operate-practice/Pages/Physicians.aspx

As per legislation, Medical Services Branch insures **medically required physician services**. Therefore, all ultrasound services submitted to MSB for payment must be medically required, clinically indicated, and documented as part of the patient's record.

The use of ultrasound equipment for non-medical purposes such as fetal gender determination and making "keepsake fetal photo albums and videos" is considered by Health Canada to be an unapproved use of a medical device and are not insured.