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 are encouraged to review and familiarize themselves with this important information.

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 MSB is 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

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 of Saskatchewan'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 3, 2026	April 3, 2026
Victoria Day	May 18, 2026	May 18, 2026
Canada Day	July 1, 2026	July 1, 2026
Saskatchewan Day	August 3, 2026	August 3, 2026
Labour Day	September 7, 2026	September 7, 2026
Thanksgiving	October 12, 2026	October 12, 2026

***Note: For the purposes of billing there are no statutory holidays observed on:**

- Monday following Good Friday (April 6, 2026)
- National Day for Truth and Reconciliation (September 30, 2026)

PEDIATRIC OUT-OF-PROVINCE TRAVEL ASSISTANCE PROGRAM

The Government of Saskatchewan implemented a program that provides financial assistance to families who require out-of-province medical care for their child. Families may be eligible to receive a reimbursement of travel expenses up to $2000 per trip. Additional information on the Pediatric Out-of-Province Travel Assistance Program (PTAP) can be found at: www.saskatchewan.ca/peds-travel

The application for specialists to complete is located under related items on the above site.

Eligibility criteria:

- Patients 16 years of age and younger
- Treatment is considered standard of care and is not experimental or part of a clinical trial
- The requested medical service is not available in Saskatchewan

All applications must be completed by a Saskatchewan physician and recommended for coverage by the Provincial Department Head of Pediatrics. For patients not followed by a pediatrician or subspecialist, the form can be submitted, but will be completed for submission to the program by one of the pediatric area department leads (contact peds.tap@saskhealthauthority.ca to find out the lead for your area).

NEW ONLINE BILLING COURSE TO SUPPORT SASKATCHEWAN PHYSICIANS AND BILLING STAFF

The Ministry of Health, in collaboration with the Saskatchewan Medical Association and the College of Physicians and Surgeons of Saskatchewan, and with the support of the College of Medicine, has developed a **comprehensive new online billing course** for Saskatchewan physicians and their billing staff.

The course is designed to enhance accuracy, consistency, and understanding in the submission of medical claims and the application of the Physician Payment Schedule. It will provide practical, case-based instruction across several core areas, including:

- Submission and reconciliation of claims
- Appropriate application of service codes
- Documentation requirements to support billing
- Effective use of Electronic Medical Records (EMRs)
- Audit processes

Upon finalization, the course will be fully accredited for both Mainpro+ and Royal College Maintenance of Certification (MOC) Section 3 credits.

Administration of the course will be overseen by the College of Medicine, which will manage registration, delivery, and accreditation processes.

The Ministry anticipates that the course *will be available to physicians and billing professionals in the coming months.* Additional details regarding registration and access will be shared closer to the launch date.

This initiative reflects a shared commitment among provincial partners to support physicians in meeting billing requirements, strengthening documentation practices, and promoting accountability within Saskatchewan's publicly funded health system.

AUDIT & INVESTIGATIONS

JOINT MEDICAL PROFESSIONAL REVIEW COMMITTEE (JMPRC)

The Joint Medical Professional Review Committee (JMPRC) is a quasi-judicial, independent decision-making body established under provincial health legislation to review the billing patterns of physicians.

Established under section 49 of *The Saskatchewan Medical Care Insurance Act* (1988) (the "Act"), its mandate is limited to assessing the billing aspect of a physician's pattern of medical practice. Given that the JMPRC is an independent decision-making body, it operates without influence from the Ministry of Health, professional associations, the College, health authority, or any individual physicians. The Committee's determinations are made impartially, based solely on the evidence before it and the statutory framework within which it functions.

WHAT IS REVIEWABLE BY THE JMPRC?

Any insured medical services contained in the Physician Payment Schedule, which are submitted to Medical Services Branch for payment are subject to review by the JMPRC.

WHAT IS NOT REVIEWABLE BY THE JMPRC?

The JMPRC's legislative mandate does not include the authority or ability to assess a physician's ***competence or quality of care***. The JMPRC is not concerned with the professional competence of a physician, but only with the billings of a physician respecting insured medical services.

When issues arise during the course of a review related to quality of care, patient safety, physician competence or any other matter not related to billing, those issues may be referred to the College of Physicians and Surgeons of Saskatchewan.

LINK TO COURT DECISIONS

Any JMPRC orders that are appealed under the Act are heard by the Court of King's Bench. Decisions issued by the Court are publicly available.

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

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

To learn more about the JMPRC, please refer to the 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 2026:

- **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 an injection
- **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
- **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 duration 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 explanatory codes '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 or on the eHealth Saskatchewan website at the following link: https://www.ehealthsask.ca/services/resources/establish-operate-practice/Documents/GUIDANCE-Referrals-JMPRCtoCPSS.pdf

GENERAL

BILLING MULTIPLES OF A SERVICE CODE

Physicians are reminded that when billing multiple units of a service code listed in the Payment Schedule with designated units or a specified maximum number, the claim must reflect the correct number of units provided.

If billing multiple units of a service code that does not include designated units, the code must be submitted on a separate line with a supporting comment explaining the circumstances.

Claims submitted without the required units and/or without a supporting comment (when applicable) will be considered duplicate submissions and will be rejected.

QUERY CLAIMS: SUPPORTING INFORMATION

When submitting supporting information for a claim, documentation only needs to be attached to the first selected line. The same report does not need to be attached to each individual line item.

Attachments in the Customer Portal are limited to 15 MB. If the documentation exceeds this size limit, it may be attached under a separate query for the same claim.

HOSPITAL CARE

Hospital care is billable by the physician responsible for the medical management of a patient admitted to hospital. This care may include:

- Acute, short-term admissions
- Extended hospital stays
- Post-surgical care that extends beyond the post-operative period
- Concurrent care by multiple physicians, when medically necessary

Key reminders for Billing Hospital Care:

- Bill only for the days you are the attending physician. Do not bill for days when care has been transferred.
- Clearly indicate on the claim when care is shared.

- Follow the appropriate hospital day spans for extended inpatient care. Refer to the Payment Schedule to determine the correct span.
- Read rejection explanations carefully and make the necessary corrections before resubmitting your claim.
- When billing surcharges in conjunction with hospital care, submit them on the same claim as your hospital care service code.

SEQUENCE BILLING FOR BASE/ADD CODES

The Payment Schedule includes many service codes structured as "base" and "add" codes, or as an initial 15-minute increment followed by additional 15-minute increments. When billing multiple related codes, proper sequencing is essential, as the order of submission directly affects claim sorting and processing.

Best practice guidelines—particularly for time-based codes—include:

1. Always bill the base or initial service code first.
2. Bill add codes, including each additional 15-minute increment, following the base code.
3. For service codes that follow a defined sequence (e.g., 220A–226A, 64B–68B) bill the codes in the order the services were performed.
4. Ensure that start and stop times recorded on the claim accurately reflect the sequence of services documented in the clinical record.

EXPLANATORY CODE 'ZT'

The Payment Schedule description for explanatory code ZT directs physicians to review the comment record on the claim for a specific message from Medical Services.

Please note: Messages from Medical Services will:
(a) provide information regarding claim adjudication; and/or
(b) request additional information required to review the claim.

Physicians should review these comments carefully before resubmitting a claim. If the comments are not visible, contact your software vendor for assistance.

PREMIUM LOCATIONS OF SERVICE (LOS) – OTHER 'E' – 50% & 'T' – 100%

During the course of routine audits, MSB has encountered a large quantity of claims inappropriately billed using the premium LOS 'Other'. Services provided in the office or alternate office should never be billed using the LOS 'Other'. As a reminder:

- If a General Practitioner is providing services in the office or alternate office from 7:00 pm – 7:00 am on weekdays or any time on weekends and statutory holidays, the appropriate premium location of service is 'F' - 10%.

- There is no premium LOS for Specialists providing services in the office from 7:00 pm – 7:00 am on weekday or any time on weekends and statutory holidays. The appropriate location of service is '1'.
- Billings for interpretations (ie. 31D) must be billed using the date and location of where the original service (tracing) was performed on the patient. It is not appropriate to hold batches of tracings for later interpretation in order to generate additional time-of-day premiums.

SECTION A – GENERAL SERVICES

815A-839A – SPECIAL CALL SURCHARGES

In the Physician Payment Schedule under the heading "*Surcharge – Special Call / Emergency / Hospital Visit / House Call"*, it outlines the criteria under which these services are billable. In brief, these services are billable when:

- ✓ **a physician attends a patient on a priority basis, and**
- ✓ **the visit causes a degree of disruption of work or of out-of-hours activity, and**
- ✓ **travel is involved.**

Additional Special Call Surcharges Information:

- Surcharges are intended to compensate physicians ***for travel to a separate location*** – it cannot be billed if a physician goes from one location in the same building (hospital) to another.
- It is to compensate for a call-out on an ***urgent basis to attend on a priority basis*** and is not intended to be used ***where the physician defers the visit to a later time for their convenience***.
- ***Times must be recorded*** on the medical record and documentation must ***support the medical necessity*** of the call-out, the location traveled from and to, and verify the degree of disruption of work or out-of-hours activity.

SECTION B – GENERAL PRACTICE

805B – VIRTUAL PARTIAL ASSESSMENT

Physicians are reminded that the virtual partial assessment (805B) is generally intended to be **equivalent to an in-person partial assessment (5B),** with the exception that a physical examination is not required.

All other core elements of a partial assessment must be met.

The service is **not intended** to capture **any telephonic contact** with a patient. Rather, it applies to a medically necessary partial assessment facilitated by telephone or video technology. As with in-person services, all required components must be appropriately documented in the medical record, and medical necessity must be clearly established and demonstrable to the Ministry of Health upon review.

The Payment Schedule assessment rules further specify that this code is not billable for:

- Discussion of normal test results
- Routine triage
- Services that require a physical examination
- Uninsured services or third-party requests
- Other scenarios explicitly identified as non-billable

Despite this guidance, several areas of ongoing concern have been identified, including:

- Submissions to the publicly funded system for uninsured third-party requests;
- Submissions where medical necessity is not established;
- Submissions where documentation is incomplete or does not support the service billed;
- Submission sin circumstances explicitly deemed non-billable under the Payment Schedule (e.g., normal test results, routine triage);
- Upcoding of virtual services to in-person visit codes;
- Submissions for telephone calls in response to pharmacy facsimiles regarding medication refills;
- Submissions for telephonic “interactions” that do not meet the clinical intent or billing criteria defined by the Payment Schedule;
- Submissions for discussions with allied health personnel, which must be billed under the applicable consultation or communication codes (e.g., 790A, 791A).

Physicians are expected to ensure that all virtual services billed under 805B meet the clinical, documentation, and billing requirements set out in the Payment Schedule.

SECTION H – ANESTHESIA

94H-158H - NERVE BLOCK SERVICES

Physicians are reminded that all services billed to Medical Services Branch must be submitted strictly in accordance with the specific descriptor of the code, **without substitution**. The clinical service provided must align with the wording and intent of the Payment Schedule descriptor.

Recent audits of claims submitted under nerve block codes (94H–158H) have identified instances where the services performed did not meet the definition of a nerve block as

described in the Payment Schedule. In many of these cases, the services more appropriately corresponded to one of the following codes:

- ✓ **380M–382M:** Arthrocentesis: puncture for aspiration of a joint and/or injection of medication
- ✓ **642M:** Injection of tendon sheath
- ✓ **614M:** Puncture for aspiration or needling, with or without irrigation or injection of medication

The audit also identified several cases where nerve block codes were used to bill for **prolotherapy**, a treatment that is not currently classified as an insured service.

Any injections related to **Botox** must be billed according to the Botox codes in the Payment Schedule (190A-199A). If there is no appropriate code, then the service is not insured.

SECTION L – GENERAL SURGERY (MINOR PROCEDURES)

898L – REMOVAL OF SUTURES AND/OR STAPLES FROM LACERATION OR SURGICAL INCISIONS (10 OR 42-DAY PROCEDURES ONLY) OF ANY LENGTH BY ANY PHYSICIAN

Physicians are reminded that any removal of sutures performed by a non-physician, such as nursing staff, are not billable.
As outlined in the Payment Schedule under the heading: **"Services Supervised by a Physician"**, only certain services are able to be billed when not personally performed by a physician. Those services include:

a) a laboratory service (V section codes);
b) the technical component of diagnostic-ray or diagnostic ultrasound procedure (W & X section codes);
c) The technical component of a diagnostic procedure involving a tracing [including, but not limited to, ECGs (30D), spirometries (601D, 611D, etc.), echocardiogram (322A, 522A, etc.), etc.];
d) An intramuscular, intradermal, or subcutaneous injection (including, but not limited to 110A, 161A, etc.);
e) A specimen collection (205A, 205A, 206A);
f) 43E Repetitive Transcranial; Magnetic Stimulation (TMS).

In these circumstances, the person performing the service must be employed by the physician in their office and for whom the physician assumes overall supervision ad responsibility.

SECTION X– DIAGNOSTIC RADIOLOGY

642X - PERCUTANEOUS INTRATHORACIC BIOPSY
643X - PERCUTANEOUS INTRA-ABDOMINAL BIOPSY

Radiologists performing biopsies are required to bill the specific, applicable service code set out in the Physician Payment Schedule and may not substitute alternative codes.

Service codes 642X and 643X can only be billed when the biopsy is intrathoracic or intra-abdominal.

There are no restrictions limiting radiologists to billing only services listed under Section X of the Physician Payment Schedule.

Additionally, in the Physician Payment Schedule under the heading "Introduction" on page 7, it states under item (5):

> *If a specific service code for the service is rendered is listed in the Physician Payment Schedule, that service code must be used in claiming for the service, without substitution*.

- ✓ **Thyroid biopsies** must be billed under code **69L (Needle biopsy of thyroid gland)**.
- ✓ **Prostate biopsies** must be billed under code **121R (Prostate, biopsy, needle)**.

There are no restrictions preventing radiologists from billing service codes 69L or 121R.

Please ensure that all biopsy procedures are billed under the appropriate service code. If you believe that the existing service codes do not accurately or adequately reflect the services being provided, you may wish to contact the SMA Tariff Committee to request consideration of amendments to the Physician Payment Schedule.