

Billing Bulletin

Billing Bulletin No. 17

Published by Medical Services Branch at 1-800-605-2965

October 1, 2026

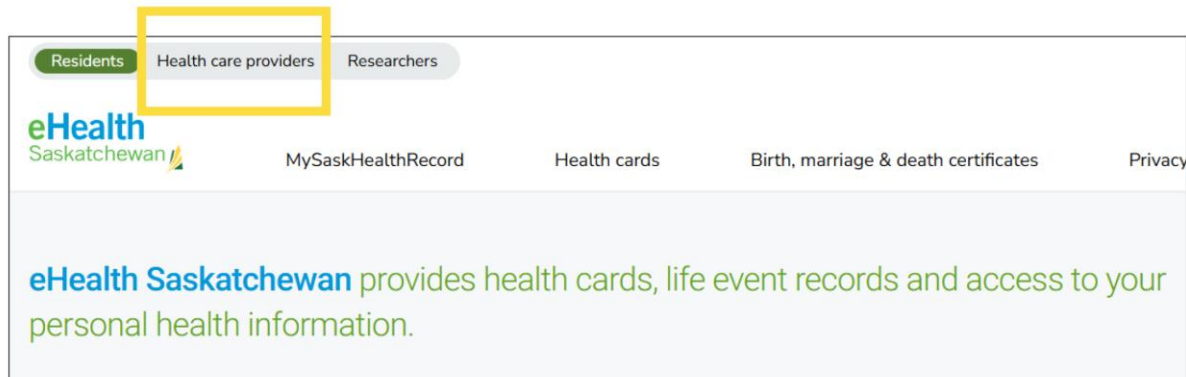
IMPORTANT HEALTH WEBSITE LINKS

All physicians are encouraged to become familiar with this important information and update bookmarks accordingly.

All Medical Services Branch **Payment Schedules, Newsletters, Operations Bulletins, Billing Bulletins, Billing Information Sheets and forms** formerly located on *ehealthsask.ca* are now available on Customer Portal and on **saskatchewan.ca** at <https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/resources-for-health-care-businesses-and-career-development/establishing-and-operating-a-practice/physicians>.

IMPORTANT NOTICE

The **eHealthsask.ca** site has recently changed. To find resources, including eHealth supported applications such as **EMR, PACS, RMS, PIP** etc. click **Health care providers** at the top of the eHealth home page. These applications will remain on *ehealthsask.ca*.



Some resources previously found on **eHealthSask.ca** are now located at **saskatchewan.ca**.

Additional resources previously found on *ehealthsask.ca* can be found by clicking **Resources for health care providers**. Links on this page will take you to the external site OR new location at **saskatchewan.ca**.

PLEASE BOOKMARK THE NEW PAGES.

CONTACT INFORMATION

For MSB inquiries related to physician registration, claims processing, physician education, physician billing or payment related inquiries 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:

[Physicians | Establishing and Operating a Practice | Government of Saskatchewan](#)

NEW ONLINE PHYSICIAN BILLING COURSE LAUNCHED

The Ministry of Health, Medical Services Branch (MSB), in collaboration with the Saskatchewan Medical Association (SMA), College of Physicians and Surgeons of Saskatchewan (CPSS) and the Division of Continuing Medical Education (CME), College of Medicine, University of Saskatchewan, have partnered to develop the Online Physician Billing Course.

This self-paced, accredited course is designed to strengthen understanding of the Physician Payment Schedule, improve billing accuracy and consistency, and support compliance with billing and documentation requirements. The course includes practical, case-based learning and covers topics such as billing obligations, claim submission and reconciliation, service code interpretation, documentation requirements, EMR utilization, and payment integrity audits.

Key Details

Format:	Online, self-paced (asynchronous)
Target Audience:	Physicians, billing clerks
Duration:	Approximately 6 to 8 hours
Access:	Mobile phone, Tablet, PC, iMac
Cost:	Free of charge
Registration:	Registration opened September 1, 2026, with continuous intake throughout the year.

Accredited

Royal College of Physicians and Surgeons of Canada: This activity is an Accredited Self-Assessment Program (Section 3) as defined by the Maintenance of Certification (MOC) Program of the Royal College of Physicians and Surgeons of Canada and approved by the Continuing Medical Education Division, University of Saskatchewan. You may claim a maximum of **2.75 hours** (credits are automatically calculated).

The College of Family Physicians of Canada: This activity meets the certification criteria of the College of Family Physicians of Canada and has been certified by the Continuing Medical Education Division, University of Saskatchewan for up to **7.0 Mainpro+®** Certified Activity credits.

For full course information, accreditation details, and registration instructions, please visit the University of Saskatchewan Continuing Medical Education website:
[Physician Billing - Continuing Medical Education | University of Saskatchewan](#)

CONTACT INFORMATION

For questions and more information, please contact cme.events@usask.ca

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
Thanksgiving	October 12, 2026	October 12, 2026
Remembrance Day	November 11, 2026	November 11, 2026
Christmas Day	December 25, 2026	December 25, 2026
Boxing Day	December 26, 2026	December 28, 2026
New Year's Day	January 1, 2027	January 1, 2027
Family Day	February 15, 2027	February 15, 2027
Good Friday	March 26, 2027	March 26, 2027
*Note: For the purposes of billing there are no statutory holidays observed on Monday following Good Friday.		

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 - Joint Medical Professional Review Committee \(JMPRC\)](#).

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.](#)

Routine audits are routinely undertaken at specific intervals to address high risk billing concerns.

The following routine audits have been undertaken thus far in 2026:

Partial assessment (5B) billed for injection service (110A/161A)

- Confirming whether the partial assessment was medically necessary and appropriately billed in circumstances where the service may have been more appropriately billed as an injection service.

Partial (5B) and complete assessments (3B) billed for uninsured third-party requests

- Confirming whether the assessment was medically necessary and insurable in circumstances when services were associated with uninsured third-party requests, including services previously submitted with a third-party request diagnosis (Z12).

Multiple surcharges (815A) billed in a day by the same doctor

- Confirming that the surcharge was billed only for the first eligible patient encounter.
- Confirming that the physician attended on a priority basis and that the visit resulted in the required disruption of work, out-of-hours activity, and travel.
- Confirming that the physician was not already present at the facility when the call was initiated.

House call surcharge (615A)

- Confirming the medical necessity and appropriateness of the surcharge, including whether it was billed for routine pre-scheduled visits to a patient's residence, retirement residence, or personal care home.

Prescription renewal by fax/email (795A)

- Confirming the medical necessity and appropriateness of the fax, including whether it was billed for the routine renewal or management of medications.

Chronic Disease Management (CDM) – 64B-68B

- Confirming that all CDM billing requirements were met, including completion of the required flow sheets and documentation of start and stop times supporting the duration billed.

Location of Service Premiums – “E”, “P” & “T”

- Confirming the accuracy of the location of service and whether the service location met the eligibility requirements of the code.

Surcharges (815A- 839A) billed with Interpretation of telephonic rhythm strips and/or ECGs by cardiologist with prompt response and advice to the referring physician on immediate case management (13I)

- Confirming the appropriateness of the surcharge in circumstances where the underlying service is telephonic in nature and does not involve travel.

Virtual partial/follow-up assessment or subsequent virtual visit provided via telephone or secure videoconference

- Confirming the medical necessity and appropriateness of the service and whether the documentation supports compliance with the requirements of the applicable virtual care code.

Records 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: [Physicians | Establishing and Operating a Practice | Government of Saskatchewan](#)

REFERRALS TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN (CPSS)

Physicians are reminded that billing matters identified through Medical Services Branch review processes may be referred to the College of Physicians and Surgeons of Saskatchewan (CPSS) when additional review is considered appropriate.

Physicians have an obligation pursuant to *The Medical Professional Act, 1981 (section (46))* and the Code of Ethics to ensure that the billings they submit for payment are appropriate and align with legislation.

In October 2024, the CPSS issued a [guidance document](#) related to billing. The document can be found on the CPSS website or at saskatchewan.ca.

GENERAL

MEET AND GREET VISITS

Physicians are reminded that visits conducted solely as meet-and-greet appointments are **not billable to the public system**. This is outlined in the “**Definitions**” section of the Physician Payment Schedule.

Physicians should also reference the College of Physicians and Surgeons of Saskatchewan’s guidelines regarding establishing a patient-physician relationship: [Establishing a Patient-Physician Relationship](#)

The Guideline states that a meet and greet “***should not include an in-depth history, physical exam or the delivery of any medically necessary service, otherwise it is considered a patient care visit and a duty of care is considered to be established.***”

SERVICES NOT RELATED TO WORKER’S COMPENSATION BOARD (WCB)

Physicians are reminded that any claim related to an open worker's compensation claim, will be rejected with explanatory code “CW”. These claims are to be submitted to WCB for consideration. Where it has been determined that the service is not related to a WCB claim, including recurring issues that are not WCB related, physicians should select claim type “W” and enter the comment “Not WCB” at the time the claim is created.

Statutory Holiday and Hospital care Surcharges (700A, 701A)

To improve the adjudication of Statutory Holiday and Hospital Care Surcharge codes 700A and 701A, system changes have been implemented to allow these claims to be reviewed manually when the associated hospital care service has not yet been paid.

Physicians are encouraged to submit surcharge codes on the **same claim** as the related hospital care service whenever possible, as this supports more efficient adjudication and payment.

Where billing system limitations prevent submission of the hospital care service and surcharge on the same claim, physicians should work with their vendor to address the issue.

If the associated hospital care claim has already been paid and the surcharge remains outstanding, physicians may submit an inquiry through Customer Portal using the Query Claim function.

SECTION B – GENERAL PRACTICE

5B – PARTIAL ASSESSMENTS – BILLED FOR ROUTINE INJECTIONS (110A, 161A, ETC) –

Physicians should be aware that injection-related services have been associated with an increased frequency of inappropriate or medically unnecessary patient visits, such as partial assessments (5B). For patients receiving routine or preplanned injections on an ongoing basis (e.g., weekly, biweekly, or monthly), **it would not generally be medically necessary to perform and bill a partial assessment at every visit solely because an injection is administered.**

A partial assessment may be appropriate when a patient presents with a new or different clinical concern requiring assessment and management, or when the condition related to the injection therapy requires reassessment. In such cases, the medical record must clearly demonstrate the medical necessity of the service and include sufficient documentation to support the code billed.

3B - COMPLETE ASSESSMENTS (3B) –

As a reminder, complete assessment services are considered comprehensive visits intended to be a comprehensive review of the patient's past and current health. All of the listed components are required to be documented and performed. Services must also be medically necessary and clinically indicated.

64B-68B – CHRONIC DISEASE MANAGEMENT (CDM)

As a reminder, in order to bill service codes 64B-68B, the Physician Payment Schedule states, among other requirements, that **approved CDM flow sheets must be used and completed.**

During routine audits, it has been observed that many flow sheets are only partially completed, with multiple relevant sections left blank (e.g., subjective, objective, etc.). In some cases, no flow sheets were used at all.

Flow sheets are intended to support established clinical care pathways and promote effective longitudinal management of chronic conditions. When they are incomplete or missing required information, their usefulness is diminished and it may become difficult to demonstrate that the service met the requirements of the code billed, including the medical necessity of the service.

5B WITH 877L, 878L & 879L – PARTIAL ASSESSMENT OR SUBSEQUENT VISIT WITH PLANTER WART TREATMENT

In circumstances where the plantar wart(s) is billed in conjunction with a partial assessment, the visit must be medically necessary and all partial assessment criteria must be met. **It would not generally be medically necessary to perform and bill a partial assessment at every visit prescheduled plantar wart treatment visit.**

Physicians are reminded that for the routine plantar wart treatment, the procedure alone would be most appropriately billed. This applies to most recurring and/or preplanned minor procedures.

SECTION L – GENERAL SURGERY

246L – COMPLEX INCISIONAL HERNIA WITH INLAY MESH

Page 220 of the Payment Schedule outlines the billing criteria for 246L – Complex Incisional Hernia with Inlay Mesh, including the documentation required to support payment.

Effective August 25, 2026, the Ministry of Health will strictly enforce the Payment Schedule requirements for this service. Physicians must include on their electronic claim:

- The applicable qualifying component(s) that support billing code 246L; and
- The total duration of the surgical procedure.

Claims submitted without the required information will be rejected as they do not meet the stated documentation requirements.

This change is intended to ensure billing submissions align with the established Payment Schedule requirements.