PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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Inside this issue

- **Contact Us**
- **Electronic claims cut–off revision**
- Upcoming Fees
- Fee Revision
- Preamble Revisions
- Liver Transplant Recipient Telephone Calls
- Sleep Studies
- Peripheral Nerve Blocks
- Pathologists – second opinion consults
- Guidelines for funding Out of Province Addiction Treatment
- Guidelines for funding Out of Province Treatment for Mental Health
- MSI Documentation Reminder
- Influenza Immunization
- Billing Guidelines for Provincial Immunizations
- Reminder: Software Vendors

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ELECTRONIC CLAIMS CUT-OFF REVISION

Please note that the previously communicated cut-off date for paper claims submission on December 19, 2011 has been revised due to the holiday season. Claims must now be submitted by 11:00 a.m. on December 16, 2011 to ensure processing for the payment date of December 28, 2011.

UPCOMING FEES

The following fee has been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective January 1, 2011.

Category	Description	Unit Value
VADT	**Intravitreal Injection of a pharmacologic agent for the treatment of wet macular degeneration** For a patient diagnosed with wet macular degeneration, this fee includes the counselling of the patient, preparation of the eye, administration of subconjunctival anaesthesia and topical antibiotic as required and injection of the pharmacologic agent.	25

NOTE: Physicians are advised to continue billing HSC 28.73D – Intravitreal Injection of Antibiotics – until MSI updates the system. Once a new Health Service Code has been assigned, it wil be published in the MSI Physicians' Bulletin.

The following fees have been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective September 1, 2011.

Category	Description	Unit Value
MASG	**Thumb CMC Joint Tendon Interpositional Arthroplasty** To include removal of the trapezium, dissection of tendon, protection of radial nerve and osteotomies as required.	190 4+T

MASG	**Total Ankle Arthroplasty with Prosthesis** Procedure includes insertion of hardware, all associated bone preparation and soft tissue procedures such as alteration of tendon length, tendon transfer and repair, and synovectomy as required.	350 4+T

Category	**Description**	**Unit Value**
VEDT	**Peripheral Blood Film Review** Review of peripheral blood film by the pathologist or hematopathologist in response to a perceived abnormality in the complete blood count as determined by local laboratory policies. Includes review of blood film, patient history, correlation with other laboratory tests, assessment or morphology of all cell lines with the provision of a report and recommendations.	10
VEDT	**Continuous Conduction Anaesthesia for relief of pain in labour** Provision of neuraxial anaesthesia for relief of pain in labour and delivery. To include the entire epidural insertion, all top-ups, maintenance, normal vaginal delivery and removal of epidural catheter.	140
VEDT	**Flow Cytometry** Flow Cytometry for the diagnosis and follow up of patients with hematologic malignancies and immune disorders.	52.90
VEDT	**HLA Identification and Crossmatch** HLA of a donor's blood followed by screening of potential recipients based on existing HLA typing. Crossmatching of potential donor recipient pairs is then performed to assess transplant potential.	52.90
VEDT	**HLA Typing** HLA typing for bone marrow and solid organ transplant patients.	52.90
VEDT	**Bone Marrow Interpretation** Examination of all slides, confirmation of cell counts, interpretation of hematopoesis and iron stains, required to render a diagnosis based on WHO criteria.	28.62

VEDT	**Coronary CT Angiography** Coronary CT Angiography performed under direct supervision of the radiologist. Fee includes the performance and interpretation of the scan with all necessary work station, plus the administration of medication to control heart rate and contrast material as required. **Not to be used as a screening test in asymptomatic patients.**	120

Category	Description	Unit Value	
VADT	**Percutaneous expansion/inflation of a tissue expander**	13	
ADON	**Morbid Obesity Surgical Add On** Billable once per patient per physician in addition to the amount payable for the major procedure(s) where a morbidly obese patient undergoes surgery to the neck, hip, or trunk and: a. has a BMI (body mass index) greater than 50 and this is recorded in the patient's health record. b. the procedure is performed using an open technique through an incision for major neck and hip surgery and an open or laparoscopic technique for the trunk and is performed under general, or neuraxial anaesthesia. c. the principle technique is neither aspiration, core or fine needle biopsy, dilation, endoscopy, cautery, ablation, nor catheterization. d. not billable for bariatric surgery.	32.9	4.6
ADON	**Repeat Open Heart Surgery** An add on code for repeat open heart surgery or revision of open cardiac surgery with pump, via a Sternotomy when the repeat surgery is 28 days or more after the previous open heart procedure.	120	
ADON	**Total Arterial Grafting** Procedures Auxiliary to Open Heart Surgery: ADON to CABG when all grafts are non-LIMA arterial grafts. Used with HSC 48.12, 48.13 or 48.14	100	
MASG	**External Fixation of Tibial plafond fracture** Closed reduction with external fixation of a tibial plafond fracture with or without minimal internal fixation. Stage one of the treatment of a tibial plafond fracture, also known as a pilon fracture, or distal	150	4+T

tibial explosion fracture. The purpose of this stage is to stabilise the fracture and allow for resolution of soft tissue swelling and wound management prior to open reduction and internal fixation of the same fracture.

Category	Description	Unit Value
MASG	**External Fixation of Tibial plafond fracture, with open reduction and internal fixation of fibular fracture** Closed reduction with external fixation of a tibial plafond fracture with or without minimal internal fixation, with open reduction and internal fixation of distal fibular fracture. Stage one of the treatment of a tibial plafond fracture, also known as a pilon fracture, or distal tibial explosion fracture, when there is a distal fibular fracture of the same limb. The purpose of this stage is to stabilise the fracture and allow for resolution of soft tissue swelling and wound management prior to open reduction and internal fixation of the same fracture.	175 4+T

NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once a new Health Service Code has been assigned, it wil be published in the MSI Physicians' Bulletin.

FEE REVISION

The following fee revision has been approved by the Master Agreement Steering Group (MASG) for inclusion into the Fee Schedule, effective September 1, 2011.

Category	Code	Description	Unit Value
MASG	91.35B	**Fractured tibial plafond, with or without fibula, open reduction and internal fixation – including removal of preexisting internal or external fixation devices (regions required)** Open reduction and internal fixation of tibial plafond facture, also known as a pilon fracture, or distal tibial explosion fracture. This is the second stage of a two stage procedure. The fee includes removal of any external and/or internal fixation previously inserted, for the same fracture.	200 4+T

NOTE: Please continue to submit claims in the normal manner. Ninety days after the system has been updated, a retroactive payment will be processed.

PREAMBLE REVISIONS

The Master Agreement Steering Group (MASG) has approved the following preamble amendments, effective September 1, 2011.

7.5.5 A Prolonged Consultation may be applied to cases where the consultation extends beyond one hour for comprehensive consultations and a half-hour for repeat consultations, ***or a half hour for OBGY consultations - specifically for preconceptual consultation(Maternal fetal medicine), consultation for issues of sexual dysfunction, reproductive endocrinology, gynaecologic oncology, and urogynaecology.*** A prolonged consultation cannot be claimed with a limited consultation. Prolonged consultations are paid in 15-minute time blocks or portion thereof. Prolonged consultations are not to be confused with active treatment associated with detention.

A prolonged consultation may be claimed only by the following specialties:
(a)Anaesthesia
(b)Internal Medicine
(c) Neurology
(d)Physical Medicine
(e)Paediatrics
(f)Psychiatry
(***g)Obstetrics and Gynaecology***

7.10.2 Pallative Care Support Visit
The Palliative Care Support Visit is a time-based all-inclusive visit for the purpose of providing pain and symptom management, emotional support and counseling to patients with terminal disease. The physician must spend at least 80% of the time claimed with the patient and cannot claim for any other visits with the patient on the same day.
Can be claimed if the patient is registered with the district integrated palliative care service.

7.10.3 Pallative Care Chart Review and/or Telephone Call
The Palliative Care Medical Chart Review and/or Telephone call, fax or e-mail advice eligible for payment are those initiated by health care professionals involved with the care of the palliative care patient. Telephone calls, fax or e-mails initiated by the palliative patient or his/her family members are not eligible. Physicians and health care professionals involved should keep a detailed record of telephone calls, fax or e-mails. Palliative care medical chart review and/or telephone calls, fax or e-mails ***can be claimed if the patient is registered with the district integrated palliative care service.***

8.3.2 Calculation of Anaesthetic Fees
A Basic Unit is listed for most procedures. It is the value assigned to each procedure to cover all anaesthetic services except the time actually spent either in administering the anaesthesia or in unusual detention with the patient. Additional procedures, not routine components of an anaesthetic procedure, will be billed either as additional anaesthesia procedures, or as replacements for, or additions to, the basic units. These procedures include the following items, for which the basic rate will be increased or replaced by a unit value specific to the factors listed below (See Billing Instructions Manual):

viii) Morbid Obesity-when providing general, or neuraxial anaesthesia for a patient with a body mass index (BMI) greater than 50, the units will be increased.

9.4.1 Surgical Rules apply to treatment of fractures except:
a) A fracture procedure (not dislocation) includes necessary after care up to ***14 days.*** The application and removal of casts or traction devices is included in the fee, even if removal takes place after the ***14 day*** period.

9.4.12 Multiple Fractures
a) Where multiple fractures are treated by the same surgeon the greater procedure is claimed at 100% and 50% is claimed for each additional fracture.
b) When multiple major fractures involve different long bones (where long bones are specified as clavicle, humerus, radius, contralateral ulna, femur, tibia and contralateral fibula), occur at the same time and are managed under the same anaesthetic, the greater procedure is claimed at 100% and 85% is claimed for each additional long bone fracture, unless specified otherwise. [This does not apply to fractures of the ulna when the radius on the same side is fractured, or fractures of the fibula when the tibia on the same side is fractured].

NOTE: Please hold all eligible service encounters to allow MSI the required time to update the system. Once the applicable changes have been made, they wil be published in the MSI Physicians' Bulletin.

LIVER TRANSPLANT RECIPIENT TELEPHONE CALLS (VIST 03.03 RO=TALR)

This code is for the provision of telephone advice by a transplant hepatologist and is only payable when the call is initiated by the physician(s) in the patient's home community who is responsible for monitoring the patient between visits to the transplant hepatologist. Both physicians must keep a detailed record of the call. This health service code may not be used for other types of telephone calls.

SLEEP STUDIES

Physicians are reminded that health service code 03.19C is to be used when a level 1 sleep study has been conducted; i.e., a sleep technician is in continuous attendance and the study takes place in a sleep centre of a hospital based sleep laboratory. It may not be used for portable at home testing which should be billed as 03.19F for Level II testing or 03.19G for Level III testing.

PERIPHERAL NERVE BLOCKS

If at the time of performing temporary nerve blocks (Health Service Code 17.72C) additional injections are needed to secure adequate analgesia, either at the trunk level or more peripherally, this is included in the original nerve block code and not payable as a multiple. Additionally, physicians are advised that only one occipital nerve block per side may be claimed.

PATHOLOGISTS – SECOND OPINION CONSULTS

Pathologists are reminded that they may not bill second opinion consults for cases that are part of a Quality Assurance program.

GUIDELINES FOR FUNDING OUT OF PROVINCE ADDICTION TREATMENT

Funding for out of province treatment for addictions treatment will be considered where it can be demonstrated that the individual patient has a significant problem which has been

unresponsive to all reasonable attempts to treat it utilizing services available within Nova Scotia's publicly funded addictions services system.

1. **Certain conditions apply to consideration of such requests:**

    - The province will only consider payment for out of province treatment if **prior** approval is given to the specific patient/client to meet a need for treatment that cannot be met within the province.

    - Consideration will only be given to a limited number of established **accredited** programs outside Nova Scotia that offer specialized programs. Extraordinary circumstances may be considered on a case by case basis.

2. **Applications for out of province treatment for addiction treatment issues must be accompanied by:**

    - A detailed **history of previous experience with addiction treatment** and some indication of why these experiences have had limited impact on recovery.

    - An indication of **the facility/program selected**; why it was selected; the likelihood of a positive outcome from treatment there and an estimate of the related costs.

    - **If available**, an up to date psychiatric assessment conducted by a Nova Scotia registered psychiatrist. This should include a full assessment including details about the present problem; previous psychiatric history; family, personal and social history; medical history; mental state examination and medication currently prescribed.

3. **In addition to meeting the conditions for out province treatment for addiction treatment:**

    - The client must be **assessed by a clinical therapist** working at Addictions Services in the client's district of residence

    - The case is to be **reviewed by the Director of Addiction Services** to determine the availability and suitability of in-province treatment and to make a recommendation for out of province treatment to the relevant physician.

    - A **follow up treatment plan** with Addiction Services (e.g. Community Based Services) upon return from out of province treatment must be included in the request.

4. **Application Process:**

    - The physician is responsible to compile all documentation and submit a letter of request to MSI for out of province treatment funding.

    - Applications are directed to the MSI Medical Consultant.

    - MSI will send request to Executive Director, Mental Health, Children's Services and Addictions for approval.

GUIDELINES FOR FUNDING OUT OF PROVINCE TREATMENT FOR MENTAL HEALTH

Funding for out of province treatment for mental health treatment issues will be considered where it can be demonstrated that the individual patient has a significant problem which has been **unresponsive to all reasonable attempts** to treat it utilizing services available within Nova Scotia's publicly funded mental health system.

1. Certain conditions apply to consideration of such requests:

- The province will only consider payment for out of province treatment if **prior** approval is given to the specific patient/client to meet a need for treatment that cannot be met within the province.
- Consideration will only be given to a limited number of established **accredited** programs outside Nova Scotia that offer specialized programs. Extraordinary circumstances may be considered on a case by case basis.
- Residents of Nova Scotia requiring medical care not available in Nova Scotia must be referred for out-of – province treatment by a Nova Scotia specialist approved as such by the College of Physicians and Surgeons of Nova Scotia.

2. Applications for out of province treatment for addiction treatment issues must be accompanied by:

- A detailed **history of previous attempts at treatment with mental health** and some indication of why these experiences have had limited impact.
- An indication of **the facility/program selected**; why it was selected; the likelihood of a positive outcome from treatment there and an estimate of the related costs.
- An up to date psychiatric assessment conducted by a Nova Scotia registered psychiatrist. This should include a **full** assessment including details about the present problem; previous psychiatric history; family, personal and social history; medical history; mental state examination and medication currently prescribed.

3. In addition to meeting the conditions for out province treatment for mental health treatment:

- There must be a stated plan for follow-up and continued care of the patient on their return to the province.

4. Application Process:

- The physician is responsible to compile all documentation and submit a letter of request to MSI for out of province treatment funding.
- Applications are directed to the MSI Consultant.
- MSI will send request to Executive Director, Mental Health, Children's Services and Addictions for approval.

MSI DOCUMENTATION REMINDER

As in the past, for MSI purposes, an appropriate medical record must be maintained for all insured services claimed. This record must contain the patient's name, health card number, date of service, reason for the visit or presenting complaint(s), clinical findings appropriate to the presenting complaint(s), the working diagnosis and the treatment prescribed.

From the documentation recorded for psychotherapy services, it should be evident that in the treatment of mental illness, behavioural maladaptions, or emotional problems, the physician "deliberately established a professional relationship with the patient for the purposes of removing, modifying or retarding existing symptoms, of attenuating or reversing disturbed patterns of behaviour, and of promoting positive personality growth and development." There should be evidence of the discussions that took place between the physician and the patient, the patient's response, and the subsequent advice that was given to the patient by the physician in an attempt to promote an improvement in the emotional well being of the patient. Similarly, for all counselling services, the presenting problem should be outlined as well as advice given to the patient by the physician and the ongoing management/treatment plan. The recording of symptoms followed by "long discussion," "long talk," "counselled," "supportive psychotherapy," etc., is not considered appropriate documentation for the billing of psychotherapy or counselling services.

Where a procedural code is claimed, the patient record of that procedure must contain information which is sufficient to verify the type and extent of the procedure according to the Fee Schedule.

Where a differential fee is claimed based on time, location, etc., the information on the patient's record must substantiate the claim.

Where the fee claimed is calculated on a time basis, start and finish times must be part of the patient record of that service.

All claims submitted to MSI must be verifiable from the patient records associated with the services claimed. If the record does not substantiate the claim for the service, then the service is not paid for or a lesser benefit is given.

Documentation of services which are being claimed to MSI must be completed before claims for those services are submitted to MSI.

All service encounters claimed to MSI are the sole responsibility of the physician rendering the service with respect to appropriate documentation and claim submission.

INFLUENZA IMMUNIZATION

For the 2011-2012 Season, the influenza immunization is not restricted to certain age groups or risk categories. Please refer to the attached schedule of provincial immunizations for the diagnostic codes to be used when billing for the influenza immunization.

REMINDERS: BILLING GUIDELINES FOR PROVINCIAL IMMUNIZATIONS

Please see the attached Schedule of Provincial Immunizations for billing purposes.

1. If one vaccine is administered but no associated office visit is billed **(i.e. the sole purpose for the visit is the immunization), claim the immunization at a full fee of 6.0 MSUs.**

2. If two vaccines are administered at the same visit but no associated office visit is billed **(i.e. the sole purpose for the visit is the immunization), claim for each immunization at a full fee of 6.0 MSUs each.**

3. If one vaccine is administered in conjunction with a billed office visit, **claim both the office visit and the immunization at full fee.**

4. If two vaccines are administered in conjunction with a billed office visit, **the office visit and the first injection can be claimed at full fee. All subsequent injections will be paid at 50 percent.**

5. For children under 12 months of age, if a vaccine is administered in conjunction with a well baby care visit, **claim the well baby care visit and the immunization.**

REMINDER: SOFTWARE VENDORS

Software developers must notify MSI three months in advance of any changes to the accredited software that might impact the claims submission process. MSI will determine if any additional testing is required to maintain accreditation status.

SCHEDULE OF PROVINCIAL IMMUNIZATIONS

Refer to the following fee schedule when claiming for individual immunization(s) not billed in conjunction with an office visit or a single immunization billed in conjunction with an office visit:

IMMUNIZATION	HEALTH SERVICE CODE	MODIFIER	MSUs	DIAGNOSTIC CODE
PENTA (DaPTP, Hib)	13.59L	RO=PENT	6.0	V069
MMR	13.59L	RO=MMAR	6.0	V069
QUAD (DaPTP)	13.59L	RO=QUAD	6.0	V069
Td	13.59L	RO=TEDI	6.0	V069
Influenza - Pregnant	13.59L	RO=INFL	6.0	V221
Influenza - Males and non-pregnant females	13.59L	RO=INFL	6.0	V048
Varicella	13.59L	RO=VARI	6.0	V069
Adacel	13.59L	RO=ADAC	6.0	V069
Menjugate	13.59L	RO=MENC	6.0	V069
Pneumococcal Polysaccharide	13.59L	RO=PNEU	6.0	V069
Pneumococcal Polysaccharide In addition to Influenza	13.59L	RO=PNEU	6.0	V066
Boostrix®	13.59L	RO=BOTR	6.0	V069
Pneumococcal Conjugate	13.59L	RO=PNEC	6.0	V069

When claiming immunization with a visit, the visit will be paid in full at 100%. The first inoculation will be in full at 6.0 MSU and all subsequent inoculations will be paid at 3.0 MSU or 50%. If the purpose of the visit is for immunization only, then the first two inoculations will be paid at 100% and all subsequent inoculations at 50% of the specified MSU.

Refer to the following table when claiming for a provincial immunization tray fee:

HEALTH SERVICE CODE	DESCRIPTION	MSUs
13.59M	Provincial Immunization Tray Fee	1.5 per multiple (Max 4)

Refer to the following diagnostic code table, when claiming for pneumococcal and varicella immunizations:

PATIENT'S CONDITION	DIAGNOSTIC CODE
At risk irrespective of age	Diagnostic code applicable to condition, e.g. 25000 diabetes mellitus
Close contact of at risk individual	V018
Well Senior	V069