PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

December 7, 2012 Volume XLVIII - #4

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On-line documentation available at:

www.gov.ns.ca/health/physicians_bulletin

NEW FEES

Effective October 1, 2012 the following new health service codes are available for billing:

Category	Code	Modifiers	Description	Unit Value
MASG	44.4A	RG=LEFT RG=RIGT	**VATS Lung Lobectomy** Video-assisted thoracoscopic surgery (VATS) to remove an entire lobe of the lung. Billing Guidelines: This is a comprehensive fee for the video-assisted thoracoscopic removal of a lung lobe to include the procedures required to visualize the operative area, mobilize the lobe and determine the extent of resection required, namely; bronchoscopy, decortication, and mediastinal lymph node dissection, where necessary. When diagnostic procedures such as bronchoscopy, lung biopsy, wedge resection with frozen section, or mediastinal lymph node sampling, are performed during the same operative session, in the same anatomical location (same lung, same lobe), and the surgeon uses these results to determine the extent of the necessary surgical resection, only the most extensive procedure performed will be remunerated.	480 13+T

Category	Code	Description	Unit Value
VADT	43.1B	**Bedside percutaneous tracheostomy** The planned, percutaneous insertion of a tracheostomy tube for a ventilated patient in the intensive care unit. Billing Guidelines: This is a comprehensive fee to include any and all procedures required to insert the tracheostomy tube including, but not limited to, any means of visualization required to assess the anatomy of the airway and confirm tube placement. Not to be billed with: Any other bronchoscopy same patient same day unless the indications for a full diagnostic bronchoscopy are recorded in the medical record. May be billed in addition to daily CRCR fees.	100 6+T

Effective January 1, 2013 the following new health service code is available for billing:

MASG	71.4B SP=OBGY SP=UROL (Interim Fee)	**Urethral sling using prosthetic material such as TVT, TOT etc, by any method** Billing Guidelines: • Cystoscopy cannot be billed in addition.	150 4+T

Note: Physicians holding eligible services must submit their claims from October 1, 2012 onward within 90 days of the date of this bulletin. Please include text referring to this bulletin for any service over the 90 day time frame.

FEE REVISIONS

Case Management Fee

Effective December 7, 2012 the following fee has been corrected to the proper amount:

Category	Code	Description	Unit Value
VIST	03.03D	Case Management Conference	• 14.5 units per 15 minutes for GPs • 17.0 units per 15 minutes for Specialists

Effective April 1, 2013 the following fee revision will be in effect:

Category	Code	Description	Unit Value
VIST	03.03D	Case Management Conference	• 14.75 units per 15 minutes for GPs • 17.25 units per 15 minutes for Specialists

Effective April 1, 2014 the following fee revision will be in effect:

Category	Code	Description	Unit Value
VIST	03.03D	Case Management Conference	• 15.0 units per 15 minutes for GPs • 17.5 units per 15 minutes for Specialists

Decortication of Lung

Effective October 1, 2012, health service code 46.41 – Decortication of lung has been revised and updated with the following information:

Category	Code	Modifiers	Description	Unit Value
MASG	46.61A	RG=LEFT RG=RIGT	**Decortication of Lung – Primary Procedure** Major decortication of lung as primary procedure for indications such as empyemectomy, treatment of fibrothorax, or clotted hemothorax. Billing Guidelines: May be billed only when decortication is the primary procedure.	280 15+T

BILLING REMINDERS

Catheter Insertion

Physicians may only claim for insertion of a catheter when they have personally performed the service. Preamble Rule 5.3.1 states "All insured services claimed must reflect services rendered personally by the physician in an appropriate clinical setting." Therefore these health service codes may not be claimed when they are carried out by another health care provider such as a nurse, nurse practitioner or X-Ray technologist as part of their usual duties. Effective December 7, 2012 text will be required on all claims explaining why the physician has claimed for the catheter insertion.

Time Based Services

As per Preamble section 1.8.1 (H) “An appropriate medical record must be maintained for all insured services claimed. The minimum record must contain, for MSI purposes, the following: (H) Time and duration of visit in the case of time-based fees”. Effective December 7, 2012 any claims for time based services must have the start and end times documented in the electronic text field. Anaesthesia services are exempt from the electronic text requirement.

HSC 09.13A and 09.13B

Regions are not required for billing HSC 09.13A and 09.13B. In addition, HSC 09.13B is only billable once per 365 days per patient.

HSC 98.12U and 98.99F - Cryotherapy of Warts

Effective December 7, 2012, health service codes 98.12U - Cryotherapy of warts and 98.99F - Cryotherapy of planter warts or molluscum contagiosum have a maximum of two multiples (ie 10 warts) claimable per service encounter.

Unbundling of Claims

Section 9.3.3 (a) of the Preamble in the Physician's Manual restricts the unbundling of a procedure fee into its constituent parts and billing for the parts individually or in combination with the procedural fee. For example, a laparoscopic assisted vaginal hysterectomy should be billed as 80.4B and not vaginal hysterectomy plus laparoscopy (80.4 + 66.83).

Effective July 1, 2010 MSI began an initiative to assess claims submitted where more than one procedure is claimed for the same patient on the same day. Please be advised that as the manual assessment of these claims continues, operative reports may be requested and there may be an increase in turnaround time.

Laparoscopy

As per Preamble 9.3.3 (d), "When one physician performs a definitive procedure on an organ or within a body cavity, only that service should be claimed. The procedure used to provide surgical exposure should not be claimed." Therefore health service code 66.83 (Laparoscopy) cannot be billed with health service codes 77.19C (Laparoscopic ovarian cystectomy), 57.59A (Laparoscopic assisted colectomy) or 80.4C (Laparoscopic hysterectomy).

Diagnostic Codes for Premium Services

Please note the following diagnostic codes are not valid when claiming for premium consults and procedures:

- V220 – Supervis Normal First Pregnancy
- V221 – Supervis Other Normal Pregnancy
- V222 – Pregnancy State Incidental
- V720 – Routine Examination of Eyes and Vision
- V7281 – Pre-OP Cardiovascular Exam
- V7284 – Unspecified Pre-OP Examination
- 36250 – Macular Degeneration Unspecified
- 64630 – Habitual Aborter/Unspecified

Billing for Services Not Provided

If a service has not been provided, it can not be claimed by a physician. Similarly, cancelled visits or procedures can not be claimed. It has come to MSI's attention that some physicians are billing for cancelled procedures. Physicians are reminded that they may not bill for such circumstances.

Cerumen (Ear Wax) Removal

Preamble 7.2.3 (a) stipulates that if the sole purpose of a visit is to provide a procedure then only the procedure may be billed. However, removal of cerumen has been an uninsured service in Nova Scotia for many years except in the case of a febrile child. Physicians may not bill either a visit or a procedural code when the sole purpose of the encounter is cerumen removal in other clinical situations.

Service Encounters with Uninsured Services

As per Preamble 5.3.3, "As part of the provision of an insured service, patients may be charged directly for the provision of consumable items not covered by MSI. These charges must be explained and agreed to by the patient before the insured service is provided."

When billing non-insured services, physicians should be familiar with Preamble Section 5.4:

"5.4 Billing for insured and non-insured services at the same visit.

5.4.1 A physician must exercise caution whenever billing MSI and the patient or a third party during the same visit. In principle, under no circumstances should any service, or any component of a service, be claimed for twice.

5.4.2 Whenever possible, the attending physician must acquaint the patient, or person responsible for the patient, with the financial obligation involved in the patient's care.

5.4.3 If the insured service is the primary reason for the visit, any additional charges for non-insured services must be explained to, and accepted by, the patient before provision of these services. Charges for non-insured services will reflect only those services over and above those provided on an insured basis. It is not appropriate to bill both MSI and WCB for the same service.

5.4.4 At no time should provision of insured services be contingent upon the patient agreeing to accept additional non-insured services.

5.4.5 When physicians are providing non-insured services, they are required to advise the patient of insured alternatives, if any exist.

5.4.6 Incidental findings

(a) If an inconsequential health matter or finding is discovered or discussed during the provision of a non-insured service, it is not appropriate to claim for an insured service.
(b) If a significant health matter or finding becomes evident, necessitating additional insured examination(s) or treatment(s), then these subsequent medically necessary services may be claimed to MSI.

5.4.7 When a non-insured service is the primary reason for the visit, any service encounter for insured services provided as a medical necessity will reflect only services over and above those provided on a non-insured basis."

Long-Term Care Clinical Geriatric Assessment (CGA)

Audits of this health service code CGA1, which was introduced in early 2011, have begun and deficiencies in completion of the documentation are being noted. Physicians are reminded that they must satisfy all requirements outlined prior to billing the CGA1 code.

Category	Code	Description	Unit Value
DEFT	CGA1	Long Term Care Clinical Geriatric Assessment	26.32

Description:

The Long-Term Care Clinical Geriatric Assessment (CGA) is an evidence-based clinical process that allows for interdisciplinary input to best assess the complexity of the nursing home resident. The CGA process and form, once completed, gives a point in time assessment of medical, functional and psychosocial needs of the resident which serves as a benchmark to treat to when the clinical condition changes. The physician is directly responsible for completing the medication list, diagnostic categories, cognition, emotional, behaviors, and provides the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessments. The frailty level has been determined to be a predictor of the clinical trajectory of the resident, which is helpful in determining what course of care is reasonable, and a reference to use when discussing a resident's care plan with the resident, families and/or staff. The physician has the option to fill out the other fields on the CGA form as well. However the CGA process is best served when all disciplines involved with the resident complete their sections so as to provide accuracy and encourage dialogue among the clinical team. The other providers who may provide input for the CGA include: nursing, social work, physiotherapy, occupational therapy, pharmacy and/or other health care disciplines consistent with their scope of practice.

The CGA form should be near the front of every nursing home chart and will serve as the lead clinical document that will travel with the resident when a transfer (ER, other facility etc) occurs. In this way accurate clinical information is provided to other caregivers the resident may need to be treated by. This will help ensure accurate communication of the resident's care directives, and all relevant baseline clinical information so any care outside the facility or by any on-call physician can be provided with this vital clinical information that will enhance the quality of care given.

Billing Guidelines:

- Family physicians will be remunerated for the completion of a Long-Term Care Clinical Geriatric Assessment (CGA) for residents of licensed Nursing Homes and Residential Care Facilities (RCF's) funded by the Department of Health only.
- The CGA may be billed twice per fiscal year (April 1 – March 31), per resident. The initial CGA is recommended to be completed as soon as possible following Nursing Home or RCF admission, once the physician and clinical team have had time to become familiar with the resident/patient.
- The CGA is normally completed through a collaborative team process involving the family physician and other licensed long-term care healthcare providers. The physician claiming the CGA fee is responsible for the diagnostic section (Cognitive Status, Emotional and Behaviors), the medication section, and providing the final overall opinion of the frailty level of the resident once the other disciplines have completed their assessment. Other sections of the CGA may be completed by the physician or by other licensed healthcare providers.
  The CGA requires one direct service encounter with the resident by the physician on the date of the final completion and signing of the CGA form. This service encounter is included in the CGA fee. The CGA evaluation process may involve additional service encounters (visits) which would be paid separately from the CGA per the Preamble requirements. The dates of all physician service encounters associated with the completion of the CGA must be tracked on the CGA form.
- Prior to claiming the CGA fee, the physician must review, complete and sign the CGA form in the long-term care facility on the date of the final CGA service encounter and place a note in the resident's clinical record (progress notes) corroborating that the CGA has been completed.
- The date of service is the date when the final CGA service encounter occurs and the CGA form is completed and signed by the physician.
- The CGA fee is billable by eligible fee-for service physicians and by eligible APP contract physicians, based on shadow billings.

It is recommended that the CGA form is attached to any applicable transfer forms, including inter facility transfers whenever possible.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this new fee are June and December of each year.

GENERAL PRACTICE COMPREHENSIVE CARE INCENTIVE PROGRAM – ADDITIONAL SERVICE CATEGORY

Pap Smears for women ages 40 – 75 years on the date of service have been added to the General Practice Comprehensive Care Incentive Program (CCIP) as an additional CCIP-eligible service

category for 2012/13. Calculation of the number of CCIP-eligible Pap Smear services will be based on claims for HSC 03.26A Pap Smear provided for women ages 40-75 years during the period July 1 to June 30 prior to the calculation of the annual CCIP payment. Other CCIP-eligible service categories include: nursing home visits; inpatient hospital care; obstetrical deliveries; maternity/newborn visits; home visits; all office visits for children under two years; and, selected GP procedures.

The CCIP provides incentives and recognition to family physicians for providing a comprehensive breadth and depth of services for their patients. To qualify for a 2012/13 CCIP payment, family physicians must have minimum total fee-for-service and/or shadow billings of $100,000, including

minimum office billings of $25,000, and reach the first activity threshold for at least two CCIP-eligible service categories during the 12-month CCIP calculation period. Payments to individual physicians are determined each year by: the total amount of CCIP funding available; total CCIP-eligible services provided; the number of physicians who qualify for a payment; and the number of service categories and activity levels per service provided by the individual physician.

EXPLANATORY CODES

The following new explanatory codes have been added to the system:

VA045 Service encounter has been disallowed as HSC 50.99A and 69.94 require text stating the reason for the intravenous/catheter insertion.

VA046 Service encounter has been refused as only one 09.13B can be paid in a 365 day period.

VA047 Service encounter has been refused. HSC 03.26C is included in the complete care code 81.8 which was previously billed for this patient on this day.

VA048 Service encounter has been refused as cystoscopy cannot be billed in addition to HSC 71.4B.

VT096 Service encounter has been refused as the maximum number of subsequent limited visits has already been claimed for this patient this week.

VT097 Service encounter has been refused as you have already been approved for a supportive care claim within the past three days (Preamble 7.6.1).

VT098 Service encounter has been refused as you have already been approved for two supportive care claims within the past seven days (Preamble 7.6.1).

VT099 Service encounter has been refused as you can only claim subsequent weekly visits after 56 days from hospital admission. Prior to that you may claim subsequent daily visits.

VT100 Service encounter has been refused as HSC 03.26C has previously been billed for this patient on the same day.

GN055 Service encounter has been refused as you have already claimed the surgeon fee for this service.

GN056 Service encounter has been refused as you have already claimed the surgical assist fee for this service.

GN057 Service encounter has been disallowed as the diagnostic code submitted does not warrant a premium fee.

GN058 When claiming multiples for a time based service the start and end times must be included in the text field.

MA020 Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/ 28.42A/ 28.44A, or 28.72 on that date.

MA021 Service encounter has been refused as you have already billed HSC 28.73E or 28.49A on that date.

MA022 Service encounter has been refused as you have already billed HSC 28.41/28.41A/28.42/ 28.42A or 28.44A on that date.

MA023 Service encounter has been refused as you have previously billed another major surgery for this patient on the same day.

MA024 Service encounter has been refused as HSC 77.19C, 57.59A, or 80.4C has been billed at this encounter.

MA025 Service encounter has been refused as HSC 66.83 has been billed at this same encounter.

MJ040 Service encounter has been refused as a 01.34A has previously been billed for this patient on this day.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, December 7, 2012. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).

CAREER OPPORTUNITY

Job Title:	Medical Consultant
Internal/External:	Internal/External
Department:	MSI Monitoring
Competition:	2012-668
Employment Type:	Part Time - Contract Position
Location(s):	Dartmouth, Nova Scotia
Reports to:	Team Leader

"To help improve the health and well-being of people and their communities."

Recognized as one of Canada's 10 Most Admired Corporate Cultures, Medavie Blue Cross understands each one of its 1,900 employees plays a key role in building a strong and successful organization. Throughout the six provinces in which we operate, we know our people make a difference in our customers' lives each day. We encourage our employees to be involved and to support activities that allow for personal and professional growth and development. As a not-for-profit organization, we also place a high priority on giving back to the communities in which we live.

If you are looking for an opportunity in a challenging, fast-paced and team-oriented work environment with a leading local organization, the career you've been looking for may be waiting for you at Medavie Blue Cross.

Role Summary:

We are currently recruiting for a Medical Consultant to join the MSI Monitoring Team. Under the supervision of the Team Leader, the incumbent will support the MSI post-payment monitoring function. The Medical Consultant will provide the medical link between the paying agency and providers. In collaboration with the MSI Monitoring Team, they also will advise key stakeholders of Medavie Blue Cross and the Department of Health and Wellness of Nova Scotia on MSI Monitoring related matters including the development of policies and procedures.

As a MSI Monitoring Medical Consultant your key responsibilities will include:

- Conduct fee for service and shadow billing audits in collaboration with the Medicare Auditors.
- Provide medical expertise and support to Pharmacare Auditors.
- Support the evaluation of select alternative funding contracts; includes interviews with providers, associations and other parties.
- Assist in the development of the annual audit plan, procedures to enhance monitoring operations, and the development of risk analysis strategies to utilize departmental resources efficiently.
- Communicate with providers, Nova Scotia residents, Department of Health and Wellness, Doctors Nova Scotia, law enforcement, other government agencies in relation to MSI audit, including Medicare and Pharmacare.
- Participate on various Department of Health and Wellness and professional committees as required.

- Resolve issues and maintain productive, professional relationships with medical provider community and Department of Health and Wellness; inform providers through bulletin articles of changing audit policies, administrative procedures and billing issues.
- Liaise with staff from other MSI departments including the provision of claims assessment support as required.
- Maintain confidentiality, respecting both patients and provider matters.

As the ideal candidate, you possess the following qualifications:

- Education: University degree with a Doctorate in Medicine.
- Work Experience: Minimum of 15 years experience as a physician in a range of practice settings. Specialist training and administrative experience would be an asset.
- Computer Skills: Computer skills in MS Office suite (Word, Excel, etc.)
- Other Qualifications: Ability to travel throughout the province of Nova Scotia.

If you are interested in working with a team of professionals in a challenging role and you possess the necessary qualifications, please email your cover letter and resume/CV directly to: Stephanie Edge, Human Resources Coordinator, Medavie Blue Cross (Stephanie.Edge@medavie.bluecross.ca).

We would like to thank all candidates for expressing interest. Please note only those selected for interviews will be contacted.

Citizenship - Useful Information

Please indicate in your application the reason you are entitled to work in Canada: Canadian citizenship, permanent resident status or work permit.

Reliability screening will be required.

Medavie Blue Cross is an equal opportunity employer.

2013 CUT-OFF DATES
FOR RECEIPT OF
PAPER & ELECTRONIC CLAIMS

PAPER CLAIMS	ELECTRONIC CLAIMS	PAYMENT DATE
December 28, 2012**	January 3, 2013	January 9, 2013
January 14, 2013	January 17, 2013	January 23, 2013
January 28, 2013	January 31, 2013	February 6, 2013
February 11, 2013	February 14, 2013	February 20, 2013
February 25, 2013	February 28, 2013	March 6, 2013
March 11, 2013	March 14, 2013	March 20, 2013
March 22, 2013**	March 27, 2013**	April 3, 2013
April 8, 2013	April 11, 2013	April 17, 2013
April 22, 2013	April 25, 2013	May 1, 2013
May 6, 2013	May 9, 2013	May 15, 2013
May 17, 2013**	May 23, 2013	May 29, 2013
June 3, 2013	June 6, 2013	June 12, 2013
June 17, 2013	June 20, 2013	June 26, 2013
June 28, 2013**	July 4, 2013	July 10, 2013
July 15, 2013	July 18, 2013	July 24, 2013
July 26, 2013**	July 31, 2013**	August 7, 2013
August 12, 2013	August 15, 2013	August 21, 2013
August 23, 2013**	August 28, 2013**	September 4, 2013
September 9, 2013	September 12, 2013	September 18, 2013
September 23, 2013	September 26, 2013	October 2, 2013
October 4, 2013	October 9, 2013**	October 16, 2013
October 21, 2013	October 24, 2013	October 30, 2013
November 1, 2013**	November 6, 2013**	November 13, 2013
November 18, 2013	November 21, 2013	November 27, 2013
December 2, 2013	December 5, 2013	December 11, 2013
December 13, 2013**	December 18, 2013**	December 24, 2013**
December 27, 2013**	January 2, 2014	January 8 , 2014
11:00 AM CUT OFF	11:59 PM CUT OFF	

NOTE:
Though we will strive to achieve these goals, it may not always be possible due to unforeseen system issues. It is advisable not to leave these submissions to the last day.

Each electronically submitted service encounter must be received, processed and accepted by 11:59 p.m. on the cut-off date to ensure processing for that payment period.

Paper Claims include: Psychiatric Activity Reports, Rural Providers' Emergency on Call Activity Reports, Radiology, Pathology, Internal Medicine Monthly Statistical Reports and Sessional Payments. Manual submissions must be received in the Assessment Department by 11:00 a.m. on the cut off date to ensure processing for that payment period.

PLEASE NOTE, THE ** INDICATES A DATE VARIATION

HOLIDAY DATES FOR 2013

Please make a note in your schedule of the following dates MSI will accept as "Holidays."

NEW YEAR'S DAY	TUESDAY, JANUARY 1, 2013
GOOD FRIDAY	FRIDAY, MARCH 29, 2013
EASTER MONDAY	MONDAY, APRIL 1, 2013
VICTORIA DAY	MONDAY, MAY 20, 2013
CANADA DAY	MONDAY, JULY 1, 2013
CIVIC HOLIDAY	*IF APPLICABLE*
LABOUR DAY	MONDAY, SEPTEMBER 2, 2013
THANKSGIVING DAY	MONDAY, OCTOBER 14, 2013
REMEMBRANCE DAY	MONDAY, NOVEMBER 11, 2013
CHRISTMAS DAY	WEDNESDAY, DECEMBER 25, 2013
BOXING DAY	THURSDAY, DECEMBER 26, 2013
NEW YEAR'S DAY	WEDNESDAY, JANUARY 1, 2014

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