PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

February 15, 2013 Volume XLIX - #1

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On-line documentation available at:

www.gov.ns.ca/health/physicians_bulletin

MEDICAL SERVICE UNIT/ANAESTHESIA UNIT CHANGE

Effective April 1, 2013, the Medical Service Unit (MSU) value will be increased from $2.32 to $2.37 and the Anaesthesia Unit (AU) value will be increased from $19.75 to $20.15.

WORKERS' COMPENSATION BOARD MEDICAL SERVICE UNIT / ANAESTHETIC

Effective April 1, 2013 the Workers' Compensation Board MSU value will increase from $2.58 to $2.63 and the Workers' Compensation Board Anaesthetic Unit value will increase from $21.94 to $22.39.

SESSIONAL PAYMENTS

Effective April 1, 2013 the Sessional payment rates for General Practitioners will increase to 59 MSUs while the rate for Specialists increase to 69 MSUs as per the tariff.

PSYCHIATRY FEES

Effective April 1, 2013 the hourly Psychiatry rate for General Practitioners will increase to $108.38 while the hourly rate for Specialists increases to $146.96 as per the tariff agreement.

NEW FEES

Effective January 1, 2013 the following new health service codes are available for billing:

Category	Code	Description	Unit Value
VADT	01.14H	**Esophagogastroscopy plus endoscopic placement of esophageal stent with or without the use imaging** This is a comprehensive fee for the placement of an esophangeal stent. It includes esophagogastroscopy, esophageal dilation where required, and placement of the esophageal stent with or without the use of radiologic guidance. Billing Guidelines: Not to be billed with: • 01.14C Oesophago-gastroscopy • 54.71 Insertion of permanent tube into esophagus • 54.92E Dilation of esophagus with esophagoscopy	90 4+T
VADT	49.98I	**Complex Cardiac Ablation for Atrial Fibrillation and complex cardiac arrhythmias (see description)** This is a composite fee for the intracardiac catheter ablation of arrythmogenic focus or foci, for the treatment of complex cardiac arrhythmias (not atrioventricular nodal reentry or atrioventricular reentry), atrial fibrillation, ventricular tachycardia, and cases of arrhythmia in patients with complex congenital heart malformations. This fee includes percutaneous right heart catheterization, transeptal left heart catheterization, all diagnostic imaging (including angiography), electrocardiograms, electrophysiologic mapping, ablation, and electric counter shock of heart as required. This fee does not apply to the treatment of *reentrant* supraventricular tachycardia *(atrioventricular nodal reentry or atrioventricular reentry).* **Billing Guidelines:** Not billable with: • 49.95, A, B • 49.96, A through H • 49.97, A through G • 49.98, A through H • ADON 50.83, 50.91, 50.98A, 13.72	796 9+T

DISCONTINUED HEALTH SERVICE CODES

Effective February 15, 2013 the following health service codes will no longer be active:

Category	Code	Description	Unit Value
MASG	54.71A	Introduction of Mousseau-Bardin tube	150
MASG	54.71B	Insertion of Celestin tube	200

Please note that these have been replaced with the new patient specific health service code **01.14H - Esophagogastroscopy plus endoscopic placement of esophageal stent with or without the use imaging.**

INCORRECT DIAGNOSTIC CODES FOR URGENT CARE VISIT SERVICES

Please note the following diagnostic codes are not valid when claiming for urgent care visits or callbacks: 3804, 5210, 7062, V681, 9190, 7030, V221, 700, 30510, 37300, 2724, 6910, 7063, 7964, 9194, V2501, 1112, 2720, 2722, 37515, 38801, 4720, 5282, 7575, 78050, 78053, 7834, 78836, 79093, 9114, 9124, 9164, 9174, V1272, V201, V241, V2509, V259, V411, V413, V6549, V658, V720, V723, V725, V729, V762.

REQUESTS FOR AN OPERATIVE REPORT

When a claim has been paid at zero with error code NR072 asking for an OR report, the original claim itself also has to be resubmitted with an action code of “R” for reassessment. If the OR report is received and no reassessment (R) is sent in for the original service encounter, the claim will not be paid. Please ensure that upon submitting the required OR report that a reassessment is sent in with text referencing the OR report.

BILLING REMINDERS

Billing for Services Provided by Medical Trainees

Preamble section 8.1.2 outlines billing rules for payment of physicians who are supervising the clinical activities of medical students or residents. Physicians are reminded that they must personally be present at the time the medical trainee is providing the service or immediately available to render assistance. An attending physician may claim for only the resident's services, or his/her own but not both. Visits on a teaching unit may only be claimed by the attending physician when he/she is physically present on the clinical teaching unit that day. If multiple services/procedures are being supervised, the attending physician may not claim a total number of services in excess of those he/she might have claimed in the absence of other members of the team.

Physicians are reminded that they may not bill for procedures or visits carried out by nurses or nurse practitioners except for a very limited number of procedures carried out by nurses/nurse practitioners who are directly employed by a fee for service family physician.

Lifestyle Counselling – 08.49C

Physicians are reminded that as per Preamble Section 8.9, “Lifestyle Counselling is a prolonged discussion where the physician attempts to direct the patient in the proper management of health related concern; e.g. lipid or dietary counselling, AIDS advice, smoking cessation, health heart advice, etc.” This is only billable by the general practitioner providing on-going primary care to the patient.

Independent Consideration

Preamble section 6.3.1 - Independent consideration is applied to certain services recognized to have wide variation in case to case complexity and time. (Refer to Billing Instructions Manual) Independent consideration services must be accompanied by complete details, including duration of service, adequate to explain and justify the number of units requested.

Exceptional Clinical Circumstances

Preamble section 6.3.3 - Exceptional Clinical Circumstances may warrant a fee other than that listed. In the event a practitioner performs a service he or she believes should be insured, but is unable to find an appropriate service code or finds an appropriate service code but feels the listed tariff does not adequately compensate the service, a request for an exceptional fee may be submitted. The request must be accompanied by complete details, including the duration of the service, adequate to explain and justify the number of units requested.

Note: The exceptional fee process is not intended for use on a routine basis when a physician disagrees with the listed tariff for a service.

EXPLANATORY CODES

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

AD047 Service encounter has been refused as HSC 98.49C must be submitted prior to the add-on 98.49D.

CR011 Service encounter has been refused as this service has already been billed for this date.

CR012 Service encounter has been refused as a fee for intensive care has already been claimed for this patient on this date. Critical or comprehensive care cannot be claimed on the same day as intensive care.

CR013 Service encounter has been refused. When a physician provides both critical and ventilator care to a patient they should claim comprehensive care. Please delete the previously paid ventilatory care and submit a claim for comprehensive care.

CR014 Service encounter has been refused. When a physician provides both critical and ventilator care to a patient they should claim comprehensive care. Please delete the previously paid critical care and submit a claim for comprehensive care.

CR015 Service encounter has been refused as a fee for comprehensive care has previously been claimed for this patient on this day (preamble 7.9.2).

CR016 Service encounter has been refused as a fee for critical or ventilatory care has previously been claimed for this patient on this day (preamble 7.9.2).

CR017 Service encounter has been refused as a fee for intensive care has previously been claimed for this patient on this date.

CR018 Service encounter has been refused as a fee for comprehensive or critical care has previously been claimed for this patient on this date.

GN059 A consult has previously been approved for your specialty during this hospitalization.

MA026 Service encounter has been refused as you have previously billed a portion of this composite service at the same encounter (bronchoscopy, decortication, or mediastinal lymph node dissection).

MA027 Service encounter has been refused as you have previously billed a VATS lung lobectomy at the same encounter.

MA028 Service encounter has been refused as you have previously billed health service code 77.3 or 78.21 at the same encounter.

MA029 Service encounter has been refused as you have previously billed health service code 77.19A at the same encounter.

MA030 Service encounter has been refused as you have previously billed health service code 77.52 at the same encounter.

MA031 Service encounter has been refused as you have previously billed health service code 78.21 at the same encounter.

VA049 Service encounter has been refused as a 01.14C, 54.71, or 54.92E has been billed at this same encounter.

VA050 Service encounter has been refused as a 01.14H has been billed at the same encounter.

VA051 Service encounter has been refused as a 49.95A, 49.95B, 49.96A,B,C,D,E,F,G,H, 49.97A,B,C,D,E,F,G, 49.98A,B,C,D,E,F,G,H, 50.83, 50.91, 50.98A, or 13.72 has been billed at this same encounter.

VA052 Service encounter has been refused as a 49.98I has been billed at this same encounter.

VT101 Service encounter has been refused as a diagnostic code used is not valid for urgent services.

VT102 Service encounter has been disallowed. Please submit a copy of the clinical record before requesting a reassessment for this claim.

VT103 A comprehensive or initial limited visit may not be claimed within 30 days of a comprehensive consultation on the same patient for the same condition. See preamble 7.2.3 (c).

VT104 A comprehensive visit may not be claimed within 30 days of a previous limited or comprehensive visit. See preamble 7.2.3 (d).

The following explanatory codes have been revised:

GN052 Service encounter has been disallowed. Please submit a reassess (action code R) along with a copy of the time sheet for the surgery performed to aid in the adjudication of your claim.

VA045 Service encounter has been disallowed as HSC 50.99A and 69.94 require text indicating the intravenous/catheter insertion was performed by the physician.

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, February 15th, 2013. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), and explanation code (EXPLAIN.DAT).