MSI Bulk Billing Transition Project: Specialty Conference Call Follow Up

February 27, 2015

This document is a follow up to the specialty specific conference calls that took place February 9 – 13, 2015. This aims to address the central questions regarding the transition as well as specialty specific scenarios. These questions and answers will also be added to the Bulk Billing FAQ document.

We thank everyone for their contributions to the questions list. If you have additional questions after reviewing this document, please reach out to MSI Programs. All contact information and additional links to resources can be found at the end of this document.

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Top 5 Questions on Bulk Billing Transition

1. What demographics or claim information will MSI require to submit patient specific claims?

Here's a quick list of what will need to be included on the claim for processing. This is the same information that is currently required by other specialties for patient specific electronic billing. These fields are required for IM, RAD and PATH physicians – if a particular field is not required for a particular claim submission, it will appear N/A in the field space.

For a detailed breakdown of the fields, please refer to the Fields Required For Patient Specific Submissions that has been updated (February 2015)

1. Provider Type
2. Provider Number
3. Provider Specialty Code
4. Patient Health Card number (if they are a resident of NS)
5. Patient Birth Date
6. Health Service Code
7. Service Start Date (the date patient had the procedure)
8. Service Occurrence Number
9. At least one diagnostic code on the claim (room for three)
10. Number of multiples being claimed on the service (default is 1)
11. Modifiers if any exist on the service. An example would be RG=BOTH for bilateral hand x-rays, or US=PREM for a service performed during premium time
12. Facility Code (hospital number)
13. Functional Centre Code for area in the hospital (outpatient, in-patient, ICU, etc.)
14. Location code (should be HOSP in most instances for radiology)
15. Physician Business Arrangement Number
16. Pay to code (usually BAPY)
17. Referring Provider Type and Referring Provider Number will be necessary for a small number of codes at this time (ex. R1)
18. Payment Responsibility (ex. MSI)
19. Program Code (MC)
20. Hospital Admit Date, depending on which functional centre the service was performed in
21. If the patient is from Out of Province, then information is required such as name, birth date, gender, address, etc.
22. Electronic Text will be necessary to facilitate the payment of some claims

Additional information on what is required for electronic claims can also be found in section 3.2.48 of the 2014 Physician's Manual: www.medavie.bluecross.ca/msiprograms

Regarding #9, diagnostic code, this should be the diagnosis of the physician submitting the claim. We recognize there are specialty specific issues that need to be considered around diagnostic codes and interpretation fees. Interim codes for Internal Medicine, Radiology and Pathology have been created for diagnoses that do not currently have the necessary codes. This

will assist in the transition period and will serve as an interim solution until such a time where a permanent solution is developed. These codes can be found here: Diagnostic Code – Interim Solution and will be uploaded to the vendor systems in time for the respective go-live dates.

How long is "interim"?

The Physician Manual Modernization project is underway and DHW has indicated that any new, permanent codes would be created to align with that project. Current estimates suggest completion in late 2017. Until such a time that new codes are formalized, these interim diagnostic codes will be used.

2. What are we expected to do if we don't have the required field information?

If you are missing information related to diagnostic codes, please refer to the Interim Diagnostic Code document. If that does not provide adequate clarification for you, please contact MSI Programs at MSI_Assessment@medavie.bluecross.ca, 1-902-496-7011 or toll free at 1-800-553-0585.

If you are missing information relating to patient identification or other fields in the claims submission form, it is best to first speak with your Health Information Systems contact.

3. Why isn't the approach a province-wide IT solution with the hospital administration systems?

That is not included in the scope of this transition as established by DHW. A province-wide IT system that meets MSI requirements for claims submissions is a multi-year undertaking. At this time the focus is aligning all physician billing under one system and moving towards a One Patient One Record process.

4. Why can't a direct data feed be created to MSI?

Claims submissions require more than just a direct data feed from an IT system to MSI. It requires an interface that can support two-way communication and not only receive data, but send responses back to the physicians.

This two way communication is essential. It ensures the adjudication response – on whether a claim was accepted, if it was not the reason why, and what follow-up is required – is delivered to the physician. In addition to the two-way communication requirements, accredited software vendors must maintain specific files to access required information for claims. For more detail on this issue, please refer to the MSI Accreditation Process - Data Feed Clarification document.

5. **Can you please clarify billing procedures? When is it billed at 100% vs 50%?**

   Any services that are currently bulk billed will continue to be paid at 100% for each service after the transition to patient specific codes. There will be no reduction to 50% for subsequent services provided to a patient on the same day.

   Currently VADT and VEDT health service codes are set up such that the first service pays at 100% and subsequent services pay at 50%. There will be no change to the adjudication rules currently used for these services after the transition.

Codes and Billing Fees

6. **CDHA DI does not capture diagnosis codes and the earliest possible date this can be captured is September 2015. Is there a generic or body part specific diagnosis code that can be used prior to this implementation?**

   Interim codes for Internal Medicine, Radiology and Pathology have been created for interpretations that do not currently have the necessary codes.

   The interim codes can be found here: Diagnostic Code – Interim Solution**.** These codes will be uploaded to the vendor systems in time for the respective go-live dates.

7. **Is there a difference between the method we currently use for patient specific billing via our vendor, and this method to transition bulk billing?**

   Example: Our current format for DOB and service start date is mm/dd/yyyy (may be transposed by vendor), the format requested is yyyy/mm/dd? Gender code is M or F, the format requested is Male or Female? Location code is I, O, E.

   If you are using the same vendor there is no difference. If you are using a new vendor for these services, there may be a difference. It is best to speak directly to your new vendor about that issue.

8. **How are multiple procedures performed on the same patient on the same day to be billed?**

   Each procedure should be billed as its own separate service encounter. If two procedures are performed at the same time, then those procedures should be billed with the same service occurrence number. If the procedures occur at different times, the earlier procedure would be

service occurrence 1 and the later would be service occurrence 2, etc. No matter the timing of the procedure all of the previously Bulk Billed codes should be billed at 100%. There is no 50% reduction for subsequent services.

9. **Are there new codes for ECG interpretation and pulmonary function test? When a patient is getting a PFT, will the second and third billing only be 50% as is in procedures? If new codes are being implemented when will they be available?**

   All the same codes that exist today in Bulk Billing will remain the same for the electronic submission. Additionally, all Bulk Billed codes that were paid at 100% will continue to be paid at 100% under the patient specific billing. Detailed information on the interim diagnosis and interpretation codes is available here: Diagnostic Code – Interim Solution.

10. **How are we to bill for EKGs and is there a modifier code to submit? The Preamble statement states multiple claims for the same procedure will only be billed at 100% for the first EKG and then 50% for the rest.**

    Follow up question: What happens if this patient has an EKG and a CXR? Are both of these billed at 100% individually?

    Detailed information on codes and modifiers for EKGs is available here: Diagnostic Code – Interim Solution

    Regarding the scenario: If a patient is provided a service (e.g. EKG) in the morning that would be billed as service occurrence 1. Then, if they had another EKG in the afternoon this claim would be billed as service occurrence 2. There will be no 50% reduction for any of these transitioning interpretation services for subsequent claims, etc. Please note however that this only pertains to the previously bulk billed interpretation services from hospitals. All other VADT, VEDT, etc. services already electronically billed will follow the same preamble rules they always have. Alternatively, if the patient has an EKG in the morning and a CXR in the afternoon, the EKG would be billed service occurrence 1 and CRX as service occurrence 2.

11. **Please clarify who the "initial provider" is – is it the referring doctor or the Radiologist reading the x-ray? How should the service occurrence number be determined? Can we consider all interpretations for one patient by one radiologist each day to be a single encounter?**

    The service occurrence field for interpretation services is calculated from the point of view of the physician performing the interpretation, not from the visit in which the patient had direct contact with a service provider.

For example: If a hand x-ray for a patient occurs at 10:00 a.m. and 2:00 p.m. with both interpretation requests sent to the same radiologist, that physician would bill those encounters as service occurrence 1 and 2 respectively. If these interpretations are split between two radiologists then each physician would bill service occurrence 1 for their reports. If two interpretation requests are generated for the same patient from the same encounter and sent to the same physician (such as hand x-ray and forearm x-ray at 10:00 a.m.) both of these services should be billed with the same service occurrence number.

12. **Currently, all bulk billing codes are paid at full value regardless of number of exams per visit or number of visits per day. Please confirm that under patient specific billing multiple diagnostic imaging exams at the same encounter or on the same day will continue to be paid at the full rate.**

    All the same codes that exist today in Bulk Billing will remain the same for the electronic submission. There is no LV 50% on these codes – all will be paid in full (100%.)

Health Information Systems

13. **As we are only 6/52 away from the proposed introduction of this change, can the current Health Information Systems be altered to allow us to extract the required information in a reasonable electronic form by that date?**

    No. Electronic data submissions require more than just a direct data feed from an IT system to MSI. It requires an interface that can support two-way communication and not only receive data, but send responses back to the physicians.

    This two way communication is essential. It ensures the adjudication response – on whether a claim was accepted, if it was not the reason why, and what follow-up is required – is delivered to the physician. In addition to the two-way communication requirements, accredited software vendors must maintain specific files to access required information for claims. For more detail on this issue, please refer to the MSI Accreditation Process – Data Feed Clarification document.

14. **Does or will our Health Information System generate the required data in electronic form that is transferrable/acceptable to MSI? Or, does the output occur in such a form as to require manual, repeat data entry to MSI?**

    No – only accredited vendors have the necessary technical systems to submit claims to MSI. The Health Information System data reports will provide the necessary information for physicians to submit claims through an accredited vendor.

General Questions

15. What are the technical specifications for electronic submission of service encounters and retrieval of the adjudication responses? What are the requirements to have software accredited?

The technical specifications are available to accredited vendors. To have claims submission software accredited, you must become an accredited software vendor. Interested parties can contact MSI Programs to get the Accredited Software Vendor information kit, which includes the following:

- A Vendor Application Form which must be completed and returned to MSI
- Medical Services Insurance Requirements for Accreditation of Electronic Submission
- MSIeLink Submitter Documentation for Electronic Claims Submission
- Service Encounter Transaction Standards
- Medicare Fee for Service Electronic Statement

We would then follow up with additional documents to aid in the development of your system when the application is received. Once someone has software that has been accredited to submit to MSI, the process to become a registered service bureau is simple.

For more details on this process, please refer to the MSI Accreditation Process document

16. What steps are necessary to become a registered service bureau?

If someone wishes to become an approved service bureau, they can contact MSI Programs and we will send them the following:

- A Service Bureau Submitter Application which needs to be completed, and returned to our office

Once the application has been processed, the name will be added to the listing of Service Bureaus, and the Submitter ID would be assigned. Accredited claims submission software is required by all Service Bureaus. To acquire the accredited software, please refer to the MSI Accredited Software Companies list available on the MSI website.

17. Can we have a sample submission file specifying the data format required for each field?

This technical information is provided to accredited vendors only. If you would like to start the accreditation process, please contact MSI Programs (see question 15 for details). For an example of a claim submission with the fields completed (sample information) please see question 35.

Data formats can vary by software vendor. And often each vendor will receive the data in different formats from different clients then format it for MSI claims submissions. If you have questions specific to your data submission to your vendor, it is best to speak with them directly first. Any additional questions can be directed to MSI Assessment.

18. Is the information required only of value when it comes to interprovincial billing? If so, why is it being applied to all patients?

No, the information required is of value to all Nova Scotian patients as it creates a complete MSI patient history. Currently if a resident requires their patient history from MSI it will be incomplete, missing any services provided that were bulk billed.

There are four main drivers behind this transition: reciprocal/interprovincial billing is one of those reasons. The other three key factors are: incomplete patient histories in the MSI system due to a lack of patient specific information in bulk billed claims; bulk billing was identified as a risk area in previous Auditor General Reports, moving to patient specific billing will address the concerns expressed by the Auditor General; and the new claims processing system being implemented at Medavie Blue Cross which will not have bulk billing as a functionality.

19. Why is Physician Services (AFP branch) encouraging us to move away from shadow billing to a better indicator of physician activity at the same time as Physician Services (FFS branch) is insisting that not only do we continue to shadow bill but we provide more detail?

DHW has no plans to move away from shadow billing as a measure of clinical activity at this time.

20. Will there be an extension of the usual 90 day acceptance window for claims to MSI in recognition of the significant disruption this new process entails?

Outdated claims submissions will be reviewed on a case by case basis and extenuating circumstances will be evaluated. Please see page 5 of the June 2013 Bulletin for details.

21. In the September 2014 Physician's Bulletin there is a new explanatory code: BK002 (Service encounter has been refused as you have previously claimed for an abdominal survey film at the same encounter). Our current system of billing diagnostic imaging studies is obviously not based on patient specific encounters. Could you please specify what MSI considers an encounter to be, with specific reference to diagnostic radiology, when we move to the new billing system?

For example: Sometimes a clinician may order a second abdominal radiograph on a particular day for a patient with a bowel obstruction, if they want to see if there is improvement or if the clinical situation changes and the clinician thinks there could be a new bowel perforation. Furthermore, a different radiologist may end up interpreting the second radiograph. If a patient has an abdominal radiograph at 10:00 a.m. and again at 8:00 p.m., one would logically assume that this is considered to be 2 separate encounters for radiology, but based on the existence of the new code above, I would like to confirm that this is MSI's interpretation as well.

For the upcoming patient specific billing for diagnostic radiology studies MSI considers an encounter to be separate from any others done the same day if it's done at a different time of day, or done by a different radiologist. You're assumption for the scenario given would be correct.

If you are billing for two different service encounters on the same day but at different times you would use service occurrence 1 for the first service and service occurrence 2 for the second, etc. If you are billing for more than one service at the same encounter they would all be service occurrence 1.

More specific details on the billing rules for radiology interpretation claims will be available on the MSI website shortly.

Specialty Specific Questions – Pathology

22. There are millions of individual lab tests performed each year at CDHA: are they all to be reported as individual tests?

Yes.

23. What should a physician do if there is no clinical diagnosis provided with tissue submitted for histologic evaluation, as is often the case? Similarly, often the history provided is "lesion," possibly the most common clinical diagnosis provided. Will "lesion" be acceptable?

The Pathology physician can use the interim diagnostic code P999.

24. Regarding clinical history – on pap smears for example, the most common clinical history provided is "routine" and the next most common history is "suspicious." Are those adequate diagnoses? What happens if the diagnosis cannot be made out?

In such cases the Pathology physician can use the interim diagnostic code P999.

25. What is the value add /intent of providing a diagnosis?

The service encounter claim information includes patient and physician demographics, patient clinical diagnoses and the description of insured service provided by the physician. This information is used for multiple purposes including health system planning, compensation model support and physician payment, monitoring and audit. Requiring a diagnosis also helps lay the foundation for future enhance statistical data collection.

26. How are multiple procedures performed on the same patient on the same day to be billed?

Each procedure should be billed as its own separate service encounter. If two procedures are performed at the same time then those procedures should be billed with the same service occurrence number. If the procedures occur at different times, the earlier procedure would be service occurrence 1 and the later would be service occurrence 2, etc. No matter the timing of the procedure all of the previously Bulk Billed codes should be billed at 100%. There is no 50% reduction for subsequent services.

Example: A bone marrow examination sample includes a peripheral blood film, flow cytometry specimen, a core biopsy sample (surgical specimen) and an aspirate sample (usually several slides). There are individual fee codes for each of these. However if the "bundling rules" are applied this will seriously decrease the payment for these very complex specimens.

Any services that are currently bulk billed will continue to be paid at 100% for each service after the transition to patient-specific codes. There will be no reduction to 50% for subsequent services provided to a patient on the same day.

Currently VADT and VEDT health service codes are set up such that the first service pays at 100% and subsequent services pay at 50%. There will be no change to the adjudication rules currently used for these services after the transition.

Specialty Specific Questions – Internal Medicine

27. Where will the people submitting the billings for things like ECG and Holters get the patient information? Also, will we need to have a referral doctor? If so, where will we get this?

The patient information can be taken from the Hospital Information Systems data reports. If the people submitting the billings had access to Bulk Billing information reports before, they will have access to the data reports for patient specific billing. If not, they will need to user access process at the district level. Referral doctors are not required for these claims.

28. For ECG billing, what information is required to submit and how is the physician supposed to obtain this information?

Follow up question: Is the IT system at Dartmouth General Hospital able to obtain and print out this info? Presently there is no 'requesting' or referring MD recorded on tracings, nor is there a Diagnosis available.

The information needed for ECG billing is listed in question 1 of this document. This information can all be obtained from the data reports generated by your Health Information System. The IT system at the Dartmouth General will be able to print this out for physicians. No requesting or referring MD will be required. For diagnosis coding, please refer to the interim codes for appropriate field entry found here: Diagnostic Code – Interim Solution

29. What about ECG's transmitted from outside hospitals (Twin Oaks, Sheet Harbour, etc). Will all this required information be readily available for billing?

Yes – it will all be available through the Health Information System. Please refer to questions under **Health Information Systems** for additional details and supporting documentation.

30. My understanding is that we have to provide a diagnostic code for the ECGs we are reading. That is not currently possible. An ECG is not a diagnosis. What would the diagnosis be for someone whom we have never seen, and who has a normal ECG?

For ECG diagnosis field, please use the follow interim code, developed for situations such as this: **7859**. A complete list of available interim codes for diagnoses can be found here: Diagnostic Code – Interim Solution

Specialty Specific Questions – Radiology

31. What happens with a CT chest and abdomen and pelvis - are these billed separately?

Yes, these would be billed separately. There are no combination codes – each on is its own claim.

32. Why do we need to specify right vs. left hand and not simply hand as it's currently coded in our system? Why is that level of detail needed?

It no longer is. After discussions with Health Information Systems leaders, we understand that specifying right vs. left hand is not a viable option for data collection. So we have removed this field requirement from the electronic claims submission form.

Now, you can simply put 'hand' in the field. However, if you do both hands, you will need to specify both in order to be paid for both.

33. How many claims can the system handle? The maximum batch allowance is 99,999 claims but an unofficial guideline is 500 claims per batch. With a claim for every encounter, this will significantly increase volumes. Has the system been tested to handle upwards of 20,000 claims per batch?

MSI conducts volume load testing on a regular basis. A batch can have a maximum of 99,999 transactions, although MSI Programs recommends that batches have between 100 – 500 transactions. This recommendation has always been in place. Following these recommendations will ensure the timely process and adjudication of electronic claims for payment purposes.

There are no issues from a volume perspective for the batch to handle a maximum of 99,999 transactions. However, there may be an issue with claims being processed in a timely manner if a group submits all 20,000 claims in one batch on the evening of cut-off date for electronic claims submission. The claims may not be adjudicated (processed) within the required time frame for payment on the upcoming pay period.

It is also recommended that physicians discuss submission criteria with their chosen software vendor.

34. There are several items of data that radiologists don't currently track for bulk billing but which will be required for patient specific billing. Is there a source for these numbers / codes?

The information that is required for the electronic claims submission already exist or should already be part of the medical record in order to claim according to the preamble. It will be available through your Health Information Systems data reports for billing. Additionally, the accredited vendors have files available with the numbers, specialty codes, facility numbers and functional centre codes.

35. Can you provide me an example of an appropriate submission for a sample John Doe patient who might have a Chest x-ray? What about a patient who might have multiple exams performed on one visit such as a Chest x-ray, CT Chest and Nuclear Medicine bone scan (just an example) Would these be 3 separate submissions? Most radiologists outside Halifax access patient information via the Hospital information System Meditech, which is about to undergo

an upgrade. It does generate a patient specific chart of exams, health card numbers, and dates. Do you know if this is sufficient for submission purposes?

Yes – currently the Health Information Systems, including Meditech, are on schedule to produce the necessary data reports for electronic billing. These reports should contain all the necessary patient information data. In the case where a diagnosis code is not available, interim codes have been created for use until a permanent solution can be achieved.

To answer your scenario: An individual is admitted to the Yarmouth Regional Hospital with chest pains on Feb 1st, 2015. A chest x-ray is performed at 1:00 p.m. and interpretation occurs by the Radiologist on the same day.

For this claim here is the information required for submission:

- Provider Type = PH
- Provider number = (ex.123456)
- Provider specialty code = (ex.DIRD)
- Patient health card number (ex.1234567890)
- Patient Birth date = (ex. 01 January 1970)
- Health service code = R404 (Chest - Single view)
- Service start date = 01Feb2015
- Service occurrence number = 1 (1st time the patient was seen that day)
- Diagnostic code = (ex. R999)
- Multiples = 1
- Modifiers = none in this instance
- Facility code = 56
- Functional centre code = INPT (in-patient)
- Location code = HOSP
- Business arrangement number = (ex. 123456)
- Pay to code = BAPY
- Referring provider type and number = Not necessary for this claim, but can be included if you wish.
- Payment responsibility = MSI
- Program code =MC
- Hospital admit date = 01Feb2015
- No electronic text necessary on this particular claim.

If a chest c-ray, CT chest, and bone scan were completed at the same visit, each would be billed as a separate service encounter with the relevant information

36. Shadow billing test run: Can I run for myself a test of the new billing mechanism? When will such testing be available to me?

No this technical information is not available to physicians, it is provided only to accredited vendors to ensure their systems meet functionality requirements. If you are an accredited vendor or are in the process of becoming one, please contact MSI Programs directly to discuss.

37. If a requisition is blank with no information, what diagnostic code should be used?

The appropriate interim code should be used for the diagnosis field; for Radiology, it is **R999**.

A complete list of interim codes for all three specialities transitioning to patient specific billing cab be found here: Diagnostic Code – Interim Solution

38. If a requisition says something that is apparently wrong, like re-check pneumonia or re-check failure, and the patient doesn't have pneumonia or failure (and never did as far as x-rays you have access to), what code should be used? If we have no indication of symptoms and the chest x-ray is normal, do we call it a routine chest, pneumonia, or failure? Or will there be a diagnostic code for "not available"?

The appropriate interim code should be used for the diagnosis field; for Radiology, it is **R999**.

A complete list of interim codes for all three specialities transitioning to patient specific billing cab be found here: Diagnostic Code – Interim Solution

39. Diagnostic codes are the other data point that is extremely hard to track with our RIS and is of questionable validity because patients have no known diagnosis at the time of imaging. Can we use the single imaging diagnostic code V725, at least until we have been able to rewrite the necessary portion of our RIS?

The appropriate interim code should be used for the diagnosis field; for Radiology, it is **R999**.

A complete list of interim codes for all three specialities transitioning to patient specific billing cab be found here**:** Diagnostic Code – Interim Solution

Contact Information

For additional questions, please refer to the continuously updated Bulk Billing FAQ Document. There is a new section at the beginning addressing recent questions and scenarios. Additional information can be found on the MSI website at www.medavie.bluecross.ca/msiprograms

If you would like to speak with MSI Programs about specific scenario questions, claims submission processes or for further information on the transition or any questions in this document, please contact us at – (email) MSI_Assessment@medavie.bluecross.ca
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