PHYSICIANS' BULLETIN

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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NEW FEES

Effective July 1, 2009 the following new Health Service Codes are available for billing:

Category	Code	Description	Unit Value	
MASG	78.49A	Sterilization by transcervical tubal occlusion (both tubes)	90	4+T
VADT	49.87A	Removal of Loop Recorder	40	4+T
PMNO	46.04D	Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when unrelated to the delivery of anaesthesia	54	
PMNO	46.04E	Acute pain management (non-obstetrical) consultation, insertion of interpleural catheter and care on day 1 when in addition to delivery of anaesthesia on that day	30	
PMNO	46.04F	Acute pain management (non-obstetrical) interpleural catheter maintenance care, per day, day 2 onwards	20	

Physicians holding eligible services must submit their claims from July 1, 2009 onward within 90 days of the bulletin date. Please include text referring to this bulletin for any service over the 90 day time frame.

Effective August 1, 2009 the following new Health Service Codes are available for billing:

Category	Code	Description	Unit Value
MASG	49.87B	Removal of cardiac pacemaker system using laser sheath removal of the pacemaker leads (multiples allowed to a maximum of two)	200 14+T
VEDT	97.99A	Breast MRI guided placement of MRI compatible clip, with or without biopsy (includes all necessary imaging)	70

Health Service Code 49.87B includes any necessary debridement of the chest wall and any imaging performed in relation to the surgery. It is not payable in addition to other codes.

Physicians must submit their claims from August 1, 2009 onward within 90 days of the bulletin date. Please include text referring to this bulletin for any service over the 90 day time frame.

TELEPHONE ADVICE AND MEDICAL CHART REVIEW

Effective August 1, 2009 a new modifier has been created for use with Health Service Code 03.03 to bill the telephone advice and medical chart review of a liver recipient at the request of the physician(s) monitoring the patient's care outside the transplant centre.

Category	Code	Modifiers	Description	Unit Value
VIST	03.03	RO=TALR	Telephone advice and medical chart review of liver transplant recipient	11.5

This code 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 phone call.

Physicians must submit their claims from August 1, 2009 onward within 90 days of the bulletin date. Please include text referring to this bulletin for any service over the 90 day time frame.

TELEMEDICINE FEES

Effective August 1, 2009 a new modifier, ME=TELE, has been created to indicate telemedicine consultation. Please ensure that this modifier is included when you bill a telemedicine consult

	Code	Modifiers	Description	Unit Value
CONS	03.07	ME=TELE	Limited Consultation	As per normal consult rate
CONS	03.08	ME=TELE	Comprehensive Consultation	As per normal consult rate

PALLIATIVE CARE CODES

The original implementation date for Palliative Care Codes was June 1, 2005. At that time the codes paid at 80% of the listed unit value (*MSI Physicians' Bulletin – May 26, 2005, Pg 2*). *Effective October 2, 2009, these codes will pay at 100% of the assigned unit value. A retroactive payment will be calculated and paid early in 2010.*

Category	Code	Modifiers	Description	Unit Value
CONS	03.09C		Palliative Care Consult	52
VIST	03.03C	RO=PCSV	Palliative Care Support Visit	25.4 for 1st 30 mins, 12.7 per each additional 15 mins (max 1 hour total)

Effective August 1, 2009, the Palliative Care Telephone advice and/or medical chart review code was increased from 7.3 units to 11.5 units. All applicable claims will be identified and a retroactive payment will be forthcoming.

Claims with a date of service October 2, 2009 onward will pay as follows.

Code	Modifiers	Description	Unit Value
03.03	RO=CRTC	Telephone advice and/or medical chart review of palliative care patient	11.5

To claim this service the call must be initiated by a health care professional, and covers up to 3 telephone calls per day per patient. Each additional group of 3 calls/per day/ per patient can be claimed at 11.5 units.

PANDAMIC INFLUENZA IMMUNIZATION

A new modifier has been created to identify a pandemic influenza immunization effective September 1, 2009. The modifier is RO=PAND, and it follows the same guidelines as other immunizations.

Category	Code	Modifiers	Description	Unit Value
ADON	13.59L	RO=PAND	Provincial immunization injections	6

REMINDERS: BILLING GUIDELINES FOR PROVINCIAL IMMUNIZATIONS

Please see the attached Schedule of Provincial Immunizations for billing purposes. When billing the influenza injection please include the applicable “at risk” diagnostic code.

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.

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.

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

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.

For children 18 months of age and under, if a vaccine is administered in conjunction with a well baby care visit, claim the well baby care visit and the immunization.

For vaccines administered to people not eligible to receive a provincially funded vaccine, submit Health Service Code 13.59L, the modifier for the vaccine given (see Appendix A) and the appropriate diagnostic code. Enter 0 in the “Claimed Unit Value” field and Y in the “Unit Value Indicator” field. It is very important to remove the Y before submitting subsequent services.

There have been additions to the high risk groups for seasonal influenza. These include anyone who lives with or cares for children under the age of 24 months, and anyone living in a home that is expecting a newborn during influenza season.

REMOTE SURGICAL CONSULT WITH REVIEW OF PACS IMAGES - PROGRAM EXPANSION AND FEE INCREASE

Following a six-month pilot program, the fee for Remote Surgical Consult with Review of PACS Images has been increased from 25 to 35 units and has been extended to all surgical specialties effective July 1, 2009. This expanded pilot program will be re-evaluated in approximately six months time.

Category	Code	Description	Unit Value
CONS	03.09D	Remote Surgical Consult with Review of PACS Images	35

Eligible services can now be submitted for dates of service July 1, 2009 onward. Physicians have 90 days from the date of this Bulletin to submit these claims. Please include text referring to this bulletin for any service over the 90 day time frame.

Billing Guidelines:

- This fee may be billed when a physician working in an Emergency Department or a surgeon encounters a complex surgical problem that requires the opinion of a surgeon practicing in the area of concern. The consultant surgeon reviews the PACS (or other such archival system) images and provides telephone advice to the referring physician and follows with a formal written report to the referring physician.
- The report must document the history, presenting complaint, the discussion with the referring physician concerning the patient's physical condition, the results of the review of the PACS images, the consultants' opinion and recommendations for management of the patient in their local community.
- The referring physician must also document that a telephone consultation was requested and provided.
- The referring physician and the surgical consultant must be situated in different facilities.
- If the patient is subsequently seen by the surgical consultant for a comprehensive or limited consultation within 30 days of the Remote Surgical Consult with Review of PACS Images, the consultant will not be paid
- The fee is only payable once per case per patient.
- This fee may not be claimed where the purpose of the phone call is to:
    - Arrange for diagnostic investigations
    - Discuss the results of diagnostic investigations

BARIATRIC SURGERY

This is to inform physicians that a bariatric surgery program has been available in Nova Scotia since September 2008. The "Obesity Network" clinic functions in conjunction with the QEII Health Sciences Centre, and as is the policy of this multidisciplinary clinic, the provision of bariatric surgery (sleeve gastrectomy) is just one facet of a broad-based weight loss program. A referral to this clinic at the QEII may be faxed to (902) 425-3817, and should contain a complete medical history of the patient.

UNATTACHED PATIENT BONUS

Effective July 1, 2008 this incentive is available for all eligible General Practitioners (GPs) who take on a patient that does not have a family physician, and meet the supplied criteria:

Category	Code	Description	Payment
DEFT	UPB1	Unattached Patient Bonus Payment Program	$150.00 (one time per patient)

Billing Guidelines

- The GP has had an established community-based family practice for at least one year prior to taking the Unattached Patient into his/her practice.

- The GP agrees to take the Unattached Patient into his/her practice following an inpatient or emergency department hospital encounter where the patient has been identified as an Unattached Patient. The hospital encounter may have been directly with the GP or the GP may agree to take on the patient through a referral from the hospital.

- The GP keeps the Unattached Patient in his/her practice and maintains an open chart for the patient for a minimum of one year.

The GP is considered to have taken on the patient on the date of the initial office visit. The Unattached Patient Bonus may be claimed at the time of the initial visit.

The Unattached Patient Bonus fee is billable in addition to the associated visit fee.

The Unattached patient Bonus may be claimed by eligible GPs paid by fee-for-service and alternative payment plan contracts.

Eligible APP Physicians will be required to shadow bill the new fee code in order to receive payment under this incentive program. Eligible claims will be reviewed and paid twice per year in the form of a cheque from MSI. Estimated payment dates for this incentive program for APP physicians are December and June of each year, with the first payments beginning in December 2009.

The Unattached Patient Bonus may not be claimed by Locum Physicians.

Starting July 14, 2009, the GP is expected to confirm and document at the initial visit with the Unattached Patient that the patient is unattached (i.e. does not already have a regular family physician). Information about the hospital encounter that resulted in the GP taking the Unattached Patient into his/her practice should also be recorded in the patient's record. This can be a referral form from the hospital emergency department, an inpatient hospital report or other documentation.

For Unattached Patients taken into a GP practice from July 1, 2008 to July 14, 2009, the Unattached Patient Bonus fee may be claimed retroactively. Documentation of the patient's unattached status and the associated hospital encounter, if not recorded on the patient's record, is not required for payment, however all other eligibility criteria must be met.

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

ADJUSTMENTS TO EXISTING HEALTH SERVICE CODES

Listed in the July 10, 2009 bulletin were new Health Service Codes 50.0A, 50.6D, 48.0J, and 06.39D with an effective date of April 01, 2009. This effective date has now been changed to January 1, 2009. All services with a date of January 1, 2009 to March 31, 2009 that have been held should now be submitted in the usual manner. Please include text referring to this bulletin for services over the 90-day time frame.

Effective July 1, 2009, Health Service Code 07.08C (Nerve conduction studies, per nerve studied) has changed from an ADON to a VADT. The unit value for this procedure has increased to 27 units, with a maximum of 6 multiples.

Category	Code	Description	Unit Value
VADT	07.08C	Nerve conduction studies, per nerve studied	27

Claims previously submitted with a date of July 1, 2009 to October 1, 2009 will be identified and re-assessed by MSI staff to ensure correct payment.

Also effective July 1, 2009, the following Health Service Codes have been revised to include multiples (up to a maximum of 4):

Category	Code	New Description	Unit Value	
MASG	93.71A	Replacement of metacarpophalangeal or interphalangeal joint of hand by synthetic prosthesis – single (regions required) plus multiples if applicable	150	4+T
MASG	94.44A	Suture flexor tendon – single (regions required) plus multiples if applicable	106	4+T
MISG	94.45A	Suture extensor tendon – single (regions required) plus multiples if applicable	50	4+T
MASG	94.55D	Tendon transfer – single (regions required) plus multiples if applicable	96	4+T

With these revisions, Health Service Codes 93.71B, 94.44B, 94.44C, 94.45B, 94.45C, and 94.55E are no longer necessary and have been termed for June 30, 2009, *Claims previously submitted with a date of July 1, 2009 to October 1, 2009 will be identified and re-assessed by MSI staff to ensure correct payment.*

CASE MANAGEMENT CONFERENCE FEE – UPDATE

Effective July 22, 2009, the Case Management Conference Fee payment has been expanded to include all conferences which are called and coordinated by Directors of Nursing or Directors of Care in all eligible Long Term Care facilities. Physicians may now claim the Case Management Conference Fee for their participation in conferences called by these individuals.

The radiologist specialties that were previously unable to bill this fee can now submit their claims.

All services with a date of January 1, 2009 onward that have been held should now be submitted in the usual manner. Please include text referring to this bulletin for services over the 90-day time frame.

Just a reminder for the year 2009-2010 the case management conference fee (03.09D) pays at 14.75 units for General Practitioners and at 16.75 units for Specialists.

ICU CODES FOR "STEP-DOWN" PATIENTS

The Intensive Care Codes are intended for use by physicians when claiming for services rendered in intensive care units (ICUs) approved by the Department of Health (see section 7.91 of the Preamble). It has come to the attention of MSI that some physicians are claiming these ICU codes for services rendered to patients who are not physically in an intensive care unit but are in step-down or intermediate units. This practice is contrary to the Preamble rules and such services will be subject to audit.

At present, there are no codes specifically designated for patients in step-down or intermediate care units. If felt to be appropriate, an application for such fee codes should be made to the Fee Schedule Advisory Committee as outlined on page 7 of the May 7, 2009 Physicians' Bulletin.

SERVICES WITH RO=INTP

For clarification purposes, any claim with the modifier RO=INTP (role = interpretation) must be submitted with the date the services were performed and not the date of interpretation.

ASSISTANT CLAIMS WITH DIAGNOSTIC AND THERAPEUTIC PROCEDURES

It has come to the attention of MSI that assistant claims are being submitted by physicians when Diagnostic and Therapeutic (D&T) procedure are performed. Physicians are reminded that service encounters by assistants are not applicable to such procedures with exceptions as outlined in Section 9.2.6 of the Preamble of the Physician's Manual.

GP SURGICAL ASSIST INCENTIVE PROGRAM – 2009/10

The GP Surgical Assist Incentive Program will maintain the majority of the 2008/09 program principles while being restructured to provide an incentive payment for all GP's who carry out surgical assist.

Starting in fiscal year 2009/10, GP surgical assist incentive payments will be provided to all eligible GP's as follows:

- All GP's who provide surgical assists during the year will receive an incentive payment for providing elective (non-premium time) surgical assists. Qualifying surgical assists billings up to a maximum of $30,000 per physician per year will be eligible for an incentive payment.
- GP's who meet the criteria of total MSI payments of $75,000 during the year, including office billings of $25,000 or more, will receive an incentive payment of 40% of their individual qualifying surgical assist billings.
- GP's who do not meet the criteria of total MSI payments of $75,000 during the year, including office billings of $25,000 or more, will receive an incentive payment of 20% of their individual qualifying surgical assist billings.
- All surgical assist payments will be based on surgical assist billings for the period April 1 to March 31 and will be paid out by the following July 30.

GP COMPLEX CARE VISIT FEE - UPDATE

Effective October 2, 2009, the General Practice Complex Care Visit Fee (which can be claimed four times per patient per fiscal year) will no longer be tracked automatically by MSI's billing system. Physicians are now responsible to track their own Complex Care Visit claims to ensure they do not exceed the allowable maximum of four claims per patient in one fiscal year (April 1 – March 31). As with all MSI claims, Complex Care Visit claims will be subject to audit, making independent tracking by the physician very important.

Because the MSI system tracks claims based on a 365 day rolling year rather than the Master Agreement's fiscal year, some Complex Care Visit claims may have been rejected. Physicians who have had Complex Care Visit claims rejected in the past year as a result of MSI's 365 day rolling year rule can resubmit these claims starting October 2, 2009.

Please take note that physicians must have their resubmitted claims (any claim over 90 days) in to MSI within 90 days from the date of this bulletin as well as including text on the resubmitted claims referencing the October 2 MSI Bulletin.

GENERAL PRACTICE REMOTE PRACTICE ON-CALL – UPDATE

As per the current Master Agreement, Schedule "G" the Community Remote Practice On-Call program in effect as of March 31, 2008, will be continued in its current form, until March 31, 2010. As of April 1, 2010, the rule/criteria regarding 45km radius from the nearest hospital emergency department, in order to determine eligibility for funding, will be strictly enforced.

Also, no new physicians or locations will be added to the program until such time as the On-Call Program Redesign Working Group presents to the Master Agreement Steering Group, any proposed changes to this program.

ELECTRONIC MEDICAL RECORDS (EMR) – UPDATE

The 2008 – 2013 Physician Services Master Agreement between the Department of Health and Doctors Nova Scotia contains funding provisions for Electronic Medical Records.

In year two of this agreement, there is a commitment to provide additional funding through an Annual EMR Utilization Grant. This particular funding is designed to recognize and value the extent of defined EMR Utilization. The eligibility and payment criteria for this year two grant are close to being complete, but not yet finalized. For now, physicians are encouraged to maximize the use of their electronic medical records. From patient charting, to e-lab results to medication management, increased use will likely result in increased payments. In the coming months, current EMR users will be asked to complete a self-assessment survey to report on their current EMR use as a means to determine eligibility and payment levels.

EXPLANATORY CODES

The following new explanatory code has been added to the system:

DE012	Service encounter has been refused as there is already one unattached patient bonus payment claim on history

UPDATED FILES – AVAILABILITY

Updated files reflecting changes are available for download on Friday, October 2nd, 2009. The files to download are health service (SERVICES.DAT), health service description (SERV DSC.DAT), explanation code (EXPLAIN.DAT), and modifier values (MODVALS.DAT)