PHYSICIAN'S BULLETIN

May 14 2020: Vol. LXV, ISSUE 11

NOVA SCOTIA MEDICAL SERVICES INSURANCE

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AS WE CONTINUE TO WORK THROUGH THE COVID-19 PANDEMIC, PLEASE CLICK HERE FOR AN FAQ ON COVID-19 BILLING. THANK YOU FOR YOUR DEDICATION IN THIS UNPRECEDENTED TIME.

★ Fees New Fees, Updated Fees and Fee Revisions

NEW FEE

Effective May 14th 2020 the following fee is available for billing:

Category	Code	Description	Base Units
VIST	03.04J	**Comprehensive Diagnostic Evaluation of Suspected Autism Spectrum Disorder** **Description** This is a comprehensive health service code for the developmental paediatrician who is present for all components of the diagnostic evaluation and assessment of patients referred with suspected autism disorder performed by a multidisciplinary team at the IWK Health Centre. This service is expected to encompass at least three hours of time with the patient and care providers plus one hour for scoring of assessment tools. This HSC may be reported only when the physician's time has been dedicated to this service encounter and no other concurrent clinical work. Time to generate a report and recommendations is considered to be included in the service. Start and stop times must be recorded in the health record. **Billing Guidelines** Reportable no more than once per patient per 12 month period. **Specialty Restriction:** Developmental Paediatrics trained in the administration of the Autism Diagnostic Interview **Location:** Restricted to IWK Health Centre LO=OFFC, LO=HOSP	284 MSU

UPDATED FEES

Effective March 6, 2020 billing guidelines have been updated to permit a surgical assistant for this service. Physicians who have been holding their SRAS claims since March 6 have 90 days from the date of this bulletin to submit.

Category	Code	Description	Base Units
VEDT	50.0B	**Endovascular Thrombectomy-Intracranial** **Description** Endovascular Thrombectomy for the purpose of revascularization of a thrombotic or embolic occlusion of one or more intracranial vessels. This comprehensive health service code includes: Selective catheterization, diagnostic angiography and all selective angiography required to perform the procedure within the vascular territory. SRAS allowed at usual rate (no specialty restriction on surgical assistant) **Specialty Restriction** Neuroradiology (DIRD with subspecialty in neuroradiology) **Location** LO=HOSP (QEII only)	300 MSU

Effective March 6, 2020 billing guidelines for 13.59O have been updated:

Category	Code	Description	Base Units
VEDT	13.59O	**Injection of OnabotulinumtoxinA for the Treatment of Chronic Migraine (Prior Approval)** **Description** This is a comprehensive code for the assessment and treatment of adults with a documented history of chronic migraine, defined as having greater than or equal to 15 headache days per month over at least a three month period, and who have not responded to at least three prior pharmacological prophylaxis therapies or for patients who are intolerant of pharmacological prophylaxis. This code includes patient assessment and counselling, preparation of ONA injections, performing all injections using the appropriate protocol, and patient observation prior to discharge. The physician must request prior approval in writing. The request must include: • The patient's clinical history of Chronic Migraine. • Documentation of previous attempts at pharmacological prophylaxis including the names of medication, duration of treatment and results. • If this is a subsequent request for continued treatment, documentation of treatment effect must be included. **Billing Guidelines** • Prior approval will be valid for treatment provided to that patient for a period of 24 months. • No more than 11 service encounters for injection of ONA for Chronic Migraine may occur over that 24 month period. • Services to be no more frequent than every 10 weeks. • If treatment continues to be recommended after this time period, prior approval must be requested again. Once a request for approval has been made to the MSI Medical Consultant, a response will be issued. If approval is granted you will be advised of a Preauthorization Number. To ensure payment of the service the Preauthorization Number must be entered in the appropriate field on the service encounter. **Specialty Restriction** SP=NEUR **Location** LO=OFFC	70 MSU

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FEE REVISIONS

The following health service codes have title and/or description changes. These changes replace any previously published language effective immediately. These title updates will reflect in the July migration.
Health service codes 03.38A,B,C have expanded specialty restrictions, these will also reflect in the July migration.

Category	Code	Description	Base Units
ADON	03.03S	**First Visit After Acute Care In-Patient Hospital Discharge – Complex Care**	10 MSU

Description:
This is an additional fee for the first office visit of the patient requiring ongoing complex care within 14 days of acute care in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care.

- The physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days.
- Not reportable in the walk-in clinic setting

A complex care patient is defined as:

- A patient with multiple (two or more) chronic conditions as defined below:
  - A condition expected to last one year or more
  - This condition requires ongoing medical management

Billing Guidelines:
ADON restricted to:

- 03.03 Office Visit
- 03.03A Geriatric Office Visit
- 03.03E Adults with Developmental Disabilities

- Reportable only if the visit occurs in the primary care physician's office or the patient home within 14 calendar days after hospital discharge (consider discharge date as day zero).
- Hospital length of stay must be greater than or equal to 48 hours.
- Not reportable if the admission to hospital was for the purpose of performing elective surgery (major or minor) or fracture care (major or minor)
- Not reportable if the admission to hospital was for the purpose of obstetrical delivery.
- Not reportable if the admission to hospital was for the purpose of newborn care.
- Not reportable for services rendered in other locations such as Nursing Homes, Residential Care Facilities, or Hospice.
- The physician claiming the service must be the provider most responsible for the patient's ongoing complex care.
- Claimable once per patient per inpatient admission.
- Not reportable for any subsequent discharges within 30 days.
- Not reportable in the same month as other monthly care fees – such as 13.99C
- Maximum of 4 claims per physician per patient per year.

Specialty Restriction:
SP=GENP

Location:
LO=OFFC, LO=HOME

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Category	Code	Description	Base Units
ADON	03.03P	**First Visit After In-Patient Hospital Discharge – Maternal and Newborn Care** **Description:** This is an additional fee for the first maternal/newborn office visit within 14 days of in-patient hospital discharge to the primary care provider responsible for the patient's ongoing care. ○ The primary care physician or their office staff should make every effort to communicate with the patient and/or caregiver within 2 business days of discharge to better facilitate the patient being seen within 14 days. ○ Not reportable in the walk-in clinic setting **Billing Guidelines:** ADON restricted to: ○ 03.03 Office Visit ○ 03.03 Well Baby Care ○ Reportable only if the visit occurs in the primary care physician's office or the patient home within 14 calendar days after hospital discharge (consider discharge date as day zero). ○ Only reportable if the reason for admission to hospital was for the purpose of obstetrical delivery. ○ Physician must be the provider most responsible for the mother and child's ongoing care. ○ Claimable once per patient per inpatient admission for obstetrical delivery. ○ Not reportable for any subsequent discharges within 30 days. ○ Maximum of 1 claim per pregnancy (mother) ○ Maximum 1 claim per infant **Specialty Restriction:** SP=GENP **Location:** LO=OFFC, LO=HOME	10 MSU

Category	Code	Description	Base Units	Anaes Units
MASG	71.7F	**Cystoscopy with Intravesicular Injection(s) of Chemodenervating Agent** **Description:** Cystoscopy with intravesicular injection(s) of chemodenervating agent, for example onabotulinumtoxinA, under direct vision. Includes urethroscopy. **Billing Guidelines:** Not to be reported with other cystoscopy related HSCs, for example: ○ 01.34A, 01.34B, 01.34C, 01.34G Not to be reported with urethroscopy: ○ 01.35, 01.35A **Specialty Restriction:** SP=UROL, SP=OBGY **Location:** LO=HOSP	90 MSU	4+T

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Category	Code	Description	Base Units
VIST	03.04F	**Complex Comprehensive Acute Care Hospital Discharge**	45 MSU

Description:
This complex comprehensive acute care hospital discharge code is intended to be used when services provided on the day of discharge require greater than 30 minutes of the physician's time. This HSC includes all services provided to the patient on the day of discharge from the acute care hospital. These services include the discharge day examination of the patient, the completion of the patient's chart, discharge summary, writing any prescriptions required for the patient, providing discharge instructions to the patient (or caregivers) and arranging for follow-up care for the patient. Every effort is made by the discharge physician to communicate with the community physician who will be most responsible for the patient's care after discharge.

It is recognized that for complex comprehensive discharges, the discharge process may occur over 2 days. For example, the discussion of the hospital stay, instructions for continuing care to all relevant caregivers, and preparation of discharge summary, prescriptions and referrals may be completed on one day and the final examination of the patient and discharge order the following day. If this situation arises, the code must be reported on the date of discharge, the cumulative time spent must be greater than 30 minutes, the code may only be claimed once by the MRP and may not be unbundled to accommodate splitting the workload.

- A visit is considered an integral part of this service and is not reportable in addition.
- Documentation of the services provided and time spent must be documented in the health record.

Billing Guidelines:
Preamble rules 5.1.30 – 5.1.31 apply. Not reportable if the patient is admitted and discharged on the same day or 24 hour period.

- Reportable by the Most Responsible Physician only. The MRP is defined as the physician in charge of the patient's care for any given day (24 hour period).
- Only once per patient per inpatient hospital admission.
- The physician claiming this health service may not report any other visit service for the same patient, same day. In addition, HSC 03.02A (Hospital Discharge Fee) may not be claimed as the service is included in the Complex Comprehensive Acute Care Hospital Discharge HSC.
- Efforts made to establish communication with the health care provider who will be most responsible for the patient's care after discharge must be documented in the health record.
- Not reportable for hospital deaths.

Do not count time for services provided after the patient physically leaves the hospital.

Specialty Restriction:
SP=GENP

Location:
LO=HOSP, FN=INPT

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FEE REVISIONS (CONTINUED)

Category	Code	Description	Base Units
VEDT	03.38A	**Bronchial Challenge Testing with methacholine or similar compounds – includes baseline spirometry and all spirometric determinations post administration of agent(s)** RO=INTP **Description:** This fee is for the interpretation of the testing and written report. The physician must be present in the pulmonary function laboratory during the time of the testing to be available to deal with adverse events. **Billing Guidelines:** Billable once per patient per day. Not to be billed with any additional spirometry same patient same day. ○ I1110 Simple Spirometry ○ I1140 Flow Volume Loops Billable only when testing is done in the hospital based pulmonary function laboratory. **Specialty Restriction:** SP=INMD, SP=PEDI, SP=RSMD **Location:** LO=HOSP	19 MSU
VEDT	03.38B	**Exercise Induced Asthma Assessment, interpretation. Includes interpretation of all serial spirometry, flow/volume loops, bronchodilation responsiveness, and oximetry required to assess the patient.** **Description:** This code is used to report the interpretation of all spirometry, including simple spirometry and flow/volume loops, oximetry, and bronchodilation responsiveness, as required to properly assess the response of the patient to exercise. **Billing Guidelines:** Only for the interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190) Do not report with: ○ I1110 Simple Spirometry ○ I1140 Flow/Volume Loops ○ 03.38C Interpretation of Spirometry Pre and Post Bronchodilator **Specialty Restriction:** SP=INMD, SP=PEDI, SP=RSMD **Location:** LO=HOSP	20 MSU
VEDT	03.38C	**Interpretation of Spirometry Pre and Post Bronchodilator** **Description:** This code is used to report the interpretation of spirometry, including simple spirometry and flow/volume loops, before and after the administration of a bronchodilator. This includes all testing required to properly assess the response of the patient. **Billing Guidelines:** Only for the interpretation of tests performed in a hospital pulmonary function laboratory (Preamble 5.3.190) Do not report with: ○ I1110 Simple Spirometry ○ I1140 Flow/Volume Loops ○ 03.38B Exercise testing for assessment of asthma **Specialty Restriction:** SP=INMD, SP=PEDI, SP=RSMD **Location:** LO=HOSP	10 MSU

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Category	Code	Description	Base Units	Anaes Units
MASG	76.95C	**Inflatable Penile Prosthesis-Insertion of all Components (Pump, Cylinders and Reservoir)**	230 MSU	6+T
MASG	76.96C	**Inflatable Penile Prosthesis – Removal of any or all Components (Pump, Cylinders and Reservoir) with or without Reinsertion**	IC	6+T

Description:
These HSC's are specific to the insertion, and/or removal, with or without re-insertion, of an inflatable penile prosthesis with all its components (pump, cylinders and reservoir) to include any urethral dilation required to insert the device.

Billing Guidelines:
Cystoscopy, when required, may be reported in addition to this HSC.
For the removal with or without reinsertion of an inflatable penile prosthesis (any or all components-pump, cylinders and reservoir) IC will be paid at 130 MSU/hr based on surgical start and stop time as documented in the record of operation which must be submitted with the claim.

Specialty Restriction:
SP=UROL

Location:
LO=HOSP

Category	Code	Description	Base Units	Anaes Units
MASG	57.59B	**Low Anterior Resection of Rectosigmoid with Low Pelvic Anastomosis (coloproctostomy)** RO=FPHN RO=SPHN	 405 MSU 300 MSU	8+T

Description:
Anterior resection of the rectosigmoid including mobilization of the colon, identification of the ureter, dissection of mesocolic vessels, with anastomosis of the bowel including all stapling as required (EEA stapler).
When an ileostomy is required an ADON fee may be used to bill for this portion of the procedure.
To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.

Billing Guidelines:
Not to be billed with:
- 01.24C Sigmoidoscopy
- 58.11 Colostomy
- 58.21 Ileostomy for ulcerative colitis
- 58.39A Ileostomy with tube

Surgical Assistant only billable when RO=SPHN is not billed

Specialty Restriction:
RO=FPHN restricted to SP=GNSG
RO=SPHN restricted to SP=GNSG

Location:
LO=HOSP

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Category	Code	Description	Base Units	Anaes Units
MASG	57.6D	**Total Proctocolectomy with Ileostomy and Abdominal Perineal Resection** RO=FPHN RO=SPHN	 550 MSU 400 MSU	8+T

Description:
This fee is for the complete resection of the entire colon, rectum, and anus with perineal dissection to remove the anal sphincter, and the creation of an ileostomy. Includes mobilization of colon, identification of ureter, dissection of mesocolic vessels, division and suture of bowel, excision of rectum and anus, omental flap for repair as required.
To bill as SPHN, the second surgeon must actively participate for 75% of the procedure time. When the second surgeon fee is billed no other assistant fee may be billed.

Billing Guidelines:
Not to be billed with any other fees for resection or suture of bowel or formation of ileostomy on the same patient same day, i.e. HSC's:

- 57.04(A or B) Enterotomy or Colostomy or Multiple Colotomy
- 57.42(A or B) Enterectomy with anastomosis
- 58.52 Closure enterostomy plus resection
- 58.53 Closure of colostomy
- 58.73 Other suture of intestine

Not to be billed with:

- 01.24C Sigmoidoscopy
- 58.21 Ileostomy for ulcerative colitis
- 58.39A Ileostomy with tube
- 66.64(A or B) Omental flap to repair extra-abdominal defect

If reported with Vaginectomy or vaginal reconstruction the operative report and record of operation must be submitted for manual assessment, i.e.HSC's:

- 82.23 Excision of lesion of vagina
- 82.3 (also A, B, C) Obliteration of vagina
- 82.52 Vaginal reconstruction
- 82.62 Repair of fistula of vagina
- 82.69(A or B) Vaginoplasty

Assistant only billable when RO=SPHN is not billed

Premium:
No – but if service is provided in premium time for medical necessity, OR report and Time Sheet may be submitted.

Specialty Restriction:
RO=FPHN restricted to SP=GNSG
RO=SPHN restricted to SP=GNSG

Location:
LO=HOSP

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Category	Code	Description	Base Units
VIST	03.03R	**Family Physician Telephone Management/Follow Up with Patient** **Description:** This health service code may be reported for a 15 minute telephone communication between the family physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face visit by the same physician within the last 9 months and has not been seen within the last 7 days for the same condition. This telephone communication is intended to take the place of an office visit initiated by the patient (or the patient's parent, guardian or proxy as established by written consent) for a new condition or exacerbation of an existing condition, or a follow up visit that would have otherwise been scheduled by either the physician or the patient, when a physical examination is not required. The patient population eligible must be either 65 years and older or be suffering from mental illness or suffering from at least one chronic disease. Chronic disease is defined as: o A condition expected to last one year or more o This condition requires ongoing medical management Mental illness is defined as: o A condition that meets criteria for a DSM diagnosis. The service is not reported if the decision is to see the patient at the next available appointment in the office. **Billing Guidelines:** This health service is reportable for a synchronous communication by telephone (or other PHIA compliant synchronous electronic verbal communication) between the family physician and the patient (or the patients parent, guardian or proxy as established by written consent) Telephone management requires synchronous communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks. The call must include a discussion of the clinical problem and management decision. The family physician must have seen and examined the patient within the preceding 9 months. The HSC is reportable for a maximum of 4 times per patient per year by the family physician and/or the practice providing ongoing comprehensive care to the patient. The HSC is not reportable by walk-in clinics. Walk-in clinics are defined as clinics/offices characterized by extended hours of operation, no requirement for an appointment, and episodic care with little or no follow-up. There is no standard patient roster and the patient list is constantly changing. The HSC is not reportable for facility based patients. The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day. The service is not reportable when the purpose of the communication is to: o Arrange a face-to-face appointment o Notify the patient of an appointment o Prescription renewal o Arranging to provide a sick note o Arrange a laboratory, other diagnostic test or procedure o Inform the patient of the results of diagnostic investigations with no change in management plan This service is not reportable for other forms of communication such as: o Written, e-mail or fax communication o Electronic verbal forms of communication that are not PHIA compliant.	11.5 MSU

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The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:

- Nurse Practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of synchronous medical discussion

Documentation Requirements:

- The date, start and stop times of the conversation must be noted in the medical record
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- The start and stop time of the call must be included in the text field of the MSI claim

Specialty Restriction:
SP=GENP

Location:
LO=OFFC

VIST	03.03Q	**Specialist Telephone Management/Follow Up with Patient**	11.5 MSU

Description:
This health service code may be reported for a 15 minute telephone communication between the specialist physician and an established patient (or the patient's parent, guardian or proxy as established by written consent) who has previously had a face to face consultation, visit or procedure by the same physician within the last 9 months and has not been seen within the last 7 days. This service is not reported if the outcome of the call is to see the patient at the next available appointment in the office. This communication is intended to take the place of an office follow up visit that would have otherwise been scheduled, when a physical examination of the patient is not required.

Billing Guidelines:
This health service is reportable for a synchronous communication by telephone (or other PHIA compliant synchronous electronic verbal communication) between the specialist physician and the patient (or the patient's parent, guardian or proxy as established by written consent)
Telephone management requires synchronous communication between the patient and physician on a clinical level; the HSC is not reportable for administrative tasks.
The call must include a discussion of the clinical problem and management decision.
The specialist physician must have seen and examined the patient within the preceding 9 months.
The HSC is reportable for a maximum of 4 times per patient per physician per year.
The HSC is not reportable for facility based patients.
The HSC is not reportable in addition to any other service for the same patient by the same physician on the same day.
The service is not reportable when the purpose of the communication is to:

- Arrange a face-to-face appointment
- Notify the patient of an appointment
- Prescription renewal

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- Arrange a laboratory, other diagnostic test or procedure
- Inform the patient of the results of diagnostic investigations with no change in management plan

The service is reportable only when the communication is rendered personally by the physician reporting the service and is not reportable if the service is delegated to another professional such as:

- Nurse Practitioner
- Resident in training
- Clinical fellow
- Medical student
- Clerical staff

The service is not reportable for telephone calls of less than 5 minutes of synchronous medical discussion.

Documentation Requirements:

- The date, start and stop times of the conversation must be noted in the medical record
- The medical record must indicate the content of the discussion, the management plan and that the patient (or the patient's parent, guardian or proxy as established by written consent) understands and acknowledges the information provided.
- A written report must be sent to the referring physician or family physician by the specialist consultant
- The start and stop time of the call must be included in the text field of the MSI claim

Location:
LO=OFFC

Category	Code	Description	Base Units	Anaes Units
MISG	23.99B	**Injection of Chemodenervating Agent into Extraocular Muscles for Strabismus** AG=CH03 **Description:** Chemodenervating agent (for example, onabotulinumtoxinA) injection of the extraocular muscle(s) for strabismus, unilateral or bilateral, in patients up to three years of age. **Specialty Restriction:** Paediatric OPTH **Location:** LO=HOSP	25 MSU	4+T

NOTE:

HEALTH SERVICE CODE CPO1 IS UNDER REVIEW AND WILL BE UPDATED IN A FUTURE BULLETIN.

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NEW AND UPDATED EXPLANATORY CODES

Code	Description
VT170	SERVICE ENCOUNTER HAS BEEN REFUSED AS HSC 03.04J HAS ALREADY BEEN APPROVED FOR THIS PATIENT IN THE PREVIOUS 12 MONTHS.
VE020	SERVICE ENCOUNTER HAS BEEN REFUSED AS AN INJECTION OF ONA FOR CHRONIC MIGRAINE HAS ALREADY BEEN APPROVED IN THE PREVIOUS 10 WEEKS.
VE021	SERVICE ENCOUNTER HAS BEEN REFUSED AS NO MORE THAN 11 INJECTIONS OF ONA FOR CHRONIC MIGRAINE MAY BE CLAIMED OVER A 24 MONTH PERIOD. IF TREATMENT CONTINUES TO BE RECOMMENDED AFTER THIS TIME PERIOD, PRIOR APPROVAL MUST BE REQUESTED AGAIN.

In every issue Helpful links, contact information, events and news, updated files

UPDATED FILES

Updated files reflecting changes are available for download on Thursday May 14th, 2020. The files to download are:
Health Service (SERVICES.DAT), Health Service Description (SERV_DSC.DAT), and, Explanatory Codes (EXPLAIN.DAT).

CONTACT INFORMATION

NOVA SCOTIA MEDICAL INSURANCE (MSI)

Phone: 902-496-7011
Toll-Free: 1-866-553-0585
Fax: 902-490-2275
Email:
MSI_Assessment@medavie.bluecross.ca

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS

Phone: 902-424-5818
Toll-Free: 1-800-387-6665
(In Nova Scotia)
TTY/TDD: 1-800-670-8888

HELPFUL LINKS

NOVA SCOTIA MEDICAL INSURANCE (MSI)
http://msi.medavie.bluecross.ca/

NOVA SCOTIA DEPARTMENT OF HEALTH AND WELLNESS
https://novascotia.ca/dhw/

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